

**OFFICER DELEGATION SCHEME  
RECORD OF DECISION**

**TO BE UPLOADED TO THE INTERNET BY DEMOCRATIC SERVICES**

<b>Date:</b> 7 <sup>th</sup> October 2024	<b>Ref No:</b> 2254
<b>Responsible Officer:</b> Nikki Ledger, Commissioning Manager for Older People, Ageing Well, and Dementia.	
<b>Type of Decision (please refer to MO Guidance):</b>	
<b>Key</b> <input checked="" type="checkbox"/>	<b>Non-Key</b> <input type="checkbox"/>
<b>Freedom of Information Status:</b> <i>(can the report go in the public domain)</i> Yes	
<b>Title/Subject matter:</b>  Investment in the Intermediate Care Reablement Service.	
<b>Budget/Strategy/Policy/Compliance:</b>	
(i) Is the decision within an Approved Budget?	Yes
(ii) Is the decision in conflict with the council's policies, strategies or relevant service plans?	No
(iii) Does the decision amend existing or raise new policy issues?	No
(iv) Is the decision significant and/or does it meet the £100,000 threshold for recording?	Yes
<b>Equality Impact Assessment</b> [Does this decision change policy, procedure or working practice or negatively impact on a group of people? <b>If yes</b> – complete EIA and summarise issues identified and recommendations – forward EIA to Corporate HR]	No

**Background:**

The Intermediate Care Service in Bury is currently under review by the Community Commissioning Team in line with several wider reviews and new guidance which support the development of Intermediate Care nationally and across Greater Manchester.

The Bury Locality Intermediate Care Strategy 2024-2027 which is currently being developed, will provide the collective vision, strategic aims and outcomes for a range of transformed and integrated IMC services. The strategy is crucial to provide a clear agreed strategic direction for improving service integration, collaboration and outcomes for local people. At the core of this is the realisation that home is the place for people to be happiest in, and that therefore all our effort both collective and individually must be focused on an absolute home first philosophy across all services and commissions.

The national traditional view of what Intermediate Care is usually composed of four key service elements of which Reablement is one, this is support delivered in someone's own home or usual place of residence that aims to help them recover skills, confidence and independence. Mostly delivered by social care support workers and practitioners.

Over the last few years National Audit Office, Local Government Association and County Councils Network in association with Newton have produced several reports about the state of Intermediate Care from a national perspective.

They consistently report amongst, other issues that there are several blockages in the intermediate care pathway. In 2023, at least 1 in 4 people expecting to receive home-based intermediate care were delayed in hospital waiting for care.

Nearly a third (31%) of hospital attendances and 30% of admissions of older adults aged 65 or above were deemed to be inappropriate or avoidable. These people would have been better treated by alternative services in the community, such as primary care and community health.

Recently GM ICB initiated a conurbation wide programme to support the implementation of NHS England's Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge in each locality. This work will aim to go beyond the framework to develop what high quality IMC looks like, enhance integrated commissioning and improve outcomes for local communities.

**Reablement Challenges and Progress**

Given the above, the most challenging issue we face as an integrated system is the continual rising costs across almost all services but particularly in social care costs.

The second most pressing challenge is waiting times.

Currently, Bury locality has anywhere between 24 to 50 residents per day awaiting differing levels of IMC services. Residents are in hospital beds or in other

inappropriate locations across the wider Greater Manchester health and care system.

On average in Bury it takes 9 days from referral to the Reablement Team until they can start providing support, this can increase the effect of deconditioning of individuals.

More recently the Bury locality has completed several pathway improvements including those enabled by the National Dementia Discharge Integration Frontrunner programme.

The programme enlisted support from Reablement, IMC at Home, and utilised support from a commissioned care at home provider to speed up hospital discharge for a people living with dementia.

The ongoing impact is that from the 5 people who has gone through this test of change, 3 have remained at home with no adult social care needs, 1 has remained at home with their previous private care arrangement in place with no additional needs, and the 5<sup>th</sup> person remained at home for 8-months with no additional care before they entered a residential care setting, further analysis is required however cost avoidance has clearly been achieved in these cases.

The test of change has evidenced that a more intensive initial outlay and level of support and intervention, has stopped people needing several weeks of care.

In comparison, the previous D2A model shows that 82% of people would have had an ongoing care need by going through a traditional D2A bed-based model yet the home-based test of change evidences significant improvement in individuals ability to remain at home, without additional care needs, therefore reducing both financial pressure and impact on capacity.

With additional capacity within the Reablement Team, and the development of additional roles, the team can achieve more positive outcomes and expand the service to more residents of Bury.

### **Intermediate Care- Reablement:**

The Reablement Team has been in place for a significant period of time and supports with the step down of people from the acute, and enables them to return home more quickly, with planned intervention and reablement to enable the person to remain at home independently and reducing the need for ongoing adult social care support.

Since the covid pandemic the service now supports people who are more physically frail. This has been evidenced using the Rockwood Scale, people are now more frail due to the following factors evident in the locality.

- Increased Prevalence of Dementia and Delirium
- Increased and reoccurring hospital stays with Long Length of Stay.
- Reduced mobility
- Delays in diagnosis and access to primary/secondary care services & Long Covid

- Increased Mental Health needs.
- Re-occurring falls.
- Right Care/Right Place NHS long term plan acute needs met in community PowerPoint Presentation
- Cost of Living Increases – nutrition and hydration deficit – bariatric increases – advising not able to pay for support.

### **Capacity and Demand:**

With the increase in identified needs, we can evidence that 79% of people who are referred to reablement may be rehabilitated and remain in their own home, additional evidence that 92% of people supported by IMC therapy to remain at home. These factors coupled with new and emerging services in the community aimed to support self-care and hospital admission prevention make the case that Bury's reablement and IMC at home is good at supporting people at home.

In 23/24 of 660 admissions, only 26% of these people had an ongoing care need, compared with D2A models of support which showed 82% of people would have an ongoing care need. This evidences the rehabilitative impact the community based, home first model has across Bury residents.

The current staffing complement within the Reablement Team can deliver 1330 hours per week, in order to meet demand, we have been commissioning 250 hours per week from the independent sector. The additional hours being requested below will ensure capacity with the Reablement Team itself.

### **Productivity and System flow:**

To increase the productivity and system flow across IMC, continue to deliver strengths-based and outcomes focused support, and to meet with future projections of need, there is a request to invest in additional roles to create capacity and support demand.

An increase of 257.5 hours (7 WTE) per week at Grade 7 is required to support service demand. This will enable:

1. Streamlining of rotas to ensure sufficient cover at all times of service delivery.
2. Building coverage into the budget to ensure there are sufficient arrangements in place to fulfil operational capacity.
3. Development of annualised hours contracts which provide a flexible working arrangement to provide support during pressure points throughout the year.

In addition to this, we propose the development of 2 new roles, Care Transfer Coordinator (ECM and Capacity), and Business Support (to Include ECM Compliance out of hours) to support productivity, monitoring and efficiencies.

**Cost:**

Additional Grade 7 capacity (7 WTE)	£245,656
2x Grade 9 posts	£86,442.16
CQC Registration fees	£3334.39
<b>Total investment required</b>	<b>£335,432.55</b>

\*Calculated using new 24/25 pay rates

**Finance Implications**

The cost set out in this report will be funded by the Adult Social Care (ASC) Discharge Grant and therefore requires no additional resource from the Council.

As part of the monthly budget monitoring cycle, Finance and Budget holders will track the expenditure linked to the ASC Discharge grant ensuring that all expenditure aligns to the funding provided.

Any financial risks/pressures identified will be highlighted to the Director of Adult Social Services as part of the monthly budget monitoring conversation whereby an action plan will be deployed to mitigate any financial risks/ pressures.

**Our Recommendations are:**

To agree with the investment required to support the Reablement service to meet the demand of people exiting the hospital in an appropriate timescale, reducing the risk of deconditioning.

To agree with the development of additional new posts which will maximise capacity and increase efficiencies.

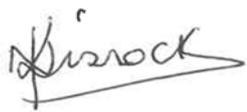
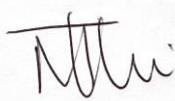
**Wards affected:** N/A

**Consultations:** N/A

**Scrutiny & Review Committee Interest:**

**Options considered:**

**Decision** *[with reasons]*

<b>Decision made by:</b>	<b>Signature:</b>	<b>Date:</b>
Executive Director – Health and Adult Care		13 November 2024
Section 151 Officer		08/12/2024
Director of People and Inclusion		19/12/2024
<b>Members Consulted [see note 1 below]</b>		
Cabinet Member		2 January 2025
Lead Member - HR		19/12/2024
Opposition Spokesperson		

### **Notes**

1. Where, in accordance with the requirements of the Officer Delegation Scheme, a Chief Officer consults with the appropriate Cabinet Member they must sign the form so as to confirm that they have been consulted and that they agree with the proposed action. The signature of the Opposition Spokesperson should be obtained if required, to confirm that he/she has been consulted. Please refer to the MO Guidance.
2. **This form must not be used for urgent decisions.**
3. Where there is any doubt, Corporate Directors should err on the side of caution and seek advice from the Council's Monitoring Officer.