Local Members' Interest
N/A

Healthy Staffordshire Select Committee - Monday 04 February 2019

Discharge to Assess

Recommendation

a. The Healthy Staffordshire Select Committee is asked to consider progress with roll out of the Discharge to Assess model of care.

Report of Director of Health and Care and the Accountable Officer, Staffordshire CCGs

Report

Background

1. The Staffordshire and Stoke-on-Trent health and care system is committed to rolling out the discharge to assess model of care in order to facilitate timely discharges from acute hospitals. Under this model here people need further reablement and support following hospital discharge they are transferred to an appropriate setting for a period of interim care – typically for up to 6 weeks. Any assessment for long term care, either Continuing Health Care or adult social care, is then carried out during this interim period.

2. The discharge to assess model of care requires the following services and functions:

    a. A **'Track and Triage'** service to accept complex referrals from the wards, determine whether they need ongoing reablement and support, determine the most appropriate setting [home or bed], and make the necessary arrangements to put interim care in place.
    b. **Home First** services to provide reablement and support at home**.** These include intermediate care, palliative care, night sitting and reablement.
    c. **Community beds** for people who are unable to return home for interim care**.** These require a **Trusted Assessor** function to enable timely transfers, as well as **GP and rehabilitation cover** to ensure active therapy and avoid deconditioning.
    d. **Active management** of Home First services and community beds to ensure that people move on.

3. We expect that 80% of discharges from acute hospitals should be 'simple and timely' – i.e. that they do not require further support from services. Of those who do receive a service after discharge we expect that at least 70% should receive reablement and support at home with fewer than 30% requiring a community bed. Staffordshire and Stoke-on-Trent have historically been over reliant on community beds rather than managing people at home – and this can be at the expense of people's long-term independence. This issue was highlighted again in the recent Care Quality Commission Local System Review.

Progress and issues

4. Progress with roll out of discharge to assess is further advanced in the North than the South of the county and 'levelling up' is one of the priorities for 2019/20. Demand and supply of services has been modelled and is shown in Appendices 1 and 2. There are ongoing issues with a deficit of Home First services, both in terms of insufficient commissioned capacity and under provision against commissioned capacity due to difficulties in recruitment.

5. The major ongoing actions required are:

    a. Further development of Track and Triage services in the south.
    b. Commissioning of additional Home First capacity for the south. This may require use of alternative providers.
    c. Recruitment of staff and improvements in efficiency by MPFT Home First services to bring actual capacity up to commissioned levels.
    d. Rationalisation of community beds as well as development of the Trusted Assessor function and GP and rehabilitation cover in some areas.
    e. Ensuring flow through Home First services and community beds through continuous active management.

North

6. The rollout of discharge to assess to support Royal Stoke has significantly improved the timeliness of hospital discharges over the last 12 months, with delayed transfers of care [DToC] falling from almost 1200 days per month to less than 600 days per month during 2018 – Appendix 3.

7. Crucial to this has been:

    a. Development of a Track and Triage service.
    b. CCGs have commissioned an additional 4200 hours per week of reablement Home First services. This has enabled many more people to be discharged to their own homes for reablement and support, rather than relying on community beds.

8. Ongoing specific actions include:

    a. Consideration of community bed requirements as part of the community hospital consultation, along with provision of a Trusted Assessor function**.**

East and South East

9. Discharge to assess to support Queen's and Good Hope hospitals remains under development and there are ongoing issues with DTOC, although the position is improved – Appendix 3.

10. Improvements to date include:

    a. SCC has commissioned an additional 615 hours per week of reablement Home First services for Queen's and up to 684 'home from hospital' Home First services for Good Hope.

b. Agreement of funding and development of Standard Operating Procedures for transfer of people from Queen's and Good Hope into the community beds at Robert Peel and Samuel Johnson hospitals.

11. Ongoing specific actions include:

    a. To develop a Track and Triage service: the function is currently carried out between acute ward and MPFT community staff.
    b. To ensure ongoing funding for those additional Home First services already commissioned and then to commission a further increase in capacity.
    c. Completion of Standard Operating Procedures for transfer of people from Queen's and Good Hope into the community beds at Robert Peel and Samuel Johnson hospitals, and then for management of these beds.

South West

12. Discharge to assess to support County Hospital is close to maturity, and to support Walsall Manor, New Cross and Russell's Hall hospitals remains under development.

13. Improvements to date include:

    a. SCC has commissioned an additional 732 hours per week of reablement Home First services for County and New Cross hospitals using non-recurrent funding from the BCF.
    b. Mobilisation of a Track and Triage service to manage community beds in care homes.

14. Ongoing specific actions include:

    a. To ensure ongoing funding for those additional Home First services already commissioned and then to commission a further increase in capacity.
    b. Completion of Standard Operating Procedures for transfer of people from these hospitals into community beds in care homes, and then for management of these beds.
    c. Consolidation of community beds in care homes into 5 block-booked from 6-7 homes with provision of a Trusted Assessor function as well as GP and rehabilitation cover**.**

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List of Appendices:

Appendix 1 – Home First Demand and Supply
Appendix 2 – Community Bed Demand and Supply
Appendix 3 – Delayed Transfers of Care