Nottinghamshire County Council

Report to Adult Social Care and Public Health Select Committee

12 June 2023

Agenda item: 7

REPORT OF THE CABINET MEMBER FOR ADULT SOCIAL CARE AND PUBLIC HEALTH

PROGRESS ON IMPLEMENTATION OF THE DISCHARGE TO ASSESS MODEL AND LOCAL AUTHORITY PLAN FOR THE NATIONAL DISCHARGE GRANT 2023 – 2024

Purpose of the Report

1. To provide a progress report on the current Discharge to Assess Model for Hospital Discharge and regarding the Adult Social Care application and plans for the 2023/24 national Discharge Grant to build on and grow existing development plans in line with the grant criteria.

Information

Discharge to Assess Model

2. The Discharge to Assess model has been implemented since March 2020 with the intention to support more people to be discharged to their own home. Embedding the Discharge to Assess model will assist in continuing to reduce the length of stay for people in hospital, to improve people's outcomes following a period of rehabilitation and recovery and minimise the need for long-term care at the end of a person's rehabilitation.

3. The Discharge to Assess (D2A) model uses pathways to plan people's discharge from hospital as follows:

   - Pathway 0 – simple discharges, people who do not need health or social care support
   - Pathway 1 – support to recover at home, with input from health and or social care
   - Pathway 2 – rehabilitation in a residential (24-hour care and support) facility
   - Pathway 3 – following life changing events, home is not an option at the point of discharge.

4. Most of the work of the Local Authority Discharge to Assess (D2A) Teams is on pathway 1, although the teams also assess and provide support to people once they are ready to move on from pathways 2 and 3 (post discharge).

Transfer of Care Hubs (ToCH)

5. The Local Authority and Integrated Care System (ICS) partners implemented a new model of Multi-Disciplinary Team (MDT) working in the form of Transfer of Care Hubs (ToCH) in September 2022 to facilitate smooth, safe, and timely supported discharges using the Discharge to Assess Pathways for people leaving hospital. This proactive approach helps to manage the flow of people leaving hospital, creating capacity for admissions to the wards for those requiring urgent treatment.

6. Supported discharges include reablement, rehabilitation and/or care support at home or in a residential setting. Each person identified as having 'No Criteria to Reside' (nCtR) in hospital and requiring a supported discharge is discussed with Therapy and Community Health Partners to identify the most appropriate response. This integrated approach aims to ensure the best outcome for the person and most efficient use of resources.

Process for Hospital Discharge:

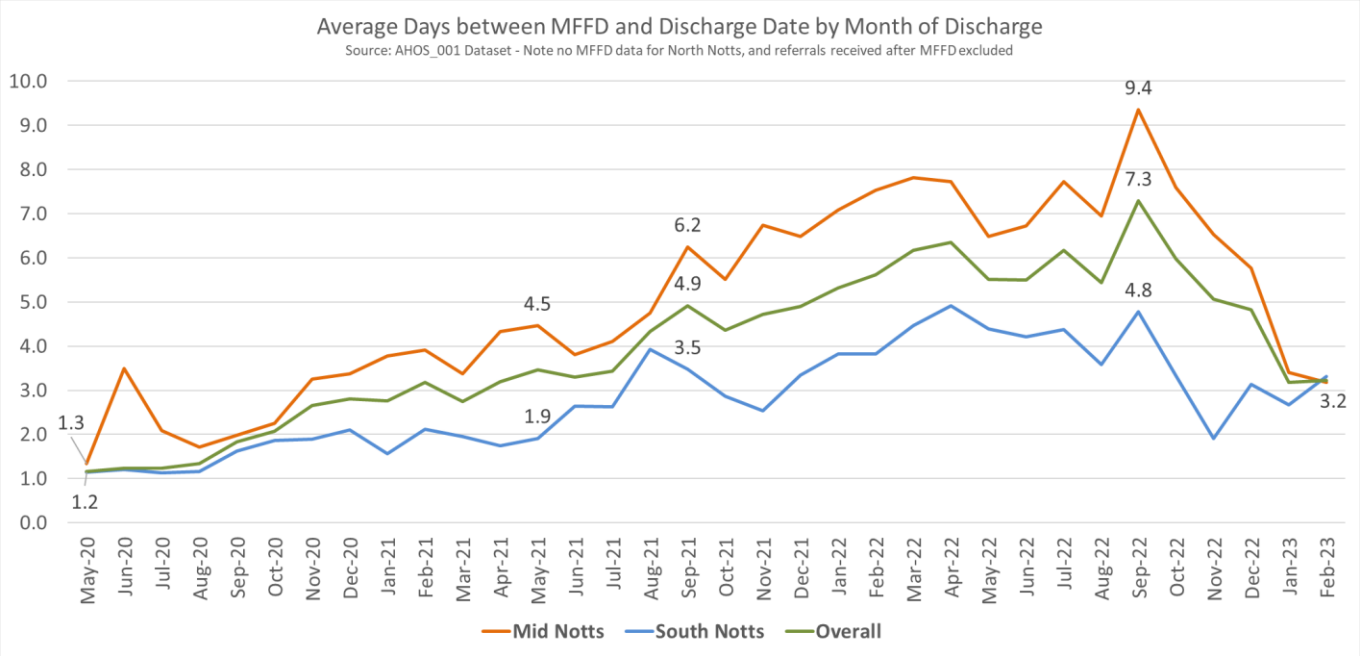
7. Every person on a hospital ward should be reviewed on a twice daily board round to determine if they are medically fit and ready to leave, at this point the date is captured as:

    - a patient no longer meets the "criteria to reside" in a hospital bed.

8. This means that for every person recorded as NCtR a pathway should have been identified for them to leave the hospital on that date, these people are also known as medically safe to transfer (MSFT).

9. Once people have been discharged from hospital Social Care staff remain involved to ensure that they have support as needed following a period of reablement, rehabilitation or further assessment.

10. The graph below demonstrates the positive impact of the Transfer of Care Hubs during the first six months of implementation, showing a reduction in time taken to arrange discharge.



Discharge Grant

11. A national commitment has been made to funding a two-year Discharge Grant, pooled into the local Better Care Fund (BCF). The budget has been confirmed for 2023 to 2024 as £4.335m for adult social care and £5.710m for the Integrated Care Board. Plans have been developed and agreed jointly and have been approved by the Chief Executives of the Local Authority and the Integrated Care Board. The plans were approved on 24 May 2023 by the Health and Wellbeing Board under national condition one of the BCF.

12. The criteria for the grant funding are:

- To build additional adult social care and community based re-ablement capacity to reduce hospital discharge delays through delivering sustainable improvements to services for individuals
- Support the principles of Discharge to Assess to enable timely discharges from hospital into appropriate short-term re-ablement/rehabilitation services, pending assessment of any further needs once they are settled back at home
- Take account of variation in levels of demand and work with local providers to determine how to best build the workforce capacity needed
- To be informed by learning from previous short-term discharge funding such as the recent Winter Fund
- Improving collaboration and information sharing across health and social care services.

13. The following plan has been developed to meet these criteria and to build on existing plans including those based on recommendations from the Local Government Association Review and Nottinghamshire Discharge Assurance Plan. A deliverability assessment was undertaken on the workforce requirements of the plan. A recruitment strategy has been developed to support delivery that includes, for example, ensuring creative use of different types of roles rather than reliance on roles that are currently difficult to recruit to, new streamlined local recruitment campaigns and processes.

14. Costs for 2023/24 have been based on a pro-rata basis for the year where they are not a simple extension and require set up time. The plan will be kept under active monitoring and review to ensure impact and review initiatives to ensure these are still required and are the best use of the funds.

Plan for Use of Nottinghamshire County Council Adult Social Care Discharge Grant 2023/24

REDUCING DELAYED HOSPITAL DISCHARGES AND SUPPORTING THE PRINCIPLES OF DISCHARGE TO ASSESS

£1,957,960

The new Transfer of Care Hub and Discharge to Assess model was deployed rapidly in the three acute hospitals during Covid. The model has a positive emphasis on supporting people directly home first and access to re-ablement/rehabilitation and therapy prior to any long-term decision about people's care and support needs. The model has, however, created additional work for social care staff that has not been fully resourced and therefore the plan is to provide extra social care capacity to:

- Provide new roles/capacity to meet higher work turnover timescales in the hospital Transfer of Care Hubs.
- Provide the Care Act assessment and therapy capacity needed to work with people following re-ablement/rehabilitation to meet the current gap of an average of 123 people per week. Sustained funding will assist with recruiting and retaining staff. Additional temporary funded staff have previously successfully reduced for a short time the number of people waiting.
- Increase the numbers of people discharged on Saturdays and Sundays (system model to be agreed in the autumn)
- Provide earlier, active review for 1,300 people a year receiving homecare to free up resources that people may no longer need
- Improve quality of practice. Supporting staff to be more strength based as well as confident in application of the Mental Capacity Act to ensure good, timely decision making to avoid unnecessary delays
- Start to work in partnership with people with lived experience, so that their views inform the development of future services
- Undertake joint strategic commissioning and procurement work with social care providers supporting hospital discharge to develop more streamlined processes and integrated working

Demand for Mental Health Services has been increasing significantly over recent years and there are pressures and delays in specialist mental health hospitals. Additional social care capacity is therefore planned to:

- Provide additional social supervision for 50 people a year to reduce hospital delays
- Facilitate timely discharge plans for an additional 50 young people a year
- Reduce delays to people leaving short term mental health recovery services
- Promoting strength based, therapy and recovery led practice

PLANNING SERVICES IN ADVANCE AND ENABLING PROVIDERS TO RECRUIT THEIR WORKFORCE

£734,290

The Local Authority already funds the voluntary sector to visit people who may need a wellbeing check after going home from hospital without additional support. Using last year's Winter Fund this service was extended to support people who do not need personal care but may need someone to help them home and settle them in, make sure the heating is on, food in the fridge and do short-term follow up work to support a successful recovery and build links into local community support. It is proposed to extend this scheme for 600 people per year. Following evaluation, the Council will work with the sector to build on the learning from this and seek to extend investment to use Technology Enabled Care to support people's independence longer and avoid re-admission to hospital or residential care.

Skills for Care (the national strategic workforce development and planning organisation for Adult Social Care) will work with partners to:

a) Develop an Integrated Care System external Workforce Strategy
b) Inform this by undertaking a deep dive into the external workforce to identify recommendations for interventions for independent sector providers to aid recruitment and
c) Produce a bespoke public website page so people can easily see all the local vacancies in the care sector that they could apply for, to encourage more applications.

LEARNING FROM THE EVALUATION OF THE IMPACT OF PREVIOUS SCHEMES FUNDED USING DISCHARGE FUNDS

£953,000

Mental Health Step Down and Reablement Service (Living Well)

Previous short-term discharge funding has been used to successfully pilot holding one self-contained unit of accommodation at Lombard Street *(*Mental Health Reablement Supported Accommodation*)* with wrap around social care and health support. This is for people experiencing mental ill-health being discharged from hospital to have short stays of up to approximately 6 weeks while their accommodation is made ready to return to, or if they need a period of more intensive support before going home. This scheme will be extended and can support 9 people a year and avoid delays in hospital.

Increased Home-Based Care support during peak times (winter)

Previous years have shown that while discharge improvement plans are being implemented, there remains a need for flexible surge capacity to avoid people remaining in hospital at times of high demand. Previously, additional hours for social care staff and additional Technology Enabled Care to have been funded and further diagnostic work is needed on the latter to improve how this is deployed to maximise maintaining people's health and wellbeing. Also, although not an ideal outcome for people who could have returned home, use of interim residential care beds has also been able to be deployed rapidly.

In 2023/24, although less than in previous years, whilst improvement plans are implemented some of this capacity will still be needed in social care. The additional Care Act assessment and therapy capacity (referenced in the first section on reducing delays) will mean that these people will be actively worked with to plan their return home from interim residential care as soon as resources to support them at home are available.

IMPROVING COLLABORATION AND INFORMATION SHARING ACROSS HEALTH AND SOCIAL CARE SERVICES **£689,750**
There is a shared aim to develop therapy-led and integrated ways of working across social care and community health re-ablement. The funding of service improvement support is required to support develop and implement joint outcomes, quality assurance and training frameworks, a single access point and shared electronic scheduling system. The impact will be to speed up the discharge process by simplifying the current fragmented referral process, as well as to make more effective use of all staffing resources across providers enabling more people to be supported home earlier. An integrated health and social care therapy training programme has been scoped and supported by the Ageing Well Programme Board. This is based on a successful Leicestershire model. Currently the skill set of health and care therapy staff is quite different and therapy staff are also hard to recruit in sufficient numbers. Having staff with the same core set of skills will aid career development, make more effective use of the resources we have and avoid hand overs between health and care therapists. The project requires a dedicated Occupational Therapy post and project support to implement, which will be funded from the grant. To deliver the strategic commissioning, contract and procurement work to support more efficient discharges from specialist hospitals for people experiencing mental ill-health, a new post has been developed and will be funded from the grant. The Integrated Care System is undertaking a procurement exercise to identify a Strategic Transformation partner to support rapid accelerator work to improve hospital discharge and strengthen community services to avoid hospital and residential care admissions. This one-off amount will be funded from the grant and appropriate stretch timescales/measures set through the early part of this work.
Nottinghamshire County Council Adult Social Care Grant Total = £4,335,000

15. A more detailed breakdown of the grant spending plan is contained in **Appendix A**.

16. The Discharge Grant will be aligned with plans from the Integrated Care Board and Nottingham City Council. The Joint Grant application was presented to the Health and Wellbeing Board on 24 May 2023 and the application was agreed.

Other Options Considered

17. Other options were considered during the development of the plan including use of agency staff rather than recruiting staff into the Local Authority for the additional posts being funded. However direct recruitment will provide consistent staffing and local employment opportunities. The options chosen are those assessed by staff within the department and partners as able to address priority gaps in capacity, have an evidence base of delivering improvement, align to existing plans and meet the grant criteria.

Statutory and Policy Implications

18. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

19. The proposed plan can be funded from the national Adult Social Care Discharge Grant 2023/2024 of £4.335m for adult social care and £5.710m for the Nottingham and Nottinghamshire Integrated Care Board. The funding will be pooled and monitored through the Nottinghamshire Better Care Fund. It is expected that fortnightly reporting against the plans will continue.

20. The Nottingham and Nottinghamshire ICB total allocation is £5,767,000. This will be distributed between the Nottingham City and Nottinghamshire County Health and Wellbeing Boards' Better Care Fund Plans using the same population-based methodology as was used for the 2022/23 Adult Social Care Discharge Fund.

HR Implications

21. There are no direct staffing implications in the proposed plan. Should funding be approved the requirements for establishing posts will be taken through each organisation's relevant governance systems as appropriate.

RECOMMENDATIONS

That:

1) Members consider whether there is any feedback they wish to give in relation to the progress information contained within the report.

2) Members consider how the Committee engages with the department to monitor the actions /issues contained within the report.

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Constitutional Comments (CD 30/05/23)

22. The report and recommendations proposed fall within the remit of the Adult Social Care and Public Health Select Committee Terms of Reference set out in the Constitution.

Financial Comments (LCD 05/05/23)

23. The proposed plan can be funded from the national Adult Social Care Discharge Grant 2023-2024 of £4.335m. Details are in **paragraph 12**. The funding will be pooled and monitored through the Nottinghamshire Better Care Fund. It is expected that fortnightly reporting against the plans will continue.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

None.

Electoral Division(s) and Member(s) Affected

All.