RECOVERY
REABLEMENT
REHABILITATION

Appendix e

BIRMINGHAM BETTER CARE
Birmingham City Council
NHS

Recovery, Reablement and Rehabilitation

Assessment Findings Summary

NEWTON

R3 RECOVERY REABLEMENT REHABILITATION

BIRMINGHAM BETTER CARE

Birmingham City Council

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ASSESSMENT SCOPE

1 Admissions

Are we admitting just the people that need hospital treatment and finding more suitable ways to look after those that don't?

2 In-Hospital Flow

Are we keeping people in hospital for no longer than is absolutely necessary?

3 Discharge Decisions

Are we choosing the best possible routes out of hospital for people?

4 Home-Based Enablement

Are we giving enablement care to the right people for the right amount of time and achieving the best possible outcomes for them?

5 Short Term Beds

Are we giving enablement care to the right people for the right amount of time and achieving the best possible outcomes for them?

Partnership working

How good are we at working together and creating continuity for the people that use our system - with a focus on what would help us work better together.

NEWTON

R3 RECOVERY REABLEMENT REHABILITATION

BIRMINGHAM BETTER CARE

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SUMMARY

The proportion of people we inappropriately admit into acute hospitals.

23%

Awareness of Rapid Response service in A&E.

Referral process, criteria and capacity in Rapid Response.

2,900 to **3,500**
people avoiding acute hospitals.

Admissions to QE Hospital

The proportion of people delayed in hospital waiting to leave.

51%

Multiple assessments, delays between each

Complex nursing care market, and starting care promptly across all providers

22,000
fewer days patients spend in hospital

Patients on wards with longer length of stay or geriatric focus in QE, Heartlands and Moseley Hall

The proportion of people we discharge out of hospitals inappropriately.

19%

Risk aversion in decision-making on discharge pathways

Knowledge of the best options for the patient; best-placed professional making decision

600 to **1,000**
people living more independently

Older adults discharged from QE, Heartlands, Good Hope, Moseley Hall

The proportion of people we could provide better short-term bed enablement for.

36%

Variable 'therapy model' across short-term beds.

Delays and risk averse decisions when leaving a short-term bed

300 to **600**
people living more independently or going home sooner

Patients in Intermediate Care or EAB beds

The proportion of people we could provide better home-based enablement for.

37%

Not fully considered by all referrers and reviewers

More input needed from therapists into plans and delivery

2,300 to **4,000**
people living more independently

Users in domiciliary care who had not received enablement in last 6 months; users who had received enablement

NEWTON

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SECTION #1:

ADMISSIONS TO HOSPITAL

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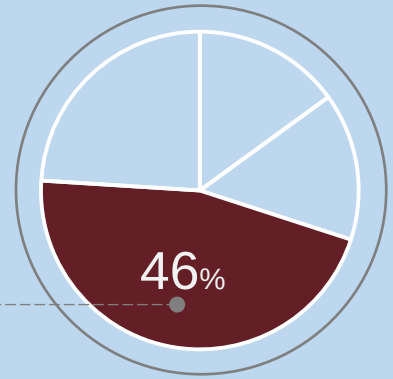
SECTION #1:

ADMISSIONS TO HOSPITAL

What treatment did these people need?

- IV antibiotics
- Clinical assessment
- Timely treatment

All these are available from the **Rapid Response Service.**



Home-based nursing

Why is Rapid Response not used?

We surveyed staff able to refer someone to Rapid Response in **A&E,** asking about their awareness and use of the service.

Their answers came under three categories:

Consistent awareness and understanding.

- We don't know how to access it - **13%**
- We use it and have no problems - **62%**
- It's good but we have problems getting a patient over to them - **25%**

The referral process is responsive (average 30 mins)

Patients being rejected due to criteria or range of services available

Capacity limited in Rapid Response due to waiting for social care assessment

Potential annualised opportunity
(QE Hospital only)

2,900 to 3,500 people
could avoid admission to Acute hospital

NEWTON

R3 RECOVERY REABLEMENT REHABILITATION

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SECTION #2:

IN-HOSPITAL FLOW

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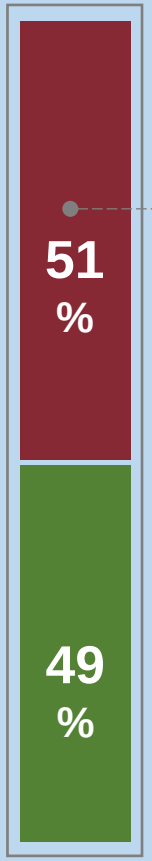


What were the top 3 reasons given for medically fit patients waiting in hospital?

16% The majority of people are waiting for an assessment of their needs.

12% The second biggest delay relates to sourcing the person's care.

8% Waiting for their care to begin.

Equal mix of health and social care assessments.

What's causing this delay?

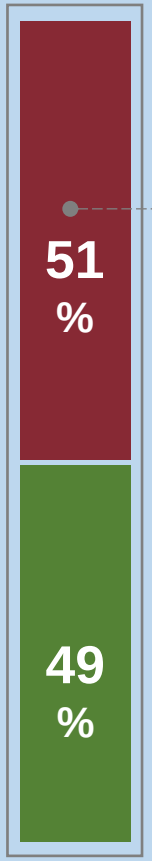
There are **13 types of assessments**.

People on average **receive 10 assessments**.

Delays are created by a combination of the **number of assessments** people receive, with the **time taken between each one**.

SECTION #2:

IN-HOSPITAL FLOW



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Priority areas for change:

Volume and timeliness of assessments in hospital

How we work with providers to find and start placements quickly

Longer-term:

Joint review of and strategy for the nursing provider market to ensure provision matches requirements.

Potential annualised opportunity
(Heartlands; Moseley Hall; Queen Elizabeth only)

22,000 to **30,000**
fewer delayed bed days

DAY 1

Therapy assessment and Social Work assessment.

Recommended for EAB.

DAY 3

EAB declines.

DAY 6

Ward declares patient palliative.

DAY 8

Ward CHC checklist.

DAY 9

Fast-track sent to CSU.

DAY 36

CSU identify nursing home.

DAY 38

Nursing home accept.

DAY 40

Discharge date missed as nursing home redecorating.

Falls ill.

DAY 47

Slips away in her sleep.

1939 - 2017

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SECTION #3:

DISCHARGE PATHWAYS

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NEWTON

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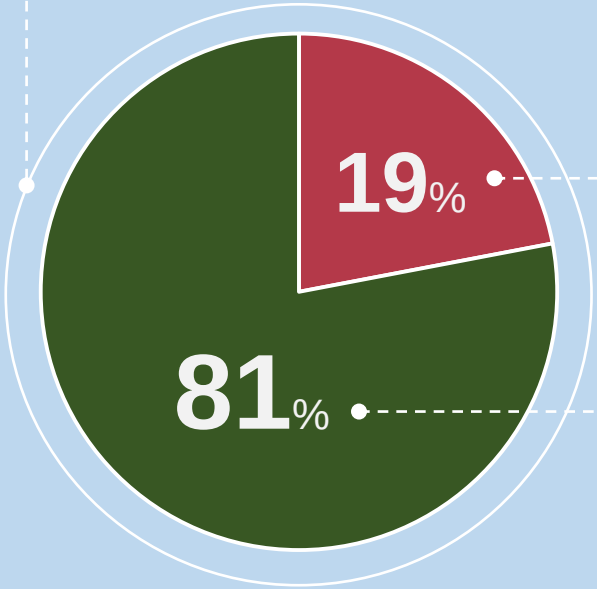
SECTION #3:

DISCHARGE PATHWAYS

204 cases reviewed.

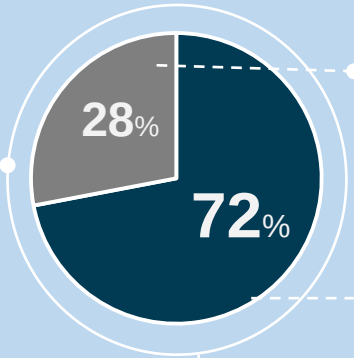
Heartlands; Moseley Hall; Queen Elizabeth.



These people would have benefited from being on a **different pathway out of hospital, one better suited to their situation and needs.**

Over three-quarters of people were on the pathway that **best suited their needs.**

Where were we sending them?



Into a care package deemed too high for their needs

Inappropriately to a short term bed, instead of home or directly into long term care

For the decision to send someone to EAB/IC, in **half** of the cases reviewed with a discharge lead, this was thought to be influenced by trying to avoid any perceived risks, i.e. EAB/IC is the safe option.

9 in 10 TOC forms reviewed came with a recommended location to discharge the patient to, before the Social Worker had assessed.

600 to **1,000**

people living more independently

Potential annualised opportunity

(Heartlands; Moseley Hall; Queen Elizabeth only)

NEWTON

Freda is 87. She lives independently at home, and despite having poor hearing and deteriorating eye sight, she lives without support. After a fall at home she was admitted to a hospital bed for treatment.

Born 1934

After her treatment was complete, she was assessed for her ongoing care needs. The ward staff advised Freda and her family that an interim bed was needed, however the OT and social worker felt that she was coping well enough on the ward – she was up and about, taking herself to the toilet – that she could return to live in her own home.

Freda's family could not be convinced by the OT and social worker that she could go home. As she had now been in for a while waiting for an EAB bed she was moved to another ward.

Here, Freda lost confidence due to a change in setting, lost mobility due to a lengthy hospital stay and became upset as she wanted to go home but didn't want to disagree with her family. The OT team recognised this and tried again to get her home but once again the family refused.

Freda now lives in a residential home.

'The moment 'residential care home' was mentioned,
was the moment the family decided that's where she's going.

I tried as hard as I could to get her home, it's where she wanted to be'.

Occupational Therapist

R3 RECOVERY REABLEMENT REHABILITATION

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SECTION #4:

SHORT-TERM BEDS

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NEWTON

SECTION #4:

SHORT-TERM BEDS

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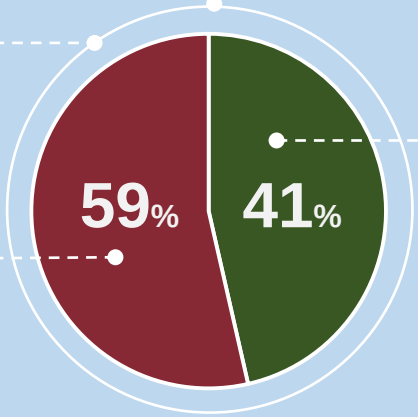
Potential annualised opportunity

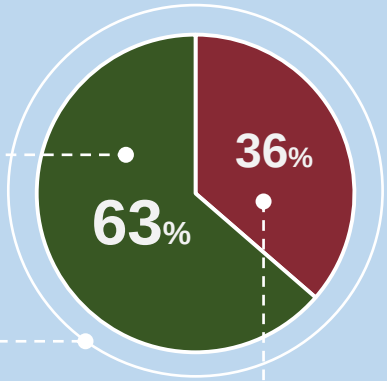
56 EAB and IC cases.



These people were **unsuitable for EAB or IC.**

These people had the **potential to be enabled**.

The majority of people achieved their maximum independence in the shortest possible time.



These people could have achieved **greater independence**, and/or in **less time**.

For the majority of these people, an outcome-based plan with clear goals and review points, worked up and regularly reviewed by Physiotherapists and OTs, would have prevented them leaving the service under-enabled or after too long a period.

R3 RECOVERY REABLEMENT REHABILITATION

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SECTION #5:

ENABLEMENT

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NEWTON

SECTION #5:

ENABLEMENT

Q1. **Are we helping the right people?**

We looked at **31 people** currently in domiciliary care who had **not passed through the service** to see if we could have helped them.

37% of them would have benefitted from our help.

What were the top three reasons given as to why we had not helped them?

44% At review or assessment, reablement was not an option that had been considered.

20% The patient or family themselves had declined our help.

16% The person hadn't met specific eligibility criteria e.g. dementia; broken bones.

Potential annualised opportunity

1,850
more people we could help each year

We looked at **39 people** who **had passed through the service** to see if we had helped them.

28%
The proportion of people we helped that the group agreed **were not suitable** for our service because of their complex health needs; very poor mobility or difficulty in being able to engage with the activities / services provided.

1,230
people we see every year that we need not

Q2. **Are we helping people achieve maximum possible independence?**

We looked at **39 people** who had **passed through the service** in the last six months.

28% of them could have achieved more during their time with us.

On average **one call a day** could have been reduced from the ongoing care packages of these service users

What held them back?

40% did not spend enough time with us / spent too long with us.

27% did not embrace the activities/service provided (either themselves or the family).

13% had no physio or occupational therapy input.

13% over-cautious when defining the care package.

Olivia is in her late 70s and was recently admitted to hospital following a fall at home. After her fall and her stay in hospital she had lost a lot of mobility and needed assistance to get out of and into bed.

Olivia was not referred to enablement as she was deemed to need a large package of two carers and four calls a day and the worker was convinced they would not be accepted.

One of the Hospital OTs reviewing the case identified this service user was independent before coming to hospital, and had potential to regain independence, especially as two carers were potentially only needed for morning and evening calls.

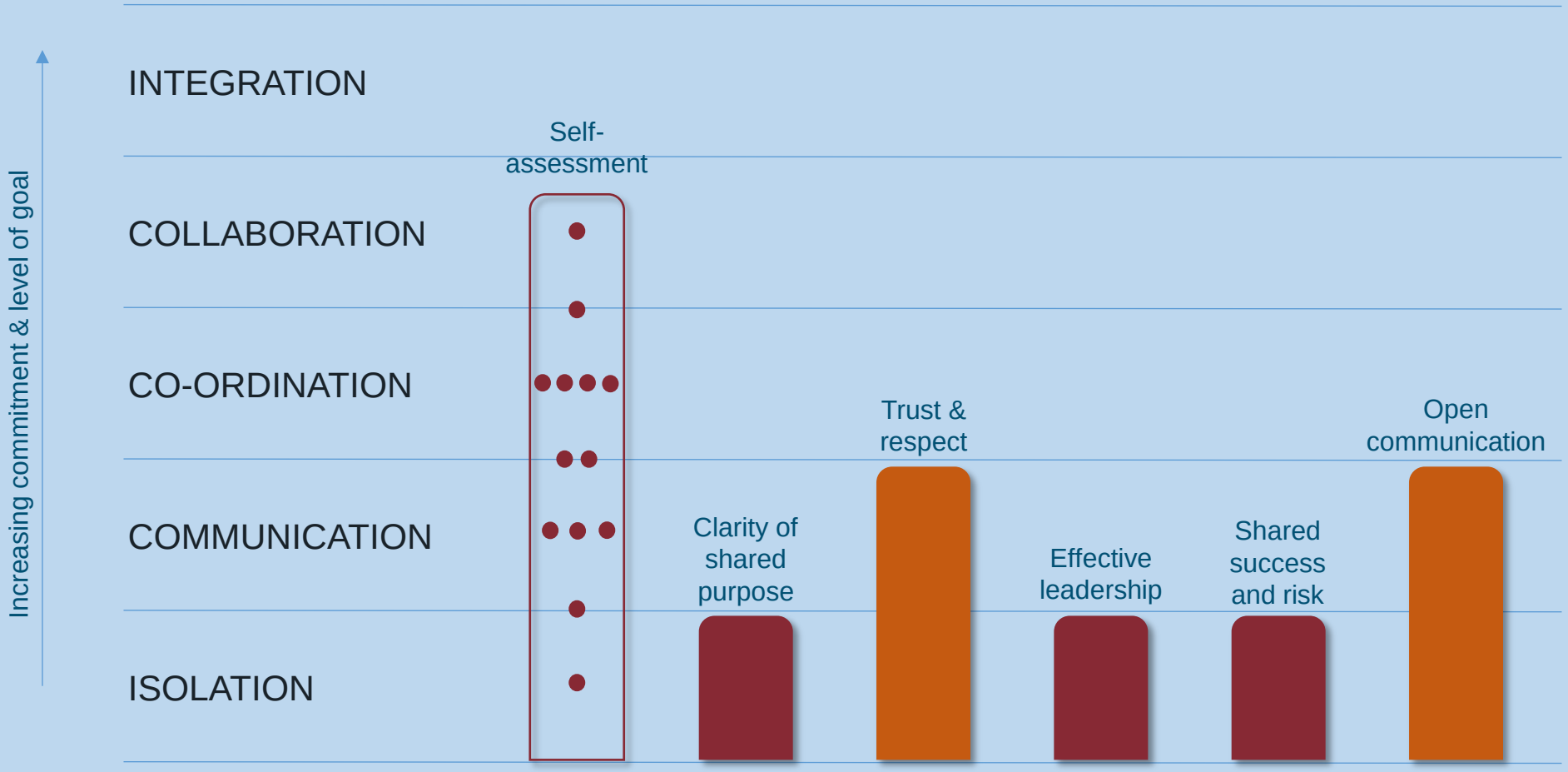
‘Why not enablement? Surely that is the crux of the service’.

Occupational Therapist

1937

SECTION #6:

WORKING TOGETHER



We ran 34x online surveys with frontline staff from all organisations, and 15x 1-2-1 meetings following a structured questionnaire to understand barriers to working together.

The combined results are summarised in the graph on the left, showing the **extent to which the organisations are working together and their weak points**.

These will need to be key areas of focus to drive and enable the success of any joint programme of work.