

Healthy Wirral - Whole System Integration			
Meeting	Board of Directors		
Date	09 January 2019	Agenda item	13
Lead Director	Val McGee, Chief Operating Officer		
Author(s)	Val McGee, Chief Operating Officer		
To Approve	<input type="checkbox"/>	To Note	<input type="checkbox"/>
		To Assure	<input checked="" type="checkbox"/>

Link to strategic objectives & goals - 2017-19	
<i>Please mark ✓ against the strategic goal(s) applicable to this paper</i>	
Our Patients and Community - To be an outstanding trust, providing the highest levels of safe and person-centred care	
We will deliver outstanding, safe care every time	✓
We will provide more person-centred care	✓
We will improve services through integration and better coordination	✓
Our People - To value and involve skilled and caring staff, liberated to innovate and improve services	
We will improve staff engagement	✓
We will advance staff wellbeing	✓
We will enhance staff development	✓
Our Performance - To maintain financial sustainability and support our local system	
We will grow community services across Wirral, Cheshire & Merseyside	✓
We will increase efficiency of corporate and clinical services	✓
We will deliver against contracts and financial requirements	✓

Link to Principal Risks in the Board Assurance Framework - please mark ✓ against the principal risk(s) - does this paper constitute a mitigating control?	
Failure of organisations across the system to delegate appropriate authority to support the integrated care system (Healthy Wirral)	✓
Failure to engage staff to secure ownership of the Trust's vision and strategy	✓
Increasing fragility of the social care market	✓
The impact of the outcome of the Urgent Care Review compromising financial stability and the future model of care	✓
Services fail to remain compliant with the CQC fundamentals of care leading to patient safety incidents and regulatory enforcement action and a loss of public and system confidence	✓
Inability to implement the Trust's clinical transformation strategy and preferred model of care - Neighbourhood care	✓
Commissioning decisions do not promote integrated working across the health and care system	✓

Failure to build the workforce skills and infrastructure to transform services to meet the demographic needs of the workforce and population	✓
Security of public health funding and subsequent contractual decisions impacting on the range of services provided to Wirral & Cheshire East	✓
Failure to foster, establish and manage the right partnerships that enable a response to commissioning intentions	✓
Development of place-based care outside of Wirral, limits the Trust's ability to expand/retain services in these areas	✓
Failure to deliver the efficiency programme	✓
Failure to achieve all the relevant financial statutory duties	✓
The impact of the outcome of the Carter Review on community services benchmarking on commissioning decisions	
Impact of supporting the delivery of the 3-year financial plan and future sustainability of the Wirral system	✓

Link to the Organisational Risk Register (Datix)

Has an Equality Impact Assessment been completed?	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
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Paper history		
Submitted to	Date	Brief Summary of Outcome
		Regular report submitted to Board.

Healthy Wirral - Whole System Integration Update January 2019

Purpose

1. This paper describes a number of strategic activities across the health and social care system which the Wirral Community NHS Foundation Trust (WCFT) is central in leading and supporting whilst ensuring an equality of partnership delivery and sustainability. At the same time, working with other community partners ensuring a strong out of hospital focus and clear leadership as work progresses in the development of Place Based Care, particularly the neighbourhood developments.

Executive Summary

2. These activities support the delivery of the Trust's strategic objectives and our organisational strategy, which is absolutely aligned to the Wirral Health and Care Commissioning Strategy and wider system resilience. These developments ensure that service delivery is integrated, that patient care is optimised and that patient experience is enhanced. This work and focus demonstrates our strength as a strong and credible partner as we move to Placed Based Care and Wirral Acting as One".
3. WCFT is either leading on or is a significant partner on a number of integration initiatives across the health and care economy. This places the Trust in a strong position as we develop Place Based Care.
4. This paper is to assure the Board of Directors of our strategic relationships, our support of the wider health and care system and our key place in Wirral, which impacts on the strategic direction, quality and service delivery of our Trust's activities and demonstrates our unique position in the health and care system.
5. As with previous years, 2019 will be significant for our Trust. As well as the high volume of work all of our teams do to support people through winter, we will have to understand what the 2019/20 planning guidance means for our organisation and probably more notably the 10 year Plan and any emphasis on further integration.

Areas of Focus

6. The paper discusses the key areas of activity which have taken place across the health and social care system on the integration agenda. The paper also demonstrates the progress made in a number of key areas of integration, notably describing the plans for winter and our response, the crucial role in the growth and development of the neighbourhood model and the growing partnership work we are working on around children's services.

Board action

7. The paper is to assure the Board of Directors of the commitment the Trust has to integration across a number of work streams and with key partners across the health and care system and the commitment to developing and enhancing out of hospital care.

Val McGee
Chief Operating Officer
04 January 2019

Healthy Wirral - Wirral Acting as One - Update September 2018

Wirral Partners Board - Wirral Acting as One

1. System meetings continue. The Healthy Wirral Executive Directors Group (HWEDG) met during November and December 2018, as did the Healthy Wirral Operational Group (HWODG).
2. Mersey Internal Audit (MIAA) is supporting the production of "One Wirral" sustainability plan. They have secured support from NHSE Right Care team, NHSI Model Hospital Team and the Getting it Right First Time (GIRFT) team, working on a number of programmes of work, Respiratory especially COPD, Frailty, Renal, Gastro and Cardio Vascular Disease. This will form the basis of a wider 5 year sustainability plan.
3. The Frailty Project Initiation Document (PID) is still in development.
4. Plan on a page for each work programmes has been completed for Learning Disabilities, Respiratory, IAPT (Improving Access to Psychological Therapies), MSK (Muscular Skeletal), Neighbourhood programme and Urgent Care. The only one outstanding is Women, Children's and Families.
5. A system planning event was held on 29 November 2018 where the following was discussed:-
 - The Planning guidance
 - Cep-Light approach
 - Shared services and opportunities
 - Governance and a review
 - Communications and Engagement
6. Partners Board meetings were held in November and December 2018, where communication on progress was discussed including progress on the work programmes, financial position, MSK and Better Care Fund (BCF) updates.

Technology and Informatics Update

7. Health Information Exchange (HIE) went live within SystmOne 5 November. This allows staff to see current live information and has been welcomed by all staff who access HIE. The data feed for social care is being tested externally to enable sharing to be brought to Wirral.
8. Wirral Care Records - work is underway with the Local Authority (LA) regarding linking Liquid Logic data into the Wirral Care Record. There have been some technical problems which meant that data on boarding had to be restarted. This relates to one of the servers within the Trust and was mitigated by manual transactions.

Healthy Wirral - Senior Change Team (SCT) Neighbourhood development

9. Senior Change Team (SCT) is the group within the Healthy Wirral programme structure leading the development of place based care with a focus on 9 neighbourhoods and action plans for addressing health and care priorities. Members include Wirral health and care commissioners and public health, WCT, WUTH, GP Federations, CWP and Age UK.
10. Neighbourhood Leadership Teams (NLTs), which include WCFT health and social care professionals and senior managers, are tracking progress against implementing these plans.
11. Following feedback from GP Coordinators and other members of the NLTs, the Senior Change Team is reviewing the communication of the Principles and Vision for Neighbourhoods, to ensure they are founded on a shared and consistent understanding of their purpose and direction.
12. Jenny Dodd's work with partners to co-produce a care model for neighbourhoods is continuing. A report has been created that identifies where there is agreement between partners on the service characteristics that neighbourhoods should have. This is being used to create a first draft of a service model. Jenny has met with Dave Harris to agree how this work will inform the Aligning Capability workforce modelling.
13. Following a successful bid to the North West Leadership Academy, a neighbourhood leadership development programme is being established. Three development events will be held with members of the NLTs between March and September 2019.
14. Through the Neighbourhood meetings, WCT clinicians and senior managers have been identifying opportunities to improve mutual understanding, including sharing information about trust services. Five 'service on a page' descriptions have been developed for practices and circulated. These are focused on services that support admissions avoidance and support independence for older people.
15. Additionally, following requests from some neighbourhood meetings, WCT has begun sharing information about community nursing patients with their practices on a trial basis, so that practices are regularly informed about which patients have joined or left the nursing caseload.

Internal work regarding the development of the infrastructure to support Neighbourhood development

16. To strengthen the links between various pieces of trust project work that influence or are influenced by neighbourhoods, WCT has established an Integrated Neighbourhoods Steering Group. This group will ensure dependencies or opportunities to maximise benefits across projects are identified and managed.
17. In December 2018, WCT held a development session with matrons and social care staff, using case studies to explore opportunities for deepening integrated working. Opportunities to share consistent information about third sector organisation were identified and a directory of commonly signposted services/groups is now in development. **Appendix 1 examples of service descriptors on a page.** These are being shared both internally and to system partners including each GP practice.
18. A Standard Operating Procedure (SOP) has been developed to support the on-going use of risk stratification to proactively identify people who may benefit from Integrated Care Coordination Team management, for recommendation to their GP. This has been combined with changes to SystmOne so that the potential for multiple screening reviews month on month is removed. This process supports contract management monitoring under the Service Development Improvement plans (SDIP's).

19. The next phase of this work is a wider focus on the development of multi-disciplinary working at practice, neighbourhood and locality level, building on existing good practice to ensure that relationships between different practices, teams and services are as effective as possible, enabling more responsive care. Proposals from this work stream will be shared with partners during Q4.

Integrated Health and Social Care

20. Work continues within Adult Social Care to continuously review standards of practice through regular audits and practice based improvement plans. Since transfer the service has continued to benefit from the infrastructure and guidance provided by the Trusts' internal audit programme. During the last quarter's report, reference was made to a number internal audits being carried out including:
- Making Safeguarding Personal (MSP) - A service wide action plan is now in development alongside recently implemented changes to the safeguarding investigation closure processes to evidence more clearly the outcomes of MSP. In addition the Trust is now part of a regional pilot to test out a newly national MSP outcomes framework developed by the Local Government Associate, Institute of Public Care (IPC) and Research in Practice for Adults (RiPfa). This pilot runs until March and will support improvement both internally and regionally
 - Trust Wide Record keeping - Overall this was positive in relation to Adult Social Care (ASC) however the need for work around contemporaneous recording keeping and use of abbreviations was identified. Feedback with teams is planned for the 22nd and 23rd January 2019
 - Assessment for financial management and charging advice – this remains a key area of focus as it has been a theme in a number of complaints. The need to make improvements is recognised and acknowledged by the service. Work is in process with Wirral Borough Council (WBC) who are providing an updated Financial Information Booklet and refresh training will be provided for adult social care staff, within the Trust. A specific action plan is also being developed to improve standards of recording of information and advice provided
21. Alongside the internal audits, the Trust commissioned Mersey Internal Audit (MIAA) to review the governance arrangements for the integrated health and social care teams, as part of the Audit programme for 2018/19. This review has now been completed and feedback will shortly be provided to the Executive Team and Senior Managers. The review considered a number of key areas including leadership, governance structures, systems and processes, risk management arrangements, accountability and reporting mechanisms. It is recognised that following the transfer of the service in 2017, we continue to be on an improvement journey and this audit will provide valuable feedback to assist in ensuring a targeted and sustained approach towards continued improvement.
22. The Transformation phase for ASC has now commenced and the Programme Initiation Document (PID) and Quality Impact Assessment (QIA) are being finalised. Progress is will be reported at the Trust's Programme Management Board (PMB). Work has already commenced in a number of priority work streams including:
- **Improving transitions for young people.** Transition Policy and SOP being updated (Jan 2019).
 - **Development of integrated assessment.** We have agreed to adopt a combined task and finish approach with partner agencies including WBC and CWP, with workshops planned for practitioners in January / Feb 2019.

- Review of Multi Agency Strategic Hub (MASH). Initial internal redesign work has been completed with enhanced social work screening now being piloted in the gateway. Further redesign work is continuing in collaboration with CWP and WBC.

A&E Delivery Board and Urgent Care Priorities/Winter plan

23. The Urgent Care Consultation concluded on the 12 December 2018. This is a CCG led, Wirral wide consultation on the introduction of an Urgent Care Treatment Centre which is mandated by December 2019.
24. The feedback from the consultation will be discussed at the CCG Governing Body meeting in January 2019 followed by discussions with providers during February 2019 on the feedback and the way forward.
25. Following the development of the winter plan, relevant services within the Trust and partners have been mobilising plans in readiness for the winter period. This forms part of a clear system wide plan to improve patient flow and outcomes for 2018/19.
26. Wirral partners continue to utilise and refine the application of the capacity and demand modelling work which is now in year two of that development. Other systems in the region have been encouraged to adopt the same approach. The plan to deliver a “safe winter” included the following requirements:-
 - Delayed Transfer of care - no greater than 2.67%
 - 25% reduction on stranded/super stranded patients
 - Agreed improvement trajectory to achieve 90% performance against the 4 hour ED standard by December 2018 and 95% from March 2019
 - Acute occupancy level - 92%
 - Zero tolerance of minor (type 3) breaches
 - Implementation of streaming
 - Timely ambulance handovers
 - Eliminating corridor care
 - Manage Monday surge
 - Full implementation of SAFER
27. Urgent care Executive leads continue to meet to provide accountability, assurance and grip and reports to the A&E delivery board.
28. Performance reporting across the system ensures a single overview position and a detailed RAG rated plan evidencing progress.
29. An additional 48 acute winter beds, 30 on the Clatterbridge site commissioned by WUTH and delivered by 4 Seasons and 18 on the acute site are planned, this is supplemented by an additional 20 community beds (including T2A, but also respite and EMI provision).

Areas of notable progress from a system perspective

30. Notable progress has been made in relation to the following priorities:-
 - Delivering and maintaining DToC performance
 - Streaming is now delivering, with new model in place from 5 November 2018
 - Community offer has significantly scaled up and evidencing return on investment including improved HomeFirst offer, 7 day therapy service with streamlined structures and processes
 - SPA (Single Point of Access) is now co-located, bringing together 3 areas of provision (Mental and Physical Health and social care duty)
 - High impact change model evidences delivery of Trusted assessor, effective tele-triage and improved support to care homes, reducing ED attendance and calls to 111 and 999
 - Developing the IUCCAS model - (Clinical advice model within 111)

Key areas for system focus attention and address as urgent priorities for the system

31. These are the areas of improvement that the system is working on and are the topics covered in the NHSE/I weekly winter call:-

- Ambulance handover and turn around
- ED and assessment area flow
- Achievement of the 4 hour standard
- Reduction of stranded and super stranded patients
- Community T2A length of stay
- Maintaining domiciliary care capacity and flow
- Reducing Non elective admissions
- Full implementation of SAFER

32. There continues to be a mixture of reasons why the above has not been delivered to date including:-

- Workforce recruitment and retention challenges, leaving critical gaps, including key clinical and leadership posts.
- Culture and behaviours, which take time to address and requires a strong system leadership approach
- Lack of system maturity to work collaboratively, organisational silos can inhibit progress
- Capacity across the system to implement and embed transformational change at pace, with limited project management support
- Gaps and delays in system data reporting, resulting in delayed escalation in key areas
- Financial challenges

Introduction of the Command Centre

33. The Trust has been supporting partners across the system since the beginning of December by providing a senior manager to attend the hospital daily to support and escalate issues which might prevent smooth patient flow. This was initially for a 3 week trial period in order to gather learning and to see what difference it made. It was felt that the information sharing could be done by telephone and this has been in place prior to Christmas and will remain in place until winter is officially over. Senior managers from the Trust have been supportive of this approach and feel it helps understanding of collective pressures and use of resources and builds relationships as well as improving patient flow. There is an escalation process in place.

Current and previous monthly performance until December 2018

4 Hour standard

December 2018	84.5%	December 2017	80.4%
November 2018	83.7%	November 2017	85.8%
October 2018	86.2%		
September 2018	89.2%		
August 2018	90.1%		
July 2018	91.1%		
June 2018	89.8%		
May 2018	89.9%		
April 2018	87.5%		
March 2018	84.2%		
February 2018	83.2%		
January 2018	86.5%		

34. Walk in Centre and Minor Injury Unit activity has remained consistently high, with 9,624 attendances in November 2018 and 9,478 attendances in December 2018.

Areas where the Trust has direct responsibility for the priorities within the plan or has significant influence

Delayed Transfer of Care

35. Delays transfer of care (DTC) performed below the national target of 2.67%. in October 2018 at 2.1% with a slight increase in November to 2.3%

Transfer and Assessment (T2A)

36. Weekly reviews of the longest length of stay patients in the Transfer to Access (T2A) beds are in place to understand root causes of any delays in transfer and discharge which impacts in the overall length of stay (LOS) target.
37. This will be augmented by a point prevalence piece of work commencing on the 7 January 2019 on patients in the T2A and rehabilitation beds within Arrowe Park and Clatterbridge including the newly commissioned beds.
38. To support safe discharge the following has been put in place in the nursing homes which accommodate the T2A beds.
- Weekly MDT meetings- the Service Manager is also attending these meetings during January 2019
 - MADE (Multi Agency Discharge Event) implemented Quarterly
 - Stranded patient reviews - monthly
39. The average length of stay (LOS) figures for October 2018 was 5.3 weeks and 6.0 weeks for November 2018. This is being closely monitored as the target is 4.2 weeks and is important to ensure flow across the whole care pathway.

Domiciliary care

40. Whilst we continue to have people waiting for care packages, we have worked hard with domiciliary care providers to prioritise flow and avoid delays in discharges in the hospital and community (T2A) beds. As of the 3 January 2019 data there were 45 patients waiting for care packages. 9 for the hospital, 6 for T2A bed and 30 in the Community. This is a decrease on the total reported activity at last Board meeting which is showing the positive impact of the additional social care winter funding allocated to Wirral.

Location (New Requests Only)	Total	Longest Wait (wks)	Average Wait (wks)
In Hospital	9	8	3
In T2A Bed	6	8	5
The Community	11	15	5
Short Term Placement	2	8	4
STAR awaiting Package	17	12	4
Total in circulation	45	15	4

Clinical streaming

41. Clinical streaming has been in place since September 2017. Phase 2 of the model was implemented on the 19 February 2018. This has not been implemented fully as the hospital has been unable to recruitment suitably qualified nurses.
42. The Trust was asked to provide a nurse to stream from the front door at the Emergency Department and a robust rota has been developed to ensure full coverage 10am-10pm, 7 days per week. This will commence on the 5 November 2018.
43. There has been effective streaming daily of between 20 – 25 patients

Tele-triage

44. The data relating to the impact of the Teletriage service on un-necessary admission avoidance has been positive demonstrating a 76% reduction in calls to 111 following the induction of all care homes into the service. North West Ambulance Service (NWAS) data reports a 13% reduction of call outs from care homes and is currently at its lowest rate in three years. The community Geriatricians and Specialist Nurses for Older Persons believe they see less care home residents in the hospital setting since Teletriage has been operational.

Single Point of Access (SPA)

45. Phase 2 of the SPA redesign has been continuing during the last quarter with all partner agencies working to develop a new optimum operating model for a Wirral wide single integrated Gateway. Led by the CCG, with representation across the health and care system, this work builds on the recent co-location of colleagues from Cheshire Wirral Partnership (CWP) into St Catherine's and the physical move to bring the three existing SPAs into one location.
46. Several workshops have been held with key operational leads to explore potential options for a new operating model and business mapping has been undertaken. The development of the model is being supported with the collection of key activity and outcome data for all three current SPA's including Social Care, Physical Health and Mental Health Services. The new operating model will aim to focus on improving outcomes for local residents by:
- Delivering a true single access point into urgent and planned care across all disciplines - Mental Health, Physical Health, Social Care and the Community Voluntary Sector Services.

- Ensure a consistent offer for individuals, patients and professionals – providing a joined integrated approach to provide the right care at the right time with a strong out of hospital focus and Home First ethos.
 - Promote optimum performance, use of resources and value for money for the system as a whole.
47. Phase 2 is due to conclude shortly and the proposed operating model will be presented to the Trusts' Executive Team and Urgent Care Executive Group for agreement and sign off. The SPA redesign programme will then be refreshed to review the timescales for implementing a new model.

Intermediate Care Community Services redesign

48. The Trust has worked closely with commissioners on the review of the intermediate care services with recommendations to improve the operating model for home and bed based community support services.
49. This was presented at the Board Development session in December 2018.
50. The team have been working on implementation of the new model from 1 November 2018 including:-
- HomeFirst duty desk has been established and the Multi-Disciplinary Team is in place
 - White boards in place to share information
 - Consultation with staff on rota changes to cover 7 days 8am-8pm
 - Operating model for bed based therapy support
 - Assessment complete to identify patients who require 2 hours crisis response
 - Work on Phase 2 of the plan has commenced including links with the SPA redesign

Collaborative working regarding Children's services

51. **Opportunities for Health Visitors and Midwives at four 0-19 bases.** Hot desks are available at St Caths, Bridle Road, VCH and Greasby Health Centre.
52. **Development of an integrated enhanced team.** The model now includes Local Authority (LA) following a meeting with the Director of Children's services in December who is keen to enhance partnership working. The Trust's Looked after Children's (LAC) nurses will be co-located in the LA LAC team from April 2019. Wirral University Teaching Hospital (WUTH) will form part of the extended team, although there are proposals for WUTH LAC to move to the Trust (as highlighted in point 65 in November's report). This model of integration will strengthen WCT's position for re commissioning of Wirral 0-19 which will commence in February 2019.
53. **Children being discharged from WUTH.** Jo Chwalko and Debbie Edwards from WUTH identified a gap in service for young people fit for discharge from the children's ward who could not return home due to waiting for mental health assessments. They have implemented a pathway for the ward to notify WCT Teen team who can provide on-going support to this cohort of young people, and will arguably speed up discharge. The evaluation of this pathway will be completed by the end of Q4. The rationale is to support the implementation of WCT's Young people's panel that will have a role in developing and improving pathways.
54. **Pathway development.** A pathway has been implemented for sharing Accident and Emergency (ED) attendances for young people with the school nurses and schools, to ensure continuity of care is in place. Data analysis has identified that more focus is needed around 'prevention' and System 1 reporting. Themes have included risk taking behaviours and drug misuse. Identifying harm can be challenging as the primary diagnosis in Walk In Centres and ED is often the injury sustained from the self-harm, not cited as the primary cause. Therefore, manual checking is often required by the safeguarding specialist nurse.

The specialist nurse will work in partnership with the Business Intelligence team to improve reporting parameters. The Young people's panel will support Integrated Children's Division (ICD) in exploring 'prevention' further. The ICD has recently recruited 30 volunteers. They will also have a role in 'patient experience' gathering the views of young people who use our services to improve the care we provide.

55. **Shadowing opportunities.** During Q4/1 a number of frontline practitioners will commence shadowing opportunities. The aim is to improve pathways and partnership working. However, there may be scope to offer future rotational positions across WCT and WUTH to enhance workforce knowledge and skills including those on apprenticeships.

Integrated Therapy's work programme

56. Work has started to review pathways across community and WUTH Dietetic and Speech and Language Therapies.
57. Patient outcome measures are being used across therapy services in WCT and within WUTH T2A bed base.
58. Joint development and delivery of training for T2A bed base staff to facilitate and improve 24hour Reablement offer was delayed due to problems sourcing venue and equipment. This has now been resolved and dates have been arranged for the training.
59. Meeting arranged for Jan 2019 to review next steps and consider alignment to neighbourhood developments.

Conclusion

60. The Trust continues to be an important and valuable partner within the local health and social care economy, and wider with the development of STP's across the Cheshire and Merseyside footprint.
61. This month's report evidences the progress that has been made across a number of projects which are related to integration, partnership and collaborative working across many layers within the health and care system. It is complex and multi-faceted.
62. Integration is the cornerstone of our care model and the Trust is ideally placed to lead. Our staff are integral in delivering the different care models and the staff supporting the development of the Neighbourhood model are well placed to drive the development because of their skills and expert knowledge.
63. The work that we did with partners to prepare for winter and now to mobiles those plan are being tested daily now that we are in the winter period. The weekly calls with NHSE/I demonstrate the important role the community plays in keeping patients safe and the daily teleconferences allows for conversations around capacity, demand and solutions.
64. We are an increasing key partner in providing or navigating to alternatives out of hospital. We have to communicate and demonstrate what our strengths are in delivering services, both nationally and locally, in partnership for the future. The added value that the Trust contributes is a holistic view of patients and their trust in us, multidisciplinary team working, knowledge of our communities, strong leadership for consensus and partnership and a willingness to embrace new relationships and collaborative working.

Board action

65. The Board of Directors is asked to be assured that the Trust is instrumental in Healthy Wirral. We are absolutely the “place” in Place Based care especially in the space of integration, urgent care, and influencing commissioning and primary care agenda’s which ensures the delivery of a high quality service which enhances patient care and patient experience.

Val McGee
Chief Operating Officer

Contributors:

David Hammond, Associate Director for Strategy and Partnerships

Sarah Alldiss, Associate Director Adult Social Care

Karen Milnes, Divisional Manager Adults and Community

Tracy Orr, Divisional Manager Urgent and Primary care

4 January 2019

ICCT (Integrated Care Coordination Team)

Referral to the ICCT means that patients are assessed and reviewed by a multidisciplinary team of different health and social care staff from the NHS and third sector



Wirral Community

NHS Foundation Trust

Duty Matrons

(for advice, signposting and clinical reviews on step-up step-down patients)

N.B. These numbers should not be given to patients or relatives .

Monday – Friday 8:30am – 5:00pm

Wallasey:
07880 247 868

Birkenhead:
07833 049 274

South Wirral:
07880 247 866

West Wirral:
07880 247 869

Who is suitable for referral?

- Age 18+
- Patients with complex health and social problems requiring referral to ***more than one service***
- Patients requiring assessment from a Community Matron, **to prevent unplanned hospital admissions** resulting from long-term conditions
- Patients over the age of 65 who are having social, physical or mental health problems impacting on them coping at home, requiring a holistic assessment from a Nurse Practitioner for Older People (NPOP). NPOPs also have a special interest in memory difficulties and Dementia/Alzheimer's)
- Patients requiring a Nursing Assessment / Continuing Health Care/ Emergency Health Care Plan

Who is unsuitable for referral?

- Patients only requiring one service e.g. Occupational Therapy for equipment
- Patients only requiring a social assessment
- Patients with long and enduring mental health problems
- Patients with substance misuse issues
- Patients requiring an urgent service (contact Rapid Community Response via SPA)

Consent must be gained by the GP prior to referral to ICCT as patient details will be shared within the MDT

What happens after referral?

- Referrals are triaged each morning Monday – Friday
- An acknowledgement letter is sent to the GP with the outcome of the triage
- A designated Care Coordinator is appointed for each patient
- The patient is contacted and a date arranged to be visited and assessed
- ICCT members meet weekly to discuss cases active on the ICCT caseload
- GPs will receive significant update letters and a Discharge Summary will be sent
- For specific queries relating to a patient who has been referred, GPs can contact the MDT Coordinator

Referral Process

Referral to ICCT is via Single Point of Access (SPA)

Tel: 0151 514 2222 –

the call handler will complete the form with you on the phone. Alternatively, email referrals can be made using the Single Referral Form on EMIS.

Emails should be sent to:

wcnt.GPReferrals@nhs.net

SPARCS – Single Point of Access and Referral to Community Services
Integrated Gateway Team – Crisis Response (formerly called Rapid Response)
SPARCS Crisis Response is a **72-hour service** for patients at risk of admission to hospital requiring an **urgent same-day assessment**.

Referral Process

Referral to SPARCS Crisis Response is via Single Point of Access (SPA)
Tel: 0151 514 2222 – the call handler will complete the form with you on the phone.

Who is suitable for referral?

- **Patients that would need hospital admission within two-hour or same day period, requiring urgent social care, nursing or therapy intervention** – for example, if their carer has been admitted to hospital, a sudden deterioration in mobility and transfers, increased falls, acute chest issues requiring physiotherapy, provision of urgent equipment to enable patient to stay at home, urinary tract or post-surgical infections, cellulitis
- Patient must be 18 years of age or over and living at home in the community

Who is unsuitable for referral?

- Patients with CVA/TIA, hematemesis, severe chest or abdominal pain
- Patients where the predominant factor is a severe mental health or drug/alcohol problem
- Referrals that can be effectively managed by standard social or health care services within the timeframe required
- Long-term conditions and adaptations - these are managed by Adult Social Care Occupational Therapy Team
- Patients requiring IV antibiotics, respite or end of life care
- A care home resident who is not at risk of hospitalisation*

*Rehabilitation at Home offers a service into residential homes.

Consent must be gained by the GP prior to referral as patient details will be shared within the MDT

Crisis Response Team

Physiotherapists,
Occupational Therapists,
Nurses, Social Workers
Technical Instructors and
Health Care Assistants who
work together to provide
short-term support and
rehabilitation in the patient's
home. We have access to:

- Specialist services and equipment
- 'Transfer to assess' (T2A) beds for patients requiring 24-hour emergency care and a management plan (*not for patients requiring respite, unless required due to an emergency situation with the main carer*).

For general queries email:
wcnt.rapid@nhs.net

What happens after referral?

- Patient will be contacted on the same day – within two hours if an urgent case
- Crisis Response Team will review GP summary and patient co-morbidities
- Patient will be triaged by SPARCS Crisis Response Team and a visit will be arranged
- Management plan will be put in place – Crisis Response will liaise with GP where appropriate
- GP will receive discharge summary with any relevant care plan/package that has been identified

Promoting People's Independence Network (P.O.P.I.N.) is a *free* service to all people of 60 and over in their own homes.



Wirral Community
NHS Foundation Trust

Referral Process

Referral to POPIN is via the Social Services Central Advice and Duty Team (CADT) within Single Point of Access (SPA)

Tel: 0151 514 2222 – option 3

Who is suitable for referral?

People over the age of 60 requiring:

- Assessments for Assistive Technology or other equipment to reduce risk around the home
- Assistance to ensure the person is claiming benefits they may be entitled to
- Information and advice for services that help people stay safe in their own home, for example, handyman services, falls prevention
- Information on any grants available (heating, insulation etc.)
- Support with referrals to Merseyside Fire & Rescue Service for home fire safety checks and smoke alarms
- Information and support with applications for housing - sheltered and extra care accommodation
- Support to access services provided by other organisations and if appropriate referrals on the person's behalf to health services
- Enabling and supporting access to private care agencies for people who self-fund or wish to arrange their own care privately
- Completion of carer assessments, if appropriate
- Advice and support to access voluntary or befriending services

Who is unsuitable for referral?

- People who are in nursing or residential homes
- People who have existing services in place from Adult Social Care

Consent must be gained by the GP prior to referral

What happens after referral?

- The POPIN Worker will visit on a day and time that is convenient and complete an assessment to identify any needs. The worker will provide advice and information about different services available and refer on if needed, to help maintain independence in the home
- After the POPIN Worker's initial visit and any follow-on referrals have been completed, the person will be contacted to check all services are in place
- The person will be contacted annually to review their circumstances if they have Assistive Technology in place, to check this is still suitable

The POPIN Service

The service aims to:

- Help people stay independent within their own homes
- Promote safety in the home
- Give advice on staying healthy and promote general well-being
- Assist people to improve their income (benefits)
- Reduce the need for domiciliary support and/or residential care
- Prevent people's circumstances deteriorating

Monday to Friday 9am – 5pm

For general queries email:
wcnt.centraladviceanddutyteam@nhs.net

Transfer to Assess (T2A) Bed-Based Service - Part of Single Point of Access and Referral to Community Services Integrated Gateway Team (SPARCS)

A multi-disciplinary team of Physiotherapists, Occupational Therapists, Social Care and Nursing Assessors who provide a 'step-down' provision for hospital discharge and a temporary 'step-up' provision for people living in their own homes who may need short-term or urgent support within a Care Home environment.

Referral Process

Referral to T2A is via the SPARCS Team within Single Point of Access (SPA)

Tel: 0151 514 2222

8am – 8pm Mon - Sun

Who is suitable for referral?

- People having frequent attendance at hospital who are not managing well with their current package of care, who require a period of assessment
- People who are at risk of hospital admission due to an emergency situation with their primary carer (**not for carer respite**)
- People requiring stabilisation and recovery from an episode of ill-health or hospitalisation, for targeted person-centred care, support and therapies to enable them to return home or to an alternative setting

Who is unsuitable for referral?

- People with significant psychiatric/behavioural problems requiring 1:1 support
- People who are continuing to use drugs and who are not entering a programme of drug rehabilitation
- People requiring end of life care (support would be via Fast Track Continuing Health Care) (CHC)
- People aged under 18
- People aged over 18 who are not registered with a Wirral GP or who are not resident in Wirral

Consent must be gained by the GP prior to referral

What happens after referral?

- T2A Team will triage and arrange to assess the person – **within 2 hours if a crisis, 2 – 4 hours if not a crisis.**
- T2A Team will complete a Transfer of Care Summary Form. If the person can be supported at home, SPARCS Crisis Response Team will put measures in place to support them. If the person requires moving to a T2A bed, transport will be arranged and the person will be moved to the Care Home.
- Significant update letters and discharge letters will be sent to the GP.
- The person will be assessed during their stay and discussed at weekly MDT and SAFER Board meetings held within the Care Home. Where possible, a package of support will be put in place to enable the person to return home as soon as possible. Where longer term placements are necessary, options will be discussed with the person and their family to facilitate the move to a suitable Care Home

Care Home Beds are available for an average of 3–6 weeks	No of T2A Beds
Daleside Nursing Home, Rock Ferry	22
Leighton Court Nursing Home, Wallasey	25
Grove House Nursing Home, Claughton	23
Elderholme Nursing Home, Bebington	16
The Dales Care Home, West Kirby	10
Summerfields Care Home EMI Residential, Birkenhead	5
Park House EMI Nursing (Winter Pressures)	3
Oxton Grange (Winter Pressures)	20

STAR – Short Term Assessment and Reablement Service –

Part of Single Point of Access and Referral to Community Services Integrated Gateway Team (SPARCS)

STAR is a non-urgent **free of charge** service provided by health and social care workers who will assess the person in their home to get a clearer idea of their needs and help them regain their independence.

Referral Process

Referral to STAR
is via Single
Point of Access
(SPA)

**Tel: 0151 514
2222 – option 3
(CADT)**

Who is suitable for referral?

- Referrals for people 18 years of age or over and living at home in the community
- People who need support services and assessment for short or long-term packages of care
- People requiring specialist equipment, assistive technology, falls alarms or reablement to enable them to regain or maintain their independence
- People who have never had services before can be referred for assessment
- People who have been an inpatient in hospital and need assistance to regain independence

Who is unsuitable for referral?

- People who already have services in place or who have had a recent assessment (within three – six months, unless their circumstances have changed)
- People who are referred **must be willing to engage** with the reablement programme and the support offered, this should be discussed with the person prior to referral

Consent must be gained by the GP prior to referral

What happens after referral?

- The STAR First Contact Team will triage the referral and **aim to contact the person or their next of kin within one week to arrange a home visit**
- A full Care Act Assessment of Needs will be undertaken by the Assessment Reablement Officer to look at the level of support required
- If eligible for services, the person will remain under STAR for **one to three weeks (maximum of six weeks)**, to allow time for them to regain their independence
- If longer-term services are required, these will be discussed with the person and their family and the Assessment Reablement Officer will commission these services. Following a financial assessment, the person may contribute towards the cost of those services.

How STAR can help:

Assessment Reablement Officers will help increase the person's confidence, find new ways to do things and offer encouragement and support.

The programme of reablement will **focus on everyday issues** such as:

- Washing and dressing
- Advice on how to reduce the risk of falls
- Helping the person cope with memory problems
- Coping with practical tasks such as laundry and cooking
- Getting around their home
- Prescribe small aids/equipment
- Practice using specialised equipment
- Supporting the person in getting into the habit of taking prescribed medication regularly

For general queries email:
wcnt.centraladviceanddutyteam@nhs.net