Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) evidence: emergency care

Wednesday 15 January 2014

Local Government Association

Submission

1. The Local Government Association (LGA)

1.1. The LGA is the national voice of local government. We work with councils to support, promote and improve local government.

1.2. We are a politically-led, cross party organisation which works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

2. The Association of Directors of Adult Social Services (ADASS)

2.1. ADASS represents Directors of Adult Social Services in councils in England. As well as having statutory responsibilities for the commissioning and provision of adult social care, ADASS members often also share a number of other responsibilities for the commissioning and provision of housing, leisure, library, culture, arts, community services and a significant proportion also hold the statutory role of children's services Director.

3. Summary

3.1. Adult social care has a critical part to play in a whole system response to improving outcomes for individuals and to minimise costly crisis interventions. Working closely with individuals, communities and health partners, adult social care is helping to develop and expand the application of effective preventative and early intervention approaches which support individuals to remain independent in their own home. However, the extent to which adult social care can mobilise and sustain this activity is determined by a number of key factors.

3.2. The need for trust, leadership and collective working is paramount. The current care and support reforms, allied with on-going and concerted efforts to integrate health and social care, are acting as a catalyst to creating and formalising these new relationships.

3.3. The combination of the Adult Social Care Outcome Framework, the new NHS Mandate, the six priorities identified in the NHS England Planning Guidance, the Better Care Fund (BCF) and the Integration Pioneer programme are all creating the right conditions to creating an integrated, whole system response to meeting individual need and improve outcomes. This in turn promotes and sustains greater independence, health and wellbeing and community resilience.

4. Funding

4.1. Adult social care is dealing with unprecedented budget reductions compounded by rising demand and the legal duty to meet assessed eligible need. These present a number of challenges in how adult social care can prioritise and extend preventative approaches, which are often additional to legal duties.

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4.2. Adult social care has not been immune to the impact of the significant reduction to council budgets. The ADASS Budget Survey shows that adult social care budgets have reduced by £2.68 billion over the last three years, which is 20 per cent of the budget.[i] This figure is made up of efficiency (75 per cent), service reductions (18 per cent), and income and charges (seven per cent). Continuing to make this level of savings is simply unsustainable.[ii]

4.3. Where possible councils have sought to protect adult social care. In cash terms we estimate that local authorities will have spent three per cent more on adult social care in 2013/14 than in 2010/11, whereas they will have spent ten per cent less in cash terms across all other services. Moreover, councils are facing demographic pressures of three per cent of adult social care budgets. It costs over £400 million a year to continue to provide the same level of service, which excludes the impact of inflation.

4.4. 30 per cent of respondents to the ADASS 2013 Budget Survey report that fewer people are currently able to access social care, while this grows to 50 per cent of respondents predicting poorer access in two years' time. However, while fewer people are accessing services, the cost of care packages for those who are is increasing.

4.5. 28 per cent report of respondents report that savings are currently putting more pressure on health, and 36 per cent predict this pressure will grow in two years' time.

4.6. The additional money for social care from the NHS, announced in the 2010 Spending Review, has helped mitigate the impact of the overall reductions to council funding. It has also helped to fund demographic pressures and some new services, particularly integrated prevention activity.

4.7. The percentage of councils operating at substantial/critical has increased over the last three years from 82 per cent in 2011/12 to 87 per cent in 2013/14. However, this does not tell the whole story. 4.2 per cent of the adult social care budget nationally (£587 million) is spent on prevention, which is not subject to eligibility, plus the number of people accessing reablement services is increasing.

4.8. It is noted that the introduction of new and extended duties under the Care Bill will have a significant impact upon councils' capacity to respond to these pressures and it will be critical that any new burdens arising from the legislation are fully funded by central government.

5. Winter pressure allocation 2013

5.1. The announcement of winter pressure allocation for 2013 is welcomed as recognition that the system requires investment to respond to fluctuations in A&E activity over the winter period.

5.2. This year's allocation was targeted at A&E departments and specifically at a small number of failing A&E departments. Only seven per cent of the initial £250 million was earmarked for adult social care. In line with previous Winter Pressure allocations, it would be helpful to see primary care and adult social care working together to provide effective preventative solutions to minimise unnecessary hospital admissions and maximise timely hospital transfers. [iii]

5.3. Alongside a more equal distribution of winter pressure money, it is noted that an earlier announcement of allocation would be helpful in supporting localities to plan and work together and the announcement in August 2013 of the allocation for the winter 2013 is seen as a positive step in this direction.

5.4. The collaborative approach taken by the establishment of the Urgent Care Boards, which includes directors of adult social services, is a positive development that will aid integration. Their weekly meetings are proving an effective way of finding solutions to local challenges.

6. Integration

6.1. Integration is a core priority for local government, central government and health. The integration and community budget pilots have shown that better outcomes for individuals and communities, as well as greater efficiency, can be achieved by shifting resources from acute hospitals and institutional care into community-based services.

6.2. The establishment of the Integration Pioneer Programme[iv] is a significant development in supporting and endorsing localities to test new arrangements and approaches to integrate across health and social care; and particularly to reconfigure hospitals. A number of the Integration Pioneers are responding to this agenda and the expectation is that the learning emanating from the Pioneers' work will be shared widely to inform other localities in shifting resources from acute settings to primary and community care.

6.3. The Integration Pioneers Programme is seeking to test and overcome barriers to more integrated care and support (reducing pressures on hospitals and adult social care departments). However, the programme is not exclusive to the selected Integration Pioneer sites and the vast majority of localities are themselves testing and developing integration approaches to include:

- Working through perceived barriers, such as competition rules, to allow integrated care to be commissioned and delivered.
- More flexibility to enable local areas to use funding creatively, for example by substituting capitation for tariffs for some client groups.
- Supporting investment in integration. Small scale examples, such as reablement teams, have reduced hospital admissions and length of stay.
- Allowing front line staff to commit resources from different parts of the system to cover the costs of care coordination.
- Streamlining the lengthy and bureaucratic process of making formal arrangements for the NHS and councils to share budgets.
- Development of electronic records which requires significant capital and revenue investment.
- Encouraging the leadership behaviours and culture change needed to work in an integrated way.

6.4. Achieving this shift in resources requires changes in NHS and local authority activity and expenditure. It also requires simultaneous changes over several years in hospital configuration, GP services, community health and social care. Short-term cuts in care capacity will imperil medium-term restructuring of

services and costs and jeopardise service improvements and greater efficiency gains.

6.5. One of the biggest potential areas for savings is through more effective care for individuals with long term conditions, most of whom are older people with a variety of needs that require an integrated response. Getting this right will help reduce unnecessary hospital admissions and improve hospital transfers. Improving standards of health care could have a positive impact on the need for social care, for instance in the treatment of people with strokes, continence problems or dementia. Intermediate care could also be used much more effectively, for instance to treat continence problems in older people who leave hospital so that they do not need to go into residential care.

7. Better Care Fund (BCF)

7.1. The £3.8 billion BCF was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The BCF is a single pooled budget to support health and social care services to work more closely together in local areas and includes a number of national conditions and performance metrics to improve arrangements to minimise unnecessary A&E activity.

7.2. This is a significant development, providing a focus and stimulus for localities to tackle some of the perceived barriers to more effective use of local resources to meet individual need and improved outcomes. It should also help minimise unplanned, expensive, crisis state interventions. Some of the BCF national conditions include the introduction of seven day working; and joined up information systems.

8. Joined-up Assessments and systems

8.1. It is widely acknowledged that effective and timely transfer from hospital is highly dependent upon effective assessment, conducted jointly by hospital and social care professionals on a multi-disciplinary basis.

8.2. Effective joint working requires effective data systems to sit alongside organisational commitment and behaviours. The focus of the BCF, the Integration Pioneers Programme and the recognition by NHS England that the recently announced Technology Fund must bring about data systems that allow both adult social care and NHS to talk together and share data, is significant. The universal application of the NHS Number, for example, will greatly assist in collaborative working to improve patient experience.

8.3. The deployment and availability of appropriate staff to undertake a transfer assessment is important and often a cause for delay. The need to involve GPs and hospital consultants in seven day working across health and adult social care is important and the inclusion of seven day working in the BCF national conditions reflects this.

9. Responsibility for Delayed Transfers

9.1. Monthly data on delayed transfers is collated and published by the NHS England. The latest data is provided below and illustrates that 25 per cent of delays are solely attributable to adult social care (this proportion has been falling from about 30 per cent three years ago). The key figures from NHS England are:

- There were 4,190 patients delayed at midnight on the last Thursday of November 2013, of which 2,678 were acute patients.

- There were 116,810 total delayed days during the month, of which 73,733 were acute. 68.3 per cent of all delays were attributable to the NHS, 25.3 per cent were attributable to Social Care and 6.4 per cent, where both agencies were responsible.

- The main reason for NHS delays was 'patients awaiting further non-acute NHS care,' which accounted for 30 per cent of all NHS delays. The main reason for Adult Social Care delays were 'patients awaiting a residential home placement or availability.' This accounted for 29 per cent of all adult social care delays. Where both the NHS and adult social care are attributable, the major reason for delay was 'patients awaiting completion of assessment', which accounted for 35 per cent of delays attributed to both NHS and Adult Social Care.

10. **Further information**

Delayed transfer

10.1. Hospital delays attributable to adult social care are the lowest for some time and length of stay is declining in many areas. Once beds are freed up it is easy for them to simply be filled up again via A&E therefore prioritisation is important.

10.2. More important, however, is the need tackle unnecessary hospital admissions in the first instance. Adult social care has a part to play in this respect through its preventative and early intervention services and support, and this underpins much of the rationale for the BCF. The NHS also has a key role to play as, at present, people are attending hospital because they cannot access their GP. Evidence from Imperial College London (summer, 2013) suggests that more than 100,000 A&E visits a year could be avoided if patients had quicker access to GP appointments.[v]

Alleviating pressures on Accident and Emergency

10.3. Silo approaches still persist and we can be better at taking a whole system approach to these problems. That said, adult social care has invested heavily in intermediate care and reablement services, and many councils now have, or are funding, staff located in Accident and Emergency (A&E) departments. The BCF will help to extend these arrangements

10.4. There is also room for improvement in developing bed-based hospital avoidance schemes. However, the potential of these is often limited by inconsistent GP and/or consultant cover, as well as a lack of availability of convenient peripatetic clinical testing (for example blood testing).

10.5. Councils, in partnership with Clinical Commissioning Groups (CCGs), are utilising their winter pressures funding, and the NHS transfer to social care, to support the system. However, current winter pressure allocation is targeted specifically at A&E Departments and the flexibility to seek community based solutions is limited by the amount made available to these settings. A fairer

distribution and advanced notice would help address delays across the whole sector in a more systematic way.

Urgent Care Boards

10.6. The Urgent Care Boards (UCBs) can play an important role in the whole system approach to tackling emergencies. In some areas the UCB is chaired by a senior director from adult social services and this approach is already showing encouraging signs of having a positive impact on avoiding and minimising emergency admissions. One particular example involves having a qualified nurse who contacts high risk patients following discharge to see if the care plan is working. Evidence is emerging that demonstrates this has helped avoid readmissions through A&E.

10.7. As with any development there will also be areas where the UCB is not maximising its potential contribution to the system. In such areas it is important to agree key outcomes, clarify the authority it holds, and ensure adult social care is an equal partner around the table.

10.8. The NHS continues to avoid investment in early intervention and prevention and there are indications across the country that there is insufficient investment in building robust services. UCBs can be a mechanism to address such issues.

Residential and nursing care

10.9. Trials in the use of telecare, telehealth and telemedicine demonstrate significant reductions in admissions from residential and nursing homes and improved quality of life for residents. For example, work in Bradford with telehealth and telemedicine within community settings is having a positive impact upon reducing hospital activity.

10.10. There are some emerging good examples of primary and social care working together in the residential and nursing care sectors. For instance, a number of councils are working with CCGs to invest in activity around falls prevention.

Prevention and early intervention

10.11. Adult social care along with its health partners has an important part to play in reducing unnecessary hospital activity. The transfer of public health responsibilities to local authorities strengthens this response in how this partnership works with individual and local communities to take greater responsibility for improved health and wellbeing outcomes, articulated in the local Joint Health and Wellbeing Strategies. Examples include national and local health awareness campaigns and wider application of health checks.

Role of integration

10.12. Directors of adult social services believe there is much room for improvement in terms of NHS hospital staff giving adult social care staff good quality information to aid assessment and discharge planning. A common problem adult social care staff currently encounters is having to frequently refer back to hospitals, which builds further delays into the system.

10.13. Internal processes in hospitals frequently mean that consultants and nursing staff work in a sequential manner, rather than ensuring tasks are completed in parallel. As a consequence patients can often be detained for much longer than is actually necessary and this is often compounded by incompatible data systems between health and social care adding further delays in assessments and joint working.

10.14. Reducing the reliance on acute care must be a shared goal. Currently, incentives for NHS Trusts to do this are insufficient. We need an approach that spans all partners and which seeks to save money in acute care by reducing admissions and reinvest that money in prevention and early intervention. As part of this, good practice must be developed and shared. The work of the Integration Pioneers should be helpful in this respect.

10.15. Specialism, and having teams both in hospital and in primary settings, has led to a significant number of 'hand-offs' and inefficiency. It means that the 'pathway' concept championed by the NHS creates problems in non-elective care. Pathways are great for single conditions without too many inter-dependencies and comorbidities. However, for the patient needing substantial urgent care the concept is not so effective, as it can result in numerous pathways that need to be knitted together. The key is therefore to provide one member of staff/case manager as the single point of contact for the individual, and to only call in other specialists when absolutely necessary. This requires role redesign.

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[i] Association of Directors of Adult Social Services, Budget Survey 2013, available at: http://adass.org.uk/index.php?option=com_content&view=article&id=914:social-care-funding-bleak-outlook-bleaker&catid=160:press-releases-2013&Itemid=489

[ii] Ibid.

[iii] NHS England, *Media briefing note: winter pressures,* available at: http://www.england.nhs.uk/wp-content/uploads/2013/11/150mill-ease-wntr-pres.pdf

[iv] NHS England, *Integrated Pioneer Programme,* available at: http://www.england.nhs.uk/2013/11/01/interg-care-pioneers/

[v] For further information on the Imperial College London report please visit: http://www3.imperial.ac.uk/