Agenda Item No.7

Social Care and Health Overview and Scrutiny Committee

14 September 2017

Discharge to Assess Pathway

Ward(s) All

Portfolios: Councillor Diane Coughlan – Social Care

Reason for scrutiny

To update members on the 2016 decision to change the discharge to assess pathway in Walsall

Context:

Discharge to Assess' (D2A) describes a pathway whereby patients, in an acute hospital setting, who are 'medically fit for discharge' (i.e. no longer acutely unwell) and who require further health and/or social care assessment are discharged to a 'transitional' pathway where those assessments can take place. The aim of the pathway is to reduce lengths of stay in hospital, facilitating acute bed capacity, ensuring a safe discharge and enabling further assessments to take place outside of the hospital setting.

Background:

1. In Winter 2014/15 the council secured provision for 40 block purchased discharge to assess care home beds, which have assisted the discharge of older people from the Manor Hospital with complex needs

2. The development of the Health & Social Care System Recover Plan, in early 2016 suggested an alternative model based on the successful 'Swift Project' introducing Discharge Home to Assess, where less beds were needed, replaced by care at home.

3. The plan suggested the consolidation of bed based provision and the releasing of funding to support the expansion of the Discharge Home to Assess pathway. This would help more people return direct to their own homes earlier and, in doing so, improve the outcomes for individuals. Additionally the service could enhance its performance in terms of timely discharge flow.

4. There is a link between discharges and Accident and Emergency (A&E) performance as delays in discharge can create capacity issues within the hospital.

5. There is a national target that no less than 95% people who attended Accident and Emergency should be seen, admitted, treated or discharged within 4 hours of

arrival. The monitoring of the Plan has suggested by the end of December 2015 the standard had only been achieved once in over 18 months at the Manor Hospital. Between January 2016 and July 2017 the standard has not been been achieved. *(The reader should note that during the same period the Manor Hospital has closed one ward).*

6. Two important initiatives forming part of the Health & Social Care System Recovery Plan have been underway since December 2015:

    - A reconfigured 'Frail Elderly Service' is helping to divert hospital admissions from within the Accident and Emergency Department; and
    - The 'Swift ward project' a multi-agency pathway approach to reduce delay and accelerate discharge for those who are medically fit for discharge

7. The enhanced multi-disciplinary approaches to supporting older people to go home are showing significant improvement in reduced care home admission rates and patient discharges out of hospital are critical to meeting Accident and Emergency targets

8. Reductions in Adult Social Care delayed discharge, of patients medically fit for discharge; have been dramatic and consistent since the monitoring commenced. An independent report commissioned by Walsall Accident & Emergency Delivery Board identified that discharge to assess relating to health delays have been significantly under-reported to date and work is ongoing with Walsall Healthcare Trust to address this.

9. Whilst the discharge to assess model supports hospital discharge it has been identified that a mainly bed based model in care homes does not address the full range of needs of these being discharged. Therefore, there was a reconfiguration of funding to expand the capacity of more community based care in line with the 'Recovery Plan' covered;

    - Decommission the 40 care home beds in nursing homes and recommission 20 care home beds (including 3 beds for people with complex needs, e.g. mental health) with an enhanced specification
    - The capacity of the 'bedded' pathway could be maintained by reducing the length of stay in the 'Discharge to Assess' beds
    - Appoint additional capacity to the 'Social Care Support Team', extend the remit of the team to support all discharge pathways and improve identification of appropriate patients for 'Discharge to assess' at home
    - Arrange General Practitioner medical cover for the 20 'discharge to Assess' beds to address and reduce high readmissions rate (average 30%) – this has been commissioned and funded directly by Walsall Clinical Commissioning Group
    - Increase Social care reablement capacity by 300 hours to enable return home and
    - Commission an additional 400 hours of domiciliary care/homecare from the market to enable people to stay at home after discharge

10. Dialogue between the Council, Walsall Commissioning Clinical Group and Walsall Healthcare Trust helped to inform an enhanced specification and in June 2016 Cabinet agreed commencement of a competitive procurement for;

- 300 hours per week additional reablement capacity
- 400 hours per week additional domiciliary care/homecare capacity
- 20 transitional beds (3 of which could be included to support people with complex needs e.g. mental health requiring EMI registration)

The annual cost of £1.56m of these services is within the Better Care Fund allocation.

11. Outcome of tender

(a) Transitional beds:

Upon evaluation of the tenders, there was no suitable provider to deliver elderly mentally infirm (EMI) provisions, therefore the panel decided to award the 17 beds for the standard transitional bed provision and spot purchase EMI provision from the existing residential and nursing framework as required.

Contracts were awarded to:

Arboretum Care Home	5 beds
Red House Care Home	6 beds
Aldridge Court Care Home	6 beds

12. There will, on occasions, be under spend from the spot arrangement and this is used flexibly to address times when the numbers require greater capacity. It is also used to facilitate discharge of non weight bearing cases where there is a need to heal before commencing a programme of rehabilitation. Based on the individual's need this can be either a bed based service or a comprehensive package of care in the individual's home.

13. Therapy/nursing and social work input to the transitional bed pathway has not reduced and continues to be required to facilitate multi disciplinary arrangements and support continual improvement in reduction of bed days.

14. Increased Community Capacity

(b) 300 hours per week additional reablement capacity:

The transformation of the service was designed to reduce reliance on bed based provision and create more capacity to support people to return directly home. Recognition of spending pressures and re-alignment with Adult Social Care savings plans has since resulted in a re-evaluation whereby any additional reablement hours required can be met via staff working additional hours or the purchase of reablement hours from the independent sector.

15. (c) 400 hours per week additional domiciliary care/homecare capacity

Delivered by providers on the reablement framework listed in D, 26,620 hours have been commissioned since February 2017 supporting 237 care packages to enable people to return and stay at home after discharge.

16. The A&E Board recovery plan has continued to be fluid and responsive to demand in order to achieve its recovery trajectory toward 95%. The additional Dh2A pathway has expanded beyond 1,600 hours per month to the limits of its funding of 4364 hrs per month or £60,000 but remains within its budget envelope.

17. (d) Reablement Framework providers as referred to above.

Contracts commenced March 2017 for five providers on a spot purchase framework.

- Serenity
- Care XY
- Caring Care
- Advance
- Custom Care

18. **Performance management**:

With regard to the bed based services, lengths of stay have reduced as planned:

- D2A from average stay of 39 days to 26
- Hollybank from an average of 30 days to 23

19. The Medically Fit For Discharge list (MFFD) has reduced significantly due to adult social care activity and the significant expansion of the Discharge home to Assess pathway. This means in February, 120 patients were on the hospital list; by August this is a figure of 67 people. Comprising of 120 patients in February 17, 100 March and a steady 90-80 May, June to 67 patients beginning of August.

20. **Future Plans**

Very recently chief officers across health and social care signed off the business case for a revised model of Integrated Intermediate Care Services. The initial 3 phases have commenced which incorporates both the bed based and non-bed based pathways. The model will facilitate process improvements, improved screening and collaboration and a seamless transition for Service users. Governance will be improved and the performance framework reviewed.

21. Intermediate Care provides a range of services to patients that require additional social care / health care post-hospital care to enable timely discharge to a safe living environment with the necessary assistance to regain function and / or confidence. This support is provided in the patient's own home (or usual residence) until long-term arrangements are in place or no further social/health care support is required.

22. An assessment of the current Intermediate Care Pathways, supporting both discharge from hospital and admissions avoidance, has highlighted weaknesses, including:

- Over reliance on bed based models for discharge
- Patients not always 'directed' to the appropriate Intermediate Care

Pathways (inconsistent compliance with pathway entry criteria)

- Over provision of Intermediate Care Service, typically due to unnecessary delays to 'exiting' the Intermediate Care service
- Inconsistent ward processes, including unreliable estimated date of discharge and inadequate compliance to SAFE (safety, access, focus and empathy) principles resulting in delays to identify patients with complex discharge needs.

23. The proposed solution is to implement a reconfigured Intermediate Care Service (ICS) Model that makes discharge home with timely access to the appropriate health and social care support as the default pathway. The focus of ICS will be to work in partnership with patients to set patient-centred goals coupled with a multi disciplined team (MDT) approach to enable and monitor progress against goals / plan. The reconfigured ICS is underpinned by consolidating disparate health and social care functions into a combined health and social care team that will provide a single service with responsibility for patients who require support to facilitate discharge.

24. The refreshed vision for the proposed Intermediate Care Services is:

- A Health and Social Care single service with responsibility for complex patients who require support to facilitate discharge from an in-patient bed.

- Provide a rapid response to care delivery in the right place at the right time to maximise patient's independence, deploying the optimum skill mix to ensure that the response provided is appropriate and proportionate to the assessed needs with the default position being for the patient to return home.

- Integration through a new shared culture, mind-set, values, objectives, working processes and practice.'

25. **Risks and Challenges**

The success of the model remains very dependent on process at ward level within the Trust and will depend on a number of improvements in the hospital and adult social care in order to ensure high numbers of appropriate referrals are received by the service in a timely manner.

26. The discharge home to assess pathway requires social work assessment outside of the acute setting, in peoples own homes. The requirement for social work staff to now travel will have an impact on assessment productivity and length of stay within this pathway. Capacity and demand modelling within the implementation phase of the new intermediate care model will seek to address this.

27. **Recommendations:**

That the Scrutiny Panel notes the content of this report.

Background papers:

Cabinet report – 29 October, 2014 (Commissioning Winter Capacity 2014/15)
Cabinet report – 27 April 2016 (Discharge to Assess)
Cabinet report – 27 July 2016 (Discharge to assess Beds Pathway Services)

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