DRAFT V2

Healthier Communities and Older People Overview and Scrutiny Panel

Date: 07 February 2017

Agenda item: Care in the Community for Older People and the Hospital Discharge Process

Subject:

Lead officer: Kim Carey, Interim Head of Access & Assessment, Community and Housing

Lead member: Councillor Peter McCabe Chair of the Healthier Communities and Older People overview and scrutiny panel.

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Recommendations:

A. That the Scrutiny Panel note the operational arrangements in place to enable older people to be supported in the community in order to reduce the need for prolonged stays in hospital.

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1 PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1. This report seeks to brief members of the scrutiny panel on the arrangements in place to enable timely discharge from hospital and describes some of the current support available in the community to enable older people to live as independently as possible.

2 DETAILS

2.1. The London Borough of Merton is supported by a number of acute hospitals, being placed as it is, in a central location. Currently approximately 60% of Merton residents use St Georges Hospital, 30% use St Helier and approximately 7% use Kingston hospital. The Borough currently has a small Hospital to Home team based at St George's Hospital, but providing discharge support for all the acute hospitals in the local area. The team comprises a Team Manager, an Assistant Team Manager, 2 Qualified Social Workers, 2 Assessment, Support and Planning Officers (ASPO's), 2 Delayed Transfer of Care (DToC) screening officers and two administrative officers, one of whom is funded by health.

2.2. The Team Manager reports into the Service Manager for Prevention and Recovery and has close links with the in-house Reablement Team, the Assessment and Initial Support teams and the Occupational Therapy Team, all of whom report to the same manager. This has enabled the development of a streamlined pathway to assessment and discharge as will be described later.

2.3. The responsibility for safe discharge from hospital rests with the hospital, who are required to make a clinical decision about when an individual is medically fit for discharge, but it is essential that all partner agencies work together to ensure a process that is robust and clear, and most importantly, has the needs of the individual at its centre. All staff are committed to enabling people to leave hospital as soon as they are fit, with a shared understanding that hospitals are not a good place to be.

2.4. Much of our recent work with the community health provider (CLCH) has been developing a joint response to people's needs, to, where possible, avoid a hospital admission, or where an admission has taken place, to enable the person to leave hospital as swiftly and safely as possible. There are plans to move staff from CLCH into the Civic Centre early in 2017 which will aid the delivery of a more integrated response to people who are in need of health or social care or indeed both.

2.5. In order to affect a safe discharge, the ward staff will refer any individual that they feel may need social care input in order to get home, to the Hospital to Home Team. Ideally, this referral will come through to the team very early in the individuals stay in hospital, ensuring that where services are already in place they can be notified of the likely discharge date, or where there are more complex needs, that these can be identified early. We call these referrals Assessment Notifications.

2.6. There are challenges to referring early, as it may not be possible early in an individual's hospital stay to identify their likely needs at discharge, but ideally the hospital to home team should be given early notice of the need for involvement.

2.7. When an individual is medically fit for discharge, the ward will send through a further notification (called a Discharge Notification), which gives a more firm date for discharge and identifies the needs. This referral will trigger a more detailed assessment which is required to be completed within 72 hours of receipt before the discharge is classed as a delay.

2.8. There has been much media coverage of late, about the number of Delayed Discharges of Care (DToC) that are the responsibility of the local authority. This DToC definition refers to the number of people, who for whatever reason, are medically fit for discharge, but cannot leave the hospital. There are a number of reasons why an individual cannot leave hospital, not all of which are the responsibility of the local authority and a detailed description of how these are defined is shown at Appendix 1.

2.9. Whilst LB Merton does experience challenges with managing the DToC numbers, comparative data shows that across London we are performing well. Whilst there is no room for complacency, despite the small team, we are managing to keep pace with increased demand, unlike many other authorities. A graph showing Merton's performance is attached at Appendix 2.

2.10. Once a Discharge Notification has been received the referral will be screened by the team and a decision will be made about what 'pathway' an individual needs to be referred down to affect their discharge.

2.11. Some individuals will have no or very simple needs that they can either meet themselves or may require help with from family or friends, if they are willing and able to provide this. There are a number of voluntary agencies with whom the Council has contracted to provide more informal support for people when they return home. Attached at Appendix 3a & 3b are some examples of this support, which are part of the Ageing Well programme, but there are many other examples across Merton.

2.12. Many older people and their families prefer to have support provided by non-statutory agencies and we are lucky to have a number of voluntary sector organisations that provide support across the borough. However, it is important to note that as the needs of individuals who are living in their own homes increases, so does the complexity of need that we are asking voluntary sector partners to support. It is also important to remember that when referring to the voluntary sector, we are not just talking about volunteers who give their time freely. Voluntary sector groups are increasingly required to employ staff to run their organisations and may need small amounts of money to enable them to run. This is not a free service.

2.13. If individuals are wishing and are able to return to their own homes and there is an indication that they will need some support, a referral will be made directly to the Re-ablement service. The name of this service is slightly misleading as the service does not just deal with people who have either the capacity or the need to be re-abled (a term that has replaced rehabilitation), this will be the subject of further review during the coming year to ensure that we are making the most of a well-trained and skilled workforce.

2.14. The Reablement service will carry out an initial assessment and support individuals for up to six weeks, to enable them to regain confidence, learn new skills or make adaptations to their living arrangements in order that they can remain living in their own home. Some individuals will have no need for ongoing support following their involvement with the service, those that do will be supported by the in-house Brokerage team to obtain care from the independent sector care agencies, or by the Direct Payments team who will arrange for a cash payment to be made to individuals in order that they can purchase their own care. The initial support from the Reablement service is provided free but if individuals need care post the delivery of this service they will be financially assessed to contribute towards their care.

2.15. If individuals are assessed as needing care in a residential or nursing home the assessment will be carried out by the Hospital to Home team who will work alongside assessment staff from health to identify if they have health needs that may either mean that they are eligible for Continuing Health Care (CHC) or for Funded Nursing Care (FNC). If eligible for CHC the responsibility for supporting an individual and their family rests with health staff and individuals will receive the service free. If they are eligible for FNC an element of the placement costs will be met by health but an individual will be financially assessed to contribute to the element of the package of care funded by the Council.

2.16. The Council provides a Brokerage team who are responsible for working with the independent and private sector to identify available care and will signpost individuals and their families to this care, act as a conduit between

the individual, hospital and the care provider in terms of arranging for the provider to visit to assess if they are able to meet the needs of the individual and are responsible for negotiating the fee level that will be paid where there is not a fixed rate for the service being provided. The Council is working with partners in health to extend this team to provide support to individuals who have mental health needs and those funded by health for CHC.

2.17. The Brokerage team will also confirm restarts to packages of care suspended whilst someone is in hospital.

3 ALTERNATIVE OPTIONS/AMBITIONS

3.1 There are a number of plans in place to improve the support that people can access in the community which will either reduce the need for a hospital admission or enable them to be discharged more speedily from hospital.

3.2 As has already been mentioned, there are plans for staff from CLCH to be based within the Civic Centre which will improve the opportunities for staff across both the Council and health to work better together. There are no plans to create new organisational structures or change employment arrangements, our plans are more pragmatic and more easily delivered. Staff in the social care teams are already meeting with health staff on a weekly basis to discuss those patients who are at risk as identified by health, social care and GP's to put joint support around them to enable them to continue to live independently in the community.

3.3 Once health staff are based within the Civic Centre it is planned that we will pull together our referral point for people who have an urgent crisis, in order that support can be provided to prevent the need for a hospital admission where this is appropriate. Managers will link the re-ablement team and the Community Health teams provided by CLCH who will work together to provide swift support and carry out quick assessments to determine how an individual can best be supported whilst they are in crisis and beyond. This will be done by making best use of the collective capacity, there is currently no new money to invest, but will be monitoring activity closely to build the business case to move investment from the acute sector to community services (both health and social care) to reflect the change in service demand.

3.4 Managers are seeking to use a similar joint approach to hospital discharge, ensuring that appropriate support is provided in a timely way and that duplication is removed. At the current time is will not be unusual for an individual to be receiving calls from very many professionals at the same time. Evidence indicates that in reality people do not mind who supports them, as long as they get the support they need, when they need it.

3.5 Both of these changes will require the refocus of the Reablement staff as indicated earlier in the report.

3.6 A programme that is currently being developed across health and social care is the Discharge to Assess process, whereby an individual is discharged early from a hospital bed, using the Home First Model, where a more full assessment can be completed. Locally this process is very new and in some instance is being applied inappropriately and simply being used as an

opportunity to clear a hospital bed, with placements being made into a residential or nursing bed with no clear information or expectation being given to individuals and their families about what will happen long term. Managers are working with the CCG to revise this practice and to plan discharge to assess into individuals homes rather than to a residential setting which ensures that more people go home, rather than defaulting to a residential or nursing bed from which it may be difficult to extricate them as they lose confidence and ability. This is the model on which the Reablement service is based.

3.7 More effective use is being made of the Occupational Therapy (OT) workers within the Reablement team to support those people being discharged home from hospital with equipment, with the community teams providing the training for the individual, their families and carers on how to safely use equipment such as hoists. The OT service is also assisting with assessments where it is indicated by agencies that people may need double handed care (support from more than one carer) in order to reduce cost and also make best use of the available capacity, which at times is stretched to capacity.

3.8 Alongside this, the Council is seeking to work more collaboratively with voluntary sector partners and to build on the excellent work that is already in place. As demand on councils has grown more demand has been made on the voluntary sector and we need to ensure that the referrals that are made to our partners are both appropriate, are funded and can be delivered. There has been a significant shift over recent years to work more closely with partners and there is a good evidence base that indicates that for many people they would prefer to be supported by people other than statutory agencies. There are some good examples of this working well in Merton and the Council has already been delegating some responsibilities, such as support to carers, to voluntary sector partners.

3.9 This is working well, but needs work to further develop this opportunity and discussions have begun with voluntary sector partners about how we better plan together and access alternative sources of funding to support the most vulnerable in our community

4 CONSULTATION UNDERTAKEN OR PROPOSED

4.1. There are ongoing and regular discussions with health partners to agree the most effective ways of working together. There are also regular meetings with the relevant voluntary sector groups to share the experience of customers and to test new thinking.

5 TIMETABLE

5.1. Work on this will continue to develop.

6 FINANCIAL, RESOURCE AND PROPERTY IMPLICATIONS

6.1. The main risk to the Council is that as more people are supported outside of a hospital setting costs will shift to community resources. This discussion has commenced with the CCG in order that investment can be moved but this discussion needs formalising in order to prevent a financial pressure on

both the Council and CLCH. This can legitimately form part of the discussion about the investment of the Better Care Fund for future years.

7 LEGAL AND STATUTORY IMPLICATIONS

7.1. This action is in line with the Care Act 2014.

8 HUMAN RIGHTS, EQUALITIES AND COMMUNITY COHESION IMPLICATIONS

8.1. These plans seek to protect individuals' human rights and seek to maximise the use of community resources and support community cohesion.

9 CRIME AND DISORDER IMPLICATIONS

9.1. None

10 RISK MANAGEMENT AND HEALTH AND SAFETY IMPLICATIONS

10.1. The main risks are financial, as highlighted above, the need to manage expectation and to ensure that available resources can meet demand.

11 APPENDICES – THE FOLLOWING DOCUMENTS ARE TO BE PUBLISHED WITH THIS REPORT AND FORM PART OF THE REPORT

- Appendix 1 - Delayed Transfers of Care definitions
- Appendix 2 – Comparator data on Delayed Transfers of Care
- Appendix 3 - Examples of current Voluntary Sector support

12 BACKGROUND PAPERS

12.1. None.