Portsmouth CITY COUNCIL

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(Please note that "Information Only" reports do not require Integrated Impact Assessments, Legal or Finance Comments as no decision is being taken)

Title of meeting:	Health, Wellbeing & Social Care
Subject:	Portsmouth Health & care Discharge to Assess Model
Date of meeting:	05/12/2022
Report by:	Simon Nightingale, Assistant Director, Health & Care Partnerships
Wards affected:	All

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1. Requested by

Councillor Winnington, Cabinet Member for Health, Wellbeing & Social Care

2. Purpose

a) To update Members (following the Cabinet report in July 2022) on the delivery of the Health and Care Portsmouth vision for developing a local, integrated intermediate care offer to enable patients within Portsmouth Hospitals University NHS Trust (PHU) to be discharged for assessment, (D2A) of their long term needs outside of the acute hospital. In doing so, Portsmouth citizens will have greater access to rehabilitation, reablement and recovery support, primarily in people's homes and in community beds where necessary that meets the needs of Portsmouth citizens without the need to wait for specific referrals.

b) To inform Members of the request from the Integrated Care Board (ICB) to support the Portsmouth Southeast Hampshire, (PSEH) Local Delivery System[1], (LDS) Remedial Action Plan for reducing ambulance holds at PHU through increasing social work capacity in D2A and considering reopening of the top floor of Shearwater Residential Home for low dependency care, subject to ICB funding confirmation.

3. Information Requested

Discharge to Assess

Section 91 of the Health and Care Act came into force on 1 July 2022, revoking procedural requirements in Schedule 3 to the Care Act 2014 which require local authorities to carry

[1] The organisations that work around an acute hospital.

out long-term health and care needs assessments, in relevant circumstances, before a patient is discharged from hospital[2].

From 1 April 2022, Adult Services has been working with the Integrated Care Board to adopt discharge processes that best meet the needs of citizens across Portsmouth and Southeast Hants. This has focused on discharge to assess, home first approach as under the discharge to assess approach, most people are expected to go home (to their usual place of residence) following discharge.

The discharge to assess model is built on evidence that the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed. An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery, where it is possible to make an accurate assessment of their longer-term needs.

In Portsmouth, we have built upon the work we achieved during the Covid Pandemic which saw the formation of our multi-disciplinary hospital discharge team and transfer of care hub. These teams comprise of professionals from health and social care, which have established links with housing and the voluntary sector, to support the principle that everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long-term health and care needs and options are assessed and agreed.

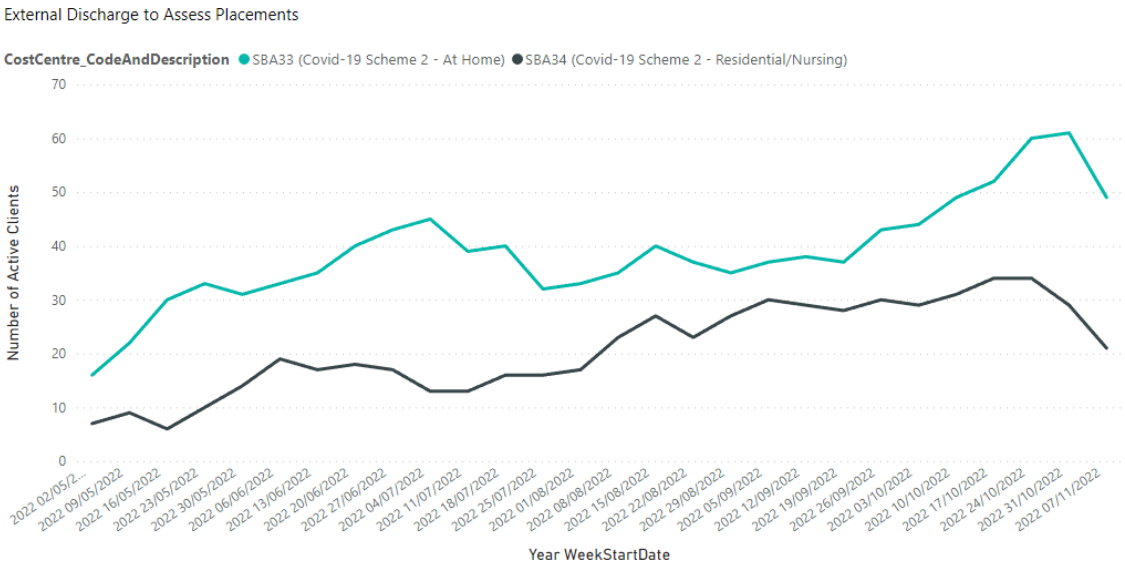
This approach reduces exposure to risks such as hospital-acquired infections, falls and loss of physical and cognitive function by reducing time in hospital, and enables people to regain or achieve maximum independence as soon as possible[3]. It also supports hospital flow, maximising the availability of hospital beds for people requiring urgent and emergency care.

Portsmouth health and care has seen an increase in demand in recent months of people on the D2A pathway and waiting assessment. Due to wider service line pressure, staff absences and capacity, there has been a delay to respond within the 4-week period of funding thereby increasing pressure on the Portsmouth City Council Adult Social Care Budget. This is being monitored weekly along with identifying further funding sources to increase D2A social work assessment capacity. This is shown in the graphs below.

Current external D2A placements as at 10th November are 56 at home with 22 within Residential / Nursing homes. However, the jointly developed D2A business case assumes, for 23/24 onwards, 10 external Residential / Nursing placements. This current level of demand for external placements is partly in response to Southsea Unit not being able to move residents on in time with the limited social work and therapy input available

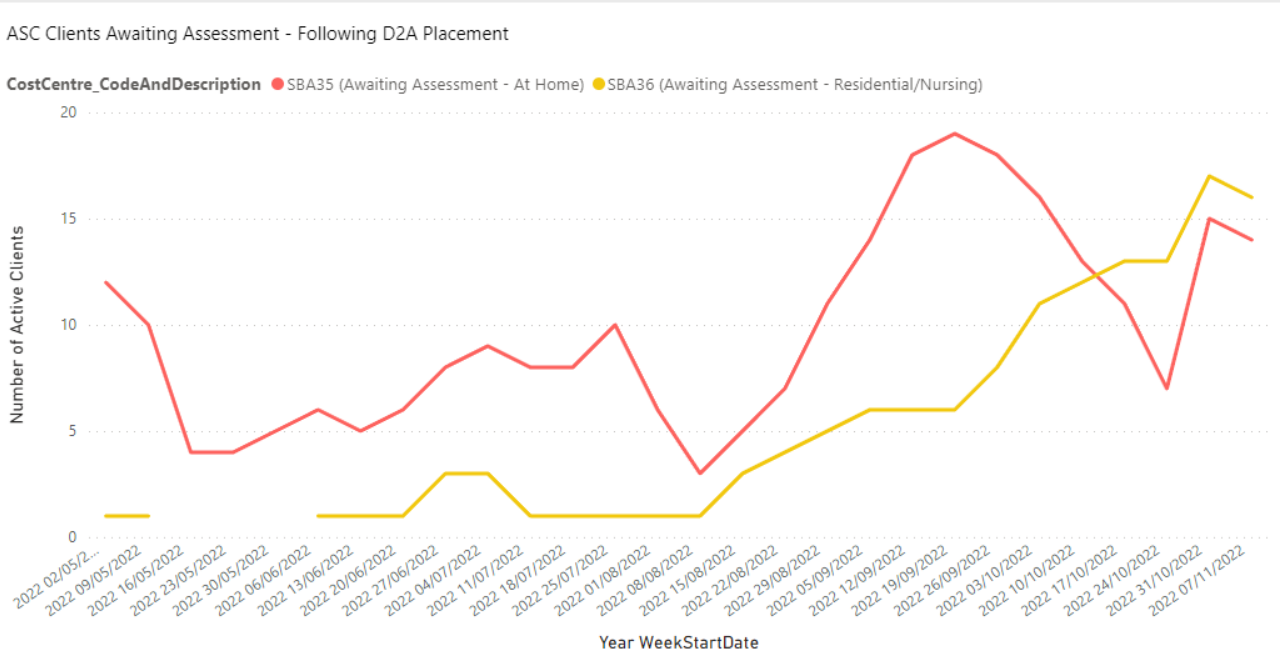
[2] Health and Care Act 2022 (legislation.gov.uk)
[3] Kortebein P, Symons TB, Ferrando A and others. (2008) Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2;63:1076–1081.

in the unit. It is expected that with Solent team in place we will see a reduction in length of stay and a reduction in external D2A placements.



Note: data for week commencing 07/11/22 shows only a part week

Current residents who have left D2A (outside of 4-week funding window) and are pending ASC assessments as at 10th November are 8 at home and 13 within Residential / Nursing homes. Ideally there should be no residents pending assessment as the operating model assumes residents will be assessed within the D2A funding window.



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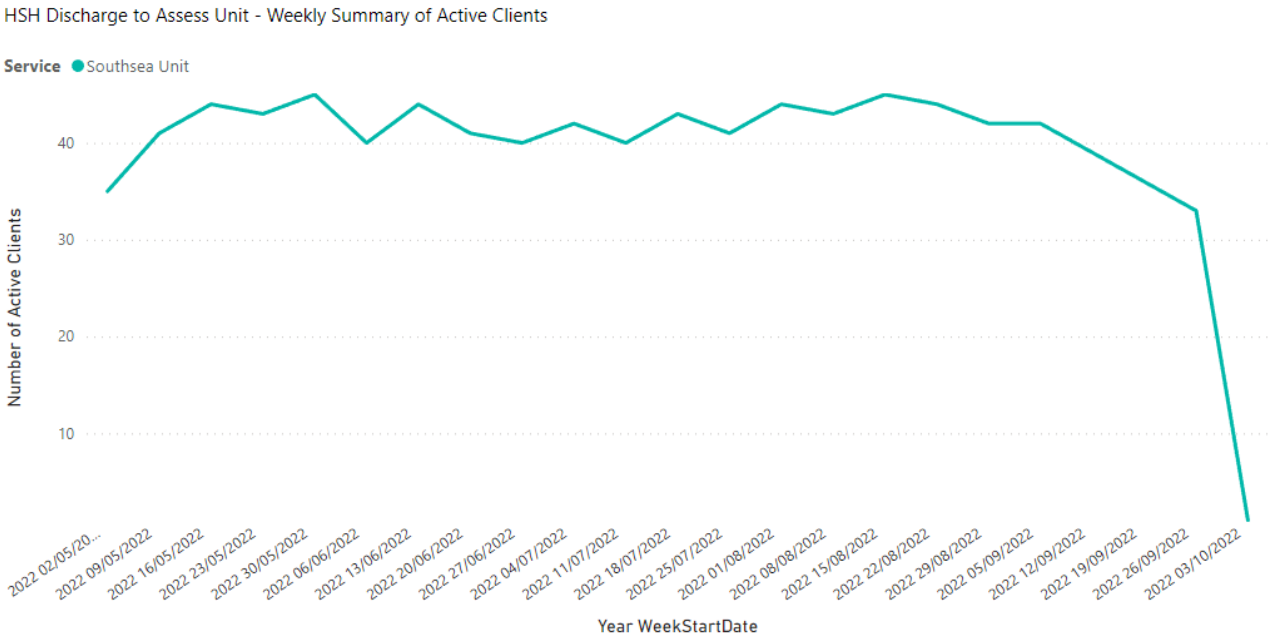
In October 2021, Cabinet agreed that the Director Adult of Care should negotiate with Health and Care partners to establish a jointly funded and commissioned D2A unit within Harry Sotnick House. This unit was known as the Southsea Unit. From the 1st of October 2022, Solent NHS Trust have been operating the unit, now called Jubilee Unit until a new name has been selected and has been established through the consolidation of staffing transferred from the closure of Solent NHS Trust led Jubilee House rehabilitation and reablement unit and the existing cohort of staff from the Southsea Unit.

It is expected that the length of stay for people remaining in Jubilee Unit will be no more than 18 days. Upon transfer to Solent, the average length of stay per person was 32 days. At the end of October 2022 this had reduced to 28 days. As Solent continue to work with the people within the Unit this average length of stay will reduce. This is being monitored through a monthly governance board which will review the data across all D2A activity to be able to take mitigating action where trajectories are not being met.

Provided below is the historical view of volumes passing through Southsea Unit, as the unit is now managed by Solent. Going forward client volume data will flow via the Solent Information Team and will be included in the D2A monthly governance meeting. There were 33 people in the unit when the Unit transitioned to Solent at the end of September with an average length of stay of 32 days. This is currently 28 days. The expectation is for the length of stay to reduce to 18 days by end of 22/23, with this dropping to 15 days in 23/24.



As highlighted above the D2A business case was jointly developed with health & care partners in the city, with funding contributions from both the City Council and the ICB.

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Whilst the City Council commission the external D2A placements on behalf of the local health & care system, the cost of these placements is funded for the first four weeks, by contributions from the ICB. Where residents' needs have not been assessed within the four-week period, and they do not have continuing health care needs, the cost of these placements is wholly borne by Adult Social Care.

Health and Care partners are working collectively to ensure people are discharged safely from hospital when they no longer need in-patient care, with timely and appropriate recovery support if needed. To ensure the D2A model remains financially sustainable, partners are also working to reduce the length of stay within the Jubilee Unit, as well as the number of placements in the external care market. Discussions are also underway to ensure the City Council has sufficient funding during 2023-24, to continue to facilitate the commissioning of the external placements.

Winter Planning

As part of ICB winter planning and in response to increased pressure experienced by the ambulance service when delayed in handing over patients to PHU, the ICB system partners have formed a Remedial Action Plan (RAP) to reduce ambulance handover delays by increasing hospital discharges and reducing avoidable hospital admissions.

Adult Services are proposing, subject to available funding from the ICB, to increase social work capacity to react faster to those waiting an assessment whilst on the D2A pathway. A further option to increase the numbers of people discharged is to consider staffing the top floor of Shearwater residential home to create up to 16 care beds. These beds would enable patients within PHU that are medically ready to leave but are delayed through not having home care available, a deep clean needed of their home, and similar social reasons, to go to a safe environment and enable the acute hospital bed to be available for urgent care.

Outline costings for the provision of 16 temporary additional beds for 5 months is in the region of £700k and would include additional social work and therapy to consider opportunities for further increasing independence of the person before going home. Recruitment would be initially via fixed term contracts, though if this were unsuccessful, we would have to consider the at risk / redundancy implications of issuing permanent contracts to attract the workforce. It should be noted that recruitment is likely to be minimum 4/6 weeks from agree to proceed.

The beds at Shearwater are one option for enabling more people to be discharged and LDS colleagues will work together to ensure the services that support the NHS this winter make the best use of any resource available.

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Signed by (Director)

Appendices:

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