The Rehabilitation Framework - The Next Steps

Towards a Community Rehabilitation and Enablement Service for Older People, Older People With Mental Health Problems, Adults With a Physical Impairment

1. Introduction

1.1 This paper describes a NHS Greater Glasgow and Clyde framework for the development of a local community rehabilitation and enablement service. The document describes the types of need that will be met by these services and how they might be managed. Whilst most development and implementation will be local the pieces of work that will be taken forward jointly across all CHPs are described in section C2.

Feedback received from the initial framework paper ‘Towards a Community Rehabilitation and Enablement Service for Older People, Older People With Mental Health Problems, Adults With a Physical Impairment’ circulated in November 2007 shows broad support across the health and social care system for the direction of travel in the framework.

1.2 The rehabilitation definition used in this framework is ‘a process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients and service users, their family and carers. Enablement means health and social care staff supporting people through promoting self help and health improvement and by encouraging them to be as independent as possible.

1.3 This framework builds on the range of previous service developments for these client groups. The objective is to bring together these existing health, social work, community based and hospital based outreach services to work better for service users through the delivery of integrated services.

1.4 From the responses, it is clear that there were a wide range of, sometimes conflicting, views on the detail contained within the initial document. This was reflected in the significant number of individual and group responses received. The later part of this document reflects the range of comments received when identifying the work program required to:

- Further develop and refine the service components, protocols and procedures required to implement the framework
- Develop implementation and change programmes including indicative timescales.

1.5 However, a strong and consistent message coming back from the engagement was that the proposed framework document was difficult to read and understand. In response to this particular issue the next section of this report will clarify the framework and be more specific about the detail. This section will also specify the current teams and services that will be included within the redesign process.

1.6 This refined version will not attempt to cover the whole content of the original document, for example the background and context remain valid. Much of the rest of the document simply needed clarification. This document is structured as follows:

Section A: A restatement of the proposed benefits for users from the development program
Section B: The refined and developed service framework
Section C: Next steps/work program etc
Section D: Governance arrangements and ongoing engagement
Section A: a restatement of the proposed benefits for users from the development program

A1. The framework builds on service developments from previous planning for Older People, Older People with Mental Health Problems and Adults with Physical Disabilities and opportunities arising from the new delivery structures within CH(C)Ps. The framework will support integration of the current range of rehabilitation and enablement services. This integration will lead to improved outcomes for service users through:

- Addressing the challenge of navigating the rehabilitation system
- Further clarity on service pathways and access to appropriate services
- Better communication and transition within proposed service tiers
- Smooth transition between primary and secondary care
- Less duplication in assessment and service provision
- Improved user and carer involvement
- Supported self care in local communities.
- Potential for earlier responses to needs

Section B: the refined and developed service framework

B1 - Framework Characteristics

B1.1. This paper proposes the creation of a single, integrated rehabilitation and enablement service framework within each CH(C)P. The framework has the following characteristics

- A comprehensive assessment, rehabilitation and care management service delivery model within each CH(C)P available to meet the health and care needs of older people, older people with mental health problems and adults with a physical disability within the local structures. This includes residents of care homes.
- A community based service framework that delivers on an assessed needs basis across all care pathways
- A service that responds to the needs of adults returning home following hospital admission: delivering assessment, discharge arrangements, community based rehabilitation and ongoing care management
- A tiered level of service model, which targets specialist functions and resources at the highest and most complex needs, is flexible and able to respond to the changing needs of individuals and allows more direct access to resources at lower levels.
- A move from providing services on an episodic treatment approach to an approach with additional focus on rehabilitation and enablement.
- A stronger focus on supported self care and self management

B2 – Underlying Principles

Principles supporting the framework are:

B2.1. Balance
Resources and service provision are balanced to address and respond at all levels of need, complexity and vulnerability e.g.

a. Responses for people with straightforward or maintenance needs will be delivered locally by support provided in coordinated and networked community resources.
b. Complex needs will be met and responses will be delivered on a much more specialised basis by integrated services.

B2.2. Enablement
A new enablement approach requires a shift from an intervention episodic approach (where inappropriate) to a more continuous, systematic approach with a specific focus on anticipatory care and enablement.

Enablement principles allow opportunities for early intervention with people who could self-manage with support. The emphasis is on self and lifestyle management through health improvement and health promotion. This also means supporting people who can use community services including culture and leisure services, lifelong learning opportunities and voluntary agencies’ services as appropriate. Information about services to be provided in user friendly and equality proofed formats.

B2.3. A Person Centred Approach - Which clearly defines:
- timescales for the receipt of services
- standards that the service should achieve / can be expected to adhere to,
- eligibility criteria for each service which make sense to users and are easily understood
- a single point of contact to guide and / or support individuals through the service framework.
- real scope for self-assessment and direct access to appropriate levels of service, which support individuals’ autonomy and self-management.

B2.3. A Team Approach - to make best use of staff resources with:
- clarity on staff roles (who does what, when, where, how)
- appropriate use of skills through targeted or weighted functions or case loads and a greater skill mix between professions and grades
- approaches to education, learning and reflective practice built in to the system
- teams working locally within CH(C)Ps to meet the needs of the local community.

B2.4. A Pathways Approach
- supporting new pathways with reduced delays and improved transition processes
- reflecting the user’s perspective,
- developing, as required, protocols and dispute resolution processes
- flexible enough to cope with an individual’s needs fluctuating

B2.5. An Engagement Approach
- ongoing focus on development through user and carer involvement and partnership with staff

B3 – The Rehabilitation and Enablement Framework Model

B3.1. The model builds on the earlier work from the Shared Assessment Framework which used a tiered service approach. Service users can move through tiers if their needs change. This will follow appropriate assessment supported by a series of service protocols and/or eligibility criteria. Some elements of service may be ongoing if people’s needs increase or pathways move them through the service tiers e.g. homecare.

B3.2. This new framework has an increased role for self-assessment, facilitating support for self-care and will also allow direct access to some services. The aim is to open up the health and social care system to support appropriate user directed care and to better target specialist professional resources to people with the most complex needs. The framework should support developing approaches to Direct Payments and Individual Budgets when the implications become clearer and approaches are agreed.
B3.4. The framework aims to ensure that access to community services at all tiers will be needs led, simplified and that any contact with the health and social care system will be able to direct service users to the appropriate level of care as efficiently as possible. It is important to recognize that people’s health and care needs may change gradually or unexpectedly and as a result they may move up or down the levels of care supported by assessment, care management and pathways.

B4 – Tier Descriptors

B4.1. To make sure there is a consistent way of providing people with the most appropriate care to meet their needs, we plan services according to tiers (or levels) of need. This can be illustrated in terms of four tiers, going from low to high level needs, and within each tier we can assess who is eligible for care, and how their care is best arranged. It is important to recognise that this is not necessarily a route followed by all people, rather a way of planning service responses for different levels of need.

B4.2. The four tiers of need and what they mean for services are:

**Tier one: Self Care**

**Needs:** people in this tier may be experiencing some loss of function and have a limited specific need for short term help but are able to carry out the activities of daily living without assistance. They need services that promote good health and wellbeing, prevent ill health, offer practical help and support, encourage independence and social inclusion, and prevent disability.

**Services:** the main service with which people in this group are likely to be in contact is primary care, particularly their GP practice. People will require information on services available to them and how to access them at an early stage. This would include advice about benefits, safety, physical activity, and carer support. Access to screening for potential problems such as vision, hearing, mental health, oral health, continence and foot health. Preventive measures such as immunisation, dietary advice, smoking cessation, advice on addictions, and falls risk prevention will also be offered. Social care and housing supports include handy persons schemes, aids for daily living, day services, care and repair, and tenancy transfers to be closer to family and friends or to move to smaller accommodation.
Tier two: Basic Support

**Needs:** people in this tier will be experiencing some loss of function and require practical assistance with tasks inside and outside the home. This assistance may be provided as required by friends or family acting as carers, or by care services.

**Services:** people in this group may require housing, health, or social care services at times. This may be practical assistance such as shopping, housework, laundry, day centres, short breaks for carers, or meals at home. Health support may include medication or Allied Health Professional treatment, district nursing or health visiting. Housing support will include minor aids / adaptations such as grab rails, housing alarms and sheltered housing.

Tier three: Multiple Care Needs

**Needs:** people will be experiencing significant loss of function and probably need personal care as well as practical assistance. Friends and family acting as carers may provide some of this assistance but they are also likely to need multiple services from care agencies. They need access to more detailed assessment and rehabilitation / treatment and social care provision to maintain their level of function and wellbeing for as long as possible.

**Services:** people in this group may require housing, health, and social care services as part of a co-ordinated package of care. Practical assistance may be similar to that in tier two. Personal care can be provided by trained home carers. Healthcare support may be in the form of community or day hospital assessment and rehabilitation from community services. Social care may be in the form of enhanced home care and overnight services and care homes. Housing support could include major adaptations or very sheltered accommodation.

Tier four: Complex and Intensive care needs

**Needs:** people will be experiencing significant deterioration of function and need both personal care and practical assistance. Friends and family acting as carers may provide some assistance, but they are likely to need significant support. People in this tier need access to ongoing assessment and rehabilitation / treatment and social care provision. Some people may experience severe loss of function that has failed to respond to rehabilitation programmes, and so require assistance in most areas of their life. It may be difficult to maintain the person in their own home

**Services:** people in this group will need a complex package of housing, health and social care services to support them, particularly when people are at risk of admission to hospital. Practical assistance may be similar to that in tier two, but with increased intensity. Home carers and enhanced care workers, supported by nursing staff, may provide personal care. Health and social care support will be more specialist or involve more complex assessment and rehabilitation, both at home and in care settings. Additional social support may be in the form of day care, respite and short breaks, again with increased intensity or specialist focus. A move to very sheltered or barrier free housing may be needed. Alternatively, people may need to move into a care home. Services should encourage people to live to as near as possible their potential in terms of physical, mental and social function. They should support people to do
things for themselves, to live their lives the way they want to, being able to engage in meaningful activity. There should be a regular review of people’s medical, cognitive, nutritional and care needs considering falls risk assessment and appropriate medical review and treatment.

**B5 - Service Delivery**

B5.1. As indicated in the introduction to this report the framework builds on the range of service developments for older people and adults with a physical disability. The development process has to date been incremental with each stage leading to further integration of health and social care functions and closer alignment of service delivery in response to physical and mental health needs. The primary driver for further change is the aspiration to deliver a comprehensive and integrated locality based rehabilitation and enablement service for older people and adults with a physical disability. The service delivery proposals outlined in the next section of the report reflect two further developments in this incremental change agenda. The changes referred to are:

a) Further devolution of service functions to localities across the health board area so that all CH(C)Ps manage the delivery of the range of community based rehabilitation and enablement health services for their local population. In some areas this will involve the transfer of services currently managed by the Acute Division and in others it will involve more local working towards integration. Detailed service redesign will consider whether some services, provided across more than one CH (C)P, will require to continue in that model or can be disaggregated for more local integration.

The following services will form part of local service arrangements

- Hospital discharge and rehabilitation delivered by supported discharge teams
- Community based specialist rehabilitation for adults with a physical disability
- Community based falls services delivered by the Community Falls Prevention Programme

In the former Greater Glasgow area this will also include

- Specialist medical/clinical input to care home residents delivered by the Nursing Homes Medical Practice and Care Home services

The action plan detailed in the later parts of this document will describe the initial system wide arrangements to manage the transition of this functionality to locality arrangements. Thereafter, the detailed redesign will take place within individual CHCP planning arrangements.

b) The development of a structured service delivery framework in each CH (C)P including locality based enablement networks and fully integrated rehabilitation teams to respond to complex and intensive care needs.

Each CH(C)P will need to develop detailed proposals for the configuration and membership of teams reflecting local circumstances and the degree of integration with local authority partners and other agencies. The enablement and rehabilitation services outlined in the following sections will describe a framework with integrated management arrangements. CHPs will be expected to deliver similar models within aligned management arrangements with social work departments.

The service delivery levels can be presented within the framework as follows
The social care element of the service models will be determined by the extent of the integration already established with local authority partners. In summary the delivery of the service responses will be organized as follows:

i. Community service networks signposting and supporting health promotion and health improvement at Tier 1
ii. Enablement service networks delivering responses at Tier 2
iii. Fully integrated rehabilitation services primarily providing service responses at Tier 3 and 4

B 5.2. **Community service networks signposting and supporting health promotion and health improvement at Tier 1**

B 5.2.1 At this first level of the service framework we should be reinforcing principles will allow opportunities for early intervention and support for people to self-manage in the community. This means supporting people to use community services including culture and leisure services, lifelong learning opportunities and voluntary agencies’ services as appropriate. This community-based approach and phase of the rehabilitation journey has strong links with anticipatory care and the supported self-care level of the long term conditions (LTC) model. This document will not repeat the content of the LTC strategy. However, the principles of self care are worthy of reflecting as we develop this local network.

B 5.2.2 Self-care can be defined as the care taken by individuals towards improving or maintaining their own health and well-being

- Supported self-care involves a process of support offered to individuals to enable them to improve their knowledge about their condition and develop the skills and ability to manage their condition effectively. Further consideration is needed to include ‘hard to reach groups’. This can be done in a numbers of different ways including:
- Patient information - high quality information, accessible and equality proofed, covering specific diseases or broader health related and general healthy living information
- Structured patient education programmes - evidenced based programmes about specific condition, eg diabetes, arthritis etc. These programmes are generally led by health professionals.
- Generic self-care training skills - programmes to support people living with any long term condition to develop skills and confidence to manage their condition more effectively
- Health Improvement and reducing health inequalities - providing opportunities for patients and carer’s to access to health, social care and voluntary sectors services, such as stop smoking services, stress centres, financial inclusion services and peer support.

BS 2.3 These principles apply throughout the framework. In responding to this at CHCP/CHP level managers should consider a range of responses aimed at:

i. Promoting good health and wellbeing
ii. Preventive health and associated services
iii. Practical help and support
iv. Maintaining / achieving social inclusion
v. Maintaining and sustaining ordinary living

B5.3 Enablement Service Networks

B5.3.1 It is proposed that enablement teams would operate within a defined geographic locality within a CH(C)P. The number of teams would be determined by each CH(C)P reflecting on local circumstances and resources. Locality enablement services will primarily be provided by AHPs and Social Work staff but will also include some elements of the work undertaken by District Nurses. How District Nurses will relate to the teams for that work will be defined through local discussions.

B5.3.2 No changes are proposed to the attachment arrangements for District Nursing teams to GP practices for areas of work such as Chronic Disease Management eg Diabetes Care or to the arrangements for Palliative Care.

Line management arrangements including objective setting and professional development arrangements will require to be in place and management capacity will be reviewed.

B5.3.3 Further integration would evolve over time but the network approach would be managed and supported by care policies and procedures, agreed eligibility and access criteria, resource management arrangements and information and management technology systems
B5. 4. Rehabilitation Services

B5 4.1 The rehabilitation service will work with service users at Tiers 3 and 4. This new integrated service will deliver complex and intensive rehabilitation for older people, older people with mental health problems and adults with physical disabilities. It is likely the service will comprise a range of multi professional and inter agency teams. The detail will require to reflect local circumstances, structures and resources. Specialist functions within this service and the detail of how they will be structured needs further development but core provision will include intensive and complex rehabilitation and care, supported discharge and admission avoidance where appropriate.

B5 4.2 Many people who require an admission to hospital will not come into contact with health and social care services on discharge. However, for those who do require support, the framework, and in particular assessment arrangements, needs to ensure that the appropriate level of support is in place. Only people who require complex packages of care on discharge will be supported from teams within the rehabilitation service.

B5 4.3 The practitioners to resource these teams will come from the existing range of rehabilitation services.

- Older people’s community rehabilitation services
- Older people’s community mental health services
- Acute hospital supported discharge services
- Health and Social Care community physical disability services
- Care Home services
- Social Work services (where agreed)
- Certain identified Nursing posts

B5 4.4 Some existing specialist rehabilitation services including Stroke, Supported Discharge, Stroke CDM and MS CDM services will remain and continue to be managed within the Acute Sector due to the strong clinical evidence base.

B5 4.5 Core to the delivery of this community based rehabilitation service will be the contribution from specialist medical practitioners. Community mental health teams have well established arrangements for medical input as part of the multidisciplinary team arrangements. Consultant input to community older people’s services has been piloted in the North Glasgow CHCP area and is resourced for all former Greater Glasgow C H ( C ) Ps. Community Physical Disability Teams also have input from consultants in rehabilitation medicine.

B5 4.6 Appendix 1 shows how this service might be constructed
Section C: next steps and future work program

C1. While the creation of CH(C)Ps provides us with increased opportunities to achieve this change to whole system working and service integration, there are a number of steps critical to success in delivering the proposed change programme. These underpinning issues for all work strands are;

- Developing an inclusive approach to the detail of service redesign including staff time for engagement.
- Realistic timescales and a phased approach to service reconfiguration which allows time for pilots of new approaches prior to implementation.
- A change management strategy supported by dedicated contributions from Human Resource, Organisational Development and Project Management. The strategy will support local implementation and processes for staff and public engagement.
- A Communication Strategy with clear regular communications to all interested stakeholders.

C2. A coordinating group established with representatives from across the NHSGGC Board area will co-ordinate further development and implementation of the framework. However, it should be noted that the vast majority of service redesign work will take place within local planning arrangements. The group has led on the development of this paper and the production of the responses document attached as Appendix 1. The group has identified work to start to implement the framework and the further work program required. These next steps are:

C2.1. To establish and implement an agreed framework for a community based ‘inreach’ model of ensuring hospital discharge including supported discharge functions to effectively meet the needs of individuals and deliver improvements in hospital discharge performance. This is particularly important for older people potentially at risk of care home admission if discharge is delayed. This transition needs to build on the existing good practice currently provided from within the acute sector. Locally this will also need to take account of current and any proposed local authority social work structures. The framework will be developed initially on a system wide basis with clear and explicit transition arrangements for functions and staff. A workshop is planned for September. Thereafter, local planning arrangements will design and implement hospital discharge arrangements at a CH(C)P level within the agreed framework.

C2.2. An initial system wide process to confirm the construct for community based rehabilitation services for adults with a physical disability / impairment and to develop the transition plan for the new arrangements. Thereafter, local planning arrangements will design and implement the service at a CH(C)P level reflecting the agreed construct.

C2.3. Development of transitional arrangements that consider how the community falls prevention service can be delivered by CH(C)Ps. Thereafter, implementation and management of the service at a CH(C)P level

C2.4. Development of transitional arrangements that transfer and devolve Care homes Services to CH(C)Ps within the Greater Glasgow area. Thereafter, implementation and management at a CH(C)P level

C2.5. Within each CHCP/CHP local work will establish the composition and roles of the rehabilitation and enablement services, team/s and team members. This requires to be fully worked through at this local level to deliver comprehensive arrangements for management, protocols for care/case management roles and professional governance
C2.6. Within the CH(C)P redesign program there is a need to develop arrangements that maintain district nursing teams practice attachments and allow their rehabilitation and enablement work to be linked with the work of others working in that field. This work will identify the appropriate skill mix and workloads within local teams and management capacity requirements.

C2.7. Early work with HI and T to revisit the options available to deliver IT solutions to support single shared assessment.

C2.8. A detailed HR plan will be agreed in partnership and will be governed by the principles of Organisational Change

C2.9. Throughout the redesign and implementation program a structured organisational development plan will be established

C2.10. Further engagement with and consideration of the role of service users and carers at all levels is required. A specific local process to empower service users and carers is required to reflect their important roles.

C2.11. An ongoing requirement is to connect the developments within the framework with the Long Term Conditions Strategy and the Future of Primary Care.

Section D: Governance arrangements and ongoing engagement

D.1 The Coordinating Group will provide reports to the PPPG and into joint planning arrangements with each partner authority. It will be responsible for commissioning further cross-cutting pieces of work including how to ensure professional leadership and performance management and for ensuring that local implementation is balanced with service equity. The group will support a consistent and system wide approach.

Further staff engagement in this process will include:

- Formal presentation of the framework to the Area Partnership Forum, Area Clinical Forum, Area Medical Committee and the Local Medical Committee
- Involvement of staff, primary care contractors, service users and carers in specific pieces of work essential to the development of the new service model
- Formal engagement through local staff partnership forums within CH(C)Ps and the Acute Division

D.2 Ongoing engagement with service users and carers will be ensured through existing structures including PPFs and joint planning arrangements

D.3 This framework and the next steps document will enable each CH(C)P to start to develop local implementation plans while taking account of their population and resources to develop an equitable and consistent approach across the health board area. Further planning of cross cutting strands and further tasks will start in September when the new Rehabilitation Coordinators are in post. Work is already underway to develop improved rehabilitation services and detailed planning and redesign to deliver the framework across Greater Glasgow and Clyde is likely to take around twelve months. During this period implementation will also be managed on a staged basis with full implementation planned to take a further six months.

A Harkness
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Appendix 1
Potential Rehab service arrangements

Rehabilitation Manager

Team Leader Mental Health Team (1)
- Team Leader Mental Health Team (2)
- Team Leader Older People Team (1)
- Team Leader Older People Team (2)
- Team Leader Older People Team (3)
- Team Leader Older People Team (4)

- Team Leader Adult Disability (1)

Nursing AHPs Social Work Psychology

- Consultant Psychiatrist

Nursing AHPs Social Work

Consultant – Medicine for the Elderly

Nursing AHPs Social Work

- Consultant in Rehab Medicine

Nursing AHPs Social Work

Nursing AHPs Social Work

Psychology

Consultant – Medicine for the Elderly