MIDDLESBROUGH COUNCIL

AGENDA ITEM: 5

OVERVIEW AND SCRUTINY BOARD

FINAL REPORT OF THE SOCIAL CARE AND ADULT SERVICES SCRUTINY PANEL

DISCHARGE FROM HOSPITAL SUPPORT PROVIDED BY SOCIAL CARE

7 JANUARY 2013

PURPOSE OF THE REPORT

1. To present the findings of the Social Care and Adult Services Scrutiny Panel's review of Discharge from Hospital – Support Provided by Social Care.

BACKGROUND

2. In its examination of Winter Pressures, the Health Scrutiny Panel had heard that one of the barriers in assisting with the efficient discharge of patients, is social care response times. In light of this information, the Social Care and Adult Services Scrutiny Panel agreed to examine the topic of Discharge from Hospital - Support Provided by Social Care.

TERMS OF REFERENCE OF THE SCRUTINY INVESTIGATION

3. The Panel concentrated its investigation on the following terms of reference:

- To examine the current working practices of hospital-based social work and establish the range of services provided.

- To identify the main causes for any delay in hospital discharge and receive relevant statistics.

- To determine measures and strategies that could be implemented in order to reduce any delayed discharge, particularly in relation to the hospital and social work interface.

- To explore the future challenges for hospital-based social work and investigate methods to cope with an increased demand on the service - for example the use of virtual wards - to better support people in their own homes and help prevent hospital admissions.

METHODS OF INVESTIGATION

4. The Panel investigated this topic over the course of 3 meetings held on 4 July, 25 July, and 17 October 2013. Information was also received at the Special Overview and Scrutiny Board meeting on 4 November 2013. A Scrutiny Support Officer from Legal and Democratic Services co-ordinated and arranged the submission of written and oral evidence and arranged witnesses for the investigation. Meetings

administration, including preparation of agenda and minutes, was undertaken by a Governance Officer from Legal and Democratic Services.

5. A record of discussions at Panel meetings, including agenda, minutes and reports, is available from the Council's Egenda committee management system, which can be accessed via the Council's website at www.middlesbrough.gov.uk.

6. This report has been compiled on the basis of information submitted to the Scrutiny Panel by the Council's Department of Wellbeing Care and Learning and the South Tees Hospitals NHS Foundation Trust.

MEMBERSHIP OF THE PANEL

7. The membership of the Panel was as detailed below:

Councillors P Purvis (Chair), F McIntyre (Vice-Chair), E Dryden, N Hussain, D G Loughborough, T Mawston, M Saunders and J A Walker

THE SCRUTINY PANEL'S FINDINGS

8. The Scrutiny Panel's findings in respect of each of the terms of reference are set out below:

TERM OF REFERENCE: To examine the current working practices of hospital-based social work and establish the range of services provided

9. In investigating this Term of Reference, the Panel examined the following issues:

- **The purpose of hospital-based social workers**
- **The purpose of the social work team based at James Cook University Hospital (JCUH)**
- **The structure of the team**

The purpose of hospital-based social workers

10. Hospital-based social workers are part of a multidisciplinary healthcare team and play a critical role in providing assessment, and appropriate interventions, to aid patients in achieving optimum recovery/rehabilitation and quality of life. One responsibility of hospital-based social workers is to collaborate in the development of a discharge plan that will meet the patient's needs and allow the patient to leave the hospital in a timely manner.

The purpose of the social work team based at James Cook University Hospital (JCUH)

11. The Council's Strategy and Delivery Manager for Community Care provided Members with an overview of hospital-based social work and the range of services provided.

12. It was conveyed to the Panel that the purpose of the team based at JCUH is to provide a hospital discharge service for individuals resident within Middlesbrough, and Redcar and Cleveland Council areas. All team staff are employed by Middlesbrough Council with a re-charge agreement in place to allow Middlesbrough to subsequently reclaim 50% of all costs from Redcar and Cleveland. The team also

provides the social work input for Carter Bequest Primary Care Hospital, Redcar Primary Care Hospital, East Cleveland Primary Care Hospital and Guisborough primary care Hospital.

13. The Panel heard that the functions of the team are:

- To ensure that, where the department is aware of an individual who appears to be in social care need, an assessment is undertaken.
- To ensure the contribution of professionals from all relevant agencies to the assessment process.
- To facilitate the design and timely implementation of support plans to meet the needs of individuals and their carers.
- To ensure that arrangements are in place to monitor and review care packages at appropriate intervals.
- To provide advice and information regarding matters of social care to staff from JCUH and the primary care hospitals and to work in compliance with agreed hospital discharge protocols.
- To arrange the transfer of case management of Redcar and Cleveland service users to Redcar and Cleveland Borough Council staff at an appropriate time.
- To manage the adult social care response to adult safeguarding alerts for individuals who are in hospital and for Middlesbrough residents within six weeks following discharge from hospital.
- To support the Clinical Commissioning Group through the participation in agreed elements of the Continuing Healthcare process.

14. The nature of the hospital-based social work team's practice requires for duties to be carried out quickly. Staff have few opportunities to see the person in their home environment at a time when the person is, or has been, unwell and is within a system that does not always recognise broader issues concerning the needs of a person post-discharge. In light of this, high demands are placed on staff, which means that it is particularly important that the Council deploy experienced, confident and resourceful staff in this setting. The Panel was advised that it is not anticipated that there is the same scope to utilise unqualified staff, as there may be within some other settings.

15. It was conveyed to the Panel that it important to remember that as the hospital-based social work team also provides the discharge service for Redcar and Cleveland Borough Council, this requires the staff to be conversant with two different ways of managing the process in terms of computer systems and administrative processes.

Structure of the team

16. In terms of the number of hospital-based social work staff, the Panel was advised that the team consists of 27 members of staff including 19 qualified social workers (16.55 full-time equivalent); one full-time equivalent Care Management Assistant; three administrative staff members (two full-time equivalent), (employed by James Cook University Hospital (JCUH) to staff the duty desk) and two administrative staff members (1.41 full-time equivalent) (employed by JCUH to provide general administrative support). The team is led by a Team Manager with the support of two Assistant Team Managers; all three are full-time and are qualified social workers.

17. The Panel was advised that in day to day practice, the team is divided into three operational sections: discharges from JCUH, discharges from the community hospitals and specialist social worker roles. Although the social worker roles are

generic, the split between the three operational roles is based on nine staff working on JCUH discharges, 3 staff working on community hospital discharges, one social worker focusing on reviews for individuals who have recently been discharged from hospital and 6 specialist social workers.

18. The 6 specialist social workers (5 whole time equivalents) are employed by Middlesbrough Council but funded by the units where they are employed. Two social workers are employed within the Regional Spinal Unit, one within the Renal Unit, one with the Stoke Unit, one is employed to specifically work with individuals who were HIV positive (as is the one Care Management Assistant), and one within the FAST team with a specific focus on preventing the admission of individuals who present at "front of house".

19. It was conveyed to the Panel that there is some funding provided for specific social work time in relation to individuals with lung cancer but this role is carried out by one of the Social Workers who also provided discharge support within the JCUH discharge segment. Additionally, one social worker is currently attached on a pilot basis to the orthopaedic wards. The "purchase" of these specialist services by the parent units is reflected in working roles over and above the normal discharge service that would be provided. It was acknowledged that further funding is required so that social workers can be linked to individual wards.

20. The team provides a social work service throughout the hospital but does not receive referrals from the paediatric wards. The team currently works a standard Council working day.

TERM OF REFERENCE - To identify the main causes for any delay in hospital discharge and receive relevant statistics.

21. In investigating this Term of Reference, the Panel examined the following issues:

- **Overview of hospital discharge**
- **The current patient journey**
- **Community Care (Delayed Discharges etc.) Act 2003**
- **Legislation in practice**
- **What is delayed discharge?**
- **Reasons for delayed discharge**
- **Social Care delays**
- **Reasons for Social Care delays**

Overview of hospital discharge

22. The Director of Operational Services and the Deputy Director for Service Transformation at South Tees Hospitals Foundation Trust (STHFT) conveyed that the timely discharge of patients with complex needs, following a period of acute illness, requires all statutory agencies to work together in close partnership.

23. The Panel was provided with details of the prevailing legislation and national guidance in terms of hospital discharge and patient assessments.

24. The Panel was advised that the key legislation around hospital discharge is the Community Care (Delayed Discharges) Act (2003). The Act places duties upon both the NHS and local authorities with social care responsibilities, regarding the discharge of patients from hospital. In addition, if a patient potentially requires a

commissioned service, assessments required as part of the Continuing Healthcare Care Framework (DoH 2012) must also be undertaken. These assessments are primarily the responsibility of Clinical Commissioning Groups (CCGs) as health commissioners, in conjunction with healthcare providers and social care.

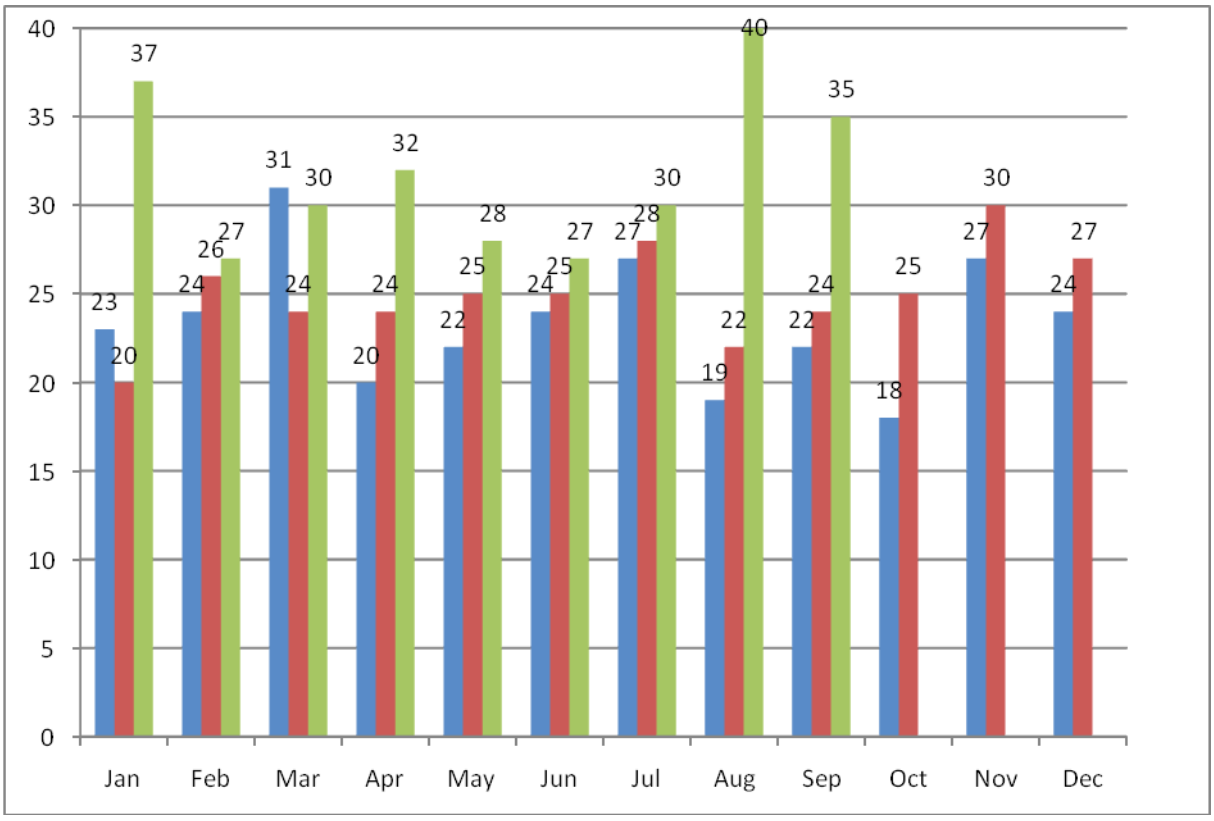
25. The Panel was informed that all patients are assessed on an individual basis, to determine with them and their families the most appropriate discharge plan. Traditionally, the range of assessments have all taken place within the acute hospital environment, and as the complexity and number of assessments and the coordination of arrangements across a number of agencies increases, so does the patients length of stay.

The current patient journey

26. It was conveyed to the Panel that on admission, a patient is assessed as to the likely length of stay and a planned date of discharge (PDD) is set. This PDD is the date that everyone works towards and should only be changed if the patient's medical condition changes. If the patient is assessed as requiring support on discharge, their consent is obtained for a social care referral to be completed.

27. However, the Panel was advised that if a patient is thought to be potentially eligible for NHS Continuing Healthcare funding, a Continuing Health Care (CHC) checklist must be completed. If the patient "triggers" a Decision Support Tool (DST) assessment, further nursing assessments are made and a meeting arranged by the CHC team, currently provided by the North East Commissioning Support Agency on behalf of the CCG. The demand for CHC assessments has increased substantially over the past 12 months as the graph 1 illustrates:

Graph 1 - Number of Continuing Healthcare Assessments undertaken on JCUH site 2011-2013



28. Further assessments are required if it is thought that the patient lacks mental capacity.

29. Members were advised that once a decision is made regarding whether the patient requires residential or nursing care, families are supported by the hospital-based social work team/continuing healthcare team to find a suitable facility. Once chosen, the nursing/residential home is required to assess the patient to ensure they can support the individual patient's needs and once this has been determined the patient can be safely discharged. This will generally take a number of days.

Community Care (Delayed Discharges etc.) Act 2003

30. The Council's Strategy and Delivery Manager informed the Panel that under the above Act, NHS bodies are required to notify the relevant local authority of individuals, whom they believe are likely to need community care services upon discharge from hospital, and work with them to assess a patient's needs. The hospital is required to consider whether the patient's individual needs have changed following their admission into hospital and if this is the case, to determine what kind of social care the patient will require following their discharge from hospital.

31. The Panel was informed that following receipt of the notification, social services are required to complete the individual's assessment and provide appropriate social care services within the timescales stipulated by the Act:

- There is a defined timescale, following the s.2 notification (the 'minimum interval' of at least 72 hours) for social services to complete the individual's assessment and provide appropriate social care services.
- A second notification, the s.5 notification follows from multi-disciplinary agreement that the patient is ready to be discharged and allows a 24 hour period for social services, within which the individual must be discharged.

32. It was conveyed to the Panel that dependent on the proposed discharge date of the patient, but not less than 72 hours, social services must assess need and effect discharge from hospital.

33. The Act also makes provision for a system of reimbursement for delayed hospital discharges. If a patient remains in hospital because the Council has not put in place the services the patient or their carer need for discharge to be safe, the Council can be fined a charge per day of delay by the NHS body. This charge is currently £100 per day. Members were informed that an agreement was reached locally that the provision for the levying fines would not be implemented; this has remained the case to date but the legislative basis for fines remains in statute. This provision was intended to provide a financial incentive for councils to promptly assess and transfer people from an acute ward (where they are at risk of losing their independence) to a more appropriate community setting as soon as they are ready for discharge, and provide an appropriate range of support. The Act does, however, place significant administrative demands on partner organisations and it was highlighted that implementation of fines would arguably run the risk of undermining the improvements made via partnership working.

Legislation in practice

34. In practice the Community Care (Delayed Discharges etc.) Act places a responsibility on ward staff to identify an individual in hospital whom they feel may be in need

social care services. Once they have identified such a patient and their consent has been obtained, the hospital staff member completes a referral form for submission by fax to the social work team based at James Cook University Hospital. If the case is already assigned to a social worker in a community-based team then it will be passed on to them, otherwise the piece of work will be allocated to one of the hospital-based social workers. The Panel was advised that it is significant to note that the Act states the health body should pass the referral once they form the opinion that the person may be in need of social care services – this is in advance of the person being ready for discharge, it may even be in advance of admission in some planned instances.

35. It was conveyed to Members that the role of the social worker thereafter, irrespective of whether they are based in the hospital or in the community, is to conduct a timely assessment of need. This ensures the contribution of other relevant professionals, and facilitates the design and timely implementation of a support plan that meets the eligible needs of the individual and their carers.

36. As previously stipulated, the timescales for the conduct of assessments and care planning are conveyed within the Act. This serves to provide a minimum time period to allow the social worker to complete the task and a maximum time period within which it is expected the task will be complete. The start time for the process begins when the referral form is received and date stamped.

37. The Panel was advised that in most instances the assessment task is a complex one. By definition, a person's presence in hospital conveys they are unwell or recovering illness or injury. The social worker must therefore rapidly gain an understanding of how they were prior to admission, what their home environment is like and how they are, or were, supported to live within it and what will be required once they leave. The social worker must support the individual to arrive at a suitable plan within the relevant timescale afforded by the referral. It was highlighted that in the vast majority of cases this is achieved successfully.

What is delayed discharge?

38. The Panel was advised that it is important to be precise about what constitutes a delayed discharge. For instance, STHFT states that:

"A delayed discharge is recorded from the date at which a patient is medically fit to be discharged from a hospital bed, but could not be discharged - DOH data standards, 2007"

39. It was conveyed to the Panel that the above definition is certainly a major practical concern for JCUH, and one which the Council supports them in resolving where possible. However, the formal definition under the Community Care (Delayed Discharges etc.) Act 2003 states that the health body must give the appropriate statutory notification (and accompanying minimum time period) to the Council to allow assessment, that there must be a multi-agency decision that the person is ready to be discharged and that the final formal notification should then be sent giving 24 hours for the social worker to facilitate discharge. Within the terms of the Act ***the case only becomes a delayed discharge if all of the procedures have been followed, the 24 hours has elapsed and the patient still remains on the ward.*** The Panel was advised that this occurs very infrequently, while delays of this nature do occur from time to time, the vast majority of delayed transfers of care result

from causes other than a failure on the part of Council staff to meet their statutory target.

40. Members were advised that the definition in paragraph 39. gives a context to the role of social workers within the hospital but there is an absolute acknowledgement that in practice the job is concerned with supporting the hospital to facilitate timely discharges wherever possible. Social workers strive to discharge people home in a timely manner as it is the correct thing to do in supporting the service user and the hospital.

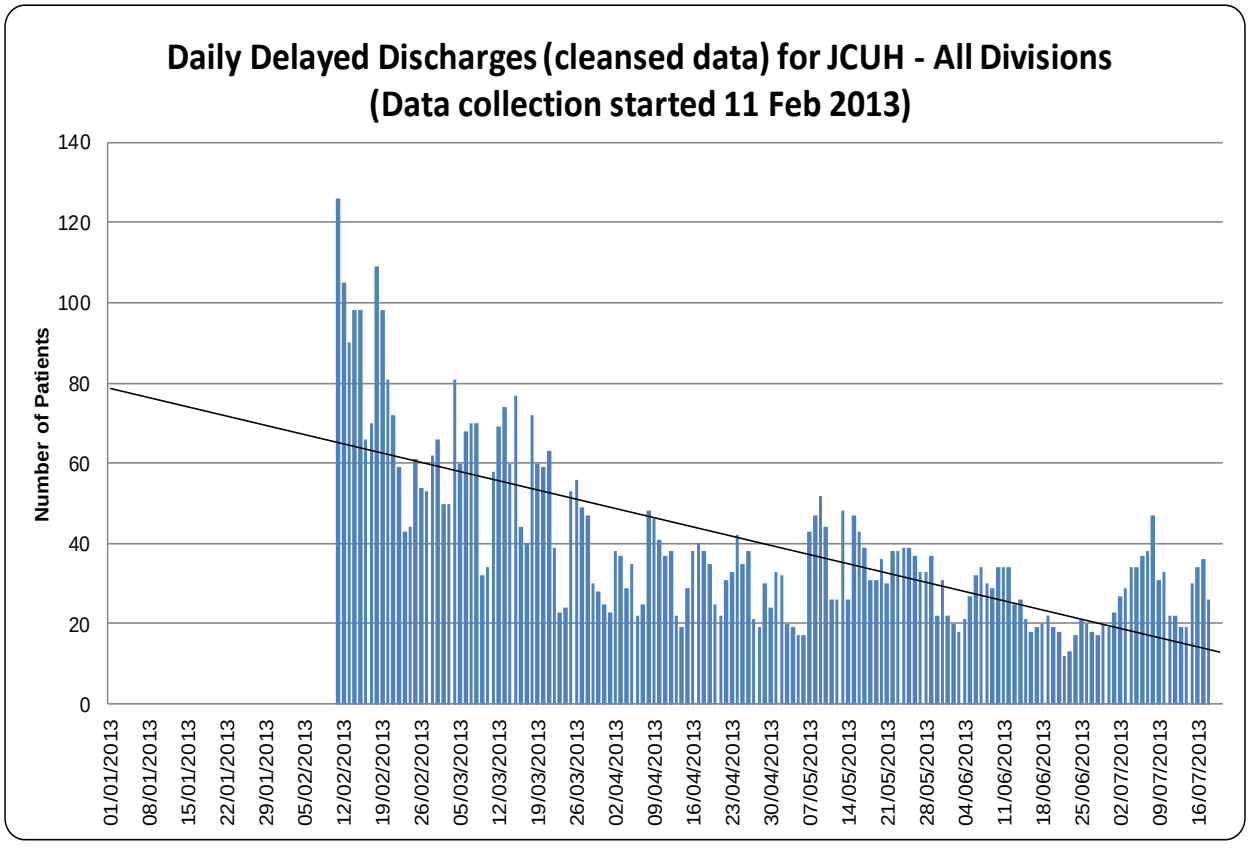
41. The Panel was informed that during the winter period last year a great deal of time was committed by staff from all related agencies in tracking delayed transfers of care on a daily basis at JCUH.

Reasons for delayed discharge

42. The Panel received evidence from STHFT regarding the reasons for delayed discharge.

43. The Panel was informed that Graph 2 demonstrates a reduction in delayed discharges over the past six months. It was acknowledged, however, that it is not yet clear whether this is due to seasonal trends or the impact of the intensive programme of improvements undertaken over the period with partner agencies.

Graph 2

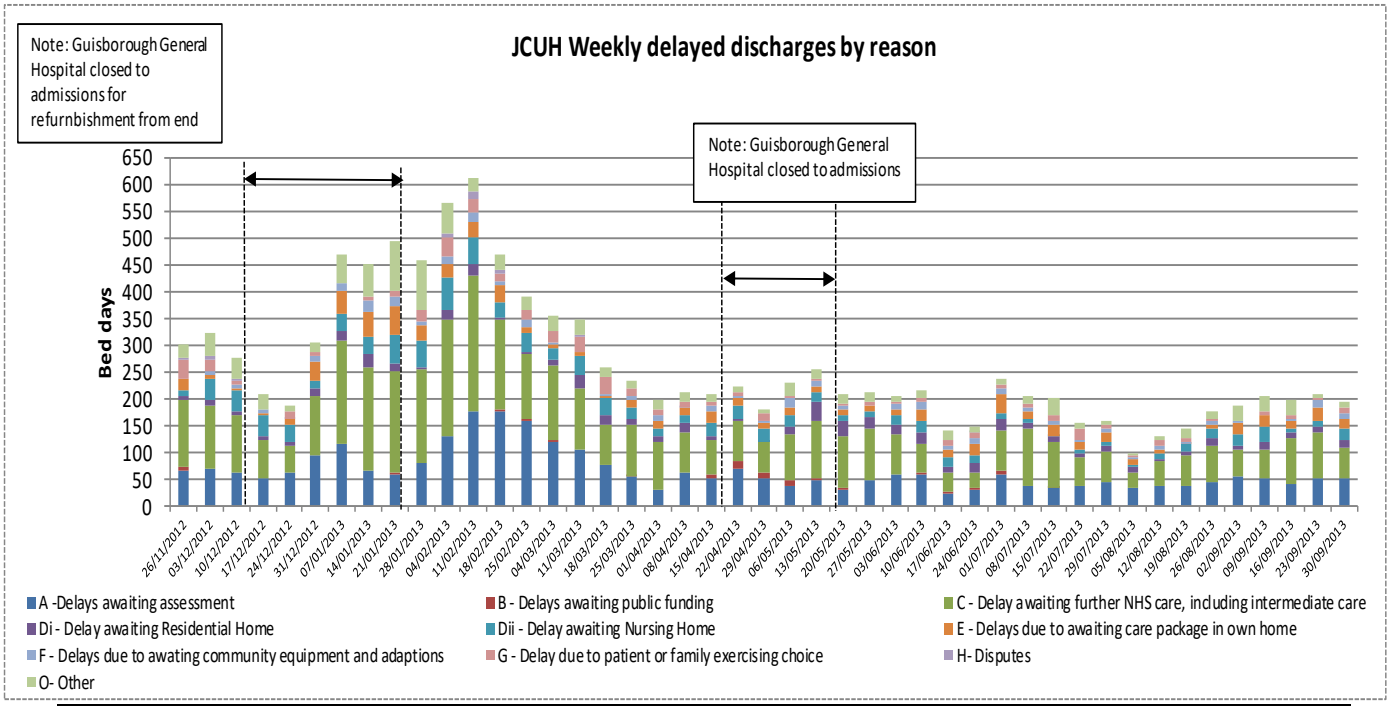


44. There are 11 codes which identify the reasons for delayed discharges as outlined in the table below:

Code	Reason for delay
A	Assessment – Decision Support Tool, social services, nursing home etc.
B	Funding
C	Awaiting further NHS care this includes intermediate care
D1	Residential home
D2	Nursing home
E	Package of Care
F	Community equipment and / or adaptations
G	Patient / Family choice
H	Dispute over funding
I	Housing
O	Other

45. It was explained to Members that Graph 3 demonstrates that the two most common delays experienced within JCUH over the past 12 months are delays due to assessment and awaiting further NHS care, including intermediate care. The numbers for which have also been considerably reduced in recent months. Once again, at this stage the STHFT is unable to determine how much of the improvement is due to the changes put in place in recent months, or seasonal variation.

Graph 3



46. The graph also demonstrates the impact of closing beds in the system for a period of time. It was highlighted that impacts on lack of capacity in other areas is not always so evident to identify, so it is important that all agencies inform others of changes in services that either increase or decrease capacity in the system. It is vital that sufficient and appropriate capacity is available to match demand - where this is not available there is a backup into acute hospital beds and an increase in delays to discharge.

Social Care delays

47. The STHFT conveyed to the Panel that whilst the hospital-based social work team generally provides a very timely response to referrals, there had been difficulties in coping with the backlog of referrals that had accumulated over Christmas 2012 and New Year 2013 within the required statutory timeframe. Confirmation was given, however, that improved arrangements for the 2013/2014 holiday period are to be implemented.

48. The Strategy and Delivery Manager for Community Care advised the Panel that, in his opinion, because of differing perceptions as to what constitutes a delayed discharge, and differing understandings of where responsibility lies for the various steps in the process, attributions of "blame" are frequently inaccurate. Consequently, the process of cleansing data to accurately identify, for instance, the cases where there was a failure on the part of a social worker to comply with a set timescale, which resulted in a delayed discharge, becomes almost impossible. It was acknowledged that while there were certainly delays caused by failures on the part of social workers, there were also delays reported in the daily documentation as being attributable to social care where no referral had been received or where, for instance, the individual was awaiting assessment by another health resource. While considerable learning has been drawn from the experience of tracking delays during the winter period last year, the focus across partners has firmly shifted away from attempting to attribute responsibility and on to a shared emphasis on developing joint processes more effectively.

49. It was commented that the hospital-based social work team is well established with even the newly qualified social workers being in post for over one year. The team are committed to improving the discharge process and are confident in advocating if they felt that a patient was not ready for discharge from hospital or if referrals are made too early.

Reasons for social care delays

Hospital discharge support from teams outside of the hospital setting

50. Evidence that was submitted by the Strategy and Delivery Manager for Community Care highlighted that the hospital-based social work team only provides a social work service for those patients who do not currently have a social worker allocated at the time of their admission to the hospital. If the patient has already been allocated a community-based social worker, then they continue to have responsibility for the patient and are expected to liaise with the hospital with regard to any assessments required or arrangements for discharge. This long established principle, which applies to both JCUH and the community hospitals, is intended to ensure that any necessary arrangements (which may include life changing decisions) are supported by the professionals who know the person's medical and emotional history best and,

if the system is working as it should, have a pre-existing positive relationship with them.

51. Although recognition of such pre-existing relationships is important, the Panel was advised that it is fair to acknowledge, however, that it is more difficult for hospital wards to communicate with social workers who are not on site and to ensure that the urgency surrounding discharges is conveyed with sufficient emphasis.

52. It was commented that the reality behind these delays on the part of community-based social workers is, in most cases, to do with the need by them to balance a high volume of case loads and the priorities of individuals. Although all social workers understand the urgency of hospital discharges, if presented with an individual at risk within the community and one who is a hospital in-patient, it is not illogical to conclude that the in-patient is safe whereas the risk may be an unknown for the person living alone. Social workers need support to manage these decisions. It is anticipated that the re-structuring of the department that will come as a result of the workforce review will better support individuals to manage these dilemmas.

Referrals

53. It was highlighted that in some cases social workers are not given adequate notice of the patient's proposed discharge date, however, the process for discharge has been amended and this is referenced later in the report.

54. It was conveyed to the Panel that in a recent audit, 50% of referrals have major absences or errors in the information received from the ward nurses which meant that clarification had to be sought before the social work task could be undertaken. The hospital-based social work team achieved the vast majority of discharges within the eight day statutory target; however, there was a problem in some cases with the quality of information provided by the ward staff and their consistency in identifying triggers for referral.

55. The Panel was interested in how delays could be avoided by ensuring that the hospital-based social work team was made aware of a person's needs prior to them coming into hospital for an operation, if it was thought that as a result of treatment that they would need social care support following their discharge. The Panel learnt that although the majority of discharges referrals were achieved within statutory timescales, the STHFT advised that where the system does struggle it is with the more unusual cases, where support may be needed from multiple agencies.

Demographic profile population changes

56. Members acknowledged that delayed discharges could arise due to an increasing number of frail and elderly patients with complex conditions requiring support from a multiple agencies. Increasing demand is referenced later in the report.

Patients who 'slip through the net'

57. A Member queried about what would happen if a patient was inadvertently not identified as requiring social care services prior to being discharged from hospital. The Panel was advised that in such cases, the patient's family could provide social care with information to prove that the patient is not ready to be discharged and in such cases, the patient's discharge could be delayed. In extreme cases if the patient is discharged and presents with a crisis, the patient could be re-admitted to hospital.

TERM OF REFERENCE - To determine measures and strategies that have been implemented in order to reduce any delayed discharge, particularly in relation to the hospital and social work interface.

58. In investigating this Term of Reference, the Panel examined the following issues:

- **Overview of joint working**
- **Discharge Steering Group**
- **IMProVE Group**
- **Clinical Commissioning Group's Urgent Care Workstream**

Overview of joint working

59. As a result of the pressure experienced last winter by all agencies within the health and social care economy, a substantial programme of joint working has been undertaken between the hospital-based social work team, the STHFT and the South Tees CCG. Members were advised that in respect, of the hospital team, there is joint working in a number of different forums aimed at improving the service.

60. With regards to reducing delayed discharge, it was emphasised to the Panel that a significant amount of work has been undertaken to streamline processes and protocols.

Discharge Steering Group

61. It was confirmed that over the past 12 months an intensive programme of work has been undertaken in partnership with South Tees CCG and Middlesbrough, and Redcar and Cleveland Councils via the Hospital Discharge Steering Group.

62. The Council's Strategy and Delivery Manager for Community Care and Team Manager for the hospital-based social work team continues to participate in this group's work. This body, is responsible for the development of the improved discharge processes for JCUH and continues to have a role in its implementation and embedding. The need to focus on winter pressures, hospital discharge and the reduction of hospital admissions are also on-going themes. Participation in the work of the hospital's Discharge Steering Group has involved reviewing and streamlining the hospital's discharge processes. This has resulted in the updating and simplification of referral paperwork and the streamlining of referral processes.

63. The STHFT conveyed that the purpose of the group is to redesign processes relating to hospital discharge and integrate with new services available in the community. These have included:

- Improvements in the recording of Planned Date of Discharge (PDDs) and Delayed discharges. This has allowed greater scrutiny of the reasons for delay and an ability to act promptly on system level issues as they occur.
- Regular meetings and/or teleconferences to discuss delays with partner agencies, particularly during periods of peak activity.
- Redesign of processes relating to social care and CHC assessments. The streamlining of assessments and determining clarity on roles and responsibilities will enable us to identify and address problems relating to capacity and demand, as we move towards winter.
- Introduction of a single point of referral within JCUH to organise transfers of care to community hospitals and Middlesbrough Intermediate Care Centre. This pilot scheme has already demonstrated that it has reduced waiting time to transfer by an average

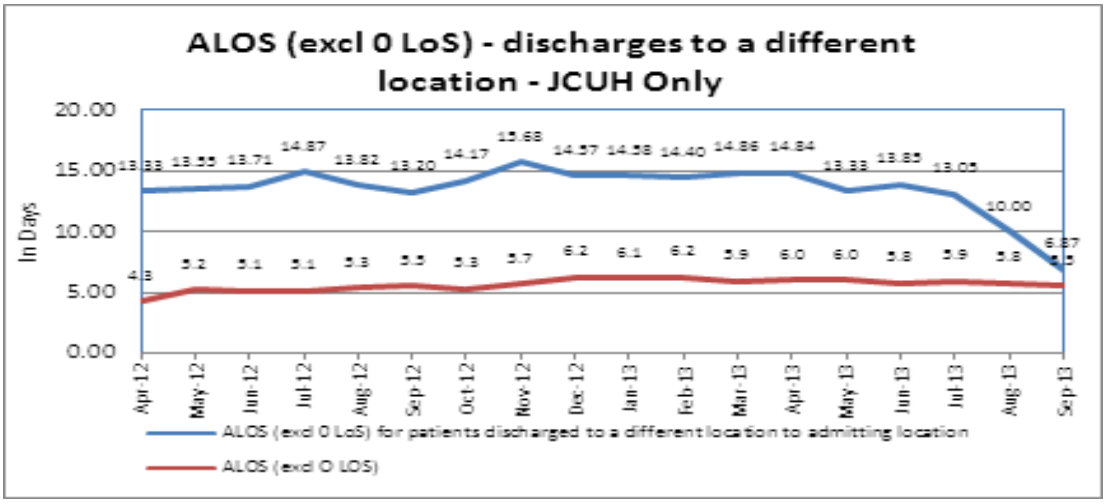
of 2.5 days per patient. This service is funded until 31 March 2014 after which a decision will be made about making it a permanent arrangement.

- Introduction of hospital case managers, who assess patients and co-ordinate discharge arrangements for patients with complex needs. This pilot continued until March 2013 and a full evaluation is currently being undertaken.

64. Extensive programme of discharge improvement workshops across all acute and community adult ward areas, between May and October 2013. This programme of improvements is introducing all new agreed standard processes outlined above and enabling ward based staff to identify and improve a range of internal processes, such as ordering of medications, transport etc. that impact on hospital discharge.

65. Members were advised that graph 4 demonstrates the substantial improvements made in the average length of stay, for patients who are discharged to a different location from where they were admitted, which primarily includes those patients who have more complex needs on discharge.

Graph 4



66. Maintaining these improvements will require on-going efforts across all health, social care and independent sector agencies. Recognition was made of the need to sustain such measures as they are subject of monthly audits to monitor discharge figures.

IMProVE Advisory Group

67. Reference was made to IMProVE (Integrated Management and Proactive Care for the Vulnerable Elderly) Advisory Group. The Panel was advised that this group is co-ordinated by the South Tees CCG and the Council is represented by the Strategy and Delivery Manager for Community Care.

68. The group's aim is to support health and social care partners in working together, using a series of principles. The group strives to build a new service model for joined up services for older and vulnerable adults which fully reflects national strategy, the clear guidelines from the Department of Health and meets the needs of the patients and service users in South Tees.

69. The work of this group has a direct bearing on the local health and social care system. The group endeavors to create effective pathways for vulnerable elderly people where admissions to hospital are minimised and where individuals are

successfully discharged from hospital into settings where their wellbeing can be sustained.

Clinical Commissioning Group's Urgent Care Workstream

70. The Panel was advised that the Urgent Care Workstream is co-ordinated by the South Tees CCG and the Strategy and Delivery Manager for Community Care provides representation for the Council.

71. The group's vision is to commission a simple, accessible, high quality service managing patients at the point they present in a robust and resilient way. This will reduce the need for urgent care with better management of long-term conditions with primary and secondary prevention.

72. The group focusses on the following key areas:

- A&E waiting times
- Ambulance delays
- Delayed discharges
- Winter planning
- Managing long-term conditions
- Preventing delays and maximising ambulatory care
- Access within general practice

73. Members were advised that this group's work has a focus on developing local health services that allow urgent access to the correct level of health care and, as such, its work directly relates to both the number of individuals who may arrive at Accident and Emergency, and may subsequently be admitted, and the systems by which people may have access to other urgent medical resources within their community.

74. Delayed discharge is of direct relevance to this group as without timely discharge the hospital system becomes clogged and effectiveness is impaired.

75. In commenting on improved processes, specific reference was made to the benefits of capturing more accurate and documented information about delayed discharges with each ward being closely monitored. Changes in the standardisation of processes ensures that legislative requirements are being met and planned discharges can be achieved in a more timely manner. In order to avoid delayed discharges, Members expressed support of the administrative changes and earlier involvement of social care in the overall process.

TERM OF REFERENCE - To explore the future challenges for hospital-based social work and investigate methods to cope with an increased demand on the service, for example – the use of virtual wards, to better support people in their own homes and help prevent hospital admissions.

76. In investigating this Term of Reference, the Panel examined the following issues:

- **Future demand**
- **Continuous improvement**
- **Strategic level improvements**

Future demand

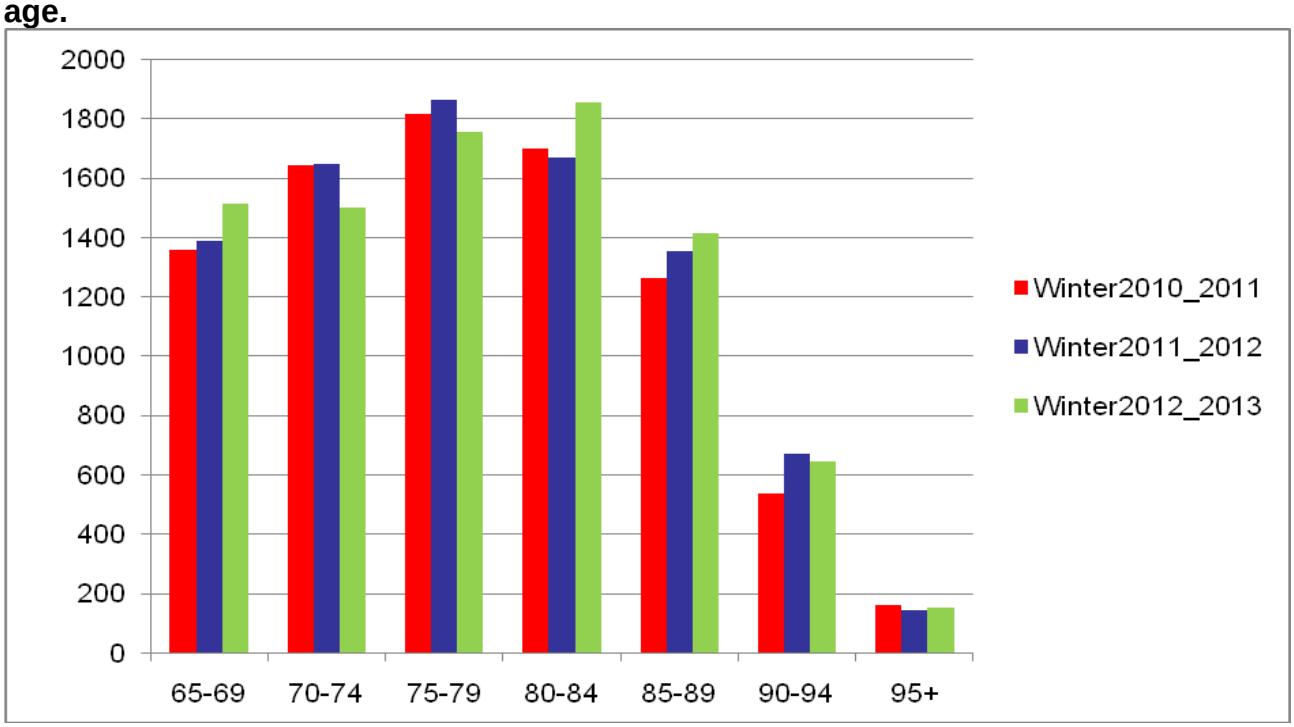
77. The Panel received information from the Council's Strategy and Delivery Manager for Community Care. The table below (based on calendar years) demonstrates growth in referrals to the team over the period from 2009 – 2012. Members were advised that this does not reflect any growth in activity in respect of patients who have a community-based social worker already allocated to them at the point of hospital admission. The figures reflect an increase of 7.5% in referral numbers between 2011 and 2012 and an increase of 13.2% since 2009. The split of referral numbers between the two local authorities has remained close to 50/50 throughout the period.

Local Authority	2009	2010	2011	2012
Middlesbrough	1341 (54%)	1316 (52%)	1262 (48%)	1368 (49%)
Redcar and Cleveland	1147 (46%)	1377 (48%)	1341 (52%)	1449 (51%)
Total	2488	2693	2603	2817

78. Members were informed that as the demographic profile of the population changes, with an increasing number of older people, the demographic profile of hospital patients reflects this position. As a consequence 1 in 4 patients admitted to hospital are over the age of 75 years.

79. Graph 5 outlines population changes to the demographic profile in the number of older patients admitted as emergencies to JCUH over the past three winters. The graph shows that the largest cohort of patients are now over the age of 80, with an increasing number requiring a range of support services on discharge for often complex conditions.

Graph 5: Number of unplanned admissions to JCUH of patients over 65 years of age.



80. It was highlighted to the Panel that if the increasing admission rate to hospital is not tackled effectively then there is no reason to predict anything but rising demand in future years. The success of adult social care and community services in supporting older and more vulnerable individuals in their own homes has the resultant effect that

when they do reach a health crisis and are admitted to hospital, then a higher than previously seen percentage will require to be discharged somewhere other than their own home. In practice, this means a discharge process than may be more time consuming and complex as the individual may be required to take life-changing decisions around where they will live.

Continuing Healthcare (CHC)

81. The Panel noted that one area of demand which could decrease was the care management of people who were assessed as being eligible for fully funded Continuing Healthcare (CHC) from the NHS.

82. Until 1 April 2013, the care management of CHC was the responsibility of the local authority. A decision has now been taken by the CCG that this role will, in future, be undertaken by the North East Commissioning Support (NECS) on behalf of the CCG and the transfer of responsibility is currently underway. In practice this means that a cohort of very dependent individuals (approximately 60 at any given time in Middlesbrough) will receive their care management support from NECS rather than from the Council.

83. The changes to care management will have an as yet unquantified impact on the hospital-based social work team in respect of individuals who are assessed as having fast-track eligibility for fully funded CHC. These are individuals who are terminally ill and generally within a few days of death and whose bleak prognosis makes them eligible for CHC funding. In many cases the recognition by medical professionals that a person is soon to die provides great urgency around the need to get home. Historically, social workers have undertaken the often complex discharge arrangements for these individuals at very short notice.

Continuous improvement

Workforce Review

84. The Strategy and Delivery Manger for Community Care informed the Panel that the purpose of the workforce review, within adult social care, is to ensure that the Council, within available resources, will enable people to remain healthy and independent for as long as possible. It will also ensure that services are available to those who need them, that keep them safe and are of the appropriate standard.

85. It was conveyed that the review was initiated as a result of the following factors:

- The Care Bill (formerly, the Care and Support White Paper)
- Increasing demands on the service as a result of changing demographics and the growing elderly population.
- Increasing expectations on the part of service users, their families and members of the public.
- Inconsistencies in the approach and application across existing fieldwork teams.
- A commitment to becoming more customer focussed.
- The need to make efficiency gains.

86. The Panel was advised that continuous improvement is sought through a number of different routes; the hospital-based social work team is of course a part of the broader adult social care workforce and, as such, will benefit from improvements being implemented across the department. The review will both streamline

processes and make a significant contribution towards the effective management of the growing demand within adult social care. It is anticipated that the workforce review will publish the proposed new structure for fieldwork teams by the end of July 2013 with a view to implementing the new structure by the end of April 2014. It is acknowledged that any proposed changes within the hospital-based social work team will need to be implemented prior to the winter pressures period. The Panel was advised that as far as the hospital-based social work team is concerned, the workforce review is expected to have little impact in respect of the structure of the team.

87. It was reported to the Panel that the agreement between Redcar and Cleveland Borough Council and Middlesbrough Council with regard to the employment of the hospital-based social work team is due for renewal and the effectiveness of the team in terms of whether it is fit for purpose will be reviewed as part of the process. The STHFT has been invited to participate in the review.

88. In summary, the review will address working hours, the make up of staff, examine the overall configuration of the team and examine whether the provision of the social work service should be extended to all patients including those who already had a community-based social worker in place. The review will also look at contingency planning for winter pressures and build upon the work that has already been carried out in response to the demands from the previous year's winter pressures.

Reablement

89. The Panel was advised that the aim of the reablement services function is to work with individuals to restore a deficiency in their functioning through the use of a therapy led, structured programme of activity. Reablement could involve helping a patient to re-learn some physical activities or domestic tasks following recovery from an injury or period within hospital. It was acknowledged by the Panel that, as there is currently insufficient resource available to provide the service, there are individuals who would benefit from this service who are not being identified. It was conveyed that at the current time, it is unlikely that reablement could be provided even if those patients have been identified as requiring the service, as there is a lack of resources. The future working model for social care conveys that reablement will be the default position and it will be assumed that individuals will require some form of reablement.

90. It was highlighted that in terms of the provision of reablement services, an assessment is carried out by an occupational therapist located in the Council's "access" team and the service (which is usually a six week package of care) is provided in the individuals home. It was acknowledged that there needed to be a change of culture in respect of the provision of reablement services. Once the reablement package is put in place, the effectiveness of the reablement needs to be monitored. If the services put in place do not have the desired effect in assisting the patient to return to full health, then a decision will need to be taken to revert to a traditional social care package.

91. The Panel was advised that planning is under way to expand the available reablement service to meet projected requirements and it is likely that the increase in the provision of reablement services will reduce hospital re-admissions.

92. It was highlighted to the Panel that discussions need to be held with the Clinical Commissioning Groups in terms of the reablement funded by health. The Panel was advised that the Council needs to look closely at its in-house provision in terms of

reablement and also consider commissioning services from the private sector, although this may be a complex issue.

93. It was conveyed that the increased reablement resources will have a primary positive impact on the hospital-based social work team's effectiveness. It is anticipated that following implementation of the department's new working model, a much higher percentage of patients will receive individually planned reablement packages with the aim of minimising the number of individuals who require on-going care and minimising the size of package for those who do. The initial role of the hospital-based social work team will be to assess a patient's reablement potential, then plan a discharge based around an initial package of reablement support in the individual's own home.

System changes

94. Members were advised that both Middlesbrough and Redcar and Cleveland local authorities have implemented new computer systems for the management of adult social care. It is anticipated that the introduction of the new computer systems will result in increased efficiency in the management of referrals.

95. A change has also been made to the hospital-based social work team's allocation system for incoming referrals, to ensure that social workers have the maximum level of time available to plan for an individual's discharge. The previous system was within the legal guidelines, and the new system does carry a slightly increased administrative pressure for social workers, but it is anticipated that it is likely to reduce hospital stays by a day, or sometimes days, and will reduce the incidence of delayed discharge. It was highlighted that discharge hospital notification has not yet been implemented at community hospitals.

Staffing

96. Members were advised that there has been an increase in the team's complement going into the winter period, compared with last year.

97. A review has also been undertaken of arrangements for annual leave over Christmas and New Year periods - this will ensure there are sufficient staff to deal with anticipated referral rates.

Allocation of hospital based social workers to specific areas

98. In order to improve the referral process, the Team Manager of the hospital-based social work team has been linking individual social workers to specific wards in order to achieve more effective adoption of new processes.

99. The STHFT conveyed that although the hospital-based social work team is very responsive to adapting to the needs of the STHFT with the resources available, an indication was given of the desire for a greater number of social workers to be allocated to specific areas in the hospital. The STHFT indicated that this will establish close working relationships and enhance the work being undertaken regarding assessment of patients prior to an elective admission, who were likely to need support from social care following discharge.

100. The Council's Strategy and Delivery Manager informed the Panel that the allocation of social workers to specific wards appears to be an effective strategy and will be continued where necessary.

Changes to hospital discharge support and working hours

101. As previously mentioned, discussions are on-going between the STHFT, Middlesbrough Council and Redcar and Cleveland Borough Council around further developments in the configuration of the hospital-based social work team. These discussions are expected to consider whether there is merit in all hospital in-patient cases being supported by the hospital–based social work team (where there is a social care requirement), in contrast to the current situation where individuals who already have a community-based social worker at the point of admission would continue to be supported by them.

102. If it is decided that the hospital-based social work team will deal with all cases for individuals who are hospital in-patients then the issue of impressing the urgency of hospital discharge arrangements on community-based social workers ceases to be an issue. If the provision remains as is currently the case, the onus falls on managers to ensure that community-based social workers comply with their legislative requirements.

103. It was conveyed to the Panel that from the STHFT's perspective, it is more challenging to communicate with community-based social workers and ensure statutory timescales are adhered to. The STHFT is of the view that all referrals should go directly to the hospital-based social work team for allocation.

104. It was conveyed to the Panel that any extension of provision over and above that, which the Council are statutorily funded for, may require consideration by the CCG, as the CCG would need to make a decision as to whether they would wish to commission such services.

105. Members were informed that the hospital-based social work team works a standard Council working day and there is currently no provision for working at weekends and bank holidays. The Panel was advised by the STHFT that weekends can be some of the busiest days of the week for non-elective patient attendances at JCUH. There is also fewer hospital discharges over the weekend than Monday – Friday. Insufficient support service capacity (including social care) can prevent patients being discharged the same day or over the weekend.

106. It was noted that whilst the hospital-based social work team works standard Council working days there has been occasions when they have worked weekends although the main areas of work during such periods had been to catch up with work from the previous week rather than on new cases. The overall concept continues to be discussed along with health professionals but it is recognised as a challenge, in that the process in developing an appropriate package of support for patients requires not only social workers but other agencies, such as occupational therapists, physiotherapists and other support services.

107. The STHFT conveyed to Members that they would like to propose that there is a social worker available on-site, particularly during peak periods of activity for A and E and the Acute Assessment Units, to support hospital staff in the coordination of discharge of patients who do not need to be admitted to hospital but do require support to return home safely.

Joint Discharge Facility

108. It was acknowledged that there needs to be set criteria and specific guidelines with regard to the discharge from hospital process. It was highlighted that the CCGs had hosted an event to set up a Joint Discharge Facility and it is anticipated that the facility will be in place before the winter period. The Panel was advised that there are some private care providers that could have a unit free to provide this facility and it is anticipated that a pilot of twenty beds will be provided initially and it could gradually be increased in the future.

Use of assistive technology

109. Members were advised that the better use of assistive technology will become increasingly vital in social care's plans to mitigate increasing demand. At present the Council uses traditional technology to help support people in their own homes, such as pendant alarms, falls sensors, GPS tracking devices etc. However, it is evident that technological developments in sophisticated sensors and smartphone applications will open up greater possibilities and will provide greater opportunities for carers and service users to monitor and control their environments. Members were advised that maintaining technical expertise in this field is crucial in maximising the independence of service users and it also has the potential to control costs or, at worst, mitigate against increasing demand.

Strategic System Level improvements

110. Although the improvements previously outlined were acknowledged , the STHFT reported that in order to significantly reduce the length of stay of such patients, who requires a significant period of rehabilitation, reablement and subsequently assessment for 24 hour care, a more radical system level redesign is required.

Discharge to assess

111. The STHFT conveyed to the Panel that there is increasing evidence from other parts of the UK, which have moved from an "assess to discharge" approach to one of "discharge to assess". This approach would require health and social care commissioners and providers to develop pathways of care which enable patients to be discharged to their own home or a step down facility, where their on-going health and social care needs can be assessed and agreed. (Improving Patient Flow, the Health Foundation, April 2013).

112. The South Tees CCG Urgent Care Group has established a task and finish group to identify what system level change is required to establish such an approach. It is also recognised that there needs to be sufficient community-based services to support a patient's recovery either in their own house or other facility.

Community-based support

113. The Panel was advised that the aim of Virtual Wards is to provide an intended means by which primary care can provide sharp focussed care to individuals experiencing specific health conditions, and support them in their own homes with the aim of preventing admission or re-admission to hospital. The care of the individual will be co-ordinated by a team of Community Matrons. Community Matrons work to specific criteria in regard of admission to, and discharge from, hospital. It was conveyed that many of the individuals do receive on-going support from social care but generally that is provided from within community-based social work teams.

114. To support this approach, there needs to be sufficient community-based services to support a patient's recovery either in their own home or other facility. This agenda is supported nationally with the allocation of reablement monies being utilised by health and social care commissioners to invest in services that promote and support independent living.

115. It was conveyed to the Panel that there is a clear drive towards further integration of community nursing, community care staff and the Clinical Commissioning Groups. It was commented that Middlesbrough Council previously had more integrated working links with community and district nursing before Middlesbrough, Redcar and Cleveland Community Services (MRCCS) amalgamated with the STHFT.

116. A Member made reference to the Integrated Community Care Teams that operates from various medical practices. Members were advised that work is ongoing with hospitals, adult social care and community care teams to try and offer a single point of contact for patients.

Time to Think Beds

117. Members were informed that where patients have already experienced services, or had a number of admissions, they may have limited potential for recovery and rehabilitation. These are the patients who currently have an extended length of stay in hospital whilst CHC assessments are undertaken. Sunderland Council has introduced a scheme of "time to think" beds, provided by a range of private providers who are commissioned by the Council.

118. "Time to think" beds are for people who are medically stable but require a further period of time to facilitate recovery, whilst undergoing an assessment of need to support their longer term requirements. Patients are discharged to a residential setting and receive intensive reablement from a physiotherapist or occupational therapist which frees up an acute bed and offers the individual the best chance of recovering well. The scheme also provides patients, their families and doctors with the opportunity to consider whether they should return to their home or move to residential care. Options for rehabilitation remain a consideration with the availability of therapeutic interventions on-site to enhance personal recovery and support care planning. The South Tees CCG IMPROVE advisory group received an initial paper in August 2013 regarding what changes would be required to implement a similar scheme and further work is currently being undertaken to pilot this approach over the winter months. The STHFT has expressed interest in the scheme and social care will be scoping this scheme to establish if it has merit locally.

Additional Information

119. In the course of the Scrutiny Panel's investigations, information came to light which, while not directly covered by the terms of reference, is relevant to the work of the panel on this topic. This related to:

Adaptations

120. Members referred to delays which have been reported in relation to the process involving cases where adaptations need to be carried out for patients with multiple requirements. The STHFT's representatives acknowledged that whilst there is a comparatively small number of such patients, the process takes time and therefore issues around finding transitional housing in such circumstances was the subject of

current discussions with Erimus Housing in identifying suitable transitional housing stock.

Community nursing

121. A Member raised a query with regard to the interface between the hospital nurse and the community nurse following the discharge of patients from hospital. The Strategy and Delivery Manager advised that the role of the patients 'named nurse' is pivotal in respect of the discharge of patients from hospital. The nurse follows a check list in respect of discharges from hospital which includes referrals to the community care system e.g. community nurses or whether a patient required a prescription before discharge from hospital.

Hospital Pharmacy

122. Members were keen to explore the issue of people's discharge being delayed due to having to wait for a prescription to be issued. The STHFT recognised that there is an issue in this area and that it could be a source of frustration to staff and patients. The Panel was advised that recruitment and retention of staff has been an issue although a new Director of Pharmacy has recently been appointed. It was noted that the development of pharmacy processes is the subject of a major review and overall improvements.

Referrals to hospitals outside the area

123. A Member queried the process for patients who are referred to a hospital outside the area in which they live. The Panel was advised that it is the responsibility of the hospital where the patient is an in-patient to assess the patient and identify any social care needs that the patient required. The hospital is then supposed to make a referral for the patient to the appropriate department of social care in the area that the patient lived. A Member commented that she was aware of cases where this procedure had not been followed.

124. The Panel was advised that if a Middlesbrough resident is an in-patient in an out of area hospital, it is the duty of the social worker from the hospital outside of the area to contact the social care team in Middlesbrough to ascertain if they require an assessment to be carried out on the patient on behalf of the Middlesbrough social care team or to establish if a worker will be sent from their department to complete the assessment. Following the outcome of the assessment, the Middlesbrough social care team is required to implement the recommendations of that assessment. Discharged patients are reviewed within 6 to 12 weeks of the patient's discharge.

125. Although information was provided on areas of responsibility in undertaking assessments, following comments regarding an apparent lack of co-ordination between health and social care in relation to out of area patients, it was pointed out that clarification is required regarding the impact of proposed legislation (Care Bill 2016). It was also noted that further information is required as to the impact of such legislation on the increasing demands of an ageing population with an increased cohort of patients with multiple complex conditions.

CONCLUSIONS

126. Based on the evidence given throughout the investigation the panel concluded that:

a) The two most common delays experienced within JCUH over the past 12 months are delays due to assessment and awaiting further NHS care, including intermediate care. However, with regards to social care delays, the true extent of delayed discharges is being distorted by the differing definitions being used by NHS organisations and local authorities. There is a need to capture more accurate and documented information about delayed discharge with each ward being closely monitored.

b) Hospital discharge encompasses a set of complex processes, responsibility for which spans all health and social care commissioners and providers. The winter pressures of 2012/13 presented significant challenges to the hospital-based social work team, just as it did to all partners within the health and social care community.

c) There is good partnership working across health and social care agencies and the system has seen some demonstrable improvements. Workstreams are perceived as being increasingly positive with a clear focus on finding joint solutions to problems. As a result of this work there is a much broader, shared understanding of the pressures on all systems and how the Council, the STHFT and the CCG can continue to tackle them together.

d) A substantial programme of joint working has already been undertaken between the Council and STHFT. This has included:

- Participation in the work of the hospital's Discharge Steering Group to review and streamline the hospital's discharge processes.
- Updating and simplification of referral paperwork.
- Participation by social workers in training to all wards to prepare ward staff for the implementation of the streamlined discharge processes.
- A change to the team's allocation system for incoming referrals to ensure that social workers have the maximum level of time available to plan for an individual's discharge.
- An increase in the team's complement going into the winter period compared with last year.
- A review of arrangements for annual leave over the Christmas and New Year period to ensure sufficient staff to deal with anticipated referral rates.

e) The work that has been undertaken in response to winter pressures has already shown benefits and the forthcoming review of the hospital-based social work team, alongside the implementation of the department's workforce review, will improve operational effectiveness further.

f) Continuing joint work is required in developing the discharge processes at JCUH in direct partnership between Middlesbrough Council, Redcar and Cleveland Borough Council, the STHFT and in the forums afforded by the CCG. Areas for consideration include the possibility of all admissions being dealt with by social workers from the hospital-based social work team, whether there is any merit in additional linking of social workers to individual wards and whether working hours should be extended. In undertaking this task, partners need to be mindful of current financial constraints and possible practical difficulties in reducing the flexibility of social workers.

g) The system is already experiencing increasing demand for services that support the frail and elderly and those with long term conditions. The increasing admission rates to hospitals needs to be tackled effectively. The challenge of rising demand from adult social care across the board is emerging as a significant challenge for the Council as a whole. Adult social care has identified key issues in tackling this demand that will apply to all services, such as a focus on the use of reablement.

h) Evidence from other parts of the UK indicates that a bolder whole-system approach may be required if the health and social care system in Middlesbrough is to enable this vulnerable group of patients to stay as independent as possible in their own homes, for as long as possible following a period of acute illness. National guidance advocates that many of the assessments currently undertaken in an acute hospital environment should ideally be undertaken outside of this environment. In doing this, patients will have time to rehabilitate and reach their individual optimal potential for functioning independently, before decisions regarding their long term care arrangements are made. The "discharge to assess" approach, the "time to think" beds facility along with sufficient community–based services are possible solutions that would promote and support rehabilitation and reablement.

i) Middlesbrough, and Redcar and Cleveland adult social care services, the Clinical Commissioning Groups and STHFT need to work more effectively together to ensure that a patient has a fully integrated single point of access for their care. Communication and interaction between the different teams and agencies is key to a successful discharge from hospital.

RECOMMENDATIONS

127. That the Social Care and Adult Services Scrutiny Panel recommends to the Executive:

a) That statistics are accurately monitored and recorded in order to establish when social workers have been unsuccessful in meeting statutory targets and that reasons for any delay are identified.

b) That the Council undertakes an in-depth review of the hospital-based social work team, in consultation with Redcar and Cleveland Borough Council and the STHFT, and that consideration is given to:

- A greater number of social workers being allocated to specific areas in the hospital.
- All hospital in-patient cases being supported by the hospital–based social work team.
- An extension of working hours, to include weekend working.

c) That the outcomes and associated actions resulting from the review of the hospital-based social work team be reported to the Social Care and Adult Services Scrutiny Panel.

d) That a pilot scheme be introduced whereby a social worker is available on-site, during peak periods of activity, for A and E and the Acute Assessment Units. Following conclusion of the pilot scheme, a full evaluation be undertaken to determine the feasibility of continuing with the arrangement.

e) That measures and strategies are implemented to ensure that closer working links are forged between adult social care and the community care teams and that a single point of contact for patients is made available.

f) That Health Scrutiny Panel receives updates on developments regarding:

- The “discharge to assess” approach
- The “time to think” beds facility
- The review of pharmacy processes

g) That discharge hospital notification is implemented at community hospitals.

h) That further work be undertaken to ensure that all nursing staff are confident in identifying how, and when, to refer a patient to adult social care.

i) That, if provision remains as is currently the case, community-based social workers attend workshops on hospital discharge, with a particular focus on supporting them to balance high volume case loads, the priorities of individuals and managing dilemmas.

ACKNOWLEDGEMENTS

128. The Panel would like to thank the following people for their help with this review: -

-	Mike Robinson	Director of Wellbeing, Care and Learning
-	Erik Scollay	Strategy and Delivery Manager for Community Care
-	Ruth Musicka	Team Manager, Hospital-Based Social Work Team
-	Susan Watson	Director of Operational Services - STHFT
-	Gill Collinson	Deputy Director for Service Transformation - STHFT

BACKGROUND PAPERS

129. The following sources were consulted or referred to in preparing this report:

- Agenda papers and minutes of the Social Care and Adult Services Scrutiny Panel meetings held on 4 July, 25 July, and 17 October 2013.
- Agenda papers and minutes of the Special Overview and Scrutiny Board meeting held on 4 November 2013.

COUNCILLOR PETER PURVIS
CHAIR OF THE SOCIAL CARE AND ADULT SERVICES SCRUTINY PANEL

Contact:
Georgina Brown
Scrutiny Support Officer, Legal & Democratic Services
Telephone: 01642 729711 (direct line)

December 2013