

**London Borough of Hammersmith & Fulham**

**CABINET**

**4 SEPTEMBER 2017**



**NORTH WEST LONDON HOSPITAL DISCHARGE - JOINT WORKING AGREEMENT**

**Report of the Cabinet Member for Health and Adult Social Care – Councillor Ben Coleman**

**Open Report**

**Classification: For Decision**  
**Key Decision: Yes**

**Wards Affected: All**

**Accountable Director: Stella Baillie, Tri-borough Director for Integrated Care**

**Report Author: Arkut Senel - Head of Hospitals & CIS,**

**Contact Details:**  
Tel: 020  
E-mail: Senel.Arkut@lbhf.gov.uk

**1. EXECUTIVE SUMMARY**

- 1.1. The West London Alliance (WLA) is leading on a programme of change across North West London (NWL) to improve the service that residents receive when being discharged from hospital. To enable this change, five of the eight NWL boroughs are collaborating to provide a more consistent service and maximise the efficiency of existing resources by working more closely together.
- 1.2. Through the collaboration of a number of different local authorities in North West London the programme aims to improve outcomes for people being discharged from hospital, including the residents of Hammersmith & Fulham (H&F). The changes will provide a more consistent transfer of care service in NWL for the residents of all partner boroughs, irrelevant of the hospital attended.
- 1.3. The WLA programme naturally progressed from the work undertaken in Hammersmith & Fulham, Royal Borough of Kensington & Chelsea (RBKC) and Westminster City Council (WCC) in 2015/16 to bring together the different hospital teams to act as one single adult social care hospital discharge function. This programme has shown a number of benefits for patients, for each local authority and for the system as a whole.

- 1.4. The benefits to be gained, as shown by the work already completed, can be divided into the following categories:
- Patient outcomes: a more consistent service supporting Hammersmith & Fulham residents
  - Staff efficiencies: a more effective and efficient use of Hammersmith & Fulham staff to support service users
  - Reduction in delayed transfer of care from hospital (DTC)
- 1.5. Previous to this work being completed, Hammersmith & Fulham residents who attended Chelsea and Westminster and St Mary's hospital did not have a social care team within the hospital site to support them. The Hammersmith & Fulham team were required to support the residents admitted to the hospital from their base in Charing Cross hospital, often needing to travel to the relevant site.
- 1.6. This led to an inconsistency in the level of support that could be provided at these sites compared to Charing Cross hospital. Hammersmith & Fulham social workers were not able to attend the wards as frequently in St Mary's and Chelsea and Westminster hospital and were not integrated with the hospital team as they were in Charing Cross.
- 1.7. Moving to a collaborative service enabled the WCC and K&C social care teams to manage the H&F discharges at these sites, providing an onsite service. This has enabled a more consistent and more effective service for H&F residents at these sites, improving their outcomes during and after discharge.
- 1.8. Prior to this change, as well as H&F residents attending St Mary's and Chelsea and Westminster hospitals receiving a poorer service, there were inefficiencies in managing the discharges from these hospitals. Staff were required to travel between hospital sites which required 1hr to a 1.5hr return journey time. Not being located on site also caused communication issues with the hospital teams and limited the establishment of successful professional relationships with the trust staff.
- 1.9. The inefficiencies are difficult to quantify. However, between April 2016 and March 2017, 5,396 adults from Hammersmith & Fulham were admitted for unplanned care to St Mary's and Chelsea and Westminster hospitals, of which 2,266 were aged over 65. Many of these residents would have required support from social care<sup>1</sup>, and by launching the new service the inefficiency issues mentioned above were removed for these cases.

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<sup>1</sup> Detailed data for 2017 social care case activity has not been collated. However, data for a similar 12 months over the period of January 2016 to December 2016 shows that 824 cases (potentially requiring multiple visits to the acute site) were opened for H&F residents admitted to St Mary's and Chelsea and Westminster hospitals. The team would have also supported other residents and acute staff with general information and advice which may not be included within the case numbers.

- 1.10. Delayed transfers of care (DTC) refers to the number of days after a person in hospital is deemed 'medically fit' before they are discharged. These days are a high cost to the health and care economy and cause a negative impact on patient outcomes and the level of long term care that they will require after discharge. Although not obligatory, the acute trusts are entitled to seek reimbursement of £150 for each delayed day that is attributed as the responsibility of Adult Social Care.
- 1.11. The new approach was launched in March 2016 and in the 12 months following this (April 2016 – March 2017) delayed days due to ASC shared service assessments in hospital were 807. For the same period in the previous year (April 2015 – March 2016) the delayed days due to ASC shared services assessment in hospital were 738. Although this shows an increase of 9% this is significantly lower than the national average of 39% for this time period; the higher DTC levels for 2016/17 can be attributed to the extreme pressure over the winter period compared to a much milder winter in 2015/16.

Furthermore, when focusing on the Imperial sites only (i.e. the sites impacted by this work) DTC has dropped by 9% and 8 of the 12 months saw zero DTC days for ASC assessments in this period, compared to 4 of the 12 months in the previous period. This provides clear evidence that the introduction of shared working has reduced delays in Charing Cross and Hammersmith hospitals.

- 1.12. Based on the learning from this work and the evidenced benefits, the programme is looking to expand the arrangement to the London boroughs of Brent and Ealing, which will and provide an even wider level of support to the residents of Hammersmith & Fulham.
- 1.13. To support this work, this report is asking the cabinet to approve a set of legal agreements that will allow staff from each Local Authority to operate on behalf of each other and to allow the sharing and processing of data between the local authorities.
- 1.14. The approval of these agreements is the key dependency remaining. Expansion of the model to Brent and Ealing could be launched within a matter of weeks after these agreements are approved.

## **2. RECOMMENDATIONS**

- 2.1. To approve the WLA (West London Alliance) Hospital Discharge Joint Working Agreement, WLA Hospital Discharge Data Processing Agreement and the Section 113 that underpins the joint hospital discharge service the boroughs of Hammersmith & Fulham, Royal Borough of Kensington and Chelsea, the City of Westminster, Brent and Ealing.

## **3. REASONS FOR DECISION AND BENEFITS**

- 3.1. This decision will further expand the described model, increasing the level of benefits to Hammersmith & Fulham residents.

- 3.2. Expansion of the model to Brent and Ealing will expand support to a number of additional hospitals including Hammersmith hospital, Ealing hospital, Central Middlesex hospital and Northwick Park hospital. Between March 2016 and April 2017, 1,632 H&F residents were admitted to these hospitals for non-planned care. Under the new model these residents would have a greater level of support and a more effective discharge service.
- 3.3. Without expanding the model to the wider boroughs, Hammersmith & Fulham residents attending these hospitals will continue to receive an inconsistent level of support due to the geographical and operational realities across NWL hospital sites.
- 3.4. Expansion to Brent and Ealing will extend Hammersmith & Fulham's ability to centre care around the service user and support them in the wider hospitals across NWL. By collaborating across boroughs, the social care teams will provide on-site support for service users over a much wider geographical area, ensuring a more consistent level of high quality care to all the residents of NWL.
- 3.5. Specifically, the programme aims to achieve a number of service user outcomes, including:
  - Residents are supported earlier in hospital and are returned home from hospital sooner.
  - Better discharge planning means the right care will be set up in the community to support the service user after discharge.
  - Residents will have an increased input into their care and their future choices.
  - Residents will be provided with clear information about the care that they will receive and their future care.
  - Residents will only have to tell their story once.
  - A much more efficient allocation of staff and resource, removing the need to travel across multiple sites and reducing the amount of duplication and hand-offs across organisations and professions.
  - Fewer communication issues due to staff being located at different sites.
- 3.6. All of these outcomes will be measured for Hammersmith & Fulham and a six-monthly report provided to H&F's Cabinet Member for Health and Adult Social Care.

- 3.7. The new model will bring a reduction in the delays in discharging patients (estimated at a £1.5m saving for the NHS by 2020<sup>2</sup>) and a reduction in the number of readmission of patients (estimated at a £1.9m saving for the NHS by 2020<sup>3</sup>).
- 3.8. Studies have proven that DTOC days lead to an increase in the need for long term care after discharge, as does an increase in the number of days in hospital (e.g. due to readmissions). The National Audit of Intermediate Care shows that for older patients, 'a wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10 per cent decline in muscle strength'. This leads to an increase level demand on long-term social care services after discharge.

#### **4. BACKGROUND**

- 4.1. At present NWL and WLA residents across the eight boroughs can attend any one of 12 hospitals sites across London and are subject to eight different adult social care systems and health funding mechanisms and a myriad of community care providers including GPs, care agencies, nursing homes, etc.
- 4.2. To address these issues, the WLA programme team has been working with five of its member boroughs (Brent, Ealing, Hammersmith & Fulham, Westminster and Kensington and Chelsea) to agree a consistent approach to managing discharges and to propose a process of joint working that will allow the management of each other's discharge cases to be more effectively managed.
- 4.3. Following on from the work completed across H&F, RBKC and WCC, a joint hospital discharge service agreement has been proposed for these five boroughs as their residents attend a large number of the same hospitals across North West London, providing a clear case for collaborating and managing hospital discharges collectively.
- 4.4. A number of collaborative initiatives have already been completed; including alignment of processes and assessments across the five boroughs and co-location of staff within the hospital to provide a more integrated management of the different hospital sites. Social workers have also been identifying service users on behalf of partner boroughs to allow for earlier discharge planning.
- 4.5. To allow for a more comprehensive management of partner discharges, the WLA has through its Solicitors M/S Bevan Brittan LLP, drafted a joint working agreement, Section 113 agreement and data processing agreement to facilitate the joint working of the joint hospital discharge service across the five boroughs.

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<sup>2</sup> Estimates based on modelling work completed as part of the project business case; based on predicted DTOC reductions (using best practice and early data from pilots) and demand and population predictions. This is across the eight CCG's in NWL.

<sup>3</sup> As above for predicted readmission rates.

- 4.6. The joint working agreement, Section 113 agreement and data processing agreement will allow social workers from each of the boroughs to work across the boroughs, access key information about those residents that attend hospital and complete an assessment on behalf of a partner borough in order to facilitate a smoother and potentially quicker discharge from hospital.
- 4.7. Although the current level of collaboration is important, the boroughs are currently limited in the level of support they can provide as they cannot complete much of the activity that is required to discharge someone from another borough.
- 4.8. All preparation activity is complete and expansion to the full model is awaiting the approval of these working agreements.

## **5. PROPOSAL AND ISSUES**

- 5.1. This report proposes setting up a joint hospital discharge service across the five boroughs of Hammersmith & Fulham, Kensington and Chelsea, the City of Westminster, Brent and Ealing that will allow the processing of information and completion of discharge activity.
- 5.2. The proposal is to manage the joint service through a hosted model. The hosted model refers to each hospital site being managed by a single host authority on behalf of the partner local authorities. This host team will act as the primary social care representatives on site, acting as a key point of contact and holding primary management of social care cases.
- 5.3. Each hosted site will be resourced with staff from across each of the relevant boroughs. Each site will be resourced with the correct number of staff to manage the total number of discharges across the different boroughs and across the different sites.
- 5.4. Staff will be managed on a daily basis by the Team Managers of the host team; the Performance and Disciplinary management responsibility will be retained by the contractual borough.
- 5.5. A social worker will manage a case on behalf of another borough when directed to do so by the host borough's management team. This will be at the request of the host management team and through a direct agreement with that team.
- 5.6. The proposed agreements will allow staff to complete assessments on behalf of a partner borough when directed to do so and to share and process data on behalf of a partner borough.
- 5.7. The WLA's Director of Adult Social Care Board will provide senior oversight of the agreements. The ongoing service governance structure consists of weekly operational management groups and monthly strategic steering groups.
- 5.8. The proposed agreements also ensure that each party ("the indemnifying party") shall indemnify and keep indemnified the other parties ("indemnified party") fully against all third party claims that may be brought against or suffered by the

indemnified party arising out of any breach of the agreements by the indemnifying party.

- 5.9. The proposed agreements also contain clauses ensuring each party agrees to provide and share such information necessary to monitor and measure the overall performance of the joint discharge service; to ensure confidentiality; to ensure data protection; and to allow termination of the agreement by any party where it no longer meets requirement.
- 5.10. The proposed agreements will allow a collective approach to managing discharge more effectively across a complex landscape of acute hospitals.
- 5.11. To ensure an even distribution of responsibility across the boroughs, Ealing will be the lead borough responsible for coordinating discharges from Hammersmith Hospital on behalf of partner boroughs with on-site senior social worker support. Although the hospital sits within Hammersmith & Fulham boundaries, Ealing also have a large number of attendances to this hospital. At this current time no senior social work representation is available at Hammersmith hospital. The case management of H&F cases is completed by the management team at Charing Cross hospital, and all communication and escalation from the Hammersmith hospital staff must happen remotely to the team in Charing Cross. Under the new model, Ealing local authority will provide senior social work representation on site and take responsibility for the case management of H&F cases. This will provide a more effective social care service for H&F residents and a more effective team to work alongside acute colleagues.

## **6. CONNECTIVITY AND INFORMATION GOVERNANCE**

- 6.1. In the short term, all five partner boroughs will log in to the network of H&F, RBKC and WCC network directly and access Frameworki/Mosaic (and vice versa). Each staff member will log on securely with their own username and password. Access to each borough's systems will be gained through either partner borough IT equipment or NHS equipment using the standard virtual private network solution used by each of the boroughs. In the medium term, a shared portal solution is being developed. This will securely submit information back to the system
- 6.2. The data processing agreement ensures that a thorough approach to data governance has been taken. Only trained social workers will be accessing and processing data and will have been through all relevant data training activities. The ownership of the data remains with the borough the customer resides in and the agreements simply provide professionals from another borough with the ability to process the data on behalf of the home borough.
- 6.3. The agreement also outlines clear quality rules and processes for the escalation through the relevant governance structures where required.

## **7. OPTIONS AND ANALYSIS**

- 7.1. There are effectively only two options; (a) to continue with the existing arrangements and not extend the joint service to cover Brent and Ealing; or (b) to support the North West London proposal to extend the agreement to cover Brent and Ealing.
- 7.2. Option (a) maintains the existing service but would not enable the provision of the enhanced service to the 1,600 H&F residents admitted to Brent and Ealing hospitals a year.
- 7.3. Therefore, option (b) is the recommended option as it improves the support H&F residents will receive.

## **8. CONSULTATION**

- 8.1. The legal agreements have been drawn up in collaboration with the legal teams, information governance teams and Caldicott guardians of each of the boroughs<sup>4</sup>.

## **9. EQUALITY IMPLICATIONS**

- 9.1. There are no equality impact implications.

## **10. LEGAL IMPLICATIONS**

- 10.1. The report brings out the benefits of setting up a joint hospital discharge service across the five boroughs of Hammersmith & Fulham, Kensington and Chelsea, the City of Westminster, Brent and Ealing. To facilitate setting up and operation of such joint hospital discharge service a suitable Section 113 agreement, joint working agreement and data sharing agreement enabling joint working across the five local authorities has been drawn up in consultation with both legal and information governance teams within each borough.

## **11. FINANCIAL AND RESOURCES IMPLICATIONS**

- 11.1. The total resourcing of each borough's hospital team will not be changed based on this proposal. The model set out here will not cost Hammersmith & Fulham anything extra.
- 11.2. Resources will be distributed to match the collective demand at each of the hospitals; including the number of resources supporting hospitals within own boroughs and resources allocated to hospitals hosted by other boroughs. Demand will be monitored regularly and changes to resourcing agreed collectively through the governance structure.
- 11.3. Resources will be allocated to reduce the negative impact of managing out-of-borough hospitals and improving the collective efficiency of the workforce across partners.

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<sup>4</sup> A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian;





*Stella Baillie*  
**Tri-borough Director for Integrated Care**

Cleared by Finance (officer's initials)	<i>[Rachel Wigley]</i>
Cleared by Legal (officer's initials)	<i>[Babul Mukherjee]</i>

**Local Government Act 1972 (as amended)**

**Background papers used in the preparation of this report**

None

**Contact officer(s):**

Rob Skipwith  
Service Development Manager, Adult Social Care and Public Health  
Hammersmith & Fulham | Kensington & Chelsea | Westminster

4<sup>th</sup> Floor, Town Hall Extension  
King Street, Hammersmith  
London W6 9JU

Tel: 020 8753 5450

***Detailed description of service***

1. The Parties agree that the hospital sites where the ‘hosted model’ will be implemented from the Commencement Date will be;

<b>Hospital</b>	<b>Host Authority</b>
Charing Cross	London Borough of Hammersmith & Fulham
Northwick Park	Brent
Ealing	Ealing
Central Middlesex	Brent
Hammersmith	Ealing
St Marys	Westminster City Council
Chelsea and Westminster	Royal Borough of Kensington and Chelsea

2. The hosted model refers to each hospital site being managed by a single Host Authority (see above) on behalf of the partner local authorities. This host team will act as the primary social care representatives on site, with responsibilities including:
  - Key point of ‘on site’ contact for the hospital staff for all five boroughs.
  - Co-ordination of support for the MDT processes across the WLA.
  - Additional route of escalation for WLA cases for each of the boroughs (please note that this will only be for cases where the direct escalation route to the borough has been unsuccessful).
  - Reciprocal case management of cases on behalf of partner boroughs.
3. The Host Authority shall appoint a manager for the service at the Hospital.
4. The Host Authority and the other Parties with staff at the Hospitals shall, enter into Section 113 agreements in respect of staff based at that hospital to enable the mutual making available of staff to provide a unified team to carry out discharge assessments for all Parties.
5. Each site will be resourced with the correct number of staff to manage the total number of discharges across the different boroughs and across the different sites. To ensure an equitable coverage of discharges across the boroughs, a number of staff will be moved to sites that are hosted by other boroughs. The resourcing of the sites will change throughout the course of this agreement to match demand and ensure equity across the boroughs.
6. The Host Authority's appointed manager will be responsible for managing the caseload and day-to-day line management of staff at each hospital site, including staff from the other Parties. The overall line management of staff will remain with the borough management team of the borough to which they are employed.

7. The case management of the staff at the hosted sites is to be managed by the host management team. This management would allow for the different borough staff to manage discharges and complete assessments on behalf of the other boroughs, based on the level of demand for each borough at the hospital/to align to the ward allocations that can be shared across the five-borough team.
8. A social worker will manage a case on behalf of another borough when directed to do so by the host management team. This will be at the request of the home borough management team, through a direct agreement with the host borough management team.
9. The handover of a case to a social worker from a partner borough will be in agreement across the team managers of the two relevant boroughs. The home borough team manager will contact the relevant host team manager and request a case is picked up. The host manager will agree or reject the request. If the request is granted the host team manager will indicate which worker is to pick up the case, and this worker will be assigned this case by the home borough.
10. The worker will manage this case until discharge at which point they will hand the case back to the home borough manager (or duty manager). The home borough can request that the host borough hand the case back to a specific home borough social worker if required at any point through the hospital journey.
11. The following outlines the key activity that will be completed by social care staff in managing cases of discharge on behalf of partner boroughs:
  - Visits to and communications with service users within the hospital
  - Communication with carers and/or family in regard to a service user's care
  - Communication with hospital staff in regard to relevant cases that require social care support in the hospital
  - Attendance at Multi-Disciplinary Team meetings discussing discharge, board rounds or any other group discussions regarding a service user
  - Assessment of service user's care needs (both short term needs and ongoing care needs)
  - Completion of social care assessments (including financial assessments where required)
  - Completion of care plans to document a service user's needs after discharge
  - Case management activities to ensure an effective and efficient process to discharge a service user safely back to the community
  - Attendance of decision panels or boards where relevant
  - Communication with brokerage teams to establish follow-on care
  - Submission of purchasing requests for follow-on care

- Communication with community care teams to hand over care responsibility
- Submission of referral forms to establish follow-on care
- Communication with residential or nursing home managers to establish and confirm follow on care.

12. The expectations of people working in the matrix are:

- **To be clear about workload.** This includes clarifying with all managers how much time is allocated to each task and deadlines. All the individual's managers have to be clear and agree how the time is split between these activities. These agreements have to be shared with the WLA Programme Manager. Managers hold their reports to account about how much time is actually spent on the various tasks.
- **To be clear about the tasks.** If conflicting messages are passed on about what needs to be done and by when, it is the individual's responsibility to escalate contradictions to the managers involved and seek clarity.
- **To be clear about accountability and ownership.** An individual's managers have to clarify to the individual who the owner is for allocated actions and who is ultimately accountable for their completion. If an individual (manager or not) does not complete an action, this is a performance management issue and has to be escalated to that individual's line manager, as well as to the manager who allocated that action.

13. Escalation routes are used to raise any issues or concerns. Within the local authority hospital social care teams these usually include performance management and risks.

- Performance management is the responsibility of everyone in the organisations involved in the five-borough hospital discharge function. All managers must recognise that effective performance management is their responsibility.
- Risks are to be considered at the outset, and mitigation built into the plans to deliver service plan objectives.
- Whenever an individual identifies a risk, they need to highlight this as soon as possible to the relevant manager, who will take appropriate action to mitigate/manage/escalate it.
- All staff are responsible for raising issues of any kind
- In particular, managers and senior staff are responsible for addressing the issue, when they come to know about it, supporting the staff who are facing it and liaising with other staff who can help solving it. In the case of issues that affect more than one borough, after the escalation, senior members of staff are responsible for liaising with the relevant boroughs to find solutions.

- Issues that affect multiple boroughs are discussed at the weekly steering group, which acts as an open forum to reach agreements, discuss mitigations and find solutions.
- Each individual is encouraged to escalate any issues to their own team managers and the team managers of the boroughs affected by the issue (where relevant).

14. For the avoidance of doubt grievance, discipline, pay review and promotion are reserved to the employing party.

15. The output from the discharge process is a recommendation to the responsible authority for the patient, and is not delegated to the discharge team.