

**Report to:** Partnerships Scrutiny Committee

**Date of Meeting:** 19<sup>th</sup> January 2017

**Lead Member/Officer:** Lead Member for Social Care (Adults and Children's Services)/Head of Community Support Services

**Report Author:** Principal Manager

**Title:** Community health & social care arrangements to support timely hospital discharge

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## **1. What is the report about?**

This report provides information about partnership arrangements within community health and social care services to monitor and address delays in arranging transfers of care, in particular from hospital. It references some key findings from a senior management joint review in relation to the issues affecting 'flow' in the whole health and social care system, which will influence joint planning going forwards. It also includes an overview of activity and the use of the Intermediate Care Fund to ease the pressure on hospital beds and achieve better outcomes for Denbighshire citizens.

## **2. What is the reason for making this report?**

Concerns have been raised by an Elected Member that Denbighshire County Council was preventing effective discharge from hospital for older people due to the structural arrangements and processes in place. This report is intended to show that discharge from hospital is a process and not an isolated event. It should involve the development and implementation of a multi-disciplinary plan involving the patient and their carer(s) as equal partners to facilitate the transfer of an individual from hospital to the next stage of care. The In-Patient Team as well as community services provided by both health and social care have a vital role to play in this complex system and it is important that we continue to work together to review the structural and operational arrangements to ensure we are as effective as possible.

## **3. What are the Recommendations?**

That Members consider the contents of this report and comment as appropriate

## **4. Report details**

### **4.1 Overview of issues from Senior Management**

At the beginning of December, senior managers from BCU, Conwy Borough Council and Denbighshire County Council spent three days considering the significant issues which the health and social care system face. It is likely a full report will be produced shortly. There are internal improvements that the Betsi Cadwaladr University Health Board (BCU) will be making, however there are some common issues which we need to tackle as partners. These include:

- Lack of capacity in certain areas of the workforce, poor processes and the need for staff development and support. This needs co-ordinated attention.
- The need to modernise services consistent with a shared vision as some of the traditional models of care for older frail individuals are no longer fit for purpose. We need a greater level of discussion on the alternative options for models of care and to plan for these. Arranging a North Wales Conference on new models has been suggested.
- A strong message from the Independent Sector about sustainability e.g. the difficulty of staff recruitment and retention; the level of funding; the reduced number of self-funders, the amount of regulation and inspection; and the increased cost of continence products and equipment. Suggested actions included the need to review our ability to deliver equipment and consumables to Nursing Homes; to promote a more co-ordinated and proportionate approach to inspection regimes; to work with Coleg Llandrillo and other Further Education establishments on how we introduce students studying Health and Social Care into a practical setting with placements in the Sector; and we need to work with the Sector to promote a positive image.

Some plans are already in formation. For BCU this is likely to include increasing Community Nursing support from 8am to 10pm to 24 hours per day, 7 days per week and thoroughly considering end of life care, including Treatment Escalation Plans and increasing 'hospice at home' services.

For Community Support Services, the plans include working with the Independent Sector to establish 'patch-based' commissioning and promoting the use of Support Budgets

## **4.2 Support for Timely Discharge**

There has been a consistent focus on supporting hospital discharge by partners within health and social care. There are weekly meetings to consider any blockages in the system for specific individuals who have been identified as being medically fit for discharge. We continue with the monthly audit for delayed transfers of care (DTCOC).

4.2.1 The Single Point of Access (SPOA) continues to be the referral point for the majority of health and social care community services and is available at the weekend. SPOA Operators continue to have access to a range of IT systems to be able to deal with any enquiries. The coordinators within SPOA remain clear about their responsibilities for facilitating discharge. The Reablement Coordinator, for instance, is now based within SPOA and this enables a more responsive Reablement service. The District Nurse in SPOA has a more active role in relation to discharge as he attends the bed meetings and reports back to the SPOA Multi-disciplinary team meetings. The Social Worker continues to monitor and review all referrals for people not previously known to Social Services. She also chases missing information from referrals for hospital discharge; the Adaptations and Equipment Coordinator is made aware of any demands for community equipment or housing adaptations that needs progressing to facilitate or support discharge and works closely with Care and Repair and the Built Environment. There is also a 3<sup>rd</sup> Sector post which has a key role in supporting discharge and preventing admission.

4.2.2 There are currently two complementary developments that have been initiated by health and social care.

Within the Locality Teams in Social Services, it was proving difficult for staff to accommodate rapid response work in relation to community crises, managed care and support for people with complex needs in the community at the same time as prioritising responses to requests for hospital discharge. A decision was taken to create a 'step-down' cluster from the existing Locality establishment to facilitate a smooth transition from hospital (including the Enhanced Care Service) to an appropriate discharge destination for each individual with the appropriate level of support and follow on intervention. The cluster came together in September 2016. There has been an initial settling in period, the establishment of working protocols and relationship building and they are now starting to become effective in their role.

Within BCU a new step-down team is being created, also from existing staffing within the hospital. The Step Down Team Manager was a post advertised to all professions across health and social care and the successful applicant was a manager from Community Support Services with an Occupational Therapy background who started in mid-December. It is hoped this will enhance the partnership working for timely discharges.

4.2.3 Other initiatives to address pressures in the system include:

- A study by occupational therapists between March and August 2016 to identify community equipment that had the potential to minimise manual handling by carers in a wide range of care situations. One particular item was effective. See appendix 1 for further details.
- One Denbighshire GP Cluster has appointed an Advanced Nurse Practitioner to work with Care Homes in Central and South Denbighshire, in an attempt to prevent inappropriate hospital admission

### **4.3 Intermediate Care Fund**

The Intermediate Care Fund has also been used to support discharge. It funds approximately £500,000 for SPOA; £100,000 for falls prevention processes; and £80,000 for early supported discharge for people who have had a stroke. This year it is also paying the rent for a 'step-down' flat in Prestatyn in the Extra Care Housing complex; an increase in community support including a team of community navigators; additional Health and Social Care Support Workers; the creation of a longer term domiciliary care team in the South of the County; a social worker and team manager in the step down cluster and part funding a housing officer in the BCU step down team.

## **5. How does the decision contribute to the Corporate Priorities?**

The partnership working in relation to hospital discharge will contribute to supporting "Vulnerable people are protected and are able to live as independently as possible" in Denbighshire's Corporate Plan 2012-2017.

## **6. What will it cost and how will it affect other services?**

It is expected that work in this area and any proposals for the future will have a positive effect on service delivery. There will be no additional costs unless funded by

grants such as the Intermediate Care Fund. Preventing inappropriate or avoidable admission and getting the discharge process right and at the right time is likely to reduce dependency on social care services

## **7. What are the main conclusions of the Well-being Impact Assessment?**

The plans for timely hospital discharge largely affect older people and their need to access to good quality community health and social care services. The approach used by Denbighshire Social Services is in line with the Social Services and Well-being Act and aims at empowering communities to become more resilient and manage their own health and well-being. As shared plans develop, there will be a need for more thorough impact assessments. Having a robust workforce development plan is crucial. See appendix 2.

## **8. What consultations have been carried out with Scrutiny and others?**

The contents of this report have been prepared in consultation with colleagues in BCU. The planning for most of the services referred to has been discussed in partnership fora such as Partnership Thursday, the Denbighshire Joint Locality Forum; the Central Area Integrated Services Board and various unscheduled care meetings and workshops.

## **9. Chief Finance Officer Statement**

Not required

## **10. What risks are there and is there anything we can do to reduce them?**

The risks to the delivery of safe healthcare within North Wales are major, which is why CSS prioritise and work closely with colleagues in BCU on this subject. The lack of care workers is a risk to the safety of vulnerable people in Denbighshire. Actions for being effective includes the need for a major culture change within the organisations as well as managing the expectations of the general public.

## **11. Power to make the Decision**

Section 7 of the Council's Constitution of the Council's Constitution outlines Scrutiny's powers with respect to policy development and review and the Authority's performance in meeting policy objectives.

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