Shropshire Council	Health and Adult Social Care Overview and Scrutiny Committee 26th March 2017	Item Public

Improved Better Care Fund (IBCF) and Projects & Delayed Transfers of Care (DToC) Update

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1. Summary

1.1 The Health and Adult Social Care Overview and Scrutiny Committee requested a report on the Improved Better Care Fund (IBCF) and Projects, detailing the outcomes which need to be achieved in reducing and maintain Delayed Transfers of Care from the acute and community hospitals.

1.2 This report will summarise this council's allocation of the ICBF and some of the projects implemented using the IBCF funds. This report will also revisit the progress to date in reducing and maintaining a lower level of Delayed Transfers of Care since the last report to this committee. There will be complimentary presentation which will further describe the impact of the different projects, which have been implemented using the IBCF, and explaining how the winter pressures have been reflected in the number of delays including readmission rates and identifying where people are three months after their discharge.

2. Recommendations:

Members are requested to:

2.1 Review progress to date in relation to the IBCF and in achieving Delayed Transfer of Care targets

2.2 To agree how this Committee wishes to receive future updating reports

3. Risk Assessment and Opportunities Appraisal

(NB this will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

3.1 The IBCF has enabled this Council to embark on many new initiatives which have resulted in positive outcomes for people needing care and support on discharge from hospital.

3.2 The IBCF tapers down over the three-year lifespan of the current grant.

3.3 The latest guidance on the IBCF and difficulties in recruiting to some posts have resulted in some projects not starting until autumn 2017.

3.4 This Council (like all councils) are assuming that any unspent money can be carried forward to next year, though this is yet to be confirmed.

3.5 We have increased the number of discharges from the acute hospital with the additional resources from the IBCF. SaTH continue to face significant pressures and need more complex discharges than what is currently being delivered.

3.6 The Council was given a target to reduce Delayed Transfers of Care ("DToC") attributed to adult social care (rather than Health) by September 2017. It was made clear that a failure to meet the target would result in the Council's IBCF funding being put at risk. This Council achieved its DToC targets and has continued to deliver low delays.

3.7 The pressures in the acute hospitals is felt in the wider health and social care economy which results in the Council's hospital social work team being put under intense scrutiny and pressure.

3.8 The number of discharges that have been agreed is not currently being achieved due to low number of fact finding assessments (referrals) from SaTH. This is being addressed by SaTH.

4. Financial Implications

4.1 <u>Improved Better Care Fund</u>

4.1.1 Within the Spring Budget Statement 2017, it was announced that local authorities would receive additional improved Better Care Funding (iBCF) over the next three financial years. Shropshire Council's allocation is as follows:

2017/18	2018/19	2019/20	**Total**
£5,976,757	£3,959,448	£1,967,260	**£11,903,465**

4.1.2 The grant is one-off and time-limited, and therefore does not change the council's underlying funding gap.

4.1.3 To the end of February 2018, the council has spent £1,677,227. Forecast expenditure for the 2017/18 financial year is £2,412,640. This level of expenditure would leave a balance of £3,564,117 of the 2017/18 grant to be carried forward for use in 2018/19 and 2019/20. The grant (including the forecast unspent balance carried forward from 2017/18) has been fully allocated over the three year period, to new schemes and preventative services. The profile of the use of the grant has been set by the council in a way that smooths the funding over the three-year period.

4.1.4 The grant has enabled the council to pilot innovative ways of working, which it wouldn't have had the resources to pilot otherwise. It is becoming clear which schemes and additional expenditure will be required to continue into 2020/21 in order to meet adult social care need. Currently, there is no indication of further grant monies, and the current picture is that funding will not be in place to enable the projects to continue. The council will be reliant on the outcomes of the Local Government Fair Funding Review to ensure that funding for adult social care is set on a more secure, sustainable, long-term basis in the future. The outcomes of the review are completely unknown at this time. It is hoped that the short-term funding for adult social care, which the council is currently receiving, will be replaced by a long-term and ongoing grant for adult social care that is set at a level that addresses the increasing cost of adult social care that the council is facing. However, the council has not received any reassurance to date that this will be the case.

5.0 Background

5.1 <u>Improved Better Care Fund (IBCF)</u>

5.1.1 In line with the strict requirements of the grant, the council has implemented a series of new schemes to provide extra capacity within adult social care, reduce pressures on the NHS and ensure that the local social care provider market is supported. The late notification of the grant, and the delay to the accompanying guidance, meant that several of the new schemes did not start until Autumn/Winter 2017.

5.1.2 The grant has enabled the Council to pilot new ways of working, without which it would not have had the resources to pilot otherwise.

5.1.3 The principles adopted in allocating the IBCF monies were ones of innovation, creativity and collaboration. The initiatives were deliberately based on the concept of trying radical new approaches which would enable the flow through the hospital system, and facilitating the discharge of patients from hospital much more quickly. The underlying principle is that a person's bed is better than a hospital bed.

5.1.4 The measures to monitor the impact of the initiatives:

a) Reduction in delayed transfers of care (target no more than 6.7 per day)
b) Reduction in the admission of people into residential care (target no more than 600 new placements)
c) Increase in the number of people supported in their own homes from hospital (80% of all hospital discharges)
d) Increase number of discharges per week from the Acute hospital (48 per week)
e) Reduction on length of stay on Integrated community services caseload (max 42 days)
f) Increase in the number of people at home after 91 days from hospital (target 78%)
g) Increase in the number of people receiving no long term care after successful Reablement. (Target 74%)

5.2 Examples of the IBCF initiative

5.2.1 Members asked for examples of ways in which the IBCF has been used

5.3 Withywoods

5.3.1 The Withywoods project has been in place for approximately 6 months. It comprises of 4 apartments within an Extra Care Housing scheme run by Shire living who are a part of Wrekin Housing Trust. The apartments are fully furnished and managed as part of the main scheme. The aim of the project is to accommodate patients who are medically fit for discharge but for some reason unable to return home.

5.3.2 The stay is for a short term period to enable further recovery, confidence and independence building until the person is able to return home. The aim is to ensure that those that are ready to leave hospital can, and to reduce the use of expensive residential care placements.

5.3.3 To date 13 patients have been discharged to these step down beds. The reasons have been varied, but in the main it has been because there was a need for them to receive intensive care before returning home with a care package. A number of these patients would have previously been placed in residential care at a much higher cost or even via accessible rooms in B&B's if they had presented as homeless. The apartments at Withywoods cost approx. £250-£280 per week depending on whether they are 1 bed or 2 bed. When the apartments are full, housing benefit covers the costs as the person is accommodated under homeless legislation in temporary accommodation. In comparison to this, the cost to Adult Social Care (ASC) on an average residential care placement is £550 - £700.

5.3.4 Through discussions with Wrekin Housing Trust it has been decided that the apartments at Withywoods will move to the newly opened scheme at Bicton. We believe that being closer to the hospital will speed up assessments, thereby enabling clients to be discharged more quickly into the step down units. The Bicton units are also a lower weekly rent meaning that there is a cost saving to ASC for any period the property is void.

5.3.5 In addition, we are in discussions with Shropshire Housing Group to start a pilot in their new frail and elderly scheme in Ludlow (2 beds) as well as discussions for purpose built step down units at the new Paul's Moss site in Whitchurch (4 beds). The units at Paul's Moss will be half the size of normal apartments meaning that the costs are lower again. They will also be high spec and fully technologically equipped meaning they can be used as guest rooms for clients wanting to experience assistive technology or as 'training flats' for those who might be having assistive tech fitted in their homes.

5.4 Additional Occupational therapists

5.4.1 We now have two dedicated qualified occupational therapists in post who are concentrating on working alongside colleagues in both health and social care ICS. Unlike colleagues in the occupational therapy team, these two practitioners are specifically working with people, who on discharge from hospital, are moving into units or beds for further rehabilitation to assist them to move back to their own homes.

5.4.2 Both practitioners attend Multi-Disciplinary Teams (MDT) meetings held in the acute hospital where people suitable to transfer for further enablement to specific 'Discharge to Assess' (D2A) nursing beds are discussed. The OT's will then engage with staff in the D2A beds to ensure that rather than just being 'cared for' they are prompted and encouraged to complete any task with minimal support with the ultimate goal of completing it themselves. The OT's also consider if equipment and assistive technology can enable the person to regain their

independence and will ensure this is in place for their discharge home. On discharge from the placement, there is a comprehensive transfer and the health therapy team will continue with any further support the person requires.

5.4.3 The OT's support the patients discharged to regain independence at Withywoods. After assessment by the OT's an enablement plan is devised with the person. The practitioner will work with the person in the unit, and will, if able to transfer safely into a car, provide support to spend time in their own home. On return home the OT will continue any required support to enable the individual to regain as much independence as possible. This will be with assistive technology, equipment and if appropriate funded support.

5.5 Additional Social work resource in Mental Health services

5.5.1 We have recruited 6 additional Social Care practitioners (support workers) to the Mental Health Social Work teams around the county, to further support and enable a preventative approach to work in Mental Health. There is already evidence of change, for example with the creation of additional client support through recovery groups in the North West and drop-in groups in the South West. The first multi-agency drop-in has recently started at the Redwoods Psychiatric Unit. This is led by a Shropshire Council Social Care Practitioner, with involvement from housing providers and benefit agencies. The aim is to prepare for discharge and support the person's recovery, which is key to the prevention of readmission. The additional staff are helping to identify community solutions around the county and work in partnership to create opportunities for our client group.

5.5.2 We are running preventative drop-ins in the south of the county, with regular sessions at Oak Bank, a facility that supports a number of service users who are homeless and may have mental health problems. Partnership work with Shropshire Recovery Partnership (SRP) will have a particular focus in the South of the County, linked with the existing drop-ins.

5.5.3 We attend the monthly Rough Sleepers Task Force forum where people who are homeless and/or sleeping rough, can be discussed, and strategies identified to resolve their housing situation. Again, partnership working and information sharing with the individual is at the forefront.

5.5.4 One of our social workers with a particular interest in supporting men with depression and suicidal thoughts has facilitated a men's group and a music group, aiming to encourage men to talk about their feelings and improve their confidence and communication skills in line with the

Suicide Prevention Strategy. The music group is held in a music shop and is co-facilitated by the owner, thereby developing community resilience and reducing stigma. The men's group is co-facilitated with a student social worker who has had an opportunity to contribute to something creative and innovative, an important part of his development.

5.5.6 We are developing "Let's Talk Mental Health" hubs. People who are referred to us who have what appears to be lower level mental health needs can access early help and signposting where appropriate. If their needs are more complex than they initially appear they can be offered a Care Act Assessment in a timely manner, and can be referred to other services as appropriate.

5.6 Integrated Community Services (ICS)

5.6.1 We have significantly increased staffing levels in ICS, our hospital social work team, which has been part of a number of initiatives that have enabled us to not only meet, but to exceed our performance targets for DToC. The team are now discharging on average 40 patients per week from the acute hospital and this is a significant increase from this time last year of 15 – 20 discharges per week.

5.6.2 We have committed a significant staffing resource of four social workers to work with the Frailty Team at Royal Shrewsbury Hospital (RSH). This is a dedicated integrated acute and community multi-disciplinary team which is based in the Royal Shrewsbury Hospital (RSH) at the Front Door with the aim of preventing admission to hospital from A&E.

5.6.3 The team is responsible for the early identification, treatment; risk assessment and planning for frail patients (people over 75). The team works together to explore all options from both a medical and social care perspective that may facilitate a return home rather than admission to hospital. This has benefits for the person, their families and the system as a whole. Evidence shows that for some older people admission to hospital can cause a decline in functional health in the longer term; wherever possible home is the best place to be. For the system, preventing admission will help with reducing the numbers in hospital and delays at the other end.

5.6.4 In its pilot phase, the project is already showing some success and our social workers have been an instrumental part in the early outcomes.

5.6.5 We now have a new Carers lead in the hospital who is developing an information hub in RSH to offer information, advice and signposting to support services for family carers throughout Shropshire. In addition to regular information sessions in the hospital the carers lead is also able to meet up with carers when their loved one is a patient in RSH either on the ward or in other venues in the hospital. The carers lead is part of the

central ICS team and RSH Frailty team who make contact if a carer comes into A&E with a family member so the carer can be seen with the following aims:

- make introductory links to carers support workers and services in the local area
- Provide information about resources and assistance available including the Carers Emergency Response Service
- Assist with contingency and future planning
- Give information about referring to the council's social care teams for further information or an assessment for the carer or a family member.

5.6.6 The post is a developing role and a real opportunity to make links with health colleagues in both RSH and Community Services to explores innovative ways to work together.

5.7 "2 carers in a car"

5.7.1 Two carers in a car is a creative service designed to meet the needs of service users at night. We found that often people need care because of falls, anxiety and need for assistance through the night. It appeared that many people being discharged from hospital who required support once or twice through the night were being assessed as requiring a residential placement, simply because there was no alternative. Additionally, assistive technology alone wasn't enough to meet need. We also found that some people who need to have a full waking night support for a short while after leaving hospital needed a service which gradually reduced post discharge. The person was thus able to have a gradual transition from 24 hour care to no right time support enabling them gradually to regain their independence and confidence.

5.7.2 This pilot scheme involves two carers who can travel to any household within the Shrewsbury area to provide support between 10pm and 7am. This support may be assistance for toilet care, to getting into bed at a later time than when regular carers are available, reassurance if just home from hospital, or as an alternative to a hospital admission where night support is required. This scheme enables care support to be provided to a number of people throughout the night for the same cost as a single residential care package.

5.7.3 The project has been running for 7 months in a small urban area and is already evidencing positive outcomes for individuals as well as cost savings.

5.7.4 On average the scheme is supporting 8 people per week. If every one of those individuals had a residential care package for 12 weeks the average cost to the Council would have been £68640. For some

individuals who needed longer term care this would have increased the cost significantly. The cost of '2 Carers in a car' for the same period has been £30240. A net cost saving of £38,400 - well over 50%.

5.7.5 From May 2018 the service will be expanded to 5 market towns across the county. We recognise that the scheme has better potential in urban areas as there is a need to meet a breakeven point to be viable. Which, in general terms equates to 3-4 people being supported each night. However, for very rural areas it is probably not a scheme that could work due to isolation, time to travel etc. although it could be developed if connected to other services.

5.8 Trusted Assessor (independent care home assessor)

5.8.1 The purpose of the role of Nursing and residential provider Trusted Assessor is to support the discharge support programme by providing assessment of an individual's abilities and needs which provider organisations can rely on.

5.8.2 Following a period of in-patient care, and prior to an individual's discharge to a Nursing or Residential Home, Social workers are required to undertake a statutory assessment or review to determine eligibility. Additionally, a separate assessment by the potential provider is currently required in order to enable a safe discharge by ensuring that the potential home setting is able to provide the appropriate level and type of care needed. Providers are required to undertake such assessments ideally in person in order to comply with regulatory requirements and to enable them to demonstrate that they are providing safe and appropriate care.

5.8.3 Currently, multiple providers may be called to assess the individual in the hospital setting, which is wasteful of resource and also potentially distressing for the individual. This process, especially in a rural County such as Shropshire can be incredibly resource intensive and as a consequence may not be undertaken within the time frames now being targeted. This programme is designed to address the capacity and speed concerns whilst also delivering quality assessments (based on knowledge of the capacity and skill sets/abilities of providers) upon which the providers can rely in the context of the regulatory duties. This independent role is key to delivering those positive outcomes for both individuals and providers.

5.8.4 We currently have one trusted assessor in post who has been working with providers to generate support and develop assessment tools for the project. Three additional posts have been recruited to and by April we will have 4 people in posts.

5.9 Discharge to Assess – Additional short term nursing beds

5.9.1 Discharge to assess aims to ensure that all decisions about a patient's ongoing support and care needs (complex discharges) are made outside the acute hospital setting. It aims to give patients access to the appropriate short stay environment and expertise to enable a more planned approach where a more accurate assessment of a patient's potential to maximise their independence can be made.

5.9.2 The key principles are:

- The default position is to enable the person to go home.
- All adult patients have access to the opportunity to improve their independence. All pathways focussed on maintaining and improving independence.
- Patients should always be cared for in the lowest level and least dependent pathway.
- An acute hospital is not the best place to assess frail older people's future needs. Assessments made in the wrong environment will potentially give the wrong solution risking patients going into long term nursing placements when given the opportunity to recover and recuperate from their acute illness or episode and improve their independence they may return home with support or to residential care instead of long term nursing placement. Ultimately the best bed for the patient is always the patient's own bed

5.9.3 The council has commissioned 20 short term nursing beds for people who need longer nursing reablement.

5.10 Impact of the Improved Better Care Fund on Delayed Transfers of Care

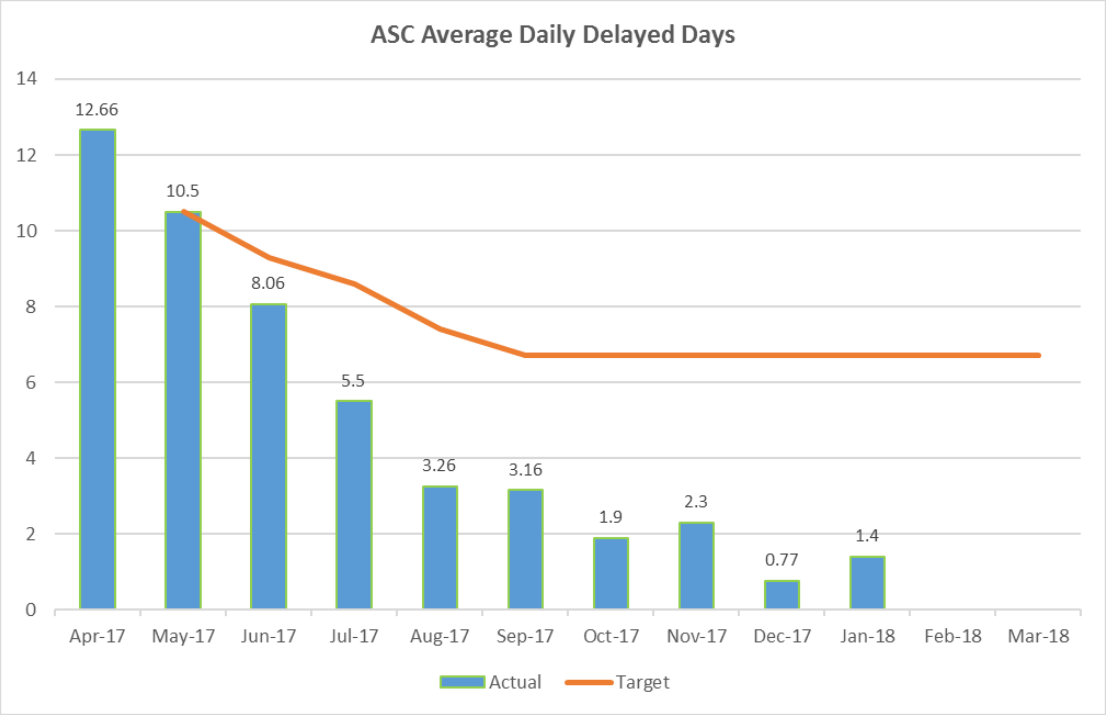
5.10.1 Members specifically asked for details on the impact of the IBCF on DTOC. The winter months have put ever-increasing pressures on our acute local hospitals. Our joint Integrated Community Service (ICS) team have been worked very hard in what has been very challenging circumstances, with the aim of taking the pressure off both our 'front door' (A&E) and the acute wards across our hospital site's.

5.10.2 I am very pleased to report that the Council has exceeded its current target in ensuring that patients do not stay in hospital longer than they need to thanks to the additional capacity from the IBCF initiatives and the hard work and dedication of our staff.

5.10.3 The additional initiatives funded by IBCF have enabled ICS, along with Shropshire Council's START Team, to help alleviate the pressure in the hospitals, by quickly finding the right support for discharged patients.

5.10.4 Rigorous performance targets were set by the NHS in July 2017 and were required to be met by September 2017. Failure to achieve the targets could have resulted in the Council's share of the IBCF being reduced or even removed in 2018/19. Performance since July has been closely monitored and action has been taken to address the number of delays. .

5.10.5 The following chart shows the daily improvement from the commencement of the baseline period; the Council not only achieved but exceeded and continues to exceed the target of 6.7 patients per day by a significant margin. This is an incredible achievement in the face of intense scrutiny and pressure.



*Calculated using number of delayed days in month attributable to Social Care divided by the number of days in the calendar month. There has been a 89% reduction between April 2017 result and January 2018 result.

5.10.6 The IBCF grant monies have been allocated for 2018/2019 and the projects described in this report are fully funded via the IBCF.

5.10.7 The IBCF is monitored monthly by the Head of Adult social care and finance business partner who meet with each project lead to monitor the impact and performance. Details of their performance will be provided in future reports once more meaningful data is available.

5.10.8 Delayed Transfers of Care performance is monitored daily by the service. There is a rigorous process in place, which involves the senior social worker deciding with SaTH whether a patient's delay is attributable to ASC/health or is a joint delay. This is then signed off monthly by the Service manager before SaTH can submit their delay performance figures.

5.10.9 Over the last 12 months, the service has developed a comprehensive set of performance data set which enables us to clearly demonstrate ASC performance to partners, and to identify areas where processes could be improved – not only for ASC but across the system. For example the service can monitor daily the number of referrals (Fact Finding assessments) received from the hospitals and the number required to enable the achievement of, the number of planned vs the expected discharges against the discharge trajectory target.

5.10.10 The performance data will be shared with committee members via a presentation.

5.10.11 The service is confident that we can maintain the low levels of Delayed Transfers of Care attributed to the Council and continue to work with health and social care partners to ensure patients do not stay in an acute hospital bed for any longer than they need to.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information) None
Cabinet Member (Portfolio Holder) Cllr Lee Chapman
Local Member
Appendices none