WARWICKSHIRE cares Better Together — 2018/19 Progress and Achievements

As we enter the final year of the Better Care Fund national programme, it is a good time to reflect on our progress so far. The Warwickshire Cares Better Together (WCBT) Programme has big ambitions to improve the health and social care system by improving the level and quality of integration and joint working. Detailed below is a summary of:

- some of our key achievements in 2018/19 that enabled more people to be supported closer to home, and
- our 2018/19 performance against prescribed Better Care Fund national metrics

Reducing Pressure on the NHS

Examples of joint preventative activity to help reduce rising Non-Elective Admission levels include:

The 'Out of Hospital' Campaign for Christmas 2018/19 was a great success raising awareness among health and social care staff of the various support and initiatives that are in place to help them make sure patients are discharged safely out of hospital before Christmas, and help care home residents avoid a hospital stay over the festive period.

The campaign also raised awareness of initiatives launched during August to October 2018 such as **Care Homes Trusted Assessors** and the **EMS + (Bed Availability Tool)**.

The Hospital to Home Service was launched in August 2018 and is delivered by Warwickshire Fire and Rescue Service and commissioned by Warwickshire County Council. The service is aimed at individuals who are medically fit to go home following their treatment within A&E, but may require transport and support to settle when they return home and prevents an unnecessary admission into hospital.

The service is available at Warwick and George Eliot Hospital's A&E departments.

In June 2019, we celebrated Carers Week and raised awareness of many **services and support for Carers** including the recently launched CRESS, which offers emergency and planned support for carers.

Significant efforts continue to be made to reduce Delayed Transfers of Care (DTOC) by:

a) NHS and Social Care local improvement plans;

b) Joint improvements, co-ordinated by the DTOC Board as part of the WCBT Programme.

The impact of this work has been a steady, consistent and sustainable reduction in DTOC.

In 2018/19 total DTOC reduced by 7,980 days delayed compared with 2017/18, a 33.5% reduction.

Over the same period, Social Care DTOC reduced by 7,705 days delayed compared with 2017/18.

Examples of Warwickshire's initiatives which have contributed to improving flow in acute settings are:

Two reduced mobility pathways which commenced in early 2019. South Warwickshire NHS Foundation Trust Out of Hospital Collaborative and Warwickshire County Council have worked together to pilot new hospital step down services to help people get the care they need outside an acute setting:

Domiciliary Home Care Support for upper limb plaster of Paris and / or braces to provide customers with support in their own home for a period of 6 to 12 weeks pending assessment.

A care homes based 'Reduced Mobility' step down pathway for individuals deemed as unable to return to their original place of residence due to temporary non weight bearing ability caused by unstable fractures or plaster of Paris on their lower limb.

The national NHS Red Bag scheme was launched locally in February 2019 to help facilitate a quick, safe and well organised handover of care when a care home resident is admitted to hospital. A dedicated Red Bag is packed that contains everything needed during their hospital stay including information about their health condition. This aims to support improved communication between care homes and hospital staff, and helps facilitate an overall smoother admission and discharge process.

The Accommodation with Support contract specifies that care home providers are to assess potential new residents being discharged from hospital within 24 hrs of referral. With recognition that this timescale can often be challenging, WCC offer the **Care Home Trusted Assessor service** which is a dedicated role designed to carry out these preliminary assessments on care home manager's behalf. As the assessors are based at the hospital sites they can efficiently carry out the assessment, freeing Managers' up to concentrate on running the care home.

The **EMS (Escalation Management System) Plus** is a web based tool to submit care home bed vacancy information, which aims to provide a single point of access for health and social care staff to assess bed availability across Warwickshire. The system was launched in October 2018 is free to use and is provided by the NHS CSU (Commissioning Support Unit).

Stabilising the Market

Joint initiatives to stabilise the commissioned provider market have been developed through the Accommodation with Support and Care at Home Boards. This is particularly challenging as the acuity of customers with complex long-term needs continues to increase.

Two examples of joint initiatives to support commissioned providers meet these challenges whilst also improving the quality of their care and prevent provider failure include:

Transforming Domiciliary Care
Since the new Domiciliary Care contract went live in 2016, our approach to commissioning domiciliary care has continued to develop and improve. This includes continuing to expand the role of the centralised Domiciliary Care Referral Team which manages all new referrals for domiciliary care services; and the training support available to commissioned providers through the **See, Hear, Act Learning Partnership**.

The **See, Hear, Act Learning Partnership**'s key message is *"a high quality service for our customers is everyone's business"*. The Quality Assurance Framework helps identify the things that providers do well. It enables high quality practice to be celebrated, shared and built upon. It can also highlight areas for improvement for prompt and effective action.

Meeting Social Care Needs

Examples of joint initiatives to support people to remain independent include:

New customer guides detailing the Reablement Support service were launched in the autumn 2018, as part of a wider preventative approach to helping people remain independent. The general rule of service delivery is: *"It's not about doing things for people. It's about giving them the skills and confidence to get back to doing everyday activities themselves."*

Preventing homelessness - Following the Homelessness Prevention Conference in October 2018, homelessness prevention workshops for social care practitioners were held in February 2019.

The workshops, were facilitated by key partners - Preventing Homelessness Improving Lives (PHIL), District and Borough Council housing teams and the Home Environment Assessment and Response Team (HEART) and featured talks and activities to support social care practitioners to:

- better identify people who are at risk of homelessness;
- deliver the Homelessness Reduction Act 2017;
- make appropriate referrals to relevant homelessness support;
- understand how HEART can support people whose accommodation is no longer suitable;
- be aware of support for veterans eg. the Armed Forces Covenant.

2018/19 Performance against prescribed national metrics

The success of the overall Better Together Programme is measured against the following 4 key metrics:

Metric	2018/19 performance
Non-Elective Admissions (lower is better)	3% above (worse than) target and 7% growth from 2017/18
Delayed Transfers of Care (lower is better)	0.3% below (better than) target and 33% reduction from 2017/18
Reducing permanent long term admissions to residential and nursing care (lower is better)	Met target and 3.6% higher (worse than) 2017/18
Effectiveness of reablement (higher is better)	7.8% above (better than) target and 3.7% improvement from 2017/18

Warwickshire County Council

To find out more about the joint work of the Better Together Programme, visit **https://www.bettertogetherwarwickshire.org/latest-news/** or email **warwickshirecares@warwickshire.gov.uk**