NORTHAMPTON BOROUGH COUNCIL

SCRUTINY PANEL 4 – ADULT SOCIAL CARE FACILITIES

6 DECEMBER 2018

BRIEFING NOTE: SITE VISITS

1 INTRODUCTION

1.1 At its inaugural scoping meeting, the Scrutiny Panel agreed that it would attend various site visits to inform its evidence base.

2 SITE VISITS

Discharge Team, Northampton General Hospital

2.1 On Tuesday, 30 October 2018, Councillor Zoe Smith (Chair), Councillor Sally Beardsworth (Deputy Chair), Councillors Janice Duffy and Arthur McCutcheon together with Tracy Tiff, Scrutiny Officer, met with the Lead Officers of the Discharge Team and the Health Assessment Team based at Northampton General Hospital (NGH).

2.2 Key information gathered from the site visit:

- A new discharge process was introduced on 29 October 2018 with the key aim of joined up working between both teams which will improve the patient experience, journey and patient flow. An Integrated Discharge Team (IDT) has been established comprising of staff from the health Discharge Team and Social Care. Social care workers together with staff from the Discharge team go out to work with the wards and meet with patients directly regarding their discharge. Whilst on the ward, The Integrated Discharge Team, which comprises, Ward staff, Therapies, Discharge, social and of course the patient, makes the decision as to the best discharge pathway for the patient. Previously, referrals for discharge planning were sent to the Single Point Access (SPA) Team who made the decision regarding the patient's discharge. This at times caused delays resulting in some discharges being deferred. In the longer term it is expected that the introduction of the Integrated Discharge Team will be of benefit to all. Newton was commissioned to undertake a case review.

The Newton Review provided valuable input into the introduction of the new discharge process. Newton also identified "*various delays and that patients stayed in hospital at NGH 128,000 days in one year more than was needed, the equivalent of 351 people spending an entire year in hospital at a cost of around £24.3 million".*

For the IDT to continue to work effectively further Social Workers are required to support every Ward, the ideal model of 1 Social Worker and 1 Discharge Coordinator on every Ward.

- There are Market Capacity constants in relation to services available for patients that require additional services and support upon discharge from acute services. The Discharge Team is an advocate in supporting a Trusted Assessor Discharge to Assess Model, as approved by NHS England, this is where patients are transferred to interim placements to continue further assessments in a non-acute environment. It is recognised that this would improve the patient's experience, patient flow and bed availability within the hospital as an acute hospital is not an appropriate setting for assessing patients once they are medically fit or optimised.

- Homelessness can be a problem for acute Hospitals it is recognised that that rough sleeping can sometimes be a lifestyle choice and in such instances individuals are discharged from hospital back to their desired destination. With the patients consent they are referred to support such as housing, money and advice etc. Some individuals need support regarding drug and alcohol abuse. Acute hospital beds is not the correct place for such support to be provided. Further interim facilities are also required to meet the needs of this cohort of patients, together with specialist support being available.

- Patients are assessed prior to discharge and if deemed appropriate a mental capacity assessment is complete to support the patients discharge. Patients are encouraged to make their own decisions regarding discharge.

- The Crisis Response Team works very well. Timed assessments are normally undertaken

within twenty four/48 hours; if further assessment is needed they are referred to Social Services. The Social Services assessment process must follow the Care Act; complex patients will take longer to assess, for example they may not have relatives, access to funds and mental capacity. In these specific situations, assessments may take considerably longer as an Independent Mental Capacity Advocate will have to be engaged before the patient can be assessed, if further interim placements were available in the Community these assessments could be conducted outside of the hospital.

- Patients over the age of 80 who spends 10 days in a hospital bed will lose 10% of muscle mass. This could be the difference between going home and going to a home. As of the 29th October 2018 there were 368 patients in Northampton General Hospital with a stay of over 7 days, 187 having been there for over 21days.

- NGH has an escalation process to support highly complex cases if required these are also escalated to the CCG and Social Services.

- Community Social Care Workers have to deal with high risk cases in the community, this has an added impact on patients waiting in hospital for a Community Social Worker. Community Social Care Workers caseloads are incredibly pressured with high volumes of community customers pending allocation.

- The CQC oversees the quality in care homes etc. Should there be safeguarding concerns such as financial, physical or emotional abuse they would be referred to the appropriate agency, Sometimes peoples' lives are chaotic and are not a safeguarding concern as to them it is "their norm."

- Avery Beds are provided by NGH, which is in close proximity to the hospital, this is a very expensive unit for the hospital to fund, these beds are used by the hospital to transfer patients while awaiting other services.

- Work with Social Services at Northamptonshire County Council is currently very good and joined up. There is a need for more joined up working with others such as Housing.

- The service and support provided by Northamptonshire Carers is excellent. An Officer from Northamptonshire Carers is based within the Discharge Team at NGH. Further resources in this area would be of great benefit to our patients in supporting discharges particularly for those that live alone,

St Andrews Hospital, Northampton

2.3 On Tuesday, 30 October 2018, Councillor Zoe Smith (Chair), Councillor Sally Beardsworth (Deputy Chair), Councillors Julie Davenport and Arthur McCutcheon together with Tracy Tiff, Scrutiny Officer, met with five Lead Social Workers and one trainee Social Worker based at St Andrews Hospital.

2.4 Key information gathered from the site visit:

- St Andrews is a charity organisation who treat patients from all over the UK. Patients are normally individuals that other providers have not been able to assist. Some patients have committed offences. There are around 600 patients on the Billing Road site and 800 across all sites. There is a very small percentage of private patients, the majority are funded by the NHS.

- Following the discharge route, patients may begin in a medium secure ward, then move to low secure before moving to locked and then discharge. Patients require support after leaving St Andrews until they move to their own home. Most are discharged from St Andrews into supported accommodation but there is often limited availability. A some patients may relapse due to the time it can take for appropriate accommodation and support to be found for them. Most patients discharged from SAH are not discharged to Northampton but will return to their home area.

- Any barriers in the discharge process are fed back via CPA reviews; an example of a barrier could be a patient does not need to remain in hospital but their care package is bespoke and expensive.

- It is aimed that patients return to the county that they came from but there are occasions where it is better for them to remain in Northampton. A referral meeting is held and a number of Agencies are involved. The laws in relation to ordinary resident status apply; an individual has to reside in a town for six months to be classed as an ordinary resident. Some

patients can't return to their home county due to issues such as exclusions, previous violence etc.

- There is a psychiatric intensive care unit at St Andrews. Patients come from all over the UK. It is usually a short term stay in the unit, 28-32 days. Once stabilised they move to a lower level unit within their own home town. There is a quick turnaround of patients in the unit. Most patients have one of the following:

  - Psychiatric breakdown
  - Drug induced psychosis
  - Bi polar

- Patients arrive by secure ambulance.

- A number of patients live with dementia. The patients are those who display challenging behaviour. They are funded by the CCG or by NHS England, depending on the level of security required.

- The young people's unit is for young people up to the age of 18. When the patient is 18 they move to adult services and less support is provided which can create problems.

- There are a number of private providers in Northampton which are mirrored in other areas. There is a need for a more joined up approach within care organisations in the community.

- There are lots of successes from the discharges from St Andrews, individuals leave feeling better about life.

- Patient from SAH would be extremely unlikely to move into local council accommodation

3 RECOMMENDATION

3.1 That the information provided informs the evidence base of this Review.