


Business Case and Project Plan

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Project Name	Short Term Assessment Rehabilitation & Reablement Service (STARRS) – Joint Intermediate Care Service.		
Project Reference	TBD		
SRO (Sponsor)	Thirza Sawtell		
Project Manager	Javina Sehgal		
Financials verified by	Antoinette Jones		
Project Start date	01/10/09	Project completion date	31/03/12

Decision Summary

What are the Investment Panel and Boards (both NHS Brent & London Borough Brent) being asked to approve?

To establish an integrated intermediate care service (across health & social care) for the benefit of our adult population to promote faster recovery from illness, to protect them from unnecessary acute hospital admission and premature admission to long-term residential care, by supporting timely discharge from hospital and maximising independent living.

Why is this approval being sought?

- To integrate the existing services across our providers and to add additional services to meet our populations needs.
- To ensure people with a primary care and social care need are treated in a community setting where appropriate.
- To reduce the number of unnecessary acute admissions for Ambulatory Care Sensitive conditions.
- To ensure our population receive the right care at the right time in the right place by the most appropriate staff to maximise independent living.
- To protecting our population from unnecessary hospital admissions, long hospital stays and premature use of long-term residential care.

What investment is required?

- A recurring additional investment of £2.2m by 2011/12 (£1.7m health, £0.5m social).
- Delivering annual disinvestment opportunities (health) estimated at £4.7m by 2011/12.
- Delivering annual disinvestment opportunities (social care) estimated at £0.6m by 2011/12

Project Description – Our desired outcomes are:

To provide intermediate care services that are readily accessible and easily navigated by patients, carers and staff, and provide 'time-bound' care designed to reduce unnecessary hospital admission, maximise independent living through re-ablement (reducing long-term residential care) in the community and accelerate return from hospital to more appropriate care closer to home.

To link existing services and to add new services which will help to deliver intermediate care in an integrated way across health and social services, by treating the patients in an appropriate community setting (where possible their home) in a timely manner to meet their health or social need.

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This service will:

- Improve the transition for patients between acute hospital services and community services.
- Reduce acute hospital activity in both A&E and unnecessary admissions for Ambulatory Care Sensitive conditions.
- Operate in an integrated way so that patients or clients see a single service operating for their benefit.
- Maximise independent living by treating people in their own homes where possible and supporting them "to do".
- Protect our population from unnecessary hospital admissions, long hospital stays and premature use of long term residential care.

It will achieve this by providing:

- A Single Point of Access (SPA) and patient brokerage function that co-ordinates all referrals and provides triage to ensure the most appropriate response to patient/client need and is the care co-ordinator for monitoring patient's progress through the whole IC pathway.
- A Rapid Response multi-disciplinary team. To provide care in the community quickly and for up to 72 hours as an alternative to a hospital admission.
- A Short-Term Service, comprising of the following parts to prevent acute admission, assist with acute discharge and to maximise independent living for patients with rehab potential.
 - Short term community beds (providing direct admission from community (step-up) and rehabilitation beds (step-down) and social need beds).
 - Time-bound community re-ablement service (to provide care in the patient's/client's home assisting them to be independent).
 - Time-bound community rehabilitation service (to provide rehabilitative therapy in the patient's home).
 - Additional services (eg telecare) to support independence and reablement

The short-term service will provide care for up to around 6 weeks. Patients will be discharged from the service as soon as their intermediate care needs have been met. Some patients will only require the service for a short time with the maximum period of intermediate care being 8 weeks. If further care is necessary patients will be referred on to generic community services.

Context

The situation for our population:

These findings are a summary of a recent study commissioned by NHS Brent to identify which services contribute to delayed discharges (both health & social) and achieving the A&E 4 hour treatment target.

- The landscape of rehabilitation and Intermediate Care (IC) services is limited in variety and availability across Brent.
- Services are not integrated, or aligned, with Social Services and locally there is no identity for IC services in a way that there is in other boroughs/ localities.
- Lack of structured investment and continuous improvement in the existing IC services has contributed to the increase in delayed transfers from hospital and the rise in unplanned admissions.
- There are opportunities to realign services to reflect the needs of patients, as well as increase clarity on the flow of patients across health and social care agencies, rather than just basing evaluation on good service availability.
- Current services are arranged across various tiers; however a lack of a consistent approach and connections between services is adding pressure on the health and social care economy generally. Also, it is likely that existing resources may not be being effectively utilised to achieve the best outcomes for patients.
- There is a need for a fundamental change in the way that services are commissioned and provided, requiring health and social care services to engage in a different approach to better serve the patient. To accomplish this there is a need to invest to develop community health and social care IC services to support people outside institutional care, ideally in their own homes.

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Brent NHS 5 year Commissioning Strategic Plan:

- Brent NHS's 5 year Commissioning Strategic Plan was published in November 2008 which clearly establishes the patient needs within Brent. The strategy discussed the following priority areas which have become the corporate objectives.

The priority areas are:

1. Increasing the life expectancy of our population by reducing premature mortality.
2. Addressing the health inequalities that exist in our borough, by working with our partners to address inequities both in health services and the wider determinants of health.
3. Promoting good health and preventing ill health, to improve the health and wellbeing of our population.
4. Ensuring the safety and improving the quality of all our services, by working with stakeholders to develop integrated and connected services, adopting the most effective models (local or regional) for each service.
5. Increasing satisfaction with our services, by continually improving our understanding of the needs, wants and preferences of our community and using this insight to guide our decisions.
6. Develop NHS Brent as a World Class Commissioning Organisation.

To deliver change in these areas the PCT created nine detailed initiatives, one of these is to improve and develop the intermediate care services within Brent to support achieving our overall goals of improving resident's health and promote independent living.

Adult Care Transformation programme:

This is system-wide transformation programme that has been developed and owned by Brent Local authority. It is accompanied by partnership working with Brent NHS, other statutory agencies, third and private sector providers, users and carers and the wider local community. Its purpose is to create a new, high quality care system which is fair, accessible and responsive to the individual needs of those who use services and their carers.

The aim is to move towards a single community based support system focussed on the health and wellbeing of the local population. This will bind together local government, primary care, community based health provision, public health, social care and the wider issues of housing, employment, benefits advice and education/training, not through structural changes, but through our local organisations coming together to re-design local systems around the needs of our population to create a seamless service.

The shared outcomes of the programme must ensure people are supported to:

- Live independently.
- Stay healthy and recover quickly from illness exercise maximum control over their own life and where appropriate the lives of their family members.
- Sustain a family unit which avoids children and relatives being required to take on inappropriate caring roles.
- Participate as active and equal citizens, both economically and socially.
- Have the best possible quality of life, irrespective of illness or disability.
- Retain maximum dignity and respect.

The immediate priorities for Brent are:

- Self directed Support (SDS) - Implement arrangements which place service users in control of their own care and introduce individual budgets.
- Modernising day care - Improve existing institutional day care and produce community based solutions focusing upon user centred outcomes inc education, employment, leisure and support for carers.
- Modernising Transport - To improve in-house transport arrangements to SEN and ASC clients to improve service.
- Redesign of Assessment and Care management - change the way we assess and review service users.
- Commissioning Unit - Improve our commissioning and reduce use of institutions.
- Develop Intermediate care services
- Develop Reablement services
- Modernise the delivery of simple community equipment

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The focus of this programme is local organisations working together to ensure the needs of their population link in closely with providing suitable intermediate care services within the community to support many of the points above.

Benefits

The tangible benefits of delivering this project are:

Description	Measure	Baseline	Target	Target Date
Reduction in acute admissions for Ambulatory Care Sensitive conditions.	Admissions avoided (measured from team), Actual acute ACS admissions.		2,265 p.a. fewer	End 11/12
A&E attendances (related to admissions) reduced.	A&E attendances avoided (measured from team).		3,000 p.a. fewer	End 11/12
Reduction in Delayed Transfers of Care	NI 131 Delayed transfers of care per 100k population.	15 (08/ 09 target) 13.6 (08/ 09 actual)	7/100k pop.	End 11/12
Reduced hospital Length of Stay	Delayed transfer of care days.	08/ 09 Social care delayed days: 1125 Willesden 1633 Acute	TBC	TBC
Reduction in the Rate of new admissions to Residential and Nursing care homes	Actual admissions to residential and nursing care homes.	73 Residential (29 dementia) 81 Nursing (22 dementia)	50% reduction	End 10/11
Increase in the number of people maintained in the community, three and six months after leaving Intermediate Care	NI 125 Achieving independence for older people through rehabilitation/intermediate care	Yet to be determined; awaiting DoH figures	TBC	TBC

In addition, the intangible benefits of delivering this project are:

- Closer working between health and social care, meeting and treating patient/client need rather than identifying which box they fit in.
- Treating patients promptly, and providing the appropriate support it is possible that patients may return to independent living sooner and require less longer-term (institutional) care in the future.
- More patients will be treated at home possibly causing less stress and anxiety.
- Time saved by referrers by having a Single Point of Access into the intermediate care service and improved efficiency of the service by triaging calls and sending the right service to the patient/client.
- Patients receiving personalisation of their care.
- Improve patient experience through receiving care across a seamless pathway
- Reduction in the number of repeat admissions to hospital and care homes.
- Increase in the number of people receiving intensive home care in the community to support their independence.

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Cost

The costs that will be incurred to obtain these benefits are summarised below:

The intermediate care service includes services which are already funded, current investment in these services (including bedded services) is approximately:

- Health ~£5.3m
- Social service ~£0.75m (250 hrs reablement, 18 spot purchased beds)

The productivity gains required from the existing services are:

- Willesden Community hospital patients LOS must reduce to an average LOS per patient of 42 days, this will free up 15 beds to be reallocated for Step-up patients. Financially this is equivalent to a £0.9m pay cost saving.
- Should this not be achieved the total costs to provide 15 beds in an alternative setting would also incur non pay charges of approximately £0.56m (at Willesden's rates) totalling an additional £1.46m.
- Existing providers demonstrate increased productivity in terms of numbers of contacts per day; decreased length of stay on caseload prior to discharge back to generic services; accelerated improvement towards patient-specific goals; improved skillmix, including use of reablement workers to support therapy programmes
- Streamlined processes significantly reduce the number of delayed transfers and reduce the LOS in acute and community bedded services

Current funding

- It is assumed is that the current funding of existing services will be continued and to complete the service we require an additional investment as detailed in the table below:

Financial summary table

Note: The investment and saving table has been removed for commercial reasons.

In summary the overall service is expected to require:

- A recurring additional investment of £2.2m by 2011/12 (£1.7m health, £0.5m social).
- Delivering annual disinvestment opportunities (health) estimated at £4.7m by 2011/12.
- Delivering annual disinvestment opportunities (social care) estimated at £0.6m by 2011/12

Managing risk

Due to the nature of this scheme there is an inherent risk of increasing capacity and costs within the community services while not achieving the level of intended disinvestments from the acute hospital sector. To minimise the financial risk we intend to:

- Monitor the integrated community service and work collaboratively to ensure that maximum efficiency is achieved delivering a value for money service.
- Track the success of the service closely.
- Make staged investments to ensure the expected benefits are being realised.

Further risks have been identified in a later section.

Investment in 09/10

We have also invested in additional services in 09/10 as an interim measure prior to full implementation of this business case. In health this includes a Rapid Response pilot and in social services additional reablement hours.

NHS Brent has also recently commissioned in addition to the above an Acute Home Care service (provided by independent provider Clinicenta) which provides intensive packages of care in the patient's own home (start date July 2009).

Meeting required targets:

The volumes and expenditure above are based on current performance. Thorough analysis has been possible for determining health care costs as data and information was available (demand & activity).

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For social care we have created validated estimates but these will need to be regularly reviewed as a whole system and single agency in order to assess future level of performance against demand and activity.

Guidance and Legislation

Since the Department of Health (DoH) guidance and NSF for Older People (Standard 3) in 2001:

'Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care'

There has been a steady increase in intermediate care services across the country. Service approaches have varied in local content and resources and have included various teams such as rapid response, community assessment and rehabilitation teams, residential re-ablement units, hospital-at-home schemes and community hospital services to 'bridge the gap' between acute hospital services, primary and community care.

However, a national survey of intermediate care (HMSC, 2006) reported: "Fragmentation and poor integration with other services remain features of current provision and continue to have an impact upon the ability of intermediate care to deliver patient-centred care and contribute towards health and social care systems as a whole." In established, integrated services, there is evidence for reduced admissions to acute hospitals and reduced residential/ nursing home placements.

A risk for intermediate care is that it becomes isolated from other mainstream services. A whole system, integrated approach with flexible criteria and pathways along with appropriate expertise is essential to successful intermediate care implementation with improved outcomes for individuals.

National studies stress the importance of multi-agency working with links to managed beds that can be used appropriately. Strong interface arrangements with a wide range of health, housing and social care services is particularly important to ensure timely assessments and patient selection onto the most appropriate care pathway as part of a whole system, integrated approach.

The Department of Health (DoH) has renewed its guidance on intermediate care publishing Intermediate Care – Halfway home in July 2009.

This document builds on the evidence of services created since 2001 to highlight the need for intermediate care to be available to:

- Treat adults of all ages.
- Renewed emphasis on those at risk of admission to residential care.
- Inclusion of people with dementia or mental health needs.
- Flexibility over the length of the time-limited period.
- Integration with mainstream health and social care.
- Timely access to specialist support as needed.
- Joint commissioning of a wide range of integrated services to fulfil the intermediate care function, including social care re-ablement.
- Governance of the quality and performance of services.

Intermediate care should be provided to people whose short-term needs can be addressed within a limited period of weeks, as part of their overall care pathway. This could include short-term rehabilitation before moving to a lower level of longer term support. Many services use a guideline of up to six weeks, while others use up to eight weeks, with flexibility for extended needs. However,

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stating a standard time period can lead to inappropriate expectations, as many people will need the service for only a short time, such as less than two weeks, and should move on as soon as they are ready.

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

The intermediate care function should be managed in an integrated way. Integration can and should exist at several levels – strategic, operational and performance management. This might be best achieved with a single manager, although it may consist of a number of multi-agency teams and facilities.

Benchmarking

Good practice relevant to the project includes

Fifteen Existing PCT Intermediate Care strategies have been researched across England to identify common objectives and common service elements.

In terms of overall objectives, the dominant themes of these services are:

- Admission avoidance (11 of 12 sampled PCTs where objectives explicitly stated);
- Supported acute discharge (10).
- Supporting patients independence (7);
- Reducing long-term care needs (6).

The most common service elements in the sampled PCTs are:

- **Community rehabilitation service** (10 of 14 sampled PCTs where service components explicitly stated);
 - Generally rehabilitation and re-ablement services providing multi-disciplinary teams providing care packages within the patient's normal residence.
- **Residential (bedded) services** (10 PCT's).
 - Generally bedded facilities in the community to provide rehabilitation following acute discharge, direct admission from community for ambulatory conditions and short-term social beds prior to long-term placement.
- **Single point of access (SPA) function** (9 PCT's);
 - A central single point for all of the intermediate care referrals to be received and triaged to ensure the appropriate response is provided to the patient.
- **Rapid Response Team** (9 PCT's).
 - Generally a service designed to prevent avoidable acute admissions by providing rapid assessment/ diagnosis for patients referred from community (GP's), A&E, NHS Direct, and Social Services. In some PCT's this team also have a presence in the A&E's to prevent admission.

The differences between the PCT's is summarised in the table below.

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Service components of sampled PCT Intermediate Care Strategies

PCT	Service component					
	Single point of access (SPA)	Rapid Response Team (RR)	Community Rehab Service	Reablement / social care	Residential services	Daycare
Bromley			3 Community Assessment & Rehab Teams (CARTs)		2 nursing homes & 1 residential home	
Bury	SPA	RR Team incl. A&E diversion	Hospital discharge, Community diversion, community rehab		Step-up & step-down beds	
Leeds	8am to 10pm. Team Co-ordinator does triage.	RR Team	4 IC teams; Interdisciplinary (incl. social/ mental health), Nursing, Physio, OT.			
Milton Keynes	SPA	RAIT (Rapid Assessment & Intervention Team) <30			Step-up & step-down beds. Incl. rapid access beds.	
Norfolk	SPA		MDT assessment & care		Community hospitals	
North Birmingham	SPA	Rapid Response Team & Community Assessment & Rehab Team merged into IC Team.			Residential rehab/ comm'ly hosp	Day rehab
Nottingham	9am to 10pm, 7-days a week	Same-day response	Local patch-based IC teams aligned to GP practices			
Oxon	6-mth pilot	RR Social service 'home care'	Community Rehab Service, District nurses, Intensive Community Support Scheme, Community I/V therapy service, new community rehab services	Social services domiciliary care incl. rapid response'	10 community hospitals, Short-stay nursing home beds.	Day hospitals
Peterborough		RR Team	Intensive Community Rehab service, Hospital at Home service	Rehab (SS) homecare service		
Rotherham			Community Rehab Team (MDT)		IC Residential Service	Millenium Day Reab Service
SE London		RR Team expanded to do assessments in community & at A&E.			Step-down beds.	
Southwark					2 bedded units (23 beds)	
Tameside & Glossop	24/7 Single point of contact (SPOC)	Admission Avoidance Team	Community Teams (Facilitating Early Discharge, Rehab &		Inpatient Units	
Torfaen	Service elements not explicitly stated					
Westminster	SPA	RR nurse team				
Count	9	9	10	3	10	3
% of sample (14)	64%	64%	71%	21%	71%	21%

[Further detail can be found in the Brent Intermediate Care Strategy, March 2009]

Even though re-ablement functions did not reside in the majority of the IC teams above, a Care Services Efficiency Delivery (CSED) Longitudinal Study (Oct 2007) identified the following results through evaluation of the experiences of four councils & schemes delivering re-ablement care:

The retrospective longitudinal study shows that in three of the four schemes:

- Over 53% left re-ablement requiring no immediate homecare package.
- Over 36% continued to require no homecare package two years after re-ablement.
- Over 34% had maintained or reduced their homecare package two years after re-ablement.

Further studies are planned within other councils to monitor this longer-term benefit.

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Options
The options that have been considered are:
<p>Option One The first option is to do nothing. If this route is taken, it is likely that the existing services will not be able to cope with reducing the required acute admissions of Ambulatory Care Sensitive conditions and the constant challenge of reducing Delayed Transfers of Care from hospitals into the community. The services will continue to operate in an isolated fashion leading to patients needs not being met within the most appropriate and cost effective environment and potentially extending their requirements for longer term services.</p> <p>Option Two Keep the current services offering intermediate care as they are (within the current providers) but add a community rapid response team element to treat patients from the community, in the community. The referral process will be kept local to the teams and they have access to existing community bed types. This would benefit the current service by adding additional community capacity but not offer true value for money as it would be difficult to track patients through the system (no Single Point of Access) and the lack of step-up beds would mean that more patients would have to be admitted to acute hospital than necessary.</p> <p>Option Three The third option is to create a fully integrated intermediate care service (across all existing IC services and providers) and adding the additional services of the rapid response element, with patient referrals controlled through a Single Point of Access (SPA) ensuring that patients get (efficiently) the correct response to their need and their care is coordinated through the menu of service provision best suited to met their needs. Direct access to community beds will ensure that patient who can be treated in the community will stay in the community.</p>
The preferred option is:
<p>Option three This option offers the ability to commission a fully integrated 'seamless' service, centrally controlled by a SPA function ensuring patients needs are met with the spectrum of services offered. The ability to place patients into a community bed directly from a community setting means that the service will be able to have a large impact on the number of acute admissions for Ambulatory Care Sensitive conditions. The patients may receive care from a number of providers and services, yet they will see it as a single service delivering their care needs.</p>

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Scope

This project will cover:

All elements of providing intermediate care services within the Borough of Brent.

Existing intermediate care type services are provided by: Brent Community Services, North West London Hospitals and London Borough of Brent social services and so this project brings together these services and adds new services to them to create an integrated intermediate care service for Brent residents.

The existing services this project will affect are:

- Continuing Care Team (NWLH CMX) – Admission avoidance (A&E) & assisted discharge.
- HART (NWLH NPH) - Admission avoidance (A&E) & assisted discharge.
- Brent Rehab Services (BCS) – Community rehabilitation.
- Willesden community hospital (BCS) – General rehab wards (Fifoot & Menzler – total 40 beds).
- Re-ablement team (LBB Social Services) – Community re-ablement service.
- Spot purchased short-term social beds.
- Acute Home Care – (Independent provider - Clinicenta) – Acute type care in patients own home.

The change in service will impact multiple stakeholders throughout the patient pathway, including (but not restricted to) GP's, 'Generic' community services such as District Nursing, Specialist nursing, Community Matrons, Community hospital providers, Acute hospital providers, Community rehabilitation teams, independent providers (such as Clinicenta).

The target population that this service will treat is the whole of our registered population 18 years or older. Although due to the nature of the service intermediate care is most likely to be utilised by the older population (over 65's resident population in Brent currently number around 33,000).

One of the key measures of this service is the reduction in unnecessary acute admissions for Ambulatory Sensitive Conditions which will be treated by the new intermediate care service, these are conditions such as:

- Chronic Obstructive Pulmonary Disease, congestive heart failure, angina, dehydration and gastroenteritis, asthma, convulsions and epilepsy, influenza and pneumonia, cellulitis, diabetes, Iron deficiency anaemia, hypertension, gangrene, pyelonephritis.(source Dr Foster).

This project will *not* cover:

1. Patients under 18 years of age.
2. Patients medically assessed as requiring acute hospital admission.
3. Patients with no intermediate care need.
4. Patients discharged from hospital without an agreed health care plan.
5. Review of capacity in the generic community services (such as District Nursing, Specialist Nursing, Community Matrons) to 'hand over' patients.
6. Providing on-going care requirements over 6 weeks of provision unless identified in the patients care plan (with goal for patients to be discharged or handed over to other services at around or before the 6 week period).
7. Joining of budgets (acute, LBB, BCS, Brent NHS) into one central intermediate care fund (note: this may happen at a later stage to be agreed by all parties).
8. Commissioning a single information system between all providers.
9. Any change in bed provision or operation of Willesden Hospitals Robertson Ward (12 specialist neuro beds).

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Delivery

The actions required to deliver the objectives are:

Agree best commissioning and procurement method (please see options paper in appendix).

Following agreement of the Business Case by both NHS Brent Board and London Borough of Brent Transformation Board, further detailed implementation work will be undertaken including:

- Development of detailed specifications and stakeholder road testing of care pathways and specifications prior to re-commissioning / procurement
- Notice given to current providers for change in services.
- Detailed joint implementation plans to be created between all services (and especially between health and social care).
- Aligning budget streams for other services which may also complement the new intermediate care service (such as telecare).
- Aligning budget stream for carers' support
- Ongoing stakeholder engagement & communications plan to be established and implemented

Project Resourcing

Current – business case

Project Role	Dates	FTE	Person filling	Agreed by
Programme Manager	Current	1.0	Javina Sehgal	
IC Project Manager	Current – Dec 09	1.0	Jonathan Ellis	
IC Implementation Lead	Current – Oct 09	0.6	Kevin Atkin	
Project lead – Rapid Response team (including SPA)	Sign off – Mar 10	0.4	Provider	
Project lead – Community rehab & reablement	Sign off – Mar 10	0.4	Provider	
Project lead – Community beds	Sign off – Mar 10	0.4	Provider	

The current project resourcing has been funded by NHS Brent. NHS Brent and London Borough of Brent have agreed that additional project resourcing will be required to support the implementation phase of the project and to ensure that the benefits are realised and return on investment achieved. Proposals for the implementation phase will be considered by the Joint Executive Team established between NHS Brent and LBB-adult social care, with the expectation that the agreed support would be appropriately funded through the established Partnership Investment Fund.

Stakeholder Engagement

- Please see detailed stakeholder engagement summary in the appendix

Stakeholder	Role	Comms & Engagement Approach
NHS & Social Care Staff including: <ul style="list-style-type: none"> • NHS Brent • Brent community services • GP's • LBB 	Well informed, feedback comments and commitment to intermediate care strategy. Focus on integration of services	<ul style="list-style-type: none"> • Face to face meetings • Presentations • Events • Bespoke Syndicated materials (e.g. for GP's and nurses) • Syndicated materials • Case studies

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<ul style="list-style-type: none"> Public Patients Carers 	Understand new service, how it impacts them, feedback comments. Focus on improving patient experience	<ul style="list-style-type: none"> Events Syndicated materials Case studies Online survey – Brent Brain.org
Community including: <ul style="list-style-type: none"> Media Brent Association of Voluntary Action Transient groups 	Aware of the key features and benefits of the new service	<ul style="list-style-type: none"> Presentations Events Syndicated materials Case studies Online survey – Brent Brain.org
Influencers including: <ul style="list-style-type: none"> Overview & Scrutiny Brent political parties 	Awareness of service. Provide Independent endorsement and help manage local opposition	<ul style="list-style-type: none"> Presentations Syndicated materials

Governance and Monitoring

Project Board membership

Role	Name	Organisation
Decisions about the appropriate structure and role of the Project Board will be taken following the decision regarding the appropriate procurement route. As a minimum it will include the key commissioning stakeholders included in the existing Project Board, namely:		
NHS Brent; London Borough of Brent / adult social care; PBC clinical representation; PEC clinical representation; GPSI clinical lead; carers representative.		

The schedule for key project decisions is:

Decision	Date	By
Go-live of integrated services	April 2010* (dependent on procurement opts)	
Project Complete	March 2011	Javina Sehgal (Project Board PM)
Benefits Evaluation	May 2011 (reporting delay)	Javina Sehgal (Project Board PM)

The additional control points when the Investment Panel will review progress are:

Control point	Date
New services commissioned and started.	March 2010
Review initial 3 months of operation (track benefits).	Aug 2010 (reporting delay)
Review initial 6 months of operation (track benefits).	Nov 2010 (reporting delay)

Reporting arrangements

- Monthly highlight report to Project Board.
- Monthly summary report to Investment Panel (via Programme Office)

Control point reviews to include:

- Review of tangible benefits through use of admission / attendance data.
- Max 2 page summary by service of current operations.

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Dependencies		
Dependency	Owner	Dependency management
Willesden Community beds must achieve an efficiency target of average LOS for step-down inpatients of 42 days. This means step-down beds will accommodate 25 beds (at current admissions) and the remaining beds will be reallocated to step-up (15 beds)	BCH – Dawn Chamberlain	Monitor provider's progress on reducing LOS.
Primary Care's Urgent Care Centre at Central Middlesex hospital will have an operational impact to the intermediate care service.	NHS Brent - Thirza Sawtell	Managed through same SRO.
Local Authority 'market testing' project around possibility of consolidating social care step-down beds.	LBB – Linda Martin	
Improvements in the management of long term conditions will have an operational impact to the intermediate care services	NHS Brent – Jo Ohlson	Coordinated through the CSP process of programme management

Risks				
Risk (to success of project)	Likelihood	Impact	Total	Mitigating Actions
GP's not referring to the Rapid Response service therefore patients attend A&E and rapid response service not fully utilised.	3	5	15	<ul style="list-style-type: none"> • Suitable communications with GPs (&PBC). • Rapid Response will attend A&E to prevent admissions.
Patients do not consent to being treated at home.	1	5	6	<ul style="list-style-type: none"> • Patients kept informed of their medical status and reassured by the service received.
Organisations acting independently and not in the required integrated way.	1	3	3	<ul style="list-style-type: none"> • Joint strategy, jointly owned within each organisation.
Ability for social service step-down beds to be provided in a single location.	1	2	3	<ul style="list-style-type: none"> • Market testing of options.
Risks (to the PCT, if the project is not delivered successfully)	Likelihood	Impact	Total	Mitigating Actions
People remaining in Acute hospital and receiving treatment that could be provided in the community (at a higher cost).	4	5	20	<ul style="list-style-type: none"> • Rapid Response 'in-reach' presence on IP wards.
Willesden operational improvements does not free up enough capacity to provide step-up beds which would need to be provided elsewhere (at additional cost) or admissions would continue into acute hospital.	5	5	25	<ul style="list-style-type: none"> • Monitor progress of LOS improvement in Willesden.
Risks (to the PCT, of undertaking the project)	Likelihood	Impact	Total	Mitigating Actions
Depending on which commissioning methodology chosen for the new services this could impact both the implementation and benefit delivery timelines.	2	4	8	<ul style="list-style-type: none"> • Commissioning options paper being created.

Business Case and Project Plan

Risks (to the PCT, of undertaking the project) - continued	Likelihood	Impact	Total	Mitigating Actions
Trust does not achieve the stated aims of reducing acute admissions for Ambulatory Care Sensitive conditions but has an increased cost base due to new services.	3	5	15	<ul style="list-style-type: none"> • Constant monitoring of KPI's and review implementation success continually.
Extra services discover currently 'unmet demand' and so capacity is utilised but admission avoidance numbers are not realised.	2	2	4	<ul style="list-style-type: none"> • Unmet demand has been estimated within the patient demand numbers.

Equalities Impact Assessment

The Strategy was reviewed and approved 17th September at the EIA Group. The submission was very well received, and was considered a model of high quality delivery, both from a strategic and stakeholder engagement perspective.

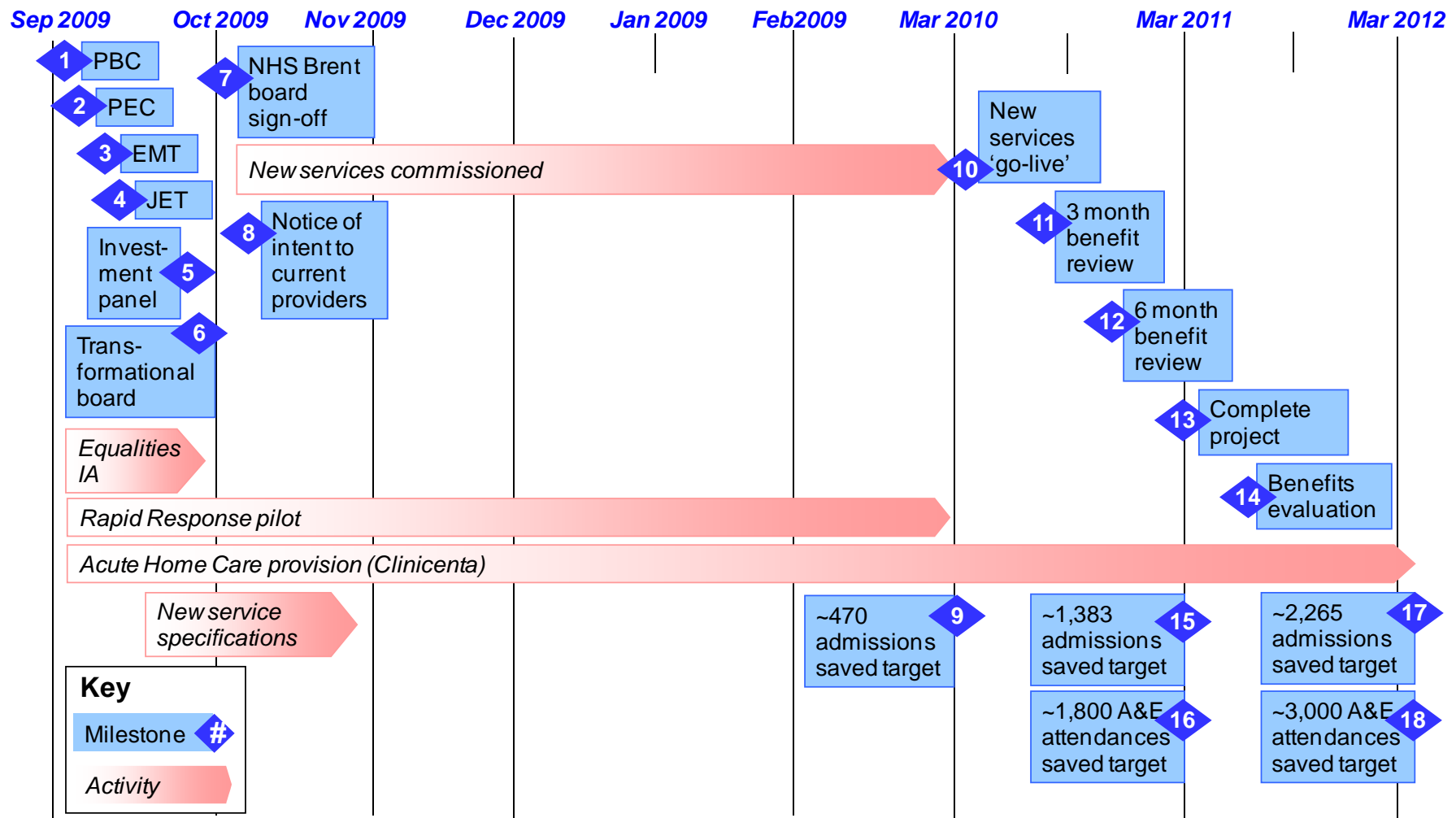
Comments for consideration as part of the service detailed design are pending distribution.

Document History

Version	Status (Draft or Approved)	Date	Author/Editor	Details of changes
V0.1	Draft	03/08/09	Kevin Atkin	Document created
V0.2	Draft	21/08/09	Kevin Atkin	Refined Thirza Sawtell comments.
V0.3	Draft	21/08/09	Kevin Atkin	LA additions
V0.6	Draft	16/09/09	Kevin Atkin	All final changes prior to submission.
V0.8	Draft	18/09/09	Kevin Atkin	GPwSI addition
V1.0	Draft	21/09/09	Thirza Sawtell	Refined for submission to Investment Panel
V1.1	Draft	23/09/09	Kevin Atkin	Changes following feedback from Investment Panel

Business Case and Project Plan

Project Timeline



Business Case and Project Plan

Appendix A – Stakeholder Engagement Campaign Summary for New Intermediate Care Services in Brent

Context

The development of STARRS has been a staged process of continuous stakeholder engagement that began in October 2008. NHS Brent recently undertook a 4 week targeted engagement campaign to 'test' the proposed new model of Intermediate Care services with key stakeholder groups. Though this campaign was not a formal consultation, it was carefully timed to ensure that feedback directly impacts this business plan and provides early intelligence in advance of delivery model planning.

Methodology

To ensure timely and optimum engagement, the focus has been face to face engagement through events, workshops and meetings. Written feedback via post and email has also been encouraged as a mid-to-long term source of feedback to which we fully expect a robust response over the coming weeks and months to inform the ongoing development of the new services.

Activity

Five core communication materials were developed and utilised through a variety of channels consisting of

1. Introductory letter/flyer – distributed via Brent Magazine, email and postal cascades to all stakeholders;
2. A five-page stakeholder brief – signed by both NHS Brent CEO and Brent Council Director of Housing and Community Care;
3. A detailed single paged 'Fact sheet' – targeted at Clinicians and Social workers but available for general download from Brentbrain.org.uk;
4. Promotional event posters – 2 major events for carers, Community organisations and the general public;
5. Power point presentations for delivery at meetings/events

We have also emphasised our open-door policy with stakeholders to be pro-active and contact us directly to arrange face to face meetings.

- Around 4,000 communication documents have been distributed across stakeholders, including some 1,000 sent directly to a wide range of community groups and individuals;
- The introductory letter/flyer which included a brief summary of the proposals with links to more information both on and off line, was included in the September edition of the Brent magazine, distributed free to almost every home in the area (99,000);
- Briefings have been provided to all local MPs and to the Overview and Scrutiny Committees for Brent;
- Almost 20 meetings, workshops and events have been held during the a four week period equating to an average of 1 face to face meeting with stakeholders every day of the engagement campaign. All comments made at the meetings were recorded and have been fed into the analysis;
- A summary of the proposals, with a questionnaire for responses, has been cascaded to all NHS and Brent Council staff in the Housing and Community Care Directorate via a combination of email, post and placement in targeted publications such as 'Outlook' for Council staff.
- Web pages promoting the campaign have been published by NHS Brent and Brent Council. A special partnership was formed with brentbrain.org which enjoys between 23,000 and 40,000 unique visits per month. Content for social networking sites such as twitter, facebook and YouTube is also being prepared.

Key messages

The analysis of the comments made during the engagement campaign revealed a widespread desire for changes to current Intermediate Care services and improvements in home and community services. With few exceptions, all participants and respondents stated that they supported the new proposals and that it seemed like there was little or nothing missing from the STARRS model though clearly this should not be translated into support for every aspect of the proposals equally.

Taking the responses as a whole, the messages that come across are fairly clear:

- People want to be sure they will receive/deliver the best possible care. This means being able to access services easily, patient access to care when and where it's needed, better coordination across different providers, better post hospital care, being treated with dignity and more support to remain living at home.
- The views and wellbeing of carers need to be better considered and taken into account
- People are concerned about whether the changes can be implemented by NHS BRENT and Brent Council within the staffing and funding available and still meet patient demand.

The message from the engagement campaign could therefore be summed up by the phrase: 'STARRS is right. It proposes *excellent specialist care, more support at or closer to home and services that are easy to access. But can you deliver?*'

Conclusions and Next Steps

The remaining development of the service will be informed through continuous stakeholder engagement.

This is demonstrated by the fact that throughout October and November there are already over 10 meetings scheduled with user groups, voluntary community sector organisations and NHS / Brent Council staff. In particular we recognise the need for more intensive face to face engagement of Ambulance services, GP's, Hospital Nurses and Brent Council staff.

Awareness and engagement of stakeholders will continue to be driven forward by securing media coverage through news articles, paid advertisements and niche publications. For example, an article will be published within the quarterly 'Partnership News' and cascaded to over 13,000 homes via the Brent Housing Partnership in the last week of September.

We discussed the plans with the PEC on 11th Aug 09 & 3rd Sep and their feedback was:

PEC stated that a single point of access SPA was to be commended. It was important for clinicians to understand the menu of clinical services offered e.g. catheter care/ iv antibiotic administration. It would be beneficial for the service to include end-of-life care and chemotherapy administration.

It was essential that clear and safe clinical pathways need to be developed and PEC agreed to be involved in this. It was suggested that this should be developed with input from both PEC & PBC.

PEC also wanted reassurance that the clinical and financial modelling was robust (provided in a follow-up meeting 3rd Sept 09).

Other hidden clinical costs were identified by the PEC (such as additional pharmacy costs which have been incorporated in the financial model).

We discussed the plans with the local authority commissioning board on 15th Sep and their feedback was:

Further engagement with social care has led to clarification around reablement requirement to support the short-term bedded service through an increase reablement capacity.

Local authority is keen to review proposals to ensure the LAA target of Delayed Transfers of Care is met with particular reference to social care current performance on delayed bed days.

Local authority is committed to supporting the intermediate care service through the use of telecare (piece of work will commence shortly to determine the level of investment from the LA as part of their contribution to the overall intermediate care model).

We discussed the plans with the Joint Executive Team (JET) on 9th Sep and their feedback was:

The JET approved the business case, including the additional social care investment to increase the reablement hours from 250 to 450 hours, and associated therapy management.

JET also requested further analysis to be carried out to investigate the possibility of providing reablement support in the short term social care bedded service. This has led to an increase in the social care financial contribution, to fund an additional 182 hours of reablement.