The Solway Alliance's Health & Care Plan For Wigton

A Summary

The challenges

The main challenges to providing health and social care for Wigton and Solway now and in the future, and the gaps in provision, include:

Service Gaps

- Services have been developed historically and in isolation and not designed to address the health and social care challenges of the area

Current Hospital facilities are old and need significant work

- Wigton hospital building is large, old and in need of continuous maintenance and is not regarded as being in a particularly accessible site. Whilst the ward is working well the accommodation is compromised and it needs work in order to bring it up to modern standards.

An aging population

- There is a significant older population residing in the Wigton and Solway area. An aging population brings health and social care challenges for those people and their families and carers. It also increases the pressure on the health and care system.
- An increasing older population will increase the need for accessible, economical housing, and dementia friendly properties.
- Increasing demand on Social Care Services.

Dementia

- The numbers of older people living with dementia in Allerdale are expected to increase by 47.9% by 2030; from an estimated 1,603 people in 2017 to 2,371 people in 2030. This in turn will affect the care provided.

Recruitment and Retention

- Similar to the regional and national picture there are significant issues with the recruitment and retention of staff across all sectors. This has led to:
    - A shortage of qualified nursing staff, resulting in a temporary unresolved closure of beds in the hospital.
    - Difficulties providing Home Care leading to service gaps in: end of life care, continuing care packages, generic domiciliary care and Hospice at Home.

Health resource has been targeted at beds

- Health resource has been aimed at providing in-patient provision for a small proportion of the community rather than developing and enhancing home based services, as a result people are being cared for in hospital instead of at home, because there hasn't been the resource in community services to provide the care at home. Unnecessary or prolonged hospital admission or stay is not in the best interest of the patient.

Our Vision, Aims and Proposals

Our vision is of a vibrant, fully integrated health and care provision delivering person-centered care in the community, including in people's homes.

Our aim is to:

- Improve the health and wellbeing of the population.
- Find the solution to the challenges from within Wigton, allocating resources in ways that promote health, wellbeing and independence.
- Support the development of a place based integrated health and social care service model.
- Be an innovative new partnership between health and care providers, the community and wider third sector and educational partners.

Our proposals will provide services for people locally where possible. Health and Care services will work in close partnership with the local community to develop a high quality, affordable, and sustainable model for this remote and rural community. The outline that follows sets out a fully integrated health and care provision delivered in a rural setting.

The proposed service model for Wigton and Solway

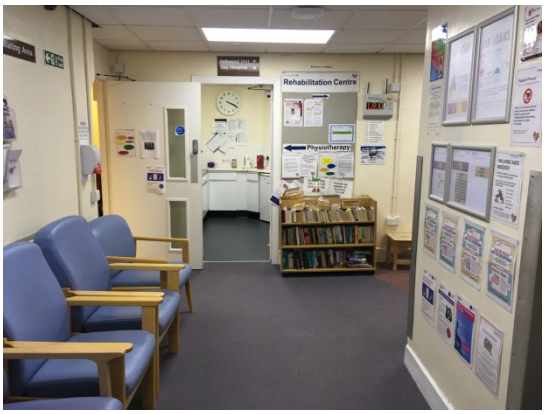
In Wigton and Solway the model is designed to provide:

- One fully integrated health and social care system – the Integrated Care Community.
- Access to an integrated bed base.
- A base in Wigton acting as a hub for community health and social care services and allowing clinicians to escalate care when needed but do so in the community, also to de-escalate using the links to health and social care services.

Integrated Care Community coordination hubs

The hub would be responsible for coordinating responses to patients with an urgent need, working with GP's identifying patients who are becoming more frail, so pre-emptive action and care planning can take place prior to crisis occurring.

Rapid response- when calls come in



- A community service that will provide an intervention and assessment service for a patient in the community causing immediate concern that otherwise would require step up to the acute.
- Referrals could be made by GP's, paramedics, or community health team. It will function 12 hours a day over 7 days per week. This will ensure that there is timely and appropriate care provided to patients who have a sudden change in their health such as acute illness, falls or exacerbation of long term condition.
- The team will be able to respond to calls from people, GP's, Paramedics, other community team members and home carers. Quick action and intervention will prevent admissions to hospital and improve care for patients.

Enhanced integrated teams – providing care to people at home and in the community

The removal of the in-patient beds at Wigton Hospital will create an opportunity to redeploy the skills of the workforce to enhance the capacity and capability of the community team and create added benefits:

- Adding capacity to support patients with more complex care needs at home and so to avoid hospital admission increasing the number of people cared for at home.
- Taking a proactive approach to shortening length of stay in hospital by seeking to help hospital discharges to occur earlier.
- Increasing capacity to undertake complex care.
- Providing more end of life care in patients' homes.
- Undertaking more proactive care planning in collaboration with GP's, identifying patients in need and acting before crisis occurs.

Access to beds

We recognise that there may be some patients who require a bed based model of care and to support them we intend to have access to a small number of beds at Inglewood Residential Home; the beds would be for nursing care, treatment and rehabilitation. The care would be delivered by community nurses and therapists who would have knowledge of the patient and be able to provide continuity of care from these beds to home in the community. The beds would be for short term care, free at the point of use for patients and the aim would not be for patients to become long term residents in care.

Discharge to assess – caring for people at home as soon as they are medically fit

This service would be managed through the coordination hub and delivered by the integrated team. It would enable the pull through of patients in hospital to the community at an early stage; their discharge needs would be assessed and operationalised on returning home. This will result in the following benefits:

- Reduction in Acute bed days and length of stay

- Reduction in hospital acquired complications
- Improved patient experience
- Improved patient outcomes

Please note this is only a summary of the full plan. Much more detail is included on the full plan which will be available on the North Cumbria Clinical Commissioning Group website.

Background to the plan:

Following the decision by the Cumbria Clinical Commissioning Group to close the beds at Wigton Hospital, there was an urgent need to develop sustainable and appropriate plans to address the healthcare needs of everyone in Wigton and Solway.

The hospital's League of Friends, together with representatives of other bodies, joined with people from the hospital trust and from social care services to develop a plan that will deliver more care to the residents of Wigton and surrounding areas, by the same staff, but delivered differently, without in-patient beds. This brought the opportunity to be clear about what the community needed, rather than just assuming anything.

Other services provided from Wigton Hospital

In addition to beds also provides –

- Base for Community staff (Community Rehab Team, Evening Nurses, Community Sisters Office)
- Meeting room facilities
- Rehabilitation Centre and Groups (weight management group, falls group, Parkinson's group, MS group and gardening group)
- Out Patient Physio and Specialist Groups (back group, knee group, women's health, hip group)
- Extended Scope Physiotherapy
- Pulmonary Rehab and Specialist Respiratory Nurse
- Midwife base
- Health Visitor base
- Children's flu and nasal spray clinic
- Public Health and Wellbeing Nurse base
- Tissue Viability Nurse base
- Heart Failure Nurses base and clinics
- Speech and Language base and clinics
- Vascular Nurse Clinic
- Lymphedema Clinic
- Continence Clinic
- Persistent Physical Symptoms Service
- Parkinson's Nurse Clinic

- Acquired Brain Injury clinic
- Urology Clinic
- District Nurse Dressing clinic
- First Steps clinics
- Diabetic Nurse clinics
- Paediatric Clinic
- Retinal Screeners clinics
- CHOC base

About Wigton and Solway

Wigton is a historic market town in Cumbria and lies just outside the Lake District in the borough of Allerdale and the majority of the Wigton and Solway area is rural.

While rural isolation affects everyone, its greatest impact is on the frail elderly, and especially those who do not drive, have no close family support and those that live alone. For this group of people, ensuring that the services they need are available close to home is fundamental to providing good care. This is especially true for people requiring end-of-life care.

Wigton and the Solway area has had to be a resilient and self-sufficient community and the inter-dependence of health and care services is especially clear here.

Please feedback on these plans by the end of December.

- What do you like
- What do you not like
- What do you need more information on
- Any other suggestions

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