Strategic Review of Intermediate Care

- Transformational initiative in Better Health Better Lives
- Priority in the Joint Commissioning Strategy
- DH Guidelines “Halfway Home”
- Projections on future need for health and social care
- Current economic situation

Analysis of performance

Residential Service

- Bed occupancy increased from 56% to 72%
- Admission rates have increased by 38%
- 72% return home after discharge
- 82% still at home after discharge – NI125 top quartile
- High levels of service user satisfaction
- Lower bed occupancy than comparator authorities
- Length of stay has increased from 35 to 39 days
- 4% admissions from community care pathways

Analysis of performance

Community Rehabilitation

- Admission rates have increased by 26%
- 81% of admissions from community pathways
- 93% remain at home after intervention
- Predicted annual saving to home care budget 2009/10 - £517k
- Home care hours reduction has increased by 110%
- High levels of service user satisfaction
- Admission rates significantly under target

Analysis of performance

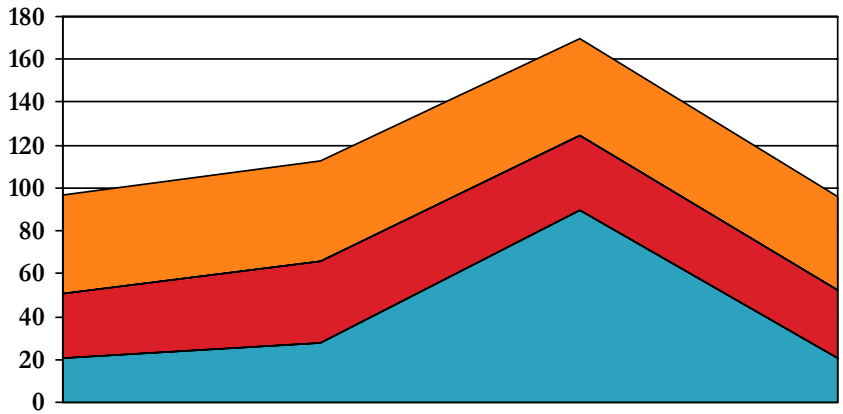
Millennium Day Services

- 88% of admissions from community pathways
- High levels of service user satisfaction
- 70% reported health/condition had improved
- 80% reported increased confidence
- 66% of maintenance service referrals come through day rehab

Recommendations

Performance management

- Refresh KPIs: Bed occupancy 80% and length of stay 28 days
- Amend framework so it reflects DH Guidance, “Halfway Home”
- Introduce KPIs on reducing unscheduled hospital admissions



Recommendations

Reconfiguration of residential beds

- Transfer provision from Rothwel Grange to Davies Court
- Nurse-led residential provision not be developed at this stage
- Decommission Ackroyd Fast Response beds by March 2010
- Commission more care enabling hours in the residential service
- Develop a bed management system

Recommendations

Development of an intermediate care hub

- Intermediate care hub at the Millennium Centre
- Co-locate and integrate all teams on this site
- Investigate capital investment to reconfigure building
- Combine rehabilitation and community integration
- Explore potential for combining intermediate care and falls prevention

Recommendations

The Intermediate Care Team

- Introduce nurse practitioners, health support workers and SALT
- Single case manager for the whole intermediate care pathway
- Single line management structure and single point of access
- A common assessment framework and single patient record
- Community stroke service to case manage stroke survivors

Recommendations

Future work and implementation

- Full review of rehabilitation services in Rotherham
- Endorse the financial model set out in Option 3
- Joint implementation plan to the Adults Board in January 2010
- Full implementation by June 2010
- Recommission the service with current providers in April 2011