Discharge Centres

Care Units in Care Homes

Short term, rehabilitation and reablement care

December 2021

Introduction and context

- This framework is published to support new surge capacity using care homes to support those (predominately older people) who can recover/ receive rehabilitation or reablement support instead of residing in a hospital bed.
- The new care units, to be established in care homes, can be used flexibly and will be suitable for people on pathways 1,2,3.
- Systems should use the framework to work with care home provider organisations to establish the care units at a scale to meet the demand from all those who are in hospital now and can leave, and the anticipated demand over the next 8 weeks.
- Up to 10,000 people per day do not leave hospital on the day they no longer meet the criteria to reside (no longer require acute care). A significant proportion of those have a long length of stay and remain in hospital due to the lack of availability of ongoing packages of care, including the lack of access to short term bedded support.
- Many systems may already have a similar service implemented or are in the process of implementation. This framework describes the model, covering the care home units as well as the ask on health and social care organisations.
- The local plan should support implementation of the units as soon as possible; enable discharges into these units and ensure the necessary wrap around of health or therapy input that will improve outcomes following the intermediate or short term support.
- The model would need to be commissioned and implemented in every system, funded from existing CCG funds or via the national discharge monies available to systems and regions.
- It is essential that we reduce the numbers of patients delayed in hospital settings as soon as possible to ensure there will be enough acute bed capacity to deal with any rise in numbers of people who are infected with the new variant of COVID-19.

Five actions for all systems

While further guidance and support will be made available to systems, the actions that systems should take now are:

1. Review discharge data to understand the demand for the service and bed numbers required now and for the next 8 weeks.

2. Agree the lead contracting authority (Local Authority or CCG) and work with care provider organisations to identify where there is capacity to stand up a care units and initiate plans to establish the service, with clear roles and responsibilities.

3. Review how therapist support can be made available to the service, either from NHS acute and community services, or from the independent and third sector

4. The lead contracting authority to agree with care providers the tariff and contractual elements to ensure any unit prices are reflective of the market factors in the local area, workforce model and cost of delivering the service.

5. Identify community care co-ordinator(s) or care manager(s) to ensure people are moving through the bedded care sites in a seamless way and are discharged promptly home from the care unit as soon as they and services are ready.

The Cohort

- This model will focus on the following cohorts of people:
  - Are medically optimised for discharge and no longer meet the Criteria to Reside in acute care
  - Are not able to return home directly from hospital, even with community health, social care and/or voluntary sector support
  - Require a period of recovery/reablement/rehabilitation in a 24 hours bedded unit (up to 4 weeks) and likely to return home.
  - Have identified recovery/rehabilitation goals, that can not be met in a patient's own home and with clear outcomes expected following the period of short term support.
  - Those that do not require specialist rehabilitation beds e.g. stroke/neuro rehabilitation
  - Those that do not require 1:1 support due to significant cognitive impairment and or behavioural challenges*.
  - People whose needs are unknown but who may not as yet be able to return home.
- A benefit of providing short term, rehabilitation and reablement care in a smaller number of care homes but each care home providing a larger number of beds, is that it focuses the expertise and ethos in these units. NHS staff (therapists, GPs etc) can then wrap their support in a concentrated way around these units.
- People will be entitled to and should have access to the same nursing assessments, care and support on a discharge pathway to a care home as there would be on other discharge pathways.
- All care should be planned and delivered with a clear outcome in mind for the patient and plans for discharge home with little or no onward reablement support needs.
- Further information on the cohort is included within the draft specification.

** 'challenging behaviour is behaviour of such an intensity, frequency of duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities' - Emerson, E. (1995) Challenging Behaviour. Analysis and Intervention in People with Learning Difficulties. Cambridge: Cambridge University Press.)*

The care/service model and outcomes expected

- Care Home workers will support people to undertake the recovery/rehabilitation activities set out in action/therapy plans (generally led by the therapists). This will require a ‘rehabilitation mindset’ from Care Home workers working in the care units. See Appendix 1 for links to various resources that can help Care units develop this approach and ethos.
- Systems should provide other resources that can support people in the care units in their recovery and rehabilitation, such as trainees, physical activity specialists and local volunteers.
- Each Care Home will already have a named GP that will be medically responsible for all residents in the care home. Consideration should be given by systems in how to support GPs with the additional medical and administrative burden with the short stay residents (for example use of ACPs for the former, and sharing admin staff for the latter).
- Having remote on-call geriatrician support has shown real benefits to support primary, community and care home professionals to receive specialist advice in intervening in deterioration of patients, or urgent escalation of needs.
- A multi-disciplinary team should review patients at least once per week and include social workers to plan for the patient’s return home.
- Systems should identify a dedicated care co-ordinator to ensure length of stay in the care unit is managed and blockages to timely discharge home are eradicated.
- The key aim is to reduce deconditioning and deterioration of patients who may be waiting in an hospital setting or who are unable to receive rehabilitation and reablement support within their home settings.
- At the end of this period of recovery/rehabilitation, people should be able to return home, with minimal or no domiciliary care requirements.
- Systems and providers must collect, report and review measurable outcomes and activity data for the service, including:
    - Discharge destination
    - Length of stay (LOS)
    - Patient and carer/family feedback
    - Outcomes including any functional outcome measures
    - Service level data via national data mechanisms on key measures such as capacity utilisation, quality and outcomes.

A flexible and co-ordinated workforce

- To ensure a therapy wrap around for people who require reablement/rehabilitation, systems will need to work across both health and care partners to create flexibility in use of resources.
- Local workforce supply and demands will determine the precise mix of workforce available across the system from acute, community and independent sector health providers as well as drawing on community assets.
- To address the shortage of therapy workforce, systems should utilise a range of professions and other roles to supplement the shortage of therapists and ensure therapists are used in the most efficient manner that leads to improved care and outcomes for patients.
- Systems should also maximise use of therapy capacity available through the independent and third sector.
  - The Patient Discharge Framework includes rehabilitation and reablement services to support discharge. Systems should consider this capacity as part of its total available capacity for rehabilitation and reablement post-discharge and how best to use this and other workforce models to meet its population demand.
  - In addition, systems should consider any local frameworks that can be called upon to purchase therapy capacity from the independent sector; and make use of community assets where possible such as physical activity specialists, to supplement therapy input and plans. This should be part of a wider workforce strategy to ensure every patient is assessed and has an action plan, that the action plan is followed, and that the patient is being supported to recover, gain independence and be discharged home.

The Care Home units

- The Care Home will need to consider availability and access to suitable equipment for use in recovery/rehabilitation exercises for example, steps, parallel bars, weights, amongst others, should these be required to support rehabilitation of the patient. Sourcing and funding for one off items can be provided through the hospital discharge fund and agreed with the local Clinical Commissioning Group.
- Care units within a care home will need to develop a ‘recovery and rehabilitation mindset’ and ensure workers are able to support people in carrying out the rehabilitation activities.
- Care Home management teams will need to allow for the extra time to process admissions and discharges. These are complex activities and will require excellent communication and relationship building with individuals across the system. Commissioners should emphasise the requirement for this role.
- Care Homes will need to review insurance cover and might need to extend that cover for the new services.
- The Care Home will be required to provide information and data on key indicators via national mechanisms including the Capacity Tracker and into local data sources.
- Over time care units should be provided in dedicated wings/parts of a care home to ensure distinctiveness and ensure a dedicated staff group. This will support a reablement and recovery ethos that supports people to be independent, rather than undertake the tasks for people, as may happen in other parts of the care home with residents that live there permanently.
- Care home providers and local health and care systems should plan for these care units to be sustainable and flourish beyond the immediate winter period.

Commissioning, Funding, and Reporting

- The existing lead commissioner (CCG or LA) should (wherever possible) use existing contracts or frameworks to commission Care units in existing well run care homes. This will avoid lengthy procurement processes and not confuse/distort the local market with new commissioners.
- Further information will be provided on guide tariff to support local rate negotiations and support a financially feasible model that would incentivise implementation of the unit, but any tariff must be agreed and determined locally.
- Commissioning coordination activity is likely to include ensuring that primary care support, transportation, additional pharmacy needs and other staffing wrap around support is available to the care units operating in care homes. Further guidance will be provided on these areas soon.
- The funding of the service (care unit weekly costs and broader cost of staffing support) in each ICS can be drawn from CCG expenditure budgets; the Hospital Discharge Fund, supplemented (if necessary) from regional discharge budgets.
- There must local oversight and leadership agreed across health and care partners, with support from the national discharge and community health team.
- Data capture connected with length of stay; outcomes; discharge destination etc will be introduced initially through Capacity Tracker, and potentially via a specific SITREP collection for each care unit

Critical success factors and dependencies

- There are good examples of similar models already commissioned by local teams and care providers who have experience in providing recovery/rehabilitation or reablement services. The useful learnings from around the country will be available and provided from the beginning of January as short modules, and the national team will support systems in sharing good practice, to expedite implementation of new units.
- Critical to the success will be:
  - A home-first ethos with a focus on home as the onward destination
  - Successful recovery and rehabilitation of people
  - Avoidance of people being admitted back to hospital
  - Maximising recovery and rehabilitation and minimising the need for long term domiciliary care packages when discharged home
  - Local system partners working together to ensure a flexible workforce, to maximise capacity and to identify new models – sharing resource and cost to get the best outcomes possible for people
  - Trusted, aligned Care Home providers with a recovery and rehabilitation ethos and mindset
  - Clear communication flows from Acute to Care Home to Social Care, including with primary care
- Key interdependencies include:
  - The availability of therapists such as occupational and physiotherapists, dietetics, speech and language therapists, to provide recovery and rehabilitation support in the care units
  - The availability of continuing health care workers and social workers to support long term care planning in an timely manner on discharge
  - The availability of voluntary sector support and where necessary, care packages to discharge people home with

What this means for…

Care Homes

- Review capacity and infrastructure – is there a distinct unit available
- Determine costs and commercial offering for discussion with commissioner
- Discuss contract with Commissioner – focus on specifics of who is doing what
- Ensure clarity in role and responsibility and commitment to an ethos of rehabilitation or identify mechanisms to improve rehabilitation ethos
- Work collaboratively with the professionals and others who are supporting the care, recovery and rehabilitation of patients
- Manage the administrative aspects of admittance and discharge, and provide required data in timely manner
- Implement requirements for reporting and monitoring
- Implement IPC processes and protocols

Provider Trusts

- Ensure Transfer Hubs and D2A teams are aware of the service and the cohort of patients that can be referred in
- Work with commissioner and other partners to determine who will provide necessary services and resources – including therapist and geriatrician support / input
- Ensure clear instructions and information is provided to support timely care within the care home
- Review current workforce to determine whether workforce can be released in part or used flexibly to support the units

Commissioners

- Agree a lead contracting authority
- Work with Trusts, Local Authorities and Primary Care to determine requirements – beds and services
- Identify care home providers and geographies and support clear communication and pathways for flow between services
- Ensure reduced inequalities in access, for instance ease of implementation in rural versus urban models
- Agree tariffs and contract for units with Care Home providers
- Commission additional services as required (e.g. from GPs)
- Identify care coordinators (or similar) to ensure effective process and service delivery
- Provide oversight and performance management locally – working jointly with partners - and provide data and information to national oversight

Appendix 1: Improving outcomes through the ethos of rehabilitation

There are several documents that describe the principles and ethos of rehabilitation and the links below sign post to these resources, which should be used in parallel.

This section is intended to support care home providers to ensure that the rehabilitation service they provide is delivered through a workforce that understands the rehabilitation ethos required to maximise patient outcomes and independence following a short period of rehabilitation support.

Resource	Description	Link
1. Social Care Institute for Excellence (SCIE) - Role and principles of reablement	Provides an overview of the role and principles of reablement in the social care sector. It describes the roles and principles of reablement, the different models used to deliver it, and illustrates the shift from traditional home care towards personalised, outcome-focussed care and describes the principles of effective reablement.	https://www.scie.org.uk/reablement/what-is/principles-of-reablement
2. NHS Community Rehab Tool-kit	A toolkit encompassing guidance and best practice, including NICE, Ageing well Programme and NHS England commission guidance for Rehabilitation.	nhs-rightcare-community-rehab-toolkit-v12.pdf (england.nhs.uk)
3. Home First, Act Now Programme	The aim of this eLearning programme is to increase awareness around Home First Principles in the Discharge Policy. The programme supports health and care professionals involved in the discharge process, to act in a way that values patient time and helps facilitate safe and timely discharge. It is developed for a range of health and care professionals including nurses, AHPs, care staff and students across NHS providers, commissioners and social care.	Home First Act Now - elearning for healthcare (e-lfh.org.uk)
4. Skills for Health	A suite of online, interactive mobile-first training courses that fulfil NHS statutory and mandatory training and enhance learning outcomes.	elearning NHS Skills for Healthcare eLearning for Healthcare and NHS
5. ECIST Youtube channel	A range of videos sharing examples of good practice	ECIST1 - YouTube