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ADULT CARE AND WELL BEING OVERVIEW AND SCRUTINY PANEL 7 NOVEMBER 2022

UPDATE ON THE ROLE OF ADULT SOCIAL CARE IN COMPLEX HOSPITAL PATIENT DISCHARGES

Summary

1. The Panel has requested an update 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). The role of Adult Social Care in the process of complex hospital patient discharges was added to the Panel's work programme and following an initial Report on 18 July 2022, and a further update has been requested.

4. The Panel has requested information about the role of adult social care in complex discharges and delayed transfers of care to show trends in the numbers of patients in hospital awaiting discharge who are unable to leave because of a care package not being in place.

5. The Panel has also asked to understand the number of discharges that the Service supports each week, the length of any delays and the reasons for the delay. The Panel would like to understand the challenges that the Service is facing.

Integrated Care Systems

The National Context

6. Integrated Care Systems (ICS) are a key part of the NHS Long Term Plan. They are expected to bring about major changes in how health and care services are planned, paid for and delivered, achieved through providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population.

7. ICSs were developed via Sustainability and Transformation Partnerships (STPs) and require a closer form of collaboration whereby NHS organisations and local

authorities take on greater responsibility for collectively managing resources and performance and for changing the way care is delivered.

8. In November 2018, the Local Government Association (LGA), with partners Association of Directors of Adult Social Services, the Association of Directors of Public Health, NHS Confederation, NHS Clinical Commissioners and NHS Providers, published a shared vision for integration entitled Shifting the Centre of Gravity: making place-based, person-centred health and care a reality.

9. Herefordshire and Worcestershire Health and Care system was formally designated as an ICS on 1 April 2021 having operated as a STP since 2016. The Clinical Commissioning Group (CCG) and all its functions transferred to become a statutory Integrated Care Board (ICB) for Herefordshire and Worcestershire on 1 July 2022.

10. The ICB is established by an order made by NHS England under powers in the 2006 Act. The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act. The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

The Local Context

11. Leaders from Worcestershire County Council (the Council), Worcestershire Acute Hospitals NHS Trust (WAHT), Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) and the Integrated Care Board (ICB) are committed to working in partnership to coordinate services for intermediate care to collectively, and effectively, meet the needs of each person – a system within a system. The aim is that people can live healthier lives and get the care and treatment they need, in the right place, at the right time, supporting the strategies of the key stakeholder organisations to create a focused approach to:

    - the delivery of person-centred coordinated care
    - the building of local “place-based” care and support systems
    - a system leadership model for further integration of commissioning and service delivery.

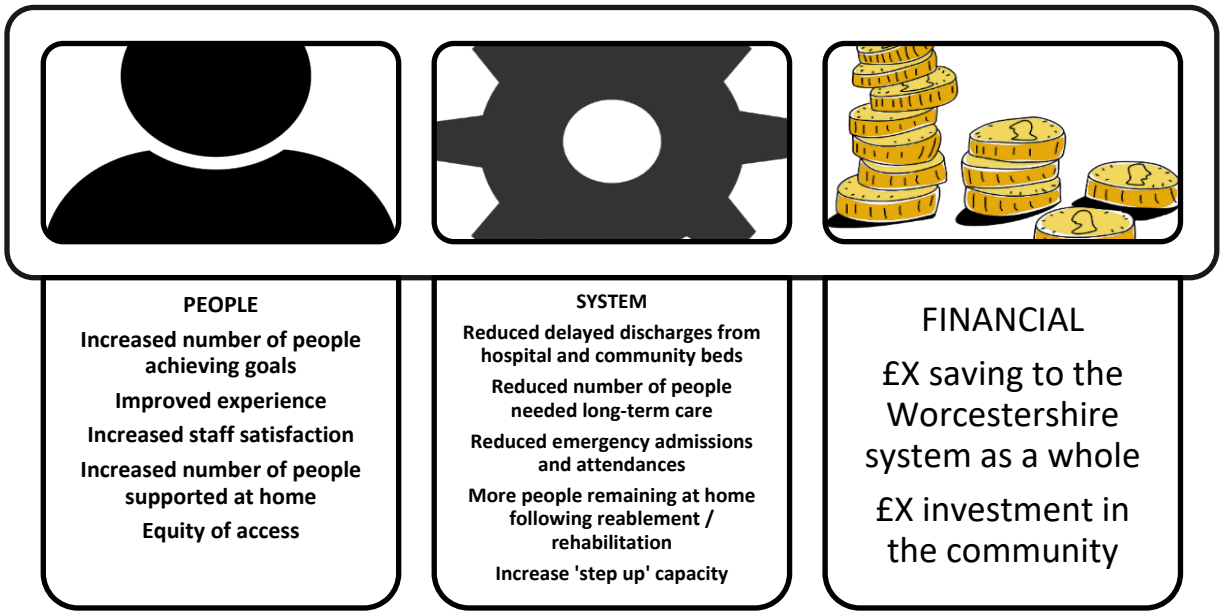
12. ICSs are part of a fundamental shift in the way the health and care system is organised. Historically, the emphasis was on organisational autonomy and the separation of commissioners and providers whereas the ICS will now look to collaborate and unite in driving forces for improvement.

Intermediate Care

13. Worcestershire’s Integrated Intermediate Care team has, due to system pressures, effectively (and successfully) operated as a step-down unit. This may present a missed opportunity to really address the system wide ambitions.

14. The illustration below shows the three key factors in delivery of an efficient ICS. Ensuring good outcomes for people, more effective flow within hospital settings with

a focus on admission avoidance and discharge and how such successful systems can save money and enable resources to be redirected to prevent hospital admissions.



15. Intermediate Care can provide a range of services to patients/customers that require additional social and/or health care, pre and post-acute hospital care. The aim being to enable a timely response to avoid an admission to hospital and/or discharge from hospital to a safe environment, with the necessary support to enable the individual to regain function and/or confidence.

16. This support is provided in the persons own home (or usual residence) or a transitional residence such as a Community Hospital bed or Care Home if longer term more complex needs are identified, until a more permanent arrangement is in place (including potentially no further social/health care support being required).

17. Intermediate Care does not define a single service; it is a term that incorporates elements of reablement, rehabilitation and recovery. The NICE Guidelines, Intermediate Care including Reablement (September 2017), provide a clear vision of the model. The guidelines state that local areas should offer all 4 types of intermediate care:

- Crisis response – to prevent an avoidable admission to hospital, offering an assessment and possibly short-term care (typically up to 48 hours but up to around 7 days) if there is an urgent increase in a patient's health or social care needs that can be safely managed at home. Adult Social Care also provide social work input via Area Social Work Duty Teams to support admission avoidance, via urgent home care and emergency replacement care.
- Home-based Intermediate Care – services are provided at home, by a team with different specialities (therapists, nurses, equipment, and social care), that support rehabilitation and recovery and can assess for any ongoing needs including NHS Continuing Healthcare (CHC). Adult Social Care also provides community reablement services to support people at home.

- Bed-based Intermediate Care – services are delivered in a community hospital or care home, for people who do not need 24-hour consultant led medical care but need a short period of therapy and rehabilitation. Adult Social Care support this via Pathway 2 and Pathway 3 (explained from paragraph 31).
- Reablement – services are provided at home, mainly by social care professionals and specially trained social care staff. Enabling the re-learning of skills and promoting recovery to build confidence to live at home. Adult social care support this via Pathway 1 (explained in paragraph 23).

18. There is recognition across the ICS that the Intermediate Care Team could be further enhanced through greater integration and a more formalised way of working. Work is currently being undertaken to scope other models across the country and consider if there are different ways of working which could provide better outcomes for individuals. Agreement from System Leaders has been given to proceed with this work, with dedicated project support, provided by the ICB. This work will commence following the completion of a review of OCT, which is currently underway, to inform the wider thinking in relation to integrated intermediate care.

Role of Worcestershire's Adult Social Care Teams Supporting Complex Hospital Discharges

Onward Care Team

19. The Onward Care Team (OCT) is made up of health and social care staff who work with individuals admitted to hospital to plan their discharge and provide advice, guidance and signposting to individuals, carers and professionals. They work with patients, relatives, carers and professionals to consider discharge options and early discharge planning, ensuring where possible patients are discharged to their own home.

20. Adult Social Care staff in Onward Care and Community Hospitals are currently working with 186 people. In the last year OCT and Community Hospital staff have had 2,111 people on the social work and social care worker caseloads, completing 7,896 episodes of work (including conversations, forms, contacts etc). They also complete over 2,300 case notes each month.

21. OCT advocate for individuals ensuring their wishes are considered and their ability to make decisions is considered. Completing mental capacity assessments, best interest decisions and considering Care Act eligibility.

22. OCT and Community Hospital staff support carers with accessing carers assessments and support to ensure carers feel supported to continue in their current role. Where a patient has complex care and support needs the team is responsible for ensuring appropriate care and support services are arranged that can meet the identified needs. The social care team is responsible for working with the safeguarding team to ensure safeguarding concerns are addressed.

Reablement Services

23. The Reablement Service supports people leaving hospital to recover at home, known as Pathway 1. It also has dedicated resource to provide community reablement to help people regain and retain independence at home. This service is

commonly referred to as Community Reablement. The service works in an integrated way with local Neighbourhood Teams – clinical staff working in the Herefordshire and Worcestershire Health and Care NHS Trust. All Pathway 1 referrals for people living in Worcestershire are made through the Reablement Service.

24. The Community Reablement service helps people who might normally receive care and support to improve independence and reduce the need for formal care packages, provides support to people currently residing in the two Prisons in the County, and is also the Service of Last Resort – providing a response in the case of provider failure or concerns, or where finding a care provider is challenging (such as in a rural part of the County). This supports admission avoidance.

25. The Reablement service experiences several challenges. Managing complex care and support for people; and working in partnership with others (including NHS partners and the care market) brings logistical and cultural (team) challenges. The service meets these challenges well, adopting a 'can do' approach to support positive outcomes for people and performs well in terms of supporting timely discharge from hospital.

26. The biggest challenge the service faces is recruitment; recruitment of front-line care staff is a national challenge, and not unique to Worcestershire. Often applicants to roles in the Reablement Service work in other parts of the Worcestershire care market, so a balance must be struck between speed of recruitment and impact on the local care market more generally.

27. Recruitment campaigns have a mixed success rate, and many applicants withdraw from the process through reasons beyond the control of the service (such as personal choices, candidate has a number of job options and chooses something else etc). The service has fine-tuned and tailored a recruitment process based on feedback from applicants who subsequently started work and has seen improvements in retention as a result.

28. The service received additional investment, endorsed by the Integrated Commissioning Executive Officers Group (ICEOG), funded through the Better Care Fund, which has enabled approximately 100 new posts to be created, and approximately 60% of these were filled within 6 months. This was achieved despite being within the Covid-19 pandemic. Whilst natural turnover of staff has meant gains above this 60% have been challenging, the Council is seeing an increase in the number of applicants following reviews of the recruitment processes.

29. One final challenge of note is the increasing demand – both in terms of care and the responsiveness of the service. People tend to leave hospital sooner, and so require more support initially. This often means that people require significant amounts of care, and the service has seen more people who require 'double handed' care, where visits require two carers to support. The pressures that the NHS has faced in terms of demand on Urgent and Emergency Care also filter through to the service – demand for timely discharge is very high in order to support patient flow through the health and social care system.

30. Communication with partners is viewed as a priority and there are several channels for communication which work on a two-way basis. Processes have been

designed collaboratively between the service and partners to support working relationships in a positive way.

Pathway 2 – The Role of Adult Social Care in Community Hospital Discharges

31. When a patient no longer meets the national criteria (known as Right to Reside) to reside in a community hospital, they are discussed at weekly Right to Reside meetings. These meetings take place between Adult Social Care and HWHCT colleagues to identify discharge plans and any barriers to these plans. Right to Reside has replaced Delayed Transfers of Care, formally referred to as DTOC.

32. Where barriers are identified adult social care staff work with providers, commissioners and individuals, families and carers to devise plans to enable discharge. This supports capacity and flow through community hospitals, ensuring individuals are discharged to their appropriate place of care in a timely manner.

Pathway 3 - The Role of Adult Social Care in provision of Intensive Assessment and Rehabilitation and Discharge to Assess beds

33. The Intensive Assessment and Rehabilitation Unit (IAR) is a bedded unit within Worcester City Inpatients Unit, with up to 21 beds. They are used for patients who are assessed by social care, at the point of discharge from acute hospitals as being unable to have their care and support needs met in their own environment and have no rehab goals identified at this point in their recovery.

34. The purpose of the service is to provide individuals with the opportunity to have an intensive assessment completed by a multi-disciplinary team, which includes social care. The purpose of this is to assess reablement potential outside an acute setting, assess their ongoing care and support needs, review options of returning home and where home is not possible to make long term plans for care home placements.

35. The social care staff in the IAR service complete Care Act 2014 needs assessments, mental capacity assessments, best interest decisions and liaise with brokerage and providers to arrange appropriate care and support to meet individual's needs.

36. The HWHCT Capacity Management Team has reported 156 people being discharged from hospitals and referred to this service in the period January to September 2022.

37. Pathway 3, on occasions, requires social care to source a small number of Discharge to Assess (DTA) beds directly in care homes for up to 4 weeks, directly from the acute hospital setting. This is usually when there is unlikely to be any rehabilitation goals and often needs that could not be met in the unit (often referred to as complex needs). Adult Social Care use its brokerage service and commissioners to source the homes and then the adult social care team review within the 4 week period and agree an ongoing plan. In periods of escalation in the acute hospitals, there can be requirements to purchase additional Pathway 3 DTA beds to support flow from the acute hospitals which can lead to additional adult social care oversight and long term cost implications.

Wrap Around Care Provision

38. ICEOG gave approval in December 2021 for a wraparound service pilot to be delivered. The pilot was commissioned, with an external provider and started on 4 April 2022. ICEOG agreed in July 2022 that the service will continue to August 2023.

39. The service is delivered using live in carers with the aim of each person receiving the service for between 48 and 72 hours minimum. The aim of the service is to support an approach which is strength based and supports positive risk taking for professionals, individuals, and families.

40. The service provides people with the opportunity to make decisions about their long-term service needs whilst in their home environment. There is capacity for four people to use the service at any one time. The Council is currently exploring the opportunity to broaden the scope of the service to support an admission prevention approach.

Adult Social Care Role in System Flow and Escalation Processes

41. A Worcestershire System Escalation Management Plan (EMP) is in place, setting out operating procedures to ensure that there is an expedient and system-wide response and timely de-escalation to any operational pressures within the health and care system. This is to ensure that residents can access the help, care, treatment and support when and where they need it to optimise individuals' independence, health and wellbeing. Adult Social Care, with all system partners, must:

    - Ensure a timely and proportionate system-wide response to operational pressures within the health and care system
    - Minimise the duration and impact of any operational pressures escalation level 3 and above
    - Minimise the impact of any escalation on the timely access to appropriate treatment and care and ongoing care and support
    - Avoid hospital acquired functional decline by maintaining effective patient flow throughout the system, including the timely discharge of patients from hospital
    - Optimise individuals independence, recovery and rehabilitation.

Levels 1 and 2 – Business as Usual Level 3 and 4 – Escalation Plan System Plan followed.

EMS LEVEL	AIM	ACTIONS	COMMUNICATIONS
1 & 2	Maintain normal business	Operational actions taken daily to prevent escalation Responding to warning signs that escalation is likely unless action is taken Partners involved routinely at operational level	Operational staff liaison Daily sitrep to inform partners of escalation level
3	De-escalate	Tactical actions taken to facilitate de-escalation. Ensure all best practice actions are being taken by all partners Senior decision makers to approve exceptional actions	Operational staff liaise with senior managers regarding actions taken and decisions required Brief system-wide executives on situation
4	Manage risk & de-escalate	Manage increased clinical, organisational & reputational risk Maintain actions to de-escalate	Communication with NHSE to provide assurance that all best practice actions are being taken by all partners

42. Below is the daily process for managing urgent care and patient flow from a system perspective:

- **Weekend system operational care 9:30 Bronze Level**, Bed Meetings to include adult social care staff from the Onward Care Team and Pathway 1 team to ensure plans are in place for the normal functioning of the hospital to ensure sufficient patient flow.

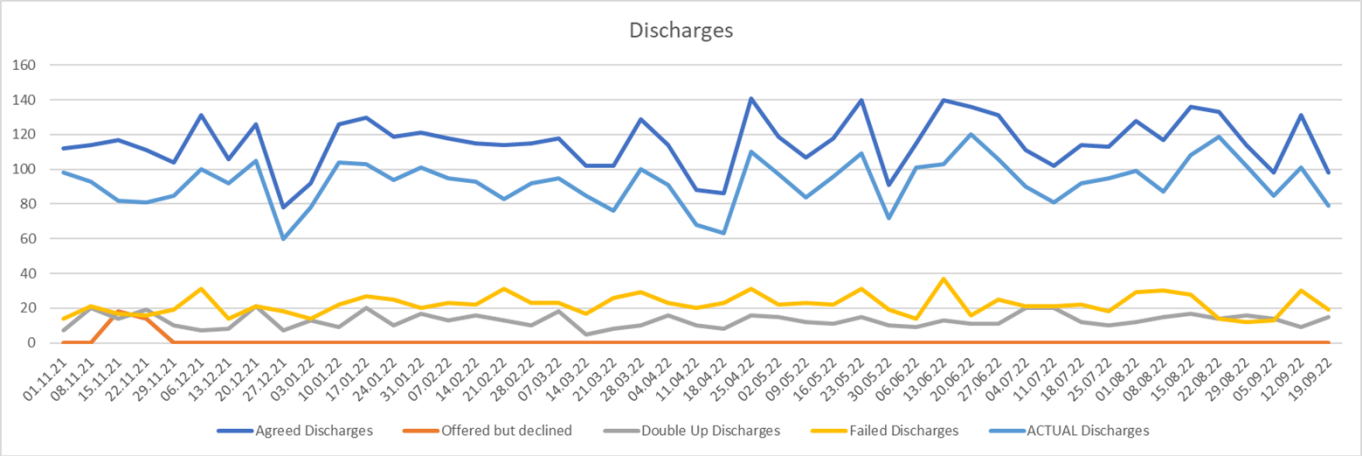
- **Daily 7 days a week 11:30, 15:00: Silver Level,** System wide tactical / operational call –chaired by ICB/WAHT/HWHCT. Silver Calls receive reports from Bronze level. The purpose of Silver is to ensure the system is supporting efforts agreed at Bronze and to determine whether additional actions are required or whether system escalation is needed. These are attended by Adult Social Care as part of the Intermediate Care/Onward Care Teams. At weekends, Pathway 1 Registered Managers report on all discharges.

Level 3 and 4

43. When Level 3 is trigged the silver calls (set out above) become Gold calls and require Adult Social Care Executive attendance. These are then attended by the Strategic Director for People or Assistant Director Adult Social Care on weekdays. Their roles are then to ensure all patients medically fit to be discharged have plans in place, any additional measures Adult Social Care can take to increase

flow are actioned, blockages unblocked and discussed regarding shared levels of risk across the system. At weekends, there is an on call Gold rota and a senior staff member will attend meetings should this level be reached.

Discharge Trends



The graph above shows the trends of discharges agreed and failed through the Intermediate Care (Pathway 1) between 1 November 2021 and 19 September 2022.

44. This data shows a total of 4,353 (81%) agreed and successful discharges, through the Intermediate Care Service. 1,036 (19%) discharges failed during this period. The reasons for failed hospital discharges that have been referred through the Intermediate Care Service are listed below.

- Not Medically Fit for Discharge 46%
- Hospital Transport 7%
- Care Agency Delay 2%
- Home Environment/Family Not Ready 10%
- Hospital Delays 15%
- Unknown/not recorded 15%
- Waiting for equipment 5%

45. The table below shows data on people who have been discharged from hospital into a Pathway 3 bed each week. The vast majority of these are people discharged to a step-down bed, but it also includes a very small number of people returning to an existing long term care home placement or going directly to a new long-term placement.

46. This data shows individuals who have been discharged from hospital in a Pathway 3 bed from 2 September 2022 for Worcestershire Hospitals.

Hospital Discharged from	02/09/2022	09/09/2022	16/06/2022	23/09/2022	30/09/2022	07/10/2022	14/10/2022
Worcestershire Acute	3	1	1	3	4	1	0
Other Hospitals	1	1	0	0	0	1	0
Total	4	2	1	3	4	2	0

47. Between July 2021 and March 2022 Adult Social Care placed a total of 48 people in 'transition beds' because there was lack of capacity, due to market pressures in domiciliary care. These were short term commissioned beds to support people medically fit for discharge but unable to be picked up on the same day by Pathway 1.

48. The short term contract was ceased in March 2022 as by then Council had reached a position where between Pathway 1 and brokering packages of care, flow could be managed without the additional capacity, which improved outcomes for people and supported people to go straight home from hospital.

Purpose of the Meeting

49. 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
    - Determine whether any further information or scrutiny on a particular topic is required.

Contact Points

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Background Papers

In the opinion of the proper officer (in this case the Democratic Governance and Scrutiny Manager) the following are the background papers relating to the subject matter of this report:

Agenda and Minutes of the Adult Care and Wellbeing Overview and Scrutiny Panel on 18 July 2022

Agenda and Minutes of the Health Overview and Scrutiny Committee on 8 July, 9 May, 9 March 2022 and 3 November, 18 October 2021.

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