APPENDIX 1

Development of an Integrated Urgent Response, Short Term Rehabilitation & Reablement Delivery Model

1. Introduction

1.1. The purpose of this report is to inform the Health and Wellbeing Board of the work taking place between Adult Social Care (ASC) and Guy's and St. Thomas' (GSTT) Adult Local Services to reconfigure the existing urgent response and short term rehabilitation and reablement services and create one integrated, multi-disciplinary service.

1.2. The report provides an overview of the case for change, the new delivery model, expected outcomes and implementation stages. (The key areas of the report will be highlighted to the HWBB by a brief slide presentation)

1.3. The design of the new service has been developed through a provider collaboration between ASC and GSTT and co-produced with NHS Southwark Clinical Commissioning Group (CCG) and council commissioners through the project's governance arrangements.

1.4. A detailed joint business case has been produced setting out the reconfiguration of resources, the shared leadership and management structure and the phased implementation plan to establish the service. This was approved in April by the Council's Children and Adults Board and GSTT's Trust Management Executive.

2. Recommendations

2.1. To note the work taking place between Adult Social Care (ASC) and Guy's and St. Thomas' (GSTT) Adult Local Services to reconfigure the existing urgent response and short term rehabilitation and reablement services and create one integrated, multi-disciplinary service.

2.2. To note the phased implementation of the changes in order to ensure a smooth transition to the new service whilst maintaining current service delivery and performance. These are set out in section 8 of the report.

2.3. To note the stakeholder engagement activities that have taken place so far and further plans to engage stakeholders in the development of the service and embed the changes across the health and social care system. These are set out in section 11 of the report.

2.4. To feedback any comments to further shape and inform the changes.

3. Service Scope

3.1. The urgent response and short term rehabilitation and reablement functions across health and social care play a critical part in avoiding admission to hospitals, and care homes and attendance at A&E as well as maximising people's independence to remain at home for as long as possible.

3.2. Appendix 1 sets out the current ASC and GSTT services or parts of services whose main function is to provide an urgent response or short term rehab or reablement within the community. The purpose of these services is to provide short term help or treatment for people in urgent need or crisis and who need short term interventions to enable them to recover, prevent or reduce the need for longer term care.

3.3. They support the following population cohorts:

- Predominantly older adults with a physical disability/ frailty
- Recovering from a short term illness or impairment or crisis
- Housebound
- Typically post-acute admission or to avoid acute admission
- Multiple pathologies/ multi-factorial
- Needing intensive (once a day or more) interventions to improve functional independence
- Health and/or social care professional skills required

3.4. The focus is on working with people with the following needs – mobility, personal care, toileting, meal preparation, home environment, family and carers. The desired outcomes for the person is to improve their independence and self- care, prevent falls, increase resilience for further illness and episodes and for the person to re-engage with the community.

4. Approach

4.1. In May 2015, with the changing national and local health and social care environment, ASC and GSTT recognised as a priority the need to consider what more could be done to further develop and improve integrated working across these pathways and achieve better outcomes and experience of services for people within existing and reducing resources.

4.2. Working alongside ASC and GSTT service managers and service heads, the Institute of Public Care (IPC) designed and facilitated the review and design process, using a project management approach informed by integration good practice and underpinned by a cultural change management methodology. This has involved working through the following steps:

- Building a leadership coalition to create significant drive and momentum for change based on a shared vision and purpose
- Taking a "bottom-up" approach to developing and articulating the strategic vision and outcomes
- Developing underpinning "design principles"

- Reviewing and learning from existing arrangements and identifying gaps, overlaps, issues and challenges
- Engaging stakeholders across the system to develop and co-produce the operating model. This has included front line practitioners, managers and people with lived experience.
- Exploring options for alternative arrangements
- Agreeing a “new model”
- Testing and learning from the new model through on-going reflection, review and evaluation against the strategic vision and outcomes, making adjustments where needed
- Final evaluation and confirming “business as usual” arrangements

4.3. This approach focuses on bringing about the cultural, attitudinal and behavioural changes as well as the practice, process and organisational changes that need to take place to deliver and sustain improvements for the service user / patient.

5. The Case for Change

5.1. The case for integrating these services has been shaped by the following:

- Feedback on existing services – current pathways can be complicated and confusing and means for some patients / service users the pathways are difficult to navigate resulting in fragmented and un-coordinated care.
- National legislation and policy – the Care Act, Better Care Fund and the NHS Five Year Forward View, promotes a vision for integration to deliver better sustainable health and social care and a system wide approach to demand management
- Local drivers – Southwark’s Five Year Forward View, Sustainability and Transformation Plan, ASC’s Vision and priorities and GSTT’s Strategic Plan, CCG Commissioning Intentions.
- Current and future population need and demand – Health and social care profile for Southwark shows demand for these type of services is expected to increase by 25% to 30% over the next decade.
- Current savings targets for both ASC and GSTT – the collective use of resources will provide scope for reducing the incidence and amount of ongoing long term support and will realise cashable savings.
- The focus is to simplify and improve the pathway for people and create one integrated health and social care service with shared responsibility and accountabilities embedded within the two Local Care Networks.

5.2. The design phases and engagement with all stakeholders generated rich conversations and consensus from which the following key messages about how services are currently operating have been distilled:

- Southwark has a rich selection of services that have developed across the whole system which play a critical part in supporting people to live as independently as possible
- There is a wealth of good practice and experience that can be shared across the teams and services that make up the pathways

- For those patients / service users who are able to access the right services at the right time they receive responsive, holistic, co-ordinated care and support.
- There are overlaps between some services as well as confusion and a lack of knowledge of the range of services and functions that make up the pathway and the roles the different disciplines play within them
- The referral routes, screening and assessment processes that have developed are complicated and confusing for practitioners and means for some patients/service users the pathways are difficult to navigate and can result in fragmented and un-coordinated care
- This confusion sometimes results in having to fit people into services rather than co-ordinating services around them in a person-centred way
- There is a willingness and commitment from front line practitioners to improve patient / service user and staff experience of the pathways through improved design and co-ordination, building on what works well now to create a person centred pathway built around the needs of the individual
- More could and should be done to improve communications between services and teams particularly to understand the different roles and functions that make up the pathway
- It is important to consider how the pathway should work in practice first and then determine the organisational arrangements to enable all staff to deliver the best possible outcomes for people i.e. form follows function
- Community health services have been delivered through an integrated contract across Southwark and Lambeth and are therefore not often organised or managed on a borough specific basis.

5.3. Current performance reflects that services in Southwark are having a positive impact on reducing people going into hospital and improving discharges from hospital. However, there is more scope for reducing the incidence and amount of ongoing long term support through an improved rehabilitation and reablement model.

6. Longer Term Vision and Starting Point for 2017

6.1. The shared purpose and vision is to bring together all urgent response and short term rehabilitation and reablement functions to create one co-ordinated health and social care delivery model that:

- Improves people's personal outcomes and experience
- Co-ordinates care around the person, streamlines the pathway, simplifies access, avoids duplication and reduces handoffs
- Improves integrated working and provides connectivity across the whole system
- Improves the pathway for staff, builds on what works well now and develops a shared and robust working culture
- Aligns with the developing Local Care Networks and is eventually embedded in the whole system, becoming population rather than service focused
- Increases the number of people accessing short term rehabilitation and reablement
- Improves outcomes to enable more people to live independently at home

6.2. Since January 2016, ASC and GSTT have been working in a co-productive way with CCG and Council commissioners to consider how we can turn the vision of this ideal service model into a reality. The challenge has been to look at how we can bring about the level of transformation and change needed to simplify and integrate the pathway, bearing in mind how the services and teams are currently configured, as well as the complexities of the different contracting arrangements.

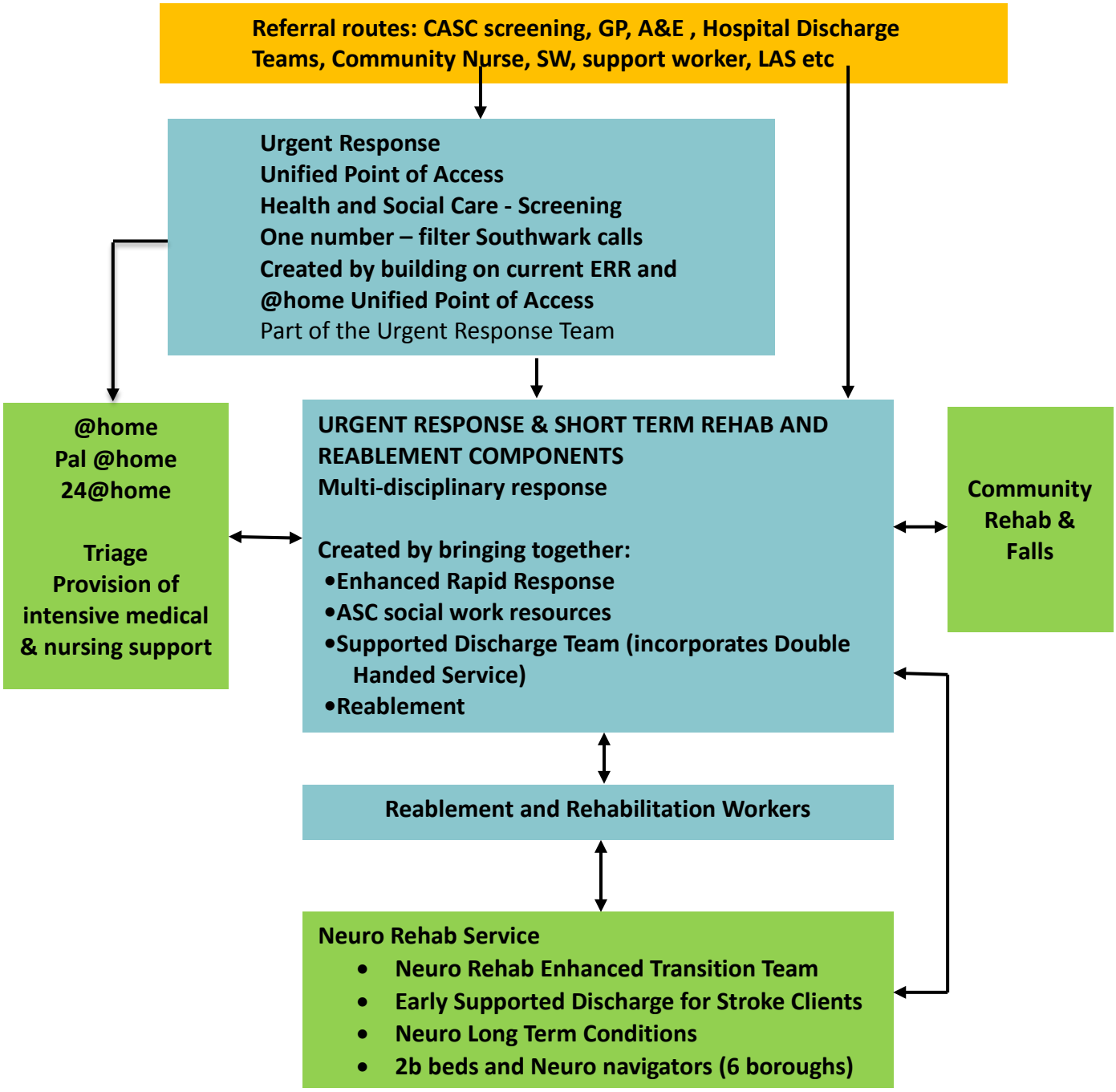
6.3. It is recognised that this will take time to achieve and needs to be tackled in manageable stages. In June 2016, the Project Board agreed that a practical starting point and a good first step towards achieving the vision would be to:

- Bring together Enhanced Rapid Response, ASC social work urgent response functions, Supported Discharge Team (incorporates the Double Handed Service) and the Reablement Service to create an integrated health and social service urgent response and short term rehabilitation and reablement service aligned to the two Southwark Local Care Networks.
- Create a simple access route to the health and social care urgent response function by building on the current ERR and @home unified point of access

6.4. It was agreed that @home, pal@home, 24@home, Neuro Rehab Service and Community Rehab and Falls will be part of the overall delivery model but will not form part of an integrated delivery service. Further consideration of how to, or whether to, integrate these or other teams will require further work. Clear pathways and joint working with these teams will be part of the overall model when implemented.

6.5. This starting point builds on existing integrated and joint working and brings together teams that already serve the same people and population with similar needs and also provide a similar set of interventions, skills and knowledge base. The components of the delivery model are set out in Chart 1 below.

Chart 1: Starting point for 2017 - Access, Urgent Response, Short Term Rehab & Reablement



7. Purpose and service criteria

7.1. The core purpose of the service would be to:

- Provide responsive, holistic, home-based, person-centred co-ordinated care, treatment and support focused on enabling people to maximise their independence or recover from illness or injury
- Improve people's outcomes to enable them to live at home, safe and well in their communities
- Reduce dependency on long term services, delay possible admission to long term care and reduce hospital admissions and A&E attendance
- Work effectively with all parts of the health and social care system to provide seamless, smooth and safe transfers

The urgent response component would be for people who:

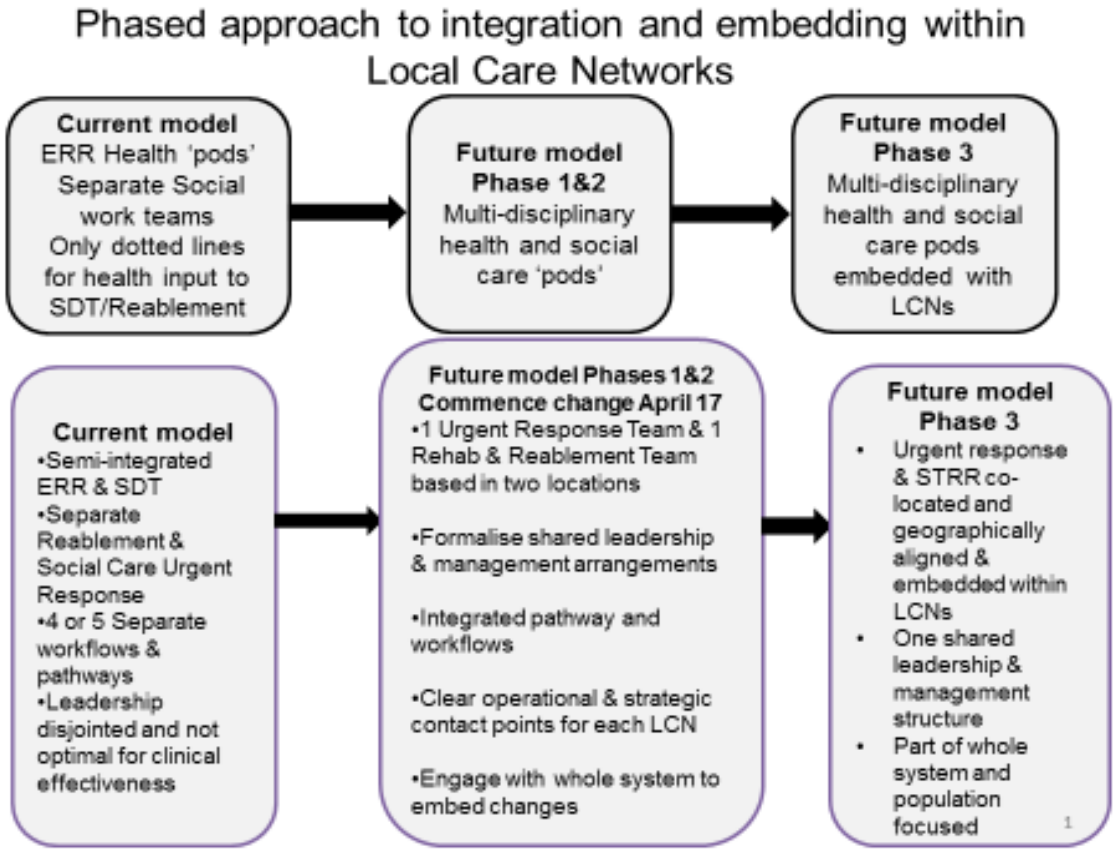
- Are 18 or over and are a resident of Southwark taking into account the different responsibilities of health and social care
- Are medically stable / predictable
- Live in the community and require an urgent response within 2 to 24 hours to:
- Prevent an avoidable admission to hospital
- Prevent a clinical deterioration
- Prevent a social crisis
- Prevent admission to A&E
- Prevent admission to emergency residential or nursing care

The short term rehabilitation and reablement component would be for people who:

- Are 18 or over and are a resident of Southwark taking into account the different responsibilities of health and social care
- Are in hospital or the community and require short term rehabilitation and / or reablement to*:*
- Help them recover from illness or injury at home so that they don't go into hospital unless they really need to
- Settle them back into living at home if they have recently left hospital
- Support them to improve their function, remain independent, safe and well at home and prevent the need for longer term care

8. Phased approach to implementing the model - alignment and embedding within LCNs

8.1. The diagram below sets out the proposed staged approach to move from how the teams are organised now towards becoming part of the whole system and population focused.



8.3. The long term plan is to geographically align staff to each LCN based on an assessment of current and future population need and demand. The service will flex across the two LCNs to accommodate levels of variation in need and ensure delivery of a flexible and responsive service alongside effective management of resources. The management team would have collective responsibility to deliver a shared service to Southwark as a whole not just to one local care network

8.4. This will take place when there is sufficient staff to ensure that two separate teams can safely deliver an urgent response to each LCN and accommodation and IT access is in place. The starting point will be to align roles and contact arrangements so each LCN is clear who to contact operationally and strategically and engage with the whole system to embed the changes.

8.6. The priority for the detailed business case has been to identify the skills mix, staffing model, shared leadership, governance structure and costs needed to establish the integrated service. Critical to the success of this collaboration will be the creation of a strong and robust leadership coalition across ASC, GSTT and CCG. Success also requires robust governance arrangements dedicated to

delivering the Vision and with the authority to make joint commitments and resourcing decisions.

8.7. Underpinning this will be a joint provider responsibility to provide a service that will deliver the shared outcomes and achieve the agreed benefits. In exploring the most effective arrangements for the shared management and delivery of the service, consideration has been given to how GSTT and ASC can move from their existing service lead and team management arrangements to create a robust shared service and team lead structure.

8.8. As this will involve GSTT and ASC disaggregating their current management structure, structural changes will be implemented in phases to ensure current service delivery is not destabilised. Appendix 2 sets out the timetable and detail of the phases. Taking a phased approach will mean that the management changes can start now building on existing integrated arrangements.

9. Financial implications

9.1. For the first phase the changes will be delivered within existing resources. There are existing pressure points and non-recurring costs which will be highlighted through the implementation phases.

10. Outcomes and benefits realisation

10.1. The development of an integrated outcomes framework and benefits realisation plan is work in progress and will be in place for when the service goes live. The main benefits expected to be gained from the changes will include:

- Improvements in quality of care offered to patients / service users
- Improved clinical and functional outcomes for patients / service users so they are able to live safe and well in their communities
- Improved patient, service user and carer experience with care co-ordinated around the person
- Improved access to services
- Improved efficiencies to the system through a streamlined pathway and a reduction in duplication and handoffs
- Improved integrated working, connectivity and communication across the whole system
- Better use of workforce and skills mix through a shared governance, leadership and management structure
- Improved recruitment and retention
- Improved professional and practice development
- Greater staff satisfaction through shared systems and models of work and by being part of a wider community response, linking in with the local care networks and contributing to the overall health and well-being of residents
- Increased number of people accessing short term rehabilitation and reablement
- Reduced dependency on long term services, possible admissions to long term care delayed, hospital admissions and A&E attendance reduced.
- Better management of more acutely ill patients in secondary care, by more appropriately managing demand of other less ill patients into a wider range of services

11. Stakeholder Engagement

11.1. A stakeholder engagement and communication plan has been drafted to support the development of a detailed business case. It is currently being reviewed and revised to ensure that relevant stakeholders are engaged in the implementation of the new service and the ongoing development of the operating model.

11.2. A key part of this will be the engagement of people with lived experience in co-producing relevant areas of the service user/patient / carer pathway. So far the design of the model has been underpinned by the need to deliver peoples' expectations as defined by the Southwark and Lambeth "Attributes of Care" and the National Voices definition of person-centred, co-ordinated care and supporting "I" Statements. A workshop for service user/patient, carers and their representatives was held on 26th January and the feedback has been fed into the design.

11.3. Discussions are currently taking place on how best to engage people with lived experience in the most meaningful way in the further development of the service. These could include:

- Linking into existing groups and forums (i.e. Citizen's Forum, Older People's Partnership Group etc) to engage and share the development of the model as stakeholders.
- When the service is in place, select individuals who are going through the pathway and carry out independent one to one semi-structured interviews to discuss and learn from their experience. This feedback would then inform actual practice as well as contribute to overall performance monitoring.

12. Community Impact Statement

12.1 As set out under the Equality Act 2010 and the Public Sector Equality Duty (PSED) an equalities impact assessment has been carried out[1]. The analysis identified the integration of these services will have a positive impact to all members of the Southwark community by providing a more localised and joined up approach. It will simplify and improve access to the pathway for both hospital and community referrals and increase the number of people accessing short term rehabilitation and reablement.

12.2. It will have a particular positive impact for older, frail residents due to health and social care conditions associated with advanced age. People will benefit from an increased emphasis on preventing and reducing significant care and support needs and avoid admission to hospitals, care homes and attendance at A&E as well as maximising people's independence to remain at home as long as possible.

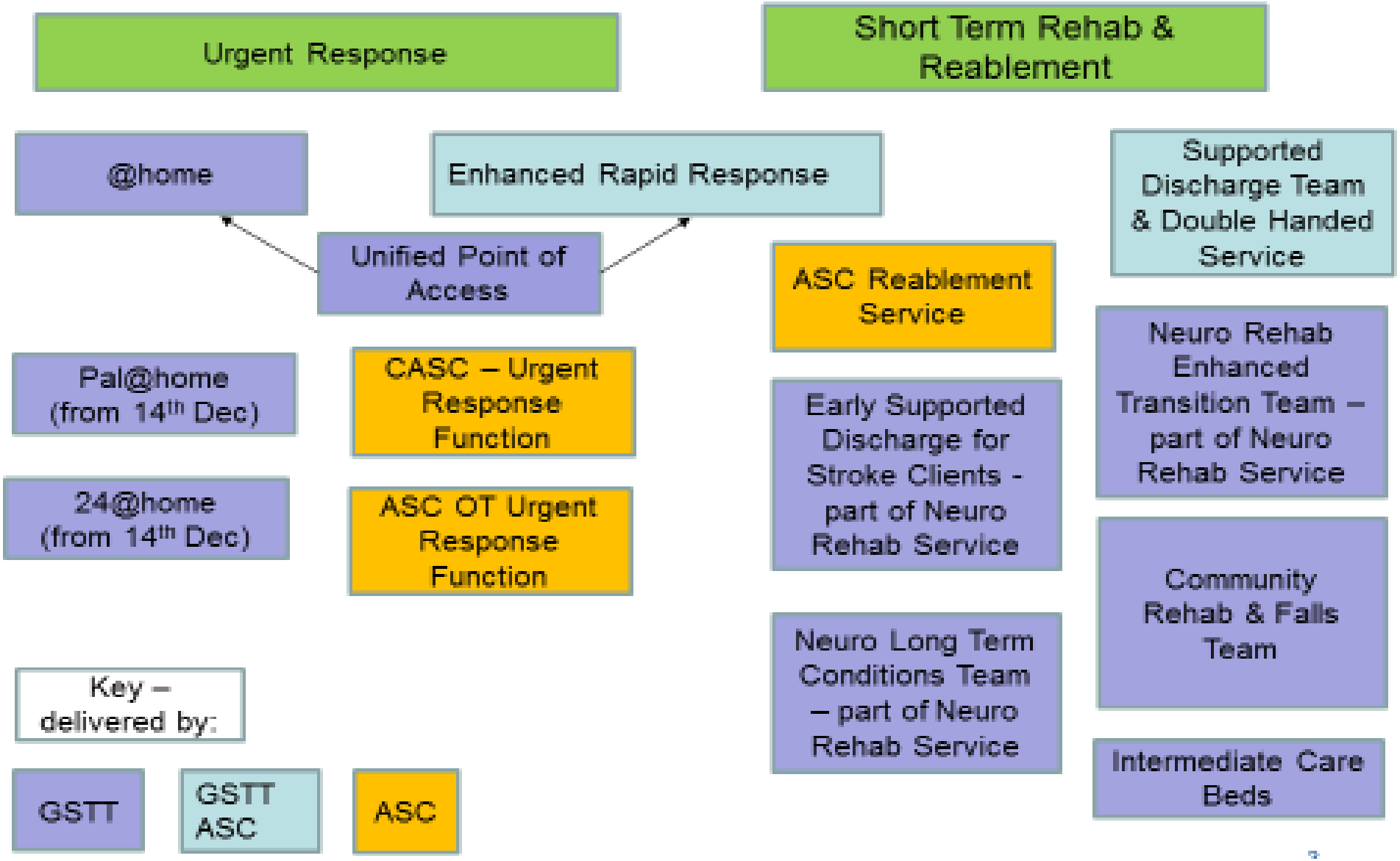
12.3. The analysis did not identify any negative impacts on the protected characteristic groups and demonstrates that the changes show no potential for discrimination. However the analysis highlighted opportunities for the council to improve the information and advice it provides, in particular via the Adult Social Care pages of

[1] Equality and Impact Analysis – Director Adult Social Care, April 2017

the council website. The analysis also identified the importance of the development of the council's community hub model to ensure that older adults, adults with a physical or learning disabilities and the carers who support them can access appropriate information, advice and support to meet their needs (the mental health community hub is already up and running).

April 2017

Appendix 1: Current services / teams in the pathway



Appendix 2: Timetable and Gateways