Nottinghamshire County Council

Report to Adult Social Care and Public Health Committee

9th October 2017

Agenda Item: 7

REPORT OF THE SERVICE DIRECTOR FOR MID NOTTINGHAMSHIRE

PLANNING FOR DISCHARGE FROM HOSPITAL

Purpose of the Report

1. The purpose of this report is to:

   a) provide the Committee, as requested, with an overview of the current role of adult social care workers in planning discharges from hospital settings

   b) to seek approval to further promote prevention and people's independence as part of planning their discharge from hospital of Hospital Discharge Packages to deliver the identified savings

   c) to seek approval to establish the following associated posts:

   - 1 permanent full time equivalent (FTE) Occupational Therapist (Band B)
   - 1 temporary 0.5 FTE Project Officer post (Band B) for two years to March 2020.

   d) seek approval to request the additional non-recurrent allocation of £10,000 from the improved Better Care Fund for the project to facilitate timely discharges from hospital to residential care

   e) seek approval for the establishment of the following posts at Queen's Medical Centre to provide social care input to the development of integrated discharge services (funded by the south Clinical Commissioning Group)

   - 1 temporary (18 months) FTE Social Worker post (Band B), £44,882. pa
   - 1 temporary (18 months) FTE Community Care Officer (Grade 5), £32,774 p.a.

   f) seek approval for the establishment of 3 FTE temporary Social Worker (Band B) and 1 FTE temporary Community Care Officer (Grade 5) posts to manage increased demand arising from hospital admissions over the winter, from November 2017 to 30th April 2018 at a cost of £83,710 to be funded from the improved Better Care Fund.

Information and Advice

Background

2. The Local Authority plans the discharge of service users from acute hospital settings in accordance with the Schedule 3 of the Care Act 2014 and the Care and Support (Discharge of Hospital Patients) Regulations 2014.

3. These provisions aim to ensure that the local authority and NHS colleagues work together effectively and efficiently to plan the safe and timely discharge of service users from NHS in-patient provision to local authority care and support.

4. In fulfilling these provisions NHS colleagues must supply the Local Authority with a **Notice of Assessment**, which notifies the Local Authority of a patient who is thought to have a social care need which requires support in order to enable the hospital discharge. The patient must have consented to the referral to the Local Authority. Social care staff then have a duty to assess the person and put arrangements in place to meet any eligible care and support needs.

5. Once it has been agreed that the patient meets three conditions for discharge, then NHS colleagues must supply the Local Authority with a **Notice of Discharge**, which confirms the agreed discharge date. The three conditions are:

   a) A clinical decision has been made that the patient is ready to be transferred (often referred to as the patient being deemed "medically fit" or "medical optimization")
   b) A multi-disciplinary team decision has been made that the patient is ready for transfer
   c) The patient is safe to discharge or transfer on the relevant day.

6. If the processes of notification are followed correctly by NHS staff then a formal day of "delay" can be declared by the NHS Trust for "social care" reasons, if the patient has not left the hospital by 11am on the day after the agreed discharge date and the reason for the delay is due to the Local Authority. Alternatively, the delay reason may be recorded as "joint" if both health and social care are causing the delay. There are nine categories to describe the causes of delays, which could be attributed to "health", "social care" or "joint" reasons. Delays attributable to "social care" can result from factors such as a delay in securing a suitable care home place or a package of home care to support independent living.

7. Across the three planning areas (South Notts, Greater Nottingham, Mid Notts and Bassetlaw) a social care team is based on site at the following six hospitals:

   - Nottingham University Hospital NHS Trust (Queen's Medical Centre & City Hospital)
   - Sherwood Forest Hospitals NHS Foundation Trust (King's Mill, Mansfield Community Hospital & Newark Community Hospital)
   - Doncaster and Bassetlaw Hospitals NHS Foundation Trust (Bassetlaw)

8. Social care staff based within the district teams are also involved in supporting the discharge of Nottinghamshire residents, including those experiencing mental ill-health, from Nottinghamshire Healthcare NHS Trust acute hospital beds across Nottinghamshire. People who live near Nottinghamshire's borders and for whom Nottinghamshire County

Council has responsibility for social care services will often attend their nearest Accident and Emergency Department in a crisis so social care also work with people staying in surrounding NHS Trusts services, such as United Lincolnshire Hospitals NHS Trust and Derby Teaching Hospitals NHS Foundation Trust.

9. Nottinghamshire County Council led a significant complex piece of work across the County from October 2015 to review and ensure consistency with the local coding of delays across agencies. This is important in order to ensure that performance is reported accurately and also to be able to use the data to identify the right actions to reduce delays. National Delayed Transfer of Care (DToC) guidance states that the Director of Adult Social Care (or their representative) should approve any delays assigned to social care as being appropriate. Processes are now in place with health to do this and whilst the majority are agreed locally at Team Manager level, the process sets out who any delays should be escalated to in health and social care for resolution.

Performance reporting

10. Delayed Transfer of Care (DToC) statistics are reported each month by each NHS Trust to NHS England and published nationally by NHS England to benchmark the performance of NHS Trusts and Local Authorities. In June 2017 the Corporate Director for Adult Social Care, Health and Public Protection's quarterly performance report to this Committee highlighted local success with Nottinghamshire ranking as the tenth best performing council nationally (out of 153 authorities) for delays attributable to social care and the top shire authority. In July 2017 this significant achievement was recognised by the Secretary of State for Health, who wrote to congratulate the Chief Executive on the Council's contribution to reducing Nottinghamshire delays across the system in the past year.

Future work to improve discharge planning and transfers of care

11. Social Care Service Directors represent Nottinghamshire County Council on the three local Accident and Emergency (A&E) Delivery Boards and Transformation programmes operating across Nottinghamshire's boundaries. Each A&E Delivery Board has a multi-agency local DToC improvement plan to put in place eight nationally mandated high impact changes:

    a) **Early discharge planning:** approval on 10th July 2017 by this Committee of the extension to March 2020 of additional temporary staff put in place for last winter has supported earlier discharge planning across the County. South and Mid Notts now have social workers linked to specific wards that have high numbers of people requiring social care assessment. This is strengthening day to day working relationships and ensuring that social care is involved at the earliest opportunity to identify and plan to meet people's social care needs. Reductions in average length of hospital stay have been achieved by this development.

    b) **Systems that model and pro-actively track patient flow** are in place across all hospitals. Nottinghamshire County Council has developed a business case for joint ICT work that could significantly improve the sharing of key health and social care data both in and out of hospital. Agreement from health to jointly progress this work is being sought.

c) **Multi-disciplinary discharge teams, including the voluntary and community sector:** social care works closely as part of integrated discharge arrangements and is engaged in work-streams to improve this. Bassetlaw has an Integrated Discharge Team (IDT) based at Bassetlaw District Hospital which won the Great British Care Award, East Midlands Care Team of the Year in 2016. The IDT team use a 'Trusted Assessor' model where all members of the team employed either from health or social care are able to complete information on an initial IDT 'Fact Find' document on the hospital wards and make a decision about what discharge pathway is appropriate for the patient and also complete an assessment notice if a full social care assessment is needed.

   Further improvement to engage housing consistently as part of integrated discharge arrangements is being progressed by the Housing and Environment workstream of Nottinghamshire's Sustainability and Transformation Plan. The second part of this report addresses the need and a proposal to improve rapid access to other preventative services at this point.

d) **Discharge to assess/Home First** means that wherever possible people are discharged from hospital once medically fit with rehabilitation/re-ablement if appropriate and assessment of their needs (including social care) takes place at home or, if required, in short term accommodation. Discharge models across the County are shifting towards this, however, full implementation and success depends on there being the right type and volume of community services available. Without this there is a risk of over-reliance on bed-based options. Social care is actively engaged in this work.

e) **Access to key services seven days a week to improve patient flow:** a multi-agency task and finish group reporting to the Better Care Fund Board is currently reviewing what is in place, what core services require extended access and the inter-dependencies between them. Social Care staff already routinely work seven days a week on a voluntary basis at King's Mill Hospital and Queen's Medical Centre and planning is underway for this to be in place at Bassetlaw Hospital for the winter. Other key social care services identified as a priority to have access to new referrals at weekends are homecare, START re-ablement and all social care short-term assessment units/beds. Work is underway to explore the most cost effective options to enable this.

f) **Trusted assessors:** this can be applied to various parts of assessment, from relying on information provided by other staff/teams/agencies so the person only has to give their information once, through to staff carrying out holistic assessments and/or assessments on behalf of different agencies. This, for example, can be between ward staff and community health care providers, integrated discharge staff and social care providers, such as care homes, or assessment for services that are funded by another agency. Joint national guidance (July 2017) clarified that this does not remove or replace statutory responsibilities such as assessment under the Care Act and is likely to be distinct from the determination of eligibility for social care and financial assessment to determine the charges a person should fund towards their care. The guidance does recognise, however, that some areas are implementing this and recommends that any Trusted Assessor arrangements require careful joint planning, competency based training and full consideration of any statutory duties that require governance decisions and formal arrangements putting in place across agencies. Any

local proposals that require this will be brought as appropriate to Committee for consideration and a decision.

g) **A focus on choice and early engagement with patients and families** is fundamental. Better information is being developed for people and their families at the point that someone is admitted to hospital, so that they can start to think about their options at the earliest point and are clear that remaining in hospital once they are medically fit to leave is not an option and alternatives are available.

h) **Enhanced health in care homes:** local work is underway across the County to improve training and support for care homes with the aim of reducing the high number of emergency admissions to hospital made by some care homes.

12. Good progress is being made across the County with implementing the eight high impact areas. Local authorities are required to evidence how they have used the improved Better Care Fund to progress these in partnership with their local systems. Discharge planning overall follows a common process (as set out in **paragraphs 2 to 6** of this report) and learning is shared across the three planning areas. Some differences in approach are appropriate, however, reflective of the different hospitals, size, patient needs and profiles, as well as the flows in and out of other services and agencies.

Planning hospital discharge care and support packages

13. National research[1] (2016) has identified that when patients with complex needs are discharged, their care and support plans are often not the most appropriate to increase their long term independence. This happens due to the tight time scales required for discharge plans, acute health staff not being aware of appropriate community discharge options and the influence, for example, hospital consultants can have on family expectations. Improved, multi-disciplinary discharge planning focusing on maximising people's independence was identified as being able to deliver better outcomes for people at less cost for 24% of people reviewed as part of this study. The role of preventative services was also key and it was estimated that between 25 and 40% of people could have benefited from timely access to preventative services but did not receive them.

14. In light of this, Nottinghamshire County Council undertook a review exercise of the care and support packages arranged by Hospital Social Work Teams. Retrospective multi-disciplinary reviews were undertaken on a sample of 24 cases to see if these discharge plans could have been improved. It indicated that in 42% of cases better joint and less risk averse support planning, coupled with rapid availability of the right services, had the potential to have led to a significantly different pathway and package. This would also have been better for the service user's health, wellbeing and independence. Furthermore, the vast majority (83%) of the alternatives were less costly to the Council for the two week period following discharge as they promoted people's independence. The review supported the national study and found that the best combination and level of care from available services/options is frequently not known about, available, or there is insufficient time for busy hospital social care teams to put these in place for service users. Several people would have benefited from low level support from community services and others from health care input which would have resulted in smaller packages of social care

[1] June 2016 'Efficiency opportunities through health and social care integration – delivering more sustainable health and care' *Local Government Association*

support. For the whole sample, the total cost of packages for the two weeks prior to the first review following hospital discharge could have been reduced by approximately 3%. As a result Nottinghamshire County Council could achieve gross recurrent savings of £245,000 per annum.

15. The review recommended four actions to deliver these savings:

a) Provide additional resources of three full time staff, one linked to each main acute hospital, to enable rapid access to the short term Connect Prevention Service as part of hospital discharge planning. This service is commissioned by Nottinghamshire County Council and is provided by three voluntary sector agencies. One third of the sample could have benefited in the longer term from this low level support. The total cost of social care packages for the two weeks following discharge could have been reduced by approximately 3% due to increased use of community and low level resources.

b) Develop the Notts Help Yourself web based directory to have an easy access section for Social Workers which aligns community resources with common pathways and conditions, community and preventative options.

c) Develop and implement a 'promoting independence' learning and development plan for hospital social workers and health staff. In a quarter of cases the multi-disciplinary review team judged that there were opportunities to reduce the level of social care commissioned. This included cases when healthcare was judged more appropriate and /or the use of low level options could have reduced the necessary size of social care package. If this inconsistency was eradicated the total two week cost of the care pathways post discharge in the cases reviewed would have been just under 10% lower than the cost of the actual care put in place. In about 13% of cases an alternative such as health led residential rehabilitation or therapeutic focused care delivered at home would have been more appropriate.

d) Provide an additional Occupational Therapist post to work across the hospital social care teams in the three local planning areas to promote the therapy and short-term rehabilitation opportunities for individuals and train health and social care hospital based staff to shape a focused support plan on discharge that has rehabilitation at the core of its delivery.

16. Further potential improvements to hospital discharge planning were also identified if more rapid access was available to housing/adaptations/homeless services as part of discharge planning. This is outside the scope of this project as it is already part of Nottinghamshire's Sustainability and Transformation Plan, Housing and Environment work-stream.

17. In order to deliver the recommendations of this review, approval is sought: to:

- Increase the value of the contract that the Council has with three independent sector voluntary services to provide the short term Connect prevention and early intervention service by an annual cost of £70,000. This will deliver extra capacity in the service equal to three additional staff and can be done within the existing contract value without a further procurement exercise being required.

- Permanently recruit 1 FTE Occupational Therapist (Band B) at an annual salary cost of £44,882 including on-costs, plus £1,500 mileage costs and one-off equipment costs of £3,000.

These costs are required permanently and so have been netted off the gross recurrent savings to achieve net recurrent savings of £130,000 per annum.

18. Recruitment to a temporary 0.5 FTE Project Officer (Band B) post is required to manage, implement and evaluate this aspect of the proposal over years 1 and 2 (starting April 2018); this is counted as a one-off implementation cost of £44,882 pa plus an annual £1,500 mileage budget and one-off equipment costs of £3,000.

Working with Residential Care Home providers to facilitate hospital discharge

19. On 12th September ASCH Committee approved a non-recurrent sum of £48,000 to enable work with residential care home providers to identify a way to reduce delays in discharging people from hospital into long term residential care. This remains a cause of both social care and health delays in Nottinghamshire. Delays are caused due to the time it can take care homes to complete an assessment on a potential new resident (for whom all re-ablement options have previously been tried), as well as re-assess people already living there who may have different needs following a stay in hospital. Care home providers can find it difficult to release staff to go to the hospital and do this in a timely way.

20. This was based on a model that was successfully piloted in Lincolnshire to recruit a nursing post hosted by the local Care Providers Association (Linca) that other care home providers would trust to do the assessment on their behalf. Hertfordshire has also established similar posts. Subsequent discussion with Nottinghamshire care home providers has identified that one post working across the whole County would not be viable. The proposed method is to have two part-time qualified nurses, one each for south and mid Nottinghamshire. Their role would be to work with care home providers to identify methodology for trusted assessments in a way that uses existing staff already involved in hospital discharge and would therefore have no, or minimal, ongoing costs. With on-costs, the costs of two such posts total £58,000 which will require an additional £10,000 to that originally agreed. This can be funded from the improved Better Care Fund (iBCF). The aim is to have the posts start as soon as possible so that there is benefit over the winter period.

Social Care support to develop Integrated Discharge at Queen's Medical Centre Hospital

21. As part of the development of the integrated discharge function moving to Discharge to Assess model, the Clinical Commissioning Groups (CCGs) have approved a business case that includes resources to support Nottinghamshire County Council to develop the future model. Funding has been agreed for use in 2017/18 by the CCG for:

- 1 temporary (18 months) FTE Social Worker post (Band B), £44,882. pa
- 1 temporary (18 months) FTE Community Care Officer (Grade 5), £32,774 p.a.

Managing additional demand in hospitals over the winter

22. NHS England chief executive, Simon Stevens, has warned hospitals that they should be braced for a "pressurised" 'flu season this winter, with an unusually high demand for beds

expected in the wake of a heavy 'flu outbreak in Australia and New Zealand in recent months. He acknowledges that there is a great deal of work to be done over the next six to eight weeks with partners in local authorities to put local systems on the right footing for the winter ahead and that services for older people are likely to be put under the most pressure.

23. Last winter, an additional six additional temporary Community Care Officers were put in place to help complete additional assessments at King's Mill, Queen's Medical and Bassetlaw Hospitals. Due to significant further demand causing, for example, 95 additional bed places to be opened at King's Mill Hospital, further staff also had to be temporarily moved into the hospitals from the District and Review teams which put pressure across the social care system. The pressures were sustained through to the Easter holidays after which, for example, the two wards with the additional 95 beds at King's Mill Hospital were again closed.

24. In anticipation of likely and potentially even higher demand again for winter and Easter 2017/2018, approval is requested for the following temporary staff for six months up to 30th April 2018 at a total cost of £83,710 to be funded from the improved Better Care Fund:

- 1 FTE Social Worker (Mansfield & Ashfield, King's Mill Hospital), Band B, £44,882 p.a.
- 1 FTE Community Care Officer (Mansfield & Ashfield, King' Mill Hospital), Grade 5, £32,774 p.a.
- 1 FTE Social Worker (Newark), Band B, £44,882 p.a.
- 1 FTE Social Worker (Bassetlaw), Band B, £44,882 p.a.

Other Options Considered

25. The project to improve and strengthen prevention and promoting independence as part of hospital discharge planning was proposed after a thorough review of national, regional and local evidence of potential new areas for savings. It has its basis in a national study by the Local Government Association, followed by local testing which supported the national work.

26. The project to work with care homes to facilitate hospital discharge was designed after considering national models and then engaging local care home providers. The original resource agreed was advised as being able to deliver the outcome in a way that is sustainable and reduces the need for ongoing future funding.

27. There is the option of not putting in place additional resources in hospitals over the winter period, however, this runs the risk of there being delays in discharging people who require social care. Whilst staff can be moved in from other areas temporarily this then starts to create pressures in those teams at a time which impacts on the overall system.

Reason/s for Recommendation/s

28. It is recommended that the Committee approve the proposal regarding "Planning hospital discharge care and support packages" with its associated costs, in order to deliver a net saving of £130,000 per annum.

29. Approval of the additional funding for the project to work with Residential Care Home providers to facilitate hospital discharge will enable a short term solution to a cause of delays for both social care and health over the winter period, as well as deliver a longer term sustainable solution.

30. Approval of additional temporary social care assessment capacity over the winter period will avoid people being delayed in Nottinghamshire's hospitals over winter, due to waiting for a social care assessment and care packages.

Statutory and Policy Implications

31. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

32. The following resources are required:

Planning hospital discharge care and support packages

- Additional capacity in the Connect Prevention and Early Intervention Service (3 FTE workers, purchased from the voluntary sector) at a cost of £70,000 pa
- Recruitment of 1 FTE permanent Occupational Therapist (Band B) at a cost of £44,882 pa plus £1,500 pa car mileage costs to be funded from the permanent savings achieved
- Recruitment of 0.5 FTE Project Officer (Band B) for years 1 and 2 counted as a one-off implementation cost of £44,882, plus £3,000 one-off car mileage budget to be funded from reserves unless a bid for the improved Better Care Fund is agreed
- one-off costs of ICT equipment for two posts is £6,000 to be funded from reserves unless a bid for the improved Better Care Fund is agreed

Working with Residential Care Home providers to facilitate hospital discharge

- additional non-recurrent funding of £10,000 from the improved Better Care Fund

Social Care support to develop Integrated Discharge at Queen's Medical Centre Hospital

- 1 temporary (18 months) FTE Social Worker post (Band B), £44,882. pa
- 1 temporary (18 months) FTE Community Care Officer (Grade 5), £32,774 p.a.

Both to be funded by the CCGs.

Managing additional demand in hospitals over the winter

- 1 FTE Social Worker (Mansfield & Ashfield, King's Mill Hospital), Band B, £44,882 p.a.

- 1 FTE Community Care Officer (Mansfield & Ashfield, King' Mill Hospital), Grade 5, £32,774 p.a.
- 1 FTE Social Worker (Newark), Band B, £44,882 p.a.
- 1 FTE Social Worker (Bassetlaw), Band B, £44,882 p.a.

All to be funded from the improved Better Care Fund

Savings that can be delivered:

- With the revised processes and the additional resources net recurrent savings of £130,000 can be achieved.

Human Resources Implications

33. There are no Human Resources implications arising from this report.

Implications for Service Users

34. The proposals will provide more opportunities to enable people to live independently, improve their health and well-being and reduce their need for care and support.

Ways of Working Implications

35. The new Nottinghamshire County Council posts will have equipment to enable mobile working and flexible use of office accommodation.

RECOMMENDATION/S

That Committee:

1) approves the promotion of prevention and people's independence as part of planning their discharge from hospital of Hospital Discharge Packages to deliver the identified savings

2) approves the establishment of the following associated posts:

- 1 FTE Occupational Therapist (Band B) and the post allocated an authorised car user status
- a temporary 0.5 FTE Project Officer post (Band B) for two years to March 2020 and the post allocated an authorised car user status.

3) approves the additional request for non-recurrent allocation of £10,000 from the improved Better Care Fund for the project to facilitate timely discharges from hospital to residential care

4) approves the establishment of two posts that will be funded by the south Clinical Commissioning Groups:

- 1 temporary (18 months) FTE Social Worker post (Band B)
- 1 temporary (18 months) FTE Community Care Officer (Grade 5)

5) approves the establishment of 3 FTE temporary Social Worker (Band B) and 1 FTE temporary Community Care Officer (Grade 5) posts from November 2017 to 30th April 2018 at a cost of £83,710 from the improved Better Care Fund.

Sue Batty
Service Director – Mid Nottinghamshire

For any enquiries about this report please contact:

Wendy Lippmann
Transformation Manager (Mid-Nottinghamshire)
T: 0115 9773071
E: wendy.lippmann@nottscc.gov.uk

Constitutional Comments (SLB 27/09/17)

36. Adult Social Care and Public Health Committee is the appropriate body to consider the content of this report, subject to the Council's Employment Procedure Rules which require all reports regarding changes to staffing structures to include HR comments, and that consultation is undertaken with the recognised trade unions.

Financial Comments (KAS 27/09/17)

37. The financial implications are contained within paragraph 32 of the report.

HR Comments (SJJ 27/09/17)

The temporary posts will be recruited to on a fixed term contract basis, the post of Project Officer will require an evaluation before advertising.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Proposals for use of the improved Better Care Fund - report to Adult Social Care and Public Health Committee on 10th July 2017.

Better Care Fund – Proposed Allocation of Care Act Funding - report to Adult Social Care and Health Committee on 12th September 2016

Electoral Division(s) and Member(s) Affected

All.

ASCPH487