Appendix F

Health and Wellbeing Scrutiny Committee: Rehabilitation and Early Supported Discharge: Policy Review recommendations 2011/12

Review Progress Summary				
not on schedule	on schedule	undeliverable	achieved	Total
0	1	0	10	11

Ref	Recommendation	Action	Owner	Due Date	RAG	Progress Commentary
(a)	Policies and strategies should have an overarching emphasis on developing performance and outcome frameworks that create incentives towards a more integrated approach. To ensure oversight of the whole system approach described in this review, these recommendations should be referred to the Health & Wellbeing Board, with oversight of delivery of the actions by the Adult Partnership Board.	The Adult Partnership Board accept the mandate from the OSC and have oversight of related strategies to ensure all opportunities for integration are maximised and included in strategy outcomes.	Chair of Adult Partnership Board (Cllr Miller)	Complete	achieved	The Adult Partnership Board has agreed to take responsibility for oversight of these recommendations and will include a bi-annual progress report as part of their update to the Shadow Health and Wellbeing Board.
(b)	In order to successfully reduce avoidable emergency admissions, further clarity is needed around which types of admissions are potentially avoidable and which interventions are likely to be effective for particular populations.	Undertake an audit of readmissions and identify and implement appropriate evidence based interventions.	Chairs of Intermediate Care Strategy Group (Jean Carter, Deputy Director of Health Housing and Adult Services / Ailsa Nokes, Strategic Lead for LTCs, NHS SOTW)	Complete	achieved	A multi-agency audit of 30 day readmissions was undertaken in March 2012. The results determined that 43% of readmissions were avoidable. A number of recommendations were made which also reflected the findings of the Emergency Care Intensive Support Team (ECIST) whole systems review in Sunderland (June 2012). A multi-agency group of statutory partner agencies worked to develop proposals for implementation of initiatives in 12/13 using ring-fenced PCT readmissions funding. Examples of some such initiatives include:

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						○ Nursing support for care homes to prevent hospital admission ○ Pro-active review and case management by community teams for patients as high risk of readmission ○ 6 week audit of mental health presentations at A&E to inform development of Mental Health Liaison service ○ Development of community geriatrician role. The 12/13 schemes are currently being evaluated and will be presented at a workshop in April 2013. Further development of these schemes and opportunities for new schemes in 13/14 including involvement of the third sector will also take place in April.
(c)	A review of the ward-based discussion groups should be carried out based on an assessment of their success against the measures and in the context of the establishment of a Single Point of Access	Map current state for multi-agency ward based discussion groups and measure their success in facilitating appropriate discharge arrangements	City Hospitals Sunderland (Anna Hargrave, Divisional Manager)	Complete		A review of multi-disciplinary discharge planning mechanisms is underway. Recommendations regarding a new Home from Hospital Team model have been welcomed by CHS FT, which is now being piloted and early indications are that it is reducing delays and minimising duplication between social work teams. This work has been linked to the expansion of the Intermediate Care Hub which is now multi-disciplinary and operates 7 days per week. Workshops have also taken place involving the third sector and independent sector housing providers to maximise opportunities for supporting timely and safe discharge.

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(d)	An audit of the timely supply and completeness of in-patient discharge information is required to set standards and quality monitoring of information continuity.	Confirm an audit has been carried out, and what the outcomes were	City Hospitals Sunderland (Anna Hargrave, Divisional Manager)	Complete	●	City Hospitals Sunderland undertakes monthly monitoring of discharge information provided to patients/carers against the CQUIN standards. Improvements in results have been demonstrated and reported to the PCT on a monthly basis.
(e)	How to achieve greater access and awareness of reablement, its impact and how it can complement Intermediate Care should be explored. This should include how reablement could be re-positioned to reach all those who could benefit by becoming an integral part of the 30-day post discharge process and how it could be expanded to an admission avoidance service.	Undertake workshop to identify beneficiaries of reablement Review of Time to Think beds Review of all intermediate care / reablement bed based services	Chairs of Intermediate Care Strategy Group (Jean Carter, Deputy Director of Health Housing and Adult Services / Ailsa Nokes, Strategic Lead for LTCs, NHS SOTW)	Complete	●	A workshop was held in August 2012 which identified recommendations regarding who could benefit from reablement. Access to Reablement for post discharge support and to prevent hospital admission has been embedded within the core offer of the Intermediate Care Hub, which now operates 7 days a week. A work programme has also commenced which is exploring the potential for more integrated working across therapies in order to front load the reablement journey with therapy input. A third strand of work has looked at the level of rehabilitation and Reablement support that should be provided to bed based intermediate care services. A review of the demand and capacity for all intermediate care / reablement bed based services was carried out in October 2012. It was agreed that this should be repeated in six months, after which recommendations for future provision should be confirmed.
(f)	The Committee would like to see the role of the district nurses aligned to the whole-system approach as described throughout this review and involved, as necessary, at each stage of a transfer of care.	Incorporate this recommendation within the existing SOTW District Nursing Review Implementation Group Action	Jacqui Lambie, Project Lead, District Nursing Service Specification Implementation Group	Complete	●	The recommendations of OSC were discussed at the NHS South of Tyne and Wear, District Nursing Service Specification Implementation Group on 14 September 2012. This group includes Sunderland CCG representatives. All agreed that the revised District Nursing

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		Plan.				Service specification now in place and the supporting improvement plan do meet the recommendations of the review and will support the whole system alignment required.
(g)	A working group should investigate possible solutions for a city-wide medication support model for vulnerable people living at home.	Dr Jackie Gillespie, Medicines Management Lead, Sunderland CCG, to be contacted and discuss the way forward	Dr Jackie Gillespie, Medicines Management Exec Board Lead, Sunderland CCG	March 2014	●	Discussions have taken place with Dr Jackie Gillespie, Medicines Management Lead, and Sunderland CCG. A review of evidence has identified that 10% of hospital admissions are related to medication incidents, including missed medications and medication not taken as prescribed. Non-recurring funding has been secured from the CCG to undertake a medication prompts pilot in Sunderland. The service will provide training in assessment for aids to take medication, expert advice and support to home care support workers, care managers and families. Staff from the Medication Prompts support service would work with individual patients and families where necessary as well as other key responsible staff. The pilot will initial focus on people with dementia, as one of the most vulnerable groups in the city. Further work will be undertaken in 13/14 to identify additional vulnerable and ‘at risk’ groups who would benefit from medication support and extend the service as appropriate.
(h)	Where evidence shows a disproportionate rate of hospital admissions from care homes, future contracts should include arrangements for employers to be required to release staff for training.	Check that contracts contain clauses for training requirements and quality standards	Sunderland City Council (Graham King, Head of Strategic Commissioning)	Complete	●	The Head of Local Authority Strategic Commissioning has confirmed that this is already in care home contracts and part of the Quality Standards Framework. Compliance is being discussed with care providers via Care North East.

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(i)	In relation to the existing discharge panel, there is a need to review and reconfigure the model for decisions on long term care.	Reconfigure arrangements	Sunderland City Council (Philippa Corner, Head of Personalisation)	Complete	●	Following a series of multi-agency workshops a formal panel no longer exists and a Whole Systems Approach to Maintaining Peoples Independence was developed. Implementation is now underway.
(j)	An increased focus on mental health support within the community, through a model of clinical governance in the community would reduce the level of A&E access and subsequent in-patient care.	Review developments already underway through the Mental Health Model of Care Board that will address this issue Consider if this recommendation will be addressed by the Mental Health Pathways Scrutiny Review	Sunderland City Council (Jean Carter, Deputy Director of Health Housing and Adult Services) NHS South of Tyne and Wear (Ian Holliday, Head of Mental Health and Joint Commissioning)	Complete	●	In April 2012 a pilot to improve access to urgent mental health services in Sunderland was launched. A new service called the Initial Response Team was established which provides clinical triage of urgent mental health referrals over the telephone and face to face, where appropriate. This service has reduced the response times for referrals to A&E; with many referrals now being seen within 1 hour (previous wait could be up to 6 hours). The Initial Response Team works closely with the Sunderland Crisis and Home Treatment Team, which as of 1 April 2012 became a universal crisis team accepting referrals from service users of all ages and abilities. The performance of these services is being monitored closely and initial feedback from service users, carers and referrers has been extremely positive. A 6 week audit of Mental health presentations at A&E took place in December 2012 and January 2013 to inform development of a mental health liaison model. A business case is currently being developed and funding secured to pilot a new liaison model. Work is going on the avoid admissions and improve discharges for mental health patients as well as other conditions, and the ongoing scrutiny review of mental health pathways should highlight any

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						specific concerns or actions. There is further work ongoing in relation to the Mental Health Strategy which will see improvements to the joint working in the community, with a strong focus on partnership working between the Council and mental health services. We are already seeing evidence that operational collaboration is having positive effects.
(k)	There should be a check list of information needed by carers which could be used as a template for discharges.	Implement revised discharge information for carers Take action on Readmission Audit feedback	City Hospitals Sunderland (Anna Hargrave, Divisional Manager)	Complete	●	City Hospitals Sunderland has introduced a 'Preparing for Discharge leaflet which outlines the responsibility of the individual and the Trust in relation to the patient journey. All patients have a nursing assessment completed which includes social and carer information. All patients have an Estimated Date of Discharge which is shared with them and carers. The role of carers is discussed at monthly Hospital Discharge Training Events. The recent Readmission Audit highlighted issues for patients and carers in not having a named contact on discharge. A draft checklist has been shared with the Carers Group and has been well received. As a result of ongoing work with the Carers Group a leaflet has been created which sets out to answer recurring queries posed by Carers. This is to be piloted on 3 wards (E58, D41 and E56 for three months prior to review and roll out. The leaflet is currently being printed.