Report to:	**SINGLE COMMISSIONING BOARD**
Date:	6 September 2016
Reporting Officer of Single Commissioning Board	Clare Watson, Director of Commissioning
Subject:	**COMMUNITY REHABILITATION SERVICES FOR STROKE AND NEURO-REHABILITATION**

Report Summary:

The Greater Manchester Heads of Commissioning, with the Stroke and Neurology Operational Delivery Networks (ODNs) have produced the attached report to provide an update on the work undertaken to date.

The report includes a proposal for the alignment of stroke and neuro-rehab services by developing a service specification for a combined model, providing a consistent approach to these areas of rehabilitation across Greater Manchester. We already commission in this way in T&G – the specifications for the previous SPRINT (neuro-rehab) and Community Stroke Team were merged in 2013-14 to form the Community Neuro Rehab Team (CNRT).

This report outlines the opportunities for GM working to achieve consistency and to identify areas where efficiencies can be made. It also outlines the following steps as essential in preparation for the implementation of a combined model:

- Consultation on a combined service specification
- Development of eligibility criteria
- Development of commissioning options with risks and benefits per CCG area
- Completion of a cost benefit analysis in order that the benefits of change required are quantifiable and assessable

Tameside & Glossop CCG are represented at Heads of Commissioning and also in the discussions with the ODNs on the details of this proposed model, and have provided information on the local service provision to inform the content of the report.

Recommendations:

The request from GM Heads of Commissioning is that each CCG takes this proposal through local governance for approval. SCB are therefore asked to APPROVE the following recommendations:

- Confirm the intention for a combined service model at a GM level
- Approve the proposal for the completion of an Impact Assessment including a cost benefit analysis
- Confirm Tameside & Glossop's involvement in this commissioning project

NHS Tameside and Glossop CCG will continue to commission a combined stroke and neuro rehab service from Tameside NHS Foundation Trust – currently the Community Neuro-Rehabilitation Team (CNRT).

The commissioning team will ensure that there are no additional

	cost implications of this piece of work for T&G Single Commission, and will work with the ICO on any redesign implications.
Financial Implications: ***(Authorised by the statutory Section 151 Officer & Chief Finance Officer)***	Proposals have been made at a GM level for a single combined service for stroke and neuro rehab. A single integrated service is already in operation across Tameside and Glossop, which is funded on a recurrent basis. We believe our service is already compliant with the aims and objectives of the current proposal, therefore we do not envisage that implementation of the combined GM service will materially impact on our financial position. However detailed KPI's and service specifications are not yet available for the GM service. As such there is some risk that once consultation has been completed, GM specifications may develop or change resulting in future pressures (though this risk is not quantifiable at this stage).
Legal Implications: ***(Authorised by the Borough Solicitor)***	The model being proposed for community neuro-rehabilitation services is a needs-led model, with a focus on sustainable change and promoting self-management. Community teams will in-reach into inpatient services to draw people out of hospital and support a seamless transition from inpatient to community services. This should result in more expedient and effective recovery. It may result ij a need to invest more heavily in these services to avoid longer hospital and nursing home stays. Any changes to the services required may require consultation and engagement.
How do proposals align with Health & Wellbeing Strategy?	NHS Tameside and Glossop CCG already provide a combined neuro rehab service which meets the Health and wellbeing priorities of: - Providing a joined up service to meet the local need, - Providing targeted support - Improve health and wellbeing.
How do proposals align with Locality Plan?	In line with the locality plan, the combined neuro rehab service provides a high quality, safe, clinically effective and local service which will deliver long term change.
How do proposals align with the Commissioning Strategy?	The combined neuro rehab service provides appropriate and cost effective services for people living with long term conditions
Recommendations / views of the Professional Reference Group:	PRG in August 2016 agreed with the recommendations
Public and Patient Implications:	One combined service allows patients and carers easier access to support and rehab. By splitting up the service there would be several access points with referrals made between services. We already operate a single service model therefore there will be no changes for our population in terms of access points. A Greater Manchester service specification would require consultation and this will include feedback from patients as well

	as therapists and commissioners. We will ensure we participate in this process.
Quality Implications:	An action plan would be put in place ensure the service offer is in line with the new service model and specification. The changes would provide extra support for patients and their carers, and also support discharges out of hospital. The specification will include robust quality outcome measures.
How do the proposals help to reduce health inequalities?	Delivering a model of care around people's neuro-rehabilitation needs will enable us to target the delivery of interventions in a way that will reduce health inequalities and broaden the range of support available to people with these needs.
What are the Equality and Diversity implications?	Equality and Diversity implications have been addressed in the development of this model, and will continue to be in the implementation and ongoing design and delivery.
What are the safeguarding implications?	All providers included in the delivery of this rehabilitation model are bound by safeguarding standards and policies. We will ensure through the implementation of this model that these are in place and that any new providers / partners understand their responsibilities.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	All partners involved in the delivery of this work will be bound by the necessary information governance guidelines.
Risk Management:	Risks related to the development and implementation of this model will be identified and managed through the ODN
Access to Information :	The background papers relating to this report can be inspected by contacting Samantha Hogg, Commissioning Development Manager: Telephone: 0161 3045300 e-mail: clarewatson2@nhs.net

1. INTRODUCTION

1.1 The purpose of this report is provide an update to the GM Heads of Commissioning regarding the work that has been undertaken, an outline of current commissioning arrangements by CCG and a draft service specification for a combined ESD and Community Neuro model.

1.2 This report further asks for the GM Heads of Commissioning to:

- Note the work to date
- Confirm the intention for a combined service model at a GM level (subject to individual CCG approval)
- Approve the proposal for the completion of an Impact assessment including a cost benefit analysis
- Define the overall timescales for the work detailed above

2. CONTEXT

2.1 Commissioning of community rehabilitation services for both stroke and also neuro rehabilitation patients is currently being taken forward by the respective Operational Delivery Networks (ODNs). It was agreed at the Greater Manchester Heads of Commissioning Group in January 2016 for both ODNs to work together with local commissioners on this issue with Bolton CCG leading on the initiative on behalf of commissioners.

2.2 It was determined that a group would be established and tasked with exploring the options to support the development of a single model and service specification for a combined ESD and community neuro service which embraces the potential differences in the two patient groups and how they are managed. Furthermore to develop shared principles for commissioning of services.

3. PROGRESS TO DATE

3.1 A group has been established with representation from both ODNs (including clinical leads) and with one or more representative from each of the CCGs across GM.

3.2 The section below details the work to date from each of the ODNs in regards to their respective areas.

4. STROKE

4.1 The acute care pathway for stroke was centralised in 2015, with standardised service specifications put in place for all stroke units. Community rehabilitation services for stroke patients are currently not standardised in Greater Manchester leading to significant variation in the model of delivery, services provided and capacity. Patients receive different post-acute care depending on where they live, with long waiting lists for more complex patients in some areas and wide variation in the type and intensity of rehabilitation support offered. Two CCGs currently have no stroke specific community rehabilitation services (Eastern Cheshire and Stockport) and others such as Salford and Trafford have separate Early Supported Discharge (ESD) and Community Neuro Rehabilitation Teams (CNRT) managing stroke patients, which evidence has shown to have less benefit in terms of patient care and efficiency than other models.

4.2 ESD provides intense rehabilitation that ensures stroke survivors have an earlier discharge from hospital. ESD teams provide rehabilitation for up to 6-8 weeks and patients who have more complex needs and dependency may be referred to either a community stroke team, a CNRT or a combined team who provide support for a longer time period. This two-tier system can result in patients waiting different lengths of time to receive rehabilitation, often with hidden waiting lists.

4.3 The recovery of patients after stroke relies on timely access to a mix of services and support, many of which are delivered by voluntary sector organisations and not the NHS. However, these services are often viewed as "add-ons" to NHS care, and are not consistently commissioned across Greater Manchester, and in many areas they are being decommissioned.

4.4 In June 2015, the Greater Manchester, Lancashire & South Cumbria Strategic Clinical Network developed an integrated rehabilitation model and service specification for stroke that if implemented across the region should reduce inequalities and be more cost effective. The model is currently in operation, wholly or partly, in half of Greater Manchester CCGs, although not via a single service specification. It includes a number of pathways for patients with different rehabilitation needs and outlines the benefits of a more integrated approach to post- acute care if implemented across the conurbation:

- Standardisation of community stroke provision and equality of access for patients across Greater Manchester. Bench marking of GM community services will be made possible.
- Timely access to rehabilitation services for all stroke survivors (not just the 40% eligible for ESD), no hidden waits and longer provision of services for those who need them
- More co-ordinated, efficient and integrated health and social services that meet the needs of patients – i.e. a blend of NHS and voluntary sector services
- Reduction in lengths of stays at stroke units
- Recently updated NICE Standards for stroke highlight the need for commissioning of a number of areas where we know there are gaps and that will need special consideration, potentially on a Greater Manchester wide basis:
- Adults who have had a stroke have access to a clinical psychologist with expertise in stroke rehabilitation who is part of the core multidisciplinary stroke rehabilitation team
- Adults who have had a stroke are offered active management to return to work if they wish to do so
- Adults who have had a stroke have a structured health and social care review at 6 months and 1 year after the stroke, and then annually
- A report has already been developed on addressing the gaps in clinical psychology, although further scoping is needed and a GM wide solution may be advantageous. Engagement with the voluntary sector will be key to improving access to vocational support and the two ODNs will work together to develop best practice and solutions in this area, although additional commissioning may be required. 6 month reviews are currently not conducted in all areas and consideration is needed as to the most appropriate organisation/team to deliver an annual review.

5. NEURO REHABILITATION

5.1 Greater Manchester neuro-rehabilitation services provide rehabilitation for people with a neurological condition. The current NHS service in GM is comprised of one hyper-acute/acute service at Salford Royal NHS Foundation Trust, four post-acute neuro-rehabilitation units (Rochdale, Stockport, Leigh and Trafford) and nine community neuro-rehabilitation services (the areas without a specialist community service are Bury, North Manchester and South Manchester). A scoping exercise of community neuro-rehabilitation services in 2015 demonstrated the extent of the variation of the services across GM. Staffing levels, entry criteria, intensity of treatment, waiting times for assessment/treatment,

assessing performance and number of referrals all differ greatly between each of the nine areas. The time people spend waiting to access community services was found to be between 5 days and 58 weeks dependent upon geographical area and/or which profession was required. The impact of the waiting times is significant to the people waiting and also has a knock-on effect on services referring into the community:

- People can deteriorate whilst waiting to access services, resulting in longer lengths of stay within the service and unnecessary difficulties for individuals
- Outcomes are unlikely to be optimised, as early intervention has been shown to result in better outcomes[1].
- People are not returning home as early as they could and not receiving care in the most appropriate setting
- People are staying longer in neuro-rehabilitation beds when there is no community service or long waits to access community services
- The knock-on effect is that people are stuck in other NHS beds (neuro-surgery, neurology, ICU, HDU etc..) whilst they wait for a neuro-rehabilitation bed
- NHS money is wasted whilst people wait in expensive inpatient services
- In December 2015 CCG Heads of Commissioning, and in January 2016 Chief Finance Officers, gave the neuro-rehabilitation ODN the 'go-ahead' to develop an outline business case to address the issues with the neuro-rehabilitation pathway, including community services. In addition, neuro-rehabilitation has been included within the top priorities for Devolution Manchester to address within 2016/17, with Salford Royal NHS Foundation Trust being appointed as the Transformational Lead for neuro-rehabilitation.

5.2 The model being proposed for community neuro-rehabilitation services is a needs-led model, with a focus on sustainable change and promoting self-management. Community teams will in-reach into inpatient services to draw people out of hospital and support a seamless transition from inpatient to community services. Access to the service will be timely and again based upon need and risk. There will be one service specification across GM to ensure equitable access, provision and quality of service. Standardised key performance indicators, outcome measures and reporting will provide assurance to commissioners and service users about the quality of services; benchmarking each area with the comparable services in other parts of region.

5.3 For the whole of the neuro-rehabilitation service (inpatient and community), vocational rehabilitation services are a vital part of the pathway. Supporting people to return to previous employment or seek new employment opportunities will have long term benefits for individuals, families and the local economy. Working with the GM Major Trauma Network and Stroke ODN, the extent of the vocational rehabilitation need will be identified, along with services that can meet that need or indeed gaps in service provision.

6. PRINCIPLES FOR COMMISSIONING COMMUNITY REHABILITATION SERVICES FOR STROKE AND NEURO REHABILITATION PATIENTS IN GREATER MANCHESTER

6.1 There are similarities and shared principles that have been established to support the commissioning and delivering care to the respective patient groups. Services need to be delivered and procured by each CCG with the idea position being the establishment of integrated teams delivering care to both patient groups using the respective model/service specification.

[1] Royal College of Physicians, 2003. *Rehabilitation following Acquired Brain Injury, National Clinical Guidelines*.

6.2 NHS England recently published guidance on commissioning rehabilitation services advocating a model that includes specialist and non-specialist services as well as peer support and community assets. It also outlines key expectations of patients, as well as principles of good rehabilitation services.

6.3 Building on this at a local level, the following principles, developed by the group, are shared across both patient groups and their respective models of care:

- Evidence based care pathways with access for patients being discharged from hospital or living in the community, using clinical consensus when no evidence exists
- Equality of patient experience across the conurbation through access to appropriate, timely care including shared decision making with patients and carers
- A consistent, flexible and needs-led approach with integration between inpatient and community rehabilitation teams, as well as other NHS providers (e.g. primary care)
- Involvement of other providers such as the voluntary sector to develop a more blended, asset based approach to rehabilitation care that addresses the wider needs of the patients and carers
- Timely discharge from the service using community assets effectively to continue longer term goals and ensuring there is capacity to provide responsive assessment and treatment times following referral to the service
- Standardised geographical inclusion criteria for all CCGs to promote efficient referrals
- As similar as possible outcome measures and KPIs that are a mixture of process indicators and measures that include patient reported experience and outcomes
- Timely discharge from hospital via in-reach to support people returning home more quickly and prevention of unnecessary readmission to hospital or attendance at GP
- Promotion of self-management where appropriate
- Ability to re-refer patients back into services they may need

7. CURRENT LANDSCAPE OF COMMUNITY REHABILITATION COMMISSIONING

7.1 Work has been undertaken via the ODNs on behalf of the group to determine the current local arrangements for the commissioning and delivery of ESD and Community Neuro across each of the CCG areas and is detailed below;

CCG	Stroke	Neuro rehabilitation
Bolton	ESD (RBH) and CNRT	CNRT within long term conditions service (RBH)
Bury	Integrated community stroke team (Pennine care)	No CNRT
Central Manchester	ESD (CMFT) and CNRT	CNRT (CMFT)
Eastern Cheshire	No stroke specific services	?
HMR	Developing community stroke team – recently awarded to	Neuro rehabilitation team – recent tender awarded to PAT
North Manchester	Integrated community stroke team (PAT)	Developing CNRT (PAT)
Oldham	Integrated model - ESD (Pennine care) and CNRT	CNRT (Pennine care)
Salford	Separate ESD (SRFT) and CNRT	CNRT (SRFT)
South Manchester	Integrated model - ESD and integrated rehabilitation team	No CNRT
Stockport	No stroke specific rehab services	STAR team (SHH)
Tameside & Glossop	Integrated model - ESD and CNRT	CNRT (TGH)
Trafford	2 providers of ESD (Pennine care & UHSM) and 1 for	CNRT (Pennine care)

CCG	Stroke	Neuro rehabilitation
Wigan Borough	Integrated model - ESD (WWL) and CNRT	CNRT (Bridgewater/WWL)

7.2 A more detailed summary of each CCG areas current community rehab services, including provider, workforce, known gaps in service and commissioned budget has been developed and shared with commissioners.

8. PROPOSED MODEL

8.1 Following the agreement of the core principles and building in the work already completed by the ODNs on their respective service areas, a draft service specification for a combined ESD and Neuro service has been developed. This service specification is in the early stages and is yet to be consulted on and developed further by members of the group.

8.2 One of the key difficulties with the development of a combined model is that the preparatory work undertaken by the respective ODNs are at different stages and working to different timescales. The work relating to the development of services for stroke are more developed with local areas already underway with implementation of the recommendations and pathways. The ODN for neuro rehab is only just coming to the end of the initial scoping work and as this forms part of a much wider programme of work looking at the whole pathway from diagnosis through to community the lead in time is much longer. The ODN for neuro are currently developing their system model and will be submitting a bid for investment from the GM Transformation Fund in September 2016.

8.3 Discussion between the commissioners and ODN leads has determined the need for further analysis of the current and future requirement for investment into both ESD and Neuro. Furthermore that consideration needs to be given to the geographical criteria for access to services which will need to be agreed on a GM basis. This will ensure that patients have a positive experience particularly pertinent to those patients living on boundaries.

8.4 Commissioners have also suggested and recommended that each CCG puts this combined model work in their commissioning intentions for providers. It may result in decommission of services which may be tough but necessary to achieve what is needed. Furthermore as each locality currently has differing service models, range of providers and range of investment, the work required for total service transformation if it is agreed for all localities to move towards commissioning and implementing a new combined model, this will inevitably present different challenges to certain areas across the conurbation.

8.5 Further work has been identified for the completion of a cost benefit analysis in order to support the development of a workforce model. Potential implications on social care will also need to be considered and quantified as part of this work.

9. NEXT STEPS

9.1 Opportunities for GM wide working to achieve a consistent approach and identify areas where efficiencies can be made (e.g. psychology) need to be explored. Local decisions on how a combined model can be achieved must be agreed across GM taking into account the nervousness of providers in implementing this change. There are a number of steps that need to be taken in preparation for the implementation of a combined model across GM;

- Consultation on the combined service specification to be completed
- Eligibility criteria to be developed and agreed on a GM basis
- Development of Commissioning options with risks and benefits per CCG area

- Completion of a cost benefits analysis in order that the benefits of change required are quantified and assessable.

9.2 Timescales need to be considered and a decision agreed as to whether implementation of a combined model can move forward now or wait for the outcome of the neuro bid in September.

10. RECOMMENDATIONS

10.1 As set out on the front of the report.