Health Scrutiny Committee (Sub-committee of the People Scrutiny Commission) 11 March 2020

Report of: Adult Social Care and BNSSG CCG

Title: **Response and Proposed Actions to ongoing pressures from our Hospitals**

Ward: All

Officer Presenting Report: Ros Cox, Head of Service Hospitals, D2A, Access and Response and First Social Work area Teams

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Recommendation

1) Note the exceptional actions taken so far to address the pressures at from hospital and the ongoing pressures that puts on adult social care
2) Note the level of positive partnership working demonstrated between Health and Care to address the pressures
3) Comment on and approve the actions set out below as a way of taking a strategic medium term approach to addressing the problem as opposed to continually 'fire fighting' by moving to a Discharge to Assess model for supported discharge from hospital

Summary

With the introduction of the integrated care bureau and the significant pressure that the system has seen from acute hospital providers this winter we have seen an increased demand, which is now unsustainable.

The pressures, specifically on social care, will force residents, previously unknown to social care, into emergency long term packages and placements if we do not work more closely across health and social care to deliver a jointly designed and funded 'Discharge to Assess' model of care. The solutions need to be built system wide and requires strong leadership, partnership working and permanent reallocations of our shared limited resources. By focusing on creating the right levels of community based intermediate care provision, both 'step up' and 'step down' to, first avoid a hospital admission wherever possible, and secondly to reduce the time spent in hospital when an admission is unavoidable. The report sets out actions and steps required to deliver on a Discharge to Assess model.

The significant issues in the report are:

- Addressing ongoing pressures from constant escalation at the hospitals due to high levels of attendances and admissions

1. Policy

The focus of this paper is to update on working across the health and social care to support early supported discharge from hospital. Whilst recognising the increasing pressure from the acute hospital the paper sets out future actions which align to national best practice for implementing a Discharge to Assess model of care that allows patients to be discharge as soon as medically able and have their ongoing care needs assessed for back in a community setting.

2. Consultation

N/A

3. Background

See attached paper

4. Other Options Considered

N/A

5. Risk Assessment

All actions proposed and taken in the paper attached comply with our social care responsibilities under the Care Act 2014

6. Public Sector Equality Duties

7. Legal and Resource Implications

Legal: no new legal implications

Financial

(a) Revenue: Actions have required additional resources from Adult Social Care to be committed. All additional capacity in intermediate care over winter has been fully funded by CCG £360k or by North Bristol Trust £240k. This funding has also covered some backfill into social work teams to meet the increased demand. However, there is an additional pressure on packages and placements out of the hospital which will be reviewed in March once the winter pressures period is over.

(b) Capital

Land

Personnel

Appendices: Appendix 1: Report: Response and Proposed Actions to ongoing pressures from our Hospitals

LOCAL GOVERNMENT (ACCESS TO INFORMATION) ACT 1985

Background Papers:
The work of Bristol Adult Social Care has regard to the following policy and national guidance:

Legislation:

- The Care Act 2014
- Simple Guide to Care-Act and-DTOC
- NHS 10 year plan
- Health and Social Care Act 2012

Best Practice Guidance:

- New Developments in Adult Social Care (IPC)
- High Impact Change Model (ADASS, LGA, NHSE)
- quick guide for-promoting independence through intermediate care – NICE / SCIE
- quick guide for understanding intermediate care NICE/SCIE
- Intermediate care including reablement (NICE guideline)
- Intermediate care including reablement (NICE quality standard)
- Intermediate care (SCIE Highlights paper)

Appendix 1: Report: Response and Proposed Actions to ongoing pressures from our Hospitals

Current System Pressures

The situation locally with continuing pressures on both Southmead and Bristol Royal Infirmary hospitals is proving more challenging than at any other period in the last few years. This is partly due to increasing demand and demographic pressures, but also historical local system management and having a model which continues to manage and assess service users in an acute hospital setting. Currently the system does not have enough intermediate care capacity to provide the level of step up and step down provision Bristol residents now require to be supported home effectively and have their ongoing needs assessed back in the community.

Throughout the summer levels of activity have remained high, bringing constant pressure all year round, as opposed to a seasonal spike in winter. This year the levels usually experienced in the winter months have increased even further and the number of single referral forms produced at the hospitals requesting a supported discharge continues to grow.

Since Dec 2019 the system has been in and out of at Opel 4, the highest level of operational pressure that can be reported short of going to critical incident, which has also happened over this period. Opel 4 can mean extremely long waits in A & E (waiting times of 12 hours have been reported), as well as people treated in corridors and escalation wards opened. The numbers of people attending A&E are some of the highest ever recorded with a high percentages of those attending being admitted, when benchmarked nationally. As the wards become increasingly overwhelmed the pressures on the community and local authorities has grown with an expectation to discharge patients who have had shorter lengths of stay putting pressure on hospital social work teams, brokerage, commissioning and our local care market.

This sustained pressure has led to both the Health and Social Care senior managers working in closer collaboration to take action:

Actions taken during this period of sustained pressure

- Working in partnership we have increased the number of Home First (35 to 45 slots initially) and Intermediate Care as part of the Intermediate Care Project that Julia Ross asked Ros Cox to take a project lead on.
- Dedicated significant management time at all levels of the organisation to help resolve the pressures and to build the relationships at a senior level across the system
- Supported the commissioning of 21 extra step down P3 beds over winter (including piloting 4 ECH flats) utilising health funds through winter pressures and money redirected from acute trusts.
- Minimised the impact on the numbers admitted to residential and nursing homes by seeking alternative solutions, such as the intermediate step down pathways and We Care and Red Cross support
- Where necessary BCC have increased the number of Social Workers using agency to bolster those parts of the system where assessments are overdue – however it is recognised skilled Social Workers willing to work in this pressured environment are limited and that Social work is best done in the community and not while someone is in crisis in hospital. Funding to do this was secured from health (£75k).
- Purchase more independently provided home care from current suppliers and others who may not be on our framework: again some prices quoted are higher than the Bristol rate and work will be done to recognise these increased pressures
- Increase in-house reablement activity with further investment and recruiting up to full establishment
- Developed alongside the BNSSG Out of Hospital Delivery Group possible solutions to complex system issues for the model into 2020/21
- Where necessary, we have had to place on some occasions at higher than the Bristol rate: those costs are being monitored and will be the subject of further discussions and review with the CCG

Moving towards a less reactive and more proactive solutions focused approach

While these last few weeks have undoubtedly been unprecedented and stressful for many, the importance now is to build on some of the solutions that have been developed and mainstream them into our business as usual, finding the permanent funding contributions in partnership with health. There are more systematic shifts needed and attention from health partners is starting to focus on admissions avoidance through community health workers and rapid step up services that prevent the need for a hospital bed. This work is essential as no system can sustain the levels of growth we have witnessed at the hospital indefinitely, with days where over 500 residents attend our two A&E departments when the system is only resourced to receive around 300.

All the actions taken so far have put further pressure on community social work and adult social care budgets. It is important to note that many of these actions have been made possible using temporary funding which does not present a sustainable solution and a permanent shift of resources needs to be found and agreed between BCC and CCG.

Transformational business cases are now being developed across the BNSSG system to support a shift in resources to allow these changes to happen. It will involve a shift in resources to increase our joint intermediate care capacity.

Existing work with system partners (CCG, Sirona, NHS Trusts)

The problem is not fixable by any one organisation. Transformation work has to be looked at and undertaken in partnership with health partners if long term solutions are to be found and to apply best practice being implemented elsewhere across the country.

Alongside the work across the system on t admissions avoidance there is already work underway to support step down from hospital:

Expanding capacity in intermediate care – Home First:

BCC led on a system wide review of intermediate care capacity. It concluded the need to move to a Discharge to Assess Model of care where full Care Act assessments only happens in hospitals by exception and that no permanent packages or placements are commissioned prior to a patient receiving the appropriate step down services in the community. Together with the CCG we want to commit to creating more Home First capacity (60 slots per week out of hospital and 18 step down slots) allowing for two thirds of all supported discharges to be supported by this default supported discharge service.

There is clear evidence that the Home First service helps maximises people's independence with 85% of service users remaining in their own home after receiving initial support. Only 5% require immediate long term care following a Home First discharge. By getting people out of hospital quickly before they become too reliant on hospital care, it ensures assessments are made in their own homes and not in a state of crisis in a hospital ward. BCC and CCG jointly found £1m to help the service get started in November 2018 using funds from BCF and iBCF. A permanent budget now needs to be agreed under the BCF as a matter of urgency to put this critical service on a stable footing and to allow for effective recruitment and service development to meet the targeted capacity required.

Re-profiling capacity in intermediate care – step down/step up beds:

BCC's review of intermediate care concluded that based on the need to support up to one third of supported discharges the Bristol system requires around 100 beds. These beds (like Home First) need to be put on a sustainable budget within BCF. Conversations with the CCG, who are the lead commissioners for this provision, are taking place now. Best practice indicates that we need a few dedicated provider units offering specialist step down beds where the right wrap around services (social care, therapies) can be made available to maximise patients' chances of returning home.

Redeveloping how community services and prevention is delivered in partnership:

Sirona take on the community contract from 1st April 2020. This presents an opportunity to review how our services align and how we structure our community preventative offer to meet Better Lives objectives. How we work with their planned locality hubs, frailty pathways and rapid response will all be critical in maintaining people in the community. One example of how this might be done is the initial work of looking at *Wellbeing Teams* to work alongside Primary Care Trusts to support multiagency teams in delivering traditional domiciliary care as well as social prescribing and reablement functions.

Internal BCC actions and review

There are a number of critical things for BCC to review. Business cases are being put together to take the following actions:

Domiciliary Care - Creation of a LA trading company in home care

This has been considered for some time but the market pressures now are such that the development of a trading company seems a strong option. The supply chain of home care remains the root cause of blockages out of intermediate care which is lessening the positive impact of moving to a discharge to assess model and forcing assessments to still take place in the hospitals. While the increase in the hourly rate from £15 to 18.20 in the past few years has helped stabilise the market, which had been at risk of total collapse, recruitment and retention issues remain a challenge and more work and input needs to be done. When prices are rising to anything up to £25 per hour the Local Authority (which already has an in house reablement service) is well positioned to create a trading company that offers good terms and conditions and attracts good calibre staff. The service could cover those areas of the city where it is difficult to currently procure care and help clear reablement blockages so it can work to its full capacity. Any in house provision would effectively be a provider of last resort that can be used much more flexibly. It would allow us the ability to set a market price rather than be completely market driven as is the case now. Moreover by using the Apprenticeship levy and seeing the company as an entry into social work or nursing or OT it may be possible to attract a broader range of staff. The in house provision and be dialled up as well as down to take account of what the private dom care market can deliver locally at any particular time.

Domiciliary Care – Market Facilitation

Over the last three years great efforts have been made to increase capacity in the market: three years ago the price paid for home care was around £15 per hour: this has been raised to just over £18 per hour and while this has stabilised the market to some extent, there are still problems in procuring sufficient numbers of hours that we need in Bristol. We are now wanting to move away from 'time and task' and the strict separation of care activities like reablement, social prescribing and domiciliary care. Best practice suggests that the support offered to residents who present with unmet needs should be more holistic and take every opportunity to build resilience and personalise outcomes for service users. We therefore want to move to a commissioned hours' model that allows us to make sure that care workers in Bristol are paid the living wage and that we are supporting the Ethical Charter. Commissioned hours assists us in working differently with the market and promoting a shift to a wellbeing model of care that provides the more holistic care residents need. We are building a business case therefore that looks at the implications of buying our care on commissioned hours rather than a task and time model: this should allow providers to pay their staff on a salaried basis and hopefully improve recruitment rates and retention. The cost benefits of this approach are still being confirmed.

Maximising the opportunities of our existing in house provision:

A review of all our in-house services - Unlike many other adult social care departments Bristol has managed to retain some in house provision. This is one of the reasons Bristol remains a relatively high spender on adult social care and so it is important therefore that we ensure maximum value for money from these precious resources. Given our need to shift our services away from paternalist focused care to a more outcomes based model that strives to support people to stay as independent as possible in their community, this in-house provision provides a great opportunity to test and learn. Work is under way to review Redfield and Concord Lodge, making use of external organisations with specialist knowledge of the market. With the new Sirona contract coming into effect from April, work will also be done to ensure maximum benefit is obtained in

integrating/co-ordinating reablement and community health care. This does not necessarily imply TUPE transfers but certainly there are benefits to be gained from developing closer working.