Nottinghamshire County Council

**Report to Adult Social Care and Public Health Select Committee**

**4 March 2024**

**Agenda Item: 5**

# REPORT OF THE CORPORATE DIRECTOR, ADULT SOCIAL CARE AND HEALTH

# PROGRESS ON IMPLEMENTATION OF THE DISCHARGE TO ASSESS MODEL

## Purpose of the Report

1. To update the Adult Social Care and Public Health Select Committee on the implementation of the Discharge to Assess model and how the use of the national Discharge Grant 2023-24 (Grant) has supported improvements.

## Information

### Discharge to Assess Model

2. National guidance on the Discharge to Assess model has been in place since March 2020 with updates following the pandemic. The aim is to support more people to be discharged to their own home in a timely way and reduce the numbers of people in hospital. In the model, an initial decision is made when the person is in hospital as to whether they need support to leave and if they need short term support, and what the best service is to provide this to help them regain their maximum independence, health and wellbeing. Any assessment about ongoing social care and health needs should only be made once they are settled back home and have had the opportunity to recover.

3. The Discharge to Assess (D2A) model uses pathways and terminology 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 and re-able to independence at home, with input from health and/or social care
   - Pathway 2 – rehabilitation in a bed based residential (24-hour care and support) facility provided by health
   - Pathway 3 – following life changing events, home is not an option at the point of discharge, if people are near the end of their for life. Health led.

4. The majority of the work of Local Authority staff in the Discharge Hubs and the Discharge to Assess Teams is supporting people home with on pathway 1. The teams also assess

and provide support to people once they are ready to leave from short term re-ablement and rehabilitation services (pathway 2 and 3 services).

5. Aligned to the national guidance, Nottingham and Nottinghamshire Integrated Care System (ICS) implemented a new model of Multi-Disciplinary Team (MDT) working in the form of Transfer of Care Hubs (ToCH) in September 2022. There is a multi-disciplinary Hub based in each of the three acute hospital Trusts and these have had an initial positive impact of it taking an average of one day less to return home after being referred to the Hubs.

6. A national commitment was made to funding a two-year Discharge Grant, pooled into the local Better Care Fund (BCF). In 2023 to 2024 the budget was £4.335M for adult social care and £5.710M for the Integrated Care Board. Plans were developed and agreed jointly to support delivery of local priorities to improve discharge. This was approved by the Chief Executives of the Local Authority and Integrated Care Board and signed off on 28 June 2023 by the Health and Wellbeing Board under national condition 1 of the BCF. The plan is attached at **Appendix A** and the rest of this report provides an update against this.

**Nottingham and Nottinghamshire Integrated Care System**

7. In January 2023 the Nottingham and Nottinghamshire Integrated Care System (N&N ICS) was placed on a list of systems that the Department of Health wanted to place under greater assurance with regard to their plans to reduce the number of people in hospital who could go home. This required a meeting with the national team to agree a plan which is regularly monitored.

8. For the recent annual assurance meeting ICS partners were able to evidence good progress with implementing the three key discharge priorities for 2023/24:

- Embedding and improving how the multi-disciplinary Transfer of Care Hubs work e.g., streamlining processes, recruiting additional posts required
- Improving the ability of community social care re-ablement and community health to support more people with higher needs directly home and maximise their independence e.g., all staff being able to support people with wearing and cleaning Aspen collars
- Improving the residential rehabilitation model e.g., ensuring that people are not placed in temporary residential beds without rehabilitation input as a ‘bridging support’ when they could have returned directly home.

9. The combination of this work has evidenced the following positive impacts over the past year:

- The system is on track for meeting the improvement trajectories all partners set for reducing the length of time it takes to support people directly home and also into a rehabilitation bed
- Once the Transfer of Care Hubs receive a referral, the average length of time it takes the Hub to arrange a person’s discharge and leave hospital has reduced over the year. An average of 24% of people are supported home the day after the referral is received and between 67% to 77% within two days of the Hub receiving the referrals. A small number of people, often who have inappropriate housing, or are homeless, or where

there are safeguarding issues, take a longer time and there is a new workstream being put in place to address this.

- The Council and Nottinghamshire HealthCare Trust are together consistently delivering the additional capacity required for social care and community health re-ablement capacity funded by the Integrated Care Board Discharge Grant so that more people are supported home first
- An average of 9% of people are now discharged with support and leave hospital at the weekend.
- In December 2023, at one of the busiest times, no-one had to go into temporary residential care from hospital because the service they needed to go home was not available, with the exception 4% of people at Sherwood Forest Hospital.
- More people with the highest health needs who may, for example, be in the end stages of their end of life, are now going home directly from hospital rather than into residential care. This is evidenced by being in the best 25% of Integrated Care Systems for this.

All these improvements are leading to a better experience for people. Overall, however, the numbers of people waiting in hospital who could have returned home have not yet significantly reduced. This is because the hospitals have had increased numbers of people arriving at Emergency Departments, as well as more people being significantly less well on arrival and when ready to go home. One of the key areas that will have a significant positive impact is for the wards to send information about people who will need support to go home to the Hubs in a timely way. In December 2023, only a small percentage of people are being referred to the Hubs before the date they were predicted to be able to go home and many were referred after the date they could have gone home. The acute hospitals all have actions plans underway to improve this.

10. Significant progress has been made on having one jointly agreed dataset that shows exactly where the person is in the hospital, which team they are with and what they are waiting for. This means that all staff have a live view of this information, know and own their responsibilities and are clear on next actions. It has also identified with much greater accuracy where the delays are, enabling appropriate action. It can also identify themes and trends, so has for example identified that the greatest area of opportunity to reduce delays is with the hospitals' internal systems. So, there are now detailed improvement plans for internal delays that have been informed by the recent external diagnostic undertaken by the System Strategic Transformation partner.

11. The national team feedback was that the quality of data and its ownership by frontline staff was a real positive and a good example of a mature, data driven partnership. This gave them confidence that the ICS will continue to deliver the improvements planned. The ICS is currently awaiting review as to whether the system remains on the national watchlist for higher scrutiny. The data work has won a Departmental Award, as well as an ICS Health and Care Award and is being cited as national good practice.

12. Moving on from the focus on discharge, there is ICS acknowledgement of the need to work on crisis/hospital avoidance because it is known that there are better outcomes for people if their health and wellbeing needs are met as soon as possible, in order to avoid people requiring longer term interventions from formal services. It is especially important therefore in order to manage social care rising demand pressures. This work is currently at the stage of the resources and scope being identified. This is at a time of significant financial

pressures and requirements to make savings in the Integrated Care Board as well as social care.

## How the Discharge Grant has underpinned improvement plans

### Reducing delayed hospital discharges and supporting the principles of discharge to assess

13. Significant investment has been made into additional staff to support discharge arrangements from both acute and specialist mental health hospitals. Sixteen additional social care posts have been recruited to in order to support the additional workload the Discharge to Assess model creates for social care and also to have enough capacity to support the increased demand in the Acute Hospital Trusts. Additionally, from November 2023, the Grant has enabled there to be enough staff to work on Saturdays as part of a pilot to understand if this is effective.

14. A further 20 staff have been recruited to reduce length of hospital stay and promote independence for working age adults. To evidence these interventions, as at 8/2/23, the Mental Health Reform project has prevented 258 admissions and 179 people have been supported into the community. The impact of the additional staff has also been felt in improved relationships between social care, health and wider partners. Communication and joint working is evident where cases are being discussed in the Hub and weekly 'huddle' meetings.

15. The extra staff capacity working with people with mental ill-health has also provided extra re-ablement support to support the independence of people experiencing a range of complex issues as part of their discharge plan. Mental health colleagues are now also engaged with plans to better support people who are receiving treatment in an acute hospital.

16. The staff capacity has also been used to improve quality of practice. The multi-disciplinary staff in the acute Hubs are now changing their culture to think more about the outcomes for people. This has had a beneficial impact in reducing the amount of people who go into short-term residential care directly from hospital who could have gone home, many of whom then remain in residential care permanently.

17. A further specific post is now working with staff to improve application of the Mental Capacity Act, focusing on how people unable to make a specific decision about their care or treatment are supported as part of hospital discharge.

### Planning services in advance and enabling providers to recruit their workforce

18. The Grant has been used to create additional voluntary sector capacity to support hospital discharge. A Supported Hospital Discharge Service contract has been awarded with a target of supporting 40 people per week (15 south, 10 mid, 5 north). They are currently recruiting staff and volunteers and are starting to make links with each of the Hubs and the reablement services. The service supplements rather than provides regulated personal care activities but offers practical and emotional personalised support to settle back home, for example, doing the food shopping, topping up gas and electricity meters, clearing out the fridge of old food etc.

19. The Grant has been used to develop a local model to use technology in the form of discrete sensors that monitor the behaviours and activities of daily life, such as motion, bathroom visits, eating and hydration. The information from these supports the operational teams with decision making and right sizing assessment and support plans to mitigate risks and increase independence. They are initially being used by the department's re-ablement and Discharge to Assess Teams following a stay in hospital, as well as in community teams to avoid crisis and re/admission. External specialists have been engaged and are supporting teams to rapidly develop new processes, deploy the technology and be able to monitor the information from it and use this to form an accurate picture of a person's needs and risks. Findings from this initial work will be reported into the ICS Urgent and Emergency Care Board with recommendations for further roll out with health partners. Fifteen devices have been deployed to date and below are some examples of the outcomes.

| | Case summary | How TEC helped | Outcome |
|---|---|---|---|
| D2A | Mr F had Lilli installed following hospital discharge with concerns for increasing needs alongside reduced mobility. | Demonstrated Mr F's independence at bedtime and that he had not been accessing the kitchen without carers. | • Care package reduced from 4 to 3 calls a day.<br>• Reablement support with his confidence in the kitchen likely to reduce package further. |
| START | There were major concerns about Mr R's mental and physical health deterioration, constant falls and suspected wandering. | Demonstrated that Mr R was wandering outside for long periods of time through the night and that the property was very cold. Upon readmission, the data from the TEC was shared with the hospital team. | • Better decision-making on hospital discharge to a P2 bed to support assessment.<br>• Prevents future crises and hospital admission through temperature monitoring and prevent wandering |
| START | Mrs L had 3 falls in 8 hours and was admitted to the hospital, where she was also treated for pneumonia. There were concerns that Mrs L was not managing and concerns with self-neglect | Demonstrated that Mrs L was managing with 2 calls per day (AM and PM) which were then reduced to alternate days. Lilli is not showing patterns of self-neglect on days without care. | • Reduction in care package to meet needs using evidence.<br>• Ongoing monitoring to ensure no self-neglect. |
| Broxtowe | There were growing concerns about Mr X's ability to manage between care calls. The family live far away and are unable to visit regularly. | Demonstrated changes in Mr X's overnight movements and behaviours which raised concerns around the management of insulin and the impact on his health | • Identified the need for a health check to look at medication and cognition.<br>• Due to concerns, family paid for respite.<br>• Provides evidence to support health intervention, prevent crises and hospital admission |
| Broxtowe | Mr G's family was worried about his ability to manage at home. They suspected that he was going to the loft to turn the boiler off, despite his mobility issues, which would leave him feeling cold. | Demonstrated that Mr G was turning the heating off through radiators, rather than the boiler, as the house was too cold on average. The information from the TEC also supported the assessment of the mobility concerns. | • Family replaced radiators, so they can't be turned off.<br>• TEC remains in situ to continue to support the assessment of Mr G's mobility and monitor temperature changes.<br>• Maintaining temperature likely to prevent future health deterioration and hospital admission |

20. Skills for Care completed the deep dive into the external workforce in November 2023. Skills for Care is currently working on the External Workforce Strategy for Nottingham and Nottinghamshire which is expected in April 2024. External providers have been able to utilise the local recruitment website called Care4Notts for advertising their roles and feedback has been positive with recruitment success and increased levels of interest for social care posts on this website.

**Learning from the evaluation of the impact of previous schemes funded using discharge funds**

21. Discharge funding has been used to extend the successful 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 six weeks whilst their accommodation is made ready to return to, or if they need a period of more intensive support before going home. The scheme can support up to nine people a year and avoid delays in hospital.

22. Previous years has 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, additional community care support and although not an ideal outcome for people who could have returned home, use of interim residential care beds have also been able to be deployed rapidly. In 2023/24, some of the funding has been used for interim residential care. In line with the strategy, as this has reduced and more people supported home first, the Grant has been used to fund additional community capacity instead. There is also clear evidence that indicates that people leaving hospital have higher support needs than in previous years. The Grant is being used to support these additional community needs and provide better outcomes through supporting people in their own homes.

**Improving collaboration and information sharing across health and social care services**

23. Two posts have been recruited to develop and implement the plan to realise the shared aim to develop therapy-led and joint ways of working across social care and community health re-ablement. The work includes developing and implementing 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.

**Next steps**

24. Next actions to implement are:

- Recruit staff to roll out the integrated health and social care therapy training programme has now been scoped based on learning from other areas that have done this successfully. Currently the skill set of health and care therapy staff is quite different and therapy staff are also hard to recruit in sufficient numbers. The aim is to develop a shared training programme for all therapy staff to have the same set of core skills. This will make more effective use of available staff, avoid health and care therapists handing over to each other as much and also aid career progression and development across health and care.

- Build on feedback forms that some teams use to have a consistent way to get feedback and design ways to involve people with lived experience of the hospital discharge process to shape the development of services.

- There are financial pressures on all partners across the ICS, including the ICB who are working up significant financial savings for 2024/25. A shift to supporting more people in the community with higher needs is in line with the Social Care and Public Health vision, there is however, a financial risk if money is not released by the ICB to fund greater community capacity. There are also risks that some of the ICB savings proposals impact negatively on Social Care and/or system progress to date. Staff across the Department are working closely with ICB colleagues with the aim of identifying and mitigating these.

- Joint planning for spend of 2024/25 Discharge Grant.

**Other Options Considered**

25. 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. The deliverability and impact of the initiatives are reviewed during the year with partners.

## Statutory and Policy Implications

26. 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**

27. The national Adult Social Care Discharge Grant 2023/2024 of £4.335m for adult social care funds the initiatives set out in this report. The funding is pooled and monitored through the Nottinghamshire Better Care Fund. The 2023/2024 Adult Social Care Discharge Grant will be fully spent.

## 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.

**Melanie Williams**
**Corporate Director, Adult Social Care and Health**

**For any enquiries about this report please contact:**

Sue Batty
Service Director, Ageing Well and Community Services
T: 0115 9774876
E: sue.batty@nottscc.gov.uk

**Constitutional Comments (CD 19/02/24)**

28. 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 (CMER 21/02/24)**

29. There are no further financial implications for this report, other than the spending of the grant as detailed in Appendix A. There are robust monitoring procedures in place to ensure grants are fully spent in the new financial year.

**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.

AS0012