Appendix 2.

NHS Telford and Wrekin

Telford & Wrekin COUNCIL

Report to the Shadow Health & Well-being Board

Report Title:	Proposal for the transformation of rehabilitation and re-ablement services within Telford & Wrekin
Item Type:	Discussion and essential information sharing
Presented by:	Joint Commissioning & Contracting Team
Date:	16 June 2011

1. Purpose

The purpose of the report is to;

- Provide a position statement of progress to transform rehabilitation and re-ablement services in Telford & Wrekin
- Set this progress and transformation within a national and local policy context
- Propose a model for the future provision of rehabilitation and re-ablement services.

2. Background

2.1 The journey so far

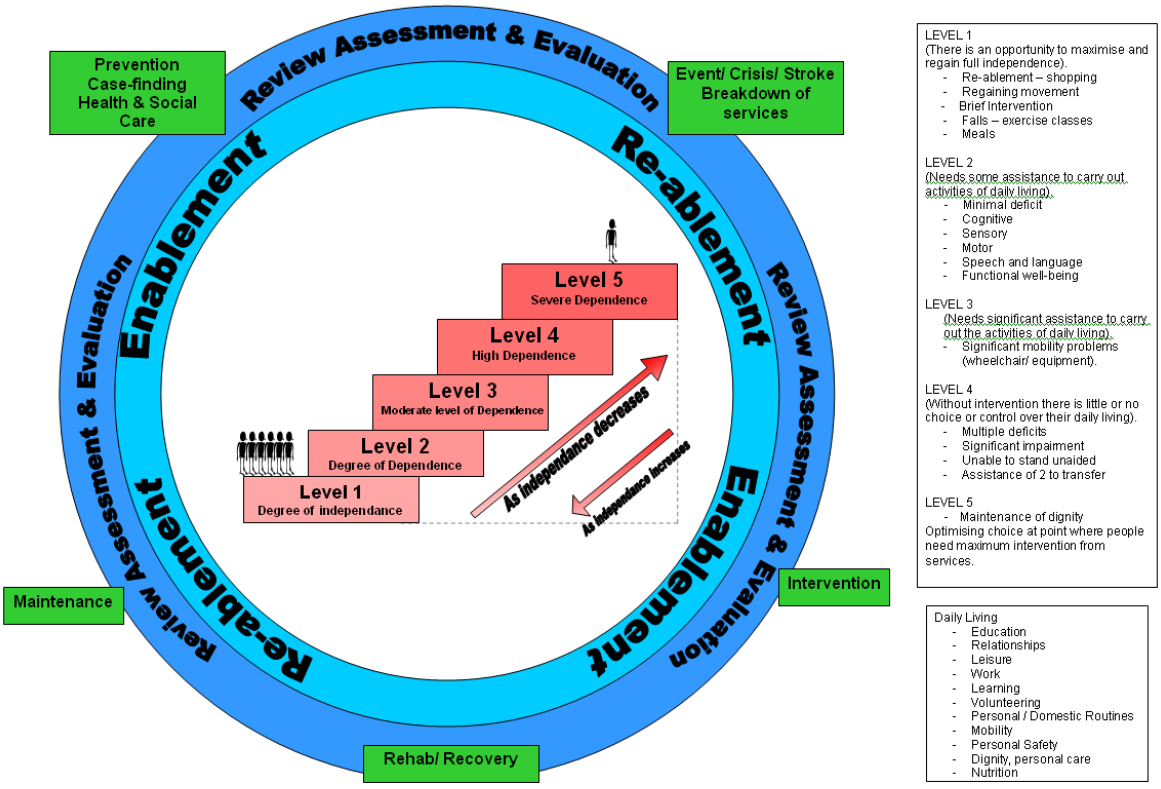
In 2008, driven by national and local policy developments, a Strategic Group was established in Telford & Wrekin to steer health and social care work-streams focusing on rehabilitation and re-ablement towards a cohesive model for the future.

Assisted by the Care Services Improvement Partnership (CSIP), the Strategic Group mapped existing services in partnership with key stakeholders (including Commissioners and Providers), consulted with partner agencies, the public and patients and produced an over-arching review of service provision.

2.1.1 Key Findings of the Care Services Improvement Partnership Review of Community Rehabilitation Services

Key findings of the Service Review
• A variety of services that are offering excellent patient care • Services do not often seem joined up, which creates confusion for the patients and staff navigating a complex system • Access to a coordinated pathway for rehabilitation is patchy and dependent on a discharge pathway from the acute hospital • Some services are not age inclusive and there is disparity between service levels dependent on patients' location across the locality • Lack of capacity in some services makes access to certain facilities, either not possible, or time-limited for some patient groups • There is a sense of missed opportunity in areas that could, with investment and development, ensure a far more coordinated and effective pathway for rehabilitation.
Key opportunities identified in the Service Review
• Access to enhanced community rehabilitation services and specialist knowledge would ensure a clearer pathway for patients and ensure a smooth transition freeing up capacity within the Intermediate Care Team (ICT), enabling it to facilitate discharge and provide more early intervention as part of set-up care. • The proposed model of re-ablement for all social care referrals really supports an integrated community rehabilitation model but should be seen as part of a rehabilitation pathway and not a separate service. • There is a great opportunity to make The Telford Rapid Assessment for the Elderly service (TRACE) a robust element within a community pathway and to link it direct to the rehabilitation and re-ablement services. Stronger links with the Emergency Care Practitioners within the Ambulance Service would also be of benefit. • The facility at the Paul Brown Unit has the potential to become the hub for a stroke rehabilitation pathway, closely linked to the rehab ward and overseeing the transition of patients from the acute into the community-based services. This could be extended to cover other rehabilitation pathways offering the opportunity to develop the unit as a centre of excellence for the economy. This would also offer support to the community-based services and staff groups as well as co-locating specialist rehabilitation knowledge.

These findings created the foundations for transformation of rehabilitation and re-ablement services in Telford & Wrekin, which began with developing a multi-agency model. This diagrammatical model of maximising independence, created the gateway for discussions between health and social care, commissioner and operational staff, the voluntary and independent sector.



On 9th April, 2009, over 60 stakeholders consulted on the maximising independence model and agreed that integration of health and social care was necessary, to deliver the approach.

Since then considerable work has been undertaken to establish a strong evidence-based proposal for transformation and operational delivery. The work and summary of findings is set out below:

Work undertaken	Summary of findings/outcomes
March, 2009, Shropshire Enablement Team commissioned to undertake a Review of Stroke Services	• Investigate utilising community rehabilitation teams within inpatient services • Stroke Wards to be encouraged to maintain contact with Social Services • Maintain continuity of health professionals seen in all capacities • SET to ensure clients receive sufficient contact time with Therapists • SET to investigate follow-up scheme, post discharge
Analysis of current service provision and pathway development for people living with Multiple Sclerosis	• Development of a patient and carer centred pathway for people living with MS
April, 2009, Putting People First in	• Development of a position statement relating to the future

partnership with Joint Commissioning undertake a review of social care re-ablement services	vision of re-ablement services, which encompassed Assistive Technology, Low Level Preventative Services, Independent Care and Support Agencies, current Re-ablement Teams (IC) and Voluntary Sector provision
July 2009, Preliminary Financial Mapping of Rehabilitation and Re-ablement Services across health and social care	• Development of financial dashboard
Acute Rehabilitation Audit November 2009	Findings: There are some very positive aspects of rehabilitation on the wards, including: o The newly introduced stroke care pathway o The planning meetings held with relatives of stroke patients o The multidisciplinary team meetings o The commitment and care of staff o The assessments and plans and interventions of the therapy services There are however other aspects of rehabilitation that falls short of the DH actions required to 'achieve the best' from rehabilitation, including: o The lack of involvement of carers in the assessment, care planning and guidance/training to support discharge and post discharge care. o The inconsistent approach to the sychological/psychiatric needs of patients and the lack of specialist mental health input o The use of standardised care plans rather than a one personalised care plan for each patient that includes action to address their medical, physical, cognitive and motivational needs. o The lack evidence that discharge is planned from the time of admission o The lack of social work involvement in all but a small minority of cases. Even then it is difficult to see if this makes any positive contribution to the rehabilitation of the patient. Recommendations A Strategy for rehabilitation should set out a framework that enables and encourages partners in health and social care to deliver integrated rehabilitation in a variety of settings. This should include rehabilitation at home (inclusive of care homes, social services settings) to improve outcomes for the service user, family and carers. The strategy should also include; o Purpose and Principles for service o Service model – across community and inpatient (including whether age specific services or not) o Funding for current and any service shifts/developments o Implementation plan (prioritised, timed and lead

	responsibilities) o Monitoring and evaluation o Public consultation arrangements (if significant change in service) The recommendations within the report provided an opportunity work with SATH on an action plan for service improvements, which has been achieved and is overseen by a Working Group within SaTH and attended by Commissioners.
Best Value Service Review of Telford Rapid Assessment Service for the Elderly (TRASE), December 2009	Summary of findings • The TRASE service offers a comprehensive medical assessment and review of activities of daily living to a limited number of older people in the Telford and Wrekin area. • It has a very dedicated group of staff whose skills at present do not seem to be fully utilized. • Pathways of referral are unclear with some key referrers choosing not to refer due to uncertainty about access criteria and service received. • Due to staffing and medical cover issues, it is not always possible to provide an appointment within the outlined timescale of 2 days resulting in some patients waiting considerably longer for an appointment. • The main referrer into the service is the IC Team and Rapid Response Service, which creates confusion as the TRASE service is seen as part of the IC service and funding stream. • Funding streams are extremely unclear and complex, which creates significant risk of duplication and failure to obtain value for money. Some service elements are being delivered on a 'good will' basis, which is not reliable for long-term consistency or service planning. Recommendations • The TRASE service should be reviewed as part of an integrated pathway of care focused on early intervention and prevention with emphasis on supporting people with rehabilitation and reablement needs following an acute episode of care or in order to prevent deterioration. • Serious consideration should be given to the development of rehabilitation and early intervention pathways that capitalize on the staff skills and resources available in the Paul Brown unit and within the TRASE team.
Review of Paul Brown Day Hospital, 2009/10	• Draft Service Review of Paul Brown Day Hospital • Stakeholder consultation on initial findings • Draft of position statement on agreed findings, between SaTH and Joint Commissioning
Consultation and development of Falls Prevention Strategy and Action Plan, February 2010	• Stakeholder consultation and development of Falls Prevention and Bone Health Action Plan. • Strategic objectives to be embedded within draft strategy for rehabilitation and re-ablement • Development of revised service specification for the Falls Programme at the Paul Brown Day Hospital •

Best Value Service Review of Shropshire Enablement Team (SET) January 2010 Best Value Review of Community Physiotherapy Team (CPT) January 2010	Findings: • Areas of good practice and evidence of standardised quality care being delivered but not being captured or collated through a robust performance management framework. • The care pathway through services from Acute – Community requires improvement. • Rehabilitation referrals and Care Pathways in the CPS/SET services need further work to ensure the service user gets treatment from the correct rehabilitation service • A stronger focus on collecting and collating feedback from service user's experiences is needed.
Position Statement of Intermediate Care Services 2010	Key findings: • Review and consider options for more robust management infrastructure to deliver service expectations within a multi-disciplinary framework model. • Pursue efficiencies by more effective rota implementation and more flexible employment terms and conditions to make more effective use of available resources. Additional resources from Social Care agreed to purchase electronic system to support the business infrastructure of the Intermediate Care Team. • Map capacity demands and needs to grow intermediate care (agreed with Social Care to increase care and support worked investment by 25%) • Need indentified for additional therapeutic/ specialist support within the team eg physiotherapist, Occupational therapist and rehab nurse. • Need to invest in data quality and recording systems to capture and inform performance reporting. • Recognised need for review of accommodation to support the team.
Development of a Joint, NHS Telford & Wrekin and Telford & Wrekin Council rehabilitation and re-ablement Strategy 2010	• Development of a joint draft strategy
A series of stakeholder workshops held between December 2010-January 2011 to further consider and refine the proposed model within the Strategy	• Discussions within the workshops on what a good local model would look like.

**All referenced reports, reviews and pieces of work can be provided from Joint Commissioning on request*

Throughout these phased pieces of work, cross-cutting themes were identified, namely, the connectivity between anticipatory care of the elderly, holistic assessment, hospital avoidance, (particularly in reference to nursing and residential homes), urgent care, rapid discharge, intermediate care and community rehabilitation and re-ablement services.

2. National Context

The Government translated the vision for Transforming Community Services (TCS) into a series of guides that took account of best practice research. "Transforming Rehabilitation Services" (DH 2009) identified those actions which had the greatest potential to improve care and achieve the highest quality services. The high impact changes summarised included;

- Work towards a philosophy of rehabilitation and re-ablement for *all*, providing a clear vision and strategy for rehabilitation services
- Build and develop multi-disciplinary and inter-agency teams to deliver local person-centred rehabilitation
- Redesign the care pathway promoting high quality, productive services, which will ensure that all individuals have a safe, efficient and effective service, which maximises health and independence.

The TCS programme compliments the Government's commitment to the transformation of Adult Social Care services set out in "Putting People First; a shared vision and commitment" (DH 2007). This followed the White Paper "Our Health, Our Care, Our Say: a new direction for community services". (DH 2006).

More recently the Coalition Government have re-affirmed their continued commitment to the current direction of travel in the White Paper "Equity and Excellence: Liberating the NHS" (DH 2010). This sets out the need for an approach that focuses on personalised care that reflects individual's health and social care needs, supports carers and encourages strong joint arrangements and local partnership. Evidence suggests that achieving the Government's ambitions requires a person-centred approach which focuses on maximising independence, health and wellbeing. This can best be achieved by providing a range of integrated services to ensure people receive the right level of rehabilitation and re-ablement, in the right place at the right time.

In 2010, the Preventative Package for Older People and the Intermediate Care Re-fresh document, Half-Way Home, (Department of Health, 2010) was published and emphasised the need to focus on the following:

- Those at risk of admission to residential care
- Inclusion of people with mental health needs
- Integration with mainstream health and social care
- Access to specialist support
- Joint commissioning of a wide range of integrated services to fulfil the intermediate care function, including social care re-ablement
- Governance of the quality and performance of services.

3.0 Evidence of best practice

Our proposals for rehabilitation in Telford & Wrekin are informed by an evidence base that includes;

- The TCS programme.
- Findings of a study of English local authorities with responsibility for adult services who are developing short-term, specialist home care-based re-ablement services.

- Findings from the national Partnership for Older People Projects (POPP) programme (DH 2010) which provided examples of efficiency savings linked to developing more effective ways of using resources whilst also improving quality.
- The University of Birmingham Health Services Management Centre (HSMC) researched rehabilitation services and identified 500 studies of good practice.
- The Health Service Management Centre (Birmingham University) and the Strategic Health Authority findings in a report entitled: 'Reducing unplanned hospital admissions'.
- The findings of the DH final report on Homecare Re-ablement- Prospective Longitudinal Study (DH 2010).

The evidence tells us the following:

1. **Provide Rehabilitation in the Community**

Rehabilitation can effectively operate as an outpatient service in the community. Important components of community rehabilitation services include; – social support, involving carers, using physiotherapy and occupational therapy, and good links between community and hospital services. Rehabilitation services provided in the community need to be well organised, include a multidisciplinary team and use venues that are acceptable and accessible to service users and staff.

2. **Multifaceted rehabilitation works best**

Two key messages emerge from the evidence; – rehabilitation should begin as soon as possible and rehabilitation that combines many different components is likely to be most effective. The most successful rehabilitation services include personalised care plans, physical and cognitive therapies, regular practice and proactive follow up.

3. **Monitor vital signs and use alert systems**

The evidence suggests that telehealth alert systems alone are not a form of rehabilitation but that they may play an important part of a wider care package. The most common form of tele-monitoring involves automated data transfer and has potential to shift care from hospital settings into the community. However, findings about the benefits of automated data transfer were not consistent. In contrast, telephone support as part of a rehabilitation care pathway has been found to improve clinical outcomes and/ or reduce symptoms.

4. **Use self referral to services where clinically appropriate**

Self referral is a way to widen access and empower service users to seek help in a timely way as their needs change. One study found that open access used fewer acute sector resources, resulted in the same quality of life for service users and was a preferred pathway for service users and GPs. This model could potentially raise concern for demand. Another study found no increase.

5. **Rehabilitation at home improves outcomes**

A number of studies suggest that home-based rehabilitation is just as effective in delivering improved functioning. However, it was also noted that home-based rehabilitation may place additional demands on carers and therefore consideration needs to be give to supporting carers and provision of regular respite care.

6. Multidisciplinary teams improve rehabilitation

There is some evidence that multidisciplinary follow up after discharge can reduce reliance on hospital care and shift care closer to home.

7. Self-care models can support rehabilitation

Several studies suggest that helping people to take responsibility for their rehabilitation and recovery is essential. One way of achieving this is through the provision of clear information. This needs to be easily accessible, inviting and needs to encourage people to apply the skills and actions to their activities of daily living.

8. Supporting carers

There is some clear evidence that supporting carers can aid a patient's recovery and rehabilitation. A UK trial recommended that carers' support should be built into the design of the rehabilitation programmes. Supporting carers is acknowledged as important but further work is required to determine the most effective methods for providing their support.

9. Ensure every service has a clear vision

Some studies would suggest that a clear service vision is missing among some specific rehabilitation services. Evidence-based care pathways are a tool to help provide more integrated and continuous care and to ensure that services have a shared vision.

There is inconsistent evidence that care pathways impact on clinical outcomes but some studies do suggest that simple care pathways can make a difference to people's quality of life and the care they receive are an area for further investigation.

10. Local ownership of services is beneficial

Local ownership and involvement is key to successful community-based rehabilitation programmes. This may include consultation, opportunities for volunteering, recruiting local staff and enabling local community groups to make use of the premises.

11. Work with care homes

The potential to work with care homes is an area that may be overlooked. They could be an alternative setting for the provision of rehabilitation services. While there is insufficient evidence that care homes either improve or reduce outcomes, one trial found significantly fewer days in hospital over a 12 month period.

12. Deliver what people want

- A single point of contact
- Quick and responsive services
- To tell their story once

- Professionals that talk to one another.

We have used this evidence-base, combined with regional partnership work with the CSED and Tom McDonald at the Department of Health, to develop an emerging picture of what looks good, underpinned by the following principles to ensure success:

- **Leadership and governance**
  - Clarity of objectives and outcomes
- **Understand what is happening now**
  - What's the baseline data? What do you want to change?
- **Focus on redesigning ineffective and inefficient services**
  - Re-design functions and pathways.
  - Do not overlay new services upon ineffective services
- **Measure what you are doing so you know whether you have achieved your objectives**

4. The Proposed Model

To enable transformation of rehabilitation and re-ablement services to be a reality, Telford & Wrekin must move towards integration of health and social care teams, which may involve, co-location of teams. This proposition has a strong evidence base (demonstrated earlier) and has been supported through stakeholder consultation and professional option.

Intermediate Care is a good example of how this already works, namely, multiple contracts, budgets and health, social care and mental health professionals, working within one locality.

Vision

Prevention, early intervention and rehabilitation and re-ablement is at the heart of future care and support. Promoting independence will deliver greater efficiencies in health and social care and provides better outcomes for people and carers.

To be most effective, health and social care services must work together. This is particularly important at a time when demand is increasing and there is a reduction in funding.

The overall aim

- Promote and maintain independence and improve quality of life
- Prevent the unnecessary admission to hospital
- Reduce the number of people admitted to long term care
- Facilitate speedy and coordinated discharges from hospital

- Reduce the number of re-admissions to hospital or inappropriate referrals to community services.

Service model

The Maximising Independence Steering Group has been established to co-ordinate all the workstreams associated with rehabilitation and re-ablement. The group supports the co-location of some health and social care teams, working in a multi-disciplinary way. The Group supports a Telford & Wrekin focus for service delivery and the alignment of management and budgets, as a first step.

The service model is defined by two components, namely, a team of health and social care staff whose function is to provide rapid assessment and intervention, for a time-limited period. This front-end component is therefore defined by time-sensitivity and capacity to react, within 4 hours and 'hold' up to 72 hours. This service will build on the good work of Rapid Response and the Enhanced Care Team.

The second component of the service model is defined by a multi-disciplinary team, providing intensive rehabilitation and re-ablement interventions for a time-limited period of approximately 6 weeks. This will largely include building on the capacity of the current Intermediate Care Service, by combining elements of other community-based services. Further work needs to be done, but this may include the following service elements:

- Intermediate Care Team
- Shropshire Enablement Team (SET)
- Community Physiotherapy Service
- Local Authority Occupational Therapy Team
- StayWell (British Red Cross)
- Speech and Language Therapy
- Intermediate Care Beds and Interim Care Beds
- Falls Programme
- Community Equipment
- Assistive Technology
- Stroke Specialist
- Stroke Rehabilitation programme

The Group has identified that medical input is an essential component of the pathway and will need to be able to deliver a falls medical assessment, access to diagnostics, complex holistic assessments of the elderly and clinical leadership. This element is currently provided by TRASE but a number of approaches are being investigated, including the appointment of a Community Geriatrician.

5.0 Measuring success

The data that measures progress towards strategic objectives:

- Number of emergency admissions to hospital
- Number of A&E visits
- Number of ambulatory care sensitive conditions admissions
- Number of admissions where mental health is deemed the primary need?
- Number of admissions to residential care
- Number of admissions to residential care, directly from hospital
- Number of admissions to residential care from short-term care

6.0 Potential health care efficiencies are detailed as follows:

- Many rapid response services are now focussing on preventing hospital admissions for people with specific conditions
  - Ambulatory care sensitive conditions
- Commissioners setting targets relating to these conditions
- Hospital admissions for these conditions significant cost to NHS

7.0 Potential social care efficiencies are detailed as follows

- Diverting from residential care, short and long-term
- Clear pathways to re-ablement
- Key information
  - Number of admissions to permanent residential care from short-term placement
- Diverting from unnecessary hospital admissions
  - Untoward and unexpected events arise in hospital
  - Independence and functionality diminishes rapidly
  - Exposes mental health frailties
  - Risks greater with increasing age
- Key information
  - Number of admissions to residential care directly from hospital
  - Increase in care packages following hospital admission

8.0 Issues/Risks

There are a number of issues that require further consideration and debate prior to progressing the concept of community-based rehabilitation developments:

- Lack of accurate cost data relating to existing services within the acute sector in particular the Paul Brown unit and TRASE.
- The gap in current funding of services e.g. TRASE
- There are a number of budget pressures where over performance can clearly be indentified and is critical to rehabilitation e.g. community equipment. It is important that in progressing this work a clear financial position statement is agreed, which is realistic to enable reconfiguration to progress.
- Lack of clarity to date regarding the requirements of procurement ie are we contemplating service redesign or tendering to reconfigure the services?
- The national evidence is weak in some areas and further work is required to develop more robust proposals.
- The information systems are still developing to inform future commissioning decisions.
- Success depends on strong leadership and governance arrangements.
- Implications in relation to the rapidly changing landscape; the establishment of the new Community Trust, the reconfiguration of services at SaTH, the Council restructure, the abolition of PCT's in 2013 and the introduction of GP led Commissioning.

9.0. Next steps

- Undertake more detailed work in relation to combining appropriate services
- Undertake more detailed work in relation to rehabilitation and re-ablement care pathways
- Develop Third Sector Partnerships to deliver Low Level Preventative work
- Undertake more detailed cost-modelling for shifts in community resources
- Develop more fully, the rapid response and multi-disciplinary team structure, including workforce mapping

10 Recommendations

- Endorse the model for rehabilitation and re-ablement and continue to build constructive relationships with potential partners, including; SaTH, GP's, Telford & Wrekin Council, NHS Telford & Wrekin, The Shropshire Community Foundation Trust (from July 2011) and the Voluntary Sector.

- Acknowledge shifts to community rehabilitation will require partnership commitment to resources

- Acknowledge the gaps in infrastructure and investment in the current system

- Support the recommendation that this model is shared more broadly at relevant Partnership Boards for wider consideration and endorsement.

-ENDS-