Title of meeting:	Cabinet
Date of meeting:	05/10/2021
Subject:	Portsmouth Health & Care - Discharge to Assess Model.
Report by:	Andy Biddle - Director of Adult Social Care
Written by:	Patrick McCullagh - Senior Project Manager
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1. The purpose of this report is to:

a. Update Cabinet (following the reports in June 2020 and March 2021) on the delivery of the Health and Care Portsmouth vision for developing a local integrated intermediate care offer which offers Discharge to Assess, (D2A) rehabilitation, reablement and recovery support, primarily in people's home and in community beds where necessary that meets the needs of Portsmouth citizens.

b. To seek the necessary approvals to enable Adult Social Care to work with Health & Care partners in the city to permanently establish a Discharge to Assess unit comprising beds within Harry Sotnick House.

2. Background/Context

2.1 There is a national directive to fully embed a 'Discharge to Assess' (D2A) and 'Home First'[1] approach in local systems. This means that people are supported to safely leave hospital as soon as they are clinically able; that assessments of people's long-term care and support needs happen outside of the acute trust and that for most people, all of this happens in their usual place of residence. Additionally, with the implementation of Criteria to Reside (CTR) (see Appendix 1), we are likely to see an increasing level of complexity and acuity for those we need to support to either avoid admission to hospital or to leave in a safe and timely manner.

[1] https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

2.2 The vision for Portsmouth is to enable people to receive the right level and type of health and care services in their own home and community wherever possible, enabling them to remain well and independent for as long as possible by maximising their recovery, managing their long-term conditions, and avoiding unnecessary hospital admissions.

2.3 In support of the vision and the national directive an integrated health and care transformation programme has been established, this programme of work has been developed to help inform the future development and design of community bed-based and home-based services to ensure we have the right capacity and capability in the right places providing the right spaces. The aim of this is to:

- Deliver the national ambition set out in the Hospital Discharge Guidance[2] (ensuring a target for the number of people Medically Optimised for Discharge, (MOFD) for Portsmouth is no greater than the locally set target of 20)
- Achieve a sustainable rehabilitation and reablement offer (home and bed based), including D2A; and,
- Be able to flex to meet additional demands.

2.4 In December 2020, a business case was presented to the Portsmouth South East Hampshire, (PSEH) strategic group, setting out the case for continued funding in 2021/22 to deliver the steps necessary to stabilise and evolve the current service model to respond to system pressures. It was intended that this would provide the foundation for building future capability and confidence to transition to a full 'home first' approach, including urgent community response, in line with national directives.

3. Recommendations

3.1 It is recommended that Cabinet:

a. Agree to the permanent transfer of the staff and related available budgets for the Victory Unit to Harry Sotnick House, acknowledging that this will result in Adult Social Care ceasing use of the Victory Unit at Wyllie Road.

b. Agree that the Director of Adult Care consider and evaluate options for the use future of the space at Wyllie Rd.

c. Acknowledge that it has been possible to establish and operate the new Discharge to Assess unit within Harry Sotnick House at the current capacity, due to a combination of both the staff resources from the Victory Unit and the funding available through the governments temporary COVID Hospital Discharge Scheme.

d. Acknowledge that health & care system partners have an ambition to establish a permanent 40-bedded D2A unit at HSH and that this proposal would require

[2] https://www.gov.uk/government/collections/hospital-discharge-service-guidance

joint commissioning with and permanent funding contributions from Portsmouth CCG.

e. Agree that the Director of Adult Care continue negotiations and enter into the necessary agreements with Health & Care partners, in consultation with the s.151 officer and the City Solicitor, (or their delegates) to establish:

i. A permanent jointly funded and commissioned D2A unit within Harry Sotnick House.
ii. Operational and funding arrangements to support people discharged from hospital, who cannot be supported within the D2A unit and require support from within the external care market, prior to a Care Act assessment being completed.

4. Discharge to Assess Model

4.1 As stated above, in December 2020 a business case was presented to the Portsmouth South East Hampshire, (PSEH) strategic group, setting out the case for continued funding in 2021/22 to deliver the steps necessary to stabilise and evolve the current service model to respond to system pressures. It was intended that this would provide the foundation for building future capability and confidence to transition to a full 'home first' approach, including urgent community response, in line with national directives.

4.2 One of the key assumptions in the business case is for the City Council to permanently transfer the funding from the Victory Unit to support the D2A bedded option at Harry Sotnick House (HSH). On 18th January 2021 in a response to the third wave of the pandemic, Victory Unit staff temporarily relocated to HSH Southsea Unit. This created an additional 20 D2A beds and allowed the Gunwharf unit to offer a designated unit for Covid positive patients. The number of D2A beds on Southsea increased as the number of designated beds decreased and from the 1st of August 2021 there are 30 D2A beds.

4.3 The discharge to assess model sets out 4 pathways (see Appendix 2):

a. Pathway 0

Likely to be minimum of 50% of people discharged:

- simple discharge home
- no new or additional support is required to get the person home, or such support constitutes only:
    - informal input from support agencies; or
    - a continuation of an existing health or social care support package that remained active while the person was in hospital

b. Pathway 1

Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.

c. Pathway 2

Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home

d. Pathway 3

For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).

4.4 The benefits of a fully mature, integrated system that has the right capacity in the right place are outlined below[3]:

- People's health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default.
- People's length of stay in a hospital bed decreases due to longer-term assessments taking place in a more appropriate situation and place. Evidence suggests this should reduce deconditioning and improve outcomes significantly for 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.
- Improves system flow by enabling patients to access urgent care at the time they need it.
- Reduces duplication and unnecessary time spent by people in the wrong place.

5. Impact of Discharge to Assess

5.1. D2A is seen to have significant potential to move medically optimised patients to community settings to assess their long-term care needs and improve acute flow.

5.2. D2A is not a new concept and has been tried and tested by other health communities across England. Local examples of D2A evidence how improvements can be made as part of ongoing changes in ways of working:

- South Warwickshire – reported 0.5m net long-term costs averted in year 1 for pathway 3
- Sheffield – The Health Foundation reported a 37% increase in patients who can be discharged on their day of admission or the following day
- Medway – Delayed Transfer of Care (DTOC) rates were down by 25% in 3 months[4].

[3] https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf
[4] . https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf

5.3. A D2A guide produced by Department for Health, ADASS and NHS England identifies benefits of a fully established D2A model include:

- People's health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default
- People's length of stay in a hospital bed decreases due to longer-term assessments taking place in a more appropriate situation and place. Evidence suggests this should reduce deconditioning and improve outcomes significantly for 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.
- Encourages NHS and Adult Social Care leaders to work together for the best outcomes and experiences for people through joint approaches to discharge to assess. This may include joint commissioning or funding
- Improves system flow by enabling patients to access urgent care at the time they need it
- Reduces duplication and unnecessary time spent by people in the wrong place
- Enhances working relationships between the health, social care and housing sectors and increases development opportunities for their staff
- Sharing responsibility, risks and skills across partners leads to innovative and creative solutions that deliver safe, effective care and support[5].

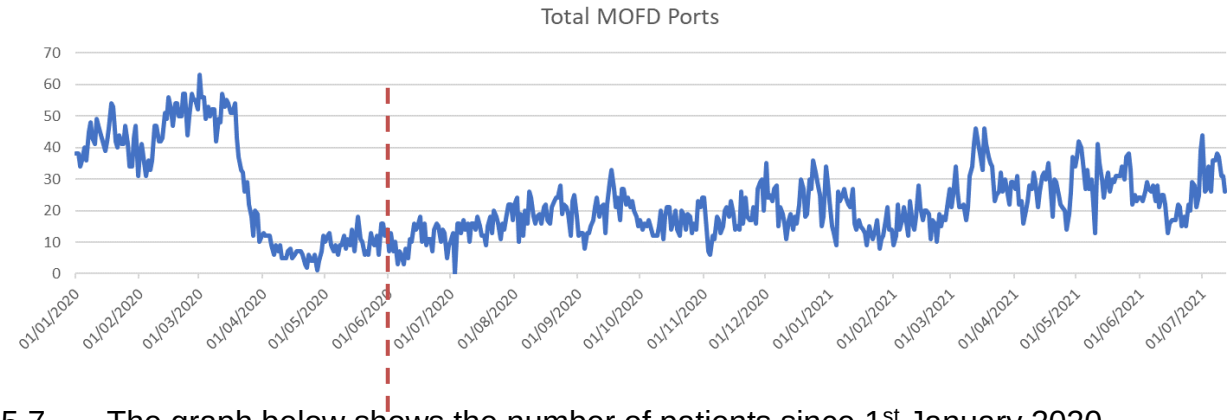
5.4. As part of the Covid discharge requirements released in March 2020 the government mandated a D2A model to be implemented in all acute trusts across England, with an intention to support more people to be discharged to their own home. Updated policy, released on by the government on 5th July 2021 says, 'Health and social care systems are expected to build on this work during the first half of 2021 to 2022 to embed discharge to assess across England as the default process for hospital discharge during the funded period.'[6]

5.5. The Discharge Hub and D2A unit went live in April 2020. Since April, the Portsmouth System has seen a significant reduction by 22 Medically Optimised for Discharge (MOFD) patients on average and 217 bed days lost. This has resulted in improved flow from the acute and a reduced the risk to patients of infection, low mood, and reduced motivation, which can affect a patient's health after they have been discharged and increase chances of readmission to hospital[7].

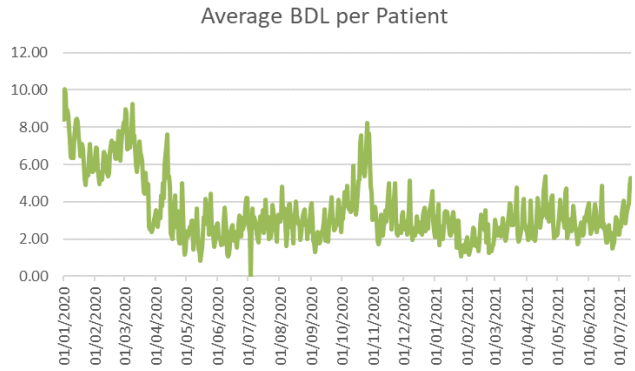
[5] . https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf
[6] https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model
[7] https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide

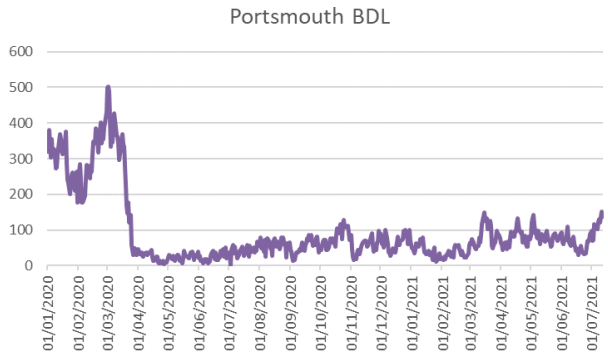
	Average MOFD	Average BDL	Average BDL per Patient
1st Jan – 6th April 2020	41.4	273.5	6.26
7th April 2020 – Current	19.4	56.3	2.94

5.6. The graph below shows the number of MOFD patients since 1st January 2020.



5.7. The graph below shows the number of patients since 1st January 2020.





5.8. Since the implementation of D2A, the number of patients discharged to a bedded option has remained stable. However, based on the discharge data, below, 56% of patients from a rehab setting and 47% from a D2A setting, return to their usual place of residence and 9% of patients from a rehab setting and 25% of patients from a D2A setting are discharged to a residential or nursing home.

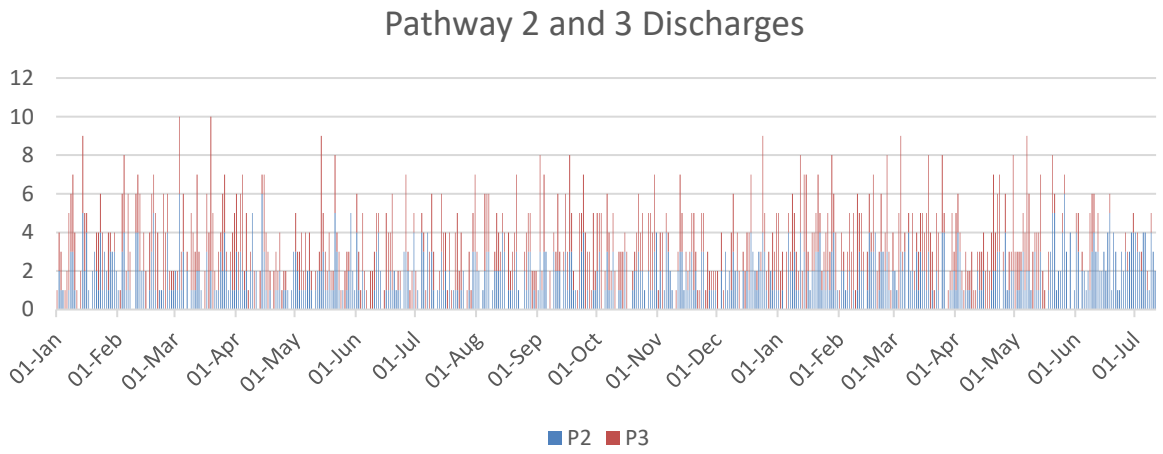
Discharge Destination	Rehab	D2A (Southsea)
Usual place of residence	56%	47%
Nursing or residential placement	9%	25%
Readmission	22%	8%
RIP	4%	9%
Other	9%	11%

5.9. The key factor is that approximately 45% of patients who were admitted to Southsea Unit returned to their usual place of residence, instead of going to a nursing or residential placement. The potential annual saving because of avoiding nursing or residential placements to PCC and CCG are in the region of £170,000 per year. This assumes all clients are full cost.

6. Demand

6.1 Since 1st January 2020 to 11th July 2021, the Portsmouth system has facilitated 1838 acute discharges to a bedded placement. This means on average 3.29 patients are discharged to a bedded placement each day. Not all individuals discharged from Portsmouth Hospital would require a D2A bed. Patients that are identified as End of Life (EOL) at the point of discharge or required a non-weight bearing bed would be discharged straight to a private residential or nursing spot purchase placement.

6.2 It should be noted that due to the Covid-19 pandemic and the stay-at-home order, the demand is not considered traditional.



6.3 From April 2020 - March 2021 - There were 57 placements, of which 11 were identified as EOL on discharge, with private providers with costs over £1K per week have been made. These were mainly placed with private providers due to requiring providers with specific skills to manage individual needs.

6.4 The additional capacity and a D2A option have increased flexibility, enabling flexible admission criteria to be able to respond to changes in demand and complexity as required, and therefore less requirement for spot purchases in private residential and nursing homes.

6.5 However, occupancy levels are relatively low, suggesting the Portsmouth system has excess bedded capacity than that dictated by demand, based on previous year data. During Covid all beds have been used flexibility for sideways moves, D2A and designated beds.

6.6 It should also be noted that throughout 2020/21, elective surgeries were cancelled to free up resource to care for patients with Covid-19. There are now many patients who are currently waiting for surgical procedures because of the pandemic. In addition, a stay-at-home order was in place, this order is likely to have had an impact on the type of demand that presented at PHU, which would have influenced the cohort demand for the discharge pathways.

7. Proposed operating model

It is proposed that the D2A unit is permanently established based on the Victory Unit funding profile, maintaining the improved Length of Stay, (LoS) for Portsmouth citizens that allow as many people discharged from Hospital to benefit from assessment and onward care planning.

7.1 During the period that discharge to assess funding is available, it is proposed that the unit continues to operate at 30 beds, funded through NHS funding, with the intention to negotiate permanent funding with NHS colleagues by the end of the 2021/22 financial year. This offers additional resilience during the winter period and acknowledges the need to maintain the discharge of people from the acute hospital.

7.2 The unit will be operated by the City Council within Harry Sotnick House (HSH). The D2A unit will accept referrals seven days a week between the hours of 9 AM and 6 PM and these beds will provide an interim placement to support hospital discharge. It will provide D2A beds for people prior to them moving on to their long-term placement e.g., a return home or alternative care home accommodation.

7.3 These beds will provide short stay following a patient's discharge from acute services to allow for assessment of a longer-term package of care, long-term placement, or return to their previous level of independence and usual care setting.

7.4 It will not be possible for the D2A unit to support all client needs. Therefore, the following exclusion criteria will be applied:

- People under 18 years of age
- People who do not meet the Accessibility/Client criteria.
- People who are not medically optimised
- People whose needs cannot be met within Southsea Unit at the time of referral following risk assessment
- Individuals with behaviours that challenge, including individuals with particular mental health needs
- Bariatric patients requiring more than the assistance of 2 staff
- People who are on oxygen therapy who cannot be supported by the Home oxygen team. (This does not include Individuals requiring non-invasive ventilation (NIV), e.g., CPAP, BIPAP or those who have a tracheostomy)
- Those people who require additional 1:1 support to maintain their safety
- Those individuals who are deemed to be end of life

- Those people who require a non-weight bearing period prior to further assessment
- Those people who have had a period of assessment prior to admission to an acute hospital, where a long-term placement has been identified and were going back through the D2A pathway will add no further value.

7.5 If permanent funding, (in addition to the Victory Unit funding) cannot be achieved for the establishment of the D2A unit this may mean that people could have to wait in hospital for assessment of need. It is in the interest of the NHS and the Local Authority to achieve discharge to assess on a permanent basis for Portsmouth citizens, given the impact further delays in hospital would have on people and their families and the health and care system.

8. The Victory Unit

8.1 The Victory opened in 2015 providing a 20 bedded unit for social rehabilitation. It currently sits as part of contract with Housing 21 who lease the site to PCC for a peppercorn rent. In return PCC agreed to provide a hot meal daily for the residents of Maritime House. This is a contractual obligation until 2025, resulting in PCC providing a chef and kitchen assistant seven days a week. Adult Social Care are currently exploring options to continue providing a meal to residents which enables these staff to fill gaps in the wider provider service, but maintains this contractual obligation.

Demand

8.2 The tables below illustrate the demand for social rehabilitation in comparison to the D2A unit

Victory Unit	2019-2020	2020-2021
% Occupied in Month (average)	70%	-
ALOS, (avg length of stay) of Discharged Pts in Month (average)	38	-
Admissions in Month (average)	11	-
Discharges in Month (average)	10	-

Gunwharf / Southsea Unit	2019-2020	2020-2021
% Occupied in Month (average)	83%	89%
ALOS of Discharged Pts in Month (average)	21	13
Admissions in Month (average)	27	35
Discharges in Month (average)	27	35

8.3 As most Victory clients were admitted from the acute hospital with a much lower acceptance criteria, the tables above clearly illustrate that more people are able to benefit from a D2A bed and its higher acceptance criteria than the Victory units' model of social rehabilitation due to the reduced length of stay and availability of a larger Multidisciplinary Team. With the move to deliver the Home first model and the

transformation of community services with the development of Urgent Community response and Discharge to Assess the Victory unit model has served its purpose.

8.4 The social rehabilitation that was provided by the victory unit has been transferred and the client cohort have been seen in their own homes by PRRT and the community independence service (CIS). There is however a small group of people who need a period low level bed-based rehabilitation which the Southsea unit will provide and has been built into the 18-day length of stay.

8.5 The best option for the future use of the Victory unit which would support the medium- and long-term financial plan would be to offer the unit to H21 (who have expressed an interest in using the unit. The key reason for this is that it is a no cost option and would free up an additional £80,000 of costs at the same as offering an increased number of extra care beds to the city.

8.6 This option supports the need to provide the maximum number of D2A beds with the greatest flexibility, within an affordable financial cost and consolidates the integrated bedded pathway between Solent and PCC and therefore delivers the hospital discharge guidance.

9. Integrated Impact Assessment

An integrated impact assessment has been completed

10. Finance Comments

10.1 The report is seeking the approval for the permanent transfer of the staff and available budgets relating to the Victory Unit to Harry Sotnick House, to establish a new permanent D2A unit.

10.2 During the COVID pandemic, the government has provided additional funding for local areas to facilitate its Hospital Discharge Scheme. This additional funding is provided through the NHS via the CCG and combined with the staff resources from the Victory unit has enabled the provision of c. 30 beds. In order to ensure the safe operation of the unit, it was necessary for the Council to take on 18 additional permanent staff at risk.

10.3 Health & care system partners have an ambition to establish a permanent 40-bedded D2A unit at HSH. This proposal would require joint commissioning with and permanent funding contributions from the CCG. Currently both parties are in discussion as to the operational and funding arrangements for a 40-bed D2A solution. Any joint commissioning arrangement would be through a variation to an existing s.75 agreement between PCC and the CCG. All proposals will require a financial appraisal to ensure the affordability for the service before any final decisions.

10.4 The D2A unit at Harry Sotnick House is not able to support all clients discharged from hospital and some people are being discharged to care settings within the

external care market in Portsmouth, prior to their Care Act Assessment being completed. These costs continue to be funded through the Hospital Discharge Scheme. Again, the City Council and the CCG are in discussions about potential long-term operational and funding arrangements to enable these arrangements to continue.

10.5 The Hospital Discharge Scheme funding is expected to continue until the end of the current financial year. Should long-term operational and funding arrangements not be agreed prior to the cessation of the temporary funding, the Council would need to: (a) reduce its D2A provision at Harry Sotnick House in line with its available resources; and (b) cease placing people in care settings within the external care market prior to the completion of their Care Act Assessment. This would result in the return to pre-COVID arrangements of completing Care Act Assessments within the acute setting.

10.6 If the decision to permanently transfer the staff and available budgets relating to the Victory Unit to Harry Sotnick House is agreed, then it will be necessary for further financial evaluation and appraisal as to the options for the future use of the space at Wyllie Rd; including the current commitment on the Council to provide a meal to residents at Maritime House.

11. Legal Comments

11.1 The City Solicitor is satisfied that it is within the City Council's powers to approve the recommendations as set out in this report. The report seeks approval for the permanent transfer of staff from the Victory Unit to Harry Sotnick House. The proposed decision is the subject of proportionate and engaged consultation with the effected colleagues.

The proposed movement of staff is a specifically agreed term within the staff contracts which permits movement within the city and subject to the needs of the employer.

Signed by

(Director)

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

Appendices:

Appendix 1 - : criteria to reside – maintaining good decision making in acute settings

Every person on every general ward should be reviewed on a twice daily ward round to determine the following. If the answer to each question is ‘no’, active consideration for discharge to a less acute setting must be made:

- Requiring ITU or HDU care?
- Requiring oxygen therapy/NIV?
- Requiring intravenous fluids?
- NEWS2 > 3? (clinical judgement required in persons with AF and/or chronic respiratory disease)
- Diminished level of consciousness where recovery realistic?
- Acute functional impairment in excess of home/community care provision?
- Last hours of life?
- Requiring intravenous medication > b.d. (including analgesia)?
- Undergone lower limb surgery within 48 hours?
- Undergone thorax-abdominal/pelvic surgery with 72 hours?
- Within 24 hours of an invasive procedure? (with attendant risk of acute life- threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Appendix2 Discharge to Assess Model