INTERMEDIATE HEALTH & SOCIAL CARE SERVICES IN DONCASTER

CORE SERVICE DESCRIPTIONS

Information provided by; DMBC, RDaSH and DBHFT (at April 2015)

Description of Key Intermediate Health and Social Care Services.
Service Area – 1. Assessment Services

Service	1a. Hawthorne Assessment Ward
Provided by	RDaSH Service Lead; Sarah Pinder, Senior Sister.
Commissioner	DCCG
What is the service role?	During the intermediate care review the service model has changed from a step up facility plus 6 Cap beds (Hawthorne) and a step down facility (Hazel) to provide separate assessment and rehab units. **Assessment Unit (Hawthorne Ward):** • Assesses step up patients to identify intermediate care need to enable supported independent living and avoid inappropriate and unnecessary acute admissions. • Assesses all step down patients from acute sector for appropriate rehabilitation and re-enablement. • 18 bed ward, accepts referrals 24/7 with a target maximum stay of 7 days **Common to both Hawthorne and Hazel Wards:** • A nurse led unit staffed with a MDT including physio, OT and have access to pharmacy, dietician, SALT and IDT social worker • Frances Street Medical Centre provides contracted GP medical cover available 8 - 6pm Mon - Fri. • Out of hours service is utilised as necessary from 6pm to 8am • Nurse practitioners work Monday – Friday, 8am – 5 pm to support the triage of patients, diagnosis, assessment and prescribing for patients. • Pharmacy services contract with Lloyds Pharmacy services in line with the whole of RDaSH • Member of IDT rotates into assessment / rehab unit • Liaison with Community Matrons, Heart Failure Nurses and Emergency Care Practitioners to improve patient care, communications and facilitate seamless transfer between services "
Where is the service based / provided	• The service is based and provided at Hawthorne Ward, Tickhill Road Hospital, Doncaster • Service lead; Sarah Pinder, Senior Sister / Ward Manager •
What is the service team structure and skill base?	• Staffing structure common to both Hazel and Hawthorne Wards: • Nursing 1 x Ward Manager, 1 x Band 6 RGN Lead ?? X Band 5 nurses • Occupational Therapist 1.4 x band 6 1.5 x band 5 • Physiotherapist 1 x band 6 (managed by Falls) 1 x band 5 vacancy currently being recruited & this is covered by locum. 1 x Rehab Support Worker (Support Workers are HCA with additional competencies and training to support the rehab function). • As at 13.04 15 recruiting to 6.75 band 2 and 4.23 band 5 vacancy. Some of these are new posts to meet the needs of the service. • The new model is under review, the skills and competencies required for staff and the Trusts roles & responsibilities have been mapped against the existing skills of staff. Management is working with clinical educators to ensure that all staff achieve the competencies required to deliver the service.
What is the service access criteria?	• Patient has to be a Doncaster resident with a Doncaster GP. • Patients need to be medically stable not requiring medical input beyond that of a GP. • Ward can take patients with any condition including those suffering from dementia and cognitive impairments, providing that their needs can be safely met by the service • Admitting patients need to understand and consent that they are to take part in a re-ablement / rehab programme. If they are unable to consent then a best interest meeting would be required.
What is the service exclusion criteria?	• Patients that are close to end of life • Patients with complex mental health problems.
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources; • Referral phone line available - open 24/7 for admission. • IDT referrals for step down from acute trust • Step up referrals from Primary Care, DN or locality teams

Service	1a. Hawthorne Assessment Ward
Provided by	RDaSH Service Lead; Sarah Pinder, Senior Sister.
Commissioner	DCCG
What is the Client profile?	• Mixture of elderly male and female - predominately female
What systems / processes are involved?	• Referrals are made by calling a dedicated phone number that is available 24hrs/day • The phone is held during core hours by senior members of staff (OT's, Physio's, who are rota'd) • In non-core hours the phone is manned by the RGN in charge of Hawthorn ward and referrals are made via this number. However, the numbers of referrals out of hours are rare. • The Lead Manager of the day is responsible for bed management • When the referral call is received the Lead takes the patients details, makes an assessment for suitability and records all details onto a ward referral document. • Additional information may be requested from the referrer, this can be faxed to the ward and includes; *FOR STEP UP* – A copy of either a signed medication list or a FP10, a covering letter, 7 days' supply of boxed medication (NOT NOMAD) *FOR STEP DOWN* – 28 days' supply of boxed medication from the DRI pharmacy, a signed discharge letter which includes a list of the current medication which the patient is taking. A copy of the IDT assessment. • If the patient is not appropriate for the service the referral is signposted to a more appropriate service / facility. • The referrer is requested to book transportation for the transfer. • If a bed is available the patient will be transferred asap, this can be done within 2 - 6hrs for Step Up patients and 24 - 36hrs for Step Down patients. • If a bed is not available, the patient is placed on the ward waiting list with the aim of transferring the patient to Hazel within 48hrs • All patients will have physio & occupational therapy assessments where personal goals and plan for rehab is agreed. • GP attends a Thursday afternoon ward round. • Hawthorne has twice weekly MDT meetings to discuss all patients care needs • Nurse Practitioners are the first point of call before the GP is contacted and they support the GP on the weekly ward round. • Upon completion of assessment by Hawthorne patient can be either discharged back to the community with or without a package of step up care or admitted to Hazel Ward for bed based intensive intermediate care support • No formal step up assessment pathway available to referrers or service users • Service follows standard discharge pathways to other health and social care providers
Which patient / client pathways would the service utilise?	• No formal step up assessment pathway available to referrers or service users • Service follows standard discharge pathways to other health and social care providers
How does the service monitor/measure performance?	• Service has a performance dashboard and is monitored at an operational level by modern matrons and ward managers and is shared with services and commissioners • Hawthorne Ward performance data, April - Oct 2014 Bed occupancy - 90% Average LOS - 12.8 days % of patients staying > 42 days - 0% • Systems for E-rostering and budgetary control are currently under review
What organisations does the service interact with?	Service interacts with all other health and social care providers including; • DBHFT, Rotherham and other out of area hospitals, Local Authorities, YAS • CAP beds • Residential homes. • RDASH support services • Mental Health teams. • Mexborough Rehab
Who does the service link with?	• CICT • Planned and Unplanned District Nursing • ECP's • GP Practices • IDT • STEPs
What is the patient's greatest need?	• Access to the most appropriate service to support the treatment of the patient's condition / crisis.

Description of Key Intermediate Health and Social Care Services.
Service Area – 1. Assessment Services

Service	1b. Rapid Assessment Pathway Team (RAPT)
Provided by	DBHFT / DMBC Service Lead; Laura DiCaccia, Senior Manager, DRI Physiotherapy Dept
Commissioner	DCCG
What is the service role?	• RAPT is a team of social workers and therapists who identify patients in ED (Emergency Department), CDU, AMU (Acute Medical Unit), SAU that have potential to be assessed, treated and or supported at home or within the community, thereby avoiding an acute admission. Patients can be admitted directly to other IC services as required. This includes direct referral to pathways including Positive Step/ MMH. For patients who require admission to an acute hospital bed, the discharge planning process is expedited. • Team work proactively with medical, nursing staff and the extended multi-disciplinary team to support and influence patient care decisions in all areas. They also work with staff to identify and signpost patients to the most appropriate pathway for discharge / transfer, but also admission e.g. patients who should be transferred directly to the Frailty Assessment Unit from the ED. • The RAPT team are able to provide necessary equipment for discharge the same day, at the point of contact and may also visit the patient the same day/day after to fit relevant pieces of equipment or assess the patient in their own home. • Working hours 8am - 6pm every day including Bank Holidays. • When a patient is assessed as fit to go home and discharged, a follow up phone call is made the next day to check that they are managing. A follow up visit or step up referral to Hawthorn or other IC support services (e.g. Falls) may be initiated as appropriate • RAPT can organise community equipment or increased packages health and social care. Liaising directly with STEPS, CICT, Hawthorne, Planned DN teams and Local Authority for Social Care • As part of the Integrated Discharge Team, the RAPT service has recently developed a Trusted Assessors model which is competency based, to ensure that patients have a full assessment to facilitate a discharge / transfer onto the most appropriate pathway using specified assessment criteria. The Trusted Assessor is also able to refer to any of the available pathways to prevent 'hand-off'
Where is the service based / provided	• The service is based at Doncaster Royal Infirmary and is provided within:- ED (Emergency Department), CDU, AMU (Acute Medical Unit), SAU • Service Lead; Laura DiCaccia, Senior Manager, DRI Physiotherapy Department •
What is the service team structure and skill base?	The RAPT staffing falls under the umbrella of Therapy IDT which is responsible for the following: • RAPT services outlined above • Ward therapy IDT discharge/transfer planning • Frailty Assessment Unit (FAU) • Complex Assessment Pathway patients • SLA for Physiotherapy input to Positive Step And includes; • 6 Therapists • 7 Therapy Assistants • 2 Social Workers • Trusted Assessors are trained to LCAT competency level • Staff rotate between Therapy IDT and RAPT to ensure continuity and consistency of skills and knowledge. • Usually have 2 staff on per shift for RAPT/Ward Therapy IDT and FAU • Presently 3 Band 6 vacancies - posts advertised and interviews planned
What is the service access criteria?	• No formal access criteria • Judgement made by A&E medical and nursing staff for referral • RAPT in reach to ED/CDU areas to screen and identify appropriate patients for assessment
What is the service exclusion criteria?	• Patient's that are not medically fit for discharge.
What is the referral source?	• It is only possible to make "step up" referrals (from DRI assessment units) Referrals usually come from the following sources; • A&E, MAU, CDU and SAU medical and nursing staff • Proactive patient searching by RAPT team.
What is the Client profile?	• Predominantly 65yrs+, frail and elderly who have fallen/at risk of falls

Service	1b. Rapid Assessment Pathway Team (RAPT)
Provided by	DBHFT/DMBC Service Lead; Laura DiCaccia, Senior Manager, DRI Physio Dept
Commissioner	DCCG
What systems / processes are involved?	• Referrals to the RAPT team are made directly by MAU, CDU, SAU and A&E by phone. • The RAPT team also visit and assess patients on MAU, CDU, SAU and ED to identify potential clients for transfer or signposting to other services. This is usually facilitated by medical and nursing staff that initially prioritises the patients. • RAPT are unable to assess patients that attend the ED from 6pm to 8am, but ED staff identify suitable patients for the team to assess the following morning on CDU /AMU for early next day assessment. • The service is therapy led but works closely with social care staff who inform assessments and suggest treatment / care options, including referral to other services • Following assessment a step up / step down / discharge plan is agreed and implemented. • Following discharge a follow up phone call is made the next day to ensure the patient is managing. If appropriate a follow up visit or step up referral to Hawthorne or other IC support services may be initiated • RAPT give priority to an A&E referral over general IDT ward work.
Which patient / client pathways would the service utilise?	• RAPT follows standard access and discharge pathways • Following assessment team will recommence existing H&SC services or send referrals to CICT/Steps for new input. This includes referral to MMH for further rehabilitation
How does the service monitor/measure performance?	• The service Clinical Therapy staff input on SystemOne, Social Work staff input on Care First • Capacity difficult to plan for, no regular patterns. Working in an unpredictable environment, this is challenging and pressure points are normally identified early in order for us to manage. • The service has been fortunate to have had additional funding for new developments eg. CAP beds and have worked differently to absorb additional demands. • The team undergo service evaluation regularly to enable us to plan services as proactively as possible. This is course reliant on staffing continuity ie. managing absences eg sick, maternity leaves • Estimate 140 patients a month seen by RAPT
What organisations does the service interact with?	• A&E, other DBHFT depts, community / voluntary IC services.
Who does the service link with?	• Service considers the RAPT model to be a good example of integrated working, and links DBHFT, RDASH and DMBC staff working together • The service links with all IC health and social care professionals
What is the patient's greatest need?	• Access to the most appropriate service to support the treatment of the patient's condition / crisis.

Description of Key Intermediate Health and Social Care Services.
Service Area – 1. Assessment Services

Service	1c. Integrated Discharge Team (IDT)
Provided by	DBHFT / DMBC Service lead; Debra Everton, Strategic Lead Integrated Discharge Pathway, DMBC A&C
Commissioner	DCCG
What is the service role?	• The team works on a transfer to assess model to facilitate complex discharges/transfer from the acute trust. • The aim of the service is to plan complex patient discharges whilst taking a holistic health and social care approach to ensure patient safety. •All complex discharges from the acute trust should be referred to IDT when the patient is medically fit to enable an initial IC assessment to be made in order to navigate patients to the correct intermediate care service in the health and social care setting. • IDT covers all DRI, Mexborough wards and Magnolia Lodge. • IDT will complete a patient follow up visit in the IC environment. • Team works as an MDT to assess discharge needs • No medical input into ward MDT other than from the consultant on the ward dealing with the patient. • 7 day service, 8am - 6pm Mon to Fri, 8 - 4 Sat & Sun. • RAPT is also part of IDT and provides a service into the emergency department to prevent inappropriate admissions.
Where is the service based and provided	• Service is based at Doncaster Royal infirmary (DRI) • Service is provided on the wards within DRI, Mexborough Montague and Magnolia Lodge. • Service lead; Debra Everton, Strategic Lead Integrated Discharge Pathway, DMBC Adults & Communities •
What is the service team structure and skill base?	• Strategic Lead appointed by DBH, RDASH and LA. • Social Care 3 deputy managers 14 Social workers 8 Assessment Officers • Discharge Nurse Specialists 1 band 7 7 band 6 • Therapy Staff - 10 • Mental Health staff 1 band 7 5 band 6 • Community Discharge Nurses 1 band 6 2 band 5 • Currently 6 nurses trained as Trusted Assessors with more training planned for both nurses and social workers. Trusted Assessor role is someone that is capable (and trusted to) interpret all the available medical and associated patient information and make a correct judgement in directing the patients intermediate care pathway. • RAPT is staffed by therapists, community nurses and 4 Social Workers (from IDT team)
What is the service access criteria?	• IDT accepts all complex referrals, including those from out of area (OOA). • No other access criteria.
What is the service exclusion criteria?	• All patients must be fit for assessment in order to ensure that discharge is planned in a timely fashion and last minute referrals to IDT are avoided.
What is the referral source?	• It is only possible to make "step down" referrals from the acute sector (wards) Referrals usually come from the following sources; • All referrals come from acute trust wards and Magnolia. • Out of area discharges access rehab services, social care and CAP through IDT.
What is the Client profile?	• Equal men and women. • Mainly elderly patients who are 70 plus but do have some younger patients.

Service	1c. Integrated Discharge Team (IDT)
Provided by	**DBHFT / DMBC** **Service lead; Debra Everton, Strategic Lead Integrated Discharge Pathway, DMBC A&C**
Commissioner	**DCCG**
What systems / processes are involved?	• Wards can ring the IDT office at any time with a referral where these will be picked up by any member of the team including the administrators. Wards that have queries about specific referrals are dealt with by the duty team between the hours of 09.30 - 11.30 and 13.30 - 15.30. • Each ward has a lead nurse who attends a daily morning Bed Meeting to update IDT on patient discharge plans • The Bed Meeting is managed by the IDT Band 7 Nurse Coordinator (IDT do not attend the ward MDT meetings). • Following the Bed Meeting the IDT team meet to discuss the work allocation. • Team members are not allocated to specific wards but are allocated to specific patients on an adhoc basis. • IDT go to the ward and undertake an assessment to complete the fact find document. • The fact find is then taken to the next IDT MDT meeting for discussion and allocation. • When the patient is transferred from the acute trust to a discharge unit, IDT continue to support the discharge process. • The programme is medically driven for patient safety, hence nursing assessments are completed first, however, the role of the Trusted Assessor is currently being developed to enable therapists and social workers to undertake initial assessments. • Patients can stay under the management of the IDT for up to 28 days through their IC journey, eg. IDT social workers attend Hazel and Hawthorn weekly MDT meetings to discuss needs and progress for discharge.
Which patient / client pathways would the service utilise?	• The service perceives there are two pathways - discharge planning and rehab. • Main onward IDT referral options include - Mexborough Montague Rehab Unit , Hawthorne / Hazel Unit, Rose House, Positive Steps (at Home Covert, Bentley and including Rowena and Oldfield) and CAP beds. • IDT do not accept referrals for patients with low level / less complex discharge needs. Wards refer directly to SPOC for these patients (IDT do not refer to SPOC for STEPS or CICT). • Occasionally a referral to SPOC might be considered inappropriate for CICT/STEPS and would be sent back to IDT for reassessment. • Social workers in IDT will undertake assessments of dementia patients for SPOC • All discharges are closed down on clinical system and passed to Area Community team for ongoing care
How does the service monitor/measure performance?	• Performance and quality data is captured electronically on a regular basis and is provided to the Performance Officer at DMBC. This data is analysed, measured against KPI's and reported. •Average report length of stay in the service is currently 28 days. • 3197 referrals in 2013/14. • 266/mth. • Managing capacity and demand is a daily challenge for IDT
What organisations does the service interact with?	• Acute Wards at DRI and Mexborough • All IC services
Who does the service link with?	• IDT are an integrated health and social care team. • IDT are the interface between acute, community and intermediate H&SC
What is the patient's greatest need?	• Access to the most appropriate service to support the treatment of the patient's condition / crisis.

Description of Key Intermediate Health and Social Care Services.
Service Area – 2. Community Services

Service	2a. Emergency Care Practitioner (ECP)
Provided by	FCMS Ltd Service Lead: Gillian Gregory
Commissioner	DCCG
What is the service role?	• The ECP service was established in Doncaster in 2009 and is provided by FCMS Ltd, commissioned by the CCG. • ECP provides an urgent care service which sits between A&E / Ambulance Services and the vulnerable patients. • The objective of the service is to avoid and prevent A&E or acute admissions. • Patients are seen in the community or own home which helps diagnosis and decision making. • The service operates 24/7/365, aiming to respond within 2 hours. • The service is not locality based, calls are triaged by a working (on duty) ECP and allocated to nearest ECP.
Where is the service based and provided	• The service is based in the Mary Woolett Centre, Danum Road, Doncaster and also have a presence in the A&E department at DRI during out of hours • The service is provided in clients own homes and across the Doncaster community as required. • Service lead; Gareth Bennett, Head of Clinical Operations (SSAFA) •
What is the service team structure and skill base?	• 15 ECP's, all at least 2 to 3yrs relevant experience, paramedics / nurses. • 10FT staff, a few PT supplemented occasionally with Bank staff or agency • ECP's are advanced practitioners that deal with injury and illness in the community. • All ECP staff have additional post registration qualifications at degree level and beyond. • All can diagnose and make treatment decisions.
What is the service access criteria?	• Anyone - but service targeted at vulnerable groups in Residential Homes, Domiciliary Care, Prisons, Schools, LD Homes, etc
What is the service exclusion criteria?	• None
What is the referral source?	• It is only possible to make "step up" referrals from the community and A&E. Referrals usually come from; GP's, OOHrs, Care Homes, Ambulance Service (for non-emergencies) • Self referrals from selected COPD patients currently under Respiratory Nurse and patients with inflatable feeding tubes
What is the Client profile?	• Majority elderly, frail.
What systems / processes are involved?	• Referrals are made to the service by telephone call to 08448 706800. • This is answered by the duty Emergency Care Practitioner who is available 24 hours a day. • The referral is triaged by the duty ECP who either accepts it as a visit and gives clinical advice over the phone or re-directs it to the appropriate service or agency. • ECP treats patient • ECPs carry a limited supply of drugs for immediate dispensing, as required. • After the ECP intervention a copy of the clinical notes is faxed to the GP and other relevant services.
Which patient / client pathways would the service utilise?	• SSAFA recently contracted by DMBC to provide support and educational service to Care Homes, called the Best Practice Project. The project is currently being run as a pilot in 12 Doncaster care homes, evaluated by Durham University. Senior carers get 4hrs of training from ECP to aid appropriate decision making for medical/social referrals and help Care Home staff to justify / validate a referral to a specific service. Staff will be able to undertake simple tests to provide basic assessment information. A Passport system has been established ensuring skills learnt will travel with Carer from home to home. • Development of referral pathways required to support step up process. • Reactive ECP service - All referrals are by phone to a dedicated number, which is available 24/7. A senior clinician will answer and triage the calls as they come in. This person will be the allocated shift coordinator and manages the workload by clinical need, location of practitioners and KPI deadline. We are contracted to get to each visit within 2 hours, however our average is closer to 1 • COPD pathway - Patients are referred by fax from Community matrons, respiratory nurses and hospital at home scheme. No proforma. Acute contacts then come directly from the patients themselves through the reactive number • BGT (peg) pathway - Patient list is managed in conjunction with DBH and should hold all relevant patients in the Doncaster area. New referrals are added either by fax or email from Endoscopy at DRI. Routine appointments are then made by our admin and notified by letter. Patients then have an admin line for issues and call our reactive number for any acute problems, like the tube being pulled out. • All acute referrals are processed and acted on within 2 hours and the routine referrals are processed as they come in, with appointments made as necessary.

Service	2a. Emergency Care Practitioner (ECP)
Provided by	SSAFA (Soldiers, Sailors, Airmen and Families Association) Service lead; Gareth Bennett, Head of Clinical Operations (SSAFA)
Commissioner	DCCG
How does the service monitor/measure performance?	• 500 - 600 per month (contract KPI 500/mth) • Each ECP averages 5 contacts per day • Data collected and performance monitored against contracted KPI's, reported monthly • Paper based at the moment but considering full automation for next contract
What organisations does the service interact with?	• Interaction with all local health and social care organisations
Who does the service link with?	• No evidence of integrated working but links with District Nurses, Community Matrons, GPs, Paramedic Crews, Social Care,
What is the patient's /client greatest need?	The client needs support and assessment at time of crisis.

Description of Key Intermediate Health and Social Care Services.
Service Area – 2. Community Services

Service	2b. Short Term Enablement Programme (STEPS)
Provided by	**DMBC** **Service Lead; Kath Lindley, Registered Manager, Adults, Health & Wellbeing**
Commissioner	**DMBC**
What is the service role?	• Takes referrals from Acute Trust and the Adult Contact Team for patients who don't have care packages and who need support in their own home to regain independence. • Assessment for Social Care support need, activity of daily living needs or provision of low level of equipment. • Offer a programme of re-ablement support for up to six weeks which covers personal care and meals. Time allocated according to client need. • Regain their everyday living skills to live independently in their own homes. • 24/7 service.
Where is the service based and provided	• The service is based in Mary Woolett Centre, Danum Road, Doncaster • The service provides support in patients own home • Service Lead; Kath Lindley, Registered Manager, Directorate Adults, Health & Wellbeing, DMBC •
What is the service team structure and skill base?	• Head of Service • Registered Manager • Deputy Team Manager • 8 Case Managers allocated to localities - two for south Mexborough to Bawtry, two for East, Moorend, Thorne and Edenthorpe, Two for North and two for Central. • 8 Support Team Managers cover morning and evening shifts. • Support Workers - 84 working broadly in localities; 6 -2pm and 3 -11pm and DMBC have a night visiting team to cover nights 9pm-6am. Work in pairs. • All staff work a rotated shift pattern. • All members of staff have one or more of the following qualifications; Social care qualifications; Social care management; HNC; NVQ; QCS in social care.
What is the service access criteria?	• Medically fit for discharge and fit to be in care of GP. • Doncaster resident. • Over 18. • Able to manage at home without continuous 24 hour support.
What is the service exclusion criteria?	• Clients who require long term support or 24 hour complex care • Clients who already have a support package or a direct payment
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector) into the STEPs service. Referrals usually come from;• DBHFT• SPOC• Community Adult Contact Team (ACT) • GP's and other Health Professionals, families/neighbours.
What is the Client profile?	• High number of female patients to men. • 60 years +, occasionally see younger clients who might have had accidents. • Ethnic minority groups under represented.
What systems / processes are involved?	**Referrals are made from a number of sources for which each have a different method;** • Hospital referrals - made for inpatients who don't have a current support plan via a telephone call from the ward to SPOC. • Community Referrals - made to Adult Contact Team (ACT) usually by phone but can be made by fax, email, online via health, letters. • One Team Working – Case Managers attend these meetings, cases are discussed and referred to STEP's. The MDT professional would complete the STEP's assessment. • Hawthorne MDT – A Case Manager attends the weekly MDT where cases are discussed and suitable patients are referred to STEP's. The MDT professional would complete the STEP's Assessment • Rapid Assessment Discharge Team (RAPT) – Patients presenting in A&E are referred to STEP's. The Social Care Worker completes the STEP's assessment • Ward 16 stroke pilot - direct referral from ward to STEPS, Support Workers go on to ward to get an understanding of the patient prior to discharge, they become familiar with the patient, increased training for staff. **When referral received;** • Case Manager will triage the referral, undertake an initial assessment of patient needs and the development of a care plan to direct support workers to provide holistic care. • The assessment is passed to the Support Team Manager who deploys relevant support staff. • The service aims to get the patient home and assessed within 24/48 hours of the referral. Assessments are conducted between 8 - 8pm, 7 days per week. Continued……

Service	2b. Short Term Enablement Programme (STEPS)
Provided by	DMBC Service Lead; Kath Lindley, Registered Manager, Adults, Health & Wellbeing
Commissioner	DMBC
Continued…	• The patient is supported for up to 6 weeks after discharge • Case Manager would review at week 2 & 4 and make any necessary adjustments to the initial plan and refer for longer term care as required. The Case Manager would update the weekly MDT on progress • After 6 weeks referrals made to other relevant organisations as appropriate e.g. Brokerage Team if further ongoing care is required Other information; • Support workers are able to request equipment from DMBC supplies (ICES) for clients. All staff are trained to assess, prescribe and fit low level equipment • Support workers will prompt clients to take medications and how to use medication devices.
Which patient / client pathways would the service utilise?	• No specific pathways mentioned
How does the service monitor/measure performance?	• STEPS monitor their own data and have a dashboard including referrals, outcomes, sign posting. • Data sent out weekly and discussed with managers on monthly basis. • 1,400 - 1,500 new assessments per year. • 1,200 - 1,300 review assessments per year • Approx 20 patients per support workers caseload at any given time • The teams feel that they have spare capacity. • Capacity of Support Worker is flexible depending upon the complexity client and service need.
What organisations does the service interact with?	• RDaSH; Local Authority; Acute Trust; out of Area Hospital; third sector providers
Who does the service link with?	• Community Nursing teams, mental health teams; statutory/voluntary agencies e.g. benefits agency, Age UK etc. • Adult contact team; LA Brokerage Team; Wellbeing team; housing; social work teams; IDT; Falls team; Community Therapy teams; One Team Working
What is the patient's /client greatest need?	• Increasing self-confidence. • Provision of packages of basic equipment.

Description of Key Intermediate Health and Social Care Services.
Service Area – 2. Community Services

Service	2c. Community Integrated Care Team (CICT)
Provided by	**RDASH** **Service Lead; Mel Gibbons, Area Clinical Manager (Unplanned Care)**
Commissioner	**DCCG**
What is the service role?	* CICT was restructured during the summer of 2014. The Community Nursing element in CICT has been reconfigured into a planned and unplanned model, the rehabilitation/re-ablement element of CICT is now a stand-alone therapy led service. Unplanned Nursing is no longer integrated into CICT (Re-ablement) in daily responsibilities, but does provide support as part of planned/unplanned community nursing provision. • Patient rehabilitation is the main objective of the service, to make a physical change / improvement to a patient i.e. increasing the strength and / or range of movement, to re-enable and return the patient to an independent state with the ability to cope with daily living at home. • The service is delivered in the patient's own home environment (7am - 6pm) and is accessed through the single point of access (SPA which is open 24/7) • In addition to the re-ablement service provision, CICT also provide a Rapid Response service to support emergency care packages until a provider has been sourced and is able support the patient. This service is accessed through the single point of access (SPA). • The service is provided 7 days per week. Physiotherapists and OT's cover Saturday mornings, but the service is only "funded" for 5 days. Staff are rota'd to cover Saturdays and take time in lieu. • Target intervention period is 6 week, but is flexible as required and is reviewed approx every 2 weeks by MDT.
Where is the service based and provided	• The service is based at the Mary Woolett Centre, Danum Road, Doncaster • The service is provided in the clients own home environment across the whole of Doncaster • Service Lead; Mel Gibbons
What is the service team structure and skill base?	CICT has an integrated multi profession workforce comprising of: • Physiotherapists – 1 WTE Band 6 1 WTE Band 5 1 WTE Band 6 (supporting the rapid response/unplanned care Nursing Services) • Occupational Therapists - 1 WTE Band 6 (as of 13.04.15, have vacancies and are seeking to recruit 1 wte) • Social Care Co-ordinators - 1 WTE Band 6 (as of 13.04.2015, have vacancies and are seeking to recruit 1 WTE Band 5 Nurse to CICT) • Rehabilitation Assistants – 35 Staff (28 WTE) Rehab Assistants are unqualified but trained and skilled in the delivery of patient centred rehabilitation packages led by Physiotherapists and Occupational Therapists. They work across the whole of Doncaster, visits are planned and "clustered" to minimise travel. • Access to other Health & Social Care Providers via referral i.e. Speech & Language, Dietetics. • Call handler vacancies, currently recruiting. Call handlers support all Community Health activities.
What is the service access criteria?	• Do not have a formal, written criteria but generally follow the following principles; • Be over 18 years of age; • Be assessed as needing intermediate care and able to remain at home because they have a safe home environment which is appropriate for the delivery of rehabilitation and therapy; • Be medically stable and not in need of an acute hospital bed; • Reside in the Doncaster defined boundary and be registered with a Doncaster GP. Referrals will only be accepted from outside the boundary where a person is registered with a Doncaster GP and where they reside within a 10 mile radius of the defined boundary. • Be without significant cognitive and/or behavioural problems; • Be able to respond to and benefit from a programme of activity, physical therapy, treatment or an opportunity for recovery; • Require a time limited intervention; • Have a planned outcome of remaining in or returning to their usual place of residence.

Service	2c. Community Integrated Care Team (CICT)
Provided by	RDASH Service Lead; Mel Gibbons, Area Clinical Manager (Unplanned Care)
Commissioner	DCCG
What is the service exclusion criteria?	• Do not have a formal, written criteria but generally follow the following principles; • Children under the age of 18; • Persons with unstable acute medical conditions/ doubt over diagnosis; • Patients with diagnosed mental health disorder for which acute psychiatric inpatient is appropriate. • Patients with acute degree of disruptive behaviour which challenges services and which the community intermediate care team, with the support of mental health services, may be unable to manage their care effectively in the community. • Drug and Alcohol related issues; • Social Respite; • Convalescence
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector) into the CICT service. Referrals usually come from any health and social care professional, client or carer can refer into the service including out of area. • DBHFT
What is the Client profile?	•Majority of clients frail and over 65
What systems / processes are involved?	• Referral calls, emails and faxes for CICT Re-ablement and the Rapid Response service come through to the single point of access (SPA) at the Mary Woollet Centre, (01302 735700). • Calls from DBHFT for the re-ablement service follow the SPOC referral pathway, which is; • SPA call handlers will take details and pass the referral onto the SPOC Social Care-Co-ordinators for triage and scheduling to either CICT (for rehab / re-ablement) or STEPS (social care) as appropriate. • For Re-ablement and Rapid Response, a Physio or OT will attend the client's home to make an assessment, agree outcome goals and care plan with the client. • Rehab packages and treatment plans are prepared by the therapy staff and are implemented by the Rehab Assistants, usually in the home environment • An intervention should last for a maximum of 6 weeks (treatment time should be managed by exception). • Patients progress is regularly monitored, reviewed and progressed by therapy staff to ensure the patient goals and care plan outcomes are being achieved. • If a social care need is identified, CICT will refer on to STEPS.
Which patient / client pathways would the service utilise?	• There are no clear referral pathways into CICT for services other than the SPOC pathway for DBHFT
How does the service monitor/measure performance?	• In the period 2013-14 there were 626 referrals to the CICT service • Approximately 50 - 60 clients receiving rehab at any one time • Team use System 1 to record client outcome data • Data is collected by admin support team • Work is ongoing to identify appropriate performance management tools such as Dashboards and benchmarking.
What organisations does the service interact with?	• CICT have interaction with all other health and social care agencies and services
Who does the service link with?	• The service links with Community Nursing (planned and unplanned) and Therapy Teams, Community matrons, STEPS, Social Care, IDT, RAPT.
What is the patient's /client greatest need?	• There are no clear referral pathways into CICT for services other than the SPOC pathway for DBHFT

Description of Key Intermediate Health and Social Care Services.
Service Area – 2. Community Services

Service	**2d. Wellbeing Team**
Provided by	**DMBC** **Service Lead; Lisa Swainston, North Area Manager, Directorate Adults & Communities**
Commissioner	**DMBC**
What is the service role?	• The Wellbeing Service is a community support and sign posting service for low level social care provided across 5 Doncaster localities, co-terminus with Health. • The Well Being Officer role supports vulnerable people in the community who are predominantly not eligible for social care services (do not meet the criteria for Community Care Assessment and service provision), but may have low level needs and need support to maximise and maintain their independence and safety. • The aim of the Wellbeing Service is to build communities by establishing support structures for communities to support themselves in difficult times, for example, by setting up and facilitating community groups (seed funding is available), and recruiting volunteers to deliver low level social support. • Communities Teams are designed to support community wide involvement, interaction and participation. e.g. new libraries groups engaging with the wider agenda to link with smaller groups to provide facilities for the community, becoming social and community centres e.g. Dementia Friends. • Wellbeing provide an early intervention and prevention service, it takes enquiries from ward members and will seek to provide resolutions as individual and community issues arise, such as dealing with anti-social behaviour, meals on wheels, social isolation, advice on safety, security for vulnerable people, etc • Two Key Principles of the Well Being Service are:- 1) We should do all we can to promote people's independence, connections and wellbeing by enabling them to prevent and postpone the need for care and support 2) People's experience of care and support should be transformed by putting them in control and ensuring that services respond to what they want. • A number of new community groups have been set up in the neighbourhoods via the community area teams, to provide on-going support and guidance, encouraging social interaction by planning activities and providing an opportunity to make friends, aim to sustain positive mental/physical health through the activities delivered ensuring early intervention and prevention can be maintained. • Service regularly attends networking partnership meetings with i.e. Public Health and AGEUK to share information, improve ways of positive working with vulnerable members of the community, and identify gaps and barriers that vulnerable / socially excluded individuals are experiencing. • The Well Being Officers also promotes and processes applications to the Fund for Older People (FfOP) grant and the Adult Innovation fund, especially Making it Real and the SEED pot distributed through the neighbourhood teams. Grants help voluntary, community and self-help groups, whose members are predominantly over the age of 50. The Well Being Officer specifically manages and monitors the Fund for Older People, making sure that local community groups are aware of this funding and supporting them with applications.
Where is the service based and provided?	•The service has multiple bases across the Doncaster locality. • Front line teams in geographic areas coterminous with other DMBC agencies, working within communities and clients own homes
What is the service team structure and skill base?	New restructure will be implemented from 1st April 2015:- • Assistant Director – Communities • Head of Service • 3 Area Managers • 1 Wellbeing Manager (borough wide) • 8 Wellbeing Officer • 3 Additional Specialist Wellbeing Officers • 46 Stronger Communities Officers • 3 Facilitation and investigation Officers • Volunteers also recruited All team members have elements of the following: • Social care background. • Experience of the role. • Interpersonal skills. • Community Capacity Building and Engagement

Service	2d. Wellbeing Team
Provided by	DMBC Service Lead; Lisa Swainston, North Area Manager, Directorate Adults & Communities
Commissioner	DMBC
What is the service access criteria?	• Currently anyone assessed as having a low level of need measured against the FACS criteria, see below. Wellbeing is the early intervention and prevention offer – so any adult who may be socially isolated, vulnerable or potential to be so. • Fair Access to Care (FACs) criteria has 3 levels: *Low level (can manage at home quite well)* *Moderate (for people that are independent but struggle with daily tasks - STEPS would work with this cohort)* *Critical, high risk and high maintenance* • The new Health & Social Care act that becomes live in 2015 will make LAs focus on the critical population and may draw support away from the low/med.
What is the service exclusion criteria?	• If less than 3 social care "items" required it shouldn't get to Wellbeing Team (guideline). • If the social care need is high client will be referred to STEPS. • If already receiving a social care package. * Reviewed dependant on purpose of social care package and the need of the client.
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources; • Health and Social Care professionals via the Adult Contact Team (ACT) • Internal referrals from other LA community staff e.g. Wellbeing Officers, Stronger Communities Officers, partner organisations, police etc. • Referrals growing from intermediate care through STEPS, CMHT, IAPT, one team working, GPs, DNs , Physio's and OT's. • Self-referral via ACT • Neighbourhood Action Group(NAG) and Case Identification Meetings (CIM) generate referrals. •The caseload for the majority of referrals comes from Stronger communities Officers, Facilitator & Investigations Officers, Adult Contact Team, St Leger Homes, the Energy Team, Ward Members, external & internal Partners, South Yorkshire Police the Community Mental Health Team, family, concerned residents, carers and also self-referrals.
What is the Client profile?	• Anyone across the age range able to carry out daily tasks. • Generally elderly however age is lower for different issues e.g. Autism/ HIV and Sensory support is generally provided to younger adults • Dementia support is increasingly being provided to younger adults
What systems / processes are involved?	• Any individual or H&SC professional can make a referral by calling the Adult Contact Team (ACT) which is the single point of contact for the Wellbeing service. • The referral is triaged by the ACT for the appropriate service need. • Clients who do not qualify for formal social care services are referred to the Wellbeing Team. • The Wellbeing Officer will undertake an assessment visit to ascertain the full level of need. • The Well Being Officer ensures that clients are able to access information, advice and other low level social / preventative services and local activities, such as Chair based exercises, Knit & Natter groups, Drug & Alcohol Action Group, Cancer Buddies, Dementia, assessment around bathing, cook and eat, allotment/healthy eating grown your own projects, food banks and many more networking partnership meetings. • The wellbeing officer can also provide practical services i.e. Minor adaptations, home security, falls prevention directly. • They also build community capacity and development community activities and networks where none exist, in addition to signposting to what is already available in the locality.
Which patient / client pathways would the service utilise?	Few formal / written pathways exist however the sources of support are numerous, a few examples are highlighted below: • Service currently working with local outlets / public outlets to develop sustainable luncheon clubs with a view to these being managed long term by community volunteers. One area has worked in partnership with a local school to develop a 'Grow your own' initiative – where local residents have been encouraged to volunteer with the school to assist the school children to grow and manage vegetable and fruit plots in their local open spaces and unused gardens • 'Making every contact count' is a model for identifying need and raising awareness in relation to health and adopting healthy lifestyle behaviours, supporting the client to access support e.g. smoking cessation and the Healthy Weight Solutions service. • There is also extensive work around alcohol use and 'knowing your limits' also raising awareness regarding the link between alcohol and finances. continued…..

Service	2d. Wellbeing Team
Provided by	DMBC Service Lead; Lisa Swainston, North Area Manager, Directorate Adults & Communities
Commissioner	DMBC
Continued……	• Falls Prevention -The Well-being service has been involved in Fall and Falls prevention via involvement with Falls Prevention Strategy group and via the community's teams establishing a Falls and Balance group. The community area teams also promote and raise awareness during Fall Prevention Week in 2015. Work will run alongside a pilot undertaken with the Communities / Wellbeing – HEART – ACT services to identify and offer early intervention support to people using emergency / callout services due to falling. This will allow us to quantify some aspects on the ECP work on falls prevention as well as offer a more proactive service of support. • Food banks - Well Being Officers attend the Doncaster Food Bank Network donation sessions every third Friday (on a rota basis), providing an opportunity to access support / advice and/or signposting. The service have organised successful collections on behalf of the Food bank service and working with New Horizons organise and establish a food bank forum.
How does the service monitor/measure performance?	• Carefirst is used to collect productivity and performance data, which is analysed, reported and disseminated to management and staff. • Service currently utilising the "Quality of Life tool" for data collection and research processes to enable robust evaluation of effective interventions and support. • Weekly performance monitoring undertaken • Information cascaded down through the management structure and through staff one to ones. • Case studies are also carried out. • Formal assessment calls referred from Adult Contact Team (for those not eligible for service provision) – approx. 450 per annum. • Referrals of clients for early intervention and prevention work collected from community and lower level services is monitored and assessed. There are approx 500 individual contacts per month • Case load - 10 - 30 clients per Communities Officer at any one time.
What organisations does the service interact with?	• Any service agency that can add support and/or value e.g. Community Voluntary Service (CVS), New Horizons, Community groups, third sector, all agencies, etc • Some Wellbeing staff work with One Team Working MDTs but not universal - although the service is working towards this.
Who does the service link with?	• Progressing to more partnership working with Service providers, community and third sector to co – produce schemes going forward and to effectively facilitate seamless service provision. For example: Pilot for Doncaster Social Prescribing with CVS / South Yorkshire Housing. Winter Warmth and Food Bank Provision integrating with Public Health teams. • Integration with community officers within the community, social prescribing and partnership wellbeing schemes being developed. • formalising links with positive steps and re-enablement teams to support when customers are moving back into their own homes after residential / hospital stays.
What is the patient's /client greatest need?	• Social isolation - engagement with community groups.

Description of Key Intermediate Health and Social Care Services.
Service Area – 2. Community Services

Service	2e. Community Nursing
Provided by	**RDaSH** **Service Lead Unplanned Care; Mel Gibbons, Area Clinical Manager** **Service Lead Planned Care; Chris Eastwood, Area Clinical Manager**
Commissioner	**DCCG**
What is the service role?	• The service provides nursing, diagnosis, prevention, and treatment, including care pathway planning, medication management, promotion of health and self-care, disease prevention and the management of either acute or long term chronic conditions. • The service provides a 24 hour 7 day a week, planned and unplanned Community Nursing Service and is pivotal in supporting adults to remain in their own homes, maximising their independence and improving their health outcomes and quality of life. • The service plays a central role in assessment, care co-ordination and provision of general nursing care, aiming to optimise health and health improvement. • The service plays a fundamental role in enabling and supporting adult patients who choose to die at home at the end of their life. • The service provides a patient centred holistic approach working in partnership with individuals, families, carers, General Practice and other professionals, in statutory, independent and voluntary sectors, providing a range of interventions and services to assist individuals to maximise their quality of life, promote independence, assist them to make informed choices and improve or maintain their health.
Where is the service based and where does it provide the service?	• The service management team is based at Tickhill Road Hospital, Balby, Doncaster • However, service teams are based on a locality model around GP practices and are responsible for patients registered with those GP practices. • Services are provided to patients who are either temporarily or permanently housebound (based on clinical judgement). Services are delivered through clearly defined packages of nursing care, within the patient's usual place of residence.
What is the service team structure and skill base?	• The Community Nursing team consists of a mix of registered nurses, nurses with a degree in community nursing, nurse prescribers, support workers and administrative support who are appropriately trained, experienced and competent and autonomous within their own professional framework. • The service also has access to and support from a number of specialist community teams.
What are the service access criteria?	**Community nursing services will be provided to adults who:** • are over the age of 18 • are registered with a Doncaster GP • are temporary residents but not registered with a GP
What are the service exclusion criteria?	• See above • Where a patient has social care needs only (although this may not become apparent until after the initial assessment has been carried out), in which case the patient is appropriately referred onwards and discharged from the Community Nursing Service. • If a patient is referred for a one off intervention and the patient is not on the caseload of the Community Nursing Service and the intervention would normally sit within the remit of the primary care team (as this is commissioned under separate arrangements)
What is the referral source?	• Referrals can be made by service users, carers, health and social care professional ambulance services, police and 3rd sector.
What is the patient profile?	• The service provides nursing care, through identified packages of nursing care, for adults who have short term needs but who are housebound • Patients who have long term conditions or complex needs from multiple conditions • Patients that require palliative care at end of life.

Service	2e. Community Nursing
Provided by	**RDaSH** **Service Lead Unplanned Care; Mel Gibbons, Area Clinical Manager** **Service Lead Planned Care; Chris Eastwood, Area Clinical Manager**
Commissioner	**DCCG**
What systems / processes are involved?	• The service provides a single point of access (SPA) across Doncaster for all referrals which is based at the Mary Woolett Centre, Danum Road, Doncaster. • Referrals are made by telephone to the SPA. The contact number is 01302 735700 • Referrals to the service are triaged by a qualified nurse (with the right level of skills and competencies) and are assessed for eligibility and acuity based on agreed prioritisation criteria. **Referrals are to be accepted on the basis that the patient:** • Meets the requirements of the definition for access to the service who are either temporarily or permanently housebound • Can be appropriately treated by the service • Resides within the services geographical boundaries **Response times:** • All referrals will be triaged within one hour • Emergency referrals - within 2 hours • Urgent- within 4 hours • Un-planned- referrals received prior to 2pm will be seen the same day. Referrals received after 2pm will be treated as Planned and will be the next day. • Planned-next day
Which patient pathways would the service utilise?	• Any that are appropriate to care of the patient
How does the service monitor/measure performance?	• Specific commissioner KPI's have not yet been determined (June 2015) but will be based on the response times indicated above.
What organisations does the service interact with?	• It is mandatory that the nursing team attends MDT meetings for patients on their caseload with complex care needs and ensure systems are in place to ensure excellent interfaces with primary care teams to ensure integrated care delivery. • The case manager will ensure that regular communication is maintained with GP's and other health and social care professionals who have an active role in the delivery of the patient's care and the family as a whole and will be advised of a suitable alternative contact in the case managers absence. • Each practice will be linked to at least one case manager with the appropriate skills - and to facilitate continuity of care
Who does the service link with?	**The service has a whole system relationship across all health and social care providers and the independent sector, working in co-operation with;** • Primary and secondary care clinicians • Children's community nursing services • Commissioners • Local community teams • Inpatient facilities • Rehabilitation services • Reablement services • Social Services • Independent and voluntary sector as appropriate • Other services as agreed with the local Healthcare Community • Emergency transport / ambulance services / Emergency Care Practitioner's

Description of Key Intermediate Health and Social Care Services.
Service Area – 3. Community Beds

Service	3a. Mexborough Montagu Rehabilitation Unit
Provided by	**DBHFT** **Service Lead; Karen Minshull, Operational Manager**
Commissioner	**DCCG**
What is the service role?	• The unit is a state of the art facility and aims to be innovative in its approach to patient rehabilitation. • 56 bedded centre that delivers rehabilitation to patients referred from the acute trust. • Within the service there are a number of therapy interventions to aid home re-ablement that cover all aspects of daily living, from washing and dressing, to movement and transfers, climbing stairs, kitchen, bathroom, bedroom, garden. • The service also supports the carer e.g. teaches them how to use a wheelchair and appliances. • The unit is undergoing refurbishment currently but it will enable independent living to be assessed in safe ward environment in a self-enclosed flat/accommodation. • Up to 13 beds are intensive therapy beds for Stroke patients.
Where is the service based and provided?	• The service is based and provided at the Fred and Ann Green Rehabilitation Centre, Mexborough Montagu Hospital , Mexborough
What is the service team structure and skill base?	• 1 x Manager Band 8a – operational over the whole centre • Nursing Staff 2 x Band 7 4 x Band 6 30 x Band 5 23.5 x Band 2 2 x Band 1 for whole centre • Occupational Therapist. 1 x Band 7, team leader for therapy 3 x Band 6 4 x Band 5 • Physiotherapy. 1 x Band 7, Rehabilitation Co-ordinator 3.6 x Band 6 (0.6 for Falls out-patients), 4 x Band 5 • Medical cover - from GP medical trainees 9am – 5pm Mon to Fri, • Out of hours advice sought via MAU at DRI - 5pm – 8am Mon to Fri. Weekends and Bank holidays 10am – 3pm.
What is the service access criteria?	• Doncaster residents. • Over the age of 18 years. • Clear intensive rehab focus. • Patient to be medically stable and able to engage in rehabilitation process.
What is the service exclusion criteria?	• None Specific
What is the referral source?	• It is only possible to make "step down" referrals from the acute sector Referrals usually come from the following sources; • Referred via IDT from DBHFT. • Out of Area hospitals can also refer Doncaster residents for therapy via IDT. The referring trust completes a referral form which is faxed to IDT, then a consultant to consultant and/or therapist to therapist conversation confirms suitability of referral.
What is the patient / client profile?	• Predominantly over the age of 65 plus but covered patients from the age of 18 plus. • Balanced male and female population.
What systems / processes are involved?	• The rehab service in its current form is a new concept and the service recognises that referral systems and processes continue to be developed. • Patients that require intensive rehab are identified by IDT and a dedicated referral proforma is completed and faxed to the Rehab Centre. • Out of area referrals for Doncaster residents can also be made via IDT (by fax). • Senior clinicians (Rehab Coordinator, Ward Managers, and Ward Sisters) work a daily rota to triage all referrals and manage patient flow. Further information may be requested from the referring ward. • A Rehab Centre ward round is conducted each morning to confirm bed state and plan for each patient. • If a referral is considered inappropriate and is refused, the ward is informed. continued…

Service	3a. Mexborough Montagu Rehabilitation Unit
Provided by	DBHFT Service Lead; Karen Minshull, Operational Manager
Commissioner	DCCG
Continued….	• If the referral is appropriate the patients name is added to the admissions list. This list is updated at least twice a day. • Available beds are then assigned to newly referred patients. • The referring wards are then contacted to check that the patient is still suitable (i.e. still medically fit). If they are, the ward is asked to organise the patients transfer.
Which patient pathways would the service utilise?	• There are pathways for stroke patients • There are also pathways from the CAP beds for a small number of complex patients who have achievable rehabilitation goals.
How does the service monitor/measure performance?	• Service accepted 644 referrals during 2013/14 • Six week profile but unit is aiming to work to a 21 day turnaround. • The service has a performance dashboard • Mexborough performance data - Apr - Dec 2014 Bed occupancy - 83.7% Avg LOS - 26.7 days % patients stay > 42 days - 19.5%
What organisations does the service interact with?	• Upon discharge the service interacts with many organisations to ensure that patients continue to receive rehab in their own home environment, as appropriate including RDaSH, DBHFT, GP Practices
Who does the service link with?	• The rehab team work autonomously. • It has been agreed that a Social Worker from the IDT team integrates 2 days per week at the rehab centre to support patients with social care needs. • Community Physiotherapists and Occupational Therapists and, Nursing teams. • GP's. • Social Worker. • Voluntary sector.

Description of Key Intermediate Health and Social Care Services.
Service Area – 3. Community Beds

Service	3b. Magnolia Neuro Rehab Ward
Provided by	RDASH Service Lead; Louise Christie, Senior Sister, Neuro Rehabilitation Inpatients
Commissioner	DCCG & other CCG's
What is the service role?	• Magnolia Neuro rehabilitation Inpatient Unit works with people coping with a range of cognitive, physical and/or emotional symptoms following a severe brain injury, as well as other neurological conditions including multiple sclerosis and motor neurone disease (MND) and many other neurological conditions. • Rehabilitation is based on a neuro-behavioural approach and focuses on enabling service users to function more independently and participate in as many of their previous roles and activities as possible, while developing their lives with privacy, dignity and respect. • The service aims to provide an integrated rehabilitation service for adults with neurological diagnosis that will enable them to achieve their optimum and behavioural function, and adapt to newly acquired difficulties / changes in their condition, and; • Provide a consistent neurological rehabilitation approach throughout the 24 hour day to the achievement of rehabilitation goals • Assist the person to set and achieve their goals, relating to their rehabilitation as an inpatient and beyond • Assist in the specialist management of neurological symptoms through a range of therapeutic approaches medicinal, remedial and complementary • Ensure a safe transition between hospital and discharge, taking into consideration the patient's strengths and abilities and co-ordinating support from outside agencies to deal with long term care needs • Provide an advisory and educational service that promotes the effectiveness of rehabilitation
Where is the service based and provided?	• The service is based at Magnolia Ward, Tickhill Road Hospital inpatient facility. • The service also provides an outreach service to the community
What is the service team structure and skill base?	• Medical cover - Consultant (from DBHFT on a Service Level Agreement) Mon - Fri, 9 -5 (Wed is a half day) • Consultant level Neuro psychologist x1, plus Clinical Psychologists. • Band 5 and 6 registered nurses • Physio's, OT's. • Band 2 Rehab assistants • Shift patterns - Early 2 Registered Nurses plus 3 Rehab Assistants; Late 2 Registered Nurses plus 2 Rehab Assistants; Nights, 1 Registered Nurse plus 2 Rehab Assistants • Plus access to local services such as Dietetics, speech therapy, social workers, etc, and regional teams assistive technologies (Barnsley), Spasticity Management (Sheffield). All the above work within the Neuro service as specialists.
What is the service access criteria?	• Patients must be aged 16 and over, residing within the geographical boundary who are either registered with a Doncaster GP or not, or within 10 miles of the Borough boundary and registered with a Doncaster GP. • Service accepts patients who have a diagnosis of a neurological condition or rehabilitation needs, for example brain or spinal tumours, including patients with non-organic diagnosis who are suitable for neuro-rehabilitation. • The patient's neurological condition needs to be currently contributing to their present problems, and there needs to be evidence that neuro-rehabilitation is an appropriate service that is likely to meet their needs in line with the above objectives. • Patients must be medically stable and ready to commence neuro-rehabilitation.
What is the service exclusion criteria?	• Service would not accept a referral for a patient currently awaiting discharge
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals from the acute sector. • Majority of referrals step down from the acute sector, direct from medical and surgical wards, and critical care. • Some referrals step up from GP's, Community MDTs, and the Neuro Outreach Team. • Referrals from other NHS commissioners across Yorkshire and Humber region are taken
What is the patient / client profile?	• The ward cares for people aged 16 and over, who have a neurological condition or injury and need rehabilitation in an inpatient setting. • The kind of neurological problems that Magnolia can help include: ■ Traumatic brain or spinal injury that some people experience following an accident ■ After a relapse or deterioration in people who have long-term conditions such as multiple sclerosis

Service	3b. Magnolia Neuro Rehab Ward - RDaSH
Provided by	RDASH Service Lead; Louise Christie, Senior Sister, Neuro Rehabilitation Inpatients
Commissioner	DCCG & other CCG's
What systems / processes are involved?	• Magnolia provides an in-reach service to the acute sector identifying patients and assessing their suitability / potential for rehab. • Referrals can be made by any healthcare professional from the acute sector or the community. • Referral proforma are faxed to the ward office. The service use their own referral documentation to get specialist patient information, but a comprehensive letter from a GP would be acceptable. • Currently 3 MDT meetings per week where all referrals are triaged • Referral decisions are fed back to the referrer, Magnolia will signpost as appropriate. • Service uses the UK ROC guidelines for neuro-rehab outcomes to ensure plan of care is individualised for needs of client • Risk management and care plans are agreed before the patient is admitted to Magnolia. • The service works closely with the acute sector physio's and neuro teams.
Which patient pathways would the service utilise?	• Existing pathways and referral processes are considered robust. • The service is currently working with the IDT to develop a pathway to access a Social Worker with specialist skills to support neuro patients as the ward does not currently have a dedicated resource.
How does the service monitor/measure performance?	• Service uses the UK ROC guidelines for neuro rehab outcomes and collects performance data • Magnolia performance data - Apr - Oct 2014 Bed occupancy - 77% Avg LOS - 67.7 days % patients stay > 42 days - 50%
What organisations does the service interact with?	• Work closely with social services as approximately 90% of patients are referred to social services for assessment and also RDaSH, DBHFT, GP Practices
Who does the service link with?	• Community Therapy Services, Community District Nurses, GP practices, IC services

Description of Key Intermediate Health and Social Care Services.
Service Area – 3. Community Beds

Service	3c. Hazel Ward - Community Rehab - RDaSH
Provided by	**RDaSH** **Service Lead; Sarah Marlow, Senior Sister.**
Commissioner	**DCCG**
What is the service role?	During the intermediate care review the service model has changed from a step up facility plus 6 Cap beds (Hawthorne) and a step down facility (Hazel) to provide separate assessment and rehab units. • The aim of the inpatient rehabilitation service is to avoid inappropriate and unnecessary acute hospital admission, provide care closer to home and enable people to remain living as independently as possible within the community • The service facilitates both early discharge from the acute hospital ie. step down for up to 28 days (target stay) and step up care from the community, for up to 7 day (target stay), supporting the patient in returning to their own home in a timely manner. • The service targets people with sub-acute conditions, delivering interventions that can be safely delivered in a community hospital environment • Hazel implements rehab / re-ablement care plans for individuals as agreed by the MDT. • 20 bedded unit for 28 day target stay. **Common to both Hazel and Hawthorne wards** • A nurse led unit staffed with a MDT including physio, OT and have access to pharmacy, dietician, SALT and IDT social worker • Frances Street Medical Centre provides contracted GP medical cover available 8 - 6pm Mon - Fri. • Out of hours service is utilised as necessary from 6pm to 8am • Nurse practitioners work Monday – Friday, 8am – 5 pm to support the triage of patients, diagnosis, assessment and prescribing for patient. • Pharmacy services contract with Lloyds Pharmacy services in line with the whole of RDaSH • Member of IDT rotates into assessment / rehab unit • Liaison with Community Matrons, Heart Failure Nurses and Emergency Care Practitioners to improve patient care, communications and facilitate seamless transfer between services
Where is the service based and where does it provide the service?	• Hazel Ward at Tickhill Road Hospital, Balby, Doncaster
What is the service team structure and skill base?	• Staffing structure common to both Hazel and Hawthorne Wards. • Nursing 1 x Ward Manager, 1 x Band 6 RGN Lead ? x Band 5 nurses • Occupational Therapist 1.4 x band 6 1.5 x band 5 • Physiotherapist 1 x band 6 (managed by Falls) 1 x band 5 vacancy currently being recruited & this is covered by locum. 1 X Rehab Support Worker (Support Workers are HCA with additional competencies and training to support the rehab function). • As at 13.04 15 recruiting to 6.75 band 2 and 4.23 band 5 vacancy. Some of these are new posts to meet the needs of the service. • The new model is under review, the skills and competencies required for staff and the Trusts roles & responsibilities have been mapped against the existing skills of staff. Management is working with clinical educators to ensure that all staff achieve the competencies required to deliver the service.
What is the service access criteria?	• Patient has to be a Doncaster resident with a Doncaster GP. • Patients need to be medically stable not requiring medical input beyond that of a GP. • Assessment by Hawthorne Ward • Can take all conditions including patients suffering from dementia and cognitive impairments, providing that their needs can be safely met by the service • Patients need to understand and consent that they are to take part in a re-ablement / rehab programme. If they are unable to consent then a best interest meeting will be required.
What is the service exclusion criteria?	• Do not take patients that are close to end of life • Complex mental health problems.
What is the referral source?	•IDT for step down referrals and step up, community referrals via Hawthorne Ward (post assessment)
What is the patient / client profile?	• Mixture of elderly male and female - predominately female

Service	3c. Hazel Ward - Community Rehab - RDaSH
Provided by	RDaSH Service Lead; Sarah Marlow, Senior Sister.
Commissioner	DCCG
What systems / processes are involved?	• Referrals are made by calling a dedicated phone number that is available 24hrs/day • The phone is held during core hours by senior members of staff (OT's, Physio's, who are rota'd) • In non-core hours the phone is manned by the RGN in charge of Hawthorn ward and referrals are made via this number. However the number of referrals out of hours are rare. • The Lead Manager of the day is responsible for bed management • When the referral call is received the Lead takes the patients details, makes an assessment for suitability and records all details onto a ward referral document. • Additional information may be requested from the referrer, this can be faxed to the ward and includes; *FOR STEP UP* – A copy of either a signed medication list or a FP10, a covering letter, 7 days' supply of boxed medication (NOT NOMAD) *FOR STEP DOWN* – 28 days' supply of boxed medication from the DRI pharmacy, a signed discharge letter which includes a list of the current medication which the patient is taking. A copy of the IDT assessment. • If the patient is not appropriate for the service the referral is signposted to a more appropriate service / facility. • The referrer is requested to book transportation for the transfer. • If a bed is available the patient will be transferred asap, this can be done within 2 - 6hrs for Step Up patients and 24 - 36hrs for Step Down patients. • If a bed is not available, the patient is placed on the ward waiting list with the aim of transferring the patient to Hazel within 48hrs • All patients will have physio & occupational therapy assessments where personal goals and plan for rehab is agreed. • GP attends a Thursday afternoon ward round. • Hawthorne has twice weekly MDT meetings to discuss all patients care needs • Nurse Practitioners are the first point of call before the GP is contacted and they support the GP on the weekly ward round. • Upon completion of assessment by Hawthorne patient can be either discharged back to the community with or without a package of step up care or admitted to Hazel Ward for bed based intensive intermediate care support
Which patient pathways would the service utilise?	• No formal step up assessment pathway available to referrers or service users • Service follows standard discharge pathways to other health and social care providers
How does the service monitor/measure performance?	• Service has a performance dashboard and is monitored at an operational level by modern matrons and ward managers and is shared with services and commissioners • Systems for E-rostering and budgetary control under review • Hazel performance data - Apr - Oct 2014 Bed occupancy - 92% Average LOS - 25 days % patients stay >42 days - 9%
What organisations does the service interact with?	Service interacts with all other health and social care providers including; • DBHFT, RHFT and other out of area hospitals, Local Authorities, YAS • CAP beds • Residential homes. • RDASH support services
Who does the service link with?	• CICT • Planned and Unplanned District Nursing • ECP's • GP Practices • IDT • STEPs • Mental Health teams. • Mexborough Rehab

Description of Key Intermediate Health and Social Care Services.
Service Area – 3. Community Beds

Service	3d. Positive Steps – Re-ablement Unit
Provided by	**DMBC** **Service Lead; Claire Warren, Registered Manager Positive Steps**
Commissioner	**DCCG & DMBC**
What is the service role?	• Positive Step is a social care assessment unit providing 33 assessment beds (22 beds dementia beds and 11 Non-dementia beds). • The unit offers patients time and opportunity for re-enablement and rehabilitation usually after a period of acute care. • The unit assesses the patient's physical and mental capability to inform decision making regarding their future care requirements. • The aim is to prepare the patient for a return home with or without a care package. • The service offer is for a maximum of 6 weeks, and aims for 4 weeks.
Where is the service based and where does it provide the service?	• Positive Step. The Avenue. Bentley. Formally Home Covert residential home. On 3 separate 11 bed units. (2 secure and 1 non-secure). • Rowena House and Oldfield House AIM/Dementia beds (12) now consolidated into Positive Step at Bentley
What is the service team structure and skill base?	• 1 x Registered Manager • 1 x Deputy Manager • 2 x 31.5 hour Night Managers • 2 x Assistant Managers • 2 x Occupational Therapists • 1 x 30hr Physiotherapist • 2 x Social Workers. • 1 x Assessment Officer • 2 x part time Activity Co-ordinators. • 1 x CPN (Mon- Thursday) • 11 x Night Support workers, (6.8 WTE) • 15 x Senior Support Workers, (10.7 WTE) • 19 x Support Workers (13 WTE) • 3 x cooks • 8 x General Assistants • 1 full time, 1 part time clerical assistant • The unit has no in-house medical cover. GP cover is contracted in from Frances Street Surgery.
What is the service access criteria?	• Doncaster resident with a Doncaster GP • Over 18 • Medically fit (no nursing needs) • 28 days medication requested (service will work with DRI pharmacy to get 7 day supply and then liaise with patients own GP for NOMADs) • Patient must want to go home.
What is the service exclusion criteria?	•Services users who do not meet the above referral criteria •Referrals will not be accepted for those service users whose sole reason for not being able to return into the community is based on the none availability of a piece of equipment or an adaptation to their property or awaiting re housing •If a Mental Health workers clearly recommends that a 24hr care placement would be in the individuals best interest, due to past history and interventions •Persons with diagnosed mental health disorders for which acute psychiatric inpatient care is appropriate •Referrals for social care respite
What is the referral source?	• It is only possible to make "step down" referrals from the acute sector and other intermediate care services Referrals usually come from the following sources; • RAPT and IDT • Do not take referrals from community.
What is the patient / client profile?	• Doncaster residents, who are registered with a Doncaster GP • Majority elderly, 65+. Occasionally younger • White, British, male and female, majority female. • Very few from ethnic minorities - nearly entirely white British. • Patients want to feel safe, supported and cared for at home. • They don't want lots of bureaucracy and administration

Service	3d. Positive Steps – Re-ablement Unit
Provided by	DMBC Service Lead; Claire Warren, Registered Manager Positive Steps
Commissioner	DCCG & DMBC
What systems / processes are involved?	• Referral from the ward to IDT for a patient that requires discharge planning. • IDT Social Workers & Discharge Nurse's go to see patient, complete a Fact find and make a Positive Step referral. • The fact find is emailed to Positive Step. • Referrals come from DRI, IDT from the wards, RAPT from ED or CDU or occasionally from Bassetlaw hospital • The Fact find and referral is completed, scanned and then emailed over to Positive Step, along with MCA paperwork etc. Work is ongoing to facilitate document transfer from the fact find to Care First IT system, in order to transfer information between services. • The Lead Manager will assess the referral for suitability and contact the ward if further information is required • Once all information is gained then the referral can either be accepted or declined. If accepted a discharge date to Positive Step is agreed. • The service aims to complete the process within 24 hours. • The unit undertake further assessments to understand the patient's ability to carry out personal care and food preparation with a view to going home; or the most appropriate place following assessment. • A set of goals are agreed with the patient • The units support workers are able to undertake basic health skills such as:- medication prompts, catheter care, simple dressings, eye drops etc. • Medical cover is provided by; • Community Nurses who are accessed through SPA • GP / Practice Prescribing Nurse (Frances Street - contract extended to Sept 2015) for a weekly clinic and unplanned visits • The carers ability to care for the patient at home is also assessed and necessary training is provided to the carer to help them understand the needs of the patient • Community Care Assessments are undertaken by social workers to informs the requirements of the patient final care package. • Patients will be discharged home with either: No support, a Wellbeing officer, re-ablement for a short term programme a package of care or to a 24 hour care home placement. • Social Workers and OT's conduct follow up visits after discharge as part of service. • Clients kept on caseload for up to 6 weeks after discharge. Once patient is stable, their care is handed over to the area team.
Which patient pathways would the service utilise?	• None specific to positive steps
How does the service monitor/measure performance?	• 312 admissions in 2013/14 • Estimated length of stay is 4- 6 weeks • Positive Step average stay 28 days. • No active waiting lists but nearly always full. • Productivity and performance data collected • All data sent to Better Care Fund team at DMBC. Working towards collating all data on Care 1st • Data analysed and reported / fed back to management and staff. • Data reports available to staff.
What organisations does the service interact with?	•RDaSH; Local Authority; DBHFT
Who does the service link with?	• No true integration • Work with GP, ECP, District Nurses, Community Social Workers and Therapists. • Working with DMBC Neighbourhood Community Manager to deploy Wellbeing Officer into the unit to identify patients that would benefit from low level social support when back at home.

Description of Key Intermediate Health and Social Care Services.
Service Area – 3. Community Beds

Service	3e. Rose House - Social Care Assessment / Rehab Unit
Provided by	**DMBC** **Service Lead; Pam Castle, Service Manager**
Commissioner	**DCCG**
What is the service role?	• Rose House is a 31 bed SCAU with an 8 bed rehab unit which offers a timely short term intervention to preserve independence and avoid unnecessary prolonged hospital stays • Rose House and rehab service currently under review
Where is the service based and provided?	The service is based at Rose House, Armthorpe
What is the service team structure and skill base?	• Community Physio's - No allocated hrs. However calls in Monday am, to pick up new referrals and physio assistant calls in on a Wednesday for continuity of supporting exercise programmes • Two Community Rehab Assistants • Community OT works 20 hrs per week • Social worker ad hoc when required. • Therapists and Social Worker attend a weekly MDT / patient review every Thursday • Medical cover from local GP as required and OOHrs.
What is the service access criteria?	• Doncaster residents • Medically fit and stable • no dementia diagnosis (as patient would have difficulty participating in a rehab programme) • Doncaster resident / GP • patient willing to undertake a programme of rehabilitation
What is the service exclusion criteria?	• Patients with diagnosis of dementia.
What is the referral source?	• It is only possible to make "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources: • Referrals from IDT via DRI, Hazel / Hawthorne and Parkhill • No referrals from community. No referral pathway to do this.
What is the patient / client profile?	• Male, female. Elderly 60+. Usually falls / fractures, strokes • Very few ethnic minorities. • Confidence building. • Emotional support • Building strength to cope with daily tasks • Convalescence.
What systems / processes are involved?	• Referrals predominantly from IDT at DRI • Service maintains daily contact with the IDT informing them of bed availability and pending discharges to facilitate discharge planning. • IDT initially telephone Rose House with referral • Fact find and therapy assessments then faxed through to Rose House prior to patient transfer. • Upon receipt of the initial referral documentation the service completes an internal referral form that ensures that all the necessary information has been collated. This is completed by the manager on duty, any queries are addressed at this point to ensure that the referral is appropriate • If there is availability it is possible to admit on the same day • 6 week max stay, strictly adhered to. Average length of stay 4 weeks. • All patients go home with / without support
Which patient pathways would the service utilise?	• No referrals from community. No referral pathway to do this.
How does the service monitor/measure performance?	• 8 rehab beds, 70-80 patients per year • 6 week max stay. • 389 patients have used the service in the last 5 years, • 99% of patients have returned home. • Standard performance data to DMBC
What organisations does the service interact with?	• RDaSH • DBHFT • GP Practices • Local Authority
Who does the service link with?	• Limited. IDT, District Nurses, RDASH therapists, local GPs, Social Work team.

Description of Key Intermediate Health and Social Care Services.
Service Area – 3. Community Beds

Service	3f. Windermere Ward
Provided by	RDASH Service Lead;
Commissioner	DCCG
What is the service role?	Is to provide inpatient care for people who have organic illnesses or symptoms of organic illness e.g. Alzheimer's Disease and types of Dementia. Patients are usually over the age of 65 but does except younger patients dependant on clinical need. The aim is to provide assessment for patients who have increased aggression, complex needs and who are becoming increasingly difficult to manage especially in the community. Windermere is a 20 bedded unit, but has not been utilising capacity for some time.
Where is the service based and provided?	Service is based at Windermere Ward at Tickhill Road Site
What is the service team structure and skill base?	• The WTE is 11.86 for qualified nurses including the ward manager and deputy ward managers & is made up from:; o 1x band 7 ward manager o 2 x band 6 deputy ward managers o 10 x band 5 staff nurses • The WTE is 10.40 for nursing assistants & is made up from: o 14 Health Care Assistants 2 of which work full time, the remainder work part time • All nursing staff are RMN trained • The minimum safe staffing levels on the ward are 2 qualified nurses and 2 nursing assistants on early / late shifts. On nights the staffing levels are 1 qualified nurse and 2 nursing assistants. • However this is fluid and is assessed in accordance to patient need and increased as required. (usually with the use of bank nurses, and occasionally agency staff) • Windermere and Coniston ward share resource from: • Matron- WTE 0.86 • 2 x OT: WTE 1.56 • 2x re-ablement workers WTE: 2.0 • 1x social worker WTE: 1.0 • Physiotherapist WTE: 0.60 • The ward has four Consultants that are based within four localities across Doncaster and each locality is supported by a CPN team. •Medical coverage is provided by 4 consultants who are supported by 3 junior doctors(F2) with the other one being supported by a speciality doctor (F3). Out of hours is covered by an on call rota of both consultants and junior doctors.
What is the service access criteria?	• The ward accepts patients over 65 from across the Doncaster locality usually under the care of a Psychiatrist. The ward does take patients under 65 years dependent upon the clinical need. • Patients are usually Doncaster residents but may take out of area patients by exception.
What is the service exclusion criteria?	• Patients are not able to self refer. • Patients are usually over the age of 65 but may take younger patients by exception • Delirium needs to be excluded
What is the referral source?	• Referrals can be received from a number of sources including: • Crisis Liaison Service • DRI Acute Wards or A&E • Care Home Liaison Service • Police 136 team – patients who need a place of safety • GPs and community staff
What is the patient / client profile?	• Balance of men and women over the age of 65 but may take younger patients by exception
What systems / processes are involved?	• On receipt of referral, Consultant will undertake a domiciliary visit to make assessment of patient. •Crisis intervention and access team work at DRI and community and also make referrals to the ward 24/7. •Often the mental health act or capacity assessment will be used to support admission and plan of care. •Consultant will telephone ward to request a patient bed and provide initial plan of care information. •All delirium needs to have been explored prior to admission– e.g. infection, toxicity etc. •The referrer/social worker tends to arrange transport for admission – usually YAS/police escort. •Admission usually takes place within a couple of hours following ward notification due to nature of patient need. •The ward manager/matron is responsible for bed management; outside 9-5 hours bed management falls to the nurse in charge or the manager on call. •Ward staff may ring GP for current medication lists, ward Dr will prescribe and prescription is ordered from

	Lloyds chemist. Patient medications will be used whilst script is dispensed. Urgent medications can be requested from Consultant Mon-Fri. •All patients will have nursing and therapy goals as appropriate. •There is one ward round per consultant each week followed by MDT review. •Mental health act or mental capacity act can be used to support admission. •CPN in the community is currently training to be an advanced nurse practitioner who is anticipated to support the ward accordingly. •Patients who are detained under the mental health Act have a 117 aftercare panel review to assess need on discharge. •On discharge most patients go to 24hour care or specialist care that provides 1:1 supervision. •Some patients go home with increased packages of care and support from community mental health staff. This enables support and education for patient and carers. •It is often difficult to try patients at home with a new package of care. Continual changes in staff that provide care in the community add to issues stabilising the patient at home. •The ward used to provide some respite beds which helped prevent carer crisis, but these are now not available. There is little provision in the community to support this type of complex patient.
Which patient pathways would the service utilise?	•Inclusion of the mental health act •Palliative care pathways – supported by Hospice intervention •Neurological pathways followed supported by Magnolia Lodge
How does the service monitor/measure performance?	•Band 6 staff and above are involved with audits and performance management •The ward does have access to LOS data but other Dashboards are not routinely used at ward level.
What organisations does the service interact with?	•Residential homes •RDaSH community services •Crisis Liaison team •Care home Liaison team •DRI – A&E and Acute wards •Pharmacy •Hospice
Who does the service link with?	•Crisis Liaison •RDaSH community services e.g. D/Nurses, Continence, SALT •ACT •GP Practices •STEPS •Step down beds •Care home •Positive Steps
What is the patients greatest need	•Support to manage high level of aggression and complex needs •Support for family to manage carer crisis

Description of Key Intermediate Health and Social Care Services.
Service Area – 4. Support Services

Service	4a. Falls Service
Provided by	**RDASH** **Service Lead; Cora Turner, Area Clinical Manager & Professional Lead OT**
Commissioner	**DCCG**
What is the service role?	• To provide comprehensive multidisciplinary falls assessment and rehabilitation to fallers in Doncaster. • Treatment is provided by skilled multidisciplinary workforce and targets all fallers, delivering interventions in the falls clinic and home environment. • The service is person centred, comprehensive and cohesive to enable patients who have fallen to live as independently as possible in the community. • A falls rehabilitation program to meet the patient's needs is agreed with the patient and carer (where appropriate); identifying realistic goals and timescales. • The patient and carers are provided with a 'My Falls Prevention Plan' which details the agreed goals, interventions and falls advice, to take away with them. • The rehabilitation program is aimed at promoting self-management, independence and physical and psychological function regarding falls. • The assessment is comprehensive and the service is able to undertake limited investigations which are reviewed by the Consultant.
Where is the service based and where does it provide the service?	• The service is based at Tickhill Road Hospital Site • The service is provided predominantly at the Falls Clinic (Evergreen) and home environments – including care homes.
What is the service team structure and skill base?	• 1 x WTE Band 7 Team Leader • 1 x WTE Band 6 Falls Coordinator (Nurse) • 1 x WTE Band 6 Occupational Therapist • 0.64 x WTE Band 6 Physiotherapy • 1 x WTE Band 5 Occupational Therapist • 1 x WTE Band 5 Nurse (2 people) • 1 x WTE Band 3 Rehabilitation Assistant • 1 x WTE Band 2 Rehabilitation Assistant (2 people) • Visiting Medical Consultants
What is the service access criteria?	• Doncaster residents that have had at least one fall in last 12mths
What is the service exclusion criteria?	• Doncaster residents that have not fallen in last 12mths
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources; • Referrals are currently received from community & hospital staff, care homes, consultants and GP's, pharmacists and outside agencies such as social services and groups such as Age UK. • Service has also developed a self-referral pathway.
What is the client profile?	• All fallers in Doncaster. • Majority of patients are aged 60+
What systems / processes are involved?	• Referrals are accepted from any service including self-referrals from patients. • Referrals are made by a letter or on a dedicated referral forms. This can be sent to the service via post or faxed. • Patients can self-refer, in which case the service will complete a referral form either in a face to face meeting or over the telephone. • Referrals are discussed at a multidisciplinary team meeting three times a week, or more often if there are a large number of new referrals. • If the referral meets the service access criteria the team decide whether the patient needs either a falls assessment, a falls assessment and medical review, or medical review by consultant only. • If a falls assessment is required this can be done on a home / care home visit or at the assessment clinic at Tickhill Road Hospital. • Appointments are made by the administrative team. • Pathway for patient care is agreed by the MDT and with the patient. • Referrals that do not meet service access criteria we will either be returned to the referrer or if appropriate, forwarded to a more appropriate service. • On receipt of a referral, an appointment letter can sent out the same day, but will normally take 2 to 3 days. • Waiting times are variable and constantly change depending on the demand at any point in time.

Service	4a. Falls Service
Provided by	**RDASH** **Service Lead; Cora Turner, Area Clinical Manager & Professional Lead OT**
Commissioner	**DCCG**
Which patient pathways would the service utilise?	• None Specific
How does the service monitor/measure performance?	• Currently 900+ active patients – for medical and falls assessments. • Length of stay variable, ranging from one off visits to multiple visits over the longer term • Waiting list system in place which is evaluated monthly • Data collected on SystemOne and reported and includes:- Outcome measures, patient feedback, professional bodies, RDaSH audits/ evaluations, Mandatory and Statutory training.
What organisations does the service interact with?	RdaSH; GP Practices; DBHFT; Local Authority
Who does the service link with?	• Parkinson's Disease Specialist Nurses – refer patients in for rehabilitation. • Interaction and integrated activities with intermediate care wards. • Falls Team have multiple interactions with other health professionals including, Falls Alliance Group, Continence, Podiatry, Orthotic Services, Pharmacy Technicians, Orthotics, Speech & Language Therapy, CPN, Mental Health Teams, Dietician and other outside agencies (DMBC, Charities.) • Patients who have completed treatment with the falls team are encouraged to access community based groups run by outside agencies – e.g. Age UK.
What is the patient's / client greatest need?	• Independence. Medical support, Physical activity, confidence, emotional support, mobility and function, home environment etc.

Description of Key Intermediate Health and Social Care Services.
Service Area – 4. Support Services

Service	4b. Older Peoples Mental Health Team
Provided by	**RDASH** **Service Lead; Jo Hirst, Senior Sister / Service Manager**
Commissioner	**DCCG & DBHT**
What is the service role?	• Older Peoples Mental Health Liaison Team are a nurse led, secondary care mental health team who specialise in the care of patients with mental health problems in hospital and care homes. • Team is split into two -5 nurses work with older people in care homes, Positive Steps and CAP beds with mental health needs and the remaining 9 staff are based at DBHFT to support wards, IDT and RAPT.
Where is the service based and where does it provide the service?	• Team is based at Tickhill Road Hospital, Ward 16. • The services provides support at the CAP beds, Positive Step, Hawthorne and Hazel wards and wards at DBHFT
What is the service team structure and skill base?	• 1 x Medical Lead / Clinical Director • 1 x Nurse Consultant (band 8) • 14 x mental health nurses. (band 6 and 7) • 2 x Physio.(band 6) • 3 x Admin
What is the service access criteria?	• Over 65, Doncaster resident with evidence or suspicion of a mental health problem
What is the service exclusion criteria?	• None
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources; • Care home referrals come from GPs. • IDT • Doctors and other Health Care Professionals on wards. • MH Nurses in reach onto the wards to identify suitable referrals
What is the client profile?	• Over 65 years, male and female with mental illness
What systems / processes are involved?	• Referrals are received from ward areas and the community for advice and support if mental health issues are of concern. • These are received by fax and phone direct to the OPMHT office at Tickhill Road Hospital. • OPMHT also have an in reach service to proactively identify DBHFT patients on the wards and triage referrals to the service. • The service ensures that inpatient mental health assessments are completed and followed up, medication & non pharmacology is organised, discharge plans are agreed, and referrals to social care have been made. Response times are 2 days for non-urgent referrals if medically optimised • Screening is completed by the senior nurse and appropriate investigative treatments requested if appropriate. When patients are medical optimised and other physical causes for presentation eliminated an assessment is arranged. • The service remains with the patient throughout their IC journey • When patients go home the older peoples mental health liaison team involvement stops and care is transferred to the community mental health teams if appropriate.
Which patient pathways would the service utilise?	• None Specific
How does the service monitor/measure performance?	• Approx 100 referrals per month • Average length of stay variable • Productivity and performance data collected by trust and reported to CCG
What organisations does the service interact with?	• DBHFT, Social Services, Care Homes, Community Teams, RDaSH
Who does the service link with?	• The service staff integrate within the clinical areas in DBHFT. • There is a RMN in IDT • The team is represented on the Community MDTs • Patient user groups.
What is the patient's / client greatest need?	• Complex Mental Health issues

Description of Key Intermediate Health and Social Care Services.
Service Area – 4. Support Services

Service	4c. Integrated Community Equipment Services (ICES)
Provided by	**RDASH** **Service Lead; Gareth Everton, Service Manager**
Commissioner	**DCCG & DMBC**
What is the service role?	• ICES is subcontracted to Nottingham Rehab Service on a 5 year contract funded by Doncaster CCG and Social services. • Service provides storage, sourcing, delivery, maintenance and installation of equipment for service users - from commodes to hoists. • Provider has 4 response times dependent upon need.
Where is the service based and where does it provide the service?	• Nottingham based Service, within office base in Doncaster Local Authority. • Provides Doncaster community wide service.
What is the service team structure and skill base?	• Service staffing provision is flexed against demand of service.
What is the service access criteria?	• Community Health and Social Care teams gate keep the eligibility criteria when assessing patient need. • NRS will respond to any order from a prescriber.
What is the service exclusion criteria?	• None Specific
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources; • Most equipment referrals come from Community Nurses ,Therapists and Social Care teams.
What is the client profile?	•The patient profile is variable as it provides equipment for children, adult and elderly residents.
What systems / processes are involved?	• Patients cannot access the services directly. • Health and Social Care teams identify a patient need for equipment • Assessor / Authorised Prescriber orders equipment from online catalogue using the NRS IT system (iRIS). • NRS have a team of customer services staff who receive the orders and process them, NRS sources, arranges delivery with client and installs equipment as required and follows up as required. • There are a series of response times which are selected by the prescriber; same day/ end of life, next day/ emergency, three day/ urgent and five day/ standard. • CCG are invoiced for Health referrals and LA are invoiced for Social Care referrals.
Which patient pathways would the service utilise?	• None Specific
How does the service monitor/measure performance?	• 2000-3500 items of equipment per month currently delivered. • Contractor collects performance data on a monthly basis and reports to ICES service.
What organisations does the service interact with?	• Many interactions with organisations including: RDASH, DBMC, DBHFT, ICES
Who does the service link with?	• The service works autonomously but links with District Nurses, Therapists, Mental Health and Social Care Teams.
What is the patient's / client greatest need?	

Description of Key Intermediate Health and Social Care Services.
Service Area – 4. Support Services

Service	4d. Complex Assessment Pathway (CAP Beds)
Provided by	**Private Nursing Home Providers – Various** **Service Lead; Ian Boldy, Lead Nurse Care Homes, DCCG**
Commissioner	**DCCG**
What is the service role?	• Complex Assessment Pathway - • 29 beds available for assessment of patients with complex needs for long term health and social care packages and funding. • Patients are moved from an acute bed to facilitate assessment in a more appropriate environment. • Assessment is undertaken by CHC staff and Social Care Assessment Officers during a 28 day process. • Beds commissioned by DCCG directly with Care Home providers since January 2014. • CAP bed medical cover is sourced from local GP's
Where is the service based and where does it provide the service?	• Adoline House (4 beds), Amethyst House (5 beds), Swallow Wood (10 beds), Benton House (5 beds) and Manor View (5 beds).
What is the service team structure and skill base?	• Service Manager • 2 Social Workers. • 2 Assessment Officers
What is the service access criteria?	• No formal written criteria, referral is down to skill and experience of referring clinician
What is the service exclusion criteria?	• None Specific
What is the referral source?	• It is only possible to make "step down" referrals from the acute sector (IDT).
What is the client profile?	• Patients with complex needs who require long term health and/or social care • Usually 70+, but getting older
What systems / processes are involved?	• The wards phone referrals to DRI IDT admin who take basic details this is then passed to the IDT • IDT then visit the patient on the ward and completes a fact find • The IDT then have a discussion about the findings on the fact find with the CAP Consultant and decide on the right pathway for the patient • A Social Worker or Discharge Nurse Specialist completes the fact find • Referral process can take as little as 1-2 hours or as long as 1-2 days dependent on staffing, demand and provision of information required. • If referral agreed, patient transferred to available CAP bed. • When patient admitted to CAP bed, assessment team will start assessment for care package. • A "Checklist" is prepared and sent to CHC and forms the basis of the decision support tool (DST). • Patient and family involved in process of discharge planning as much as possible. • The CHC assessment and funding process usually takes about 4 weeks
Which patient pathways would the service utilise?	• Most patients will require long term residential and nursing care
How does the service monitor/measure performance?	• 29 beds. • New model currently under review / evaluation • Admin team collects and sends to DMBC for analysis and reporting.
What organisations does the service interact with?	• Acute trust, RDaSH, Local Authority home care providers,
Who does the service link with?	• Close working with IDT, Consultants, DN's, CHC, Specialist Community Nurses, Social Workers
What is the patient's / client greatest need?	

Description of Key Intermediate Health and Social Care Services.
Service Area – 4. Support Services

Service	4e. Out of Hours Service (OOHrs)
Provided by	**FCMS** **Service Lead; Gillian Gregory**
Commissioner	**DCCG**
What is the service role?	• The Out of Hours (OOH) service provides a GP medical service to the population of Doncaster during the times that GP practices are closed. • OOH operate 6pm to 8am Mon - Fri, 24hrs Sat, Sun and Bank hols. • DBHFT contracted by CCG to provide the OOH service, they host and administer it and have sub-contracted the medical element to Doncaster Medical Services Ltd (DMSL). • The service is provided at the A&E department at DRI • The service is led by local GP's and nursing staff.
Where is the service based and where does it provide the service?	• The service is based at Doncaster Royal Infirmary in A&E department
What is the service team structure and skill base?	• 1 x Medical Director (GP) • 2 x Local Clinical Leads (GP's) • 58 x Local GP's work on rota. 1 - 8 working at any one time, dependent upon demand. • 6 x ECP's work on rota, usually 1 per shift. • Administration, drivers and transportation provided by DBHFT.
What is the service access criteria?	• None
What is the service exclusion criteria?	• None
What is the referral source?	• The service receives self-referrals and referrals from other health professionals. • OOHs receives referrals from community IC services predominantly Hazel/Hawthorne and care homes which are dealt with accordingly.
What is the client profile?	• Anyone

What systems / processes are involved?	• The service is essentially a telephone triage model operated from a platform called ichat, delivered in A&E.
	• Patients are:
	  • Assessed on the phone and verbal signposting/information given or
	  • Given an appointment with OOH GP in A&E and treated and discharged or
	  • Referred on (A&E or ward) or
	  • GP will conduct home visit (rarely).

Which patient pathways would the service utilise?	• For Hawthorne referral, in hours GP would have to refer to Community nursing team to get CICT to assess to clear for ward admission. • No consistent approach to IC referrals OOH.
How does the service monitor/measure performance?	• 3-400 contacts / day on a weekend, 100/d contacts mon - fri • Performance data collected and reported to DBH who report to DCCG
What organisations does the service interact with?	• Interaction with intermediate care (IC) is limited. • The service perceives that it does not have the ability to refer in to intermediate care services due to the hours worked. • Interaction with acute services at DRI • Interaction with RDaSH community nursing teams
Who does the service link with?	• Nurses
What is the patient's / client greatest need?	• Clinical need and reassurance

Description of Key Intermediate Health and Social Care Services.
Service Area – 4. Support Services

Service	4f. Telehealth Service
Provided by	**RDaSH** **Service Lead Planned Care; Chris Eastwood, Area Clinical Manager**
Commissioner	**This is a non commissioned service**

What is the service role?	• This was a commissioned service until 2 years ago. Is now funded internally by and for RDASH
	• Service supports RDASH Doncaster Community Integrated Service (DCIS) in service delivery.
	• Service provides;
	  ○ Telephone Support – provides support to patients on the DN caseload who are called by the team on a regular rota to determine their condition. Cardiac patients with anxiety issues are also supported. Service also provides discharge support (post stay 24hr / 90 day follow up calls) for Hazel/Hawthorne wards, details logged to SystemOne. All calls seek to identify potential issues at an early stage and react to avoid admissions, eg. Social isolation
	  ○ Tele Monitoring – Use the Docobo care portal. Patients enter vital signs and current health status, these readings are then transferred by a secure website to the Community Telehealth Nursing team for assessment. Nurses then triage the readings and advise the patients on self care and management. Patients can also text the nursing team for help and advice. Patients can receive this service for 3 – 12 months but this is managed by exception.
	  ○ Tele Coaching – approx 6 telephone calls over 3 month period to influence patient life style and, or behaviour change.
	  ○ The service also supports DCIS where ever contact by telephone is required, such as, the delivery of ECG test results by phone on behalf of the Community Cardiac Team, this could include the giving of life style advise to the patient.
	• Patients seeking telephone support call the SPA and are then directed to the Telehealth Team (9-5, 5/7) if they call out of Hours or are in crisis they will be signposted elsewhere.
	• Service operates Monday to Friday, 9am – 5pm.
	• The service is currently (May 2015) being reconfigured and expanded.
	• The service is now (temporarily) part of the Planned Care service.

Where is the service based and where does it provide the service?	• Service is based at Honeysuckle Lodge, Tickhill Road Hospital • When required Telehealth equipment is delivered and installed in the patients own home and very occasionally in a residential / nursing home but this is a non commissioned service so generally not available. • Docobo system can now be installed on patients own android device which is becoming more popular.
What is the service team structure and skill base?	• 1 FT x B7 Service Improvement / Project Manager (ends 29/05/15) • 1 FT x B5 Staff Nurse • 2 PT x B5 Staff Nurses (30hrs/week each)
What are the service access criteria?	• Patient needs to be able to communicate over the phone • For Docobo service patient can also text if necessary • Must be able to speak English • Must have the capacity to want the service and understand how to use although a carer can use by proxy • Some technology works wirelessly so will work in environments other than the home eg. Caravans
What are the service exclusion criteria?	• See above
What is the referral source?	• Service receives approximately 120 referrals / mth. • Many come through the Electronic Referral System on SystemOne from; Cardiac team, Hazel/Hawthorne, Community Respiratory team, Bentley GP Practice (pilot, not commissioned) • A small number from IDT at DRI to target repeat A&E attenders and support patient discharge, this is a new initiative
What is the patient profile?	• Tele monitoring used generally by complex patients ie those with COPD, heart failure, diabetes, general poor health and occasionally palliative patients. • Frequent admitters to hospital, high demand patients • Cardiac Team referring newly diagnosed patients whilst they are titrating their medication, these go onto the Docobo system to monitor vital statistics.
What systems / processes are involved?	• RDASH Community and Specialist nursing teams can refer a patient directly to Telehealth from their Agile Device via SystemOne • The referral is picked up by the on duty nurse who triages and allocates to the caseload • GP's or other refers can call the SPA who will pass the referral onto the Telehealth team

Service	4f. Telehealth Service
Provided by	RDaSH Service Lead Planned Care; Chris Eastwood, Area Clinical Manager
Commissioner	This is a non commissioned service
Which patient pathways would the service utilise?	• Service utilises internal RDASH pathways eg. Cardiac rehab, respiratory, etc
How does the service monitor/measure performance?	• 266 patients currently receiving Telehealth services from 2.6 wte nurses, this is not full capacity. 1 fulltime Telehealth nurse can manage a caseload of 150 patients. However being a small team staff absence causes issues with capacity. • Capacity – equipment - 150 x blood pressure monitors, 150 SPO2's, loaned to patients for a maximum of 3 months • Service collects stats / data on templates from SystemOne for tele monitoring, telephone support and tele coaching • SystemOne also produces reports for internal management • Service also contributes patient data to NACRA a national cardiac database • No internal KPI's other than supporting Hazel/Hawthorne with their contracted KPI of contacting 90%+ of patients discharged • Send out "your opinion counts" forms to patients either 3 mth into treatment or after discharge
What organisations does the service interact / link with?	• All RDASH DCIS services; CNS, DN, Cardiac Team, etc • IDT at DRI • Bentley GP Surgery • DMBC Telecare, Social Workers • Voluntary sector, eg. Age UK, Silverline
Patients greatest need?	• Psychological support

Description of Key Intermediate Health and Social Care Services.
Service Area – 4. Support Service

Service	4g. Telecare Service
Provided by	**DMBC - Service Lead - Gary Jones**
Commissioner	**DMBC**
What is the service role?	• Telecare is equipment and systems that support people to live safely and independently. • Using sensors and timers, the user or a carer is alerted to a potential health or safety risk. By minimising potential risks the equipment can help people to remain safe, secure and independent in their own home. • The Telecare Service can range from the basic home alarm and pendant to a whole range of enhanced sensors.
Where is the service based and where does it provide the service?	• The monitoring element of the service is based in the Civic Office, Waterdale, Doncaster, whilst the response and installation team are based at the Mary Woollett Centre in Doncaster. • The service is provided all across the Doncaster geographical borough for those eligible and those who choose to pay for the service (see service access criteria).
What is the service team structure and skill base?	• In terms of installation staff, there are 3 Telecare Officers who have extensive training and experience of current installation protocols, provided by Tunstall and Tynetec and receive regular refresher training as and when required. • They are managed by the DMBC Heart (Home Emergency Alarm Response Team) Manager who also manages a team of shift-based 24/7 responders who respond to calls across the borough.
What are the service access criteria?	• The pendant alarm service is a Universal Service with access to anyone willing to pay the charge. • The enhanced Telecare Service (above and beyond the basic pendant alarm) is currently linked to an assessment of need. • Current charges are £3.20 per week exc. of VAT. • Anyone over 65 years and in receipt of Housing Benefit or Council Tax Benefit due to low income will receive the service free of charge.
What are the service exclusion criteria?	• N/A
What is the referral source?	• Adult Contact Team, Social Work or health professionals such as Occupational Therapists, District or Specialist Nurses, Steps Re-ablement Team, DMBC Wellbeing Officers and Hospital Discharge Teams
What is the patient profile?	• Anyone, of any age, who can access the basic pendant alarm service. • People of varying age and with wide ranging needs can be assessed for enhanced telecare equipment including those with a risk of falls, those living with dementia and those with a learning disability. • The service also benefits people recently discharged from hospital, support for carers and more generally for those living at home who require reassurance/support to remain independent.
What systems / processes are involved?	•
Which patient pathways would the service utilise?	• The current Telecare Service pathway is through the Social Work or health professional route due to the need for an assessment. • Access for the basic pendant alarm is direct and people can self-refer.
How does the service monitor/measure performance?	• A Telecare performance dashboard is used to monitor various aspects of the service including but not limited to the number of referrals, referral agencies, installation timescales, nature and cost of equipment fitted. • The demographics telecare users are also collated including gender, age, reason for access and desired outcomes.
What organisations does the service interact / link with?	• DMBC are members of the TSA and interact with Doncaster CCG, the monitoring centre, installation team and a number of providers of Telecare equipment to monitor and keep ahead of new developments into the market. • We also attend various third sector and community events to promote Telecare and the range of equipment available in relation to Falls, Carers, Dementia week etc.
Patients greatest need?	• The highest reasons for referrals are Falls/Mobility and Dementia.

Description of Key Intermediate Health and Social Care Services.
Service Area – 5. Third Sector Support Services

Service	5a. Living Well Project
Provided by	**New Horizons** **Service Lead; Trevor Smith, CE.**
Commissioner	**Macmillan**
What is the service role?	• This project aims to support cancer survivors and sufferers with low level social support (from dog walking to a shopping service) and financial advice, predominantly with regards to benefits claims and other financial issues such as debt management. This is delivered by utilising and working with quality assured service providers and agencies. • New Horizons also administer the Macmillan support grant (up to £1500/ patient) for financial support in difficult times.
Where is the service based and where does it provide the service?	• Service delivered principally at home but can be delivered across the health and social care community at any facility. • New Horizons are based in Oxford House, Robin Hood Airport, Doncaster
What is the service team structure and skill base?	• 5 X Project Coordinators • 27 X trained volunteers • 20 X volunteers undertaking training. • 2 X Administrative / support staff
What is the service access criteria?	• Client to be a cancer sufferer or have a life threatening condition (the bias towards cancer is driven by Macmillan funding).
What is the service exclusion criteria?	• None specific
What is the referral source?	• It is possible to make both "step up" referrals (from the community) and "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources; • St Johns Hospice • GP's • District Nurse's
What is the patient profile?	• Variable age range, no limits. • Anyone with or surviving cancer • Anyone suffering some other life threatening condition. • Service considering expansion into Dementia and stroke. • Clients needing benefits advice i.e. with help in applying for housing allowance, pensions, blue badge etc. Service will support clients to apply for benefits i.e. application forms, work with relevant agencies on behalf of client, etc. • Clients that are socially isolated - service supports patient to meet / get involved with local interest groups and community. • Psychological support "knowing someone is there" has been identified as most common need.
What systems / processes are involved?	• The referral pathway is 'one telephone call' into the service, either directly to Meeting New Horizons or the Living Well Team at St. Johns • A Referral Form can also be completed by either NHS staff or the Living Well Team at St. Johns and emailed or faxed to the service. • Service receives self-referrals and referrals from our 'Survivor Friendly Organisations'. • Patient referred to New Horizons and seen by Living Well Adviser within 7 days - usually at home but will go where ever required. • Assessment of need completed and support plan agreed with client and support plan implemented • The client's personal information is entered onto database, creating a digital client file, and also a paper file to which intervention/outward referrals/outcomes can be added contemporaneously. • The Admin Support Officer, or any member of the Meeting New Horizons Team upon receipt of the referral, will telephone the client within 24 hours of the referral being received by our service – the Client will receive information as to our service, and a Home Visit will be arranged. • The Home Visit will be arranged within 5 working days of the telephone call to the client, unless otherwise stated by the client, and organised for a convenient time to suit them. They are advised as to the information/documentation they may need to have available during the home visit. • Our electronic and client paper files are kept updated contemporaneously in order for us to track interventions, outputs and outcomes etc, and feedback on our service is sought at the end of every case. • The Adviser will review the case regularly over a 6 month period and support the client as required

Service	5a. Living Well Project
Provided by	New Horizons Service Lead; Trevor Smith, CE.
Commissioner	Macmillan
Which patient pathways would the service utilise?	• none specifically
How does the service monitor/measure performance?	• 450+ seen in 7 months. • Performance data collected and shared with DMBC and Macmillan • Client benefits assessed to support contract management
What organisations does the service interact with?	• All public sector health and social care agencies • Various 3rd sector providers and charities.
Who does the service link with?	• Works autonomously, little integration with other services.

Description of Key Intermediate Health and Social Care Services.
Service Area – 5. Third Sector Support Services

Service	5b. Home From Hospital
Provided by	**Age UK** **Service Lead; Vicky Ferres, CE.**
Commissioner	**DCCG & DMBC**
What is the service role?	• The service is primarily for, elderly people being discharged from hospital that don't need (or qualify for) formal support i.e. a package of home care or rehab, but have been identified as being at risk of re-admission (e.g. potential faller) • Provides day to day practical support including - shopping, cleaning etc. Building clients confidence to live independently at home and if possible, get them back to the level of independence they had previously. • 4 week maximum intervention • Home from Hospital service is a pilot project commissioned 18 months ago (3 year contract, until April 2016) by CCG and DMBC.
Where is the service based and where does it provide the service?	• On the wards at DRI and in the clients home. • The service is administered from the Age UK office at 109 Thorne Road, Doncaster
What is the service team structure and skill base?	• Mix of 4 x paid and 9 x voluntary staff. • Volunteers are trained to assess clients and deliver the service, but usually have no formal Health or Social Care qualifications. • 4 staff work for 2 days in reaching onto wards at DBHFT to identify potential clients. • 4 staff and 9 volunteers work in the community to deliver the service • Age UK can deploy additional domiciliary support as required.
What is the service access criteria?	• The service is for elderly people being discharged from hospital that don't need formal support / package of care / rehab, but have been identified as being at risk of re-admission
What is the service exclusion criteria?	• Anyone receiving a formal support package.
What is the referral source?	• It is only possible to make "step down" referrals (from the acute sector and other intermediate care services). Referrals usually come from the following sources; • Discharge Co-ordinators, ward staff, or specialist staff from intermediate care services that have identified that the client doesn't need a formal package of care but would benefit from some support. • Patients can also self-refer within 48 hours of discharge if unable to cope. • HfH staff in-reaching onto wards.
What is the patient profile?	• Usually elderly patients from DBHFT. • Clients greatest need is for re-assurance, social contact, knowing someone is there if required, and feeling safe.
What systems / processes are involved?	• DRI ward staff can refer directly to the Home from Hospital service by telephone / fax / email (through the Doncaster AGE UK office) • Patients are also identified directly by HFH staff that visit the wards proactively seeking out appropriate clients • A basic assessment of the patients need made by HfH staff on the ward. • The HfH service then contact STEPS at Mary Woolett Centre to check eligibility for HFH service i.e. that client is not already receiving a formal package of care. • The service then coordinates the delivery of the service with the discharge of the patient to ensure that needs are met as soon as possible.- e.g. put heating on, provide basic groceries, etc. • The service carries out a level 1 falls assessment and will signpost client to services as appropriate • Service will support the client for 4 week maximum. • After 4 weeks service will signpost client to other agencies as appropriate.
Which patient pathways would the service utilise?	• Ideal pathway would be - patient identified on ward, support agreed prior to discharge and patient met on doorstep as they arrive home • if patient declines service on ward, HFH will give them a card with telephone contact in order for the patient to self-refer within 48hrs.
How does the service monitor/measure performance?	• Activity and performance data collected by service and shared with DMBC. • Service uses an outcomes tool called LEAF. • Doncaster have developed the Doncaster Outcome Tool (DOT), in liaison with Sheffield Hallam and DMBC. Service to pilot DOT in the community • Service receives approx 10 referrals / week. • Activity peaks on Friday afternoons. • The service aims for a 4 week maximum input to client

Service	5b. Home From Hospital
Provided by	Age UK Service Lead; Vicky Ferres, CE.
Commissioner	DCCG & DMBC
What organisations does the service interact with?	• DBHFT. • Community Nursing Service.
Who does the service link with?	• Link with other agencies but no integrated working

Description of Key Intermediate Health and Social Care Services.
Service Area – 5. Third Sector Support Services

Service	**5c. Social Prescribing**
Provided by	**CVS/South Yorkshire Housing Association** **Service Lead: Mandy Willis, Social Prescribing Manager**
Commissioner	**DCCG**
What is the service role?	• A social prescribing project contracted by Doncaster CCG with links to Sheffield Hallam University for evaluation. • The aim of this project is to reduce the impact of demand for unplanned care, to find solutions to non-medical issues and thus reduce unnecessary visits to GP, A&E, OOHs, etc. • The service seeks to support patients that present regularly at the GP where their social environment is effecting their health e.g. bereavement, debt, and isolation. • The service provides support to clients who are vulnerable and lonely, encouraging them to participate in local community life. The project will provide transportation and a volunteer social companion to take the person to a community group and stay with them. • The service acts as a conduit / liaison between GP practices and the third sector (providers)
Where is the service based and where does it provide the service?	• Initially piloted in 2 GP Locality areas of North West and Central Doncaster. • On 1st February 2015 the project expanded to include the South West GP locality area. The service now works with 28 GP Practices.
What is the service team structure and skill base?	• 1 x Social Prescribing Manager- 37 hours (CVS) • 1 x Social Prescribing Manager- 14 hours (South Yorkshire Housing Association) • 6 x Social Prescribing Advisors -137 hours per week, • 1 x Data Officer -7hrs per week, • 1 X Social Prescribing Support worker -30hrs per week, • 1 x Access and Participation Co-ordinator-30 hrs per week. • Staff have an excellent range of skills and qualifications including; Diploma in Social work, Counselling, Nursing, Information, Advice and Guidance Level 3, Health and Social Care, IAPT, Teaching and Counselling and experience of working in both in the Statutory and Voluntary sector.
What is the service access criteria?	• Service available to patients needing non-medical support who meet level 3 on the Risk Stratification Tool, plus one or more long term conditions.
What is the service exclusion criteria?	• Any one assessed as less than level 3 on the Risk Stratification tool. • Residents living in a non-funded GP locality area.
What is the referral source?	• It is only possible to make "step up" referrals (from the community) Referrals usually come from the following sources; • GP practices involved with the pilot • GP/Practice Nurse referrals The referral form requests information under the following 7 headings: • Managing symptoms • Housing Solutions • Healthy Lifestyles • Looking after Emotional Wellbeing • Making Connections • Work and Volunteering • Managing money and welfare issues
What is the patient profile?	• Any patient referred by GP • Any patient post 18 years who has one or more long term condition and deemed to require referral by the GP for non-medical issues (social needs) • All referrals are from GP's, the service will work with all communities, however there is a very low rate of referral for people from BEM communities. Services requested by clients • Emotional Wellbeing • Making Connections • Managing Symptoms • Housing Solutions • Managing money/welfare issues • Healthy Lifestyle • Work, volunteering and activities

Service	5c. Social Prescribing
Provided by	CVS/South Yorkshire Housing Association Service Lead: Mandy Willis, Social Prescribing Manager
Commissioner	DCCG
What systems / processes are involved?	• With the patient's permission, the GP writes a "prescription" and sends it to the Social Prescribing Team (SPT) at CVS or SYHA. • Practices fax through referral. • Referrals can also be received via post/email/telephone and can be picked up at the surgery • Referral received at fax machine/in post at Doncaster CVS and entered into book, along with date and source of referral • Referrals collected by Social Prescribing staff at regular intervals. Referral is entered onto database with profile and date • Social Prescribing Manager allocates referrals to Social Prescribing Advisors • Advisor makes initial contact with client within 2 weeks of receiving referral • Advisor visits client within 4 weeks of contact date • Assessment of need is made and an options plan co-produced with client • The team utilise the CVS online directory to identify relevant services. This directory is constantly under review, new community groups and services are added as appropriate. The service acts as the conduit between the patient and the service provider organisation. • Referrals made and clients supported with access • The service introduces the patient to the support service and facilitates attendance as required. This is reviewed after 12 weeks or as required. • Number of repeat visits determined by client's needs • The GP practice and client receive feedback on the intervention and outcomes from the service • Exit Strategy
Which patient pathways would the service utilise?	• None specifically
How does the service monitor/measure performance?	• Data collected and held at Doncaster CVS in compliance with data protection act. • Shared with DMBC • Data collected includes: referral organisations, client, GP practice, demographic information, long term conditions, A&E visits, Practice visits, referral source, ref issues requiring support • Targets - 600 contacts for the year. From 1st September 2014 to 18th March 2015 the project has received 338 GP referrals • The average length of intervention is approximately 3 months, which incorporates approximately 4 Adviser visits. • Caseloads are managed by taking a flexible approach to staffing and resource allocation.
What organisations does the service interact with?	• GP practices, LA, third sector organisations,
Who does the service link with?	• Co-ordinating closely with the LA Adults & Communities Team, Area Managers and Wellbeing Officers to ensure minimal overlap and provision of a complementary service.

APPENDIX 1.

Description of Key Intermediate Health and Social Care Services.
Service Area – Community Services

Service	2f – Community Therapy Services
Provided by	DBHFT, RDaSH, SYCIL, DMBC
Commissioners	Various
What is the service role? What is the service team structure?	**Speech and Language Therapy;** DBHFT – Outpatients – 1.7 wte (combination of B8a to B4), Mexborough Montagu Hospital (MMH) 0.2 wte (B5/B6) RDaSH – General - 2.2 wte (B6/B7), Stroke Rehab Team, 0.8 wte (B4) **Dietetics Services;** DBHFT – Outpatients – 2.1 wte (B5/B6/B7), MMH 0.1 wte (B5 & B7) DBHFT – Renal Outpatient's – 0.75 wte (B6/B7), MMH 0.45 wte (B6) RDaSH – Community – 3.84 wte (B7, B5 & B2) RDaSH – Adult Mental Health – 0.2 wte (B5 & B7) RDaSH – Learning Disabilities – 0.2 wte (B5) RDaSH – Older Peoples Mental Health – 0.2 wte (B5) **Physiotherapy Services;** DBHFT – Domicilliary /Community – 9.45 wte (B3 to B7) DBHFT – Respiratory / COPD – 2.0 wte (B3 & B6), MMH 0.4 wte (B6) DBHFT – Pulmonary Rehab – 1.4 wte (B3 & B6), MMH 0.4 wte (B3 & B6) DBHFT – Early Supported Discharge – 1.0 wte (B6) DBHFT – MMH Rehab – Neuro/Rehab/Falls, 1.1 wte (B3, B5 and B6) (B3, B5 and B6) DBHFT – MSK Clinics – 24.8 wte (B2 to B8), MMH, 5.8 wte (B3 to B8) DBHFT – CATS – 10.7 wte (B3, B6 and B8) DBHFT – Rheumotology – 1.8 wte (B2 to B8), MMH 0.1 wte (B6) DBHFT – Womans Health – 3.0 wte (B3 to B7), MMH 0.1 wte (B6) RDaSH – Evergreen – Falls Service/Day Hospital – 1.44 wte (B5 & B6) RDaSH – Intermediate Care – Hazel/Hawthorne – 3.0 wte (B5 & B6) RDaSH – Neuro Rehab / Outreach – 4 wte (B6 & B7) RDaSH – Cardiac Services – 2.8 wte (B3, B6 & B7) RDaSH – Stroke Rehab Team – 3.45 wte (B5, B6, B7) RDaSH – CICT Re-ablement – 2 wte (B6 & B7) RDaSH – Hospice – 0.1 wte (B6) SYCIL – 0.93 wte (B6) **Occupational Therapy Services;** DBHFT – Early Supported Discharge – 1.0 wte (B6) RDaSH – Occupational Therapy – 7 wte (B3 to B6) RDaSH – Evergreen – Falls/Day Hospital – 4.2 wte (B2 to B7) RDaSH – Hazel/Hawthorne – 4.8 wte (B3 to B6) RDaSH – Neuro Rehab / Outreach – 5.9 wte (B2 to B6)4.2 wte (B2 to B7) RDaSH – Community Stroke Team – 9.0 wte (B2 to B6) RDaSH – CICT Unplanned / Re-ablement) – 26.1 wte (B2 to B6) RDaSH – Hospice – 1.1 wte (B5 & B6) SYCIL – 0.85 wte (B5) DMBC – 29.0 wte (Grade 11 to Grade 5, equivelant to NHS B2 to B8)