West Dunbartonshire
Community Health Partnership

West Dunbartonshire Council

NHS Greater Glasgow and Clyde

DRAFT
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MOVING FROM CARE TO ENABLEMENT: DRAFT FRAMEWORK FOR REHABILITATION

The West Dunbartonshire Joint Future Partnership welcomes the opportunity to contribute to the above-noted consultation. We have considered the paper at a number of our joint planning groups and it has stimulated considerable debate.

We have therefore collated the various comments received, into a single Partnership response. We hope that our response helps take the framework on to its next stages.

Key Messages

We support the key messages as summarised in the opening pages of the document, and hope that the finalised framework equips service planners to redesign services to achieve these goals.

We note that the framework makes mention of a number of strands of activity that contribute to rehabilitation processes, and we believe that by taking full account of these factors, the finalised framework might offer an holistic view of how rehabilitation opportunities should be maximised. We support the ethos of attempting to shift the focus from traditional "medical" models, to a more balanced view that takes account of social and psychosocial factors. The inclusion of unpaid carers as part of the model of care is welcomed and we would hope that the finalised framework expands on the role and contribution of this vital component of rehabilitation systems.

We would however suggest that the draft framework is not entirely clear as to whether the term "long-term conditions" includes children and young people. Clarification of this point in the final version would be appreciated.

Context and Background

The paper attempts to incorporate the requirements of "Delivering for Health" and highlights " … *the need for a decisive shift in the balance of care within the NHS* …" (page 6). However, our partnership suggests that the framework should go further. The need for a more systematic approach to managing services relating to long-term conditions is recognised, and local partnerships are already attempting to map care pathways that take account of NHS services across acute, primary, secondary and tertiary services. By necessity this mapping also takes account of social services (within statutory and voluntary sectors), and of the role and inputs of unpaid carers. Without inclusion all of these constituent parts, the range, scope and responsibility for rehabilitation could be underestimated or even misrepresented.

While taking account of the full spectrum of inputs would broaden the context of the framework, we believe that it would not dilute the focus, but rather would offer scope for a more rounded and patient-centred redesign. We note that the draft framework has matched the shared principles of Delivering for Health and Changing Lives, so there is clear recognition that rehabilitation goes beyond NHS services. Making this more explicit would send a clear message of flexibility towards a more holistic model, and away from the traditional strongly medicalised view.

Page 7 promotes the use of the CHP Long-Term Conditions Toolkit, which we strongly support. However we would suggest that the role of care management, within the context of the Scottish Executive National Training Framework, should be more explicit.

Page 10 identifies some of the key messages from "Better Outcomes for Older People" and helpfully sets these in the context of the Rehabilitation Framework. However we believe that it is equally important to address the need for psychological and psychosocial support if our older people are to be encouraged to sustain momentum and motivation during what can often be a lengthy rehabilitation programme. We would therefore suggest that services should be encouraged to measure outcomes in terms that encompass physical improvement, but also emotional and psychological well-being.

Page 11 lists some of the key service areas that should be involved in the delivery of older people's services. While we recognise that this is not designed to be a comprehensive directory, we would suggest the key omissions might be housing services and equipment/adaptations services.

Page 12 helpfully highlights that there is a large number of older people living independently in the community without need of services. The paper goes on to suggest "*local authorities and health professionals should encourage physical activity programmes specifically targeting older people*." Our partnership proposes that the framework should take the opportunity to take this further. Rather than "encourage", we suggest that there should be a requirement to develop structured programmes with ring-fenced resources and an outcome-based performance management framework. This could be incorporated into Local Improvement Targets (LITs).

Page 14 discusses targeting individuals on incapacity benefit, and supporting them back to work. Whilst we fully support this principle, we would caution that all such individuals must have access to money and benefits advice services and advocacy. This should help to resolve the financial "benefits trap" that many people find themselves in during the phase between benefits and finding employment.

Attention should also be given to the arbitrary health care costs of prescription and travel that affect many people managing long term illnesses and conditions.

Page 15 – "Rehabilitation services should be more accessible to those who use services, including direct access when essential". We suggest that "*when essential*" is removed. In cases where services are essential, there is almost always a referring professional involved. In most other cases direct access would be beneficial to the patient, and could potentially stem any worsening of the condition.

Section 5 (beginning page 16) introduces recommendations for action, and divides these into subsets.

<u>Access</u>

Our planning groups have consistently agreed that time-limited interventions do not represent a patient-centred approach to service delivery. However, we recognise that resources are limited and would therefore suggest that any time restrictions should be flexible and linked to clearly articulated and realistic agreed goals. This approach has the added dimension of empowering the patient, as he or she will share the responsibility for rehabilitation rather than being a passive recipient of services.

Bullet point 4 asserts "better hospital and public transport is needed in community settings to enable people to access rehabilitation services". We suggest that more focus should be given to taking rehabilitation services away from hospitals and into communities. This would help alleviate the transport issue, and would also provide a more relevant setting for rehabilitation. However it should be recognised that transport will remain a key element irrespective of service location. Community settings may reduce travel times and be handier but will not obviate considerations about transport and mobility issues.

Again the recommendation uses the term "when essential". We strongly believe that this phrase should be removed. There is no indication of the definition of "essential", or of who should define this term at the point of need.

Recommendation 1.3 should be more explicit about the responsibilities of acute sector practitioners in transitions of care.

Recommendation 1.6 is not clear. Our local discussions have arrived at multiple definitions of the term "local facilities". We therefore suggest that the terminology be clarified.

Recommendation 1.7 could usefully be linked to specific outcomes and targets such as LITs.

Local Service Provision

Recommendation 2.2 proposes that partners should identify "at risk" individuals and develop models of anticipatory care. Our partnership fully supports this principle, but the framework should recognise that this type of work is resource-intensive in its developmental stages.

Enablement and Self-Managed Care

We fully support recommendation 3.3 but would caution that for some degenerative conditions, care should be taken to ensure that patients do not feel that they have failed in their self-management when a decline occurs.

Recommendation 3.5 suggests local directories of services. While these are valuable tools for both patient and practitioner, maintenance of such databases is always difficult without ring fenced resource.

Comprehensive and Evidence-Based Services

Recommendation 4.3 proposes the development of a Managed Knowledge Network for Rehabilitation. The potential benefits are regarded by our partnership as substantial, but given the scope of rehabilitation and the volume of knowledge available, such an endeavour would be best managed centrally, by NHS NES.

Sustainable Multi-Professional Teams

Recommendation 5.1 promotes team working through a number of strands that are recognised as cornerstones to joint working. Our partnership supports this approach but would caution that while the principles seem to be relatively straightforward, the application of these principles can be quite complex. Both Agenda for Change and Job Evaluation have worked largely as parallel processes, meaning that this type of integration can raise issues around grading and terms and conditions. This comment is made not to suggest that the approach should be abandoned, but rather, that a national view is perhaps needed to achieve a consistent approach across all agencies and locations. Besides the grading or Terms and Condition issues, there are likely to be training issues which will have to be resourced.

Recommendation 5.2 goes on to highlight further the need for training to align the approaches of staff from different agencies. We would suggest that such training needs to address the fundamental difference between the medical model (risk avoidance) and the social model (risk identification and management).

Capacity

The recommendations are in line with our local approach to joint working. However, we wish to draw your attention to the term “community workers”, used at the second bullet point on page 28. It is perhaps worth noting that “Community Worker” is a specific job title/role in local government. For clarity it may be helpful to use the term “community-based workers”.

Conclusion

These comments have been collated after considerable discussion with officers, practitioners, service users and carers. Overall, there is a sense of a fairly ambitious review of rehabilitation services, but that the framework needs to be underpinned by a clear vision of what it hopes to achieve. We would be keen to see a more explicit drive to move away from hospital services, in favour of community-based rehabilitation, with the associated resources (both staff and finance) moving to accommodate this.

We remain concerned that the draft framework still appears to focus more on a medicalised model of rehabilitation. While medical outcomes are often more measurable, we would assert that interventions are more likely to achieve optimum success if the whole circumstances of the person – including emotional, psychological and social – are considered when developing the rehabilitation plan. There is little mention of psychological services in the framework, but the contribution is potentially vast and very powerful.

We hope that these comments contribute positively to the further development of the framework, and look forward to receiving the next draft.

Yours sincerely

(Keith & Bill)