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alexander
engage. challenge. change.

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Rehabilitation – From Principle to Implementation

Monday 23rd February 2015
South West House Taunton 9.30 am to 4 pm

A Few Opening Words

Stephen Illingworth

Clinical Lead

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Code for today

- Please listen generously and give in the same way.
- Get up to speed as fast as can.
- Be in the room; and if you can't resist an excursion, come back in thoughtfully.
- Today is a group of system peers working together.
- Watch the body language.
- No big 'big make wrongs'.

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Introduction and scene-setting

Keith Pople

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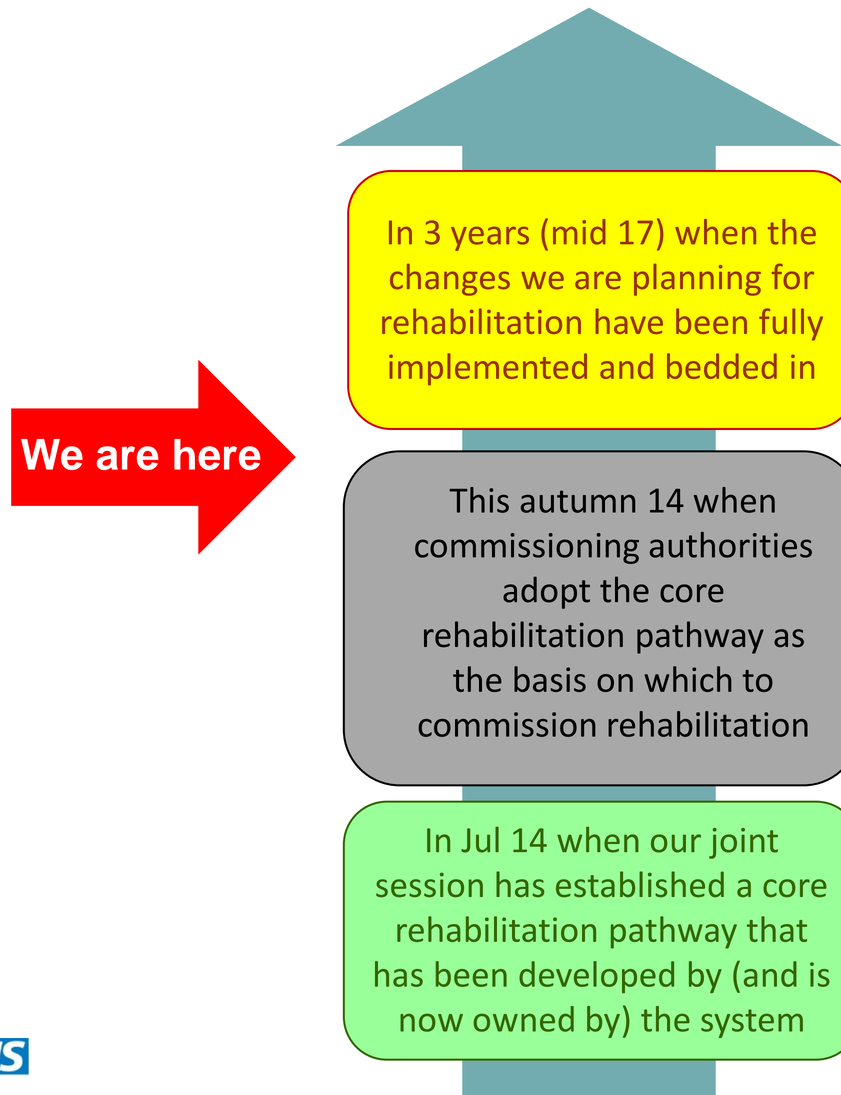
Progressive success focussed on citizen needs



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Desired Integrated Rehabilitation Pathway – High Level Summary

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Definitions

Design Principles

BEFORE MY REHAB

I have had an acute episode and have been treated for it

or

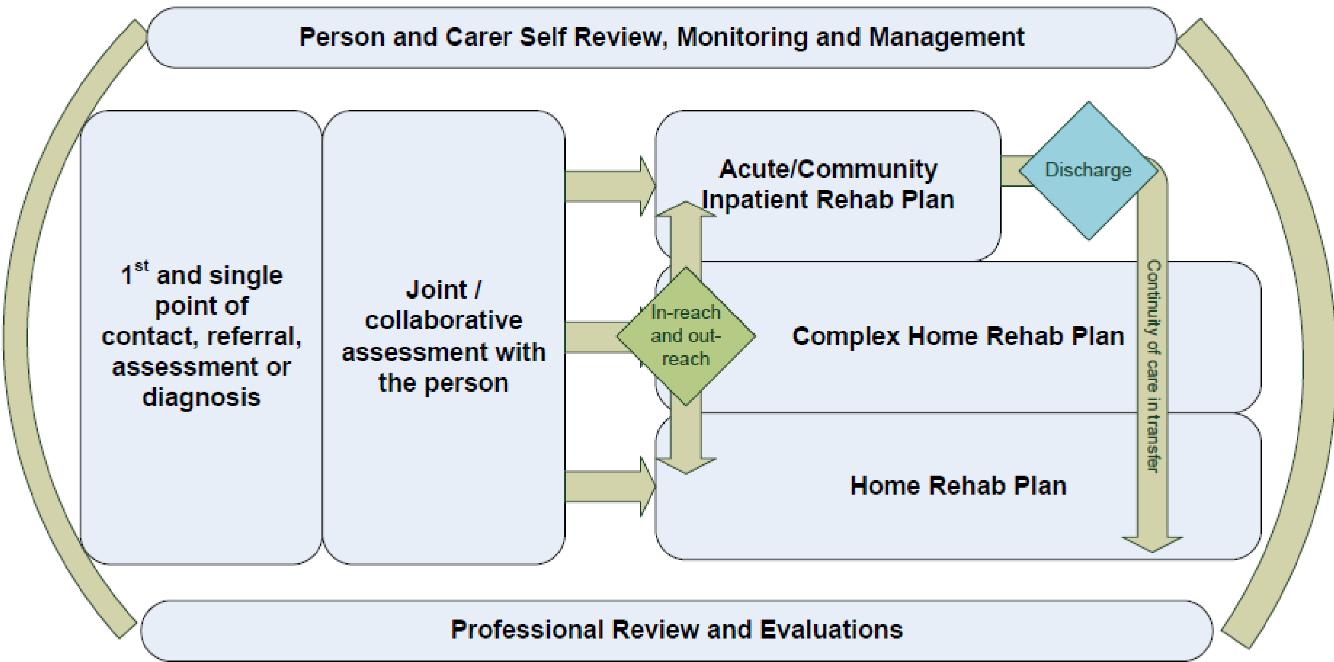
I have been diagnosed or assessed

or

I have been coping at home but I am starting to struggle. I need some help to keep me independent

and

I do not have any critical health or social care needs now
I want to understand both my own, my family's and my carer's roles
I want to understand how things might progress in the future
My family and my carer want their needs considered



AFTER MY REHAB

I feel in control of my life again and I am able to make a contribution to the things that are important to me.

I can manage matters by myself / with my carer / family / community. I have no further need for formal support.

I understand how I might progress in the future.

My family / carer feel that their needs have been considered.

I feel respected and listened to and I know how to get the right help in a timely fashion if I need it.

I understand both my own, my family's and my carer's role.

Shared analysis of demand on the system for forecasting, prioritisation and innovation

The person-centred rehabilitation lens

Continuous assessment and improvement

Self-management

Sustainability

Carer views

Innovation

Monitoring

Acute / community in-patient rehab plan

Personal

Complex home rehab plan

First single POC

Joint, collaborative assessment of need, options, choices, outcomes, incentives, management

The person, their carer and family in their community

Managed conclusion of formal rehabilitation care and support

Rehab Plan

Technology

Feedback

Home rehab plan

Incentives

Education

Re-assessment

Continuous assessment and improvement

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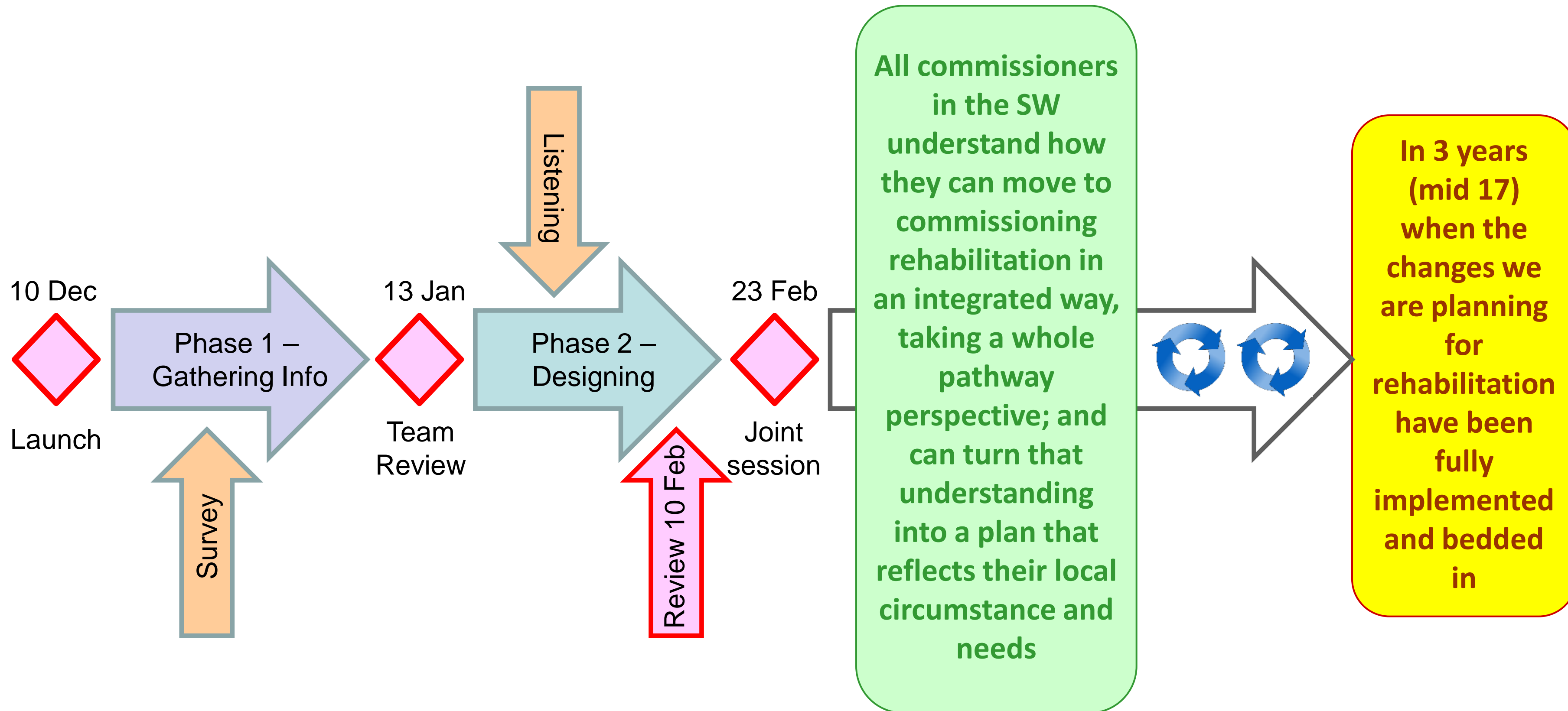
Goal-directed planning



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Purpose

- For commissioners to build the knowledge and confidence to accelerate progress towards joint commissioning of rehabilitation, based on a single core pathway.

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Objectives

- To have refreshed an understanding of the need for a better approach to rehabilitation in the South West; and recent progress.
- To have discussed the following; and understood how both may facilitate progress locally:
  - Experience of success.
  - Experience of difficulty.
- To have heard what business leaders and managers will look for, if they are to be expected to support the necessary change in commissioning.
- To have made or revised local plans for progress, challenged and supported by others.
- To have discussed and agreed how the SCN may best add value in the future, so that the core pathway becomes more widely accepted.

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Outcome

- Attendees better understand how they can turn local commitment to the core pathway into commissioning plans that reflect their local circumstances and business realities.

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Agenda before lunch (10.00 am to 12.45 pm)

- *9.30 Registration and refreshments available*
- 10.00 Welcome – Stephen Illingworth
- 10.05 Introduction and scene-setting
- 10.15 The system leaders' perspective of rehabilitation – Ann James *
- 10.30 Where are we and what's been happening (including results of the Survey) – Ruth Hall
- 10.45 Lessons from South Glos – Kathryn Hudson *
- *11.15 Refreshments*
- 11.45 Group Work 1 – Learning from local successes and problems
- 12.30 This work in the context of IPC – Frances Tippett *
- *12.45 Lunch*

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* with questions

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Agenda after lunch (12.45 pm to 4.00 pm)

- *12.45 Lunch*
- 13.30 The business perspective of how to make progress – Suzanne Tracey and Sharon Fossali *
- 14.00 Group Work 2 – developing plans (challenge and support)
- *14.45 Refreshments*
- 15.15 Collaborative commissioning: what it should be able to offer to help – Steve Sylvester *
- 15.30 Group Work 3 – what the SCN can do to help in the future
- 15.50 Final questions
- 16.00 Close

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* with questions

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The system leader's perspective of rehabilitation

Ann James

CE Plymouth Hospitals NHS Trust

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Where are we and what's been happening?

Ruth Hall

Quality Improvement Programme Manager
Strategic Clinical Networks

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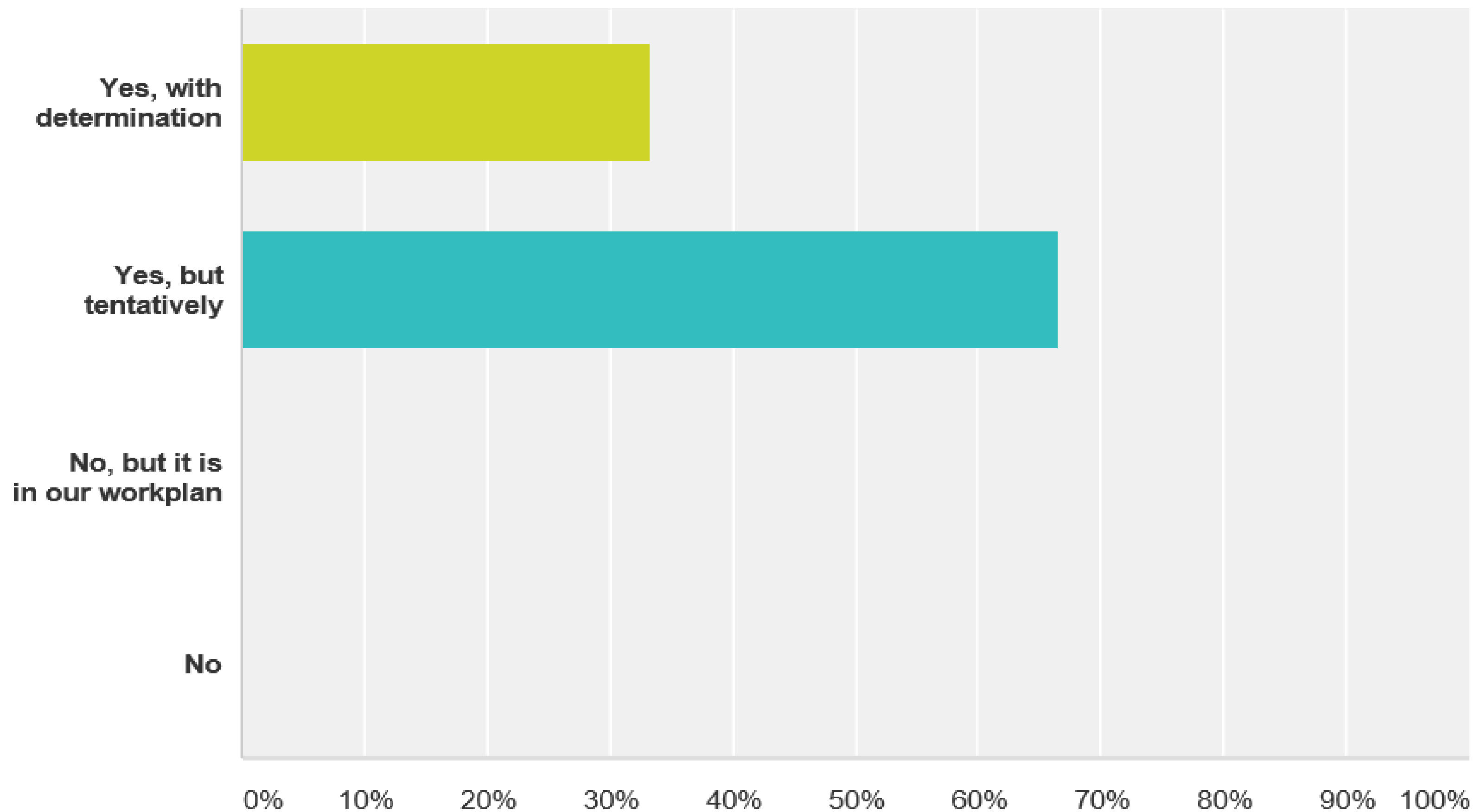
Where we are and what has been happening

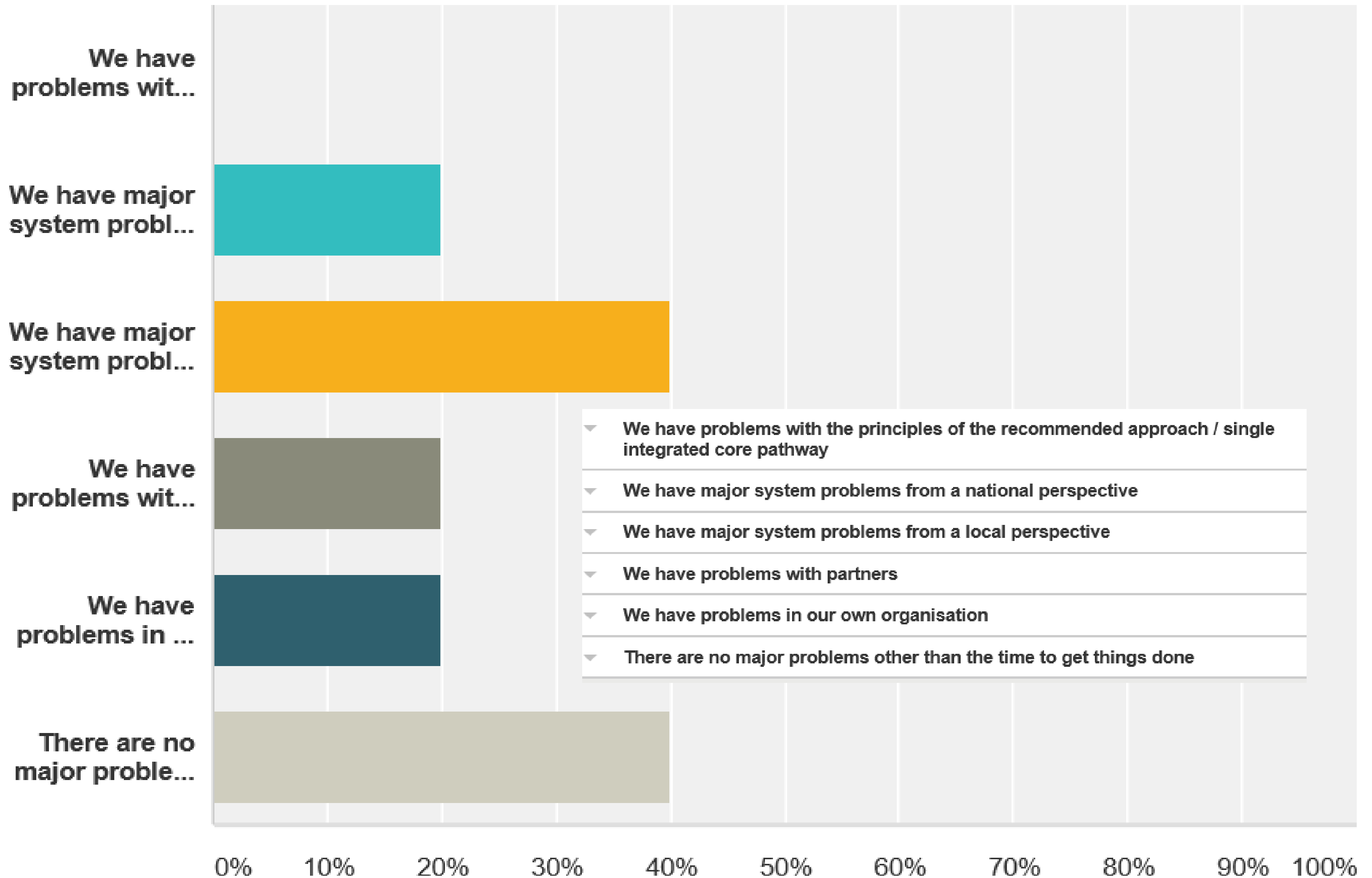
- Pathway and principles circulated to all SW commissioners – Oct 14.
- Message that came back – how can it be commissioned?
- Needed to address blockers head on and identify any enablers.
- That's the purpose of this day!
- Survey monkey circulated to ensure today meets your needs.

Is reconfiguration of rehabilitation services a priority for you and have you started to move to implementation?

Answered: 9 Skipped: 1

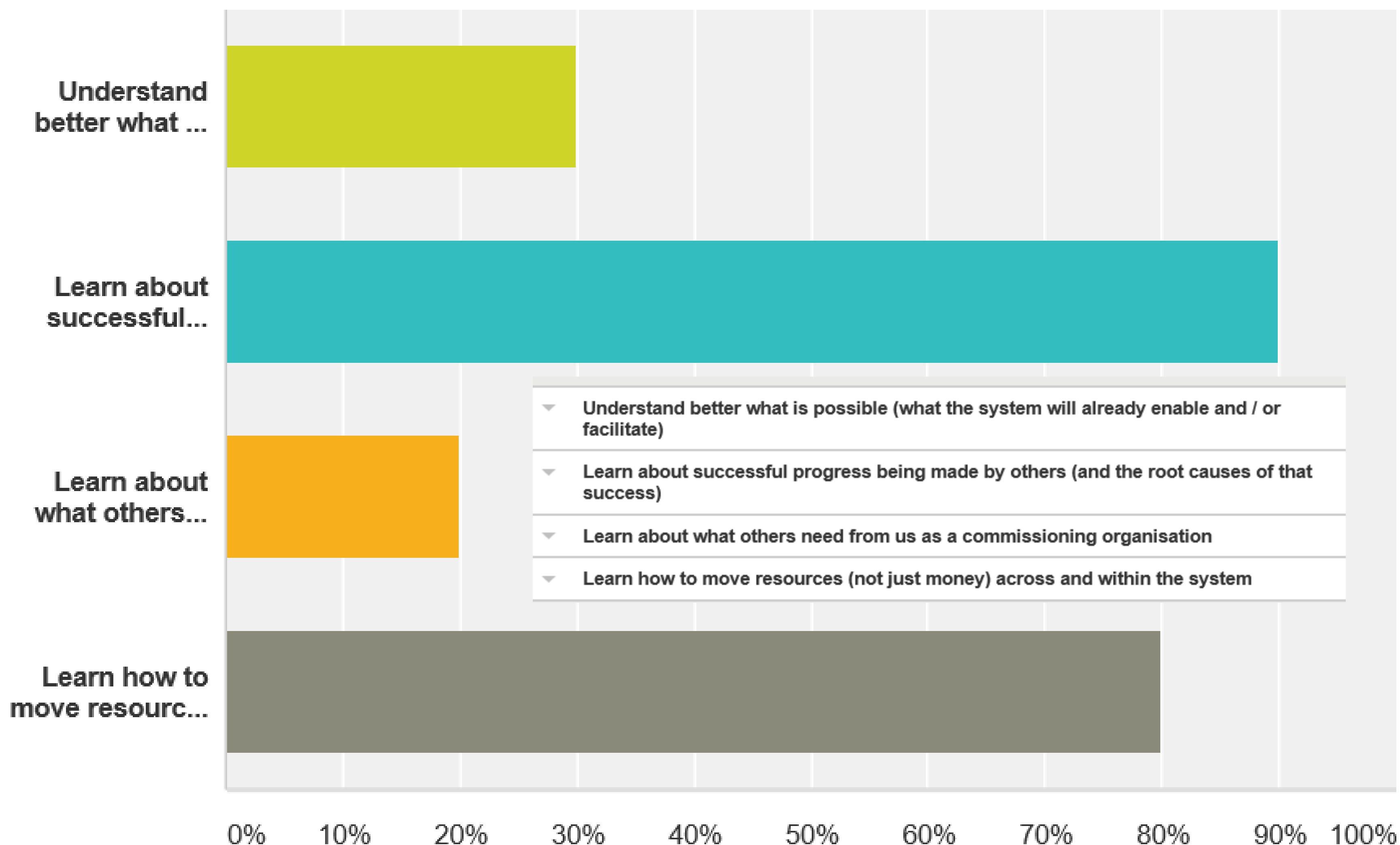


What barriers are preventing progress



What would most help you to improve to make progress?

Answered: 10 Skipped: 0



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Lessons from South Gloucestershire

Kathryn Hudson

Commissioning for Change: The story of Rehabilitation so far in South Gloucestershire

South Gloucestershire Council

NHS
South Gloucestershire
Clinical Commissioning Group

North Bristol NHS
NHS Trust

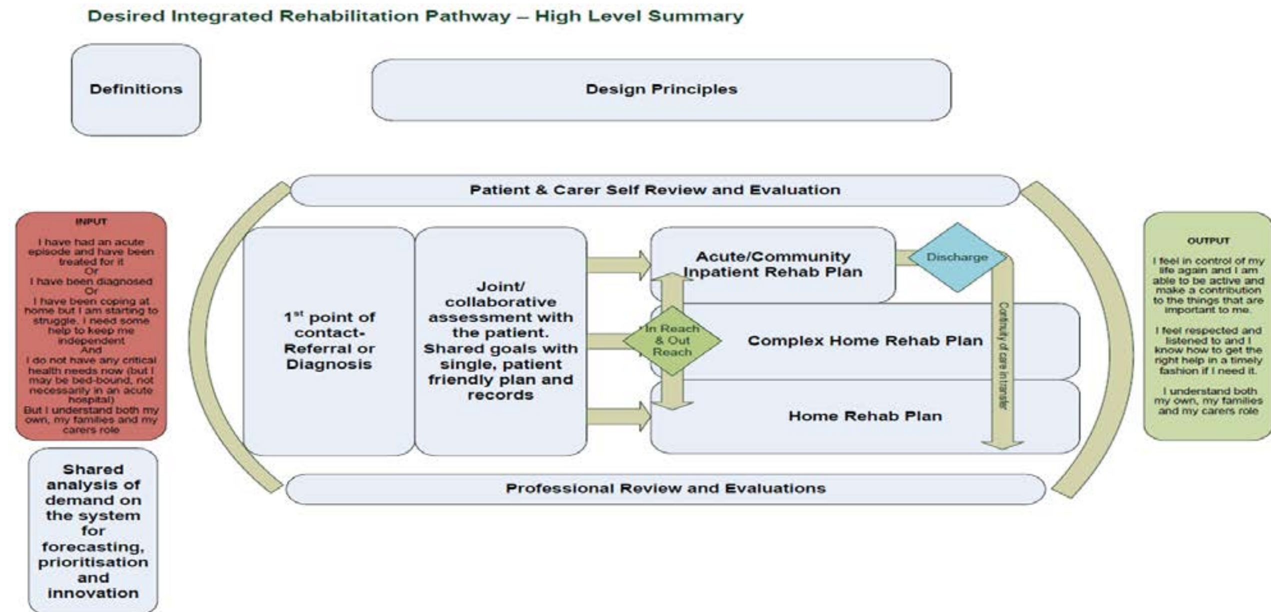
Sirona care & health

Grand National of Commissioning

- 2 full circuits
- 30 of the most testing fences jumped twice
- fences with hidden depths and turns

Preparation for the Starter's Whistle:

- 2 year strategic planning
- Multi-stakeholder engagement
- Model for implementation



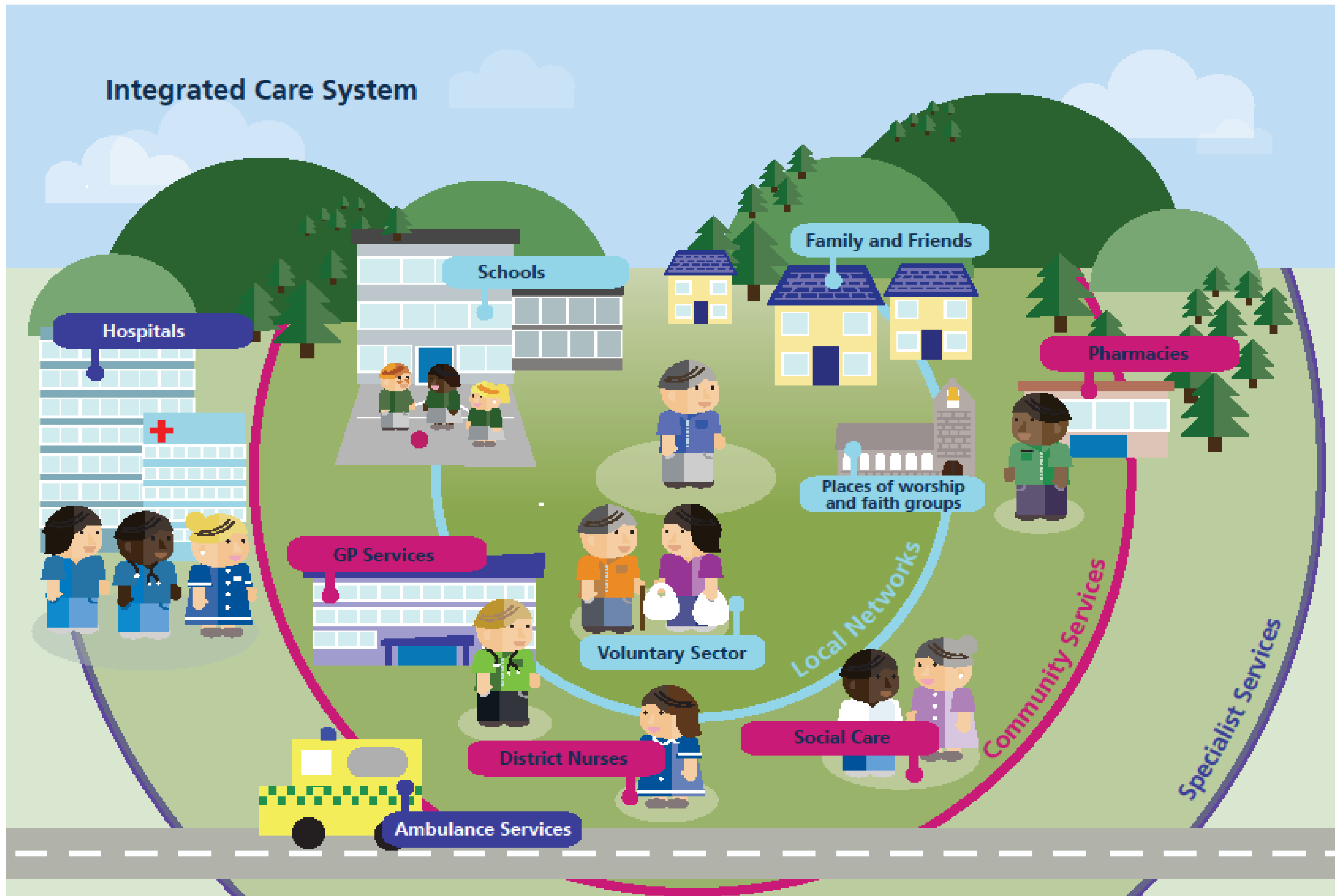
Hurdles

- Cross-cutting rather than single service or client group
- Local and national context e.g. strategic plans & structural reorganisations
- Existing services and contracts not organised to respond
- Implications of change (Financial; contractual; legal; power; whole system; political)
- Understanding and articulating the story for change

Sharing the Experience

* no quick win!
* opportunistic commissioning for marginal gains
* keep listening to the people and their families
* keep eye on the contractual and financial context and opportunities for change
* stick to the story and keep telling it

INTEGRATED CARE SYSTEM



ANY QUESTIONS?

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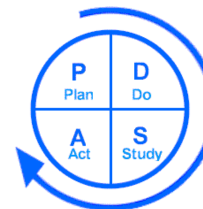
Some ideas from Ann and Kathryn

- Always remember – it's the story of the individual.
- Speak to business leaders with a vocational voice first.
- Meeting real individual choice usually requires the use of less resource.
- Spot the champions in the system and work with them.
- Be bold enough to take a scarce opportunity.
- Spot changes that will tend to support a really big strategic imperative.
- Plan to sweep up behind you.
- The 5YFV **is** the rehabilitation model.
- A small victory is still a victory – aggregation of marginal gains.
- Hang the rehab model on something you are already doing.
- PDSA – it was right then, it's right now.
- Fund it through BCF or QIPP?



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Group Work 1

Learning from local successes and problems

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Local successes and problems

- In table groups from each individual either:
  - Either one local success.
    - Then try to find the root cause of success.
  - Or one local problem.
    - Then try to find the unblocker.
- Be prepared to bring one success and one problem into the room.

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Local successes and problems: Successes

Resources

- There is money in the NHS we just need to change where it is being spent.
- Successes – rural & village example.
- Small changes consistent with overarching plan.
- People/recruitment/capacity/waiting (everywhere i.e. OT/PT/SW and care workers).
- Consider people as resources. Reward their involvement with non-financial means.
- Cornwall periodically use community rehab staff including housing as in reach into acute – can arrange seamless community follow up – started driving bed crisis but want to extend. Using technical officers at weekends.

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Local successes and problems: Problems

Resources

- Risk of discouraging people from using their own resources.
- Risks – socially isolated people.
- Minimal living wage and travel time included for carers.
- How to provide rehab clinicians type roles – if difficult to recruit/encourage
- 7 day a week services – need to cover key decision making staff as well as ops staff.
- Services not delivered at right level.
- Appropriate spaces not available (capacity issues)
- Regular admission – no maintenance rehab in community. Finance don't flow with person. May not save resources in persons lifetime.

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Local successes and problems: Successes

Integration/collaboration

- H&SC working together regarding collaborative recruitment.
- Integration or collaboration via budget, process, co-location, management of the interface.
- Giving these people ‘permission’ to really work as part of the team (e.g. IT).
- Developing single integrated teams (health and social care).
- Shared decision making (& info governance).
- Sharing records between organisations & trusted assessments (city wide opt out – up north).
- Problem & opportunity – fully integrated funds/pooled budgets.
- Pooled budgets in other areas LD/equipment/MH.
- How to get organisations to work together – financially/legally – BCF
- Organisations working collaboratively – need a lead organisation.

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Local successes and problems: Successes

Integration/collaboration – cont.

- MDT approach to high risk – 35 GPs share records and 7 day working with CVS coordinators.

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Local successes and problems: Problems

Integration/collaboration

- What is working is it partnership?
- Problem & opportunity – fully integrated funds/pooled budgets.
- Mental health – mental health and housing still not as engaged as need to be – also education and training although acknowledgement of role in pathway and CVS.
- Organisations working collaboratively – need a lead organisation.

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Local successes and problems: Successes

Commissioning

- Being clear in contracting/construct monitoring.
- Outcomes focussed commissioning.
- Help to live at home (subcontract out).
- Commission care on pathway not organisation – IPC.

Re-commissioning leg ulcer service.

- Engaging with providers.
- Demonstrate mutual benefit.
- Found ‘gold standard’ service as an example to local provider.
- Overcoming resistance to change.
- Included clinicians and finance when demonstrating best practice.
- Change delivered from front line.
- Importance of stories to persuade.

Local successes and problems: Problems

Commissioning

- Use of/working with the voluntary sector (community resilience) – difficult to commission this
- Difficulty measuring outcomes with small scale approach.

Neuro rehabilitation

- Different commissioners
- Different standards
- Moving between providers
- Where is funding?
- Specialised Comms – unpicking what is in and what isn't.

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Local successes and problems: Successes

Self-care/personalisation

- People developing their own support plan (Bristol & WECIL).
- People accessing own GP record.
- Link to integrated personal commissioning – individual to the person.
- Recognise some variation is helpful for choice.

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Local successes and problems: Successes

Service models/principles

- Importance of good navigators. Tell story once – navigator role.
- North Somerset – care navigators attached to contracts and brokerage. Hard to get them into hospitals and primary care – need to make this simpler. Piloted out of hours but demand not there.
- Is the rehab prescription a tool to support this? Needs to begin in the community.
- Linking different types of rehab.
- Getting buy in from relevant stakeholders consistently.
- Plans helped to show implications of decisions made elsewhere (unintended consequences).

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Local successes and problems: Successes

Service models/principles

- Co-ordinated schemes for supported living accommodation
- Provider forum
- Person based assessment
- Successful planned exit

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Local successes and problems: Problems

Service models/principles

- Care navigators to guide people through system – just adding layers to the system?
- Neuro – Spec, LA, CCG com pathway split.

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Local successes and problems: Successes

Submission of Prime Minister's Challenge Fund Bid

- Common Goals.
- Defined timescales.
- Not immediately embroiled in detail.
- Aim to create 100,000 appointments in urgent care.
- Create freedom time.
- Convinced senior leaders to come together.
- Dropped organisational baggage
- BANES – PM challenge fund – to put in place primary care discharge teams.

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This work in the context of IPC

Frances Tippett

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The business / finance perspective of making progress

Suzanne Tracey RD&E FT
Sharon Fossali Gloucestershire CC

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Finance and Business Leaders' Perspective

- Explain the compelling benefits for service users/patients.
- Construct a robust Business Case, based in sound business and financial practice.
- Model the necessary investment and the consequent savings, building robust evidence as you go.
- Address management of risk (the risk that your assumptions will be wrong).
- Explain fit-for-purpose governance arrangements.
- Take an outcomes focus.
- Build permissive relationships and culture.
- Remember the LG political environment.
- Use statutory financial mechanisms to support commissioners.

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Group Work 2

Making plans

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Making plans

- Working in geographical groupings:
  - Come up with some ideas for making progress in your own organisation / system.
- Then:
  - Explain your ideas to another group.
  - Ask questions / make suggestions to improve / encourage.
- Be prepared to share one idea.

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Taking plans away from today

- Gloucestershire:
  - Understand the top 5 rehab areas >> build a business case in one priority area.
  - Extend CH-led rehab services in one of the 7 CH areas.
- Devon
  - Build a robust and explicit link between BCF plans and rehab.
  - Understand the utility of plans for IPC in management of LTCs.

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Taking plans away from today

- Wiltshire
  - Review the intermediate care specification to better address MH needs (may well expose a need for workforce cross-skilling).
- Somerset
  - Use the rehab care pathway as an over-arching 'test' for Somerset rehab plans, including for the four test-and-learn pilots already underway.

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Taking plans away from today

- Bristol / South Glos
  - Present a business case to CCG Board by end Mar for the Phase 2 rehab projects.
  - Prepare a more generic rehab BC to go to BNSSG stakeholders to justify movement of system resources and sharing of risk and reward.
  - Pilot the rehab prescription.
- North Somerset
  - Examine the use of care navigation in the new rehab pathway.
  - Do a gap analysis in rehab services.

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Taking plans away from today

- Specialist Commissioning
  - Work with the SCN on further developing the core rehab pathway approach:
    - Gap analysis / flow improvement.
    - Capacity requirements.
    - Baselining.
- South of England
  - Develop a scalable and transferable BC template.
  - Understand how collaborative commissioning can help.

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How collaborative commissioning might help

Steve Sylvester
NHS England

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Plenary Session

Help from the SCN

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Help from the SCN

- In table groups briefly discuss the ***special value that the SCN can create*** for the public service system in the SW, on the way to implementing a jointly commissioned, equitable and consistent model of rehabilitation, that is firmly grounded in evidenced good practice.

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Help from the SCN

- Be the rehab champion in the SW – an independent catalyst for multi-agency work.
- Provide a forum for sharing skills and knowledge in rehab – a Centre of Excellence.
- Gather and share evidenced good practice, including service specifications.
  - 'Translate' them to the necessary system audiences.
- Promote equality between rehab organisational stakeholders e.g. NHS, LG, 3rd sector.
- Understand and publicise alignment with IPC.
- Develop and benchmark rehab outcomes.

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Help from the SCN

- Create a picture of finance flows – what is being spent on rehab, where and by whom.
- Assist with priority setting.
- Build an approach to collaborative rehab tools and audits.
- Build the BC for a better and better funded SCN.

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A Few Closing Words

Stephen Illingworth