ADULT SERVICES AND HEALTH SCRUTINY PANEL

Venue: **Bailey House, Rawmarsh Road, Rotherham. S60 1TD**

Date: **Thursday, 21 January 2010**

Time: **10.00 a.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Apologies for Absence and Communications.

4. Declarations of Interest.

5. Questions from members of the public and the press.

6. Health Services provided to People with Dementia (herewith) (Pages 1 - 5)
   A themed meeting based on the following questions:

   - How is your organisation equipped to meet the needs of dementia patients?
   - How do you work with other healthcare providers to ensure the best care for this group of patients?

   Representatives from Rotherham's local health trusts will give presentations to answer the key questions above, with each presentation being followed by questions from Panel and LINk members.

   - Dominic Blaydon, Programme Manager – Long Term Conditions, NHS Rotherham

   - Jan Smith, Assistant Director, Older People's Mental Health Services, Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust

   - Trisha Bain, Deputy Chief of Quality and Standards, Carol Lavelle, Project Lead, InterQual The Rotherham NHS Foundation Trust, Jane Chantler, Business and Service Manager HealthCare For Older People

   - Steve Page, Director of Standards and Compliance, Yorkshire Ambulance Service NHS Trust

For Information Only

7. Strategic Review of Intermediate Care Services (herewith) (Pages 6 - 62)

8. Minutes of a meeting of the Adult Services and Health Scrutiny Panel held on 12th November 2009 (herewith). (Pages 63 - 69)

9. Minutes of a meetings of the Cabinet Member for Adult Social Care and Health held on 26th October 2009, 9th & 23rd November 2009 and 7th December 2009 (herewith). (Pages 70 - 96)

Date of Next Meeting:-
Thursday, 11 February 2010

Membership:-

Chairman – Councillor Jack
Vice-Chairman – Barron
Councillors:- Blair, Clarke, Goulty, Hodgkiss, Hughes, Kirk, Turner, Wootton and F. Wright

Co-opted Members

Mrs. I. Samuels, Kingsley Jack (Speakability), Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Taiba Yasseen, (REMA), Mrs. A. Clough (ROPES), Jonathan Evans (Speak up), Victoria Farnsworth (Speak Up), Mr. G. Hewitt (Rotherham Carers' Forum), Ms. J. Mullins (Rotherham Diversity Forum), Mr. R. H. Noble (Rotherham Hard of Hearing Soc.) and Parish Councillor Mrs. P. Wade

Agenda Item 6

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:**	**ADULT SERVICES AND HEALTH SCRUTINY PANEL**
2.	**Date:**	**21 January 2010**
3.	**Title:**	**Health Services provided to People with Dementia**
4.	**Programme Area:**	**Chief Executive's**

5. Summary

This report explains the approach and background to a themed scrutiny meeting on Health Services provided to people with dementia.

6. Recommendations

That the information gathered at the meeting forms the basis of the Panel's submissions to the Care Quality Commission relating to its assessment of NHS providers in 2009/10.

7. Proposals and Details

7.1 In late November 2009, the Care Quality Commission issued guidance on Scrutiny's involvement in the assessment of health and adult social care in 2009/10. It gives a deadline for OSC comments relating to NHS providers of the end of January 2010.

7.2 The scope for making comments is very broad, but it has been decided to use services provided to people with dementia as a focus for discussions at the meeting. This topic has recently been in the news (both locally and nationally) and will illustrate how well local health services are provided for vulnerable patients.

7.3 It is important to emphasise that the focus is not purely on dementia services - but will also include other NHS services provided to this group of patients. For example, a person with dementia may need to see his or her GP, may break a limb, have other long-term condition or require transport to an outpatient clinic etc. The way that different healthcare organisations work together is key to good patient care and treatment, so evidence of how this happens will be important to the discussion.

7.4 Representatives from the four local health trusts (NHS Rotherham, Rotherham Foundation Trust, Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust and Yorkshire Ambulance Service) will be each giving a presentation that answers the following questions:

- How is your organisation equipped to meet the needs of dementia patients?
- How do you work with other healthcare providers to ensure the best care for this group of patients?

7.5 The Panel is undertaking this piece of work in conjunction with the Rotherham Local Involvement Network. In advance of the meeting, the LINk will be asking its members about their experience of health services provided to people with dementia. LINk members will be attending the meeting to join Panel members in raising issues and ask questions based on their experiences.

8. Finance

The meeting will take the place of a scheduled Adult Services and Health Scrutiny Panel meeting and will therefore result in any additional costs.

9. Risks and Uncertainties

That comments to the CQC will be limited to the issues surrounding the care of people with dementia.

10. Policy and Performance Agenda Implications

Commenting on local health trusts' performance within the remit of health scrutiny committees.

11. Background Papers and Consultation

Voices into Action – your part in our assessment of health and adult social care 2009/10, Care Quality Commission, November 2009

Contact: *Delia Watts, Scrutiny Adviser, direct line: (01709) 822778*
e-mail: delia.watts@rotherham.gov.uk

Update on Dementia Services – Background Paper by Dominic Blaydon, Programme Manager

• There was a Yorkshire and Humber Regional Peer Review of the Rotherham Health and Social Care Community in relation to the National Dementia Strategy on 8th December 2009. The initial feedback is due on 23 December 2009, with the final report to be sent on 15 January 2010.

• There will then be a Yorkshire and Humber Best Practise Event on 9th March 2010, following which all Health and Social Care Communities will be expected to draft and submit an Action and Implementation Plan for improvement.

• This Peer Review has been used to establish a baseline from which to prioritise actions and measure improvements.

Key priorities emerging from the National Dementia Strategy that have implications for RFT;

• Early diagnosis essential and, therefore access to diagnostics. RFT's current wait time for MRI/CT Scans is approximately 10 days, with urgent scans done on demand.

• End of Life Pathway specifically for Dementia – as part of the Liverpool End of Life Care Pathway, a specialist pathway is being developed for patients with dementia. Recommendations are expected spring 2010.

• Staff training

• Providing services and care settings that specifically meet the needs of patients with dementia.

In terms of the current and planned RFT response to the National Dementia Strategy;

• A Dementia Collaborative is to be established within RFT – initial meeting planned for 28 January 2010 – the aim of the meeting is to map out care pathway for patients with dementia, identity any issues and discuss the needs and requirements of patients with this diagnosis to aid the development of an alternative level of care for these patients whilst in the acute setting. Key stakeholders across the whole health community will be participating.

• HCOP have identified a lead consultant for Dementia – Dr Hafiz

• There is a commitment to review care pathways, with joint working already established between RDASH and RFT. Dr Okwera (RFT) and Dr Simon Wright (RDASH) are already working together on how pathways and liaison can be improved.

• The Mental Health Liaison Team already in-reach into RFT, in particular in HCOP, to provide clear referral processes, to provide specialist advice, and to provide training.

In terms of training for RFT staff;

• HCOP have always supported the Alzheimer Course – over 60 staff have been through this training

• Unqualified staff will be accessing NVQ training in Dementia Care, which has been accredited through Sheffield Hallam University. There are currently 32 staff booked to go through this training.

• RDASH Mental Health Liaison Team will be facilitating a rolling training programme for qualified staff from January 2010 – this is a training programme accredited through Stirling University.

Good Practise;

• RFT recently won a BMJ Award for " Best Patient Information" in relation to their development of Dementia Diaries. This work is being built on with RDASH to have some joint information across the pathway.

As part of the RFT Falls Collaborative work , a 'managing dementia' podcast was developed for staff to issue to provide them with up to date information on managing patients with dementia in their care. This has been distributed to all HCOP wards.

ROTHERHAM BOROUGH COUNCIL – REPORT TO MEMBERS

1.	**Meeting:-**	**Adult Services and Health Scrutiny Panel**
2.	**Date:-**	**21st January, 2010**
3.	**Title:-**	**Strategic Review of Intermediate Care Services**
4.	**Directorate:-**	**Commissioning & Partnerships**

5. Summary

The purpose of the report is to seek ratification of the recommendations set out in the Strategic Review of Intermediate Care. The review makes recommendations on service reconfiguration which will improve current performance and strategic relevance.

6. Recommendations

It is recommended that the Adult Services and Health Scrutiny Panel:

- **Supports the recommendations set out in the Strategic Review and the positive impact this will have on service user outcomes and performance.**

7. Proposals and Details

Development of an Intermediate Care Hub

It is proposed that Day Care, Community Rehabilitation and Residential Teams are merged and co-located. A new multi-disciplinary health and social care team would be set up to support service users through the intermediate care pathway. The service would adopt the **Common Assessment Framework** and deliver integrated health and social care plans.

Millennium would become a dedicated hub for intermediate care services in Rotherham, providing day rehabilitation, a **Single Point of Access** and a focal point for all service delivery. There are significant benefits to this service model. It will establish a clear service identity with a range of services being delivered from the same site. Co-location of staff will facilitate effective communication and peer support. Greater integration will improve efficiency and help develop a person centred approach to rehabilitation.

The Strategic review recommends that a programme of refurbishment is carried out on Millennium to make it fit-for-purpose. It proposes that capital grant is transferred from the NHS Rotherham Operational Plan to Rotherham MBC to pay for the necessary works.

Reconfiguration of the Residential Service

It is proposed that Rothwel Grange is decommissioned as an intermediate care facility and that a new residential unit be developed at one of the new local authority residential units. The plan is to convert one wing of 15 beds into intermediate care provision by December 2009. This is dependent on vacancies becoming available during this timeframe. Vacancies are being held at present, and used for respite provision, in order to maintain bed occupancy.

The new-build homes are fully compliant with National Care Standards and the Disability Discrimination Act. Bedroom sizes are spacious, en-suite facilities are provided, doorways and corridors have been widened for the use of disability and bariatric equipment. There is also ramped access to the building.

It is proposed that Fast Response beds are decommissioned and that the savings made are reinvested to improve performance, outcomes and quality elsewhere in the service. There are a number of reasons why it is appropriate to decommission the service:

- The unit cost per patient is prohibitive.
- There is capacity in the intermediate care residential units to fill the gap left by loss of beds
- The intermediate care residential units can meet the needs of people referred into the service
- Reducing bed capacity will help improve performance on bed occupancy across the service
- Decommissioning will release savings that can be reinvested

Millennium Day Rehabilitation Service

It is proposed that the maintenance service is reconfigured so that it delivers time-limited rehabilitation and community integration programmes. The service will continue to provide day care services to current service users for up to 6 months. There are also 4 service users who originally attended the Crinoline House day centre in 1998. Upon closure of this centre, Elected Members promised that anyone who still wanted to attend in a social care capacity would be allowed to do so. Commissioners are fully supportive of honouring this agreement.

The new service will deliver time limited community integration and rehabilitation programmes, which focus on; improving physical function, training and support on healthy lifestyle, development of mental well-being, reducing social isolation, condition management and maintaining independence

Extending the Multi-Disciplinary Approach

It is proposed that the intermediate care team is enhanced so that it can deliver a broader range of health services. The service would introduce nurse practitioners, speech and language therapy and health support workers to support the residential service and those working in the community. The health support workers would deliver low level nursing **and** rehabilitation support.

8. Finance

The Joint Commissioning Team has carried out financial modelling on 3 options.

1. 5% reduction in the intermediate care pooled budget
2. Zero growth
3. £200,000 additional investment from the NHS Rotherham Operational Plan

Option 1 - 5% Reduction in the Intermediate Care Pooled Budget

A 5% reduction in the intermediate care pooled budget could be achieved by decommissioning the Ackroyd Fast Response beds and the spot purchase beds and not reinvesting savings back into the service. Benefits include: removing poorer performing service elements and delivering better value for money. However, adopting this option would mean that the service would not comply with new national guidelines for intermediate care. It would dilute a service that could have a direct impact on costs further down the care pathway. Finally NAS would have difficulty meeting rising level of need and demand from hospital discharge

Option 2 - Zero Growth

This assumes that there will be no additional revenue commitment from NHS Rotherham or Rotherham MBC but that savings from the decommissioning of Ackroyd and the spot purchase beds are reinvested. This option would remove poorer performing service elements, delivering better value for money. Reinvestment would assist the process of reconfiguration, making the service strategically relevant. Targeted reinvestment would improve performance and deliver savings in the social care economy. There would also be increased level of compliance with the new DH guidelines. However all nurse-led support would be removed from service. The service would still not comply with new national guidelines for intermediate care and additional income from NHS Rotherham could not be used to address strategic objectives of NAS.

Option 3 - £200,000 Investment from the NHS Rotherham Operational Plan

This option incorporates additional investment from NHS Rotherham to incorporate specialist nurses, speech and language therapy and health support workers into the intermediate care service. It would assist the service in supporting people with nursing needs, reducing likelihood of hospital admission. This service model would be more likely to generate savings further down the care pathway. It would deliver full compliance with new DH guidance on intermediate care and full implementation of the intermediate care review.

9. Risks and Uncertainties

The key risks associated with reconfiguration of the current service are:

- Inability to obtaining capital investment for the refurbishment of the Millennium Centre could obstruct co-location of workers and the development of an intermediate care hub
- Removal of nurse-led beds reduces level of compliance with national guidance and Better Health Better Lives
- Reduction in the Millennium Maintenance Service could be politically sensitive

The risk associated with obtaining capital investment could be addressed by transfer of capital grant from NHS Rotherham to Rotherham MBC from NHS Rotherham's Operational Plan. The risks associated with decommissioning nurse-led beds could be mitigated by the addition of nurse practitioners into the intermediate care team.

10. Policy and Performance Agenda Implications

The Strategic Review responds to recent DH guidance on intermediate care "Halfway Home". The guidance places greater emphasis on preventing admission to residential or nursing care. It calls for greater integration between health and social care and states that the intermediate care pathway should have a single point of access, which filters out inappropriate referrals and signposts people to an appropriate part of the service. The Review addresses each of these issues, setting out proposals which will make the service compliant.

Effective intermediate care services have a positive impact on the following indicators from the Adult Social Care Self Assessment Survey. The following indicators relate to the number of people funded by the Local Authority:

- Number receiving non-residential intermediate care to prevent hospital admission
- Number receiving intermediate care in a residential setting to prevent hospital admission
- Number receiving non-residential intermediate care to facilitate hospital discharge
- Number receiving intermediate care in a residential setting to facilitate hospital discharge

The Outcomes Framework highlights where effective intermediate care services can have most impact on the performance of Rotherham MBC. Key performance characteristics for performing excellently on Outcome 1: Improved Health and Well Being include:

- Consistently low numbers of people who have to go into hospital for preventable reasons
- Low number of people whose hospital discharge is delayed due to lack of social care
- Well developed services to prevent avoidable admissions and support independent living
- Well developed rehabilitation services across the area
- Levels of permanent care home placement are low.

Intermediate care also has an impact on the National Local Government Indicators

NI 125	Achieving independence through rehabilitation
NI 131	Delayed transfers of care from hospital
NI 132	Timeliness of social care assessments
NI 133	Timeliness of social care packages following assessment
NI 134	The number of emergency bed days per head of weighted population
NI 139	Older people receiving the support they need to live independently

11. Background Papers and Consultation

Strategic Review of Intermediate Care
DH Guidance on effective Intermediate Care Services: "Halfway Home"

Contact Name : Dominic Blaydon – Joint Commissioning Team

Strategic Review
Intermediate Care Services

October 2009

Table of contents

Introduction

The Joint Commissioning Strategy and Better Health Better Lives identifies the development of effective intermediate care services as a transformational initiative. This review is a key step towards implementation of this priority.

Section 1 considers the strategic framework within which the intermediate care service operates. It provides a definition of intermediate care and looks at what local strategy documents say about future service development.

Section 2 sets out projections on future health and social care need. It explains why intermediate care services are so important if we are to meet the demographic challenges of the next 10 years. There is a significant amount of evidence that suggests that the costs of home care, residential care and secondary care will be unsustainable unless we can reduce need through rehabilitation.

Section 3 considers the implications of Department of Health guidance “Halfway Home”. This document provides a revised definition of intermediate care. It sets out the key components of a good intermediate care service and provides evidence of effectiveness.

Section 4 maps current provision in Rotherham. It identifies and explains the function of each service element; the residential service, community rehabilitation, the Millennium day rehabilitation and maintenance services, the fast response beds and the intermediate care GP service.

Section 5 benchmarks the Rotherham intermediate care service against neighbouring PCTs. The Joint Commissioning Team visited services from Leeds, Sheffield and Bassetlaw.

Section 6 focuses on current performance. It looks at progress that has been made since the service was last reviewed and identifies areas of performance that still require attention. This chapter also considers the overall effectiveness of the performance management framework for intermediate care.

Section 7 contains a full gap analysis of the service. It identifies areas where reconfiguration, disinvestment or reinvestment are required and makes a range of recommendations for service change.

Section 8 does some financial modeling. It presents three investment options. Option 1 sets out proposals for 5% disinvestment in the service. Option 2 considers how the service could be reconfigured with zero growth. Option 3 explains how the service could be enhanced with additional investment.

Finally Section 9 presents proposals for implementation of the review recommendations and future commissioning arrangements.

Summary of recommendations

R1 Targets on current KPIs for bed occupancy and length of stay in the residential service should be revised for 2010/11 to 80% and 28 days respectively

R2 Develop a bed management system which informs the hospital and community health workers of bed availability and provides daily monitoring of bed occupancy and length of stay

R3 The joint performance management framework should be adjusted to include KPIs and reporting information identified in DH Guidance, “Halfway Home”

R4 New KPIs should be introduced on reductions in unscheduled hospital admissions for people with ambulatory sensitive disorders

R5 Create a new Intermediate Care Team which incorporates the community rehabilitation service, residential therapists and the social work service

R6 The Intermediate Care Team should adopt a case management approach, co-ordinating rehabilitation packages for service users through the whole intermediate care pathway

R7 Develop a single line management structure for the Intermediate Care Team led by a senior therapist working exclusively in-service

R8 Develop an intermediate care hub at the Millennium Centre, co-locating the Intermediate Care Team

R9 A single point of access to be developed for the intermediate care service, which incorporates an out-of-hours access point

R10 Develop a new lease agreement for the Millennium Centre which specifies the use of the Millennium Centre as an intermediate care hub

R11 NHS Rotherham and Rotherham MBC to investigate potential for capital investment, ensuring the building is fit for purpose

R12 Decommission Rothwel Grange intermediate care beds by December 2009. Transfer provision to Davis Court or Lord Hardy Court and increase capacity by 3 beds

R13 Commission additional care enabling hours in the residential service to meet higher level of need and increase level of activity for residents

R14 Decommission Ackroyd Fast Response beds by March 2010

R15 Integrate Millennium rehabilitation and maintenance teams into the Intermediate Care Team

R16 Reconfigure the maintenance service so that it provides a 6 week rehabilitation and community integration programme

R17 Continue to provide day care provision to those in the maintenance service for up to 12 weeks. For those service users who moved from Crinoline Day Centre in 1996 service will continue indefinitely

R18 Develop new service specifications for both elements of the day care service, ensuring clear distinction between the two in terms of service delivery and outcomes

R19 Reduce the number of Millennium maintenance places from 30 to 24 per day

R20 Open up the care pathway for both day rehabilitation services to other health and social care professionals

R21 Nurse-led residential provision should not be developed at this stage. As the service reaches the end of contract commissioners should review interqual data and reassess

R22 The intermediate care team should be enhanced to include nurse practitioners, health support workers and a dedicated speech and language therapy service. Health support workers will provide appropriate nursing and therapy interventions.

R23 Introduce dedicated social services officers to the intermediate care team

R24 The community stroke service to have case management responsibility for people discharged from the stroke unit into intermediate care. These service users will have equal access to all other elements of the intermediate care service.

R25 Providers of the intermediate care and stroke rehabilitation service will produce a joint action plan on the development of Netherfield Court as a stroke rehabilitation facility

R26 A common assessment framework and single patient record is introduced for the service

R27 The service incorporates a specialist occupational therapist and community psychiatric nurse to help meet the mental health needs of service users and that all staff are required to undergo specialist training in dementia care

R28 NHS Rotherham to work with key stakeholders to develop further proposals on a new model for delivering medical support to the intermediate care service

R29 The intermediate care residential service be accredited for End of Life Care by 2011

R30 Carry out a feasibility study on a combined intermediate care and falls prevention service

R31 Commissioners carry out a review of rehabilitation services across Rotherham, focusing on the potential for developing a rehabilitation hub on the Badsley Moor Lane site

R33 Endorse the financial model set out in Option 3, with NHS Rotherham committing additional investment of £200,000. Additional investment is non-recurrent

R34 Rotherham MBC and RCHS submit a joint implementation plan to the Adults Board in January 2010 and that the review recommendations be fully implemented by June 2010

R35 Rotherham MBC and NHS Rotherham recommission the service with current providers in April 2011 if conditions are met. The service will otherwise be subject to an open tendering process

1: Strategic Framework

1.1 Definition of intermediate Care

Department of Health guidance from the National Service Framework for Older People (2001) Standard 3 defines an intermediate care service as one which is targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care or continuing NHS in-patient care. Intervention focuses on active enablement with view to maximising independence and returning home. The service is provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery. The service is time-limited, normally no longer than six weeks and frequently as little as one to two weeks. There should be cross-professional working, with a single assessment framework, single professional records and shared protocols.

Recent DH guidance "Intermediate Care – Halfway Home"[2] extends this definition. There is a greater emphasis on preventing admission to residential or nursing care. Intermediate care services should now include adults of all ages, such as young disabled people managing their transition to adulthood. There should be better services for people with dementia or mental health needs and greater flexibility on length of stay for these service users. The new guidance calls for greater integration between health and social care. The intermediate care pathway should have a single point of access, which filters out inappropriate referrals and signposts people to an appropriate part of the service. A care pathway should be planned, which takes people through the entire episode of intermediate care to long-term support if needed.

1.2 The Joint Commissioning Strategy

One of the key priorities of Rotherham's Joint Commissioning Strategy for Adult Services is the development of effective intermediate care services. The strategy responds to recommendations from national reviews which incorporate both health and social care perspectives. *Our Future Health Secured; A Review of NHS Funding & Performance*[3] identifies intermediate care services as having made a significant contribution to the reduction in delayed discharges from hospital. The *Wanless Social Care Review of Older People's Services*[4] also recognises the contribution that intermediate care has made to reducing hospital length of stay. However it also highlights the benefits of developing a broader role; to prevent hospital admission, promote self care and improve independence. Finally, *Our Health, Our Care, Our Say*[5] explains that investment in intermediate care since 2001 has already resulted in a significant reduction in delayed discharge from hospital. The White Paper advocates greater use of intermediate care services to enable more people to be cared for in the community.

The Joint Commissioning Strategy commits Rotherham MBC and NHS Rotherham to the following joint actions:

- Commission an Intermediate Care Service which fulfils the functions identified in the Wanless Review
- Develop a fully integrated Intermediate Care Service

- Develop joint commissioning arrangements, service level agreements, pooled budget arrangements and a joint performance management framework
- Remove all age restrictions on the Intermediate Care Residential Service
- Review and reconfigure the Community Rehabilitation Service
- Improve performance of the Intermediate Care Service

1.3 Better Health, Better Lives

Better Health, Better Lives is the strategic plan for NHS Rotherham. It identifies key priorities for health, setting out what it hopes to achieve and what actions are required. One of the transformational initiatives identified in *Better Health, Better Lives* is *accessible, high quality intermediate care services.* The strategy commits NHS Rotherham to reconfigure the existing service so that it can:

- Provide a service option for people with long term conditions who experience an acute exacerbation, which does not need to be managed in hospital
- Rehabilitate people on discharge from hospital so that they can re-adjust to life back in the community
- Provide a short-term solution for people ready to be discharged from hospital in order for their long-term care options to be assessed and arranged

The strategy states that NHS Rotherham will work with Rotherham to reconfigure the residential service so that it incorporates new nurse-led step-up and step-down provision. The new service will provide alternative care pathways out of hospital, reducing hospital length of stay and delivering a stepping stone back to full independence. Nurse-led step-up provision will provide GPs and community based health professionals with an alternative to hospital care, reducing admissions to hospital and residential care.

The Community Rehabilitation Service will be reconfigured. Commissioners and providers will explore the potential for co-location of health and social care staff. The new service will improve performance by increasing the capacity of home care enablers and targeting those people who would benefit most. Commissioners will develop a new performance management framework which measures the long term impact on service users. Commissioners will also explore the potential for extending intermediate care to incorporate a specialist falls service.

1.4 Impact on Key Performance Indicators

Effective intermediate care services have a positive impact on the following indicators from the Adult Social Care Self Assessment Survey. The following indicators relate to the number of people funded by the Local Authority:

- Number receiving non-residential intermediate care to prevent hospital admission
- Number receiving intermediate care in a residential setting to prevent hospital admission
- Number receiving non-residential intermediate care to facilitate hospital discharge
- Number receiving intermediate care in a residential setting to facilitate hospital discharge

The Outcomes Framework highlights where effective intermediate care services can have most impact on the performance of Rotherham MBC. Key performance characteristics for performing excellently on Outcome 1: Improved Health and Well Being include:

- Consistently low numbers of people who have to go into hospital for preventable reasons
- Low number of people whose hospital discharge is delayed due to lack of social care
- Well developed services to prevent avoidable admissions and support independent living
- Well developed rehabilitation services across the area
- Levels of permanent care home placement are low.

Intermediate care also has an impact on the National Local Government Indicator set and Vital Signs:

NI 125	Achieving independence through rehabilitation
NI 131	Delayed transfers of care from hospital
NI 132	Timeliness of social care assessments
NI 133	Timeliness of social care packages following assessment
NI 134	The number of emergency bed days per head of weighted population
NI 139	Older people receiving the support they need to live independently

VSA 14	Implementation of the Stroke Strategy
VSC 03	Proportion of adults supported directly through social care to live independently
VSC10	Number of delayed transfers of carer 100k population
VSC 04	Proportion of people achieving independence 3 months after rehab
VSC 11	Proportion of people with long term conditions supported to be independent
VSC 20	Number of emergency bed days per head of weighted population

2: Needs Assessment

The following needs assessment considers future demand for services which intermediate care can have the greatest impact on if delivered effectively. It looks at the effect of the ageing population on the demand for social care provision, particularly home care and residential care. This section also considers projected increases in the demand for hospital care.

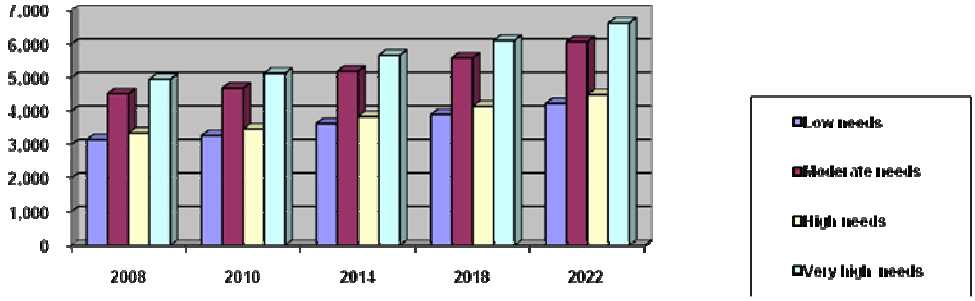
Department of Health guidance on intermediate care "Halfway Home" [2] states that intermediate care has an important function in reducing reliance on home care, delaying admission to residential care, preventing avoidable admission to hospital, facilitating hospital discharge. This needs assessment highlights the importance of such services at a time when demand for critical health and social care services is set to increase.

2.1 Projections on social care need

Rotherham's Joint Strategic needs Assessment (JSNA) [7-P143] predicts that the number of older people in Rotherham is likely to increase by 48% over the next 20 years. There are currently 5,200 people in Rotherham who are 85 years and over. The population for this age group is projected to grow by 81% over the next 20 years. People who are over 85 are most likely to require formal support so this demographic is more relevant when projecting future need for intermediate care.

Figure 1 categorises local social care need and helps predicts future demand for adult social care. It is estimated that there are currently 15,970 people (38%) in Rotherham who are over 65 years and have a formal social care need. Of these 8,300 are unable to perform one or more activity for daily living (ADL) and therefore require direct support.

Figure 1: Projected Social Care Needs for People over 65 years in Rotherham[2 p39]



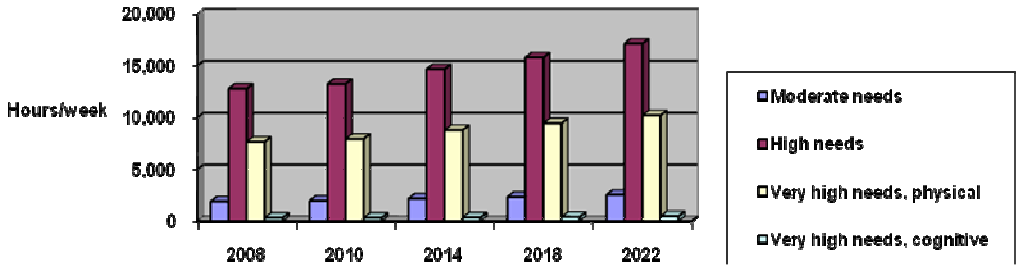
The number of people with a social care need is predicted to increase by 24% in the next 10 years. The number of people with a high or very high need is also predicted to increase by 24%.

2.2 Projections on need for home care

Figure 2 predicts the number of home care hours which will need to be commissioned by the Local Authority over the next 14 years. Figures assume that the demand for home care grows in line with the growth of the older population.

It is estimated that there is a total of 22,660 home care hours provided by the Local Authority each week currently in Rotherham, including 8,000 people with very high needs. If service provision tracks the growth of the older population home care provision will increase by 15% to 25,990 by 2014 and then by a further 24% to 28,010 by 2018.

Figure 2: Projected Increase in Provision of Home Care in Rotherham



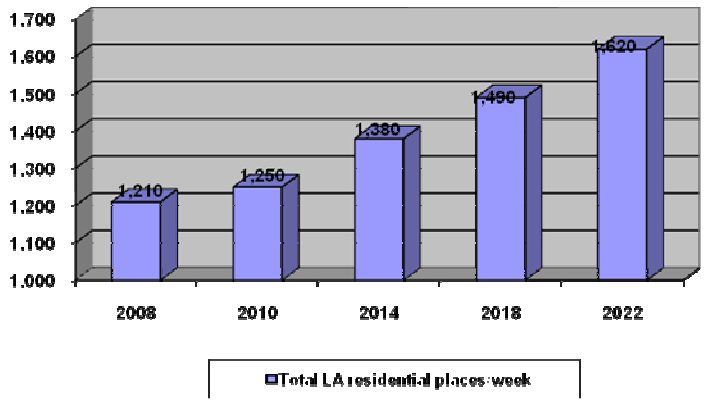
The cost of home care in Rotherham for 2008/09 was £9,738,519. Currently 3,120 people are in receipt of a home care service – of which there are 2,769 older people. [9] The average cost per person is £3,517 per year.

2.3 Projections on need for residential care

There are currently 2,413 beds in residential and nursing homes in Rotherham which provide care for around 1,767 people who are financially supported by the Local Authority. Approximately 75% of beds are for older people with the remaining 25% for people with learning disability, physical disability or mental health needs.

Figure 3 predicts future numbers of residential and nursing care places per week required in Rotherham based on the growth in the older population. It provides information on the publicly funded residential population. People in residential and nursing homes are assumed in to be in the "very high" needs group. Publicly funded care packages are assumed to be not available for people in the "low" to "moderate" needs groups.

Figure 3: Predicted Need for Residential Care in Rotherham (Older People) [2 p30]



It is estimated that there are currently 1,210 residential and nursing places provided per week for older people in Rotherham. Assuming that the number of placements grows at the same rate as the older population this is set to increase to 1,380 places by 2014 and 1,490 by 2018. This is an increase of 14% and 23% respectively. 38% of all placements are funded by the Local Authority.

The costs for residential and nursing care for older people in Rotherham were £19,217,963 for 2008/09. There are approximately 1,767 people placed in residential care placements of which approximately 1,210 are older people. The average cost of residential care for older people is £15,883 per person per year.

There has been a 2% reduction in the number of people entering long-term care in Rotherham from 1,802 people in 2005/06 to 1,767 people in 2007/08. Although the number of people in long-term care has reduced slightly, the needs of people in the Homes are much greater.

2.4 Hospital admissions

From the JSNA it can be shown that NHS Rotherham had the second highest rate of hospital admissions in the region in 2007-08. There were 253 admissions per 1000 population, significantly higher than the average rates of 217 regionally and 199 nationally.

NHS Rotherham had the highest level of hospital admissions in the region for people with cardiac disorders; 21.0 admissions per 1000 population compared to 16.9 regionally and 15.0 nationally. It also had the highest regional level of admissions for respiratory conditions; 12.4 per 1000 compared to 8.9 regionally and 8.0 nationally. Overall NHS Rotherham had higher rates of admissions than the regional and national averages for every HRG chapter except for vascular disorders, obstetrics and neonatal.

The needs weighted total cost of acute admissions is higher than the regional and national rates. The possible causes of the relatively high needs weighted total cost could be due to; low provider admission threshold, lack of community care provision, high levels of inappropriate referrals, lack of post discharge community support and ineffective discharge planning.

NHS Rotherham had the second highest rate of emergency admissions to hospital in the region during 2007-08. Rotherham had higher rates of emergency admission than the regional and national averages for nearly all HRG chapters except vascular and musculoskeletal disorders. Rotherham has the highest rate of emergency admissions in the region for 19 conditions identified as those which could be prevented by effective community services. This could be due to factors such as higher levels of morbidity and a more complex case mix. However other factors could include; lack of appropriate community care provision, post discharge support and effective discharge planning.

Rotherham had the highest regional percentage of emergency admissions discharged home with no overnight stay in 2007-08. This suggests low provider threshold for admissions, high level of inappropriate referrals and/or classification of A&E observation beds as in-patients. The standardised cost rate for emergency admissions per 1000 of the population in NHS Rotherham was 5th highest in the region and higher than the national and regional averages.

3: Summary of national guidance

Department of Health guidance on intermediate care "Halfway Home" [2] considers the effectiveness of different models of intermediate care. It explains why intermediate care is important and provides evidence for specific types of intervention.

3.1 Why is intermediate care important

Intermediate care services should enhance quality of care and help people maintain maximum physical and cognitive function. They should have an impact on the health and social care system by making more effective use of capacity and establishing new ways of working. Intermediate care is an important element of recent policy developments. It addresses national policy objectives such as care closer to home, the transformation of social care, the NHS Next Stage Review, transformation of community services, carers' and national dementia strategies.

An earlier review of intermediate care, *NSF for Older People, supporting implementation: Intermediate care: moving forward*[6] sets out the guiding principles of intermediate care:

- person-centred care
- whole system working
- timely access to specialist care
- promoting healthy and active life

3.2 Key components of effective intermediate care services

DH guidance identifies key elements of the intermediate care function.

The core service should generally be provided in community-based settings or in the person's own home. Intermediate care should incorporate a range of services, including beds in residential settings, some with nursing care. Intermediate care may include a rapid response team to provide assessment and immediate intervention in people's homes, to reduce inappropriate admissions to hospital. The service could also include more intensive support and treatment at home to prevent avoidable admission or to facilitate discharge. This type of service is sometimes described as 'hospital at home'. Part of the service should be available on a 24-hour, seven days a week basis, with access to assessment.

The guidance identifies ways in which these key elements of service can be delivered. *Rapid Response Teams* can prevent avoidable admission to hospital by early intervention during periods of exacerbation. These teams can work with GPs, A&E, community health and social care services to deliver short-term intensive support at home. *Acute care at home,* delivered by nurse-led specialist teams, can provide medical treatment at home, including administration of intravenous antibiotics. *Residential rehabilitation* is specifically for people who are unable to return home but are medically fit to leave hospital. These services can be provided for people who do not need 24-hour consultant-led medical care but require a short period of rehabilitation, ranging from one to about six weeks. *Supported discharge,* delivered in a person's own home, combines nursing and therapeutic interventions, home care and community equipment. Finally

d*ay rehabilitation services* can be provided for a limited period in a day centre, possibly in conjunction with other forms of intermediate care.

DH guidance states that all services delivered as part of an intermediate care package, including home care, day care and residential care, should be free to the service user.

Intermediate care should encompass a wider preventative role, aiming to promote confidence building and social inclusion. It should link closely with social care re-ablement, acute or urgent healthcare (including out of hours primary care services), A&E, community health services and management of long-term conditions, primary health care, domiciliary social care, day care and residential or nursing care homes. Effective links are necessary so that potential users are referred into the service from any of these services as soon as the need arises.

The intermediate care function should be managed in an integrated way both from an operational and commissioning perspective. DH guidance suggests the appointment of a single manager with overall responsibility for service delivery.

The emphasis of intermediate care should be on active enablement. Those with all types of conditions should be eligible, with inclusion being based on individual need rather than diagnostic group. Care should be arranged on the basis of a holistic assessment, in which the individual's wishes and those of their carers are fully considered.

The DH guidance emphasises the need to develop a common assessment framework. It recognises that this can help to avoid multiple assessments and facilitate a holistic approach to care provision. The assessment should lead to integrated care planning, with an identified case manager for each service user. All care plans should be regularly reviewed whilst intermediate care services are being delivered.

3.3 Evidence from research

Some evidence that the intermediate care function is effective has begun to emerge from a number of major research programmes, although conclusions are mixed. The DH guidelines set out some of the key findings [2-p13]

Intermediate care projects within the Older People's Use of Services (OPUS) research programme found improvements in people's quality of life and abilities but suggested that intermediate care services needed to be clearly targeted if they were to reduce admissions. Although there is evidence that intermediate care may contribute to a fall in delayed discharges, an evaluation of a well resourced city-wide service found no improvement in patient outcomes and a greater subsequent use of hospital. Conversely the Partnership for Older People Projects (POPPs) did provide evidence that intermediate care services improved users' quality of life and contributed to a significant reduction in emergency hospital bed days. These projects were judged to be cost effective.

Systematic reviews of hospital at home schemes and supported early discharge concluded that these can provide satisfactory alternatives to treatment in an acute hospital. There is evidence that community rehabilitation services are beneficial for some groups of patients, such as those

recovering from stroke. A hospital at home service requires active treatment by health care professionals, in a person's home for a limited period. It may provide a more intensive level of medical care than is normally provided in most intermediate care services.

A systematic review of admission avoidance through hospital at home[2-p25] has indicated that this service can provide a satisfactory alternative to treatment in an acute hospital. There were no significant differences in the outcomes of functional ability, quality of life or cognitive ability. However patients reported increased satisfaction when they were treated at home. There was no significant reduction in the death rate at 3 months for the hospital at home group. Two studies indicated that hospital at home was less expensive than admission to hospital.

Evidence cited in an early review of intermediate care[6] presents limited but positive evidence for the benefits of community rehabilitation teams. The review suggests that such teams should be considered as part of a comprehensive intermediate care service, of which hospital at home is one component.

The evidence for the effectiveness of residential nurse-led units or nursing home based intermediate care is limited. While they may be safe and effective, there is evidence that they are not cost-effective. Studies of nurse-led units indicate that these could provide appropriate care for certain patients. However there is evidence that the development of such units can lead to increased lengths of stay. Also, a high proportion of service users refuse the option of care in such units.

Finally, intermediate care services in which patients saw a smaller number of practitioners tended to have better outcomes

4: Map of current provision

Rotherham currently has the following intermediate care services:

4.1 Intermediate Care Residential Service (ICAB)

This service provides rehabilitation for people who are considered unsafe to remain in or return to their own homes but who would have the capacity to live at home if provided with suitable rehabilitation services. The service is responsible for the delivery of intensive residential rehabilitation packages. It targets the following groups of people

- People being discharged from hospital who require a period of rehabilitation
- People who are living in residential care but wish to move back into their own home
- People at high risk of admission to hospital or residential care
- People with a long term condition living at home who require rehabilitation
- People who are experience an exacerbation but do not require hospital care
- People experiencing mobility problems or at a high risk of a fall.

Table 1 provides a breakdown or beds across the borough.

Table 1 – Distribution of Intermediate Care/Fast Response Beds

Name of Home	No. of Beds	Status	Category
Ackroyd	6	Independent	Residential – Fast Response
Broom Lane	8	Independent	Residential – Intermediate Care
Netherfield Court	21	Local Authority	Residential – Intermediate Care
Rothwel Grange	12	Local Authority	Residential – Intermediate care

All referrals for the residential service are routed through a single point of access at Netherfield Court. The therapists based at this unit triage service users and decide on the appropriate venue for care. A separate assessment then has to be carried out by the appropriate unit manager to ensure that the home is able to meet the care needs of the service user. Admissions to Broom Lane, Netherfield and Rothwel are between 7.00 am and 8.00 pm. This is in compliance with CQC regulations. Ackroyd are able to accept admissions from 8.00 am to 10.00 pm.

Only Ackroyd is able to provide nursing support to service users. Broom Lane has nursing staff in the other wing of the home, so if required the intermediate care unit can draw in nursing support. Rothwel and Netherfield utilise the district nursing service to assist with tasks such as wound dressing. There are two District Nurses specifically allocated to provide support to the intermediate care service.

The residential service has 8.5 wte occupational therapists and 3.4 wte physiotherapists. The units employ residential care workers, care enablers, domestic and catering staff. Each unit has a minimum of 2 care enablers on duty in the morning and 1 enabler in the afternoon. Therapists are responsible for developing rehabilitation plans. Care enablers are expected to work alongside residents to deliver this plan.

Bariatric patients are usually admitted to Netherfield, which has a specially adapted room in order to accommodate equipment such as hoists. However, there is no bariatric bed available in this room.

The residential service can accept admissions from hospital over the weekend as long as the assessments have been undertaken previously by therapists and Unit Manager. The service has strong links with the community geriatrician who assesses all patients admitted to ICAB. The community geriatrician visits each home once a week.

4.2 The Community Rehabilitation Service (CRT)

The Community Rehabilitation Service is a multi-disciplinary team which brings together occupational therapists, physiotherapists and home care enablers to deliver short-term rehabilitative support and optimise independence for people in their own homes.

The main aims of the service are to:

- Provide a multi-disciplinary rehabilitation service to individuals in their own homes
- Increase independent living skills, optimise physical function and improve confidence
- Reduce the need for high-cost home care packages
- Reduce the risk of inappropriate admission to hospital or long-term care

The service is delivered by a multi-disciplinary team, which consists of 4.3 wte occupational therapists, 5.7 wte physiotherapists. The therapists are supported by 400 hours of care enabler provision. The team is distributed across the borough. Therapists are located at a number of sites and are employed by Rotherham Community Health Services. Care enablers are home-based workers with a central base at Manvers. The care enablers are employed by Rotherham MBC

Initiation of service is subject to an assessment by a relevant health or social care professional. A separate assessment will be undertaken by an intermediate care therapist to establish whether the therapeutic needs of the person can be met by the service.

Once an assessment has been carried out the team develops an individually tailored rehabilitation programme. This programme is implemented by care enablers assigned to the community rehabilitation service. The rehabilitation programme is reviewed by therapists on a regular basis.

Care enablers in the community rehabilitation service carry out a dual function. They are responsible for working with service users on rehabilitation programmes, improving physical and occupational function. However they are also responsible for delivering home care services that have been identified as part of a social care package. Currently care enablers work with the majority of people (95%) who have a home care package in place.

The service is generally available for up to six weeks, although this is flexible depending on individual need. If a service user receives home care the community rehabilitation service will reassess the care package on completion of the rehabilitation programme and make recommendations to the assessment and care management team on how much home care support is now required.

4.3 Millennium Day Rehabilitation and Maintenance

This service provides rehabilitation in a day care setting to improve safety, function and independence. It usually constitutes the final stage of a service user's rehabilitation programme after they have received service from ICAB and/or CRT. The Millennium Day Rehabilitation Service is split into two elements.

The day rehabilitation service is available for people for up to six weeks, although this is flexible depending on individual need. It has a multi-disciplinary team consisting of an occupational therapist (0.5 wte), a physiotherapist (1.0 wte), a rehabilitation support worker (1.0 wte) and a rehabilitation assistant (1.0 wte). The service receives 20 people for rehabilitation two days per week. All service users are transported into the day centre by the Rotherham MBC's adults transport service. Rehabilitation sessions run from 10.00 am to 3.00 pm. Clients pay for the full cost of a meal and part of the transport costs. The rehabilitation team carries out some outreach work, providing follow-up rehabilitation at home.

Rehabilitation assessments and individualised programmes are developed by the physiotherapist. Rehabilitation assistants are then responsible for delivering the programme with the service user. Programmes are reviewed every three weeks.

The Maintenance Service supports approximately 30 people per day throughout the week. It has a specialist team which consists of 4 support workers and 2 rehabilitation assistants. The team delivers a combination of individual rehabilitation and group work. Service users attend maintenance for 1 day per week. There are approximately 150 people receiving the service at any one time. The service is time limited, with a maximum maintenance period of 6 months.

The rehabilitation and maintenance services are co-located at the Millennium Centre. The building is owned by NHS Rotherham and leased to Rotherham MBC. The current lease is due to expire in April 2010. The centre is located next to two other rehabilitation centres:

- Breathing Space, which delivers rehabilitation programmes for people with COPD
- Park Rehabilitation Centre which incorporates neurological, amputee and orthopaedic rehabilitation

There is a fully staffed kitchen on-site, which provides lunch to between 34-40 service users, five days per week.

The day centre has recently been awarded beacon status.

4.4 Fast Response Beds

The intermediate care pooled budget includes a significant allocation for fast response beds.

These are utilised by the Fast Response Service a multi-disciplinary team of therapists and district nurses who deliver short-term hospital-at-home and palliative care services. The Fast Response Service prevents hospital admission by delivering intensive primary medical support at home. The intervention period is 72 hours, by which time the patient should be sufficiently stable to allow mainstream primary health and adult social care services to take over.

Referrals mainly originate from Accident and Emergency or community health services, although there are referral pathways from the Yorkshire Ambulance Service, local GPs and Social Services.

The Fast Response Team has access to 6 temporary residential beds at Ackroyd for people who require a short period of rehabilitation. These dedicated beds can be accessed for up to two weeks and can sometimes be used as a route into Intermediate Care. The Fast Response beds are currently managed by Rotherham MBC.

Fast Response beds can be accessed between 8.00 am and 10.00 pm. Admissions to intermediate care beds are between 7.00 am and 8.00 pm.

4.5 Community geriatrician and GP Service

Medical support for the intermediate care service is currently delivered through two key services.

The intermediate care pooled budget funds a General Practitioner service which provides primary care support to the residential units. On admission to the units all residents are temporarily registered with St. Ann's Surgery. The GP service provides standard medical cover for these residents. There are protocols in place to ensure smooth transition to the originating GP once a resident has been discharged from the residential service.

RCHS employs a community geriatrician who provides some consultancy support to the residential units. The community geriatrician visits the units once a week to assess new admissions and monitor residents who have specific health needs. He also provides targeted support to the Fast Response beds at Ackroyd, carrying out comprehensive health assessments and medication reviews. The community geriatrician undertakes exploratory work on underlying conditions, initiates blood tests, does some screening and carries out medication reviews. This service is not funded through the intermediate care pooled budget.

5: Benchmarking with neighbouring authorities

As part of the strategic review of intermediate care services the joint commissioning team has looked at the service models being developed in Sheffield, Leeds and Bassetlaw. This has helped gain an understanding of different approaches and provided an opportunity to share ideas on service development.

5.1 Leeds intermediate care service

Leeds has a population of around 750,000, with around 225,000 people being over the age of 50 years. This is around 3 times the population of Rotherham.

Intermediate care services are commissioned and funded by the PCT. All intermediate care workers are employed by the NHS. The service is split into five localities, with a co-located multi-disciplinary team serving each area. The service incorporates the following key elements.

Sub-Acute Unit – Seacroft

Seacroft is a nurse-led sub-acute unit which is run on the Leeds Teaching Hospital site. The service is delivered by the PCT provider arm. The sub-acute unit has 24 intermediate care beds, 18 step-up community beds and 6 step-down beds. Step-up beds are for patients who are medically unwell and require nursing input.

Medical support for the unit is delivered by 1.5 wte consultant geriatricians. There is GP out of hours cover. Medical cover is not provided during the night. There are x-ray facilities on site, ultrasounds, and a same day phlebotomy service.

Referrals from the community are from GP's and community health workers during day-time hours. The length of stay target is 14 days but the service is currently performing at 18 days. The unit receives approximately 300 admissions per year and costs approximately £1.2 million. Unit cost per person is £4,000. The service would be cost neutral if 500 admissions a year were achieved. Currently occupancy rates are 90%.

Community Intermediate Care (CIC Beds)

These are equivalent to the ICAB service is Rotherham. There are 150 CIC beds over 18 sites incorporating step-up and step-down provision (includes beds at Seacroft). This is approximately equivalent to the number of beds provided per head of population in Rotherham.

Approximately 66% of admissions to the CIC beds from hospital. 57% of service users continue to receive support from the community intermediate care team. 31% of discharges from CIC beds are re-admitted to hospital or move residential care. The intermediate care service employs a part-time community geriatrician who carries out ward rounds for the CIC beds.

Community Intermediate Care Team

There are 5 locality based community intermediate care teams in Leeds. These are nurse-led multi-disciplinary teams which incorporate therapists, nurses and health support workers. Each team incorporates a rapid response element, which can respond to urgent need.

There is also a part-time dietician who provides advice and support on rehydration, diabetic care and monitors people who have had a recent weight loss.

The service is delivered by the PCT provider arm. It targets people who are over 60 years but if someone had rehab needs they would not be excluded from the service.

Each team has a co-ordinator who triages referrals. Health support workers are responsible for delivering care and rehabilitation packages. There is a competencies framework in place for these workers so that they can provide low level therapy and nursing support. The health support workers provide support in washing and dressing practice, shopping. They deliver exercise programmes formulated by physiotherapists. They are able to carry out blood pressure and oxygen level monitoring. They also carry out catheter care and take blood.

Rapid Response provides cover between 8.00 am to 9.30 pm. in the day time. There is a separate service provided at night by Rapid Response which is available between 9.30 pm and 8.00 am. The service provides nursing support for 72 hours and then, if applicable, patients are moved on to rehabilitation.

Joint Care Management Teams

This team is responsible for carrying out joint health and social care assessments for people being discharged from hospital. It is jointly funded and brings together case managers from the PCT and Local Authority. Team members have a mixture of nursing and social work qualifications.

The team will lead on the following assessments:

- Where a joint health and social care package are required on discharge
- Where there is a risk of hospital readmission
- Where an assessment is required for continuing health care

Bed Bureau

The Leeds intermediate care service incorporates a bed bureau which monitors vacancy levels in the CIC beds. The bureau has been successful in ensuring that bed occupancy levels remain high. The bureau can generate performance reports relating to bed occupancy, length of stay and discharge delays.

5.2 Sheffield Intermediate Care Service

Sheffield has a population of 550,000. There has been a recent merger of 4 PCTs, each of which operated different models of intermediate care. The PCT has recently completed a service review, the recommendations from which have recently been implemented. The service is split into 3 elements.

Community Intermediate Care Team

Like Leeds, Sheffield has an integrated team located on two sites. The PCT provider arm employs the team, which includes nurses, physiotherapists, OTs and health support workers. The health support workers deliver a combination of health, therapy and social care support. They are responsible for implementing a holistic health and social care package in the service user's own homes.

The service has a single point of access. Once a referral is received, service users are seen within 2 hours. GPs, community health workers, A&E, and hospital discharge teams are able to refer into the service.

Community Stroke Service

In Sheffield there is also a community stroke service, which comes under the umbrella of intermediate care services. This service picks people up on discharge from the Stroke Unit and adopts a case management approach. Case managers are responsible for navigating service users through the intermediate care pathway. They deliver care and support but also co-ordinate any external services coming into the service user. The community stroke service works closely with the intermediate care team.

Beechill Rehabilitation Unit and Resource Centres

Beechill provides residential intermediate care services for orthopedic and stroke patients. It is a nurse-led facility which provides medical input during the day. Beechill is run by the PCT provider arm and is a precursor to a larger 120 bed new-build scheme. The unit is staffed by nurses, social workers, physiotherapists, OTs and health support workers. It is supported by a GP who visits weekly and a community geriatrician who visits twice a week.

Average length of stay is currently over 6 weeks but the intention is to bring this down to between 21 to 28 days.

In addition to Beechill, Sheffield has three resource centres which provide residential beds. These beds are funded by Adult Social Services. There is some specialist provision for people with dementia.

Community Geriatrician

Sheffield employs 4 specialist community geriatricians for intermediate care. These jointly funded post are responsible to both the Acute Trust and the Primary Care Trust and works across the secondary and primary care boundary. The community geriatricians work mainly with people who need step-up provision but they do work in the resource centres, rehabilitation unit and with people at home. It provides re-assurance to GPs and community health staff when they are having to make judgments about admission to hospital. Community geriatricians attend MDT to identify patients who require additional consultant support.

5.3 Bassetlaw Intermediate Care Service

Bassetlaw has one residential Local Authority intermediate care unit, which is part of a larger residential care complex. There are 15 beds supported by therapy staff and generic support workers.

The average age of residents is 82 years, most having co-morbidities. 17% of all referrals are from the rapid response service. Community referrals are often falls related or where there is a crisis. Generic support workers carry out low-level nursing tasks including; testing blood pressure, blood oxygen levels and carrying out blood sugar testing

Average length of stay at the unit is 27 days, the length of stay depending on complexity and patient expectation. The service does not experience delays as a result of social care assessments but there can be some delay in setting up home care packages. The unit manager sets a provisional date of discharge early in placement to enable effective discharge planning. All patients are given an estimated date of discharge shortly after arrival. Senior managers are notified when there is a late discharge.

Bed occupancy rates are good; 86% in 2007/08 compared to 80% in 2004/05. Bed status is emailed to key stakeholders on a daily basis.

6: Current Performance

The joint performance management framework for intermediate care services was established in April 2008. It monitors progress on key indicators for the residential service, community rehabilitation and day care.

The following section shows how performance has improved since joint commissioning arrangements were agreed between NHS Rotherham and Rotherham MBC.

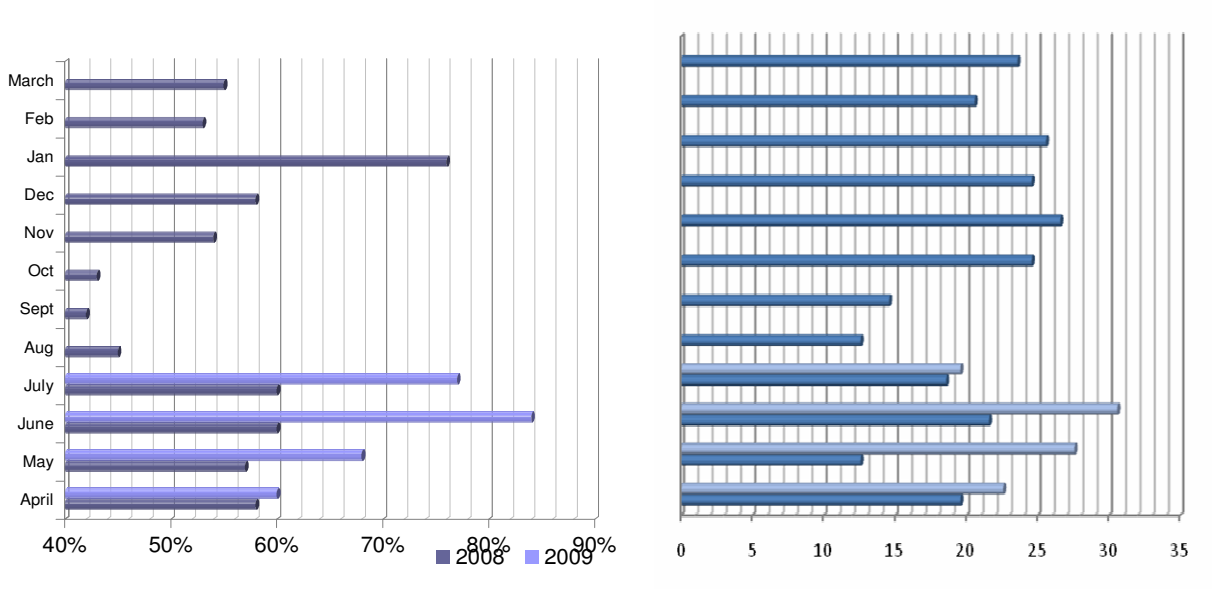
6.1 Intermediate Care Residential Service

Bed Occupancy & Admission Rates

Figure 4 shows the performance profile for the intermediate care residential service on bed occupancy since April 2008.

Figure 4: Current performance - Bed occupancy/admissions

Bed occupancy *Admissions*



Since joint commissioning arrangements were in place there has been an improvement in performance on bed occupancy and admission rates. In 2008/09 there were 14,965 available bed nights of which 8,379 were occupied. The bed occupancy rate was 56% against a target of 70%. The service received 250 admissions, which was significantly under the target of 325.

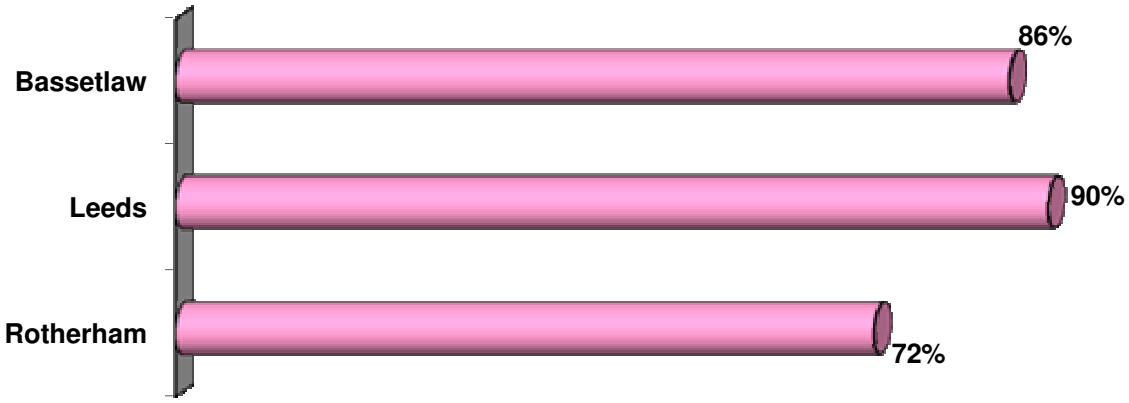
Issues which affected bed occupancy rates included:

- Low referral rates from the hospital
- Difficulties in meeting the needs of people who required double handling
- Lack of capacity for people with mental health or cognitive problems
- Lack of clarity on eligibility
- Limited care pathways from the community

During the financial year (2009-10) the service has provided an additional 642 bed days within the first 4 months. Bed occupancy rates are currently running at 72%, exceeding the target (70%). Admission rates have increased by 38% during the first four months of 2009/10 and the service is predicted to reach target this year (325).

Figure 5 compares bed occupancy with benchmarking authorities. This shows that, although there has been a significant improvement in bed occupancy in Rotherham, it is still significantly lower than neighbouring areas.

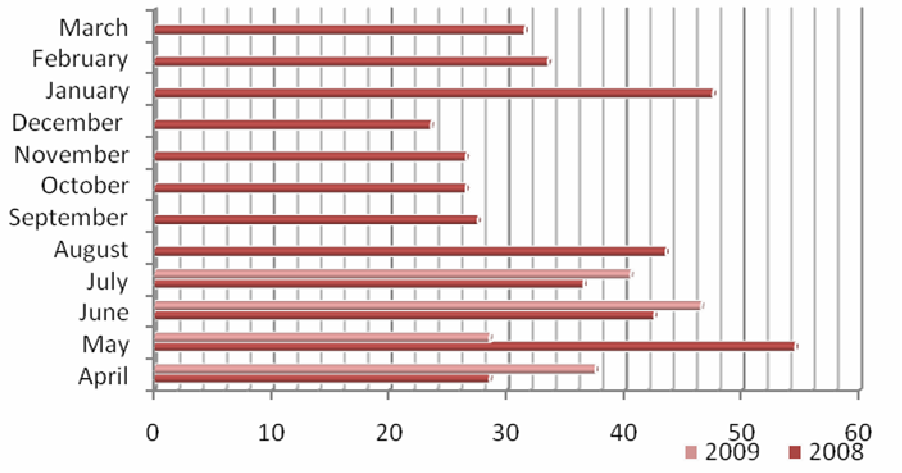
Figure 5 – Bed occupancy – benchmarking



Length of Stay

Figure 6 shows the performance profile for the intermediate care residential service on length of stay since April 2008.

Figure 6: Current performance - Length of Stay (days)

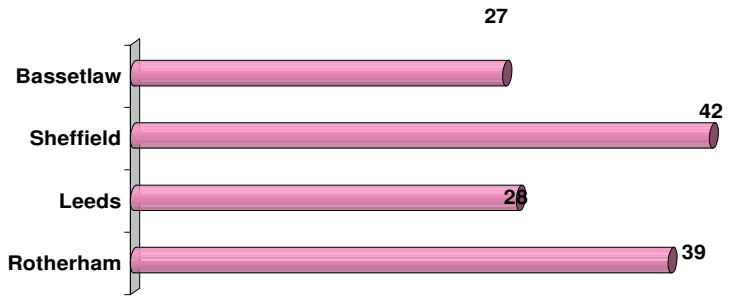


In 2008/09 the average length of stay in an intermediate care bed was 35 days. This was exactly on target. Length of stay has increased to 39 days during the first 4 months of 2009/10. The main reasons for this increase are:

- Increased volumes of service users going through the service
- Increase in admissions for people with high needs during hospital amber/red periods
- Delays in social work assessments being undertaken
- Delays in putting in place appropriate home care packages
- Delays in finding residential/nursing care placements or appropriate housing
- Inability of Community Rehabilitation Service to pick people up on discharge
- Delays in equipment being provided in a timely manner.

Figure 7 compares length of stay with benchmarking authorities. This shows that length of stay in Rotherham intermediate care units is quite high compared to neighbouring authorities. The graph does demonstrate that the current target of 27 days is realistic and attainable when compared to other areas.

Figure 7 – Length of stay (days) – benchmarking



Admission Profile

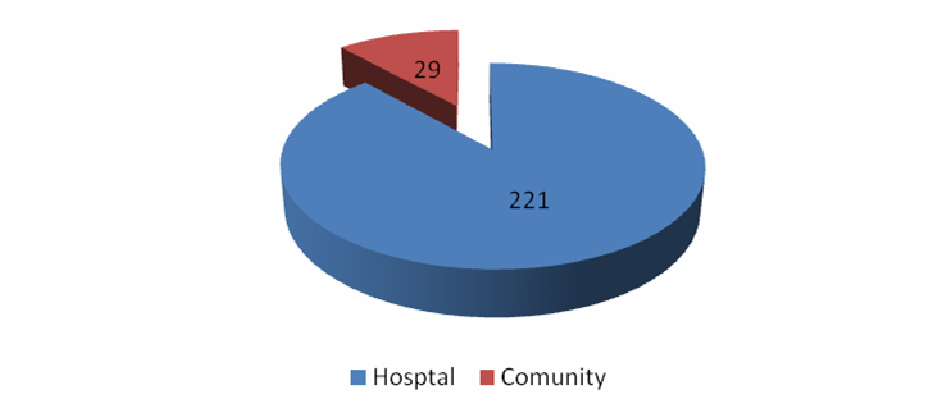
Figure 8 shows the admission profile for the intermediate care residential service. It splits admission between those from the community, which potentially prevent hospital admission and those which facilitate hospital discharge.

During 2008/09 the residential service was primarily being used to facilitate hospital discharge. 88% of all admissions were from hospital, with approximately 12% from the community.

During the first quarter of 2009 96% of admissions were from hospital with 4% from the community. Community pathways into the service are now in place to enable GPs and

Community Matrons to refer into the service. However increased numbers of community referrals have not yet fed through.

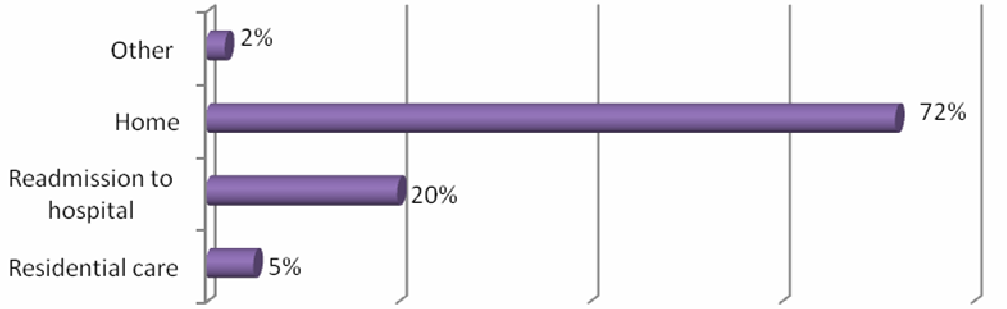
Figure 8: Admissions profile – 2008/09



Outcome Profile

Figure 9 shows the outcome profile for the intermediate care residential service.

Figure 9: Outcome profile – 2008/09



There were 228 discharges from intermediate care beds in 2008/09. Approximately 72% of service users returned home, with 5% moving to residential care. This suggests that the service is having a positive outcome for people in maintaining their independence for as long as possible.

However, 20% of all service users were re-admitted to hospital. There are a number of potential factors which could have contributed to the high rate of readmissions:

- Inappropriate discharges from hospital to Intermediate Care as a result of poor assessment or pressure to discharge, especially during amber/red alert periods
- Higher dependency levels of people being discharged from hospital to intermediate care
- People entering the service with limiting long-term conditions that are more advanced
- Low threshold for re-admission by the Intermediate Care GP

Analysis of Current Performance – Residential Service

At the point of admission the general profile of a service user is someone over 75 years, who has rehabilitation needs and is not fit to return home. This profile indicates that the service is targeting a particularly vulnerable group, who without intervention, would be at high risk of admission to long term residential care. Despite these presenting needs the service successfully returned home over 72% of users in 2008/09. Only 5% moved on to long term residential care. The review therefore concludes that the Intermediate Care Residential Service does reduce the number of older people who move from hospital into long-term residential care.

The introduction of a joint performance management framework has led to a significant improvement in bed occupancy and admission rates. The numbers of people going through the service has increased and there is greater confidence from hospital staff that the needs of service users can be met. However lengths of stay and re-admission rates remain high.

Although the residential service is successful at facilitating early hospital discharge it should also prevent unnecessary admission to hospital. The admissions profile indicates that the residential service is still primarily being used to facilitate timely hospital discharge. There are not enough community based admissions and the pathways into Intermediate Care are still limited. The limited access to the residential service from the community has recently been addressed with new admission protocols being introduced for GPs, Community Matrons and District Nurses. However even with these protocols in place it is unclear whether the current service model can cater for the needs of people with long term conditions living in the community who suffer an exacerbation.

6.2 Community Rehabilitation Service

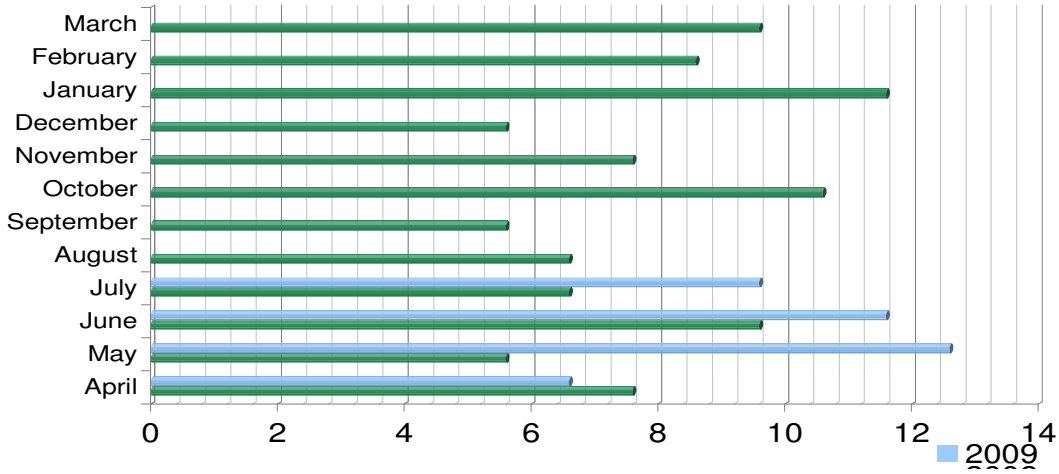
Number of admissions

Figure 10 shows the performance profile for the community rehabilitation service on number of admissions since April 2008. In 2008/09 there were 100 admissions to the community rehabilitation service, significantly under the target of 115.

Factors which have an impact on admission rates include:

- Higher proportion of people who require double handling and therefore more input from care enablers
- Increased support to stroke survivors who require extended rehabilitation packages
- Increased support for people with dementia who require extended rehabilitation

Figure 10: Current performance – Number of admissions



During the first four months of this financial year admission rates have increased by 26%. The service is predicted to improve on last year's target (125) but is still under target for 2009/10 (165). The average length of time for a rehabilitation package was 37 days in 2008/09 against a target of 35 days. 92% of service users were at home at the point of discharge from service, exceeding the target of 90%.

Admission profile

Figure 11 shows the admission profile for the community rehabilitation since April 2008.

Figure 11: Admission profile

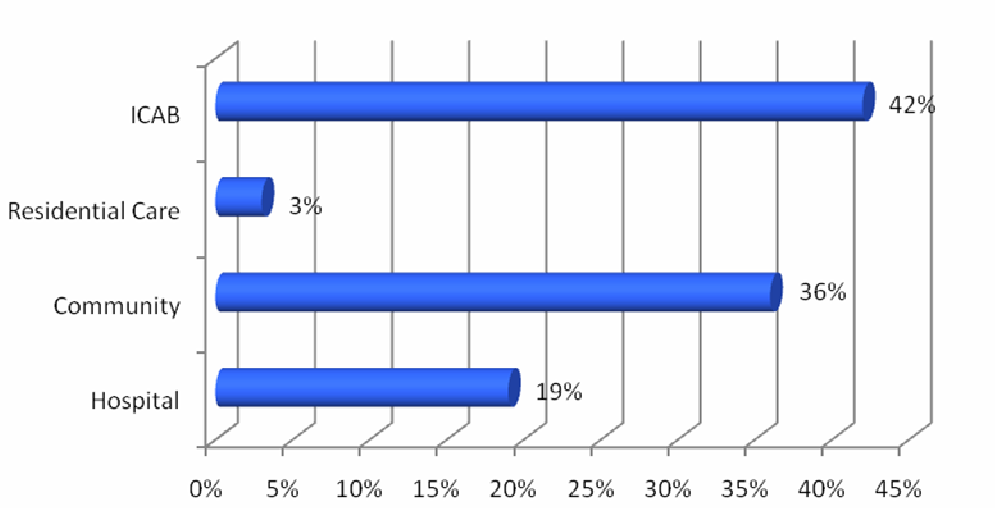


Figure 6 shows an even spread of admissions to the community rehabilitation service from the intermediate care residential service (ICAB) (42%) or community services (36%). Only 19% of admissions are to support people on discharge from hospital. There were a limited number of people (3%) who accessed the service from 24 hour residential care.

Outcome profile

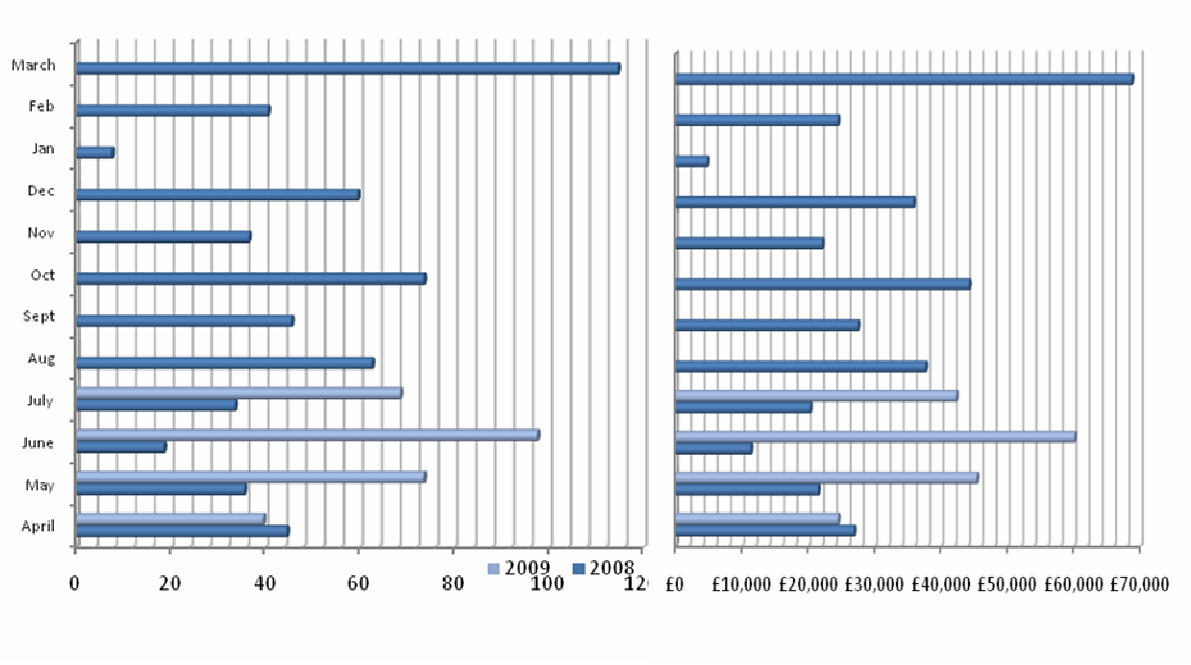
During 2008/09 93% of service users remained at home after intervention, with 2% of people moving to long-term 24 hour residential care and 4% re-admitted to hospital. This suggests that the service is having a positive outcome for people in maintaining their independence for as long as possible.

Figure 12 shows the impact of the community rehabilitation service on home care hours and costs. Since joint commissioning arrangements were in place there has been an improvement in performance on reductions in home care hours and home care costs. One of the main aims of the service is to reduce home care packages by increasing levels of independence. During 2008/09 there was a total reduction of 578 home care hours per week for people who had been through the service. This constitutes a saving of £345,644 per year to home care budget directly attributable to the intervention of the community rehabilitation service.

During 2009/10 performance on reducing home care hours and home care costs improved significantly. During the first four months of this year home care hours reductions have increased by 110%, from 134 per week to 281 per week. The predicted annual saving to the home care budget is £517k for 2009/10 compared to £346k last year.

Figure 12: Outcome profile – Home care

Reduction in home care hours *Estimated savings to home care*

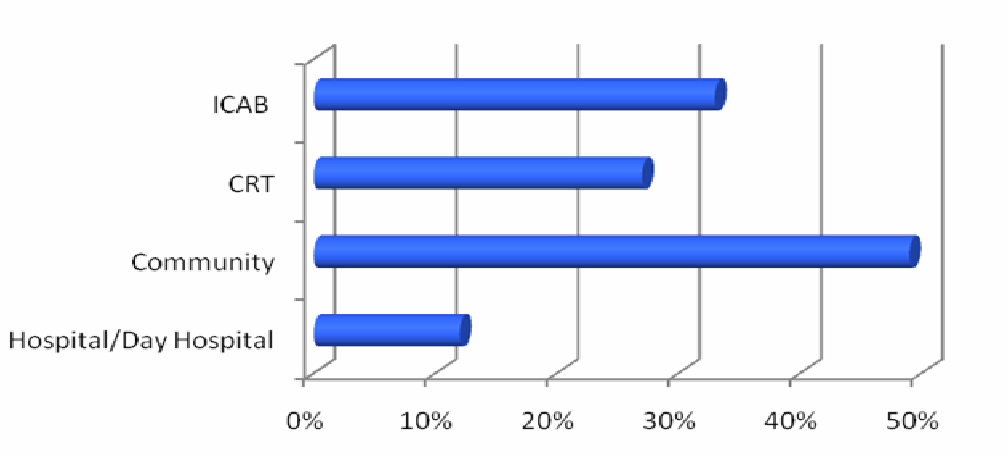


6.3 Millennium Day Centre

Millennium Day Rehabilitation

In 2008/09 132 people attended the millennium rehabilitation service. Figure 13 shows the admission profile into the service for 2008/09.

Figure 13 – Admission profile – day care 2008/0909



88% of admissions to the day rehabilitation service are through community pathways and so are therefore more likely to have an impact on reducing hospital admissions. Approximately 66% of people who use the day rehabilitation service were referred to the maintenance service. In 2008/09 there were 78 admissions to millennium maintenance. The only referral pathway into this service is from the millennium rehabilitation service. The average length of stay for the maintenance service was 44 weeks.

6.4 Ackroyd – Fast Response Beds

In 2008/09, there were 2,190 available bed nights of which 709 were occupied. Bed occupancy rates were 32% at this unit. The low occupancy rates are due to the lower rates of admission combined with earlier discharges. The average length of stay for the service is 13 days. During the first four months of 2009/10 bed occupancy rates dropped further to 28%.

Approximately 33% of Fast Response referrals were accommodated at Netherfield Court or Rothwel Grange during 2008/09.

6.5 Evidence of impact on hospital admissions

A new national indicator (NI 125/VSC 04) was introduced in October 2008 which measures the benefit to individuals from intermediate care and rehabilitation following a hospital episode. The indicator captures the proportion of people who are over 65 years of age who have been discharged from hospital with the intention that they will return to their own home. Data is captured 91 days (3 months) after hospital discharge. The indicator is part of the Department of Health Vital Signs and National Local Government Indicator set. In Rotherham recording of this indicator started in September 2008.

Figure 14 shows the age and gender profile of people who have been discharged from hospital into intermediate care. During 2008/09 around 11% of discharges were people aged between 65-74 years, 47% between the ages of 75 to 84 years and 42% who are aged 85 years and over.

There is a large majority of women accessing intermediate care services from hospital. 79% of all hospital discharges into intermediate care were women.

Figure 14: National Indicator (NI 125) – Age and gender profile - 2008/09

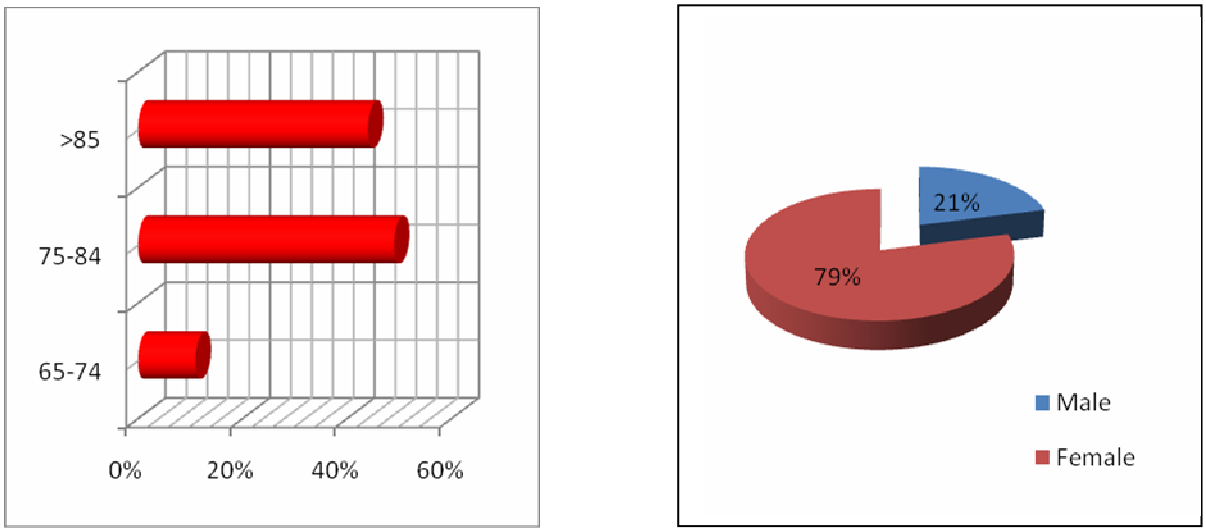
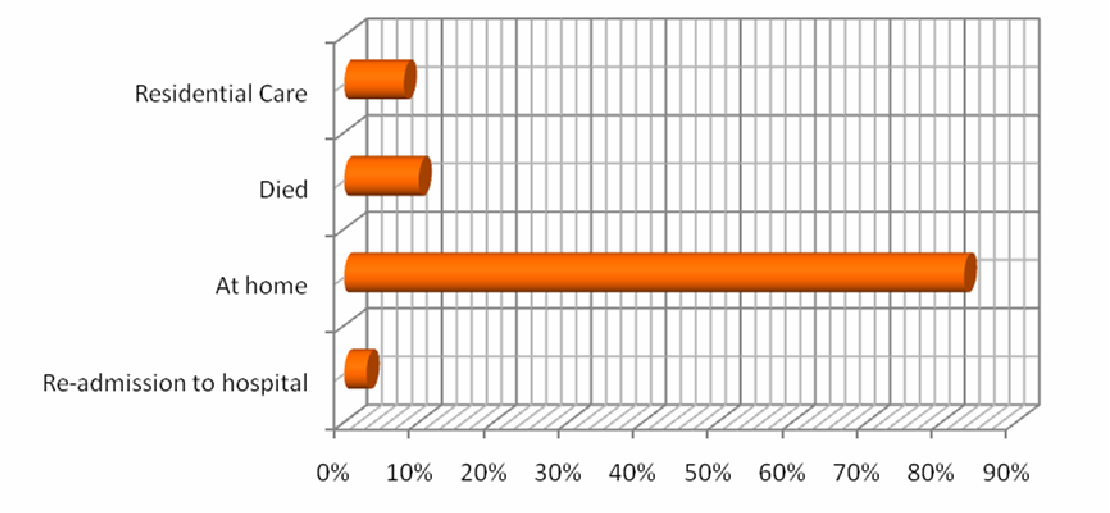


Figure 15 shows the outcome profile for this cohort. During 2008/09 80% of older people discharged from hospital to intermediate care were still at home after 91 days. So far in 2009/10 the proportion of older people still living at home has increased to 82%. Rotherham is currently on target to achieve the top quartile nationally on this indicator.

100% of people aged 65-74, 86% of people aged 75-84 and 74% of people aged over 84 years still living at home 3 months later after hospital discharge. This suggests that the age profile within the service has a significant impact on its ability to achieve targets on NI 125.

Figure 15: National Indicator (NI 125) - Outcomes Profile – 2008/09



6.6 Service User Satisfaction

From 1st April, 2009, customer care exit questionnaires have been distributed to all people in receipt of intermediate care services. Between April and July 2009, 94 questionnaires have been completed which constitutes an overall response rate of 56%. The target response rate is 50%. 53 questionnaires (53%) have been received from the residential service, 24 questionnaires (66%) from community rehabilitation and 17 (55%) from the Millennium Rehabilitation Service. Feedback from questionnaires indicates a high level of patient satisfaction.

- 98% stated that their condition has improved or remained stable since discharge
- 96% stated that the service has re-enabled them to undertake daily living tasks
- 96% stated that the intermediate care service was good, very good or excellent

These service user satisfaction rates were all above target.

The Joint Commissioning Team also carried out a series of interviews with service users as part of the review. This provided a range of views and opinions of the care and support received.

Residential service

13 people were interviewed from the residential service. 77% of service users started physiotherapy within 3 days of entry to the service. Once therapy had started approximately 60% had 5 exercise sessions per week. Sessions included arm and hand exercises, stair work, balance exercises and walking. Only 54% of service users saw an occupational therapist within 3 days of entry to the service. Once therapy had started 23% had 5 daily-living sessions per week. Sessions included meal preparation, laundry skills, other household chores and home visit.

85% of service users stated that the physiotherapy and occupational therapy had been helpful. The same proportion of service users reported an improvement in their condition and confidence levels since arriving. 92% reported satisfaction levels of good or very good. 100% of service users said that the food was good, very good or excellent. Service users said that the care provided by staff was excellent.

Community Rehabilitation Team

4 people were interviewed from the community rehabilitation service. The low number of respondents is due to either problems with people not being able to differentiate between services provided within their own homes or a reluctance to speak to someone that they did not know.

All respondents received six weeks rehabilitation which has helped them to prepare and cook meals, undertake household and personal care tasks, build up confidence and assisted with mobility problems.

Sessions included exercises for hands and legs and support with walking. 50% had been supplied with equipment. All respondents felt that their health and confidence had improved. 75% of respondents were still in receipt of home care but at a reduced level prior to admission. 75% said hat that the service was very good and 25% said that the service was excellent. 75% said they would definitely use the service again and 25% said they would probably use the service again.

Millennium Day Rehabilitation

20 people were interviewed from the day rehabilitation service. 65% reported an improvement in walking. All respondents felt that they found it easier to do personal and household tasks since receiving rehabilitation. 70% felt that their health/condition had improved. 80% of those interviewed felt that their confidence has improved. 70% had been supplied with equipment. 65% thought the service was excellent. All respondents said that they would definitely use the service again.

Under 65 Consultation

Consultation was undertaken with 15 service users who were under 65 years of age and who had been in receipt of residential and non-residential intermediate care services in 2008/09. This was part of an exercise for the recent CQC inspection of Physical and Sensory Disability Services. 84% of service users were returned home after discharge from service. 86% felt that their health/condition had improved since being in receipt of intermediate care services and that they were now able to undertake daily living tasks. 66% felt that the length of stay was about right. 93% reported that their level of satisfaction ranged from good to excellent.

From all service users who had been involved in the interviews there was a range of positive feedback.

- If you required any help during the day or night staff would attend straight away.
- The enablers were friendly, put me at ease and I received one-to-one dedicated support. The enablers provide a reliable service and they always turn up on time. They help you in any way that you ask and are always courteous and polite.
- The enablers are very patient and showed me how to do basic meal preparation.
- The physiotherapist was very encouraging in order to try and get me to walk more.
- I went from a walking frame, then to use crutches and now I only use a walking stick.
- The occupational therapist ensured that I had right equipment in my home.
- Exercise sessions have helped me to walk about much better and are now able to do my daily living tasks. The transport usually turns up fairly on time.

The service users that were interviewed made the following suggestions for service improvement:

- More daily activities, especially in the afternoon.
- Therapy support for longer, perhaps another two or three weeks
- Services need to be targeted to an individual's needs and abilities.
- Need to have a group of people at a similar age and in similar situations.
- Therapy needs to be pitched at the right level as exercises were too easy
- Everyone else was in their 70's and 80's and I would have liked to have been able to see more younger people living there for some social interaction and being able to talk to them at meal-times.

7: Gap Analysis

7.1 Performance analysis

Analysis of current performance

The new performance management framework for intermediate care services has helped deliver a significant improvement in the quality and effectiveness of the service.

Bed occupancy in the residential service has increased by 16% from 56% to 72%. There has been a significant increase in admissions with a predicted increase of 25% this year from 250 per year to 300 per year. During 2008/09 72% of people using the residential service returned home. 82% of people discharged from hospital to intermediate care are still at home 91 days after entry to the service (NI 125). Rotherham is currently on target to attain top quartile on this indicator nationally.

The residential service is however underperforming on length of stay. In 2008/09 the average length of stay in an intermediate care bed was 35 days. This has increased to 39 days during the first 4 months of 2009/10.

93% of those who used the community rehabilitation service remain at home after intervention. The community rehabilitation team continues to perform well on reducing home care packages. During the first four months of 2009/10 home care hours reductions have increased by 110% from 134 per week to 281 per week. This constitutes a predicted annual saving to the home care budget of £517,000 for 2009/10 compared to £346,000 last year. The community rehabilitation service is underperforming on the number of people utilising the service.

The Millennium Day Centre supports over 250 people per year. The service focuses on improving safety, function and independence in a day care setting. It works almost exclusively with people who have been referred from the community and is successful at preventing hospital admissions.

There is still scope for improving performance across the intermediate care service. Benchmarking services are currently achieving bed occupancy rates of over 80% and lengths of stay of around 28 days. It is proposed that local KPIs are amended to reflect bed occupancy levels and lengths of stay levels in other areas.

R1 Targets on current KPIs for bed occupancy and length of stay in the residential service should be revised for 2010/11 to 80% and 28 days respectively.

One of the reasons for low bed occupancy levels is lack of awareness of availability amongst hospital staff and community health workers. Leeds PCT operate a bed management service which has been highly effective in ensuring that occupancy levels remain high. It informs relevant professional what the bed availability is on a daily basis and identifies people who have been in a residential bed for more than 6 weeks.

It is proposed that the intermediate care service develop similar provision in Rotherham. This will help improve performance on bed occupancy and length of stay.

R2 Develop a bed management system which informs the hospital and community health workers of bed availability and provides daily monitoring of bed occupancy and length of stay

New requirements from national guidance

New Department of Health Guidance[2] has highlighted a number of measures that should be monitored within the joint performance management framework for intermediate care services. Rotherham already incorporates a number of these measures. The guidance recommends that KPI suites should include the following quality indicators:

- Number of people achieving individual goals
- Number of people with dementia accessing the service
- Number of people from the BME community accessing the service

In additions to these indicators the guidance advises intermediate care commissioners to collate information on primary diagnosis to help identify conditions which are not properly represented. It suggests that new targets should be introduced which extends anticipated lengths of stay for people with dementia and those who have had a stroke. Commissioners should monitor length of stay in acute care prior to admission to intermediate care. They should also extend NI125 to 6 months to monitor the long term impact of intermediate care on service users.

R3 The joint performance management framework should be adjusted to include KPIs and reporting information identified above.

Measuring impact on hospital admissions

One of the key functions of intermediate care is to prevent hospital admission. Currently the performance framework does not adequately measure the impact of intermediate care on the number of people with ambulatory sensitive disorders being admitted to hospital. It is proposed that new KPIs are introduced which measure this impact. Because the rates of admission for people with ambulatory sensitive disorders can be affected by external factors these KPIs should not be used as a measure of contract compliance. However they will be taken into consideration by commissioners when the service is scheduled to be recommissioned in March 2011.

R4 New KPIs should be introduced on reductions in unscheduled hospital admissions for people with ambulatory sensitive disorders

7.2 Development of an intermediate care hub

The last review of intermediate care services in 2007 made recommendations on service integration. We now have a pooled budget which incorporates all intermediate care services. Clear commissioning arrangements are in place with the joint commissioning team responsible for commissioning of the service. There is a service manager with overall responsibility and clear protocols in place for joint management of health and social care staff.

However there are still issues which act as obstacles to integration. Currently the community rehabilitation team is based at three different sites; Crinoline House, Maltby Service Centre and Manvers. The residential service therapists are located at Netherfield Court. There are dedicated therapists for the residential service and community rehabilitation with no cross-over between the two. There are some benefits to having separate community and residential therapy teams. The skill-sets for the two groups of workers are different and the split ensures that one side of the service does not dominate. However significant benefits can be gained from combining and co-locating the two therapy teams.

It is proposed that the community rehabilitation service is reconfigured so that it incorporates the therapy team at Netherfield and the social work service. This new Intermediate Care Team will adopt a case management approach, preparing and co-ordinating rehabilitation programmes at home and in the residential service. A case manager will be identified for all service users on admission to the service. Therapists will act as case managers supporting service users through the full intermediate care pathway. Case managers will be responsible for improving physical function, achieving outcomes identified in rehabilitation plans and ensuring that support is properly co-ordinated. Whilst reconfiguring the service consideration will need to be given to current knowledge, skills and competencies of staff.

R5 Create a new Intermediate Care Team which incorporates the community rehabilitation service, residential therapists and the social work service

R6 The Intermediate Care Team should adopt a case management approach, co-ordinating rehabilitation packages for service users through the whole intermediate care pathway

It is proposed that the new community rehabilitation service is subject to a single line management structure. Therapy and social care staff will receive professional line management from their employing organisation. Operational line management will be through a dedicated senior therapist working exclusively in-service. Overall responsibility for the service will remain with the Enabling Care Manager at Rotherham MBC.

R7 Develop a single line management structure for the Intermediate Care Team led by a senior therapist working exclusively in-service

It is proposed that the Intermediate Care Team is co-located and based at the Millennium Centre and that this Centre becomes a dedicated hub for intermediate care services in Rotherham. There are significant benefits to this service model. Primarily it will establish a clear service identity with a range of services being delivered from a single point of access. Co-location of staff will facilitate effective communication and peer support. Greater integration will improve efficiency and help develop a person centred approach to rehabilitation.

The Millennium Centre is located next to two other specialist rehabilitation centres. Park Rehabilitation specialises in orthopaedic, amputee and neurological rehabilitation. It has a gymnasium, hydrotherapy pool and extensive facilities. Breathing Space provides day rehabilitation and residential services to people with Chronic Obstructive Pulmonary Disorders. The siting of an intermediate care hub at Millennium provides an opportunity to combine pathways and enhance provision through joint working.

R8 Develop an intermediate care hub at the Millennium Centre, co-locating the Intermediate Care Team

It is proposed that a single point of access for all intermediate care services should be provided from the Millennium Centre hub. There are significant benefits in having a single point of access. It enables the service to identify the most appropriate care pathway on entry to intermediate care. It provides a focal point for assessment, reducing the likelihood of inappropriate admissions to the residential service and providing a consistent interpretation of the admission protocol.

DH guidance on intermediate care services recommends the development of an out-of-hours single point of access. It is proposed that commissioners work with Rotherham MBC to incorporate an out-of-hours access point to intermediate care as part of the integration of Rothercare and Assessment Direct.

R9 A single point of access to be developed for the intermediate care service, which incorporates an out-of-hours access point

As well as the intermediate care day rehabilitation and maintenance services the Millennium Centre houses a BME day care service for 1 day per week and the RNIB Talking Book Service. If the community rehabilitation team is to be re-located to Millennium all non-intermediate care services would have to be transferred to an alternative site.

Although the building has the capacity to incorporate the new community rehabilitation service alongside the day and rehabilitation services, the configuration of the building is not fit for purpose.

NHS Rotherham owns the building which is leased to Rotherham MBC. The lease is due to expire in March 2010. Rotherham MBC pays an annual rent of approximately £38,000 and also liable for repairs and dilapidations. The full cost of the rent is met from the intermediate care pooled budget.

It is proposed that NHS Rotherham and Rotherham MBC develop a new lease agreement which specifies the use of the Millennium Centre as an intermediate care hub. NHS Rotherham and Rotherham MBC will investigate the potential for capital investment ensuring the building is fit for purpose.

R10 Develop a new lease agreement for the Millennium Centre which specifies the use of the Millennium Centre as an intermediate care hub

R11 NHS Rotherham and Rotherham MBC to investigate potential for capital investment, ensuring the building is fit for purpose

7.3 Reconfiguration of the residential service

Although the performance of the residential service is improving there is a significant issue relating to the quality of the environment at one of the units. Rothwel Grange is one of three intermediate care residential units and currently provides 12 rehabilitation beds. Recent investigations by Rotherham MBC have shown that the unit requires extensive refurbishment if it is to achieve standards contained within the Care Standards Act, 2000, and the Disability Discrimination Act, 2005.

Even if the investment were available to help meet these standards this part of the service would not be viable in the long term. Unlike other units, bedroom sizes are small and there are limited en-suite facilities for service users.

There have been persistent low bed-occupancy rates in this Home over the last three years, which has had an impact on performance across the service. In 2008-09 the bed occupancy rates were 49%

It is proposed that Rothwel Grange is decommissioned as an intermediate care facility and that a new residential unit be developed at one of the new local authority residential units. Commissioners will work with Rotherham MBC to switch provision to Lord Hardy Court or Davis Court located at Rawmarsh and Dinnington respectively. Each Home currently has 60 residential and respite beds including EMI provision. Homes are split into wings, each of which operates independently. The plan is to convert one wing of 15 beds into intermediate care provision by December 2009. This is dependent on vacancies becoming available during this timeframe. Vacancies are being held at present, and used for respite provision, in order to maintain bed occupancy.

The new build is fully compliant with National Care Standards and the Disability Discrimination Act. Bedroom sizes are spacious, en-suite facilities are provided, doorways and corridors have been widened for the use of disability and bariatric equipment. There is also ramped access to the building.

Consultation has taken place with residents at Rothwel Grange, relatives, staff and Trade Unions over a six week consultation period to ascertain views on the proposed closure. A report was considered by Elected Members in June 2009 detailing the outcome of the consultation. Rotherham MBC supports the de-commissioning of Rothwel Grange by the end of December 2009.

R12 Decommission Rothwel Grange intermediate care beds by December 2009. Transfer provision to Davis Court or Lord Hardy Court and increase capacity by 3 beds.

One of the key issues that the review has highlighted is the limited number of care enabling hours available in the residential service. This lack of care enabling hours means that it is virtually impossible for the beds to operate safely at full capacity. If the residential service were to reach occupancy levels above 80% the staffing structure would be unsustainable. Lack of care enabling hours also restricts the type of service user that can be supported.

The service is unable to take significant numbers of people with high levels of need. Also the there is limited capacity to support people who require double handling. A significant number of service users who require double handling are passed on to the community rehabilitation service for home-based support. The cost of supporting these patients is extremely high.

Service user feedback has highlighted the need for additional care enabling input during the afternoons. This would increase levels of activity throughout the day, allowing the extension of activity and enabling programmes

It is proposed that the care enabling hours in the residential service are significantly increased. This will ensure that the service can better meet the need of people who require double handling

and those with high care needs. Increasing the capacity of care enablers will also remove one of the main barriers to high bed occupancy in the service.

R13 Commission additional care enabling hours in the residential service to meet higher level of need and increase level of activity for residents

7.4 Decommissioning of Fast Response Beds

The Fast Response beds provided at Ackroyd Clinic have been under-utilised over the last two years. During 2008/09 there were only 56 people who accessed the service. Average bed occupancy was 32%.

The Joint Commissioning Team has carried out an audit of patients referred to Ackroyd. 90% of those who accessed the service had no nursing needs. Of the cohort of patients who had a there was no-one who required 24 hour nursing care.

Approximately 3% of Fast Response patients that require a residential bed are already placed in intermediate care residential units. Fast Response patients with nursing needs are being accommodated within the intermediate care beds with support from Rotherham's district nursing service.

The Fast Response Beds are commissioned as a block contract and cost £133,224 in 2008/09. The cost per patient for last year was £2,379 with an average length of stay of 13 days.

It is proposed that Fast Response beds are decommissioned and that the savings made are reinvested to improve performance, outcomes and quality elsewhere in the service. There are a number of reasons why it is appropriate to decommission the service:

- The unit cost per patient is prohibitive.
- There is capacity in the intermediate care residential units to fill the gap left by loss of beds
- The intermediate care residential units can meet the needs of people referred into the service
- Reducing bed capacity will help improve performance on bed occupancy across the service
- Decommissioning will release savings that can be reinvested

R14 Decommission Ackroyd Fast Response beds by March 2010

7.5 Millennium Day Rehabilitation Service

Recent DH guidance "Intermediate care – Halfway Home"[2] supports the development of intermediate care day rehabilitation. The guidance advocates the use of day care to provide a wide range of interventions, including flexible attendance for assessment, a range of specialist services such as continence services, falls assessment, mental health assessment and therapy outreach to people's homes.

Millennium Day Services are valued by service users and have a significant impact on physical function. The service incorporates a social element, reducing isolation and improving the mental well-being of those that use the facility.

Although the service is far better than those that exist in other areas there are still some issues that need to be addressed. The service provides limited outreach support. The interface between the rehabilitation and maintenance service is unclear and there is a disjointed relationship with other parts of the service.

Co-location of therapists to Millennium will help develop better links between the residential service CRT and Millennium Day Care. Currently the day rehabilitation and maintenance services are delivered by multi-disciplinary teams located on site. It is proposed that these teams are merged and integrated into the new intermediate care team. Rehabilitation assessments and individualised programmes will be the responsibility of case managers. Rehabilitation assistants and support workers could remain specialised in day care rehabilitation and deliver day rehabilitation programmes but they would be situated in the generic intermediate care team.

R15 Integrate Millennium rehabilitation and maintenance teams into the Intermediate Care Team

Currently the maintenance service has 30 places and supports 24 people per day throughout the week. A significant proportion of these service users have attended the service for over 6 months. Clearly these service users should already have reached their rehabilitation potential and so it is assumed that they are using the service as a social day care service. This is an inappropriate use of the intermediate care pooled budget.

It is proposed that the maintenance service is reconfigured so that it delivers time-limited rehabilitation and community integration programmes. The service will continue to provide day care services to current service users for up to 12 weeks. There are also 4 service users who originally attended the Crinoline House day centre in 1996. Upon closure of this centre, Elected Members promised that anyone who still wanted to attend in a social care capacity would be allowed to do so. Commissioners are fully supportive of honouring this promise.

The new service will deliver time limited community integration and rehabilitation programmes, which focus on:

- Improving physical function
- Training and support on healthy lifestyle
- The development of mental well-being
- Reducing social isolation
- Condition management
- Maintaining independence

Programmes will be structured and delivered over a 6 week period. Referral pathways into the service will be opened out to include; GPs, community health staff, the hospital and social care staff.

R16 Reconfigure the maintenance service so that it provides a 6 week rehabilitation and community integration programme

R17 Continue to provide day care provision to those in the maintenance service for up to 12 weeks. For those service users who moved from Crinoline Day Centre in 1996 service will continue indefinitely

It is proposed that new service specifications be developed for this service and the traditional rehabilitation programme, ensuring that the specifications draw a clear distinction between both. The traditional rehabilitation service will focus on physical function and service user's capacity to carry out activities of daily living. The reconfigured maintenance service will focus on community integration, quality of life and mental well-being.

R18 Develop new service specifications for both elements of the day care service, ensuring clear distinction between the two in terms of service delivery and outcomes

R19 Reduce the number of Millennium maintenance places from 30 to 24 per day

R20 Open up the care pathway for both day rehabilitation services to other health and social care professionals

7.6 Development of nurse-led beds

"Better Health Better Lives" states a commissioning intention to reconfigure the intermediate residential service so that it incorporates new nurse-led step-up and step-down provision. This will provide new care pathways out of hospital, reducing hospital length of stay and delivering a stepping stone back to independence.

Commissioners have looked in detail at the potential for development of an intermediate care nurse-led unit and have concluded that there is not a strong enough case for development of this type of provision in Rotherham at this stage.

There is no evidence of significant demand for nurse-led residential provision. Rotherham already has 6 nurse-led fast-response beds at Ackroyd Clinic. These beds have been under-utilised over the last two years. Bed occupancy rates in 2008/09 were only 32%. 90% of those placed at Ackroyd had no nursing needs. Of those that did there were none who could not have been cared for in an existing intermediate care unit. Further evidence of limited demand for this type of provision can be seen at Breathing Space. This nurse-led residential unit, which specialises in supporting people with COPD is under-occupied, currently running at 60% bed-occupancy.

As part of this review commissioners have estimated the cost of delivering a nurse-led intermediate care unit (based on 2008/09 figures). The annual cost of a 14-bed unit is approximately £400,000, which constitutes 12.5% of the intermediate care pooled budget. In order to generate resources from within the pooled budget commissioners would have to decommission the Ackroyd Fast-Response Beds (£133k), the spot purchase beds (£98k) and 8 of the current rehabilitation beds (£143k). There would be no resource remaining for reinvestment into other parts of the service

Early indications from the interqual pilot[8] are that there are a significant number of people currently in hospital whose needs could be met in a nurse-led unit. Over a 16 week period from February to June this year case managers identified 581 bed days that could have been saved on acute wards if a nurse-led step-down unit had been available. However case managers also identified 832 acute bed days that could have been diverted into a therapy-led service. It would not be sensible to attach too much weight to interqual data at this time because it is at an early

stage of development. However indications are that more acute bed days could be saved by investing in, and making better use of therapy-led services.

R21 Nurse-led residential provision should not be developed at this stage. As the service reaches the end of contract commissioners should review interqual data and reassess

7.7 Extending the multi-disciplinary approach

Although commissioners are not recommending the development of a nurse-led residential service, we recognise that the service does require more nursing support. The new DH guidance states that intermediate care teams should include nurses and a wider range of community health workers. Nursing skills are required for people with long-term conditions or those who require treatments such as intravenous antibiotics. Incorporating nurses into the service also provides reassurance to community health professionals, including GPs, who refer patients when they are in exacerbation.

It is proposed that the intermediate care team is enhanced so that it can deliver a broader range of health services. The introduction of specialist health services will improve outcomes and enable the service to accept people with a higher level of need. Savings from the decommissioning of Ackroyd and the Fast Response beds should be reinvested to provide these specialist health services. It is proposed that the service introduce nurse practitioners and health support workers to support the residential service and those working in the community. The health support workers should deliver low level nursing **and** rehabilitation support. They should be trained to carry out this combination of tasks using an integrated competency framework. It is also proposed that the service introduces a speech and language therapy service, providing support to people who have difficulties with swallowing, dysphasia and communication.

This service enhancement could be achieved in one of three ways:

- Reinvestment of savings from decommissioning of Ackroyd and spot purchase beds
- Merging the Fast Response Service with the intermediate care team
- Providing additional investment from the NHS Rotherham Operational Plan

R22 The intermediate care team should be enhanced to include nurse practitioners, health support workers and a dedicated speech and language therapy service. Health support workers will provide appropriate nursing and therapy interventions.

In 2008/09, 31% of discharges from the residential service were late. One of the main reasons for this was delays in social work assessments. These delays had an adverse effect on performance, in particular NI 125 and SAS data.

It is proposed that the intermediate care team incorporates dedicated social services officers who would be responsible for undertaking social care assessments for service users whilst in-service. The inclusion of these posts would increase throughput and improve performance on KPIs in both residential and community

R23 Introduce dedicated social services officers to the intermediate care team

7.8 Supporting people who have had a stroke

NHS Rotherham is currently commissioning a specialist community stroke team. This multi-disciplinary team will incorporate specialist nurses, therapists and support workers. It will support around 200 patients after leaving hospital. It will deliver early supported discharge, rehabilitation and secondary prevention services. The service will be fully integrated with specialist social care provision that is already in place. It will adopt a case management approach, delivering personalised care plans and promoting self management. All services will be delivered as part of an integrated care plan, attaining optimum outcomes in relation to pharmacy, primary care services, social care, orthotics, equipment and adaptations and assistive technology.

The intermediate care service had traditionally offered rehabilitation packages to people who have suffered a stroke. The community rehabilitation service employs therapists who have a background in neurological conditions. There have also been a number of stroke patients who have been referred to the residential service.

National Clinical Guidelines for Stroke (2008), published by the Royal College of Physicians recommends that all patients discharged home directly after acute treatment but with residual problems should be followed up by specialist stroke rehabilitation services. Standard 5 of the National Service Framework for Older People (2001) states that people who have had a stroke should be treated by a specialist stroke service, and subsequently, with their carers, participate in a multi-disciplinary programme of secondary prevention and rehabilitation. Standard 5 focuses on the development of specialised stroke services.

In order to achieve compliance with national clinical guidelines it is proposed that the specialist community stroke team has case management responsibility for stroke victims. The team will be able to refer people to intermediate care but will maintain responsibility for case management and will co-ordinate rehabilitation packages whilst a person is on the intermediate care pathway.

It is proposed that Netherfield Court be designated as a residential rehabilitation unit for stroke survivors. Providers of both services will review provision at Netherfield Court to establish whether the unit is fit to deliver stroke rehabilitation. They will produce a joint action plan which will ensure that Netherfield can fulfill this function in the future.

R24 The community stroke service to have case management responsibility for people discharged from the stroke unit into intermediate care. These service users will have equal access to all other elements of the intermediate care service.

R25 Providers of the intermediate care and stroke rehabilitation service will produce a joint action plan on the development of Netherfield Court as a stroke rehabilitation facility

7.9 Common Assessment Framework and Person Held Records

The new DH guidance on intermediate care advocates a common assessment framework for intermediate care services. This creates efficiencies and speeds up the assessment process by helping to avoid multiple assessments in different settings by different professionals.

The single patient records can be kept within units for other professionals to obtain access such as General Practitioners and Community Geriatricians. A copy of the record could also be kept within people's own homes who are in receipt of the home care enabling or day rehabilitation service. The use of mobile technology for staff who work in the community would be beneficial in order to complete assessments electronically within the person's own home.

R26 A common assessment framework and single patient record is introduced for the service

7.10 Meeting the mental health needs of people in intermediate care

Rotherham's "Older People's Mental Health Strategy" (2006-09) identified the need for intermediate care and Fast Response services to be adapted so people with mental health problems were included. There is a high probability that patients requiring intermediate care for physical reasons will also have an underlying mental health disorder.

The Department of Health's "Securing Better Mental Health for Older Adults" (2005) sets out the argument for establishing, developing and improving mental health services for older people. The paper argues that intermediate care needs to be configured so that it meets the needs of older people with mental health problems. It acknowledges the co-existence of mental and physical illness in people receiving the service. The paper argues that intermediate care services, whether institution or home-based, are currently primarily focused on physical disorders and tend to exclude those with mental illness.

Objective 9 of The National Dementia Strategy (2009) states that intermediate care. It states that care pathways out of hospital and those aimed at hospital prevention often exclude people with dementia. The strategy contradicts the assumption that people with dementia cannot benefit from rehabilitation. It identifies clinical evidence that people with mild or moderate dementia can benefit from physical rehabilitation. The strategy acknowledges that people with severe dementia may need more specialist services geared to meeting their mental health needs as well as those providing general physical rehabilitation.

The National Stroke Strategy Impact Assessment (2007) identifies that 50% of stroke survivors will suffer from depression within 3 months.

In order to address the issues highlighted in these strategic documents it is proposed that staff who work in intermediate care services are required to receive specialist training in dementia care and that they receive advice and support from specialist mental health workers to help ensure that people with dementia are able to benefit from rehabilitation and re-ablement opportunities.

The intermediate care residential service has historically been supported by a specialist mental health occupational therapist and community psychiatric nurse. These posts were frozen in 2005, but have recently been re-introduced. The posts carry out assessments of need and signpost people to relevant specialist services. The Mental Health CPN and OT Service are managed by RDaSH. The specialist CPN and OT have a major role to play in the assessment and treatment of memory and cognitive problems. Mental health problems are a major factor in delaying discharges from the intermediate care residential service.

R27 The service incorporates a specialist occupational therapist and community psychiatric nurse to help meet the mental health needs of service users and that all staff are required to undergo specialist training in dementia care

7.11 Reconfiguration of the GP and Community Geriatrician Service

The GP and community geriatrician service make an important contribution to the intermediate care service. As well as providing basic medical cover they are effective at managing risk and ensuring that the health needs of service users are being met.

There is some overlap between the two services and stronger links are required between the two roles. It is proposed that the residential service develops a person held record for residents in which interventions from both the GP and community geriatrician service can be recorded.

Further work should be done on developing the role of the community geriatrician and/or the GP service. It is important that the clinical support available to the service is able to respond to those people who have a high level of need. It is anticipated that, in the future, there will be more people using the service who have significant health needs. The GP and community geriatrician service will have to be able to respond to this.

It is proposed that a separate piece of work is carried out to consider a new model for delivering medical support to the intermediate care service. There is potential for the community geriatrician to act as a medical consultant responsible for intermediate care. A dedicated community geriatrician for intermediate care could carry out ward rounds on the residential units, and hold overall responsibility for health care plans. The role could be expanded so that it provided support to people who whose condition was being managed at home

The current GP service could be extended so that it took a more pro-active approach to managing the health needs of people on service. The GP service could take on some of the functions identified for an enhanced community geriatrician service. It could also be commissioned to deliver a fast response service to people receiving intermediate care who experience an exacerbation.

R28 NHS Rotherham to work with key stakeholders to develop further proposals on a new model for delivering medical support to the intermediate care service

7.12 End of life care pathway

The new DH guidance on intermediate care identifies intermediate care residential services as being an important part of the End of Life care pathway. The service is committed to delivering the Gold Standards Framework for End of Life, which aims to:

- Improve quality of care provided for all residents from admission to the home.
- Improve the collaboration with GP's, primary care teams and specialist teams.
- Reduce the number of hospital admissions in the final stage of life
- Enable people to die with dignity in their place of choice

Accredited homes receive a quality hallmark award. Rotherham MBC is intending to ensure that 30 Homes are accredited by the end of 2011. It is proposed that all three intermediate care units be accredited within this timescale.

R29 The intermediate care residential service be accredited for End of Life Care by 2011

7.13 Links with other rehabilitation services

NHS Rotherham and RCHS are currently developing a falls prevention service in Rotherham. The service is one of the transformational initiatives identified in Better Health Better Lives. Funding has been secured, a specification agreed and the service is scheduled to start in January 2010. The main aim of the service is to reduce the incidence of falls related injuries and reduce associated secondary care costs.

The service is divided into three tiers. Tier 1 focuses on population wide identification, intervention and prevention. Tier 2 is a primary care falls service delivered by RCHS incorporating rehabilitation and triage. Services include a series of 12 week rehabilitation programmes aimed at reducing falls risk, maintaining physical function and improving confidence. Tier 3 is a multi-disciplinary specialist falls service based at RFT.

There is a significant degree of overlap between the falls prevention service and intermediate care. Both carry out rehabilitation assessments for people who are a falls risk. Both services deliver time-limited rehabilitation programmes aimed at improving physical function. Finally both services are delivered by the same provider.

It is proposed that NHS Rotherham commissioners work with RCHS to explore the potential for combining the falls prevention and intermediate care services. A feasibility study should be carried out to establish whether a combined service could:

- Deliver efficiency savings for the health and social care economy
- Deliver a single care pathway for people identified as a falls risk
- Enhance the quality of care being delivered to service users in both parts of the service

R30 Carry out a feasibility study on a combined intermediate care and falls prevention service

The development of an intermediate care hub at the Millennium Centre provides an opportunity to link intermediate care with other rehabilitation facilities based on the same site.

Breathing Space is a specialist rehabilitation facility for Chronic Obstructive Pulmonary Disorders (COPD). The service is currently being piloted and is scheduled for evaluation. Breathing Space incorporates 20 nurse-led beds for respite and rehabilitation. It also includes a day rehabilitation programme, accessed by GPs, community matrons and community health workers.

Park Rehabilitation Centre provides day rehabilitation for people with orthopaedic, amputee or neurological needs. There are specialist teams on site for both types of rehabilitation. The Centre has a gymnasium and hydrotherapy pool. This rehabilitation centre is owned by NHS Rotherham but leased to Rotherham Foundation Trust.

All three of these rehabilitation services have been commissioned separately and service different care pathways. There is scope for cross-utilisation of facilities and there is potential for generating efficiencies by streamlining rehabilitation provision across the site.

It is proposed that NHS Rotherham carry out a separate review of rehabilitation services across Rotherham, which maps current provision and considers ways in which to streamline services. The review should focus on the potential for developing a rehabilitation hub at the Badsley Moor Lane site.

R31 Commissioners carry out a review of rehabilitation services across Rotherham, focusing on the potential for developing a rehabilitation hub on the Badsley Moor Lane site

8. Financial modeling and option appraisal

The Joint Commissioning Team has carried out financial modeling on 3 options.

1. 5% reduction in the intermediate care pooled budget
2. Zero growth (0%)
3. £200,000 additional investment from the NHS Rotherham Operational Plan

All options assume that the value of the pooled budget in 2009/10 was £3,242,000. Currently Rotherham MBC contribute 53% of the pooled budget with NHS Rotherham contributing 47%. All options are based on budget values during this year[9].

8.1 Option 1 - 5% reduction in the intermediate care pooled budget

A 5% reduction in the intermediate care pooled budget could be achieved by decommissioning the Ackroyd Fast Response beds and the spot purchase beds and not reinvesting savings back into the service.

Benefits

- Removes poorer performing service elements, delivering better value for money
- Limited impact on current service and KPIs

Disadvantages

- Service would not comply with new national guidelines for intermediate care
- Dilutes a service that could have a direct impact on costs further down the care pathway
- Service will have difficulty meeting rising level of need and demand from hospital discharge
- Removes all nurse-led support from the service

Recommendations that would not be implemented

R13 Introduction of additional care enabling hours to the residential service
R24 Introduction of nurse practitioners, health support workers and a SALT service

8.2 Option 2 - Zero growth (0%)

This assumes that there will be no additional revenue commitment from NHS Rotherham or Rotherham MBC but that savings from the decommissioning of Ackroyd and the spot purchase beds are reinvested.

Benefits

- Removes poorer performing service elements, delivering better value for money
- Reinvestment assist process of reconfiguration, making the service strategically relevant
- Targeted reinvestment will improve performance and deliver savings in the health economy
- Increased level of compliance with the new DH guidelines

Disadvantages

- All nurse-led support removed from service with no replacement
- Service would still not comply with new national guidelines for intermediate care
- Service effectiveness on preventing hospital admission would be compromised

Recommendations that would not be implemented

R24 Introduction of nurse practitioners and health support workers

8.3 Option 3 - £200,000 investment from the NHS Rotherham Operational Plan

This option incorporates additional investment from NHS Rotherham to incorporate specialist nurses and health support workers into the intermediate care service.

Benefits

- Service able to support people with nursing needs, reducing likelihood of hospital admission
- More likely to generate savings further down the care pathway
- Compliance with new DH guidance on intermediate care
- Service is better able to respond to people with high needs
- Would enable full implementation of the intermediate care review

Disadvantages

- Increase in revenue costs for the service

NHS Rotherham Board has recently agreed that no new recurrent investment will be made in services unless savings can be guaranteed elsewhere in the care pathway. In light of this it is proposed that NHS Rotherham and Rotherham MBC endorse Option 3 with NHS Rotherham making a non-recurrent investment into the service until the current service level agreement expires in March 2011. At this point the service will have been evaluated to assess its impact on secondary care costs and NHS Rotherham can decide whether to continue the investment.

R33 Endorse the financial model set out in Option 3, with NHS Rotherham committing additional investment of £200,000. Additional investment is non-recurrent.

9. Implementation and future commissioning

The timetable for approval of the intermediate care review is set out in Table 2

Table 2 – Timetable for approval of intermediate care review

Action	Date
NHS Rotherham Management Executive	20th October
NHS Rotherham Professional Executive	4th November
NHS Directorate Management Team	10th November
NHS Rotherham Board	16th November
Cabinet Member for Health and Social Care	23rd November
Adults Board	26th November
Adult Services Health and Scrutiny Panel	3rd December

After approvals it is proposed that Rotherham MBC and RCHS develop an implementation plan for the first Adults Board meeting in 2010. The implementation plan should ensure full compliance with the review recommendations by June 2010 allowing a 6 month implementation period.

R34 Rotherham MBC and RCHS submit a joint implementation plan to the Adults Board in January 2010 and that the review recommendations be fully implemented by June 2010

The current service level agreement for the intermediate care service is due to expire in March 2011. It is proposed that the service is recommissioned with the current providers at this time if the following conditions have been met:

By January 2010 current providers should have:

- Developed an implementation plan which has been approved by the Adults Board

By June 2010 current providers should have achieved:

- Full implementation of the review recommendations within the timescales set
- Continued improvement in performance on all KPIs but particularly on bed occupancy, length of stay, readmissions to hospital and the number of people supported in the community

By December 2010 current providers should have achieved commissioner-set targets on:

- Secondary care costs of people with ambulatory sensitive disorders
- Reduction in the number of people with an ambulatory sensitive condition admitted to hospital

It is proposed that the service is put out to open tender if these conditions are not met.

R35 Rotherham MBC and NHS Rotherham recommission the service with current providers in April 2011 if conditions are met. The service will otherwise be subject to an open tendering process

References

1. The Rotherham Joint Commissioning Strategy

2. Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities

3. Our Future Health Secured? A review of NHS funding and performance (Kings Fund)

4. Wanless Social Care Review: Securing Good Care for Older People (Kings Fund)

5. Our Health, Our Care, Our Say (DH)

6. NSF for Older People: Supporting Implementation Intermediate Care - 2002 (DH)

7. The Rotherham Joint Strategic Needs Assessment

8. Presentation on results from Interqual February – May 2009

9. Spreadsheet on financial modelling of intermediate care services

ADULT SERVICES AND HEALTH SCRUTINY PANEL
Thursday, 12th November, 2009

Present:- Councillor Jack (in the Chair); Councillors Barron, Blair, Clarke, Goulty, Hughes, Kirk and Wootton.

Also in attendance were Jim Richardson (Aston cum Aughton Parish Council), Russell Wells (National Autistic Society), Mrs. A. Clough (ROPES), Victoria Farnsworth (Speak Up), Mr. G. Hewitt (Rotherham Carers' Forum), Ms. J. Mullins (Rotherham Diversity Forum) and Mr. R. H. Noble (Rotherham Hard of Hearing Soc.) Mrs D Swanson; Councillors Doyle and P Russell

Apologies for absence were received from Councillors Hodgkiss, Turner and Mr K Jack

51. COMMUNICATIONS.

Rotherham Carers Centre

Councillor Doyle gave an update in respect of the Carers Centre in Rotherham.

He reported that it had been agreed at his delegated powers meeting on Monday 9th November that the new centre would be situated on Drummond Street in the town centre. It was in close proximity to other council offices within easy access of local transport links. It also provided access for disabled people.

There would be a Carers Engagement Officer, a Carers Support Officer and a Public Support Officer housed within the centre offering a first class service for all carers.

National Networking Event for Health, Care and Wellbeing Scrutineers

The Chair announced that the National Event for Health, Care and Wellbeing for Scrutineers was to be held on Tuesday 24th November 2009 at Thackray Museum in Leeds between 11.00 am and 3.00 pm. There was one place still available and anyone interested should contact Delia Watts.

52. DECLARATIONS OF INTEREST.

No declarations of interest were made at the meeting.

53. QUESTIONS FROM MEMBERS OF THE PUBLIC AND THE PRESS.

There were no members of the public and press present at the meeting.

54. PERSONALISATION AGENDA - PRESENTATION BY TOM SWEETMAN, INNOVATIONS MANAGER

Tom Sweetman, Innovations Manager and Richard Waring, Direct Payments Manager gave a powerpoint presentation in relation to progress made in respect of Personalisation in Rotherham.

The presentation drew specific attention to:-

- The story so far
- What's it all about?
    - It's about people
    - It's about services
    - It's about quality
    - It's about partnerships
- Who benefits?
- It's about vision
- What does it mean for Members?
- Key role for Members
- Where did the plan begin?
- Guiding Principles
- Positive Feedback
- Rotherham – National Praise
- The Plan
- Direct Payments
- Hot Off the Press
- The Way Ahead

A question and answer session ensued and the following issues were discussed:-

- How many more staff would be required to make personalisation viable and would it require additional budget? It was confirmed that personalisation had been introduced to give a greater choice to customers but at no extra cost. Therefore there would be no additional budget or staff required.
- A comment was made about relatives being employed under the direct payments scheme and it was queried whether this was a change in policy. Confirmation was given that this would only be allowed in special circumstances and would be more the exception rather than the rule.
- It had been suggested in the presentation that personalisation would allow customers to live a more "normal" life. A query was raised as to how this would be achieved in reality when most services were only available up to early evening. It was confirmed that direct payments would allow a customer to employ a personal assistant who would work the hours to suit their needs.
- Concerns were raised that there were customers that preferred to use the more traditional services but would not be able to as a result of direct payments. Assurance was given that this would not be the case, direct payments would allow customers a wider

choice, which would include the more traditional services.

- A query was raised about the Social Care Reform Grant and what it had been used for. The Director of Commissioning and Partnerships confirmed that it had been used in a variety of ways including, setting up direct payments, supporting services through re-commissioning, employing more social workers and setting up the many visioning days which had taken place.
- How other services could take up the personalisation agenda? This would centre around demand for specific services such as transport and leisure services
- If services were tailored around the individual were there risks of
    - Not being able to benefit from economies of scale when commissioning services to get best value?
    - Services not being able to expand or forward plan because they had no long term contracts?

  It was confirmed that personalisation was all about customers being able to choose the services they wanted and therefore services would have to change to accommodate this.
- A concern was raised as to how customers would be assisted with the legalities of employing staff ie personal assistants. Confirmation was given that agencies were employed to assist with employment law and payroll services.
- It was felt that personalisation was going to be an excellent way to overcome the existing problem of social isolation which old people often suffered from.

The Chair thanked Tom and Richard for their informative presentation.

55. ROTHERHAM COMMUNITY HEALTH SERVICE - PRESENTATION BY LORRAINE WATSON, ASSOCIATE DIRECTOR

Lorraine Watson, Associate Director, Adult Services Rotherham Community Health Services gave a presentation in respect of the role of Rotherham Community Health Services.

The presentation drew specific attention to:-

- Areas to be covered:
    - Split between NHS Rotherham and Rotherham Community Health Services
    - Overview of what Rotherham Community Health Services provide
    - Changes there were going to be
    - Value for money and high levels of service could be demonstrated.
- National Agenda/Background Information
- Rotherham PCT
- Rotherham Community Health Services – Adult Services
    - Services for Long Term Conditions
    - Acute Care in the Community

  - Health and Wellbeing and Reducing Inequalities
  - Rehabilitation services
  - End of life care
- Changes
- Transforming Community Services Programme
- Value for Money and High levels of Service demonstrated
- Commissioning Strategy – Better Community Services

A discussion took place around rehabilitation following strokes and whether this had been linked into the new services. It was confirmed that access was given to the various tests when a patient arrived at hospital with symptoms of a stroke and rehabilitation was available for 6 months following discharge from hospital.

Also it had been identified that there had been a gap in relation to rehabilitation for cardiac patients but this had now been rectified.

Reference was made to the split between NHS Rotherham and the Community Health Service and a query was raised as to whether this was a true split. Confirmation was given that there was still a statutory link between the two organisations but in real terms they were working independently of each other.

56. ANNUAL REPORT OF THE JOINT LEARNING DISABILITY SERVICE - PRESENTATION BY JACKIE BICKERSTAFFE, HEAD OF LEARNING DISABILITY SERVICE

Jackie Bickerstaffe, Head of Learning Disability Service gave a powerpoint presentation in respect of the Annual Report of the Joint Learning Disability Service.

The presentation drew specific attention to:-

- The Learning Disability Service
- Partnership
- Staff
- Inspections
- Performance
- Finance
- Health
- Main Team Objectives
- 2009/10 Developments
- Achievements

The Chair commented that the NHS in-patient Assessment and Treatment Unit had 6% of bed occupancy taken up by other Authorities. She asked what steps were taken to ensure that generating income in this way did not lead to lack of beds for local people when needed. It was confirmed that it was the aim of the outreach service to reduce the number of

admissions into hospital and to give care in the home.

57. PROGRESS OF PERFORMANCE CLINICS INTO JOINT DISABILITY EQUALITY SCHEME

Consideration was given to a report in respect of the progress of Performance Clinics into Joint Disability Equality Scheme (JDES).

At the Scrutiny Panel meeting on 4th December 2008, the Panel expressed concern at the lack of progress being made in respect of the JDES.

An initial clinic was held on 18th May 2009 with a follow up clinic being held on 30th September 2009. It transpired that there had been no single point of contact within the council on the JDES since March 2008. The Community Engagement Cohesion Manager commented that responsibilities needed to be split between directorates with directorates and user groups communicating effectively.

The JDES contained numbers actions, grouped thematically within six 'Strategic Aims' in order to run and deliver services to improve the lives of disabled people.

The Disability Network was to include representation of all groups including physically disabled, people with mental health problems, having learning disabilities, older and younger people and people from BME communities.

At the May performance clinic it was recognised that there had been a collapse of several important networks due to funding issues and there was still a need to re-establish the disability group of users and voluntary groups who would engage with officers.

Discussions had taken place regarding the Disability Network membership and a request had been made to view the database. This had been refused due to data protection issues and the following suggestions were made as an alternative:-

- That the Council contact people direct to ask them if their details may be passed on
- NAS had its own database of user forums which was up to date
- That visitors to the Fair's Fayre be added to the database and asked at the time if they were happy for their details to be shared.

It was confirmed that Voluntary Action Rotherham had the contract from the Council to manage the LINk (Local Involvement Network) which had an extensive membership which may be a way forward in terms of co-ordinating the work.

Another strategic aim was to set up a Centre for Inclusive Living in

Rotherham and to work with other organisations to achieve this.

At the performance clinic in September there had been some discussion around this and it was suggested that an imaginative solution to this would be to include carers, advocacy and disabled people as part of the continued modernisation of social care. Discussions were in progress about whether there needed to be an actual facility to accommodate this or whether it could be a virtual service.

It was suggested that the ongoing work in relation to the Centre for Independent Living be brought to a future meeting of the Scrutiny Panel.

The Scrutiny Officer reported that the next JDES meeting would be taking place on Wednesday 13th January 2010 at 9.00 am at the Council Offices at Doncaster Gate and all partners would be invited to attend.

Resolved:- (1) That the Panel's concern about lack of progress on the JDES be noted.

(2) That Councillor Sharman, Chair of the Performance Clinic be invited to report on progress made in early 2010.

58. NHS PERFORMANCE RATINGS 2008/09

Consideration was given to a report which detailed the annual performance ratings for all NHS organisations in England. These rates were evaluated on how effectively organisations manage their finances and the quality of their service.

Revolved:- That the performance of the local health trusts be noted.

59. CQC ADULT SOCIAL CARE INSPECTION REPORT

Consideration was given to a report which summarised the findings of the Care Quality Commission Inspection of Adult Social Care focussing on Safeguarding Adults and Physical Disability and Sensory Impairment.

Resolved:- That the findings of the Inspection be noted.

60. MINUTES OF A MEETING OF THE ADULT SERVICES AND HEALTH SCRUTINY PANEL HELD ON 1ST OCTOBER 2009

Resolved:- That the minutes of the meeting of the Panel held on 1st October 2009 be approved as a correct record for signature by the Chair.

61. MINUTES OF A MEETINGS OF THE CABINET MEMBER FOR HEALTH AND SOCIAL CARE HELD ON 28TH SEPTEMBER 2009 AND 12TH OCTOBER 2009

Resolved:- That the minutes of the meetings of the Cabinet Member for

Health and Social Care held on 28th September 2009 and 12th October 2009 be received and noted.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
Monday, 26th October, 2009

Present:- Councillor Doyle (in the Chair); Councillors Gosling, Jack and P Russell.

Apologies for absence were received from Councillors Barron and Walker.

H46. MINUTES OF THE MEETING HELD ON 12TH OCTOBER 2009

Resolved:- That the minutes of the meeting held on 12th October 2009 be approved as a correct record.

H47. MATTERS ARISING

Common Assessment Framework for Adults – Phase Two Demonstrator Site Programme

The Strategic Director reported that the bid for Common Assessment Framework for Adults – Phase Two Demonstrator Site Programme had been unsuccessful. He confirmed that it was being investigated as to why Rotherham had been unsuccessful when other authorities had been successful and he would report back on the findings at a future meeting,

H48. DOMESTIC VIOLENCE CONFERENCE - 16TH NOVEMBER 2009

Consideration was given to attendance at the Domestic Violence Conference in London on 16th November 2009. The Cabinet Member was asked to agree attendance for a member and a nomination was sought.

Resolved:- (1) That the Cabinet Member agree to attendance for a Member at the above conference;

(2) That Councillor Hilda Jack be nominated to attend.

H49. CHAMPION FOR PUBLIC HEALTH

Consideration was given to the nomination of a Member to undertake the role of Champion for Public Health.

Resolved:- (1) That Councillor Jo Burton be nominated to undertake the role.

H50. LAUNDRY SERVICE OPTIONS APPRAISAL

Shona McFarlane, Director of Health and Wellbeing presented the submitted report which provided a summary of the options appraisal regarding the future of the laundry service.

The laundry service currently ran from the Fitzwilliam Centre with around 180 individual service users. In addition there were a number of ongoing contracts with organisations including Breathing Space and Rotherham Hospice. It was a "one size fits all" service which collected laundry from pick up points, washed and dried it before returning it to the pick up point for the service user (or home carer) to collect. It ran on fixed days in particular areas and in this aspect was not personalised.

It had been agreed by Assessment and Care Management (Health and Wellbeing) that existing service users would receive individual care needs review and these were now underway. In terms of consultation, existing customers received a letter about the future of the service in April 2009 and this would be followed by a questionnaire.

Of the original 12 members of staff, 3 had been redeployed and one had retired, which left 8 working in laundry. They had all been interviewed by HR and Service Manager regarding redeployment and were considering a variety of options.

One of the key areas for consideration was the ongoing costs of repairs and maintenance which would be a major factor in determining future viability. The building on Fitzwilliam Road was owned by RMBC and there were some areas of routine maintenance which needed dealing with if the building was to continue being used. The main areas for consideration were:

- The boilers needed to be replaced at an approximate cost of £40,000
- Some re-wiring was required, possibly a full re-wire at a cost of up to £30,000.

RMBC were the only South Yorkshire Authority which provided an in-house service as Sheffield had no laundry service, Barnsley provided a continence service only and Doncaster provided an ordinary service only.

Other Authorities had no special internal arrangements to cover incontinence laundry and continence advice and support was routinely given by NHS and community nurses. This included provision of continence wear and bedding protection, following an assessment of need.

The options were appraised based on:-

- Strategic Fit
- Financial Issues

The options considered were:-

1. Retain current service provision
2. Review the current operation of the service to improve efficiency,

reduce costs and increase income
3. Close the in-house service with no replacement
4. Develop a Social Enterprise in partnership with VAR (Voluntary Action Rotherham)
5. Tender the Service

The options were compared and the two least favoured were 1 and 5 as they did not meet financial or strategic intentions and priorities.

A SWOT analysis of the remaining 3 options was presented in the options appraisal and the analysis favoured option 3 to close the service, although option 2 also had some appeal dependent on strategic priorities. Option 4 was not considered to be an option because of the prospect of TUPE applying to existing staff. VAR had clearly stated this would present unacceptable financial risk to them and their partners and was, in effect, a "deal breaker".

A discussion ensued about option four and it was felt that more communication should have taken place if the only problem was the prospect of TUPE applying to existing staff. It was confirmed that there was also the matter relating to the cost of buildings and that staff could have justifiably taken the Authority to an employment tribunal which would have incurred costs.

A concern was raised about customers using the incontinence service. It was felt that there was a risk of infection spreading if laundry was done at home.

A query was raised as to the number of clients who were referred to the specialist service at the hospital to overcome incontinence. The Director of Health and Wellbeing was unsure of the exact figure but felt that of the 180 service users that there was very few accessing this service.

A discussion took place around the underuse of the Neighbourhood Centres and whether it was possible to encourage people to make more use of them. Confirmation was given that this was being looked at as part of the Neighbourhood Centre Review.

It was noted that not all customers had a washing machine in their home and the question was raised as to how this would be overcome. It was confirmed that each case would be dealt with on its on merit and resolved accordingly.

One member queried why the option to increase the amount charged for the laundry service had not been explored. There were two reasons why this had not been put forward as an option:

1. It would need to be increased to £7-£9 per load, which most people would be unwilling to pay.

2. Even with this sort of increase there would be very little income received as a result.

Members commented that the only alternative being offered appeared to be for laundry to be done at home. It was queried as to what other services were available to customers within the community. The Director of Health and Wellbeing confirmed that there were other service providers available at a cost, or there was the option of using launderettes.

Members queried how many customers used the laundry service with incontinence problems, and of those how many had learning difficulties. The Director of Health and Wellbeing was unable to give an exact figure but confirmed that any customer with these needs would be supported. With regard to the customers with learning difficulties, confirmation was given that these service users were supported by the Leaning Disability Service and therefore were not included in the figure quoted of 180.

Resolved:- (1) That the conclusions of the Options Appraisal be noted.

(2) That the Cabinet Member confirm the closure of the laundry service with all service users being given a full assessment of needs and appropriate measures be introduced to meet those assessed needs in a personalised way.

THE CHAIRMAN AUTHORISED CONSIDERATION OF THE FOLLOWING ITEM TO MEMBERS INFORMED

H51. CARERS ASSESSMENT

Councillor Jack wished to place on record her appreciation to the department following the recent assessment which had taken place in respect of her husband. She confirmed that the support they had been given was excellent and she felt that recognition needed to be given to the staff involved.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
9th November, 2009

Present:- Councillor Doyle (in the Chair); Councillors Barron, Gosling, Jack, P Russell and Walker.

H52. MINUTES OF THE MEETING HELD ON 26TH OCTOBER 2009

Resolved:- That the minutes of the meeting held on 26th October 2009 be approved as a correct record.

H53. CENTRE FOR INDEPENDENT LIVING

Shiv Bhurton, Housing Access Manager presented the submitted report which provided information relating to work undertaken to explore the concept of and establish the need for a fit for purpose "Independent Living" Centre in Rotherham.

Independent Living Centres vary within our immediate region in terms of how they were delivered and why they were originally developed. They were mainly a service which provided free and impartial assessment and information to any potential user on a range of issues, typically including:-

- Assistive technology and equipment such as aides, chairs, beds, kitchen equipment and stair lifts
- Information on benefits and employments
- Careers training to enhance independence
- Advocacy services
- Support with Direct Payments and Individual budgets

They were typically non-residential, private, not for profit, consumer controlled, community based organisations providing services and advocacy by and for persons with all types of disabilities. Their goal was to assist disabled people and their families/carers achieve their maximum potential within their home, life and communities. They served as a focus for advocacy as well as pressure groups working to improve access to housing, employment, transportation, communities, recreational facilities, and health and social services. Independent Living Centres promotes and enables a focus on delivering services for the vulnerable disabled groups in line with a 'social model of disability' by reducing barriers to access and changing attitude to improve inclusion.

A review of the document was undertaken last September and it was agreed that rather than commissioning a discreet Independent Living Centre, further work should be undertaken to improve access to and make better use of existing resources such as the South Yorkshire Centre for Inclusive Living at Doncaster, the Extra Care housing facilities and REWS. This would determine any gaps in existing services for disabled people that could then be identified in our commissioning priorities when developing the right CIL model.

A task and finish group was established to explore:-

- How to ensure that the range of existing service were better coordinated so that disabled people, their families and carers could make the best use of the available resources in the Borough.
- How existing services could be improved to ensure that the needs of disabled people were better served and whether there were any gaps that needed to be identified in our commissioning priorities
- How and where we should direct out Preventative Technology Grant to establish demonstration sites to showcase the available equipment available to disabled and vulnerable people. This would include exploring partnerships with commercial business such as the Parkgate Mobility centre or making better use of existing resources such as at our Extra Care Services, within REWS, hospitals or joint service centres and partnership developments venues such as Breathing Space.
- Obtaining feedback from stakeholders such as the PCT and joint service providers in mental health and learning disabilities.

The group was set up in November and key stakeholders and partners were invited to contribute and progress the above actions. The membership gradually expanded to include representatives from the following:

- Voluntary Action Rotherham (VAR)
- Age Concern
- RMBC – Strategy team
- RMBC – Chief Executive team
- RDIS – Charlott Bailey
- Joint Equipment service – REWS
- Service User – Mr Qureshi
- User – Lizzie Williams
- South Yorkshire Centre for Independent Living (SYCIL)
- South Yorkshire Transport
- Speak Up Advocacy service

The group progressed work up to April 2009 and concluded with the following:-

- That a centrally located CIL in Rotherham Town Centre would not meet the needs of all the disabled residents within the Borough
- That similar activity in relation to the development of a CIL in Rotherham, by Charlotte Bailey and Mr Qureshi and also the Chief Executive office through Zafar Saleem, would benefit from merging as one project.

- That such a project should be formally led by service users with support from RMBC providing appropriate resources

It was clear through the group that a collective and coordinated approach supported with resources was key to progress further, which triggered group members to refocus on developing a user lead steering group with support from VAR, SYCIL and Speak Up. To further enhance support for this development, NHSR provided a one off grant of £6k to secure an experienced information officer, alongside support from Speak Up and VAR. The two primary objectives identified were:

- To develop a User led Steering Group to lead on the development of a CIL
- To deliver an Independent Living Equipment Exhibition to raise awareness.

To date the Information Officer from SYCIL had been working towards building links. Work was also ongoing on supporting plans for a model of providing brokerage/care navigation support for people moving onto Individual Budgets and the development of the most appropriate CIL model that would suit the Borough of Rotherham.

As initial needs were identified to focus around aids and equipment as well as Independent Advocacy, it was the intention of the group to be more involved in the wider review of the Joint Equipment service partnership agreement between RMBC and NHSR. This review was planned to be completed by January 2010 with a view to inform a new way of making aids and equipment accessible to disabled customers which supported choice and control.

Resolved:- (1) That the development of a Centre for Independent Living be not recommended for the reasons outlined in the business case, which were principally about value for money.

(2) That the further work underway be noted and support be given to the user led steering group to enable better access to services, information and advice to enable independent living.

H54. ADULT SERVICES REVENUE BUDGET MONITORING REPORT

Mark Scarrott, Finance Manager (Adult Services) presented the submitted report with provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March 2010 based on actual income and expenditure to the end of

September 2009.

The approved net revenue budget for Adult Services for 2009/10 was £72.9m which included additional funding for demographic and existing budget pressures together with a number of new investments and efficiency savings identified through the 2009/10 budget setting process.

The latest budget monitoring report for Adult Services showed some underlying pressures of £2m, however after taking account of a number of achieved savings and assuming the achievement of all management actions it was forecast that there would be an overall net overspend of £225k by the end of the financial year, a reduction in the forecast overspend by £95k since the last report.

Management actions of £1.004m were endorsed by the Cabinet Member on 14 September 2009 and since the last report a further £135k Management Actions had been identified to reduce the budget pressures. A total of £408k had already been achieved to-date and were now included in the detailed forecasts. This reduced the underlying pressures to £956k and left a balance of £731k management actions to be achieved by the end of the financial year.

The latest year end forecast showed the main budget pressures in the following areas:-

- Home Care as a result of delays in shifting the balance of provision to the independent sector (£740k). The 70/30 split was achieved at the end of July 2009 and the balance had now moved beyond 70/30 towards an 80/20 ration that the Cabinet recognised as the optimum level based on experience elsewhere in the country.
- Independent sector home care provision for Physical and Sensory Disability clients had increased by an additional 970 hours since April 2009, a further 38 clients were now receiving a service. This was resulting in an overspend of £332k against the approved budget.
- A significant increase above approved budget in clients receiving a Direct Payment within Physical and Sensory Disabilities and Older Peoples Services (£380k).
- Additional one-off expenditure was being incurred in respect of the costs of boarding up, removal of utilities and security costs at the former residential care homes prior to them transferring to the Council's property bank (£200k).
- Delays in the implementation of budget savings agreed as part of the budget setting process for 2009/10 in respect of meals on wheels (£240k), laundry (£160k) and the bathing service (£40k).

These pressures had been reduced by :-

- Additional income from continuing health care funding from NHS Rotherham (-£305k).

- Delays in the implementation of new supported living schemes within Learning Disability services (-£205k).
- Savings within independent residential care due to an increase in income from property charges (-£428k).
- Savings on the reconfiguration of Extra Care housing (-£315k).
- Slippage in recruitment to a number of new posts (-£78k) where additional funding was agreed within the 2009/10 budget process.

The Directorate continued to identify additional management actions to mitigate the outstanding budget pressures above. A number of management actions had already been achieved and were included in the financial forecasts. These included additional savings on supported living, residential short stay placements, independent residential care costs within Older People services and savings from the decommissioning of in-house residential care.

To further mitigate the financial pressures within the service all vacancies continued to require the approval of the Directorate Management Team. There was also a moratorium in place on non-essential non-pay expenditure. Budget meetings with Service Directors and managers took place on a monthly basis to robustly monitor financial performance against approved budget including achievement against the proposed management actions and consider all potential options for managing expenditure within the approved revenue budget.

Resolved:- That the latest financial projection against budget for the year based on actual income and expenditure to the end of September 2009 for Adult Services be noted.

H55. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972.

H56. CARERS RESOURCE CENTRE

Chrissy Wright, Director of Commissioning and Partnerships presented the submitted report which set out proposals to use resources available for carers more efficiently and effectively by not renewing the contract for the Carers Forum with the current provider and instead utilising the money and other investment from Carers Group to develop a Carers Resource Centre.

In addition, there were significant performance and prevention benefits

associated with the development of a Carers Resource Centre which were issues identified in the CQC Inspection. The centre would host a range of services; information and advice in one place, which would help more carers than existing services and would deliver far more outcomes. The proposal was based upon consultation with carers and underpinned the public commitments and targets that have been made within Rotherham's Local Area Agreement and Joint Carers Strategy.

Resolved:- (1) That the development of a Carers Resource Centre which would include the Carers Forum be approved.

(2) That the location of the site at Drummond Street be approved.

(3) That the additional expenditure of £30k from Carers Grant be approved.

H57. FEE SETTING - INDEPENDENT SECTOR RESIDENTIAL AND NURSING CARE 2010/2011

Doug Parkes, Business Manager presented the submitted report which sought the agreement of Elected Members to set the fees to be paid to Independent Section Residential and Nursing Care Providers for 2010/2011 in accordance with the established inflation formula.

This inflation linked formula was a contractual commitment.

Due to the combination of the low pay inflation rate and the negative rate of non-pay inflation there would be no increase in the baseline fees for 2010/2011.

However, in order to continue to drive standards, additional funding had been made available to pay a premium to those homes achieving the Gold Status in the Council's Home from Home Quality Premium Scheme.

Resolved:- That the report be received and the fee levels for Residential and Nursing Care Home, as set out in paragraph 7 of the report be agreed subject to consultation with the Contracting for Care Forum, to be effective from 11th April, 2010.

H58. RE-COMMISSIONING OF VCS CONTRACTS FOR PERSONALISATION

Chrissy Wright, Director for Commissioning and Partnerships presented the submitted report which set out options for recommissioning Third Sector services for those contracts that expired on 31st March 2010 to achieve re-commissioned services for personalisation and to achieve efficiencies. Consultation period of 90 days would commence immediately post decision.

Each option included an impact assessment that detailed the risks

associated with the delivery of that option.

Resolved:- (1) That the three options proposed for recommissioning for personalisation of the Third Sector contracts due for renewal on 31st March 2010 be considered.

(2) That the implementation of Option 3 be supported.

H59. CHAMPION FOR OLDER PEOPLE - UPDATE

Councillor Walker, Champion for Older People reported that she had recently met with Jackie Clark and Lucy Pullen to address the issue of social workers. She confirmed that the meeting had been very productive and her next step was to meet with Carol Smith who was responsible for Council buildings.

Councillor Doyle wished to place on record his thanks for the work that all Champions undertook.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
Monday, 23rd November, 2009

Present:- Councillor Doyle (in the Chair); Councillors Barron, Gosling, P Russell and Walker.

An Apology was received from Councillor Jack

H60. MINUTES OF THE MEETING HELD ON 9TH NOVEMBER 2009

Resolved:- That the minutes of the meeting held on 9th November 2009 be approved as a correct record.

H61. IMPROVEMENT PLAN FOR RMBC EQUIPMENT

Shiv Bhurton, Housing Access Manager presented the submitted report which set out the current position with regard to the provision and maintenance of hoists within customers' homes and the actions taken to improve the process and communications with customers.

The equipment was provided to some of the most vulnerable customers to enable them to remain in their own homes and to improve the quality of their lives. It was essential that the communication process was improved to ensure that they were fully aware of the timescales and procedures to be followed for servicing and maintenance of equipment. It was also vital to take control of the process to ensure that customers were kept up to date with information. As part of the process the Adaptations team have met with the supplier to identify any other customers who may not be covered by an up to date warranty agreement.

Current maintenance and servicing arrangements were:

(a) Customers who live in Council properties

- 1 year manufacturer's warranty followed by lifetime cover provided by KEIRS covered as part of the normal repairs arrangement delivered by the Council housing team
- Customer contacts Rotherham Connect as they do for any repairs within their property
- This level of support in the Public sector properties had been in existence for over 5 years
- Customers undergo a financial assessment to ascertain their contribution to the cost of the equipment.

(b) Customers who were owner occupiers/private tenants/Housing Associations tenants

- For Hoists delivered to customers prior to 2009, manufacturers (Westholmes) cover – 1 year servicing was arranged by the

customer/carer with the manufacturer
- For Hoists delivered to customers during and post 2009, 1 years manufacturers warranty followed by 4 years extended warranty – post 5 years servicing was arranged by the customer/carer with the manufacturer
- Customers undergo a financial assessment to ascertain their contribution to the cost of the equipment.

The extension of the maintenance in owner occupier properties from 1 year to 5 years was a recent innovation for Rotherham and sees as best practice in mitigating risks to customers and compared positively in comparison with other local authorities practice. No authority had a longer guarantee period. Customers who lived in council properties enjoyed a full and permanent extension of the warranty. This was because the adaptation was linked to the property and not the person and may be used in the future to provide support for customers with similar conditions.

Initial discussions had taken place to review contract arrangements for the provision of hoists and similar equipment. Changes to contract conditions were now being drafted and a meeting had been set up with Westholmes and Kiers to discuss varying the lifetime of the warranty for the equipment. The purpose of the meeting was to address the different arrangements that currently existed between the council tenants and the owner occupiers' experiences.

A joint review, with NHSR, of the Rotherham Equipment and Wheelchair services (REWS) was ongoing and the scope of the review included examination of the potential to bring in line all definitions related to adaptations and equipment. If an adaptation could be defined as 'equipment' then there would be a greater capacity for extending the warranty period. The review was due to report in March 2010.

There were a number of proposed improvements to the communication with customers and their carers. Some of these had already happened as an immediate response to the issues highlighted above:

- Adaptations team had reviewed and improved the quality of the information provided to the customer and their carer when they initially received the equipment –There must be clear service standards presented upfront to the customer when they receive the hoist-process complete.
- Adaptations team had established a database to flag up the need to contact customers, 3 months prior to a service requirement or a warranty expiring. Contact was then made with the customer and the supplier to ensure that servicing took place. Suppliers would be contractually obliged to operate their own system but this was a fail safe approach for the benefit of our customers. In this respect we were operating as a champion for our customer to ensure that they were always kept in the picture – completion by end November.

- Assistance would always be available from within the adaptations team to support customers who struggled with managing their maintenance package. This would be an important part of the continued support that followed the fitting of an adaptation.
- Adaptations team to inform all care managers/social workers that equipment maintenance and servicing was to be raised at each review –- completion end November
- Support through the process of arranging further individual warranty cover for customers who desired that independence and choice
- Adaptations team to inform domiciliary care providers to check all maintenance dates on all equipment at each visit - This was as part of an engagement with all care providers to ensure that they were fully aware of their responsibilities completion end November
  That arrangements were put in place with REWs that emergency manual hoists were available whenever required, this would be included in the work of the REWs review which was ongoing.

A discussion took place around the speed at which repairs were undertaken once they were reported. It was confirmed that 2010 Rotherham Limited had arrangements with Keirs to respond very quickly, but it was unclear exactly what the timescale was. It was agreed that this would be checked and reported back to members.

Resolved:- (1) That the significant and speedy steps which had been made to improve the support and communication being offered to customers be noted.

(2) That the potential financial implications of extending the warranty period with manufacturers be noted and that work continue to find alternative solutions.

(3) That the work being undertaken with customers, partners, carers and manufacturers to improve the quality of customer experience be noted.

H62. EXCLUSION OF THE PRESS AND PUBLIC

Resolved:- That, under Section 100A(4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in Paragraph 3 of Part I of Schedule 12A to the Local Government Act 1972.

H63. SHELTERED HOUSING WARDEN SERVICE - SHORT TERM OVERSPEND REDUCTION PROPOSALS

Shona McFarlane, Director of Health and Wellbeing presented the submitted report which set out recommendations for short term/interim solutions to reduce the projected overspend of the Sheltered Housing

Warden Service. A meeting had previously been held with both the Cabinet Member for Health and Social Care and the Cabinet Member for Housing and Neighbourhoods on 29th July, 2009 when plans to merge the Warden and Enabling Care Services had been presented. Members had agreed in principle to the future direction of travel being to integrate the Sheltered Housing Warden role and the Care Enabler Role. It was confirmed that any proposals would not be completed in the current financial year.

Recommended:- That the information provided and noted by the Cabinet Member for Health and Social Care, will be considered by the Cabinet Member for Housing and Neighbourhoods and received for further consideration.

THE CHAIRMAN AUTHORISED CONSIDERATION OF THE FOLLOWING ITEM TO MEMBERS INFORMED

H64. REVIEW OF NON RESIDENTIAL FEES AND CHARGES

Doug Parkes, Business and Finance Manager presented the submitted report which set out the Directorates current charges benchmarked against local neighbours and members of a Chartered Institute of Professional Accountants (CIPFA) benchmarking group.

It also set out potential charging options for consideration which would contribute to achieving the Directorates 2010/11 budget setting savings target of £4.9m.

An extensive, 6 month consultation exercise would be required in year one. If a decision was delayed to March 2010 then the savings in 2010 would be halved.

Resolved:- (1) That the charging proposals be considered.

(2) That the timeline for implementation of any changes be considered.

(3) That, subject to further discussions on financial impacts of these proposals, Members agree to the commencement of consultation on these proposals.

(4) That the other revised charges set out in Paragraph 7.10 of the report be agreed and implemented with effect from Monday 5th April 2010.

CABINET MEMBER FOR HEALTH & SOCIAL CARE
Monday, 7th December, 2009

Present:- Councillor Doyle (in the Chair); Councillors Barron, Gosling, P Russell and Walker.

Apologies for absence were received from Councillor Jack .

H65. MINUTES OF THE MEETING HELD ON 23RD NOVEMBER 2009

Resolved:- That the minutes of the meeting held on 23rd November 2009 be approved as a correct record.

H66. ADULT SERVICES REVENUE BUDGET MONITORING REPORT

Mark Scarrott, Finance Manager (Adult Services) presented the submitted report which provided a financial forecast for the Adult Services Department within the Neighbourhoods and Adult Services Directorate to the end of March 2010 based on actual income and expenditure to the end of October 2009.

The approved net revenue budget for Adult Services for 2009/10 was £72.9m. Included in the approved budget was additional funding for demographic and existing budget pressures together with a number of new investments and efficiency savings identified through the 2009/10 budget setting process.

The latest budget monitoring report for Adult Services showed some underlying pressures, however after taking account of a number of achieved savings and assuming the achievement of all management actions it was forecast that there would be an overall net overspend of £225k by the end of the financial year.

Management actions of £1.139m had been identified to reduce the budget pressures. A total of £640k had already been achieved to-date and were now included in the detailed forecasts. This reduced the underlying pressures to £724k and left a balance of £499k management actions to be achieved by the end of the financial year.

The latest year end forecast showed the main budget pressures in the following areas:-

- Home Care as a result of delays in shifting the balance of provision to the independent sector (£674k). The 70/30 split was achieved at the end of July 2009 and the balance had now moved beyond 70/30 towards an 80/20 ration that the Cabinet recognised as the optimum level based on experience elsewhere in the country.
- Increase in residential and nursing care short stays over and above approved budget for clients with a physical and sensory disability

(+£144k).

- Independent sector home care provision for Physical and Sensory Disability clients had increased by an additional 970 hours since April 2009, a further 38 clients were now receiving a service. This was resulting in an overspend of £347k against the approved budget.
- A significant increase above approved budget in clients receiving a Direct Payment within Physical and Sensory Disabilities and Older Peoples Services (£380k).
- Additional one-off expenditure was being incurred in respect of the costs of boarding up, removal of utilities and security costs at the former residential care homes prior to them transferring to the Council's property bank (£200k).
- Delays in the implementation of budget savings agreed as part of the budget setting process for 2009/10 in respect of meals on wheels (£240k), laundry (£160k) and the bathing service (£40k).
- Continued pressure on the cost of external transport provision for Learning Disability Day care clients (+£134k).

These pressures had been reduced by :-

- Additional income from continuing health care funding from NHS Rotherham (-£269k).
- Delays in the implementation of new supported living schemes within Learning Disability services (-£290k).
- Savings within independent residential care due to an increase in income from property charges (-£555k) and slippage in intermediate care spot beds (-£40k).
- Savings on the reconfiguration of Extra Care housing (-£315k).
- Planned delay in developing rehabilitation and supported living facilities for clients with a physical and sensory disability (-£157k).
- Slippage in recruitment to a number of new posts (-£78k) where additional funding was agreed within the 2009/10 budget process.

The Directorate continued to identify additional management actions to mitigate the outstanding budget pressures above. A number of management actions had already been achieved (£640k) and were included in the financial forecasts. These included additional savings on supported living, residential short stay placements, independent residential care costs within Older People services and savings from the decommissioning of in-house residential care.

To further mitigate the financial pressures within the service all vacancies continued to require the approval of the Directorate Management Team. There was also a moratorium in place on non-essential non-pay expenditure. Budget meetings with Service Directors and managers took place on a monthly basis to robustly monitor financial performance against approved budget including achievement against the proposed management actions and consider all potential options for managing

expenditure within the approved revenue budget.

Resolved:- That the latest financial projection against budget for the year based on actual income and expenditure to the end of October 2009 for Adult Services be noted.

H67. ADULT SERVICES CAPITAL MONITORING REPORT

Mark Scarrott, Finance Manager (Adult Services) presented the submitted report which informed members of the anticipated outturn against the approved Adult Services capital programme for the 2009/10 financial year.

It provided detail of the approved capital programme for the Adult Services department of the Neighbourhoods and Adult Services Directorate, actual expenditure for the period April to the 18 November 2009 and the projected final outturn position for each scheme.

Actual expenditure to the mid November 2009 was £312k against an approved programme of £1.5m. The approved schemes were funded from a variety of different funding sources including, unsupported borrowing, allocations from the capital receipts, Supported Capital Expenditure and specific capital grant funding.

The following information provided a brief summary of the latest position on the main projects within each client group.

Older People

The two new residential care homes opened in February 2009. The balance of funding (£230k) related to outstanding fees and the cost of any final minor works.

The Assistive Technology Grant (which included funding from NHS Rotherham) was being managed jointly and was being used to purchase Telehealth and Telecare equipment to enable people to live in their own homes. There was a procurement plan to spend the remaining funding which included lifeline connect alarms, low temperature sensors and fall detectors within peoples homes. A small element of the Department of Health specific grant (£13.5k) issued in 2007/08 to improve the environment within residential care provision was carried forward into 2009/10. Plans to spend the remaining balance of funding were being reviewed.

Learning Disabilities

The small balances of funding (£10k) carried forward from 2008/09 were to be used for the purchase of equipment for Parkhill Lodge and within existing supported living schemes.

The refurbishment at Addison Day Centre (Phase 2), funded from the Council's Strategic Maintenance Investment fund was now complete and awaiting final invoices.

Mental Health

A small balance remained on the Cedar House capital budget and would be used for the purchase of additional equipment.

A large proportion of the Supported Capital Expenditure (SCE) allocation had been carried forward from previous years due to difficulties in finding suitable accommodation for the development of supported living schemes.

Suitable properties continued to be identified and spending plans were being developed jointly with RDASH. The possibility of funding equipment purchased for direct payments was also being considered to reduce the current pressures on the mental health revenue budgets and was included as a management action (£50k). Further options were also being considered to provide more intensive supported living schemes with a range of providers and to fund a range of new assistive technologies for mental health clients, which would support their independence with access to 24 hour support.

Management Information

The balance of the capital grant allocation (£85k) for Adult Social Care IT infrastructure was carried forward from 2008-09 and used with this years grant allocation to fund the Adults Integrated Solution as part of introducing electronic care management.

Resolved:- That the Adult Services forecast capital outturn for 2009/10 be received and noted.

H68. STRATEGIC REVIEW OF INTERMEDIATE CARE SERVICES

Consideration was given to a report presented by Dominic Blaydon in relation to the Strategic Review of Intermediate Care Services.

It was proposed that Day Care, Community Rehabilitation and Residential Teams be merged and co-located. A new multi-disciplinary health and social care team would be set up to support service users through the intermediate care pathway. The service would adopt the Common Assessment Framework and deliver integrated health and social care plans.

Millennium would become a dedicated hub for intermediate care services in Rotherham providing day rehabilitation, a Single Point of Access and a focal point for all service delivery. There were significant benefits to this service model. It would establish a clear service identity with a range of

services being delivered from the same site. Co-location of staff would facilitate effective communication and peer support. Greater integration would improve efficiency and help develop a person centred approach to rehabilitation.

The Strategic Review recommended that a programme of refurbishment was carried out on Millennium to make it fit for purpose and proposed that capital grant was transferred from the NHS Rotherham Operational Plan to Rotherham MBC to pay for the necessary works.

It was proposed that Rothwel Grange was decommissioned as an intermediate care facility and that a new residential unit be developed at one of the new local authority residential units. The plan was to convert one wing of 15 beds into intermediate care provision by December 2009. This was dependent on vacancies becoming available during this timeframe. Vacancies were being held at present, and used for respite provision in order to maintain bed occupancy.

The new-build homes are fully compliant with National Care Standards and the Disability Discrimination Act. Bedroom sizes are spacious, en-suite facilities are provided, doorways and corridors have been widened for the use of disability and bariatric equipment. There is also ramped access to the building.

It was proposed that Fast Response beds were decommissioned and that the savings made were reinvested to improve performance, outcomes and quality elsewhere in the service. There were a number of reasons why it was appropriate to decommission the service:

- The unit cost per patient was prohibitive.
- There was capacity in the intermediate care residential units to fill the gap left by loss of beds
- The intermediate care residential units could meet the needs of people referred into the service
- Reducing bed capacity would help improve performance on bed occupancy across the service
- Decommissioning would release savings that could be reinvested

It is proposed that the maintenance service was reconfigured so that it delivered time-limited rehabilitation and community integration programmes. The service would continue to provide day care services to current service users for up to 6 months. There were also 4 service users who originally attended the Crinoline House day centre in 1998. Upon closure of this centre, Elected Members promised that anyone who still wanted to attend in a social care capacity would be allowed to do so. Commissioners were fully supportive of honouring this agreement.

The new service would deliver time limited community integration and rehabilitation programmes, which focussed on; improving physical

function, training and support on healthy lifestyle, development of mental well-being, reducing social isolation, condition management and maintaining independence

It was proposed that the intermediate care team was enhanced so that it could deliver a broader range of health services. The service would introduce nurse practitioners, speech and language therapy and health support workers to support the residential service and those working in the community. The health support workers would deliver low level nursing **and** rehabilitation support.

It was felt that there needed to be more linkage between the community and hospitals and district nurses as communication was found to be weak.

Resolved:- That the recommendations set out in the Strategic Review and the positive impact this would have on service user outcomes and performance be supported.

H69. ADULT SOCIAL CARE 2ND QUARTER (APRIL TO SEPTEMBER) PERFORMANCE REPORT FOR 2009/10

John Mansergh, Service Performance Manager presented the submitted report which outlined the 2009/10 Quarter 2 Key Performance Indicator (KPI) results for the Adult Social Care elements of the Directorate.

At the end of the quarter, 75% of Key Performance Indicators (KPIs) were on target compared to 57% at the end of the 1st Quarter.

The following performance measures did not achieve their quarter 2 targets;

- **NAS 1 (PAF D40) Percentage of clients receiving a review**

Productivity levels had improved since August but the indicator was currently rated as 'off target'. The indicator was slightly closer to target than reported in the 1st quarter performance report and, based upon the actions we had put in place following a corporate performance clinic held on 24th September 2009, it was predicted that we would achieve our year end target. Performance had increased from 17.92% to 35.59% since the 1st quarter of the year.

A performance clinic had been held with RDaSH (Rotherham, Doncaster and South Humberside Mental Health Trust) in August 2009 and since then they had doubled their review rate over the past two months and had put an action plan in place with an aim to review 100% of their clients by year end.

The following performance management actions were in place to improve performance;

- Team managers to authorise all reviews so that they can be counted.
- Arrangements made for telephone reviews to take place on clients in receipt of Rothercare service.
- Provider reviews to be undertaken and counted for clients in residential and nursing care placements.
- RDASH to update their records and ensure all reviews undertaken this year are counted.

NI136 (Vital Signs 3) People supported to live independently through social services (LAA)

This indicator included a combination of people that were receiving care managed services following a community care assessment and those people that are receiving services from the voluntary sector.

Current performance levels indicated that 5,572 service users were being helped to live at home, which was an improvement of 61 since the 1st quarter. This score was based on last year's voluntary sector figures plus people currently in receipt of an assessed care package.

To achieve next year's target approximately 2,000 extra service users would need to be helped by the end of the year. The frustration with this indicator was that a lot of prevention activity was not captured within the definition for this indicator. So for example, the 900 telecare installations that would be undertaken this year and the provision of 14,000 items of equipment were not included within the definition. These were national issues which are being debated.

The following performance management actions are in place to improve performance;

- Intermediate Care and Community Rehabilitation services would be captured within the indicator (these were currently not included).
- The list of providers for our Grant Funded Services return (the mechanism we had to use to capture people receiving services within the voluntary sector) had been updated.
- All providers had been visited to ensure they understood the importance of completing this information and that this was used to inform commissioning decisions.
- Include Occupational Therapy equipment within the indicator as other Councils do (these were currently not included).
- Mental Health action plan in place which would ensure caseloads were up to date and all clients were included within the score.

NI 132 Timeliness of social care assessments

Performance had remained the same since the 1st quarter of the year. Based upon the actions put in place following a corporate performance

clinic held on 24th September 2009, it was predicted that the year end target would be achieved.

There had been a significant amount of management action undertaken on this performance indicator. Resources had been targeted to reduce a backlog of new assessments which was created last year following a knock on effect of prioritising a series of high profile safeguarding investigations. Weekly performance clinics had been put in place to recover performance levels. Additional RDaSH, who were one of the poor performing elements of the services, had put an action plan in place and assessment rates had doubled over the last quarter.

The following performance management actions were in place to improve performance;

- Review of the intake service had been completed which had identified delays within the assessment process which had been removed. Some of the staffing had been reconfigured so that we could concentrate on achieving the 28 day target. The team would also receive additional administrative support.
- Weekly report sent to all managers showing assessments due in the week ahead.
- Each social worker had been given a target of 4 countable pieces of activity per week and weekly performance monitoring was in place.
- Diary Management – All Team Managers to use electronic diaries and include tasks.
- Team meetings included Performance as a standing agenda item.
- Tight monitoring of contact details recorded by Assessment Direct to speed up the time taken from initial contact to the start of the assessment.
- Mental Health action plan was in place and they aim to carry out 100% of assessments within 28 days between October and March.

NI 133 (Vital Signs 13) Acceptable waiting times for care packages

Performance had deteriorated since the 1st quarter of the year with the amount of care packages being arranged within 28 days decreasing from 91.42% to 86.59%.

Performance clinics had been held to understand the reasons for delays which had identified areas for improvement. We were confident that the year end target would be achieved by implementing the following performance management actions;

- Clarification had been sought from Department of Health around measuring waiting times for transitional cases from CYPS and Direct Payments.
- We would monitor and reduce waiting times from assessment to request being sent to brokerage.

- Brokerage service to manage the domiciliary care waiting list and use in house home care in areas where supply is low.
- Mental Health action plan was in place. Between October and March, they aimed to have 100% of service users newly assessed and accepted for specialist care to have a completed care plan within 10 working days of undertaking the assessment.

Resolved:- That the results and the remedial actions in place to improve performance be noted.

H70. SUPPORTING PEOPLE PROGRAMME PAPER 2 PROCUREMENT TIMETABLE

This item was deferred to a future meeting.

H71. CARE QUALITY COMMISSION (CQC)

Tom Cray, Strategic Director for Neighbourhoods and Adult Services presented the submitted report which summarised the result and findings of the 2008 social care Annual Performance Assessment (APA) process for Rotherham conducted by CQC (Care Quality Commission) which was published on 2nd December 2009.

The 2009 adult social care Annual Performance Assessment (APA) identified that Rotherham was '***Grade 4: Performing excellently***' Authority which, based upon a slightly different and now a harder test assessment methodology, was an improvement on the score achieved in 2008. The judgements were made on a sliding scale of 'performing poorly', 'performing adequately', 'performing well' and 'performing excellently'.

The following outcomes were just some of the reasons why CQC had rated the adult social care service as 'performing excellently' this year. Progress made included:

- Investigating an additional 275 safeguarding referrals during the year and training 2,000 staff to make people safer and feel safer,
- Social workers undertaking an additional 1,297 pieces of activity compared to the previous year meaning that we were able to change care packages as and when people's lives changed
- We had reduced the average length of stay in 'intermediate care' services from 55 days to 35 days meaning that people were going home quicker and staying at home which was where the vast majority of people wanted to be,
- 837 vulnerable people were given help through assistive technology such as bogus caller alarms targeting the elderly,
- The Consultation Cafe involved over 250 users of Meals on Wheels in a direct consultation - 97 % satisfaction rating from our customers.
- An additional 1,168 disabled people were provided with minor

equipment this year to help them to continue to live independently,
- Waiting times for Occupational Therapy assessments had improved from 20 months to 7 weeks,
- The Council was helping 132 more people to live at home and carried out 219 more assessments on carers than last year,
- High levels of customer satisfaction for services,
- There had been significant improvements in waiting times for new social care assessments and care packages, and
- There was a reduction of 54 older people admitted to permanent residential and nursing care last year as they were able to remain at home.

Adult social care services were assessed under the methodology of the Social Care Outcomes Framework. The CQC report set out high level messages about areas of strength and areas for development for the next 12 months. The judgements were made under the following outcome areas;

- Improved health and emotional well being,
- Improved quality of life,
- Making a positive contribution,
- Exercise choice and control,
- Freedom from discrimination and harassment,
- Economic well being,
- Maintaining dignity and respect, and a separate and now unscored judgement relating to;
- Leadership, and
- Commissioning and Use of Resources.

The key areas of strength affecting people using our services noted within the CQC report were:-

- Working with partners the council could demonstrate improvement in the differences in how healthy people were
- The council had a range of information on healthy living and the activities to promote health
- The council could demonstrate positive end results for people who used intermediate care and reablement services
- Provision of assistive technology to promote the safety and well-being of people in their own homes
- The council's work with organisations in reducing crime and making people feel safer
- The council's approach to customer services and the way they listened to customers
- The council's approach to working with carers and setting up systems that support direct payments for carers
- The development of a single point of contact through Assessment Direct
- The high number of direct payments for carers
- The attainment of the Cabinet Office Customer Service Excellence

and compliance with level 5 of the Local Government Equality Scheme
- Implementing the neighbourhood 'no calling zones'
- Improving access for older people from BME communities
- The council's systems and process to support and advise the people of Rotherham and carers in accessing employment and managing their finances
- The council had raised the profile of adults safeguarding and made good progress in raising awareness
- The council could demonstrate that it managed incidents of institutional abuse and poor standards of care
- The council could demonstrate that it was fulfilling its duties as a supervisory body in relation to the deprivation of liberty standards

The key areas for development identified within the report were contained within our 'sustaining excellence plan'. 9 out of the 13 areas were 'continue to' recommendations which acknowledge the progress we had made and that CQC would be ensuring that they kept a close eye upon over the next 12 months. The areas for development were:

- The council should continue to work with NHS Rotherham in sustaining improvements in the differences in how healthy people were and to ensure that the pace of improvement is in line with national comparators.
- Continue to review and implement the findings from the review of the use and availability of adaptations and equipment and the timeliness of care packages.
- Continue to work on developing the market management strategy in order to identify gaps in the market and further support work on its services that were tailored to meet people's own individual needs agenda.
- Continue to implement the recommendations from the CQC's Service Inspection in July 2009.
- To increase the number of assessments completed within 4 weeks and the numbers of first contact assessments to ensure people received packages of care in a timely manner.
- To ensure that people with a physical disability and/or sensory impairment could access and use an individual budget.
- To continue the council's work with the Young Adult Transitions team within the physical disability service, to ensure young adults from the age 14 years onwards received the care in a safe and timely manner.
- Continue to implement the finding from the Service Inspection for the development of advocacy services for all groups of people.
- Continue to invest in technology to support people feeling safe at home.
- Continue its activities to get more people with a mental health problem into employment.
- To increase employment for people in vulnerable groups.
- To address all of the recommendations from the Service Inspection

relating to safeguarding arrangements.
- To continue work to ensure the council fulfilled its duties as a supervisory body in relation to the deprivation of liberty standards.

Members commented that it was important that all staffed were made aware of how much they were valued. Confirmation was given that staff were constantly praised for their work and this was filtered down to front line staff. The Cabinet Member wished to place on record his personal thanks to all staff for their efforts.

Resolved:- (1) That the outcome of the assessment be noted

(2) That the 'Sustaining Excellence Plan' put in place to improve the areas for development identified within the report be endorsed.

(3) That the report be taken to the next Cabinet meeting as a requirement of CQC

(4) That it be noted that this report will be shared with the Councils external auditors (KPMG), which was also a requirement of CQC.