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| **Report to:** | **RESILIENT COMMUNITIES SCRUTINY COMMITTEE** |
| **Relevant Officer**: | Karen Smith, Director of Adult Services |
| **Date of Meeting** | 9 March 2017 |

# THEMATIC DISCUSSION – INTERMEDIATE CARE SERVICES

**1.0 Purpose of the report:**

1.1 To inform the Committee about the Intermediate Care services available in the Community in Blackpool and support a thematic discussion.

**2.0 Recommendation(s):**

2.1 For discussion as part of the Intermediate Care themed Scrutiny item.

**3.0 Reasons for recommendation(s):**

3.1 To ensure services are effectively scrutinised.

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| 3.2a | Is the recommendation contrary to a plan or strategy adopted or approved by the Council? | No |
| 3.2b | Is the recommendation in accordance with the Council's approved budget? | Yes |

3.3 Other alternative options to be considered:
None.

**4.0 Council Priority:**

4.1 The relevant Council Priority is 'Communities: Creating stronger communities and increasing resilience'.

**5.0 Background Information**

5.1 Intermediate care services are designed to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home, and to ensure that people are supported to have assessments for long term services in an environment which is supportive and enabling.

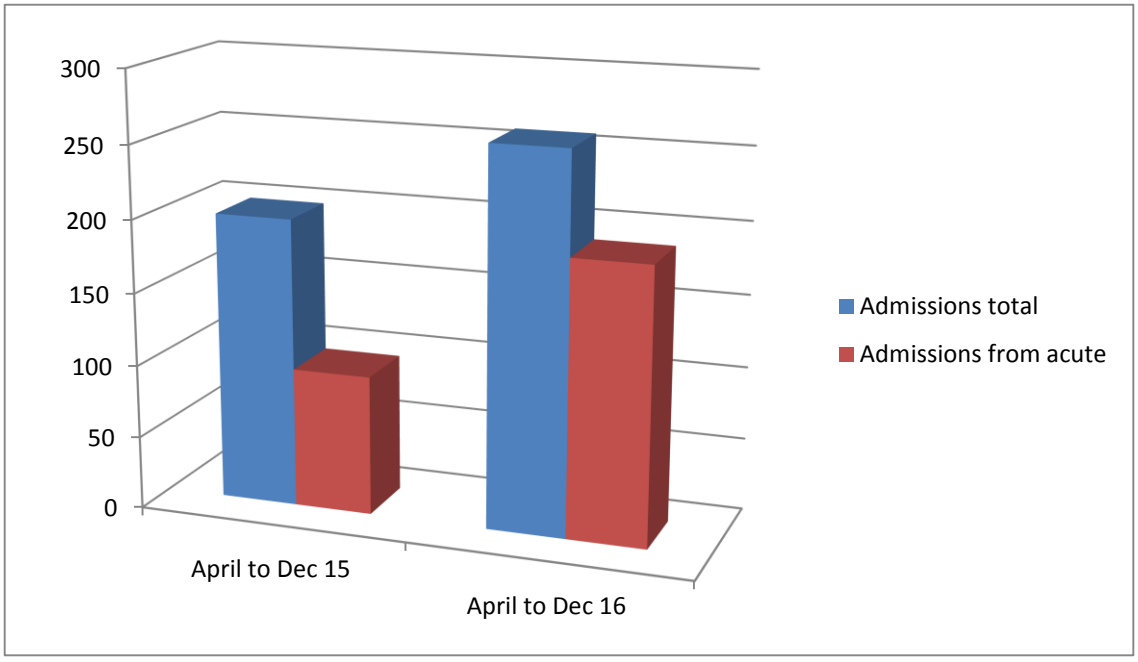
Intermediate care services are delivered by professionals in health and social care working together to support people to achieve their goals.

5.2 In Blackpool our main community Intermediate Care Services are the reablement service which supports people in their own home and the Assessment and Rehabilitation Centre (ARC) service which supports people in a residential environment to facilitate a hospital discharge or prevent an admission. There is an increasing focus nationally and locally on delivering reablement services as close to home as possible, and this is supported by initiatives with the neighbourhood teams, rapid response and early supported discharge in health.

5.3 In April 2016, Blackpool Clinical Commissioning Group (BCCG), Blackpool Council and Blackpool Fylde and Wyre Teaching Hospitals (BFWTH) refocussed investment in Blackpool to focus on delivering a more intensive service from one site and directly routing more people directly home from hospital to receive support. In recognition of the change to delivering more services at home, there was a reduction in bed based services from 53 to 33. The Assessment and Rehabilitation Centre service is now an integrated Health and Social Care service, supported by staff from the Council and the Blackpool Fylde and Wyre Teaching Hospitals with the Council holding the Care Quality Commission registration.

## 6.0 Residential Rehabilitation – ARC

6.1 In April – December of last year, **96** people were admitted to Assessment and Rehabilitation Centre following a stay in Hospital, with a total of **199** admissions. In the same period in 2016, **189** people have been admitted to the Assessment and Rehabilitation Centre following a stay in Hospital, with a total of **259** admissions.




The overall number of admissions to Assessment and Rehabilitation Centre has increased by **30%,** with **97%** increase on the number directly from hospital.

6.2 With new, more focussed services in place and continuing to develop, **increased capacity has been achieved through reducing length of stay**. A new referral pathway has been put in to support referrals from community health services, these are now routed through the Rapid Response team. This team explore all options for the person to stay in their own home and receive support.

6.3 There are consistently vacancies available in residential rehabilitation, so we can be confident that although there has been a reduction in residential resource, there are not referrals routinely being declined due to service availability. It is the case, however, that there has been a higher demand for the ten beds which are "clinically led" with GP oversight and 24 hour nursing support, though this has been infrequent and with focus on timely discharges, capacity is freed up promptly to support new admissions. On one occasion to date there was a delay in admission of intensive stroke patients due to therapy availability, though admissions were arranged for these patients as soon as possible and alternative care was not required.

6.4 Length of stay has decreased from an average of 42 days per person prior to April 2016 to 29 days, with far fewer people staying more than six weeks. In this period last year 61 people stayed over 42 days, this year it has been 33.

6.5 The main reasons for delays in discharge has been the delivery of a complex two carer package of care, significant change in accommodation not foreseen on referral and finding a care home “for life” following a thorough assessment.

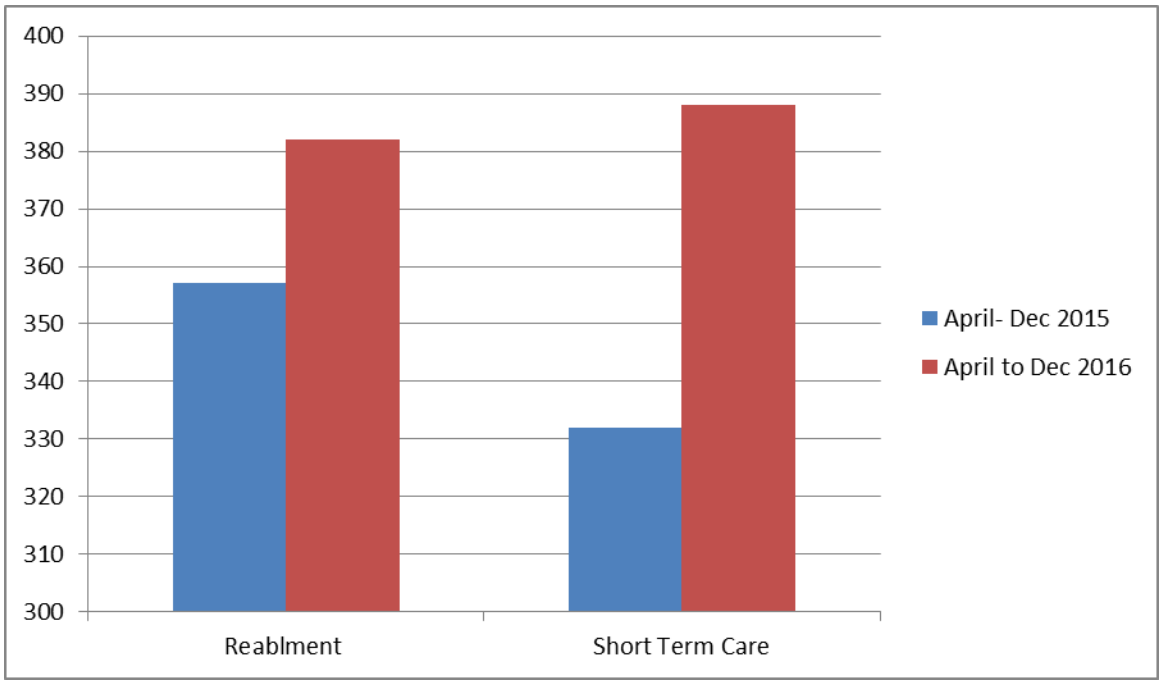
6.6 Last year, the 74% of people discharged were able to return home. Despite a significant increase in acuity with the introduction of clinically enhanced beds, over 70% of the people discharged in the first nine months of the service have been able to return home.

6.7 Where people have been discharged home from the ARC, a system follow up check is completed after 91 days. In this check for discharges in 96% of people discharged were still at home.

**7.0 Reablement at Home**

7.1 Our in house Home Care teams work with other professionals in the community to support timely discharges from, and prevent avoidable admissions to, hospital. The reablement at home function is commissioned from the team where the person has identified rehabilitation potential and will be working toward a reduced dependence on care services. The team also support timely discharges through the provision of short term care where a service provider is being identified, and will support people be as independent as possible during this period.

7.2 In 2015, the team supported 689 people between April and December. In 2016, the number has been 770. Overall there has been an 11.8% increase in demand for these services, with an increase of 7% in reablement services and 20.5% increase for short term care.




7.3 Most demand can be met with the resources available for Care at Home, however, where there is delay due to availability the themes are the availability of specific time slots or packages which require two carers. Additional resource has been secured until September 2017 to ensure that demand to meet hospital discharges can be met and discussions are ongoing with health colleagues to ensure that discharges are manageable next Winter.

7.4 The service is developing strong links with the developing neighbourhood services to maximise the potential for independence for individuals who have had a significant change to support them to access the right support and guidance, particularly where there is new medication, or where they have a new condition which they need to learn to manage.

7.5 In the last quarter of this year, the team worked with service users to reduce their dependence on formal care services and increase their control over their daily lives. Just under 400 hours per week were reduced from care packages through a successful reablement programme. 63% of people successfully completed the programme, with 66% of these requiring no ongoing formal care services on discharge.

7.6 Follow up system checks 91 days after discharge show that 87% of the people supported are still at home three months after their reablement period.

Does the information submitted include any exempt information? No

**List of Appendices:**
None.

**8.0 Legal considerations:**

8.1 None

**9.0 Human Resources considerations:**

9.1 None

**10.0 Equalities considerations:**

10.1 None

**11.0 Financial considerations:**

11.1 None

**12.0 Risk management considerations:**

12.1 None

**13.0 Ethical considerations:**

13.1 None

**14.0 Internal/ External Consultation undertaken:**

14.1 None

**15.0 Background papers:**

15.1 None