



Report to: Overview & Scrutiny Co-ordinating Committee
Cabinet

Date: 26 May 2009
18 June 2009

Subject: Care Closer to Home

Report of: Select Committee No. 4 - Health

Contact officer: Diane Taylor 01942 827135

Purpose / summary: To inform members of the recommendations arising from the Health Scrutiny Committees fourth report on Care Closer to Home. The report focuses prevention and support following discharge from hospital with a particular emphasis on older people.

Alternative options considered and reason for selecting the one recommended: None

Recommendation / decision: Recommendations are within the report

The decision will be made as a result of this report and will be published within 48 hours

Risks / Implications: The risk of not carrying out these

recommendations could have effect on performance through the LAA

Financial:	None as yet
Staffing:	None as yet
Policy:	Scrutiny
Equal Opportunities - Has a Diversity Impact Assessment been conducted?	A diversity impact assessment is not necessary at this stage, however, equality and diversity implications have been considered.
Wards affected:	All

Property Implications – Does the proposal involve a reduction, addition or change to the Council’s asset base or its occupation?

No

If yes, have the property implications been agreed with the Corporate Property Officer?

Does this proposal have significant implications for the Council and the local population?

A diversity impact assessment is not necessary at this stage, however, equality and diversity implications have been considered when producing this report.

Does this proposal involve a new policy or procedure or significant changes to an existing policy or procedure?

A diversity impact assessment is not necessary at this stage, however, equality and diversity implications have been considered when producing this report.

Has the Service Director - Borough Solicitor confirmed that the recommendations within this report are lawful and comply with the Council’s Constitution?	Yes / *
Has the Service Director - Corporate Services confirmed that any expenditure referred to within this report is consistent with the Council’s budget?	/ No *
Are any of the recommendations within this report contrary to the Policy Framework of the Council?	/ No *

* delete which applicable

For Cabinet reports only :

Categorisation of the report:	x
Discussion leading to a decision	
Monitoring	
Sharing for corporate understanding	

	x
Discussion	
Decision	
Information	

Tracking/Process:

	Consultation	Ward Members	Partners
Panel	Overview & Scrutiny	Cabinet	Council

List of Background Papers in accordance with Section 100D of the Local Government Act 1972:

Title of document	Which meeting did it go to?	Date of meeting	Copy available from?

Proper Officer Sue Johnson

Date 15 May 2009

Report of Select Committee No. 4 – Health

Care closer to home

Issued March 2009

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Foreword

This is the fourth report of the Health Scrutiny Select Committee and outlines our investigation into the services provided in the Wigan Borough for those that are receiving services at home or within the community to help them to live more independently.

We have focused on prevention and support following discharge from hospital with a particular emphasis on older people.

Prior to the and during the course of the review, Adult Services and partners have carried out a number of reviews in this area. The recommendations arising from these reviews have been considered in this report. Our continued good relationships with all partners has enabled the sharing of useful and timely information to inform this review. This is down to the hard work, commitment and collaborative working between the Wigan, Wrightington and Leigh (WWL) NHS Hospital Trust, Ashton, Leigh and Wigan Community Health Care and we to improve health services for local people.

Health Scrutiny is a challenging area of the Patient and Public Involvement agenda and we are committed to playing our full part. The aim of Health Scrutiny is to make recommendations that lead to improvements in the health and well being of local people.

I would like to add my personal thanks to the members of the Committee, and everyone else that gave evidence – written or verbal or took part in consultations.

I do hope we can continue to work in this highly successful and productive way.

Cllr Ged Bretherton
Chairman Health Scrutiny Select Committee
March 2009

Executive Summary and Recommendations

Introduction

We have undertaken this review in our responsibility to scrutinise health services as part of our wider role in enabling health improvement in our area.

This report describes our fourth review, which began in August 2008. The aim of the review was to suggest recommendations for improvements in services that deliver care which promote independence and care closer to home. It investigates what current services are available, proposals for future provision, their effectiveness and impact on patients and carers.

To explore the issue fully we developed terms of reference. It comprised of a number of tasks:

- 1 To understand the services that are provided through the 'hospital care at home' scheme including care provided at home and in the community
- 2 To understand how the closure of Whelley hospital will impact on this service and the residents of Wigan.
- 3 To gain a picture of our performance under the following indicators:

Local Area Agreement

- NI124 - % of people with a long term condition who are supported by people providing health and social care services to be independent and in control of their condition - this figure will be provided annually from the PCT HE Patients Survey.

Local indicators:

- Carers receiving needs assessment or review and a specific carers service, or advice and information
- % of vulnerable people achieving independent living

- 4 To identify gaps in provision and areas for improvement.
- 5 To explore good practice nationally and locally.

A number of methods were chosen to investigate the review's objectives – they are summarised below:

- Baseline research to find out the current position including current performance against key indicators.
- Consultation with those already receiving the service. This had already been undertaken by Wrightington, Wigan and Leigh (WWL) NHS Trust. They undertook a survey in July 2008 to explore patient and public views regarding the development of the Hospital at Home Service.
- Witness hearings which are formal meetings where key people are interviewed by the Select Committee. This involved officers from the Primary Care Trust, the Acute Trust, officers from the council's Adult Services Department, ALW Community Health Care (provider arm of the ALWPCT) and a carer representative.
- Research of national, regional and local good practice.

Recommendations

Our recommendations have been summarised into three areas of Assessment through to discharge, co-ordination, collaboration and communication and support to carers. These are shared in more detail on pg 23 of this report.

What is health scrutiny?

In January 2003, Wigan Council was given new responsibilities to scrutinise health services as part of our wider role in health improvement and in reducing health inequalities in our area. This function is delegated to the Overview and Scrutiny

Committee who have established a dedicated Health Select Committee to undertake this challenging role.

This new power enables us to take a strategic view of health needs within the area and to scrutinise priority issues. These priorities may be thematic on issues of a public health nature, such as homelessness or services for older people or a specific service oriented priority such as the provision of and access to chiropody services.

A number of duties are placed upon NHS bodies in relation to the overview and scrutiny committees. These range from providing information to overview and scrutiny committees to consulting on substantial developments or variations in service.

The outcomes and recommendations of health scrutiny are intended to contribute to policy development on matters affecting the health and well being of communities.

The Health Select Committee was established in May 2002. This year (2009) it had 6 members and was chaired by Cllr G Bretherton Membership included; Cllr C Rigby, Cllr J Hurst, Cllr M Dewhurst, Cllr L P Holland, Cllr B.J. Fagan and co opted member Cllr. M Winstanley. The committee was supported by Diane Taylor and Alison Cain who provide policy support. This committee undertakes formal scrutiny reviews; hears progress reports from health and social care services and is formally consulted on major service developments. All reports are submitted to the Overview and Scrutiny Committee for ratification.

A Forward Plan of areas to be scrutinised is produced annually by the Health Select Committee in consultation with elected members, local people, health and social care agencies, council officers. This sets out a work programme but is flexible and can be amended to respond to new and emerging priority issues. The current plan is available

from Diane Taylor, Business Partner, Chief Executives Department, Town Hall, Wigan, telephone 01942 827135.

Our fourth health scrutiny review- Care closer to home

To produce recommendations for improvements in services that deliver care which promotes independence and care closer to home. With a particular focus on prevention and support following discharge from hospital of older people.

The review has followed a terms of reference as set out on page 4.

1. Background

Being hospitalised can be a traumatic experience, especially for older people. Hospitals are noisy, disorienting, full of strangers and infections often spread among patients.

Studies have shown that for older people with certain acute conditions, hospital-level care can be provided at home for less money and with fewer clinical complications than in-hospital care. In addition, the study found that patients recover sooner when "hospitalised" at home, and they and their families were more satisfied with the whole experience.

The Government's adult social care green paper, "Independence, well-being and choice" describes the change in delivering care as moving from, "A system, where people have had to accept what is offered, to one where people have greater control over identifying the type of support or help they want and the choices and influence over the services on offer."

The term 'choice' may include choice of provider, professional, service, timing or access channel and might be offered to the user through any or all combinations of these. Services that more obviously demonstrate some element of 'choice' or 'personalisation' include:

- adult social care – direct payments for users
- corporate customer focus – widening access to services
- public health – support to make your own health choices; support tailored to individual circumstance

1.1 Why we chose this area for review

1.1.1 Closure of Whelley Hospital and impact of current provision

Patients at Whelley Hospital mostly required only nurse led care or were awaiting arrangements to be put in place for discharge from hospital to a more appropriate environment. There was no access to other medical and support services at Whelley and 70% of patients were already medically discharged. Patients at Whelley were staying much longer than needed, being exposed to risks of infection and loss of independence. A number of initiatives have been considered to change, modernise and improve the services to elderly patients in partnership with primary care and the council's Adult Services. Members took part in the consultation exercise regarding closure of Whelley Hospital, and although agreement with closure was made, they did raise concerns about the impact on other service providers and the effect on patients and carers. The review considers the services available to support those patients who would have normally been placed at Whelley Hospital.

1.1.2 Local Area Agreement (LAA) National Indicator Set (NIS) performance

NIS	Description	Current performance (q2)	Quarter 3
NI 124	% of people with a long term condition who are supported by people providing health and social care services to be independent and in control of their condition	Measured annually, figures not available as yet	Measured annually, figures not available as yet
NI 135 - Local	Carers receiving needs assessment or review and a specific carer's service, or advice / information	Target set was 19.4 . The projected target for qtr 1 was 15.8 based on the mid year actuals and is under target.	18.7 - This is a projection based on the mid year actuals and is under target. Awareness is being raised with all staff through discussion in various forums. Written processes have been amended to emphasise the issue. System checks are being undertaken to identify and address areas of low performance.
Local (SP) NI 141	% of vulnerable people achieving independent living	Target set was 82% . Qrt 1 figure was 84.6 Overall performance is 2.8% up on the previous year which was in the upper quartile for performance.	Target set was 82%, performance for quarter 3 was 85.6% overall which reflects excellent performance against the latest national data received (08/09 q1) where the upper quartile is 79.7%. Locally, performance is 3.8% higher than for the 07/08 year and an improvement in quarter 3 performance (87.6%) has raised the overall performance by 1.4%.
NI 130	Social Care clients receiving Self Directed Support per 100,000 population (Direct Payments and Individual Budgets)	Target set was 184 . Qrt 1 figure was 228.9 - Above Target - this is actual to date and the increase this quarter is expected to continue to year end.	341 - Above target - this is actual to date and the increase this quarter is expected to continue to year end. The numerator this year includes those on the Direct Payments Scheme and carers receiving one off payments to assist them in their caring role. The continuous improvement in both areas is as a result of focused efforts to increase take up across the Dept .

Not in LAA but useful for providing background for priority			
NI 142	% of vulnerable people who are supported to maintain independent living	Target set was 98.70% . Qtr 1 figure was 98.5% - Overall performance is 0.1% down on the previous year and is down 0.2% against target set for the year	Target is 98.7. Actual performance was 98.1% - Overall, when compared to the latest national data (08/09 q1), this figure is below the upper quartile of 98.8%. It is also 0.6% below the target set for the year of 98.7% and 0.5% down on the 07/08 annual performance.
NI 134	Emergency bed days per head of the weighted population	No target set as yet but work is currently underway to agree suitable target. Actual for June 08 = 15532 this is compared to 16739 for June 07	Reported a quarter in arrears
NI 132	Timeliness of social care assessments. % of assessments completed on time	The target for Q2 was 78% and the actual figure was 77%	Actual performance 65% against a target of 78%. A historical backlog of some cases awaiting assessment in the Occupational Therapy team have been cleared, which whilst being beneficial to those people, have had a negative impact on the performance indicator. Excluding the backlog performance would have been around 73%.

1.1.3 The Department of Health's social care Green Paper, 'Independence, well-being and choice' (2005)

This paper reinforced by the White Paper, 'Our health, our care, our say: a new direction for community services' in 2006, described the vision for the development of a personalised approach to the delivery of adult social care.

1.1.4 Social and physical impact

Research evidence provided suggests that treatment closer to home would provide the following benefits and outcomes to patients and their carers:

- Rapid access to diagnostics and assessment
- High quality care; in the best location for patients
- Would reduce admissions and time spent in Hospital
- Would improve elderly people's independence
- Would reduce risk of infection
- Would provide services tailored to the needs of the individual

1.1.5 CPA Annual Audit letter

This letter suggested that our approach to delivery of services to older people was good, but needed to demonstrate improvement in the areas of assessment and discharge.

2. Findings

We undertook research globally, nationally and regionally to give members an understanding of the need to change

2.1 Globally

Research from **Australia and New Zealand** has shown:

1. A growing list of conditions are manageable in home care
2. Some evidence that care at home is cheaper but this is inconclusive
3. That home treatment is a safe alternative to hospitalisation for selected patients, and may be preferable for some older patients.
4. A randomised control trial found high levels of patient and carer satisfaction with home treatment

2.2 Nationally and Regionally

Both national and regional research tells us, there are a range of different models of care, including services that are provided in community hospitals, virtual services, nurse/allied health professional - led services, consultant led clinics provided in community settings and intermediate services. We have summarised this information below:

Bury PCT

Bury PCT are looking to roll out ICATS (integrated clinical assessment and treatment service). Launched in 2007, the service will be staffed by fully qualified consultant-led clinical teams offering a range of assessment, diagnosis and treatment services for people with musculo-skeletal problems, such as osteoarthritis.

Eastern and Coastal Kent PCT

The Intermediate Care Team here is a multi-disciplinary team which promotes independent living –especially for older people – and provides care and assistance to help people to stay in their own home environment for as long as they possibly can. While many people helped by the intermediate care service are elderly, the service is available for anyone aged 18 or over who may need additional help to remain in their own home.

The team facilitates early discharge from hospital and prevents admission to hospital or a care home, where this can be avoided. The team is made up of nurses, occupational therapists, physiotherapists, support workers and administrative staff.

Whipps Cross University Hospital and NHS Waltham Forest (Jan 2009)

A new scheme, concentrating on those patients with COPD (Chronic obstructive pulmonary disease) means that patients can now be treated in the comfort of their own homes. The Supported Early Discharge (S.E.D.) initiative is now being provided by Whipps Cross University Hospital and NHS Waltham Forest. A specialist Respiratory Team has been developed to assess the suitability of home treatment. Factors such as medication, condition and support at home are important and can affect whether a patient is eligible for this service.

Specialist nurses are able to visit patients at home according to an agreed care plan and as well as appropriate equipment such as Oxygen and nebulisers being made available, an out-of hours service has been set-up to provide extra support around the clock.

Leicester City NHS

Leicester City NHS will be moving some out patient and day case services that are currently carried out in hospitals to community clinics over the next few years in order to move services closer to the patient. These will include;

Diabetes, Ophthalmology, (eyes), Dermatology, (skin), Ear, Nose and throat, Orthopaedics (bones/skeletal system), Urology (urinary system) and Gynaecology.

Cumbria NHS

Currently undertaking consultation in relation to their plans for care closer to home. Under the proposals more health care would be provided in the community and local health services would be managed by family doctors, creating professional-led services which are built around the needs of local people.

2.3 What's happening locally?

The Select Committee contacted service providers and voluntary agencies in the borough to find out details of current provision in the borough. From this we found that there are a number of service providers operating in the borough to support independence. This support ranges from informal voluntary and community group provision to structured services with eligibility and assessment criteria. The specific focus of this review is around care provided in the home for those who have been discharged from hospital and prevention from admittance or re-admission, and in particular the older person.

We also sought information from a consultation exercise undertaken in July 2008 by WWL NHS Trust to explore patient and public views regarding the development of the Hospital at Home Service. And the views from North West

Ambulance Service NHS Trust were sought in relation to their development of services to support Care Closer to Home.

2.3.1 Ashton Leigh and Wigan Community Healthcare

In his recent review of the NHS, Lord Darzi supported the creation of strong, independent – yet NHS – community provider services. Ashton, Leigh & Wigan Community Healthcare are one of just six NHS organisations which are pioneering the transition to Community Foundation Trusts.

The Trust's objective is to improve and modernise patient services, to combine many individual services to create an integrated healthcare organisation capable of delivering the right care for the right patient in the right place at the right time. Providing joined up services by looking at care pathways through a care group structure as outlined below:

- Scheduled and Primary Care
- Long Term Conditions
- Acute Care
- Unscheduled Care
- Children and Young People
- Health and Wellbeing

The benefits and outcomes for local people will be:

- Meet levels of expectations from the patients/public for local 24/7 care.
- The development of Ashton Leigh and Wigan Community Healthcare and their aim for Foundation Trust status.
- Closer working between agencies.
- More accountability to Foundation Trust members
- The provision of high quality healthcare that meets the needs of the local communities

On scrutinising witness evidence and other research, the committee have summarised our findings under the following headings to help to give clarity to our recommendations.

2.3.2 Impact of closure of Whelley Hospital on the Hospital at Home Scheme and service provision

Members were concerned about the impact of the closure of Whelley Hospital and the available beds. They were also interested in how the Hospital at Home scheme was developing. In March Members requested updates from the Trust. The following information was obtained:

Closure of Whelley Hospital

The number of beds on the RAEI site has not been affected by the closure of Whelley Hospital. There are 506 beds on site, during the winter period all are frequently in use. As it progresses towards summer, and the unscheduled care demand decreases, some beds are closed. In addition to the escalated beds on the RAEI site this winter we opened additional beds at both Leigh and Wrightington, to accommodate patients who had recovered from their acute phase of illness but still required care.

There has been excellent progress in reducing the length of stay in hospital with 1.26 days being cut from the average of all acute admissions during 2008/09, freeing up beds for use. This is largely due to work done both internally and with our health and social care partners to improve processes around discharge. There is still further work to do in ensuring new community services are fully utilised e.g. Hospital at Home, as these become more established we expect the flow of patients through the hospital to be smoother.

The Trust has under achieved on the government target of 98% through A&E within 4 hours, reaching 97.4% for 2008/09. However even during the difficult months of January, February and March 2009 performance was better than during the same period in 2008 when Whelley was open.

Impact on the Hospital at Home scheme

The Hospital at Home service allows patients to receive the same level of care in their own home as they would if they were being treated as an inpatient in hospital. This means that the service would enable some people to be treated in their own home rather than having to go into hospital or to get home earlier from being in hospital.

The impact of the closure of Whelley hospital on the Hospital at Home service has been minimal as the majority of the patients who were cared for in Whelley hospital were either involved in slow rehabilitation or waiting for long term care placements.

The only noticeable increase for the service has been in the number of IV antibiotics given which could be due to the fact that some patients previously attended the day ward at Whelley/assessment centre to have this treatment. Analysis of the first six months shows that the majority of the referrals come from GPs, so the service is preventing avoidable hospital admissions.

2.3.3 Assessment through to discharge

An assessment is the way that professionals obtain information about a patient to help them work out if they are eligible for services. This would

normally take place in hospital and would include family and carers to build up a true picture of what help and support a person may need to help them to be comfortable and safe in their own home.

Our evidence gathering has highlighted issues around the assessment process. We are aware of the drop in performance in the National Indicator NI132 timeliness of assessments - all adults. Quarter 3 performance has shown an actual figure of 65% against a target for the period of 78%. However, further scrutiny of this area tells us that despite the implementation of a number of initiatives, issues remain concerning assessments conducted by the Occupational Therapy Service.

The reason for our relatively poor performance, which has suffered a downturn over the past year, is that a historical backlog of assessments in the Occupational Therapy service had been generated. This backlog had accrued due to extremely high demand for assessments and difficulties experienced recruiting additional staff to meet demand.

Adult services have assured us that they will be subjecting this area of performance to a radical review via a 'Performance Clinic' approach involving relevant officers and Performance colleagues from the Business Transformation Team, which will give a different perspective and possibly alternative solutions.

However this review is more concerned with the need to develop a more effective joined up approach from all agencies from assessment through to discharge.

Case Study

Joyce talked about her recent experience as a carer for her husband and some areas that had worked well as some areas where she had experienced difficulty. Alongside difficulties with transport, Joyce highlighted an issue with the discharge process. Her husband was in hospital and had been seen by 3 different doctors who had agreed that he was to be discharged the next day and told him this. Joyce's husband was pleased and mentally prepared himself to go home. Joyce also made preparations for the next day. However, the next day the

physiotherapist said that Joyce's husband couldn't go home due to him not being mobile enough. Joyce felt that this had a really negative impact on her husband's well-being and mental state. Joyce also talked about how as a carer this was difficult and disruptive for her as she had made preparations. Furthermore she felt that this placed strain on her as her husband was upset and she had the impact of this as her husband didn't want to say anything to the professionals as he didn't want to be seen to 'rock the boat'. Joyce emphasised that a consistent message involving all staff was needed to help with a good discharge process.

Planning for discharge from hospital should start as early as possible - before admission wherever possible, especially for elective surgery. Failure to plan properly can lead to longer stays in hospital or people ending up in the wrong place without proper care or treatment. Discharge planning should not be a medically led process; it is important to involve all relevant members of the multi disciplinary team, particularly in determining whether the patient is safe to transfer from an acute ward.

Responsibility for co-ordinating discharge should lie at ward level, particularly for those patients whose discharge is relatively straightforward. For those who have more complex needs, the ward staff may need help from an integrated discharge team. Ideally this should be a team of different professionals (nurses, social workers, therapists) based together and with a single line manager or co-ordinator.

Nationally, there is well documented NHS best practice on effective discharge process. Examples of these include:

- Estimated date of discharge (EDD)
- Regular morning ward rounds
- Access to rapid diagnostics
- Early senior specialist input in A&E.
- Well supported multi-disciplinary meetings.

Other key features for effective discharge include:

- A no blame culture & constructive relationships on the ground.
- Commitment to multi-disciplinary team meetings from all relevant agencies.
- Integrated discharge teams.
- A shared analysis of the reasons for NHS and social care delays locally.
- Not closing down options by inappropriate early messages (e.g. "you need a care home").
- Regular training sessions on discharge for mixed groups of staff using anonymised or representative case examples.
- Open and healthy relationships with community services run by PCTs, social services department or others, plus a full and responsive range of post-acute options.

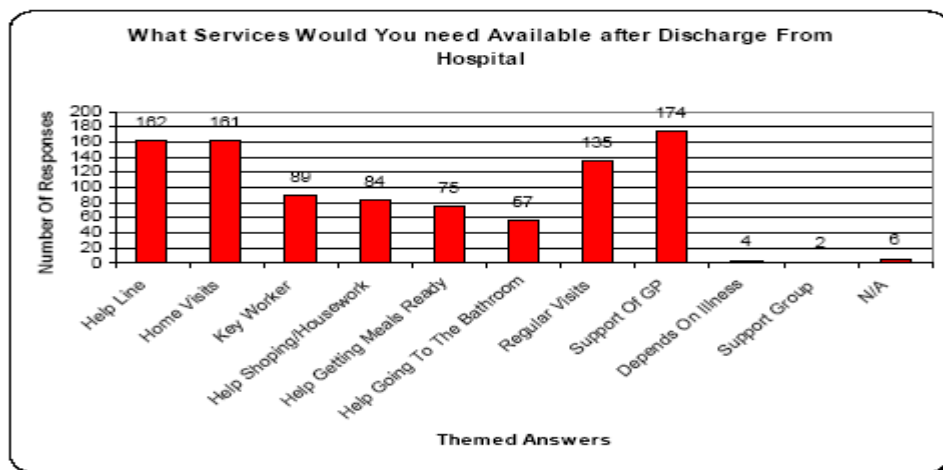
Regularly reviewing the discharge experience of patients and carers should be seen as an important and regular activity.

2.3.4 Co-ordination, collaboration and communication

Although new services are being developed and current services exist to support independence, our research suggests that this is not always co-ordinated in the interest of the patient or carer. This can lead to confusion and frustration for the patient and inadequate support, which can lead to re-admission, increased intervention and patients not receiving a holistic approach to service provision.

We have also found that that there is no whole integrated system that understands services available and the demand needed from those services at one point in time.

Consultation has highlighted that most reliance lies with GPs to provide a gateway to the most appropriate care available. The majority of patients - 84.5% - would need support from their GP made available to them following discharge from hospital other options of care support were a helpline and home visits. (See graph below.)



We question whether or not the GP would have all the relevant information available at a point in time to enable them to make relevant and supportive decisions.

Our evidence suggests that it can be difficult for professionals, patients and their carers to have a full picture of what services are available to them and when.

Evidence provided to us from North West Ambulance Service NHS Trust suggests that there is currently no 'whole system' capacity management system in the North West. To deal with integrated emergency and urgent care, which in turn would support the development of Care Closer to Home initiatives. They suggest that an integrated system would manage whole system capacity by providing the following:

- A 'real time' view of capacity in different acute hospitals across the North west
- The ability to direct ambulances to transport patients to the local A&E department best placed to accept and treat them within the performance standard
- A comprehensive region-wide directory of out of hospital facilities and services with 'real time' view of capacity
- A robust and reliable referral process to enable health care professionals to refer patients safely to these alternative care providers

The benefits of whole system capacity management would be as follows:

- Greater equalisation of activity pressures across hospital sites
- Fewer breaches of the 4 hour A&E target
- Fewer diverts and extended turnaround times impacting on ambulance service capacity
- Fewer unnecessary hospital admissions – better for patients and more cost effective for commissioners
- More seamless and timely pathways between services for patients – reduction in delayed discharges
- Better utilisation of out-of hospital facilities and services.

2.3.5 Support to carers

Performance on carers receiving an assessment of their needs and specific services NI 135 is slightly lower than target. For Quarter 3 the actual score was 19.3 and the target for the period 19.4. Evidence from our witness suggested that in practice this is an issue, and carers don't always receive the information and support that they need to assist them in their caring role. However, we are aware that there are some recording issues with this indicator. For example, awareness regarding carers' assessments/reviews is being raised with all staff through discussion in various forums and written processes have been amended to emphasise the issue and system checks are being undertaken to identify and address areas of low performance.

A carer and Carers Hospital discharge worker from our Adult Services attended our meeting to provide evidence from their perspective.

The discharge worker is a key point of contact with all staff in hospitals but also with other agencies that could refer to her service for support. She is aware of the improvements necessary to improve the discharge process involving the carers the patient and the professional as a three way approach. She outlined her concerns and offered ideas for improvement.

Concerns

- The closure of Whelley Hospital could cause potential anxiety for carers as it was known as a place that people formerly went to for rehab and respite.
- That if people are discharged earlier this may make carers feel rushed into making decisions

- There was recognition, that it may be good practice to treat people in their own home but concern was stressed that this may place extra burdens on carers.

Improvements suggested

- Tagging medical records to include carer information to enable quick contact at the point of admission and to encourage involvement in patients care. Training ward staff, agencies, and professionals to signpost carers to her at earliest opportunity and developing a carers' charter.
- Enable professionals to appreciate the valuable role carers play in preventing patients reaching crisis point thus triggering re-admission and worse outcomes and cost implications and encourage carers to have an assessment of their needs
- Professionals to give carers 24/48 hrs notice to arrange discharge.

3. Recommendations

3.1 Assessment through to discharge

- The Joint Discharge Policy between Adult services and Wrightington, Wigan and Leigh NHS Hospital Trust and Ashton Leigh and Wigan PCT should be reviewed in light of the outcomes from the recent reviews and audits of joint discharge arrangements. As an interim measure to this, we would suggest that multi disciplinary teams provide patients and carers with at least 24 hours notice to arrange discharge, and there should be no late night or weekend discharge for vulnerable or older patients.

3.2 Co-ordination, collaboration and communication

- Ensure all professionals who are involved in arranging discharges continue to have effective information and training in order to assess and refer patients and carers to appropriate services
- The professionals involved explore the possibility of strategically developing on a regional basis the integrated system as highlighted by the North West Ambulance Trust

3.3 Support to carers

- Medical records should be tagged by named staff to identify carers at an early stage to involve them in patients care and to ensure their take up of relevant support services.
- Develop a joint agency Carers Charter to provide clarity on what you can expect when a patient in your care is admitted and then discharged from a hospital setting.
- Social Care professionals should ensure that a separate, holistic Carers Assessment is offered out and recorded.
- Develop robust systems to jointly monitor complaints and problems, or re-admissions which have resulted from poor discharge arrangements and ensure that this information is used to improve future discharge arrangements.

We would be grateful if you could share with us how you intend to address these recommendations with responsibilities and timescales identified.

Extract from the minutes of the Overview and Scrutiny Co-ordinating Committee held on Tuesday 26 May 2009.

7 Care Closer to Home – Select Committee final report: The Chairman of the former Health Select Committee, Councillor G M Bretherton presented the findings of the final report on the Select Committee's review on Care Closer to Home. The report set out the key aims of the review, methodology, successes with appropriate case studies, areas for improvement and recommendations.

Members asked a number of questions, which included the following salient points:-

- Could the sustained growth in Direct Payments be maintained?
- What was the reason for a short fall in Occupational Therapists?
- What safeguards were being put in place to prevent patients being released from care too early?
- What monitoring was there of readmissions?
- Who should be involved in determining the home care package for patients?

Councillor Bretherton advised that he would provide a response to all Members of the Committee in respect of the sustained growth of Direct Payments and any issues relating to the recruitment and retention of Occupational Therapists following the meeting. He went on to advise that patients who required only nurse led care would be discharged from Hospital once a suitable home care package had been put in place prior to the patient being discharged.

Councillor Bretherton also advised the Committee that discharge planning should not be a medically led process and that it was important to involve all relevant members of the multi disciplinary team, particularly when determining whether a patient was safe to transfer from an acute ward.

Resolved: The Committee:-

- accepts the report now submitted;
- endorses the recommendations set out within the report and the need to respond adequately to them;
- requests a report on the progress against the recommendations in six months time;
- refers the final report to the Cabinet for detailed consideration; and
- thanks the Chairman, Members of the Select Committee, Diane Taylor, Policy Officer, and Alison Cain, Policy Support Officer for their hard work in relation to this review.