Better Together – ASSIST Hospital Discharge Scheme

Shared learning database

Organisation:

Mansfield District Council (MDC)

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Mansfield District Council (MDC) has reorganised and restructured elements of its housing service to create the Advocacy, Sustainment, Supporting Independence, and Safeguarding Team (ASSIST).

Its purpose is to deliver bespoke, wrap around holistic support services to meet the needs of Adult Social Care and Health (ASCH) customers and carers. The aim of this is to deliver better outcomes for people by preventing homelessness, promoting independence, reducing/preventing admissions to hospital and residential care, evidencing cost effective ways of providing integrated services. An example is ASSIST Hospital Discharge Scheme.

The development, implementation, delivery of the ASSIST Hospital Discharge Scheme relates specifically to NICE Guidance NG27 recommendation 1.5:

- Being integral to the discharge planning process and agreed protocols.
- Sharing relevant information within a multi-disciplinary team.
- Addressing factors that could prevent expedited and safe discharge.
- Supporting people within the community post discharge.

This example won the 2017 NICE Shared Learning Award.

Guidance the shared learning relates to:

- **Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27)**

Does the example relate to a general implementation of all NICE guidance?

No

Does the example relate to a specific implementation of a specific piece of NICE guidance?

Yes

Example

Aims and objectives

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Aims and objectives

The aim of the Hospital Discharge Scheme (HDS) is to support the early discharge and immediate residential care of patients from Kings Mill Hospital and to receive clients from health, housing and social care partners in central Nottinghamshire. It achieves this by working towards the following objectives:

- Prevent avoidable homelessness.
- Support tenants to remain adequately housed.
- Reduce or prevent avoidable or elongated admissions to Hospital or residential care.
- Expedite discharges from Kings Mill Hospital – Emergency Department (ED) and ward discharges.
- Expedite discharges from residential care in Mansfield.
- Reducing falls by assessing and removing hazards in the home to prevent re-admission.

- Supporting the hospital's Emergency Department *'front door'* by engaging with people who have a social need and freeing up hospital staff to deal with emergencies.
- Helping people remain in their homes for as long as possible.
- Supporting people who are EOL to remain at home if it is their preference.
- Improving patient experience by delivering a bespoke service.

In accordance with NICE guidance NG27 the focus for the HDS was to support the transition between in-patient hospital settings and the community or care home settings for adults with social care needs or those medically fit people who could not leave hospital without intervention.

The HDS is a project that responds directly to that demand by supporting the early discharge and immediate residential care of patients from Kings Mill Hospital in

Mansfield, and through the delivery of services to clients from health, housing and social care partners across the central Nottinghamshire sub-region.

To deliver the scheme, the ASSIST team works directly with Sherwood Forest Hospitals National Health Service Foundation Trust (SFHNHST), the Adult Social Care and Health team at Nottinghamshire County Council, Mid Nottinghamshire Clinical Commissioning Group. Although initially focussed on the MDC administrative area, the scheme also delivers and co-ordinates some of the equivalent services in Ashfield and consequently engages with wider stakeholders from the public, private and third sectors across both areas.

Working together has demonstrated a much stronger co-ordination between social care, health, housing and the community. It has not only built up resilience to the pressures faced by public services but made a significant difference to people's lives showing 'better together' does work.

Reasons for implementing your project

Mansfield is the largest urban area in Nottinghamshire outside Nottingham city with a population of approximately 105,000 and is one of the most deprived local authority areas in England and Wales. The health of people in Mansfield is worse than the English average, and the life expectancy for both men and women is also lower than the English average. Those aged 65+ represent the second largest age group of the population (17.7%) and as much as 23.7% of the population if living with a limiting long-term illness. This level is the highest in Nottinghamshire and significantly higher than the regional and national average.

The social demographics of the area are important to understand as they help to explain the high level of demand placed upon public services delivered by the NHS and local authorities within the area.

The HDS was initially launched as a pilot operating between October 2014 and April 2015 to address that demand. An independent appraisal of the scheme undertaken by Nottingham Trent University Business School evaluated the benefits of the pilot and found that the efficiency of hospital discharge had significantly reduced the burden on hospital beds. Evidence demonstrated that there was clear service and financial justification for the continuation and extension of the scheme. It was evident that MDC was a unique contributor to the scheme providing services that deliver improved outcomes for service users across the community and, through affective partnership working, deliver much more than could be achieved through financial investment alone.

On the strength of this assessment the council and its partners presented the service delivery model and outcomes of the pilot scheme to the Mid Nottinghamshire CCG. The outcome of this was to recommend that, on the strength of the pilot, the Hospital Discharge Scheme should continue. The scheme and its outcomes were subsequently presented to the CCG board who took the decision to approve funding for the council to deliver the service over an extended period. The additional £175,000 agreed by the CCG, allowed MDC to further demonstrate how the wide

range of interventions and infrastructure available enables the council to be a unique contributor to the delivery of the scheme and the partnership relationships that exist to make the scheme the success it has become.

How did you implement the project

The Hospital Discharge Scheme commenced operations as a pilot in for a week in September 2014 and has been in full operation since July 2015 providing holistic *'whole system'* interventions that support the early discharge of patients from hospital. It is delivered in partnership with Nottinghamshire County Council and SFHNHST based at King's Mill Hospital. Its purpose is to ease *'bed blocking'*, a well-documented issue at both a national and local level, and does so by:

- Expediting hospital discharge.
- Preventing hospital readmissions.
- Sourcing alternatives to residential care.
- Providing access to a 24/7 service.
- Utilising housing stock to meet local need.
- Fast-tracking repairs to properties.
- Providing key safe installation and minor adaptations.
- Installing lifeline and telecare.
- Prioritising the letting of existing adapted accommodation.
- Using temporary accommodation to facilitate discharge.
- Accessing food banks and furniture projects.
- Supporting the hospital's Emergency Department *'front door'* by engaging with people who have a social need and freeing up hospital staff to deal with emergencies.

In delivering the scheme, MDC prioritised its resources to respond to hospital and residential care discharges which required the commitment of staff across Housing Services to meet individual service user need. Employees working for ASSIST are based at King's Mill Hospital on a daily basis working with service users to assess individual needs and provide them with a wide range of services and support including the following:

- Completing relevant forms e.g housing and benefit applications.
- Facilitating discharge by co-ordinating actions required to expedite a safe discharge.
- Co-ordinating accompanied viewings including suitability assessments with OT's and social workers

- Arranging property sign up at the hospital and case conferences with families and carers.
- Providing resettlement service e.g arrangement of removals; commissioned services e.g. cleaning, installation of key safe and assistive technology (lifeline; fall detectors; monitored smoke alarms), and the arrangement of food parcel, clothing, furniture and white good deliveries.
- Providing specialist support to access services including welfare entitlements and debt advice through the council's Financial Inclusion Officers.
- Signposting service users to a range of other agencies as appropriate including Macmillan nurses, Age UK, Jigsaw, and private landlords regarding suitability of accommodation.

Key findings

The outcomes of the hospital discharge scheme have been recorded, measured and evaluated in a number of ways:

- Scoring assessment, patient health and well-being, pre-intervention and post-intervention.
- Number of interventions preventing hospital readmissions.
- Reduction in length of stay at hospital.
- Reduction in delayed discharges ('bed blocking').
- Service user satisfaction survey.
- Number of patients offered a service.
- Number of patients receiving a service.
- Number of patients with completed support packages.
- Number of patients signposted to other support services.
- Patient case studies.

The latest phase of evaluation of the service was undertaken by Nottingham Business School, Nottingham Trent University (based on findings and calculations of activity in the twelve-month period ending September 2017).

The number of interventions and the general case mix of individuals benefiting from the service have continued to be similar to the previous evaluation periods at approximately 50-55 per month and the aggregate savings of the scheme have generally been comparable to the previous evaluation period. However the costs of operating the scheme have fallen significantly to £149,500 (annualised) as a result of multi-skilling staff and improving and expediting systems and processes and better inter-organisational collaborative working.

The scheme continues to have a significant beneficial impact on a considerable cohort of some of the most vulnerable patients/clients as well as significantly reducing direct and indirect costs to the NHS and Social Services.

The evaluation identified the following key findings:

The number and mix cases appears to be 50-55 per month or 600-660 per year.

The costs of operating the service have fallen to approximately £150,000 per year.

The financial return on investment to the Nottinghamshire Health and Social Care System is over 900%

The annualised savings to Nottinghamshire County Council reablement services is £107,000

The annualised savings to the hospital from avoidance of readmissions is £186,323.

Despite pre-dating the Mid-Nottinghamshire Better Together programme, the project reflects this more holis

Case Study - Mr C

Mr C a frail elderly gentleman 78 years of age with no family was living alone in his own home which had recently been broken into. Working in the garden he fell from a ladder and was admitted to hospital.

His home lacked basic facilities. No central heating or hot water just coal fires. The toilet facilities were at the bottom of the garden and there were no facilities inside the property. The roof was leaking and daylight could be seen though the tiles. The joists to the first floor were rotten, there were no floorboards, and the lath and plaster ceilings had all come down. The electrics were in contact with water. Mr C was confined to the downstairs rooms of the accommodation.

Once Mr C was medically fit for discharge, concerns about him returning to accommodation that appeared to be unfit for habitation. Very reluctant to look at other types of housing but he eventually agreed to go into a respite unit and was prioritised for re-housing near his home.

Case Study - Miss B

A referral to the Assist team was made to supply and fit a lifeline, key safe, grab rails and a monitored smoke alarm and support with light domestic tasks and shopping after a fall at home which caused head injuries.

An assessment also concluded that Miss B required encouragement to complete daily tasks and rehabilitation due to the injury she had sustained to her head. Safe and well checks were also required three times a week to ensure that Miss B was coping at home. A referral was made to the furniture project for a new sofa as the leather sofa she had was no longer suitable due to her slipping off it. A fabric one was ordered.

At the very start of the 4 weeks support the staff identified tasks Miss B she was unable to do this due to her impairment, however as the weeks went by Miss B gained back her strength and stamina and was able to complete the tasks herself or with the guidance from staff that visited.

Key learning points

- Understand the challenge and complexities being faced.
- Focus on collective outcomes.
- Build trust, confidence, rapport with partners.
- Have a creative problem solving approach.
- Respect each other's roles and responsibilities.
- Multi-skill staff to deliver a streamlined service.
- Re-model internal services to expedite hospital discharges.
- Use NICE guidance relevant to the service development (NG27 in this case).
- Ensure housing is central to the partnership.

This integrated approach has risen to and addressed many challenges by developing creative and innovative ways of facilitating and expediting safe discharges from hospital in partnership with Health and Social Care colleagues .

The optimal effectiveness of the scheme was heavily dependent upon the mutually respectful, reciprocal and close working relationships that developed and maintained, at both individual and organisational levels between all the principle public services, commissioners and providers contributing. This has been and still is critical to the development and the success of the scheme to date.

We are still learning and re-defining the scheme as it grows. There is always room for improvement and wherever there is a gap in the service we work alongside our partners to address it.

Moving forward we are looking at another arm of the scheme by providing 'social triages' within GP surgeries to prevent people accessing health and social care services to address a social need. For example relationship breakdown; financial difficulties due to benefit sanctions and having no money to live on which affects their health and well-being; veteran support; people being abused financially, violent or coercive behaviour from partners; parenting issues managing behaviours of children; poor property conditions; health and well-being advice; long term conditions.

A key focus for the above development will be to look at the 'root cause' of the presenting issue and 'breaking the chain of causation' in an integrated way.

Contact details

Name:
Christine Fisher
Job:
Operational manager for the Hospital Discharge Scheme and ASSIST
Organisation:
Mansfield District Council (MDC)
Email:
cfisher@Mansfield.gov.uk