HEALTH AND WELLBEING BOARD

4 June 2013

Title: Joint Assessment and Discharge Service	
Report of the Corporate Director of Adult & Community Services	
Open Report	**For Decision**
Wards Affected: ALL	**Key Decision:** Yes
Report Author: Bruce Morris, Divisional Director of Adult Social Care	**Contact Details:** Tel: 020 8227 2749 Email: bruce.morris@lbbd.gov.uk

Sponsor:

Anne Bristow, Corporate Director of Adult & Community Services

Summary:

Opportunities for improved joint working between health and social care have been developed through the Integrated Care Coalition. The shadow Health & Wellbeing Board has previously received presentations and reports on proposals being developed by the Coalition, including a report on the Joint Assessment and Discharge service on 12 March 2013.

This paper provides more detail on the design principles for a joint service that would facilitate the discharge of patients from Queens and King George Hospitals and an implementation plan following a workshop on 29 April 2013 led by LBBD. Key health and social care partners from across Barking and Dagenham, Havering and Redbridge began planning the development of a joint service and it was agreed that LBBD will take the lead on this project on behalf of the coalition.

Recommendation(s)

The Health and Wellbeing Board is asked to note the progress of this project and comment on the design principles and implementation plan. Further updates will be provided to the Board as the project progresses.

Reason(s)

Health and Wellbeing Boards across the three boroughs will have a key role in the governance of the programme. They will need to agree how the new service meets the needs of their local residents and consider implications for other services.

1 Introduction

1.1 Previous reports have described the work of the Integrated Care Coalition and the agreement between the statutory health and social care organisations grouped around the BHR "economy" to explore joint design and planning work on areas where we have a mutual interest.

1.2 Last year Ernst and Young worked with the Integrated Care Coalition on a number of ideas that would potentially make better use of existing resources and improve the experience of local residents. One of the proposals was to consider a joint service that would facilitate the discharge of patients from Queens and King George hospital. On 27 February, the Integrated Care Coalition asked LBBD to undertake further work on designing an integrated team to support people back to home with dignity and respect.

1.3 A workshop was held on 29 April led by Anne Bristow where the key partners of from health and social care in the three boroughs began planning the development of this service. The design principles and key milestones were discussed and partners asked LBBD to lead the work on behalf of the coalition partners.

2 The Design Principles

2.1 The workshop agreed the following six design principles for the Joint Assessment and Discharge (JAD) team:

- The service will be efficient. Both the timeliness and quality of discharge will be improved.
- The service will have authority to make decisions about the need for Continuing Health Care, and these processes will not delay discharge. However, the guiding principle is that patients and their families will not normally be expected to make life changing decisions such as permanently moving to institutional care from an in-patient bed.
- The service will have access to all relevant patient information and this will be shared within the service. The service will work towards a shared information system and provide management reports for Coalition partners to meet the requirements of statutory returns, and provide a better understanding of where further system redesign is required.
- Where patients' hospital admission is a consequence of a breakdown in care and treatment in the community, "long-term conditions"; "primary care" (integrated case management, health and social care clusters etc.) is in the best position to assess risk and review plans for care, support and treatment, and will therefore be responsible.
- However, the primary aim of the service will be to get patients back to their own homes with dignity and compassion managing independently, rather

than directing people to services. This will require knowledge and skills of working with family networks, and utilising community capacity.

- The locus of the service will therefore be in the community, to ensure close working and a seamless patient journey to “primary care”.

3 Project Support

3.1 Partners have agreed to contribute to project support costs:

- LB Barking and Dagenham and LB Havering have each contributed £10,000;
- CCG Barking and Dagenham and CCG Havering have each contributed £10,000;
- LB Redbridge and CCG Redbridge have each contributed £5,000;
- BHRUT and NELFT have each contributed £10,000.

4 Project Group

4.1 The group will include representatives from NELFT, the three boroughs and the Clinical Commissioning Group. Terms of Reference for the project group were agreed at the first meeting on 14 May.

5 Project Milestones

Month	Milestone
May	Project group established
	Terms of Reference of project group agreed
June	Staff engagement
	Implementation Plan designed
July	Management of service agreed
September	Health and Wellbeing Board agreement
October	Integrated Care Coalition agreement
November	Implementation
April	New service begins

6 Mandatory Implications

6.1 Joint Strategic Needs Assessment

Barking and Dagenham's updated JSNA outlines:

- A high level of deprivation which impacts on a gap in life expectancy at birth between males and females
- Mortality rates are higher than the England average
- Significant health inequalities base on ethnicity, with people of black ethnicity more likely to have an emergency hospital admission

Having an integrated and cohesive hospital discharge service that will help support a borough with poor healthy life expectancy is very important. The proposed changes should positively impact on the hospital discharge process with the priority of supporting people in their own home.

The proposed service aligns with a number of themes of the Joint Strategic Needs Assessment, cross-cutting long term conditions, end of life care and emergency re-admissions.

6.2 Health & Wellbeing Strategy

The development of a new Joint Discharge Service will assist with achieving the outcomes of the Health & Wellbeing Strategy. The proposed new service will aim to 'improve health and social care outcomes through integrated services'.

6.3 Integration

The new joint team will be an integrated team merging the functions of several teams across Barking and Dagenham, Havering and Redbridge. The aim is to develop a new seamless service out of hospital.

6.4 Financial Implications

The agreed contributions to project support costs, as detailed in section 3.1, will be met from within current resources of the contributing organisations. At present there are no additional resources to fund the new joint service. As the project group develops the new joint service, the financial implications of the emergent service will be identified and funding aligned within current resources.

Implications completed by: Dawn Calvert, Group Manager Finance, LBBD

6.5 Legal Implications

There are no specific legal implications that arise from this report at this stage.

Implications completed by: Shahnaz Patel, Senior Lawyer, Legal Services, LBBD

7 Non-Mandatory Implications

7.1 Staffing Implications

If the proposals for a joint service are agreed there will potentially be implications for staff who are involved in the hospital discharge process whichever organisation employs them. Formal consultation processes will be used to manage any changes in line with each organisation's agreed procedures.