HOSP Briefing Paper – Re-providing Rehabilitation Services In Portsmouth

1. Introduction

Portsmouth City Council, NHS Portsmouth, Solent Healthcare and Portsmouth Hospitals Trust have been working together since late 2007 on a project to redesign community support services to avoid referral to institutional care and safely reduce the length of any care away from home. This briefing paper expands on updates to the HOSP since 2007 and sets out the particular guidance which gives the context for this work. This programme of work, known as the Health and Social Care Partnership Programme (HaSP) has identified clear benefits for patients, summarised below and has undertaken substantial consultation to understand the options to re-design community services. The re-design of rehabilitation and re-enablement bedded unit involves the decommissioning of Ward D1, and putting in place an enhanced community team, along with bedded units in St Mary's Hospital and Portsmouth City Council's 'Four Sites' project. For staff involved in providing support in bedded units a number of meetings were held, and this paper details them. The consultation for the service design process that has brought together the results of conversations with GP's, patients and the third sector is described. Furthermore the workshops, with more than 400 staff across all the organisations working together on HaSP, which informed the options presented to the Integrated Commissioning Board, have been detailed. Current work on areas of concern in the service re-design and work underway to resolve these concerns are also discussed.

2. Guidance

The Department of Health have issued guidance requiring rehabilitation services to focus support and treatment in the community, chiefly "**Intermediate Care – Halfway Home** *Updated Guidance for the NHS and Local Authorities Circular" (DH 2009)*. This report undertook 'Systematic reviews of hospital at home schemes and supported early discharge' and concluded that these can provide satisfactory alternatives to treatment in an acute hospital. The PCT made it clear in its letter to HOSP in August of 2009 that intermediate care and rehabilitation at St Mary's Hospital would be reviewed as part of the developing Business case for the re-provision of the Community Campus. In addition the King's fund paper *Avoiding Hospital Admissions* (2010) finds evidence that suggest that some of the changes proposed can and may support hospital admission avoidance. The British Medical Journal research paper 'Effects of locality based community hospital care on independence in older people needing rehabilitation: randomised controlled trial' BMJ (published 1 July 2005**)** found much greater functional independence where post acute services were delivered in the community. The 'Hospital Care at Home: Supporting Independent and health lives' report " 2010, produced in association with Dr Foster found:

- 66 per cent of patients receiving home-based healthcare believed that their symptoms had improved, relative to receiving care in a hospital setting
- 86 per cent felt that their overall quality of life was better

- No patients felt that their quality of life had deteriorated versus in-hospital care
- 100 per cent of consultants surveyed said they would continue to refer appropriate patients to the scheme

In addition the White Paper: Building A National Care service, DH, 2010, sets out a challenge to provide more care closer to home.

3. Benefits for Patients

The move to the new model of service co-ordinated under the HaSP programme was developed to provide benefits for patients and service users.

The vision for this programme is to build a Health and Social Care system in Portsmouth City that supports people to develop and implement their own plans for health and well-being. This will be delivered through focussed community support that seeks to avoid referral to institutional care and safely reduce the length of any care away from home, in line with national benchmarks

This should enable local people to enjoy good health and a high quality of life, with consistent and measurable improvements.

The benefits for patients and service users the HaSP service is expected to deliver are described below:

- To achieve the most personalised and effective services possible for the people of Portsmouth
- To improve the responsiveness of services at the first point of access
- To ensure that members of the public and staff have access to advice and information about services
- To ensure the provision of timely person centred assessment according to level of need
- To minimise the need for long term intervention from statutory services
- To ensure the delivery of services that enable people to maximise their potential and maintain their independence
- To develop flexible workforce with the knowledge and skills to provide customer focussed care
- To provide professional support to people to implement their own plan to stay well
- To reduce waste and increase capacity within the services in the scope of the project, increasing the likelihood patients get the right support when they need it

The service re-design to deliver these benefits took place in a series of work shops involving over 400 staff from across the health and social care system. In order to be sure the system would meet the needs of patients and service users extensive consultation was undertaken with patients and service users, GP's, third sector organisations and staff about what worked and didn't work, and what we could learn from people's experiences, especially the experience of patients and service users.

In discussion with Portsmouth Hospital Trust representatives at the HaSP programme board it became clear there was support for the integrated model of service delivery. As a result of consultation however, commissioners were made aware of the concerns of Hospital consultants that some people might experience a longer stay in acute care. Work is underway between all partners on the Board to try and resolve this issue.

3.1. Specific Improvements in Rehabilitation Care

The model for the proposed for the rehabilitation service is as follows:

- Community based rehabilitation and re-enablement team
- 2 units for receiving rehabilitation as a stay away from home
- Community Medical Consultant support
- On site access to diagnostic services
- On site and in-reaching therapy support
- Social work and re-enablement support

In order to put this model into place all current services for rehabilitation need to be reconfigured. In order to release funding to support this re-configuration it is necessary to decommission Ward D1. The funding will be used to put in place rehabilitation service on the St Mary's community campus and enhance the community rehabilitation team. This re-configuration needs to align with Portsmouth City Council and NHS Portsmouth plans which include the development of the Four Sites project and the re-provisioning of services on the St Mary's Community Campus.

The benefits of this model include for patients:

- More patients can be supported to stay in their own homes for longer when they are ill
- Patients will have the same team supporting them to move from a community bed to home, their service will be better joined up.
- Patients will not have to keep repeating their story to different staff
- One professional can co-ordinate all the person's support, as they get better
- Patients will get help to develop their own plan to get well and stay well
- Patients have a better chance of building their confidence to live independently in the community
- Patients will be able to have more choice and control over how their rehabilitation works
- Patients will not have long waits between treatments for health and social care
- Patients will be able to maintain their well-being more effectively
- Patients will be able to take more responsibility for their own care, if they want it, enabling them to get well quicker
- Patients will spend less time in a hospital bed
- More Patients can get help to stay out of Hospital in the first place

4. Consultation

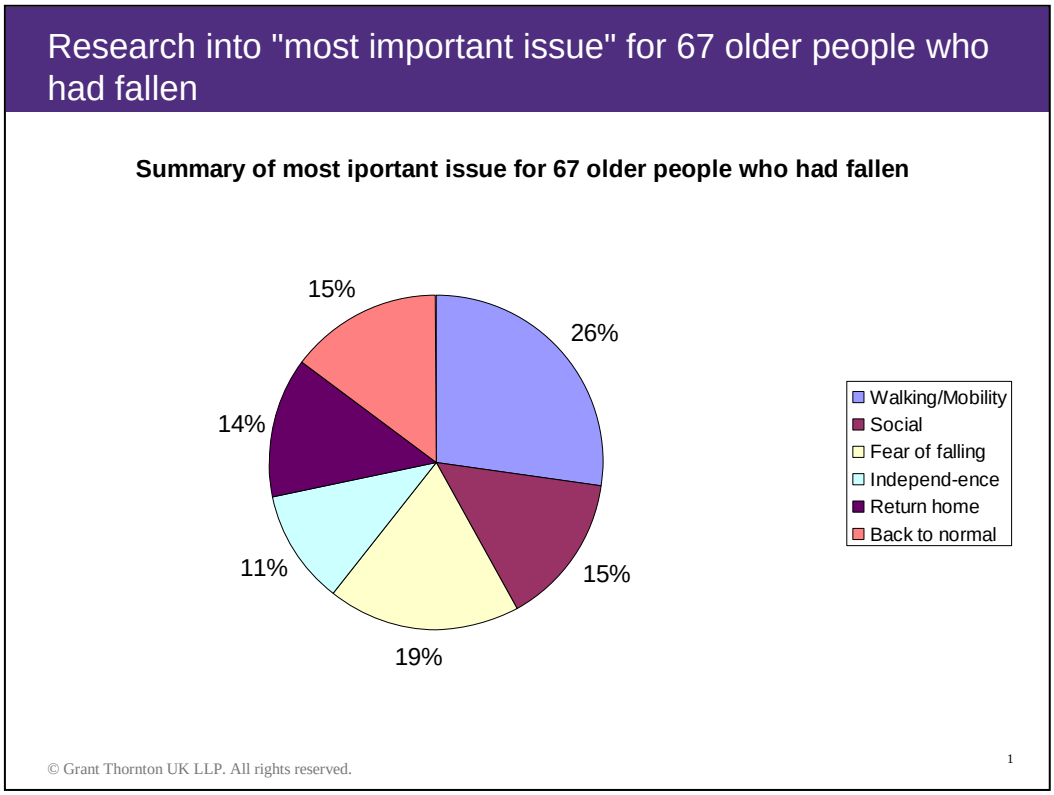
The following consultations with patients, GP's and voluntary sector groups informed the decision to decommission Ward D1.

Staff were also consulted as part of the service design and activity such as waste walks undertaken, staff involvement is detailed separately in section 5.

4.1. Patients

In order to canvass patient's views on the best model of services for community health, rehabilitation and social care we looked at complaints along with scoping work for the Health Reform Demonstration Systems (HRDS) project and talked to 67 people who had recently used local health and social care services.

These were the issues which most concerned older people receiving Health and Social Care Support:



The key finds of the HRDS project are as follows:

- Lack of knowledge amongst staff regarding what services are provided and what their access criteria and routes in are.
- Multiple gatekeepers across multiple services with an exclusive rather than inclusive approach to referral management.
- Duplication of referral and provision.
- Inequity in access to medical intervention across services
- Evidence of inappropriate/ineffective use of available resource. Decisions can be influenced by targets and resources rather than the individual needs

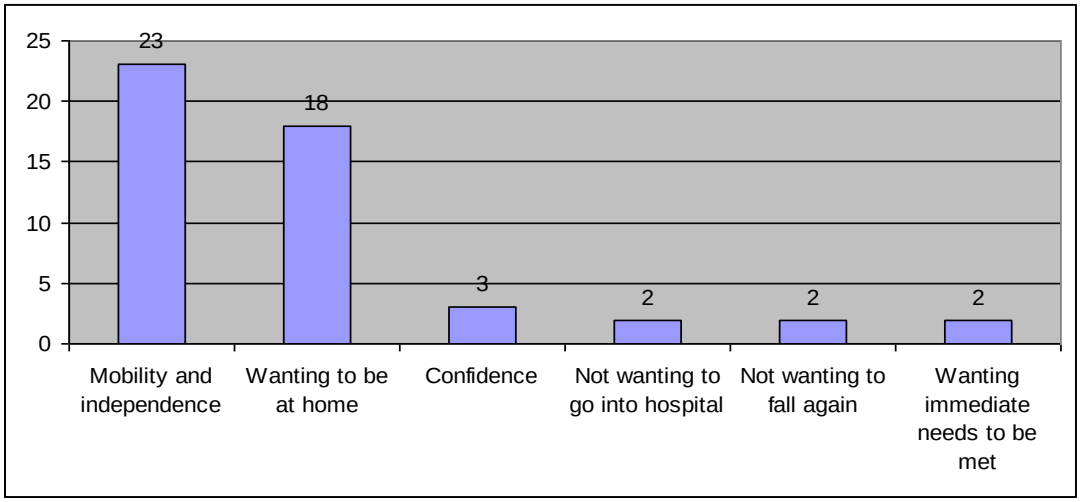
- Older people often present with complex needs (mental health, learning disability, physical health needs). Services tend to respond effectively to some but not all of these needs.
- Lack of information sharing between professionals and services, and across organisational boundaries.
- Delays in transfer or delivery of care.
- Isolated reconfiguration of services within individual organisations outside of an overarching commissioning strategy

Of Complaints to the Hospital for people in rehabilitation:

- 5 % were about the Emergency Department
- 8 % were about transport
- 14 % were about falls whilst in hospital
- 73% were about discharges and transfers

A survey was undertaken across emergency, rehabilitation and community services. There is a detailed breakdown of responses from all 67 people, however two of the key summary charts showing the answers to the survey questions are laid out below: *People were asked What did you want to achieve/what was important to you after you fell?*

Mobility, independence and wanting to be supported at home are clearly very important to older people, as this summary table shows.



Then people were asked: Have we helped you to achieve that in the service you used ?

ED	5/7 felt needs hadn't been met: - once 'people' acknowledged pelvis was problem, yes but not until then - no, I don't know what's happening to me - too slow. Asked questions on arrival but no physical exam for 2 hrs
EXTON 5/6	Lack of progress and lack of physiotherapy
REMBRANDT UNIT	Didn't feel any progress made during stay (but acknowledges was confused some of the time)
VICTORY	3/8 clients expressed felt lack of progress, but little expectation this was likely
ILS	discharged from hospital needing support but significant delay from social services and physio for support
BRADBURY	Acute stay, felt had gone backwards, not able to walk with stick in hospital had to use a frame

4.2. GP Engagement

4.2.1. GP Survey

A survey was issued to all GP's in 2008**,** 19 responses were received of which 16 were useable. When asked whether Health and Social care services relating to rehabilitation met their patients' needs these responses were received:

Location	Yes	No	Not Completed	Comments
a) Rapid response team	**10**	**4**	**1**	**Depends on availability. If available.**
b) ADH (Falls Clinic)	**14**	**1**	**0**	
c) Rembrandt Unit	**6**	**4**	**6**	**Not accessible**
d) ILS	**2**	**5**	**9**	
e) Community and IP Physio	**14**	**0**	**1**	**Com physio often refer back.**
f) OT Services	**11**	**2**	**3**	
g) Victory Unit	**0**	**8**	**8**	**No referral access**
h) Exton 5/6	**1**	**6**	**9**	**No referral access**
i) Community Rehab team	**6**	**4**	**6**	

When GPs' were asked if they could identify 3 areas of service improvement, we received these responses:

- A&E identification of fallers *2
- In patient orthopaedic admission assessment *2
- Continue elderly assessment service + Soc Service / OT assessment
- Speed up provision of help at home
- GP access to some sort of community bed *5

- More rapid response availability particularly in Winter
- Falls service needs to be one stop and initial assessment by Consultant and not nurse or junior doctor, to focus evaluations and formal follow up to assess benefit of service and interventions
- Details about service
- Educate A&E to be selective, they refer to falls clinic every time someone falls no matter how many times they have already been seen in Falls Clinic
- Easier access, user friendly referrals, central referral point
- Clear pathway, teamwork, social v health all the time *13
- Improve staff on rapid response team, clearer guidelines for rapid response.
- More rapid response input, especially the non-nursing aspect, more rehab beds to be able to refer to.
- Clear pathway to ILS

4.2.2. GP On line survey

Seven GP's responded to this on line survey about the development of the HaSP model in May 2009. The GP's who responded valued continuity and co-ordination of care and access to social care funding most highly. One Point of access to services and a single integrated rehabilitation team were favoured options.

4.2.3. GP Stakeholder Engagement Event,

This event was held on Friday 18th September 2009 in order to provide an indepth discussion on the suggested model and ask GP's how best to engage with them in developing the detail of the model. Portsmouth's GP population was contacted and offered money to purchase locum support if they attended. 2 GP's attended and the points they discussed are detailed below:

- Strong relationships with community health and social care staff were important for surgeries
- The relationship between GP Clusters and Health and Social Care clusters might strongly support good relationships
- There was an experience of better health outcomes for patients where personal relationships existed between community health and social care workers and GP practices.
- What were the expected improvements in the patient journey and how did affect GP intervention?
- How will the one point of access make a difference to the support that people receive
- How quickly we people referred to the one point of access receive support
- The branding of the short term stabilisation, intermediate care and re-enablement team, and community health and social care team should be very strong and clear so that the purpose and function of the team is well understood
- Programme Steering Group should be aware of other developments like the COPD strategy group
- How did the integrated teams relate to the community mental health teams

- Will the typical clients be vulnerable older people
- Who exactly are the group of professionals involved in the service

They asked to be consulted through GP's already involved in the PCT and the Target group meetings.

4.2.4. GP Commissioning group

The proposed rehabilitation model and proposal to decommission D1 was taken to the PCT's Clinical Innovation Group on 23 March 2010. This group is made up of 4 GPs from across the City and 4 GPs on the PCT's Professional Executive Committee. The group had an advisory role, providing clinical input into the commissioning decision making process. The group supported the proposals and move to a community inpatient service with community geriatrician support. No objections were raised to the proposal to decommission D1.

4.2.5. GP Target meeting

The changes proposed by the HaSP Board were presented to 137 GP's at the 'Target' meeting of 24th November 2010. At the same meeting a smaller workshop ran to discuss the issues in detail. There were 15 GP's at the meeting, they raised no objections to the proposal to decommission ward D1.

4.3. Other Consultation

In addition to Patients and GP's to following groups have also been consulted on the development of the detailed HaSP model of service

- Ambulance Service
- Well being and prevention network
- Community First
- Older Peoples' forum
- Portsmouth Overview Group

No issues of concern about the HaSP model were raised in discussions at these consultations.

5. Service Design

5.1. Consultation with staff working in bedded units

In all four workshop and meetings took place with staff who worked in bedded units, to help design the service provided as a stay away from home. The options presented to the Integrated Commissioning Board were drawn from the work of these groups.

- 19th August 2009, workshop for 30 people took place in St James involving staff from Exton 5/6 (now D1), Amulree Day Hospital, Rembrandt Ward, Victory Unit and staff from therapies and community teams
- 16th October a large workshop was held to develop the "Blueprint" of services, this included senior operational managers from across the

teams involved in HaSP and looked specifically at decommissioning ward D1

- 26th February 2010, meeting with Strategic Director Margaret Geary and PHT Consultants, along with commissioners and therapy staff to discuss decommissioning of Ward D1.
- 18th March 2010, a workshop with the range of professionals involved in bedded units and commissioners took place. Portsmouth Hospital Trust presented a case study of rehabilitation on Ward D1

5.2. Audits of capacity and medical need

Audits of need on ward D1 took place in 2006, 2009 and 2010. the 2006 audit did not include social care's bedded rehabilitation. This was looked at across health and social care in 2009 and 2010. Staff working on Ward D1, Rembrandt and the Victory Unit were asked about the needs they met.

5.3. Waste Walks

Service design activity was carried out in the HRDS and HASP programme. The design activity was largely carried out in workshops. Other activity consisted of 'waste walks' to identify inefficiencies and staff workshops for Hospital Staff, Community Health Staff and Adult Social Care staff. This activity took place between March 2008 and March 2010.

The following issues were discovered on waste walks and led directly to the service design decision which seeks to commission rehabilitation in the community, rather than in acute care to try and reduce waste in the system and improve patient experience.

Index	Operational Area	Issue Description
IC1	Community Physio	Waiting list of up to 6 weeks with some lack of continuity between acute and rehab service.
		Service Monday - Friday with potential 72hr wait before triage
		Hospital referrals with POMR moved to holding file until notes arrive
		Patient notes passed from other services treated with professional caution and may be reassessed
IC2	Community OT	Service Monday - Friday with potential 72hr wait before triage
		Cross referencing with Social Care as 2 systems in place for recording referrals
		Time taken for Qualified staff to Triage depends on quality of referral
		Patient notes passed from other services treated with professional caution and may be reassessed

		Ongoing plan of work may require long term involvement - up to two years
IC3	Independent Living service	50% of referrals returned for further information
		Capacity issue with referrals rejected but expected to come back in future
		Clients may be referred to panel after 2/3 weeks because not appropriate for ILS to continue rehab
		If reenablement person may have more than one assessment and one strand of work may end before another.
IC4	Community Rehab Team	Discrepancy in catchment areas for PCT and PCC
		Mix of paper and IT systems resul;ting in shared MDT paper file
		Waiting lists for specialties within the team vary
		Confused referral route
		People do not always know they have been referred, and CRT cannot access NHS records so don't know who else is involved.
		Duplication of information on several IT and paper systems in Health and Social Care
		Problems getting equipment which may lead to exceeding 6 weeks intervention
IC5	Victory Unit	Different approach to initial assessment depending who is on rota
		Rota for assessors - matched to type of referral
		Suitable Housing a block to discharge
IC6	Exton 5/6	Inappropriate, non rehab. admissions when beds vacant
		Need to refer back for more information from referrer
		Key nurse approach not always possible
		Referrals to SW made before client reaches Exton
		Different approaches from Consultants to documentation
		Duplication of recording of test results
		Staff delivering acute care not rehab
		Therapy services only 5 days pw
		OT in community ? Responsiveness on ward
		No acute facilities - transfers back to acute wards
		Outliers receive rehab service by default not on needs
		Perception of delayed discharge more problematic on Exton 5/6 because Social Care not charged for delayed discharge from rehab wards.
		Referral to ILS - does delay limit access to service
IC8	Rapid Response	GP summary required - responsibility of referrer to obtain
		Referral to Social Care after 48hrs to make sure 'in

		system'
		Have to chase SW for update and setting up of care package.
		Increasing inreach in response to ED escalation

5.4. Workshops

Overall, twelve workshops were held with almost 500 staff from 2008 until 2010. These workshops included staff from the range of services included in the Scope of the HaSP programme. This includes rehabilitation services and community health and social care.

Staff included in these discussions were:

- Senior Management Team, Social Care
- Senior Commissioners
- Portsmouth Hospital Trust Business Management
- Solent Health Care Operational and Clinical management
- Consultant Geriatricians
- Ward based staff and Managers
- Occupational Therapy Managers and staff
- Physiotherapy Managers and staff
- Independent Living Services Managers and staff
- Re-enablement service Managers and staff
- Commissioners
- Nursing Managers and staff
- Social Work Managers and staff
- Information Systems staff

6. Resolving concerns over support offered D1

11th March 2011, a meeting with Commissioners, Consultant Geriatricians from Portsmouth and Southampton, and Managers in Solent Healthcare and Portsmouth Hospital Trust took place. Dr Ian Gove, consultant geriatrician from Southampton was invited to consider in more detail the Southampton rehabilitation service which also has community bed based provision. PHT confirmed its commitment to work in partnership with the PCT and PCC to develop the new model, but required more detail on the proposals, some which has now been provided, and some of which needs to be developed jointly. A further meeting is planned for April to agree the staffing levels on the new unit. It may also be possible to look at the staffing levels and configuration of other older people's wards on the QA site to increase rehabilitation opportunities as part of the acute care pathway.

7. Conclusion

The re-design of community services has taken place in the context of guidance issued by the Department of Health and the research and consultation with patients and service users undertaken by Commissioners through the HRDS and HaSP projects. The benefits to patients and service users have been established by consulting with them to understand their experience and looking at what improvements would be most valued by them. Primary care GP's have been consulted on many occasions and consultation

with a wide range of professions and organisations involved the field of Health and Social Care have been a feature of the community service re-design. This re-design was undertaken in collaboration with over 400 staff and partners in the voluntary sector through workshops and ‘waste walks’. There are still some concerns from Consultant Geriatricians directly affected by the redesign, commissioners have agreed to work on resolving these concerns over the coming months, whilst the re-designed service is being put in place.

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14th March 2011