ACH/21/132
Health and Adult Care Scrutiny Committee
26 January 2021

IMPLEMENTING SPOTLIGHT REVIEW RECOMMENDATIONS: RAPID RESPONSE SERVICES

Report of the Locality Director – North and East (Care and Health)
Devon County Council and NHS Devon Clinical Commissioning Group

1. Summary

1.1 Following the Spotlight Review of Rapid Response services in 2018, Health and Care Scrutiny made a series of recommendations for action. This report is the second annual update to Health and Care Scrutiny on the implementation of the recommendations. The recommendations have been grouped to provide coherent response and the considerations have been progress rated; green for either completed or embedded and amber for in progress or on-going requirements.

1.2 The next scheduled report would be presented to a new Health and Adult Care Scrutiny Committee. Members of the current Committee are asked to consider the approach for the next report, including whether any requested updates should be contained within on-going progress reporting of the Integrated Care System.

2. Introduction

2.1 Short Term Services (STS) describes a range of services that provide support and care at home with a view to preventing avoidable admissions to hospital, enabling discharge from hospitals in a timely fashion and reduce need for long term care. Short Term Services include Social Care Reablement, Rapid Response or Urgent Community Response.

2.2 Reablement supports people to regain confidence, learn or relearn the skills necessary to undertake daily living activities such as washing and dressing, preparing and cooking meals or getting out and about in the community. Individuals will agree their goals and how they can be supported to do these things independently. The goals are reviewed regularly, and the number of visits and support given will be adjusted as people gain in confidence. The Service can continue for a maximum of four weeks.

2.3 Rapid Response, or Urgent Community Response, provides care for people in their own home when they are experiencing deterioration in health or breakdown in care arrangements. This is a short-term service for up to seven days.

2.4 Progress on many workstreams across health and care has either been paused or limited over the last months as the response to COVID-19 has consumed capacity and rewritten short-term priorities nationally and locally.

2.5 Despite progress in some areas contained within this report, clearly there are key areas that have had to be deprioritised, but not forgotten, and new opportunities for progress identified. The intention is still to provide an assessment of the capacity and requirement of Short-Term Services across the system, but unfortunately we are not fully there yet. That said, as we continue to develop and embed arrangements at 'place' we have the opportunity to produce this assessment more meaningfully.

2.6 The latest local activity data for Short Term Services is provided in Appendix A

3.0 Recommendations and updates from Spotlight Review

Recommendation 1: Continue to develop the rapid response service	
Considerations	**Update / response**
Consideration of joint teams to provide both Rapid Response and social care reablement, enabling the team to have more flexibility to respond to need.	• The short-term services project is focused on creating integrated teams across Devon. The team takes an enabling, strengths-based approach to promote an individual's maximum independence, whether in crisis or recovery. A central project group maintains strategic overview and meets monthly to ensure progress and alignment. • A service specification has been developed to ensure consistency across Devon. • A shared job description will be used across both services, with job evaluation, competencies and consultation due for completion by April 2021. • In the meantime, each locality is examining their practice to ensure services are as closely aligned as possible, including co-location of staff, a 'no wrong door' (single point of access) approach, IT systems, joint referrals and staff training. • Project data is being recorded to ensure that outcomes can be measured and tracked for impact.
Explore the feasibility of GPs as part of the Rapid Response team as a standardised approach across Devon	• There have been significant changes in primary care since this recommendation was put forward, and these have been considered when developing Devon's new short-term services offer. • GPs will be part of the development of the short-term services offer but each Primary Care Network will shape their own local services in order meet the needs of their population. • GP access to the Rapid Response team will be strengthened and improved as both Rapid Response and Social Care Reablement have a single point of access. This will extend

	beyond primary care and include South West Ambulance NHS Trust. • The integrated short-term services teams will be integral members of the multidisciplinary teams (MDT), contributing to MDT meetings with primary care in line with the enhanced primary care development (including the Enhanced Health in Care Homes national requirements).
Record all calls and Rapid Response teams take a proactive approach where there is no help available, calling back health professionals when care is available, if not already done	• This is now standard practice and a core part of the strengths-based approach of the service.
Recommendation 2: Support the system to work	
Considerations	**Update / response**
The Scrutiny Committee continue to scrutinise other aspects of system flow to ensure that appropriate care is available when needed and avoid bottlenecks.	• Officers will support the ongoing involvement of Scrutiny in this issue.
Scrutiny to celebrate the successes of Rapid Response and receive a yearly report on the number of people being kept out of hospital because of the service.	• Officers will produce a yearly report for the committee and will liaise with the Scrutiny committee to agree the timing of these. This is the second annual report. • In 2019-20, our performance on the national measure on sequels to short term services where there was either no support or support at a lower level, was 80.5%. This is below the regional comparator (81.4%) but above that for England (79.5%). Our overall ranking is 65th of 152 local authorities.
Consideration to be given to a review of the geographical limitations that may be placed upon a service – where a patient can only be treated where they are registered in area.	• The development of Primary Care Networks (PCNs) includes alignment with local health and social care teams. • Community Health and Social Care Teams in Devon are based on natural local geographies (coastal and market towns) and clusters of GP practices within these communities. This is to facilitate the local delivery of services; and to maximise efficiency e.g. to reduce staff travel time to deliver more face to face time with people. This model enables effective multi-disciplinary working.
That consideration be given to provide a	• In our previous report, we described how the Long Term Plan would include detail of capacity in community health, social care

comprehensive description of the amount and type of community health and social care required at a local level.	and primary care services. Completion of this review and publication of this plan was placed on hold at the beginning of the Covid-19 pandemic, so we are unable to report on this at this time. • The work is planned to recommence once we are through the pandemic and will feed into systemwide plans to move to an Integrated Care System (ICS). The draft plan confirmed our commitment to transforming out of hospital care and centred on aspects such as personalised care, Primary Care Network development, tackling inequalities and Population Health Management (PHM) • PHM includes focusing on the wider determinants of health and the crucial role of communities and local people. • The ICS and PHM encompasses health and social care, but there are also local authority statutory responsibilities with regard to social care and market sustainability. • In January 2020 Cabinet approved our Market Position Statement, and in September 2020 Cabinet approved our Annual Market Sufficiency Report. These are key documents in helping us understand the changing needs of our population, as well as the way the market will need to be shaped to meet that need. • Our Market Position Statement includes a demographics and need analysis, wider impacts on demand and factors that will affect markets. • A more detail response is contained in Appendix B
Recommendation 3: Increase GP and other agency's confidence	
Considerations	**Update / response**
Publish a patient satisfaction on website including a 'you said – we did' response form	• From April 2020, a new question has replaced the original NHS Friends and Family Test question about whether people would recommend the service they used to their friends and family. • There have been delays in some services being able to implement the new guidance in full due to the impact of the coronavirus. Data submission and publication for the NHS Friends and Family Test restarted for acute and community providers from December 2020, following the pause during the response to COVID-19. The first data submission will be December's data, submitted from the beginning of January, and will be published in February 2021. • Once this data is published, we will circulate it to the Health and Adult Care Scrutiny Committee.
Review the phraseology used to describe patients in the Rapid Response service.	• Rapid Response is one of the services described under the heading of intermediate care or short-term services, a range of services which support people to stay at home and/or to allow them to return home from hospital as soon as possible.

	• The short-term services project will better align the range of services to improve and enable better understanding of the nature of these services and the phraseology used to describe people who use them. This includes engaging with the public, with a member of the community joining the central project group. This input from the community will be vital to ensure suitable and targeted communication about the services, as well as agreement on the use of descriptive terms.
Publicise and promote the 'yellow card' scheme where GPs are able to feedback on systems that are not working as well as they could.	• This is indeed our practice and we continue to promote this valuable feedback mechanism
Recommendation 4: End of Life Care Support	
Considerations	**Update / response**
Review of all Hospices role in end of life support with a view to increasing public sector funding.	• As per our previous report, the Devon-wide End of Life Care Board brings together representation from providers from across the system to define and implement the local priorities for end of life care for the Devon population. All four adult hospices in Devon are key partners in this work. • As part of the pandemic response we have closely with EOLC care providers at an accelerated pace to enhance integrated ways of working; additional national funding has been made available to facilitate this. EOLC is included in within each locality's community capacity and demand plan which includes hospice provision.

4. Local Care Partnerships and Integrated Care System

4.1 The Health and Adult Care Scrutiny Committee has been informed of the development and progress locally to becoming an Integrated Care System and how Local Care Partnerships will lead the delivery and development of services at place level to ensure that they meet the needs of the local population and population health is improved.

4.2 Key to this is Population Health Management which uses data to help inform the planning and delivery of care to best meet population need – both shorter and longer term so we can design and target interventions to improve population health and wellbeing.

4.3 Devon is a wave 2 pilot area for PHM, although the programme has been delayed by the pandemic. Nonetheless, good progress has been made, including:

- Building an integrated data set ("One Devon Dataset") using local primary, community, acute, mental health and social care data.
- Five Primary Care Networks are involved in the pilot, including health and care community teams. These are using PHM in identifying key population groups and providing targeted interventions through local multi-disciplinary teams.

4.4 Ongoing progress with population health management will include the planning, arrangement, reach and delivery of short-term services and will enable us to provide a comprehensive description of the amount and type of community health and social care required at a local level.

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Electoral Divisions: All

Cabinet Member for Adult Social Care and Health Services: Councillor Andrew Leadbetter

Chief Officer for Adult Care and Health: Jennie Stephens

Local Government Act 1972: List of Background Papers
Contact for Enquiries: Tim Golby
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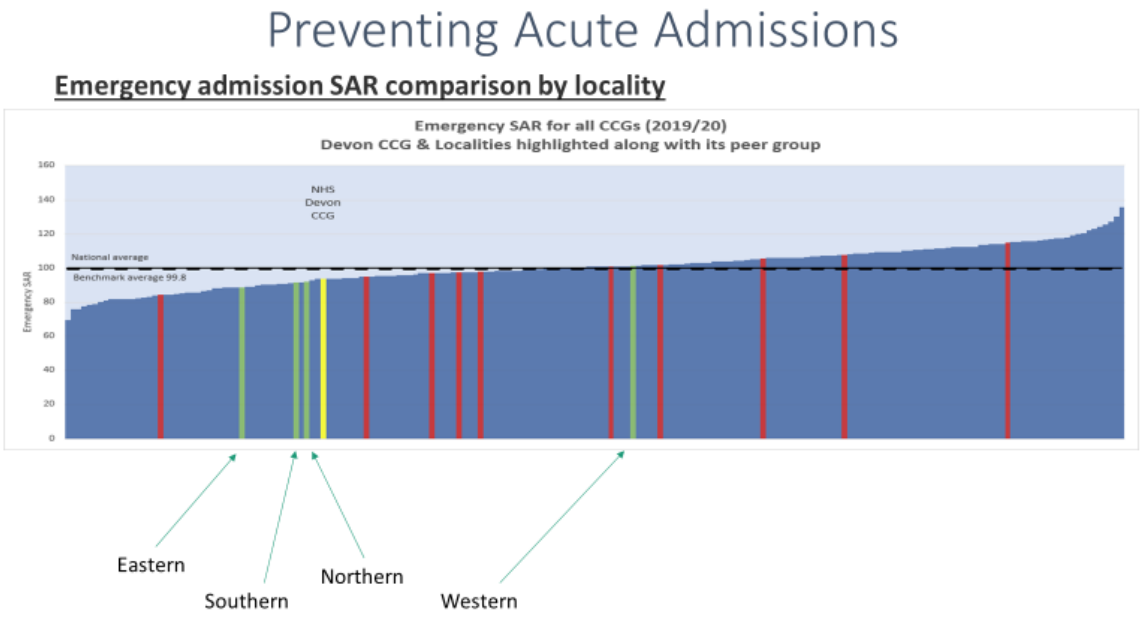
Background Paper	**Date**	**File Reference**
Nil		

The above mentioned Reports are published on the Council's Website at:
http://democracy.devon.gov.uk/ieDocHome.aspx?bcr=1

Appendix A: The latest local data available for Short Term Services

1. Health and care outcome measures are influenced by many factors and services, meaning it is difficult to separate out the impact of specific community services. However, traditionally used measures of acute admission avoidance, effective discharge and care closer to home continue to be relevant

2. Eastern, Northern and Southern all see low emergency admissions for their population, with Western at average levels. This suggests effective out of hospital services in preventing admission, and this includes the short-term services offer.

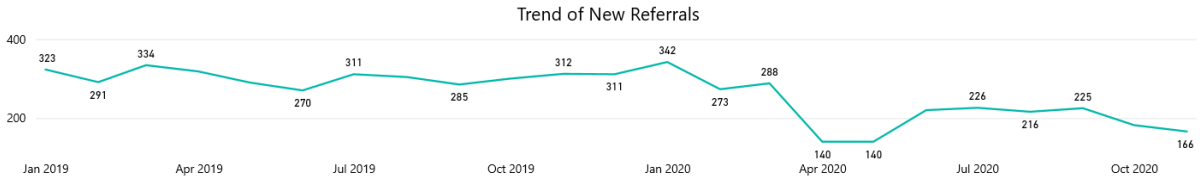


3. During the 12 months to November 2020, 2,729 referrals were received by Social Care Reablement for short term services to maximise independence:

   - 1,940 (71%) were received following hospital discharge.
   - 2,396 (88%) of referrals were accepted after initial triage and 1,491 of which were assessed as suitable to progress to a service following goal planning discussions.
   - 1,429 people completed services in the 12-month period with 1,218 (85%) not requiring a referral back to social care for an assessment for further support.

4. The pandemic resulted in a significant monthly drop in the number of new referrals received by the service (Graph 1) during the Spring. This appears to relate in part to available capacity within the service (redeployment, backfill and sickness absence) and personal choice with people electing not to receive services to reduce contact with others. Changes in reporting in the South (with staff redeployed to a merged rapid response / SCR team) will also have contributed to this reported apparent drop in referrals to SCR.

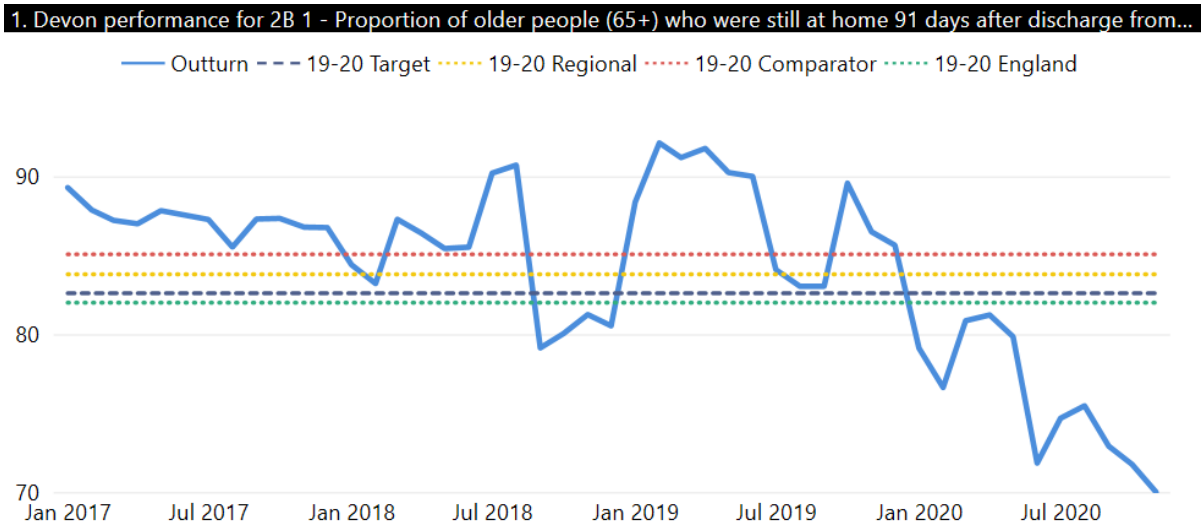
Graph 1: Trend in new referrals to Social Care Reablement



Source: Social Care Reablement Power BI Report

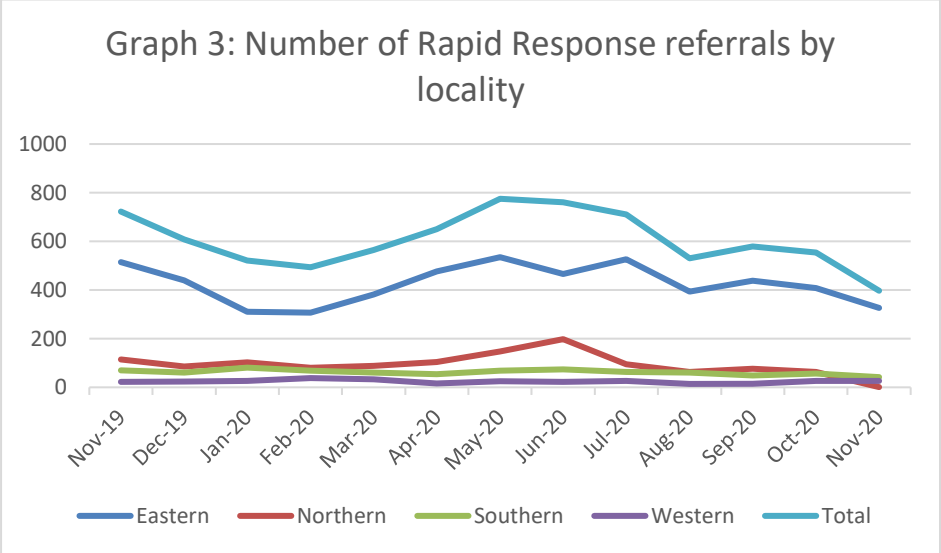
5. We think the same is the case for the reasons behind the decline in the `proportion of people aged 65 and over who were still at home 91 days after discharge from hospital into rehabilitation/reablement services (Graph 2).

Graph 2: ASCOF 2B1 – The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into rehabilitation/reablement services



6. The latest data shows performance at 70.0% (November 2020): a decline compared to the provisional outturn of 85.8% (March 2020) which was ahead of both regional and national comparators. There has also been changes to the recording of hospital discharges due to the Discharge to Assess guidance during the pandemic that will have impacted the data.

7. Graph 3 shows the number of referrals to the Rapid Response service (a joint health and care service) by localities. This data is only an indication as there is not a consistent approach to collecting, recording and reporting the data across the localities. This approach will improve as localities develop within the emerging ICS arrangements.



8. The table below gives an indication of the outcomes individuals are experiencing following receipt of a Rapid Response service in Northern, Southern and Western Devon. Recording processes across the localities are different which accounts for gaps in the data.

9. Given the operational pressures at this time and the subsequent redeployment of staff we have been unable provide the corresponding figures for Eastern Devon.

	Northern	Southern	Western
Outcome was care at home	1,132	359	221
Care at home spot purchased through local agency	98		162
Outcome was Acute Hospital admission	112	117	69
Outcome was Community Hospital admission	3	22	5
Placement in another care setting e.g. Hospice, Res or nursing care, respite	262	43	49
Night sits (spot purchased from agency)	413	569	
Devon Cares restart	176	n/a	n/a
Deceased	85	65	17

Appendix B: Further supporting detail in response to recommendation 2

1. In our 2019 update, we referred to our Joint Strategic Needs Assessment and the National Institute for Health and Care Excellence (NICE) guidance on intermediate care and reablement. Since then we have also conducted a comprehensive gap analysis of the short-term services in each locality to help inform our planning for the future, and this has informed our responses to the other recommendations in this report.

2. Those responses focused specifically on our short-term services; below we describe our approach to understanding the amount and type of health and social care required at local level.

3. The demand outlined above informs our priorities for the planning of care and health services as follows – although the impact of COVID-19 will require a refresh of these figures once we emerge from incident management:
   - Addressing a shortfall of approximately 40 places in the supply of carehome placements for people with complex needs and behaviours that challenge.
   - Addressing a shortfall of circa 2,800 hours per week (8% of total commissioned hours) in the regulated personal care market, circa 50% of which is in Exeter and South Devon.
   - Delivering alternative “care with accommodation” solutions, especially in relation to Extra Care Housing and Supported Living and improving access to replacement (respite) care
   - Addressing shortfalls in the unregulated market to better support people with disabilities, mental health needs and autism

4. Our Market Position Statement has more detail for each part of the market. Our two biggest areas, in terms of volume and challenge, are personal / domiciliary care and care homes - described in more detail below.

4.1 Domiciliary Care

4.1.1 Over the last two or three years there has been a steady reduction in the number of people referred for personal care. Numbers have reduced from 3,400 in April 2017 to approx.3,000 people as at December 2020.

4.1.2 This is substantially due to the strengths-based approach to care and support and to the success of our short-term offer in meeting people’s needs, returning them to independence rather than long term care. Nonetheless this remains our biggest area of challenge, with a particular focus on growing and retaining the personal care workforce in order to meet demand.

4.1.3 Covid-19 has impacted our ability to deliver additional capacity, meaning we have had to make temporary investment in solutions which rely on staffing from outside of Devon. Commissioning plans for spring 2021 onwards will focus on the development of an exit strategy to shift temporary solutions to the local market, and building local resilience to respond to demand for care at home.

4.2 Care Homes

4.2.1 DCC and the NHS buy circa 31% of the registered beds across Devon. Ostensibly there are enough beds to meet short to medium term need but, without change, there will be a shortfall by 2028. There are particular pressures in finding places for people with learning disability, dementia and with complex mental health needs, some of whom are currently placed outside of Devon.

4.2.2 Supply varies at market town level and availability of places in nursing homes is particularly challenging in some areas, especially in parts of the north and south of the county.

4.2.3 Our assessment is that:

- Some people in care homes with nursing could have their needs met in other locations, freeing capacity for those who need nursing oversight 24/7.
- People who need a care home are becoming more dependent and complex, especially where combined with mental health needs (including dementia). This will require a different profile for the care homes estate and its workforce, with buildings that are fit for purpose and technology-enabled
- N.B. Covid19 has an impact on the care home market with regards to the type of need and supply of availability. There will be a commissioning plan in Spring 2021 to address market sufficiency in direct relation to the supply of care home placements for people with complex needs and behaviours that challenge.