Wiltshire Council

Health and Wellbeing Board

21st March 2024

Subject: BCF Reporting Q3

Executive Summary

I. The BCF Q3 quarterly reporting document was submitted to the national team on 9th February 2024.
2. Authority for sign-off prior to submission was agreed by the HWB Chair on 9th February 2024.
3. This is a formal presentation of the documents to the Board.
4. The Q3 reporting focussed on performance against metrics and spend and activity.
5. Additional requirements were a formal response to the Q2 feedback and the submission of a BCF funded scheme case study.

Proposal(s)

It is recommended that the Board:

i) Notes the quarterly report submitted to the national team on 9th February 2024 (Appendix A).

Reason for Proposal

It is a condition of funding that the BCF reporting submissions are agreed and signed off by Wiltshire HWB.

Helen Mullinger
Better Care Fund Commissioning Manager
Wiltshire Council

Wiltshire Council

Health and Wellbeing Board

21st March 2023

Subject: Better Care Fund Quarterly Reporting

Purpose of Report

1. To formally present the BCF nationally required Q3 quarterly reporting submission.

Relevance to the Health and Wellbeing Strategy

2. The Better Care Fund supports the integration of health and social care services across Wiltshire, 'ensuring health and social care is personalised, joined up and delivered at the right time and place'.

3. Regular reports are required by the national team to monitor our performance against the submitted plans, agreed at Health and Wellbeing Board.

Background

4. The Health and Wellbeing Board signed off the BCF plans for 2023-25 on 20th July 2023.

5. It is a condition of funding that BCF plans and monitoring reports are agreed and signed off by Wiltshire HWB. Previous quarterly reports are as follows:
    - Q2 was submitted to the national team on 31st October 2023 and included a refresh of demand and capacity figures.
    - The was no requirement to submit a Q1 report.

6. The Q3 reporting also required the submission of a case study highlighting the impact of BCF spend. We prepared a case study that highlighted the work and outcomes of the changes to the PW2 bedded rehabilitation provision. This case study is attached at Appendix B.

7. We were also required to make a formal response to feedback received on our original demand and capacity modelling. This response is attached at Appendix C.

Main Considerations

8. We are on track to meet four of the five performance metrics. We have exceeded our target for residential admissions. Changes to Pathway two and increased capacity in pathway one will increase the number of people

returning to independence and will likely reduce the need for residential admissions. We also acknowledge that our target was very conservative and work is underway to understand the reasons behind the admissions which will inform a more realistic baseline for 2024-25 reporting.

Next Steps

11. That the submission is formally noted by the Board.

12. The next submission required for national reporting is a refresh of the 2023-25 planning. Details are yet to be published but it is likely that a submission will be due in May/June 2024.

Helen Mullinger
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Wiltshire Council

Report Authors:
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Appendix A: BCF quarterly report: Submitted 9th February 2024 (separate document)

Appendix B: BCF required Case Study: PW2 Development

Title: Pathway 2 Case Study

HWB area / location: Wiltshire

Organisation: Wiltshire Council

Date**: 06/02/24**

Scheme type(s): Intermediate care services

Brief description of the case study, including how it is linked to either full or partial Better Care Fund (BCF) funding:

This case study relates to the re-commissioning of Wiltshire Pathway 2 (PW2) bed cohort. This service is fully funded by the Better Care Fund and has had a positive impact upon the discharge outcomes for the residents of Wiltshire.

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Would the author / organisation be willing to present the information captured in this case study at any BCF event / webinar / virtual visit? Yes

All information captured in this document will be shared on the Better Care Exchange once it has been agreed for publication.

By agreeing to publication you consent to:

- The document being published by BCF and shared publicly through our communications channels
- BCF using the information you have provided both in full or partially
- The publication being shared with BCF partners (NHS, the Department of Health and Social Care, the Department for Levelling Up Housing and Communities) for their own use.

Overview

This case study will set out the rationale, process and final model change for PW2 bed provision in Wiltshire. PW2 beds are a short-term, time-restricted, goal-based service with health and social care assessments and interventions to support people to maximise their potential to live as independently as possible.

PW2 beds are required for people who no longer meet the NHS criteria to reside in hospital, but who are not able to return home without further assessment and rehabilitation in a bedded facility. These beds are not for people who require long term care from hospital, are end-of-life or are likely to be readmitted to hospital. The aim is to enable people to return home.

The existing PW2 model was assessed against customer-based outcomes as well as how well it was supporting system flow. This case study will demonstrate the impact that the change in PW2 model has had on Wiltshire discharges from hospital:

- 65% of customers have returned home, since the change of model.
- there has been an 8% reduction in readmissions to hospital.
- 14% reduction in permanent transfers into care homes.

Aims and objectives

The aim of the service is to reduce length of stay in hospital for people who are NCTR who require further assessment or rehabilitation, increase the opportunities for people to return to living safely and independently at home and to reduce admissions to long term care.

Method and approach

The methodology behind the re-model of Pathway 2 was an evidenced review of the existing model, partnership working and co production.

The review evidenced the following factors:

- Inequitable access to therapy - As the national requirement for discharge moved at pace during the pandemic, D2A and IR beds were sought at various locations across the county. The resulting provision was a piecemeal collection of beds in homes across the county which was not an efficient use of therapy or social care resources, given the travel time between homes and inevitably resulted in an inequitable service for patients.

- Excessive lengths of stay – from June 2022 to September 2022 the average length of stay in a D2A or IR bed was 56 days. Some stays were over 100 days. These lengths of stay indicated that an individual would have been better suited to another placement, for example a long-term bedded care or end-of-life placement. It also reduced discharge capacity across the system.

- The beds were not meeting patient needs - The change in access criteria because of the Hospital Discharge and Community Support Policy and Operating Model[1] created a cohort of patients with higher complexity and clinical need than the existing beds could meet. The analysis of outcomes (see Table 1 and Appendix A) showed excessive lengths of stay, hospital readmissions and end-of-life cases that indicated a level of complexity not usually compatible with intensive, short-term therapy.

- Home closures due to infection outbreaks – whole home closures are a significant risk to patient discharge and flow as it removes beds from the system and requires spot purchases elsewhere. It was evidenced that not all venues were able to provide optimum mitigation against this risk in terms of infection, prevention and control. Whole home closures had a significant impact on the ability to discharge patients from hospital.

- Effective use of support services - The model had become unstainable, with therapists and social care staff having to travel large distances between individual care home beds to deliver therapy and social care support.

A new model of delivering the PW2 beds was proposed which aimed to increase the capacity per bed, make more efficient use of therapy, social care and provider resources and result in increasing independence and a return home for more patients. The need for change from the perspective of the service users can be seen in Table 1:

Table 1: PW2 Discharge Outcomes ('old' model)

PW2 discharge outcomes	**Average % (Oct 20-Mar 22)**	**Notes**
Hospital readmission	17%	This is likely due to a worsening of an existing condition – whatever the reason, PW2 bed are not appropriate for this level of need.
Nursing home	18%	These customers would have been better suited to PW3 rather than a therapy-based bed
Residential home	14%	
Home independently	10%	This is the aim for most people being admitted to a PW2 therapy-based model
Home with Package of Care	16%	

Home First	12%	For those discharged with Home First it is assumed this could have been an option in the first instance. The bed review showed a high proportion of PW2 customers who, on clinical reassessment, were deemed to have been appropriate for Home First rather than a bedded facility.
End-of-life	13%	On many levels, this is not satisfactory, and alternative bedded provision should be found.

Alongside the analysis of the PW2 destination outcomes a stratification of the patients using the pathway was conducted. This was achieved collaboratively between the Better Care Fund, Adult Social Care, the Integrated Care Board and Health colleagues as well as Care Providers. The stratification highlighted that if the correct patients are admitted into a therapy-based bed model then Wiltshire would require between 53 and 61 beds.

Table 2: Stratification Criteria

PW	**Definition**	**Current outcomes (Oct 21-Mar 22) as % of demand**	**Beds required**	**Beds required plus 15% capacity to aid system flow**
2a	Medically stable cognitively and physically able to participate in rehabilitation activities. Current dependency, rehabilitation or cognition mean not yet able to be managed in community	21%	22 PW2 Hub Model	25
2b	As per 2a plus: Higher rehab complexity (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation)	20%	21 PW2 Hub Model	24
2c	Clinical risk is too high to go home at this stage. relatively low rehab e.g., end of life care	16%	18 Nursing beds	21
2d	As per 2a plus; Both clinical risk and rehab requirements are high (but not reaching requirement for NHSE&I Level 1 and 2 rehabilitation) delirium and complex MH with clinical complexity	10%	10 PW2 Hub Model (Complex)	12
2e	Residing in P2 due to lack of P1 capacity	6%	6 HomeFirst Service	
2f	Residing in P2 due to other reasons (e.g., P3, Specialist capacity, other	11%	12 PW3	14
-	Hospital readmissions from PW2	20%	21 Community Hospital or clinical optimisation	24
Totals of PW2a, 2b and 2d suitable for PW2 'Hub' model			53	61

Better Care Fund Commissioners worked in collaboration with providers, social care, therapy teams, the patient flow hub and brokerage colleagues to create a pilot which ran from 1st September 2022 – 28th November 2022. The pilot had the following aims:

- To understand what needed to be in place to successfully deliver the 28-day LOS ambition.
- To test how to identify those patients that will benefit most from a therapy-based model.
- To 'test' ways of collaborative working.
- To understand how to affect a cultural shift in the provision of therapy to improve independence and increase the number of people returning to their own homes.
- Over the course of the pilot there were positive outcomes around the number of discharges that took place and the length of stay. There were 44 discharges, an average of 14 a month, compared to an average of 7 per month prior to the start of the pilot. These discharges included patients who were admitted into the home prior to the pilot commencing on 1st September 2022.
- Prior to the pilot, admissions to the beds averaged 4 per month. During the pilot this averaged 10 per month.
- The average length of stay for patients admitted during the pilot was 28 days. Some patients did exceed the 28-day target. Of 15 patients to exceed the 28-day length of stay, only 2 was due to the patient requiring further rehabilitation. The other patients were held up by issues such as awaiting a package of care, home adaptations, or onward placements.
- The model proved to have improved outcomes for patients on discharge (table 3).

Table 3: Pilot Outcomes

Outcome	'Old' D2A/IR beds	New Model
Returned home (independently or with a package of care)	31%	56%
Returned to an acute setting	17%	20%
Discharged to either a nursing or residential home	35%	21%
Passed away	14%	7%

Healthwatch Wiltshire were included as partners at the start of the pilot and were able to evidence feedback from service users and staff. Service users were very complimentary of the service they received, that they were aware of their rehabilitation goals, and most were very motivated and intent on recovering as soon as possible to get home. All appreciated the amount of rehabilitation they were receiving.

Staff were clear that being able to work closely across teams (social care, therapy, and care home) had a positive impact on care. More staff have input to the goal setting, providing a more holistic picture of the patient. This was cited as an improvement on the usual way or working. Being on site gave professionals the ability to see patients both frequently and easily so questions and issues could be addressed face to face rather than through time-consuming emails. Several care home staff commented on how the different way of working resulted in a quicker turnover of patients. While this could be a challenge in terms of familiarising themselves with patients and

the additional paperwork, they cited they appreciated working with patients who were able to make a recovery and be discharged home. This was very satisfying for staff.

As a result of the positive outcomes the decision was made to implement the pilot processes into new block bed contracts for 60 beds, across two sites.

Successes, measurable impact and quantifiable benefits

The positive outcomes from service users have continued through into the main contract, which started on the 1st of April 2023.

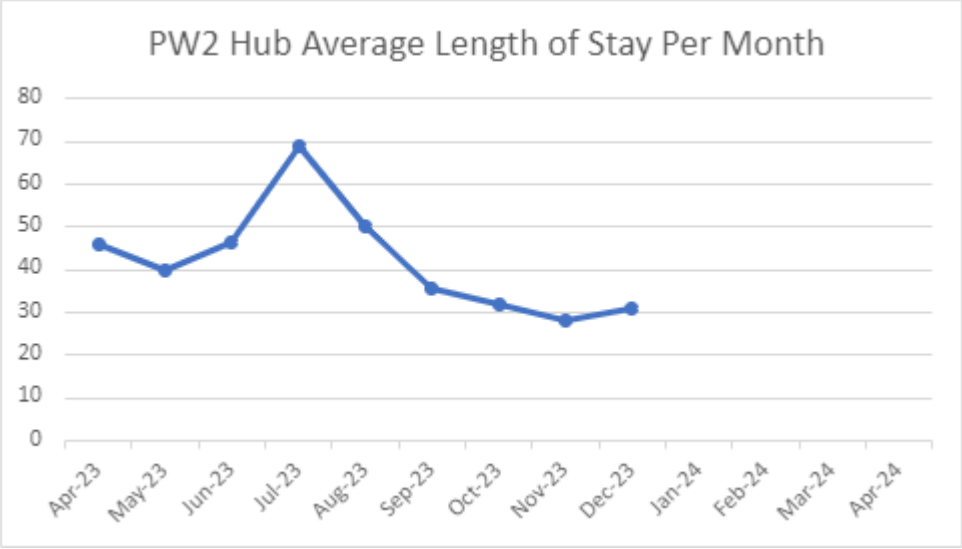
Table 4: Admissions/Discharges

Outcome	'Old' D2A/IR beds	Contract – Apr 23 onwards	Percentage Increase since 'old' PW2 model
Average monthly admissions into contracted PW2 Beds	4	22	450%
Average monthly discharges into contracted PW2 Beds	7	23	228%

- Table 4 demonstrates the positive impact that the change of model has had upon both admissions and discharges. This can be seen through in increased number of admissions into the home and discharges after receiving therapy.

- The length of stay (diagram 1) has also been positively impacted by the change in model. From September 2023 onwards the average stay has been 28 days.

Diagram 1: Average LOS per Month



- The outcomes of the individuals using the new therapy model have also improved (table 5). A higher proportion of individuals using the service are returning home. There is still a percentage of service users who are being discharged into either nursing or residential setting and this is being investigated further to ensure the correct individuals are being admitted into the therapy beds.

Table 5: New Model Outcomes

Outcome	Existing	Model Pilot	Therapy Model

	D2A/IR beds		Apr 23 - onwards
Returned home (independently or with a package of care)	31%	56%	60.5%
Returned to an acute setting	17%	20%	12.5%
Discharged to either a nursing or residential home	35%	21%	23%
Passed away	14%	7%	3%

- The average vacancy rate for the beds, which sits at 1.35 bed per month, shows that the beds being used for the therapy model are consistently occupied.

To conclude, the evidence shown above demonstrates that the change of PW2 discharge model to one based around therapy has had a positive impact on outcomes for the individuals using the service whilst also greatly increasing the number of individuals that can access the PW2 therapy model. The new therapy model has meant an improvement in patient outcomes at a lower cost than previously.

Challenges

The main challenge is managing the assessment process for access to the service to ensure that the correct cohort of individuals, who meet the therapy guidelines, are admitted into the bed base.

Links can also be draw between correct admissions and the increased length of stay in the PW2 beds. It can be suggested that if individuals being admitted are unable to engage with therapy teams it will have a direct impact of the length of stay as they are unable to be discharged within the 28 days target. However, it must be acknowledged that we are aware that not all those admitted into the beds will be discharged within 28 days. If an individual requires an extended period of therapy to ensure they have a positive discharge outcome and a return home this is the main aim of the beds.

Key learning points

The main learning points to take away from this case study are based around ensuring that all parties involved in the model and the subsequent pilot are aware of and adhere to the admission criteria. We found that there was confusion around who was eligible for admission and who was not. Upon reflection, if a change of model were undertaken more engagement events would be arranged to ensure that all parties involved fully understand the eligibility criteria.

Next steps

The next steps of the PW2 Therapy beds will be to investigate the increased length of stay and conduct a deep dive to look at the individuals using the service to ensure they are meeting the specified criteria for the therapy beds.

Appendix C: Formal response to Q2 Feedback (separate document