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

Overview

Health and Wellbeing Board

2nd May 2017

Purpose

- To outline the work taking place between ASC and GSTT to integrate GSTT adult community services with Southwark Adult Social Care in 2017/2018 to simplify and improve access to home-based rehabilitation, social care support and reablement

- This integration aims to:
  - Avoid admission to hospital, care homes and A&E attendance
  - Support people to live at home, regain independence, maximise choice and control and live safe and well in their communities
  - Improve experience & outcomes – personal, staff & system

- Recommendations:
  - Note work taking place and the phased implementation of changes to ensure a smooth transition whilst maintaining current service delivery and performance (section 8)
  - Note stakeholder engagement activities taken place so far and further plans to engage stakeholders in development of the service & embed the changes (section 11)
  - Feedback any comments to further shape & inform changes

Context

- **Provider driven -** Initiative to further integrate, simplify & improve the pathway - work commenced May 2015

- **Approach –** Building a system leadership coalition, “bottom up” design - co-productive working with commissioners from January 2016

- **Approved –** 5th & 6th April 2017 by Council’s Children & Adults Board and GSTT Trust Management Executive

Summary

Changes:

- Service operates as a single integrated pathway in North and South Southwark, with simple access to urgent services (within 2 hours) and short term access (within 2 days)

- Will keep people at home with intense rehabilitative support provided by both GSTT and Southwark Adult Social Care services and help people go home from hospital faster through services working together better

- Managerial, workflow and service integration will be phased over a 12-18 month period, with gateway reviews to progress planned organisational and pathway changes

- Complex change requires co-location of staff, new line management and team structures, realignment of professional supervision, and strong joint-working arrangements for managing outsourced domiciliary/reablement contract staff.

Case for change

- **National & local drivers**: Care Act, Better Care Fund, NHS Five Year Forward View, Southwark's Five Year Forward View, Sustainability & Transformation Plan, ASC Vision & Priorities, GSTT's Strategic Plan, A&E Improvement Plan
- **Better management of demand:** Reduce people entering A&E, demand on acute services, number of delayed discharges and long term care packages
- **Alignment / become part of LCNs:** Focus on populations, and local provision in networks
- **Creating a multi-professional workforce:** Provide person-centred, joined up care which will reduce duplication & hand offs
- **Improving productivity:** Address skills gaps and realise efficiencies
- **Outcome based commissioning and alliance contracting:** Opportunity to move towards a quality driven and more cost efficient model
- **Delivering commissioning intentions:** Contribute towards; Rehab Pathway; Dementia Pathway; Care at Home & Reablement procurement; Falls prevention

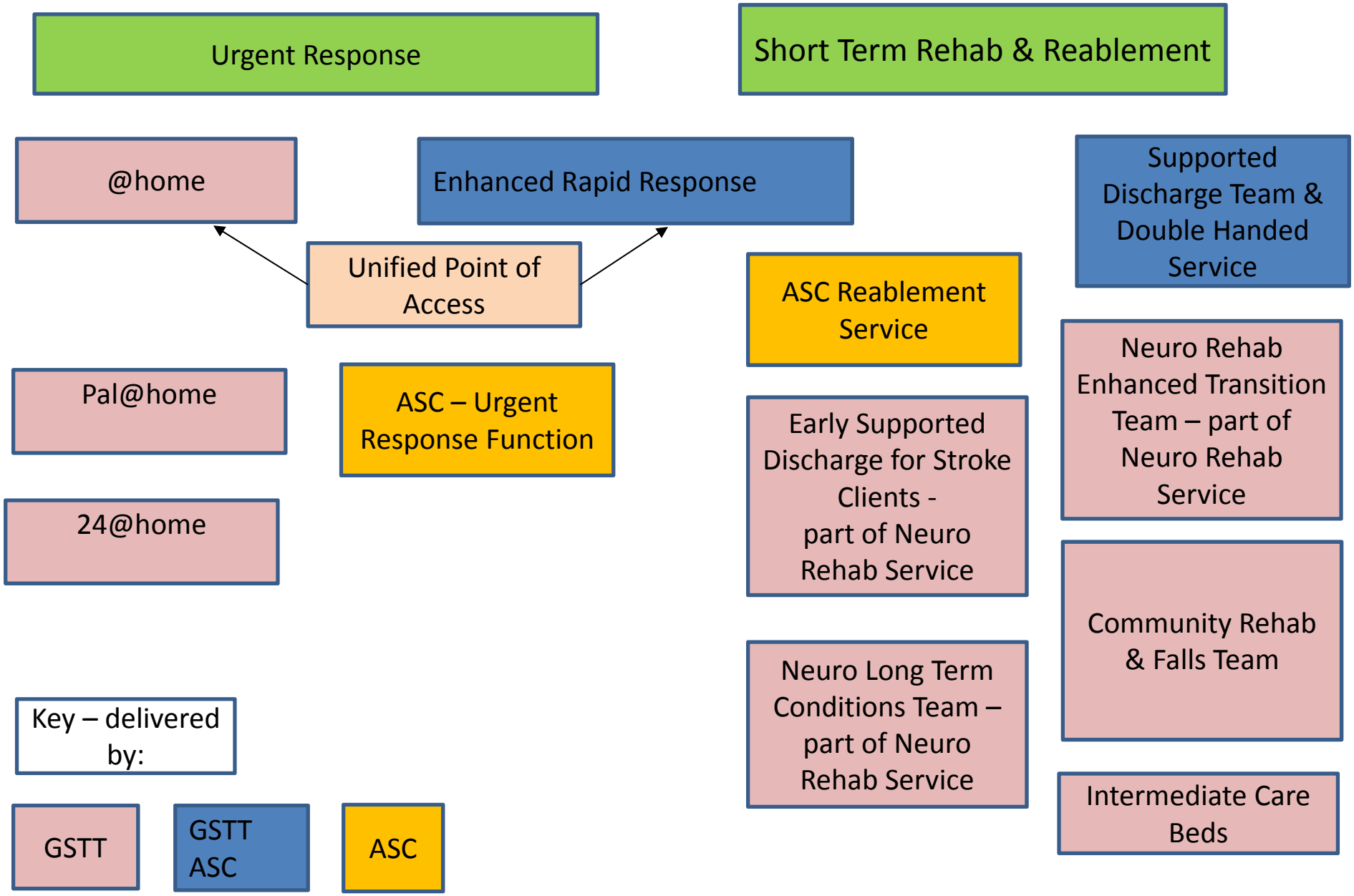
Current population cohorts

- Predominantly older adults with a physical disability/ frailty
- Recovering from a short term illness or impairment or crisis
- Housebound
- Typically post acute admission /avoiding 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

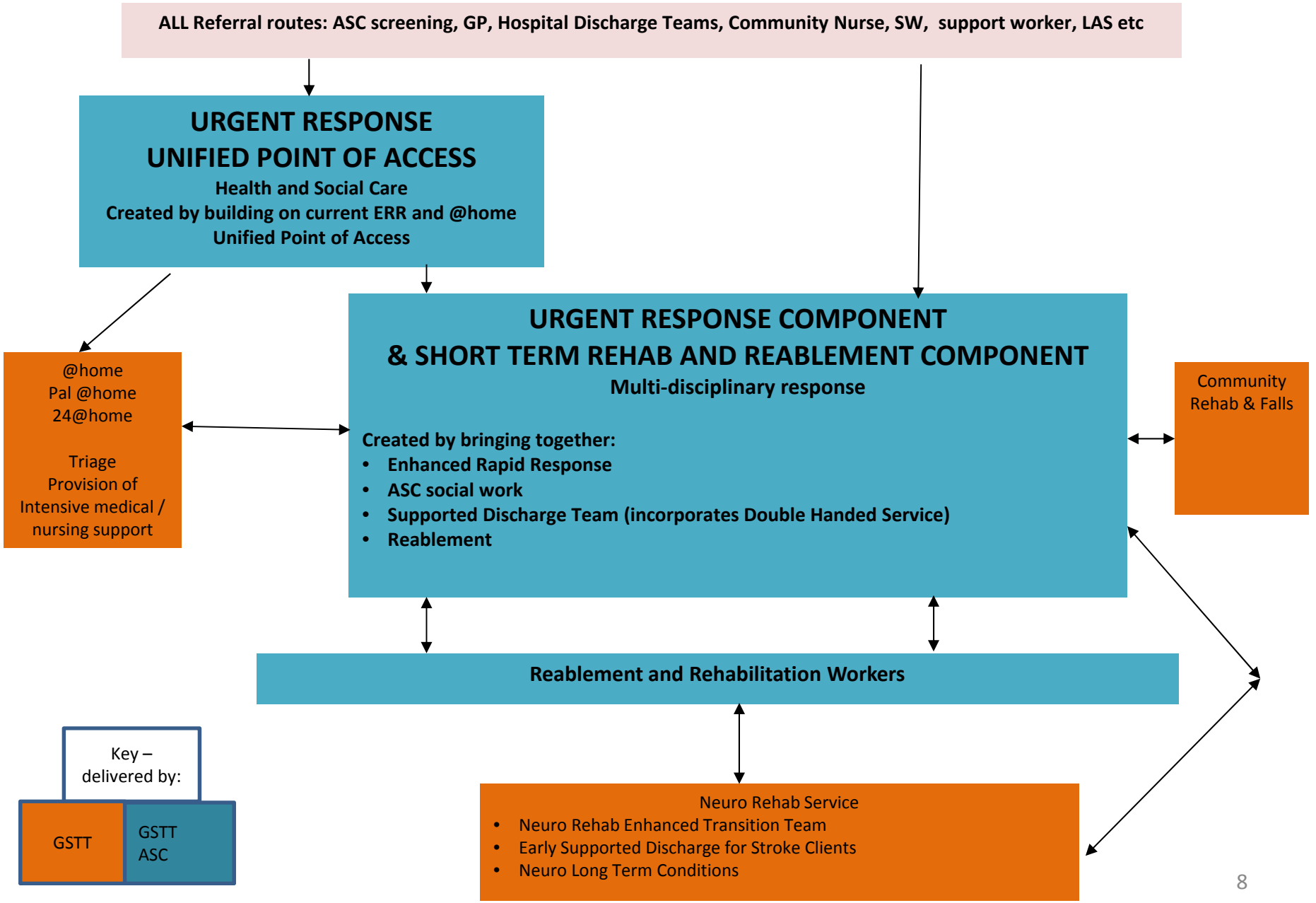
Desired Outcomes:

- Improved independence and self care, prevention of falls, resilience for further illness/episodes, re-engaging with community
- Focus on the following needs – mobility, personal care, toileting, meal preparation, home environment, family and carers

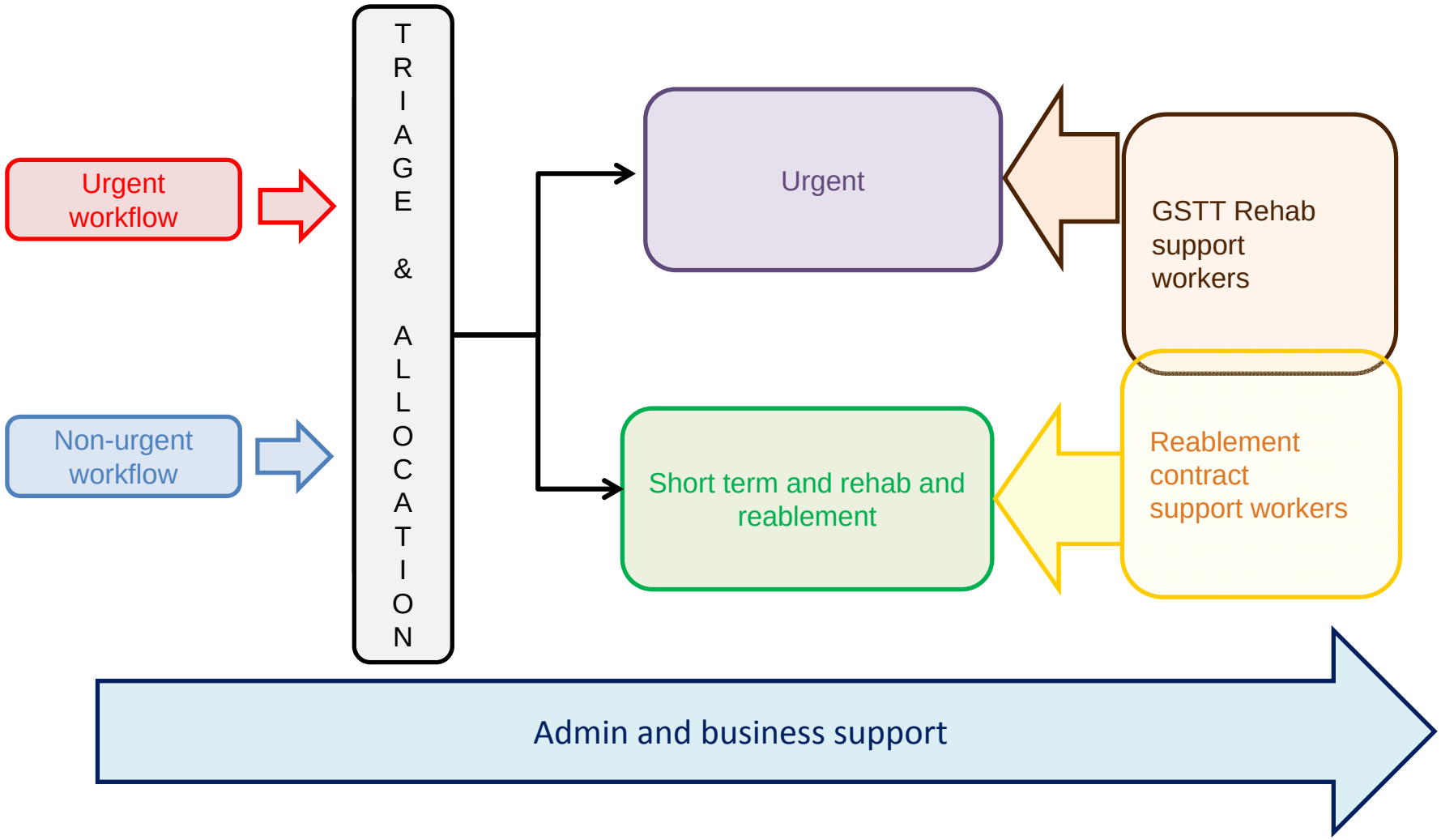
Current service configuration in the pathway



Future configuration: Access, Urgent Response, Short Term Rehabilitation & Reablement



Workflow structure phase 1&2 – Formal Shared leadership and management with MDT ‘pods’, LCN contact/liaison, 2 locations, joined up urgent/non urgent workflows



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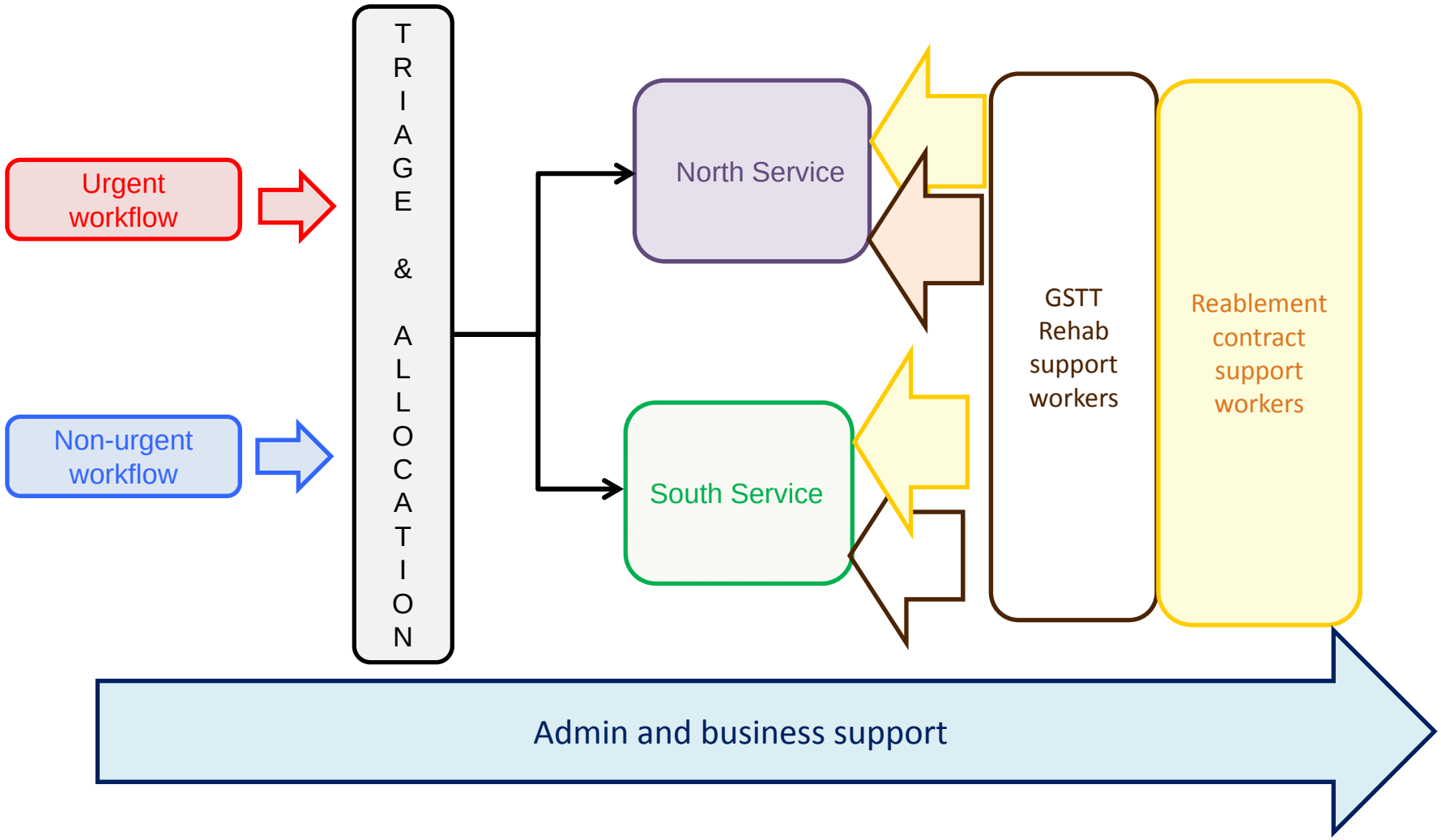
Workflow structure phase 3 – One leadership and management structure, organised by LCN, all workflows joined up, support staff work throughout pathway



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Phases: April 17 to April 18

Phase 1
April – Sept17

- Establish shared governance, benefits and outcome arrangements
- Formalise joint management from 'As is' roles, develop options and consultation for disaggregation of GST Lambeth and Southwark management structure
- Review Reablement and urgent social care workflow demand (numbers and skills/staffing needed)
- Identify possible financial and contractual, premises and IT changes required

Phase 2
September 17 – March 18

- Review learning- from phase 1, define accountabilities and review governance, benefits and outcome arrangements
- Staff consultation for GST leadership and management roles. New structure agreed
- Agree Reablement workflow requirements and implement change to practice and define revised skill mix
- Agree Reablement contract and GSTT RSW staff transition plan to both work across whole pathway
- Further clarification of any financial and contractual changes : Progress Premises and IT changes

Phase 3
April 18 onwards

- New structure in place with Lambeth Southwark split and/or agreement on what is shared
- Clear final accountability and responsibility structure and shared governance, benefits and outcomes arrangements in place
- Final staffing skill mix implemented with GST and Reablement contract staff working across whole pathway
- Aligned and integrated practice standards and protocols in place for all workforce
- Financial arrangements agreed for 18-19: Changes to premises and IT implemented

Why are we recommending this approach?

- Can start the arrangements now, establish the service & resources, maximising use of vacant posts where possible
- Allows current management experience to be utilised for transition and start up
- Allows 3 to 6 months for GSTT to disaggregate management posts and for ASC and GSTT to consider equity in grading for management posts and clarify accountabilities –e.g. with CQC
- Can establish one leadership & management team made up of Service, Team and Deputy Leads / Managers
- Learn from doing, build confidence and trust, make sure we move to robust arrangements underpinned by a working culture that will sustain integrated working in practice
- Continue to work on understanding/agreeing needs of the service users in the changed workflow, staffing and skills mix, accommodation and IT access
- Continue to engage stakeholders in the development of the model
- When confident have the critical mass - teams can be realigned to North and South LCNs

Proposed leadership & governance

Agreed governance structure across CCG, Council & GSTT to oversee performance and delivery of the agreed outcomes

Based on a coalition approach – recommended the Project Board continues to oversee changes, performance and delivery of agreed outcomes and benefits

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Director ASC & Director of Operations & Strategic Development Adult Local Services -GSTT

Overall leadership responsibility for service delivery model and achievement of service outcomes (integrated outcomes framework)

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Assistant Director ASC Older Person's and Physical Disabilities
Head of Local Rehabilitation and Integrated Care, Adult Local Services, GSTT

Shared responsibility and accountability for operational delivery and performance of the service

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Shared Service Lead(s)- responsible for management and delivery of the service

Short term -shared by Clinical Lead /Head of Service GSTT & Service Manager ASC
Long term – create one joint post

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Urgent Response, Short Term Rehabilitation & Reablement Management Team

Service Leads (Managers), Team Leads (Managers) and Deputy Team Leads (Assistant Team Managers) would form a management team responsible for managing resources to deliver a shared service to Southwark

Key risks & mitigation

Key risks:

1. Potential for reduced ability to recruit and retain skilled professionals – and reduced capability to recruit, train and supervise staff
2. Risk combined staffing component not able to adequately fulfil needs of all service users resulting in dilution of skilled clinical staff resource affecting ability to meet complex patient needs.
3. Possibility of destabilising Lambeth services and leadership
4. Integration may distract leadership from existing operational activity and action plans (including recruitment ,mobile working and productivity) and meeting CQC requirements
5. Risk of reduced patient satisfaction and outcomes if needs are not met with appropriate level of skill or dose intensity (frequency)

Management & mitigation:

- Detailed risk log completed as part of developing the business case, with staff engagement
- Clinical effectiveness safety and satisfaction summarised in the Quality Impact Assessment
- Risks will be mitigated through the phased approach, with gateway decision points between phases before moving to next phase

Glossary of terms

- **Adult Social Care (ASC):** provision of social worker, assessment of needs and providing outsourced support such as washing, dressing, meals, housework to promote independence at home, based on peoples ability to meet their own personal and social needs.
- **@home:** intense immediate nurse led support for the medically deteriorating adult accepting referrals from hospital, A&E, London Ambulance and General Practice, several visits a day.
- **Contact Adult Social Care (CASC):** referrals to social care are processed through a 'contact' team and are prioritised
- **Community nursing:** provision of skilled nursing care in the home
- **Double-handed service:** service for people needing two staff to transfer, mobilise or support in the home
- **Enhanced Rapid Response (ERR):** provided by GSTT and ASC, intense immediate therapist led support and rehabilitation for functionally deteriorating adults (often the elderly), several visits a day.
- **Falls:** specialist service providing falls assessment diagnosis treatment and low intensity exercise provision and 1-1 physio (typically once per week)
- **Neuro rehabilitation:** specialist service , 5 pathways across Lambeth and Southwark, inpatient (2b) bed's at Pulross, community rehabilitation for stroke , long term conditions and brain injury (NETT)
- **Reablement:** time limited, social care funded, intensive home care support package to help people regain their functioning after an illness or deterioration. People are assessed by social workers and therapists, and Reablement care and support is provided by Reablement support workers. Reablement care is provided by an outsourced provider in Southwark, provided by GSTT in Lambeth
- **Rehabilitation**: therapy led ,goal orientated, interventions to improve function, mobility and regain skills and abilities.
- **Supported Discharge (SDT):** provided by GSTT therapy staff, managed by ASC, intense immediate therapist led rehabilitation post discharge from hospital, several visits a day.
- **pal@home**: twilight and overnight nurse support for palliative care patients in the home