APPENDIX A – Discharge Plan 23/24

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 waiting in these. 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
- Facilitating 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 Council already funds the voluntary sector to visit people who may need a well-being check after going home from hospital with no 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 etc. and do short term follow up work to support a successful recover 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 also 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 will work partners to:
a) develop an ICS 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

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 approx. 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.

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 and additional Technology Enabled Care 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 have 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 in order to implement, which will be funded from the grant. In order to deliver the strategic commissioning, contract and procurement work to support more efficient discharges form specialist hospitals for people experiencing mental ill health a joint post has been developed and the social care 50% will be funded from the grant. The ICS 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