North Durham Clinical Commissioning Group
Durham Dales, Easington and Sedgefield Clinical Commissioning Group
Darlington Clinical Commissioning Group

Review of Inpatient Rehabilitation in County Durham and Darlington

A review of ward 6 within Bishop Auckland Hospital

Pre-Consultation Business Case

Contents

1.0 Executive Summary

The following report outlines the commitment from the local health system within County Durham and Darlington to develop inpatient and community rehabilitation services. As part of this transformation programme ward 6 was identified as an area for review. The outcome of this project is detailed within this pre-consultation business case (PCBC).

Although the scope of the project relates to the current ward 6 at Bishop Auckland Hospital (BAH) the work also took into account the wider strategy on bed utilisation and the development of community based services.

The aim of the project focused on the current utilisation of ward 6 against national and local best practice and clinical standards. Patients (and their families) who have been cared for on ward 6 in the last two years were asked about their experiences and had an opportunity to feedback on any areas for development. County Durham Healthwatch led this engagement work on behalf of the CCGs and Trust.

Ward 6 is currently a 24-bedded, nurse-led step down facility based in BAH with no therapy/rehabilitation support.

The review was clinically led and as a result there were four options which were agreed for consideration. An options appraisal process was undertaken with standardised criteria used to score each option against. Again this was a clinically led process.

The outcome of this appraisal was the determination that the preferred option was to change the functionality of the current ward 6 into a dedicated rehabilitation facility and to relocate this elsewhere within BAH to ensure effective use of resources. Specifically it is proposed that ward 6 would relocate to be adjacent to ward 16 (so in effect be ward 17) to ensure therapy resource could be further strengthened and used across the two wards. Ward 17 is currently not used as an inpatient facility.

Further to this, following extensive service improvement work within CDDFT, the service is confident that the capacity available could be reduced by eight beds as patients would be more effectively managed and discharged. This recommendation is a result of the implementation of a range of ongoing initiatives within the acute setting to manage patient flow and use the most appropriate care setting to manage people's conditions.

A new model for community services was introduced in 2018 which strives to deliver more care closer to home. The proposed model of care outlined within this business case for inpatient rehabilitation takes account and is aligned to the ethos of #homefirst (in County Durham, with the intention of rolling out in Darlington also) and care closer to home.

The following PCBC outlines the current services delivered, the gaps against best practice and national clinical standards. The review details the options appraisal process and the preferred option to be put forward for formal consultation. The final section of the PCBC demonstrates the potential impact of implementing the preferred model and how the local system would know if the change had made a positive impact on patient care.

2.0 Vision

Our vision and commitment is:

- **To develop a person-centred model of care that delivers care closer to home**
- **To minimise variation and maximise the health outcomes of our local population**
- **To ensure that patients (and their families) achieve their rehabilitation goals in conducive environments staffed by multi-disciplinary teams**
- **To ensure care is accessible and responsive to people's needs**
- **To ensure timely and supportive discharge is achieved consistently**

2.1 Scope

To present a robust evidence based business case to review the model of care for inpatient rehabilitation across County Durham and Darlington, with a particular focus on ward 6 at BAH.

The scope of this project relates to ward 6 at BAH which is a 24 bedded, nurse-led unit which currently delivers step down care. The service has no therapy input and is therefore not a rehabilitation facility. Although the project is specifically reviewing this ward at BAH, this is set within the context of the wider local health system and the ongoing work programmes aimed at ensuring care is delivered closer to home and hospital usage is optimised.

2.2 Aims and Objectives

To present a robust evidence based business case, which describes the model of inpatient rehabilitation care for the population of County Durham and Darlington, with a particular focus on rehabilitation care at Ward 6 BAH.

- **To review the current usage of rehabilitation beds across County Durham and Darlington**
- **To understand the effectiveness of care provided currently and to review appropriateness in line with new community based services**
- **To engage with patients and carers who have used services within Ward 6 at BAH to gain an understanding of their experiences and their views on a different approach to their care**
- **To outline for the future provision of rehabilitation inpatient care with a specific focus on Ward 6 at BAH**
- **To outline a preferred option for a new model of care which assesses impact on the system and individual patient care**

3.0 Background and Introduction

Ward 6 is currently a 24-bedded, nurse-led step down facility based in BAH with no therapy/rehabilitation support. The ward currently accepts patients who are:

- orthopaedic non-weight bearing patients, irrespective of post code
- Medically fit and stable or patients that require step-down nursing support, patients that are unable to be discharged home
- patients requiring complex discharge planning and who are then inpatients awaiting a Decision Support Tool
- patients deemed to be homeless who don't require health care

The CCGs and Trust are working in partnership to understand the current use of ward 6 at BAH, the review of this service has highlighted that patients on this ward could have been potentially cared for in a more optimal way. There is a concern that following a review of best practice and up to date clinical standards that rehabilitation is not being delivered to this cohort of patients.

As a local health system we believe that people should be given the opportunity to achieve their rehabilitation goals within environments that are conducive to recovery. Section 3.2 describes what good rehabilitation looks like and the current model of care in this instance does not deliver against this set of standards.

There have been a number of improvement projects which have been implemented over recent years to ensure that our local population receives care that is appropriate, timely and where possible delivered closer to home. As part of this longer term vision a new community contract was put in place in 2018. CCGs and CDDFT have a major emphasis on community services focusing on;

- Prevention and maintaining independence
- Supporting patients with long term conditions
- Managing crisis and supporting a return to independence

Since the contract was awarded in 2018 the CCGs and provider (CDDFT) are working together on a period of transformation. Reviewing services to ensure they meet best practice and clinical standards. The review of ward 6 sits within the wider context of this work ensuring that community bed provision is utilised to best effect and in line with the care closer to home agenda.

It is important to ensure that people are cared for in the most appropriate setting whether that be in an inpatient or community setting. Unnecessary lengthy stays in a hospital bed is not good for patients; this is due to contributing factors of sleep deprivation, increased risk of falls and fracture and risk of catching healthcare inquired infections.

The "home first" mindset across health and social care systems is more than good practice it is the right thing to do. When patients are medically optimised they should be supported to return to their own home / place of residence.[1] Health and social care professionals should work together to do everything possible to

[1] National Service Framework for NHS continuing health care and NHS funded nursing care) www.gov.uk

discharge the patient home, especially older people so they can enjoy their lives in their home environments.

For those patients who require inpatient based rehabilitation it is important to ensure that care is delivered where possible closer to home and in the most appropriate setting. The health and care system understands that there is a potential need for robust inpatient rehabilitation services however we need to ensure best use of this resource. Within County Durham there are a range of community hospitals available for use from County Durham and Darlington residents. Figure seven outlines the current usage of those facilities.

Bed provision needs to be aligned with the community services model of care with robust criteria for referrals and discharge. Whilst people are in these settings, care needs to be planned and managed effectively to ensure people achieve their optimum rehabilitation goals.

A review of the current arrangements for inpatient rehabilitation care is a key initiative for CDDFT and CCGs to be compliant with national and best practice rehabilitation care. In consideration of the PCBC, the following key points should be taken into account;

- Integrated Care Partnership (ICP)/Integrated Care System (ICS) Alignment
- CCG strategic aims
- Local and National Evidence
- Best use of public funds
- Care closer to home
- Reducing length of stay in acute NHS beds
- NHS Long Term Plan

3.1 Demographics and Prevalence

County Durham and Darlington have an ageing population, the Joint Strategic Needs Assessment (JSNA) 2015 estimates the overall population of County Durham is projected to grow by 4.2% between 2014 and 2024. This projected growth is higher than the growth expected in the North East (2.5%), but lower than in England (7.2%).

The number of people aged 65 and over has increased by 26.4% between 2001 and 2015. This increase in the county was higher than that across the region (19.1%) and nationally (23.9%). By 2024 the number of people aged 65 will increase by 19.3% and by 47.5% by 2039. [2]

In the period 2004 to 2014 the population of Darlington has increased to 105,396, an increase of 6.1% which uses ONS mid-year estimates for this period. The number of people aged 65 and over is expected to increase from 21,000 in 2016 to 24,000 in 2025, which is an increase of 12.5%. The life expectancy for males and females is also lower than the national average.

The increase in the older population creates a demand for services, requiring organisations to focus on managing demand and prevention, therefore a change to

[2] County Durham Joint Strategic Needs Assessment
County Durham Council
www.durham.gov.uk

the model of rehabilitation care delivered is a priority for County Durham and Darlington NHS Foundation Trust (CDDFT) and County Durham and Darlington Clinical Commissioning Groups (CCGs) in order to meet patients' needs and be compliant with national evidence and best practice.

3.2 National Context and Evidence Base

The World Health Organisation[3] states that rehabilitation intervention should be aimed at achieving the following broad objectives:

- Preventing the loss of function
- Slowing the rate of loss of function
- Improving or restoring function
- Compensating for lost function

Rehabilitation is a philosophy of care that focuses on the impact of health conditions on a person's life to maximise their potential and independence. It helps ensure people are included in their communities, employment and education rather than feeling isolated from the mainstream and pushed through a system with ever-dwindling hopes of leading a fulfilling life.

It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.[4] There is strong evidence that people see rehabilitation as vital; this was highlighted during NHS England's stakeholder engagement project to determine "what good looks like" from an individual's perspective, which led to the development of the document Rehabilitation is Everyone's Business: Principles and Expectations for Good Adult Rehabilitation.[5]

The 10 principles of good rehabilitation services:

1. Optimise physical, mental and social wellbeing and have a close working partnership with people to support their needs
2. Recognise people and those who are important to them, including carers, as a critical part of the interdisciplinary team
3. Instil hope, support ambition and balance risk to maximise outcome and independence
4. Use an individualised, goal-based approach, informed by evidence and best practice which focuses on people's role in society
5. Require early and ongoing assessment and identification of rehabilitation needs to support timely planning and interventions to improve outcomes and ensure seamless transition
6. Support self-management through education and information to maintain health and wellbeing to achieve maximum potential
7. Make use of a wide variety of new and established interventions to improve outcomes e.g. exercise, technology, Cognitive Behavioural Therapy

[3] World Health Organisation (2012)
Concept paper: WHO guidelines on health-related rehabilitation (Rehabilitation Guidelines)
http://www.who.int/disabilities/media/news/2014/15_01/en

[4] NHS England: Commissioning Guidance for Rehabilitation (2016)
www.nhsengland.nhs.uk

[5] Rehabilitation is everyone's business: Principles and expectations for good adult rehabilitation NHS (2014)
Wessex Strategic Clinical Networks.
www.networks.nhs.uk/nhs-networks/clinical-commissioning-community/improving-adult-rehabilitation-services/principles-expectation

8. Deliver efficient and effective rehabilitation using integrated multi-agency pathways including, where appropriate, seven days a week
9. Have strong leadership and accountability at all levels – with effective communication
10. Share good practice, collect data and contribute to the evidence base by undertaking evaluation/audit/research

These expectations and principles reflect the aims of a future health and care system and are drawn directly from the comments of service users and are underpinned by peer-reviewed evidence.[6] [7]

County Durham and Darlington Commissioners have reviewed the current provision of rehabilitation services using the NHS England "ten top tips for commissioning local rehabilitation services" guidance. In the case of ward 6 the review has highlighted that although rehabilitation should be provided for this cohort of patients it currently isn't due to the lack of therapy provision.

National best practice suggests that people should be actively supported in their discharge at the earliest opportunity and indeed where possible patients should be "discharged to assess". Implementing a 'discharge to assess' or 'home first' model is more than good practice, it is the right thing to do (NHS England Quick Guide to Discharge to Assess / Publications Gateway Reference 05871 2015).

Where appropriate, people should be assessed for their needs once in their "usual place of residence". Assessments would be carried out by a trusted assessor in the patient's own home to understand better their needs and to plan longer term care. People should be supported to return to their home for assessment of longer-term care and support needs (NICE guideline, Transition between hospital settings and community or care home settings for adults with social care needs 2015.)

There needs to be the ability to meet the needs of individuals and there needs to be a standardised approach to the provision of care such that it is not influenced by where a patient lives.

The Long Term Plan (LTP) sets out the ambition of having more intensive community based rehabilitation in place in order to reduce length of stay and hospital admissions in order to plough any cost efficiencies to improving direct patient care.

[6] The Five Year Forward View
NHS England (2014)
www.england.nhs.uk/

[7] Hard truths: The journey to putting patients first Vol 2
Department of Health (2014)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/270103/35810_Cm_8777_Vol_2_accessible_v0.2.pdf

4.0 Local Context

There are three CCGs leading this review across County Durham and Darlington, they are North Durham, Durham Dales, Easington and Sedgefield (DDES) and Darlington. The main provider for both acute and community services is County Durham and Darlington NHS Foundation Trust (CDDFT) who are key partners/experts in this review. They operate out of three main sites with a range of community hospitals and services delivered in local settings.

	Acute Sites	Community Hospitals
County Durham and Darlington NHS Foundation Trust	University Hospital of North Durham	Chester-le-Street Hospital
	Bishop Auckland Hospital	Shotley Bridge Hospital
	Darlington Memorial Hospital	Sedgefield Hospital
		Weardale Hospital
		Richardson Hospital

The overall population of County Durham and Darlington is just less than 650,000.

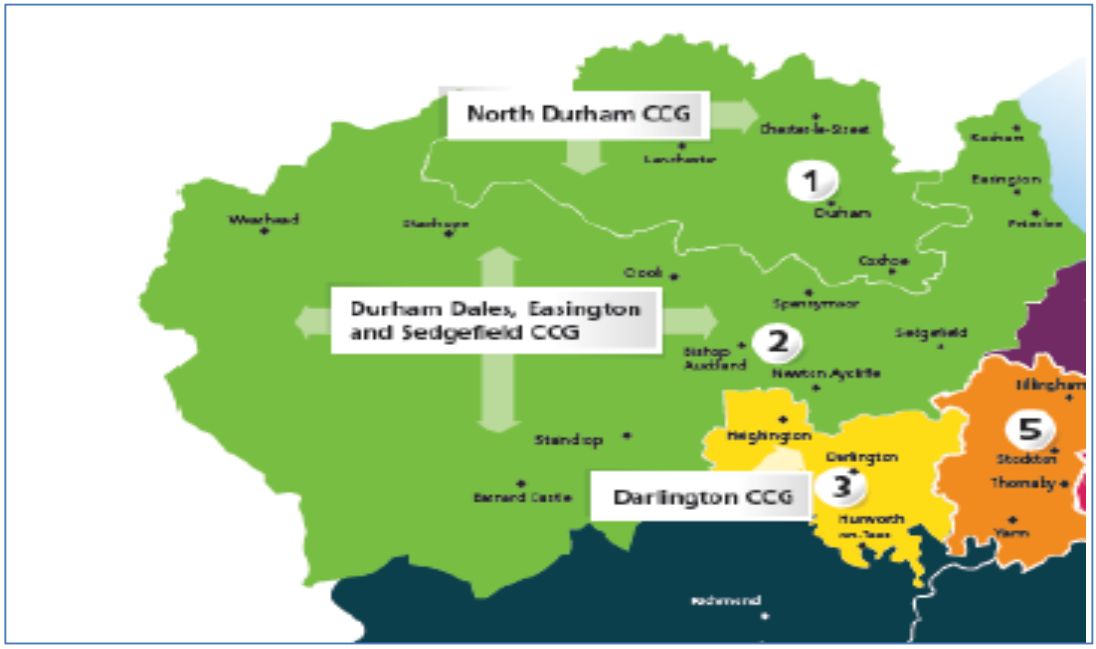

Figure 1 – geography of three CCGs within County Durham and Darlington

There is an opportunity to improve both the quality and efficiency of the care we commission and provide. If we are to have safe, sustainable services that are set up to facilitate greater advances in care and outcomes we need to address three key factors:

- Changing patterns of need;
- Improving clinical standards of care;
- Making the best use of an expert workforce

A change to the model of delivery for rehabilitation care is a key initiative for Commissioners and CDDFT and supports the #Next Step Home agenda. In line with CCG strategic aims and priorities, the revised model will:

Manage resources effectively - through reducing lengthy stays within an inpatient setting providing better value for money for the health system and workforce efficiencies.

Invest in primary care and community services – provide a standard, equitable and appropriate rehabilitation pathway.

Secure the right services in the right place - the model will ensure patients are treated in the right place, at the right time, by the right clinician.

Make services more accessible and responsive to the needs of our communities – the model will be accessible for our local population.

Any service review outcomes need to contribute towards CCG priorities to provide high quality care closer to home.

CDDFT has been involved with a series of hospital-based improvement programmes including SAFER and PJ Paralysis. Both of these transformation programmes focus on the time spent during an acute episode ensures the benefits of hospital based care are maximised and that patients have a focus of recovery.

SAFER is a tool used to aid patient flow – that is the transition of care within a system, from the time a patient enters the hospital to the point at which they are discharged. The toolkit is designed to reduce unwarranted variation and to ensure care is delivered in a seamless way. The key elements of SAFER include

- Patients receiving a senior review before midday to ensure robust decision making and action
- All patients will have an expected discharge date at the earliest point in their care episode
- Early (supported) discharge will be delivered
- Where patients are in hospital longer than 7 days, a multi-disciplinary team will review patients with a clear 'home first' mindset

PJ Paralysis (figure two) is an initiative aimed at getting patients out of bed and into a chair with their own clothes on wherever possible. This is proven to aid recovery, reduce length of stay, promote wellbeing and enable people to feel dignified. Staff on all wards throughout CDDFT were engaged in this work to ensure patients have the opportunity to gain the best possible outcomes from their care in hospital and to be discharged home at the earliest point.

Figure 2 – PJ Paralysis campaign

4.1 Quality and Performance

Figure three demonstrates there has been a reduction in Length of Stay (LoS) over the two year time period; however figure four shows there has been a higher rate of admissions over all.

As the data shows the main cohort of patients are over the age of 65 and although admissions have increased there is also a larger number accessing community care as part of their care pathway (408 referrals into community care in 2017/18 compared to 732 in 2018/19) and LoS has reduced to accommodate this greater flow of patients.

Bed occupancy rates have also decreased although it must be noted that a proportion of that reduction can be attributed to the inclusion of escalation beds in the total figures. However the system recognises that overall the bed occupancy has reduced over time and there is an opportunity to review how resources are being utilised to best effect.

	2017/18	2018/19
Average LOS	22.12	12.34
Bed occupancy	95.25%	79.43%

Figure 3 total average LoS and bed occupancy on ward 6 at BAH

Range	2017/18	2018/19
15-19	1	
20-24		1
30-34	1	1
35-39	3	
40-44	1	3
45-49	10	6
50-54	10	14
55-59	10	13
60-64	24	30
65-69	28	31
70-74	35	71
75-79	58	86
80-84	73	118
85+	137	219
	391	**593**

Figure 4 admissions onto ward 6 BAH by age range (2017/18 and 2018/19)

Figure five shows LoS by locality. There has been significant progress made in terms of integrated working with the local authorities within County Durham and Darlington which has had a positive impact on LoS. Included in this is the aim to manage non-weight bearing (NWB) patients in a non-hospital setting. This is another example of where the system is working to ensure only those who need it are seen in a hospital setting, freeing up capacity to manage those who need it most.

Further work is required with Local Authorities and other partners outside of the area to replicate this good practice in terms of timely discharge and seamless transition into the community. There are plans in place to develop this, to ensure that people receive the same level of care and access to pathways. The implementation of the new community contract places an emphasis on prevention.

The data suggests that 81% of all admissions (2018/19) were as a result of an emergency attendance via the Emergency Department at one of the acute hospitals. It is anticipated that more is being done in recent years to prevent the more frail and elderly population from being admitted into hospital by proactive management in the community. The transformation of community services over the last year will hopefully demonstrate the management of this vulnerable population cohort and will reflect in the coming years' worth of data.

	2018/19			
Ward Hospital	DDES	Dton	Durham	Other
B06	12.22	11.77	12.56	14.42

Figure 5 Average LoS on ward 6 at BAH (2018/19)

Figure six shows the increase in admissions year on year by locality. Only 20% of the increase is from the Durham Dales area, the immediate catchment area for BAH. Looking at the information it shows that many people are admitted to ward 6 from outside of the BAH vicinity and therefore there is an opportunity to understand

if people could be managed within a community hospital closer to home. See section 12 for further details.

Locality	Sum of 2017/18	Sum of 2018/19	change year on year	% change	% of increase by area
Chester le Street	24	37	13	54%	6%
Dales	105	147	42	40%	21%
Darlington	66	100	34	52%	17%
Derwentside	28	50	22	79%	11%
Durham	62	90	28	45%	14%
Easington	4	10	6	150%	3%
HRW	4	12	8	200%	4%
M'boro	1	1	0	0%	0%
OOA	3	5	2	67%	1%
Sedgefield	91	135	44	48%	22%
Sunderland	2	6	4	200%	2%
(blank)	1	0	-1	-100%	0%
Grand Total	391	593	202	52%	100%

Figure 6 change in admissions year on year by locality

Figure seven shows the current use of community hospitals across County Durham and Darlington, as highlighted there is scope to use these more in any future model of care.

	2018/19					
Admitting Hospital	Easington	Durham Dales	Sedgefield	Dton	Durham	Other
Weardale	2	209	26	20	87	2
Sedgefield	61	57	233	104	87	15
Richardson	1	291	58	216	8	32
Shotley Bridge	15	67	9	5	2294	81
Chester le Street	2	2	3		36	4
B16	2	20	21	9	19	3

Figure 7 current admissions into community hospitals by locality

5.0 Patient Experience and Feedback

CCGs and provider organisations have a duty to engage and consult on any potential major service change as described within the NHS Act 2006.[8]

As part of the review an initial patient experience exercise was undertaken by CDDFT with the patients residing on the ward during a period of time in 2018. The feedback received was, as expected, complimentary in terms of the quality of nursing care provided.

A further engagement exercise was commissioned by the CCGs and CDDFT in early 2019. County Durham Healthwatch agreed to capture the views of the patients and their families residing on the ward during May and June 2019. They

[8] NHS Act 2006
www.legislation.gov.uk

also, with help from CDDFT were able to contact patients (and their families) who had been in the care of ward 6 at some point over a two year period.

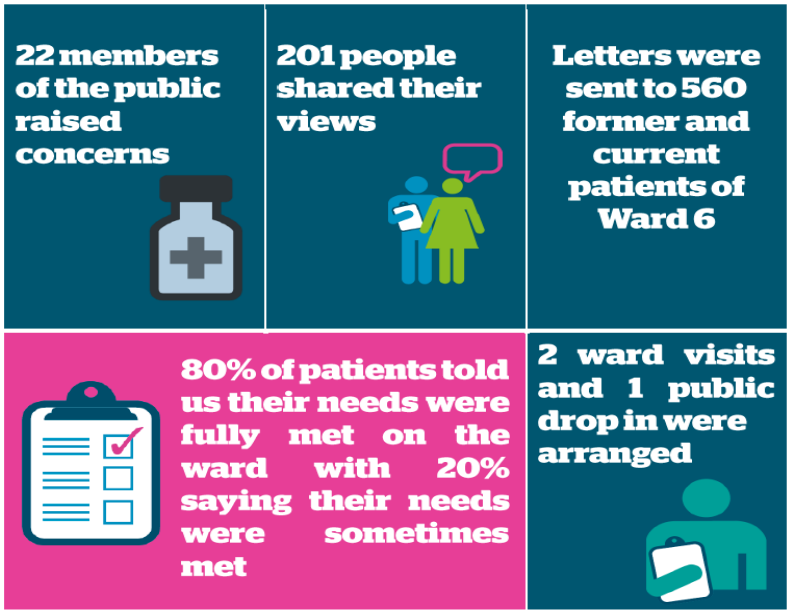

Figure 8 Overview of patient and carer engagement activity

The report from County Durham Healthwatch is available in appendix one, however some of the key characteristics included:

- 49% of respondents were transferred from UHND
- 45% of respondents were transferred from DMH
- 6% of respondents were transferred from another ward at BAH
- The majority of those surveyed (70%) returned to their usual place of residence

The key recommendations from the report included:

- **The need to retain step down facilities, particularly for those more complex discharges. In particular it was felt that patients (and their families) needed to be supported through this discharge process and involved in any decision making.**
- **Therapeutic intervention should be offered (where appropriate) to all both within an inpatient and community setting**
- **To continue delivering holistic support - to coordinate support from a number of sources including families, charities and health and social care agencies**
- **The review needs to take into account the extended length of time some patients are staying on the ward to see if there are steps they could take to reduce this, where appropriate**
- **Using the comments made by patients completing the survey to help shape future services**

6.0 Staff Engagement

Staff and wider stakeholder engagement has taken place with clinical and non-clinical staff throughout this review process, to gain their ideas and suggestions for improved models of care. This engagement was supported by a Human Resources (HR) Process.

We have had ongoing dialogue with teams across health and social care to understand the challenges faced and working with them to understand how inpatient services could be maximised and improved for patients and their families.

During November 2018, staff from ward 6 and the wider system were involved in reviewing patient scenarios – real life examples of patient journeys which involved a care episode on ward 6 at BAH. The attendees analysed by the workshop teams, with a view to determining the best possible pathway, which included;

- Identifying care needs
- Patient /carer expectations and process issues impacting length of stay
- What could have been done differently to improve the patient pathway
- Highlighting any issues/barriers that may need addressing

The highly skilled staff have been using their knowledge and expertise to outline where within the current service their maybe some gaps in terms of achieving the very best possible clinical outcomes. We have listened and involved them throughout this process (see options appraisal process section nine) and will continue to communicate and engage as we continue with this project.

7.0 Current State

Ward 6 at BAH provides nurse-led step down care with 24 beds, it was initially set up nine years ago for stranded patients aged 18 years and over. Stranded patients are those deemed to be both medically and therapy fit with a hospital stay of over seven days. Super stranded patients have a length of stay of 20+ days.

The ward has evolved over time to include non-weight bearing patients, homeless people, patients with complex care needs and those waiting for packages of care or social work assessment. The ward is managed by Advanced Nurse Practitioners with limited or no access to therapy teams. No dedicated rehabilitation support is available.

Figure nine shows where people who access ward 6 have been transferred from during 2018/19. The majority of people are being transferred from University Hospital North Durham (UHND) and Darlington Memorial hospital (DMH).

Once on ward 6 the average length of stay in 2017/18 was 22.12 days, due to the ongoing transformation work within the Trust this decreased to 12.34 days during 2018/19. More detailed information is available in section 4.1.

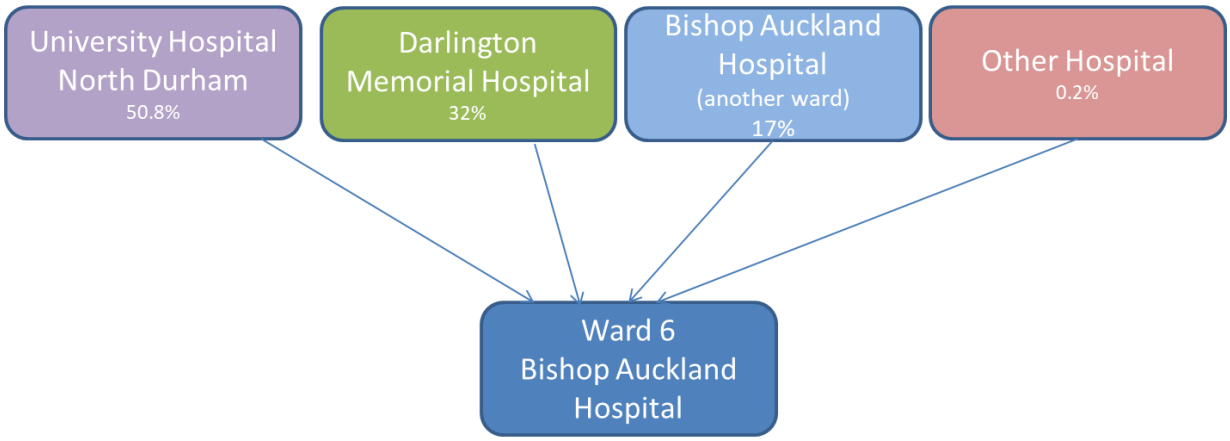

Figure 9

CDDFT Strategy 'Our Patients Matter' sets out the purpose to provide safe, compassionate and joined-up care to the local populations with the aim of achieving the vision – to get care right, first time, every time for all of our patients.

In striving to deliver the safest, quality care for patients, the CCGs and Trust have reviewed the services provided for the groups of patients who have been transferred to Ward 6 to ensure they have received the 'right care' in the 'right place' by the 'right person' and that it was the best possible care that it could be comparing to national evidence and best practice.

Patients appear to be inappropriately transferred to Ward 6 due to acute bed pressures and often holistic considerations of patient's needs are not always a priority. With robust discharge planning, proactive management and timely consideration, "home first" could have better patient outcomes.

Figure ten demonstrates that the majority of those discharged went back to their usual place of residence (prior to admission into hospital). The work carried out with clinical staff looking at typical patient scenarios explored the opportunity of people being discharged home at an earlier point in their pathway. Systems and processes are now in place to ensure that clinicians set expected discharge dates at the point of admission in the acute ward i.e. UHND or DMH with a view to planning for that discharge at the earliest opportunity.

	2018/19			
Discharge Destination Description	DDES	Dton	Durham	Other
Usual Place Of Residence	158	41	83	8
Temporary Place Of Residence	23	13	26	2
Nhs Provider (General/Young Phys. Disab)	11	4	1	2
Nhs Provider (Mentally Ill/Learning Dis)			1	
Nhs Nursing/Residential Care/Group Home	1	3	8	
Local Authority Part 3 Residential Accom				
Not Applicable - Patient Died/Stillbirth	17	5	9	
Non-Nhs Residential Care Home (Not La)	28	20	10	3
Non-Nhs Nursing Home (Not La)	54	14	39	9

Figure 10

The points of interest raised with the current model will be explored further in the business case within the options appraisal and preferred options sections (nine and ten).

In Darlington, there are two week step down nursing beds for those who require 24 hour nursing, but are awaiting a complex package of care to be established, or DST to be undertaken are commissioned. There is an opportunity for this commissioned facility to be further utilised.

Rehabilitation provision in the community in Darlington is delivered via RIACT which is made up of a workforce which supports falls, stroke/neuro rehab and domiciliary rehab services including crisis response 8am-8pm, 7 days a week.

The service is made up of the following roles and WTE:

Role	**WTE**
Community Charge Nurse	1
Community Staff Nurse	4.5 (2 of these people are due to come into post) (3 of these roles rotate with DNs)
Associate Practitioner	3.8
Care and Support Worker	4.34
Clinical Lead Physiotherapist	0.56
Specialist Physiotherapist	2.2
Physiotherapist	1.45
Occupational Therapist	1
Specialist Occupational Therapist	1.45 (1 of these people are due to come into post)
Total	**20.3**

Figure 11

Overall activity for RIACT is as follows and demonstrates a 9% increase in referrals between 2017/18, and if activity continues as is in year, will see a further increase of at least 2% by the end of 2019.

	Total referrals to RIACT
2017	3302
2018	3605
2019 (upto 4th July 2019)	1837

Figure 12

The service acts as the first point of contact for RIACT and reablement service (DBC) and also manages access to the CCG fourteen commissioned rehabilitation beds also providing the rehabilitation support into these beds and additionally to those eligible for community RIACT services as part of an intermediate care model of care, for upto a period of 6 weeks.

Eligibility and exclusion criteria's for the fourteen rehabilitation beds is as follows:

Eligibility:

- Are aged 18 or over, with an identified rehabilitation need
- Do not require the involvement of a secondary care medical consultant
- Are medically optimised to be managed in the community by primary care (GP)
- Registered with a Darlington GP
- Is recovering from an acute health episode which no longer requires hospital care and can be safely managed in a rehabilitation bed
- Would benefit from a period of rehabilitation to enable onward discharge to home
- Are prepared to engage in a programme of rehabilitation
- Palliative patients with rehabilitation potential
- Cannot be supported by health domiciliary care or other community health services (continuing health care residents are excluded as the district nursing service now can commission independent sector placements/ domiciliary care)

This service will exclude the following: (not intended to be exhaustive or exclusive)

- Adults whose primary need is for specialist mental health care.
- Children under 18 years of age.
- Residents who require 24 hour nursing care.
- Residents who are not registered to a GP practice in Darlington.
- Individuals at high risk of self-harm to themselves or who may pose a risk of harm to others or who have behaviours that cannot be safely risk assessed and managed in Ventress Hall.
- People with End of Life Care needs.
- Residents who are able to be cared for in their own home.
- Residents where the sole reason for admitting is dementia or deterioration in
- Cognitive functioning. (Physical Care needs must outweigh any mental health needs and must be the primary reason for admission. Increasing confusion due to a physical problem should not be excluded.)
- Carer crisis - these residents should be referred to Social Services
- Residents who require medical intervention other than that which can be provided by a GP/community services.
- Residents who are unable to participate in a rehabilitation programme due to an acute state of confusion such as delusion.
- Residents who refuse to engage in a rehabilitation programme

Capacity and Demand for current bed based rehabilitation beds is highlighted below and demonstrates that the usage is consistently in the region of 80% which means that the beds are not being used to capacity. However, in 2018/19 there is a pattern emerging of increased breaches, identifying a challenge in either discharging people from services in a timely manner, or being able to meet the needs of those within the service to meet their rehab potential within the allotted six weeks as part of the current intermediate care service:

Figure 13

	Total Number of Admissions	Percentage Occupancy (Average)	Number of Breaches (exceeding 6 weeks stay)
2017/18	211	83%	0
2018/19	190[1]	81%[2]	19

[1] March Admission figures for Eastbourne were not provided and are not included.
[2] Excludes March 2019 as Eastbourne LOS information was not provided.

8.0 Case for Change

The current model of inpatient rehabilitation care is not standardised and is not always compliant with national evidence and best practice. The current model is not fit for purpose to address the needs of the local population; services are often developed based around estate as opposed to the demand required. Patients residing in inpatient based rehabilitation care have considerable therapy and social needs, resulting in long length of stays.

As described earlier we know that it is best for patients to be discharged home at the earliest opportunity to maximise their rehabilitation goals. Another consequence of prolonged length of stay is the impact on financial resource and the best use of public money and inappropriate use of limited inpatient facilities and skilled workforce.

Ward 6 currently accepts patients who are;

- Orthopaedic non-weight bearing
- Medically fit and stable
- Requiring step-down nursing support
- Unable to be discharged home for example where a change in package of care is required
- Requiring complex discharge planning awaiting a Decision Support Tool (DST)
- Deemed to be homeless who don't require healthcare

CDDFT has drawn upon national recommendations and best practice to carry out quality improvement initiatives over the last year which has been enhanced by the evolving work of the Teams Around Patients (TAPs) through the community contract and has seen an increase in the number of patients receiving appropriate care as detailed below:

- An increase of Non weight bearing patients being supported at home with temporary home modifications and the utilisation of therapy support The patient's rehabilitation is expedited in their own home. If the patient does require inpatient care then they are supported at a facility close to their home.
- Implementing the SAFER[9] bundle, has enabled earlier discharge planning which has reduced the number of medically fit and stable patients being transferred to Ward 6. Now they are supported by the local authorities and partner agencies to return to their home by implementing enhanced care packages, where required.
- Using the Discharge to Assess methodology and "home first" philosophy more in-patients waiting for a Decision Support Tool (DST) are supported with involvement of Trusted Assessors to return home while these discussions take place.
- The use of The Homelessness Reduction Act, 2017- Duty to Refer Guidance 2018 is helping to ensure that services are working together effectively to prevent homelessness by ensuring that peoples' housing needs are considered when they come into contact with public authorities.[10]
- A Non-Weight Bearing four month pilot was commissioned from February 2019 – June 2019 by County Durham Local Authority, 10 beds were commissioned from two residential care homes on a "Time to Heal" basis to avoid potential lengthy hospital stays. The pilot proved to be a useful exercise with valuable learning. Although activity was lower than expected. It was thought this was due to CDDFT becoming more adept to move non-weight bearing patients into community settings with appropriate support from partner agencies. There is a plan to explore whether this model could be rolled out further.

There is much evidence to support the need for appropriate rehabilitation services for the local population, it is widely recognised that longer stays in hospital can lead to worse health outcomes and can increase care needs. One week in bed equates to 10% loss of strength and in an older person that 10% can make the difference between dependence and independence. [11]

Appropriate rehabilitation services:

- Focus on good outcomes for patients, driven by the goals patients set increasing patient independence
- Centred around patients' needs, not their diagnosis
- Relies upon multidisciplinary team working
- Deliver cost savings, by unnecessary bed occupancy
- Increase collaborative working between social care, secondary care and community care to provide a safe sustainable service

[9] Emergency Care Improvement Programme
The SAFER Patient Flow Bundle
NHS Improvement
https://improvement.nhs.uk/documents/633/the-safer-patient-flow-bundle.pdf
[10] Homelessness: duty to refer
www.gov.uk
[11] Functional Impact of 10 Days of Bed Rest in Healthy Older Adults
The Gerontological Society of America 2008
www.bgs.org.uk/blog/

8.1 Workforce challenges

Within the current service there is no therapy input onto ward 6. The service is nurse-led with senior clinical leadership from Advanced Nurse Practitioners (ANPs).

CDDFT want to promote their model of care for inpatient rehabilitation and there seamless links into the community to demonstrate that it is a great place to work; to retain and attract the very best in terms of highly skilled and competent staff.

8.2 Financial challenges

- Inefficient care models are driving up costs. Insufficient focus on prevention and treating people in the wrong care setting both push up the cost of care. This is most obvious in the occupation of acute beds by patients who could have been better treated in community settings, discharged sooner, or whose admission could have been avoided in the first place.
- The cost of bank and agency staff has an impact on all services. Any initiative implemented to improve the recruitment and retention of staff, means that limited resources can be used to provide high quality direct patient care.
- Unwarranted variation in clinical practice is increasing the cost of care, increasing opportunity cost through increased claims on clinical time, or both.
- A robust community model of care is required to prevent people requiring inpatient care. Where community services are provided seamlessly there is a timely transition from hospital to home. Inpatient beds are used where required and discharge is delivered in an efficient way.

9.0 Options Criteria and Process

A clinically led group was set up to develop options for the future model for the cohort of patients currently utilising ward 6 at BAH. Representation on the group included consultants, matron, ward sister, therapy leads, operational managers and commissioners. Alongside this the group had access throughout to the feedback received from the engagement work which was carried out by County Durham Healthwatch.

The criteria, which was used to measure options against were chosen to help ensure high quality, long term inpatient rehabilitation services are sustainable longer term for County Durham and Darlington.

Clinical quality	Maintains or improves clinical outcomes; timely and appropriate services; minimises clinical risk	Patient, Public and carer Engagement – Experience and Feedback
Sustainability/flexibility	Ability to meet current and future demands in activity; ability to respond to local/regional/national service changes	
Equity of access	Reasonable access for urban and rural populations	
Efficiency	Delivers patient pathways that are evidence based; supports the delivery though access to resources	
Workforce	Provides environments which support the recruitment/retention of staff; supports clinical staffing arrangements	
Functional suitability	Provides environments suitable for delivery of care; clinical adjacencies with other relevant services/dependencies e.g. imaging	
Acceptability	Acceptable to service users, carers, relatives, other significant partners	
Cost effectiveness	Provides value for money	

Figure 14 options appraisal criteria

Each option was assessed against the range of criteria identified by the multi-disciplinary group with supporting information used from the patient engagement exercise carried out.

9.1 Options Appraisal

The table below (figure 15) outlines the options that were assessed. On this basis there are four options to consider, one of which includes continuing to deliver the current model of service.

Option	Description
1	**Do nothing and remain as is**
2	**Re-purpose into an inpatient rehabilitation ward with a reduction of eight beds – co-locate with ward 16**
3	**Re-purposing ward 6 facility as a care home model**
4	**Close all ward 6 beds**

Figure 15 Options for future service delivery

The options appraisal process was undertaken and each option was assessed against the criteria and given a score out of 10 for each component. The table below summarises some of the key points raised and outlines the scores for each element.

Option one – do nothing

Criteria	Score (out of 10)	Narrative
Clinical quality	5	• Ward is currently utilised by those deemed medically fit • There are more appropriate uses for the inpatient provision • The quality of nursing care provided is extremely good
Sustainability/flexibility	5	• The ward currently manages people who could be managed in the community • There is a need to flex the beds to ensure they meet the needs of the local population • The ward does provide additional capacity at times of high demand
Equity of access	5	• People from across County Durham and Darlington as well as out of area utilise the ward • BAH is closer for those who live in the South of County Durham and Darlington

Criteria	Score (out of 10)	Narrative
Efficiency	4	• The inpatient facility is not efficient in terms of managing patients to a point of discharge due to the model of care available, mainly due to lack of therapies • Increased length of stay, which could be improved by more effective discharge processes and community provision
Workforce	6	• Seen as stand-alone unit in terms of pathways and interfaces
Functional suitability	7	• BAH provides a suitable environment to deliver care • Unable to access therapy input in current location due to limited resource
Acceptability	8	• The level of care experienced by patients and their families is good overall • People in the south of the county and in Darlington benefit from the location
Cost effectiveness	3	• Current model is not cost effective • Resource could be better utilised to provide rehabilitation offer
Total	**43**	

Option two - Re-purpose into an inpatient rehabilitation ward with a reduction of eight beds – co-locate with ward 16

Criteria	Score (out of 10)	Narrative
Clinical quality	7	• Criteria for these beds would need to be developed • Rehab service with therapy input to promote rehabilitation • The quality of nursing care provided would be retained
Sustainability/flexibility	7	• The ward could provide additional capacity at times of high demand • Model with fit with new ways of working re: bed optimisation and community services
Equity of access	9	• Support in the community • LoS will be reduced so access issues will be limited • Use of all inpatient rehabilitation beds can be utilised to deliver care closer to home
Efficiency	8	• Opportunity to use optimum number of beds to ensure rehab input is provided for those who need it • Co-location of ward 17 to make best use of therapy provision
Workforce	8	• Using economies of scale of existing therapy provision to deliver • Therapy input required at this stage would be based upon ○ Physiotherapy – 5 days a week ○ Occupational Therapy – 5 days a week ○ SALT and dietetics according to need
Functional suitability	7	• There are appropriate number of beds and facilities available on ward 17
Acceptability	7	• Resources will be re-purposed to ensure a more sustainable model is in place • The level of care experienced by patients and their families is good overall • A slight reduction in beds may create concern, however the PCBC demonstrates better use of resource
Cost effectiveness	8	• Better use of resources to manage the demand • Changes to bed configuration will result in therapy input to inpatients
Total	**61**	

Option three – Re-purposing ward 6 facility as a care home model

Criteria	Score (out of 10)	Narrative
Clinical quality	3	• Criteria for patients accessing this would need to be developed in line with service model • Ratio of nursing staff per patient will be reduced
Sustainability/flexibility	3	• Flexibility to use when system in high demand • Sustainability risk re workforce retainment
Equity of access	3	• The model could be offered to all in the CDD area • Travel implications for those out of the Bishop Auckland vicinity i.e. family
Efficiency	4	• Efficient in terms of staff costs • Low efficiency in relation to cost of facilities
Workforce	4	• Working on a care home based staffing model • Potential ratio of: ○ 1 qualified nurse (band 5/6) per 24 beds ○ 1 HCA per eight beds ○ Local GPs would be aligned to ward (used as and when required) ○ Potential to require band 7/8a Monday-Friday to manage ○ Existing community infrastructure i.e. district nursing would be utilised • NHS staff would not want to work within this model • Risk of de-skilling
Functional suitability	4	• Retaining all 26 beds on ward 6 • Hospital facilities are used to deliver services which don't require that level of estate
Acceptability	4	• Retaining all 24 beds on ward 6 • Unacceptable use of NHS estate and workforce
Cost effectiveness	7	• The model would be more financially viable • The ongoing cost of NHS estate and equipment would be costly for the level of service provided
Total	**32**	

Option four - Close all ward 6 beds

Criteria	Score (out of 10)	Narrative
Clinical quality	3	• Criteria for patients accessing this would need to be developed in line with service model • Ratio of nursing staff per patient will be reduced
Sustainability/flexibility	3	• Flexibility to use when system in high demand • Sustainability risk re workforce retainment
Equity of access	3	• The model could be offered to all in the CDD area • Travel implications for those out of the Bishop Auckland vicinity i.e. family
Efficiency	4	• Efficient in terms of staff costs • Low efficiency in relation to cost of facilities
Workforce	4	• Working on a care home based staffing model • Potential ratio of: ○ 1 qualified nurse (band 5/6) per 24 beds ○ 1 HCA per eight beds ○ Local GPs would be aligned to ward (used as and when required) ○ Potential to require band 7/8a Monday-Friday to manage ○ Existing community infrastructure i.e. district nursing would be utilised • NHS staff would not want to work within this model • Risk of de-skilling
Functional suitability	4	• Retaining all 26 beds on ward 6 • Hospital facilities are used to deliver services which don't require that level of estate
Acceptability	4	• Retaining all 24 beds on ward 6 • Unacceptable use of NHS estate and workforce
Cost effectiveness	7	• The model would be more financially viable • The ongoing cost of NHS estate and equipment would be costly for the level of service provided
Total	**32**	

9.2 Preferred Option

Following consideration of the necessary risks and challenges for each option, option two is the preferred model, enabling this to be implemented quickly and efficiently.

The preferred model will be assessed using NHS England's four key tests in relation to major service change which is fundamental to any proposed transformation.[12]

1. Strong public and patient engagement
2. Consistency with current prospective need for patient choice
3. Clear clinical evidence base
4. Support for proposals from clinical commissioners

The preferred model will need to provide assurance against the fifth test affecting bed reconfiguration:

- Demonstrate that sufficient alternative provision, such as increased GP or community services is being put in place alongside or ahead of bed closures and that new workforce will be there to deliver it.
- Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions.
- Where a hospital has been using beds less efficiently than the national average, it has a credible plan to improve performance without affecting patient care for example Getting it Right First Time Programme (GIRFT)

The preferred option following the appraisal for a new model of care is to move the physical location of the ward to ward 17, co-located with ward 16.

This will be a rehabilitation facility with dedicated therapy input and nursing care. Patients will access the service following an episode on an acute or other community inpatient facility for rehabilitation. This recommendation follows a process of evaluation on a range of options based on the information available at that time. The service will deliver better care, value and quality for our local population and wider neighbouring geographical areas.

This service will be aligned to the community model of care to ensure that patients are supported in terms of their discharge and that the transition is seamless.

Currently there are 24 beds on ward 6. The preferred option would include a reduction in beds by eight so the total number which would be located on ward 17 would be 16 beds. Ward 17 is currently utilised as a paediatric dental clinic (one day a week) this would be relocated elsewhere in BAH. The reduction in beds accounts for the decreased overall length of stay and throughput of patients due to the nature of the rehabilitation available and indeed the transformation of community services to ensure people are discharged home at the most appropriate time.

The net reduction in inpatient beds is eight as compared to the current model. However there has been a review of current bed utilisation across all CDDFT estate to ensure that all acute and community bed provision is optimised and care is delivered closer to home wherever possible. The better value calculation (of 20%) is

[12] Planning, assuring and delivering service change for patients
NHS England
www.england.nhs.uk

based on innovation and improvements to productivity, of which the Trust is currently implementing several initiatives for example SAFER (explained in section four); which has been rolled out across all care of the elderly and medical wards.

CDDFT has increased the trusted assessor resource to facilitate “Discharge to Assess”, and “Assess to Admit”, along with recent improvements to internal discharge facilities to allow an increase in the daily usage of discharge lounges.

The Trust have given assurance that through these new ways of working which includes greater use of bed provision within all community hospitals as well as more smarter processes for discharge planning that the reduction of eight beds will provide the optimum level of capacity.

The service will deliver better care, value and quality for our local population and wider neighbouring geographical areas.

10.0 Benefits Realisation

What are the benefits to patients of changing ward 6 into a rehabilitation ward and ensuring care closer to home wherever possible?

The main aim of the proposal is to deliver best practice and service provision which ensures that services are delivered at the right time and in the right environment for the people of County Durham and Darlington. This includes delivering hospital based care when required with a view to ensuring patients and their families are involved and supported in their discharge back into the community.

The benefits of delivering a robust inpatient and community rehabilitation model include:

- The ethos of recovery with a focus on targeted rehabilitation
- Supporting an earlier discharge from hospital
- Delivering care closer to home in community hospitals and at home
- Providing continuity of care from hospital to home
- Delivering a more equitable service for all patients
- More integrated working with the whole health and social care system to ensure care is delivered seamlessly for patients and their families
- Ensuring patients maintain their independence wherever possible

Better use of resources

- Ensuring a multi-disciplinary team is in place with dedicated therapy input and workforce contingency
- Further integration of acute and community teams to ensure greater use of staff resource and to reduce any delays in discharge
- Dedicated therapy input would potentially reduce length of stay and therefore beds would be used in a more efficient and appropriate way
- Best practice standards for rehabilitation would be met
- A better of funding for the whole system ensuring that individuals are seen and managed in the most appropriate way
- Greater ability to ensure a reduction in delayed discharges

- A reduction in multiple handovers to clinical teams as the need for step-down beds is lessened due to improved community based provision

11.0 Risks

The associated risks with the preferred option have been reviewed and mitigations would be actioned if it was agreed to commission the proposed model of care. Figure 16 details these risks and accompanying mitigations.

Figure 16

Risks Associated with Preferred Model	
1	**Risk** – The inability to realise the efficiencies such as reduced length of stay to enable an investment in therapy provision
	Mitigation – Ongoing management of key quality performance indicators to ensure services continue to deliver new model of care To ensure the SAFER way of working continues to be implemented across all wards within CDDFT
2	**Risk** – Discharges are not managed as effectively as they could be resulting in delays
	Mitigation – To ensure that ward 6 staff are supported and involved in ongoing improvement work to ensure effective discharge management. To ensure staff on all wards (particularly acute) are supported to begin discharge planning in line with best practice at the earliest opportunity.

12.0 Testing out the Preferred Option

In addition, the PCBC seeks to demonstrate compliance with the NHS England four tests of service reconfiguration:

- strong public and patient engagement;
- appropriate availability of choice;
- clear, clinical evidence based; and
- clinical support.

What this means for patients

In terms of the current admissions into ward 6 at BAH, figure 17 shows the percentage usage by locality. From this information it is evident that admissions are fairly distributed across the area except for Easington.

Locality	% Total Admissions
North Durham	25.5%
Durham Dales	24.7%
Easington	2.65%
Sedgefield	26%
Darlington	20.7%
Other	1.6%

Figure 17 – usage of ward 6 by locality

If we break this down by postcode area it becomes clearer in terms of where patients flow into ward 6 currently.

As highlighted in figure 18 currently the main cohorts of patients utilising ward 6 are from Bishop Auckland, Darlington, Crook and Durham. What is also evident is there are people utilising these services from more widespread locations including Stanley and Consett.

Postal area	2017/18	2018/19
Unknown	1	0
Durham	32	34
Chester Le Street	26	35
Houghton Le Spring	2	9
Durham	27	58
Consett	10	24
Stanley	17	25
Darlington	31	59
Richmond	0	7
Barnard Castle	3	6
Bishop Auckland	85	83
Crook	21	55
Spennymoor	12	40
Ferryhill	21	36
Darlington	35	46
Shildon	11	23
Newton Aycliffe	47	34
Northallerton	2	1
Bedale, Hawes, Leyburn	1	2
Catterick Garrison	2	2
Newcastle Upon Tyne	1	6
Blaydon On Tyne	0	1
Sunderland	0	1
Middlesbrough	1	0
Stockton On Tees	1	0
Wingate	0	1
Trimdon Station	0	2
Middlesbrough	0	1
York	1	0
Out of Area	1	2

Figure 18 – usage of ward 6 by area

For people in postcode areas near to BAH this maybe the closest/most convenient hospital for them to use and therefore would continue to use the facility. Where patients choose to go to another community hospital closer to home, this new model of service would accommodate that. CDDFT do have a Choice Policy in place which sets out very clear expectations in terms of options available to patients following discharge from an acute site.

In terms of utilisation of other community hospital sites there are some key headlines for consideration. The information below shows that the majority percentage of people do access their local community hospital. However it identifies that there is still scope to develop processes and systems to ensure wherever possible people are managed closer to home.

- **60% of admissions into Weardale Community Hospital are from Durham Dales locality**
- **41.8% from Sedgefield and 18.7% from Darlington are admitted into Sedgefield Community Hospital**
- **48% of people from Durham Dales and 35.6% from Darlington access the Richardson hospital**
- **92.8% of admissions into Shotley Bridge Community Hospital are from North Durham patients**
- **76.5% of admissions into Chester-le-Street Community Hospital are from North Durham patients**

In terms of the proposed model of care it is envisaged that patients who need ongoing inpatient rehabilitation would be admitted onto a community hospital close to where they live where possible. It is important to recognise that ward 6 is part of a wider model of care relating to community hospitals across County Durham as well as intermediate care provision and community based care. The proposed model for inpatient rehabilitation at BAH is aligned to this wider network of care provision.

There is also work ongoing with County Durham Local Authority to manage non-weight bearing patients within a care home setting on a ‘time to heal’ basis. This will support the effective use of inpatient based bed provision, ensuring only those who have a clinical need are using this limited resource.

Patients admitted onto this particular ward will experience a standardised approach to inpatient rehabilitation as is in place across the Trust. This will include robust care plans with key recovery goals identified and management in place to achieve these

goals. Discharge planning will be a core function of the ward utilising the principles of SAFER to ensure high quality, effective care is given to all patients.

13.0 Proposed Future State

The CCGs and CDDFT are proposing to improve the availability of rehabilitation to those people who require inpatient based care at BAH. The ward will remain (in a slightly different location on the BAH site) with a reduction of eight beds but with a guarantee of therapy input. This proposed service change will ensure that all hospital sites have appropriate rehabilitation provision in place so that inpatient facilities are utilised effectively.

Patients' value therapy and the effect it can have on their recovery. There is strong evidence to show that skilled therapy provided at the right intensity can greatly improve outcomes. The proposed model contributes towards the CCG's priorities to provide high quality care closer to home.

13.1 Service Model

It is increasingly acknowledged that effective rehabilitation delivers better outcomes and improved quality of life and has the potential to reduce health inequalities and make significant cost savings across the health and care system.

A person-centred approach is fundamental to ensure that rehabilitation is as an active and enabling process for each individual. It ensures that support is built around a person's own circumstances and responds to the diversity of needs that will be present. This includes consideration of mental and physical health, and the relationship between these which is critical to planning effective care.

The 'Home first' model aims to stop patients being stranded on hospital ward and results in fewer people going into residential care.[13] With all of the above in mind our focus is to ensure people are discharged home at the most appropriate point in their pathway, with a robust care plan and comprehensive community service offer.

Using the data available to us and understanding our population needs we have determined that there will be a need for inpatient based rehabilitation at BAH. Within the current model we know that the lack of therapeutic intervention is a major issue for patients and their families. Therefore we propose that the future inpatient model needs to include a multidisciplinary workforce to best meet therapy need of our population.

We propose based on the data available that we could reduce the bed base by eight beds whilst improving the level of care and rehabilitation available for patients. This would ensure that whilst patients are in an inpatient setting that they receive the best available rehabilitation to enable them to go home at an earlier stage and with a better level of functionality the programme of work regarding community based services has ensured a better more integrated delivery model to ensure that patients are seen in their own home where possible by a range of professionals to aid their recovery.

[13] NHS England Quick Guide To Discharge to Assess / Publications Gateway Reference 05871 2015
www.nhs.uk/NHSENGLAND

13.2 Specific Measurable Outcomes

Focusing on outcomes is one way of enabling the transformational change required in the healthcare system. Outcomes need to be meaningful to people who use rehabilitation services and enable them to maximise their potential, manage their healthcare themselves and promote independence. The Government's Mandate to NHS England for 2016-17[14] has an expectation that improvements will be demonstrated against the NHS Outcomes Framework[15] so as to provide evidence of progress and enable comparison of services locally.

Consideration will be given to the level of outcome data to collect which demonstrates a patient centred approach and impact upon their individual rehabilitation goals.

Outcome measurement tools need to be appropriate for the client group, health condition and method of service delivery.

Data collection should allow for benchmarking against other services and show how existing inequalities have been reduced in terms of access to services, experiences of services and if outcomes have been achieved.

The following key areas will be covered:

- Key performance indicators
- Monitoring of service and patient outcomes (quarterly meetings and evaluation metrics)
- Patient waiting times (assessment and treatment)
- Patient satisfaction
- Clinical governance

Continuous improvement of the service and impact upon the length of stay and will be reviewed through existing governance arrangements and mechanisms.

13.3 Performance Management

The performance management framework will be implemented through existing contract management arrangements.

The following key areas will be covered:

- Key performance indicators
- Monitoring of service and patient outcomes (quarterly meetings and evaluation metrics)
- Patient waiting times (assessment and treatment)
- Patient satisfaction
- Clinical governance

Continuous improvement of the inpatient rehabilitation model and the impact upon patient length of stay will be monitored through existing governance arrangements and mechanisms.

[14] The Government's Mandate to NHS England for 2016-17
www.gov.uk/government/publications/nhs-mandate-2016-to-2017
[15] NHS Outcomes Framework
Department of Health (2014) The NHS outcomes framework 2015/16
www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015

14.0 Project Plan

The Director of Commissioning Strategy and Delivery for Durham Dales, Easington and Sedgefield and North Durham CCGs will sponsor this project with the support of colleagues from the CDDFT, Local Authorities and Commissioning and Delivery Team to implement the preferred model.

High Level Milestones:

- Public Consultation October 2019
- Implementation Plan February 2020
- Launch April 2020

The Patient Engagement Report prepared by County Durham Healthwatch and Consultation and Engagement plan to accompany this business case can be found as appendix one and two.

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