Briefing 17/20 May 2017

Insights into Social Care Practice

'Insights' is a series of case studies, intended to promote and share the good practice among APSE member authorities in delivering adult social care.

Luton Borough Council: Reducing DTOC rates attributable to Social Care

In brief:

In 2016, the number of Delayed Transfers of Care (DTOC) recorded as attributable to Social Care at Luton Borough Council was 40% of the average figure for local authorities across England and monthly reported figures are showing a decreasing trend (Fig.1) (LG Inform, 2017). In November 2016, the council was ranked number 1 within England for low DTOC rates, with a DTOC rate of 0. (LGA, 2017)

Over the last decade, the council has demonstrated leadership in ensuring smooth pathways out of hospital through commissioning a supply of step-down reablement, therapy and home-care facilities, facilitating an Integrated Discharge team, structured in such a way as to foster good-working relationships, developing a culture of collaborative working, supporting and developing a committed workforce.

What follows outlines the ways of working within Luton Borough Council's Discharge, Assessment and Rehabilitation team through which the council enables seamless transitions for local residents from hospital to home.

An Integrated Discharge Team

The Integrated Discharge Team for residents of Luton is a 100 strong team of Social Workers, NHS Discharge Managers Discharge Officers and Administrators and Cambridge Community Services Liaison Sisters, co-located within the Discharge Hub at Luton and Dunstable Hospital.

The team is managed by Marilyn George, Integrated Operational Manager at Luton and Dunstable Hospital who uniquely manages the work of all staff within the team, both staff of the Council and the Hospital Trust.

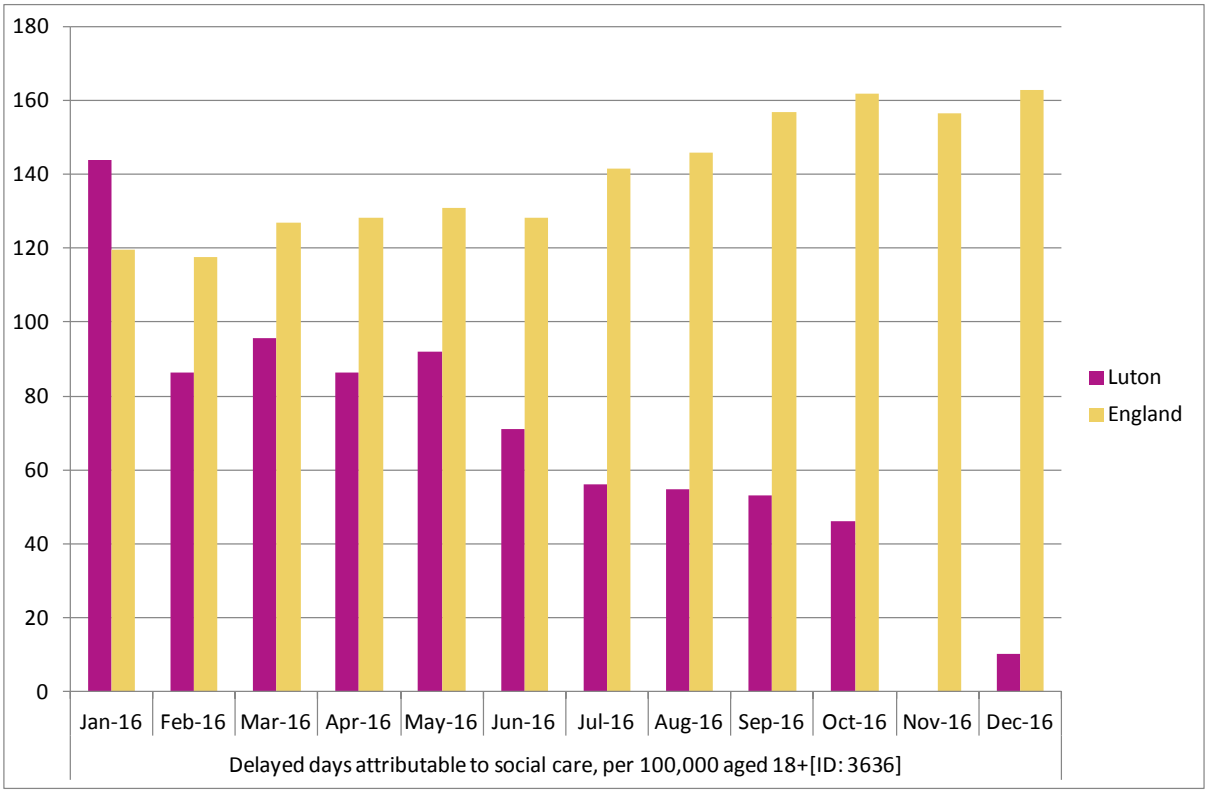


Figure 1 (LG Inform, 2017)

A social worker from the Discharge team is allocated to each ward and thus each build relationships with hospital staff working on the ward and experience and expertise in supporting the particular needs of the patients on that ward. Marilyn's role, jointly managing both staff at the Council and the Hospital Trust enables clear and consistent leadership of the team and consequently an effectively, 'joined-up' approach to managing patients' discharge from hospital.

Seven days a week, social workers form part of the Multi-Disciplinary Team (MDT) meetings on wards ('Board Rounds'), to discuss plans for the safe and efficient discharge of their patients. They also meet as a Social Work team every day to discuss any received 'Assessment Notices' from NHS colleagues, signalling that patients' care needs (and possibly their carer's needs), need to be assessed in anticipation of their expected discharge from hospital and to ensure that assessment duties are allocated between them in the most efficient and effective way

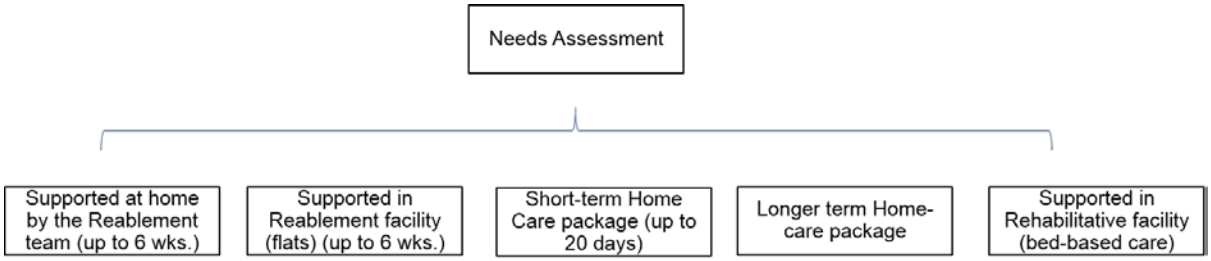
Through their contributions to MDT meetings and regular meetings as a Social Care team and through their location within the hospital itself, Luton Borough Council's Social Workers can act promptly on Assessment Notices, with a broader understanding of the patients' health needs and their health colleagues' concerns

surrounding the patients' discharge as they liaise with those who have taken responsibility for their care throughout their stay in the hospital.

Prompt action mitigates any delays and allows the identification of complex cases early, which in turn contributes to low DTOC rates, attributable to Social Care.

Pathways out of hospital

To enable Social Workers to ensure a smooth pathway out of hospital for patients, further to their assessment Luton Borough Council (LBC) have commissioned several key pathways from hospital to the community.



Reablement Team

The Reablement team is a team of Support workers who closely work with the hospital to safely manage the patient to be discharge in a timely way. The hospital Social Workers act as Trusted Assessors for the Reablement Team who, after discharge, will support patients at home to recover back to their base line and to independent living within their community. The Reablement Team will continue their link with the Social Work Team and if required a further Social care assessment can take place at the end of the patient's Reablement Journey.

Reablement Facility

Where patients may not be ready to return home, they may spend up to 6 weeks in one of Luton Borough Council's six Reablement flats where patients may receive more intense support from the Reablement team to prepare them to return to their own home.

Short-term Home Care packages

Luton Borough Council's Home Care Transfer Team are established to provide short-term care packages (up to 20 days) whilst the council's brokerage team are establishing appropriate arrangements for the patient's care needs in the longer term. This team has been established as part of the council's commissioned Home Care Framework and works effectively for those people not accessing the Reablement Service.

Longer-term Home-care packages

Where these can be established (or re-established) prior to discharge by the council's brokerage team this will be established and patients will return home, with longer-term home-care provisions in place.

Rehabilitative facility

Together, Luton Borough Council and Luton CCG have commissioned a therapeutic rehabilitative facility, with 20 beds where patients who continue to need bed-based care can continue their recovery for up to 6 weeks. Moorland Gardens' Nursing Home is staffed by Virgin Care Therapists and again, Social Workers are located within the nursing facility to enable smooth discharge in to the community.

With a broad range of step-down facilities, including an option of a short-term care package for 20 days, patients are able to smoothly transfer from their hospital bed, on to a more appropriate care facility for their needs, freeing up valuable hospital beds. Few are unable to be supported through one of these pathways, freeing the team to undertake the work necessary to also enable a smooth transfer in more complex cases such as where the patient has no recourse to public funds or no home to return to. Pathways within such situations are uniquely determined by the Discharge manager, according to the patients' needs in liaison with the council's Homelessness team and voluntary sector partners.

Leadership and Culture

Under-pinning the success of the team, is an exceptional commitment to delivering smooth transfers of care across the Trust and Council staff and throughout the community and partner bodies, a network of strong and trusting working relationships. In Luton, it is a work of a community of providers, staff, family, friends and volunteers around the patient that enables timely transfer from hospital to reablement or care.

The presence of social workers on hospital wards and the role, Integrated Operational Discharge Manager, bridging both bodies responsible for ensuring smooth transfer aids good communication, enabling a developed understanding among Trust staff about the processes and care pathways beyond the hospital doors and the co- location of staff facilitates early-planning for patient discharge, closely linked with clinician's directions.

Staff commitment also fosters a culture of early planning and a fastidious approach to preparing appropriately for a patient moving on from hospital care in to the care of Adult Services. As Maud O'Leary Director of Adult Social Care at the Council comments**, 'You have to be committed to be in it as the challenges are so great and in Luton, we're all in it'.**

Demonstrating the wider commitment to collaborative working between partners, monthly meetings of the 'Luton Primary Community and Social Care Delivery Board' are consistently well attended and all are committed to a practise of continuous improvement, regularly evaluating, tweaking and improving discharge processes.

A small home care framework, with 7 preferred providers enables the development of close- working relationships between commissioners and providers and coterminous boundaries for the Council and Clinical Commissioning Group limits the requirement for multi-directional communication and joint-working somewhat, providing an ideal context for good and productive working relationships.

The council's Executive member, Cllr Naseem Ayub is the Chair of Luton's Health and Wellbeing Board, demonstrating the council's commitment to taking a lead role in responding to the health needs of the borough and a pro-active approach to supporting colleagues in Healthcare to meet demands for NHS services This is seen also in the pro-active commissioning of such a range of patient pathways out of hospital, a step that recognised by officers as exemplary in responding to the demand on both the Council and Trust to enable smooth transfers of care.

'Patients and staff thrive in a committed and joined-up working culture and we are delighted that in a context of reducing resources Delayed Transfers of Care, attributable to Social Care are exhibiting a decreasing trend in Luton, for which we must credit our dedicated workforce and the foresight of long-serving, Council Cabinet members who have invested in making sure we have the right pathways of care from hospital to home'
– Sally Rowe, Director of Adult Social Services, Luton Borough Council

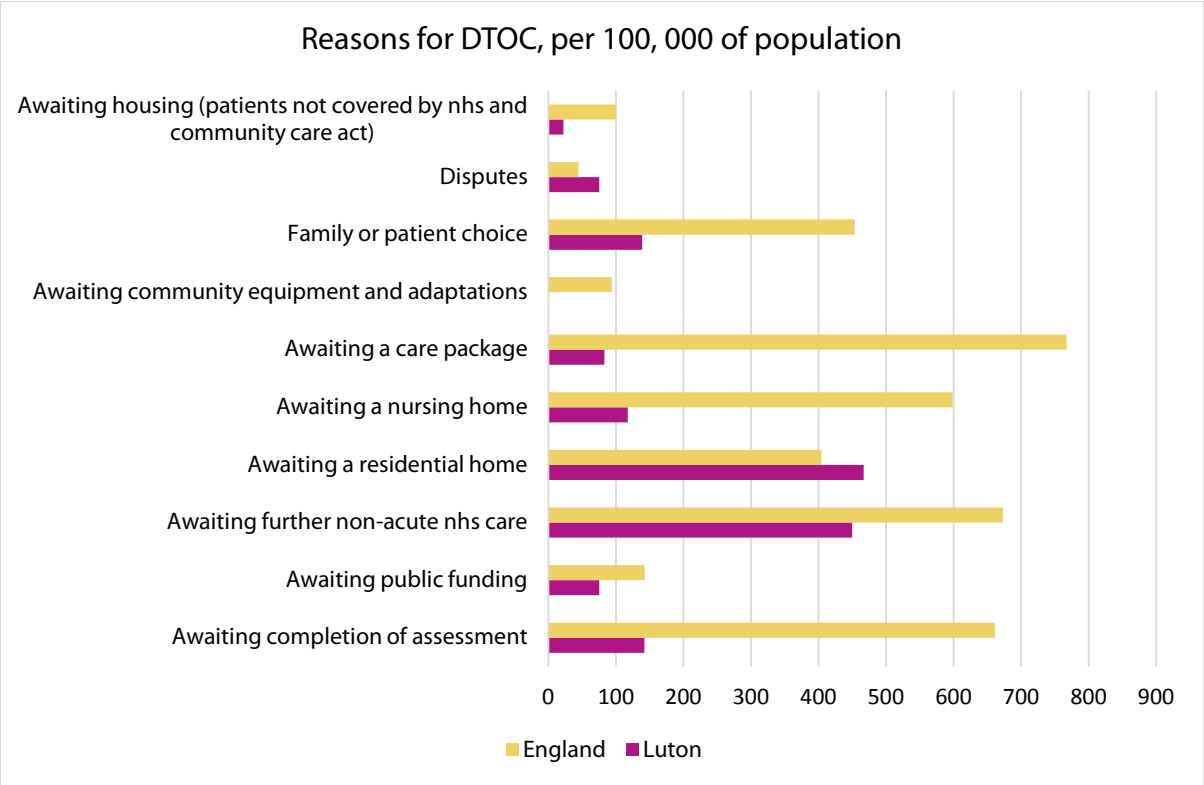


Figure 2 (LG Inform, 2017)

APSE comment

A recent Government, Statistical Press notice, 'Monthly delayed transfers of care data, England, December 2016' demonstrated a clear upwards trend in the number of delayed days across England with the total figure for December 2016, 73% higher than in December 2013 and the total number of days delayed attributable to Social Care in December 2016 140% higher than in December 2013.

Against this national picture and in a context of reducing resources for Social Care, Luton Borough Council's success in securing a downwards trend in DTOC rates is exemplary. Figure 2 shows the significantly smaller proportion of delays due to awaiting a suitable care page at Luton Borough Council in 2016, as compared to the National picture.

APSE would urge councils to consider their opportunity to reflect the approach at Luton Borough Council in providing a range of step-down facilities and in particular to commission short-term home care provision to compliment wider Home Care facilities and allow a longer lead-in time to successfully broker longer term care packages whilst freeing up a hospital bed. Equally to strive to replicate their integrated and collocated discharge team of council officers and hospital staff, responding as a homogenous team to Discharge and Assessment notices, two key components of the council's success.

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