Re-ablement Strategy Summary: "Maximising Independence and Keeping People at Home for Longer"

Introduction:

This document serves as a summary of the Strategy outlining a joint approach across Wandsworth Health and Social Care to establish an equitable, evidence based, patient centred Intermediate Care and Re-ablement Service for the future, aiming for implementation of a fully commissioned Service by April 2013.

It sets out to describe the outcomes of a jointly commissioned Service, and describes the actions needed to develop a seamless approach aiming to maximise people's independence and keep them at home for longer.

Across health and social care the terms "re-ablement", "enablement", "rehabilitation" and "intermediate care" tend to be used loosely and the boundaries between the services they refer to are often blurred. This can often create confusion for service users, people referring into the services and other stakeholders.

By developing a single Service, which comprises of a systematic tier of integrated functions, we can ensure an equitable Service which is easy to refer to and eliminates confusion between the terms used and blurring of boundaries between functions it includes.

Background:

Intermediate Care and Reablement Services in Wandsworth are provided in a disjointed way with health and social care doing things differently.

NHS Wandsworth and Wandsworth Council have identified Intermediate Care and Re-ablement Services as a key opportunity for service realignment to ensure that they are being effectively utilised to deliver the best outcomes for patients.

The integration of these functions is seen as essential to the transformation of health and social care services to maximising people's independence.

NHS Wandsworth and Wandsworth Council are committed to investing in a unified "Tier" of **integrated intermediate care and re-ablement functions** that includes the current Intermediate Care Service, STAR (SGH), START (Re-Ablement) service, and the bed based units (Dawes House and Mary Seacole) and recognises the links with Day Hospital provision and the Community Virtual Ward.

This transformational reform of Intermediate Care/ Re-Ablement will provide an overarching approach to care with shared assessments and support planning processes, reviewed eligibility criteria to ensure equity of service provision, and will be more responsive to individual and community needs.

The service will aim to provide support to individuals' physical and psychological needs, including those with dementia, and recognises the impact of psychological wellbeing on health and recovery outcomes.

Strategy Outcomes:

- To provide a Service which is readily accessible and easily navigated by patients, carers and staff
- To provide time bound care designed to reduce unnecessary hospital admissions, maximise independent living through re-ablement in the community and accelerate return home from hospital to more appropriate care closer to home.
- To link existing functions and to add new functions if required which will help to deliver the Service in an integrated way across health and social care by treating patients in an appropriate community setting (where possible their own home) and in a timely manner to meet their health and social needs.

The Service will:

- Improve the transition for patients between acute hospital services and community services
- Reduce acute hospital activity in both A&E and unnecessary admissions for Ambulatory Care Sensitive Conditions
- Operate in an integrated way so that individuals see a single Service operating for their benefit
- Maximise independent living by treating people in their own homes where possible and supporting them “to do” rather than “be done to” regardless of their destination of care
- Reduce unnecessary hospital admissions, long hospital stays and premature use of long term residential care

The service will NOT:

- Support individuals who do not meet the agreed Service eligibility criteria (to be jointly agreed by Health and Social care).
  Exclusion criteria should include:
  - Individuals under the age of 16
  - Individuals who are acutely medically unstable, or whose medical needs cannot be met in the community
  - Individuals who require long term care or end of life care
  - Individuals whose cognitive impairment interferes with engagement in the reablement process
- Duplicate work carried out by the Community Virtual Ward but will compliment this Service

Proposed Service Structure

Development of a "**Tier"** of functions which uses a **whole system approach** to create a continuum of care with a clearer identity, purpose, structure and with better cross-organisational team-working and leadership.

GOVERNANCE STRUCTURE

Strategy Group

Integrated Health and Social Care Management Team

Has the remit to review achievements of performance targets, long term resource requirements, and to propose trials of new facilities or ways of working

Operational Management Group

Heads of Streams, Units, Departments, Project Leads

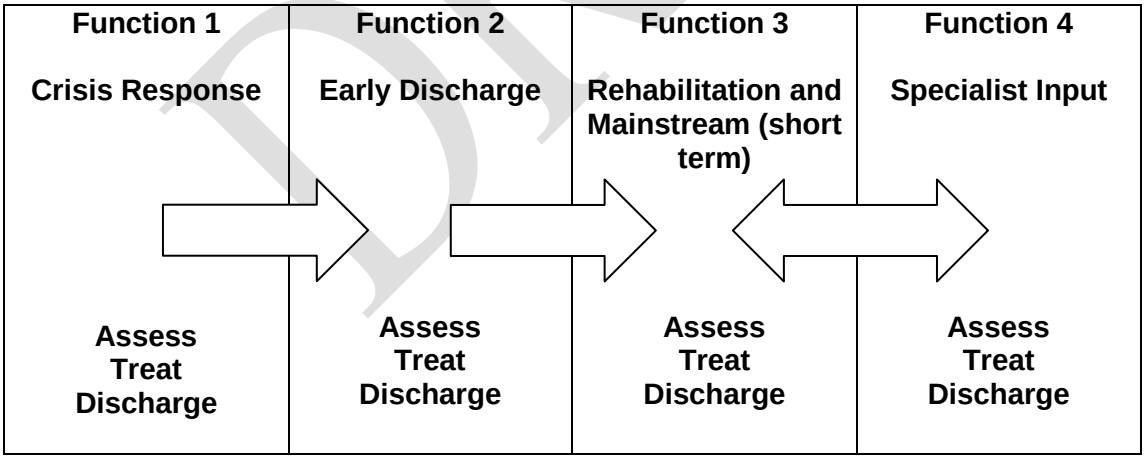
Has the remit to monitor demand, flows and bottlenecks and to flex resources across the four functions

Single Point of Access

Open 24 hours/7 days per week

Takes referrals from all sources, logs them, initial screening/assessment (urgent assessments within 2 hours if needed) directs to appropriate stream, gives advice or information

MULTI –DISCIPLINARY TEAMS ACROSS HEALTH AND SOCIAL CARE SUPPORTED BY CORE TEAM OF APPROPRIATELY SKILLED CARERS/SUPPORT WORKERS
"THE BUILDING BLOCKS" OF THE SERVICE



Handover to locality based services and review

Function	Brief overview
Crisis Response	Rapid assessment and intervention focusing on care provision and treatment in the community quickly as an extension of the Community Virtual Ward Could be a response to urgent health need or breakdown of care Intervention may take place in individuals own home, or may require rapid access to community bed to avoid hospital admission Intervention very short term, i.e. resolve crisis and then refer on to mainstream/ rehabilitation team, specialist community teams or locality based services Time frame to be determined but should be between 72 hours- 10 days maximum
Early Discharge	Focus on supporting individuals at home following hospital discharge, either in a community bed or in own home Actively pulls patients from acute to community Time frame to be determined, provides a short term assessment of needs and allows for settling in time to predict accurate care needs
Mainstream Rehabilitation	Either in a community bed or in own home Short term service up to six weeks
Specialist input	E.g. mental health, specialist nursing, Telecare/Telehealth Able to provide timely input at all stages of continuum of care on a needs basis

Key features of Integrated Model :

- The tier encompasses a range of functions managed within a co-ordinated system of care in such a way as to ensure that there is early engagement, based on a holistic assessment of need and coupled with the provision of short term care. There is a pro-active pull through of patients wherever possible.
- Multi-disciplinary team of health and social care staff including experienced practitioners ; this may include skilled clinicians, nurses, therapists, social workers, and care/support staff, mental health specialists and medicine management specialists with rapid access to specialist care and services such as Mental Health, Telecare and Telehealth
- The re-ablement philosophy is embedded across all functions of the tier, and is aimed at ensuring skills are maintained by the individual.
- Strong leadership across all functions
- Monitoring across all functions to ensure individuals are pulled through until handed over fully re-abled to community services.
- Referrals made via a single point of access
- Timely, holistic and robust clinical assessment of need, to ensure individual is being referred to the right service at the right time.
- For anyone over age of 16
- Strong interface with the community virtual ward, primary care, day hospitals and other community based services

Contd./

- Same day access to equipment for activities of daily living
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- Short term intervention (up to 6 weeks)
- Free of charge in line with Local Authority Circular (DH) (2010) which states “Regulation 4(2) of the 2003 Regulations requires that intermediate care is provided free of charge for the first six weeks. Accordingly, re-ablement services are likely to fall within the definition of intermediate care services and should not be charged for the first six weeks”.

Service Outcomes:

A single service delivery model will have numerous benefits for all:

Individual:
Maximising choice, control and independence with more personalised care in the community
Improve the patient experience through receiving care across a seamless pathway
Putting the patient at the centre by individually tailoring goals
Providing equity of access to the Service

Providers:
Clear identity of service provision
Improves the quality and continuity of care given
Opportunities for training and development
Involvement in service development
Increased patient facing time

Commissioners:
Avoid duplication of services
Ensure value for money and efficiency
Develop co-ordinated services
Share best practice and expertise
Share intelligence about service needs and developments

Benefits for all:
Optimum use of health and social care resources
More care delivered in a community setting
Reduced number of high cost care packages
Streamlined processes to avoid duplication
Improved communication systems across health and social care
Reducing admissions to hospital
Reducing length of hospital stay
Reducing delayed discharges
Reducing the number of long term intensive home care packages and premature admission to long term care

More specific service performance and outcomes will need to be measured for the following areas:

- Number of referrals to the Service
- Source of referral
- Increase in referrals from primary care
- Primary / secondary diagnosis / conditions treated
- Reasons for referrals not accepted
- % of individuals with BME background
- Time from referral to assessment
- Time from assessment to admission to the Service
- Number of delayed transfers of care and reason why
- Activity
- Reduced acute LOS for certain defined conditions (source ambulatory care sensitive conditions)
- Numbers treated at home
- Numbers treated in residential or nursing home bed
- Length of stay in service – (measure of throughput to demonstrate that achievement of 6 weeks for most patients)
- Delays in discharge from the Service and reason
- Change in functional capacity before and after intervention
- Self reported improved patient experience
- Reduction re-admissions to hospital
- Reduction in avoidable hospital admissions
- Impact of level of care and ongoing support needs
- Impact on residential / nursing home admission rates
- Cost of occupied bed days
- Discharge locations
- Location of individual 3 and 6 months after leaving the Service

All of this activity should be monitored against the targets agreed with the service under each heading, and relies on an appropriate clinical governance framework being in place.

Attach 3

Strategy Timescales:

1	Strategy summary agreed by WPCT/WASSD management and commissioning teams. Joint Commissioning Steering group established	Sept 2011
2	Baseline data gathering, including: • Re-admissions audit information • Delayed Transfers of Care audit information • Referrals to long term care from acute • Number of intensive home care packages • Mapping existing Services to include service utilisation/capacity issues, current outcomes, resources, eligibility criteria • Public health completion of needs assessment to ensure evidence base	Sept / Oct 2011
3	Strategy summary agreed by Professional Executive Committee and Health and Wellbeing Board	Oct /Nov 2011
4	Engagement with stakeholders, service users and carer involvement	Oct 2011
5	Launch Event : • Defining the model and re-branding using agreed common language • Project groups to map four functions • What we have that works well/what are the gaps	Nov 2011
6	Consolidation of data from event	Dec 2011
7	Establish joint commissioning/provider project groups: • Single Point of Access • Crisis Response • Early Discharge • Mainstream / Rehabilitation • Specialist Input • Eligibility criteria • Assessment procedures • Communication systems (there may be more as an outcome of the launch event)	Dec 2011
8	Refined Business Case including a Service Specification for overall model and functional components including: • Benchmark outcomes/target setting against baseline • Governance and monitoring arrangements • Financial implication of proposed Service delivery model	March 2012
9	Agree joint commissioning plan with Directors	March 2012
10	Complete refined operational project plan for implementation Formation of operational management team	March 2012
11	Implementation of project plan	March 2012-March 2013
12	Operational implementation of fully commissioned Service	April 2013

Strategic Objectives/ Outcomes of Integrated Service Delivery Model

Rapid and reliable access for referrers to a 'joined up' service across health and social care with a single point of access and joint care pathways and processes

RATIONALE	COMMISSIONING INTENTIONS
Streamlining referral pathways and procedures and reducing areas of duplication in assessment Rapid access to an assessment of need so that care can be put in place in a timely manner to avoid an admission or facilitate a discharge from hospital Improved care co-ordination through integrated health and social teams for patients with complex needs and long term illnesses	Establish a project group to work through operational implementation of a 24/7 Single Point of Access that links in with the Community Virtual Wards Single Point of Access Establish project groups to develop clear definitions of the Services' four functions and establish specifications for each, ensuring there are robust links between all four functions and clear links with the Community Virtual Ward. Engage with GPs on all aspects of the Service ensuring familiarity with the referral process and availability Review of the medical support to the Service to ensure patients receive appropriate and timely intervention regardless of their place of care Map current referral pathways, assessments and procedures across service areas and begin to identify loopholes, areas of duplication, and areas of good practice on which to build Develop joint care planning and a co-ordinated / unified assessment procedure and process, and care pathways to ensure individuals move through the system in a timely and appropriate way Develop a shared information/communication strategy for allowing access to reports and data across Health and Social care Establish which processes and procedures work well/where there are areas of duplication or bottlenecks, and

	establish project plan to streamline processes and implement direct referral processes where appropriate Ensure all stakeholders are aware of new model and how to refer via the Single Point Of Access Ensure a robust assessment process which is carried out at the most appropriate time by specialist clinicians who can identify the most appropriate pathway Ensure robust exit strategies from each function

Preventing avoidable admissions to hospital (Function 1)

A Crisis Response function that focuses on inappropriate admission avoidance as well as facilitated timely discharge Time limited packages of care in the setting which promotes optimum recovery. Reductions in inappropriate hospital admissions by increasing referrals from GP's and primary care	Map current services providing this function and financial investment into Crisis Response Consult with providers and commissioners as to what an ideal Crisis Response service should look like, and begin to establish function specification Identify gaps in service provision to assist with this Gather up to date audit data regarding re-admissions into acute hospital and reasons why to assist in identifying gaps in service provision Early engagement with GPs and primary care Establish project group to develop Crisis Response function Ensure GP and primary care input into project groups to develop a Single Point of Access and function specifications Develop clinical pathways from acute to community for Ambulatory Case Sensitive Conditions

Supporting Timely Discharges from hospital (Function 2)

An Early Discharge function which focuses on discharge facilitation and settling in, and which actively pulls through patients from the acute setting	Map current services providing this function and financial investment into Early Discharge Consult with providers and commissioners as to what an ideal Early Discharge service should look like, and begin to establish function specification Identify gaps in current service provision Establish project group to develop Early Discharge function
Reduced lengths of stay in hospital by development of clear care pathways for specific conditions	Establish care pathways for a range of conditions which can be treated in the community (Ambulatory Care Sensitive Conditions)

Improve quality and maximize independent living and reduce the number of people unnecessarily admitted to long term care following a hospital stay (Functions 3 and 4)

RATIONALE	COMMISSIONING INTENTIONS
Ensure that no one is transferred directly from an acute ward to long term residential care unless in exceptional circumstances without being offered a period of intermediate care /reablement	Develop clear pathways for individuals in acute/community care to the Intermediate Tier Set targets and a trajectory for the reduction in numbers of individuals who are admitted directly into long term care from the acute setting

People are able to live in the place of their choice for as long as it is their best interest.	Ensure patient choice and input into their goal setting and care plans are central to all care provided within the Intermediate Tier Ensure that assessment, review and decision making takes place in the community rather than in the acute setting following the opportunity for rehabilitation, recuperation and recovery. Ensure there are clear pathways linking the Service with the Self Directed Support process
Improvement in health outcomes for the local population by optimising the functional independence of patients enabling more people to continue or resume living at home	Establish clear outcome measures for each of the functions which monitors a change in functional capacity before and after intervention
Improved intermediate care for people with dementia, people with learning disabilities and people with complex needs	Ensure links with local implementation of the Dementia Strategy in providing early intervention services to help people with dementia remain independent for as long as possible Ensure the service is accessible for patients with dementia and other mental health conditions and is supported by direct and timely referrals for specialist assessment and advice Develop training programme for carers/support workers with competency framework
Investment in Telecare and Telehealth to support people to remain in their own homes	Increase awareness of Telecare and Telehealth options to ensure staff within the Service can refer appropriately and in a timely manner Review pathway for referring into Telecare and Telehealth services Ensure that Telecare and Telehealth become an integral component of the rehabilitative and re-ablement processes, by ensuring they are considered at the beginning of the re-ablement process, and early triggers for

	referral to these services are incorporated into the assessment process. Utilise evidence base from local reviews and Whole Systems Demonstrator study to assist in shaping future service provision in Wandsworth

Robust performance management and governance

RATIONALE	COMMISSIONING INTENTIONS
A service that ensures the focus is on achieving outcomes for individuals	Ensure that the future monitoring and commissioning of the Service should be monitored via a joint commissioning support agency between Wandsworth Clinical Commissioning Group and WASSD Ensure individuals remain at the centre of their goal and support planning Ensure appropriate outcome measures are used across the intermediate tier of functions Work towards a system of sharing clinical records across the multi-disciplinary team to enhance communication and trust
A Service that values its workers and improves staff morale	Investment in staff training and professional development time Involvement of clinicians in Service development Improvement of current systems to reduce time trying to overcome the constraints of the system and more time delivering care and focusing on the benefits to the patient Ensure there is ready access to the specialist skills required to enable the Service to support the needs of individuals with long term conditions including mental health needs

High quality service based on best practice and research	Ensure leads for each area keep up to date with current research to advice best practice model Allow time for continued professional development across the tier Establish clear governance structures
Length of stay / measure of throughput to demonstrate outcomes are achieved with target 6 weeks for most patients	Ensure robust data collection systems are in place to capture outcomes and targets are agreed (see below)
A reduction in bed days lost after patients are agreed by the multidisciplinary team to be fit for discharge is achieved.	Establish smooth referral pathways and processes and enhanced communication across acute and community services Identify clear exit strategies from all services areas with appropriate professional input to ensure discharges are not delayed
Investing in workforce development to ensure that services support people with more complex needs	Implement training needs analysis and ensure rollout of training programme to ensure staff have to skills to treat complex cases, long term conditions, frail, older people and individuals with dementia or mental health needs and learning disabilities Ensure a competency and performance management framework is developed across the Service
Deliver more cost effective services in order to meet the current and future demand within existing resources	Monitor Service against outcomes as set out (page 4/5) Reduce number of high cost care packages and ensure targets are set against baseline data Reduce number of admissions to residential/nursing home environments and ensure targets are agreed and set against baseline data Reduce number of delayed transfers of care and ensure targets are set against baseline data

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