**Report to Adults, Health and Active Lifestyles Board:** 20th September 2022

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| **Title of report**: | An update on the Community Neurological Rehabilitation services redesign |
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## BACKGROUND

During 2021 colleagues from the Leeds Community Healthcare and NHS Leeds CCG (now the ICB in Leeds) attended/engaged with the Adults, Health and Active Lifestyles Board to inform the Board of its plans for patient, carer, staff and stakeholder engagement as it develops a new model of delivery for community neurological rehabilitation services whilst continuing to deliver its interim model (see **appendix A**). This engagement included:

- Attendance at a Scrutiny Board Working Group on 26 April 2021
- The submission of further referral/activity data and update paper on the planned engagement in June 2021
- Attendance at 5 October 2021, Adults, Health and Active Lifestyles Board to present a further update on the community neurological rehabilitation engagement and redesign themes prior to the model for redesign being agreed.

A report has been requested by the Scrutiny Board in September 2022 to update on the outcome of decision-making processes and the service model agreed.

**AN UPDATE ON THE COMMUNITY NEUROLOGICAL REHABILITATION SERVICES REDESIGN**

## 1. Progress made since last presentation to the Scrutiny Board (5 October 2021) and the model agreed

1.1. Following dialogue with the Scrutiny Board last year on our planned engagement for the redesign of community neurological rehabilitation services in Leeds, the very strong themes identified through engagement with patients, carers, staff and stakeholders for inclusion within a new model were concluded at the 5th October 2021 meeting as:

- The Home First offer will form a key element of the new model
- The length of inpatient rehabilitation needs to be tailored to individual patient needs, with the conclusion that with a focus on the home first approach and a more responsive community offer, a reduction of inpatient beds is likely
- A route for self-referral into the service is essential for those known to the service
- A more responsive service is required in order to provide rehabilitation in the right place at the right time for the patient
- A need to deliver the appropriate intensity of rehabilitation at the right time to meet patients goals effectively
- Speech and Language Therapy needs to be embedded in the service
- The offer should also accept patients that require only one discipline to meet their specialist rehabilitation needs

In October 2021, we confirmed to the Scrutiny Board that the redesign needs to be undertaken within existing financial resources and therefore a selection of options were to be considered as the final service model was to be developed and agreed to incorporate the above key themes.

We are pleased to confirm that immediate progress was made, in concluding the patient and carer engagement, and presenting four key options (**appendix B**) to the Executive teams of Leeds Community Healthcare and NHS Leeds CCG (in October 2021, with a preferred option supported (known as option 3a). The recommendation was in turn supported at the city's Leeds Long Term Conditions Population Board on 12 October 2021.

An Equity and Quality Impact Assessment (EQIA) was completed on the final model during November and December 2021, with the options and preferred model presented to the NHS Leeds CCG Governing Body in January 2022. The model and phasing as outlined below was agreed by the NHS Leeds Governing Body.

### 1.2 The model/ambition

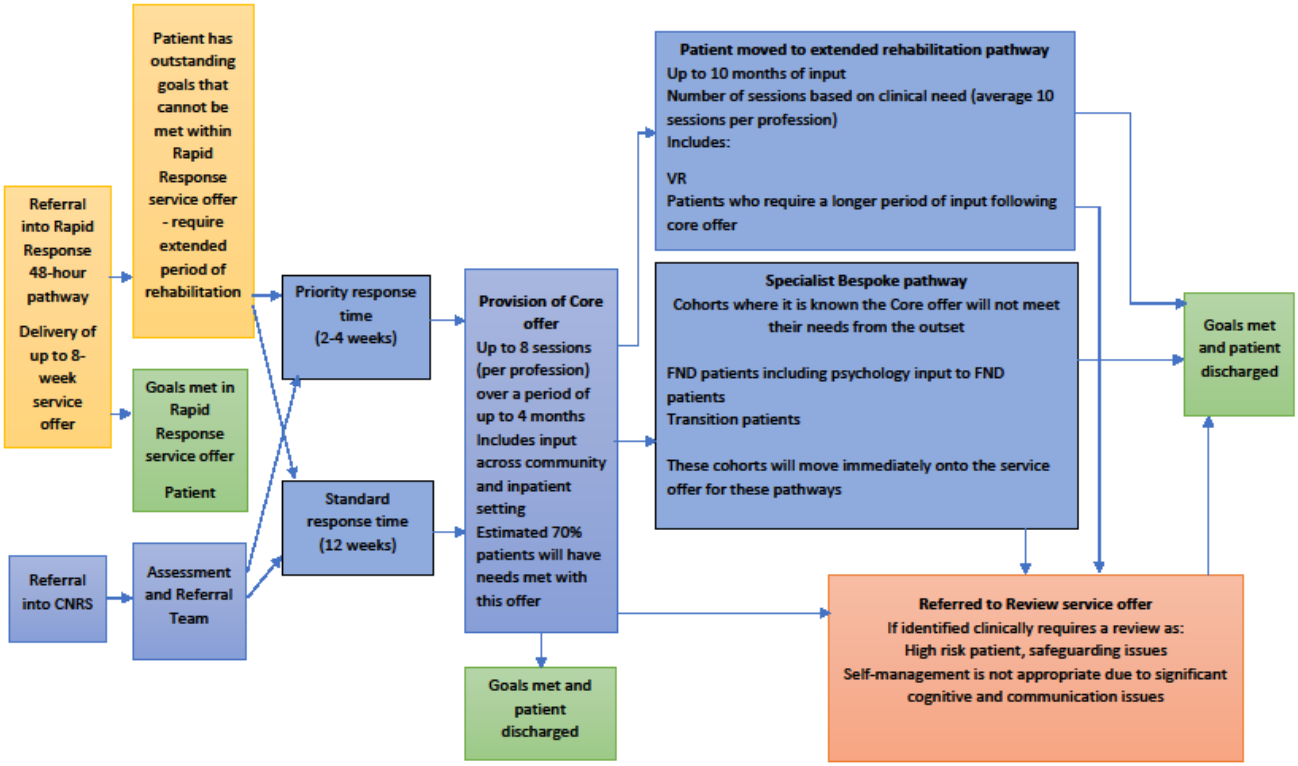
An ambition has been defined for the new service model for community neurological services in order to address the key themes from staff, stakeholder, patient and carer engagement, data analysis, demand and capacity work:

- To provide high quality and timely neurological rehabilitation to Leeds patients
- To ensure timely equitable access for all that need community neurological rehabilitation
- To work collaboratively with partners in Leeds

This ambition will be delivered by implementation of the model as outlined within **Figure 1** and includes six key elements that will form the service offer in the long-term.

1) An Assessment and Referral function
2) A Rapid 48-hour response pathway
3) A core 'home first' service offer
4) An extended rehabilitation service offer
5) Bespoke specialty pathways
6) Inpatient rehabilitation

Figure 1. High level view of the ambition for a CNRS service offer




**N.B.** it is estimated that 70% of patients will have their needs met by a core offer with 30% patients requiring an extended pathway or bespoke specialist pathways.

Due to the complexity and identification of unmet need identified as part of the redesign assessment, a phased approach to the redesign was also agreed by the CCGs Governing Body:

- Pre-Phase 1- 2022/23 (preparation work required to facilitate implementation of phase 1 including recruitment and skill mixing and ongoing work to clear the waiting list backlog)
- Phase 1 (22/23); with subsequent agreement that implementation will now be by April 2023, due to the delays outlined in section 2. Due to system uncertainty regarding additional financial resource, phase 1 is to be delivered within the current funding envelope of £2.8 million. Phase 1 therefore excludes an offer of extended rehabilitation and bespoke pathways and expansion of the rapid response offer to include all neurological conditions, as these developments exceed the financial envelope. It is anticipated that these elements will be funded as we release current fixed estates costs into future phases. The impacts/risks of these exclusions were assessed within the completed EQIA.
- Phase 2 aspiration (within 2023/24): Provide an enhanced assessment and referral function, expand the rapid response offer and deliver 100% 'home first' core offer, in addition to elements included in phase 1.
- Phase 3 aspiration (within 2024/25): Phase 3 aspiration (2024/25): Provide extended rehabilitation and bespoke pathway in addition to elements included in phase 1 & 2.

The model and option selected for phase 1 of the service redesign allows for the provision of a rapid assessment and referral function (within 48 hours), a core offer to patients (up to six sessions per profession for 4 months), a rapid response offer and the opportunity to test and pilot the provision of one bed, over seven days a week in a different inpatient setting with the service providing therapy and rehabilitation nursing input via an in-reach model.

As we discussed previously with the Scrutiny Board, it was envisaged that fewer inpatient beds would be needed and at the time of agreeing the model with data analysis suggesting one bed might be needed, instead of the original five that was previously offered.

On this basis, the decision was therefore made to signal the intention to withdraw the LCH inpatient beds from the estates at St Mary's permanently with an estates review commencing to explore the longer-term estates options for neurological rehabilitation outpatients and community stroke services (which are also based at St Mary's). This work therefore aligns with the city-wide stroke priorities.

The rationale for not keeping the beds at St Marys, relates to the clinical governance risks and costs associated with treating just one patient onsite at any one time.

Growth in referral activity (15%) across the service has been factored into the model. A significant benefit of the model is that all patients referred will be seen within 2-4 weeks if urgent and within 12 weeks if routine (waits have historically been +38 weeks) and will reduce variation in practice whilst enhancing patient self-management and personalisation.

Please note that pre-phase 1 implementation has commenced; therefore, the interim model as outlined in **appendix a** currently remains in place.

## 2. Challenges faced and impacts/risks

A number of workstreams/project groups have been established by LCH to mobilise the redesign (move to phase 1 of our redesign). Unfortunately, progress has been delayed by several months due to the Omicron variant of COVID earlier this year and capacity constraints within the team. Workstreams with key updates are outlined below:

Comms and engagement: Following approval of the redesign in January 2022, communications and engagement began with staff within the service to inform the case for change (HR process) whilst also forming a Staff Health and Wellbeing workstream to monitor this and offer the right support as and when staff require this during the change.

In addition, a 'You Said, We Heard' resource was prepared for patients; please see **section 3**. Current patients of the service have been kept up to date with service changes throughout with the services website reflecting the current service offer. Current patients and any patient entering the service have also received a letter regarding the current service offer and what to expect.

Case for change:

The case for change (HR consultation process) has been commenced to facilitate the release of resource to ensure appropriate skills mix of staff for phase 1 (i.e., inpatient staffing resource aligned to increasing physio, OT and psychology workforce to support the Home First model). The case for change has been supported by LCH Staffside and HR. During the case for change consultations, feedback from staff has indicated that we need to further review service data and learning from the past year as we plan the proposed inpatient offer with an aim to ensure that resources are utilised effectively to maximise the service offer within phase 1. Further discussions are therefore planned regarding the long-term planning/phasing of the provision of the inpatient bed with the Long-Term Conditions Population Board. Full recruitment and skills mixing will therefore not go ahead until October when the case for change process and outcome is agreed.

Backlog trajectory: Backlog trajectories have been challenging to work through due to data inaccuracy. A significant piece of work has been undertaken to validate LCH waiting lists. All trajectories are beginning to demonstrate a reduction in waiting times now or in the next couple of months, with all waiting lists estimated to align with our new model aspirations of patients being seen within 2-4 weeks if urgent and within 12 weeks if routine (waits have historically been +38 weeks) by early 2023. It was previously agreed that we cannot proceed to phase 1, until waiting lists are reduced and in line with our new ambition for waiting times.

Estates: The service specification for the inpatient bed is being developed with exploration regarding opportunities in the city for the provision of the community neurological rehabilitation inpatient bed. System-wide estates colleagues are also involved in mapping work to consider the future longer term estates options for outpatient CNRS and stroke services (phase 2 onwards).

Performance and data: Significant BI resource to date has been allocated in backlog trajectory work. The next priority for BI and LCH Clinical Systems teams is to ensure accurate clean data is collected to support continued service reporting in line with the new

model/evidence agreed outcomes. Data will also inform and guide future development through the phased approach.

Systems and Processes: Before commencing with phase 1 go live, dedicated resource is needed to revise referral processes and forms and develop patient-initiated follow-up routes/re-referral and self-management tools. Self-management tools and opportunities are currently being mapped by the service with consideration of digital innovation and opportunities to work with the third sector as encouraged by the Scrutiny Board last time we met.

As identified good progress is being made across all work streams, with waiting times improving and the team progressing as much work as possible within existing resource. It is envisaged that phase 1 will formally commence in quarter 4 of 22/23 based on progress as identified above.

In terms of **mitigation**, regular updates have been provided to the Leeds Long Term Conditions Population Board, which includes representation from all system partners, to keep all updated. In addition, we continue to provide patients with the 'interim' model, which is well received.

We do not believe there are patient / health inequality impacts caused by the delay to implementing this new service model. All patients are receiving an offer of care currently, with our personalised home first approach in many ways enhancing access to services, i.e., delivery of care close to home, reduced travelling for patients and the opportunity to identify risks in people's homes, etc.

## 3. Engagement with people, patients and carers

As identified above, staff engagement has progressed via the Case for Change and formal HR Consultation on the new model. Staff have been engaged with at all stages.

As we have not yet implemented the model and we are not in the position to complete a 'You Said, We Did' report, we have completed a 'You Said, We Heard' report. This is included in **appendix C**. This is available at LCH Neurological Rehabilitation Service (leedscommunityhealthcare.nhs.uk) and has also been shared with the participants of the original engagement via Voluntary Action Leeds (VAL) and has also been shared with patients direct via the service. We continue to keep other stakeholders updated on the service redesign via the Long-Term Conditions Population Board and our governance routes via the West Yorkshire Integrated Care System.

## 4. Revised implementation plans/ next steps

Our revised implementation plan/next steps are:

- Discussions are planned regarding case for change staff consultation reflections to further review service data and learning from the past year as we plan the proposed inpatient offer with an aim to ensure that resources are utilised effectively to maximise the service offer within phase 1. Further discussions are therefore planned regarding

the long-term planning/phasing of the provision of the inpatient bed with the Long-Term Conditions Population Board during September and October 2022.

- Phased implementation of the new model is expected from during quarter 4, 2022/23, with full details of the model to be made available on the services website following full approval.
- A 'You Said, We Did' report will published at this point outlining the new service model and ongoing satisfaction from the service.

## 5. Conclusions

5.1. Scrutiny members are asked to acknowledge the positive work and priorities progressed to date despite the challenging climate.

5.2. Scrutiny members are asked to note the revised timescales as documented.

## Appendices

### Appendix A: Community Neurological Rehabilitation Service Offer Details

| Service Offer Within Leeds (prior to COVID-19) | Service Offer in Leeds (as of 1st September 2020) – Interim Offer |
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| • Immediate Occupational Therapy intervention to facilitate earlier discharges from hospitals (patients who have sustained a Traumatic Brain Injury or Neuro Oncology condition)<br>• Multi-disciplinary rehabilitation in a community setting i.e. care homes, leisure centre, community facilities – work place, educational facilities or healthcare settings<br>• Regional inpatient 5 bed unit, based at St. Mary's hospital, provision of multidisciplinary rehabilitation through planned short-stay admissions for those with complex neuro conditions.<br>• Day-unit service for individuals who require more intensive multidisciplinary input than that provided in community settings.<br>• Consultant-led clinics for assessment and management of spasticity.<br>• Out of area referrals accepted (a small number per annum). | • Home First offer<br>• Implementation of new prioritisation criteria<br>• Up to 6 sessions of each profession (as required) over 3 months (extended in cases of risk/safety issues in patient episodes – on an individual basis)<br>• Inpatient unit at St. Mary's not currently open to admissions<br>• Priority patients / those waiting over a year are being prioritised<br>• Pilot of new triaging role<br>• *Spasticity and Review clinics* restarted at St. Mary's Hospital – currently led by medics and only linking with therapists when an urgent/priority therapy need is identified.<br>• All new patients have face-to-face appointments<br>• For review and follow up appointments alternatives to face to face are considered (e.g. phone calls, video calls or face-to-face if required)<br>• *Therapy Clinic* slots available at St. Mary's Hospital where therapists are able to provide interventions that cannot be provided at home e.g. where environment that is not conducive to rehabilitation, or if a patient requires specific equipment. Clinic use is being reviewed as part of service review.<br>• Out of area referrals redirected back to the referrer to explore alternative local services provided within the patients area or advise referral to Leeds Teaching Hospitals NHS Trust. |

The Community Neurological Rehabilitation Service (CNRS) delivered by Leeds Community Healthcare NHS Trust has historically the following elements of service provision.

- *Community Neurological Rehabilitation Team (CNRT)* which aims to provide rehabilitation in a community setting. This can include within the home, leisure or community facilities, work place, educational facilities or healthcare

settings. Within this remit, the team offers rehabilitation in order to optimise function, participation, quality of life and enhance independence.

- *Community Neurological Rehabilitation Centre (CNRC)* which is a regional inpatient unit that provides multidisciplinary rehabilitation through planned long-stay admissions (2 week blocks of rehabilitation) for individuals with complex needs due to a neurological condition who are medically stable. Additionally, the inpatient unit also offers a day service for those who require a more intensive input than what is available from the community facilities.

- *Community Neurological Discharge Team (CNDT)* within CNRS. This team has been running since January 2019 providing immediate occupational therapy input on discharge from hospital for patients that have experienced a traumatic brain injury. The team works alongside therapists and medics in Leeds Teaching Hospitals NHS Trust (LTHT) supporting and facilitating earlier discharge from hospital for this cohort of patients. They provide 8 weeks of intervention once the patient leaves hospital supporting the individual to reintegrate into society, return to work, provide rehabilitation and providing advice and support as the patient transitions to home life.

## Appendix B: The Options

Option 1: Provide no inpatient beds (exit St Marys), provide a 'home first' core offer for 100% of patients, provide assessment and referral function as-is and continue to provide the as is rapid response function (Community Neurological Discharge Team which is OT only and only provides input to Traumatic Brain Injury patients).

Option 2: Provide 1-5 inpatient beds at St Marys, provide a 'home first' core offer however resources only allow delivery for 50-70% of patients, provide assessment and referral function as-is and cease the as is rapid response function.

Option 3a: Provide 1 inpatient bed, bought in from another provider, with the service providing therapy and nursing rehabilitation into the bed, provide a 'home first' core offer for 100% of patients (however resource means that this will be a limited offer), provide assessment and referral function as-is and continue to provide rapid response function.

Option 3b: Provide 2 inpatient beds, bought in from another provider, with the service providing therapy and nursing rehabilitation, provide a 'home first' core offer 100% of patients (however this will be a significantly limited offer due to the resource available), provide assessment and referral function as-is and no rapid response function.

When considering the development of the options, value for money and cost effectiveness were considered. The options outlined how the service can deliver an efficient and effective service whilst trying to ensure it is accessible to all and is responsive to patients' needs. The options also considered the engagement feedback from patients, carers and stakeholders.

**Appendix C: Community Neurological Rehabilitation Redesign, You Said, We Heard**

| | You said | What we are doing | How can you help? (How can patients, carers, members of the public help) |
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| **Information** | People want better communication whilst waiting to access the service, including length of expected waits and details of the service offer and what people/carers can expect | We will look to improve our communication with people on the waiting list and ensure we use a variety of formats to do that<br><br>We will provide details of the current service offer, and set expectations regarding elements to be delivered at home / in other community settings | Make sure that the service has your correct contact details and that you have told us the best time and preferred way to get in touch. |
| | Following discharge, people didn't like the word 'final review' and would like the option of support post discharge | We will not use the word 'final review'. We will ensure that patients and carers are sign posted to voluntary third sector organisations and peer support groups once therapy/treatment has finished for further information and support. Digital tools will also be provided which will help with future self-management | Let us know what a "good discharge" would look like to you. We are always keen to hear feedback as your views and experiences can help shape the service. In addition, any ideas on which support groups/organisations you would find useful are always welcome. |

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| **Accessibility** | If inpatient rehabilitation is needed people prefer to be seen in local hospital and community settings rather than big general city hospitals | A location/offer for in-patient stays for rehabilitation has not been identified yet, but we will not be looking at a big general city hospital, for provision of this | |
| | People need to be given a range of options of how to access the service | We want to make the referral process as easy as possible.<br><br>The referral form will be reviewed to ensure it is accessible and easy to use for health care professionals and that they are aware of the service.<br><br>For re-referral we will provide you with clear information on how to come back to the service if you need to following discharge. | Talk to the service about the re-referral process once you are discharged and the range of options available.<br>Make sure you keep hold of the information to contact the service if you need to |

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| **Quality of service** | Carers, friends, and families want to be more involved and would value more flexible visiting times for inpatient stays (if inpatient rehabilitation is needed) | We will look at doing some more engagement around this area to identify specifically what carers, friends and families value about being more involved and how we can improve inpatient stay experience when this is needed. | Help us identify what being involved looks like to you to help shape this. |
| **Equality of access** | People from diverse communities need more assurance about what to expect before they arrive for their in-patient stay and / or enter the service | A detailed communication plan around the new service model will be drawn up which will include a variety of forums/formats/languages to ensure it is accessible to all.<br>We will also look at the idea of filming a video of what to expect which can be sent to patients. | Get involved and tell us what you think of our communication plan and help shape what the video could include. |