SOCIAL SERVICES SCRUTINY COMMITTEE – 18TH JUNE 2019

SUBJECT: **PREVENTING UNNECESSARY HOSPITAL ADMISSIONS**

REPORT BY: **DAVE STREET CORPORATE DIRECTOR SOCIAL SERVICES**

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1. PURPOSE OF REPORT

1.1 To update members of the Social Care and Well-Being Scrutiny Committee on initiatives in practice to prevent unnecessary admissions to and facilitate timely discharges from hospital.

2. SUMMARY

2.1 Home First is one of a suite of initiatives sponsored by the Gwent Regional Partnership Board to support the continued development of a '*seamless system'* of care, support and wellbeing in Gwent in response to the Welsh Government's new long term plan for health and social care 'A Healthier Wales'.

This paper sets out to explain what Home First is, why it was created, what it aims to deliver and how its effectiveness will be measured and monitored.

2.2 Discharge to assess (D2A) is an initiative the Community Resource Team (CRT) have introduced in Ysbyty Ystrad Fawr (YYF). This was initially piloted and is now an established discharge pathway. D2A aims to reduce the amount of time individuals stay in hospital unnecessarily, who can be safely discharged back to the community with minimum or no formal support in place and an assessment carried out post discharge at home. Evidence suggests assessing an individual in their own home reduces their level of dependency, which in turn often reduces the level of support required long term. Focus also shifted to helping individuals achieve what matters to them by providing creative individual solutions that includes using their own strengths as well as family and community links rather than commissioning standard care provision.

3. RECOMMENDATIONS

3.1 Members note the progress that has been made in Home First across the region using transformation grant funding.

3.2 Members note we are currently in the middle of a Wales Audit Office – Well-Being of Future Generations examination of the authorities Well-Being Objective 5 "work in partnership with Aneurin Bevan University Health Board (ABuHB) to prevent unnecessary admissions to hospital and facilitate timely discharges "A report on the outcome of the examination will come to the committee in due course.

4. REASONS FOR THE RECOMMENDATIONS

4.1 To report on progress on Objective 5 - Creating a county borough that supports a healthy lifestyle in accordance with the sustainable Development Principle within the Wellbeing of Future Generations (Wales) Act 2015.

5. THE REPORT

5.1 The pressures, challenges and demands in adult social care have been well documented both locally and nationally. The demand for social care services are growing in the context of significant demographic changes and the growing incidence and large prevalence of complex, long term conditions. The ageing population means over a quarter of the population in Wales is aged 50 plus. Those aged over 65 are expected to increase from around 600,000 in 2013 to 900,000 in 2037 and the number of over 85s is growing at an even faster rate (Age Cymru, 2015). Wales also has a higher proportion of people aged 85 plus compared to the rest of the UK (Stats Wales, 2012). The Population needs assessment for the Gwent region has highlighted some key points

- There are significant increases projected for the over 65 years of age population when an estimated 1 in 4 people (26%) will be aged 65 or older – which is broadly similar to Wales.
- By 2036, it is estimated that the number of people aged 85 and over will increase by 147%.

5.2 As expected, the challenges experienced in adult social care are mirrored in the health service. Changes in how people live their lives and the success of the NHS in keeping people alive for longer means demand for care is rapidly rising. Wales currently has the highest rates of long-term limiting illness in the UK. All these factors affect people's health and increases demand on health and care services.

5.3 The impact, whilst all year round, is exacerbated in the winter months. The ageing population, accompanied by increasing co-morbidity, medicalisation, frailty and social isolation, is a long term driver of unscheduled care demand in the hospitals. As people live longer but have fewer children, there is an increased proportion of the population who are dependent on care. On average, older people have lower baseline functions, greater frailty and lower resilience. This leads to greater need for support for the activities of daily living, tipping over into acute ill health at a lower threshold, and slower recovery from illness, which places increased demand on health and social care services.

5.4 While attendance at Emergency Departments (EDs) remains generally static, the complexity of patient need and other influencing factors have resulted in performance not improving despite numerous initiatives focussed on EDs efficiency. The complexity and severity of conditions of those admitted places a huge strain across ED. The most significant issue is not the numbers of people presenting at ED but the ability to provide alternatives to admission alongside the ability to transfer patients safely and quickly from hospital to their place of residence and to prevent readmission.

5.5 Winter planning is high on the agenda for Welsh Government to ensure there is an effective flow for patients. In essence, the previous service at the front door EDs could not cope with the rapid presentations with limited exit routes. This resulted in

- Delays due to social care assessments
- Longer stays on short term wards
- Patients being admitted into the hospital system unnecessary
- Increased dependency of clients
- Ambulance back ups

5.6 To avoid the repeat of the previous problems, the five Local Authorities in the Gwent area have worked in collaboration to provide an alternative response to these patients. In line with the philosophy of Social Services and Wellbeing Act the response promotes the maximisation of independence utilising strength based assessments hence the name **Home First** not hospital admission by default.

5.7 The winter of 2017/18 saw high levels of escalation at all hospital sites due to pressure across the urgent care system in Gwent with the highest volume of attendances at Royal Gwent Hospital and Nevill Hall Hospital emergency departments for 9 years' experienced in June and July. Alongside this, GP referrals to secondary care assessment continue to rise.

5.8 In March 2017, ABuHB commissioned an external organisation (My Care my Home, MCMH) to provide a rapid assessment and emergency domiciliary care response to the EDs in Neville Hall facilitating 10 discharges a week. The intervention of a private organisation in the hospital discharge processes generated some concerns and challenges to the five Gwent Local Authorities which were shared with ABuHB. Towards the end of the pilot in May 2018 there were a number of lessons learnt for all partners.

- Rapid assessment from **one** team on site has positive benefits
- An extended service 7 days a week keeps the flow going
- The introduction of a private company to a systems response creates a 'stand alone' procedure that does not flow or tap into any of the existing support systems

Assessments by MCMH resulted in an over provision of care on discharge which was difficult to reduce when expectations had already been set thus increasing dependency and calling upon an increasing use of a scare domiciliary care resource inappropriately.

5.9 In response to Winter Pressures ABuHB expressed a wish to secure a support service for EDs that would:

- Develop a standardised definition for Home First Model.
- Provide a single point of access for the clinical teams in order to expedite discharge assessment, normally within 1 hour.
- Provide accelerated discharge times of 4 hours, but no longer than 24 hours.
- Provide a home first pathway for patients as a viable option to short term admission into hospital, through short term care options-Front door turnaround.
- Provide a Gwent wide Local Authority discharge process, with Local Authorities working in partnership for the Home First model.
- Enhance the current step up/down pathway as an alternative community pathway from acute hospitals.
- Provide information, advice and assistance empowering patients to meet their own needs using their networks and resources.
- Provide an opportunity to think in a whole system way and support cultural change.
- Prevent unnecessary moves from district general hospital setting into community beds in order to increase patient flow-avoiding missed opportunities to discharge.
- Develop a pathway to discharge people directly to Community Frailty service especially reablement to promote independence and reduce reliance on traditional services.
- Provide necessary equipment and minor adaptations in order to expedite discharge.
- Provide bridging packages of care and support until long term provider is in place to reduce length of stay for people.
- Provide assessment at home/assessment beds daily using Local Authority experienced care staff to reduce and or cease care packages/support as soon as possible to ensure capacity and flow.
- Provide a pull model for wards across district general hospitals.
- Provide this service alongside Third sector organisations which support the Home First model.
- Provide services between 8am -8pm, weekend and Bank Holidays.

- Provide an opportunity to grow our own "Home First" champions across the Gwent Health and Social Care community.
- 12 hr 7 day service, including bank holidays and weekends with on-call provision
- Rapid discharge for medically fit patients, assessment within 1 hour and discharge within 4 hours, but no longer than 1 day
- Provide a bridging service (package of care) of 14 days along with assessment within persons home during the period, over-night stays (night sits) when required to support earlier discharge
- Support 10 discharges a week from Nevill Hall Hospital and/or Ysbyty Aneurin Bevan Hospital
- Support 15 discharges a week from Royal Gwent Hospital and/or Ysbyty Ystrad Fawr and /or County Hospital.

5.10 As an alternative to commissioning a private provider the five Local Authorities put together a collaborative offer to the health board that would meet the targets and requirements above through:

- The employment of 'rapid assessors' based in the EDs in the RGH and NHH that would assess of behalf of the five Local Authorities. Managed by a newly appointed Home First manager the assessors will be hosted by Newport City Council and will be expected to provide assessment support from 8 am to 8 pm during weekdays when recruitment finalised and 9 am to 5 p.m. on the weekends. In addition the rapid assessors will provide support on bank holidays including Christmas Day. The first few months have been supported by existing practitioners on a rota basis drawn from the five Local Authorities, they continue to provide cover on the weekends whilst the model is tested.
- Each Local Authority has increased the capacity of their rapid response home care services or in some cases introduced a new service. In Caerphilly this has meant an increase of six 14 hour Emergency Care @ Home posts.
- Rapid Assessors will also be able to arrange taxi transport to facilitate discharge where this has been assessed to be a blockage to discharge.
- Following endorsement by the Regional Partnership Board the proposal was incorporated into the Regional Transformation Offer to Welsh Government in order to secure funding from the Transformational Grant.

5.11 The following Key Performance Indicators have also been agreed

- Number of people discharge using this route per week against the target , can split North and South and by LA
- Number /Percentage of people who didn't require transport
- Number and description of items of equipment provided
- Number and description of minor works of adaptations undertaken
- Number of people who were not discharged as planned and reasons for this
- Compliance with target time of assessment to commence within 1 hour
- Compliance with target time of discharge 4 hours but no more than 24 hours
- Number of people referred directly to reablement and/ or assessment beds
- Volume of people being discharged using the route
- Feedback from people and their carers/families on the service

5.12 **Conclusion**

It is fair to conclude that it has been very difficult to report accurately on performance against the KPI's due to two main issues Firstly access to IT for staff, to all 5 LA systems which has very recently been resolved and secondly definitions in terms of medically fit, where people have been referred and then been deemed not fit to be discharged and they are seen again at the next ward round issue is double counting and failure to discharge. As a result of this a performance officer has been appointed by the authorities, they have commenced in post and are developing a standard reporting tool to address anomalies which will be populated monthly.

The feedback from staff both local authority and health has been extremely positive in terms of the ability to work across organisational boundaries to achieve the right outcome for people and organisations in preventing unnecessary admissions to the wards.

6. ASSUMPTIONS

6.1 It has been assumed that the transformation grant process will include quarterly monitoring and evaluation, to inform an exit strategy should the transformation grant funding cease in March 2021.

7. LINKS TO RELEVANT COUNCIL POLICIES

7.1 **Corporate Plan 2018-2023**

Objective 5 - Creating a county borough that supports a healthy lifestyle in accordance with the sustainable Development Principle within the Wellbeing of Future Generations (Wales) Act 2015.

8. WELL-BEING OF FUTURE GENERATIONS

8.1 A healthier Wales*

The report should also state how it is consistent with the five ways of working as defined within the sustainable development principle in the Act. The five ways of working of the sustainable development principle, listed in the Act are:

- Long Term – The importance of balancing short-term needs with the need to safeguard the ability of future generations to meet their long-term needs The models link to clinical futures and the opening of the University Grange Hospital
- Prevention – The initiatives focus on prevention of loss of peoples independence and autonomy
- Integration – Links to objective 5 of Well-Being plan
- Collaboration – Home First is collaborating with the 4 other local authorities in the ABUHB footprint to provide a consistent service regardless of where someone lives
- Involvement – Feedback from people who have used the service will be integral to developing Home First.

9. EQUALITIES IMPLICATIONS

9.1 An EIA screening tool has been completed in accordance with the Council's Strategic Equalities Plan and supplementary guidance. No potential for unlawful discrimination and /or low level minor negative impact has been identified; therefore a full EIA has not been carried out.

10. FINANCIAL IMPLICATIONS

10.1 There are no financial implications associated with this report.

11. PERSONNEL IMPLICATIONS

11.1 There are no HR implications associated with this report.

12. CONSULTATIONS

12.1 The report reflects the views of the consultees.

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