Paper 4

East Ayrshire CHP Forum

10th September 2010

Subject	**Community Rehabilitation Service East Ayrshire Community Hospital (EACH)**
Purpose	**To advise the CHP Forum of progress to date To highlight issues requiring further consideration**
Recommendation	**The CHP Committee is asked to note the implementation of the community rehabilitation service in EACH from Monday 30th August 2010, for a pilot period of 6 months in the first instance.**

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1. Background

1.1 East Ayrshire Community Health Partnership OLG Adults and Older People has identified rehabilitation and enablement as a priority workstream within their CHP sub structure.

1.2 The agreed model for rehabilitation and enablement includes:

- The establishment of integrated community rehabilitation and enablement services
- A single point of contact used to access a menu of rehabilitation and enablement services across the care spectrum,
- Rehabilitation hubs within the locality 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

1.3 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 around the areas of the north and south of East Ayrshire, focusing on two proposed hubs, East Ayrshire Community Hospital (EACH) and Kilmarnock (hub yet to be agreed). Current service mapping is taking place within these areas, 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.

2. Current Position

2.1 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.

2.2 The group have mapped the appropriate services, and have agreed a proposed pathway to pilot the integrated service.

3. Proposals

3.1 It is proposed to undertake a 6 month pilot, which will test the opportunities for integrated team working. The pilot will focus on a clear referral criteria, which will initially look at multidisciplinary referrals from the Cumnock GP practice and early discharge opportunities within Burnock Ward with the intention to roll out to other local GP practices as the pilot develops. The focus for the pilot would be to facilitate early discharge and prevent both acute and community hospital admissions.

3.2 The pilot would also use the concept of a single telephone number for all referrals and triage, utilising a co-ordinator and daily allocation meeting format to develop integrated working practice. This number would be the current day hospital number, and would initially be from 9-5, Monday to Friday. Current out-of-hours numbers would be utilised as normal.
Weekly multi-disciplinary meetings would allow fuller discussion of individuals and weekly review of the functioning of the pilot. Multi-disciplinary meetings would take place within the day hospital, avoiding patient contact time.

3.3 The virtual team members would come from:

Occupational Therapy
Physiotherapy
District Nursing
Day Hospital
Speech and Language Therapy
Dietetics
Burnock Ward
Social Work Teams, both hospital and area teams
Administration

To avoid duplicate assessment, joint paperwork will be agreed using Single Shared Assessment, with facilitated access to shared databases. Opportunities for case/care management will be considered incrementally.

3.4 The proposed start date for this pilot service is the 30th August, with a regular review and process incorporated.

3.5 This service change will be seen as the starting point of an incremental service

delivery improvement and redesign process, supporting shifting the balance of care.

4. Benefits/Outcomes

4.1 The EACH community rehab and enablement services group will utilise measurement tools and learning from Rapid Response Service and other community services to identify service benefits, and to measure and report pilot outcomes.

Data gathered will include:

- Referral rates
- Accepted referrals
- Assessments
- Treatments provided
- Outcomes
- Day hospital/ day care activity
- Non-accepted referrals and reasons
- In-patient bed days saved due to:

  a) prevented hospital admissions
  b) early discharge from GP unit

- Individual pathway costings
- Patient feedback
- Staff feedback

5. Risks

5.1 The key risks are related to capacity and managing expectation.

There is also a risk that current IT systems will not support an integrated approach.

Contingency plans will be developed as part of the implementation process to manage these risks.

6. Resource Implications

6.1 The pilot will commence within existing budgets and staffing levels. Further work is being carried out to identify opportunities to support this work with additional staff, within available budgets.

6.2 If the pilot highlights evidence of unmet need and demand, and if the pilot results demonstrate positive outcomes including value for money, consideration should be given to shifting resources to meet this demand.

6.3 There is also potential to consider the utilisation of an element of the resource transfer monies resulting from the closure of beds to enhance this service as it develops

7. Impact Assessment

7.1 An Impact Assessment will be conducted as part of the implementation process.

8. Recommendation

8.1 The CHP Committee approved the implementation of the pilot at its meeting on 23rd August 2010

8.2 The CHP Forum is asked to note the progress in developing this innovative pilot and receive a future progress report within 6 months from the OLG Adults and Older people

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(Updated by CHP Facilitator- September 2010)