

# Making intermediate care better

in Barking and Dagenham, Havering and Redbridge



## Foreword from the clinical directors

As doctors, we want to help people live as healthily as possible, making sure they get the right care, when they need it. As local GPs, we've always known what our patients need and want. Now we're also in a position to lead changes that we believe will make a real difference to local people.

We've always known that people don't want to go into hospital unless they really have to and that if they do, they want to come home again as soon as they can. We also know that they are likely to recover better outside hospital, in a familiar place, close to their family and friends - as long as they also have the right care and support from nurses, therapists and care workers. That's what we want to make happen.

In the past we haven't done as well as we could to provide care for people at home. We've known for some time that in other areas they do things differently and people generally recover more quickly. We wanted to learn from them and provide a different, better sort of care, but we didn't want to make any permanent changes until we knew that they really were an improvement and until we'd heard what patients thought of them. We have looked at evidence from the UK and overseas which shows better results for

patients and want to implement this locally. We're pleased to see that the trials of the new community treatment team and the intensive rehabilitation service have helped more people to get care and treatment outside hospital.

We are also pleased to hear from patients and carers that they've appreciated this support at home. This success means we're now in a position to talk about what we do in the longer term.


This document explains what we want to do. Please do read about our proposals, ask us if anything's not clear and let us know what you think about what we want to do.

It's your NHS and we want you to help shape it locally.

**Dr Jagan John**, clinical director, integrated care, Barking and Dagenham Clinical Commissioning Group

**Dr Gurdev Saini**, clinical director, frail elders, Havering Clinical Commissioning Group

**Dr Mehul Methukia**, clinical director, integrated care, Redbridge Clinical Commissioning Group



"I couldn't have got a better service if I went private."

## Introduction

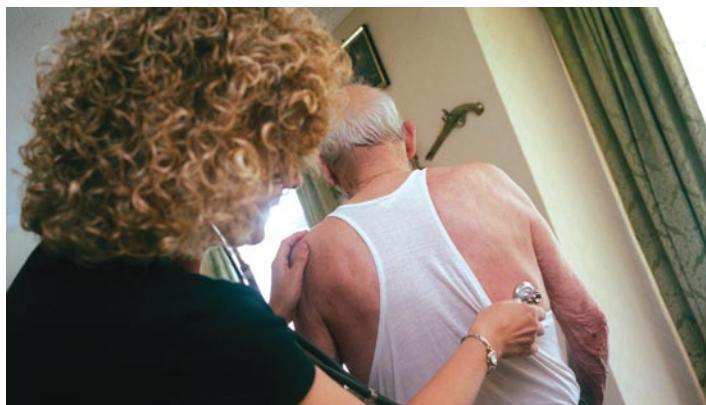
**This document talks about intermediate care in Barking and Dagenham, Havering and Redbridge. It explains what we have been doing during the past year to try out new ways of working and what we would like to do in the future to make those services better.**

We have set out different options and what we think would be the best option and why. We want to know your views, whether you agree or disagree, and if there is anything else you want us to consider.

We want to establish permanently the new intermediate care services that we have been trialling, which would mean that more people could receive care in their own homes. We also want to merge the three existing community rehabilitation units into one unit, on the King George Hospital site in Goodmayes. We believe this would result in better, more individual care that would help people to recover more quickly.

These services are currently provided by North East London NHS Foundation Trust (NELFT), and we intend for these services to continue to be provided by NELFT.

We would especially like to hear from local residents, people aged 65 years and over (as most of the people who use intermediate care services are in this age group), carers, health professionals and our partners in the community and voluntary sectors about whether they think our proposals would improve intermediate care services for local people.



**Intermediate care** means services that provide people with specialised care from nurses, therapists and other professionals, without them needing to go to (or stay longer in) hospital. These services can be provided in different places - people's own homes, community rehab units or residential homes, for example.

Our new intermediate care services are the **community treatment team (CTT)** – a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home having a health or social care crisis at home – and the **intensive rehabilitation service (IRS)**, a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's home.

**Rehabilitation** means helping people to recover after an illness or injury. **Community rehabilitation (or rehab) units** are buildings with beds for people who don't need to be in hospital any more, but can't go home because they need intensive 24 hour support and care.

## How to make your views known

### There are a number of ways in which you can give your views:

Visit our websites and fill in the online questionnaire

Complete the questionnaire at the end of this document and send it back to us

Write a letter to  
FREEPOST I Y 426  
ILFORD  
IG1 2BR

Email: [haveyoursay@onel.nhs.uk](mailto:haveyoursay@onel.nhs.uk)

Call: 020 3688 1089

**All comments must be received by 5pm,  
Wednesday 1 October 2014.**

### Our websites:

[www.barkingdagenhamccg.nhs.uk/intermediatecare](http://www.barkingdagenhamccg.nhs.uk/intermediatecare)

[www.haveringccg.nhs.uk/intermediatecare](http://www.haveringccg.nhs.uk/intermediatecare)

[www.redbridgeccg.nhs.uk/intermediatecare](http://www.redbridgeccg.nhs.uk/intermediatecare)

### How to find out more

If you want to find out more about our work to improve intermediate care before you comment, you can visit the intermediate care page on our websites. Or call us and we can send information to you.

We will be out and about in Barking and Dagenham, Havering and Redbridge talking to people about our proposals – the dates and times for these events are below, and you can also find the latest information on our websites.

If you would like someone to come and talk to your community group about our proposals, please email [haveyoursay@onel.nhs.uk](mailto:haveyoursay@onel.nhs.uk) or call **020 3688 1089**.

#### **Barking and Dagenham – Thursday**

**11 September, 4-7pm**

Barking Learning Centre

2 Town Square

Barking IG11 7NB

#### **Havering – Thursday 21 August, 4-7pm**

Romford Central Library

St Edwards Way

Romford RM1 3AR

#### **Redbridge – Thursday 31 July, 4-7pm**

Redbridge Central Library

(formerly Ilford Central Library), Clements Road

Ilford IG1 1EA



## Background to the proposals

Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (CCGs) have been working together with the local councils and local health service providers to improve health and social care services for local people. We want to make services more joined up with each other and focused on what individual people need, not on what is convenient for the services.

We need to improve people's experience of care and make sure it's the best quality, so we know we are delivering the right care, in the right place, at the right time.

We need to make sure the health and social care system is 'future proof'. We know the population is growing and getting older. We need a system that will care better for people now and can also care for more people in years to come.

We must ensure that services are efficient and deliver value for money.

**As part of this work, we have been focusing on improving local intermediate care services.**



"This is an outstanding brilliant service, what you have done in 21 days is unbelievable. My mum was in hospital for 13 weeks and was nowhere near where she is today with her walking. My mum is now able to walk which I never thought would happen."

## So what is intermediate care?

Intermediate care helps people get better quicker without needing to go to hospital, and also helps get people out of hospital and back home, sometimes after a stay in a community rehab unit.

These services are most often needed by older people, for example if they have a fall and hurt themselves which makes them less mobile and less able to care for themselves. They can also be needed by younger people, though, if they have an ongoing health problem that sometimes flares up making them unwell and needing help. We do not include specialist care for people who have had a stroke when we talk about intermediate care.

Historically, local people needing this kind of care have generally been cared for in beds at community rehab units when they could have been cared for at home, if the right services were in place to help them. This means that there are more intermediate care beds across our area compared with other areas.

This is an old-fashioned way of providing care and it does not take into account people's individual needs. The results for patients are generally not quite as good as if care was provided in other ways. For example, it often takes longer for people to recover fully. Being in a bed makes patients more likely to get an infection and to lose their independence.

People tell us they want to be cared for and supported in their own homes. We know people locally have been spending longer in community rehab units than people do elsewhere, and this can make it much harder for them to return home and live independently. By providing home-based services, patients recover more quickly and have a good experience of care.



To find out more about the evidence behind this, visit our websites:

[www.barkingdagenhamccg.nhs.uk/intermediatecare](http://www.barkingdagenhamccg.nhs.uk/intermediatecare)

[www.haveringccg.nhs.uk/intermediatecare](http://www.haveringccg.nhs.uk/intermediatecare)

[www.redbridgeccg.nhs.uk/intermediatecare](http://www.redbridgeccg.nhs.uk/intermediatecare)

By caring for people at home where possible we would prevent most people from having to go into a community rehab unit.

Of course, there are times when people *do* need to stay in a community rehab unit – for example they're not mobile enough to go home – and we would make sure that they can do this and the care they get there is excellent.

By improving the way we look after people in a community rehab unit and making sure they get personalised, focused care, with access to a range of therapies, patients would need to spend less time there.

To be clear, both the care at home and the care in a bed at a community rehab unit are intermediate care.

## What are the new services we have been trialling?

We have been trialling two new services to help people to stay at home.

### **Community treatment team (CTT)**

This is a team of doctors, nurses, physiotherapists, social workers and others who together care for people at home so that they either don't need to go into hospital or return home from hospital sooner.

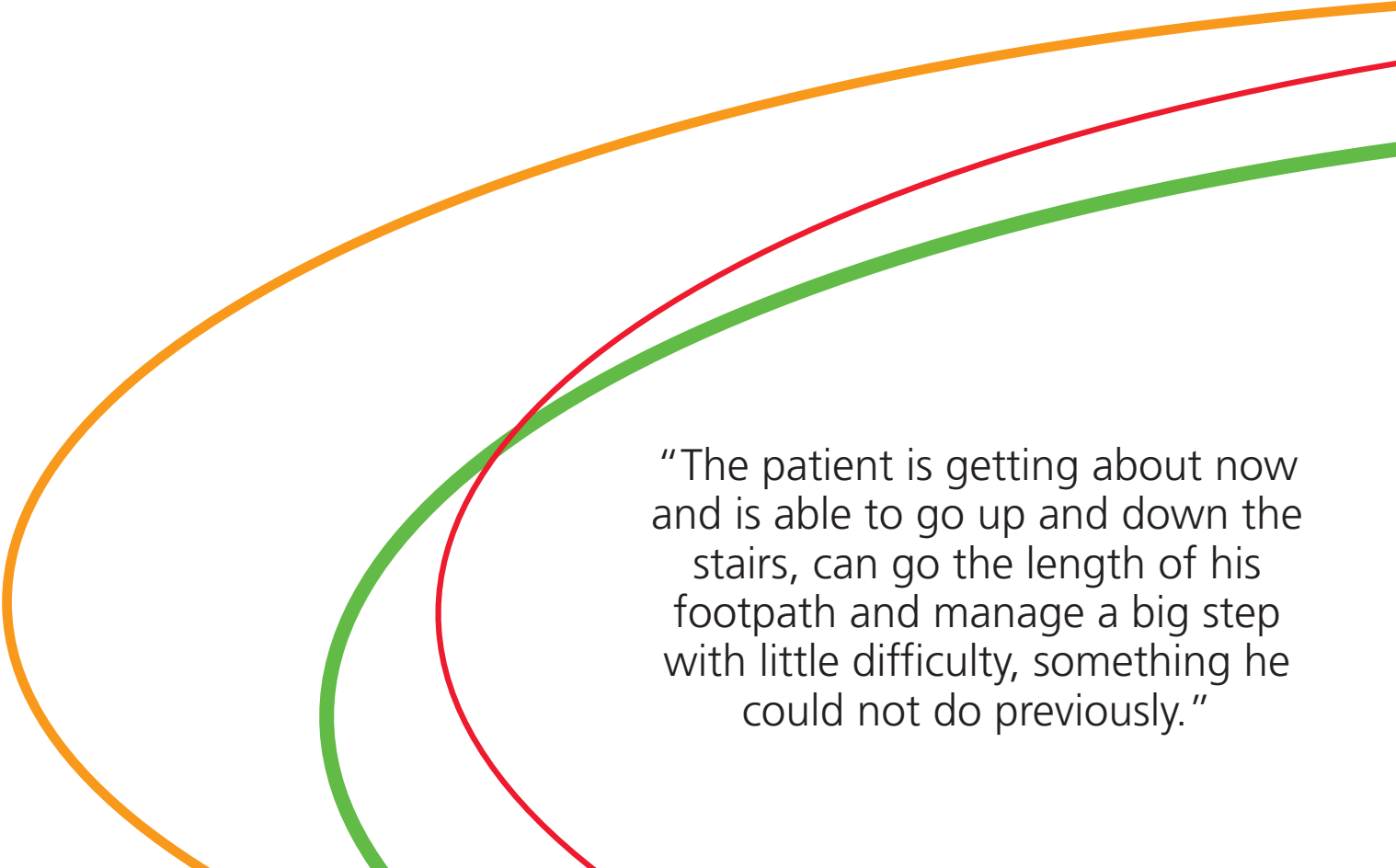
The CTT started in Barking and Dagenham and Havering in January 2013, where it ran from 8am - 8pm, seven days a week. In November 2013, the service was expanded to include Redbridge, and the hours across the three boroughs were extended for an additional two hours a day, until 10pm.

### **Intensive rehabilitation service (IRS)**

This is a team of physios, occupational therapists, healthcare assistants and others offering intensive physio and other therapy in a patient's own home, with up to four visits a day depending on the patient's needs. The service operates from 8am - 8pm, seven days a week.

### **What do patients think of these services?**

Patient satisfaction rates for both the new services have been consistently high across the three boroughs since the trials began. On a scale of 1-10, with 10 being 'very satisfied' with the service, CTT has averaged 8.7 and IRS 9.0 out of 10. You can see some of the comments patients have made about the services throughout this document.



“The patient is getting about now and is able to go up and down the stairs, can go the length of his footpath and manage a big step with little difficulty, something he could not do previously.”

## Community rehab units

**At the moment there are three community rehab units used by people from Barking and Dagenham, Havering and Redbridge.**

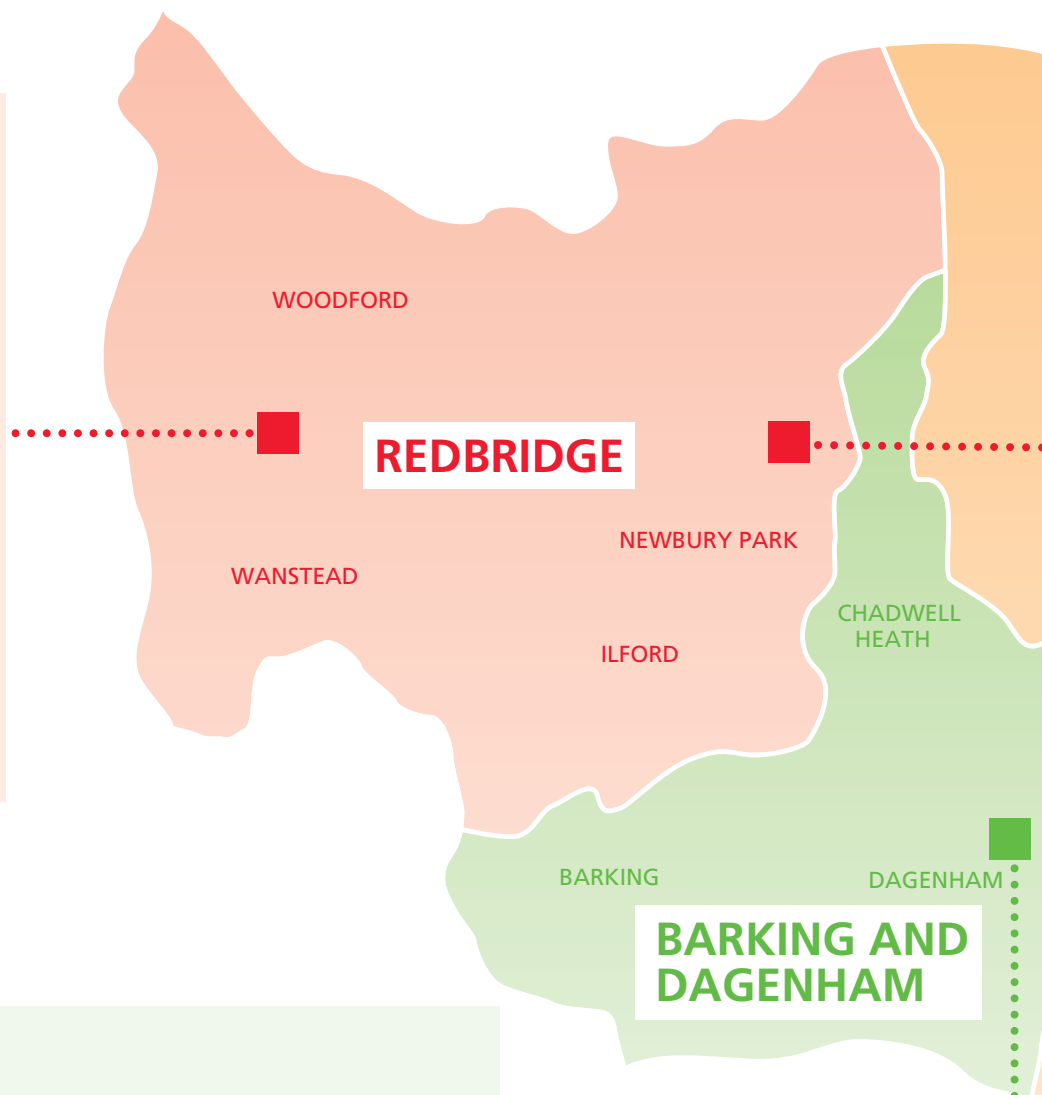
### Heronwood and Galleon Unit in Wanstead

#### Capacity and facilities:

48 beds, in two wards.  
Physiotherapy gym, dining room and day room.

**Public transport:** Average links. Two bus routes are within five minutes' walk. Nearest underground station is 10-15 minutes' walk.

**Parking:** Free limited parking on site for staff and visitors. Limited parking in residential streets.



### Grays Court in Dagenham

**Capacity and facilities:** 26 beds, in single rooms, some of which have en-suite facilities but which are too small for equipment like hoists and wheelchairs. Physiotherapy gym, day rooms, dining area, consultation rooms.

**Public transport:** Poor links. Nearest bus route is 10 minutes' walk away. Nearest underground station is 20 minutes' walk.

**Parking:** Free limited parking on site, used by staff and visitors. Limited parking on residential streets.

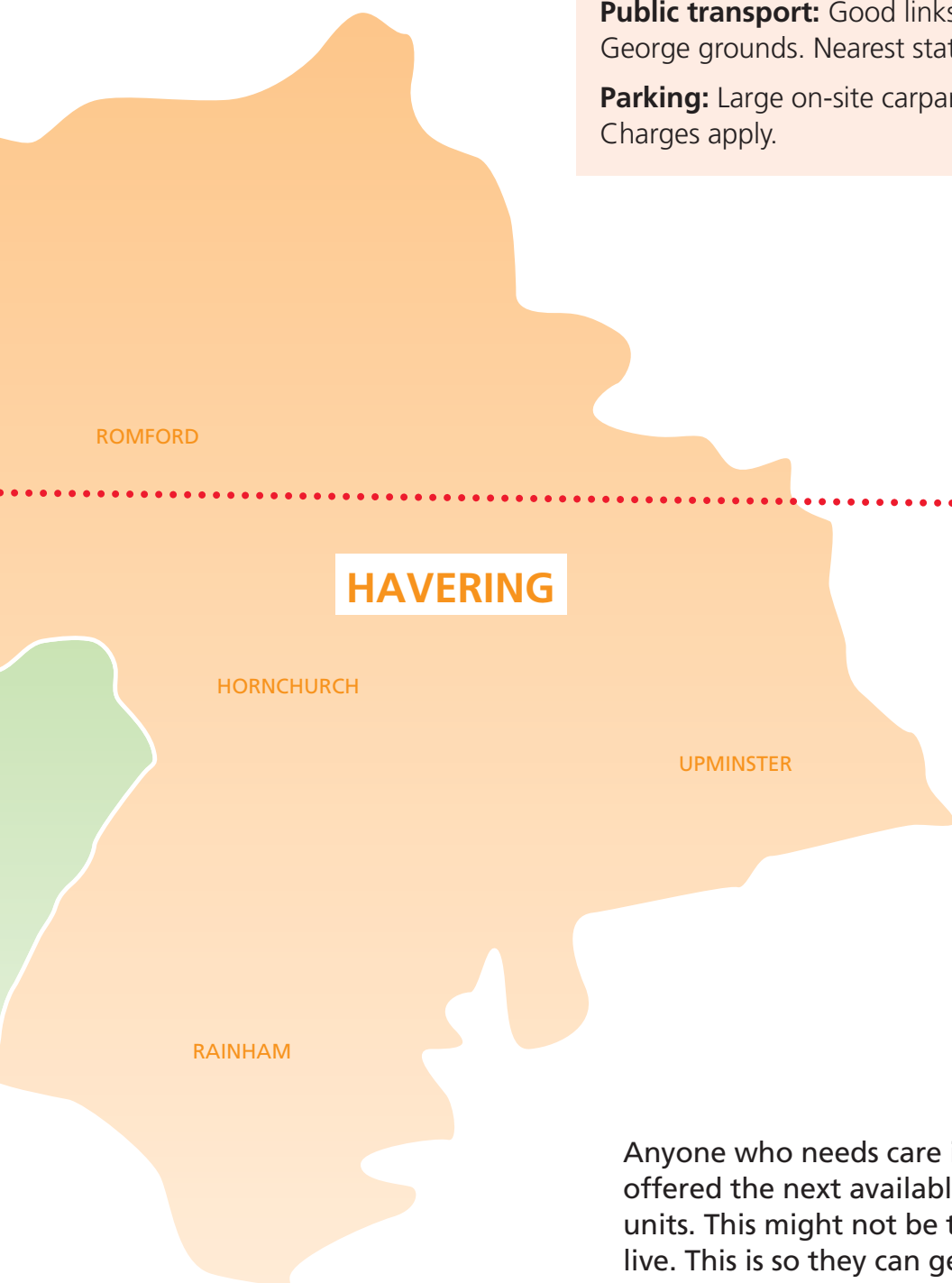


### Foxglove Ward (King George Hospital) in Goodmayes

**Capacity and facilities:** 30 beds, in one ward (with another ward identified for expansion). Day room, physiotherapy gym on ward and access to a larger hospital gym. Access to other hospital services and facilities.

**Public transport:** Good links. Four bus routes stop in King George grounds. Nearest station is 15 minutes' walk.

**Parking:** Large on-site carpark for staff and visitors. Charges apply.



Intermediate care services used to be provided at St George's Hospital in Hornchurch, but this site was closed for health and safety reasons in October 2012 and remains closed.

Anyone who needs care in a community rehab unit is offered the next available bed in any of the three units. This might not be the one closest to where they live. This is so they can get access to rehabilitation as quickly as possible, which should help to speed up their recovery. If they prefer to wait for a bed at another unit, they can do so, but generally people want to start their rehabilitation quickly.

## Bed numbers: now and in the future

There is capacity for 104 community rehab beds across these three sites. However at the moment these beds are not all being used as there is no need for them. From looking at how the services have been operating recently and particularly since the trial of new services began, we have worked out that we would only need between 40-61 community rehab beds over a year if the home-based CTT and IRS were both running all the time. This is because most people would receive care in their own home and so would not need a community rehab bed.



When working this out, we have taken into account the fact that more beds are generally needed over the winter months.

This means if we did not reduce the numbers of available beds, at any one time during a year there would be between 43 and 64 unused community rehab beds. It costs hundreds of thousands of pounds to keep these available, whether they are occupied or not, in building upkeep, electricity and so on. We also need to duplicate staffing across the sites.

### Case study: Sunita stays in a community rehabilitation unit

**Sunita is a 77 year old woman who is unsteady on her feet and is in hospital following a fall. She also has a chest infection.** She no longer needs to be in the hospital, but she's not mobile enough to go home, and she is afraid of falling over again. CTT and IRS won't be enough for her – she needs help to move around safely, but she also needs 24 hour care. Sunita is referred to a community rehab unit. A nurse from the unit comes out to visit her, assesses her to make sure that the unit is the right place for her to go. It is and she's offered the next available bed.

While in the unit, Sunita receives 24 hour nursing care, physio and occupational therapy. The team regularly assess her and set her small but achievable goals to build her confidence and make sure she is progressing. After two and a half weeks, Sunita is feeling confident enough to go home, and the unit team supports this. They plan how she will manage after leaving. IRS staff visit her on the ward and once she's back home and develop an intensive rehab plan for her. The district nurses and the social care team also review Sunita's needs and provide the support she needs to stay at home safely, with the support of her family.

Sunita is happy to go home, pleased that she will have the support she needs to continue to recover. She is feeling stronger and more confident.

## Why we want to change the way we offer intermediate care

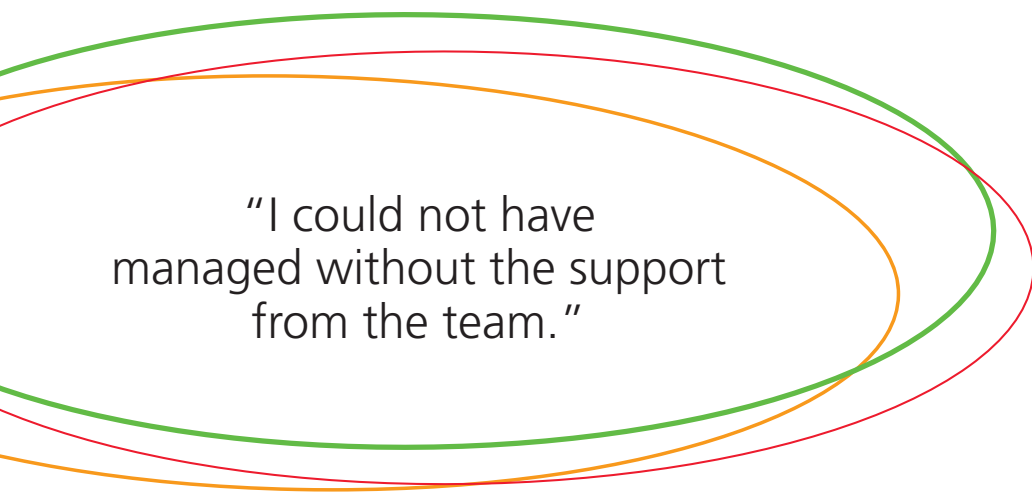
We want people to get better care and to recover more quickly. We want them to be able to stay at home, if at all possible, because that's what patients and their families want. Keeping people at home helps them to stay independent for longer and it reduces the risk of them picking up a new infection and becoming more unwell.

We want to make sure that we are using NHS money in the best possible way. This means spending our budget on services that would help patients the most. It means making sure that we are running services as efficiently as possible, saving money where we can so we can reinvest it in different and better services.

Since introducing CTT and IRS on a trial basis, we have found that a lot of beds in community rehab units are not now being used, because the teams care for people in their own homes (in the first six months of the trial, 29 beds weren't used). During the trial we have found that people are able to access care and support sooner. We know that for the majority of people care at home is the right thing, they do not need to go to hospital or a community rehab unit, and they recover as well, and in some cases better and quicker at home. Patients who have used the new services have told us they have had a very good experience and received high-quality care.



“Everybody wants to go home from hospital – as soon as they are ready and able to.”



“I could not have managed without the support from the team.”

### Case study: Reg is helped at home by the Community Treatment Team

**Reg is 55 years old. He lives on his own and he has Chronic Obstructive Pulmonary Disease (COPD) which sometimes makes it hard for him to breathe.**

Reg visits his GP a lot about his COPD because he's not confident about managing it and he's ended up in A&E in the past. His GP tells him about the local community treatment team (CTT), who can help him to manage his condition.

Reg has struggled to breathe all day but tries to manage with his existing medication. By 4pm, Reg is finding it harder to breathe and this triggers a panic attack. (Panic attacks can be very frightening and intense, but they are not dangerous and won't cause you any physical harm).

Instead of calling 999, as he would have in the past, he calls the CTT. The administrator asks him some questions and tells him how long it will be before someone calls him back. He's called back within 10 minutes as his case is a priority because it is clear he is having difficulty breathing. (The CTT will contact all patients within two hours). A senior nurse asks him questions about how he's feeling. Because of what he says, she allocates his case to a

community nurse who arrives at his house within two hours. Reg is thankful that he can receive help at home as, like lots of people, he finds hospitals stressful, which generally makes him feel worse.

The nurse does various tests and notes his temperature has gone up and his oxygen levels are outside the normal range. They talk through his medical history and what medication he is on. The nurse advises Reg that he should now start taking the medication he has for when he has an attack. They discuss how he can manage his shortness of breath, and she carries out a blood test to rule out any further medical concerns. The CTT continues to monitor Reg's progress over the next two to three days and they keep his GP informed.

The nurse also refers Reg to the specialist respiratory team who will work with him in the longer term to help him manage his condition, looking in detail at the medication he's on and working with a physio and occupational therapist.

Reg feels much more confident about managing his COPD in the future, and knows he can always call the CTT if he needs them.

## What are the options for intermediate care?

We looked at the possibilities for improving intermediate care services for local people then drew up a list of five options. We then looked at the advantages and disadvantages of each option.

- What would be best for patients and help them to recover as quickly as possible?

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- What would be easiest for patients and carers to help them live their normal lives where possible?

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- How well does each option fit in with all the other local health and social care services and any plans there might be to develop those in the future?

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- Could we afford to pay for the services in each of the options and are some options more or less expensive than others?

We have to make sure that we spend our limited NHS money in a way that makes sure we get the most we can for local people. We do not have enough money to spend on everything that everyone wants and if we spend more on one service then we have less to spend on another. That's why it's really important that we get the balance right.

As well as thinking about how much it would cost to run the services in the future, we thought about how much it would cost to make any changes. This would include the cost of any changes that we might need to make to modernise buildings, for example.



When we evaluated the options, we took into account both non-financial and financial criteria and we weighted these 60:40, meaning the financial aspects were not as important as things like quality of care and patient experience. Detail of these processes and the evidence behind our thinking, including information on finances and the pre-consultation business case is on our websites:

[www.barkingdagenhamccg.nhs.uk/intermediatecare](http://www.barkingdagenhamccg.nhs.uk/intermediatecare)

[www.haveringccg.nhs.uk/intermediatecare](http://www.haveringccg.nhs.uk/intermediatecare)

[www.redbridgeccg.nhs.uk/intermediatecare](http://www.redbridgeccg.nhs.uk/intermediatecare)

“Walks well now, able to walk with a stick.”

## The five options we considered in detail were:

### Option 1: Stay as they are now

CTT and IRS – same number of beds – beds on three sites

This option means things would not change from how they are now. There would be the same number of beds on the same sites and there would be the new CTT and IRS services that we have been trialling.

Under this option, patients would benefit from the popular home-based care services which help patients to recover more quickly. They would also have more choice if they needed care in a community rehab unit as there would be three community rehab units offering care.

Under this option, there would be unused beds in the community rehab units because more people would be cared for in their own homes. This means money would be wasted.

This option would not be affordable because it is the most expensive option. We would not be able to pay for the new home-based services while still running the same number of beds across three community rehab units. We managed to find additional money to pay for the trial but we cannot carry on running both home-based and bed-based services at this level in the long term.


### Option 2: Go back to before the trial

No IRS – No CTT in Redbridge and reduce CTT hours in BD and Havering – same number of beds – beds on three sites

This option means we would go back to how things were before we started trialling the new services. That means there would be no IRS in any of the boroughs and no CTT in Redbridge. The CTT in Barking and Dagenham and Havering would reduce their hours again, by two hours a day. There would be the same number of beds on the same sites.

Under this option patients in all areas would get a reduced service, particularly in Redbridge. The reduction in services would be in the home-based services that patients and carers really like and which help people to recover more quickly.

This option is not affordable in the longer term. No IRS (and no CTT in Redbridge) to support other services would mean longer waits for the services that do exist. That would make those services less productive and patients would take longer to leave hospital. That would be more expensive in the long term than what we are proposing.



“We’re extremely happy with the service and have recommended to our friends already.”

### Option 3: New services and three sites

#### CTT and IRS – fewer beds – beds on three sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs and we would still have three community rehab units. There would be fewer beds overall though because we would take out the ones that aren't needed.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would still be able to choose from the three current units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

This option is not the most affordable option because we would have to pay all the costs of keeping three community rehab units open, even if we weren't using all the space in each building.

### Option 4: New services and two sites

#### CTT and IRS – fewer beds – beds on two sites

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to two and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to choose from two units (although they might have to wait for a bed if they wanted a specific unit, as they do now).

Having beds on a number of sites has some disadvantages. It is harder to ensure the same consistency and quality of care. If beds are spread over a number of sites, we need more staff than if they are all on one site. The workforce is less flexible if we are running a number of units.

We considered all combinations of which two sites could stay open, but for the reasons explained above, did not feel this option would provide high quality care. For a detailed description of this process, see the pre-consultation business case on our websites:

[www.barkingdagenhamccg.nhs.uk/intermediatecare](http://www.barkingdagenhamccg.nhs.uk/intermediatecare)

[www.haveringccg.nhs.uk/intermediatecare](http://www.haveringccg.nhs.uk/intermediatecare)

[www.redbridgeccg.nhs.uk/intermediatecare](http://www.redbridgeccg.nhs.uk/intermediatecare)

This option is more affordable than options 1-3, but it doesn't offer the best value for money because we would still have to run two separate units on two separate sites.

**Option 5: New services and one site****CTT and IRS – fewer beds – beds on one site at King George Hospital**

This option means we would have the new home-based services (CTT and IRS) in all boroughs. We would reduce the number of community rehab units to one at King George Hospital and we would reduce the overall number of beds.

Under this option patients would benefit from the popular and effective home-based services. Those who needed to stay in a community rehab unit would be able to.

This option would be the most affordable because we would pay for the new services with the money that we saved by reducing bed numbers

and by reducing the number of sites from three to one. It would also be the best value for money as we would reduce duplication (for example paying to run three buildings).

This is also the best option clinically – it would allow us to deliver a better service, with better results for patients. Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly and patients would have better access to specialist therapy and nursing support.

This option is our preferred option and we explain why in the following section.

**Summary of options**

Option	Is there a community treatment team?	Is there an intensive rehab service?	How many beds overall?	How many community rehab units?
1	Yes	Yes	104	3
2	Yes, with reduced hours (Barking and Dagenham and Havering) No (Redbridge)	No	104	3
3	Yes	Yes	40-61	3
4	Yes	Yes	40-61	2
5	Yes	Yes	40-61	1



## What do we think would be best in the future?

We want to be able to continue the new services that we have been trialling – the community treatment teams in all three boroughs for 14 hours a day, and the new intensive rehabilitation service, because the trial has been very successful. We have had really good feedback from patients and carers about the services – they think they are an improvement.

As much as possible, patients have been helped to stay at home, which has helped them to get better quicker and to stay independent.

We also want to make sure that we have the right number of beds for people who do need to stay in a community rehab unit. We want those beds to have the right supporting services around them.

After thinking about the advantages and disadvantages of all the options, **we think option five is the best option**. This is because we think it would result in the best and safest care.

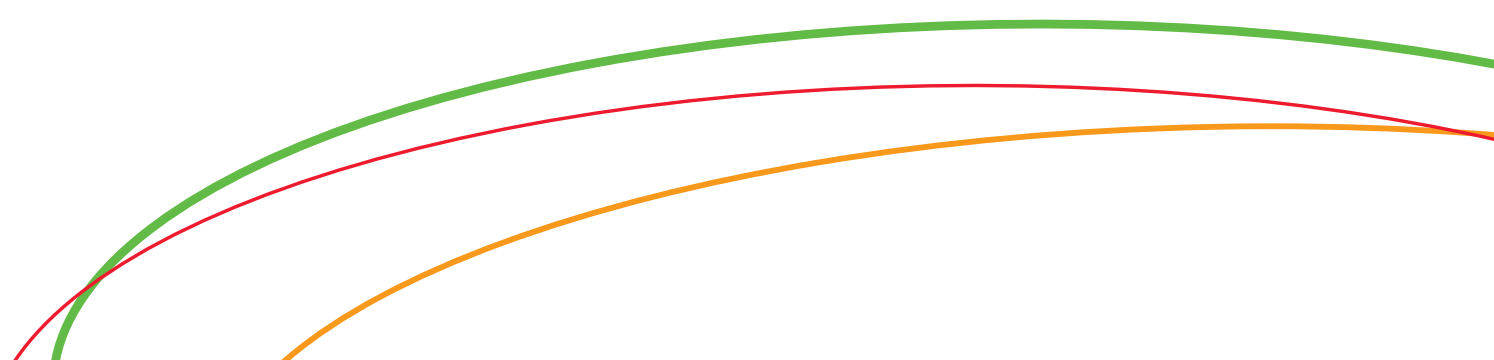
Option five would mean:

- **We would continue to run the community treatment team and the intensive rehabilitation service that we have been trialling.**

This means most people would get care at home and would not need to travel or stay in hospital. They would be able to lead as normal a life as possible and stay close to family and friends. We know that helping people to stay out of hospital means they are more able to stay independent for longer. Those people who do need to go into hospital would be helped to return home more quickly than in the past. This is because people who have been helped by these services think they are much better than going into hospital.

- **We would reduce the total number of beds across the three boroughs to between 40 and 61.**

This means that we would always have 40 beds and we would always be able to increase the number of beds up to a maximum of 61, depending on how many people need a bed at a time. We do not think we would ever need more than 61 beds at any one time. This is because fewer people would need a bed because they are being cared for at home and those who do need a bed for a while would not have to stay in the unit for as long.



### ■ We would move all the beds onto one site

Having a service in one place rather than in a number of smaller units, means patients get better more quickly. It is much easier to make sure care is of consistent quality and clinicians say this is the safest way to provide care (rather than on two or three sites).

We could use staff much more efficiently and flexibly and we would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

We realise that moving from three sites to one would make it harder for some people to visit a relative or friend, but we think the benefits to patients should make it worthwhile. For example, patients will go home sooner than they do now. Some people are already travelling – people in Havering travel to Redbridge to visit Foxglove ward. We think this can be offset by the majority of people being seen in their own home, and not needing to travel.

### ■ We would locate the service on the King George Hospital site.

This location is fairly central to the three boroughs, there are good, well-established transport links and car parking is available on the site.

Locating the service on this site means it could link in with other health services where necessary. There is enough room here to be able to have up to the maximum number of beds that we think we might need at any one time. There is not enough room on either of the other two sites for 61 beds.

It would mean that we would no longer need two community rehab units – Heronwood and Galleon unit in Wanstead and Grays Court in Dagenham.

We do not own either of these sites, so we cannot make decisions about what would happen to them, but we would work with the owners and other local stakeholders to help them decide how best to use the sites.

For information on the advantages and disadvantages of the different sites, look at the 'Community rehab units' section.



“The service has made a massive difference to my mobility. I would not have been able to recover to the level I have.”

### Case study: Doreen goes home from hospital with the help of the Intensive Rehabilitation Service

**Doreen is an 86 year old widow living by herself. She has high blood pressure, rheumatoid arthritis and walks with a stick but is otherwise in good health.**

One day, Doreen falls down her stairs and can't get up, so her neighbour calls 999. An ambulance takes her to Queen's Hospital where an x-ray shows she's broken her leg. She has her leg set under anaesthetic, and spends three weeks recovering on an orthopaedic ward.

While she is in hospital, Doreen has physiotherapy to work on her strength and mobility and an occupational therapist helps her to practise tasks like washing and dressing and moving about safely.

When Doreen no longer needs to be in hospital, instead of going to a community rehab unit, she is referred to the Intensive Rehabilitation Service (IRS). Staff from the service talk to the hospital therapists, nurses and doctors and to Doreen about her situation - how she is recovering, and what kind of care she needs to complete her recovery at home.

Once Doreen is back home, the IRS team visit her and talk to her about her goals. She wants

to be able to climb her stairs safely, and walk to her neighbour's house, so between them they work out a plan to help her achieve this.

This involves up to 21 days of intensive rehabilitation at home. She is visited twice a day every day and receives care from a physio, occupational therapist, rehabilitation assistants and a nurse. As Doreen becomes more confident moving around, the team does more with her – helping her to manage the steps in her back garden.

The team reviews Doreen's progress throughout her rehabilitation and looks at what other help she needs. Both they and Doreen think she has recovered well, thanks to the intensive support. They let Doreen's GP know about her progress so she can follow up and refer Doreen to other services such as district nursing. They also talk to the council's social care team to make sure she has someone to help her do her shopping

Doreen feels safe to continue to live in her own home, with the support of NHS and council services.

## Questions and answers

### **How did you decide on the preferred option?**

The executive committees of the three CCGs set up a steering group with senior doctors and managers (including the nurse director and finance director) from all three boroughs. This group developed and appraised the options against a set of criteria, coming up with a recommended preferred option. The governing bodies of the three CCGs then considered what they had done, and agreed we should consult the public and other stakeholders on that preferred option.

### **When would you make these changes?**

If agreed, we would need to talk to Barking, Havering and Redbridge University Hospitals NHS Trust, which owns King George Hospital, to agree when we would be able to start to use more space. We'd need to take the time to make any changes properly, at minimum disruption to patients, so any move would probably take place in the 2015/16 financial year.

### **Have you factored population changes into the planning?**

Yes. We always use the most up-to-date population information and projections to make sure that we plan appropriately for current and future needs.

### **Isn't this just all about saving money?**

No. The reason we want to make changes is because we think we can make things better for patients so they recover more quickly and most of the time recover in their own homes. We have also had great feedback on the services – patients like them. This is about spending money where it will have the greatest impact and result in the best care and results for patients.

But anything we do has to be affordable. We have a limited NHS budget and if we spend more on one service then we have to cut what we spend on something else.

### **What if I want to recover in a bed at a community rehabilitation unit, not at home?**

If you wanted to recover in a bed at a community rehab unit, we would talk to you about why you wanted to do this. If we thought you would recover more quickly at home we would explain why. We would discuss any social care needs you might have and we would talk to you about how we could help you remain independent. Of course, anyone who is in clinical need of a bed would get a bed.

### **Why can't we keep three community rehab units?**

Clinicians tell us the safest way to provide high-quality care is by having a service in one place rather than in a number of smaller units, as this means patients get better more quickly. Running one unit would mean we could use staff much more efficiently and flexibly. We would cut down on duplication of tasks, which would mean staff would have more time to spend with patients. A single larger community rehab unit is much better able to cope with fluctuations in demand. Patients would have better access to specialist therapy and nursing support. The links with CTT and IRS would be better than if they were dealing with a number of units.

### **What would happen to the buildings if the decision is made to centralise services?**

We do not own the sites, so we cannot make decisions about what would happen to them. We would work with the owners and other local stakeholders to help them decide how best to use the sites.

Work would also need to be done to the available space at King George Hospital. This would mean looking at the way the space is laid out so government requirements to put men and women in different areas are met. Other work, such as painting and decorating and getting IT systems set up would also be needed.

### **What about the St George's Hospital site in Hornchurch?**

Havering CCG is still working with the site's owners and NHS England to develop a new health centre on the site. That is still in the planning stage and so any new centre would be some way off.

### **Wasn't it the plan to put the rehabilitation beds that moved off the St George's Hospital site in 2012 back into the new health centre?**

The public consultation on the redevelopment of St George's supported the preferred option not to include any beds, but to ensure flexibility the CCG has made sure there is enough space in the plans for some short-term care beds (not intermediate care beds). As this is still at the planning stage, it would be some time before any new centre was up and running and we want to make these improvements more quickly.

### **What about involving social care and social workers?**

The CTT includes social care staff as well as NHS staff, so the team thinks about the patient's needs as a whole, rather than separating them out into health or social care. The IRS also has very good links with social care.

### **Do local authorities and care providers support these proposals?**

These proposals have been agreed by the Integrated Care Coalition (ICC), a group of health and social care partners including local councils and care providers, which was established to review and propose how health and social care services can be made better for local people.

Following an in-depth review of local services, the ICC published a 'case for change' which identified a need to improve and modernise the way intermediate care services are delivered. A strategy was developed which took into account examples of alternative models and approaches here and overseas, and involved extensive local clinical, professional and public engagement.

"I would like to be able to score higher than 10."

## We want your views

We want you to tell us what you think of these proposals. Please complete the questionnaire at the end of this booklet and send it back to us, or write to:

**FREEPOST I Y 426  
ILFORD  
IG1 2BR**

If you'd prefer to send an email, send it to **haveyoursay@onel.nhs.uk**

You can also call: **020 3688 1089**

**All comments must be received by 5pm,  
Wednesday 1 October 2014.**

### **How your views will be considered**


Once the consultation closes, we will review and analyse all the responses we receive.

We will use this information to write a report for each of the three CCGs' governing bodies to consider, alongside any other evidence and/or information available (for instance the equalities impact assessments) and make a decision on the most appropriate way forward. They will also be able to see all the consultation responses in full.

If you are responding on behalf of an organisation or you represent the public (like an MP or a councillor) your response may be made available for the public to look at. If you are responding in a personal capacity, we will not publish your response but we may use unnamed quotes to show particular points of view.

We will put the dates of the governing bodies' decision-making meetings on our website. These are meetings held in public, so you are welcome to attend and all the reports they will look at will be published on our websites.

If you let us know your contact details (by filling this in on the questionnaire), we can keep you up to date with our work.



“Brilliant service, helpful,  
good treatment, and  
good communication.”

## Questionnaire

**Please tell us to what extent you agree or disagree with the following statements:**

- 1** The NHS should permanently run the new home-based services that have been trialled (the community treatment teams and the intensive rehabilitation service) because they help people to get better more quickly and to stay independent.

Strongly agree    Strongly disagree    Agree    Don't know    Disagree

Comments

- 2** The NHS should reduce the numbers of community rehabilitation beds if it can be shown that they are not used and are not needed.

Strongly agree    Strongly disagree    Agree    Don't know    Disagree

Comments

- 3** The NHS should reduce the number of community rehabilitation units because this is the best way to provide high quality, safe care.

Strongly agree    Strongly disagree    Agree    Don't know    Disagree

Comments

## Questionnaire continued

**4** We believe that option five – home-based services where possible and one community rehabilitation unit on the King George Hospital site, with 40-61 beds - is the best way to organise intermediate care services in the future.

Strongly agree    Strongly disagree    Agree    Don't know    Disagree

Comments

**5** If you disagree with our preferred option (option 5) please tell us what you think we should do instead.

Option 1    Option 2    Option 3    Option 4    None of them

Comments

Use this space if you want to tell us anything else



# Monitoring questions

We would find it useful if you could tell us a bit about yourself so we can see what sorts of people are responding and whether they think differently from other groups. That helps us to understand if what we want to do might have more of an impact on some groups of people than others.

You don't have to give us your name if you don't want to and we will still take your views into account.

## Name

## Are you providing this response as a representative of a group:

Yes  No

If yes, what is the name of the group

## Would you like to be kept up to date with information about the NHS (including this consultation)

Yes  No

If yes, please give us your email or postal address

## Which borough do you live in

Barking and Dagenham  Havering  
 Redbridge  Other

## Are you?

Male  Female  Prefer not to say

## Are you responding as a...

Service user  NHS staff member  
 Carer  Local resident  
 Other  Prefer not to say

## Are you employed by the NHS?

Yes  No  Prefer not to say

## What is your ethnic background

### White

White British  White Irish  
 Any other white background

### Mixed

White and Black African  
 White and Black Caribbean  
 White and Asian  
 Any other Mixed background

### Asian

Asian British  Indian  
 Bangladeshi  Pakistani  
 Chinese  
 Any other Asian background

### Black

Black British  Black African  
 Black Caribbean  
 Any other Black background  
 Any other ethnic group  
 Prefer not to say

## Which belief or religion, if any, do you most identify with?

Agnosticism  Atheism  
 Buddhism  Christianity  
 Hinduism  Islam  
 Judaism  Sikhism  
 Other  Prefer not to say

## Do you consider you have a disability?

Yes  No  Prefer not to say

## How old are you?

Under 16  16-25  
 26-40  41-65  
 Over 65  Prefer not to say

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

#### English

This document is about our plans to improve some of the health services in Barking and Dagenham, Havering and Redbridge. If you cannot read the document and would like to know more, please contact us and tell us what help you need. Let us know if you need this in large print or a different format. If you do not speak English, please tell us what language you speak.

#### Bengali

এই নথিটি বার্কিং ও ড্যাগেনহাম (Barking and Dagenham), হ্যাভারিং (Havering) ও রেডব্রিজ (Redbridge)-এ কিছু স্বাস্থ্য পরিষেবার উন্নয়ন সংক্রান্ত আমাদের পরিকল্পনার বিষয়ে তৈরী করা হয়েছে। আপনি যদি নথিটি পড়তে না পড়েন এবং এ বিষয়ে আরো জানতে চান, অনুগ্রহ করে, আমাদের সাথে যোগাযোগ করুন এবং আমাদের বলুন যে, আপনার কি সহায়তা প্রয়োজন। আপনার যদি এটি বড় হরফের মুদ্রণ বা অন্য একটি ফরম্যাটে প্রয়োজন হয়, আমাদের তা জানান। আপনি যদি ইংরেজীভাষী না হন, অনুগ্রহ করে, আমাদের জানান যে, আপনি কোন ভাষায় কথা বলেন।

#### Lithuanian

Šiame dokumente atspindi mūsų planai patobulinti kai kurias sveikatos priežiūros paslaugas Barkinge ir Dagenhame (Barking and Dagenham), Haveringe (Havering) ir Redbridže (Redbridge). Jei negalite perskaityti šio dokumento ir pageidaujate išsamesnės informacijos, susisieki su mumis ir pasakykite, kokios pagalbos jums reikia. Informuokite mus, jei pageidaujate dokumento stambiais rašmenimis ar kitokio formato. Jei nekalbate angliškai, informuokite, kokia kalba kalbate.

#### Portuguese

Este documento é acerca dos nossos planos para melhorar alguns dos serviços de saúde em Barking e Dagenham, Havering e Redbridge. Se não puder ler o documento e desejar saber mais, contacte-nos e informe-nos que tipo de ajuda necessita. Informe-nos se necessita em tamanho maior ou num formato diferente. Se não fala Inglês, informe-nos qual o seu idioma preferido.

#### Punjabi

ਇਹ ਦਸਤਾਵੇਜ਼, ਬਾਰਕਿੰਗ ਅਤੇ, ਡਾਗਨਹੈਮ (Barking and Dagenham), ਹੈਵਰਿੰਗ (Havering), ਅਤੇ ਰੈੱਡਬ੍ਰਿਜ਼ (Redbridge) ਵਿਚ ਕੁਝ ਸਿਹਤ ਸੇਵਾਵਾਂ ਵਿਚ ਸੁਧਾਰ ਸਬੰਧੀ ਸਾਡੀਆਂ ਯੋਜਨਾਵਾਂ ਦੇ ਬਾਰੇ ਹੈ। ਜੇ ਤੁਸੀਂ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹ ਨਹੀਂ ਸਕਦੇ ਅਤੇ ਇਸ ਬਾਰੇ ਹੋਰ ਜਾਣਕਾਰੀ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਡੇ ਨਾਲ ਸੰਪਰਕ ਕਰੋ ਅਤੇ ਸਾਨੂੰ ਦੱਸੋ ਤੁਹਾਨੂੰ ਕੀ ਚਾਹੀਦਾ ਹੈ। ਜੇ ਤੁਸੀਂ ਇਸ ਸਫ਼ੇ ਨੂੰ ਮੋਟੀ ਛਪਾਈ ਜਾਂ ਕਿਸੇ ਹੋਰ ਫਾਰਮੈਟ ਵਿਚ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਸਾਨੂੰ ਦੱਸੋ। ਜੇ ਤੁਸੀਂ ਅੰਗਰੇਜ਼ੀ ਭਾਸ਼ਾ ਨਹੀਂ ਬੋਲਦੇ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਸਾਨੂੰ ਦੱਸੋ ਕਿ ਤੁਸੀਂ ਕਿਹੜੀ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ।

#### Romanian

Acest document este despre planurile noastre de a îmbunătăți o parte din serviciile de sănătate din Barking și Dagenham, Havering și Redbridge. În cazul în care nu puteți citi acest document și ați dori să aflați mai multe, vă rugăm să ne contactați și să ne spuneți de ce ajutor aveți nevoie. Spuneți-ne dacă documentul trebuie să fie într-un format mare sau într-un format diferit. Dacă nu vorbiți limba engleză, vă rugăm să ne informați ce limbă vorbiți.

#### Tamil

இந்த ஆவணம் பார்க்கிங் அண்டு டாகென்ஹாம் (Barking and Dagenham), ஹாவெரிங் (Havering) அண்டு ரெட்ப்ரிட்ஜ் (Redbridge) ஆகியவற்றில் உடல்நல சேவைகள் சிலவற்றை மேம்படுத்துவதற்கான எங்களின் திட்டங்கள் பற்றியது. உங்களால் இந்த ஆவணத்தைப் படிக்க இயலவில்லை என்றால் மற்றும் மேலும் தகவல்களைப் பெற விரும்பினால், எங்களைத் தொடர்புக் கொண்டு, உங்களுக்கு என்ன உதவி வேண்டுமென்று கேளுங்கள். உங்களுக்கு இது பெரிய எழுத்துக்களிலோ அல்லது வேறு வடிவத்திலோ வேண்டுமென்றால் எங்களிடம் தெரிவியுங்கள். உங்களுக்கு ஆங்கிலத்தில் பேச தெரியாது என்றால், நீங்கள் என்ன மொழியில் பேசுவீர்கள் என்று எங்களிடம் கூறுங்கள்.

#### Urdu

یہ دستاویز بارکنگ اور ڈی جینہم (Barking and Dagenham) بیورنگ (Havering) اور ریڈ برج (Redbridge) میں صحت کی چند خدمات کو بہتر بنانے سے متعلق ہمارے منصوبوں کے بارے میں ہے۔ اگر آپ یہ دستاویز نہیں پڑھ سکتے اور اس کے بارے میں مزید جاننے کے خواہاں ہیں، تو براہ کرم ہم سے رابطہ قائم کریں اور ہمیں بتائیں کہ آپ کو کیا مدد درکار ہے۔ اگر آپ کو یہ دستاویز پڑھنے پر ٹیٹ یا کسی دیگر فارمیٹ میں درکار ہے تو ہمیں بتائیں۔ اگر آپ انگریزی میں گفتگو نہیں کرتے، تو براہ کرم ہمیں بتائیں کہ آپ کون سی زبان بولتے ہیں۔

This document was developed with the help of patient representatives from across our area.