WIRRAL COUNCIL

HEALTH & WELLBEING OVERVIEW & SCRUTINY COMMITTEE

8 NOVEMBER 2011

SUBJECT:	***REPORT OF PROGRESS MADE TOWARDS NHS INTEGRATION RE: HOSPITAL DISCHARGE/STAR SERVICE***
WARD/S AFFECTED:	***ALL***
REPORT OF:	***HOWARD COOPER***
RESPONSIBLE PORTFOLIO HOLDER:	***COUNCILLOR ANNE MCARDLE***
KEY DECISION	**NO**

1.0 EXECUTIVE SUMMARY

1.1 The purpose of this report is to update members on the progress of integration between health and social care services that will support hospital discharges and prevent unnecessary hospital admissions. The report covers 4 areas of service development:

- The development of the Rapid Access Service
- The reprovision of reablement services
- The further integration of the hospital discharge team
- The reprovision of intermediate care beds

These service developments are taking place as part of the introduction of a new model of service called 'team around the adult'. This has been developed to improve outcomes for service users by ensuring that they receive the right support at the right time, and the arrangements for moving onto different services as part of a pathway of recovery and rehabilitation are effectively co coordinated.

1.2 The integration of such services will support the Council's corporate priority of ensuring that the widest possible options for care and support are made available to Wirral residents and that those services help people to gain full independence after serious illness. The provision of hospital discharge services under the community care legislation and delayed discharges act is a statutory function for the department of adult social services. Effective services that support hospital discharge or prevent avoidable admissions financially benefit the whole health and social care economy.

2.0 BACKGROUND AND KEY ISSUES

2.1 In November 2010 a report was brought to Overview and Scrutiny Committee to update members on planned improvements in the hospital discharge pathways and services. Following that report there have been a number of

new initiatives which have been implemented and an update is contained within this report.

2.2 **Implementation of the Rapid Access Service**

2.3 The Wirral Rapid Access Service is a service that provides short term temporary support (a maximum of two weeks) through the provision of domiciliary care in the home or a care placement for service users on discharge from hospital or to prevent a hospital admission.

2.4 The service is commissioned by NHS Wirral and the Wirral pathfinder Clinical Commissioning Groups primarily to reduce delayed discharges at Arrowe Park Hospital during the period of winter pressures, but also to improve access to social care from the community to avoid unnecessary hospital admissions.

2.5 The service is accessed by partners across the health and social care economy including the Department of Adult Social Services, Wirral University Teaching Hospital, Wirral Community Trust and provided by several independent sector providers of domiciliary care and care homes.

2.6 It provides rapid and immediate access (within 24 hours of referral) to domiciliary care packages and care home beds for up to 2 weeks, with the support of locally integrated health and social care multidisciplinary teams in the community who ensure that support is arranged after the two week period is completed.

2.7 The service began in December 2010 as part of a number of initiatives to deal with the seasonal increase in admissions at Arrowe Park hospital and to ensure that patients could be safely transferred when they were ready for discharge. It provided additional capacity to discharge provision and the other ranges of services and has been very successful in reducing the period of time that patients are delayed in hospital.

2.8 An analysis of the impact on Arrowe Park hospital of the service has confirmed that it has saved 14,759 hospital beds to date. In addition there has been a further positive impact by a significant reduction in delayed discharges from 200 days in October 2010 to 20 in July 2011. Wirral is now has the 2nd lowest level of delayed discharges compared to all other PCTs in the North West of England; and Wirral University Hospital Teaching Hospital have reported a significant improvement in hospital throughput during 2011. The key success of this service is the support provided by health and social care teams in the community to ensure patients are supported into services that they require after the two week period.

This infrastructure has been developed over a number of years and has provided the basis for a more effective planning and support of patients with health and social care needs in the community.

2.9 The benefits of the scheme have been recognised through it being shortlisted for a National Health Service Journal Award in Quality and Productivity with the result to be announced on 15 November 2011

3.0 REPROVISION OF THE HOME ASSESSMENT AND REABLEMENT SERVICE

3.1 The Short Term Assessment and Reablement (STAR) Service was commissioned as part of the wider council efficiency plan in 2010/11, and as a replacement to the well established HART service which provided active rehabilitation and support to service users in their own homes for a six week period for the purpose of recovery and regaining independence..

3.2 The new STAR service required that the direct provision of enablers would be sourced by external providers with the assessment function of the service remaining in house.

3.3 Following a tender process three providers have been contracted to work in a partnership arrangement with the Department of Adult Social Services to deliver the enabler element of the assessment and reablement service. The STAR assessment function has been co located into locality teams to embed the practice of offering reablement to any new service users prior to the commencement of support planning.

3.4 The three agencies commissioned were Local Solutions, working primarily in Birkenhead, Professional Carers, working primarily in Wallasey and Housing 21 working within Bebington and West Wirral, but also providing a Wirral wide service to support hospital discharges.

3.5 At the beginning of May, following a period of reablement training for agency staff which was delivered by DASS, the service began accepting new referrals. Data from the new service indicates the following:

- 474 referrals have been received by the new STAR service since it came into commission in May 2011
- 163 people have been discharged from the service without needing ongoing support
- 218 people have been discharged requiring reduced support
- The average length of stay in the service is 3.5 weeks
- As a snapshot of activity on 13 July, 153 people were receiving the service

3.6 As a final part of the STAR reprovision project In November the hospital STAR assessment team will move to be based on ward 41 at Arrowe Park to join the already established Integrated Discharge Team. The move will enable the STAR service to be able to provide a seven day a week service and maximise the support offered to service users on discharge from hospital. Other planned benefits will be better communication and efficiency to improve patient outcomes.

4.0 INTEGRATED DISCHARGE TEAM AND DISCHARGE PLANNING

4.1 The primary and critical issue in relation to supporting timely and seamless hospital discharges are the operational arrangements for communication and joint working across the health and social care professionals.

4.2 The co location of health and social care professionals on ward 42 at Arrowe Park Hospital, with the aim of improving joint working occurred last year. This has strengthened the discharge planning process and improved joint working with health social care housing and the voluntary sector staff on site.

4.3 In addition a new initiative on hospital wards has been introduced called the 'Board Round'. This involves a daily meeting to assess patients progress to discharge with all the relevant staff involved. This has now been implemented on the majority of wards following a multidisciplinary Rapid Improvement Process Workshop hosted by Arrowe Park. Further to this it has been identified that all professionals involved in the discharge planning process would benefit from training to develop their skills in planning for more complex discharges.

4.4 As part of these improvements a steering group of health and social care representatives has been established to pull together a suitable training and competence programmed which will be provided to multidisciplinary groups of staff within the hospital. This will also include social care staff. A core concept within the training will be to support the model of the 'team around the person' to ensure smooth transitions for people moving from hospital into community care pathways. This has been further supported by the implementation of new systems of monitoring the discharge activity within the integrated discharge team.

5.0 REPROVISION OF INTERMEDIATE CARE BEDS WITHIN GROVE HOUSE AND HOYLAKE COTTAGE HOSPITAL

4.5 Intermediate care is a service that provides short term time limited (a maximum of six weeks) programmes of rehabilitation and recovery for service users in care homes. The service needs to be provided as part of a discreet unit with a dedicated therapeutic support provided by occupational therapists and physiotherapists. As part of the councils wider efficiency plan in 2010/11 a decision was made to reprovide intermediate care under new contracts exclusively in the independent sector which required the closure of the Pensall and Poulton council residential care units.

4.6 Following a tender exercise two providers were selected to provide intermediate care. These are Grove Nursing Home and Hoylake Cottage Hospital (Residential and Nursing Home). It is planned to provide 40 intermediate care beds within the dual registered facilities which can flexibly accommodate people with a range of needs through a period of recovery and rehabilitation.

4.7 Intermediate care requires additional infrastructure to support therapeutic programmes of recovery, and dedicated clinical and social care support. In

response DASS has supported the development of a full time dedicated social worker has been appointed on a pilot basis with a view to improving throughput and outcomes for service users within the units. There is also a dedicated therapy team funded and delivered by the health community trust, clinical input funded by the PCT, and planned for sessions from a community geriatrician service.

4.8 The medium term plan is to have 20 beds being provided by both units by March 2012. In the interim period Grove House has been providing 30 beds. Hoylake Cottage began taking service users in September 2011 with a view to expanding its provision by the aforementioned date.

4.9 There remain some contractual matters to resolve with regard to this provision. Performance measures have also been included in the contract specification to ensure that the provision is used to best effect. A project is in place to ensure that pathways in and out of the service are underpinned by the 'team around the adult' model. This will include outcome measures where the impact of rehabilitation will be measured and quality assured.

4.10 Intermediate care is a shared initiative with NHS Wirral and discussions are underway to confirm long term shared funding arrangements for this service

6.0 RELEVANT RISKS

6.1 The support of patient flow through the acute hospital trust is a critical area for the council and its health partners due to the impact upon the health and well being of Wirral residents

7.0 OTHER OPTIONS CONSIDERED

7.1 This report is of information on progress only and does not require a development of options.

8.0 CONSULTATION

8.1 No consultation requirements are directly arising from this report.

9.0 IMPLICATIONS FOR VOLUNTARY, COMMUNITY AND FAITH GROUPS

9.1 Voluntary community and faith organisations are already involved in the support of hospital discharge arrangements but are not directly affected by this report.

10.0 RESOURCE IMPLICATIONS: FINANCIAL, IT, STAFFING AND ASSETS

10.1 None arising directly from this report.

11.0 LEGAL IMPLICATIONS

11.1 None arising directly from this report

12.0 EQUALITIES IMPLICATIONS

12.1 Has the potential impact of your proposal(s) been reviewed with regard to equality?

No but the impact of some of the service developments described within this report have already been equality impact assessed.

13.0 CARBON REDUCTION IMPLICATIONS

13.1 There are no environmental issues arising directly from this report.

14.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

14.1 There are no planning issues arising from this report.

15.0 RECOMMENDATIONS

15.1 That members note the information contained within this report.

16.0 REASON/S FOR RECOMMENDATIONS

16.1 To confirm the direction of travel and member support for making further improvements on the discharge of service users from hospital and their rehab.

17.0 PLANNING AND COMMUNITY SAFETY IMPLICATIONS

17.1 None.

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APPENDICES

None.

REFERENCE MATERIAL

None.

SUBJECT HISTORY (last 3 years)

Council Meeting	Date