

Transforming Community Services: Ambition, Action, Achievement

Transforming Rehabilitation Services



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Transforming Rehabilitation Services

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Introduction

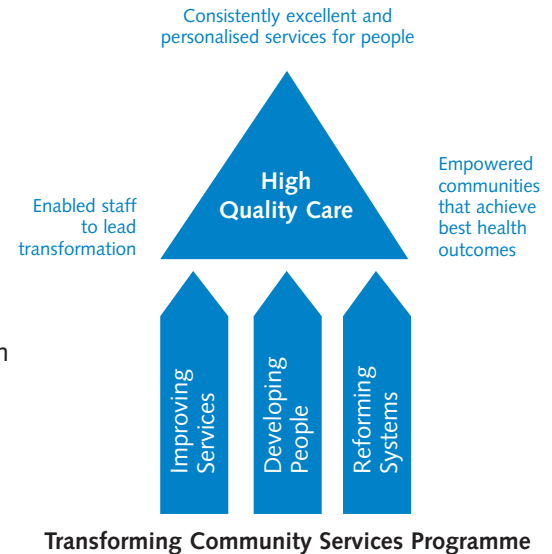
Effective and efficient community services are the foundation of healthcare in the NHS. They help people stay healthy and care for them through debilitating illness and at the end of their lives. They are a lifeline for some of the most vulnerable, and at their best are innovative, flexible and personal. However, we face some major challenges:

- there is great variation in service quality and health outcomes
- much activity and achievement goes unmeasured
- we lack usable data, tariffs and currencies
- there is disparity in quality, productivity and costs
- infrastructure is frequently outdated
- access can be uncertain and confusing.

We recognise that the environment is changing for community services which – like all health services – face the challenge to drive up quality and drive down costs. The Transforming Community Services Programme is therefore about delivering improved quality *and* productivity, as well as building on preventive approaches to reduce costs associated with lifestyle related disease and preventable complications.

The Transforming Community Services Programme has set out a far-reaching plan to resolve some long-standing issues by harnessing the energy and enthusiasm of everyone to provide consistently high quality care. This will mean that the best, currently available for some, is there for all.

The programme takes a three-pronged approach: improving services, developing the people who provide them, and aligning systems to underpin the transformation.



About the guides

There are six transforming community services guides for frontline staff and their leaders. Many practitioners will be interested in one particular guide and some will be interested in elements of more than one. The guides therefore have a common format and the first sections apply to all service areas and are the same. Subsequent sections cover specific changes and will differ between guides. Four of the guides deal with services for adults and older people. One guide relates directly to services for children, young people and families. The health and wellbeing guide contains information to enable all practitioners and teams to maximise their contribution to good health outcomes and reducing inequalities and is therefore relevant to all.

These best practice guides demonstrate what is considered to be best practice across community services and have been developed in conjunction with experienced and committed health professionals. They highlight a number of actions that people have said make a real difference to patients. They are based on a framework of '*ambition, action and achievement*'. By this we mean:

- Clearly setting out your **ambition**
- Taking **action** to deliver the ambition, using the best available evidence
- Demonstrating and measuring **achievement**

The Six Transforming Community Services Reference Guides

- Transforming Health, Wellbeing and Reducing Inequalities
- Transforming Services for Children, Young People and Families
- Transforming Services for Acute Care Closer to Home
- **Transforming Rehabilitation Services**
- Transforming Services for People with Long Term Conditions
- Transforming End of Life Care

Quality for community services

The Next Stage Review states that high quality care requires a high quality workforce. In keeping with this, the guides describe **six transformational attributes**, which individuals and teams will need to demonstrate in order to meet the requirements of their high-performing 'practitioner, partner, leader' roles. These are in the later sections of the guide and are specific to each service area.

These guides will be successful if they help deliver the aspirations of *The Next Stage Review* and enable:

Practitioners closest to patients to lead change themselves and realise their own high ambitions for the care that they provide.

Provider organisations to align high quality care to organisational vision and strategy.

Commissioners to understand the constituents of high quality care and enable **world class commissioning** decisions to be made that are clinically led and focus on achievements.

Our guidance on the **Quality Framework** for Community Services is part of the overarching quality improvement programme outlined in *High Quality Care for All*. The programme focuses on **bringing clarity to quality and measuring quality**, as the foundation for broader quality improvement. It is aimed at all those with a role in providing or commissioning community services.

Useful links and further information on these six transformational guides, national policy can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

Quality

A common misconception is that quality is expensive. On the contrary, quality can and should be a powerful way of cutting costs, doing things right first time without the need for repetition, and is the most effective way to reduce unnecessary cost. It's when things go wrong they become expensive and inefficient.

Quality Indicators

*More than 70 potential indicators of high quality care have been identified. They cover effective practice, safety and people's experience to help us to **measure what we value**, to benchmark and improve the quality of care we deliver. These are a starting point and more work is needed to refine, develop and pilot them to ensure that they enable practitioners to measure the ambitions set out in the transformational guides. They are not comprehensive and we know there are gaps, which is why we are asking for your views on what are good effective indicators of quality*

Ambition

1

Getting the basics right – every time

People have urged us to stress how important it is to ensure that the basics are in place – not doing so compromises service users' experience and practitioners' ability to deliver high quality productive services as efficiently and effectively as possible. Provider management and clinical teams need to work together to get these right. What follows are recommended actions and how they can be measured through achievements. They are based on evidence and professional consensus and are for local organisations to consider when planning quality, innovation and productivity improvements.

Actions to deliver the basics for all community services

1. Know about local health needs and plan services accordingly

- Work with your public health observatory (public health team in the commissioning PCT) to access information on the health needs of your population: identifying those who may be disadvantaged or marginalised in society: target need.
- Work with your commissioners to agree the outcome data that needs to be collected for a specific service area to demonstrate effective intervention. Ensure that you have robust systems in place to collect this data. Link this to the quality framework and, if appropriate, contracts including the payment framework for commissioning, quality and innovation ([CQUIN](#)).
- Develop systems and processes, which encourage constant patient, service user and carer feedback. Audit changes, which have been made as a result of feedback on user experience.

2. Create effective health and care partnerships

- Strengthen partnership working across health and social care. Work in partnership with organisations such as ambulance trust, acute trust, social services, GP practices (and practice-based commissioners), the voluntary and independent sectors so that care and treatment can be aligned along a care pathway and co-ordinated around the needs of the service users.
- Start discharge planning at the earliest possible moment. Make sure all practitioners are involved in this process, care is co-ordinated, and discharge summaries provided for all key services involved in the patient's care.

3. Implement new services/approaches

- Addressing variability, working efficiently, demonstrating high levels of productivity and achievement of ambitions for quality are always important and particularly so in an economic downturn. Ensure that your teams use the most up-to-date and appropriate evidence and tools to ensure effective working. This may include the [NHS Institute productive series](#) or lean management techniques.
- Support teams to develop creative approaches to service provision, which will improve choice, personalisation, efficiency and effectiveness, for example, reducing avoidable admissions to the acute hospitals through making the best use of social care resources.
- Support and empower practitioners to develop innovative multidisciplinary teams using approaches such as the transformational attributes.

4. Access and availability

- Provide local health information about your services: the access, availability and choices, for patients, the public and professionals. Check against the experience of those using your services to ensure understanding.
- Provide clear information about out-of-hours service provision to patients, the public and practitioners. This should include the service and current contact details. Use self-referral as the optimum route and use new technology, for example, text and email where possible. Audit these services regularly to ensure that they meet the quality standards.
- Provide the right resource, in the right place, at the appropriate time in accordance with need. This may mean extending or changing the hours of service provision to 24 hours a day, overnight or weekend care. This may also mean working with other partners to ensure systems are in place to access care. This may include capacity management systems, access points and telephone triage. Partners should include the out-of-hour provider and ambulance trust.
- Provide the right equipment to the right patient in a fast and efficient manner and have systems in place to retrieve equipment no longer needed. You may need to undertake an equipment audit to ensure that the demand for equipment matches the resource available. Transforming Community Equipment Service (TCES) was launched in 2008. Its aim is to create a new service delivery model that puts users and carers at its heart giving more choice and control.

5. Care planning and case management

- Ensure that there are robust systems in place to safeguard children and young people and for adult protection.
- For people with long term or complex health care needs:
 - Provide a [personalised care plan](#) and, where appropriate, use joint care planning or integrated assessments such as the single assessment process or common assessment process (CAF).

- Provide patients and carers with a named key worker or case manager to ensure high quality, safe and effective continuity of care.
- Ensure that you are familiar with your PCT's local carers strategy, providing all carers with a holistic assessment in their own right and giving the appropriate information, support and advice for them to remain healthy and within their own home.

6. Information and technology

- Provide clinicians with appropriate IT and ensure that, where safe and practical to do so, clinical pathways are interlinked using shared records and joint care plans. This could include investment in IT web design solutions or portable IT solutions for remote access working such as tablets, laptops and palm tops.

7. Education and training

- Commissioners and provider management teams must be responsible for developing a competent workforce that will deliver sufficient current and future services safely, effectively, and which have a positive impact on service user experience. Practitioners and clinical teams need to review best practice and prioritise development plans for service delivery.
 - Equip practitioners with a wide range of skills, knowledge and competence to meet the future demands on community services, including the impact of new service models and shifts in care settings, e.g. from hospital to community and patients' homes.
 - Provide access to robust training and education, clinical supervision and improved clinical, leadership, managerial and business skills to improve health outcomes.
 - Use and develop evidence based practice and validated research to improve clinical practice.

Achievement

- ★ Clinical and multi-agency teamwork is supported by a robust infrastructure that enables all practitioners to deliver high quality care, achieve agreed outcomes, maximise productivity, promote, and measure service user experience.
- ★ Variability in productivity is reduced by efficient, effective systems, clearly described and measured.
- ★ Community services contribute to the efficiency and effectiveness of partner services, for example acute trusts; primary care and social care to provide a seamless care model.
- ★ Practitioners have the confidence that these systems will support them when working in the community and allow them to spend the maximum amount of time with individuals and families.

Benefits realisation

With the increasing focus on **quality and innovation with productivity**, it is important to be able to demonstrate that the benefits envisaged (i.e. our ambitions) are actually derived (i.e. our achievements): this is known as **benefits realisation**. Actions to create the change and the delivery of outcomes should be monitored through a plan to track the implementation and the service improvements. The improvement plan should be aligned with the PCTs strategic priorities, focused on delivering improvements in health outcomes for the local population and in line with the aspiration for [world class commissioning](#).

Productivity defined

- Productivity is a measure relating a quantity or quality of output to the inputs required to produce it.
- It is the quality of being productive.

Ambition**2**

Making everywhere as good as the best

Actions to achieve the best – ‘high impact changes’

The actions below, grouped under seven main headings, have gained support from all those who took part in developing the guides as most likely to have the **greatest potential to improve care and achieve the highest quality services**. In all of these guides, we have used the best research evidence available; however, we know that there are significant gaps in community service evidence. We have also drawn on expert professional opinion and service user experience to provide robustness to these **recommended actions and achievements** that practitioners should consider to deliver our ambition.

Summary of high impact changes

- Work towards a philosophy of rehabilitation and reablement for all providing a clear vision and strategy for rehabilitation services.
- Build and develop multidisciplinary and inter-agency teams to deliver local person-centred rehabilitation.
- Redesign the care pathway promoting high quality, productive services which will ensure that all individuals have a safe, efficient and effective service, which achieves and maintains maximum health and independence.

- Promote and enable self-care, providing support for families and carers throughout the service user's journey.
- Invest in services that will maximise an individual's potential to return to work, providing alternative pathways (e.g. volunteering) for work related activities where this is not practical.

1. Know about local health needs and plan services accordingly

Identify current and future local rehabilitation needs and plan services accordingly

- Services should be based on up-to-date public health data, local demographics, service user and carer experience, Local Area Agreements (LAA), and joint strategic needs analysis (JSNA). They should be predictive and proactive providing quality services that meet the needs of patients and communities.
- Involve the local community in all aspects of rehabilitation provision. This may include working with local user and carer led organisations, Partnerships for Older People Projects (POPPs), local voluntary organisations, LINKS, Local partnership boards and local thematic groups.
- Intermediate care services should form part of the rehabilitation pathway ensuring that admissions are prevented, facilitating early discharge and enabling people to achieve the optimum level of independence for their long term future.

2. Create effective health and care partnerships

Build and develop multidisciplinary and inter-agency teams to deliver person-centred rehabilitation that is responsive to the changing needs of service users along the care pathway

- Develop partnerships across the local health economy so that services can be delivered in new ways and settings (not necessarily health settings).
- Develop new roles and skills to support service redesign, e.g. extended scope physiotherapists, health and social care support workers and learned skills such as motivational interviewing and cognitive behaviour therapy (CBT).
- Make use of rehabilitation specialists across organisations and professions to enhance core and extended teams and improve choice and access for service users and carers.
- Deliver rehabilitation at home (inclusive of care homes, social services settings) to improve outcomes for the service user, family and carers.
- Ensure that discharge planning commences on patient admission.
- Ensure that rehabilitation teams make close linkage with continuing healthcare services so that, where appropriate, packages of care can be set up effectively and efficiently with no time delay for patients.
- Ensure that rehabilitation teams monitor an individual's progress and, where practical, prevent re-admission into hospital. This may mean joint working and the use of joint data systems/ red-flag systems with partners such as, the ambulance trust, primary care teams and out-of-hours providers. This will ensure that individuals are re-routed to an appropriate care setting or care provided at home.

Support individuals to return to work as quickly and effectively as possible

- Ensure that discharge planning includes exploring the individual's potential to return to work and/or provides alternative solutions so that work-related activities can continue.
- Work with employers to ensure that work environments promote and support individuals to remain in work/return to work.
- Work with employment agencies and organisations to explore alternatives to work related activities, such as volunteering, for those who may be unable to return to previous employment due to limited mobility or ill health issues.

Enable and empower service users to choose self-care

- Work in partnership with local authorities to support service users and carers wishing to make use of self-directed budgets ([personalised budgets](#) and [individual budgets](#)) and [independent living funds \(ILF\)](#).
- Empower service users to develop the knowledge skills and confidence to monitor their condition themselves.

3. Implement new services/approaches

Ensure the needs of carers are built into the rehabilitation programme

- Provide tailored information for carers and service users.
- Ensure the needs of family members and carers are considered when equipment in the home is required. This may include the day and time of delivery, training and skills required and specialist alterations if needed.

Involve the local community in supporting rehabilitation services

- Work in partnership with other agencies to explore work and leisure opportunities for service users. This will include leisure centres, voluntary groups and private companies.
- Use all opportunities to reach those who may be marginalised from society. This may include running clinics and workshops in the workplace, high street, churches, or through local networking meetings.

4. Access and availability

Improve access to rehabilitation including use of self-referral

- Provide clear information about the service to other practitioners, service users, carers and the public.
- Be clear about the access points for the service. This may mean developing a single point of access, triage or referral and/or working with partners such as the ambulance service or out-of-hours providers to develop systems and processes for actioning responsive support, advice or care.
- Use self-referral to enable and empower service users to seek timely support as their needs change.

5. Care planning and case management

Ensure that rehabilitation services have a clear vision, clear goals and a clear strategy

- Define rehabilitation as an underpinning principle/philosophy rather than a separate service.
- Use evidence based care pathways as a tool to provide a shared vision.
- Have a whole systems approach to care in conjunction with the local authority and other health economy organisations so that all are clear on the interrelationship between health, social care, voluntary sector, third sector, independent sector and user-led providers.

- Use case managers/named professionals who can work on a 1:1 level with service users and carers to optimise the benefits of rehabilitation.

6. Information and technology

Use technology to support and sustain benefits of rehabilitation

- Use assistive technology including telecare to optimise health and wellbeing including continuing maintenance.
- Use technology such as telehealth to enable and empower people to monitor their own conditions.
- Use regular telephone support/video linkage (telephone) as part of the rehabilitation programme.
- Think broadly about 'non-health' technologies and services e.g. computer game products, leisure centres to normalise activities for an individual.

7. Education and training

Develop the multidisciplinary team (including service users, carers and families)

- Promote shared decision making between clinicians and service users/carers.
- Use buddy systems, peer educators, expert patients and independent advocacy services as appropriate to meet the needs of service users and carers.
- Develop non-specialist staff with the appropriate skills and competences e.g. health and social care workers, assistant practitioner roles, physiotherapy assistants and occupational therapy technicians as well as specialist staff with appropriate skills and competences.
- Incorporate patient, carer and family education and training when planning individualised care.

Achievement

- ★ People receive high quality services to manage their condition and maximise the potential for health and independence – there is a reduction in the variation of quality of services and in the health outcomes to which they contribute.
- ★ Improved access to rehabilitation services with improved early identification and support to return to/access work.
- ★ Partnership working across the whole health economy to ensure joint care pathway planning.
- ★ People are supported to develop the knowledge skills and confidence to monitor their condition themselves and to have the opportunity to participate in expert patient programmes.
- ★ Early management of those at risk of being off work due to ill health and for supporting people to remain in employment.
- ★ Self-referral systems are in place to empower service users to seek timely support as their needs change.
- ★ Case management and care planning are person-centred and people choosing to hold individual budgets for any part of their care receive support to do so.
- ★ Future needs are modelled on local registers/demographics thus; there is a predictive, proactive approach to planning.
- ★ Evidence, professional consensus on good practice, experience of service users and productivity tools are rapidly appraised and adopted to increase efficiency and effectiveness.
- ★ Innovation and creativity are supported within organisations and throughout health and care services. This will include the Transforming Community Services (TCS) innovation and leadership award scheme with emerging findings on what constitutes a high quality service. Lessons learned are implemented rapidly, disseminated nationally and adopted to improve services.
- ★ Measuring quality, continually seeking improvement, and demonstrating high quality services to service users, public and commissioners is endemic: we need to move from **'valuing what we measure to measuring what we value'**.

Measuring what we value

Quality indicators for community services will be piloted with clinicians and community providers in Autumn 2009. Indicators in rehabilitation services organisations should think about:

- The percentage of people with complex needs who have an integrated care plan.
- The proportion of people with an identified case manager/key worker.
- Measures of intermediate care – patient flow and length of stay, and percentage of people still living at home three months after discharge.

Ambition**3**

Delivering evidence based practice

Actions to improve the quality of commissioning and provision through implementing evidence

What does the evidence say?

More than 18,000 studies were analysed by the Health Services Management Centre (HSMC) to examine the evidence for a range of community services.

Useful links and further information on all the studies can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

What follows are **recommended actions and their achievements for rehabilitation services**, based on evidence and professional consensus and are for local organisations to consider when planning quality innovation and productivity improvements.

Provide rehabilitation in the community

There is some good evidence which suggests that rehabilitation could operate as an outpatient service in the community. A systematic review of community neuro-rehabilitation identified important components of community rehabilitation services – social support, involving carers, using physiotherapy and occupational therapy, and good links between community and hospital services. However, rehabilitation services provided in the community need to be well organised, include a multidisciplinary team and use venues that are acceptable and accessible to service users and staff.

Multifaceted rehabilitation works best

Two key messages emerge from the evidence – rehabilitation should begin as soon as possible and rehabilitation that combines many different components is likely to be most effective. The most successful rehabilitation services include personalised care plans, physical and cognitive therapies, regular practice and proactive follow-up.

Monitor vital signs and use alert systems

The evidence suggests that alert systems alone are not a form of rehabilitation but that they may play an important part of a wider care package. The most common form of telemonitoring involves automated data transfer and has potential to shift care from hospital settings into the community. However, findings about the benefits of automated data transfer were not consistent. In contrast, telephone support as part of a rehabilitation care pathway has been found to improve clinical outcomes and/ or reduce symptoms.

Use self-referral to services where clinically appropriate

Self-referral is a way to widen access and empower service users to seek help in a timely way as their needs change. A study of patients with inflammatory bowel disease found that open access used fewer acute sector resources resulted in the same quality of life for service users and was a preferred pathway for service users and GPs. This model could potentially raise concern for demand. However research in Scotland and pilots in England where self-referral to musculoskeletal services was available found no increase.

Rehabilitation at home improves outcomes

A number of studies suggest that home-based rehabilitation is just as effective in delivering improved functioning. However, it was also noted that home-based rehabilitation may place

additional demands on carers and therefore consideration needs to be given to supporting carers and provision of regular respite care.

Multidisciplinary teams improve rehabilitation

There is some evidence that multidisciplinary follow-up after discharge can reduce reliance on hospital care and shift care closer to home. Several studies have suggested that there are six factors which impact on how well teams work together in healthcare:

- team size
- multiprofessional composition
- good organisational support and equipment
- regular team meetings
- clear goals and objectives
- regular audit and review.

Self-care models can support rehabilitation

Several studies suggest that helping people to take responsibility for their rehabilitation and recovery is essential. One way of achieving this is through the provision of clear information. This needs to be easily accessible, inviting and needs to encourage people to apply the skills and actions to their daily activity. Written materials to support self-management can help but if used alone they may have little effect on behaviours, health outcomes or service use. Educational sessions to enable self-management are also required.

Supporting carers

There is some clear evidence that supporting carers can aid a patient's recovery and rehabilitation. A UK trial recommended that carers' support should be built into the design of the rehabilitation

programmes. Supporting carers is acknowledged as important but further work is required to determine the most effective methods for supporting them.

Ensure every service has a clear vision

Some studies would suggest that a clear service vision is missing among some specific rehabilitation services. Evidence based care pathways are a tool to help provide more integrated and continuous care and to ensure that services have a shared vision.

There is inconsistent evidence that care pathways impact on clinical outcomes but some studies do suggest that simple care pathways can make a difference to people's quality of life and the care they receive and an area for further investigation.

Local ownership of services is beneficial

Local ownership and involvement may be key to successful community-based rehabilitation programmes. This may include consultation, opportunities for volunteering, recruiting local staff and enabling local community groups to make use of the premises.

Work with care homes

The potential to work with care homes is an area that may be overlooked. They could be an alternative setting for the provision of rehabilitation services. While there is insufficient evidence that care homes either improve or reduce outcomes, one trial found significantly fewer days in hospital over the next 12 months.

Achievement

- ★ Community practitioners have access to information on evidence based practice and audits delivered have successful outcomes.
- ★ Commissioners and providers work together to ensure that where good evidence exists this is implemented within local services.
- ★ The time taken from evidence collection to implementing the innovative change is improved.
- ★ Important components of community rehabilitation services are in place including – social support, involving carers, using physiotherapy and occupational therapy, and good links between community and hospital services.
- ★ Rehabilitation services are well organised, include a multidisciplinary team and use venues that are acceptable and accessible to service users and staff.

Achievement: What do transformed community services look like?

Case study

Leeds Incapacity Employment Project (LIEP)

This is a partnership initiative implemented by Leeds Musculoskeletal Service and Leeds City Council in partnership with Job Centre Plus and Leeds Mental Health Services. The multidisciplinary service aims to provide a client-centred experience, breaking down physical, psychological and social barriers and facilitating people's return to work. It is aimed at people claiming incapacity benefit who have a musculoskeletal problem and comprises a six-week programme delivered in local community and leisure centres. Key to the approach is the active involvement of clients in the design and delivery of the programme.

Contact: billy.mcclean@nhs.net

Case study

Northumberland Community Stroke Service

This integrated service across health and social care provides specialist assessment and functional rehabilitation to adults following a stroke. The service is delivered in the person's own home, and focuses on specific goals set by the person. Following discharge the service user can self-refer back to the service at any time. There are five teams based around population groups. Initially set up to support the transition from hospital to home following a stroke, the service now also provides support in getting people back to work and back to community activities a year and more after a stroke. Reviews are carried out in people's own homes and may lead to a further period of rehabilitation focusing upon decreasing social isolation and promoting independence.

Contact: louise.lewis@northumberlandcaretrust.nhs.uk

The TCS innovation award winners for services related to rehabilitation are listed below. The Department of Health will be working with the leads of these new and innovative services to support the successful development of these pilots. Useful links and further information, including regular updates can be found on the Transforming Community Services (TCS) website www.dh.gov.uk/tcs

The TCS innovation award winners: Rehabilitation Services

- [Calderdale PCT](#) – Innovation council
- [Derby County PCT](#) – Care home support service
- [Hampshire PCT](#) – Training to enable nutrition screening to identify at risk patients
- [Kirklees CHS](#) – Productive teams and empowering change with service users
- [NHS North Somerset](#) – Development of generic assistant practitioner
- [NHS Wakefield](#) – Integration in action
- [NHS Sefton](#) – Developing a healthy workforce
- [Portsmouth City PCT](#) – Develop and support ‘expert’ carers targeting young carers with no access to local services
- [Redbridge PCT](#) – Reconnect using community resources
- [South of Tyne and Wear PCT](#) – Improving safety of care by supporting access into community services via single point of contact
- [Stoke Community Health Services](#) – A simple point of access for patients with integrated planning and delivery of care
- [Telford and Wrekin PCT](#) – Transforming patient care using the year of care approach
- [West Kent PCT](#) – Self-referral for supported discharge

Ambition

4

Developing and supporting people to design, deliver and lead high quality community services

Actions to develop a 'social movement approach' to change owned and lead by local services and practitioners

Transformational change happens when those delivering care are motivated and inspired to do things differently.

The *Next Stage Review* emphasised the need for a high quality workforce to deliver high quality care and introduced the healthcare professional for the 21st century being 'practitioner, partner, leader'. Contributors to the programme have built on the concept of a practitioner, partner, leader as attributes for community practitioners that will generate radical improvement.

Many good initiatives flounder because insufficient attention is paid to the staff themselves and the actions needed to create the climate in which the desired attributes can ensure success. Organisations implementing change will want to consider how they promote such attributes in their own workforce, and the action needed on a number of fronts. How staff are educated and trained, managed and led, how services are commissioned and regulated, and how performance is monitored. These all contribute to the creation of a positive, enabling culture in which staff constantly strive to improve safety, effectiveness and experience of care. Conversely, the same factors can mitigate against empowerment, motivation and personal accountability, reducing the likelihood of success.

Social movement

A group of people with a common ideology who try together to achieve certain general goals; features include:

- Energy
- Mass
- Pace
- Momentum
- Passion
- Commitment
- Spread
- Sustainability

Demonstrating the six attributes in rehabilitation services

Practitioners and teams who are:

Health promoting practitioners

- Working within a philosophy of enable/reablement and maximising independence.
- Working within a philosophy where promoting and maximising health and wellbeing is part of the role of every healthcare professional.
- Using expert patient programmes to enable people to manage their condition and maximise wellbeing and independence.

Clinical innovators

- Maximising the full potential of technology in rehabilitation.
- Implementing the full opportunities from extended scope practice, for example, new roles, joint posts between health and social care and skills such as motivational interviewing and cognitive behavioural therapy (CBT).

Professional partners

- Working in partnership with others: primary care, the ambulance trust, the acute trust, social services and the third sector to join up clinical care pathways and deliver effective care, which supports sustainable outcomes of rehabilitation.
- Working with employers and employment organisations to enable people to return to work or have access to alternative work opportunities.
- Working with the voluntary sector in local communities to look at alternatives to care such as volunteer recruitment, family support.

The six transformational attributes for community practitioners

Health promoting practitioners focusing on health, wellbeing and addressing health inequalities

Clinical innovators and expert practitioners enabling increasingly complex care to be provided at home

Professional partners in an expert to expert relationship with patients and in building teams across organisations

Entrepreneurial practitioners exploring business opportunities including expanding social enterprise and other innovative approaches

Leaders of service transformation individual, organisational and across systems

Champions of clinical quality using new techniques and methodologies to embrace continuous improvement

- Adopting person centred approaches to care planning such as supporting people with individual health budgets.

Entrepreneurial practitioners

- Maximising opportunities and demonstrating the ability to lead and further develop effective productive services which promote self-referral wherever appropriate and multidisciplinary ordering of investigations and onward referral.
- Seeking out business opportunities to develop new ways of delivering rehabilitation services either with existing providers or through new service development. This may include thinking about social enterprise or integrated care organisations (ICO).
- Developing positive risk opportunities when delivering rehabilitation.

Leaders of service transformation

- Working with commissioners, managers and others to redesign care pathways which will address all the elements of integrated rehabilitation services.
- Understanding the business process, the impact of the economic downturn and productivity/efficiency measures and how to put together a business case which can evidence value for money whilst ensuring high quality care and patient safety.
- Having the ability to lead the team to deliver high quality services, for example, supporting people as they develop new skills and extend their role.
- Displaying influencing skills and ability to implement change.
- Modelling leadership behaviours such as courage, integrity and excellent communication.
- Displaying expert leadership skills ensuring that the attributes become embedded within work

practice and used as part of the annual appraisal cycle in conjunction with the leadership, quality framework (LQF).

Champions of clinical quality

- Using new techniques and methodologies to embrace continuous improvement. Ensure you are able to measure quality in terms of patient safety, evidence and effectiveness and through people's experience of the services offered.
- Driving up standards by seeking and using patient, carer and family feedback to improve service satisfaction.
- Implementing quality improvement processes such as Plan, Do, Study, Act (PDSA) cycle and quality indicators.
- Displaying expert leadership skills ensuring that the attributes become embedded within work practice and used as part of the annual appraisal cycle in conjunction with the leadership quality framework.
- Displaying expert clinical skills, values and authority to champion the quality of community-based services locally.

Achievement

- ★ People are developed to be high quality community 'practitioners, partners, leaders' who can clinically own and lead local change.
- ★ Local practitioners (individually and as teams) use the transformational attributes applied to their services together with evidence based practice to become part of the 'social movement' for transformation of community services.

Next Steps: Taking forward the best practice guides

Taking forward the guides: Providers

- Share the guides widely with relevant staff and stakeholders including PCT provider committees, local partners and frontline clinical teams.
- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.
- Discuss the priorities and agree an action plan for 'Getting the basics right – every time' with relevant staff and stakeholders.
- Discuss and agree with commissioners the priority high impact changes and agree the action plan for taking forward.
- Where an evidence base exists ensure this is accessible to staff and services – audit performance on evidence based service delivery.
- Gain widespread clinical, managerial and commissioning support to take forward agreed service redesign strategies.
- Build agreed priority areas for action into 2010/11 service improvement plans and as appropriate through service contracts which may include the [CQUIN](#) payment framework.
- Consider how to involve patients and carers in any proposals to change pathways.
- Consider reviewing the ability of local systems to support data collection and real measurement to support local improvement.

Taking forward the guides: Practitioners and clinical leaders

- Share the guides widely with all members of your team, including local delivery partners.
- Consider undertaking a stock-take of where you are against 'the basics' and 'the high impact changes' to identify priorities for improvement.
- Agree where the team can take action to improve quality based on evidence and good practice. Plan and implement local action.
- Where change requires wider action, discuss and agree with senior managers the priority areas for taking forward.
- Consider how to actively involve local people, service users and carers in all proposals to change care pathways.
- Consider how change will be actioned and benefits measured, for example, through clinical audit, user satisfaction, improved performance on outcomes.
- Consider the workforce implications and the impact on roles within the team.
- Identify any training and development requirements and agree a plan for addressing.
- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Taking forward the guides: Commissioners

- Share the guides with relevant commissioning leads, including PBC colleagues and joint commissioning partners.
- Consider, in line with [world class commissioning](#), incorporating changes into local commissioning strategies and, where appropriate care pathways.
- Discuss and agree with community providers the priority high impact changes.
- Build agreed priority areas for action into 2010/11 service specifications and contracts and, if appropriate, consider possible goals to link with, through [CQUIN](#) payments.
- Identify relevant indicators from the initial community services indicator set to monitor progress (assured set available Autumn 2009).

Policy documents: Rehabilitation services

High Quality Care for All: NHS next stage review final report (DH, 2008)

Our Health Our Care Our Say: a new direction for community services (DH, 2006)

The Operating Framework 2009-10: for the NHS in England (DH, 2009)

The National Service Framework for Long Term Conditions (neurological) (DH 2005)

10 High Impact Changes in PCT Commissioning Practice (2009)

National Service Framework for Older People (DH, 2001)

National Stroke Strategy (DH, 2007)

Review of the Health of Britain's Working Age Population – working for a healthier tomorrow (TSO, 2008)

Improving Health and Work: changing lives – the Government's response to Dame Carol Black's review of Britain's working age population (TSO, 2008)

The Cross Government Strategy, Health, Work and Wellbeing: caring for our future. October (DH, 2005)

Framing the Contribution of Allied Health Professionals: delivering high-quality healthcare (DH, 2008)

Modernising Allied Health Professionals (AHP) Careers: a competence-based career framework (Skills for Health/DH, 2008)

Self-referral Pilots to Musculoskeletal Physiotherapy and the Implications for Improving Access to other AHP Services (DH, 2008)

The Information Management Handbook for Allied Health Professional (AHP) Services Version 1.0 (DH, 2008)

National Institute for Health and Clinical Excellence (NICE) Improving Outcomes Guidance (IOG) for Cancer Services.

Putting People First (DH, 2007)

Common Assessment Framework (DH, 2009)

Useful links and further information on these six transformational guides, national policy, evidence based research, case studies and innovation in practice can be found on the Transforming Community Services (TCS) website: www.dh.gov.uk/tcs