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Adult Care and Well Being Overview and Scrutiny Panel
Monday, 18 July 2022, 2.00 pm, County Hall, Worcester

Membership

Councillors:

Cllr Shirley Webb (Chairman), Cllr Jo Monk (Vice Chairman), Cllr David Chambers, Cllr Lynn Denham, Cllr Paul Harrison, Cllr Matt Jenkins, Cllr Adrian Kriss, Cllr James Stanley and Vacancy

Agenda Supplement

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ADULT CARE AND WELL BEING OVERVIEW AND SCRUTINY PANEL 18 JULY 2022

THE ROLE OF ADULT SOCIAL CARE IN COMPLEX HOSPITAL PATIENT DISCHARGES

Summary

1. The Panel has requested a Report on the role of Adult Social Care in complex hospital patient discharges.

2. The Strategic Director for People and the Cabinet Member with Responsibility for Adult Social Care have been invited to the meeting to respond to any questions the Panel may have.

Background

3. Panel Members will be aware of the current significant pressures on urgent care nationally and at the two Worcestershire Acute Hospitals, including ambulance handover delays, which is subject to ongoing scrutiny by the Health Overview and Scrutiny Committee (HOSC). This Report on the role of Adult Social Care in the process of complex hospital patient discharges has therefore been added to the Panel's work programme.

4. The Worcestershire economy sees a high number of people admitted to long term care from hospital which indicates it is an outlier and not compliant with national guidance where the expectation remains that 95% of people will be discharged home, with some 45% of those requiring support. Furthermore, 4% will access a short-term bedded facility for intermediate care before returning home, and only 1% will be accessing a care home directly from hospital.

5. The Worcestershire Health and Care System (Worcestershire Acute Hospitals NHS Trust, Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire County Council Adult Social Care) has come under increased scrutiny regarding Emergency Department performance and ambulance handover times. Whilst a proportion of this may be due to operational matters, a significant proportion are patients deemed medically fit for discharge. Delayed discharge can be due to several factors which can adversely affect flow through the hospital and availability of beds for those in Accident and Emergency/Medical Assessment Unit who need admission.

Complex Hospital Patient Discharges

6. There are two categories of hospital patient discharge:

- Simple Discharge – where a patient is discharged to their own home and will need little or no additional care once they leave hospital, for example, a

simple discharge is one that be carried out at ward level with the multidisciplinary team-this is often referred to as Pathway 0.

- Complex Discharge – where a patient needs more complex care after post-discharge from hospital, for example, funding issues, change of residence or increased health and social care needs.

7. No two weeks are the same regarding the numbers of patients supported by the Council with hospital discharges. Over the last two months, the total number of complex discharges supported by Worcestershire County Council from Pathways 1 to 5 are:

May-22: - 559
June-22: - 428

In comparison to simple discharges (Pathway 0): -

May-22: - 2985
June-22: - 2333

The Process

8. For all patients who are identified as requiring a complex discharge, details are entered onto a patient tracker to provide oversight to the Worcestershire System which enhances communication and discharge planning. For patients in community hospitals, information is captured and recorded for the right to reside, i.e. need to stay in hospital, and formal meetings are held twice weekly to track patient progress and discharge. Daily meetings are held regarding patients in Intensive Assessment Rehabilitation beds.

The Challenges

9. Prolonged stays in hospital often have a detrimental impact on patients, especially for those who are frail or elderly. Spending a long time in hospital can lead to an increased risk of falling, sleep deprivation, catching infections and sometimes a decline in cognitive and physical health needs. Despite this, nearly 350,000 patients spend more than three weeks in acute hospitals each year.

10. As the demand for urgent care increased in late summer 2021, a visit and subsequent report by Dr Ian Sturgess (Clinical Lead for NHS England and NHS Improvement) and his team recommended the development of an Integrated Intermediate Care Service across the community and social care to bring about better collaboration to reduce waste and the improved coordination of staffing and pathway resources, as well as reporting on patient demand in a single and accurate manner to support hospital discharge.

11. Ongoing system escalations led to the Chief Operating Officers across the Worcestershire System to immediately move to pilot this integrated way of working to ease the immediate urgent and emergency care pressures in September 2021.

12. Whilst Adult Social Care already provided support for hospital discharges via the Reablement Team (an overview of which is provided at **Appendix 1**) and the Onward Care Team (an overview of which is provided at **Appendix 2**), it was

accepted by System Leaders from the recommendations made by Dr Ian Sturgess that work between the Worcestershire System partners was being undertaken in isolation making the pathways (detailed at **Appendix 3**) difficult to navigate. There were delays in handovers, duplication of effort and separate reporting lines and accountability for health and social care staff regarding facilitating hospital discharges.

Areas to highlight

13. The main areas to highlight to the Panel are:

- An integrated Intermediate Care Service was formed as part of a trial with the aim of consistently, enabling more than 80% of patients discharged into reablement services to remain at home after 91 Days. The reablement service provided by Worcestershire County Council consistently exceeds this target for individuals over 65 years as detailed below, endorsing 'HomeFirst' is the best outcomes for individuals:

  Jan-22 - 87%
  Feb-22 - 84.5%
  March 22- 80.8%

  (Please note indicators are run in arrears to allow for purchasing to flow through the system)

- The Reablement Service has received a rating of 4.5/5 from people who have used the service and/or their family/carers
- The Onward Care Team (OCT) cluster model (dedicated staff identified to support early discharge planning) was launched in January 2022
- The Safe to Transfer (STT) approach and paperwork has been introduced. This focusses on describing care needs as opposed to prescribing needs and initiates a rapid response from the OCT who match the service response and pathway required to the request
- A performance dashboard is now in place, refining the demand and capacity data needed to support the service
- Structures have been reviewed and front-line teams have been aligned alongside Neighbourhood Teams which have resulted in increased flexibility and responsiveness
- A streamlined discharge, assessment and allocation process has been agreed, minimising the number of 'hand-offs' between teams. These updated processes have removed duplication and increased a timely response to individuals therefore improving patient experience.
- A single process for people to exit from Pathway 1 (PW1) support has been agreed, ensuring accountability and responsibility for delays in accessing on-going care. This has reduced delays for people exiting PW1 from Neighbourhood Teams thereby maximising team capacity
- The numbers of discharges to all pathways have either decreased or remained broadly level from that experienced pre-pilot, but the decrease is particularly marked for Pathway 3.

Issues for the Panel to Consider

14. The Integrated Intermediate Care Team has made a significant impact

regarding patient outcome and improved flow through the hospital of which Adult Social Care is an integral element. A formal review is being undertaken which will be presented in August 2022 to the Integrated Commissioning Executive Officers Group (ICEOG) which highlights the achievements (some of which are described above) and recommendations for a future service provision.

Purpose of the Meeting

15. The Panel is asked to:
    - Consider and comment on the information provided regarding the role of Adult Social Care in complex hospital patient discharges;
    - Agree any comments to be made to the Cabinet Member with Responsibility for Adult Social Care; and
    - Determine whether any further information or scrutiny on a particular topic is required.

Supporting Information

Appendix 1 – Overview of the work undertaken in the Reablement Service
Appendix 2 – Overview of the work undertaken by the Onward Care Team
Appendix 3 – Overview of the Discharge Pathways

Contact Points

Emma James / Jo Weston, Overview and Scrutiny Officers, Tel: 01905 844964 / 844965
Email: scrutiny@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance) the following are the background papers relating to the subject matter of this report:

Agenda and Minutes of the Health Overview and Scrutiny Committee on 9 May and 9 March 2022, 18 October 2021, 27 June 2019, 14 March 2018 and 11 January 2017

All agendas and minutes are available on the Council's website here.

Appendix 1

Brief overview of the Reablement Team

What is reablement?

The reablement approach supports people to do things for themselves. It is a 'doing with' model, in contrast to traditional home care which tends to be a 'doing for' model.

Reablement services help people to retain or regain their skills and confidence so they can learn to manage again after a period of illness.

The service is usually provided in the person's own home by a team of mainly social care professionals. Consistency of workers is important to enable a relationship to be built with the person and for progress to be properly monitored.

Reablement, not rehabilitation

Reablement is an approach that, irrespective of diagnosis, aims to assist people to continue to live as they wish. It seeks to enable the individual to do ordinary activities like cooking meals, washing, dressing, moving about the home and going out.

Reablement is used to support discharge from hospital, prevent readmission or enable an individual to remain living at home. It can be provided for anyone who will benefit from it. It is typically provided for up to six weeks although it is not unusual for someone to need only a couple of weeks of reablement.

There is a tendency for the terms 'reablement', 'rehabilitation' and 'intermediate care' to be used interchangeably. The **National Audit of Intermediate Care** defines reablement as services that help people live independently, provided in the person's own home by a team of mainly social care professionals.

Local authorities have a duty to prevent, reduce or delay needs for care and support (Care Act 2014 s2) for all adults including carers; this means early intervention to prevent deterioration and reduce dependency on support from others. Reablement is one of the ways to fulfil this duty. It is a flexible and inclusive approach that can be used with a variety of different people including those with physical disabilities, cognitive impairments and learning disabilities.

Promoting/maintaining independence

Offering and providing more support than people need can make them more dependent on others. Reablement support workers are trained to stand back, observe, encourage, and prompt the individual to learn new skills or re-learn skills they may have lost.

At times this approach is difficult for those struggling to complete a task and for those observing.

Key features of the reablement approach

- Focuses on a person's strengths to promote and maximise independence and wellbeing.
- Rebuilds confidence after a spell of illness, deterioration in health, an injury, a hospital admission, or an acquired disability.
- Different to traditional home care as it involves care providers standing back and encouraging the promotion of self-care skills that may have been lost.

- Supports people to regain or retain skills to enable them to manage with minimal or no support.
- Short-term and intensive; typically provided for up to six weeks.
- Not means-tested – the service is free to people who meet the locally defined eligibility criteria.
- A focus on restoring independent functioning, rather than resolving healthcare issues.
- Aims to prevent re-admission to hospital or premature move to a care home.
- About setting and working toward meaningful goals.
- Aims to reconnect people with their communities to reduce social isolation.
- Can help to reduce the amount of care the person needs from carers and family.
-

The benefits of reablement

Research has shown that people who have received a reablement service view it positively and see the benefit of improvement in their confidence, functional ability, mobility, independence and wellbeing.

It has also been found that even for people who were previously receiving traditional home care services, reablement approaches brought about improvements in independence, which in turn prolonged their ability to live at home and reduce the amount of traditional care subsequently required.

This supports the view that everyone should be considered for reablement as part of the review or re-assessment process.

The reablement approach offers benefits to all concerned.

- For the **person** it offers increased independence and improved quality of life.
- For **carers and family members**, they can enjoy seeing their relative improve and can ultimately spend less time supporting or caring for them, and therefore more time just enjoying their company.
- For **staff**, this is a rewarding approach where improvements lead to a feeling of real achievement.

The role of reablement support workers

Reablement is an intensive service provided by reablement support workers who have received additional training; they may also be assisted by occupational therapists or physiotherapists who will give expert advice and support.

Reablement uses a ‘doing with’ approach, which involves supporting people to do things for themselves. Support workers are taught to stand back and allow the person the time to complete a task on their own. This may involve the person being shown a different way to carry out the task to achieve independence, such as putting the weaker arm with the least amount of movement into the sleeve of a top first. The worker may also support the individual to reconnect to their local community by providing information, as well as by promoting confidence in outdoor mobility and the use of public transport.

Supporting people to do things for themselves initially takes more time, so reablement support workers are likely to visit more frequently and stay for longer than a conventional home care worker who may have done the task more quickly on behalf of the person. Throughout the process, reablement support workers stand back, observe, encourage, and prompt the individual to learn or re-learn skills they may have lost. At times, this approach is difficult for those struggling to complete a task as well as for those observing.

Types of support

Reablement focuses on what the person can do for themselves and sets goals that can be realistically achieved. Goals are usually focused on ordinary day-to-day things such as:

- Mobility (Moving around the home and going out)
- Making food and drinks
- Personal care
- Housework
- Shopping
- Maintaining contact with family, friends, and community groups

Reablement support is not limited to day-to-day tasks, and can also involve:

- **Income maximisation** – ensuring the person has access to information and advice to ensure they receive all their financial entitlements and benefits.
- **Health and wellbeing** – supporting independence with medication and monitoring any health issues or deterioration - ensuring the person can access appropriate help.
- **Managing pain** – It is hard to motivate someone if they are in pain. If the person has had an injury, it may be very painful at first and it is important to work with the individual so they can do tasks at a tolerable level. The reablement team ensure that the person has access to support from healthcare professionals so that pain is well managed.

Assessment and goal setting

When a person is referred to a reablement service, a reablement assessor, an occupational therapist or social worker will visit them to assess their abilities and needs in relation to the goals the person identifies. The person's views are central to the process and carers and family are included as appropriate. The process seeks to identify strengths and overcome barriers that could be:

- **physical** – relating to illness or disability
- **environmental** – relating to the layout of the home
- **psychological** – relating to fear or confidence.

For each task, the goal is for the individual to achieve it independently or with minimal assistance. The occupational therapist may become involved in the assessment for adaptations and mobility aids and can be integral to the success of the outcomes.

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Appendix 2

Overview of the Onward Care Team

The team is made up of social workers and social care workers who work closely and collaboratively with the acute trust wards and staff to provide advice and guidance around discharge planning. They work with patients, relatives, carers, and professionals to consider discharge options and early discharge planning. The team is responsible for confirming the discharge plans for patients with ongoing care and support needs who are within the Worcester Acute Hospitals (Alexandra Hospital and Worcester Royal Hospital). Where a patient has complex care and support needs the team is responsible for ensuring appropriate discharge planning is complete. This includes liaising with appropriate professionals and teams to ensure pathways can meet the needs of individuals, where it is confirmed, existing pathways cannot meet the required needs for the individual, appropriate discharge options are arranged outside of the standard commissioned pathways.

The Onward Care Team:

- Arrange discharge for individuals with complex care and support needs which cannot be supported by existing commissioned pathways.
- Work collaboratively with wards to provide appropriate advice and guidance around discharge planning including those patients who have Out of Area Local Authority or Health services and are currently inpatients in Worcester Acute Hospitals.
- Update Worcestershire Patient Tracker with discharge planning, ensuring notes are up to date and codes correct.
- Confirm discharge plan (pathway) for the patient, ensuring compliance with pathway criteria and that patient wishes have been considered. Ensuring the discharge to assess model with HomeFirst approach is at the forefront of discharge planning.
- Participate in early discharge planning with patients, relatives, and ward staff to ensure discharge plans are clear at the point a patient becomes medically optimised for discharge. This is contingent on early referrals by ward staff.
- Ensure appropriate professionals have been involved and where pathways have confirmed they are unable to safely meet the individual need, that alternative options are arranged.
- Participate and lead the daily Triage Hub meetings.
- Complete Safe to Transfer forms for patients who are Fast Track CHC eligible.
- Participate in Discharge Cells, MDTs, and conference calls to support discharge planning.

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Appendix 3

Overview of Pathways

Pathway 0	Pathway 1	Pathway 2	Pathway 3
•Patient returns to usual place of residence •Fully independent-no further support required •Restart package of care (POC) with no changes •Has pre-exisiting community services in place •may require support from VCSO/Age UK (contract in place)	•Patient returns to usual place of residency with interim support (provided by the Reablement Team). •New POC or increase of exisiting package. •Temporary reablement to maximise indepence. •Assessement of some additional care and support (including therapy, nursing, domiciliary care and/or new equipment •The individual is safe between calls/overnight.	•Patient is transferred to a non-acute bed (community) and receives rehab and assessment until able to return safely home. •Short term bedded rehab with or without reablement and assessment •Unsafe to be at home overnight/between care calls •Includes specialist rehabilitation	•Patient is transferred to a new long-term bed/assessment and receives complex support and/or assessment for their needs •Complex/significant health and/or social needs which require a new placement •Life changing health care needs •Complex end of life of mental health needs •Complex housing and homeless needs •Requires live in care with multi professional input

The National Audit of Intermediate Care (NAIC) undertaken in 2018/19 collected data from providers and found that 'HomeFirst' should be the default for all patients. The audit stated that at least 95% of over 65's leaving hospital should be going straight home/ normal place of residence, either on pathway 0 or pathway 1. From September 2020, up to 6 weeks reablement at home has been funded where it is completely new; or for any additional reablement services which are added to a pre-existing care package.

For the very small number of people who really cannot go straight home and need rehabilitation in a community bed (Pathway 2), the aim is to get them home as soon as possible. If they then require some further enablement on their return home, additional to any pre-existing care package, this is funded for up to 6 weeks.

Pathway 3 – is for less than 1% of individuals admitted where 24-hour care in a nursing home is required, probably on a permanent basis.

The primary outcome from navigating through the pathways in a collaborative manner is to reduce the use of acute beds, have shorter lengths of stay in hospital, provide system cost savings, and most importantly improve the overall patient experience by promoting 'HomeFirst' where appropriate.

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