Meeting: Adult Social Care, Health & Wellbeing Sub-Committee

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Title: CARE Point

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Service:	Health, Education, Care and Safeguarding	
Wards affected:	All	

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1. Purpose of Report

The purpose of this briefing note is to share with you the present status of the CARE Point Service (**C**o-ordinated, **A**ccess **R**esponse **E**xperts) and the plans for the future.

2. Recommendations

The Sub-Committee is invited to examine the progress made in developing and implementing the CARE Point Service.

3. Details

The Better Care Fund sets out a framework for existing Health and Social Care funding to be invested as a financial incentive for joint working to improve the outcomes and experience of those accessing services.

Local areas are tasked with using funding to:-

- Deliver care that is centred on individual needs.
- Acting earlier to ensure that people can stay at home safely and independently without the need for a hospital admission.
- Share data and outcomes
- Provide an overall improvement of continuity of care.

To this end there has been a lot of work and consultation carried out to review the services via the Older Persons Integration Board. Across Health and Social Care there are a number of initiatives which are focused upon improving hospital discharge and preventing unnecessary admission to hospital. This can be confusing for the referrer not alone the person using the service. Stakeholders told us that they were unsure of which team to refer to and who would best meet the needs of the patient/customer either in

hospital or their own home. All too often a hospital admission was easier than referring to one of the teams. Using the resources available to us it was agreed that the health and social care teams would be brought together to provide a single point of access for rapid assessment and appropriate short term support/rehabilitation packages.

Progress to date

The following teams are based on the North Tyneside General Hospital site and create the **CARE** point service.

- Administration Staff – Health and Social Care
- Reablement Discharge Team (Hospital Social Work Team) – Social Care
- Reablement Home Support Team – Social Care
- Hospital to Home Team – Health
- AART (Avoiding Admission Resource Team) – Health
- Nurse Practitioners – Health

By consolidating the resources the team consists of social workers, social service officers, nurse practitioners, nurses, occupational therapists, physiotherapists, locality leads, support staff and administration staff. Representatives of the teams have taken part in process mapping days to identify duplication of tasks and to streamline the referral pathway via one administration function. This work has enabled the teams to understand demand and plan effectively for crisis and short term interventions.

An Operational Service Manager (OSM) has been appointed to oversee the delivery of the service; the teams continue to practice within their professional boundaries and have direct supervision and line management accountability from their relevant clinical lead or line manager.

The **CARE** Point team will provide a proactive and rapid response usually within two hours of the referral. The care and support interventions will be provided by the member of the team most appropriately skilled to the meet the needs of the patient. Additionally, the team will have access to health and social care resources and the ability to deploy support staff 24/7 to prevent an avoidable admission and facilitate early discharge. The team will also have access to loan equipment and Care Call community alarm and assistive technology solutions to keep the person safe and able to summon help if needed during the rehabilitation period.

As well as developing **CARE** Point a pilot of Discharge to Assess is currently taking place. The rationale behind this is to fast track patients from the ward to their home via the **CARE** point team who will assess the patient/customer whilst they are at home. This enables an earlier discharge from hospital by applying a multidisciplinary approach to the assessment outside of the hospital setting.

Future planning

Whilst the teams are based on the site of the hospital they are presently not directly co-located as one team. Work is in progress to identify a location within the hospital setting which will bring the teams together.

Due to the closure of the Cedars Intermediate Care Resource Centre in December, a small Community Rehabilitation Team will be developed to enhance the rehabilitation pathway from hospital to home using the skills of the health and social care staff who have worked within a proactive multi-disciplinary team and have significant rehabilitation

experience. This team will join **CARE** point and be accessed via the single point of access. Patients/customers on hospital wards, in Princes Court intermediate care beds and those in short term placements will be supported to maximise their independence and shorten the length of stay using this element of **CARE** point.

Work is underway to look at the customer journey through the various pathways of which **CARE** Point will be part. The trusted assessor approach to assessment will be tested via this service. This means that it will be the professional leading the customers care and support who goes on to plan discharge, aftercare and support rather than passing the patient/customer from one professional to another.