Shropshire Council

Date: Monday, 12 November 2018

Time: 10.00 am

Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

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HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TO FOLLOW REPORT (S)

7 Delayed Transfers of Care (Pages 1 - 12)

To revisit progress with reducing delayed transfers of care. [Report to follow]

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Health and Adult Social Care Overview and Scrutiny Committee 12 November 2018	Item Public

Reducing Delayed Transfers of Care - Update

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1. Summary

1.1 This a report to update the Committee on the Council's continued progress in reducing delayed transfers of care ("DTOC"). This is the third report to committee in the last 12 months.

1.2 There will be complimentary presentation which will describe 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.

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2. Recommendations:

2.1 To note and make comments on the progress to date in relation to 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 consultations)

3.1 The pressures in the acute hospitals continue to be 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. The

impact of the continued pressure on staff wellbeing needs to be monitored carefully.

3.2 The decision by SaTH board to close PRH accident and emergency hospital at night may have unintended consequences on Shropshire residents and cause delays in discharges. Shropshire Council is involved in the system planning meetings to ensure there is minimal impact.

3.3 Out of county hospitals sometimes declare a delay that has not been agreed with Shropshire council. We now have established relationships with Stoke, Wolverhampton and Herefordshire acute hospitals who contact Shropshire when a Shropshire resident is admitted however there are occasions when other hospitals still declare without agreement which can impact on Shropshire DTOC performance.

3.4 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 a system wide rapid improvement week commencing 5th November to understand why FFA number continue to be below target.

4. Financial Implications

4.1 Within the Spring Budget Statement 2017, it was announced that local authorities would receive additional improved Better Care Funding (iBCF) over 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**

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

4.3 In the financial year 2017/18 the council spent £2,110,463. Year to date in 2018/19 (end of October), the council has spent a further £2,149,595. Total forecasted expenditure for the 2018/19 financial year is £4,673,944. This level of expenditure would leave a balance of £3,151,798 of the 2017/18 and 2018/19 grant to be carried forward for use in 2019/20. The grant (including the forecast unspent balance carried forward) 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.

4.4 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 and prevent DTOC.

4.5 Ahead of the budget announcement it was declared that Adult Social Care would receive one off monies to help alleviate winter pressures on the NHS, getting patients home quicker and freeing up hospital beds, of which Shropshire's share was £1.394m. The budget announcement confirmed this and added there would be further funds in 2019/20 to aid the immediate pressure in social care

4.6 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. Background

5.1 Delayed Transfers of Care (DTOC)

5.1.1 DTOC has been the focus of intense national attention over the last 12 months - Shropshire Council like all councils was expected to reduce the number of patients delayed in hospital.

5.1.2 Early in 2017 Shropshire Council, a middle performing authority at the time, was required to improve its DTOC performance by 60%. Rigorous performance targets were set by the NHS and required to be met by September 2017. Failure to achieve targets could have resulted in the Improved better care fund grant money being removed.

5.1.3 By collectively implementing innovative measures, Shropshire Council exceeded its target, achieving a 75% improvement by September 2017 and a 97% reduction in DTOC between May 2017 and May 2018.

5.1.4 The latest published data (September 2018) 0.3 patients per day were delayed, significantly lower than the new target of 1.3 set by the National Delayed Discharge Programme Board.

5.1.5 Joint delays within Shropshire have historically been higher than the English and West Midlands regional averages. Rates within Shropshire

have been: 2014/15 – 12.6% 2015/16 – 17.3% 2016/17 19.9% 2017/18 – 13.7% whilst national rates have typically been between 6 – 8%

5.1.6 In the year-to-date the joint delay rate currently stands at 11.7% (April – August) which brings us closer to the national average. During 2017/18 there were 3 months where performance was lower than 10% whilst this year this has been achieved in 3 of the 6 months. t Performance for joint delays in August was recorded at 6.8% compared to 7.3% for England. In September joint delays are reported at 2% compared to 7% for England. Whilst there can be monthly fluctuations in results the recent data shows early signs of a step change in reducing the number and rate of joint delays.

5.1.7 Shropshire council Adult social care service has grasped the challenge of DTOC with creativity, collaboration and innovation.

5.1.8 The Council's continued success has been driven through key actions including:

- Creative spending of IBCF monies, developing radical new approaches to moving people through the hospital system.
- Strong leadership and relationship building with health partners to develop trust, including daily contact in the search for constructive solutions to delays.
- Developing a vision for the team, engaging staff to ensure a sound knowledge base and clarity about roles and expectation.
- Staff empowerment and support to lead in partnership meetings and build effective relationships. Staff take full responsibility for jointly agreed processes.
- Robust connections between internal and external teams that are crucial to the DTOC and admission avoidance process. Building communication and team relationships through negotiation, facilitation and mediation has been vital.
- Daily scrutiny and challenge is an established part of the approach. Head of Service and Service Managers are immersed in the detail, applying a 'check, chase, challenge' focus to community and hospital information before recording and sign off.

- Interrogation of performance data to scrutinise current performance, identify gaps and respond in a timely manner to promote improvement.

5.1.9 The team is now safely and appropriately discharging up to 70 patients per week from the hospitals: a huge improvement on last year's 30-40 a week.

5.1.10 A number of projects/ initiatives designed to support effective market stewardship, improve provider performance, gain and maintain county wide market coverage and improve DTOC are currently running within the sector.

5.1.11 **Incentivising**

A programme of incentives is underway that targets the specific issues which are identified by the provider market and brokerage team as problematic and a deterrence to their picking up care packages. These incentives can be authorised by the brokerage team manager and monitored by the Business manager to ensure that outcomes are recorded and that resources are responsibly used. This will ensure we don't have a blanket approach to package's that may have been picked up anyway.

- **Rural Incentives**: An amount of travel time can be added to a package (or group of packages) if it is in a difficult to reach location and hits a 48-hour delay.

- **Urban incentives**: We are discussing professional carers parking permit options with colleagues in the parking department

5.2 Working with Stroke Victims

5.2.1 The Committee have asked for an explanation as to how we work with patients (and their carers) who are recovering from a stroke.

5.2.2 Shropshire Council has dedicated social worker's and a social care practitioner (overseen by senior practitioner) who work at the Princess Royal hospital and Royal Shrewsbury hospital stroke wards. Patients who have had stroke and who don't need further specialist health care (i.e. further hospital based rehab) follow the same "discharge to assess" pathways. The Council does not currently hold specific data on patients who have experienced a stroke but with our new social care IT system which goes live on December 10th we will be able to record specifically the outcomes for patients discharged following a stroke and this information can be provided in a future update to the Committee.

5.3 Readmissions rates

5.3.1 Another important measure is identifying the situation of a patient 91 days following discharge from hospital. This measure is key in establishing the appropriateness of discharges. The national performance indicator captures patients discharged between October

and December in 2017 who were at home 91 days after discharge. In Shropshire we achieved 81.7% compared to the national average of 82.9 and in the west midlands 79.7%

5.3.2 So far in 2018, we have data on patients discharged between April and July 2018 of which there were 513, 450 were at home 91 days from their discharge of the 63 patients not at home, 39 had died, 7 had been readmitted back into hospital, 12 were in permanent placements and 3 in temporary placements. We are therefore currently reporting 85% of patients discharged from hospital are at home 91 days following discharge.

5.4 Update on iBCF Projects

5.4.1 In the last report to scrutiny there was a detailed description of the projects funded by the improved better care fund ("iBCF"). For this report there is an update on some of the key projects that have supported the reduction in delayed transfers of care.

5.5 2 carers in a car background and updated summary

5.5.1 As the committee will be aware**,** we commissioned a domiciliary care provider to deliver a 7 night a week service which started in July 2017 and is still running. This contract requires two carers who can travel to any household within the Shrewsbury area to provide support between 10pm and 7am. This support is for things like assistance for personal care, 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.

5.5.2 Referrals can come from hospitals, Accident and Emergency, Out of Hours Doctors Service, Emergency Duty Team, social care practitioners, district nurses, or GP's. In order to keep costs down the carer team are able to take referrals directly throughout the night via secure email to their smart phone, so the referrals can come to the office in the day and to the carers in the night. We have commissioned 5 different contracts in 5 market towns; over 50 people already with this new service. Currently 24 people who would otherwise have had to go into residential care or had night sit services are being supported and we have delivered just under 3000 visits

5.5.3 We have created a unique service that gives the right support at the right time, doesn't create overdependence and supports quicker hospital discharges, and it costs the council less money

5.6 Independent Care home assessors

5.6.1 As described in the scrutiny report for the March 2018 Committee the purpose of the role of the Independent Care Home Assessor is to support the discharge process by providing an independent assessment of an individual's abilities and needs which provider organisations can rely on.

5.6.2 Following a period of in-patient care, and prior to an individual's discharge to a Nursing or Residential Home, the Council's social care practitioners are required to undertake a Care Act assessment or review to determine eligibility for Council funded services. 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 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.

5.6.3 Previously, multiple providers may have been asked to assess the individual in the hospital setting, which is wasteful of resource and also disruptive and potentially distressing for the individual and their families. This process, especially in a rural County such as Shropshire can be incredibly resource intensive and as a consequence may not be achieved within the time frames now being targeted. This 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.

5.6.4 **2 Outcome:**

- Effective and timely discharges from Acute Hospital settings into Residential/nursing provision by enhancing established discharge processes through liaising with and working on behalf of providers, contributing knowledge of their capabilities and capacity within those processes and undertaking necessary informed assessments.
- 90% of providers are now relying on the independent assessors and that is still increasing
- 77 referrals were received and completed in August – target was 80 in 6 months so they will meet the target.
- Telford and Wrekin are so impressed by our success that they are also setting up their own Independent assessor's team. This is great

news as the two teams will be able to support each other with local assessments, cut travelling down and save time.

5.7 Technology Enabled Care (TEC)

5.7.1 Technology Enabled care is key in supporting people at home in preventing admissions into hospital and residential care and also supporting patients to return back home from hospital**.**

5.7.2 A series of Technology Enabled Care projects have been developed. Specifically, they look at how technology can support and improve care service provision.

5.7.3 This committee has previously shown great interest in TEC so for the purpose of this report I have provided an update on three projects as well as describing the potential for a fourth:

- Hospital Discharge Telecare Pilot
- The Broseley Project
- Beech Gardens Step-Down Beds
- Technology Enabled Care Community Hub

5.8 Hospital Discharge Telecare Pilot

5.8.1 This is a pilot testing out a scheme designed to support hospital discharge as well as reducing readmissions and the need for ongoing care through the provision of telecare equipment.

5.8.2 This model, and variations of it, are being used in other parts of the country. Working with “Wellbeing” a telecare provider, Shropshire Council is exploring how effective this model is locally and identify what, if any, amendments are needed to ensure its success.

5.8.3 The model sees the Council fund the telecare provision and monitoring costs for the first 13 weeks following a patient’s discharge from hospital.

5.8.4 The pilot has been running since the end of 2017 in the Central Shropshire area only but is in the process of being rolled out to the rest of the county by December 1st.

5.9 The Broseley Project

5.9.1 In recent years we’ve begun to see advanced technology make its way into everyday devices. Smart devices that can “talk” to each other, artificial intelligence, voice and facial recognition are now enabling us to interact with household devices in new and intuitive ways.

5.9.2 This offers huge potential for the provision of health and care services, enabling people to remain independent and living in their own homes for longer and in some cases reducing the need for more intrusive ongoing care. The Broseley Project (called as the first phase uses volunteers from the Broseley area) explores these possibilities and looks to see if everyday consumer technology can be used or repurposed to delay or prevent the need for more intrusive forms of health and social care support.

5.9.3 Initially the project will test 3 items of existing consumer tech – an Amazon Echo Show, an Amazon Echo Dot, and a Samsung Gear-Fit Pro fitness tracker. The first phase of this project explores whether these 3 devices, working together can address 3 key issues:

- Social Isolation
- Falls Detection
- Fall Prevention

5.9.4 Using a shared community calendar, the Echo can remind and prompt people about events taking place in their community (e.g. the community bus is in town today, there's a coffee morning tomorrow etc), thereby facilitating social inclusion. The Echo Show can be used as a video phone (with others who also have an Echo Show), so there is potential to access services, friends, and social groups for those who are rurally isolated.

5.9.5 The fitness tracker currently records if you have ascended a staircase as well as measuring steps taken over a given distance. We will test if these functions can be repurposed to detect a fall (a sudden drop in height) or if someone is taking more steps to cover the same distance (a possible indicator of a falls risk).

5.9.6 Working with the Lady Foresters Centre and Hitachi we have identified a pool of around 20 Broseley residents who have expressed an interest in this project. Our only criteria being you had to live in the Broseley area and be aged 65 or over.

5.10 Beech Gardens Step-Down Beds

5.10.1 The provision of Step-Down beds, providing a safe environment for reablement or rehabilitation for patients after a spell in hospital is essential especially for patients recovering from strokes.

5.10.2 One such facility is at Beech Gardens in Ludlow, where 2 self-contained bungalows have been commissioned as Step-Down beds.

5.10.3 To support this facility, Shropshire Council has equipment these bungalows with the type of Technology Enabled Care most likely to be used to either support reablement and/or ongoing care at home. This provides a safe environment for equipment familiarisation and brings added value to any reablement.

5.10.4 In addition to traditional Technology Enabled Care, the Council is also fitting out the bungalows with consumer technology that has the potential to support ongoing independence. It is hoped that the use of such equipment will provide a learning opportunity to better understand what technology best supports people post hospital discharge.

5.10.5 There is also an opportunity to use these bungalows as a demonstration and training site, supporting staff and individuals make better informed decisions about longer term care options.

5.11 Technology Enabled Care Community Hub

5.11.1 With advances in technology and the blurring between what is “Assistive Technology” and what is “Consumer Technology”, the choices facing individuals and professionals alike about Technology Enabled Care can be overwhelming.

5.11.2 With this in mind, Shropshire Council is exploring the creation of a Technology Enabled Care Community Hub.

5.11.3 Based at the Lantern in Shrewsbury and hosted by the Independent Living Partnership (ILP) as part of their existing community equipment demonstrator “home”, this will be a place where Technology Enabled Care devices will be available for demonstration to both professionals and the general public alike.

5.11.4 Initial talks have begun with ILP. This covered agreement in principle to the proposal, the range of equipment to consider, and practicalities around referrals, public access and training for professionals.

5.11.5 It was felt that the range of equipment should include the most used technology issued by Shropshire Council, but also other useful consumer technology.

5.12 Preventative Services

5.12.1 The continued investment in preventative services has further contributed to a reduction in hospital admissions, and prevention of delayed discharges.

5.12.2 The commissioning of the 'Help at Home' and 'Universal Prevention' contracts, along with other small grants, has contributed to enabling individuals to remain in their own homes with support to ensure they are able to continue to meet their health needs and prevent deterioration leading to poor health and admissions to Accident and Emergency departments

5.12.3 The availability of these services also enables discharges from hospital to take place following an admission where an individual requires low level care and support to manage their health needs but does not require formal Council-funded care and support. These services can be accessed immediately when someone has been identified as medically fit for discharge and can support them to get home if required. This also reduces pressure on the domiciliary care market enabling them to pick up them more complex discharges.

5.12.4 The funding of the British Red Cross Integrated Community service. One member of the BRC Home from Hospital team sits in the Integrated Community Service team at William Farr House (ICS Central) working to wrap care around any patient that needs it from the moment they are ready to be discharged from hospital. They conduct a brief assessment that identifies exactly what a patient needs to move from hospital to the best place for their on-going care to be provided.

5.12.5 Once home, BRC conduct a more comprehensive assessment that results in patient-centred goals being set that allows them to implement a short-term package of care or reablement, optimising the patient's independence. They also refer onto the Home from Hospital service preventing readmission into hospital.

6. Conclusion

6.1 Shropshire Adult social care has had a remarkable year of, innovation and achievement. We have been identified as one of the most improved Council's nationally for DTOC targets and have reached the finals of the National Social Worker awards for best team of the year and have also reached the finals in the LJC awards for the 2 carers in a car innovative project. The service has worked hard to develop excellent relationships with partners in health, voluntary and private sectors, resulting in an unprecedented confidence in hospital social work. It has a strong social care identity and ethos with an approach of collaboration, innovation, exploration and above all, tenacity.

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