NORTH AYRSHIRE
Health and Social Care Partnership

Integrated Joint Board
13 September 2018

Subject:	**Pan-Ayrshire Enhanced Model for Intermediate Care and Rehabilitation**
Purpose:	To provide an overview of the work being undertaken to meet the Pan-Ayrshire Enhanced Model for Intermediate Care and Rehabilitation as part of New models of Care for Older People and People with Complex Care Needs
Recommendation:	The Integrated Joint Board is asked to note the progress of the Pan-Ayrshire Model for Intermediate Care and Rehabilitation.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
WTE	Whole Time Equivalent
TLG	Transformational Leadership Group
SPOG	Strategic Planning Operational Group
ICT	Intermediate Care Team
HSCP	Health and Social Care Partnership

1.	**Introduction**
1.1	It has been widely reported that people are living longer than ever before but with multiple and often complex conditions. In addition, improvements in medicines, treatments and technologies mean an increasing number of younger adults will require support with complex health and social care needs. This means, now more than ever before, we need to review our services and systems in order to be able to respond to these future needs, and keep people well and independent for as long as is possible.
1.2	The New Models of Care for Older People and People with Complex Needs Programme has been underway since October 2015. Led by NAHSCP, this Pan – Ayrshire work has been overseen by the New Models of Care for Older People and People with Complex Needs Programme Board (Programme Board).
1.3	The Models of Care work initially covered 5 key areas of work; Community Care, Elderly Mental Health, Rehabilitation and Intermediate Care, Acute Interface and End of Life. However, due to the scale and complexity of the New Models of Care for Older People and People with Complex Needs, it was agreed at the NHS Scrutiny meeting on 14 March 2017 to divide the programme into key components beginning with the Pan-Ayrshire Enhanced Model for Intermediate Care and Rehabilitation (The Model).

2.	**Current Position**
2.1	Over the past 12 months the Intermediate Care and Rehabilitation Network (The Network), a range of representatives from across the three partnerships and acute services have helped to design a four tier model for Intermediate Care and Rehabilitation across Ayrshire. The model was developed around Intermediate Care and Rehabilitation Hubs (Hubs) which provide a single point of access in each HSCP area, with screening and clinical triage, ensuring the person is seen by the right service, first time.
2.2	The model supports people at different stages of their recovery journey and will link up and build on existing intermediate care and rehabilitation services; reducing duplication and fragmentation of services across Ayrshire and Arran, offering more timely access to rehabilitation, and better outcomes for people. Further detail of the model can be seen in Appendix one, the Implementation plan
2.3	The proposed benefits and impacts from the model were described within a business case reflecting the cumulative impact of all aspects of the model working together to ensure the reduction in occupied bed days, drawing on sound local and national evidence. The business case proposes a 30% increase (approx. 2486 referrals) to Intermediate Care and Rehabilitation, which would result in cost avoidance of £4,052,014 for a required investment of £2,516,175 to employ an additional 51.4 WTE staff across Ayrshire and Arran. This equates to 24,860 Bed days avoided, which is the equivalent of the closure of 28 beds in University Hospital Ayr and 39 beds in University Hospital Crosshouse. This model was signed off by TLG in February 2018.
2.4	It was agreed through the Programme Board that The Intermediate Care and Rehabilitation Network (The network) would be re-configured as a work stream to support implementation of the Model. The Network has developed an Implementation Plan and work has been programmed in for the rest of the year. This work has been very positive, constructive, and action focussed to date, with a clear commitment to improve outcomes for the people of Ayrshire and Arran.
2.5	The Implementation Plan outlines the specific pieces of work required in order to meet the proposals outlined the business case. The following key areas of work have been agreed: • Workforce • Clinical Pathways • Outcome Focus/Digital • Communication and engagement • Intermediate Care and Rehabilitation Hubs • Operations Sub-group The Implementation Plan outlines in detail the work supported by these groups with a detailed programme schedule.
2.6	Key areas of work to date have focussed around the development of a communication plan, the recruitment for the 50 new intermediate care and rehabilitation posts and move to seven day working required to develop the Intermediate care and rehabilitation Hubs all key to the new model of intermediate care and rehabilitation.
2.7	Recruitment for the posts has been underway since 6 July 2018 with a rigorous recruitment campaign shared with the Primary Care Programme. In addition, a Recruitment Information Evening was held on 24 July 2018 with over 180 prospective

	applicants in attendance and supported. Interest in the posts is high and we are confident the first wave of recruitment will fill many of the posts needed. Further recruitment will be needed to cover internal backfill and any posts that were not suitably filled. These are linked to national recruitment issues and were highlighted in the risks of the business case.
2.8	Implementation of the key parts of the Model is planned for the end of October 2018, with the Intermediate Care and Rehabilitation Hubs moving to seven day working to provide alternatives for unnecessary acute hospital admission over the weekends.
3.	**Proposals**
3.1	The Integrated Joint Board is asked to note the progress of the Pan-Ayrshire Model for Intermediate Care and Rehabilitation.
3.2	**Anticipated Outcomes**
	The model will ensure a reconfiguration of existing services and structures is undertaken to increase access to Intermediate Care and Rehabilitation services, reduce system wide inefficiency, develop the interface with Acute Hospital Services, improve service user experience which will help to meet the increased demand for health and social care in Ayrshire and Arran.
3.3	**Measuring Impact**
	The proposed benefits and impacts from the model were described within a business case reflecting the cumulative impact of all aspects of the model working together to ensure the reduction in occupied bed days, drawing on sound local and national evidence. The business case proposes a 30% increase (approx. 2486 referrals per year across Ayrshire) to Intermediate Care and Rehabilitation, which would result in cost avoidance of £4,052,014 for a required investment of £2,516,175 to employ an additional 51.4 WTE staff across Ayrshire and Arran. This equates to 24,860 Bed days avoided, which is the equivalent of the closure of 28 beds in University Hospital Ayr and 39 beds in University Hospital Crosshouse.
4.	**IMPLICATIONS**

Financial:	This additional funding has been agreed through NHS Ayrshire and Arran revenue budget for 2018/19.
Human Resources:	The new Model will require an additional 51.2 staff, this will see a strengthening of existing ICT and Community Rehab services. In addition, the Organisational Change process has commenced to transition the existing ICT workforce to a work pattern which supports seven day operation of the service. .
Legal:	No issues
Equality:	No issues
Children and Young People	No issues
Environmental & Sustainability:	No Issues

Key Priorities:	The model will ensure a reconfiguration of existing services and structures is undertaken to increase access to Intermediate Care and Rehabilitation services, reduce system wide inefficiency, develop the interface with Acute Hospital Services, improve service user experience which will help to meet the increased demand for health and social care in Ayrshire and Arran. This is in line with our priorities for Prevention and Early Intervention and Bringing Services Together.
Risk Implications:	Risk to recruiting all staff as with some professions there are national recruitment issues e.g. Physiotherapists and GP's.
Community Benefits:	Implementation of this model supports timely access to rehabilitation, provides alternative to hospital admissions, and supports self management – all in line with the ambitions of keeping people independent and at home, or in a homely setting.

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	x
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5.	**CONSULTATION**
5.1	There has been on-going consultation with the Models of Care Steering Group and the Intermediate Care and Rehabilitation Network, as well as updates to SPOG and TLG.
6.	**CONCLUSION**
6.1	It is anticipated that the outcomes from the Pan-Ayrshire Enhanced Model for Intermediate Care and Rehabilitation will enable people to stay at home or a homely setting and reduce the need for Acute Hospital Care

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Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation

Implementation Plan

Version 0.3

1 Version Control Record

1.1 Document Sign Off

Programme Name	Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation		
Directorate	Pan-Ayrshire		
Programme Reference	OPCC-ICREH-1718-8		
Programme Lead	David Rowland	Sign off Date	
Clinical Lead	Billy McLean	Sign off Date	
Finance Lead	Eleanor Currie	Sign off Date	
Programme Manager	Annie Weir	Sign off Date	
Executive Sponsor	Eddie Fraser	Sign off Date	

1.2 Revision History

Version Number	Date	Status	Description of Changes	PMO/QIA comments (If applicable)	PMO date	PMO Status
0.1	14/6/18	Initial Document	Initial draft			
0.2	25/6/18	Feedback from group	Second draft			
0.3	27/6/18	Feedback from Edie Fraser	Page 15 – first paragraph Page 12 – key linkages Page 14 – table headings			

2 Contents

3 Purpose of the document

This Implementation Plan describes how the three Ayrshire Partnerships and the Acute Services will work together through the New Models of Care for Older People and People with Complex Needs Programme to deliver the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation.

The Implementation Plan (the plan) sets out shared definitions and commitments for how the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation will provide a common framework across a range of services including Falls/frailty; delirium, stroke; orthopaedic; respiratory; neurological disease.

It outlines how the proposals outlined in the business case for the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation will be operationalised through effective governance processes across the following key areas of work:

- Workforce
- Clinical Pathways
- Outcome Focus/Digital
- Communication and engagement
- Intermediate Care and Rehabilitation Hubs
- Operations Sub-group

Finally, it outlines a clear and agreed shared schedule of work in order to release the capabilities of the model and realise the proposed benefits as outlined in section seven, in order to enable more people to remain at home and ensure the provision of high quality care delivered by the right person, at the right time in the right place.

4 Background

Within Ayrshire and Arran, in line with the rest of Scotland, we continue to live longer than ever before. We know the older we get, our health needs tend to become more complicated and we may need support with a range of multiple and potentially complex conditions. In addition, advances in medicines, treatments and technologies provide the opportunity to transform how and where people can live their lives. However, we recognise, in its current fragmented form, the health and social care system is financially unsustainable and we are challenged to work more effectively within existing resources.

The three Ayrshire Partnerships and the Acute Services have been working together through the **New Models of Care for Older People and People with Complex Needs** programme to design an overarching response to some of these key issues. The high level model is outlined on page seven. This has been to develop a common framework to ensure a consistent approach that could be applied locally to reflect the differing needs, ambitions and operational arrangements of the different partnerships. However, the following shared principles were agreed in order to:

- Place the older person and those with complex care needs at the heart of decision-making about their assessment, treatment, care and support, with a focus on maximising independence;
- Create a fully integrated, community-based physical health, mental health, and social care team within each Partnership;
- Focus on preventative care and early intervention to support the effective management of long-term conditions;
- Establish home or homely setting as the norm for the delivery of specialist health and social care service delivery;
- Offer consistency and continuity of care for individuals at home, in a homely setting and in hospital; and
- Make use of technological advances to support the older person and those with complex care needs in managing their long-term condition(s) with rapid support, when required, from the integrated team.
- Support the individual receiving care and their family in planning, securing and delivering the highest quality of person-centered end of life care.
- Connect people to a local community based support network

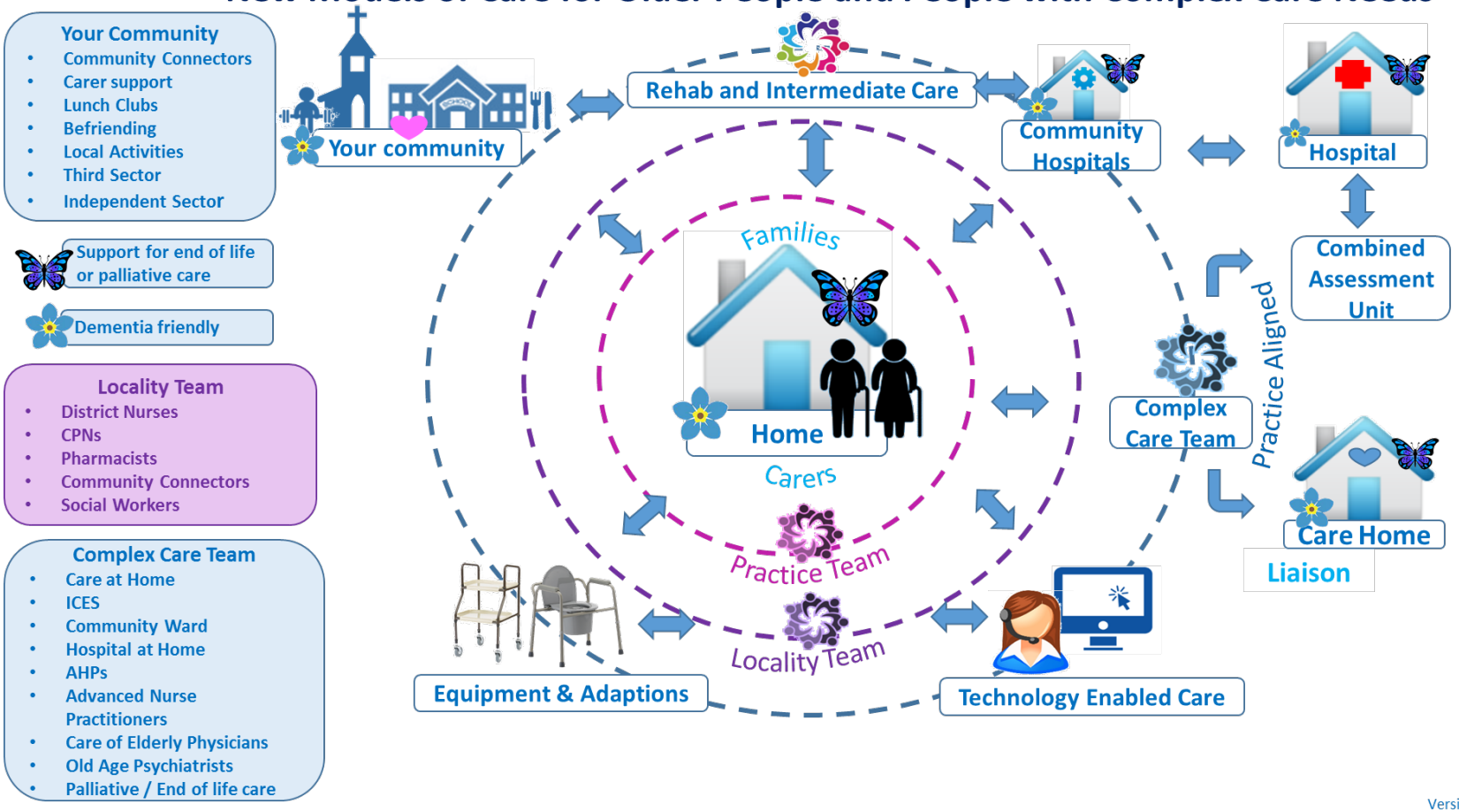
The programme has five key components of care.

- Supporting people to stay at home or a homely environment (including Care at Home, Care Homes, GP and community services),
- Supporting older people with mental health issues

- Supporting people to regain independent living through rehabilitation
- Supporting people with hospital care, when appropriate
- Supporting people towards the end of their life

In order to identify key areas the work has been focused on components of care focused around the needs of older people and people with complex needs rather than service structures. This is the first of these components of care for supporting people to regain independent living through rehabilitation and is presented as the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation.

New Models of Care for Older People and People with Complex Care Needs



Version 0.11

5 Definitions and Principles for Intermediate Care and Rehabilitation

Intermediate care can best be described as a continuum of integrated primary and community-based services for the assessment, treatment, rehabilitation and support for older people and adults with long term conditions at times of transition in their health and support needs [Scottish Government, 2012].

The components of Intermediate Care across Ayrshire are best delivered as a continuum of integrated local services with pathways that enable continuity of care for service users, blurring of roles for practitioners, trusting relationships between staff in different settings, and opportunities for staff to rotate across teams and care settings.

Core Principles that underpin Intermediate Care in Ayrshire and Arran:

- Delivered at home, if safe and appropriate, or as locally as possible
- Accessible, flexible and responsive through Intermediate Care and Rehabilitation Hubs that ideally operate 7 days a week, ideally 24 hours a day
- Focused on rehabilitation, reablement and recovery
- Targeted at people at risk of emergency admission, or re-admission, to hospital, or to avoid premature permanent admission to a care home.
- Based on holistic assessment to maximise independence, confidence and personal outcomes sought by the individual
- Linked with, and complementary to, local community, health, and specialist services
- Co-ordinated support (either on site or in reach) from multi-professional and multi-agency team with the required expertise in providing support to people with complex needs
- Time limited, with anticipatory care and discharge planning from day one
- Jointly commissioned by the partnership, in collaboration with the Care Inspectorate (if there are to be new roles for care providers)
- Managed for improvement, gathering information on experience and outcomes and using this to inform service improvement.
- Assistive technology and digital health and care solutions enable service users to remain independent, safe and confident in managing their health and wellbeing
- Supported by information systems that ensure users, carers and professionals can access and share the information, advice and care plans required to deliver and evidence high quality person centred care

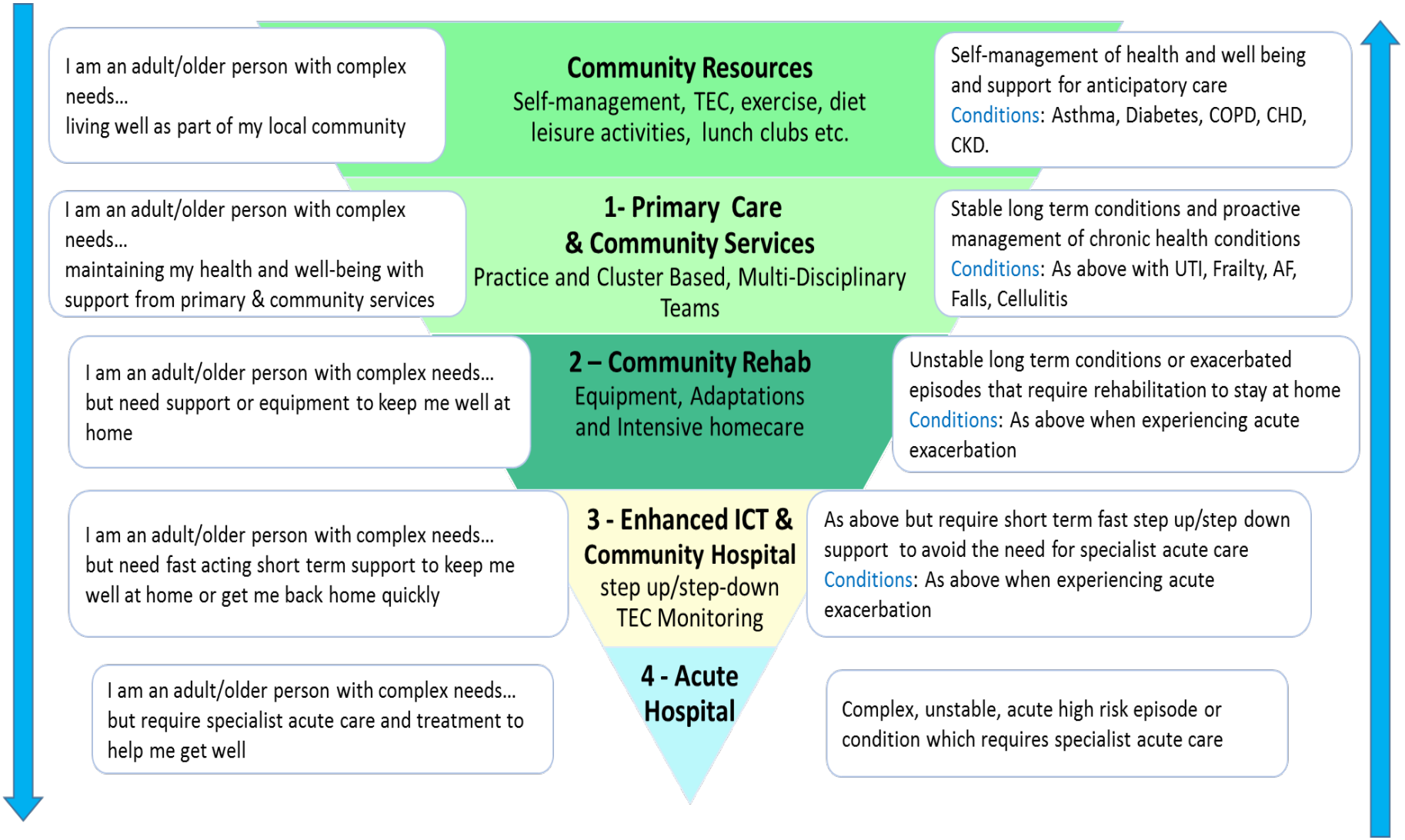
In addition there are great opportunities to support individuals across Ayrshire to stay healthy for longer and to improve their ability to self-manage their own conditions through the implementation of telehealth, better access to information and professional support, peer support and coaching, technology and online courses and education.

The Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation will provide a common framework across a range of services including Falls/frailty; delirium, stroke; orthopaedic; respiratory; neurological disease. The model has been developed by the Intermediate Care and Rehabilitation Network and is built around four tiers:

1. Individual requires support as part of primary and community services but can remain at home. (This includes intensive medical support, rapid response and the use of remote clinical monitoring in the home with technology).
2. Individual requires Community Rehabilitation in order to stay at home
3. Individual requires quick responding short term Enhanced Intermediate Care or step up/step down into community hospital
4. Individual is complex / unstable and requires acute hospital care

Within Ayrshire and Arran all services and partners are starting from different parts of their journey towards the model and therefore some aspects of the model will require more development than others in certain areas, and this may vary across the partnerships. It is important to highlight that each tier is dependent on a whole system approach to function effectively. It will be the cumulative effect of the components working together as part of the New Models for Care for Older People and People with Complex Needs to improve outcomes for patients and carers and reduce reliance of acute hospital care.

In addition, further development of multi-disciplinary locality teams and how they will work alongside practice aligned teams and complex care teams (specifically Enhanced ICT) will be developed to ensure people are supported appropriately. Practice and locality teams will provide proactive management of chronic health conditions whilst Enhanced ICT will provide fast acting, short term support to people with unstable, long term conditions, or exacerbated episodes to enable them to remain at home whenever possible. How individuals will be supported, by which team and the most beneficial conditions are outlined in the graphic below. A glossary or the key service components agreed across Ayrshire and Arran are included in section eleven and explained throughout the model.



* Please note fluid application of the model relies on case planning/management between the services at time of handover/discharge

6 The Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation

The Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation (the model), focusses on providing high quality care and support through early intervention and preventative action to help stop older people and people with complex needs becoming unwell in the first place, or supporting them to manage their conditions more effectively at home, or a homely environment. The enablers for this will include Technology Enabled Care (TEC) and locality based Multi-disciplinary teams.

The model is developed around Intermediate Care and Rehabilitation Hubs (Hubs) which provide a single point of access, with screening and clinical triage, ensuring the person is seen by the right service, first time. The hubs will operate 9am-5pm, 7 days per week. The model supports people at different stages of their recovery journey and will link up and build on existing intermediate care and rehabilitation services (see page 13). This will reduce duplication and fragmentation of services across Ayrshire and Arran.

Tier 1 – Individual is supported at home – by primary and community services

The new multi-disciplinary Intermediate Care and Rehabilitation Teams based around the Hubs will work alongside Primary Care colleagues and existing locality based teams to provide more extensive, proactive, and anticipatory management of chronic health conditions to enable people to stay at home.

Tier 2 - Individual is supported at home – with community rehabilitation

Community rehabilitation will support individuals to live independent, healthy lives in their own home /homely setting. It will be available 9am-5pm, 5 days per week, via early intervention approaches, self-management programmes and co-ordinated through the Hub. Community rehabilitation will support people to achieve personal health and wellbeing goals. The model will require investment in community rehabilitation in order to meet the additional demand from Integrated Care Teams (ICT) and Acute Care of Elderly (ACE) practitioners, in order to support slower, longer term rehabilitation, which is goal focussed rather than time limited.

Tier 3 - Individual is supported at home – by Enhanced Intermediate Care Teams (ICT)

ICT provide rapid access to time limited assessment, rehabilitation and support by multi-disciplinary health and social care teams, co-ordinated through the hubs, 9am-5pm, 7 days per week. The teams reduce admission to hospital and enable early supported discharge supported by an appropriate clinical specialist that provides an alternative to hospital (hospital at home) through specialist, coordinated and comprehensive care and treatment of people in their own homes. In addition, this approach will improve the flow of people currently staying in hospital over the weekend. The development of the model was supported by Dr Anne Hendry (Clinical Lead for Integrated Care) who was instrumental in the success of NHS Lanarkshire Hospital at Home Service.

Tier 3 - Individual cannot be supported at home – and requires step up/step down care

Step up/Step down care recognises that sometimes people do not require acute hospital care. They may be either:

- Not ready to return home and require time to rebuild confidence and regain abilities (via a reablement approach), or
- Due to deterioration in health and wellbeing, they are at risk of avoidable admission to hospital.

The step up/step down services provide a 24/7 time limited episode of intermediate care provided in a community hospital or a dedicated care home setting. (A separate business case is developing this aspect of the model.)

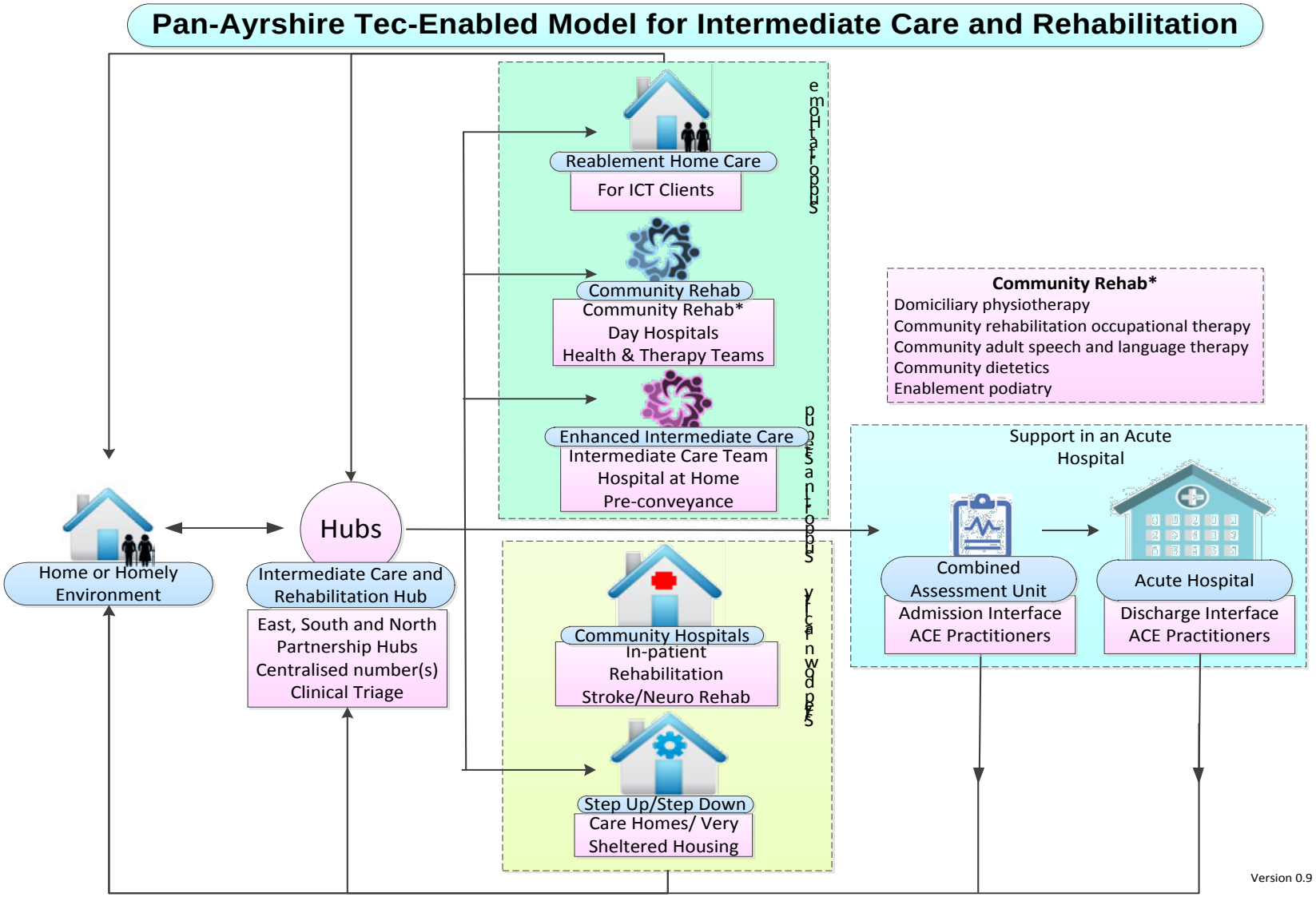
Tier 4 - Individual cannot be supported at home – and requires acute hospital care

Intermediate care and rehabilitation teams will work more closely with specialist staff in acute hospitals who are based in the Emergency Departments and the Combined Assessment Units (ACE Practitioners, Advanced Nurse Practitioners and the Frailty Unit). They identify and assess older people who are frail or have complex support needs and work together to get the person home or to step down, or specialty bed (e.g. stroke). This will help prevent avoidable hospital admissions and enable people to remain safe and independent in their own homes.

In addition, once people's immediate acute needs have been met in the acute hospital, teams will ensure that people are discharged from hospital to their own home or community environment as soon as they are medically fit.

Key linkages

It is worth noting that many elements of the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation have key linkages with other Transformation Programmes. In the case of the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation there are critical interdependencies with the Acute Frailty Pathway, Respiratory Primary Care Improvement-Ambitious for Ayrshire, Mental Health Strategy: Action 15 – to increase the mental health workforce.


Pan-Ayrshire Tec-Enabled Model for Intermediate Care and Rehabilitation
Home or Homely Environment
Hubs
Intermediate Care and Rehabilitation Hub
East, South and North Partnership Hubs
Centralised number(s)
Clinical Triage
Reablement Home Care
For ICT Clients
Community Rehab
Community Rehab*
Day Hospitals
Health & Therapy Teams
Enhanced Intermediate Care
Intermediate Care Team
Hospital at Home
Pre-conveyance
Community Hospitals
In-patient Rehabilitation
Stroke/Neuro Rehab
Step Up/Step Down
Care Homes/ Very Sheltered Housing
Community Rehab*
Domiciliary physiotherapy
Community rehabilitation occupational therapy
Community adult speech and language therapy
Community dietetics
Enablement podiatry
Support in an Acute Hospital
Combined Assessment Unit
Admission Interface
ACE Practitioners
Acute Hospital
Discharge Interface
ACE Practitioners
Version 0.9

7 Benefits

The proposed Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation offers a faster and more co-ordinated response to deterioration/crisis by preventing unnecessary acute hospital admission and where possible supporting people's recovery at home or a homely environment, through Intermediate Care and Rehabilitation Hubs, 9am-5pm, 7 days per week. This will smooth the flow of individuals requiring acute / bed based care and improve the flow of people home from hospital, particularly over the weekend period. This will enable more people to remain at home and ensure the provision of high quality care delivered by the right person, at the right time in the right place. Proposed benefits from the tiers – are outlined below:

Ref	Description	Owner	Frequency or Measurement	Current Performance	Additional Performance	Target	Timescale
	Re-design of Existing Services Through Hubs						
1	Increased activity for East Hub	EAHSCP	Annual 5%	3036	152	3188	By March 19
2	Increased activity for North Hub	NAHSCP	Annual 10%	1355	136	1491	By March 19
3	Increased activity for South Hub	SAHSCP	Annual 7.5%	1020	77	1097	By March 19
	Additionality from Investment in New Model						
4	Increased activity for East Tier 1	EAHSCP	Annual 15%	3036	607	3491	By March 19
5	Increased activity for North Tier 1	NAHSCP	Annual 20%	1355	271	1626	By March 19
6	Increased activity for South Tier 1	SAHSCP	Annual 20%	1020	204	1224	By March 19
7	Increased activity for UHA Tier 3	UHA	Referrals annually	0	520	520	By March 19
8	Increased activity for UHC Tier 3	UHC	Referrals annually	0	520	520	By March 19

These potential impacts reflect the cumulative impact of all aspects of the model working together to ensure the reduction in occupied bed days, drawing on sound local and national evidence. The business case proposes a **30% increase (approx. 2486 referrals)** to Intermediate Care and Rehabilitation, which would result in **cost avoidance of £4,052,014** for a required **investment of £2,516,175** to employ an **additional 51.4 WTE staff** across Ayrshire and Arran. This equates to **24,860 Bed days avoided,** which is the equivalent of the closure of **28 beds in University Hospital Ayr** and **39 beds in University Hospital Crosshouse**.

8 Governance

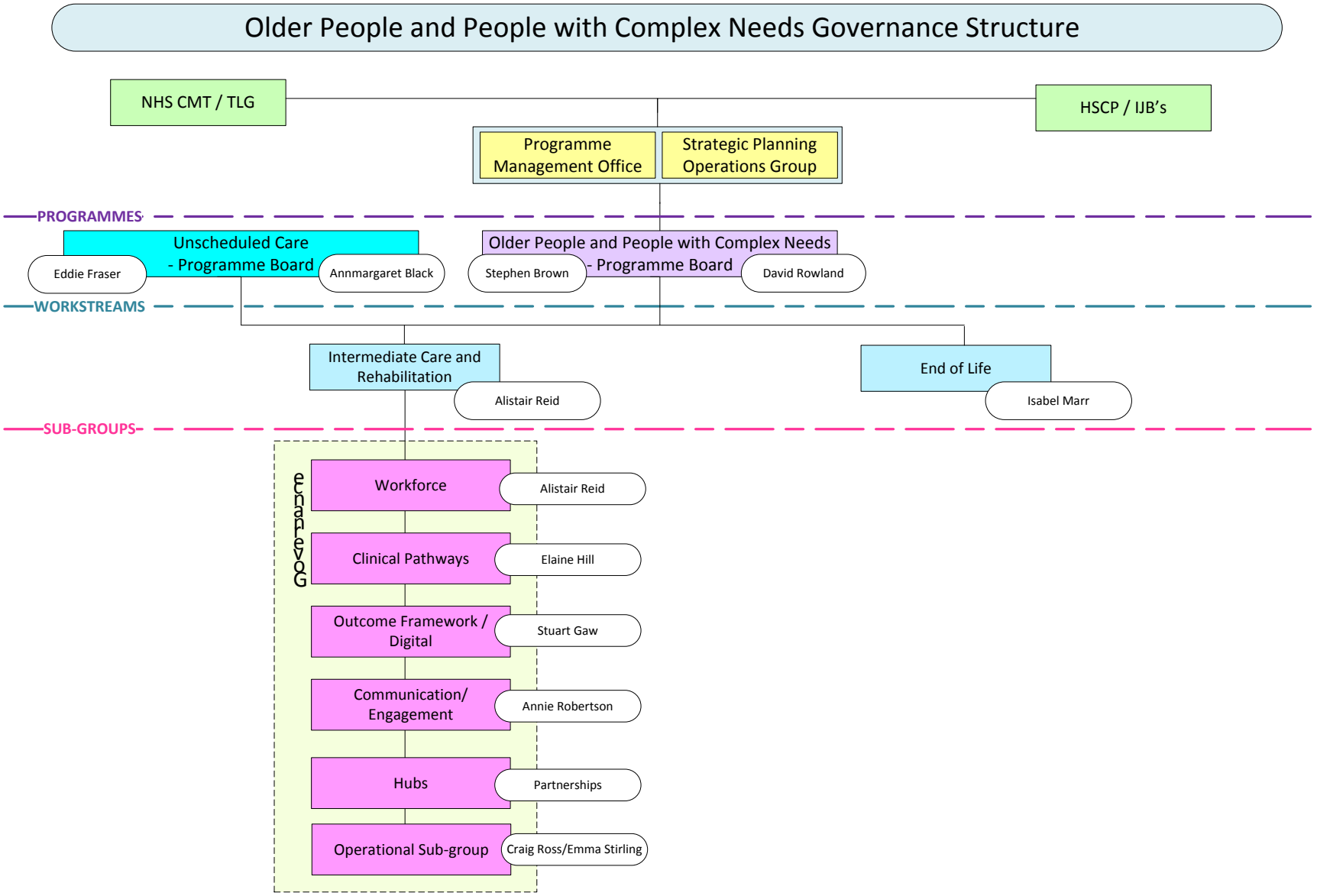
The business case for the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation was led by Stephen Brown Director of NAHSCP – as part of the wider **New Models of Care for Older People and People with Complex Needs Programme**. The TLG agreed that the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation would be an area of focus as part of the Delivery Plan for 2018/19. However, as this is moving to the implementation phase – it would now form a key strand alongside the **Unscheduled Care Programme** and therefore report to Eddie Fraser Director of EAHSCP, with on-going information provided to the **New Models of Care for Older People and People with Complex Needs Steering Group (steering group)**. The governance structure is outlined below.

It was agreed the Intermediate Care and Rehabilitation Network (the network) will form the work stream for the implementation work. The following key areas of focus have been agreed:

- Workforce
- Clinical Pathways
- Outcome Focus/Digital
- Communication and engagement
- Intermediate Care and Rehabilitation Hubs
- Operations Sub-group

These would all be underpinned by governance, which will be dealt with nearer the end of the outputs from the work streams. Effective clinical and care governance provides assurance around the quality of services and safeguarding high standards of care across a range of services and sectors and to ensure continuous learning and improvement. The proposed outline operating model will support professional governance assured through professional leadership structures and their corresponding professional governance groups ensuring adherence to standards and guidelines, and a consistent pan–Ayrshire approach.

Further details of responsibilities of the Intermediate Care and Rehabilitation Network and governance process are available in the Intermediate Care and Rehabilitation Network Terms of Reference.


Older People and People with Complex Needs Governance Structure
NHS CMT / TLG
HSCP / IJB's
Programme Management Office
Strategic Planning Operations Group
PROGRAMMES
Unscheduled Care - Programme Board
Eddie Fraser
Annmargaret Black
Older People and People with Complex Needs - Programme Board
Stephen Brown
David Rowland
WORKSTREAMS
Intermediate Care and Rehabilitation
Alistair Reid
End of Life
Isabel Marr
SUB-GROUPS
Enhanced OG
Workforce
Alistair Reid
Clinical Pathways
Elaine Hill
Outcome Framework / Digital
Stuart Gaw
Communication/ Engagement
Annie Robertson
Hubs
Partnerships
Operational Sub-group
Craig Ross/Emma Stirling

Version 0.5

9 Implementation

9.1 Workforce

The Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation depends upon an integrated, multi-disciplinary and responsive team. This will require that all Intermediate Care and Rehabilitation teams and the Acute Hospital interface, who are employed across the three Ayrshire Partnerships and Acute Services, to come together under a shared framework to operate more effectively and improve outcomes for local people. In order to deliver the model as described, this requires two key elements examined in more detail below:

- transitioning the existing workforce to a 7 day working model
- ability to recruit necessary workforce

The **Workforce Subgroup** has taken responsibility for recruitment readiness, and the workforce transitions towards seven day working. In anticipation of funding being realised by NHS Ayrshire and Arran in June 2018, it created a pack for the NHS Workforce Scrutiny Group with the Rehabilitation and Intermediate Care Vacancies required for the model, this was approved at its meeting on 16 May 2018.

It is recognised in order to recruit the **51.4** FTE additional posts across Ayrshire and Arran an attractive, innovative and streamlined process will be required. These posts are outlined in appendix one. Where possible, recruitment will be shared across other programmes in the Strategic Services Change Programme – to reduce cost and promote the scale of transformation underway in Ayrshire and Arran. This will link to a Communication Plan to ensure messaging about recruitment is shared as extensively as possible.

The **Workforce Subgroup** will tackle the following key pieces of work (these are linked to the Implementation schedule)

Transitioning the existing workforce to a 7 day working model

- general consultation with employees and representatives re move to 7 day working
- individual staff meetings with representatives
- clinical governance requirements
- implementation of seven day working

Ability to recruit necessary workforce across Ayrshire

- create job descriptions/advert for Workforce Scrutiny panel
- undertake shared recruitment across Ayrshire
- manage recruitment gaps and backfill
- develop competency framework/skills development
- clinical governance requirements

In addition, once the workforce is recruited and seven day working is in place the **Workforce Subgroup** will work with other programmes to ensure a shared induction, clear service orientation, on-going training and competency are embedded as part of a clear clinical governance framework to ensure safe and effective practice.

9.2 Clinical Pathways

The Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation has a clear role in providing alternatives to admission, however, in addition, supporting condition specific earlier discharges from acute beds for individuals requiring recuperation and/or re-ablement after a period of specialist inpatient rehabilitation such as:

- pulmonary
- respiratory
- HARP
- Stroke

The Clinical Pathways Sub group will ensure clear transitions for people when they transfer between services to ensure the best possible outcome for each individual and ensure that existing and emerging local specialist clinical pathways align and interface effectively with the approach agreed for intermediate care and rehabilitation in Ayrshire.

9.3 Outcome Focus/Digital

In order to describe the benefits outlined in the business case the **Outcome Focus/Digital Sub group** agreed to develop a shared outcomes and performance framework to ensure all 3 Ayrshire's are recording and reporting progress in the same manner through the same case management systems where possible. This would include monitoring of key data including number of referrals, bed days saved, cost avoidance and unfunded beds that can be closed within Acute.

In addition, the Outcome Focus/Digital Sub group will take responsibility for ensuring all-digital, IT and TEC related solutions are undertaken on a shared basis across Ayrshire to ensure systems support partnership working and improved outcomes for local people, where possible.

9.4 Communication and engagement

In order to ensure the Pan-Ayrshire Model for Enhanced Intermediate Care and Rehabilitation is properly understood amongst all stakeholders we will develop a detailed Communications Plan. Effective implementation of communication messaging and public engagement will greatly enhance the understanding required to ensure the effective roll out and implementation of the model.

The Communication Plan will outline:

- Audiences
- Key messages
- Methods
- Timescales

As part of the Communications Plan we will develop a communications log to undertake shared communication across the key stakeholder groups and ensure consistent messaging.

9.5 Intermediate Care and Rehabilitation Hubs

The Intermediate Care and Rehabilitation Hubs (the Hubs) will provide a single point of access, screen and clinical triage and signposting via centralised telephone number(s) to a range of locality based services in each Partnership. As a minimum, these will include; Intermediate Care Team, Day Hospitals (Health & Therapy Teams); Community rehabilitation (Domiciliary Physiotherapy, adult Community SLT, Community OT rehabilitation, Podiatry enablement pathway, Dietetics, Adaptations); Pharmacy, Community hospitals; Falls Service and Reablement/homecare. Each individual partnership will be responsible for their own hub development work, reporting back through the **Network** and **Steering Group**.

Each Partnership is starting from a different point in their journey when it comes to development of the Hubs however, the work will include 7 day working and include establishing a base for the Hubs, developing the associated infrastructure and developing partnership specific pathways and protocols outlining a clear plan for when people transfer between services, or when the

intermediate care service ends. This will also incorporate any partnership specific issues around workforce e.g. partnership specific induction, service orientation and on-call arrangements.

9.6 Operational Subgroup

The Operational Subgroup aims to develop improved understanding of all partnership IC&R service models through a collaborative shared approach, to achieve following objectives:

- Agree operational approaches for issues affecting all areas, such as:
    - Minimum dataset terms and definitions
    - Developing a standardised approach to triage where possible
    - Assessment and recording
- Provide a forum for sharing & developing best practice and prior learning
- Develop shared collaborative solutions to common challenges

Membership includes operational and service leads from all partners, comprising health and social care practitioners, clinicians and administrative staff.

10 Schedule

Work area Ref	Area of Work	Risk Ref	Owner	Start	Finish	May 18 1	June 18 2	July 18 3	Aug 18 4	Sept 18 5	Oct 18 6	Nov 18 7	Dec 18 8	Jan 19 9	Feb 19 10	Mch 19 11
1	**Intermediate Care and Rehabilitation Workforce**															
1a	**Recruitment Planning for all New Posts (HSCPs)**		**Heads of Service**	**June 2018**	**July 2018**											
	Develop Job Descriptions/Person Spec to HR Scrutiny Panels		Alistair Reid	June 2018	June 2018											
	Develop recruitment plans		Alistair Reid	June 2018	July 2018											
1b	**Transition Existing Workforce**	R9	**Alistair Reid**	**May 2018**	**September 2018**											
	Review Existing ICT Contracts - (5 Over 7)		Partnership Leads	June 2018	June 2018											
	Develop Workforce Engagement Plans		Partnership Leads	May 2018	June 2018											
	Consultation of existing workforce/representation		Partnership Leads	June 2018	July 2018											
	Individual staff discussions		Partnership Leads	July 2018	July 2018											
	Develop Weekend Working Protocols: Staffing Requirements		Partnership Leads	July 2018	July 2018											
	Start Date for Existing workforce		Partnership Leads	October 2018	October 2018											
	MDT shadow working /skills development /training in local processes/systems		Partnership Leads	September 2018	October 2018											
	Gateway Review (SPOG)		David Rowland	September 2018	September 2018					◆						
1bi	**Phase 1 - Recruitment - all posts**		**Alistair Reid**	**May 2018**	**September 2018**											
	Recruit posts		Partnership Leads	May 2018	July 2018											
	Start New Posts		Partnership Leads	August 2018	August 2018											
	MDT shadow working /skills development /training in local processes/systems		Partnership Leads	August 2018	September 2018											
1bii	**Phase 2 - Recruitment (Medical Cover, Physio, internal staff changes)**	R12	**Alistair Reid**	**August 2018**	**November 2018**											
	Recruit posts		Partnership Leads	August 2018	October 2018											
	Start New Posts		Partnership Leads	October 2018	October 2018											
	MDT shadow working /skills development /training in local processes/systems		Partnership Leads	October 2018	November 2018											
	Gateway Review (SPOG)		David Rowland	November 2018	November 2018							◆				
1biii	**Phase 3 - Recruitment (Medical Cover, Physio, internal staff changes)**	R12	**Alistair Reid**	**November 2018**	**February 2019**											
	Recruit posts		Partnership Leads	November 2018	January 2019											
	Start New Posts		Partnership Leads	January 2019	January 2019											
	MDT shadow working /skills development /training in local processes/systems		Partnership Leads	January 2019	February 2019											
	Gateway Review (SPOG)		David Rowland	March 2019	March 2019											◆
2	**Clinical Pathways and Governance**															
2a	**Develop Clear Governance and Support Structures**		**Elaine Hill**	**July 2018**	**September 2018**											
	Map Existing Governance structures		Professional Leads	July 2018	August 2018											
	Identify Professional skills / knowledge and link to pan-Ayrshire workforce planning		Professional Leads	August 2018	August 2018											
	Review of local on-call arrangements to ensure robust cover		Professional Leads	August 2018	August 2018											
	Develop links to local and Pan-Ayrshire Governance structures		Professional Leads	August 2018	September 2018											
	Review and monitoring of all governance mechanisms		Professional Leads	August 2018	September 2018											
	Gateway Review		David Rowland	September 2018	September 2018					◆						
3	**Outcomes Framework and Digital**															
3a	**Develop and Outcomes/Performance Framework**			**May 2018**	**August 2018**											
	Develop shared KPIs and dashboards		Stuart Gaw	May 2018	August 2018											
	Develop local SOPs and pathways		Stuart Gaw	May 2018	August 2018											
	Develop additional local KPIs and pathways		Stuart Gaw	May 2018	August 2018											
3b	**Develop TEC Enabled Models**		**Kathleen McGuire**	**July 2018**	**December 2018**											
	Develop Clear pathways, governance and support structures		Kathleen McGuire	July 2018	September 2018											
	Scope and identify digital opportunities within each pathway		Kathleen McGuire	August 2018	October 2018											
	Scope and identify Hub call operating systems for single point of access and triage		Partnership Leads	October 2018	October 2018											
	Identify ICT and ehealth process requirements and link to eHealth planning and agile		Partnership Leads	October 2018	October 2018											
	Identify and review workforce digital skill, knowledge and link to workforce planning		Kathleen McGuire	November 2018	November 2018											
	Develop links to local pan ayrshire TEC hub and governance structures		Kathleen McGuire	December 2018	December 2018											
	EAHSCP - Develop Business Contingency Plan/ Link To Existing Continuity Plan		Maggie V/ Fiona M	October 2018	October 2018											
	Gateway Review		Kathleen McGuire	December 2018	December 2018								◆			
4	**Communication and Engagement**															
4a	**Develop communications and awareness**		**Alistair Reid**	**May 2018**	**January 2019**											
	Develop shared communication plan		Annie Robertson	May 2018	June 2018											
	Communication re phase 1 recruitment		Comms Leads	June 2018	July 2018											
	Communication re phase 2 recruitment		Comms Leads	August 2018	October 2018											
	Report shared pathways and KPIs to Delivery Groups		Heads of Service	September 2018	September 2018											
	Communication re changes in intermediate care and rehabilitation		Comms Leads	September 2018	September 2018											
	Communication re responsibilities of hubs and contact numbers		Comms Leads	September 2018	October 2018											
	Communication re phase 3 recruitment		Comms Leads	November 2018	January 2019											
1	**Intermediate Care and Rehabilitation Hubs**															
1a	**Develop Intermediate and Rehabilitation Hubs**		**Heads of Service**	**June 2018**	**September 2018**											
	Clarify Core Services Into "Hub" Model		Partnership Leads	June 2018	July 2018											
	Develop Service Pathways		Partnership Leads	June 2018	July 2018											
	Develop Business/ Admin Processes		Partnership Leads	June 2018	July 2018											
	Align staff to new service model		Partnership Leads	September 2018	October 2018											
	Gateway Review (SPOG)		David Rowland	October 2018	October 2018						◆					

◆ Milestone

11 Glossary

The definitions below have been agreed on a Pan-Ayrshire basis to give shared understanding and meaning to different aspects of Intermediate care and rehabilitation:

Intermediate Care and Rehabilitation Hubs – The Hubs provides a single point of access, screen and triage and signpost 7 days per week via a centralised telephone number(s) to a range of services. For example; Intermediate Care Team, Day Hospitals (Health & Therapy Teams); Pharmacists; Community rehabilitation (Domiciliary Physiotherapy, SLT, Community OT, Podiatry, Dietetics, Adaptations); Community hospitals – step up/stepdown facility; Falls Service; Reablement / homecare; Social Work, Complex cases; Telehealth Care. The services work with people who require assessment, treatment, rehabilitation and care, to provide an alternative to hospital admission, enable them to be discharged as early as possible from hospital, maximise health & well-being ensuring they stay as independent as possible.

Reablement - a time limited episode of enabling support at home with an individual and their family to build confidence and encourage independence after an illness or decline in function.

Intermediate care at home (provided by Intermediate Care Teams / Intermediate Care and Enablement Teams) – To provide rapid access to time limited assessment, rehabilitation and support by a multi-disciplinary health and social care team, to provide an effective alternative to unnecessary hospital admission, facilitate early supported discharge and to support people to be as independent as possible in their home or homely setting at times of transition in their health or support needs.

Hospital at Home (H@H) / Community Ward) - a time limited episode of enhanced specialist care at home as an alternative to being treated in an acute hospital environment and where the care is overseen by a consultant / equivalent specialist (eg GPs with an interest). In addition, proactive, coordinated, anticipatory care management for people with complex chronic disease or frailty at high risk of future exacerbations and emergency admissions to hospital or to a care home. Care and support are coordinated for each individual by a lead professional generally for a number of months. The episode is generally overseen by a specialist practitioner working with a community Multi-Disciplinary Team.

Enhanced intermediate care at home (provided by Intermediate Care Teams / Intermediate Care and Enablement Teams) – To provide rapid access to time limited assessment, rehabilitation and support by a multi-disciplinary health and social care team, as an alternative to being treated in an acute hospital environment and facilitate early supported discharge overseen by a consultant / equivalent specialist (e.g. GPs with a special interest) working with a multi-disciplinary team. In addition, the team will provide

proactive, coordinated, anticipatory care management for people with complex chronic disease or frailty at high risk of future exacerbations and emergency admissions to hospital or to a care home and support people to be as independent as possible in their home or homely setting.

Community Rehabilitation Teams - Community Rehabilitation will support individuals and communities to live the healthiest lives possible in their home /homely setting. This is delivered through early intervention approaches, self-management programmes and may be uni-professional, or coordinated multi-disciplinary rehabilitation. Community Rehabilitation will support people to be as independent as possible by enabling achievement of individual health and wellbeing goals. Community rehabilitation includes the following services; domiciliary physiotherapy; Community rehabilitation occupational therapy; Community adult speech and language therapy; Community dietetics; Enablement podiatry and Health and Therapy Team/Day Hospitals

Appendix 1

	North			South				East			
Staff Group	Enhanced Intermediate Care North	Community Rehab North	Hub North	Enhanced Intermediate Care South	Community Rehab South	Hub South	CAU South	Enhanced Intermediate Care East	Community Rehab East	Hub East	TOTAL
NURSING STAFF	1.0	-	-	1.0	-	-	-	-	-	-	2.0
PHYSIO STAFF	1.0	1.0	-	1.0	1.0	-	-	1.0	1.0	-	6.0
OCCUPATIONAL THERAPY	1.0	1.0	-	1.0	1.0	-	-	1.0	1.0	-	6.0
PODIATRY	-	-	-	-	-	-	-	-	-	-	-
DIETETIC	-	0.5	-	1.0	0.5	-	-	-	0.5	-	2.5
SPEECH & LANGUAGE THERAPY	-	0.5	-	-	0.5	-	-	-	1.0	-	2.0
ADMINISTRATION	-	-	2.0	2.0	-	2.0	-	-	-	2.0	8.0
PHARMACY	1.0	-	-	1.0	-	-	-	1.0	-	-	3.0
MEDICAL / SERVICE MANAGER	-	-	-	-	-	-	-	-	-	-	-
TECHNICAL INSTRUCTOR	3.0	-	-	1.0	-	-	-	-	-	-	4.0
TEAM LEADERS	-	-	-	-	-	-	-	-	-	-	-
HOMECARERS	-	-	-	-	-	-	-	6.9	-	-	6.9
SOCIAL WORK	-	-	-	-	-	-	-	-	-	-	-
GP (10 SESSIONS)	1.0	-	-	-	-	-	-	-	-	-	1.0
PRACTITIONER	2.0	-	-	2.0	-	-	-	-	-	-	4.0
ANP	1.0	-	-	2.0	-	-	-	3.0	-	-	6.0
GRAND TOTAL	**11.0**	**3.0**	**2.0**	**12.0**	**3.0**	**2.0**	**-**	**12.9**	**3.5**	**2.0**	**51.4**