Bristol Clinical Commissioning Group

Proposed Rehabilitation, Enablement and Re-ablement Model of Care for Bristol

Author, including organisation	Elizabeth Williams, Project Manager, NHS Bristol
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Introduction
The purpose of this paper is to ask the Bristol Health & Wellbeing Board to assess the proposed changes to rehabilitation, enablement and reablement services before more detailed due diligence work commences.

Background
In October 2012 a review of Rehabilitation services was established across Bristol, North Somerset and South Gloucestershire by the Healthy Futures Programme. A high level model of care has been produced and further workshops have been held with all the key stakeholders in Bristol to produce recommendations of how to improve rehabilitation, enablement and reablement services locally.

Proposal or Update on the situation
The table below summarises the issues and the recommendations made:-

Question 1	**How can we create more capacity in the community to enable us to cope with the reduction in acute hospital beds?**
Recommendations	1. **Investigate moving resources from the acute to the community sector.** 2. **Develop plans to increase community access to diagnostics and consultant opinion, whilst allowing community clinicians to continue to manage the patient's care.** 3. **Create an inter disciplinary team led bed base which requires minimal medical supervision for those patients who are medically fit for discharge but need to remain in a bedded facility for rehabilitation.** 4. **Reduce the need for community teams to come into hospitals in order to carry out**

	assessments of patients through shared assessments (see below question on collaborative working).

Question 2	**How can we make discharge planning (and other joint working) a collaborative effort between community and acute teams?**
Recommendations	**1. Investigate a single assessment process and set of paperwork to facilitate sharing of assessments between hospitals and the community.** **2. Integrate hospital, community and social care staff working in rehabilitation and reablement services into a single team** **3. Make use of integrated care coordinators on wards to pull patients who are fit for discharge into the community.** **4. Dispose of the section 2 and section 5 processes as a mechanism for controlling demand for social care and integrate social workers into hospital discharge planning.**

Question 3	**Do we require additional bedded rehabilitation capacity in Bristol? If so, what type and where?**
Recommendations	**1. Undertake a snapshot audit of patients currently in hospital in UH Bristol and South Bristol Community hospital to determine dependency of patients.** **2. Model different scenarios for bed provision, including therapist-led and residential home / nursing home beds.**

Engagement with patients, carers and communities

There has been active stakeholder engagement via a number of workshops held across BNSSG. In Bristol we have held workshops at Southmead and in the city centre. There is also Bristol Local Involvement Network representative on the Rehabilitation Project Board.

Local people have helped produce a document which describes what matters to them in relation to rehabilitation and they have reviewed the proposals

described above and were very positive that the changes suggested are in line with what patients want.

An equality impact assessment of the changes suggested is planned.

Supporting Data/links to further information
Please see the attached document 'Bristol proposed rehabilitation model of care' in Appendix 1 for more information.

Recommendations
Bristol Transitional Executive Group Meeting is asked to review the proposed recommendations listed above and feedback to the Healthy Futures Rehabilitation Review Team if they are happy for further detailed work to be done on these proposals during due diligence.

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Appendix (5) A Bristol Rehabilitation Model of Care

Bristol proposed rehabilitation model of care

Contents

Version no.	1.1
Status	Final
Author	Hayley Burton
Approver	Rehabilitation Project Board
Date for approval/ Date approved	4th March 2013
Agreed circulation of this version	Public

Version	Date	Reviewer	Comment
0.1	29th January, 2013	Hayley Burton	Initial draft
0.2	11th February, 2013	Hayley Burton	Additions following meeting with UHB therapy leads
0.3	12th February, 2013	Hayley Burton	Additions following meeting with Liz Sutton
0.4	13th February 2013	Luke Culverwell	Minor amendments to GPSU section.
0.5	18th February 2013	Hayley Burton	Changes to intermediate care and HSC OT service – comments from Jayne Clifford
0.6	18th February 2013	Hayley Burton	Changes to community complex neuro service
0.7	25th February 2013	Hayley Burton	Addition of changes proposed following meeting on 18/02/13
0.8	1st March 2013	Hayley Burton	Changes to section 1, Recommendation 1
1.0	14th March 2013	Hayley Burton	Amendments following 4th March project board
1.1	20th March 2013	Elizabeth Williams	Amendments following 20th March Bristol Council Directorate Leadership Team

1. Executive Summary

Having reviewed how rehabilitation, enablement and reablement services are currently provided three areas for improvement were highlighted and at an event on the 18th of February 2013 recommendations for addressing these areas were discussed. The table below summarises the issues and the recommendations made.

Question 1	**How can we create more capacity in the community to enable us to cope with the reduction in acute hospital beds?**
Recommendations	**1. Investigate moving resources from the acute to the community sector including social care where appropriate.** **2. Ensure the shift from hospital to community includes an assessment of the impact on social care capacity and ensure planning for future capacity is done jointly between health and social care.** **3. Develop plans to increase community access to diagnostics and consultant opinion, whilst allowing community clinicians to continue to manage the patient's care.** **4. Review the current provision of bedded rehabilitation which is available for people requiring minimal medical supervision for those people who are medically fit for discharge but need to remain in a bedded facility for rehabilitation and reablement.** **5. Reduce the need for community teams to come into hospitals in order to carry out assessments of patients through shared assessments (see below question on collaborative working).**

Question 2	**How can we make discharge planning (and other joint working) a collaborative effort between community and acute teams?**
Recommendations	**1. Investigate a single assessment process and set of paperwork to facilitate sharing of assessments between hospitals and the community.** **2. Investigate how best to further integrate hospital, community and social care staff working in rehabilitation and reablement services into a single pathway.** **3. Make use of integrated care coordinators on wards to pull patients who are fit for discharge into the community.** **4. Review section 2 and section 5 processes to design a**

	system that facilitates timely discharge and enables greater collaboration between hospital and community staff. This should take account of all the health and social care needs of the patient.

Question 3	**Do we require additional bedded rehabilitation capacity in Bristol? If so, what type and where?**
Recommendations	**1. Undertake a snapshot audit of patients currently in hospital in UH Bristol and South Bristol Community hospital to determine dependency of patients.** **2. Model different scenarios for bed provision, including therapist-led and residential home / nursing home beds.**

2. Introduction

The Healthy Futures Rehabilitation, Enablement and Reablement Project aims to agree the future models of rehabilitation services that will operate across Bristol, North Somerset and South Gloucestershire.

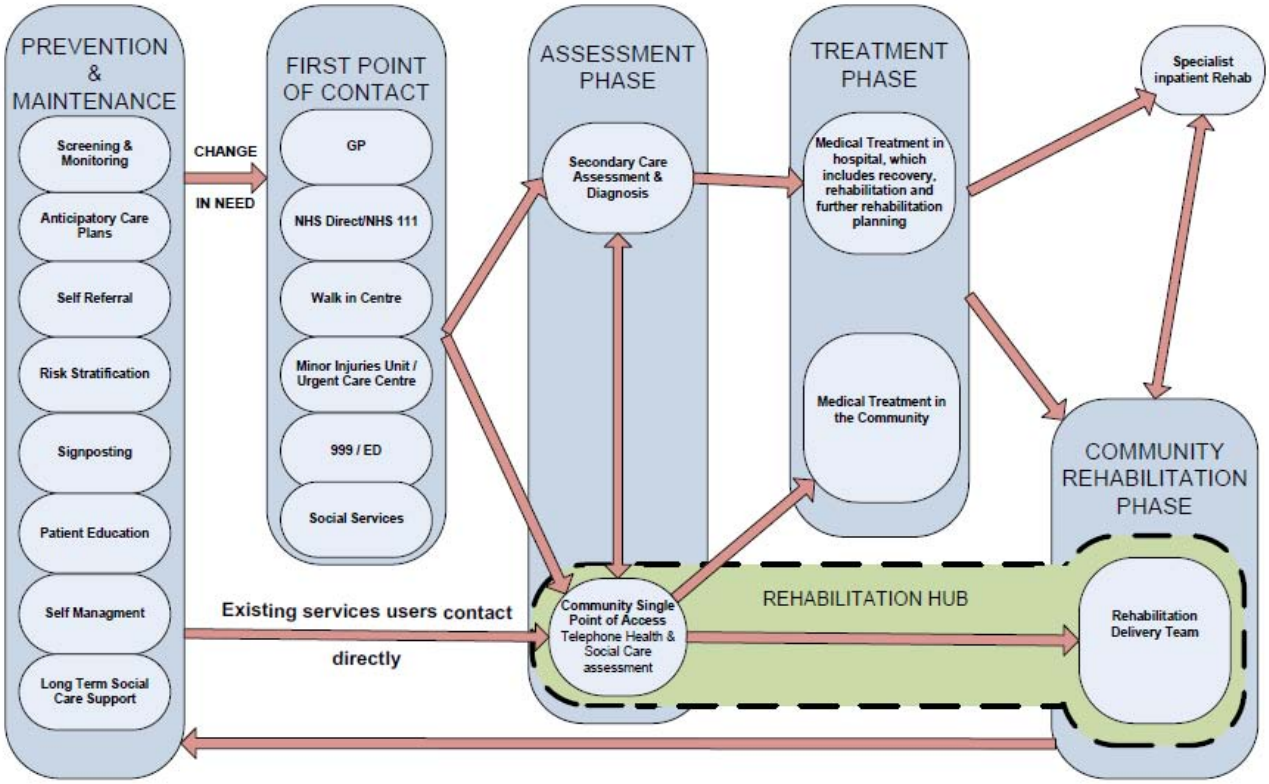
In the first phase of the project (Project Initiation) two workstreams were set up with the purpose of describing what rehabilitation, enablement and reablement services are currently provided in both the acute and community settings for each of the three Bristol, North Somerset and South Gloucestershire (BNSSG) areas. Section 5 of this document describes proposed improvements to current services in Bristol.

For details of services currently provided in South Gloucestershire and North Somerset please refer to documents entitled ‘South Gloucestershire Rehabilitation Current State‘ and ‘North Somerset Rehabilitation Current State.

3. Process to design a new service model for rehabilitation

As part of the Second phase of the project (Designing Service Models) a Design and Describe event was held on the 11th January 2013 and attended by over 50 key stakeholders. This event was attended by key stakeholders, including representatives from Bristol Clinical Commissioning Group, University Hospitals Bristol NHS Foundation Trust, Bristol Community Health, Bristol City Council and Bristol Local Involvement Network. During the afternoon of the workshop these stakeholders started designing a new future model of care for rehabilitation in Bristol. These individuals worked together to ensure the proposed model of care builds on existing services and developments in rehabilitation, enablement and reablement. At the event two other groups of stakeholders from South Gloucestershire and North Somerset simultaneously designed future models of care for rehabilitation in each respective area. The three outputs of the event have since been drawn together to produce a high level model of care for rehabilitation services across Bristol, North Somerset and South Gloucestershire (BNSSG) (Figure 1).

Figure 1: High Level BNSSG Rehabilitation Model of Care v0.6



A further half day workshop took place on the 18th February 2013 and was attended by the key Bristol stakeholders. The aim of this event was to focus on agreeing a more detailed system wide approach to rehabilitation in Bristol, based on the high level BNSSG model. Details of changes proposed are described in section 5 of this document.

4. Summary of the current rehabilitation, enablement and reablement services currently provided in Bristol

To enable us to agree on how rehabilitation services in Bristol could be improved we needed a detailed understanding of the 'current state'. A summary description is set out in this section. Detailed descriptions can be found in a separate "Current State" paper which can be downloaded from the Healthy Futures website (www.avon.nhs.uk/rehabilitationreview) or obtained in hard copy by emailing healthy.futures@bristol.nhs.uk or telephoning 0117 9841597.

4.1. Prevention and maintenance

Prevention and maintenance has been identified as essential to long-term patient care. There has been a shift in focus within the NHS and social care, from sickness and cure to wellness and prevention, which is reflected in the fact that the management of long term medical conditions and other issues relating to old age are being given a high priority.

This project will not be focussing on preventative services, there is however another Healthy Futures project which is focusing on improving this part of patient care. There are a wide range of services in Bristol relevant to rehabilitation, which aim to keep people healthy and independent, including:

- **Telehealth:** There are remote monitoring devices available to patients with COPD or Heart Failure from Bristol Community Healthy. As part of this service daily recordings are sent to a named clinician from a device used in the patient's home, through a secure IT network.

- **Falls prevention:** There is a lot of work current being done by UHB (inpatients and outpatients) with regards to fall prevention.

- **Care Direct:** This is the main way the public can contact adult social care at Bristol City Council. An advisor at care direct will give information, advice and tell the individual about other organisations that will be able to help them.

- **Well Aware:** The Care Forum, six local authority/NHS partners and others have come together to develop a comprehensive database of health, wellbeing and community resources in Bristol, Bath & North East Somerset and South Gloucestershire.

- **Third sector / voluntary / support groups:** In Bristol there are a number of organisations which promote independent living and offer information or rehabilitation/reablement services and support. This is not an exhaustive list but provides an example of some of the organisations where help and support can be sought:
    - WE Care & Repair
    - Living (previously the Disabled Living Centre)
    - British Red Cross (Home from Hospital service, support at home service, dementia support and medical equipment)
    - Age UK Bristol
    - The Carers Support Centre
    - Bristol Black Carers and other BME carer support groups
    - Bristol Area Stroke Foundation
    - Headway Bristol
    - Frenchay Hospital Cardiac Support Group
    - British Lung Foundation (Breathe Easy support group)
    - Action for Blind people(Bristol Rehabilitation Service for people with a visual impairment)
    - Parkinsons UK Bristol and other neurological support groups

- **Diabetes and Nutrition service:** Bristol Community Health provides four different types of free courses within the community in Bristol, North Somerset and South Gloucestershire to help people with diabetes manage their condition.

- **Patient education provided by UHB:** There are lots of services offered by UHB which fall under the banner of patient education. Patient Education is core to the programmes offered at SBCH for Out Patients. These include movement disorders, neuro, fallers sessions, voice clinics, nutrition (not just diabetic programmes) and rheumatology.

- **Assistive Technology and Telecare devices:** Bristol City Council supplies a range of the most popular types of equipment to adults who are eligible for a service from Health and Social Care.
- **Healthy Hearts (Phase IV) Cardiac Rehabilitation:** Phase IV of cardiac rehabilitation is a long-term service provided by Bristol City Council that involves ongoing exercise and the maintenance of lifestyle changes.

- **Better Breathing Classes:** Better Breathing classes are run by Bristol City Council and designed to help respiratory patients to exercise under supervision of trained instructors at their local leisure centre on a long term basis.

- **Long term social care support:** Bristol City Council provides a range of care packages to support people living at home, such as regular visits from a domiciliary care worker.

- **Extra Care housing:** Enables older residents to live independently in their own home, with a range of care and support services available on site 24 hours a day, seven days a week.

- **Mobile Meals:** This service is provided by Bristol City Council and provides a choice of hot meals directly to people's homes between 11am and 2pm seven days a week. **Other independent meals services** also provide delivered meals across the city.

- **Day centres and services:** Day centres provide people with support, activities and social contacts.

- **Respite care:** Respite care provided by Bristol City Council can help carers or an older or disabled person caring for themselves at home. Someone else takes on the caring for a short time.

- **Sitting services:** Carers can arrange for someone to come in the house and sit with the person they care for.

- **Integrated Carers Team:** Bristol City Council and NHS Bristol have come together as partners to continue and improve their support for carers. Carers who are not eligible for other services provided by the council can apply for a personal budget which can be used flexibly.

- **Occupational therapy, equipment and adaptations**: A Bristol City Council service which help older and disabled people to remain living independently at home, by:
    - providing advice about living independently at home
    - providing equipment like a raised toilet seat
    - arranging minor adaptations like a stair or grab rail
    - arranging major adaptations such as a level-access shower or a stair lift

- **Care and Repair:** provide homeowners and private tenants aged 60 and over a range of services such as financial and welfare advice, help with disability adaptations, list of approved contractors.

4.2. First point of contact

When a person's health or social needs change they will enter the model of care. This change maybe planned, such as going into hospital for a planned procedure, or it may be the result of a slow deterioration in a person's health, or a rapid deterioration or crisis. If there is a change in need a patient or their carer in Bristol may make first contact in one of the following ways:

- By visiting a GP
- By contacting social service directly
- By calling NHS Direct which will be replaced by NHS 111 in April, 2013
- By visiting a Walk-in Centre at Boots in Broadmead
- By visiting the Minor Injuries Unit at Southmead Hospital
- By visiting the Urgent Care Centre at South Bristol NHS Community Hospital
- In a critical or life threatening situation by calling 999. (There is currently a pilot in place with Great Western Ambulance Service in which they assess the category c cases (lowest need) to see if they could be dealt with more successfully by the Rapid Response service rather than taking them to a local Emergency Department).
- By visiting a local Emergency Department at the BRI or Frenchay Hospital
- By contacting social care directly via care direct

4.3. Assessment Phase

This document will focus on patients who access services provided by University Hospitals Bristol, however it is acknowledged that some Bristol residents may use services provided by other acute trusts. Services provided by North Bristol Trust are described in the South Gloucestershire Current State document, while services provided by Weston Area Health Trust are described in the North Somerset Current State document. To gain a full picture, this document should be read alongside these other two documents.

Hospital Assessment & Diagnosis:

- **REACT:** This service is an admission avoidance service located in the emergency departments at the BRI and Frenchay Hospital. REACT is provided by Bristol Community Health in-reaching into the Emergency Departments. The REACT service aims to maximise a patient's independence by identifying those who are suitable for the Intermediate Care Service.

- **General Practitioner Support Unit (GPSU):** This service is based next to the Emergency Department at the BRI. Following discussion with the referring GP the duty GP in the unit will either see the patient in the GPSU or direct them to an alternative assessment area e.g. ED or MAU.

- **Assessment by the UHB therapy team:** If there is a decision to admit the patient to the BRI from ED, the patient will enter a medical or surgical pathway.

- Physiotherapy and occupation therapy work on a blanket referral basis and all patients that are admitted will be seen by a member of the team
- Patients will be referred specifically to Speech and Language therapy if necessary
- Patient's nutritional status will be screened by the nurses after admission and will be referred to the nutrition and dietetic team if necessary

Community Assessment & Diagnosis:

- **Discharge of patients from BRI and referral to community:** If the patient needs continued support in the community post discharge the therapy team from the BRI will refer them to one or more of the community services provided by Bristol Community Health or Bristol City Council. The therapy staff at the BRI will co-ordinate the referral and will need to know which community service is the most suitable to refer the patient on to.

- **Rehabilitation services provided by Bristol Community Health:** The longer-term rehabilitation services provided by Bristol Community Health take their own referrals. There is currently no SPA or coordinated joint assessment procedure for these services.

- **Intermediate Care SPA:** There is a single point of entry into the Bristol Intermediate Care Service which covers both the step-up and step-down elements provided through a single phone number and email via a standardised form.

- **Assessment through Care Direct**: If an individual calls Care Direct and requires further support from the adult social care team at Bristol City Council someone from care direct will carry out an assessment over the phone.

4.4. Medical treatment and rehabilitation provided in acute hospital

At University Hospitals Bristol (UHB) the four therapy services (Physiotherapy; Occupational Therapy, Speech and Language Therapy, Nutrition and Dietetics) are delivered through the clinical services divisions.

In-Patients who require rehabilitation following an acute episode:

- **Stroke patients:** Patients receive early assessment and rehabilitation by therapists on the Acute Stroke Ward and are set some early goals for therapy which are usually related to feeding, sitting, balance and mobility**.** There is clear Royal College Physician guidance on stroke, so the pathway is written and standards it describes audited.

  - **Trauma Patients:** The trauma ward at the BRI contain patients with multiple types of injuries including fast-track fractured neck of femur pathways. (slow stream rehab pathway via SBCH)
  - **General Medical Patients:** High incidence of respiratory conditions. There is a noteable level of admissions linked to addiction of drugs and alcohol
  - **General surgery Patients:** General Surgery wards at the BRI including vascular patients and amputees.
  - **Older people:** Older peoples wards at the BRI
  - **Oncology Patients:** These patients are based at Bristol Haematology and Oncology Centre
  - **Cardiac Patients:** Patients are based at the Bristol Heart Institute and start the first phase of a cardiac rehabilitation programme post surgery.
  - **Respiratory Patients:** Includes COPD, Cystic Fibrosis and Asthma patients on the respiratory wards at the BRI - includes 6 high care beds
  - **ENT and Head & Neck Patients:** Based on wards at the BRI, Bristol Haematology and Oncology Centre, and St Michaels Hospital
  - **Women's Health/Gynae Patients:** Based at St Michaels Hospital
  - **Neuro Patients:** In-patient neuro rehabilitation capacity at the BRI is very limited and there is no dedicated resource or specialist leads. An initial acute assessment is provided and initial rehabilitation and treatment. Head injuries are generally managed on the trauma wards, and other neurology patients are managed across a variety of medical wards across the BRI.
  - **Major trauma patients**: There are major trauma patients who are transferred from NBT to UHB. There are no major trauma rehabilitation consultants at UHB to take these patients, so these patients are generally under the care of trauma patients who are less skilled in rehabilitation.

- **University Hospitals Bristol out-patient therapy services:**
  Most outpatient's services provided by UHB are delivered from the BRI, although there are some outpatient clinics run from South Bristol Community Hospital and other health centres. Patient can be referred to out-patents after an acute phase as an in-patient or from the community

- **Specialist Commissioners** commission inpatient neurological and spinal cord rehabilitation from the following locations:
  - Brain Injury Rehabilitation Unit, Frenchay
  - Neuro rehabilitation at the Royal National Hospital for Rheumatic Disease, Bath (there is currently a consultation exercise in place to discuss the future of this service)
  - Duke of Cornwall Spinal Treatment Centre, Salisbury

4.5. Medical Treatment & Rehabilitation in the Community

- **Rehabilitation Beds for Slow-stream Trauma, Stroke and Older peoples rehab:** UHB have rehabilitation beds located at South Bristol Community Hospital (SBCH). Patients who require further rehab and are unable to manage in the community due to a level of unpredictable health needs or functional ability are referred from the BRI to one of the 56 rehabilitation beds (15 Stroke rehab, 41 older people's) at SBCH.

- **Early Stroke Supported Discharge Team:** This service is for patients at the BRI and SBCH who can be discharged and receive continued rehabilitation at home or in a care home depending on where the patient lives. The ESD team will provide care between one and two weeks, depending on the needs of the individual patient and the progress they make.

- **Intermediate Care and Reablement:** Bristol Community Health and Bristol City Council's Health and Social Care team work in partnership to provide urgent or planned healthcare assessments for people in their own homes or place of residence. The following services fall under the umbrella term Intermediate Care and Reablement:

    - **Rapid Response**: An admission avoidance (Step-up) service which provides community based care for people suffering acute episodes of illness. Patients can be visited in their own home or place of residence for up to 10 days. This service involves medial stabilisation, e.g. provision of intra-venous antibiotics, and/or rehabilitation and reablement. This service is managed directly by Bristol Community Health.

    - There are 4 **nursing safe haven beds** which have been commissioned in a nursing home for use by patients who are under care of the rapid response team. These beds can also be occupied for 7-10 days.

    - There are 3 **non-nursing safe haven beds** located at South Bristol Rehab Centre for patients who are under the care of Rapid Response but don't require nursing care. These beds can also be occupied for 7-10 days.

    - **Rehabilitation Centres:** Bristol has two rehabilitation centres, with 37 rehabilitation beds (in addition to the 3 non-nursing safe haven beds at South Bristol Rehabilitation Centre). They provide a residential level of care as defined by the CQC. The centres are located in Henbury (North Bristol Rehabilitation Centre) and Knowle (South Bristol Rehabilitation Centre). There is a maximum length of stay of 6 weeks, but normal patient stay is generally less.

    - **Reablement Resource Centre (Westleigh):** There are a further 10 reablement beds located at Westleigh care home, St George for patients with a lower need for therapy input.

    - **Community Rehabilitation Service:** Patients can receive up to 6 weeks intensive, home based rehabilitation through the community rehabilitation service. There are three teams working in Bristol: Inner and East, North and West and South. Care is delivered by rehabilitation workers, who are competency-based therapy assistants working under the supervision of a therapist.

    - **Community Reablement Service (formally STAR):** The reablement service is run by Bristol City Council for people who are finding it difficult to look after themselves, or are having problems continuing to live at home. These are people who are at risk of admission to long term care or hospital, or requiring long term care packages, who have predominantly social care needs. Care is delivered by council staff and the purpose of the team is to

assist less complex patients who require a much lower level of therapy input – mainly helping patients to build confidence and relearn skills.

  - **Supporting Dementia team:** In November 2012 a new service was introduced to intermediate care for those specifically with dementia. This service has the same model as the reablement service but is for 12 weeks rather than 6 weeks.

- **Community Healthcare Teams:** Depending on a patients individual need, the appropriate health care professional from the team will visit the patient at their home or in their place of residence. The Community Healthcare Teams are made up of:
  - Community Matrons
  - Community Nurses
  - Community Nurses for Older People
  - Healthcare Assistants

- **Disabled Adults Resource Team (DART):** This Bristol Community Health service works with disabled adults who primarily have physical impairments. The service offers an assessment and discussion of current needs, and then treatment if that is helpful. They also advise on suitable adaptations and equipment that could help the patient.

- **Domiciliary Physiotherapy:** A Bristol Community Health service which provides rehabilitation and self management strategies for patients within their own homes or in a community setting. The service aims to help people to recover their movement and function as much as possible through teaching and helping patients to engage in movement, exercise and therapy techniques.

- **Musculoskeletal assessment and treatment service (MATS) and Spinal Service:** This service assess and manages the care of patients with musculoskeletal and spinal conditions. Patients are seen by an experienced specialist Physiotherapists or Podiatrists who will listen to them, assess them, provide treatment advice on how to manage their pain and determine the best course of care.

- **Occupational Therapy provided by Bristol Community Health:** This service is provided in the most relevant setting for the patient such as the place they live, or where they require most support.

- **Cardiac rehabilitation (Phase III)**: Phase I – III of cardiac rehabilitation is offered to people who have had a cardiac event. This includes Myocardial Infarction or cardiac surgery e.g. heart bypass or fitting of a stent

- **Pulmonary Rehabilitation Service:** Pulmonary rehabilitation is a combination of exercise and education sessions. It is aimed at people with breathing difficulty, most commonly those with COPD, but people with other chronic lung disease may benefit.

- **Home from hospital services provided by the independent and third sector:**
  - Hospital at Home
  - Redcross - Home from Hospital service

5. Changes proposed

While collecting the information on the 'current state' described above a wide range of stakeholders were asked how services could be improved and the following priority areas were highlighted:

- Health and Social Care working more closely together
- Care should be provided as closed to home as possible and co-ordinated from the community
- More co-ordination between rehab teams in hospital and community based services
- The need for a Single Point of Access (SPA) to community health and social care services
- Care should be tailored to the needs of individuals and access to services should be available when needed
- The idea of a 'non-linear' pathway through hospital and rehabilitation services with discharge to community actively considered at multiple points with specific identification of what needs to be in place at each point for safe discharge.
- Funding should be directed to services which provide best support to independence
- There should be a focus of prevention and maintenance of independence
- Sharing of information is crucial and the success of the connecting care project
- 7 day working – trial currently taking place at the BRI

A meeting with all the key stakeholders within Bristol was held on the 18th February, 2013 (see Appendix 1 for a list of those present) and the following recommendations were agreed:

Question 1	**How can we create more capacity in the community to enable us to cope with the reduction in acute hospital beds?**
Recommendations	**1. Investigate moving resources from the acute to the community sector including social care where appropriate.** **2. Ensure the shift from hospital to community includes an assessment of the impact on social care capacity and ensure planning for future capacity is done jointly between health and social care.** **3. Develop plans to increase community access to diagnostics and consultant opinion, whilst allowing community clinicians to continue to manage the patient's care.** **4. Review the current provision of bedded rehabilitation which is available for people requiring minimal medical supervision for those people who are medically fit for discharge but need to remain in a bedded facility for rehabilitation and reablement.** **5. Reduce the need for community teams to come into hospitals in order to carry out assessments of patients through shared assessments (see below question on**

	collaborative working).
Discussion & background	***Governing principle****: We need to create a presumption that all rehabilitation should take place in the community unless a patient's medical needs can only be met in hospital, and to distribute resources appropriately. We need to refocus care provision on community services working in partnership with acute clinicians.* The group agreed that patients should receive rehabilitation in the community unless their medical needs can only be met in an acute setting. In order to assess the appropriate balance of rehabilitation resource between the community and acute sectors, the group recommended: • Creating an agreed definition of 'medically fit' which both acute and community clinicians and therapists ascribe to. • Defining a clear rehabilitation pathway for each patient group which identifies the level of function or improvement which marks the end of acute rehabilitation, and moving towards a presumption that any rehabilitation after this point should be provided in the community. • Undertaking a multidisciplinary snapshot audit of patients in hospital in BNSSG on a given day to determine the dependency profile of these patients and to ascertain the following, according to the agreed definition of medical fitness and readiness for non-acute rehabilitation: o Patients appropriately receiving acute medical care. o Patients appropriately receiving acute rehabilitation. o Patients receiving non-acute rehabilitation which would more appropriately be delivered in a non-acute bedded facility (either because of the intensity of the therapy, or because the patient is unfit to return home). o Patients receiving non-acute rehabilitation which would more appropriately be delivered at home. o Patients receiving sub-acute or non-acute medical care which could more appropriately be delivered in a non-acute bedded facility. o Patients receiving sub-acute or non-acute medical care which could more appropriately be delivered at home. o Patients not receiving rehabilitation or medical care, but who cannot return home for some other reason and who could more appropriately be managed in a non-acute bed. This work should inform decisions about the number of community and acute beds required. Detailed proposals should be drawn up

	for inter disciplinary team rehabilitation beds for patients who are medically fit but who need to have rehabilitation delivered in a bedded facility. The group recognised that limiting community access to diagnostics was seen as a way of controlling demand for these services, but that this also limited the efficiency of community services and reduced the range of patients who could be successfully managed in the community. Secondary care is more risk averse and secondary care clinicians do not have the benefit of a prior relationship with the patient and familiarity with their condition which is often enjoyed by community clinicians. This means that where patients are sent in to hospital for diagnostics it is difficult for community teams to pull them back out. The group recommended: • Expanding the range of HOT clinics which are available to assist community services in supporting patients in the community. These should operate on the presumption that patients attending for diagnostics or consultant opinion will return home the same day. • Expanding the availability of telephone advice and guidance from a consultant which intermediate care teams have access to. • Agreeing a protocol between community services and acute clinicians for the sharing of clinical risk in cases where patients remain in the community. • Investigating the possibility of a single intermediate care team managing step-up and step-down patients, to reduce the disruption caused where patients go into hospital for diagnostics and are then admitted.

Question 2	**How can we make discharge planning (and other joint working) a collaborative effort between community and acute teams?**
Recommendations	**1. Investigate a single assessment process and set of paperwork to facilitate sharing of assessments between hospitals and the community.** **2. Investigate how best to further integrate hospital, community and social care staff working in rehabilitation**

	and reablement services into a single pathway. **3. Make use of integrated care coordinators on wards to pull patients who are fit for discharge into the community.** **4. Review section 2 and section 5 processes to design a system that facilitates timely discharge and enables greater collaboration between hospital and community staff. This should take account of all the health and social care needs of the patient.**
Discussion & background	***Governing principle***: *Don't create new teams to try to manage the gap between acute, community and social care. Instead, focus on closing the gap through integration and joint working.* *Move from a 'push' model where each team waits to respond to demand to a 'pull' model where each team is enabled to proactively identify appropriate patients and to take over their care as soon as the patient is ready.* The group discussed how, at present, acute and community team conduct separate assessments of patients needs and draw up separate rehabilitation plans. The group recommended that each patient should have a single rehabilitation assessment and plan, which would follow them from the community to hospital and back out again. At each stage the plan should be updated only to address changes in the patient's condition or level of function which had occurred since the last review. In order to achieve this, the group recommended: • Creating an agreed definition of "medically fit" and agreed rehabilitation pathways for all patient groups, which both community and acute clinicians and therapists would follow (See question 1, above). • Creating a single set of assessment paperwork which both community and acute therapists would use. The group considered how current working practices are an example of a 'push' model where the hospital decides when a patient is ready to leave. Community services must wait until the 'green light' is given and then take patients on demand. Both teams have a limited understanding of how the other works and are distrustful of the other's processes. The group considered how a single rehabilitation team could improve efficiency by promoting joint working. Consultants are also more likely to support discharge at an earlier stage if they are assured about the continuity of care and rehabilitation support which patients will receive. Reduced handoffs and improved ability to manage capacity would also result.

	Integration of teams could be achieved by all rehabilitation therapists, including those working in hospitals, being employed by the community or vice versa. Some members were concerned that if community therapists were employed by acute trusts, they would be pulled into managing inpatients when trusts are in red or black escalation. The group discussed the use of Section2 and Section 5 processes for notifying local authorities of patients who needed social care input. This process is designed to give social services advance notice of impending discharges so that provision can be made, but is not effective and is another example of an unhelpful "push" dynamic which impedes flow in the system. The Group recommended that hospital social workers should be integrated into discharge planning and should participate in board rounds to identify patients who are approaching discharge. This would enable social workers to be proactive in arranging support for these patients, creating a pull dynamic to facilitate discharge.

Question 3	**Do we require additional bedded rehabilitation capacity in Bristol? If so, what type and where?**
Recommendations	1. **Undertake a snapshot audit of patients currently in hospital in UH Bristol and South Bristol Community hospital to determine dependency of patients.** 2. **Model different scenarios for bed provision, including therapist-led and residential home / nursing home beds.**
Discussion & background	***Governing principle***: *We need to understand whether patients need to be in a bed before we can consider how many beds we need.* It was recognised that a model which results in patients being discharged from acute hospitals earlier may require additional provision of community beds. It was suggested that the requirement for Bristol beds at the redeveloped Frenchay site had disappeared following the opening of South Bristol Community Hospital, which has 10 more beds than the old Bristol General. However, more work needed to be done to establish how many patients currently receiving rehabilitation in an acute setting could be cared for elsewhere.

	The group agreed that it was necessary to consider a full range of bedded options, including inter disciplinary team led beds and use of residential home beds but it was noted that residential homes are often averse to taking patients for rehabilitation because they are not confident that adequate therapy or medical cover will be provided. These concerns need to be addressed through increasing community capacity.

Appendix 1

List of stakeholders at the meeting to plan how rehabilitation services can be improved in Bristol, held on the 18th February 2013

Name	**Organisation**
Richard Lyle	Bristol Clinical Commissioning Group
Lizanne Harland	Bristol Somerset Clinical Commissioning Group
Liz Sutton	Bristol City Council
Jayne Clifford	Intermediate Care and Reablement, Bristol City Council
Gillian Seward	Bristol Local Involvement Network
Chris Easton	University Hospitals Bristol
Claire Madsen	Bristol Community Health
Claire Chapman	Bristol Community Health
Also in attendance	
Martin Howard	Best West Commissioning Support Unit
Elizabeth Williams	Best West Commissioning Support Unit
Hayley Burton	Best West Commissioning Support Unit
Luke Culverwell	Best West Commissioning Support Unit