HEALTH AND SOCIAL CARE SCOTLAND

Embedded and emerging good practice in health and social care

Aligned to the *Framework for Community Health and Social Care Integrated Services*

Health and Social Care Partnership: North Lanarkshire				
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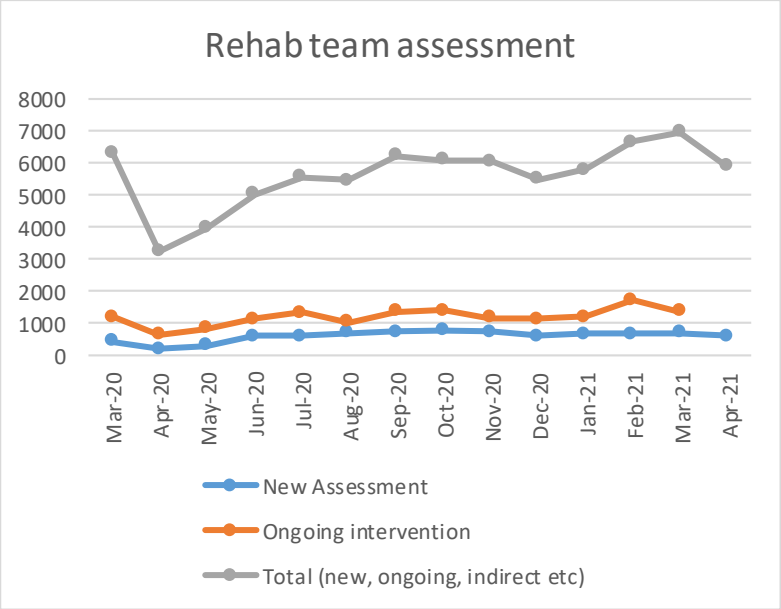
Name of good practice: Integrated Rehabilitation Team incorporating planned date of discharge (PDD) and home first/discharge to assess (D2A).				
Select (x) all areas that apply to your good practice (select more than one if applicable)				
CLIENT GROUP	Children and young people	x	Older adults	x
	Younger adults	x		
SETTING	City		Remote & rural (incl islands)	
	Corporate		Urban	x
SERVICE AREA	Addictions		Management team	
	Admission avoidance		Mental health	
	Community care services incl care at home/care homes	x	Physical disabilities	x
	Day services		Physical health	x
	Housing incl Homelessness		Primary care	
	Intermediate Care incl Hospital at Home	x	Rehabilitation	x
	Justice services		Social care services	x
	Learning disabilities		Supported discharge	x
	Other – please specify			
ELEMENTS of FRAMEWORK	Anticipatory care planning		Live independently at home or in a homely setting	x
	Assets based approach	x	Manage own care	
	Connect with communities		Reablement	x
	First point of contact		Seamless working with acute	x
	Enhanced care in care homes / supported accom		Short term targeted interv to meet more complex needs	x
	Fully integrated community teams	x	Teams aligned with general practice	
	Other – please specify			
ENABLERS	Agile working	x	Information sharing	x
	Aligned plans		Infrastructure	
	Clarity of vision		Management information	
	Clinical and care governance		Shared accountability	x
	Collaborative leadership		Strong team ethos	
	Culture and values		Technology	x
	Fit for purpose premises		Well-developed lead professional roles	x
	Improvement capacity		Well-developed relationships	x
	Other – please specify			

North Lanarkshire HSCP

Integrated Rehabilitation Team

SITUATION	Our Integrated Rehabilitation Team is committed to improving and evolving a community-based model of health and care. Multidisciplinary teams include a range of professionals involving physiotherapists, speech therapists and occupational therapists within the six localities in North Lanarkshire. It's part of our drive to help people live safe, healthy, independent lives within their own communities. Our teams do this through: • giving individuals the right information, support and care they need • responding to individuals' needs efficiently and effectively • offering guidance and support at the right time, in the right place and in the right way. During the pandemic, the teams remained working within the community and delivering rehabilitation within off site bed facilities as well as in people's own home. We were supported by other allied health professionals (AHP) colleagues from community/ acute settings, who were deployed as their service was stood down and for whom we provided support and training. Our objective was to help facilitate discharge from hospital and to avoid unnecessary admission. From March 2020 to April 2021, the teams had 12,994 referrals, approximately a 25% increase in the number of referrals overall. Furthermore, the teams remained working in the community when buildings were closed, people were concerned about visits from the team due to COVID-19 and pandemic restrictions. Additionally, there were numerous requests from various universities requesting student placements that were required to ensure that students had achieved relevant clinical experience/time in order to graduate.
ACTIONS TAKEN	We introduced Home First/'Discharge to assess', aiming to provide early supported discharge, to include the provision of intensive rehabilitation which may have previously been provided in acute hospitals and to respond in crises to prevent admission where possible. New technology was quickly introduced, teams had to learn to use and adapt how best to support service users in the community ensuring safe delivery of services assisting service user to meet their outcome the team have adapted well to the use of new technology such as Microsoft teams and near me (secure appointment site, run by the NHS). They have changed practice to ensure that we still support citizen offering input via telephone, near me and conducting visits where required. The teams also developed new initiatives: 'Planned date of discharge (PDD)' and Home First/'Discharge to assess (D2A)', changing the way they delivered services to meet the needs of service users. PDD led to a 50% reduction in the delayed discharge of service users who were clinically ready to be released. Home First/D2A involves assessing the service user at home to identify any difficulties they may be experiencing in their day-to-day life because of illness, disability or physical difficulty. D2A led to 371 being assessed in their own homes, rather than waiting in hospital, over this period.

	Making Life Easier Clinics (to assess service users' equipment needs) could not be held, so the teams adapted their service and conducted what assessments could be safely carried out via telephone and near me appointments. Making Life Easier website remained available to people to use online assessment In addition to this, the teams have also offered OT and physiotherapy student placements recognising that the importance of students completing their clinical hours in order to qualify, placing additional demands on the teams. The rehabilitation teams have not been afraid to think beyond the traditional pathways and process offered by the service. They have actively challenged tradition to offer the best journey for service users, enabling them to achieve what is important to them and promoting positive risk enabling. In addition, they are about to commence on a new initiative using the life curve app to further support an active, healthy, ageing journey.
OUTCOME / IMPACT	Rehabilitation team assessment and intervention from March 2020 to April 2021 demonstrated in table below: 
MEASURES/ INDICATORS OF SUCCESS	**Feedback from users:** *Exemplary rehabilitation team – this is how it should be done. My mother was recently admitted to hospital as an emergency with severe pneumonia, which was complicated by a partially collapsed left lung and a very low serum sodium level, which had made her extremely confused and, eventually, unable to walk or stand. Before her admission, she had been socially active and a regular attender at local groups and family events, although deafness and slowly declining mobility sometimes made life challenging for her.* *She was admitted via Accident and Emergency into a medical assessment ward in January (probably the worst time of year to be admitted I feel, when acute services are under maximum pressure), then had several ward moves during her short admission. After a few days, she was medically fit for discharge, but remained a shadow of her former self. At discharge, she was referred to the Wishaw Rehabilitation Team under the 'Discharge to Assess' programme.* *Within two hours of discharge, she was assessed by an occupational therapist who gave us lots of helpful advice, always based on my mother's own wishes and needs. She then very rapidly organised personal home care services to help with washing and dressing in the morning and evening, hand rails to enable my mum to access her bedroom and bathroom upstairs, walking aids for both upstairs and downstairs, toilet adaptations, a key box, community alarm and inputs from wider team members, including a physiotherapist, the sensory care team and the local fire service.*

	This story is about the excellent person centred care delivered by this team, which is an example of the type of high quality rehabilitation services that enable people who are at high risk of being readmitted to hospital to remain in their own home.

Even better if …
(enablers to further the principles of integration and result in even better outcomes if …)

- Other services, such as social work, district nurse service and home support service also conducted discharge to assess.
- The ability to make Microsoft Teams calls and share files between health and social care members would assist with the principle of integration between teams and ensure better communication.
- Introduction of a multi-disciplinary team in each sector to deal with duty, avoid admission, discharge to assess and moving and assisting.
- Introduction of single-handed care practice across the partnership.
- SWIS Replacement was in place and other systems within the partnership could share information.
- The introduction of the 3-conversation model (strength-based approach), including changing how we document assessments and associated developments.
- The introduction of the recommendations with the Equipment and Adaptation Service Review.
- Further development of Making Life Easier Website to promote self-management and clinics.

NATIONAL HEALTH AND WELLBEING OUTCOMES	
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	x
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	x
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	x
5. Health and social care services contribute to reducing health inequalities.	x
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	x
7. People who use health and social care services are safe from harm.	x
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	x
9. Resources are used effectively and efficiently in the provision of health and social care services.	x
Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)	
1. Transforming the approach to improving health, wellbeing and independence	x
2. Building stronger community care systems and primary care services	x
3. Establishing a new focus on mental health	
4. Securing a sustainable acute hospital service and specialist care service	
5. Strengthening future partnerships to ensure a modern sustainable workforce	x

Links to any published reviews/evaluations	

Before submitting this example of good practice please ensure approval and sign-off by your head of service / chief officer.	
Approved for online publication *(signature and position)*	Ross McGuffie, Chief Officer
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