

Establishing Care Units in Care Homes - Toolkit

Short term, rehabilitation and reablement care

January 2022

NHS England and NHS Improvement



Contents

1. [Introduction and Context](#)
2. [Process map](#)
3. [Resources](#)
4. [Tariff drivers](#)
5. [Critical success factors](#)

Appendix 1: [Improving outcomes through the ethos of rehabilitation](#)

Please email england.communityrehab@nhs.net with any questions or feedback on this toolkit.

1. Introduction and context

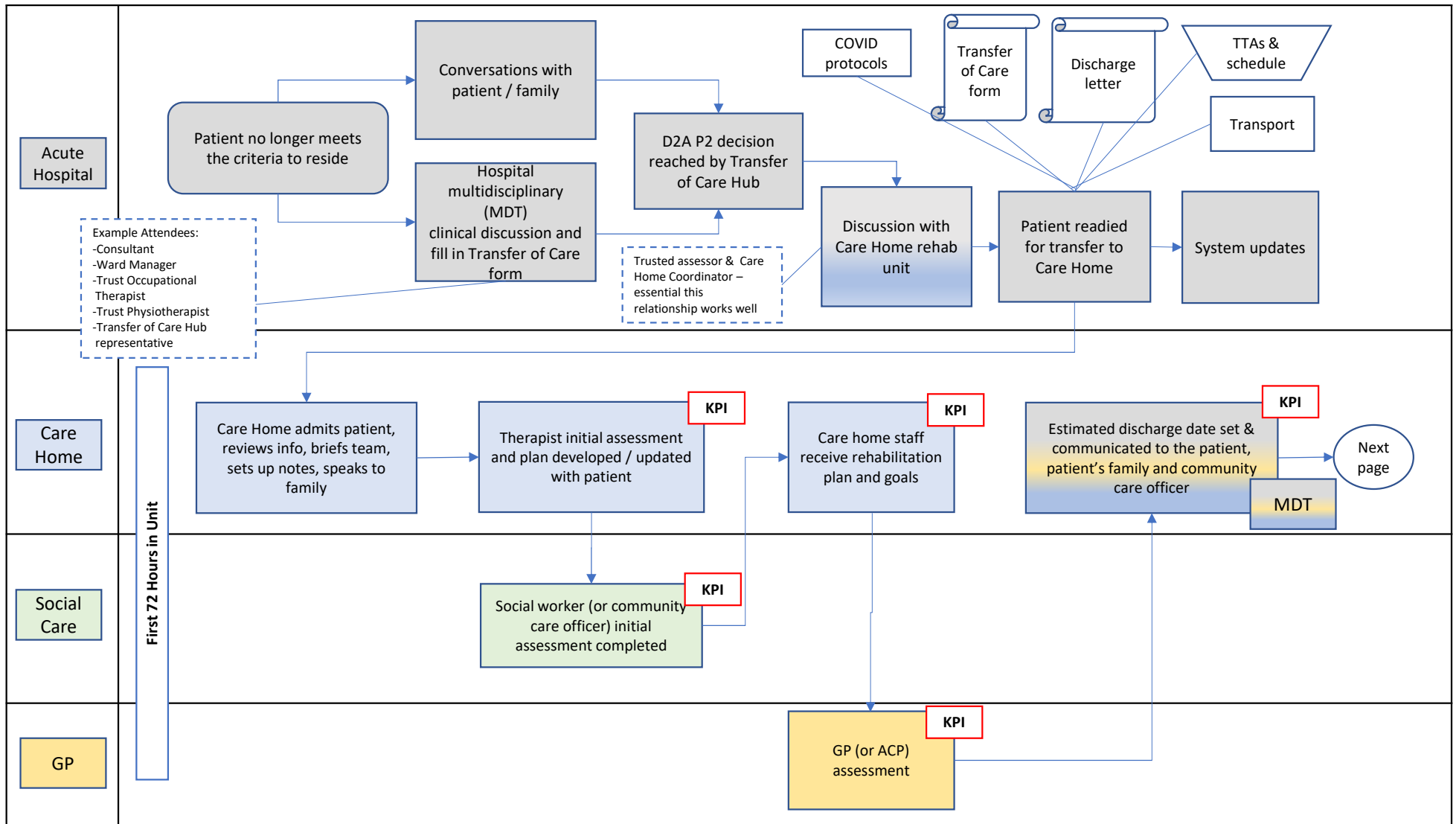
- Up to 10,000 people per day do not leave hospital on the day they no longer meet the criteria to reside (no longer require acute care). A significant proportion of those have a long length of stay and remain in hospital due to the lack of availability of ongoing packages of care, including the lack of access to short term bedded support.
- In December, NHS England and NHS Improvement published a [service specification and framework](#) to support new surge capacity using care homes to support people (predominately older people) who can recover and receive rehabilitation or reablement support instead of residing in a hospital bed. The framework set out expectations for systems to work with care home provider organisations to establish the care units at scale to meet the demand from all those who are in hospital now and can leave¹.
- The care units, to be established in care homes, could be used flexibly and will be suitable for people on pathways 1,2,3² ensuring the necessary wrap around of health or therapy input that will improve outcomes following the intermediate or short term support.
- This toolkit contains further information around critical enablers to support systems in implementing units. It contains:
 1. A process map – intended to support the allocation of responsibilities required to deliver successful units.
 2. Resources – highlighting the variety of human and other resources required for a successful implementation, and options and ideas to source those resources.
 3. Information on tariffs - intended to provide transparency of the cost drivers that care home providers will experience, to support negotiations between commissioners and providers.
- Some systems already have a similar service in place and this toolkit was developed using learning from those systems and other partners, including care provider organisations, to understand what works well and what they would improve. To support implementation, systems can also draw on learnings from the implementation of other initiatives such as virtual wards, and Early Supportive Discharge pathways (for instance the stroke pathway).
- The content in this toolkit has been produced in consultation with geriatricians, nursing, AHPs, commissioners, local authorities, GPs, care home providers and other stakeholders, whose time and insight is gratefully acknowledged.
- In this pack, 'rehabilitation' is used for brevity to cover all relevant forms of recovery, rehabilitation and reablement.

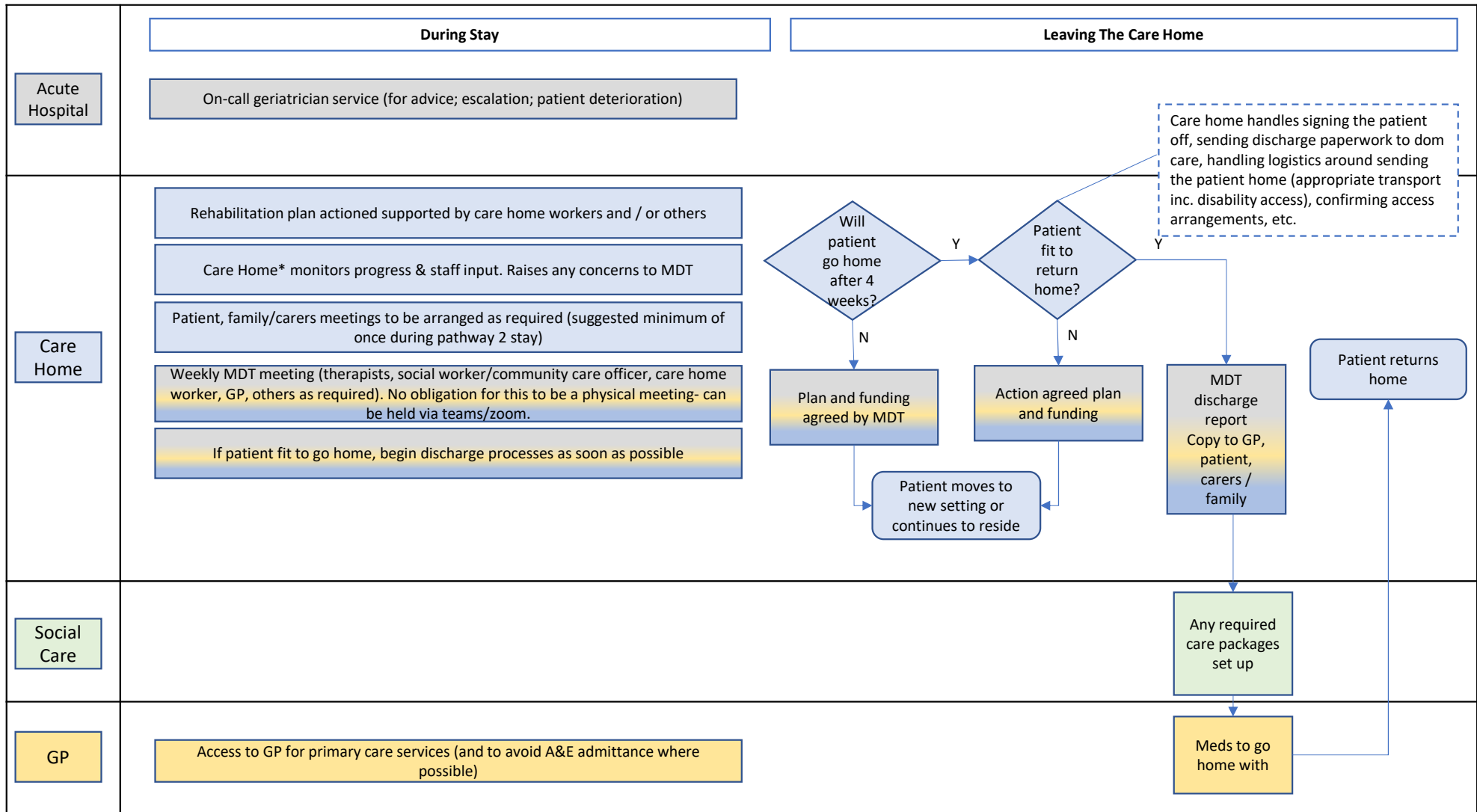
1. <https://www.england.nhs.uk/wp-content/uploads/2021/12/B1272-accelerating-the-numbers-of-people-discharged-home.pdf>

3 | 2. Definitions: <https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model>

2. Process map

- Slides 5 and 6 comprise a process map intended to support the allocation of responsibilities and commissioning required to deliver successful units. It is an example of the processes that may need to be followed in a successful unit.
- Critical to success is local system partners working together to ensure a flexible workforce, to maximise capacity and to identify new models – sharing resource and cost to get the best outcomes possible for people
- The process map should be used by local health, social care, care home and other partners in discussing how the care units will work, what the roles and responsibilities across partner organisations and services are, and what services need to be commissioned or contracted for.
- In slide 7 are a series of start-up questions designed to elicit further clarity on expectations, roles and responsibilities across partners (systems will hopefully have more to add as they discuss between partners and providers)
- Systems should engage with their Infection Prevention and Control (IPC) teams to clarify the IPC responsibility in the units. Refer to [UK Health Security Agency](#) for further guidance.





Questions to support the contracting and start-up of units

- Is there an agreed Transfer of Care form?
- What admittance criteria are there at this specific unit? (What levels of illness / dependency can this setting successfully manage?)
- Is 7-day admittance required?
- How does electronic information get sent to the care home?
- How is the 'Care Home Coordinator' (or similar role) delivered by the care home?
- How are each of the resources in the outlined in section 3 of the toolkit, being provided?
- What out-of-hours cover expected for:
 - GPs?
 - Therapists?
 - Nurses?
 - Care Coordinator?
 - Geriatrician support?
- What happens if staff working in the unit are sick or on annual leave?
- What is the agreed IPC policy, including outbreak measures? (Refer to local IPC teams and the UK Health Security Agency for further guidance.)
- When do MDT meetings happen?
- If repeated MDT non-attendance, who does care home escalate to?
- Who arranges and pays for transport from care home to a person's own home?
- If the person stays longer than 4 weeks, what are the financial arrangements?
- What if the individual receiving care needs a domiciliary care package but one is not yet available?
- How are medicines prescribed and delivered?
- Who sends information to the registered GP of the individual receiving care in the unit?
- Who writes the discharge report?

3. Resources

This section is intended to highlight the variety of human and other resources required for a successful implementation, and to provide options and ideas to source those resources. It is hoped that this information will enable commissioners to swiftly implement the required care home units, and optimise the outcomes for patients.

Below are the main categories of resource or workforce suggested for a successful unit:

1. **Rehabilitation support** – following a plan developed by a therapist or therapists, this activity involves supporting individuals in carrying out activities to improve their function. It is different from personal care and requires a mindset that fosters knowledge, confidence and capability, enabling independence and autonomy. **See slide 10** for details of options for delivering this activity.
2. **Rehabilitation assessment and planning** – this is the professional assessment of rehabilitation and reablement needs, and must be carried out by a registered therapist. **See slide 11** for more details.
3. **Nursing** – some people may require regular nursing (particularly for example those who are post-operative). Commissioners and care providers should ensure that sufficient nursing resource is available to the new units, based on the acuity of the person. For example, delivery of certain medicines (e.g. insulin, tinziparin) and management of catheters or other devices may require several visits per day including out of hours. Nurse visits can also be used to proactively support an individual's recovery and avoid readmittance to acute hospital settings.
4. **Other clinical services** – for example mental health practitioners, dietitians, speech and language therapists, other AHPs. The local system should identify and be ready to deploy these resources as necessary.
5. **Clinical leadership** – commissioners should identify a named clinical lead who has accountability for the clinical aspects of the units. It will be for local systems to determine who that individual is but they must have sufficient competencies to discharge the role safely. There are various models that can be used including: the GP associated with the Enhanced Health in Care Homes (EHCH) contract; an alternative GP with appropriate interests; an AHP or advanced nurse with appropriate competencies, supported by Primary Care where necessary. Leadership qualities will be essential for this role.

Continued overleaf.

3. Resources (continued)

6. **GP and pharmacy needs** – patients are discharged from the acute hospital setting, so they fall under the responsibility of Primary Care. **See slide 12** for suggestions on how commissioners can ensure there is GP cover and access to pharmacies.
7. **Geriatric escalation** – to support care homes in dealing effectively with deterioration or escalation of need. **See slide 13** for more details.
8. **Social workers** – as well as the initial assessment, Social Care input will be essential in achieving a prompt return home for people who are deemed able to leave the unit (with a package of domiciliary care if needed). Ideally a specific Social Worker would be allocated to the unit to build relationships.
9. **Family members, friends, community support and advocates** – as per normal practice family members and other support should be included in conversations and decisions. They are a useful resource in supporting patients in actioning their rehabilitation plans, with some instruction from registered therapists. This has the further benefit of enabling family members, friends and others to better support the person after they have returned home, which may further reduce the chances of readmission.
10. **Process and administration management** – existing units have found the frequent admittance and discharge of patients, plus the need to coordinate multiple organisations, requires specific resource. **See slide 14** for more details.
11. **Transportation** – the journey from hospital to care home and from care home to domestic residence will require coordination between agencies, including ambulance services, but could also include family, carers and third sector resources.
12. **Equipment** – a list of rehabilitation equipment was provided in the Service Specification. A distinct space to carry out rehabilitation exercises, and facilities to aid reablement (for example a kettle or kitchen) are desirable.
13. **Technology** – the care home should provide wi-fi access to workers attending these units if requested. Systems should communicate securely with the care home and systems should consider how this will be achieved whilst meeting GDPR and other regulations. Providing the care home with an NHS.net address, access to NHS mail and the NHS cyber-security toolkit are options.

Rehabilitation support

Care Home workers

Care home workers are a good option to support people in carrying out activities to improve their function. Testimony from care home organisations that already provide rehabilitation units was that workers often get improved job satisfaction from supporting rehabilitation, and that it provides opportunities for career progression.

However, as acknowledged in the framework, rehabilitation requires a different ethos and mindset from carers, as well as additional time. With some training and support from therapists and management, many care workers will be able to adopt a rehabilitation mindset. Appendix 1 contains links to various resources that can help care units develop a rehabilitation approach and ethos.

Clarity in communication is essential in the management of the person being rehabilitated. Care homes and registered therapists should work together to ensure instructions and messages to care home workers are consistent, and that conversations about the capacity and development of care workers are aligned.

Other resources

There are a variety of additional or alternative resources that commissioners could call upon to support rehabilitation activities in the new units. Health, Local Authority, private sector, voluntary community and social enterprise partners should be consulted to identify opportunities within the local geography. Opportunities include but are not limited to:

- Therapy Support Workers and Therapist students on placement with local providers
- Physical activity specialists, such as those potentially already employed by Local Authorities to provide group exercise classes
- Local volunteers from charitable and independent organisations that already work with older people
- Workers in private sector settings, such as gyms, for example personal trainers
- Family members, carers, advocates

Delegation of competencies to care workers and other staff must be undertaken in line with Health and Care Professionals Council (HCPC) guidance³.

10 | 3. See also AHP Support Workers competency, education and career development framework - Realising potential to deliver confident, capable care for the future - https://www.hee.nhs.uk/sites/default/files/documents/AHP_Framework%20Final_0.pdf

Therapists

- To manage or address any workforce shortage issues, or plug any gaps, systems should think innovatively about using their resources efficiently to deliver successful units, whilst ensuring other services are not being impacted and delivery issues are not being created elsewhere.
- The focus of registered therapists should be on the assessment of people receiving care in the unit and development of rehabilitation plans. Support of those plans can be carried out by other resources. Working with care home management, therapists should lead in the development of a rehabilitation culture and mindset, and provide guidance and support to care home workers and others who are supporting patients. Where registered therapists delegate tasks to other resources, they must ensure that those individuals have sufficient competence and confidence to carry out the tasks.
- Therapists could be sourced from the existing health system, be that hospital or community (or a combination of both). Systems should think innovatively about job plans and scheduling to free up resource wherever possible.
- Alternatively (or additionally) commissioners should consider the use of therapists from the private or charitable sectors, be that contracted directly, or commissioned through the care home (see Tariff guidelines for more information). There are numerous successful examples of care homes providing therapists around the country.
- Where commissioners contract directly with private therapists they should ensure those individuals have up-to-date registrations, mandatory training and CPD. NHS Professionals, bank or locum agencies should provide those assurances.
- Where private therapists are unfamiliar with the local health system, there is likely to be a need for some form of induction and access to relevant technology and systems.
- Note that the clinical lead for the unit (see slide 8) will have responsibility for overall clinical governance and will need to be satisfied with the competence and performance of therapists and other staff.

GPs and Pharmacies

- Local systems should ensure appropriate services and a suitable package of support are in place for the units, including GP and medicines access. Wherever possible the onsite service should coordinate remote access to a person's registered GP practice for advice and consultation where needed and to ensure access to prescribed medications e.g. by agreeing and informing of a nominated pharmacy who can deliver medicines to the site.
- On the basis patients will unlikely be residing within their registered practice area, commissioners will need to decide on how best to manage any urgent face-to-face needs, whether through extension of existing Integrated Urgent Care/Out of hours pathways or commissioning dedicated support services. They should ensure there is sufficient support for the medical and administrative burden of short stay residents.
- Where the individual receiving care in the unit is not a registered patient of the member practices, commissioners should agree on an approach with the PCN to proactively support temporary registration and management of all patients discharged to rehabilitation beds.
- Advanced Care Practitioners (ACPs) may be able to carry out some of the responsibilities of GPs as per existing practice.
- All clinical information should be recorded and transferred to the patient's substantive GP record.

Clinical leadership of the rehabilitation units

As per slide 8, commissioners should identify a clinical lead for the unit. It will be for local systems to determine who that individual is but they must have sufficient competencies to discharge the role safely. The conversation should include the care home, as some of them may already have a named GP that is medically responsible for long term residents in the care home. Consideration should be given to whether the existing GP is able to take on the role for the rehabilitation unit.

The clinical lead could be a GP with appropriate interests (or an AHP or advanced nurse with appropriate competencies / specialisms, supported by Primary Care where necessary). Leadership qualities will be essential for this role.

Geriatric escalation

Having remote on-call geriatrician support has shown real benefits by providing primary, community and care home professionals specialist advice and intervening where there is deterioration or urgent escalation of needs.

Along with the beneficial outcomes for the person, systems should consider the cost-benefit advantages of this support in avoiding emergency hospital admittance, and identify how it can be provided. It should include out of hours cover.

One opportunity might be to align processes and resource as part of virtual wards / Hospital at Home implementations. The following paragraph is taken from recent guidance:

“Ensure that patients [or care homes] are given clear information on who to contact if their symptoms worsen, including out of hours. There should be clear pathways to support early recognition of deterioration and appropriate escalation processes in place to maintain patient safety. Training on escalation processes should also be provided to [carers] as necessary.”

Ref: [PAR1207 i Supporting information Virtual ward including Hospital at Home](#)

Process and administration

With rapid and frequent admittance of people, and multiple organisations involved in delivery, a key role in successful existing rehabilitation units is a **Care Home Coordinator** (or similar title). Ideally this would be an employee of the care home provider whose job is to liaise with various organisations and family members; admit people, ensure they receive the appropriate care and rehabilitation, and manage their return home. The role requires a combination of skills including the ability to build trust, connections and relationships as well as organisational skills and ability to follow processes. It will be for the care home to determine which resources they use to fulfil this role.

An important relationship will be with the **Trusted Assessor** or **Transfer of Care Hub / Discharge team** in the acute hospital. To ensure the right person is referred into the unit who can benefit from short term recovery/rehabilitation/reablement support, it is important that there be good communication with the trusted assessor or Transfer of care hub and the co-ordinator, and that trusted relationships are developed.

Below is a guide to some of the key responsibilities of the role and person specification, drawn from examples of where this role or a similar role is already in place:

Responsibilities

- Liaison with Discharge Team / Transfer of Care Hub
- Liaison with family
- Patient admittance process, including medicine receipt, system updates, staff briefing, etc
- In first 72 hours ensuring relevant agencies / individuals have attended the patient (inc. early engagement with Social Care)
- Managing the care staff, in particular ensuring rehabilitation mindset, and ensuring people are rehabilitated and discharged
- Discharge from care home processes
- Information / data / updates sent to relevant agencies
- Completing required local and national reporting
- General management of the facilities in the unit

Person spec / Desirable experience

- Experience of delivering and managing care in a care home
- Excellent relationship building skills
- Excellent communication skills, with attention to detail
- Task and process oriented
- Excellent organisational skills
- A rehabilitation mindset (or aptitude to quickly develop one)

4. Tariffs

- These tariff guidelines are intended to provide transparency of some of the main cost drivers that care home providers may experience, and to support negotiations with commissioners and providers on appropriate rates, which may expedite the process. Note that systems will need to commission other activities – not just care homes – in order to deliver a safe and successful solution (e.g. primary care services). See the Resources information above for more details.
- Some systems already have a similar service implemented and the national team has consulted with these systems to understand what works well and what they would improve. The tariff guidelines reflect much of their knowledge and experience.

Tariff drivers

Local commissioners should work with their Local Authority partners and use their experience of contracting and knowledge of the local market to achieve an agreed rate with care home providers, based on the service specification provided, plus any local requirements.

Working with the Local Authorities will give commissioners the fullest appreciation of the local market and it may even be desirable to use the Local Authority as the lead commissioner.

Commissioners should expect the tariff to be higher than standard long term residential beds. The extra costs are based on the following drivers:

1. Additional carer resource to support rehabilitation activities. Encouraging and supporting patients to complete their rehabilitation activities takes longer than pastoral and personal care provided for residential care.
2. Most units will require additional management overhead, up to 1 full time equivalent manager given the amount of administration with regular patient inflow and discharge; additional reporting requirements; and regular communication with members of the multi-disciplinary team, patients and families. Where 7-day admission is required, sufficient management cover should be costed for.
3. Rehabilitation equipment, which if not provided by the local health system will need to be sourced at commercial rates. See service specification for requirements.
4. The number of beds being commissioned will have an impact on the rate. Units with more beds will have lower rates than comparable smaller units as fixed costs are spread across each bed.
5. The length of the contract will have a bearing on cost given that potentially considerable start-up and close-down activities will need to be amortised over the period
6. Other cost drivers might include but are not limited to: updated and more costly insurance cover; the costs of COVID impacts and risks; capital works to make facilities fit for purpose; additional wifi or other ICT infrastructure.

Rates illustration and funding

Rates illustration

The mean average weekly cost of a residential care bed in England in 2020/21 is £768⁴, although local average rates vary considerably.

Beds in rehabilitation units will cost significantly more than the average local rate due to additional care worker hours to support rehabilitation activities and other cost pressures detailed earlier. The volume of beds commissioned will also have an impact on the per bed rate.

In reviewing a small sample of existing units in care homes, the bed rate varied between 40% and 100% *higher* than standard residential beds.

Note that these scenarios *exclude* commissioning of therapists through care homes. In this case the rates would be higher again.

As mentioned earlier, commissioners should work closely with Local Authority partners to get a full understanding of the local market, towards an outcome of reasonable, sustainable rates.

Funding

The funding of the service (care unit weekly costs and broader cost of staffing support) in each ICS can be drawn from CCG expenditure budgets; the Hospital Discharge Fund (available until March 2022), supplemented (if necessary) from regional discharge budgets.

17 | 4. https://lginform.local.gov.uk/reports/lgastandard?mod-metric=11386&mod-area=E06000031&mod-group=AllSingleTierAndCountyLainCountry_England&mod-type=namedComparisonGroup

5. Critical success factors

A reminder of the critical success factors and dependencies from examples of similar models already commissioned by local teams from around the country.

- Critical to the success will be:
 - A home-first ethos with a focus on home as the onward destination
 - Successful recovery and rehabilitation of people
 - Avoidance of people being admitted back to acute hospital settings
 - Maximising recovery and rehabilitation and minimising the need for long term domiciliary care packages when discharged home
 - Local system partners working together to ensure a flexible workforce, to maximise capacity and to identify new models – sharing resource and cost to get the best outcomes possible for people
 - Trusted, aligned care home providers with a recovery and rehabilitation ethos and mindset
 - Clear communication flows from hospital to care home to social care, including with primary care
 - Clear communication to patients and their carers/ families
 - Staff working at the unit feel supported in their role
- Key interdependencies include:
 - The availability of therapists such as occupational and physiotherapists, dietitians, speech and language therapists, to provide recovery and rehabilitation support in the care units
 - The availability of continuing health care workers and social workers to support long term care planning in an timely manner on discharge
 - The availability of voluntary sector support and where necessary, care packages to discharge people home with

Appendix 1: Improving outcomes through the ethos of rehabilitation

There are several documents that describe the principles and ethos of rehabilitation and the links below sign post to these resources.

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

Resource	Description	Link
1. Social Care Institute for Excellence (SCIE) - Role and principles of reablement	Provides an overview of the role and principles of reablement in the social care sector. It describes the roles and principles of reablement, the different models used to deliver it, and illustrates the shift from traditional home care towards personalised, outcome-focussed care and describes the principles of effective reablement.	https://www.scie.org.uk/reablement/what-is/principles-of-reablement
2. NHS Community Rehab Tool-kit	A toolkit encompassing guidance and best practice, including NICE, Ageing well Programme and NHS England commission guidance for Rehabilitation.	nhs-rightcare-community-rehab-toolkit-v12.pdf (england.nhs.uk)
3. Home First, Act Now Programme	The aim of this eLearning programme is to increase awareness around Home First Principles in the Discharge Policy. The programme supports health and care professionals involved in the discharge process, to act in a way that values patient time and helps facilitate safe and timely discharge. It is developed for a range of health and care professionals including nurses, AHPs, care staff and students across NHS providers, commissioners and social care.	Home First Act Now - elearning for healthcare (e-lfh.org.uk)
4. Skills for Health	A suite of online, interactive mobile-first training courses that fulfil NHS statutory and mandatory training and enhance learning outcomes.	elearning NHS Skills for Healthcare eLearning for Healthcare and NHS
5. ECIST Youtube channel	A range of videos sharing examples of good practice	ECIST1 – YouTube
6. Hertfordshire Care Providers Association (HCPA)	Award-winning organisation that supports training and development within care homes in Hertfordshire. Willing to share their materials and welcome anyone to join their courses.	https://www.hcpa.info/about-us/ Ref: Emma Brown emma.brown33@nhs.net