Better Support for Hospital Discharge
Development of Hospital Dashboards

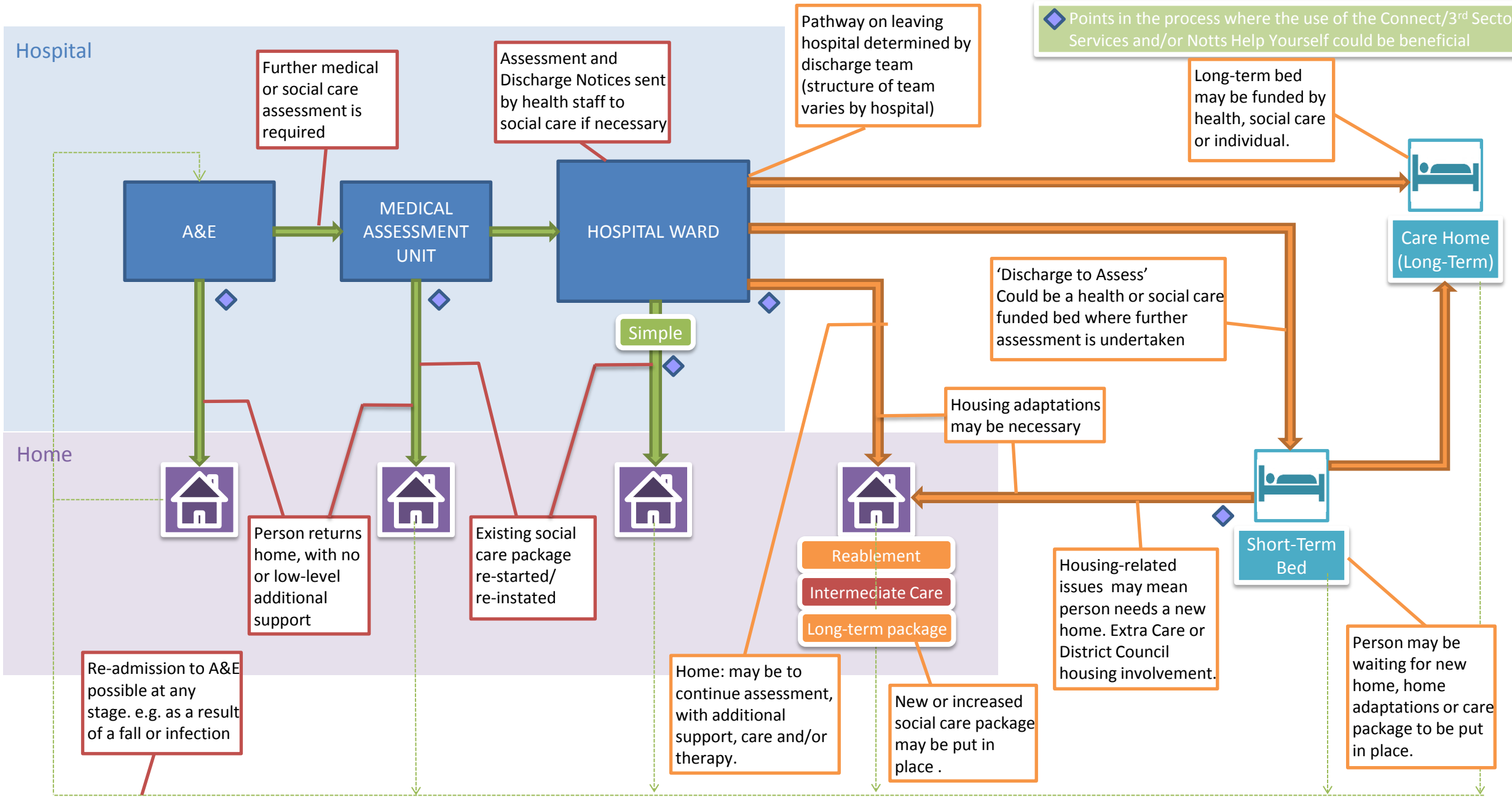
Currently Identifying scope for a dashboard for the Hospital Discharge Teams

- interim data being collected by hospital teams.
- final version of dashboard using data from Mosaic spring 2019
- additional analysis to embed a culture of continuous business improvement

Measures being considered include:

- Destination/package type [actual]
- Preferred destination/package type [if this is different to actual]
- Reason why preferred destination/package type was not possible
- Additional support [e.g. Connect, Assistive Technology]
- Whether package is a new package, restart or increase?
- Number of new LTC packages set up, broken down by package type
- Cost of POC/Average care package size, broken down by package type
- Number of admissions to bed based STC & length of stay (reason for admission)
- Number of assessments completed

HOSPITAL DISCHARGE PATHWAY (GENERALISED)



CONNECT SERVICES: BACKGROUND

Service Summary

The Connect service was commissioned to: provide **short-term** support to self-care for people at risk of **deteriorating health and independence** as a result of age, mobility, disability, long term health condition or bereavement.

The service is targeted at people who have lived independently but are now at risk of escalating need. It will provide **information, advice, signposting or short-term help** to support people to work out how they can adapt to their circumstances in order to continue to **self-manage**.

- The Connect service was commissioned by the Council in January 2016 for a three year period, there are three providers across the county. Connect offers two tiers of support:

1. **Brief Interventions:** one or two visits in order to provide quick and simple, early intervention solutions to wide range of issues, whilst forming the basis on which more complex needs can be identified and addressed
2. **Short-term Support:** outcome-focussed support working towards specific goals set out in a support plan, as an estimate, this support could last around 3 months.

- As a result of the October 2017 Committee Report, the **contract value was increased** to give each provider the resource for an **additional member of staff** to provide a direct link between the hospital discharge teams and the Connect service.
- The Connect Hospital Discharge Worker will work closely with the discharge teams and take referrals directly from them. Each worker is expected to take **9 referrals per fortnight**.
- Each worker is **expected** to provide support to 204 people per year who are being discharged from hospital. Countywide, this equates to **612 individuals a year**.

612

Expected number of individuals supported by Connect Hospital Discharge Worker per year

Connect Hospital Discharge Worker

The Connect Hospital Discharge Worker's support would involved an **initial assessment visit at home** and **up to four further contacts over a two week period**. The type of support offered includes:

- Connecting people to their local community, family or friends;
- Supporting people to achieve more appropriate or safer housing;
- Providing benefits and financial advice;
- Giving information and advice on transport; activities and groups; support to better manage long term conditions;
- Identifying and accessing talking therapies, appropriate care services and bereavement support.
- Supporting people to acquire the skills or access the technology to enable them to continue to live with as little formal social care support as possible.
- Support to problem solve any issues that are presenting challenges to a person's independence

Target Group

- Referrals to the Connect Worker should be for individuals where it is very likely that a social care package will be required.
- This could include people who are returning home with a new or increased care package, people receiving a reablement service and people who are being assessed at home (including those returning home with Home First).
- The main Connect contract identifies a set of characteristics which suggest a risk to independence, it is suggested that people referred to the Connect Worker should present with 3-5 of these characteristics.

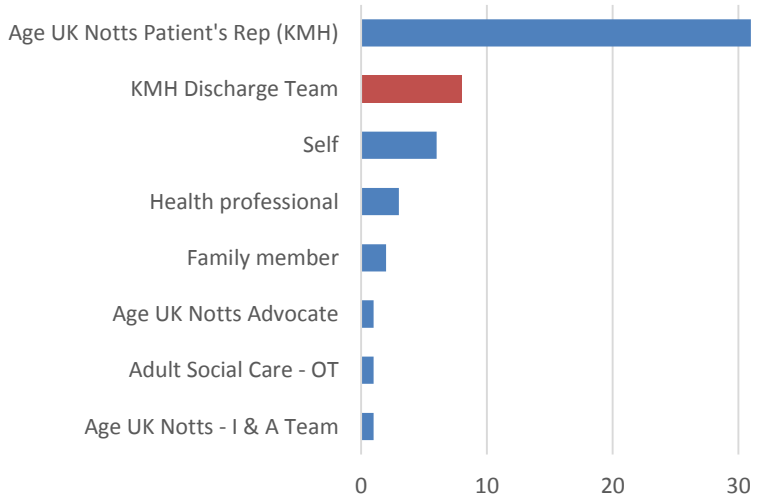
Lead for Connect: Malcolm Potter, Commissioning Officer (NCC)

CONNECT: ACROSS THE COUNTY

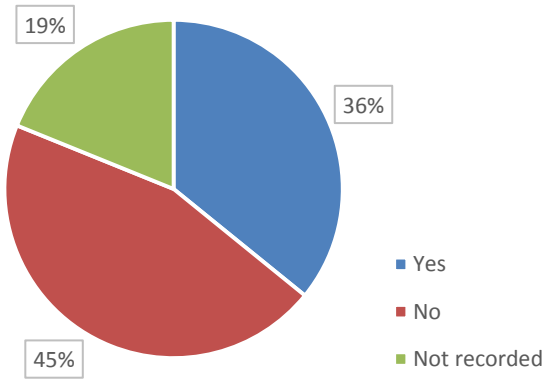
MID

- The provider in **Mid-Notts** is Age UK. This is the area where the Connect Worker has been in place for the longest; the worker was recruited in January and is now based with the Discharge Team **two days a week**.
- The social work team have given positive feedback about the new arrangement and shared anecdotal examples of how the worker's input has meant discharge can happen more quickly.
- The information below is based on **53 cases** allocated to the Connect Worker based at King's Mill Hospital in Q4 17/18 (**Jan-Mar 18**) and is taken from Age UK's quarterly monitoring information. It offers an **initial snapshot** of cases in the first three months of this newly introduced role.
- On average during this period, the Connect Worker has received **4.2 referrals per week**.

REFERRER TO CONNECT WORKER



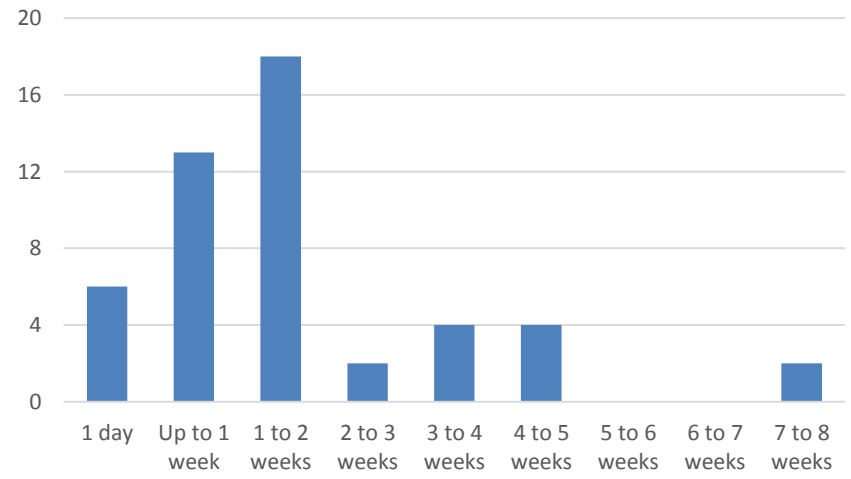
Is the person receiving social care services at the point of referral?



- In their first three months, the data recorded shows that the Connect Worker received **8 referrals from the Hospital Discharge Team**, this represents **15%** of referrals received.
- Currently **at least 45%** of people the Connect Worker has supported are recorded as **not** being in receipt of social care services.
- In order to reach the right target group, and as the worker becomes more embedded, there needs to be more referrals directly from workers in the Discharge Team.

- Of the 53 cases, **85%** were recorded as receiving 'Brief Intervention' and **15%** 'Short Term Support'.
- The graph below shows duration of support based on referral date and the date the case was closed (4 were cases were still open at the end of Q4 and are not included).
- It is recorded that a support plan was produced in 4 out of the 53 cases (7.5%)

DURATION OF SUPPORT



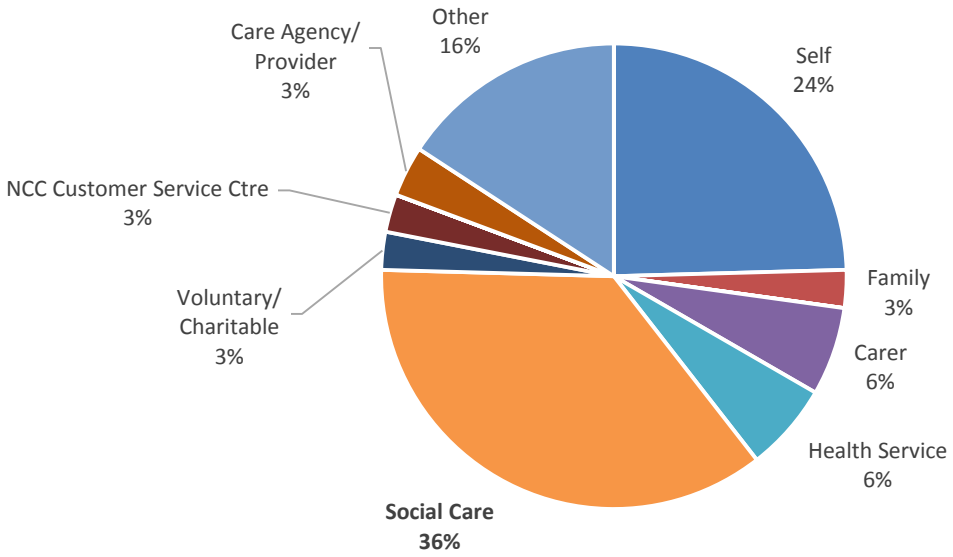
CONNECT/3rd SECTOR SERVICES: BASSETLAW

NORTH

- The provider in the **North** is NCHA (Nottingham Community Housing Association).
- The Connect Worker has been appointed and has been introduced to the Integrated Discharge Team and now spends two days a week (Tuesday and Thursday) at Bassetlaw Hospital.
- The Connect Worker has also been linking in with the Royal Voluntary Service who visit the hospital daily (RVS) providing a Home from Hospital service at Bassetlaw Hospital.

- Because the workers are not yet fully embedded and referral routes are not established, data is not yet available on referrals the Connect Worker has received.
- To offer some context, the charts below shows the referral sources for the **main** Connect Service in Q4 2017/18. This gives a sense of how well utilised the main service is by other social care teams in the area.

Referrals to main Connect Service (NCHA)
Q4 2017/18 (Total: 197)



Further Work

- Further work needs to be undertaken to map out and better understand the other services on offer to support people being from discharged from hospital and their interaction with Connect and other 3rd Sector services.
- As part of this, discussions are already underway with RVS and Hospital to Home.
- BCVS have recently made contact with the IDT and are to scope and develop opportunities for a three month pilot scheme which is likely to start mid November 2018 - where people are supported following discharge from Bassetlaw Hospital in order to prevent re-admission.
- IDT and BCVS discussions have taken place around how they could support the IDT with potential areas identified as: Transport, Pets, and Support for people to attend follow up appointments.
- Further works is also required to agree with Discharge Teams and the Connect Workers the most suitable referral process (in particular in South and North).
- Ongoing monitoring of referral rates, sources and outcomes will also be undertaken.
- The IDT acknowledges that the voluntary sector plays a vital role in maintaining people at home

Integrated Accelerator Pilot

- **Background to the NHS England Integrated Accelerator pilot**
- On 20th March 2018, the Secretary of State announced Nottinghamshire as one of three sites (including Gloucestershire and Lincolnshire) to pilot health and social care taking a pro-active and joined-up approach to:
    - **assessment for people with health and social care needs**
    - **personalised care and support planning for health and social care outcomes**
    - **offering more integrated personal budgets for health and social care funding (where beneficial).**
- Through the pilot, local people will receive better and more joined up care. This will be achieved by multi-disciplinary teams working across organisational boundaries to deliver more joined up care as simply and effectively as possible.
- The benefits of this approach are:
    - **better health and wellbeing outcomes**
    - **reduced demand on health and care services**
    - **better experience for people and their families.**

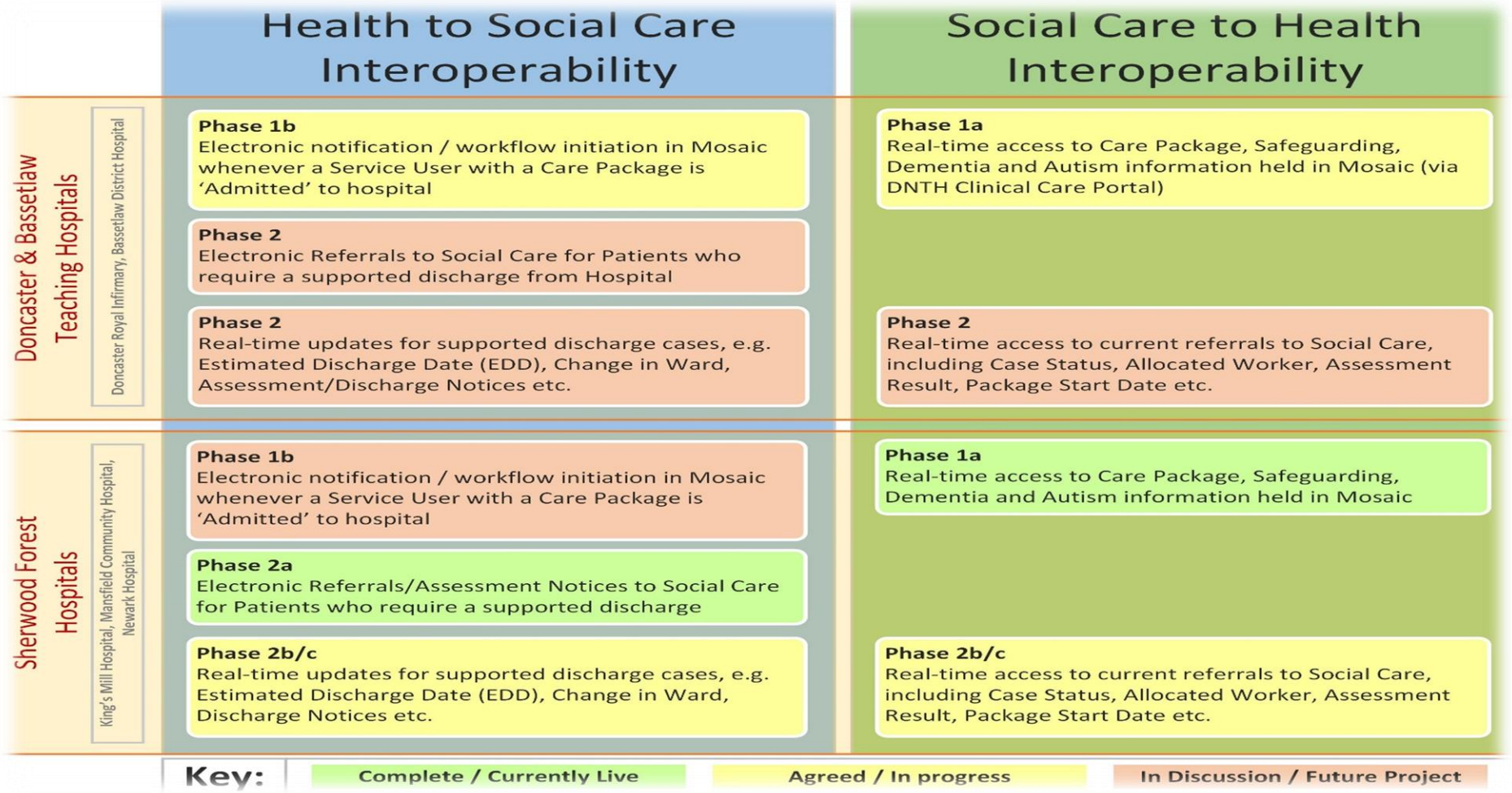
Integrated Accelerator Pilot

- There will be a phased approach to the introduction of a joined-up assessment, person centred care and support plans and personal health budgets. The pilot will begin in two NCC ASCH integrated care teams (there is a third pilot site in Nottingham City) and focus mainly on older adults in the following locations:
- Mid Nottinghamshire – North Mansfield and South Mansfield Local Integrated Care Teams (over 65s)
- South Rushcliffe Care Delivery Group (over 65s)
- In Bassetlaw, learning from the pilot sites in Mid and South Nottinghamshire will be used to inform local developments on joined up assessments and support planning.

Integrated Care Teams Project

- In March 2018 the findings of the Integrated Care Teams evaluation by Nottingham Trent University (NTU) and PeopleToo was reported to the ASCH Committee.
- This evaluation found multi-disciplinary working across health and social care achieves better outcomes for services users and can also realise savings for social care, but this was dependent on the right conditions for integration being in place.
- The Integrated Care Teams project is implementing the best practice model for how front line health and social care staff will work together most effectively and efficiently across the County.
- The Council has funded a one year Project Manager up to March 2019 to support the work.
- The project will align existing district social work teams with community health based integrated teams. In Bassetlaw this project will begin to align the Older adults social care teams with the 3 Integrated Neighborhood Teams, further aligning with the 3 Primary Care homes across Bassetlaw (Larwood, Newgate, Retford & Villages). Initial implementation meetings have already taken place with relevant stakeholders and a phased approach to roll out is planned over the next 4 months.

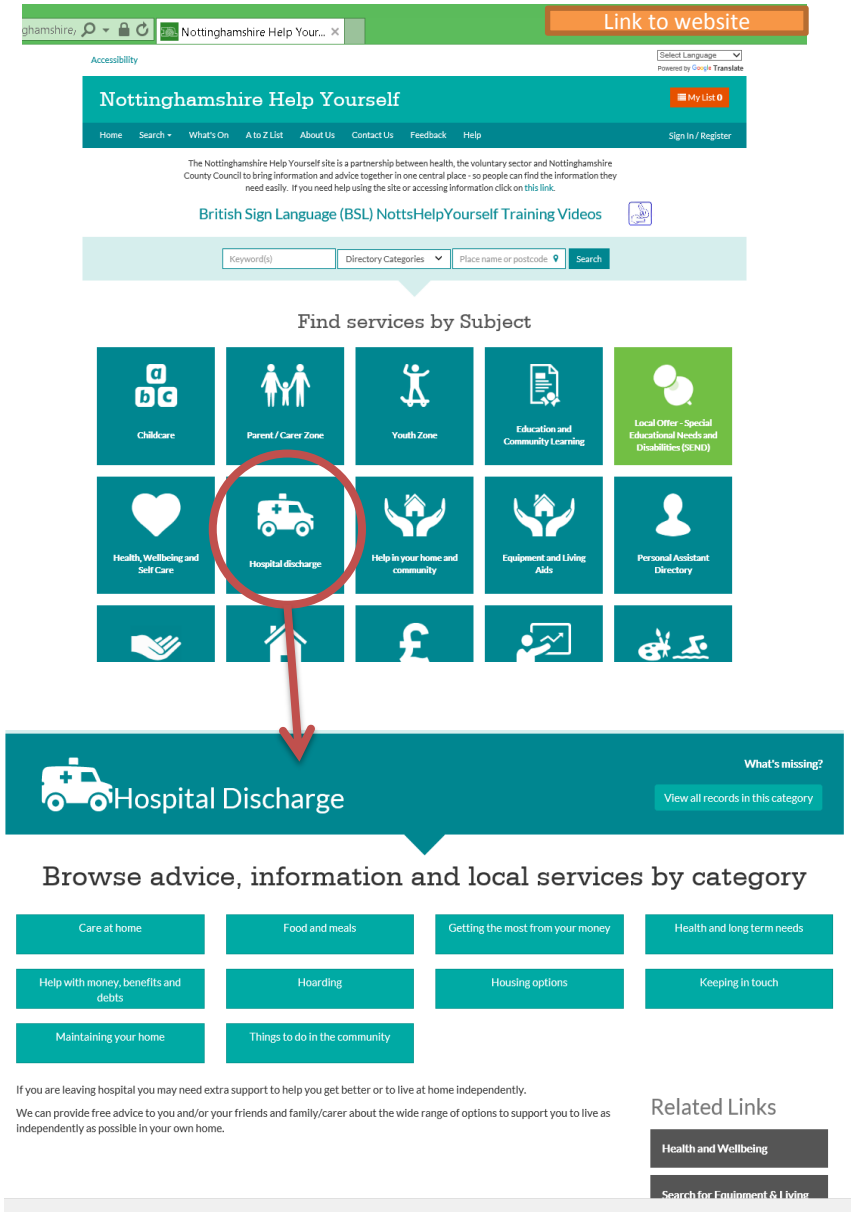
Interoperability Project



NOTTS HELP YOURSELF

Work So Far

- **Notts Help Yourself** (NHY) is a public website providing access to a database of community organisations and services across the county.
- Users can **create an account** and log into the website in order to save information (information about Personal Assistants is only available to users with an account).
- A Hospital Discharge **'button'** has already been created, this is the icon on the front page of the NHY website.
- The button takes the user to the Hospital Discharge **'landing page'** which shows categories of service relevant for people being discharged from hospital.
- The button went live on the NHY website on **16 January 2018**.
- During December 2017, the button and content of the landing page were **tested by a selection of staff** in Hospital Discharge Teams and Review Teams across the county.



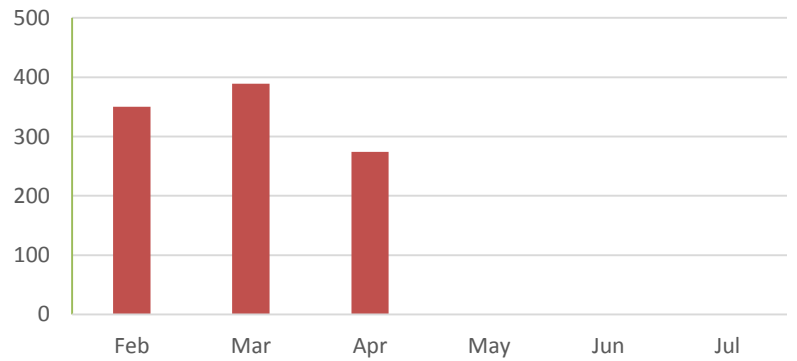
Lead for NHY: Gavin Butterworth, Commissioning Officer (NCC)

Data

- The **number of clicks** on each button is reported monthly and is also shown as a **percentage of the total number of clicks** on all buttons.
- For the 'Hospital Discharge' button, data starts from February 2018 (see table and graph below).

Hospital Discharge Button	Feb	Mar	Apr
Number of Clicks on Button	350	389	274
% of Total Clicks (on ALL Buttons)	2.6%	1.7%	1.3%

- This data provides a baseline, this project should result in an increase in the number of clicks over time.
- At the moment this number does not include clicks made by people who are logged into the website., this issue is being resolved by the NHY team.
- It is also possible to report on clicks on individual providers (e.g. the three Connect services)



Number of clicks on 'Hospital Discharge' button on NHY

How adult social care is helping people stay independent

Last year we:

Received **60,458** enquiries

Supported **3848** people **to regain independence** after a fall, illness or operation.

Supported **234** older people in extra care giving them their own home and own front door, with 24/7 support on site if they need it

Meals at home **1052 adults**
5250 meals a week
275,000 meals a year

Gave **864** people technology such as falls monitors, to help them live independently at home.

1186 people go to day services for activities and friendship

Spent **£4.35m** on respite care to give families a break from caring

Carer support **£4.7m**

Paid 64 Shared Lives carers to provide a home or support for people with care needs

Invested **£36m** to help 700 people with learning disabilities to live independently

6,631 people helped to live independently in their homes through home care and other support

Funded 3,345 people in long term residential or nursing home placements.

Worked with **380** people to gain employment

Key issues over the next 4 years – Adult Social Care

- **Demographic changes**
  - By 2030 65-84 year olds increasing by over 30% and 85+ year olds by over 90%
  - By 2030 expected increase in people with learning disabilities to 17,000 people, with 48% growth in people aged over 65
  - By 2026 32% increase in people with profound and multiple learning disabilities - 330 people in 15 years

- **Statutory work – assessments, reviews, safeguarding, mental capacity and mental health**
  - 73% increase in carers' assessments and reviews since the Care Act introduced in 2015
  - Safeguarding enquiries have increased by 23% in same period
  - Mental Health Act assessments – 21.7% increase on 2015/16 (1653 in 2016/17)

Key issues over the next 4 years – Adult Social Care

- **Green Paper and funding**
  - Health and Social Care Green paper – delayed publishing now likely to be Winter 2018 or early 2019.
  - Extending the role of the state in paying for adult social care – Part II of the Care Act delayed in 2015 until 2020. Main provisions:
    - change to the financial threshold for means tested care from £23,250 to £118,000
    - cap on care costs of £72,000, although there will be some costs (e.g. accommodation)
- **Integration with health and other public services**
  - Better Care Fund
  - Sustainability and Transformation Partnerships – South Yorkshire And Bassetlaw STP
  - Integrated Care Systems - Bassetlaw
  - Accountable Care Partnership - working together to bring the Bassetlaw Place Plan to life - bringing together a number of partners to take responsibility for the cost and quality of health and social care for a defined population within an agreed budget.

ANY QUESTIONS