TOWARDS A REHABILITATION AND ENABLEMENT SERVICE

1. PURPOSE

1.1 The purpose of this paper is to inform members of proposals for the development of a Rehabilitation and Enablement Service for Older People, Older People with Mental Health Problems and Adults with a Physical Disability, including the history of this development and the main implications for the CHCP.

2. BACKGROUND

2.1 The last ten years have seen major changes in the way, in which our health and social services work together, to improve the service experience and outcomes for our service users and patients. Evidence of this has been in developments around the Joint Future agenda and in the integration in our Learning Disability, Addiction and Mental Health Services.

2.2 The review of health services in Scotland recommended a transformational shift in the management of long term conditions (Professor D Kerr, Building a Health Service Fit for the Future). The Rehabilitation and Enablement Service offers a framework to deliver some of the outcomes contained in this report. (Better Health, Better Care continues to support this shift)

2.3 The establishment of CHCPs brought together, within a single management arrangement, health and social care services for older people with both physical and mental health problems and adults with a physical impairment.

2.4 The Heads of Health and Community Care were tasked by the CHCP Directors and the Disability and Rehabilitation Planning and Implementation Group (Rehab PIG) to agree proposals for the further development of rehabilitation services within CHCPs. The paper attached as Appendix 1 is the product of this work.

2.5 The Rehabilitation and Assessment Directorate (RAD) of the Acute/Hospital Operating Division of NHSGG&C currently manages a significant number of
community rehabilitation services, including health support to residents of care homes, Community Physical Disability Teams and Community Falls prevention programmes. It was agreed that the RAD would host these functions for a period of time until further work could be carried out to fully develop the future vision of rehabilitation services for the City.

3. NEED FOR CHANGE

3.1 The scale of the task and the complexity of the care system for older people and adults with a physical impairment in Glasgow are significant. As a result it has been impossible to develop a comprehensive whole system approach to social and health care delivery. The system is characterised by a significant number of small specialist teams, generic services, multiple assessment tools and variable care management arrangements. However the limitations in our current arrangements are:

- Fragmented service arrangements and care pathways that see service users being passed between numerous teams
- Significant inconsistency in service delivery models across the system and between localities
- An underinvestment in Information Management and Technology, and management capacity in specific areas including district nursing
- Incomplete realignment of older peoples’ health services aimed at achieving better synergy in physical and mental health care
- Limited progress in modernising services to respond to the changing needs and aspirations of young and older adults with physical impairments, and older adults with mental health problems
- Limited progress towards arrangements that see the service users influencing how needs are assessed and how care is arranged or provided

4. KEY ELEMENTS OF SERVICE REDESIGN

4.1 The proposal recommends the creation of a single, integrated rehabilitation and enablement service within each CHCP. This represents significant change for CHCPs and partners in hospital settings in the management and delivery of services. This change will require an organisational development programme relevant to the scale of this redesign to enable staff and stakeholders to shape the new service.

4.2 The framework proposes an integrated system at all levels with services delivered on a 4 tiered basis, dependent on individual needs e.g. from level 1-Self Care to level 4 -Intensive. The service would deliver across the care spectrum, from pre habilitation, direct access to enablement and through to those requiring intensive support and rehabilitation. Service features will include:

- The establishment of a CHCP fully integrated rehabilitation team responding to the needs of adults and older people.
- The establishment of ‘aligned’ geographical enablement teams of health and social care practitioners responding to lower level and complex needs based around clusters e.g. GP practices.
- A stronger focus on enabling self care and management, allowing direct access to some services e.g. equipment, budgets
- A move away from providing services on an episodic interventionist approach to a focus on rehabilitation and enablement.
A ‘through care’ approach; care management responsibility for adults and older people who experience an acute episode of hospital care being retained by community teams including discharge arrangements and community based rehabilitation.

CHCPs being responsible for the delivery of enhanced health inputs to care homes residents.

5. ISSUES

5.1 The proposed framework sees a significant change to the organisation and management of rehabilitation services in Glasgow. The following issues will require attention:

- Stakeholder reaction – every member of the rehabilitation workforce will be affected by the proposals and there is a need to ensure appropriate engagement during this initial phase of discussion and in the longer term as implementation plans are developed. Significant workforce issues that will require the establishment of robust personnel arrangements include:
  - the potential movement of significant responsibility and workforce from the RAD to CHCPs
  - the establishment of enablement teams that will impact on current working practice of community staff eg district nursing, Allied Health Professionals, Social Work

- Organisational capacity and the pace of change – engagement with partners and managing the redesign proposals will be undertaken in the current climate of other change programmes for children’s services (including the health visitor review) and the agreed redesign of learning disability day services.

- Service stability - it is essential that service delivery does not deteriorate during the implementation phase.

- Ensuring visibility of the respective sub-groups – there will be concerns that as we move to more holistic models of care that some groups including adults with a physical impairment and older people’s mental health issues will not be given adequate attention.

- Affordability – The proposal has identified a number of existing resource deficits and recommends an extension of direct access arrangements. Transitional or ‘bridging’ resource may be necessary in any move from existing arrangements to the new framework. As a minimum project management, personnel, workforce planning, finance and organisational development capacity will be required.

- Infrastructure – in order to deliver the locality arrangements, front line staff and teams will require appropriate support infrastructure. To this effect CHCP administration capacity and arrangements, information systems and plans, and accommodation strategies will need to be reassessed.

- Management and Leadership Arrangements – both management and professional leadership capacity and structures will need to be reassessed in response to the proposed service framework.

6. RECOMMENDATION

6.1 The Committee is asked to:

- note the content of this report and the attached Appendix
• **agree** that extensive engagement takes place with partners during this initial discussion period to 15th February
• **request** a summary of discussions from the consultation at a future meeting

**JACQUELINE TORRENS**  
Head of Health and Community Care  
1 February 2008

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**Appendix 1**

**Towards Community Based Rehabilitation and Enablement Services for:**

- Older People  
- Older People with Mental Health Problems  
- Adults with a Physical Impairment
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EXECUTIVE SUMMARY

This proposal aims to take the next step, building on the history of service improvements that has brought services for Older People, Older People with Mental Health Problems and Adults with a Physical Impairment to where we are today, to capitalise upon the opportunities presented by the creation of Community Health and Care Partnerships, and to continue the journey of care from fragmentation to service integration. This paper suggests the creation of a single, integrated service framework within each CHCP that supports a through care or single pathway model of care. The framework has the following characteristics

- A comprehensive service delivery model within each CHCP, responsible for the care needs of all older people, older people with mental health problems and adults with a physical impairment within their locality including residents of care homes.

- A community based service framework that delivers on an assessed needs basis across the care spectrum from prehabilitation to palliative care and supports individuals through care/case management, proportionate to their needs.

- A service which will be responsive to the needs of adults who experience an acute episode of hospital care by delivering assessment and ongoing case/care management including discharge arrangements and community based rehabilitation.

- A tiered level of service model, which targets professionals and resources to the highest and most complex needs, and frees access to resources at lower levels.

- A move away from providing services on an episodic interventionist approach to a focus on rehabilitation and enablement.

- A stronger focus on self care and self management, allowing those with the lowest levels of need direct access to some services.

- To achieve this service change the paper proposes that Rehabilitation and Enablement Teams are created within CHCPs, which would entail the redesign of existing specialist rehabilitation services and all community based health and social care services and/or systems.

- An inclusive and person centered redesign process be commissioned to draw on existing best practice, model new practice and structures creating services for the 21st century.
1. **BACKGROUND & CONTEXT**

1.1 The last decade or so has seen us all engage, in a range of ways, on a journey towards more coherent and comprehensive services and service arrangements for older people, older people with mental health problems, adults with a physical impairment.

1.2 Some 7 years ago, in November 2000 the Scottish Executive published the report of the Joint Future Groups (JFG). Locally in Older Peoples’ Services, Older Peoples’ Mental Health Services and in Adult Physical Disability Services, a number of initiatives developed, which have been important staging posts on this journey;

- Shared Assessment Framework — Older People
- Community Older Peoples Teams (COPT)
- Community Elderly Mental Health Teams (CEMHT)
- Rapid Discharge Response Arrangements
- Enhanced Home Care
- Greater Glasgow Independent Living Equipment Service (G Giles, known as “the Joint Store”)
- Direct ordering of Home Care Services (from hospitals)
- Direct Payments
- The development of Managed Care Networks (MCNs)
- Commissioning programmes in Older People, Older Peoples’ Mental Health and Adults with physical impairment — aimed at creating more and a more diversified range of community based living options
- Best value review of Day Services (SWS) aimed at regularising and adding to the network of Social Care Day Services and Opportunities (implemented in part)
- Pilot of shared assessment (baseline) physical disability. (Implementation held pending I.T support)
- Integrated Discharge arrangements

1.3 Many of the above initiatives built on earlier actions around the re-commissioning and reconfiguring of institutional care models (largely hospitals) e.g.

- Gartloch
- Woodilee
- Cowglen

1.4 These programmes saw the development of newer models of care in specialist dementia nursing and residential care, supported living/accommodation and at the same time resourced the expansion of community infrastructure e.g. CEMHTs, short breaks/day opportunities.
1.5 Alongside work in Older People, Older Peoples’ Mental Health and Physical Disability Services, we have seen the development of integrated services amongst our community care neighbours in:

— Learning Disability
— Mental Health (Adult)
— Addictions
— Homelessness

1.6 At the same time, we have seen initiatives to redesign and mainstream resources for general health and social care services to respond to shifts in the balance of care, moving from a care group to a broader, inclusive rehabilitation framework, informed by community need;

- The creation of Social Work fieldwork practice teams
- New contracts for G.P, Pharmacy, Dental and Optometry services
- The development of out-of-hours nursing services
- Work to redesign integrated occupational therapy services (yet to be implemented).
- The recently issued NHS GG&C Strategic Framework for the Management of Long Term Conditions
- The development of a service framework for older people that has evaluated positively through the joint futures process including the JPIAF arrangements
- A system that has managed significant change in the balance of care from institutional and hospital based services to community based alternatives offering greater flexibility to service users
- The development of a number of rehabilitation services that are regarded as models of good practice including hospital discharge teams, medical supports to care home residents and Community Older People Teams.
- Arrangements that have consistently delivered delayed discharge performance figures that compare favorably with other partnership areas
- The development of carers centres and improvements in mechanisms to involve users and carers

1.7 However, there are limitations in our current arrangements that the proposals in this paper seek to address:

- A number of services or systems of care rather than a whole service system working in a fully integrated way
- The development of service teams without the commensurate investment in support infrastructure including accommodation, IM & T and administration support
- Significant inconsistency in service delivery models across the system and between localities
- Care pathways that see service users being passed between numerous specialist teams
• An underinvestment in management capacity in specific areas including district nursing

• Incomplete professional leadership arrangements including Occupational Therapists

• An underinvestment in community based allied health professions e.g. physiotherapy, dietetics, podiatry

• Incomplete realignment of older peoples health services towards achieving better synergy in physical and mental health care

• A need to modernise services to respond to the changing needs and aspirations of young and older adults with physical impairments, and older adults with mental health problems

• Limited progress on developing arrangements that see the service users influencing how needs are assessed and how care is arranged or provided

1.8 There is further a requirement to remedy key deficits in our current service system significantly;

• Growing our Older Peoples Mental Health psychology service to meet the needs of our users and the requirements of the Mental Health Delivery Plan

• Resource and Implement the strategic agreement on Occupational Therapy integration in Glasgow City.

• Release professional resource capacity by the implementation of the Administration Review in Glasgow City freeing up professional staff to provide functional tasks.

• Continue to improve upon waiting times and discharge requirements in particular linked to the ongoing work on AHP waiting times.

• Maintain the resource investment in Health Visitor Support Staff directed to older peoples care and support.

1.9 We have also seen our approach widen from an exclusive concern on care services, towards a broader response that reflects Older Peoples’ concerns. This is well evidenced in Glasgow’s Seniors Charter, with a need for similar approaches to be collectively pursued for adults with a physical impairment.

1.10 Perhaps most starkly our service users, their carers and staff have told us that they want to see –

• Less duplication in assessment and provision
• Better communication with each other
• No division between primary and secondary services
• Reduced barriers to service.
• Self Sufficiency in supportive communities.
• Clarity on service pathways
• Joined up working
• Earlier responses to needs
1.11 What we now need to achieve or articulate is how we can;

- bring all service elements into a single system
- plan to organise this
- identify resource adjustments / requirements which would be necessary to fully deliver the model being proposed.

1.12 These are the overarching aims of this paper, we will also give some consideration to; current thinking on integration, some of the key principles we would wish to underpin a model of rehabilitation and enablement and a brief summary of our conceptual approach.
2. CURRENT THINKING ON SINGLE SYSTEM WORKING

2.1 Community Health and Care Partnerships provide us with increased opportunity to improve the effectiveness of ‘single system working’ and better manage the interface between Acute and Community Health and Social Care.

2.2 This has led us to reflect on service integration for older people and adults with a physical impairment, and because the term integration tends to mean different things to different people, we propose the following definition

A single system of service planning and delivery put in place and managed, together, in Partnership.

2.3 While partnership is needed to create an integrated system, it is not the same as integration. For us, the move to integration could be described as a journey from fragmentation to integration.

2.4 Coordination can produce some of the benefits of integration. It can improve communication, speed of response and reduce duplication. Integration can produce additional benefits where changes in our collective identity create opportunities for; organisational efficiencies, clearer joint processes of accountability, more robust team working and team leadership, new opportunities for investment and an increased capacity to advocate and negotiate on the service users behalf.

2.5 The experience, and evidence, of integration would suggest that;

2.51 Integration is most needed and works best when it is, a multi disciplinary/agency response, focused on a specific group of people with complex needs, and where the system is clear and readily understood by users and practitioners and carers.

2.52 A clearly defined vision and strategy for the new service has been worked through involving all participants in the system.

2.53 Cross-service management issues are addressed (i.e. line reporting and professional reporting structures, conditions of service issues resolved) and effective leadership is in place.

2.54 While there is continuing debate on co-location, it is commonly agreed that

— Co-location is critical to an integrated service and to accelerating the process of integration
— However we should not co-locate unless the physical conditions, systems and support can be put in place
— If not co-locating, look to centralise common services and multi professional teams.
— Co-location needs to be supported with appropriate organisational development input, whether delivered by managers or external specialists.
Each CHCP is operating within a different environmental and operational context and has inherited variable physical resources. As a consequence it would be difficult to build any ‘integrated service’ entirely on a pre-requisite of co-location. However, CHCPs are currently preparing estates strategies that offer greater opportunity for multi-agency developments. Co-location of integrated teams should be seen as a minimum. However, co-location of other teams within the service network would also be desirable and deliver service gains.

It is essential that the capital planning arrangements of the parent organisations are developed to respond to this agenda. However, in the short to medium term co-location may not be deliverable in many locations and effective IT networks will be essential.

3. UNDERPINNING PRINCIPLES OR REQUIREMENTS

3.1 We would suggest a number of principles or requirements which underpin our model of system and service integration, moving towards a community rehabilitation and enablement service which spans a population based focus at lower levels of need to an individual focus at the upper end of the need spectrum.

3.1.1 A Balanced Approach — which balances need and response between low levels of need and higher more complex levels of need and vulnerability

a. Low level of need responses are viewed as deliverable on a system wide basis by virtual teams where co-ordination not team integration would be the key to improved service delivery. This requires system redesign.

b. High/ complex needs – where services would be delivered on a much more specialised basis through an integration of our current older people, older people mental health and physical disability specialist rehabilitation resources and supported discharge services. This requires system redesign.

3.2 A Rehabilitation and Enablement Approach — This may require a shift from an intervention episodic approach (for some service users) to a more continuous, systematic approach with a specific focus on anticipatory care, rehabilitation and enablement. This is consistent with models with definitions of pre-habilitation, rehabilitation and habilitation, and the National Delivery Framework (February 2007). In addition the NHS Greater Glasgow & Clyde Strategic Framework for the Management of Long Term Conditions includes the following in its building blocks for implementation of the Framework:

- Patients and carers as active participants in care informed and fully involved in decision making about care, fostering a culture of self care & well being.

- The anticipation and early identification of, and response to, problems or exacerbations of condition.
• The provision of proactive and structured care based on clear evidence of effectiveness

• Staff trained in people centered approaches. Multidisciplinary teams will span the divide between primary and secondary care and health and social care making the change in attitudes, behaviours and culture required to achieve this approach.

3.3 For the purpose of this document and the framework we propose as a definition of rehabilitation:

_A process aiming to restore personal autonomy to those aspects of daily life considered most relevant by patients / or service users, their family and carers._


3.4 **A Service User Centered Approach** which clearly defines — timescales for the receipt of services, standards that the service should achieve / can be adhered to, eligibility for each service which make sense to users carers and staff and are easily understood and navigation — a single point of contact to guide and / or support individuals through the service framework. Finally, and critically, for a modern user focused service, real scope for self-assessment and direct-access to appropriate levels of service, which support individuals’ autonomy and self-management.

3.5 This supports the ethos of the 21st Century Social Work Review Scotland, where members of the User and Carer Panel commented:

_“We expect to make a positive difference to our lives... The outcomes we want include having power and control, being able to take risks and contribute to society. This means that there needs to be a shift away in power from people who commission and provide services to service users and carers.”_

3.6 While “In Control Scotland” is at the beginning of its work individualised care and direct access to services is consistent with the new English white paper ‘Our Health. Our Care, Our Say’, which seeks to consolidate this policy direction.

_“Individual Budgets offer a radical new approach, giving greater control to the individual ... individual budgets will together revolutionise the way care is provided with a much stronger focus on personalised purchasing”_

3.7 **A Team Approach** which best utilises staff resources. Where there is clarity on staff roles (who does what, when, where, how) skills and skill mix, through weighted functions or case loads which makes best use of staff resources,
education, learning and reflective practice built in to the organisation of the system and team, through a variety of approaches, including mentoring, secondment, rotation. Teams should be locally based within CHCP’s; alive to the needs of the community they serve.

3.8 A Pathways Approach which identifies the pathway from the user’s perspective, designs new pathways with reduced delays and improved processes, and develops, as required, protocols and speedy dispute resolution processes.

4. A CONCEPTUAL FRAMEWORK

4.1 The service system model builds on the earlier work on the Shared Assessment Framework; tiers of service approach. Linking the tiers or levels of service or intervention are the key processes of assessment and care management. Underpinning the model will require the development of a series of care pathways and service eligibility criteria and protocols.

4.2 This model has been refreshed from its earlier development by an increased role for self-assessment, facilitating support for self-care and complimenting this with direct access to some services. This represents a freeing up of the health and social care system towards user directed care. This is consistent with a desire to support user autonomy and target professional resources to the most complex needs. It supports developing trends towards Direct Payments and Individual Budgets. It is, however, controversial not least because, as yet, we do not know what demands and cost impact this could have on the system. As for other elements, of the emerging model, developments in direct access will require further detailed work, pilot developments, evaluation and review.

4.3 Figure 1 represents, in summary, a diagrammatical representation of the model; further detail is given on page 1
At its most basic, the model proposes that the System be integrated at all levels but only the intensive tier of the service being delivered in an integrated team. The move through service levels can be cumulative i.e. picking up some services at level 2 which continue to form part of the service package at level 4.

5. DESCRIPTION OF A SINGLE SERVICE STRUCTURE

5.1 This section outlines the proposed stratification (service tiers) within the single service structure, which is designed to meet the full scope of needs of services users from those who are self managing to those who require intensive support. The proposals in this paper give a direction of travel and systematic approach. The detail will require to be taken forward in focused work with all affected stakeholders. The definition of the services in each tier articulates:

- The service trigger
- The levels of care/case management
- The method of delivery
- The service elements

The table in Appendix I charts each tier at a glance.

5.2 Tier 4 - Intensive Support.
5.2.1 At this level, service users are identified as requiring intensive support services, which will be triggered by a comprehensive, specialist assessment and managed through care/case management. It is suggested that services within this tier will be delivered largely through specialist city wide services and new/redesigned integrated multi-disciplinary rehabilitation teams within CHCP’s.

5.2.2 Examples of service elements at this level would include specialist medical services, specialist care homes, mental health act intervention including care programming approach, specialist support to care homes, complex care packages (12-24 hour care), and intensive rehabilitation.

5.3 Tier 3 – Complex Support

5.3.1 As with tier 4, services at this level are triggered via a comprehensive and where appropriate specialist assessment, and are managed via a care/case management process, however the level of support is not as intensive. Services will be delivered by CHCP based multi-disciplinary enablement teams, which will not necessarily be integrated but will however be managed as part of a single integrated system. Service elements at this level would include adult protection, care packages and care homes which cover up to 12 hours per day, enhanced home care, rehabilitation, and overnight care.

5.4 Tier 2 – Maintenance Support

5.4.1 At this tier services are triggered via a baseline assessment and service users are identified as requiring a basic level of care/case management through a process of monitoring and review, which may be provided via an administratively supported process. Services at this level will focus on enablement and may be delivered either by teams or by individual professions, and as for Tier 3, do not require to be integrated but rather managed within the single integrated system. Services are provided in aligned geographical localities, around communities. Elements of Tier 2 services include homecare, community alarm service, telecare, low level nursing intervention, podiatry, low level physiotherapy, falls prevention, aids to daily living.

5.5 Tier 1 - Self Care

5.5.1 Tier I services will be triggered via an agreed minimum core dataset, and at this level services are universal, and often accessed, directly by service users. The focus at this level is on self assessment, self management and direct access, there is no care or case management. Services may be delivered by co-ordinated CHCP and city wide services. Examples of services elements at this level include GP's and other Primary Care Contractors, housing, sport and leisure, employment support, condition specific support groups and social clubs, and services provided by voluntary organisations.
5.6 Empowerment

5.6.1 For the wider population of adults and older people, who require lower levels of support and who seek to remain as active members of the community, empowered to manage their own health and social care needs, we need to create opportunities across the community and within the CHCP’s for them to be involved - as volunteers, through paid work, participation in learning, leisure, culture and sport.

5.6.2 Releasing professional resources and empowering users at tier 1, could afford opportunities at tiers 2 and 3 to redirect resource to rehabilitative approaches and target resource in a more focused way to those with greater and more complex levels of need. This will require us to embrace new and wider systems of partnership with the community, voluntary organisations, widest range of other agencies, e.g. culture and sport — but most fundamentally responsible trusting and responsive relationships with service users and carers.

5.6.3 This will require us to adopt a user led development perspective.

5.7 Carers

5.7.1 The key contribution of carers will require to be supported at each tier of the service framework; therefore support to carers appears at all levels. Further dialogue needs to take place with Carers Organisations as, while carers continue to seek appropriate information, consultation and support, they have been less eager to engage in formal carers assessments.

5.8 I T

5.8.1 A central plank of developing a single system for health and community care and ensuring that it works in practice is an effective IM&T infrastructure. This is necessary to make sure that information is shared and available to staff across the various tiers of the service to facilitate the delivery of the appropriate services for clients in a timely manner. This will require significant investment in I.T. infrastructure and information management systems. The Management Research team undertaking CH(C)P evaluation highlighted, at the June 2007 evaluation event, that the most significant “snagging issue” was that of the need for an effective and efficient I.T. infrastructure (Fig. 2). It is unlikely that effective and sustainable progress can be achieved in developing our approach without effective I.T. systems.
6. BRINGING ALL CARE SERVICE ELEMENTS INTO A SINGLE SYSTEM

6.1 It is important, in considering the proposition of this model, to highlight two key factors which differentiate the proposed responses for Older People/Adults with a physical impairment and the responses for other community care groups:

6.2 Firstly, the scale, volume and range of transactions and interactions for Older People, Older People with Mental Health Problems and Adults with a physical impairment is far greater than that of all other care groups, often with very high numbers, requiring either a long term single input e.g. home care, or a short term single input e.g. post operative wound care. It is therefore neither desirable nor achievable to create an integrated team for the whole system. It is however necessary, to create an integrated model for the whole system responding to all needs, not just those at the complex (sometimes referred to a specialist) end of the need continuum. ‘In recognition of this we have designed a model to meet the needs of all of these groups.

6.3 Figure 3 below demonstrates that at Tier 1, services to those with lowest levels of need are generally provided by specific professional groups, with a limited requirement for shared assessment or shared care.

6.4 At Tier 3, delivering services to those with higher levels of need, there is a greater requirement for professionals to move towards shared assessment and a care management approach.
6.5 Secondly it may not be possible to achieve complete coterminosity for all elements of the system — significantly GP practice lists. It is likely that the system-wide model will be one of “loose/tight properties”. At the intensive end of the health and care need spectrum, the rehabilitation and enablement teams will have a discrete and multi-disciplinary team structure within CHCP geographical boundaries; while for the universal elements of the system the team will have much more permeable professional boundaries with system integration facilitated by I.T. and effective communication networks.

6.6 Diagrammatically the service system within each CHCP could be represented as below in Figure 4.
7. STRUCTURES, TEAMS AND INTERFACE MANAGEMENT

7.1.1 Currently services for older people, older people with mental health problems and adults with a physical impairment are delivered at a variety of locations and by a variety of professional groups and teams.

7.2 Any integrated service system will require current services to be redesigned and reorganised —not just amalgamated — to achieve a whole system approach to the delivery of services in the CHCP area. A genuinely joint arrangement needs to build upon what is good about existing structures and ways of working from the perspective of the professionals involved - but also from the perspective of service users, carers, voluntary and community organisations.

7.3 Fundamentally an integrated service would allow resources to be targeted towards both health and social care needs. This will no doubt present challenges in providing reassurance and accountabilities on budgetary integration, and requires an appropriate financial regime to support management decision making.

7.4 Teams

7.4.1 Within each CHCP there would be two types of teams working at different levels of the service
7.5 Tier 4 Services - **Rehabilitation Team** (Integrated multi-disciplinary team)

7.5.1 To achieve a truly comprehensive community based rehabilitation service, which puts service users needs at the heart of its activity and to address the current issues of the multiplicity of teams, professionals and assessment processes, it will be necessary to redesign all existing specialist community Rehabilitation Services.

7.5.2 Added to these resources could be dedicated input from CHCP Social Work and Community Nursing Services, and additional specialist input e.g. geriatrician support.

7.5.3 Clearly the composition and roles of the team and team members would require to be fully worked through and arrangements for professional and managerial governance identified.

7.5.4 The following key interfaces with the integrated team would also require to be clearly delineated:

- General Practitioners
- Primary Care Services e.g. The Primary Care Mental Health Team.
- Acute Hospital Services

7.5.5 The Rehabilitation Team would work with Clients identified as requiring Tier 4 services, and interface with colleagues in Acute in relation to facilitating the discharge process. Figure 5 shows the relationship and links between Tier 4 services and acute services and services in Tiers 2&3.

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**Figure 5**

[Diagram showing the relationship between Tier 1, Tier 2, Tier 3, and Tier 4 services, and the interface management between them.]
7.6 Tier 2 and 3 Services - **Enablement Team(s)**

7.6.1 The Enablement Team would work with service users at Tiers 2&3 of the service, and would operate as a local network, both uni and multi-disciplinary. Each ‘enablement team’ could operate within a defined geographic locality within a CHCP e.g. aligned with Community Planning Partnerships, (2 per CHCP), and would comprise:

- General Practitioners
- District Nursing
- Liaison Nurses
- Social Work Practice Teams
- Allied Health Professionals

7.6.2 Practice would be integrated and key interfaces managed through care policies and procedures agreed eligibility and access criteria, resource management arrangements, governance systems and significant coherent Information and Management Technology Systems.

8. **RESOURCE REQUIREMENTS**

8.1 While the creation of Community Health and Care Partnerships provide us with increased opportunities to achieve a step change in whole system working and service integration there are a number of key considerations critical to success in delivering change.

8.2 These are:

- Developing an inclusive approach to the detail of service re-design – this will require staff time to be freed up to allow for real contribution to the detail of service design.

- 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 time contributions of Organisational Development and Project Management resource. The strategy should incorporate support to the leadership resource, and include a process for staff and public engagement, delivered through a change management framework.

- As a priority, an I.M and T, strategy with clear timescales, linked to the overall project plan. The strategy will clearly identify the processes to develop an IT system and business processes, to support the delivery of integrated single system working.

- An accommodation strategy for each CHCP, Health and Community Care Service which articulates short, medium and long term accommodation aspirations for the co-located integrated teams, the network of virtual teams and linking to the work on CHCP service access / service hubs.
• A Communication Strategy and maintenance system

• Early consideration should be given to ensuring project management support and capacity for the development of an implementation plan. Appendix 2 presents a draft action plan to develop a detailed implementation plan and programme.
## Appendix 1

<table>
<thead>
<tr>
<th>Service trigger</th>
<th>Tier 4 – Intensive Support</th>
<th>Tier 3 – Complex Support</th>
<th>Tier 2 – Maintenance Support</th>
<th>Tier 1 – Self management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service trigger</strong></td>
<td>Specialist / Comprehensive Assessment</td>
<td>Specialist / Comprehensive Assessment</td>
<td>Baseline Assessment</td>
<td>Agreed minimum dataset</td>
</tr>
<tr>
<td><strong>Levels of Care / Case Management</strong></td>
<td>Intensive care / case management. Integration of services is essential at this tier with multi agency, multi disciplinary teams. Focus on rehabilitation</td>
<td>Care / Case management of complex cases Single system but co-ordination not integration</td>
<td>Monitoring &amp; review via virtual teams. Single system but co-ordination not integration. Reviews requested by agencies or service users, via an administratively supported process</td>
<td>Self–Management No case management. Core data set of information is gathered via an agreed minimum data set across all services.</td>
</tr>
<tr>
<td><strong>Method of Delivery</strong></td>
<td>Services delivered by specialist city wide services and / or via CHCP integrated older peoples multi disciplinary teams</td>
<td>Co-ordinated approach to service delivery via virtual teams working in aligned geographical localities</td>
<td>CHCP wide and also city wide services. Equality and equity of access to services across all CHCP’s.</td>
<td></td>
</tr>
<tr>
<td><strong>Service elements</strong></td>
<td>• Complex care packages covering 12 to 24 hour care.</td>
<td>• Care packages covering 12 hour / overnight care</td>
<td>• Home Care</td>
<td>• GP’s &amp; other Primary Care Contractors</td>
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<tr>
<td></td>
<td>• Specialist care homes</td>
<td>• Enhanced Home Care</td>
<td>• Telecare</td>
<td>• Housing</td>
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<td></td>
<td>• Mental Health Act Interventions</td>
<td>• Rehabilitation</td>
<td>• Sheltered / Barrier free housing</td>
<td>• Sport &amp; leisure</td>
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<tr>
<td></td>
<td>• Care Programme Approach</td>
<td>• Residential nursing Homes</td>
<td>• Palliative Care</td>
<td>• Employment</td>
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<td></td>
<td>• Specialist support to care homes</td>
<td>• Condition specific teams</td>
<td>• Daycare</td>
<td>• Voluntary Groups</td>
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<tr>
<td></td>
<td>• Specialist medical services e.g. heart failure</td>
<td>• Falls prevention</td>
<td>• CDM Support</td>
<td>• Condition Specific Orgs.</td>
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<td></td>
<td>• Chronic pain</td>
<td>• Adult Protection</td>
<td>• District Nursing</td>
<td>• Community Groups</td>
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<td></td>
<td>• Carers support</td>
<td>• Carers support</td>
<td>• Allied Health Professionals</td>
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<td></td>
<td>• Intensive Rehabilitation</td>
<td>• Care Homes</td>
<td>• Aids to daily living</td>
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<td>• Carers support</td>
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<td>• Care Homes</td>
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</tbody>
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Appendix 2

**Planned work to inform project plan.**

<table>
<thead>
<tr>
<th>Information Management and Technology</th>
<th>Lead</th>
<th>Timescale</th>
<th>Current Update</th>
<th>Resources</th>
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</thead>
<tbody>
<tr>
<td>Action</td>
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<tr>
<td>Develop &amp; Establish baseline minimum dataset for Tier 1 services</td>
<td>CHCP</td>
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<tr>
<td>Develop &amp; Establish core baseline assessment for Tier 2 services</td>
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<tr>
<td>Develop &amp; Establish specialist assessment for Tier 3 &amp; 4 services</td>
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<tr>
<td>Develop &amp; Establish administratively driven monitoring and review process for Tier 2 services</td>
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<tr>
<td>Develop &amp; establish multi agency / disciplinary review and monitoring tool for Tier 3 &amp; 4 services</td>
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<tr>
<td>Development of IT system to support delivery of care for all Tiers of the integrated system</td>
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<tr>
<th>Workforce Plan</th>
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<tr>
<td>Redesign Team Management Structure</td>
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<thead>
<tr>
<th>Staff &amp; Team Development</th>
<th>Lead</th>
<th>Timescale</th>
<th>Current Update</th>
<th>Resources</th>
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<tbody>
<tr>
<td>Action</td>
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<tr>
<td>Roll out care management training</td>
<td>CHCP</td>
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<tr>
<td>Design and deliver an organizational development programme to support the development of integrated services and teams</td>
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<tr>
<td>Services &amp; Infrastructure</td>
<td>Lead CHCP</td>
<td>Timescale</td>
<td>Current Update</td>
<td>Resources</td>
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<tr>
<td>Redesign Rehabilitation Team</td>
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<tr>
<td>Redesign Enablement Team</td>
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<tr>
<td>Identify opportunities and options for co-location</td>
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<tr>
<td>Address boundary and co-terminosity issues to support integrated single system</td>
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<tr>
<td>Map rehabilitation and intermediate care services currently in place</td>
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<tr>
<td>Review of Physical Disability Service</td>
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<tr>
<td>Reconfigure residential / nursing home care</td>
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<td>Develop new models of care at home / balance of care</td>
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<td>Extend Independent Living Fund / Direct payments</td>
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<td>Modernise Delivery of respite services</td>
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<td>Implement Individualized budgets</td>
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<td>Specify District Nursing alignment arrangements with General Practice</td>
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<tr>
<td>Redesign of hospital assessment and discharge function including relationship to practice team function and resource requirements</td>
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<tr>
<td>Management Structure and Team Development</td>
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<tr>
<td><strong>Action - Hospital Social Work re-design</strong></td>
<td><strong>Lead</strong></td>
<td><strong>Timescale</strong></td>
<td><strong>Current Update</strong></td>
<td><strong>Resources</strong></td>
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<tr>
<td>Redesign Nursing structures</td>
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<tr>
<td>Implement OT integration plan</td>
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<tr>
<td>Creation of service aligned virtual teams for tier 2&amp;3 services</td>
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<tr>
<td>Creation of specialist teams for Tier 4 services</td>
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<tr>
<td>Development of the Management Structure to support and deliver Tier 4 services</td>
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<td>Establishment of arrangements for liaison between Acute and Tier 4 services</td>
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<tr>
<td>Development of management Structure to support and deliver Tier 2&amp;3 services</td>
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<tr>
<td>Establishment of arrangement for liaison between tier 2/3 and 4 services</td>
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