Leeds CITY COUNCIL

Agenda Item 8

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**Report of the Director of Adult Social Services**

**Scrutiny Inquiry into Residential Care**

**Date: 10 November 2010**

**Subject: Health Service Direct Discharge into Residential Care.**

| **Electoral Wards Affected:** | **Specific Implications For:** |
|---|---|
| | Equality and Diversity ☐ |
| | Community Cohesion ☐ |
| ☐ Ward Members consulted (referred to in report) | Narrowing the Gap ☐ |

**Executive Summary**

Discharge from hospital directly into residential and nursing home placements is a trend which has increased since April 2009 This trend has added to the in year budgetary pressures for Adult Social Care (ASC) and impacts on individuals who, with reablement and alternative community support could have been supported to maintain independence within their own homes and communities.
ASC is working closely with the NHS to reform the health and social care system to create a culture where people are supported to maintain their independence and to maximize use of reablement and assistive technologies.
In the short term both social care and health recognise the need for immediate actions. The Unplanned Care Board(a joint ASC/NHS forum) have been tasked to lead on this and have put in place an action plan which addresses issues in the system with actions targeted around both hospital avoidance and discharge.

## 1.0 Purpose Of This Report

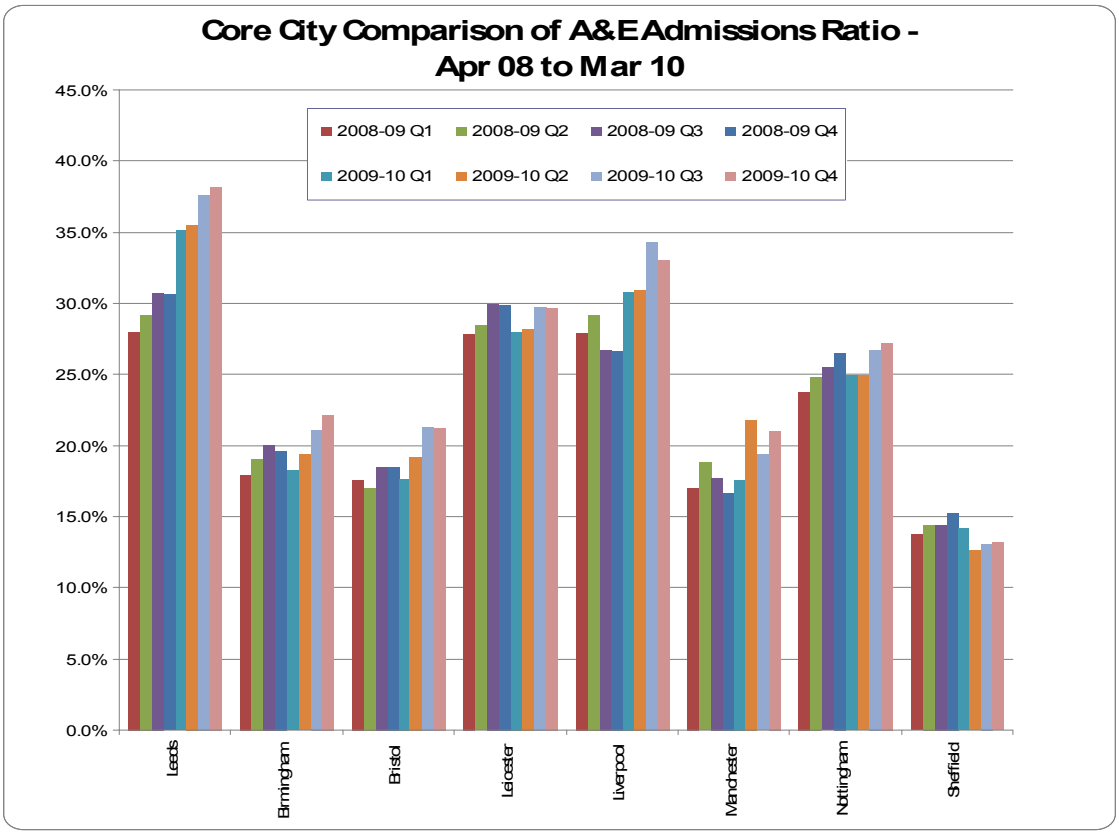
1.1 The Scrutiny Board enquiry ,as a result of its investigation into Residential Care, has requested a specific report on "Health Service - Direct discharge into residential care without a further period of recovery of assessment. Budget impact and proposals to restore good practice". Rather than incorporate this into the current enquiry a separate report has been commissioned on this particular issue and is provided here for the November Board meeting

1.2 The purpose of this report is to give Adult Social Care Scrutiny Board information on the work currently being undertaken around hospital avoidance and discharge pathways.

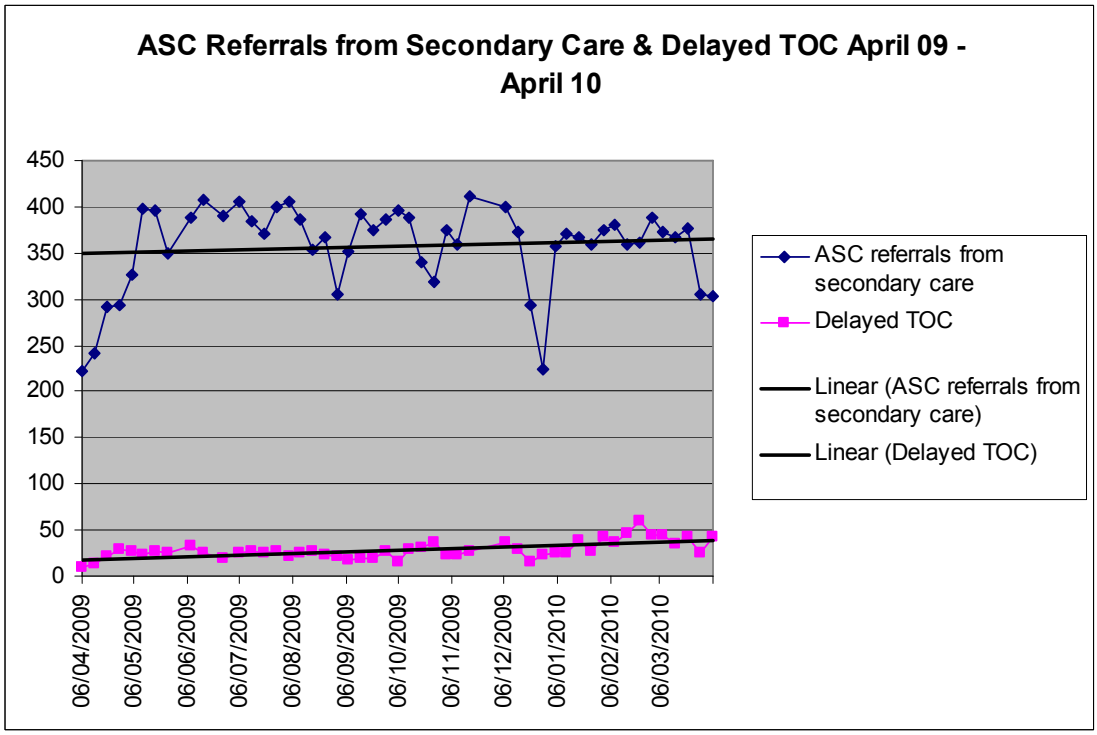
1.3 The report discusses the role of the Intermediate Tier Programme Board in driving this agenda forwards and highlights some of the initiatives that are being actioned.

## 2.0 Background Information

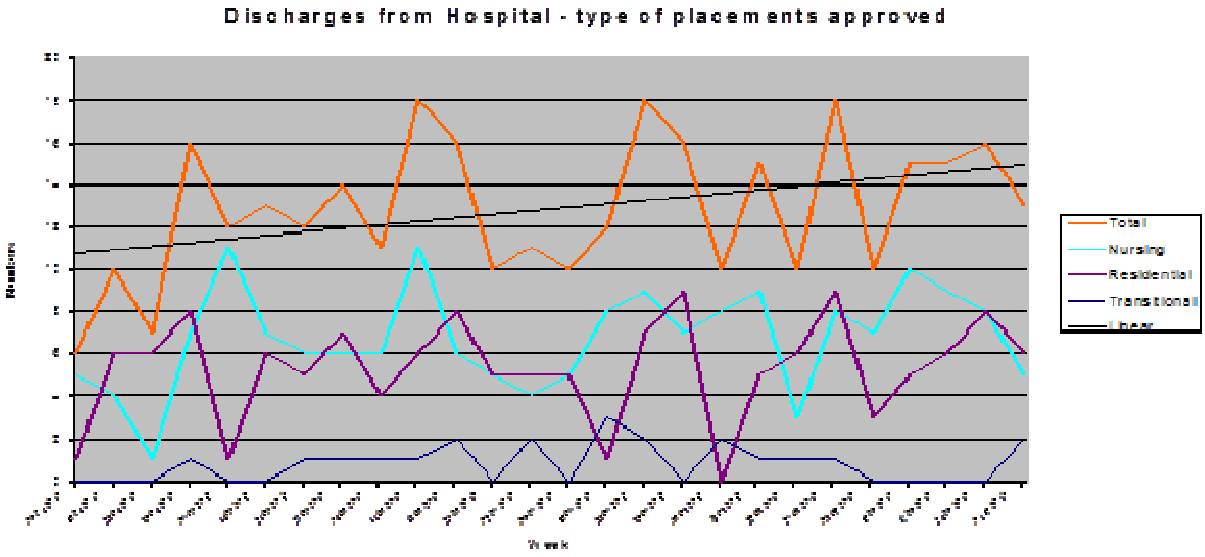
2.1 A trend in increasing hospital admissions has been identified in Leeds. This is impacting on both Health and Social Care Services. A core city comparison of A&E admissions ratios from April 08 – Mar 10 shows that Leeds Teaching Hospitals NHS Trust (LTHT) is an outlier.




2.2 Over the time period April 09 to April 10 Adult Social Care referrals from secondary health services show an increasing trend. The percentage of referrals from secondary care to ASC were 33.6% of all referrals to ASC in Q4 0809. This increased to 38.9% of all referrals to ASC in Q1 0910 and remains a consistently higher percentage to date.




2.3 The graph below shows the trend in residential placements direct from hospital. The placements are split between residential, nursing and transitional beds.




2.4 To successfully tackle the rise in admissions to hospital and the impact that has on both services and service users a multi-agency partnership approach is required. The NHS Leeds Community Services Commissioning Strategy 2009-2013 identifies the Intermediate Tier Pathway as a priority for transformation. It describes a vision where all adults are given an opportunity for recovery, reablement and rehabilitation before decisions are made to meet long term care needs, with services focused on earlier preventative interventions to support independence, health and wellbeing. For some people, this will mean being enabled to self care, and for others sustained support to manage their long term health and social care needs.

2.5 Intermediate care has an important function in meeting the health and social care needs of individuals to prevent unnecessary admission, expedite appropriate hospital discharge and avoid premature admission to care homes.

2.6 In March 2010 the Intermediate Tier Programme Board was established following a recommendation from the Joint Strategic Commissioning Board. The Intermediate Tier Board is jointly chaired by NHS Leeds and Adult Social Care and has representation from all partner organisations in the Leeds health and social care system. The Board's vision for the future is to enable people, regardless of age, with complex health and social care needs, including those with mental health needs, to be cared for closer to home avoiding the need for unplanned hospital attendances and admissions and reducing the need for long-term admission to residential or care homes.

2.7 There are a number of workstreams sitting under the Intermediate Tier Programme Board including a workstream on Tackling Delays which is led by the Unplanned Care Board. The Unplanned Care Board has put together an action plan to unpick and address discharge issues.

**3.0 Main Issues**

3.1 As indicated in 2.2 and 2.3 the number of referrals from secondary health services into social care are increasing and at the same time there is an upwards trend in residential placements direct from hospital. Looking at the whole system there is also an increase in admissions to hospital and this trend is growing in the older age groups and particularly pronounced in the over 85s age group – a group which is relatively low in numbers but impacts significantly on ASC services.

3.2 For some of these individuals a placement direct from hospital to residential or nursing care may be entirely appropriate. It may reflect degeneration in physical fitness and episodes in hospital increasing in frequency and the individual may no longer be in a position to maintain their independence. For others a period of reablement followed by appropriate ongoing support, if needed, may prevent admission to long term residential care.

3.3 Both Health and Social Care are committed to transforming services to create a culture where people are supported to maintain their independence where possible. 2.4 describes the vision for transforming the intermediate tier pathway, this sits alongside the transformation work being undertaken by ASC in implementing Putting People First. In the long term the transformation of health and social care services will alter the way services are provided and people's expectations in terms of support. This is being progressed in parallel with short term actions to impact on budgetary pressures in the interim.

3.4 In putting together an action plan on tackling delays in discharge from hospital and ensuring that where possible people are supported to maintain their independence the Unplanned Care Board are targeting actions at key points in the pathway. This begins with initiatives to keep people out of hospital. There are a number of actions aimed at hospital avoidance – if people are not admitted into hospital in the first instance then they are not debilitated by hospitalisation. For those who have been admitted there are a number of actions being progressed to ensure that partner organisations work together to minimise duplication and to ensure that appropriate supports are available to people to get them back into the community. One of the key strands of this action plan is the rollout of reablement services within the hospital pathway. This is currently being piloted.

3.5 **Reablement.** The whole systems approach Leeds ASC has adopted to develop the Leeds Reablement Service has been specifically designed to remove service bottlenecks and blockages and hence minimise service delays following hospital discharges and other points of entry into service. Part of this work is to ensure that the right resources are in place throughout the reablement process. This is in terms of the development of the new homecare reablement service, which is being sized based on projected service demand for this and coming years; and also in terms of ensuring other existing teams involved in reablement (e.g. Hospital Social Work teams and Initial Response Teams) are adequately resourced to handle reablement case loads.

3.6 Reablement works to the existing hospital discharge protocol and timeframes, so service users are placed back in the community within 72 hours of hospital discharge. To ensure hospital discharges are not delayed, service users are assessed for reablement in hospital prior to discharge, to ascertain the reablement outcomes that will go into individual plans. The CSS SkILs (Skills for Independent Living) service is a new 7 day a week service being developed for all service users in the community, whether following hospital discharge or as community customers, so service users discharged from hospital on a weekend will receive service without interruption or delayed discharge. To ensure individual plans reflect service users' local environments, reablement plans are reviewed within one first week of hospital discharge when the service user is back in a community setting.

3.7 Sitting alongside Reablement services are the intermediate care services provided in the community by the NHS. ASC have been working with health colleagues to ensure that as Reablement services are developed the opportunity to link with intermediate care is considered. Both services aim to ensure the timely transfer of care from hospital to the most suitable community setting. Leeds' ASC officers have worked closely with NHS Leeds and NHS Community Services colleagues to map the interface into ASC for hospital discharges, to ensure a smooth transition from hospital into the community. The hospital discharge pathway into reablement has been mapped and agreed, and a draft set of entry requirements for both the Reablement Service and the Intermediate Care Team have been drawn up, clearly delineating referral types and exclusions from both services.

3.8 This partnership approach is also being applied with LTHT. Hospital OTs are being utilised in the reablement service to ensure that customers who enter the reablement service via hospital discharge receive a functional assessment prior to discharge. A functional assessment is where the assessor engages the customer in actual tasks for example, mobility, daily living skills, domestic, work or leisure activities, which the assessor observes and analyses to determine the limiting factors and opportunities for improved performance. Where there is a need for a functional assessment and a hospital OT is unavailable, a community OT from the Council's Disability Services Team will provide one. The functional assessment is a key part of the reablement process, allowing outcomes based assessments and full reablement plans to be completed, clearly highlighting both what reablement customers can, can't and would like to do following a period of reablement, then setting reablement outcomes accordingly.

3.9 The Intermediate Tier Programme Board has identified the need to explore the interface between Reablement Teams and Intermediate Care Teams (ICTs), and possible integration between them, as a priority workstream for the programme. The intention is that this could lead to wider integration between health and social care services at locality level. A Project Group has been established to take forward the following actions:

- Work on the respective pathways for reablement and intermediate care, ensuring clarity regarding getting people into the right service and how people could transfer between the two services
- Development of common assessment tools for use by OTs in Reablement Teams and therapists in ICTs
- Development of common outcome measures
- Establishing channels of communication between the two services to enable each to know whether the other is already involved with a particular client
- Establishing co-location and alignment of teams where possible, linked to the development of Neighbourhood Health Teams focused around GP practice populations
- In the medium term, to consider possible integration of support workers across health and social care

3.10 **Use of transition beds.** Adult Social Care is also reviewing its use of transition beds. Within LCC residential services where we have voids it is proposed these can be used to facilitate discharge from hospital by being used as transitional beds. This is a best value approach as it makes good use of empty beds but also avoids the need to pay for transition beds in private accommodation.

3.11 The challenge in using beds in this way is that service users are in a residential setting and may quickly lose their independence skills and become resistant to returning home when everyone around them is permanently resident. This is particularly so for relatives and family who naturally want to avoid risk and see residential care as safer option. ASC are currently exploring the viability of grouping voids together to create transitional units with a reablement culture where the culture is to enable rather than “do for” residents thus ensuring independent living skills are not quickly lost.

3.12 **Exploration of a joint night service with health.** In considering the services which would need to be in place to give a GP assurance that they do not need to admit to hospital, or to expedite discharge; the potential availability of night support has been raised. Adult Social Care, NHS Leeds and NHS Leeds Community Services are currently in discussion on the viability of a joint night support service. This would be targeted at hospital avoidance and assistance with hospital discharge by providing service users with access to support 24/7. The feasibility for this needs careful consideration to ensure there is a need for this type of service, that it could achieve its objectives and that it offers value for money.

3.13 **Changing expectations and behaviours.** An important piece of work is to change the culture within the system – in GPs surgeries and community healthcare and in hospitals. NHS Leeds are progressing work with GPs and Community Matrons firstly to raise awareness of alternatives to hospital admission and secondly to look at developing a single point of access to these services so busy health staff do not need to go through a list of community options to find the appropriate one for their patient

3.14 Work also needs to take place to change the culture in hospitals. There needs to be a move away from a culture where hospital staff assume a residential placement is most appropriate without consideration of reablement and other alternatives like Assistive technology options. If service users and their families are given to believe that they need a residential placement then it is much harder to give the individual or carer the confidence that the service user will, following a period of reablement, be in a position to continue living in the community.

## 4.0 Implications For Council Policy And Governance

4.1 Leeds City Council needs to continue working in close partnership with health taking a whole system approach to tackling trends on hospital admission and discharge direct to residential care. Where there are opportunities to work innovatively in partnership to address these issues we need to consider how we can make this happen.

## 5.0 Legal And Resource Implications

5.1 A whole system approach to tackling this problem is vital as changes in one part of the health and social care system made in isolation can impact negatively elsewhere and prove costly to partners. The intermediate tier programme board has put in place measures to ensure that the true cost to the whole system is captured and understood.

## 6.0 Conclusions

6.1 A trend in increased admissions to residential care direct from hospital has been identified and a number of initiatives are being put in place and actioned to reverse this trend. In the medium term health and social care are working together to undertake a whole system transformation to develop a culture and services which promote independence and support people to live in the community. In the short term the multi agency unplanned care board have in place an action plan to tackle pressures and take practical measures now.

## 7.0 Recommendations

7.1 Scrutiny Inquiry are asked to note that there is a multi agency system wide approach to tackling the trend in increased admissions to hospital and its impact on services, including admissions to residential care. A number of short, medium and long term actions are in progress to tackle this and progress is being monitored and reviewed by the Intermediate Tier Review Board which is jointly chaired by ASC and NHS Leeds

## Background Documents referred to in this report

NHS Leeds Community Services Commissioning Strategy 2009-2013

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