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Active Recovery Single Care Record

Date: 31 July 2024

Report of: Programme Manager, Active Recovery

Report to: Chief Officer - Strategy and Resources

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

Brief summary

Approval has been given to create and implement a new SystmOne unit for access by LCC Reablement staff and LCH Therapy staff to assist in the shared care of people using the Active Recovery service in Leeds.

Recommendations

The Chief Officer of Strategy and Resources is recommended to:

Approve the decision of 223k implementation/one-off costs plus £119k ongoing/recurrent costs for the creation and implementation of a new SystmOne unit for access by LCC Reablement staff and LCH Therapy staff.

What is this report about?

1 Active Recovery is a partnership between Leeds Community Healthcare NHS Trust and Leeds City Council, to combine forces to deliver a single, joint home-based short-term rehabilitation offer to the people of Leeds. The vision is to move from two pathways/two services/two organisations to a single pathway and service delivered by two organisations working in partnership.

2 The project started in 2022 with the establishment of the joint Triage Hubs to enable joint referral management.

3 Subsequently, under the auspices of HomeFirst, Active Recovery has implemented citywide improvements particularly focussed on reablement throughput and outcomes and, in the East/North of the city implemented a joint delivery team known as the 'pilot team'. The pilot team was established in August 2023 and is continuing to develop new ways of working ahead of citywide rollout.

4 The Active Recovery Pilot Team has enabled the testing of a new joint approach to delivering our service, enabling increased efficiency and effectiveness, with a 27% increase in people finishing the service with no ongoing care needs, and positive impact on overall workload.

5 The Pilot Team is currently working on two separate recording systems, undertaking separate paperwork and assessments. LCH staff use SystmOne whilst LCC staff use a combination of paper records for most recording, and CIS as an office-based record.

6 The pilot team has developed several work arounds to maintain safety and continuity. These include regular joint meetings, joint visits to undertake assessments, and shared access to several interim technological solutions to view patient information. However, despite these work arounds, the pilot team way of working is not sustainable and presents several risks to safety, efficiency and effectiveness. A Single Care Record would enable the work of the team with a person to be captured and would support shared care and delegation.

7 In January 2024 senior leaders in LCC and LCH agreed to progress with citywide rollout of the joint delivery model. It was determined that a Single Care Record was essential to this rollout in order to address the risks identified and support staff efficiency and effectiveness and deliver a joined-up service for the people we are here to support.

8 A Single Care Record Task and Finish group was established led by Dawn Greaves, Associate Director of Digital Transformation at LCH and James Weatherall, Service Manager at LCC, with involvement from digital colleagues in both organisations. The Task and Finish Group developed the options appraisal that had been undertaken in Autumn 2023. A recommendation from the options appraisal was to proceed to a Single Care Record using a new dedicated SystmOne unit – this option has been approved and funding sourced via the Market Sustainability and Improvement Fund.

What impact will this proposal have?

9 The benefits that can be derived from the implementation of a single care record are as follows:

Summary of benefits

- **Active Recovery can support more people**
  Reduction in hospital and short-term bed length of stay, enabling system flow, freeing up hospital and short-term bed capacity; (and, in time, step up capacity to enable people to be supported at home rather than requiring hospital admission, reducing long-term care requirements for people entering home care; and enabling home ward capacity).

- **Active Recovery can deliver better outcomes with people**
  The pilot area in the East has facilitated even further reductions in long-term care requirements in care homes and via home care. The pilot in the East/North contributes to 50% of the benefit to the city, with both the South and West making up the remaining 50%. By rolling out the ways of working adopted in the East, financial savings will increase. By introducing further improved ways of working with a Single Care Record, further savings opportunities will become reality.

- **Improve staff utilisation through reduction in duplication across LCC and LCH**
  Currently, both an LCC Case Officer and an LCH Occupational Therapist (OT) must do an assessment each on one patient. Moving to a Single Care Record would enable a single initial assessment to be completed and to record the outcome on SystmOne for staff from both organisations to view.
- **Improve staff utilisation through simpler, safer delegation**
  Currently, Therapists are unable to discharge a patient without a Reablement visit as the Reablement Case Officer has overall accountability for the patient's record. A Single Care Record will eliminate this need, enabling delegation to the Therapist, therefore saving Case Officer resources. The workload of Therapists will need reviewing to evaluate the impact of this change.
- **Reduce unnecessary visits**
  Timely, live data on SystmOne will reduce unnecessary 'wasted' visits of SkILs Workers and Case Officers in LCC.

- **Improve staff retention**
  A Single Care Record will contribute to better working processes for our staff, in turn helping to relieve over-worked staff and simplify processes that 'drag down' day to day staff experience and satisfaction. The Pilot team has worked on two separate patients' records, with LCH working on SystmOne and LCC completing paper-based records. For a therapist to have clinical oversight of Reablement case notes, and expand the Rehabilitation offer, they require all LCH Therapy and LCC Reablement patient notes to be on one care record. Having notes on one record will allow more scope to reduce visits quicker and create more capacity for patient flow. Due to the aging population, it is anticipated that referral numbers will increase therefore creating more capacity and flow is essential.

  In other areas of the city, LCC Reablement and LCH Therapy are not integrated into one team and there are two separate rehabilitation offers and some patients are under the care of both LCH Therapy and LCC Reablement with different rehabilitation goals. Merging the two rehabilitation offers together to create one offer has been found to improve patient outcomes and reduce hospital re admissions. To avoid duplication and create more capacity, a single care record is required.

  The Leeds Health and Wellbeing Strategy 2023-2030 acknowledges that our health and care workforce is facing pressures both inside and outside the workplace. Worsening mental and physical health is a real concern. We have a highly motivated, creative and caring workforce in our city, working hard to deliver high quality care for people in Leeds. But we need to create the conditions that enable them to thrive in work. This means giving our employees the right skills for the future, expanding career opportunities, offering flexible working, and ensuring they have access to the best technology and training.

  The Healthy Leeds Plan outlines the health and care contribution towards delivering the vision of the Health and Wellbeing Strategy. It sets out the high-level ambitions for improving health outcomes for the people of Leeds both collectively and at a population level. The Plan describes two overarching system goals that the Leeds Health and Care Partnership are collectively committed to delivering, and priority areas of focus in relation to delivery of the goals. These goals are to **reduce preventable unplanned care** use across health settings and increase early identification and intervention (of both risk factors, and physical and mental illness).

  A Single Care Record will improve the service provided by Active Recovery as a whole, thereby contributing towards the Healthy Leeds Plan and the Leeds Health and Wellbeing Strategy.

- **Digital improvements**
  A Single Care Record will bring the SKiLS Reablement service into a fully digitised service record, in line with national requirements.

  There is a strong link to the Leeds Digital Strategy, which aims to make better use of data and technology, by taking a person-centred approach to service design and delivery. This will improve the way we can support

people in their daily lives, helping them achieve their ambitions and overcoming any challenges they may face.

This Single Care Record will work towards the Leeds Digital Strategy aim of 'Living and Ageing Well', where the aim is to utilise new technologies to deliver health and wellness services tailored for individuals and ensure that peoples' information follows them through their journey regardless of the organisation they are interacting with. A Single Care Record will contribute to achieving the Leeds Digital Strategy in several ways including:

- Ensuring information can be shared between partner organisations, adhering to rigorous information governance policies and procedures.
- Data sharing between services/organisations - deliver shared infrastructure and improved joined-up working.
- Acceptance of new digital technologies and digital services - promote the city as a centre of innovation excellence that champions co-produced innovation and idea development.
- The ability for everyone to analyse and interpret data.
- Data driven planning and improvement of services.
- Improved understanding of population health that drives understanding, decision making and the proactive targeting of services.
- Assurance that people have confidence that their personal data is being managed appropriately.
- Access to the data and information that services need.
- Access to comprehensive information about the people using services without having to rely on people to 'fill the gaps' and explain multiple times.

- **Improved People's Experience**
  Leeds Active Recovery - joined up care with rehab at the centre (youtube.com)

- **Collaboration**
  The Leeds Health and Wellbeing Strategy 2023 to 2030 reaffirms our vision to be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest. The people of Leeds have told us what is important to their health and wellbeing; they want to see that care that is **communicated well, coordinated** and compassionate. We will do this through **collaborative working** and **bold leadership**.

  The refreshed strategy has been launched at a time when we have seen great progress in the transformation and integration of our health and care system. The creation of the Integrated Care Boards and Integrated Care Partnerships as part of the wider health and care system in Leeds gives us the opportunity to make more progress on what matters to our communities. Partnerships at all levels: neighbourhood, local, regional and national, will help us achieve our vision.

  Preventing people needing expensive reactive, acute or emergency care will be a priority in this strategy as we see all public services facing an unsustainable rising tide of demand. As part of an integrated system, people and organisations will work together to develop joined up health and care services that focus on the people who use them. Improving health services also needs to happen alongside maintaining financial sustainability. This remains a major challenge. Rising cost pressures and sustained and increasing demand of health and care services means making the best use of the collective resources across organisations and sectors.

  A Single Care Record facilitates these aims of communicating well, being coordinated and working collaboratively. The Active Recovery service will contribute to preventing acute and emergency care.

- **Value for Money**

Recurrent costs for implementing the Single Care Record are £119k, estimated to deliver £308.5k savings in staff time, in addition to enabling Active Recovery rollout which will deliver additional benefits to people and savings in long-term care requirements.

- **Service improvements**
  The Active Recovery model is not sustainable without a Single Care Record to enable effective joint delivery and support staff to ensure shared care and delegation. This has been identified as an essential requirement for the service and a lack of a Single Care Record will pause rollout. Active Recovery is a core component of the city's intermediate care offer with this rollout setting the foundations for future development of home-based intermediate care services.
  By investing in this solution now, further opportunities for digitally integrated working within other Alliance services will be easier to rollout in the future (for example, within Rehab and Recovery Beds).

- **Data and reporting improvements**

  Current reporting is piecemeal with data being drawn from CIS for SkILS reablement and SystmOne for LCH Neighbourhood Teams. This does not support a unified view of the offer to support effective working and visibility of Active Recovery as a whole at team, service, system level. There are also limitations to sharing with care delivery partners including primary care, as Active Recovery is not all on one.

How does this proposal impact the three pillars of the Best City Ambition?

☒ Health and Wellbeing ☐ Inclusive Growth ☐ Zero Carbon

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What consultation and engagement has taken place?

Wards affected: All Leeds wards		
Have ward members been consulted?	☐ Yes	☒ No

11 Elected Member has been briefed on 27 June 2024.

12 Adults and Health DLT and Leeds Community Healthcare Trust Leadership Team have been briefed and agreed the proposal.

13 Digital Board has approved the proposal.

What are the resource implications?

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Costs

- Implementation costs can be covered by the Market Sustainability and Improvement Fund (MSIF)
- Recurrent costs (£120k) may also be covered for 24-25 from the MSIF and would be part-year initially (dependent on implementation date). Costs will be built into 25-26 and future years, with offsetting savings from reviews. There is a small risk that the MSIF will not be recurrent, but our position is to assume it will continue. If the funding does drop out, we will have to determine alternative funding/savings to ensure this work continues.

Assumptions are:

- IT Hardware costs are being covered by LCC.
- Microsoft Office 365 license costs are being covered by LCC.
- If 4G sims are required these costs are being covered by LCC.
- LCC will have their own HSCN connection.
- There are no additional reporting requirements for LCH and that all that will be required for LCC is an automated data extract that LCC can import to a warehouse for reporting on.
- There is no expectation to receive any funding in LCH to operationalise the new unit, except the SystmOne licensing costs. All other costs are sunken costs. LCH will require recurring funding to support ongoing.

Item	Costs
Implementation (non-recurrent)	
Laptop Device inc Smartcard reader (175 staff x £850)	£150k
CIS development for SystmOne export (*may be delivered within existing staff through prioritisation of this work within IDS)*	£22k
Clinical systems/training/support *(assume delivered within existing staff through prioritisation of this work within LCH clinical systems team)*	£51k
Total (implementation/non-recurrent)	**£223k** (£140-162k actual)
Ongoing costs (recurrent)	
SystmOne licencing costs	£45.6k (inc VAT)
Systems support (systems support, training, admin, BI) – *contribution to LCH clinical systems team costs*	£74k
Total recurrent	**£119.6k**

What are the key risks and how are they being managed?

Risk	Mitigation
As result of a lack of priority, capacity, capability, funding, there is a risk that there is insufficient support to enable timely progress with improvements to Active Recovery at Home systems, resulting in a delay to delivery of benefits to staff experience and efficiency, people's outcomes, and system impact.	AR systems task and finish group established to confirm approach and resource requirements; Agreed to progress dedicated unit on SystmOne; discussions with CityDigital group to support prioritisation of this development; business case to be developed. Funding identified to support implementation and develop project plan.
Due to a lack of shared understanding of AR capacity and demand requirements for citywide rollout, competing demands for NT therapy capacity, and overall gaps in workforce availability there is a risk that citywide rollout of AR will be delayed leading to reduced impact on people,	Detailed capacity and demand modelling being led via AR workforce task and finish group to inform plans on rollout and quantify risk. This modelling is dependent on availability of systems to support new ways of working.

negative impact on staff morale and inequity in offer.	

What are the legal implications?

15 Legal implications revolve around information governance and the use of people's personal data. These implications will be included and mitigated throughout the design and build of the new single care record.

Options, timescales and measuring success

16 What other options were considered?

Option 1 – Expand use of current SystmOne units used by LCH to LCC

Single Care Record for Active Recovery (LCC and LCH) using existing system set up in LCH

CHOSEN OPTION: Option 2 – New SystmOne unit for LCC and LCH, hosted by LCH

Single Care Record for Active Recovery (LCC and LCH) delivered by creation of new standalone SystmOne unit, hosted by LCH but accessed by Active Recovery staff from both organisations.

Option 3 – SystmOne, CIS and Shared Care Record

System for each service delivery organisation with holistic service user view provided by a shared care record.

How will success be measured?

17 By achievement of the benefits outlined in section 10 above.

18 Active Recovery will have a set of KPIs attached to the service and the monitoring of these KPIs will be achieved, in part, by the single care record.

19 The aim of the service is to improve the outcomes for the people of Leeds enabling them to remain in their own homes for longer with the right short-term rehabilitation offer. Overall success will be measured against this aim.

What is the timetable and who will be responsible for implementation?

21 Delivery will consist of 3 key workstreams over an estimated timeline of c. 42 weeks, c. June 24- Mar 25, although the IT teams are investigating if this can be done quicker (senior leadership request for systems to be in place by 1 December to support winter pressures).

22 SystmOne Unit Configuration, to be undertaken by LCH Clinical Systems Team working with the Active Recovery service – this will also need to include consideration of data flows and reporting for both LCC and LCH.

23 User Training to be delivered by Clinical Systems Team working with Active Recovery leadership and LCC Digital Skills team **Staged Roll out** to Active Recovery teams across the city

24 Appendices

- Equality Assessment.

25 Background papers

None.