Adults Children and Education Scrutiny Commission

28th January 2019

Report of: Director Adult Social Care

Title: **Winter Resilience**

Ward: **City Wide**

Officer Presenting Report: Terry Dafter: Director Adult Social Care

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Recommendation:

The Scrutiny Commission are asked to note the work undertaken during 2018 to prepare for pressures on the two local acute hospitals over the winter period.

The significant issues in the report are:

Last year the pressures on the acute hospitals in Bristol in terms of Delayed Transfers of Care were considerable and Bristol was one of the poorest performing Local Authorities in the country.

Following interventions by NHS England work has been undertaken on a number of key areas of concern, including reablement, social work capacity and the creation of an Integrated Care Bureau and a Home First service.

The impact of these measures is outlined in the report in terms of performance data over the Christmas and New Year period.

1. Summary

1.1 Work has been ongoing over the last ten months to improve and create new services to address the winter pressures around Delayed Transfers of Care. This report outlines the actions taken and the impact so far on performance.

2. Context

2.1 In terms of definition a 'delayed transfer of care' occurs when a patient is ready to leave hospital or similar care provider, but is still occupying their bed. Delays can occur when patients are being discharged home or to a supported care facility such as a residential or nursing home. Delayed transfers, or DTOC, can cause considerable distress to a patient and their families and affect waiting times for NHS care as ultimately the number of beds available for other patients is reduced.

2.2 NHS England defines a patient as being ready for transfer when:

- a clinical decision has been made that the patient is ready for transfer
- a multi-disciplinary team has decided the patient is ready to transfer and
- the patient is safe to discharge/transfer

2.3 The proportion of delayed transfers of care due to social care has risen steeply since 2015, but the majority of delays are still attributed to the NHS. While the system requires that delays are attributed to either social care or NHS this can often be too simplistic when applied to the real world. Patients can be delayed waiting for onwards 'step down' care for example, such as intermediate care, which is often jointly commissioned and provided. There may be delays waiting for support for equipment such as hand rails to be fitted at home or there may be disagreements with families concerning where a patient should be transferred or waiting for a residential home of choice. This results in national data on the reasons for delays being collected in several categories: The largest numbers of delays nationally in 2016/17 were attributed to people awaiting a care package in their own home, with people awaiting completion of an assessment of their needs also figuring highly.

2.4 Reducing delayed transfers of care has been a key focus of recent national policies, especially in relation to the Better Care Fund (BCF), which is a pooled budget aimed to help Councils and the NHS plan together to deliver local services, aimed at keeping patients out of hospital and improving integration. The conditions for spending the BCF are straightforward:

1. Plans must be jointly agreed
2. NHS contribution to adult social care must be maintained in line with inflation
3. Agreement to invest in NHS commissioned out of hospital service which may include 7 day services and adult social care
4. Managing transfers of care ensuring people's care transfers smoothly

2.5 The BCF in Bristol amounts to £32.437m with the amount dedicated to social care coming to £18.248m. On top of this, the government introduced an Improved Better Care Fund (iBCF) in the 2015 spending review which is a grant paid direct to local government with a condition it is pooled into the BCF plan. The iBCF is paid directly to the Council as a grant with three purposes:

1. Meeting adult social care needs
2. Reducing pressures on the NHS
3. Ensuring the local social care provider market is supported

2.6 There is no requirement to spend across all three purposes or to spend a set proportion on each.

2.7 It is through use of the BCF and iBCF that investment in services to address the problems in Bristol has been maintained.

2.8 Last winter the number of delays in Bristol was relatively high, to the point where in some months the Council was among the third worst performing authorities in England. Delays attributed to social care were mainly due to awaiting packages of care, though waiting for social care assessments was also problematic. The position was so challenging that an intervention by NHS England was required: this was through the commissioning of a short term piece of consultancy work by Newton Europe who undertook a 'deep dive' review of some of the background data around DTOC and made a number of recommendations. These recommendations mainly focused on the capacity of our reablement service and the flexibility of the social work teams to undertake the required assessments of need. General availability of home care support was also a contributing factor.

2.9 On the back of this poor performance and making use of iBCF and BCF funding, the following initiatives have been introduced.

2.10 <u>An Integrated Care Bureau</u>

There has been significant improvement since October 2018 with the launch of the Phase 1 virtual Integrated Care Bureau (ICB) across Bristol, North Somerset and South Gloucestershire. This offers a single point of referral for people leaving hospital and so offers a much more streamlined process for patients and for hospital staff. The bureau has focused on hospital discharges and a move to a single referral form across health and social care. The single referral form has proved particularly helpful in providing the basic information required to make an informed decision on how best to facilitate discharge.

Performance information to date has shown reductions in duplicate referrals and, whilst not fully quantifiable, indicates a significant reduction in the length of time to discharge patients who need additional support to leave hospital.

2.11 <u>Increased capacity in Reablement</u>

Reablement is a key element in helping people leave hospital. A short term period of intensive support for up to six weeks can ensure someone is successfully placed back at home, often without need for further involvement. The view from Newton Europe was that there was insufficient capacity in the service to meet the level of demand so what was required was both an increase in the number of staff and a review of the length of engagement with each particular individual. In other words a more intensive, but shorter reablement offer could be just as effective as a more protracted episode. Moreover there was an over-reliance on paper and traditional office files underpinning the administration of the service.

The outcome of this has been an expansion of the reablement team by just under 20 full time posts and an ongoing recruitment campaign has been launched. Work has also commenced reviewing the level of involvement around each referral and staff teams have been engaged in looking at their operational practices and their offer as a service. Alongside this there is a move towards equipping staff with more mobile technology and a computerised rostering system linked to the client database.

Another challenge for the service has been that once someone has been successfully reabled, a lack of capacity in the home care market has meant it has proved difficult to close a case if ongoing home support is required from the independent sector. Efforts have been made to remedy this situation but it is still proving challenging in some parts of the city.

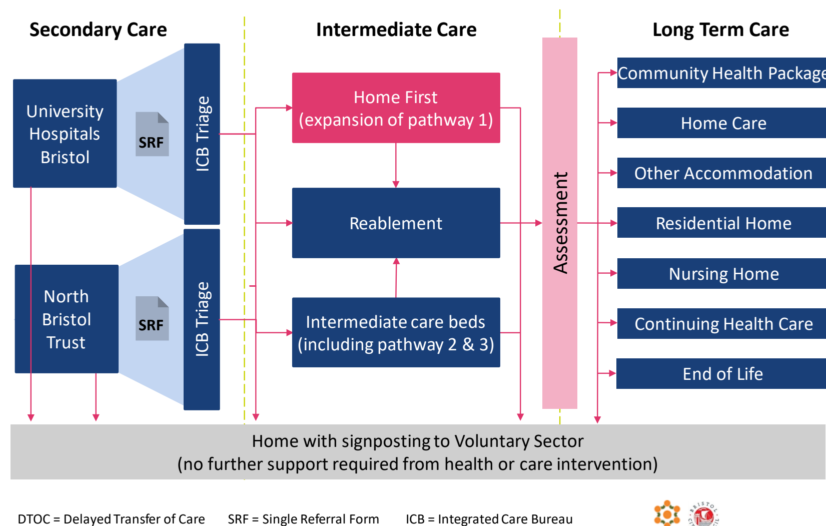
Overall, however, there is evidence that the reablement teams are now more able to meet demand and have become more efficient in their processes and administration. This whole approach is a key workstream within the Better Lives Programme.

2.12 Social Work Capacity

Data from the Newton Europe exercise demonstrated that while there was sufficient availability of social workers for most of the year, at times of peak demand the service was not able to cope and delays in assessments quickly mounted. To address this issue a small team of social workers was created to work across both hospital sites depending on need. Interestingly the Newton Europe exercise also showed that social workers spent on average just over a day a week chasing inappropriate referrals made by hospital staff incorrectly judging that a social worker was needed to facilitate someone's discharge. The creation of the Integrated Care Bureau has gone a long way to address this issue.

Despite the creation of this team the problem of people waiting for a social work assessment remains a challenge in terms of the DTOC data. Bristol still seems to be an outlier with respect to this indicator and work is being undertaken to understand why this is happening, given the overall improvement in performance over the recent period. It is felt that this may be due to the way certain circumstances are categorised and recorded but more work is required.

2.13 Home First Service



The other major exercise undertaken this year has been the creation of a Home First service. The diagram above outlines its position within the system: fundamentally it means that when someone is deemed fit to leave hospital they are sent home where the assessment for any future services is undertaken. This reduces the demand on the hospital and also means the assessment is undertaken in a much more relaxed environment outside of the ward setting. The model, which continues to evolve in Bristol, looks to maximise a patient's rehabilitation and reablement potential and delivers positive outcomes through targeted short-term interventions. This approach allows for a more complete discharge to access model to be applied right across health and care reducing social care's overreliance on undertaking assessments in an acute setting and waiting for long-term care packages straight from a hospital bed.

While the service has only recently started and is still not fully staffed, early evidence indicates that the model has huge potential to make a positive difference to the system. Around 226 service users have started with Home First (around 28 a week) and it is slowly expanding. Interestingly, and surprisingly, only 2% of people referred have required a Tier 3 package of Home care in the medium term, an indicator we will be closely monitoring over the next few months.

2.14 Performance through the winter so far

Adult Social Care, in collaboration with the CCG, have committed the BCF and iBCF to create the services outlined above. We have also used the funding to increase the price paid for independently provided home care, which has helped increase availability over the last 12 months. So far the outcome has proved very positive and the performance compared to last and previous years is set out below in the two slides from a recent presentation to the Urgent Care Oversight Board.

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

NBT Christmas 2016 - 2018

	2016	2017	2018
(NBT) 4 hour performance	78.1%	68.6%	86.5%
(NBT) Number of Attendances	222.2	234.7	245.9
(NBT) Number of Emergency Admissions	117.7	128.0	157.4
(NBT) Number of Discharges - Emergency	114.5	123.1	156.8
(NBT) LOS > 14 Days 2018	274.2	302.7	192.2
(NBT) G&A bed occupancy for acute hospital / community beds at 1000	no data	98.0	91.8

- Table is conditionally formatted to show comparison of numbers between each year rather than against a static target.
- Data refers to an average of the Christmas period only. This is a 4 week period from early Dec to early Jan.

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NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Group

UHB Christmas 2016-2018

	2016	2017	2018
4 Hour Performance Trust %	81.8%	83.3%	84.5%
4 hour performance BRI %	75.6%	73.2%	75.2%
(UHB) Number of Attendances BRI	175.8	189.9	191.7
(UHB) Number of Emergency Admissions BRI	73.5	80.4	79.6
(UHB) Number of Emergency Discharges	76.5	74.0	91.4
(UHB) BRI LOS > 14 Days	127.6	111.2	101.1
(UHB) G&A bed occupancy for acute hospital / community beds at 1000	n/a	91.9	88.0

- Table is conditionally formatted to show comparison of numbers between each year rather than against a static target.
- Data refers to an average of the Christmas period only. This is a 4 week period from early Dec to early Jan.

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The above slides show that while in general activity around the number of admissions to the two hospitals has remained high, performance in terms of length of stay and bed occupancy has improved. This shows that there is little sign of the hospitals being blocked by people not being able to leave. It should also be noted that hospitals operate

at what are called OPEL levels, with Opel 4 being the one that is called when the hospital is extremely challenged with respect to attendances and discharges. When at Opel 4, daily calls are required between key stakeholders and all services are escalated to try and deal with the situation. So far through the winter neither of the hospitals have hit Opel 4 and most of the time they are at Opel 1 and 2 with the occasional blip towards Opel 3. This is in stark contrast to last year when Opel 4 was happening frequently and awaiting packages of care was seen as one of the prime reasons for the problem.

Bristol is not alone in having improved figures as it would appear that nationally and regionally the picture around DTOC is much better. However it is reassuring to see the measures introduced have made a difference and it is to be hoped that the improving picture will continue through the remaining months of winter.

3. Policy

3.1 This work relates to the strategic themes of the Corporate Plan around Empowerment and Caring. The recent corporate peer review also tasked the council with improving its DTOC performance.

4. Consultation

a) Internal

Not applicable

b) External

Extensive consultation has been outlined with the CCG and other stakeholders across the health system.

5. Public Sector Equality Duties

a) Before making a decision, section 149 Equality Act 2010 requires that each decision-maker considers the need to promote equality for persons with the following “protected characteristics”: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. Each decision-maker must, therefore, have due regard to the need to:

i) Eliminate discrimination, harassment, victimisation and any other conduct prohibited under the Equality Act 2010.

ii) Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it. This involves having due regard, in particular, to the need to:

- remove or minimise disadvantage suffered by persons who share a relevant protected characteristic;

- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of people who do not share it (in relation to disabled people, this includes, in particular, steps to take account of disabled persons' disabilities);

- encourage persons who share a protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

iii) Foster good relations between persons who share a relevant protected characteristic and those who do not share it. This involves having due regard, in particular, to the need to:
- tackle prejudice; and
- promote understanding.

b) This work is inclusive and reaches out to vulnerable adults and older people ensuring they are able to return home from a period in hospital safely and with appropriate levels of support based on their needs.

Appendices:

Appendix A - Newton Europe Report

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985
Background Papers:

None