Paper 7

NHS Ayrshire & Arran

East Ayrshire Community Health Partnership Committee

4th April, 2011

Services for Rehabilitation and Enablement for Cumnock Hospital

SEARCH - Interim Report

Subject	**Community Rehabilitation and Enablement Service East Ayrshire Community Hospital Interim Report**
Purpose	• **To advise the CHP committee of progress to date** • **To highlight issues requiring further consideration**
Recommendations	• **The Committee acknowledges progress to date** • **The Committee endorses the relevance of this report in light of the Reshaping care agenda.**

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1. BACKGROUND

1.1 East Ayrshire Community Health Partnership OLG identified rehabilitation and enablement as a priority issue within their CHP sub structure.

1.2 The agreed model for rehabilitation and enablement includes:

- The establishment of integrated community rehabilitation and enablement services across East Ayrshire
- A single point of contact used to access a menu of rehabilitation and enablement services across the care spectrum,
- Rehabilitation hubs within the localities around which integrated services should be developed.
- Integration of the nationally agreed falls prevention and management pathway.
- A focus on improved access to services e.g. community equipment

2. CURRENT POSITION

2.1 Within East Ayrshire CHP, at present, an incremental approach is being taken to

service change, taking account of the services and management structures already in place. Redesign activity is currently focusing on the areas of north and south East Ayrshire, focusing on the establishment of two proposed hubs, East Ayrshire Community Hospital (EACH) and Kilmarnock (hub yet to be agreed).

2.1 Current pilot work is taking place within Cumnock Hospital (EACH), supported by the service improvement team, involving current early/supported discharge arrangements, locality social care teams, rapid response team, home from hospital, hospital social work teams and day hospitals. This development work is identified within the Transformational Plan through Reshaping Care for Older People

2.3 A series of meetings have been held within EACH, with full representation from a range of services, These meetings have focused on the opportunities for the development of a single point of access to a range of integrated community rehabilitation and enablement services the EACH operational group.

2.4 The group mapped the appropriate services, and agreed a proposed pathway to pilot integrated service *(Appendix 1)*.

3. PROGRESS TO DATE

3.1 Early implementation work was commenced on 30th August at EACH. The pilot has focused on clear referral criteria, which includes multidisciplinary referrals from the Cumnock and Ballochmyle GP practices and early supported discharge opportunities from within Burnock Ward. The focus for the pilot is to prevent both acute and community hospital admissions and support early discharges from East Ayrshire Community Hospital.

3.2 The pilot uses a single telephone number for all referrals and triage, utilising day hospital staff to answer calls, receive and manage referrals. This number is the current day hospital number, with the team available from 9-5, Monday to Friday. Current out-of-hours numbers are utilised as normal. The team agreed that daily allocation meetings, which progressed to three meetings per week, provided adequate opportunities for allocation and MDT discussion of individuals.

3.3 The virtual team members come from:

- Occupational Therapy (additionally funded 3 days per week)
- Physiotherapy
- District Nursing
- Day Hospital
- Dietetics
- Speech and Language Therapy
- Burnock Ward
- Support Assistant(Home from Hospital service)
- Geriatrician
- GP

These staff members are currently employed within existing services, and are bringing their expertise and resource to this initiative whilst continuing to deliver mainstream services.

3.4 Rapid Response Team paperwork is being utilised to provide continuity across the NHS system. Access to individual social services information is obtained by the social work office within the hospital, through accessing single shared assessment information. The activity information has been collected and entered into the rapid response database, which has allowed collation and formation of report *(Appendix 2).*

4. OPPORTUNITIES

A number of opportunities exist to further develop this work :

- The further development of a Single Point of Access to services. This would include full administration support to enable SPOC to provide the contact point for a range of rehabilitation and enablement services (see Appendix 3)
- Alignment, through redesign, of staff to support capacity issues to allow improved response times, expand supported discharge opportunities, and manage increasingly complex patients (SPARRA)
- Further develop integration of primary care services, e.g. pharmacy and GPs, to support the case management of long term conditions or end or life patients
- Improved links with District nursing services, other specialist nurses, and services
- Further develop the existing supports provided through geriatricians, and day hospital.
- Further develop communication systems between mainstream and home from hospital home care staff.
- Development of a referral point for repeat fallers, through community alarms, for assessment and management.
- Joint training plan developed
- Integrate talking points methodology/ outcomes approach to assessment, care planning and discharge.

5. CHALLENGES

There have been a number of challenges to the commencement and development of this initiative.

- Capacity of staff working within the virtual team, whilst continuing current roles within prospective organisations
- Duplication of assessment processes and paperwork
- Operational administration and co-ordination role, database support
- Referral criteria development and communication
- Engagement with referrers
- Storage of records and paperwork
- Integration of Single Shared Assessment paperwork
- Case/Care management of appropriate patients

6. NEXT STEPS

- This report is considered through partnership structures, as an excellent starting point for hub development.
- Development group and staff are integral to the development of the next steps, including reshaping care progress
- The group approve the progress and continue to support SEARCH
- To support the continued development of integrated health and social care service models within EACH.

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On behalf of SEARCH Development Group

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