READING BOROUGH COUNCIL

REPORT BY EXECUTIVE DIRECTOR SOCIAL CARE AND HEALTH

TO:	**ADULT SOCIAL CARE, CHILDREN'S SERVICES AND EDUCATION COMMITTEE**		
DATE:	**13 JULY 2022**		
TITLE:	**DELIVERING OUR 'HOME FIRST' APPROACH DURING COVID**		
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1. PURPOSE OF REPORT AND EXECUTIVE SUMMARY

1.1 The purpose of this report is to provide an update on the Council's offer around supporting residents back home from hospital and our support to our local acute and community hospitals (excluding the Mental Health inpatient hospital) during the Covid pandemic. This report also provides assurance that Adult Social Care is working with health partners to ensure ongoing timely discharge from hospital post pandemic

2. RECOMMENDED ACTION

2.1 That Adults, Children and Education Committee note the report

3. POLICY CONTEXT

3.1 National Context:

3.1.1 From the outset of the COVID-19 crisis it was felt that the demand for acute hospital beds would be in high demand and thus the optimisation of flow out of the hospital would be a priority. In March 2020 as part of the Government's response to COVID, legislation was introduced with immediate effect that changed the timescales and approaches associated with hospital discharge focussing on a "Home First Discharge to Assess (D2A) Operational Model". These changes have undergone further adaptation since their initial implementation and are now the expected ongoing Hospital Discharge and Community Support model as set out in the Government's Policy and Operating model published on 31st March 2022.

3.1.2 In order to support this new discharge policy, the Government introduced a national Hospital Discharge Fund in March 2020 to cover the additional costs to the community health and social care system of supporting hospital discharge:

- For the period 1 March 2020 – 30 June 2021, eligible costs would be reimbursed from the NHS for the period up to 6 weeks post discharge
- For the period 1 July 2021 – 31 March 2022, eligible costs would be reimbursed from the NHS for the period up to 4 weeks post discharge
- After 31 March 2022, the NHS post discharge funding would cease

3.1.3 The NHS Discharge to Assess guidance changed the terminology used for patients who would not have normally been discharged or who would have been delayed once being classed as 'medically fit for discharge'. This term was changed to 'medically optimised for discharge'(MOFD) and indicated that the patient's care and assessment of need can safely be continued in a non-acute setting. However, some of those patients were identified as having further care needs (referred to as Pathway 1), some of which were complex (referred to as Pathway 3), at point of discharge, this enabled the assessment, once MOFD, to take place outside of hospital, at home or in another suitable setting, where necessary.

3.1.4 The additional Discharge to Assess funding has allowed Adult Social Care to stabilise the patient at home or in another setting based on their immediate needs, to reassess and where possible to reduce the care package to a sustainable, least restrictive level and support discharge of patients who are self-funders, which in the past have blocked acute beds.

3.2 Local Context

3.2.1 In response to the new guidance, Reading stood up a range of provisions and arrangements to deliver the new discharge requirements.

3.2.2 Reading already offered 4 independent living flats at Charles Clore Court which added capacity and flexibility to meet pressure now, and in the future which supports both a timely hospital discharge process alongside the ability to use the flats for people who might otherwise be admitted into a hospital bed, but don't have acute needs.

3.2.3 In the first phase of the Pandemic additional bedded capacity was commissioned at Riverview Nursing Home of 10 beds, as well as short term urgent bed capacity at the Holiday Inn up to 20 beds. Reading Borough Council acknowledged the pressures caused by the unprecedented numbers of patients requiring discharge over the initial Covid pandemic period. There were a cohort of patients who could not go directly home during the Pandemic. Positive feedback was received from system partners, service users and staff, regarding the short-term discharge arrangements service located within the Holiday Inn.

3.2.4 With the learning from the Holiday Inn model and 3-month interim funding from Berkshire West Clinical Commissioning Group, we piloted a future model of discharge to assess and admission avoidance for Reading. In January 2022, a temporary Discharge Service at Huntley Place was opened, as a new resource to support people with home care needs, on discharge Pathway 1, who are unable to go directly home from hospital because they are waiting for care provision or changes to their home environment before discharge.

3.2.5 Huntley Place Discharge to Assess was set up as an evolution of the Holiday Inn and care home or nursing home placement, it was a service to support people who require temporary access to care and support. The number of beds and associated level of care was scalable depending on the need. The service was set up with a reablement ethos,

with a view to right-sizing packages of care and supporting a positive risk assessment approach for discharges home.

3.2.6 See appendix A for further information on Huntley Place

3.2.7 In addition to bedded capacity Adult Social Care were able to increase capacity across the 'Home First' pathway i.e. Social Workers, Occupational Therapists, and Care Assessors working in the hospital, supporting the discharge to the patient's home or care home, and undertaking the assessment in the community, rather than in the hospital setting. Adult Social Care have been able to offer extended hours in the weekday evenings and weekends. All this has resulted in reduced length of stay in the hospital and hospital flow during very difficult covid and winter pressures.

4. Current Position

4.1 Reading's HomeFirst Pathway

4.1.1 Reading has succeeded in stepping up the additional capacity at pace to respond to the new guidance and has made significant improvements in the length of stay of patients who were previously significantly delayed in hospital. However, delivering the Government expectations around Home First – which is that 95% of patients go straight home from hospital has been challenging, in Reading the figure is 87%.

4.1.2 In 2019/20, 9.4% of Reading based patients had a length of stay (LoS) over 14 days and 4.7% had a length of stay over 21 days. However, in 2021/22, to date, the 14 day LoS has increased to 9.6% and the 21 day LoS has increased to 4.9%. These percentages for Reading have continued to be consistently lower than the National averages however, which for 2021/22 were 11.8% for 14 days and 6.2% for 21 days. The increase in LoS is possibly a reflection of the complexity of cases in hospital.

4.1.3 There is a strong over reliance on bedded support and it has been estimated that to achieve the 95% expectation, approximately 2 patients a week would need to move from being admitted to a Discharge to Assess bed to being discharged straight home with the necessary health and care support around them to enable this. This estimate does not account for any additional growth in discharge numbers/demand.

4.1.4 Increased costs of onward care which have been shown to be primarily linked to increased levels of complexity and dependence, but also potentially the over-reliance on beds which could mean that their capacity for reablement and independence is not being maximised. Patients are leaving hospital at a much earlier stage in their recovery than in previous hospital discharge models, thus increasing the likely levels of complexity on discharge.

4.1.5 Based on our reviews of placements, placing patients in a temporary care home setting post discharge does not deliver good outcomes and in the majority of cases has resulted in the patient remaining in that setting, therefore Reading Borough Council will continue to work with system partners to adopt a home first approach.

4.2 Alternative Options Considered and Rejected

4.2.1 The following alternative options have been considered and discarded:

- Do nothing is not an option for the reasons outlined in 4.1.3 - 4.1.5 above. The current over-reliance on bed-based care does not meet the Government's

expectations of Home First, does not offer best outcomes for local residents and is not sustainable in the long term

- Reverting back to the previous model of discharge where assessment back home was not the norm and people's long term care needs were assessed whilst still in hospital is also not an option because this would not comply with the Government's Discharge requirements and increased hospitalisation increases rapidity of deterioration and the potential for higher long term care costs.

4.3 Next Steps

4.3.1 From 1st May 2022, Reading Borough Council will be continuing their discharge to assess services, as per pre COVID, these include:

- Adult Social Care will work closely with ward staff to determine the patient's care needs on discharge, and work with the multidisciplinary team in triage calls to decide which pathway is most appropriate for the patient.

- ASC and Ward staff will work jointly in the patients discharge pathway to remove any barriers to a timely hospital discharge i.e. such as potential delays in the provision of specialist equipment or environmental adjustments (i.e. bariatric equipment, hoarding etc.) so that effective multi-agency planning can take place as early as possible.

- The 4 x Discharge to Assess (D2A) Pathway 1 Step-down/Step-up beds will be continued at Charles Clore Court, dependent on availability, and whether service users meet the criteria for this setting.

- ASC will ensure assessments for complex patients, pathway 3 cohort, will be undertaken on the wards rather than in the community or D2A care facility, these include assessments for patients who require care placements, require high levels of home care packages of care and/or, have any safeguarding or home environmental issues.

- The use of 1:1 support in care homes provided under D2A would need greater oversight and if there are any health needs a Continuing Heathcare assessment or joint funding application will need to be made.

- People who would normally fund their own care will be identified in hospital and supported to make informed choices about their care arrangements. If they require a Care Act assessment, and an ability to regain skills and confidence in the interim period, they will be given the option to go through the reablement pathway the same as any resident. However, it will be made clear that reablement is up to 6 weeks and after the reablement offer residents will be required to fund their own care arrangements or receive support to commission their care.

- For patients who are identified as Local Authority funded, and potentially having a primary health care need, RBC staff will complete a Continuing Healthcare Checklist on the ward, once this has been accepted by the Clinical Commissioning Group as a positive check list, discharge planning will take place with commencement of a Care Act Assessment and Mental Capacity and Best Interest decisions as required, the Multidisciplinary Team for the Continuing Healthcare will take place in the community post discharge. For patients who are found to be eligible for NHS Continuing Healthcare having a primary care need, the cost of the placement will be back dated to the date the check list was accepted, in line with the National Framework

- For Private funders who are not requesting a Care Act Assessment and Local Authority support, it would be expected that arrangements would be made by the ward or Clinical Commissioning Group if the person or family request a check list to be complete prior to discharge, were required Adult Social Care can offer information and advice

- For Fast Track patients, these will be referred to the Clinical Commissioning Group by the palliative team prior to discharge, irrelevant of funding stream (private or Local Authority)

- RBC hospital discharge to assess staff will provide a full service from Monday to Friday, 9am – 5pm. In addition, social work and manager on call support from 9.00 – 1.00 p.m. on Saturdays only.

5. CONTRIBUTION TO STRATEGIC AIMS

5.1 The Home First pathway ensures that Strategic Aims set out in the Reading Borough Council Corporate Plan are met:

Thriving Communities

- Prioritising the needs of the most marginalised groups and the most vulnerable adults and children in our communities.

5.2 Furthermore the following ambitions are realised through the action plan of the Autism Partnership Board

- To promote equality, social inclusion and a safe and healthy environment for all
- Contributions to Community Safety, Health and Wellbeing of residents.

6. ENVIRONMENTAL AND CLIMATE IMPLICATIONS

6.1 There is no environmental or climate implications arising from this report as there are no changes to services.

7. COMMUNITY ENGAGEMENT AND INFORMATION

7.1 There has not been any formal community engagement regarding this work, however, we have been working in close partnership with community health, acute and Clinical Commissioning Group to develop the ongoing Discharge to Assess pathway.

8. EQUALITY IMPACT ASSESSMENT

8.1 As there are no planned changes to services an Equality Impact Assessment is not required

9. LEGAL IMPLICATIONS

9.1 The National Hospital Discharge Guidance – 31st March 2022 sets out guidance for local authorities and NHS bodies to work with partners to improve the discharge pathway.

9.2. In addition, the Care Act 2014 set out the Council legal requirement to support residents for care and support needs on discharge from hospital.

10. FINANCIAL IMPLICATIONS

10.1 Reverting back to pre-covid pathway should enable Reading Borough Council ensure care packages offer reablement and independence in line with the ethos of the Care Act 2014.

11. BACKGROUND PAPERS

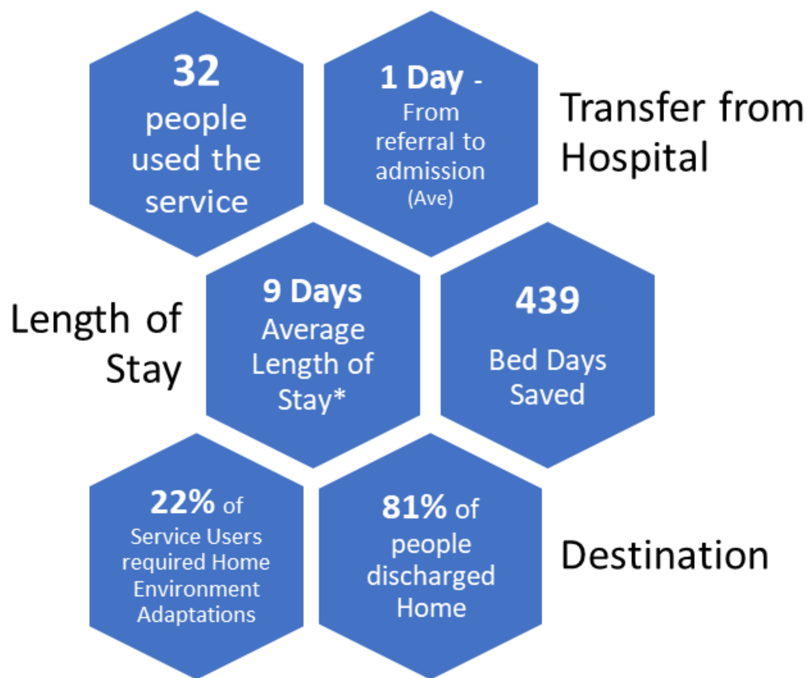
11.1 The National Hospital Discharge Guidance – 31st March 2022 (Hospital discharge and community support guidance - GOV.UK (www.gov.uk))

11.2 Care Act 2014[1]

[1] Care Act 2014 (legislation.gov.uk)

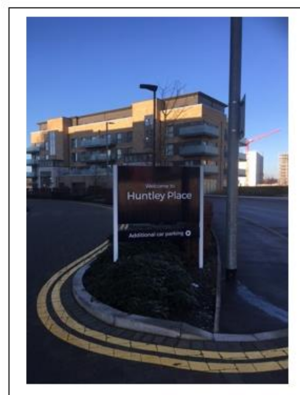
Appendix 1: Huntley Place – Discharge to Assess (Extra Care)

The additional discharge to assess beds opened at Huntley Place in January 2022 to support hospital discharge over the winter period has been a great success. The service was made available for 11 weeks and it was clear that strong, therapy led, leadership was the key to the effectiveness of the service, coupled with the collaborative nature with the accommodation and care providers. Members, from the different service providers engaged in the project, all agreed that it felt like a "one team approach" and that they were all in it together. One member stated that "freeing up hospital beds has a massive impact and could in fact contribute to saving lives" as a result of freeing up much needed hospital beds, when patients are ready to leave but just need some extra care and therapy to enable them to return home. The impact of timely hospital discharge is on the flow, and the discharges to Huntley Place released bed capacity at point of need within the acute hospital setting and contributed to preventing ambulance delays at the front door.



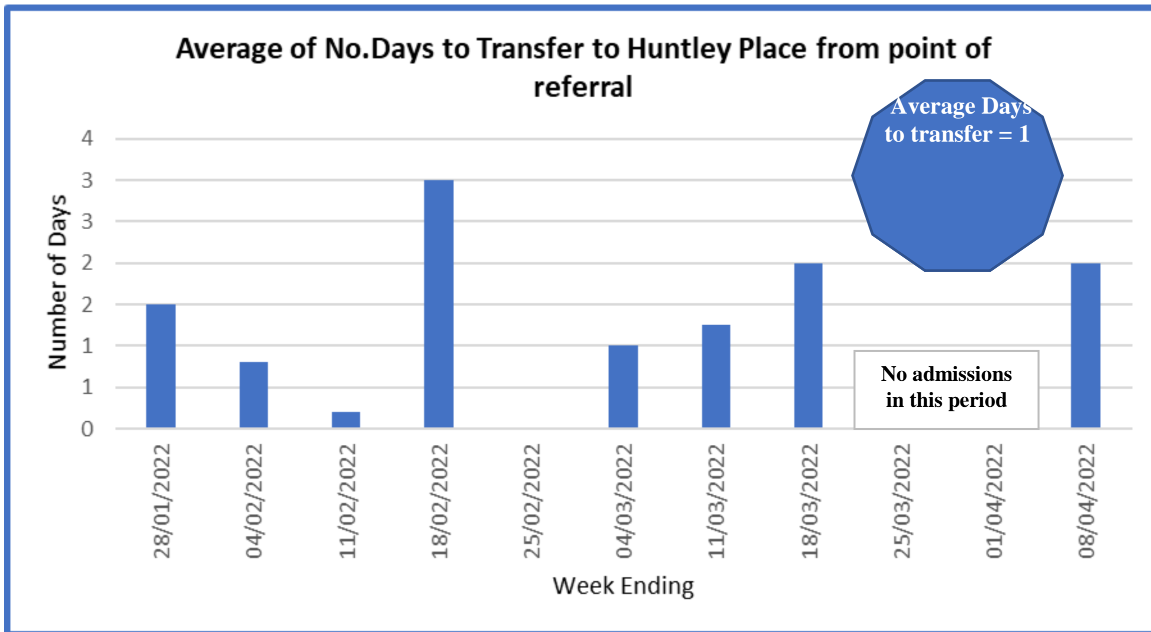
*(*excl. complex cases with environmental issues to be resolved before returning home. The average length of stay for all service users was 13 days).*

The Team

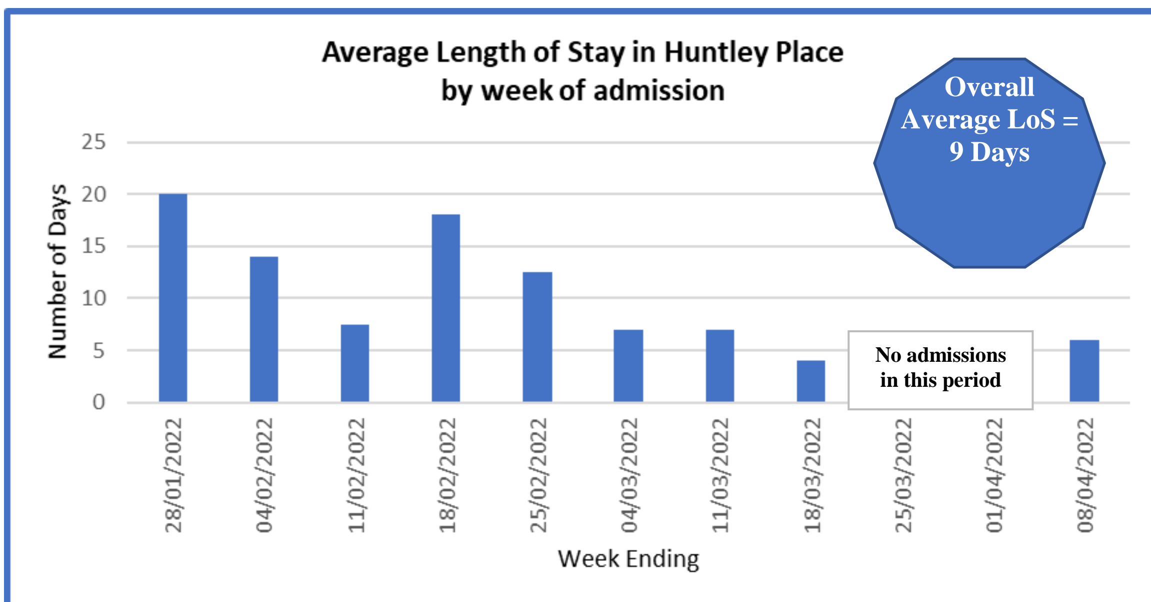


The Environment

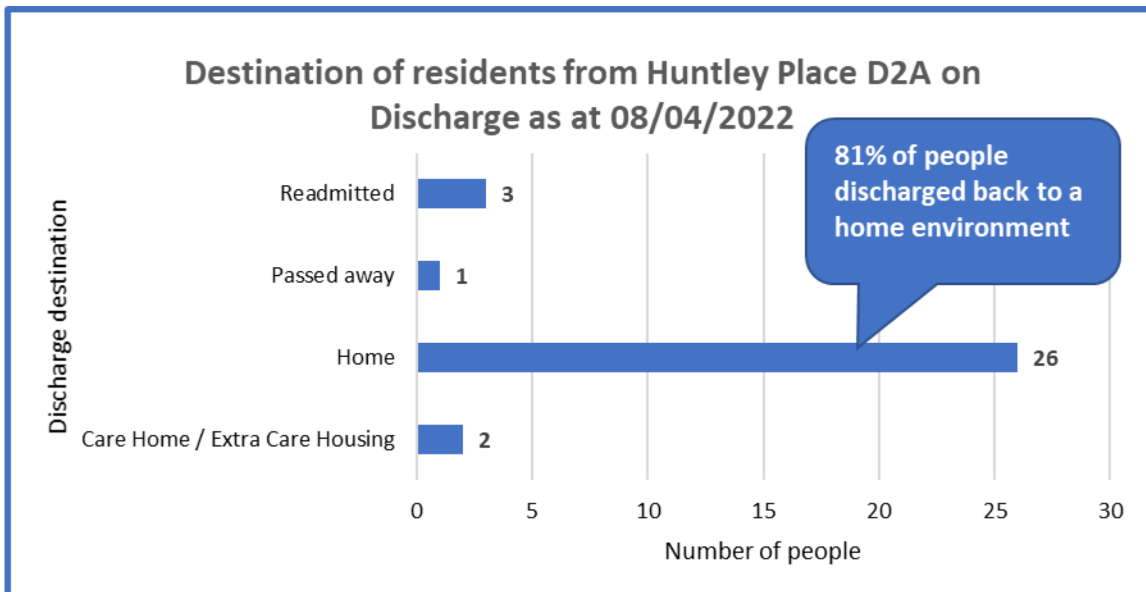
Charts and Statistics
Transfers into Huntley Place, once a referral had been made to them was on average no longer than 1 day.



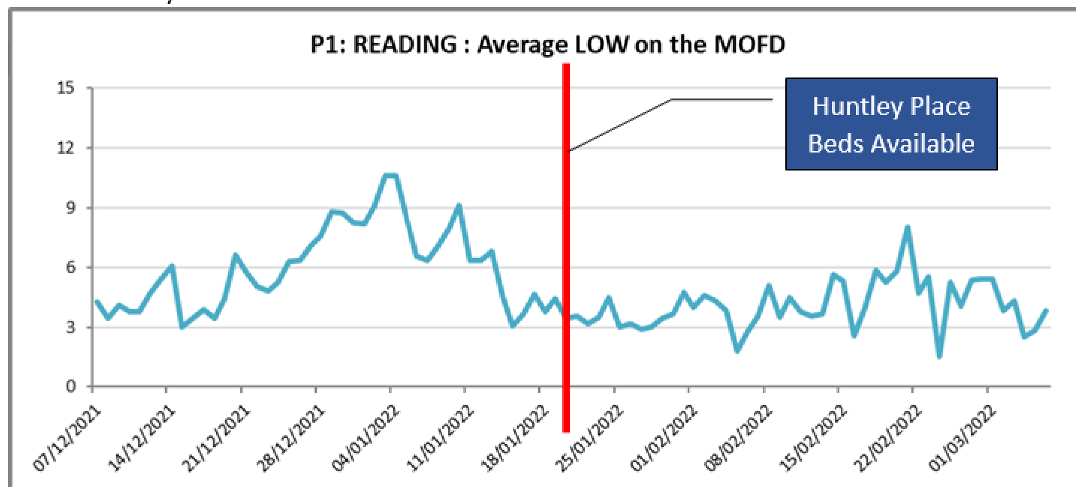
The average length of stay was 9 days. **Note:** This excludes 4 people who had much more complex needs and required significant home adaptations. If those people are included the average length of stay was 13 days.



81% of Service Users returned home following a short stay at Huntley Place, with strength-based therapy led support that enabled them to regain independence.



There has been a positive impact on hospital discharge flow since the implementation of the D2A beds at Huntley Place *(latest data available from Rapid Community Discharge service)*:



Source: RCD Dashboard 23/03/2022.

	Total No. of bed days in HP	Cost per bed day (HP)	National Ave Cost Hospital Bed	Cost difference per bed day	Total
Bed costs and Benefits *(see note)*	439	£273.64	£400	£126.36	£55,470.36

Note: *£245 is the bed cost used by RBFT to calculate savings (when beds are not closed to admissions), which is less than the cost of the bed at Huntley Place. However the primary saving was on hospital bed days (439) saved and delivery of a therapy led service to reduce likelihood of deconditioning. The impact of timely hospital discharge is on the flow, the discharges to Huntley Place released bed capacity at point of need within the acute hospital setting and contributed to preventing ambulance delays at the front door. 22% of those bed days saved, were for people who Members from the different service providers all agreed that it felt like a "one team approach" and that they were all in it together. were unable to be discharge directly home, due to unsuitable home environments, where adaptations were required.