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Report title: Supporting Hospital Discharges	
Report to: People and Families Policy and Scrutiny Committee	
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Date: 12 May 2022	**For:** Consideration
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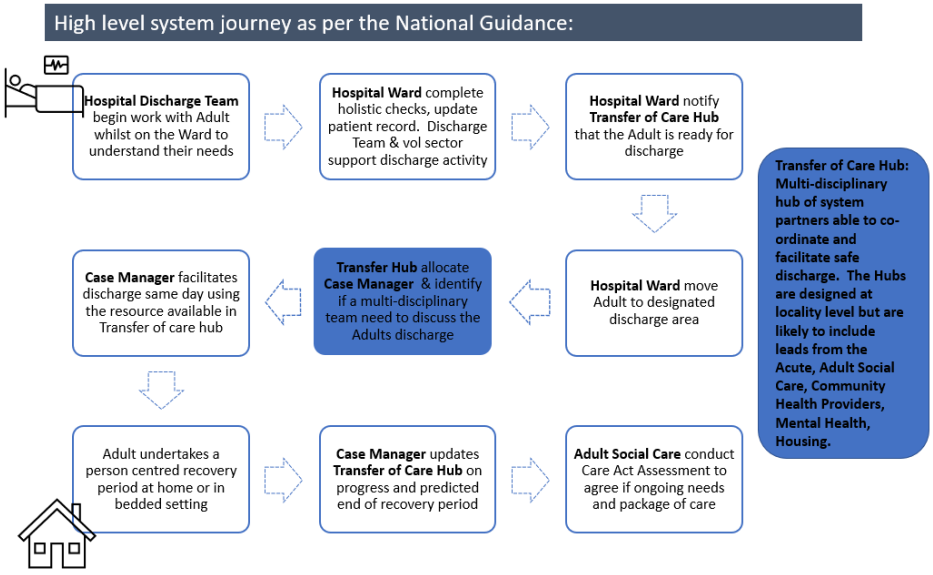
1. Purpose

This briefing note is to support discussion at the PAF scrutiny committee on 12 May via outlining the current challenges and mitigations in relation to achieving good discharge flows from acute hospital provision in Essex. It will cover three core strands:

- Actions taken over winter and more recently, to support the care market
- Our review of 'Discharge to Assess' (D2a) arrangements in Essex (D2a is the mandated model for supporting people to leave hospital)
- An update on the Connect project (Connect is the countywide programme of work to optimise the processes and services which support discharge)

2. Background

The timely and appropriate discharge of people from hospital is vital to ensure acute capacity is available for those who need it, and that people are able to regain their independence as quickly and as fully as possible following a hospital stay. The system that supports hospital flow is complex and involves many factors including workforce capacity, process design, contracted provision to support discharge (and avoid admission) and adherence to both statutory legislation and good practice guidance. The diagram below, illustrates the discharge from hospital pathway:



The Covid-19 pandemic has proved a particular challenge for supporting hospital discharges. It has had an impact on the way hospitals operate to ensure infection control, and on the supply and functioning of discharge pathways (for example, testing and procedures in care homes, workforce recruitment in the community-based services, like reablement and domiciliary care, that are needed to meet additional demand). Further challenges have included rising inflation, particular geographies with insufficient workforce supply restricting capacity in domiciliary care and reablement, exacerbated by a loss of care workforce as adjacent sectors opening up after Covid, for example hospitality and retail.

Broadly, the Council has responded in three ways;

- Solutions to maintain the viability of care providers who are involved in the discharge pathway, and optimisation of current supply including via process improvement and relationship development – maximising and ensuring the viability of available capacity in the domiciliary care market
- Implementing New Ways of Working, and new local data and dashboards for system leaders, that support operational staff in their daily work with adults leaving acute hospital care, Reablement Care and adults receiving Assessment in the community – driving down the demand for domically care.
- Embedding of the recommended D2a arrangements and guidance; and the necessary work on interfacing with the NHS that this involves – ensuring affective use of domically care, and supporting strong leadership of systems impacted by the fluctuating availability in domiciliary care.

These will be covered in the course of this paper.

3. Actions taken to support the care market

Care markets are vital to the smooth discharge of people from acute hospitals via ensuring support is available for those who need it in order to return home. Particular challenges faced by this system as it approached Winter 2021-22 included:

- long term trend toward care at home accelerating at a speed which the domiciliary care market was struggling to absorb
- Fee levels for domiciliary care being comparatively low (13th out of 15 County Councils, 2020/21 CIPFA statistical neighbours) meaning providers of these services struggling to retain or recruit staff who are being attracted by other sectors offering higher salaries and more attractive conditions
- Occupancy levels in care homes fell during the pandemic from around 96% to 78%. They have now recovered to over 80% with large variations between homes. However, based on internal assessment, there are a number of homes that are unlikely to remain financially viable.

Actions taken to mitigate these issues were focussed on three things:

The first area of focus has been workforce recruitment, retention and wellbeing; core actions on this centred on:

a. ensuring access to local and national funding streams including the DHSC Workforce Recruitment and Retention Fund (£4m allocated to all providers for staff retention),the Workforce Grant (£3m allocated

locally to support all contracted providers with immediate pressures), and the Covid relief fund (extended to support recruitment and retention in care homes).

b. Uplifts for both 'Live at Home' framework and 'Integrated Residential and Nursing' Framework providers were secured at February cabinet with further proposals being developed in light of recent pressures from inflation and fuel price rises.
c. Additional workforce actions included access to the EPUT 'Here for you' wellbeing offer, training and education from ESCA and ECC's own recruitment team offered a free of charge service to the care market until March 2022, building on promotion of vacancies through social media.

The second set of initiatives were around support for capacity and flow in the system. An important part of this has been the block purchasing of residential care home beds from good and outstanding quality providers with high level of vacancies for use as short term 'step-down' options. This helped both in the support of vulnerable suppliers and also in bolstering capacity for acute hospital discharge. Alongside this, the Council was required to commission a 'designated setting' for people who were Covid-19 positive and who needed to isolate in residential care after a hospital stay. Other solutions in support of discharge flows have included;

- 'Bridging' contracts in all areas of the county to ensure speedy discharge where reablement providers are unable to pick up cases immediately.
- 'Provider of Last Resort' capability to ensure good quality care is available should other suppliers be unable to main support for people
- A package exchange trial programme so that domiciliary support could explore setting up more efficient care round through swapping packages with other providers, subject to the individuals approval
- Infection prevention and control fund, vaccines and rapid testing monies totalling £10.4m passported to the market to support COVID related costs until March.
- Incentive payment scheme for providers who pick up 'hard to source' cases commonly linked to particularly challenging geographies (rural Braintree, Uttlesford).
- Proposal to develop domiciliary care blocks in hard to source locations, structured to support sustainability.

The last area of focus was ensuring our responses were inclusive and accessible to vulnerable groups. A direct payment mitigation plan was developed to ensure personal assistants, and those they care for, have access to information and guidance; Care technology has been deployed across supported living to assist in ensuring needs are met; a designated settings site at Long Wood was mobilised at the peak of Wave 2 to ensure younger adults could access this provision if needed; existing provision (reablement for example) was reviewed to ensure inclusive access criteria; additionally the Approved Mental Health professional (AMHP) staffing establishment has been increased permanently by two FTE and has created a bank of AMHPs from which it is able to draw upon in periods of high unpredictable demand.

Whilst the sum effect of these initiatives was positive in ensuring the health and care system remained viable through winter and beyond, it is recognised that challenges continue. Planning has already commenced for winter 2022-23 across both the NHS and social care, factoring in cessation of some of the national Covid funding streams, such as the Hospital Discharge Fund; work is also underway to shape markets sustainably, via both decisions on pricing and cost of care and also longer term commissioning projects aligned to the ASC business plan intentions.

4. Actions taken to drive down demand and support stronger operational decision making

The Connect Programme emanates from a 2019 system-wide diagnostic activity, which lead to 3 ECC Wide workstreams, focussing on:

a) improving the **effectiveness of reablement services and increasing the volume of adults who can use the service** (sponsored by Matt Barnett, Head of Commissioning) – the aim was to enable about 1,240 more people each year to benefit from reablement;
b) supporting **more independent outcomes through social care decision-making** (sponsored by Simon Froud, ASC Director) – the aim was to enable about 1,500 more people to achieve more independent outcomes and avoid higher packages of care; and
c) **improving discharge outcomes** (sponsored by Simon Griffiths, ASC director and Michelle Stapleton, acute hospital director for operations) – the aim was to avoid about 240 admissions into residential care each year.

By way of an update on the Discharge Outcomes work, the programme now reports that;

- All acute hospitals across Essex have embedded new ways of working, including multi-disciplinary team meetings and better visibility of data. This has supported a reduction in use of bedded settings on discharge from hospital.
- Discharge to Assess (D2A) teams are working to support people who are discharged to an interim bed. Since September 2021 D2A teams across Essex have adopted the 'Perfect First Week' process to ensure that all people discharged into interim beds have a clear plan for their next step within the first week of discharge. This has supported more people to be returned home.
- D2A teams have also moved to 7 day working, flexible to the needs of the system and population it supports.

Currently, the programme can show around 170 fewer people have been discharged into Residential Care against the baseline period. This produces an increased in the number of adults who return home, either directly from acute hospital care, or from an interim bedded setting following acute hospital care.

However, the impact of this is mitigated by the work in the Reablement and Supporting Independence workstreams, where;

- Due to the impact of work done with ECL, we have seen a reduction of the level of need of people exiting Reablement by 21% more than before the

programme – this equates to over 6000hrs less dom care hours in use per week.

- The care provided to adults following their Care Act Assessment or Review has been right-sized due to new ways of support ASC practitioners, leading to a reduction of just under 3,000 fewer dom care hours in use per week.
- The Discharge Outcome work drives more people through Reablement, meaning more adults benefit from the improved ability of ECL to support adults into independence at home, with reduced dom care hours.

These new ways of working are underpinned by new data and dashboards, and regular Improvement Cycle meetings. The process, data and improvement cycles are locally lead, and rated for sustainability as part of the programme infrastructure.

5. Actions taken to develop and support strong system leadership

D2A System Review

In March 2020 the Department for Health and Social Care released National Discharge to Assess (D2A) Guidance. The guidance was revised on numerous occasions during the Covid-19 pandemic, but the spirit remained the same, systems were to think "Home First" and a person's needs should be assessed away from the Hospital setting.

Across Essex there have been varying degrees of implementation of the model. Rate of implementation has been dependent on Market pressures, workforce pressures and existing structures.

In October 2021 ECC ASC, with the support of health partners, commissioned a Countywide System Review of the D2A processes in place across the Essex footprint. The aim of the system review was to hold a mirror up to the existing operating models and identify where the National guidance has been adopted, where there are gaps, and draw an inference on the impact of those gaps. The diagnostic would then be shared for systems to utilise at their discretion.

The system review was undertaken in each locality by mapping two elements against the October 2021 National D2A guidance:

- The Current D2A Operating Model to understand the leadership roles and responsibilities and teams involved
- The processes that take place on the major pathways and using KPIs to study the outcomes and flow along these.

Engagement for the review was excellent from the system making the output more valuable.

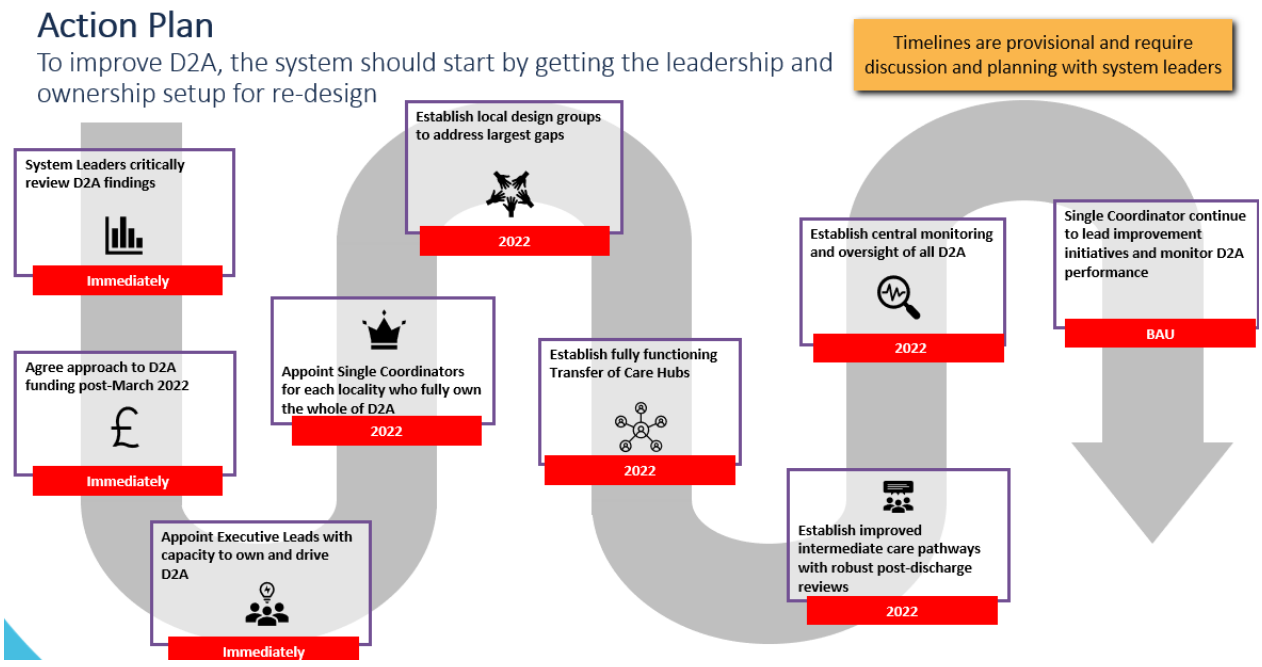
The review found that great progress had been made across Essex to implementing D2A and frontline operational workforce are doing an incredible job of supporting patients and adults whilst under immense pressure. The review has highlighted gaps, measured the impact of the gaps and recommended approach to re-design.

Key Findings are below but it should be noted these findings are from last November and D2A has remained a priority for improvement in all areas so this position would have changed.

KEY FINDINGS

- **Operating Model:** Every area of Essex is configured differently to deliver D2A Pathways, which will lead to variation in outcomes in each system. None of these areas are fully aligned with the D2A Guidance
- **Leadership & Governance:** There are strong leadership examples at an organizational level and the seeds of promising collaboration but no one person taking responsibility for the success of D2A. The system-level leadership and co-ordination of the D2A pathways recommended in the guidance is a significant gap.
- **Transfer of Care Hubs:** discharge teams/hubs have not been established with the recommended multi-disciplinary input – too often decision making is acute-led and the remit of the current discharge teams does not extend beyond the acute discharge
- **D2A Community Assessments:** There is no coordinated MDT approach to assessing and adjusting the care someone requires when they are first discharged – either home or into bedded settings. There are pockets of good practice via teams working together but there has been little formal design or resourcing to deliver this effectively
- **Community Pathways:** The set-up of community pathways makes it challenging to implement D2A effectively with appropriate rehabilitation support and Home-first culture. High quality rehabilitation pathways would enable individuals to step up/down as required – including on Day 1 if the acute discharge was not ideal

A detailed diagnostic of the Review output was shared at Place level with system Partners. The diagnostic proposed a roadmap/Action plan that could be adopted for driving change.



Current status of the Review

The Review has been well socialised with key stakeholders in Health and Social Care across Essex, Southend and Thurrock. It is for each Locality to now determine how they best use the output to drive transformational change.

One of the biggest areas to be addressed so far by all areas is the gap in coordinated System Leadership. West Essex was already starting the recruitment process last November for a Single Co-Ordinator, they were also happy to share their approach to hiring a system role with other Essex localities to share learning which has been welcomed. As Single Coordinators become more established this should naturally start to drive transformation / development of Transfer of Care Hubs, a vital part of the operating model.

Adult Social Care's next steps:

Each Local Director will advocate in their locality using the learning from the review.

A set of Countywide Principles: A set of Principles are currently being prepared to form a consistent Countywide offer around the role of Adult Social Care in Transfer of Care Hubs. The Principles once finalised internally will then be shared with Partners for their consideration. We want to be a fair and consistent partner and want our Health partners to understand our Principles and feel able to hold us to account also.

Governance: Discussions are currently underway aqs to the best way to sustain a Countywide dialogue around D2A Transformation. It is proposed that what good looks like will eb agreed by the existing Connect Steering Board and the currently well attended Countywide D2A Outcomes Board will become the forum for Single Co-ordinators to collaborate and engage with ASC.