EAST AYRSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

INTEGRATION JOINT BOARD: 28TH AUGUST 2019

COMMUNITY HEALTH AND CARE: COMMUNITY REHABILITATION SERVICE (KIRKLANDSIDE DAY HOSPITAL)

Report by Senior Manager, Locality Services

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. East Ayrshire Council	
	3. NHS Ayrshire & Arran	√

PURPOSE

1. The purpose of the report is to provide an update on the position of the Community Rehabilitation Service (known as the Kirklandside Day Hospital), and to seek approval for a new service delivery model.

BACKGROUND

2. The Integration Joint Board (IJB) at their meeting on 25th January 2017 approved the engagement plan to support service change and re-provide inpatient care previously delivered from Rowallan Ward on the Kirklandside Hospital site.

3. The Day Hospital was provided on the Kirklandside Hospital site for many years providing outpatient assessment and support. Staffed by a team of Nursing staff who work closely with Occupational Therapy and Physiotherapy staff, patients were brought in by transport and typically spent the majority of their day within the venue. Rehabilitation, education and exercise classes were delivered, along with consultant geriatrician clinics.

4. Following a service review, the Kirklandside Hospital site was deemed not fit for purpose due to environmental challenges that impinged on patient care. A subsequent report to the IJB on 14th June 2017 detailed the comprehensive stakeholder engagement process undertaken including the work of the Stakeholder Reference Group (SRG), the options development process and the option developed by the group to re-provision the inpatient care.

5. The proposed new service model was approved by the IJB on the 30th November 2017. The team were to align with other services in the community and offer the service in a mobile approach in a range of community settings. This aimed to deliver services more flexibly with opportunities to strengthen staff structures and provide a more localised service that is efficient, safe and effective for patients.

6. In order to facilitate this new service model the Kirklandside site was declared surplus by the IJB on 28th August 2018 with the resultant relocation of 88 NHS and Council employees and their respective service bases, from the Kirklandside Hospital site to other locations in Kilmarnock.

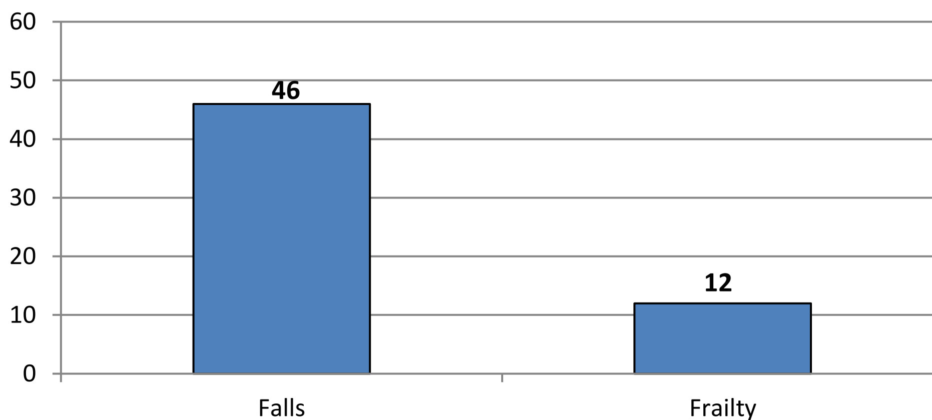
7. Prior to the move, Kirklandside Day Hospital staff and key stakeholders worked with Organisational Development to develop the Community model agreed by the SRG as a test of change which was then implemented in October 2018. The new mobile community based model tested provision of assessments within people's own homes, and delivering exercise and education classes within the Alzheimer's Scotland building in Kilmarnock town centre. Rather than traditional consultant-led model, this gave an opportunity to test a new Nursing and Allied Health Professional (AHP) model.

8. The new model was tested alongside existing model, so that people from some areas would continue to receive "usual care" including assessment by the Consultant Geriatrician and people from the other areas receiving care using the new mobile community-based model. Those people residing in postcodes KA1, KA2, KA16 and KA17 were included in the test of change, using a nursing and AHP-led service delivery within the community. All people received a comprehensive assessment including medical history, physical observations, and functional assessment and falls history, and where clinically indicated these people were then assessed by consultant geriatrician within outpatient clinic. This test of change was evaluated using both quantitative and qualitative data.

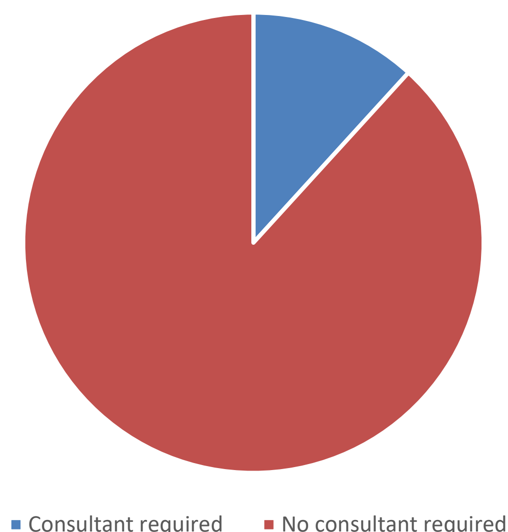
9. The results are outlined below, covering six month period from October 2018 – April 2019:

- Total referrals received: 58
- Exercise class attendances: Total = 98 (average of 16 per month or 4.3 per class)

Referral reason



Consultant assessment required in Test of Change areas = 12%



Qualitative data

10. Patient satisfaction questionnaires returned high levels of satisfaction with the service. The stakeholder surveys also indicated that the ongoing role of Day Hospital service was unclear as virtually all patients were already being referred to other services such as the Intermediate Care Team (ICT), Falls service (Technical instructor), Domiciliary Physiotherapy and Community Rehabilitation Occupational Therapy.

Staffing

11. At present, the staffing and non-pay resource within the service is as follows:

Band:	Post title:	Number of staff:	WTE:	Cost:
2	Nursing assistant	2	1.47	£40,794
5	Staff nurse	2	1.60	£60,467
7	Senior charge nurse	1	1	£55,571
-	**-**	**5**	**4.07**	**£156,832**
Total annual budget (including non-pay costs and room hire costs)				**£161,590**

PROPOSAL FOR SERVICE REALIGNMENT

12. An Enhanced Intermediate Care and Rehabilitation (EIC&R) model was implemented in November 2018. This provided additional staffing resource to both Intermediate Care Team (ICT) and Community Allied Health Professional (AHP) services and introduced seven day working. A single point of contact was created through an Intermediate Care and Rehabilitation administration hub for all community rehabilitation and intermediate care referrals to reduce duplication and ensure an approach of "Right Person, right support, right time".

13. The test of change indicates limited demand for the Day Hospital service owing in part to other changes to EIC&R services, which has highlighted significant duplication by the Day Hospital for people who were being seen by other services prior to Day Hospital input. There is therefore evidence that these other services are already addressing rehabilitation needs, and thus the service is not providing added value.

14. There is also evidence that requirement for consultant assessment is less than the current provision (less than 15% of all cases indicated a need for senior medical review), which highlights the important role of AHP and nursing staff in managing this level of care appropriately in the community.

15. It is recognised that there is considerable experience amongst the current staff group, with a range of transferable skills that could be utilised more effectively within ICT to improve skill mix, to support self-management of frailer people with long term conditions and reduce unscheduled care presentations.

16. There is a significant gap in rehabilitation capacity within ICT and slower-stream self-management supports. Whilst specialist pulmonary rehabilitation provides excellent supported self-management for Respiratory patients, there remain gaps for other patients who may be more likely to use care in an unscheduled way who are typically moderately to severely frail elderly or those with complex co-morbidities.

17. There is therefore an opportunity to realign resources from the currently underutilised Day Hospital service to create new roles to support rehabilitation and self-management. This is consistent with the priorities of prevention and early intervention supporting people to look after and improve their own health and wellbeing and live in good health for longer; either at home or in a homely setting in their community.

18. Realigning the two Band 2 Nursing assistant posts into ICT with the necessary training and development would increase capacity to deliver effective rehabilitation programmes and reduce unscheduled care demand.

19. Realigning the registered nursing staff (Bands 5 and 7) within ICT will allow closer working with the Advanced Nurse Practitioners (ANPs) with a particular focus on self-management.

20. Full support has been ongoing to ensure that staff are supported during this transition from Kirklandside Hospital site to new bases and for proposed new roles. Staff side have been consulted and this will continue with support from HR to ensure all processes will be adhered to.

CARER/PEOPLE WHO USE SERVICE IMPLICATIONS

21. Through realignment of existing staff resources, care will be improved ensuring that the right person provides support first time and access to consultant is available where this is clinically indicated. Satisfaction with service provision will be monitored to ensure increasingly high standards of care and experience are achieved.

22. Consideration must be given to the potential for negative unintended consequences to future service users through realignment of existing resources. To ensure this does not happen, a full review of current pathways and assessment procedures within other services such as ICT, Falls Service, Domiciliary Physiotherapy and Community Rehabilitation Occupational Therapy is required to ensure that all relevant evidence-based standards are met. New pathways to access Consultant geriatrician assessment for those who meet agreed criteria will also be designed and implemented.

FINANCIAL IMPLICATIONS

23. The proposed changes will reduce room booking costs, reduce duplication and ensure more efficient use of the limited consultant geriatrician resource, estimated to save approximately £2160 per annum.

24. The move to staff delivering community-based model will mean additional travel costs: based on projections from April and May 2019, these are anticipated to be approximately £1580 per annum, against an existing travel and subsistence budget of £740, meaning a shortfall of £840.

25. Overall this is expected to provide a saving of at least £1320 per annum.

HUMAN RESOURCE IMPLICATIONS

26. Human Resources, Organisational Development and trade union representatives have been involved in supporting staff and managers throughout the test of change, through regular meetings and development and planning sessions. This close engagement will continue as and when staff are required to move to new job descriptions and realigned roles, to ensure that staff feel valued, supported and have sufficient investment in their development needs for undertaking new roles.

LEGAL IMPLICATIONS

27. There are no legal implications.

EQUALITY IMPLICATIONS

28. There are no equality implications

RISK IMPLICATIONS

29. Careful consideration of risks associated with cessation of the existing Day Hospital service will be made, in order to negate any potential detriment to service provision in future. As above, current relevant service pathways and procedures will be reviewed to ensure that all necessary functions are maintained.

COMMUNITY PLANNING

30. This proposal supports the priorities outlined in both the HSCP Strategic Plan and the Community Planning Partnership Wellbeing Delivery Plan which seeks to support people have greater choice and control in how care is designed and delivered.

RECOMMENDATIONS

31. IJB members are asked to;

(i) Approve the proposal to realign Day Hospital services with IC&R to improve service delivery and patient care;

(ii) Note that the following specific actions will be undertaken:

  a. Conduct a review across the following services, to benchmark standards for falls prevention and rehabilitation, and implement any improvements as identified:
    i. Enhanced Intermediate Care & Rehabilitation
    ii. Community Rehabilitation OT
    iii. Domiciliary physiotherapy
    iv. Falls service (Technical instructor)

  b. Review geriatrician and falls pathways across Ayrshire alongside Assistant General Manager at Crosshouse to support criteria led referral to consultant

(iii) To issue a Direction to NHS Ayrshire and Arran in respect of implementation of the new service model; and;

(iv) To otherwise note the content of the report.

Maxine Ward
Senior Manager, Kilmarnock and Northern Locality Services
7th August 2019

Implementation Officer
For more information contact Craig Ross, Service Manager, Authority wide services
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Background papers

Integration Joint Board Reprovisioning Kirklandside Report –25th January 2017
Integration Joint Board Reprovisioning Kirklandside Report – 14th June 2017
Integration Joint Board Reprovisioning Kirklandside Report –30th November 2017
Integration Joint Board Reprovisioning Kirklandside Report – 28th August 2018

Appendix 1 – Feedback

Extract of email received from daughter of person in receipt of ICT:

"My mum was a patient in Crosshouse Hospital for around 10 weeks from Oct to late Dec 2018 with discitis and when she was discharged she had the home from hospital team come in to see her for a number of weeks. I just wanted to say a huge thanks to all the staff who visited my mum on her return home to rehabilitate her and get her back to doing so much of what she had been doing previously.

Mum had lost her confidence and despite having care 3 times daily on discharge she is now independent with self-care, cooking, cleaning and even back to driving. She doesn't have the same stamina that she had previously and is not walking the miles that she was doing before but without your fantastic team of OT's, Physios etc. I know she would not be as able as she is now. They gave her the confidence to push herself and regain her independence.

Please pass on my ***sincere thanks*** *to the team, this service is essential in ensuring our aging population continue to be as active and able for as long as possible."*