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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

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UPDATE REPORT: MEDWAY INTERMEDIATE CARE AND REABLEMENT SERVICE

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Summary

This report provides an update to the Committee on the new Intermediate Care and Reablement Service with examples of learning from the first six months of the contract's operation.

The report also details some potential developments which are being explored as a result of that learning to streamline and improve the service people receive when they are ready to leave hospital and return home.

1. Budget and Policy Framework

1.1 An initial report on the first six months of the Home First discharge programme was presented to Overview and Scrutiny in November 2016.

1.2 At that time, as the new Intermediate Care and Reablement Service had mobilised the previous month, it was agreed that a report would return to Health and Adult Social Care Overview and Scrutiny Committee detailing the learning from the first six months of operation.

2. Background

2.1 Home First is a multiagency response service that supports hospital discharge for people that are medically stable and have reablement potential: the significant difference is that the reablement is delivered in their home setting or a community bed not, as has traditionally been done, in a hospital ward.

2.2 Once their clinical needs have been met, people who meet the criteria are discharged to their home and have an assessment undertaken within two hours by an occupational therapist. Following this assessment, a reablement

package is put in place for up to six weeks to regain full or as near to full independence as is possible.

2.3 The work to establish a Home First pilot service, which ran between April and October 2016, identified that there was a need to provide a bed-based reablement service for those people ready to begin their return home but who needed some additional support to reach their optimum recovery.

2.4 An interim report on Home First was presented to Health and Social Care Overview and Scrutiny in November 2016. This report is planned as a follow up to that initial paper.

2.5 Through a process of competitive dialogue, Partnership Commissioning, on behalf of the Council and Medway Clinical Commissioning Group, commissioned a service which would transfer the care of someone requiring additional reablement from the hospital setting to either their own home or a community-based bed. The two sites involved in providing this bed-based service are Britannia Unit, at Amherst Court and Platters Farm.

2.6 The new Intermediate Care and Reablement Service (IC&RS) commenced on 1 October 2016 with Medway Community Healthcare as the lead provider for that service.

2.7 As well as the Home First service which was piloted the IC&RS also includes a non acute bed-based element that extends reablement to people requiring further support to get them ready to go home. This is achieved through further rehabilitation and enhanced health care at home.

2.8 The opportunity to provide this type of support away from the hospital setting has many advantages, not the least of which is a less hectic / medically focussed daily routine which allows the staff supporting the person to devote much more time to the reablement function and achieving outcomes that positively promote independence.

2.9 There are 36 beds available within the system, these are split as follows:

- Britannia Unit: 20 beds is able to meet more complex needs as care is provided by qualified nurses, therapists and rehabilitation assistants.
- Platters Farm: 16 beds in a residential care setting that are supported by therapist in-reach to assist people to achieve their enablement goals.

2.10 While each setting generally focusses on supporting a number of different elements of reablement, the overall goal, though, is to enable the person to return home as quickly and safely as they can. Crucially, this approach enables the families of patients, where possible, to be involved in their journey home.

2.11 There is a separate facility for those requiring reablement or recovery from stroke which operates in parallel with IC&RS. Stroke is not covered by this report as it is a separate contract.

2.12 People referred to the IC&RS spend, on average, 27 days receiving support. During this time progress towards independence is constantly monitored and

if the therapists identify there is an obvious need for additional on-going support once the person returns home, this is organised while they are still receiving reablement.

2.13 In the first six months of operation:

- Since the new service started it has seen 801 people who received reablement at home and 203 patients who received reablement in a community-based bed.
- 73% service users improved their independence, the remaining 27% showed little improvement.
- 84% are discharged within six weeks – those staying longer have complex needs to be addressed before their care can be transferred.
- Home First - service capacity 150 referrals per week - average received 96 per week. This has improved recently with introduction of different referral systems at MFT. At times the team has taken up to 10 per day and taken referrals for following day.
- Home First - average length of stay 21 days.
- 98% have the service in place within 24 hours.

3 Advice and analysis

3.1 The implementation of IC&RS has contributed towards improving the way discharges from Medway NHS Foundation Trust operate. In the Executive Summary of the recent CQC Inspection of Medway Maritime Hospital in January 2017 the Inspector noted: *“Medway has one of the lowest delays to transfer of care in the country.”*

3.2 The implementation of new services like these have contributed to the stabilisation of DToCs recorded, however, it is clear that more needs to be done so people do not reach the DToC threshold.

3.3 Taking IC&RS lessons learnt into consideration and the need to continue actively promoting a culture of ‘Home First’, there is an emerging plan to increase the number of people requiring more in-depth assessments to a setting away from the acute hospital.

3.4 Discussions are underway to set up a “Discharge Hub” which will provide the opportunity to transfer the care of people who require further assessment to agree the next stage of the care journey. It is proposed that for those who are medically fit, these in-depth assessments take place in a community setting rather than in the hospital as they presently do.

3.5 It is clear that where someone is likely to have additional health needs, especially if there are early indications of challenging behaviours, mental health or dementia, assessments are likely to be more reliable if undertaken at home or in a more suitable environment such as Britannia or Platters Farm. This enables the requirement for ongoing support to be based on a ‘truer’ presentation of the person’s actual needs.

3.6 Similarly we wish to increase the number of people being discharged to be assessed and enabled in their own homes including care homes.

4. Financial implications

4.1 The contract is monitored monthly to ensure that spend is on target and that the Key Performance Indicators (KPIs) are being maintained.

5. Legal implications

5.1 There are no specific legal implications raised by this report.

6. Recommendations

6.1 The Committee is asked to note the progress detailed within this report.

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Appendices

None.

Background papers

None.