TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **26th July 2023**
Report for: **Information**
Report of: **Emma Brown, Director of Adult Social Care, Trafford Council**

Report Title

Discharge from hospital support

Summary

The purpose of this report is to provide an update to the committee on the services in place to ensure safe, timely and effective discharge from hospital.

The report details the strategic context of the work across Manchester and Trafford and the recent enhancement of Trafford governance to drive forward the Trafford specific elements of the overarching plan. The report also contains information and performance data on services and schemes in place which form part of the 'Improving Lives Every Day' programme. It provides an overview of the Discharge to Assess (DtA) activity and several additional schemes which have been co-designed with partners across health and social care to improve the experience of Trafford people, avoiding hospital admissions and improving their discharge.

Recommendation(s)

Health Scrutiny are asked to:

- Note the content of this report and progress to date

Contact person for access to background papers and further information:

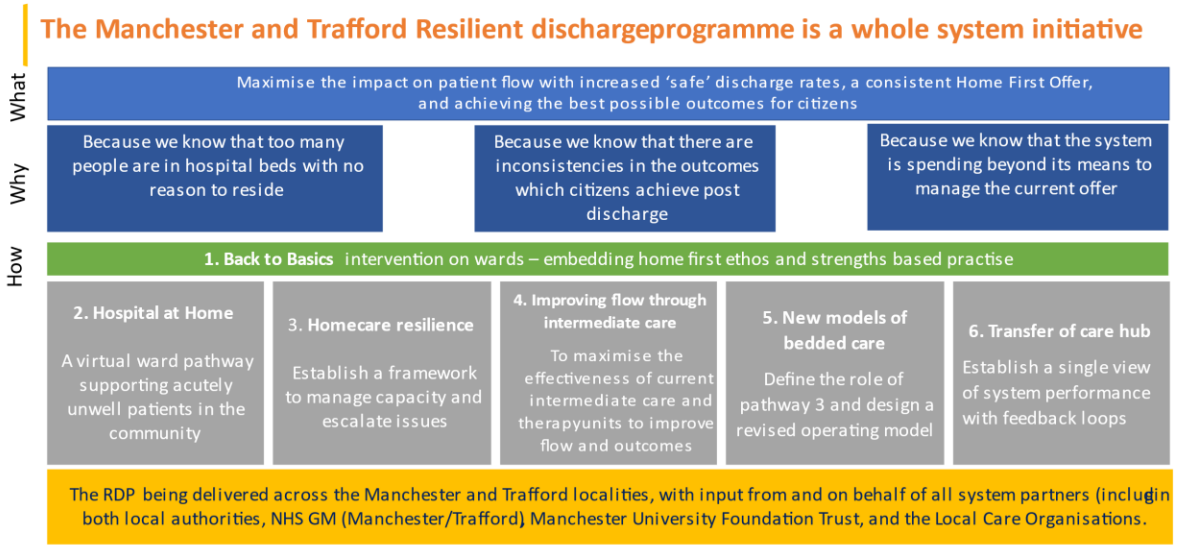
Name: Emma Brown, Director of Adult Social Care, Trafford Council

1. Resilient Discharge – Trafford and Manchester

1.1 Trafford Provider Collaborative Board has identified three strategic priorities for 2023/24. Resilient discharge is one of the priorities alongside urgent care and the neighbourhood model. These priority areas will be delivered through a 'prevention lens' and the focus will be on upstream, preventive and community interventions which align with the ethos and aims of the Trafford Locality Plan.

1.2 Feeding into the Trafford Provider Collaborative Board is the work which has been established across the Manchester and Trafford footprint. Jointly, Manchester and Trafford localities have established a 'Manchester and Trafford Resilient Discharge Programme'. The resilient discharge programme is a whole system initiative that aims to maximise the impact on patient flow with increased 'safe' discharge rates, encompassing a consistent 'Home First' offer and achieving the best possible outcomes for citizens. A visual of the programme explaining the what, why and how is below in figure 1.

Figure 1:



1.3 To ensure the pan-locality approach described in figure 1 is embedded in Trafford and nuanced appropriately to accommodate Trafford's needs, recent changes to governance

have been made to strengthen connectivity across partners and contributing services / programmes of work.

1.4 There is an acknowledgement from partners a 'Trafford Plan' is required, and to drive this work we have created a Trafford Resilient Discharge Programme Tactical Working Group which will hold the Trafford plan and address specific actions from the Manchester and Trafford Board. It will have a direct connection into the Trafford Heath and Social Care Steering Group an onward to the Trafford Provider Collaborative Board and when appropriate the Trafford Locality Board for escalation and/or decision making.

1.5 The tactical group has replaced several thematic and organisational focussed groups to enhance collaboration and visibility of our respective services and plans.

2. Resilient Discharge – Improving Lives Every Day

2.1 We are maximising our Integrated Professional & Clinical Leadership to ensure that our residents can continue to remain living well in a place they consider to be their home for as long as possible. Across Adult Social Care Statutory Assessment & Commissioning Services, we have launched our Improving Lives Everyday Programme under the Living Well at Home strategic ambition.

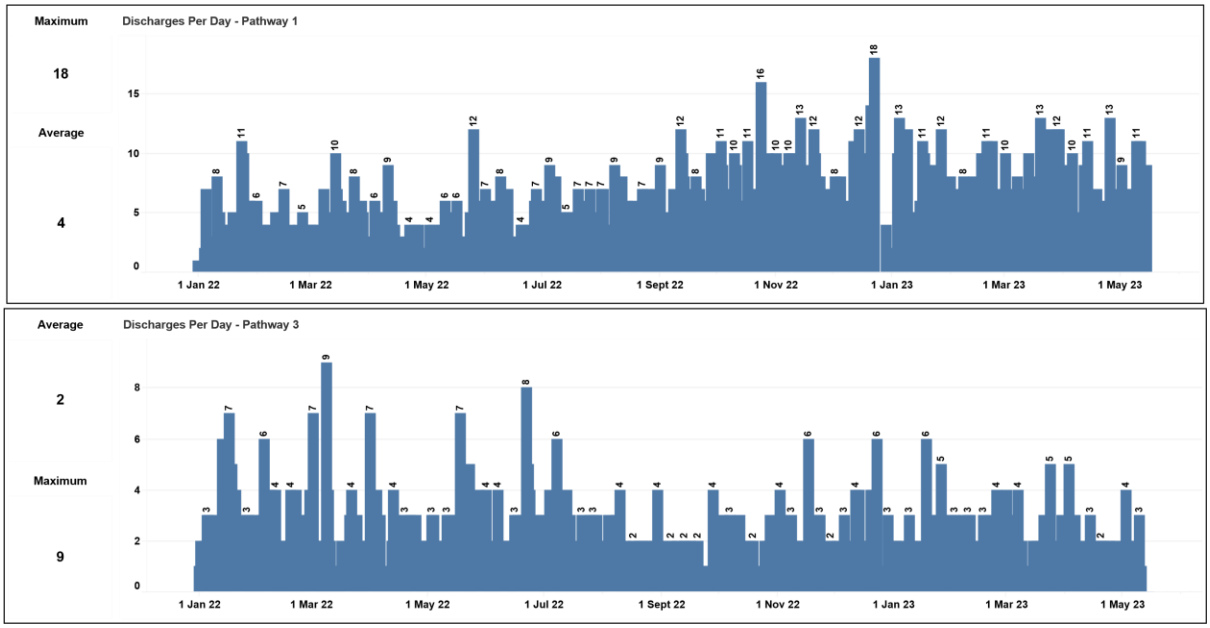
2.2 The Programme essentially consists of:

- Ensuring that the Voice of Our People informs everything which we do
- Being as efficient & effective as possible to ensure we can increase our capacity to meet demographic challenges within our existing resources
- Adopting a modern approach by maximising our digitalisation opportunities for both our workforce & our People
- Ensuring that our people receive the right level of care at the right time

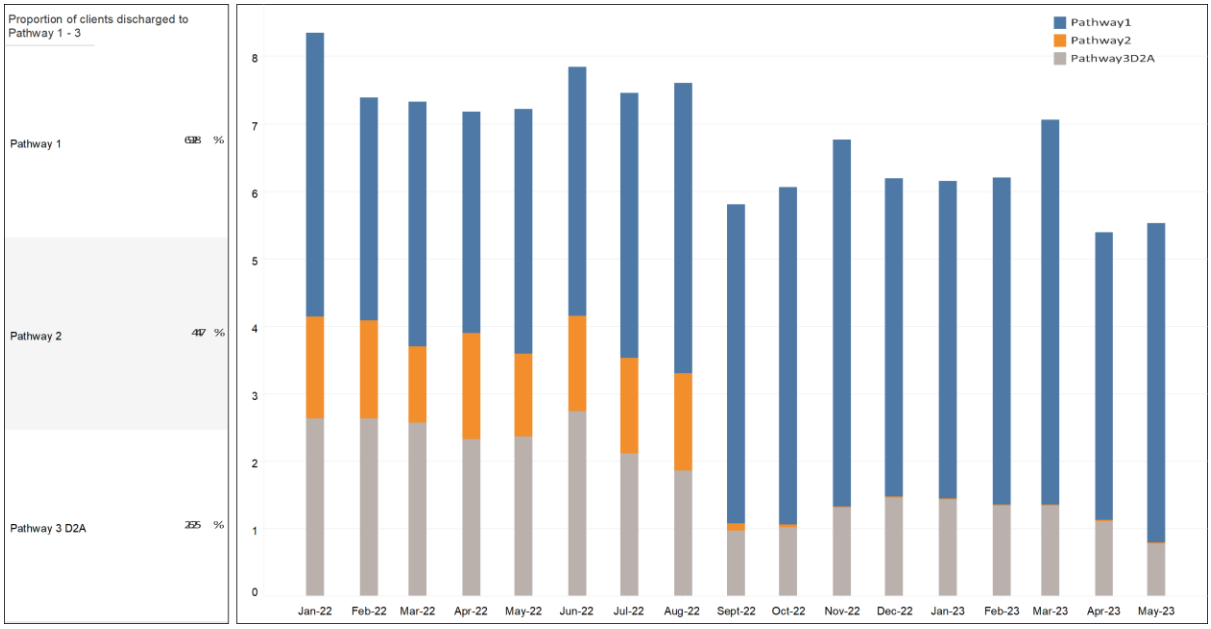
2.3 This document provides an overview of our Discharge to Assess (DtA) activity and several schemes which have been co-developed across Health and Social Care to improve the experience of our people, avoiding hospital admissions and improving their discharge.

3. Discharge to Assessment Monitoring July 2023

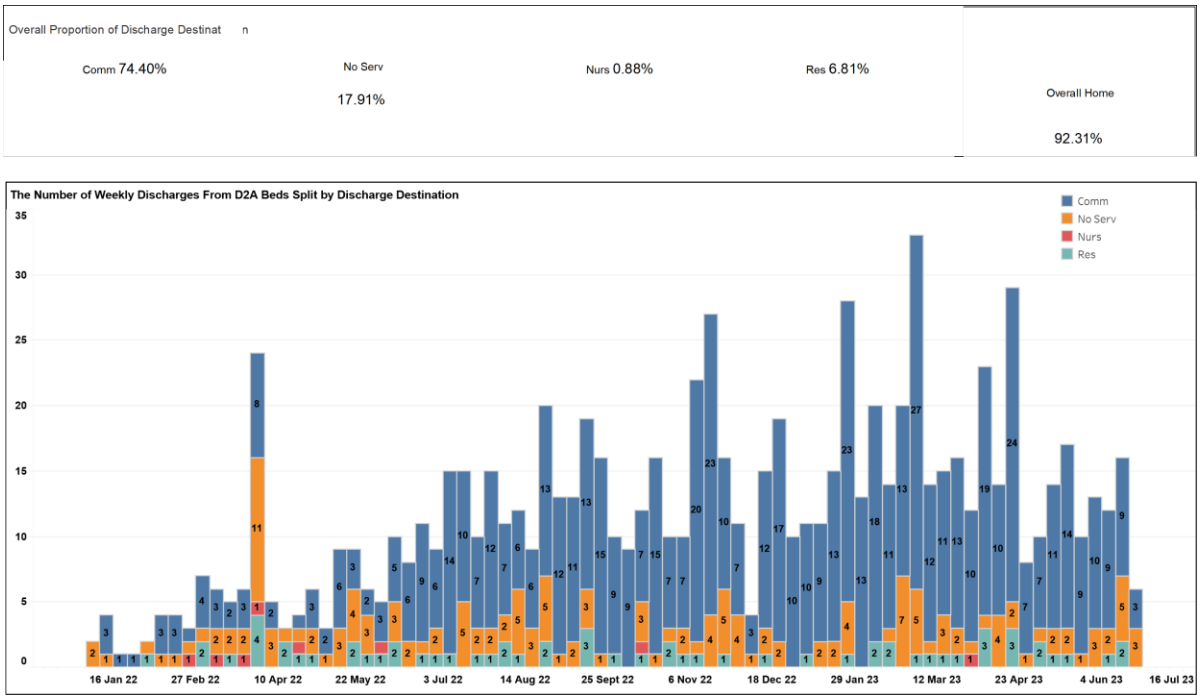
3.1 Average Daily Hospital Discharges by Pathway



3.2 Proportion Discharged from Hospital on to Each Pathway



3.3 Clients Discharged from D2A Beds



4. Trusted Assessment

4.1 Our Stabilise and Make Safe Service (SAMS) provides rehabilitative care and support to our residents typically where they have been discharged from a hospital setting.
We are developing a 'trusted assessment model with one of our providers where they will be undertaking an assessment of the person's needs under the Care Act (2014) to enable long term care and support needs to be identified quickly following a person-centred assessment. In turn, this will 'free up' our SAMS capacity to enable more people to be supported in their neighbourhood.

4.2 Pathway 1: Enhancement (Homecare)

4.3 Overnight care: We are committed to ensuring that our people can receive the right care at the right time. To achieve this, we are developing in collaboration with a Homecare provider an overnight support service for our residents during times of need (including overnight 7 days a week). This usually occurs when their informal carer has become unwell or has been admitted to hospital.

4.4 This approach will ensure that the person being 'cared for' will be able to remain in their own home and will avoid any further distress/unrest or hospital admission. Our Social Care & Health workforce would then undertake an assessment of the person's needs the following working day.

5. Transport

5.1 Throughout the pandemic we accessed several centrally funded grants, one of which supported one of our providers to purchase a vehicle. This has enabled the provider to delivery in excess of 350 additional homecare hours in areas of the Borough where trans port links are extremely limited and time restrained and where employee's did not have access to their own vehicles.

5.2 We have agreed to extend this model through 2023/24.

6. Reason to Reside Lead: Accommodation

6.1 We know that sometimes, people remain in hospital longer than necessary due to reason which pertain to their accommodation related needs. It may be an environmental issue, health and safety or personal issue. Whilst the needs of the people which fall into the above category may not have 'eligible' care and support needs (under the Care Act, 2014 (Statutory Duty for Local Authority) , ensuring people can leave hospital is the right thing to do.

6.2 Consequentially, we have secured additional capacity to address the complex housing related issues, our people face by employment of a dedicated Lead (fixed term contract 23/24). Further, we are working more closely with our Housing colleagues to ensure hotel capacity is brokered where required.

7. Right Care for You

7.1 The purpose of this project is to ensure our people receive a dignified and less restrictive level of care where their assessed needs have been identified as requiring the support of two registered carers.

7.2 By maximising a modern approach to equipment, this will result in care only being required to be delivered by one carer as opposed to two; maximising our workforce capacity.

7.3 We learnt prior to the global pandemic, that this approach worked effectively for both our residents and workforce and we want to build on this through 2023/2024.

8. Enhanced Training for our Providers

8.1 In 2021/2022 Abuka was commissioned to deliver training to our Care Home providers to support our residents who present with more complex needs such as, specialist Dementia, distressed behaviour, PEG feeding etc.

8.2 The proposal for 2023/24 is to strengthen our training offer to include our Homecare providers, internal workforce & for those in receipt of Direct Payments (DP's) or Personal Health Budgets (PHB's).

9. Social Work Resource in Wythenshawe Emergency Department

9.1 We recognise that on occasion our residents are admitted to hospital due to non-medical reasons where they could be cared for at home.

9.2 We have therefore agreed we will pilot the presence of a Social Worker in the Emergency Department of Wythenshawe Hospital to see if this model would be effective to support our residents more holistically as opposed to a hospital admission.

10. Health Recovery & End of Life Care

10.1 We know that our residents' needs are not linear and on occasion people may need a different 'type' of care other than Discharge to Assess (DtA); usually this follows either a health-related condition which no longer require in patient care. Consequently, the person may not be able to return home directly from hospital as they require an extended period of recovery.

10.2 We have agreed to provide a Health Recovery bed-based option as part of our Winter planning. This support will be available for up to 6 weeks.

10.3 End of Life care needs to be dignified and we know that syringe drivers ensure that medication can be delivered in a way which is less intrusive than alternative methods. We are committed to ensuring that the last weeks/days of our residents lives are as painless of possible whilst in accordance with their wishes.

11. Digital Solutions Officer

11.1 Technology enabled care is an important aspect of meeting our residents care and support needs without the need for physical presence. We have several solutions which may include pendant alarms, sensor technology and key safes to ensure our residents safety whilst at home.

11.2 We have witnessed an increased in demand for these provisions for people being discharged from hospital. As a result, we have developed a temporary option, but this requires monitoring and re-distribution once permanent alternatives have been sourced or deemed no longer required. It is for this reason we have agreed to a fixed term post to support us manage this increased demand throughout 2023/24.

11.3 Just roaming, Just checking, Genie connect. We have purchased 45 Genie's for our residents to promote their independence. Genie provides verbal prompts a bit like an enhanced Alexa but includes video calls to family, friends & professionals:

- Video calling-voice activated (family, friends, professionals)
- Personalised verbal prompts built in by family/providers/professionals -Medication prompts, nutrition hydration prompts, appointments, personal care etc)
- Entertainment built in (BBC I Player, Netflix (with subscription etc)
- Digital Support Workers

- Dashboard (for workforce, including Assessment Teams)
- Mood 'check'
- No access to the World Wide Web (www)

11.4 We will be 'testing' ten of our Genie's in the following area's:

- Preparing for Adulthood (PfA)
- Stabilise & Make Safe (SAMS)
- Extra Care (older people)
- External Learning Disability Supported Living Provider
- The remaining five will be available for our people who may benefit

12. Proactive care pilot: Enhanced Health at Home

12.1 Our pilot is engineered to work towards objectives set out in the NHS Long Term Plan, through an integrated neighbourhood model with system partners, looking to support individuals with multiple long-term conditions, including frailty to remain well at home.

12.2 With the support delivered by an MDT, we are confident that our approach will contribute to reduced avoidable episodes of ill health which result in the need for the individual to access unplanned or emergency care. With holistic assessment, personalised care & support planning, coordinated care by the MDT agreeing interventions and support, people will be supported to stay at home, achieve better outcomes for their health & wellbeing while addressing and reducing health inequalities for this group.

13. Social Workers deployed into Northwest Ambulance Service (NWAS) Control Room

13.1 We are acutely aware that there is a disproportionate focus on supporting our residents to be discharged from hospital. We need to be focused on ensuring our residents can remain in their own home.

13.2 We want to re-energise our ethos and one solution is for our Social Workers to support NWAS in our ambition to ensure that where our residents require social care support, this can be delivered in the community.

14. Voluntary Community Faith Social Enterprise (VCFSE) Sector investment

14.1 Statutory services and our commissioning Care Providers cannot possibly deliver everything for our residents. Consequently, we have decided to invest further in our VFSCE sector to deliver our Living Room projects where our people can attend to not only stay warm but also to engage in meaningful activities including; homework clubs, coffee mornings, afternoon tea, yoga, meaningfulness sessions etc.

14.2 Further support for our 'Living Rooms' can be source here: Response | Trafford Community Hubs (traffordhubs.org)

15. Carers Centre

15.1 The Carers Centre is a substantial resource for our informal carers and they have requested support to ensure that our carers are aware of the support that is available to them specifically where their loved one is in a hospital setting.

15.2 Our Carers Ambassadors will be available initially at our Wythenshawe site and will provide additional resources to enable our carers to make informed decisions.

16. Toy House

16.1 The Toy House is an inspirational community asset which provides local support to the residents of Urmston & beyond.

16.2 They provide a timetable of person-centred activities across an all ages from new Mothers, people experiencing mental health with associated needs ,older aged adults and adults with a learning disability.

16.3 The Toy House have asked for additional support to 'grow' their volunteer workforce and we think by promoting our Personal Assistant (PA) offer for those in receipt of Direct Payments (DP's) or Personal Health Budgets (PHB's) is an opportunity to develop a structured approach into paid employment.

17. Rapid Assessment Pilot

17.1 We know that once our residents are discharged from hospital and enter our DtA provision, in excess of 87% of people return home.

17.2 This may be because of several reasons, but we believe if we had a Health & Social Care model which met people on their first day this may improve our residents' outcomes even further.

17.3 We have developed this pilot in partnership with Manchester Foundation Trust (MFT), who will be providing Occupational Therapy & Physiotherapy assessments & interventions to support individuals during this assessment period.

18. Specialist Stroke Social Worker

18.1 We have recently been successful with a bid to secure a Social Work position embedded into our Community Neurorehabilitation Community Team. This is a positive step forward & will help us support our residents who have experienced a stroke and need an MDT approach to their care, both in the community and supporting people to leave hospital.