WIRRAL COUNCIL

HEALTH AND WELLBEING OVERVIEW AND SCRUTINY COMMITTEE:
1 NOVEMBER 2010

REPORT OF THE DIRECTOR OF ADULT SOCIAL SERVICES

HOSPITAL DISCHARGE REVIEW FROM DISCHARGE TURNAROUND TEAM

Executive Summary

This report summarises the actions which have been completed from the Turnaround Team report which was commissioned in January 2010 by the Chief Officers of NHS Wirral, Wirral University Teaching Hospital Foundation and the Department of Adult Social Services. The aim of the report was to improve the experience for people being discharged from hospital.

This item falls within the Social Care and Inclusion portfolio.

1 Background

1.1 In January 2010 a report was commissioned by the Chief Officers of NHS Wirral, Wirral University Teaching Hospital Foundation Trust (WUTH) and Department of Adult Social Services (DASS) the remit of the report was to;

- Identify the factors which contribute to the unsatisfactory patient/person experience and the reasons for delays in patients receiving appropriate care.
- Make recommendations which facilitate the achievement of the shared objective.
- Consider the cultural issues which may contribute to the sub-optimal operation of the current system and make recommendations for improvement.
- Suggest a range of Key Performance Indicators (KPI)/performance dashboard which will facilitate strong local performance management and early identification and rectification of operational problems.

1.2 The report and the recommended actions arising were shared within the three organisations as an agreed template for improvement. This report will outline the actions completed to date and the actions outstanding.

2 Key actions implemented

2.1 <u>Formation of an integrated discharge team</u>
The Social Workers and Assessment and Support Officers employed by the Department of Adult Social Services have been co-located with the Patient Flow Practitioners employed by the Acute Hospital Trust, to ward 42 within Arrowe Park Hospital.

This was to improve the discharge process by integration of key professionals involved in the patient journey. The location also houses the patient advocacy scheme and the voluntary home from hospital service. There is also an agile working space for staff from the Home Assessment and Reablement Team (HART).

2.2 Implementation of Social Care Pathways to Support the Primary Care Assessment Unit

An Assessment and Support Officer has been appointed to work with the Primary Care Assessment Unit (PCAU) which was set up to prevent hospital admissions. The post has been successful in supporting the medical team by providing low level and preventative support to people to maintain them within the community.

2.3 Improved information for carers

Marketing events providing information about a range of Adult Social Services provision are taking place in a kiosk in the main foyer of Arrowe Park Hospital. Information is available for carers to register with WIRED and there has been good uptake for this.

From 6 September, pre-publicity about personal budgets and assistive technology went on display in the hospital foyer and this remains in situ, directing people to (Central Advice and Duty Team) CADT for further information. Future events are planned including information about the smart house and assistive technology

Work is also underway with GP surgeries to identify carers who are not known to Adult Social Services but would need to access help quickly if they suddenly became unable to care. This will build upon the current concept of a registration system but with the aim to have a single registration point and to implement an emergency response system.

2.4 Capacity Management

The Deputy Chief Operating Officer for the acute trust has corporate responsibility for bed management. Standard presentation of information on bed capacity and demand is in place at bed meetings seven days per week. A standardised handover of information to duty managers is in place.

Weekly extended length of stay figures are published and issued to the executives and senior divisional management teams. The lead nurse in the medical division is tasked with ensuring that patient pathways are being proactively managed. Within the medical division each ward is set weekly discharge targets. Actual discharges are reported weekly and reviewed by managers and clinical teams to ensure effective patient flow.

The Department of Adult Social Services have had negotiations with the independent domiciliary care providers to look at ways of improving response and capacity within the system to support more timely discharges. Care management processes within the hospital have been amended to support this.

2.5 Review provision of Single Point of Access via the unplanned Care Services with a view to diverting all GP referrals that require a hospital admission via the Primary Care Assessment Unit (PCAU) initially

Following assessment at PCAU if hospital admission is required then PCAU would arrange this via Wirral Hospital University Trust. This has been in place since May 2010. The recently appointed Clinical Directors for Urgent Care for WUTH and primary care are revising the clinical pathways between WUTH/PCAU and vice versa, to ensure that patients are seen in the right place by the right clinician at the right time.

2.6 Review current form and function of Provider Services Discharge Team (PSDT), incorporating extended hours/provision, involvement in end of life care, links with localities structure regarding Community Nursing referrals and Continuing Health Care involvement

Complete, and PSDT commencing extended hours and weekend provision on 2 October 2010.

2.7 Review current provision of Community Equipment Service regarding hours/provision, list of equipment, online ordering for Wirral University Teaching Hospital staff

Complete and increased provision of equipment to WUTH for discharge implemented.

2.8 Implementation of Estimated Dates of Discharge

Following two multi agency workshops that were facilitated by WUTH and which used Kaizen efficiency improvement methodology a system of work called multidisciplinary board rounds were piloted on acute medicine for the elderly wards from May 2010.

The board round system uses estimated dates of discharge and a multidisciplinary approach to improve the discharge planning process. This work has been driven by the Medical Division and from 4 October 2010 daily Multi Disciplinary Team (MDT) board rounds have been established on all medical, acute medicine for the elderly and elderly rehabilitation wards. Estimated dates of discharge are established within 24 hours of admission and reviewed at the daily MDT board round. This system also acknowledges the need for social care staff to be involved earlier within the discharge planning process. Patient flow practitioners have been designated to work with named wards; social work, occupational therapy and physiotherapy have adopted the same model so that named MDT's are linked to wards.

2.9 Integrated Care at Home

Wallasey locality has been piloting an integrated care at home scheme which involves a multidisciplinary approach to problem solving. This has proved very effective but has highlighted the need for community access to intermediate care step up facilities. Bebington and West Wirral and Birkenhead localities are about to implement similar models.

3 Outstanding actions

3.1 Consider models of provision for nursing/residential care home patients. Incorporating a single point of access for this patient group, telephone triage, assessment via nursing/GP based at all day health centre/PCAU

This recommendation was placed on hold by Chief Executives due to other developments within Urgent Care including Single Front Door. Appointment of Clinical Director for Unplanned Care is currently reviewing this recommendation with a view to implementation.

3.2 Review of the intermediate care pathways

Over the summer a review of the patient journey through intermediate care was undertaken by the Strategic Health Authority on behalf of the local health and social care partners. The findings from this utilisation review were reported to stakeholders at the end of August. The main issues identified by the review were: -

- There is poor access to intermediate care from the community
- Access to medical care could be improved
- Length of stay could be improved (although the report acknowledged that Wirral sites are performing better than other parts of the country)
- Readmissions to hospital could be improved
- Poor psychological support for people in the system
- Management of discharges could be improved with discharges being spread more evenly over the week
- Fragmented clinical notes
- Lack of input from medicines management

These findings are being used to inform a review of the criteria, pathways and delivery of intermediate care.

3.3 Further Actions

There are a number of further outstanding actions which relate to the modeling of community support services required to enable hospital discharges and admission prevention. This needs to be supported by joint commissioning decisions. These models will need to be progressed within a wider strategic agenda of transfer of funding responsibilities from NHS Wirral to GP consortia and be informed by other developments such as the proposals of the Task Force groups and council consultation proposals regarding service priorities.

4 Financial Implications

The achievement of timely discharges from and appropriate prevention of admission to hospital, provide financial benefits across both the health and social care system.

5 Staffing Implications

There are no direct staffing implications that arise from this paper.

6 Equal Opportunities Implications/Health Impact Assessment

There are no equal opportunities or health impact assessment issues that arise directly from this report but the individual improvements in service delivery described within the report will have positive impacts on health and wellbeing.

7 Community Safety Implications

There are none directly arising from this report.

8 Local Agenda 21 Implications

There are none directly arising from this report.

9 Planning Implications

There are none directly arising from this report.

10 Anti Poverty Implications

There are none directly arising from this report.

11 Social Inclusion Implications

There are none directly arising from this report.

12 Local Member Support Implications

There are none directly arising from this report.

13 Health Implications

The improvements described will improve the health and social care economy.

14 Background Papers

Turnaround Team report.

15 Recommendations

That Members note the content of this report.

JOHN WEBB
Director of Adult Social Services

Name Anne Bailey
Title Service Manager
Ext no 666 4839

Date 13 October 2010