STROUD DISTRICT COUNCIL
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Community Services & Licensing Committee
INFORMATION SHEET
28th March 2018

Briefing on Hospital Discharge Issues for Stroud District

This briefing was prompted by three things:

- A new Care Navigator scheme has been introduced in Gloucestershire to improve the hospital discharge advice.
- SDC were approached by Stroud Hospital's discharge technician for information about the services we provide that would be useful to patients returning home. This raised alarm bells for us as we have provided this information via various channels before.
- We were alerted to a new District Council discharge scheme running in Norfolk which was highly praised in the 'Medical Journal'.

This briefing sheet investigates the two models and outlines work we will do to improve the situation in our district.

I spoke in depth to the Norfolk Council officer in charge of their scheme. Broadly speaking I think the Gloucestershire model is better for SDC because the Gloucestershire Clinical Commissioning Group are funding it our new scheme.

Norfolk 'District Direct' in brief:

- 5 Norfolk districts put in a staff member a week to work in the hospital, giving housing, DfG, healthy community etc advice. This was DISTRICT funded – we could not do this.
- Patients are given a very sort survey on admission asking about their housing and personal care situation. The district staff then follow this up with detailed advice.
- The pilot had many positive outcomes for patients and freed up beds.
- Adult Social Care have given the Districts a bit of funding to continue but not enough to cover the whole service.
- They are not certain if their CCG will fund them.
- Getting into the hospitals and getting agreement for the pilot to happen was extremely hard work and took the Norfolk officer a very long time.
- It feels like their districts had to shout about their services and put their own money in up front before the ASC/CCG would listen and I don't think Gloucestershire is in that situation at all.

In Gloucestershire:

- We have a very new system and it is a work in progress.
- We have new Care Navigators working out of our hospitals (including a manager)
    - 2 x Gloucester Royal
    - 1 x Cheltenham
    - 1 x Forest of Dean
    - 1 x North Cotswold and Cirencester
    - Tewkesbury will be recruited next
    - Stroud and Vale Hospitals after that.

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- They collate information that will be useful to patients and families when they return home.
- One navigator sees about 40 people a week.
- The CCG fund this along with some additional moneys associated with 'Warm and Well' to give energy/heating specific expertise.
- When it's **working** - patients and families get good tailored advice to help return home or to new accommodation with confidence.
- When it's **not working** – the Care Navigators hear about someone arriving that morning and they are leaving that afternoon. There is no time for a proper assessment or advice.
- The Care Navigators rely on contacts with local knowledge especially for the rural areas where they do not have the expertise. Our HWB Partnership in Stroud will be essential to our Care Navigator when they are in post.

From our District's point of view:

- Several of our teams need to know about hospital discharges to signpost and maximise numbers for our services eg. DfGs, Healthy Homes, community activities for health/isolation/carers.
- Other teams need better communication with Hospital Discharge staff to avoid wasting our officers time or dealing with panic situations eg. Sheltered Support workers chasing around to find tenants, Housing Advice finding emergency accommodation.
- It's important that we maintain clear communication with our care navigators to ensure they have all the info they need and don't waste time ringing round a lot of agencies when they could come straight to a known contact at the Council.
- The Gloucestershire Care Navigator Manager I met liked the sound of Norfolk's short admissions questionnaire so we could use this with a bit of local tweaking.
- I feel we already have better relationships with our hospitals and Gloucestershire CCG than they appear to have in Norfolk.

Going Forward

The Stroud Hospital discharge technician was not aware of the new Care Navigator in Gloucestershire so I have put her in touch with their manager. They do not know when they will employing someone to cover the Stroud district but by starting to communicate now, we hope our local discharge process might improve.

I am also acting as the central point of contact for our local discharge technician if she needs to know something about an SDC service. Since our first meeting she has already called upon the services of the Neighbourhood Wardens for two people leaving hospital with no initial home support.

Our Stroud District Health & Wellbeing Partnership informs the Community Wellbeing Agents about local services and activities that could be useful to patients. I have added the Care Navigator manager and our local discharge technician to our mailing list so they receive the same local information.

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