Havering
LONDON BOROUGH

CABINET
14 December 2016

Subject Heading:	**Integration of Reablement and Rehabilitation**
Cabinet Member:	Councillor Wendy Brice-Thompson, Cabinet Member for Adult Services and Health
CMT Lead:	Barbara Nicholls, Director of Adults Services
Report Author and contact details:	Keith Cheesman, Interim Head of Integration keith.cheesman@havering.gov.uk 01708 433742
Policy context:	Supports priorities in the Joint Health & Wellbeing Strategy: • Better integrated support for people most at risk • Quality of services and patient experience •
Financial summary:	To arrange for the contract for a new joint Reablement and Rehabilitation service to be commissioned for a period of 12 months at a cost of c£1.5m pa, funded from the Better Care Fund
Is this a Key Decision?	YES - Expenditure or saving (including anticipated income) of £500,000 or more
When should this matter be reviewed?	6 months following mobilisation
Reviewing OSC:	Individuals

The subject matter of this report deals with the following Council Objectives

Havering will be clean and its environment will be cared for	[]
People will be safe, in their homes and in the community	[x]
Residents will be proud to live in Havering	[]

SUMMARY

The London Borough of Havering (LBH) have worked in partnership with Havering Clinical Commissioning Group (CCG) and North East London Foundation Trust (NELFT) to design a new integrated Reablement and Rehabilitation service. This is an excellent opportunity to re-design how reablement and rehabilitation are delivered to remove duplication in the system and ensure a joined up approach for the service user. The new model is expected to enhance the quality and effectiveness of the service and therefore be of benefit to service users, supporting them to remain independent in their own home.

The chosen procurement route is a Prior Information Notice (PIN) for a period of 35 days, if there is no interest from other providers in the market then a Voluntary Ex Ante Transparency Notice (VEAT) will be issued with a direct contract award to NELFT. If other suitable providers do express interest, the process will switch to a full procurement exercise and Cabinet will be asked to consider the outcome of the tender process before award of contract.

The contract will be awarded for a period of 12 months allowing a full procurement process to take place.

The cost of the new integrated service will be met from existing budgets and the use of BCF funding.

RECOMMENDATIONS

In consideration of the content of this report, Cabinet is asked to:

- **Approve** the waiver of the Council's Contract Procedure Rules to allow the direct award of a Reablement contract to NELFT, if no other bidders respond to the Council's PIN notice;

- **Agree** to authorise the Director of Adult Services, in consultation with the Directors of Finance, HR & OD and Legal and Governance to finalise contractual arrangements with NELFT, should no other bidders respond to the Council's PIN Notice ensuring that all TUPE issues are dealt with accordingly to give effect to the new arrangement;

- **Agree** that the new model should be mobilised as soon as possible following contract award

- **Approve** the Director of Adult Services, after consultation with the Director of Legal and Governance to finalise arrangements to negotiate the early

termination of the current contract with Family Mosaic, in accordance with the terms and conditions of the contract.

REPORT DETAIL

1. Background

On 5th September 2016 an Executive Decision was taken by the Director of Adult Services to approve the following:

- The council will enter into formal discussions with NELFT to design a new integrated Reablement and Rehabilitation service.
- The Family Mosaic (FM) Reablement contract will be terminated early in accordance with clause 29.1 subject to agreement being reached with NELFT regarding the specification of the new service and costs and terms of the varied contract.
- LBH will enter into discussions with Havering CCG to agree the approach and prospective service design.

2. Service Design

LBH have engaged with all partner organisations to agree a new service model for the integrated reablement and rehabilitation service. Key stakeholders include:

- NELFT
- Family Mosaic
- Havering CCG
- Barking Havering & Redbridge University Hospitals NHS Trust (BHRUT)
- Service users

LBH have hosted a series of workshop sessions that have mapped the current pathways and explored in detail the opportunities for integration across the services. In addition to this Adult Social Care (ASC) commissioning staff have met with FM management fortnightly to manage this process, this has included detailed discussions regarding the current model and key learning points for the future. FM have been very supportive of the process.

FM entered a consultation period with their staff on 12th September. As part of this process the staff were notified that the contract was likely to terminate early and LBH were working in partnership with Family Mosaic and NELFT to explore the possibility of NELFT delivering an integrated service as a single provider. They were informed that if LBH reach an agreement with NELFT regarding the new service model and contractual terms then the staff would transfer to NELFT under TUPE. There would be no redundancies for Family Mosaic staff as part of the transfer.

NELFT have attended staff Q&A sessions with FM and the response from staff has been very positive. They are welcoming the changes and are pleased that the model is being considered carefully by LBH. Operational

staff attended the design sessions and in their input was invaluable when identifying issues with the current service and suggesting changes for the new model.

3. The case for change

The mapping of the current pathways for both services highlighted more duplication and fragmentation than originally thought, particularly if a patient is referred for both reablement and rehabilitation as part of a hospital discharge process:

- Four assessments by three different organisations
- Two separate referral routes - reablement referred via the Joint Assessment and Discharge Team (JAD) and Integrated Rehabilitation Service (IRS) referred via telephone triage. This results in duplication for the acute therapists.
- At the point the person has been discharged and is receiving support at home they will have had four different care planning documents produced.
- IRS and FM staff will be working to two different care plans with potentially a different set of goals, staff will only be aware of the other organisation delivering care/support if they come across each other in the patients home.

Engagement with staff has highlighted that the way the current service is contracted and delivered limits its success:

- Visits are usually limited to 30 minutes – this restriction does not allow for a 'reabling' approach especially in the mornings.
- The review process doesn't encourage earlier reviews with a social worker if it is clear the service user does not have reablement potential – this has had a negative impact on Family Mosaic's capacity to meet demand.

As part of the consultation for the Accountable Care System work with 3,007 public and 742 staff in summer 2016, there is clear desire for greater integration of services. 72% of public responses said they think closer working among health and social care professionals in their area will make the health and care services they receive better. Almost a third indicated that they are confused about the different health and social care services available in their local area. Those with Long Term Conditions, who have greater need for services, are the most confused about what services are available to them locally, with people feeling most confused regarding social care service. The conclusions of the Ipsos MORI research findings report indicate that:

- People want a more responsive, joined up system that delivers timely care closer to their homes
- Residents recognise the positives of more integrated working

4. The New Model

The overarching principles are:

- Integrated rehabilitation and reablement service provided by NELFT

- Options for rehabilitation only, reablement only or a combination of both services to achieve the goals identified at assessment.
- Access to the service via hospital discharge and from the integrated locality teams and the Community Treatment Team as a preventative model
- Single point of referral and triage in the hospital following one assessment from acute therapy staff
- Aligned assessment process for rehabilitation and reablement resulting in a single goal orientated care plan
- Service delivered by a range of staff with a varied skill set – rehabilitation assistants, therapists reablement staff, health care assistants
- Flexible review process – progress against goals continually reviewed and joint reviews with therapists and social workers as required.
- Stronger links with the community locality teams, care will be transitioned from the 'Intermediate Care' tier to the community.

The integration of the reablement and rehab services will not result in any change in the criteria for access to the service and therefore does not require service specific public consultation. The changes being made as part of the integration are process improvements ensuring a more streamlined experience for the service user. A change of service provider does not require public consultation.

5. Outcome Measures

The current contract is commissioned by the number of hours delivered but that is not the approach that will be taken with the new contract. Activity will be monitored by the number of people going through reablement and the focus of performance will be the outcomes of the individuals receiving the service. All service users will have a number of goals/outcomes agreed as part of the assessment process, achievement against these outcomes will be reported on an individual basis as agreed with the provider.

In addition to the individual goals, there will be a range of outcome based measures in the contract which are aligned to the ASC outcomes framework including:

- Number of people reaching 50%, 75%, 100% of their goals
- Service user satisfaction – perception of reaching goals and feeling enabled to live independently at home
- Number of people admitted/re-admitted to hospital during the period of reablement
- Number of people admitted to hospital within 91 days following the end of the reablement period
- Number of people requiring long term package of care following reablement
- Carer feedback – number of carers who report that they have been included or consulted in discussions about the person they care for

6. Benefits

The key benefits of commissioning and delivering reablement as an integrated service with rehab are:

- ✓ Reduction in duplication across the system from the assessment in the hospital to the review process at the end of service period
- ✓ One assessment and care planning process for those requiring both services
- ✓ Reablement and rehab staff working towards the same goals/outcomes with the service user increasing the likelihood of them being achieved
- ✓ The single referral point for triage will support the hospital discharge process
- ✓ Relationships will be strengthened across social workers. Reablement and IRS therapy staff resulting in improved communication and a move towards a trusted assessor approach
- ✓ There will be significant opportunity for cross organisational learning and the reablement staff will be integrated into the therapy team resulting in an improved quality of service
- ✓ Occupational therapists will add significant value to the reablement team in terms of assessment and goal setting.
- ✓ Drive towards outcomes will ensure every session with service users is focused towards them achieving their goals, reducing dependence and the need for support

7. Contractual Process

Officers considered a number of options for the re-provision of this service and have concluded that the most effective service would be the integrated approach proposed. By choosing to integrate with rehabilitation services, and to avoid duplicate rehab services operating in the same geographic area through different providers, it was decided that it would be most expedient to contract NELFT either directly or via the block contract held by the CCG. It is also believed that it is not in the best interests of patients to fragment that provision from the other community health services.

Although reablement is jointly funded via BCF monies the current service is commissioned directly by LBH and the contract is between LBH and FM.

BHR CCGs commission the Intensive Rehabilitation Service (IRS) as a part of the large block contract with NELFT and the specification is detailed within the ‘intermediate services’ section.

We have consulted with the North East London Commissioning Support Unit (NELCSU), the CCG and LBH procurement regarding the contractual options.

The chosen procurement route is to issue a Prior Information Notice (PIN) for a period of 35 days, if there is no interest from other providers in the market then a Voluntary Ex Ante Transparency Notice (VEAT) will be issued with a direct contract award to NELFT.

The contract will be awarded for a period of 12 months allowing a full procurement process to take place.

LBH will retain full control of the performance monitoring of the contract and will liaise directly with NELFT regarding monthly performance information.

If other suitable providers do express interest, the process will switch to a full procurement exercise and Cabinet will be asked to consider the outcome of the tender process before award of contract.

8. Cost

The cost of the FM contract originally was £1,609,400 per annum but in light of difficulties in fulfilling contracted hours there has been a reduction in cost, enacted through a variation of contract to £1,413,947in 16/17. Directly as a consequence of the capacity difficulties, additional homecare support ('emergency reablement') is being commissioned at a cost of c£260k in the year to October 2016, bringing the total annual cost of reablement to £1.60-1.67m. Family Mosaic are re-paying a proportion of the money associated with the undelivered hours, but this is not sustainable.

The cost of the new contract is set out below. The pricing has been provided over three years, although the contract term is for two years.

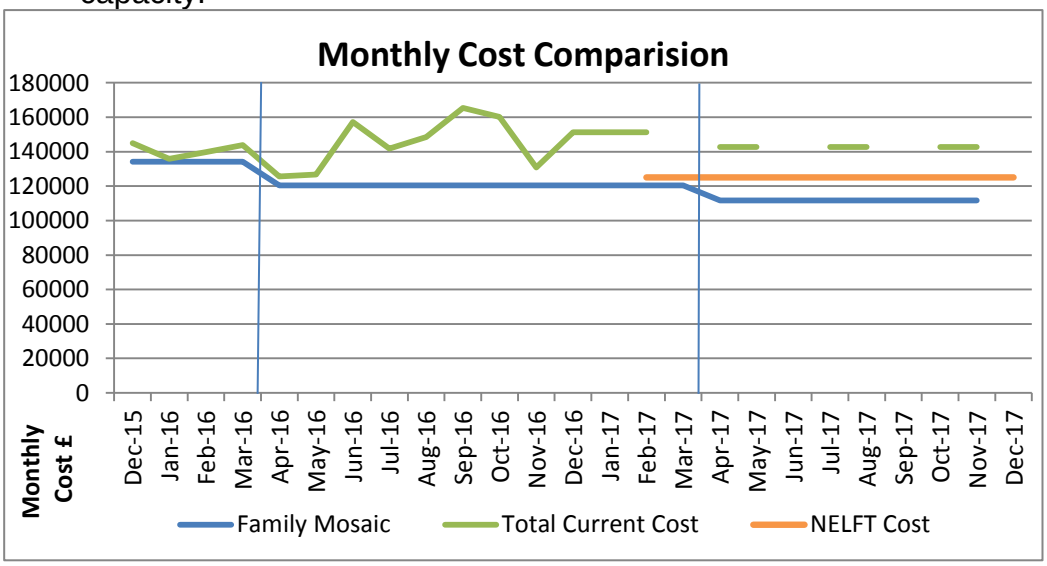
12 months cost (assumes start date 1st Feb 2017)	yr1	yr2	yr3	
	£1,500,467	1,529,819	1,583,711	
Financial Year	16/17	17/18	18/19	19/20
	£250,078	£1,505,359	£1,538,801	£1,319,759

The contract cost agreed for the new service of £1.5m includes an increase in the capacity of circa 30% and the requirement for a same-day response from NELFT which will support emerging requirements to manage the majority of discharges via the "Discharge to Assess" model while at the same time marginally reducing the overall cost of the current service. The Adult Social Care budget however will not reflect savings as the reduction in overall cost will reduce the budget pressure resulting from the unbudgeted emergency reablement costs.

The service is funded from the Better Care Fund (BCF) Section 75 Pooled Fund Agreement; the BCF is jointly funded by LBH and Havering CCG and the reablement service is specifically jointly funded on a 50:50 basis. Under the terms of the Section 75 currently, LBH draws down on the S75 pool to pay for the contract; this would switch to the CCG drawing it down in the future if they were to award the contract.

Although this contract is not for a specified number of hours, the notional effective rate per hour for care will reduce from £30.95 to £24.60.

Taking into account the block contract value and the additional spend on Emergency Reablement, the new service will represent an increase in contract cost but a reduction in overall spend. The staff capacity has been increased from c39FTE to c50FTE and the additional capacity in the new service is expected to remove the need for the emergency reablement capacity.



As described above, the service is currently funded jointly by Havering CCG and LBH from within the Better Care Fund section 75 pool. The Better Care Fund plan and pool will be reviewed according the schedule prescribed by NHS England.

The Adult Social Care budget will not reflect savings as the reduction in overall cost will reduce the budget pressure resulting from the unbudgeted emergency reablement costs.

9. Savings and Efficiencies

Although no savings have been expressly identified as part of the recommissioning of the service, it is anticipated that the improved service would enable the delivery of cost reductions within the Home Care expenditure. There is national evidence to suggest that the majority of reablement service users have a positive functional outcome following the intervention. The National Audit of Intermediate Care (NAIC) 2015 evidenced that 75% of people maintained their dependency level upon discharge when compared to the pre hospital level. For intermediate care and reablement services in particular success is determined predominantly by improved outcomes, level of dependency and patient reported experience and outcomes (PREM and PROM).

The University of York Social Policy Research Unit and the University of Kent Personal Social Services Research Unit carried out a longitudinal study exploring longer term impact of Reablement. The outcome demonstrated a significant decrease in social care service use for reablement service users

compared to home care. The costs of social care services used by the reablement cohort during the 12 months post discharge were 60% less than the costs of social care for people not receiving reablement. Whilst this is positive, the value of the data is limited due to it being based on a small number of service users. There is limited data nationally regarding reductions in homecare costs as a direct result of reablement and it is therefore not straightforward to demonstrate the relationship between investment and cost.

The reablement service is representative of Havering's demand management strategy and it is expected that there will be a positive impact on demand for homecare from the new service compared to the previous one. We have taken learning from our experience and responded to national policy initiatives to integrate reablement and rehabilitation into a single service which is an exciting development and puts Havering at the forefront of the integration agenda in this field. The current reablement service commissioned by LBH is resulting in 46% of people not requiring further care. In other areas figures up to 60% have been reported and we will be aspiring to improve. It should be noted however that these figures can also be influenced by the type of case that comes through the reablement service, their original complexity and their likelihood of recovery, illustrating the difficulty in coming up with categorical evidence of comparative impact. However with a throughput of 1,300 people a year in Havering, there is an opportunity to make a significant impact on avoiding or diminishing the need for longer term homecare support.

Whilst it is acknowledged that there are challenges with relating a successful reablement intervention with a cost reduction, every effort will be made to understand the impact of the service.

There will be a number of performance measures, monitored closely to determine the impact that will be applied to different cohorts of people that have gone, or will go, through different pathways, including:

a. Those who have received standard homecare (with no reablement)
b. Those who received reablement from Family Mosaic 2016/17
c. Those receiving support from the new reablement service

A cost comparison will be made between the cohorts to establish the impact the new reablement service is having. In addition to this, level of dependency prior to the intervention will be compared to the dependency level post reablement intervention. Performance measures, activity and cost will be monitored monthly and ASC will work closely with finance colleagues to use the available information to determine impact.

REASONS AND OPTIONS

Reasons for the decision:

The Care Act 2014 (Part 1, Section 3) requires that Local Authorities exercise their functions with a view to ensuring the integration of care and support provision with health provision and health-related provision where it considers that this would:

(a) promote the well-being of adults in its area with needs for care and support and the well-being of carers in its area,

(b) contribute to the prevention or delay of the development by adults in its area of needs for care and support or the development by carers in its area of needs for support, or

(c) improve the quality of care and support for adults, and of support for carers, provided in its area (including the outcomes that are achieved from such provision).

Reablement services are provided under a statutory duty in Section 2 of the same Act which stipulates that Local Authorities must provide or arrange services, resources or facilities that maximise independence for those already with such needs, for example, interventions such as rehabilitation/reablement services

This decision is necessary to enable the Council to commission a new integrated Reablement and Rehabilitation service in partnership with Havering CCG through the mechanism of the Better Care Fund. This is an excellent opportunity to re-design how reablement and rehabilitation are delivered to remove duplication in the system and ensure a joined up approach for the service user. The new model is expected to enhance the quality and effectiveness of the service and therefore be of benefit to service users, supporting them to remain independent in their own home. Finally, the revised service model is expected to enable the Council to respond to emerging models of hospital discharge processes and a drive towards prevention in the community.

Other options considered:

1. Do Nothing

This was not deemed as a viable option due to:

- There will be continued lack of capacity resulting in pressures on the rest of the market, this impacts LBH's ability to support effective discharge processes.
- There will be a continued requirement for emergency reablement which will result in financial pressure of approximately £260k until the end of the current reablement contract next November
- People who are eligible for reablement are not receiving it due to lack of capacity

2. Undertake full procurement process to re tender the reablement service

This option was considered and although it would provide an opportunity to re-design and re-commission the service there were some significant limitations:

- A full procurement process could take up to 8-12 months which would mean that LBH would still suffer the effects of the lack of capacity
- Commissioning a reablement service independently of the rehab service would mean that we continue to have a fragmented service resulting in duplication and inefficiencies across the system.

3. Undertake full procurement process to re-tender the reablement service as a joint, integrated service with rehabilitation

This option was considered but was not deemed viable because NELFT are currently providing all community services across BHR including rehabilitation. It would therefore not be advisable to commission a separate provider to deliver the rehab element if it was integrated with reablement. NELFT would be unable to bid for the tender as a separate integrated service because of the way they are contracted by the BHR CCGs.

IMPLICATIONS AND RISKS

Financial implications and risks:

The increased cost of the recommissioned service will be met from existing budgets and the use of BCF funding, with additional benefits of anticipated savings in future domiciliary care expenditure (currently not quantified). At present, Havering has to procure additional emergency home care from other providers resulting in budget pressures, the procurement will contribute towards the cost avoidance relating to the emergency provision, with the overall objective being to reduce the demand for Home care and enable more users to live independently in the community.

As mentioned in the body of the report, a good quality reablement service appears to contribute to a reduction in the need for home care unfortunately, lack of reliable data has meant we have been unable to ascertain the extent we can expect cost reductions. In this instance, the re-procurement was necessary as a short term solution to mitigate escalating expenditure on emergency home care and to re-procure a reablement service that provides continued access to care for those with “assessed” needs discharged into the community, especially from the clinical setting. The commissioners, operational teams and finance will work together to ensure the service meets its objectives, and agree to evaluate performance on an ongoing basis with several key objectives including the development of efficiency targets as more reliable data becomes available.

Risks:
There is a risk that the new service is perceived not to represent Value for Money as it has not been subject to a normal tender or procurement process. This is covered in Section 11.
It is possible that the Better Care Fund process changes, affecting the basis on which the service is jointly funded. In this event, a new and separate agreement and section 75 pooled fund would be required in order to continue to commission this service through the CCG.

Legal implications and risks:
The Care Act 2014 came into force on 1st April 2015 and provides an updated legal framework for care and support and introduces a number of new rights, responsibilities and processes. Of particular note is the new duty under sections 3, 6, and 7 of the Act which requires Local Authorities to:

- Carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health-related services
- Cooperate generally with relevant partners in performing their functions related to care and support and
- In specific individual cases cooperate in performing their respective functions relating to care and support.

The department's recommended option is in compliance with the Care Act 2014.

Any re-provision of services, including the integration of these services, must comply with the Care Act and its statutory guidance set out in pages 281-300 and Care Act regulations. Any market re-shaping of services must also take into account the main principles under the Care Act and its statutory guidance including the focus on outcomes and well-being, promoting quality services, including through workforce development and remuneration and ensuring appropriately resourced care and support, supporting sustainability and ensuring choice.
Local authorities must ensure their commissioning practices and the services delivered on their behalf comply with the requirements of the Equality Act 2010 and should encourage services that respond to the fluctuations and changes in people's care and support needs.

Such an agreement will support the Council in the exercise of its duties under s3 of the Care Act 2014, which establishes a duty to ensure the integration of care and support provision with health and health-related provision.

Health, social and other related services fall within the Light Touch Regime (LTR) under Chapter 3, Section 7 of the Public Contracts Regulations 2015 ("Regulations 2015"), as set out in Schedule 3 for contracts relating to health, social and other related services. Services subject to the LTR, with a contract value that exceeds the current threshold of £589,148 is subject to the full requirements of Regulations 2015.

The light touch regime provides an open and transparent process for procuring health, social and other related services but allows significant flexibility in the way that process is designed and implemented. The contracting authority can use its own processes and award criteria in a way that best suits the particular purpose and specific outcomes sought.

The proposed NELFT contract for the services set out within the body of this report fall within the LTR.

The award of the contract to NELFT would be a Direct Award Contract ("DAC"), the allowable reasons for a DAC are as follows:

i) Extreme Urgency;
ii) **Absence of tenders, only one bidder received or suitable bidders in response to an invitation to tender**;
iii) For reasons of protection of exclusive rights or technical reasons there is only one possible supplier;
iv) A direct award call off over £5,000 under a framework agreement.

If the Council receives no bidders after they publish its PIN notice, then it shall rely upon reason **ii**, listed above as justification for the award of the direct award contract to NELFT.

Human Resources implications and risks:
The recommendations made in this report do not give rise to any identifiable HR risks or implications that would affect either the Council or its workforce as the current contract is being delivered via an external provider. Any TUPE obligations or implications are the responsibility of the current provider and new provider NELFT.

Equalities implications and risks:
There are not anticipated to be any negative impacts arising from this proposal to current and future users of this service all reconfiguration stated in this document will lead to better accessibility and outcomes. In relation to the cessation of the current contract provided by family mosaic subject to the staff being TUPE'd across to NELFT there should be minimal impact on staff. Staff within the current provider organisation should be provided with access to relevant information that allows them to move to the new model of working and where required and any special needs that may be identified will need to be taken account of and measures put in place to allow staff to seamlessly transition to the new model The EIA gives further details.

BACKGROUND PAPERS

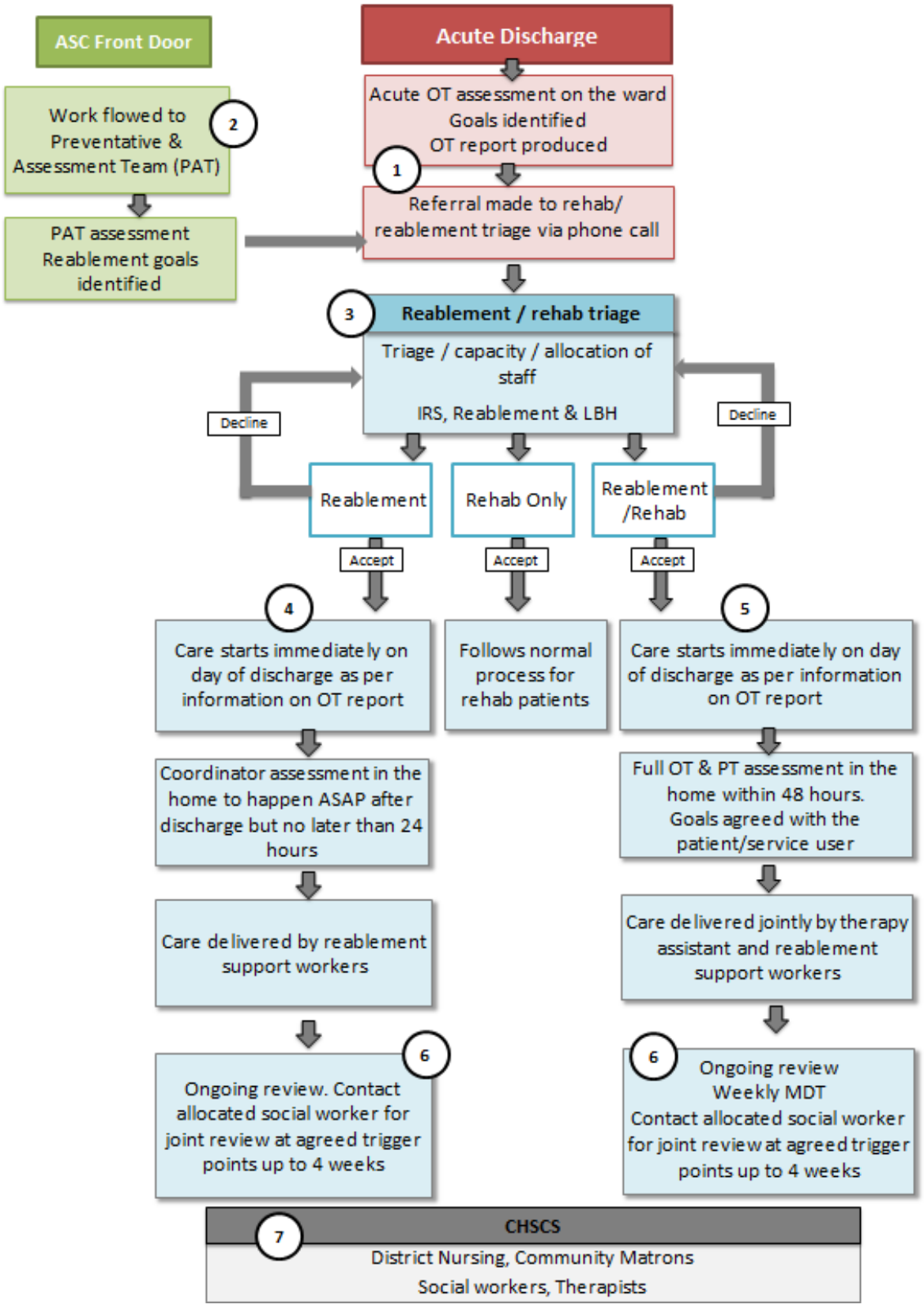
Cabinet, 14 December 2016

1. Home Care Reablement Service: Investigating the longer-term impacts (prospective longitudinal study) 2010, The University of York Social Policy Research Unit
2. National Audit of Intermediate Care 2015
3. Integrated Care in Barking and Dagenham, Havering and Redbridge, The Case for Change 2012
4. Ipsos MORI Social Research Institute “BHR Accountable Care Organisations: residents’ research findings from the Tri-borough survey (FINAL). June 2016

Appendix 1 – High Level Mobilisation Plan

1.	**Governance / contracts**	
1.1	Due diligence group meeting fortnightly	Oct – Feb
1.2	Operational group meeting fortnightly	Nov – Feb
1.3	Havering CCG Governing Body	Nov
1.4	Final specification agreed	Dec
1.5	LBH Cabinet	Dec
1.6	Contract award	Dec
1.7	Procurement process	Dec - Feb
2.	**HR**	
2.1	Consultation period	Sept – Oct
2.2	1:1 sessions with staff	Jan / Feb
2.3	Training needs identified	Nov
2.4	TUPE list agreed	Jan
2.5	Recruitment programme for vacancies	Jan
2.6	Staff added to ESR/Payroll	Jan /Feb
2.7	Welcome pack for staff developed	Jan /Feb
3.	**Operational**	
3.1	Service pathways finalised	Jan
3.2	LBH process changes agreed	Jan /Feb
3.3	Configuration of RIO to capture info	Jan /Feb
3.4	Documentation agreed	Jan /Feb
3.5	Agile working arrangement agreed	Jan /Feb
3.6	Staff to be added to all relevant NELFT systems	Jan /Feb
4.	**Communication**	
4.1	NELFT communications	Jan /Feb
4.2	LBH communications	Jan /Feb
4.3	External stakeholders communication	Feb
5.	**Performance/reporting**	
5.1	Performance indicators agreed	Jan
5.2	Recording mechanism agreed	Jan
5.3	Configuration of RIO for data capture	Jan /Feb
6.	**Implementation**	
6.1	New service ‘go-live’	Mar

Appendix 2 Pathway Design



1.Assessment and Referral – acute discharge
Reablement potential will initially be determined by the assessment carried out by the acute Occupational therapist (OT) in the hospital. Goals will be identified and an OT report will be produced. The JAD social workers will no longer re-assess the patient on the ward as this was a direct duplication of assessment. Referrals for reablement and or/rehab will be made to a triage team via a phone call.

2.Assessment and Referral – ASC front door
When a referral is made via the ASC front door the preventative and assessment team (PAT) will carry out a high level assessment in the persons home to determine reablement potential. If the person had reablement potential a referral will be made to the triage team via a phone call.

3.Triage
The triage team will include members of staff from IRS, reablement and ASC. Each referral will be triaged by a member of the team based on the information provided by the acute OT or PAT worker; it will be decided if the person required rehab, reablement or a combination of both. The referral will be accepted or rejected at this stage directly by the service. If, on occasion, there are issues with capacity within the reablement service the referral will be passed through to the brokerage team who will source care from another provider.

4.Reablement
If the person requires reablement *only,* care will start immediately upon the day of discharge. A full assessment will be carried out in the person's home within 24 hours, this will build on the information provided by the OT or social worker (if from the community) and will clearly outline the goals that have been agreed with the service user. Care will be delivered by the reablement support workers but they will have access to therapists from IRS if required for support.

5.Reablement and Rehabilitation
Care will start immediately upon the day of discharge as required. There will be a full OT/PT assessment in the person's home within 48 hours which will outline the goals for rehab and reablement. Care will be delivered by a combination of rehab assistants and reablement support workers who will work to a single care plan to help the service user achieve a single set of outcomes. The staff will be supported by the OT/PT as required.

6.Review
There will be ongoing review at every visit, for the 'reablement only' service users, this will align with the process for rehab review. People receiving reablement and rehab as a combined service will be reviewed weekly at a Multi-Disciplinary Team meeting. There will be a flexible approach to review timescales. The reablement support workers will alert the allocated social worker when a review is required to determine ongoing care requirements when people have reached approximately 70% of their goals, but, in any case, no later than 4 weeks after referral. The teams will also be encouraged to request a review with a social worker at an earlier stage if they have reason to believe reablement is not the correct service for the person.

7.Community Health and Social Care Service (CHSCS)
On-going care will be managed by the health and social care teams in the community which includes district nursing, community matrons, social workers and therapists. The CHSCS teams will also be able to refer into the triage team if a need is identified for reablement or rehab.

Appendix 3 - Risks

Risks associated with the recommendation of proceeding with the new integrated service model:

Risk	Mitigation
There is a market challenge on why the new service has not been tendered via a full procurement process.	The issue of the PIN will evidence whether or not there are any interested market providers.
A full procurement process, as a result of additional interested providers, would delay implementation timescales significantly causing an issue with capacity and service provision for the current provider.	Work would be required with the current provider to mitigate any impact. Increased emergency provision may need to be enhanced/increased.
The pensions arrangements are complex and may delay the implementation date	Work is underway already to understand the position and to form a possible action plan
Making changes to a key discharge pathway during a period of high pressure (winter) could disrupt the discharge flow.	BHRUT staff have been involved in the development of the model and are already aware there could be some changes to the pathway. The proposed model simplifies the current process for acute staff and is likely to be more efficient. Pathway and referral information will be clearly communicated to all stakeholders in the month leading up to 'go live' date
The implementation of the integrated service will result in some changes for staff delivering the service which could impact delivery in the first 1-3 months.	- Staff have been involved in the design process of the new model and are aware of potential changes. - Staff will be given as much information as possible regarding different ways of working prior to 'go live' so issues can be dealt with in advance. - There will be training opportunities with NELFT prior to mobilisation. - Additional management resource will be made available to staff in the first few weeks to deal with operational issues.
Process changes associated with implementation could result in the new provider not being able to take as many cases as required in the very short term	ASC commissioning will monitor this closely from the 'go live' date and will explore the possibility of commissioning additional capacity from emergency

following transfer of staff.	homecare providers in the event there is an issue with capacity over and above what is currently being experienced.
The planned 'Go live' for R&R coincides with the launch of the new active homecare framework. Although there are no significant process changes in Feb for homecare there is a risk that some of the providers will not meet the criteria for the framework and there will be reduced capacity.	Regular communications with the commissioner for the new homecare framework. There will be more information available regarding the number of providers meeting the criteria by the end of Dec so plans can be put in place prior to mobilisation of the new reablement model if required

There are also risks associated with **not** taking the recommended option and continuing with the current contract until Nov 2017

Service Delivery
It is likely that service delivery will either remain at current levels or continue to decline for the remainder of the contract term because there are issues with recruitment and retention of staff, the financial viability of the service to the provider is low. This will be increasingly difficult to manage both financially and in terms of finding capacity in the market to deliver the hours that Family Mosaic are unable to provide. There is not sufficient capacity in the market to respond to an increased demand for a prolonged period of time.

Financial
The ‘lost hours’ and the cost of providing alternative care results in a contract inefficiency.

Reputational
The consistent inability to deliver the required reablement hours holds reputational risk for both LBH and Family Mosaic