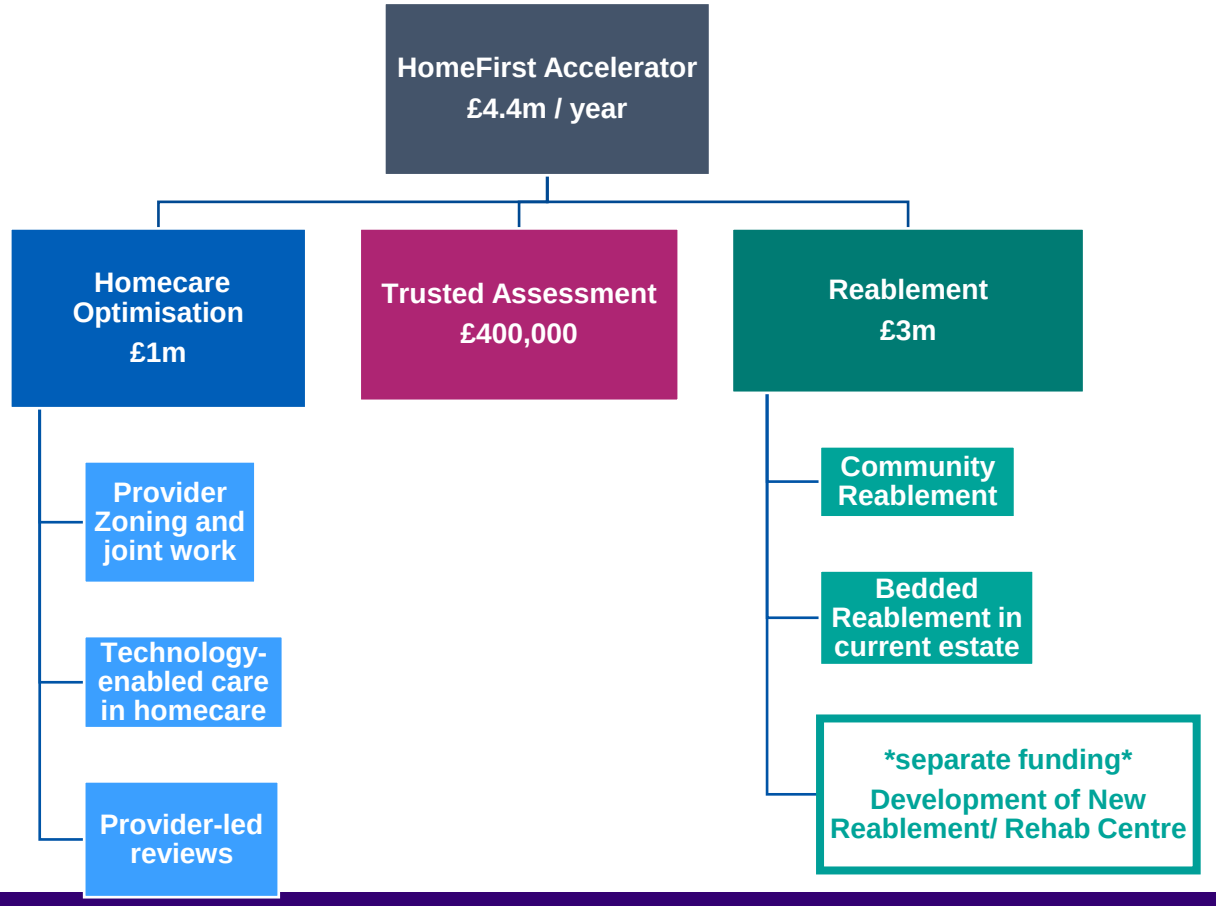
Dorset - Better Care Fund 2023/24 Quarter 3 Return

Case Study: Dorset's Home First Accelerator Programme

Overview: Dorset's HomeFirst Accelerator Programme

- A robust programme of activity to redesign the social care out-of-hospital provision as part of the developing ICS Intermediate Care strategy
  1. **Homecare optimisation is improving the conditions for delivering sustainable homecare**
  2. **Trusted assessment – led by Dorset Care Association, is transforming our approach to assessment in hospital, reducing discharge delays and utilising partner provider skills to conduct proportionate assessments as part of our Pathway 1 avoidance and discharge pathways**
  3. **Our Reablement services have been strengthened with rapid stand-up of short-term bed capacity, and emerging plans for ambitious new bedded facilities**
- Sits alongside a wider plan of action around developing the provider market in homecare

- Due to the clear alignment between this programme and the BCF objectives, we added new investment into BCF 2023-25 via additional NHS contributions.



Home Care Optimisation

Aims & Objectives

- Since the midst of the Covid pandemic, in Dorset, like many other areas of the country we had seen a decline in homecare capacity
- This was leading to long waiting lists for care, and over-reliance on residential placements as an alternative, particularly to support hospital discharge.
- We needed to work with the market to improve the conditions and create a sustainable landscape

Method & Approach

- Fair cost of care approach to inform rate setting
- Implementation, through our contracting framework, of a zoned approach
- Commissioners and providers worked closely together to review rounds, identify opportunities to optimise areas, reducing travel time and increasing capacity for care
- Piloting with trusted Providers to:
  - Identify existing packages where an alternative TEC offer may reduce face to face care requirements
  - Conduct review activity for an identified cohort on behalf of the Local Authority

Trusted Assessment

Aims & Objectives

- Care Homes require an up-to-date assessment of a person's care and support needs, in order to ensure they can safely provide care.
- Prior to 2021/22, the assessment process was regularly adding several days to a person's hospital stay, once they had been deemed 'fit for discharge.' This was negatively impacting those individuals' outcomes, but also 'blocking' acute hospital beds for others needing treatment.
- Conflicting pressures for both providers and hospital teams had led to often strained relationships, with reduced levels of trust. This had resulted in every individual needing an in- person assessment by the provider, even if the person was returning to their care home placement.
- The Dorset System needed an independent party, appropriately skilled and experienced, who could carry out swift assessments on behalf of providers, to build trust, but also reduce demands on the hospital staff by improving discharge rates, helping people home as soon as they are medically fit to leave, freeing resources for those waiting.

Method & Approach

- Dorset Care Provider Association host independent Trusted Assessors, based in the Acute hospital, to attend the ward to:
  - conduct initial assessment on behalf of identified provider
  - Track the patient through discharge pathway, reducing impact of potential delays, such as pharmacy, paperwork, transport
  - Follow up with provider within 48 hours of the individual getting home to ensure they had settled.
- Initially piloted with only those returning to their care home.
- It is now supporting all new and returning residents, plus people returning to an existing home care package, and offering support to all adults from 18 years.
- The TAs also offer admission avoidance support via on-call arrangement, meeting individuals at ED and updating directly to the home to secure a return home rather than admission.
- TAs now regularly attend key ICB led operational groups as part of System Flow, but also as a System Escalation response.
- More recently TAs now support more complex cases, with a more general assessment of needs, to identify a potential provider and / or offer advice to System professionals on most appropriate care setting to meet care and support needs.

Reablement

Aims & Objectives

- Our community based reablement capacity had been hampered by similar challenges to homecare.
- Shortage of therapists meant that as a System we were unable to offer consistent therapy support to any additional surge response beds.
- This was leading to longer length of stays and reduced opportunities to maximise independence via Pathway 2.

Method & Approach

- Our Reablement provider (DC Local Authority Trading Company) effected a rapid stand up of 30 short-term bed capacity
- With a plan to strengthen the therapy leadership as resources allow
- Emerging plans (via alternative capital funding) to develop new bedded facilities (this is a separate workstream but linked to HFA)

Home Care Optimisation:
Successes, measurable impact and quantifiable benefits

Successes

- There is a continued shift to correct the balance of homecare and residential care
- Although overall demand continues to challenge the System, we have good flow through P1 services due to long term care availability
- Availability of Homecare is critical to help contain social care pressures and allow us to invest in the **right care, right time, right place** to support the system and enable best outcomes for individuals.
- Now 89% of DC homecare packages are from framework providers (at our published rates) – an improvement from 72% in Jan 23
- We have maintained both a far reduced waiting list and reduced waiting times.
- There is often no waiting lists in some zones.

BCF Metrics

- Supports meeting of:
  - Avoidable Admissions
  - Discharge to usual place of residence
- Improving position on:
  - Residential Admissions

Data

- Supporting 1100 people, age 65+, with long term council funded care and support each month
- Maintaining flow through Pathway 1; approx. 50 people, age 65+, supported who need ongoing long term care each month

  (approx. 35 council funded, 15 self funded)

Trusted Assessment:
Successes, measurable impact and quantifiable benefits

Successes

- No failed discharges to date
- 4 full time Trusted Assessors and a Development Lead, based at Acute, but reach into Community Hospital
- Recently agreed reciprocal approach with Acute on Somerset border
- Currently being implemented at BCP Council area acutes
- During periods of Industrial Action (particularly Ambulance) TAs have been on ‘on-call’ to support Care Homes manage with non-injury falls. Armed with lifted equipment they were able to offer support to Homes when there were long delays for Ambulance attendance.

BCF Metrics

- Supports meeting of:
  - Avoidable Admissions
  - Discharge to usual place of residence

December 2023 Data

- 109 providers signed up
  - Up from 62 in Jan23
- People waiting just 37 mins for their assessment
  - Down from 1hr45mins in Jan23
- 85 patient contacts in the month
  - 932 total since Jan23
- 62 people in the month returned to normal place of permanent residence
  - By reducing a person’s stay in hospital by just 1 day across these 62 people offers a £26k cost avoidance in month to our acute Partners.
- 669 people in total supported since Jan23

Reablement:
Successes, measurable impact and quantifiable benefits

Successes & Data

- Average bed occupancy in reablement services up to 78%, and growing
- 27 day length of stay in reablement bedded support with 92% admitted within 48hrs.
- ~500hrs monthly reduction in weekly care requirement of those completing reablement, based on hours required at start of intervention
  - At our average published homecare rates this represents £11.5k per week cost avoidance

BCF Metrics

- Supports meeting of:
  - Avoidable Admissions
  - Discharge to usual place of residence
- Improving position on:
  - Reablement – still at home after 91 days

Challenges & Barriers

The Home First Accelerator Programme has been challenged as follows, but have had most impact within the Reablement Workstream:

- **Communication / managing of expectations**
  - Reablement beds were stood up at speed, under a ‘live development’ approach, gradually increasing the number of beds available, and the nature of support needs that could be met - We should have more clearly articulated this to partners to build System wide ownership.
  - Engagement with Primary Care / Community Health colleagues; the level of acuity that could be supported was impacted by availability of Community Health Teams. Engagement has since improved and Community Teams have provided training to Reablement Teams, sharing of information on discharges between Acutes and Community is also improved.

- **Availability of therapy / wrap around resources.**
  - Like many areas of the country we are limited in therapy resources, several recruitment drives have not been as fruitful as we need.
  - Working with our Reablement provider to plan therapy approach, live conversations underway with System Partners to explore how existing resources may be deployed differently.
  - Using our LATC we plan to form an Academy that will link with Academic partners to bring new therapy recruits into the System.

- **Acuity of care and support needs, on discharge**
  - Levels of acuity have continued to remain high, MDTs carefully consider the most appropriate discharge pathway to support individuals, such as utilising step-down beds before going home. However, our Reablement performance has been impacted due to high care needs on discharge, and ability to support that level of care in the community.

Next steps

- Finish rolling out zonal homecare optimisation during Q1 of 24/25
- Further develop trusted assessment, building quality and expanding programme
- Continue to build on proactive communication across all workstreams
- Continue to explore options to optimise existing community-based resources to support and manage acuity at home.
- Build therapeutic capacity of community reablement, this includes plans to develop a new bedded facility for high quality therapeutic reablement
- Longer-term priority to shift some of our focus into the front door – preventing admission through deployment of reablement capacity in community, P0 support from VCS to divert away from ED, etc.
- Continue to work closely with Partners to build a stronger System wide shared view on our future Intermediate Care Strategy; that builds resilience for winter and supports better targeting of our interventions.
- Further develop our modelling and data capture so we can track how much we are saving through improved interventions

BCF Support

- Dorset have recently been offered the D2A support offer and we are currently following this up with Partners in Care and Health at the LGA
- If there are other areas, the BCF Team are aware of, who have recently implemented a therapy led approach into Reablement we would be keen to reach out to understand and learn from their approach.

Contacts for further information

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