Delivering Core NHS and Care Services during the Pandemic and Beyond.

Health and Social Care Committee: May 2020

Written Evidence submitted by Professor Peter Murphy and Nottingham Civic Exchange.

Summary

This submission relates to the issue of **"meeting the needs of rapidly discharged hospital patients with a higher level of complexity".**

It is derived from a research project that investigated a pioneering early discharge from hospital scheme known as 'Working Together – the ASSIST' project in Nottinghamshire.

In the post Covid-19 era we need better and more advanced systems for delivering post-hospital accommodation, medicine management and out-of-hospital support. This project highlights the evidence and results of doing it differently. We need to be better at keeping hospital occupancy down and a key way of doing that is minimizing delayed transfers of care and optimising care in the most appropriate setting.

In 2016 the National Audit Office (NAO 2016) estimated that the NHS spends around £820m a year treating older patients who no longer need to be there. The NAO noted that **"without radical action to improve local practice and remove national barriers, this problem will get worse and add further strain to the financial sustainability of the NHS."** There is little doubt that the problem will continue to be a challenge to of the Health and Social Care system post Covid-19.

The Nottinghamshire project focussed on the early identification and rapid response to patients' changing housing and support needs on discharge from Kings Mill Hospital in Mansfield. Although not detailed in this submission a similar scheme was developed

by Nottingham Community Homes (NCH 2019) in a larger urban setting within the City of Nottingham based on discharges from the Nottingham University Hospitals Trust.

The purpose of both projects was to deliver bespoke, wrap around holistic support services to meet the needs of Adult Social Care and Health (ASCH) customers and carers.

The aim is to deliver better outcomes for people by preventing homelessness, promoting independence, preventing and reducing avoidable admissions to hospital and residential care, and evidencing cost effective ways of providing integrated services.

The Mansfield project won the Shared Learning Award in the 2017 National Institute for Health and Care Excellence (NICE) and the lessons from both Mansfield and Nottingham formed part of the National Housing Federations campaign 'Home from hospital' (Copeman *et al.* 2017) and the Local Government Associations campaign 'managing our ageing population' (LGA 2017) which both sought local and national support to extend and increase the services that social housing providers offer to help people out of hospital, and into a suitable home with the right support.

Safe secure and suitable accommodation makes a significant contribution to public health and is a critical factor in the World Health Organisations 'wider determinants of health'. It will be critical to taking both financial and clinical pressure off the NHS and achieving government ambitions for developing Integrated Care Systems to meet the 'triple aims' (of the government and NHS England) of providing for future population health requirements, reduce health inequalities while reducing long-term per capita costs in the NHS.

The issues have been and will be further exacerbated by the Covid-19 pandemic and there is an urgent need to proactively plan, prepare and address these issues and scale up the provision by housing providers. The National Housing Federation identified four key components to what needs to be a sector-wide offer based at acute hospital providers:

- An increase in the number of housing step down units and beds nationally which can facilitate efficient discharge from hospital.

- Increased numbers of housing staff seconded to discharge teams locally to coordinate and speed up transfers of care.
- Care packages to help prevent people from needing to go into hospital in the first place and to reduce readmissions.
- A commitment to facilitating robust evaluation of this solution

Submission

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 are 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 aim of the Mansfield Scheme 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 as well as occasional ad-hoc referrals. Significant delays could potentially be reduced, if, post-release, suitable housing accommodation and/or arrangements were in place in advance of the patient discharge date. This was facilitated through both early triage of potential housing needs and immediate action on re-housing adaptions or commissioning support services. It achieved 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 End of Life to remain at home if it is their preference.
- Improving patient experience by delivering a bespoke service.

The project 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 subregion.

To deliver the scheme, the ASSIST team worked directly with Sherwood Forest Hospitals National Health Service Foundation Trust (SFH NHS FT), the Adult Social Care and Health team at Nottinghamshire County Council, and the two Mid Nottinghamshire Clinical Commissioning Groups. Although initially focussed on the Mansfield District Council administrative area, the scheme also delivered and co-ordinated some of the equivalent services in adjoining Ashfield DC and consequently engages with wider stakeholders from the public, private and third sectors across both areas.

Working together required significantly improved co-ordination between social care, health, housing, welfare providers and the community. It built up resilience to the pressures faced by public services and made a significant difference to people's lives showing 'better together' does work.

MDC re-prioritised its resources in order to respond to hospital and residential care discharges and 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 commission for them from a wide range of services and support

The Hospital Discharge Scheme provided holistic 'whole system' interventions that support the early discharge of patients. It is delivered in partnership with Nottinghamshire County Council and SFH NHS FT based at King's Mill Hospital. It 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.

Key findings

The third phase of evaluation by Nottingham Business School, was based on findings and calculations of activity for the twelve-month period ending September 2017 (Murphy *et al.* 2017, 2020).

The number of interventions and the general case mix of individuals benefiting from the service had stabilised and were 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.

The costs of operating the scheme fell significantly to £149,500 (annualised) as a result of multi-skilling staff and improving and expediting systems and processes and better interorganisational collaborative working. This significantly increased the return on investment

The evaluation identified the following key findings:

- The number and mix cases appears to be 50-55 per month or 600-660 per year. However, the costs of operating the service had fallen to approximately £150,000 per year.
- The annualised savings to Nottinghamshire County Council reablement services was £107,000 The annualised savings to the hospital from avoidance of readmissions was £186,323.
- The project reflects the holistic or 'population health management' approach

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.

It was apparent to the evaluators that there were a number of factors that were critical to the potential success of the discharge scheme, that were available in Mansfield but were not universally available in all housing authority areas. There are also a number of service configurations, patterns of deployment, inter-organisational and inter-personal relationships that were critical to successful delivery of the pilot project that also may not be universally available.

In order to assess whether the service is scalable, replicable, and/or portable, and to help target any future investment the project identified

a) critical success features that made the project a success,

b) critical success factors that may be missing in other areas but could potentially be developed.

c) critical success factors that may not be available in other areas and cannot realistically be developed.

The development of the Nottingham Community Homes scheme helped refine these factors but also indicated that some parts of the scheme could be implemented in most areas, as was demonstrated by the various case studies in 'Home from hospital' and 'managing our ageing population' publications.

Recommendations

That the Department of Health, NHS England and the Ministry of Housing, Communities and Local Government be requested to plan, prepare and proactively address these issues, in consultation with the LGA and the National Housing Federation, so as to scale up the provision by social housing providers to be a sector-wide offer based at acute hospital providers. This should include:

- An increase in the number of housing step down units and beds nationally which can facilitate efficient discharge from hospital.
- Increased numbers of housing staff seconded to discharge teams locally to coordinate and speed up transfers of care.
- Care packages to help prevent people from needing to go into hospital in the first place and to reduce readmissions.
- A commitment to facilitating robust evaluation of this solution

About the authors

Professor Peter Murphy is the Head of Research and Professor of Public Policy and Management at Nottingham Business School within Nottingham Trent University. He has previously been a non-executive member of the Nottingham PCT, the Nottinghamshire PCT and the Joint Nottingham and Nottinghamshire PCT. He Chaired the Transition Board for Nottingham and Nottinghamshire NHS following the implementation of the 2012 Health and Social Care Act. From 2000-2009 and prior to joining the Business School he was a Senior Civil Servant in Whitehall having previously been the Chief Executive of Melton Borough Council in Leicestershire.

Nottingham Civic Exchange is Nottingham Trent University's pioneering civic think tank with a primary focus on issues relating to the city and the region. Nottingham Civic Exchange enables discovery by creating a space where co-produced approaches are developed to tackle entrenched social issues. Nottingham Civic Exchange supports the role of NTU as an anchor institution in the city and the region. Nottingham Trent University holds engagement with communities, public institutions, civic life, business and residents at the core of its mission.

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