CARE, HEALTH & WELLBEING
OVERVIEW AND SCRUTINY COMMITTEE
18th September 2018

TITLE OF REPORT: **Helping People to Stay at Home Safely**

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Care, Wellbeing and Learning

SUMMARY

Care, Health & Wellbeing Overview and Scrutiny Committee have agreed that the focus of its review in 2018-19 will be "helping people to stay at home safely".

At the Overview and Scrutiny Committee on the 18th June 2018, Committee agreed that the review will consider how health, social care and voluntary services support people's confidence and independence to live safely in their own home. The review will centre on the 6 core themes of

- Assistive technology and digital information;
- Enablement services;
- Housing options to support independent living;
- Commissioning for enablement outcomes;
- Emergency and community services;
- Personalisation and choice.

The Committee will consider the range and extent of current activity in these areas, with a view to agreeing a set of recommendations.

This report will focus upon how the Local Authority and Gateshead Health Foundation Trust are working collaboratively as part of the Gateshead Care Partnership to provide community based Enablement approaches to residents of Gateshead enabling people to be as independent as possible. The report will also detail the trusted assessor models and interface between the Local Authority and Gateshead Health Foundation Trust (Queen Elizabeth Hospital - QEH) which serve to seamlessly discharge people from hospital back to their own homes.

Background

The ageing population means that there will be an increase in demand on both health and social care in future years. Around 53,000 people (1 in 4) in Gateshead have one or more long term conditions. Over 8,000 of these have three or more long term conditions. There is a significant difference in health inequality across the borough (as much as ten-years difference) and healthy life expectancy in Gateshead is significantly lower than for England: for men it is 59.1 years compared to 63.3 and for women 60.6 years compared to 63.9. Around 22% of people in Gateshead reported that their health limits day to day activities compared to around 18% nationally. (Census 2011). Significantly, Gateshead residents have higher levels of dementia, COPD, coronary heart disease and stroke prevalence than national average levels across England. The population is ageing: it is projected that by 2039 there will be an additional 14,400 people aged 65 or older, an increase of 38%.

To effectively respond to a Gateshead population that is getting older with an increase in the number of people with life limiting illnesses, the Council's Adult Social Care Provider service has remodelled its services. These include; PRIME Enablement service (short term domiciliary care support), Rapid Response, Promoting Independence Centres (Eastwood, Shadon House and Southernwood), Blaydon Resource Centre and Shared Lives. These services all serve to optimise the ability of Gateshead residents to continue living independently in their own homes and attaining a high quality of life. The majority of these services are registered by the Care Quality Commission and have either an 'Outstanding' or 'Good' rating.

Outcomes

Following a comprehensive assessment of a service user's needs, Enablement is provided to an individual whereby employees either within PRIME or Eastwood Promoting Independence Centre will provide support to people to attain outcomes against allotted timescales, with the overarching aim to ensure that a service user is able to be supported at home with either no or a minimal level of support.

The key Enablement approaches are:

- The use of Assistive Technology to promote service user's independence;
- The operation of MDT teams to embed joint positive risk-taking approaches;
- The concentrated use of people's life history / biography to get the best out of service users;
- The use of TSI (Training in Systematic Instruction) as the cornerstone of the Enablement provision;
- The emotional support given to family carers.

The Enablement Framework introduced by the Adult Social Care Provider service has been pivotal to ensuring that people's individual functioning and self-confidence are optimised, equipping them with the ability to continue living in their own homes. Key successes have been:

- PRIME (short term domiciliary care service) supporting over 1300 people in the last 12 months. 80% of individuals who use the service attain their Enablement goals and of those individuals who used PRIME after being discharged from hospital, 89.4% were still living at home 91 days after leaving hospital.

- The Council provides a domiciliary care Rapid Response service that provides immediate support (average 27 minute response time) to people in a crisis situation. The primary aim being to stabilise the crisis situation and to prevent an acute hospital or residential care admission. The service won the 'Putting People First Personalisation' award at the 2017 North East Care Awards.

- Eastwood Promoting Independence Centre has adopted an effective Trusted Assessor model facilitating timely discharges from acute hospital wards. An integrated social and health based team delivering rehabilitation, reablement and recovery provision has enabled 79% of frail individuals to return home.

- Shadon House, has worked in partnership with the registered charity, Equal Arts,

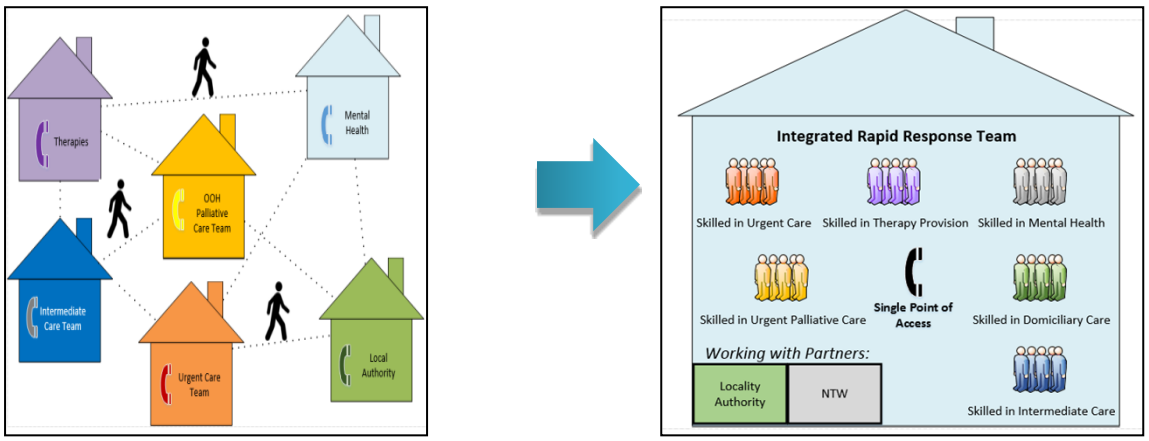
to provide a comprehensive social, therapeutic and recreational activities programme including music, drama, dance and hen therapy. Shadon House has an 'outstanding' CQC rating. One professional commented during the inspection "It takes consummate professionals to achieve what Shadon House staff members do, this is social care excellence.

- Blaydon Resource Centre provides day support to people with dementia, serving to maintain people's personal skills, communicative ability and provide invaluable respite for family carers. The service has an extensive activities programme which serves to stimulate the meaningful occupation of people with a dementia condition.

OSC Committee members are visiting the sites of Blaydon Resource Centre, Shadon House and Eastwood Promoting Independence Centre on the afternoon of Tuesday 9th October 2018.

Gateshead Community Services

We are currently undergoing a transformation plan, which includes collaborative working with health and social care to achieve improved outcomes for the people of Gateshead. One of the key areas of work has been to create one single rapid response team that incorporates staff skilled in urgent nursing care, domiciliary care, palliative care, mental health and intermediate care. It was identified that we have multiple telephone numbers and referral routes for accessing services that patients/service users would require for a timely intervention.



Aims

- It would aim to offer care and support to patients in their place of residence to:
- Keep people living independently and healthily at home by managing chronic disease in times of crisis;
- Prevent avoidable emergency hospital admissions;
- Prevent unnecessary admissions to care homes;
- Prevent people going into long term care;
- Reduce delayed transfers of care from hospital;
- Support carers in times of crises.

Implementation

A phased approach to achieving our goal of the Single Rapid Response Team is as follows:

- Phase 1 Nursing integration from May 18;
- Phase 2 Nursing and Therapy integration from September 18;
- Phase 3 Local Authority integration from September 18;
- Phase 4 Mental Health to follow on from phase 3.

This work is at an early stage but is progressing on schedule. We currently have two working groups to bring this piece of work together with key representatives from health and social care.

Trusted Assessment: Hospital Transfers of Care to Eastwood

Many people wait too long to be discharged from hospital resulting in poor experience of the health and care system and poorer outcomes. Trusted assessment is a key element of best practice in reducing delays to transfers of care of people between hospital and home. By using trusted assessors, we can reduce the numbers and waiting times of people awaiting discharge from hospital and help them to move from hospital back home or to another setting speedily, effectively and safely.

Due to previous winter initiatives, the trusted assessment process was developed in May 2017 for patients identified as requiring an intermediate care bed based in QEH. The aims of the process to reduce re-admissions to QEH and ensure the patients were within medical parameters to progress with re-ablement, rehabilitation, recuperation in a bed based environment. The identification of suitable patients occurs at the daily board round, the therapist takes responsibility to complete the first part of the assessment process. If the patient is suitable for an intermediate care bed, part 2 of the referral is completed by a Frailty Nurse to explore the medical aspect.

Outcomes

The data provided over a 12 month period (2017- 2018) measured against a similar cohort of patients prior to the Trusted Assessment development. During this period the Frailty Nurses reviewed 85 patients in Queen Elizabeth Hospital and neighbouring Newcastle Hospitals to facilitate repatriation.

- **80%** of patients identified as suitable for the Intermediate Care Beds were transferred to Eastwood

- **20%** of patients were declined due to the following reasons: Clinically unwell, suitable for transfer home, too dependent, declined by patient, declined by Eastwood.

- **50%** reduction in hospital attendances, during the patients stay at Eastwood.

- The number of individuals who are still living at home 91 days post hospital discharge period. Within a recent Council performance clinic it was reported by the Performance Management team that Eastwood's return for this financial year, covering Apr – July' 18, showed an improvement as the rate was 85% (over 15% higher than it has been for previous years).

Trusted Assessment: Hospital Transfers of Care into Reablement Services

Following on from the Trusted Assessment work with Eastwood, we were asked to scope out expanding Trusted Assessment to Gateshead Local Authority services; Rapid response and PRIME reablement services. It was identified that the Discharge Liaison nurses would be ideally placed to complete the pilot.

The aim was to identify patients in the emergency care department who would benefit from reablement services, reducing admissions to QEH and improving patient outcomes. Patients on ward areas were not to be part of the pilot, the daily MDT would continue to support the identification of potential patients.

Implementation

- Shadowing opportunities arranged for all Discharge Liaison Nurses to observe the operational function of rapid response/PRIME services.
- This shadowing embedded trust between health and social care, as they developed an understanding of the respective services provided.
- The pilot commenced on 20th November 2017. Discharge Liaison Nurses attended Emergency Care department shift handovers to assist with the identification of suitable patients.
- The project expanded to four ward areas in January 2018, following pilot review meetings.

Challenges

- From November 2017 to January 2018, it was identified a total number of 25 of patients were suitable for reablement services in Emergency Care at QEH. This pilot demonstrated the cohort of patients we were aiming to support, in the Emergency Care dept were clinically unstable and not suitable for reablement services.
- Health and Social Care jointly agreed to expand the pilot to four ward based areas.
- Service pressures over Easter Period
- Limited Care First Access (Gateshead LA, IT system)
- Delays in winter funding affected recruitment and start dates for extra nursing staff to work within the Discharge Liaison team.

Outcomes

- Since expanding to the pilot to ward areas, a total number of **106** patients have been identified for reablement services.
- The pilot is now established and remains part of the Discharge Liaison Nurses Role on a daily basis.
- Increased capacity for the Social Work team based at QEH to deal with the more complex social cases

Next Steps

- To continue the trusted assessment model due to the good working relationships that have been developed across health and social care. Currently 157 trusted assessments have been completed
- Ward areas, reviewed following changes to the Stroke Patient Pathway.
- Discharge Liaisons Nurses to work Monday – Friday due to end of extra winter funding.
- Potential for therapists to become trusted assessors to support timely transfers of care

The social work assessment teams role in supporting our older population and those people with complex Physical, Mental Health and Learning Disability are working closely with the QE Trust in;

1. **reducing the number of delayed discharges to prevent people staying in hospital longer than necessary and being at risk of hospital acquired infection as well as blocking beds for those who need a hospital admission**.

Delayed discharges continue to be a challenge to the both Gateshead Health Foundation Trust and Gateshead Council with this year's target having been reduced.

Bridging Service

One of the main reasons for delayed discharges was people waiting for a long-term package of home care to start in the community. Due to the workforce issues the home care market is facing, not only in Gateshead but the rest of the country, Providers don't always have the resources to enable packages to start as soon as someone is ready to leave hospital.

To enable people to leave hospital as soon as they were ready for discharge, the Council need a service that is responsive and has staff available to start within two hours. It was agreed to pilot over a three-month period a new approach with the independent sector providers. They agreed to have a small team of salaried staff who will deliver support to enable people with a long-term care need to be discharged and receive support for a short period of time whilst waiting a long-term package of care.

The Pilot was evaluated and overall proved very successful. It enabled over fifty people to return home on the day they were fit to leave hospital. The overrall satisfaction from service users and their families was really high with the vast majority rating the service good to excellent.

The Council agreed that the service was required all year round and have commissioned the service with three providers (Clece Care, Comfort Call and Dale Care) from September 2017 to March 2019.

Function of the social work team

A social care assessment team is based within the QE hospital. The team work closely with Trust staff in supporting safe discharges. Most wards within the Trust have an allocated social care worker who is the link person for people who may require social care support for discharge. The link worker attends the daily "board rounds" where they are involved in the multi-disciplinary meetings discussing patients and identifying with the multi-disciplinary team any person who may require advice and/or support from social care.

Further on-going work to support the Trust are the;

- Weekly Surge Meeting – A problem solving meeting to discuss specific cases where there are possible issues relating to discharge.
- Winter Planning Meeting – Looking at any issues from the winter beds (ward 6)
- Daily Surge Meeting Gold command – This meeting is ad hoc and can be called on at very short notice when the Trust is in a particularly difficult position.
- Patient Flow meetings – These meetings discuss the Patient Flow Plan 2017-2019 which is looking at best practise discharge planning.

2. **Supporting Gateshead Community Services in providing care closer to home for people with health and social care needs.**

As part of the review of the Council's Adult Social Care Assessment model, two locality teams have been developed who work across the 5 geographical areas. These teams work with people aged 18+ who have a physical health problem and people with an organic mental health problem which primarily will be older people.

As part of the Trust Community Service locality working, link worker from each of the teams has been developed. The aim of the link worker is to be able to give advice/information, signpost or complete assessments if required. In turn this should help delay or prevent a hospital admission or delay the need for longer term social care support.

The locality working is in a relatively embryonic stage, however, there is commitment across both organisations to develop this further.

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