# Meeting of the Adult Social Care Select Committee

## Wednesday 17th January, 2024 at 6.30pm
## In Committee Room 2 at the Council House, Priory Road, Dudley, DY1 1HF

## Agenda - Public Session
**(Meeting open to the public and press)**

1. Apologies for absence.

2. To report the appointment of any substitute members serving for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meeting held on 15th November, 2023 (Pages 4 - 11)

5. Public Forum

6. Corporate Quarterly Performance Report – Quarter 2 (1st July – 30th September, 2023) (Pages 12 - 28)

7. Dudley Adult Social Care Activity – Average Number of People Delayed (Pages 29 – 171)

8. Preparing for Adulthood (PFA) (Pages 172 - 190)

9. Progress Tracker and Future Business (Pages 191)

10. To consider any questions from Members to the Chair where two clear days notice has been given to the Monitoring Officer (Council Procedure Rule 11.8).

**Chief Executive**
**Dated: 9th January, 2024**

**Distribution:**
Councillor L Johnson (Chair)
Councillor J Elliott (Vice-Chair)
Councillors A Aston, S Bothul, R Collins, T Crumpton, A Davies, M Hanif, A Hopwood, A Qayyum and C Sullivan.

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# Minutes of the Adult Social Care Select Committee

## Wednesday 15th November, 2023 at 6.00 pm
## In the Council Chamber,
## The Council House, Priory Road, Dudley

**Present**:

Councillor L Johnson (Chair)
Councillor J Elliott (Vice-Chair)
Councillors A Aston, S Bothul, T Crumpton, A Davies, M Hanif, P Lee and A Qayyum

**Dudley MBC Officers:**

M Bowsher (Director of Adult Social Care), M Spittle (Head of Access and Prevention, Commissioning, Performance and Complaints), J Cox (Adult Service Manager), C Petford (Team Manager Adult Safeguarding) and S Griffiths (Democratic Services Manager)

**Also in attendance:**

Dr P Kingston (Independent Chair – Dudley Safeguarding Adults Board)

Councillor M Rogers (Cabinet Member for Adult Social Care)

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21 **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of Councillors R Collins, A Hopwood and C Sullivan.

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22 **Appointment of Substitute Member**

It was reported that Councillor P Lee had been appointed to serve as a substitute Member for Councillor R Collins, for this meeting of the Committee only.

23 **Declaration of Interest**

No Member made a declaration of interest in accordance with the Members' Code of Conduct.

24 **Minutes**

With reference to Minute No. 17 of the meeting held on 7th September, 2023, the Director of Adult Social Care advised there were three places available for Members of the Select Committee to join the Adult Social Care STAR awards on Monday 18th December, 2023 at Himley Hall. An email would be circulated to Members. The Director asked that interested Committee Members confirm their attendance by the end of November.

**Resolved**

That the minutes of the meeting held on 7th September, 2023, be confirmed as a correct record and signed.

25 **Public Forum**

No issues were raised under this agenda item.

26 **Annual Adult Safeguarding Report and Deprivation of Liberty Safeguards (DoLS)**

A report of the Director of Adult Social Care was submitted on a summary of the previous 12 months of performance in relation to Adult Safeguarding and Deprivation of Liberty Safeguards (DoLS). The report also set out a recommended sustainable plan to meet the requirements of DoLS in light of Liberty Protection Safeguards (LPS) being delayed indefinitely while identifying preparations to meet the regulatory framework for the Care Quality Commission (CQC) Inspection of Adult Social Care in 2023/24.

The Committee received a data summary for Adult Safeguarding (September 2023) and the Dudley Safeguarding Adults Board's Annual Report for 2022/2023. Dr P Kingston (Independent Chair of Dudley Safeguarding Adults Board) attended the meeting and addressed the Committee alongside C Petford (Team Manager for Adult Safeguarding) and the Director of Adult Social Care. The Director expressed thanks to the Safeguarding Team for managing the safeguarding process in a timely and proportionate fashion. The Director noted that further work was required to reduce the number of outstanding DoLS assessments but there was a clear rational for prioritisation of cases.

Arising from the presentation of the report, Members asked questions, made comments and responses were provided as follows:-

(a) The Chair (Councillor L Johnson) raised a concern regarding evidence there was a risk that DoLS referrals were increasing and the capacity to complete assessments had decreased, which might lead to an increase in citizens being illegally detained. The Director of Adult Social Care referred to the complexity of DoLS assessments and emphasised the need to undertake assessments in a necessary and proportionate fashion. Further infrastructure to undertake DoLS reviews would be requested as part of the Council budget setting for 2024/25 onwards.

(b) The Chair (Councillor L Johnson) requested clarification of the comment that, compared to many local authorities, Dudley had a very high number of safeguarding concerns, in part due to the way contacts were recorded. Dr P Kingston reported that approximately 6,000 concerns were recorded each year. The Council operated an 'open door' approach and a review of the system for recording and reporting was being considered.

(c) Councillor A Aston commented on the increase in safeguarding concerns over the past 8 years without a corresponding increase in the budget provision. Clarification was sought on the process following a safeguarding report and how this might be escalated to a full investigation. The Director of Adult Social Care referred to the system operated by the Multi-Agency Safeguarding Hub (MASH). Concerns were referred to a Senior Social Worker and up to 70% of concerns were dealt with at the triage stage. In appropriate cases, requests for information were made to partners/agencies. There was a high statutory threshold for conversion to Section 42 enquiries (Care Act 2014).

(d) In response to comments from Councillor T Crumpton, the Director of Adult Social Care acknowledged inherent risks in relation to safeguarding concerns for vulnerable adults, including people with dementia. There was a growing number of cases. Decisions were made on individual cases taking account of the best evidence available. In cases of doubt, these should be referred to the MASH and ongoing efforts were being made to raise awareness of the safeguarding process with both the public and professionals. There was a continual focus on education and the adoption of best practices in safeguarding. It was acknowledged that there should be genuine reasons as to why cases were dealt with in the MASH, due to their complexity or the need for a decision. All cases were unique and decisions needed to be made in the best interests of each individual, following detailed consideration. All decisions needed to be proportionate and defensible in the circumstances and complex cases required professional judgement regarding DoLS.

(e) The Vice-Chair (Councillor J Elliott) referred to reasons for the increase in domestic abuse referrals. Dr P Kingston outlined various reasons, including increased education and the visibility of domestic violence issues and some victims feeling more prepared to report issues. This was acknowledged as a multi-faceted issue and reference was made to the impact of Covid-19 lockdowns and an increase in alcohol and drug related referrals. Although the profile of domestic abuse had been raised through increased public knowledge, media and social media, it was acknowledged that some difficulties remained in reporting cases. The Director of Adult Social Care referred to the significant increase in self-neglect and self-harming cases and the need to build multi agency data trends with a view to increasing the focus on prevention and the re-positioning of resources accordingly.

(f) Councillor M Hanif referred to the section of the report on life expectancy, health conditions and health inequalities and expressed concern about the increase in the suicide rate in Dudley. This was recognised as a growing concern. Support would need to be a focus for future learning and development and the future service offer in Adult Safeguarding. Dr P Kingston referred to ongoing work on suicide prevention being undertaken by Public Health and other agencies.

(g) Councillor T Crumpton referred to a breakdown of domestic abuse data, including statistics concerning different social groups and ethnicity. Dr P Kingston acknowledged the points and referred to ongoing challenges. It was acknowledged that difficulties had arisen in engaging with appropriate community representatives and faith groups. Councillor T Crumpton expressed concern that more work should be undertaken to target resources appropriately.

**Resolved**

(1) That, subject to the comments outlined above, the report and assurances about the safeguarding of adults in Dudley Borough be noted.

(2) That the draft priorities for the Safeguarding Adults Board for 2023/24 be noted.

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27 **Quarterly Performance Report – Quarter 1 (1st April to 30th June, 2023)**

A report of the Director of Adult Social Care was submitted presenting the Quarter 1 Adult Social Care Select Committee performance report for the financial year 2023/24, covering the period 1st April to 30th June 2023. It was noted that the performance information was aligned to the 3-year Council Plan. The Committee reviewed the performance report and Members were invited to refer any identified performance issues to the Director of Adult Social Care.

The Cabinet Member for Adult Social Care commented that the corporate quarterly performance report was also regularly reviewed by the Overview and Scrutiny Committee and commended the Adult Social Care Directorate on its ongoing performance. The Director drew the Committee's attention to the continued improvement in assessment times and reduction of waiting lists and acknowledged the focus had now moved to ensuring performance on completion of annual reviews improved.

**Resolved**

That the report be noted.

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28 **Market Position and Sustainability**

A report of the Director of Adult Social Care was submitted on the current adult social care market position, key market sustainability issues and the market sustainability plan.

The Committee received a detailed presentation from the Adult Service Manager outlining key market challenges, risks and sustainability plans. Following the presentation, Members asked questions, made comments and responses were provided as follows:-

(a) Councillor T Crumpton referred to the importance of care homes to the overall care system in terms of caring for older people who might otherwise be in hospital. Reference was made to the need to address staff shortages associated with the recruitment and retention of care and personal assistants, funding challenges and the need for increased collaboration across the health and adult social care sector. The Director of Adult Social Care acknowledged these issues and the budgetary challenges faced by partners within the Integrated Care System. The significant budget challenges faced by Adult Social Care would need to be considered in the context of the Council's overall financial position and budget setting process.

(b) Councillor T Crumpton commented further that the funding situation in relation to adult social care had not been adequately addressed at a national level and fewer care homes were faced with increasing demands. It was acknowledged that the Council's budget setting process would be scrutinised by Members during January, 2024.

(c) Councillor A Aston commented on the volatile nature of the care market and stressed the importance of this issue being highlighted to all Members of the Council. Ongoing difficulties with recruiting personal assistants was widely acknowledged and had been raised at the direct payments user group.

(d) Councillor A Davies referred to a potential extra care development in Brierley and questioned whether connections had been made with West Midlands Combined Authority concerning funding opportunities. The Director of Adult Social Care referred to the need for the proposal to be economically viable in terms of capital and ongoing revenue funding and undertook to check on progress.

(e) Councillor A Davies referred to the place-based domiciliary care model and queried the level of interest in the tendering process and the operational date. The Adult Service Manager confirmed there had been considerable interest and it was anticipated that the contract would be operational from 1st April, 2024.

**Resolved**

(1) That the report and presentation on the adult social care market position and key pressures be noted.

(2) That the Market Sustainability Plan be noted.

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29 **Adult Social Care Select Committee Progress Tracker and Future Business**

The Committee received the progress tracker and programme of planned future business for the 2023/24 municipal year.

**Resolved**

(1) That the Adult Social Care Select Committee Progress Tracker and Future Business, be noted.

(2) That the programme of business for the Committee meetings in January and March, 2024 be reviewed, in consultation with the Chair and Vice-Chair, to take account of the scrutiny of the Council's budget proposals.

30 **Questions under Council Procedure Rule 11.8**

There were no questions to the Chair pursuant to Council Procedure Rule 11.8.

The meeting ended at 7.35pm

CHAIR

Agenda Item No. 6

**Meeting of the Adult Social Care Select Committee – 17th January 2024**

**Report of the Director of Adult Social Care**

**Corporate Quarterly Performance Report – Quarter 2 (1st July – 30th September 2023)**

## Purpose

1. To present the Quarter 2 Corporate Quarterly Performance report of the financial year 2023-24 covering the period 1st July to 30th September 2023. Aligned to the 2022-25 Council Plan.

## Recommendations

2. It is recommended that the Select Committee:
   - Review the contents of the Quarter 2 performance report, any identified performance issues must be raised and referred to the Director.
   - Review directorate service summary sheets, which provide a detailed account of activity and achievements carried out during the quarter.

## Background

3. The quarterly performance reports provide our Adult Social Care Select Committee with progress against the delivery of the 3-year Council Plan priorities and our Future Council Programme:
   - Dudley the borough of opportunity
   - Dudley the safe and healthy borough
   - Dudley the borough of ambition and enterprise
   - Dudley borough the destination of choice

4. The Future Council programme incorporates everything we do, it sits at the heart of the Council Plan enabling our services. The comprehensive programme ensures the council is 'fit for the future'. The programme's key themes are:

- People
- Digital
- Place
- Process
- Financially sustainable

5. Directorate plans will show the operational activity to deliver the objectives in the Council Plan alongside our other strategies such as the 'Living with Covid Plan', 'Children's Improvement Plan' and the 'emerging climate change strategy'.

Corporate Key Performance Indicators/Key Initiatives (actions)

6. Overall, there are 11 Adult Social Care KPI's that have been identified for Corporate reporting. These are all quarterly measures. When mapping the measures to the council plan priorities, the breakdown is as follows:

- Dudley the borough of opportunity; 9
- Dudley the safe and healthy borough: 2

7. We continually review how we monitor and report on performance. In addition to corporate KPI's being reported, we also report against key initiatives/actions aligned to our council plan priorities and the outcomes Dudley aims to achieve for our residents. The table below provides the number of actions by directorate including the number of KPI's for this financial year.

| **Directorate/service** | **Action** | **KPI – Corporate** |
|---|---|---|
| Adult Social Care | 29 | 11 |

8. The Corporate Performance Management team have developed a document which clearly maps out the Corporate KPI's via the directorate service plans clearly showing the alignment to our council plan priorities. For further information or to review the document, please email the CorporatePerformance mailbox.

Q2 Performance Summary

9. In Quarter 2, of the 11 measures to be reported all have available data, however 2 of the measures are reported retrospectively for Q1. This is due to a lag in which the data becomes available for reporting.

10. The outturns for the collective 11 measures show, 5 are "On or Exceeding Target", 1 "Within Tolerance" and 3 "Below Target". Additionally, 2 measures have no targets therefore a score is not available. A detailed account of those measures below target are detailed on page 7 of the report.

Performance short-term and long-term trends

11. The report also compares direction of travel comparing short term trend and annual trend within the respective scorecards. Short term trends (trend from Q1 to Q2) indicate:

- Improved: **7**
- Consistent: **1**
- Worsening: **1**

12. 2 KPI's are excluded from the above as they become reportable from Q2 only.

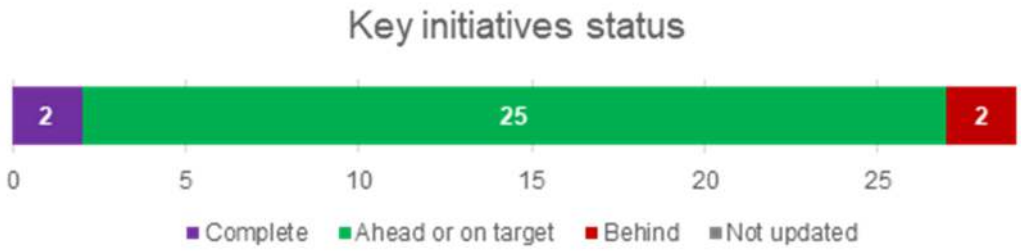
13. New KPI's for 2023-24 cannot be compared for annual trend, as annual trend compares the current quarter with the same quarter last year. For those where an annual comparison is possible trends indicate:

- Improved: **1**
- Consistent: **0**
- Worsening: **0**

Key Initiatives / Actions Monitoring

14. As stated in section 4, we also monitoring delivery on key initiatives/actions aligned to our council plan priorities.

15. Actions are identified in directorate service plans and replicated in Spectrum journals. Teams then provide narrative regarding progress as well as assigning a status of either behind, on target, ahead or completed. The chart below illustrates the progress made on key initiatives/actions recorded for quarter 2. Please refer to Spectrum for action narrative aligned to directorate service plans.




Key activities / awards and accreditations

16. The following provides highlights of key activities that have taken place across Adult Social Care in Q2. Awards are recorded on the central awards database.

17. Access and Prevention

One of our domiciliary care providers has won a regional award and been named as Best Home Care Provider 2023.

18. Assessment and Independence

The realignment of Living Independently team has created a more efficient way of accessing social care assessments. This has released capacity to prioritise outstanding 12-month reviews which continue to reduce month upon month.

19. Mental Health

The first cohort of attendees at Woodside Day Centre are approaching the completion of their 12-week intervention and we look forward to implementing further improvements within this service.

20. Successor and Business Change

We have completed the public consultation on options for our Adult Social Care Vision. This had resulted in 962 responses overall with 45% expressing a preference for the chosen option. This will continue to feed into our overall branding and communication plan for Q3.

Additionally, there have been several further deliverables as part of the Successor programme. Mental Health has a new team and work-tray structure for the Mental Health Community Teams. This will improve the efficiency, accessibility, and timeliness of Mental Health based assessments, which are underpinned by legislation.

21. Reviews

Care Act Reviews were an area of focus during Q2. This has involved:

Assessment and Independence teams joining up with Dudley Integrated Health Care team to assist us to carry out assessment 12 monthly reviews until March 2024.

Mental Health have begun an exercise to reprioritise existing reviews and this work will complete in Q3. In addition, practice has been revised and updated to reflect priority of allocation for overdue reviews.

DDS have undertaken an exercise to ensure tasks remain in the correct trays which has inflated reported figures for Q2. However, a targeted review of reviews beginning at the end of Q2 is being launched to substantially reduce these in Q3 onwards.

Directorate Service Delivery

22. Inclusive to the report, the Directorate Service Summary provides a detailed account of service delivery. Please refer to Appendices for detailed information on service delivery for Quarter 2.

COVID-19 Situation in Dudley

23. The Corporate Performance Report also provides information on the Covid-19 situation in Dudley. The report provided is the latest data at the time the final Corporate Performance report is circulated to the committee prior to the scrutiny meeting. For a live account on the Covid-19 situation in Dudley please go to https://www.dudley.gov.uk/coronavirus/ and navigate to Data Dashboard.

## Finance

24. There are no direct financial implications in receiving this report

## Law

25. There are no direct law implications in receiving this report.

## Risk Management

26. As part of the new risk management framework approved at audit and standards committee, risk reporting does not sit within performance reporting processes, each directorate develop a risk register for monitoring purposes. However, performance and risk management work in partnership to ensure directorate performance and risk management are monitored accordingly, providing assurance directorates work towards our council priorities.

## Equality Impact

27. There are no special considerations to be made with regard to equality and diversity in noting and receiving this report.

    No proposals have been carried out.

    No proposals have been made, therefore does not impact on children and young people.

## Human Resources/Organisational Development

28. There are no specific direct human resource issues in receiving this report. In terms of the Council's sickness level and the management of attendance, the People and Inclusion team continues to work with Directors and Heads of Service to assist and provide support in tackling those areas identified as having high levels of sickness.

## Commercial/Procurement

29. There is no direct commercial impact.

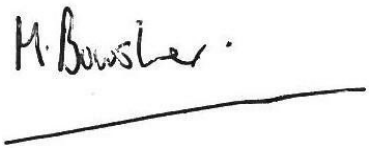
## Council Priorities

30. The Council Plan and Corporate Performance Management Framework enables a consistent approach for performance management across the organisation, aligning the Council Plan, Borough Vision and Future Council Programme and provides that golden thread between them.

31. Our Council Plan is built around four key priority areas, and our Future Council Programme. The Council Plan is a 3-year **'**Plan on a Page**'**. Each directorate has a directorate service plan that aligns to the priority outcomes that the Council is striving to achieve and includes an assessment of how the service has contributed towards these priorities along with a range of key performance indicators to enable us to keep track of progress.

32. Performance management is key in delivering the longer-term vision of the Council. Quarterly Corporate Performance Reports are reported and reviewed by Strategic Executive Board, the Deputy and Shadow Deputy Leader and Scrutiny/Select Committees.

33. This will help to enable the council to deliver the objectives and outcomes of the Council Plan and in turn the Borough Vision.



**Matt Bowsher**
**Director of Adult Social Care**

**Report Author:** Leigh Steel, Performance Manager

Telephone: 01384 816667

Email: leigh.steel@dudley.gov.uk

**Appendices**

Appendix 1.1 – Q2 Adult Social Care Quarterly Performance Overview
Appendix 1.2 – Q2 Adult Social Care Quarterly Performance Scorecard
Appendix 1.3 – Q2 Adult Social Care Service Summary Sheet

# Appendix 1.1 – Q2 Adult Social Care Quarterly Performance Overview

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## Adult Social Care overview

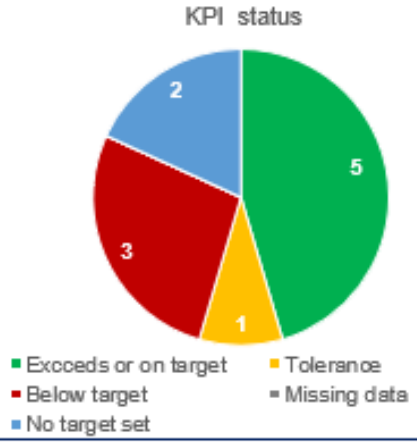
The following pages provide a dashboard overview for the directorate of Adult Social Care. They show the status of corporate key performance indicators and of key initiatives/actions being delivered. KPI scorecards are used to report and monitor performance outturns for the given quarter along with exception commentary for those measures below target.

### Key performance indicators

KPI's due to be reported: 11

KPI's reported: 11

KPI's missing data: 0




**KPI short term trend**
Comparing 2023-24 Q2 to Q1

7 improving | 1 consistent | 1 worsening

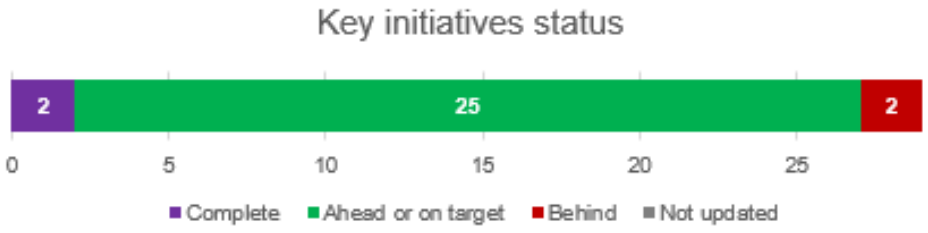
**KPI annual trend**
Comparing 2023-24 Q1 to 2022-23 Q1

1 improving | 0 consistent | 0 worsening

*KPI's new for 2023-24 cannot be compared.*

### Key initiatives/actions

| Key initiatives due to be updated | Key initiatives updated | Key initiatives not updated |
|---|---|---|
| 29 | 29 | 0 |




### Council plan links

The table below provides a breakdown of key initiatives and corporate KPI's by directorate for this financial year including any not due to be reported this quarter.

| Council plan priority | Key initiatives | Corporate KPI's |
|---|---|---|
| Dudley the borough of opportunity | 25 | 9 |
| Dudley the safe and healthy borough | 0 | 2 |
| Future council | 4 | 0 |
| Total | 29 | 11 |

# Appendix 1.2 – Q2 Adult Social Care Quarterly Performance Scorecard

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## Adult Social Care scorecard

| | Performance Indicator | 2022-23 Qtr. 1 outturn | 2022-23 Qtr. 2 outturn | 2022-23 Qtr. 3 outturn | 2022-23 Qtr. 4 outturn | 2023-24 Qtr. 1 outturn | 2023-24 Qtr. 2 outturn | 2023-24 Target | 2023-24 Score | 2023-24 Short term trend | 2023-24 Annual trend | Benchmarking comparator data |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Borough of opportunity | **PI.2617** Number of new Care Act assessments carried out for people aged over 65 | New measure | | | 172 | 142 | **167** | 147 | ★ | ↗ | N/A | Local measure, no external benchmarking available |
| | **PI.2132** % of contacts to adult social care with an outcome of information and advice/signposting | 9% | 23% | 25.6% | 26.5% | 25% | **28%** (3,312 / 11,693) | 23% | ★ | ↗ | ↗ | Local measure, no external benchmarking available |
| | **PI.2618** Total number of carers assessments completed by Carers Network | New measure | | | 48 | 60 | **126** | 120 | ★ | ↗ | N/A | Local measure, no external benchmarking available |
| | **PI.2620** Number of people awaiting a Care Act review where the last review or assessment was over 12 months ago | New measure | | | 419 | 522 | **503** | 380 | ▲ | ↗ | N/A | Local measure, no external benchmarking available |
| | **PI.2621** Number of new people aged over 65 into residential care or nursing care | New measure | | | 80 | 119 | **112** | 89 | ▲ | ↗ | N/A | Local measure, no external benchmarking available |
| | **PI.2622** Number of new people aged over 65 receiving a long-term care package (home care) in the community | New measure | | | 219 | 289 | **336** | 214 | ★ | ↗ | N/A | Local measure, no external benchmarking available |
| | **PI.2623** Number of people awaiting an OT assessment (18+) | New measure | | | 819 | 659 | **556** | 700 | ★ | ↗ | N/A | Local measure, no external benchmarking available |
| | **PI.2628** % of Adult Social Care Providers with a CQC rating of Inadequate | New measure | | | 0% | 0% | **0%** (0 / 85) | See note* | | → | N/A | 1% national average<br>1% West Midlands average |
| | **PI.2625** % of Adult Social Care Providers with a CQC rating of Good or Outstanding | New measure | | | 70% | 72% | **71%** (60 / 85) | See note* | | ↘ | N/A | 79% national average<br>73% West Mids average |

* Measures are for information only to illustrate Dudley's market position vs region and national (comparator information is published in the Service Summary Sheet)

There is a time lag for the following KPI's due to the nature of their collection and validation. Therefore they will be reported three months in arrears i.e., Quarter 1 data presented in Quarter 2.

| | Performance Indicator | 2022-23 Qtr. 1 outturn | 2022-23 Qtr. 2 outturn | 2022-23 Qtr. 3 outturn | 2022-23 Qtr. 4 outturn | 2023-24 Qtr. 1 outturn | 2023-24 Target | 2023-24 Score | 2023-24 Short term trend | 2023-24 Annual trend | Benchmarking comparator data |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Safe & healthy | **PI.2626** % of S42 individuals with outcomes expressed, fully achieving their outcomes | New measure | | | | **66%** (67 / 102) | 72% | ▲ | Available Q2 | N/A | Region 62.4%,<br>England 65.8% (2021/22) |
| | **PI.2627** % of S42 individuals with outcomes expressed, fully & partially achieving outcomes | New measure | | | | **97%** (99 / 102) | 98% | ● | Available Q2 | N/A | Region 93.6%,<br>England 94.7% (2021/22) |

*Short term trend compares current quarter with previous quarter within the same year. Annual trend compares the same quarter between years.*

## Appendix 1.3 – Q2 Adult Social Care Service Summary Sheet

### Service Summary Sheet

| | | | |
|---|---|---|---|
| **Directorate** | **Adult Social Care** | | |
| **Year** | **2023/24** | **Quarter** | **2** |

**Benchmarking** *with local authorities/nearest neighbours*
*Please consider if a Delivering Better Outcomes proforma should be completed also.*

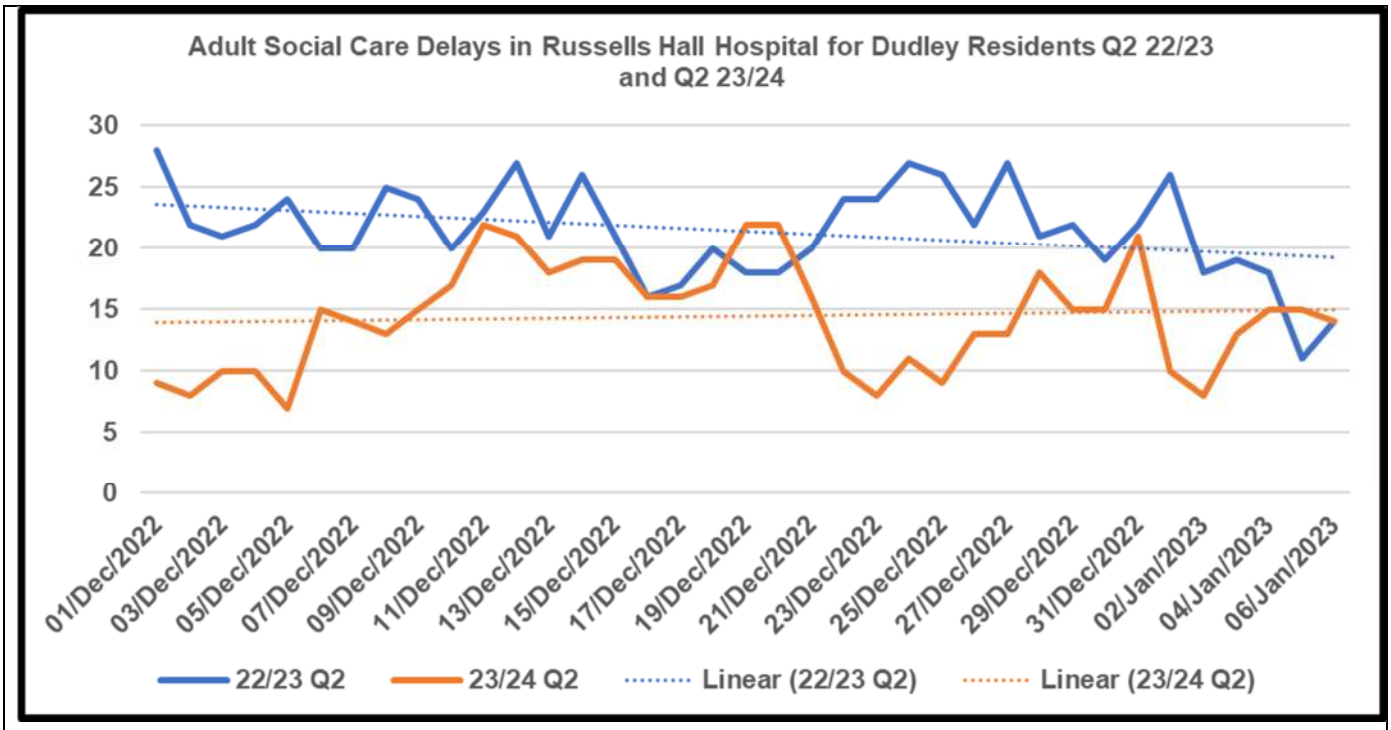
Adult Social Care continues to benchmark against a larger suite of indicators on a regular basis, for example through monthly Directorate scorecards, as well as requirements for regional and national reporting. The comparisons below are those which relate to corporate indicators only. It should be noted that comparator data is based on time periods prior to latest local data available and so does not always reflect recent trends. Benchmarking is refreshed on an annual cycle alongside the release of national statistics.

| Performance Indicator | Qtr. 2 | Target | West Midlands average | Statistical neighbour average | National average |
|---|---|---|---|---|---|
| PI.2628 % of Adult Social Care Providers with a CQC rating of Inadequate [AC04] | 0% | n/a | 1% | n/a | 1% |
| PI.2625 % of Adult Social Care Providers with a CQC rating of Good or Outstanding [AC06] | 71% | n/a | 73% | n/a | 79% |

**Overview of service delivery**
*Include any issues / risks*

Presented below is a selection of additional key performance metrics overseen by our Adult Social Care Leadership Team (ASCLT) enabling on-going assessment of the quality of care and support provided across services.

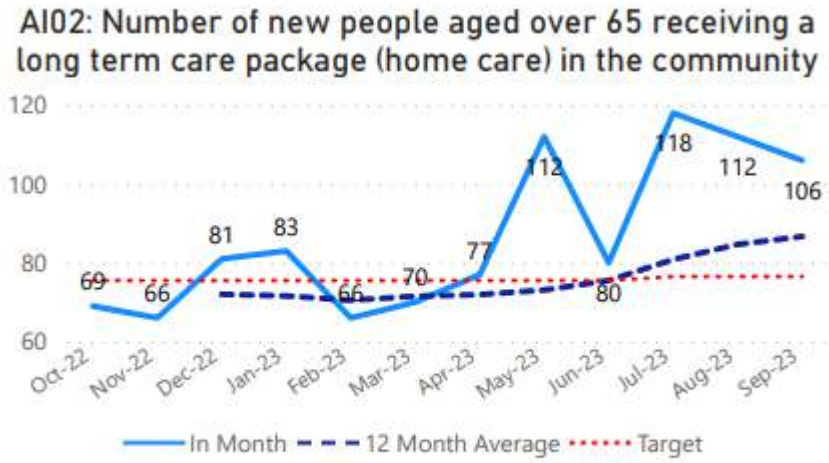
**Assessment and Independence**
**AI00: Live Delays**





| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 33 | 30.9 | tbc | Smaller is better | Latest Month |

AI01: Demand profile for permanent residential care over Q2 has decreased downwards from the high demand plateau seen in May through to July.

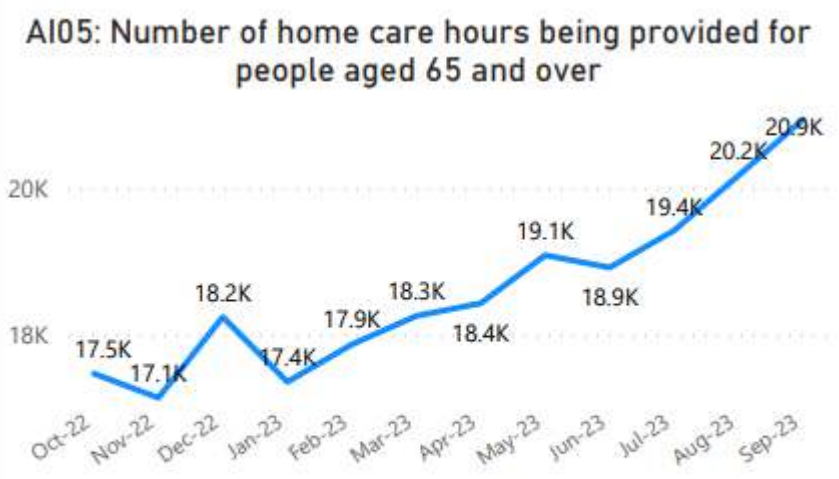



| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 106 | 76.5 | tbc | Bigger is better | Latest Month |

AI02: A 12-month peak was observed at the start of the quarter, which then continued to decline throughout the remainder.


| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 854 | tbc | tbc | Smaller is better | Latest Month |

A103: Grant monies which supported the increased demand for social care during the pandemic via funding contracts for assessors has ceased whilst demand rates remain at pandemic levels. However, end of Q2 however has started to show a decrease in the number waiting for a Care Act review on a month-by-month basis.




| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 20941 | n/a | tbc | Neutral | Rolling Year |

A105: Volume of home care hours being provided in Q2 represents an increase compared to Q1.

## Access and Prevention


| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 1730 | tbc | tbc | Bigger is better | Latest Month |

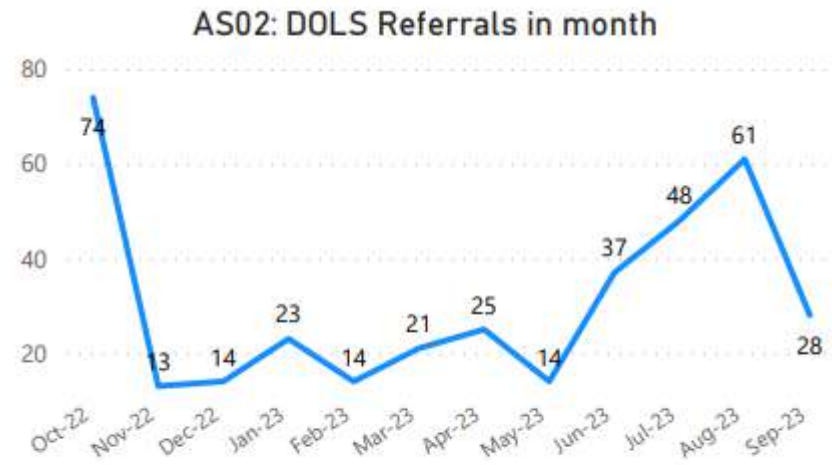
AP01a shows an increase of contacts into services when looked at as a rolling 12-month average to smooth out fluctuations. This is attributable to completion and growing usage of the Citizen Portal and improvements to data-platforms recording both current and 'new contacts' previously discounting when a person is already known to Adult Social Care.

## Adult Safeguarding


| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 645 | n/a | tbc | Neutral | Latest Month |


| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 76 | 56 | tbc | Bigger is better | Latest Month |

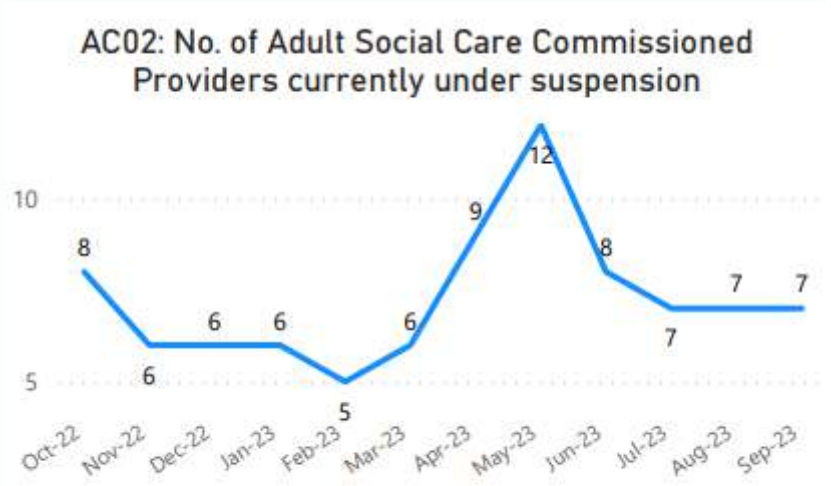
AS01a/AS04: Safeguarding concerns are referred to the Multi-agency Safeguarding Hub (MASH) or via Access to social care teams if the individual has an allocated worker. If Safeguarding concerns meet Care Act 2014 threshold criteria information is gathered to ascertain if this meets the criteria for a Section 42 (Care Act 2014) enquiry. Enquires are then coordinated through ASC or "caused" to be completed through system partners. As safeguarding involves a mix of complex and relatively straightforward cases a variable distribution of cases is to be expected as demonstrated above.




| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 28 | n/a | tbc | Neutral | Calendar Month |

AS02: Deprivation of Liberty Safeguards (DoLS) are referred to the authority from care homes and hospitals. The numbers of referrals received vary as people subject to DoLS may move which increases referral rates or remain where they are or recover mental capacity which would lead to a reduction in referrals. DoLS lasts a maximum of 12 months when it must be renewed which also influences referral rates.

## Adult Commissioning



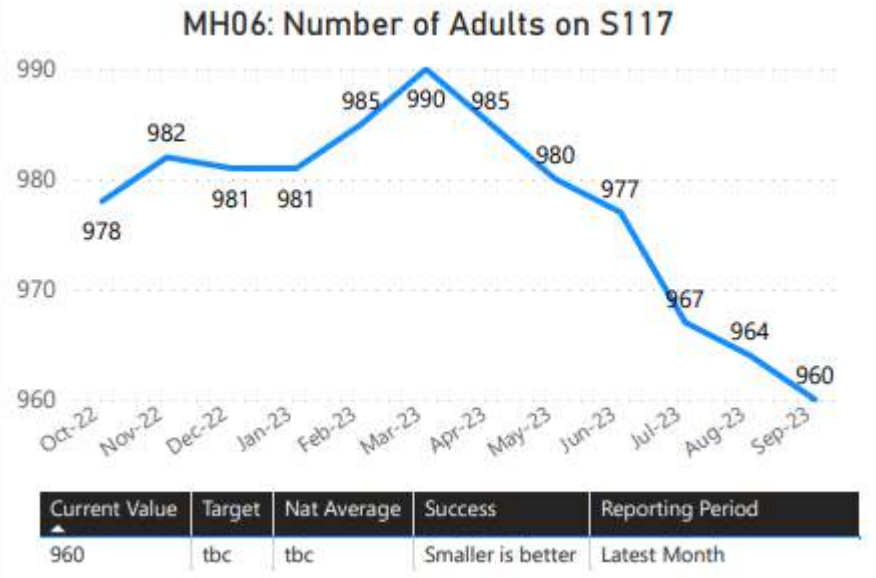

| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 7 | n/a | tbc | Smaller is better | Rolling Year |

AC02: Commissioning continue to work with providers to address issues – Quality Officers ensure monitoring is based on key risk metrics. Suspended services are prioritised for quality assurance support with the intention to steer providers to deliver safe quality services.

## Mental Health


| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 3 | 3 | tbc | Smaller is better | Latest Month |

MH02: Data demonstrates low numbers of people with mental health needs moving into residential care- meaning appropriate support has been offered in a community setting.




| Current Value | Target | Nat Average | Success | Reporting Period |
|---|---|---|---|---|
| 960 | tbc | tbc | Smaller is better | Latest Month |

MH06: Proportion of people with a S.117 has continued to decrease throughout Q2 after a peak at the end of 22/23 Q4.

**Service achievements**
*Report of any external accreditation, awards, positive publicity, during the past quarter*

**Assessment and Independence**

Teams have continued to reduce the number of people entering residential and nursing care. The consistent enabling of timely discharges from hospital results in people having more opportunity to maintain their levels of independence and return home.

The realignment of Living Independently team has created a more efficient way of accessing social care assessments. This has released capacity to prioritise outstanding 12month reviews which continue to reduce month upon month.

**Mental Health**

- **Woodside Day Centre**: Citizens have been attending Woodside Day Centre to support their recovery. The centre offers a range of activities and therapies that help them improve their well-being and social skills. We thank the staff at the centre for their dedication and compassion. We look forward to making improvements to the programme and enhancing the offer as we move forward, the first cohort of Woodside attendees are nearing completion of their 12-week intervention.
- **Permanent workforce**: We have successfully moved to a more permanent workforce, which has improved our stability and continuity of care. We have also established clearer team identities and structures, which have enhanced our communication and collaboration. We welcome all the new members of our teams and appreciate their contributions.

- **Referral pathways**: We have streamlined our referral pathways, so that all referrals come through a single point of access rather than directly to our teams. This has reduced the duplication and confusion in our processes and ensured that each referral is assessed and allocated appropriately. We thank our colleagues at the SPA for their cooperation and support.
- **Digital platforms**: We have increased our exposure on digital platforms, such as our website, social media, and MS Teams. This has helped us reach out to more people who may need our services and raise awareness about mental health issues. We also use these platforms to share useful resources, tips, and stories that can inspire and motivate our citizens and staff.
- **Duty/ Triage Process**: We have implemented a new duty/ triage process, which aims to provide a timely and effective response to urgent and complex cases. The process involves a duty worker who triages the referrals and contacts the citizens, a duty manager who oversees the process and provides guidance, reviews the cases, and decides on the next steps. We have received positive feedback from both citizens and staff about this process.

**Opportunities for improvement**
*Information relating to service complaints / compliments and learning from these*

Areas of monitoring and learning as a result of complaints received in Q2:

**Practice** - to discuss analysis of presenting concern, risk assessment and conduct with assessors
**Communication** - improve the quality of communication and ensure an appropriate response.
**Procedure** – Finance to add additional step within their Financial Assessment process to ensure any/all previous F/A's are checked for any savings/capital recorded

**Any additional information relating to performance**

**Meeting of the Adult Social Care Select Committee - 17th January, 2024**

**Report of the Director of Adult Social Care**

# Dudley Adult Social Care Activity – Average Number of People Delayed per day.

## Purpose of report

1. To provide the Select Committee with an overview of supported hospital discharge activity assisting the residents of Dudley to return home.

2. To appraise Select Committee of the following areas:

    - That a resident who has care and support needs is assisted with their discharge to their place of residence.
    - That Adult Social Care services are adopting discharge processes that best meet the needs of the local population.
    - Residents are supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible outcomes.
    - NHS bodies and Local Authority ensures that local funding arrangements are agreed by all partners and are aligned with existing duties, including those under the Care Act 2014 and Mental Capacity Act 2005.
    - That the integrated discharge infrastructure supports safe and timely discharges.

## Recommendations

3. It is recommended that: -

    - Select Committee reviews and considers the effectiveness of Assessment and Independence teams to support residents with care and support needs to return to their place of residence.

- The Head of Assessment and Independence reflects the views of Select Committee in the ongoing evaluation of improvement delivery.

- Any further work identified is undertaken to enhance the supported discharge and assessment provision for the residents of Dudley.

## Background

4. In March 2022, the Department of Health and Social Care published Hospital Discharge and Community Support Guidance. (See Appendix 1)

5. This guidance sets out how NHS bodies and Local Authorities can plan and deliver hospital discharge and recovery services from acute and community hospital settings.

6. The Dudley health and social care system have used this guidance to adopt discharge processes that best meet the needs of the local population.

7. Dudley health and care system have embedded the Discharge to Assess model for supporting adult patients to return to their place of residence.

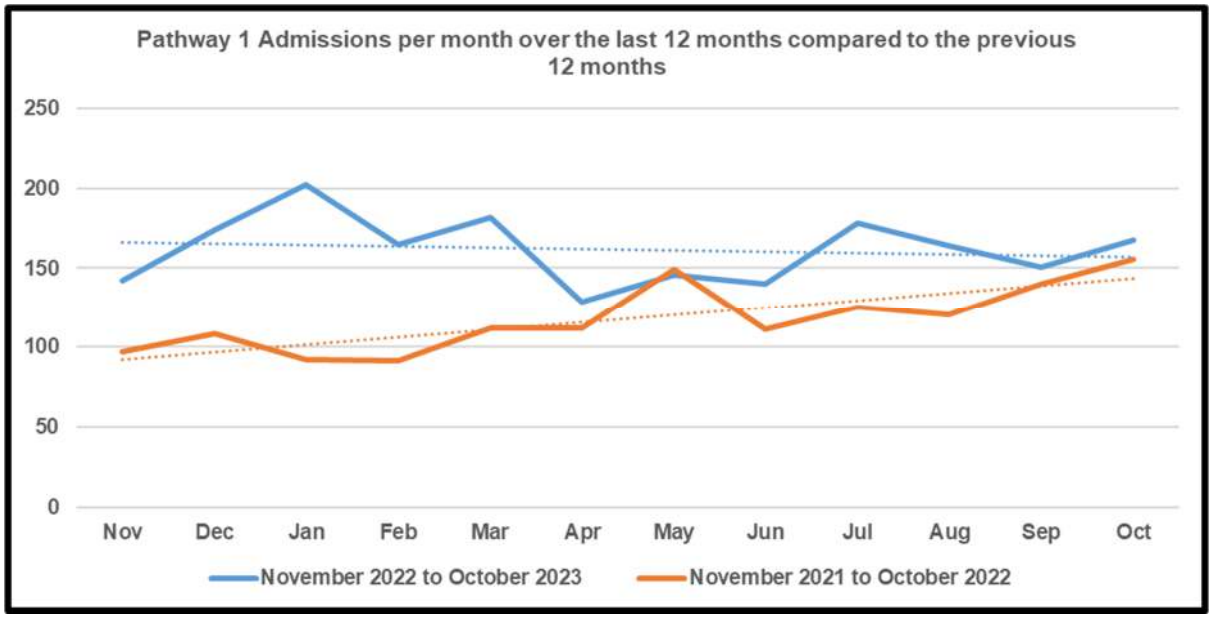
8. Under the approach of discharge to assess most people are expected to go home. Also on national evidence, the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed.

9. Any assessment of longer-term or end of life care needs should take place away from the acute setting. This is when it is possible to make an accurate assessment of their longer-term needs. It also 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.

   Dudley Residents who have care and support needs are assisted with their discharge to their place of residence.

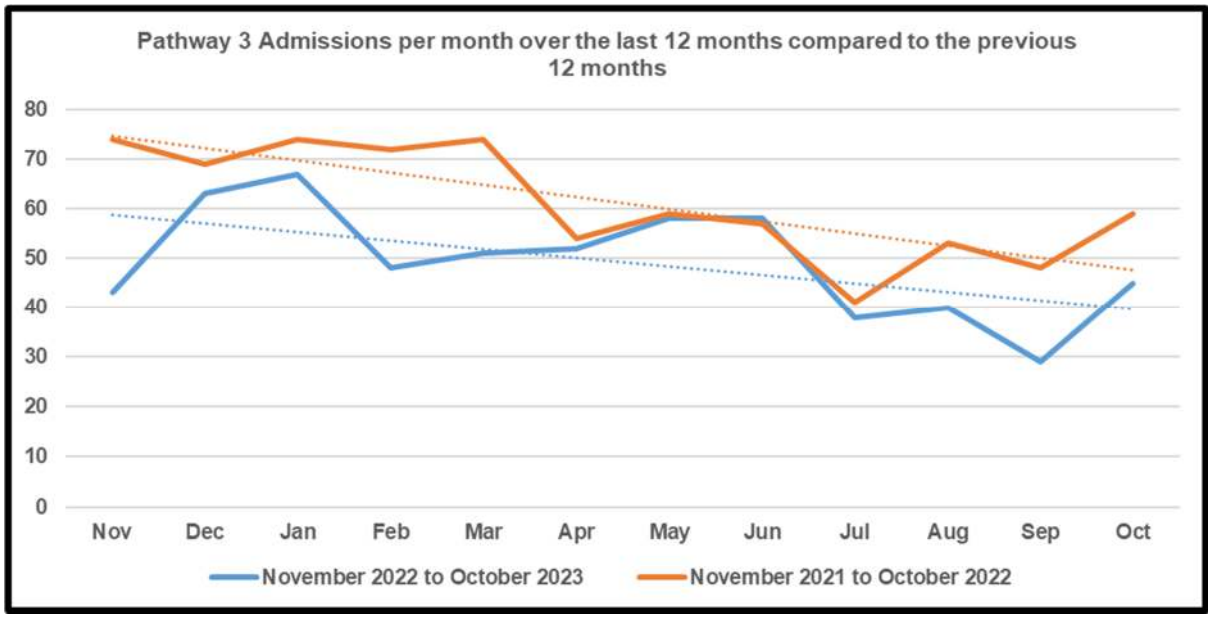
10. Activity of supported discharges from Nov 2022 to Oct 2023

Pathway 1 (going home with a care package). The activity over 2023 has had an increased demand which has accounted for 528 more people being supported at home than the previous year.




| Period | Average | Total | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2022 to October 2023 | 162 | 1941 | 142 | 174 | 202 | 165 | 182 | 129 | 146 | 140 | 178 | 164 | 151 | 168 |
| November 2021 to October 2022 | 118 | 1413 | 97 | 108 | 92 | 91 | 112 | 112 | 149 | 111 | 125 | 120 | 140 | 156 |

11. Pathway 3 (discharge to a temporary placement) has seen the demand for assessment periods in a residential or nursing setting to be reduced. The intention for our services is to keep as many people as appropriate in their own homes so they can be as active and independent as possible.




| Period | Average | Total | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2022 to October 2023 | 49 | 592 | 43 | 63 | 67 | 48 | 51 | 52 | 58 | 58 | 38 | 40 | 29 | 45 |
| November 2021 to October 2022 | 61 | 734 | 74 | 69 | 74 | 72 | 74 | 54 | 59 | 57 | 41 | 53 | 48 | 59 |

12. On average delays attributed to Social Care from Russell's Hall Hospital are less in the last 12 months compared to the 12 months before. This year delays are less than the previous year following our intention to allow people to go home first and receive care and support at home.

13. Below we can see the reasons why pathway 1 discharges have been delayed over the last 12 months (November 2022 to October 2023)

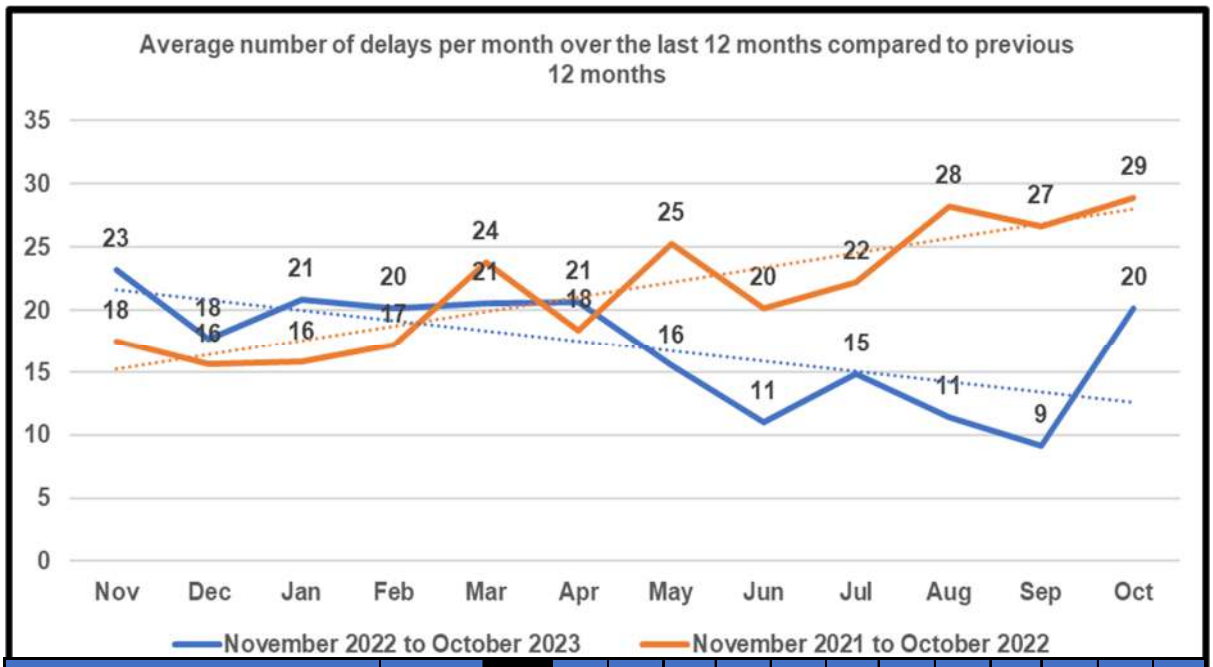
| Pathway 1 Delays | Average | Total | 11/2022 | 12/2022 | 1/2023 | 2/2023 | 3/2023 | 4/2023 | 5/2023 | 6/2023 | 7/2023 | 8/2023 | 9/2023 | 10/2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 152 | 1820 | 140 | 123 | 205 | 153 | 169 | 146 | 156 | 146 | 158 | 123 | 124 | 177 |
| Care Package | 112 | 1342 | 85 | 77 | 165 | 111 | 143 | 99 | 102 | 94 | 131 | 99 | 79 | 157 |
| Brokerage | 1 | 5 | 1 | | 1 | 1 | | | 1 | | | | 1 | |
| Equipment | 4 | 43 | 4 | 2 | 2 | 9 | 5 | 5 | 5 | 4 | 1 | 2 | 3 | 1 |
| Family | 2 | 22 | 3 | 3 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 3 | 2 | 2 |
| HTFACH | 1 | 1 | 1 | | | | | | | | | | | |
| ICT | 2 | 8 | | 1 | 4 | | | | 1 | 1 | | | 1 | |
| Keysafe | 1 | 3 | | 1 | | 1 | | | | | | | | 1 |
| Late Referral | 19 | 189 | 31 | 24 | 20 | 21 | 11 | 20 | 14 | 28 | 10 | | 10 | |
| Moving & Handling | 1 | 2 | | | 1 | | | | | 1 | | | | |
| NFFD | 7 | 80 | 4 | 4 | 7 | 3 | 3 | 2 | 9 | 7 | 5 | 12 | 16 | 8 |
| RIP | 2 | 9 | 3 | 1 | 1 | | 1 | | 1 | | 2 | | | |
| Safeguarding | 1 | 5 | 1 | | | | | 1 | | | 1 | 1 | 1 | |
| Screening | 1 | 4 | | 1 | 2 | | | 1 | | | | | | |
| Therapy | 1 | 8 | | 1 | | 1 | | 2 | 2 | 1 | | | 1 | |
| Transport | 2 | 23 | 6 | 3 | 1 | 1 | 1 | 1 | 2 | 4 | 1 | | | 3 |
| TTOs | 6 | 62 | 1 | 2 | | 1 | 3 | 14 | 16 | 4 | 6 | 5 | 6 | 4 |
| Ward | 2 | 13 | | 3 | | 3 | 1 | | 1 | | | 1 | 3 | 1 |
| WMAS | 1 | 1 | | | | | | | | | | | 1 | |

14. The main source of a delay in discharge has been coordinating the package of care. The redesigned discharge team aims to reduce the amount days delays in the planning process.

15. Below we can see the reasons why pathway 3 discharges have been delayed over the last 12 months (November 2022 to October 2023)

| Pathway 3 Delays | Average | Total | 11/2022 | 12/2022 | 1/2023 | 2/2023 | 3/2023 | 4/2023 | 5/2023 | 6/2023 | 7/2023 | 8/2023 | 9/2023 | 10/2023 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 46 | 553 | 62 | 59 | 64 | 43 | 47 | 49 | 55 | 50 | 32 | 33 | 33 | 26 |
| Brokerage | 12 | 140 | 16 | 8 | 5 | 8 | 17 | 19 | 14 | 12 | 6 | 12 | 9 | 14 |
| Allocated Worker | 1 | 6 | | 1 | | | 1 | 1 | 1 | 1 | | | 1 | |
| Care Home Delay | 2 | 21 | 3 | 1 | 9 | | 1 | 2 | 1 | 1 | 1 | 1 | 1 | |
| Care Package | 2 | 3 | 1 | | 2 | | | | | | | | | |
| Complex Patient | 2 | 11 | | 1 | 4 | 2 | 1 | | 2 | 1 | | | | |
| Covid Swab | 2 | 11 | | 3 | 3 | 1 | | 2 | 1 | | | | | 1 |
| Equipment | 2 | 22 | 1 | 1 | 2 | 2 | | 2 | 4 | 3 | 3 | 3 | 1 | |
| Family | 3 | 31 | 3 | 4 | | 3 | 2 | 4 | 4 | 5 | 2 | 2 | 1 | 1 |
| Funding Decision | 6 | 68 | 5 | 3 | 10 | 4 | 5 | 8 | 3 | 6 | 10 | 7 | 4 | 3 |
| HTFACH | 4 | 47 | 6 | 8 | 3 | 7 | 4 | 3 | 4 | 4 | | 1 | 3 | 4 |
| ICT | 2 | 12 | 2 | 4 | 4 | | | 1 | | 1 | | | | |
| Late Referral | 6 | 57 | 11 | 14 | 4 | 3 | 4 | 1 | 9 | 6 | 4 | | 1 | |
| NFFD | 3 | 38 | 10 | 3 | 2 | 1 | | 1 | 5 | 7 | 2 | 3 | 3 | 1 |
| RIP | 2 | 16 | | 2 | 3 | 3 | 4 | | 1 | 2 | 1 | | | |
| Safeguarding | 1 | 7 | | | 1 | 1 | 1 | 1 | 2 | | | | 1 | |
| Screening | 2 | 24 | 1 | 3 | 2 | 1 | | 3 | 3 | | 1 | 2 | 7 | 1 |
| Therapy | 2 | 5 | | | 3 | | | | | 1 | | | 1 | |
| Transport | 1 | 1 | | 1 | | | | | | | | | | |
| TTOs | 2 | 12 | 1 | 2 | 4 | 1 | | | 1 | | 2 | 1 | | |
| Ward | 3 | 21 | 2 | | 3 | 6 | 7 | 1 | | | | 1 | | 1 |

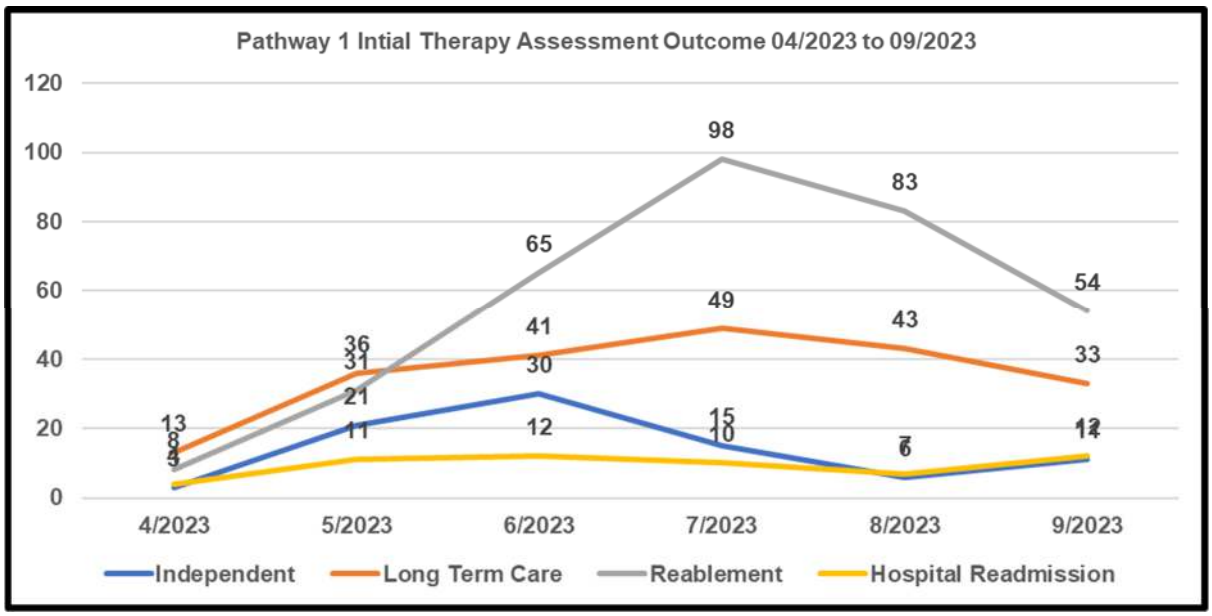
16. The main source of delay for placements was awaiting homes to be identified. Since April 2023 we have introduced a brokerage team which provides identified placements within 2 days.




| Period | Average | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| November 2022 to October 2023 | 17 | 23 | 18 | 21 | 20 | 21 | 21 | 16 | 11 | 15 | 11 | 9 | 20 |
| November 2021 to October 2022 | 22 | 18 | 16 | 16 | 17 | 24 | 18 | 25 | 20 | 22 | 28 | 27 | 29 |

<u>Adult Social Care services are adopting discharge processes that best meeting the needs of the local population.</u>

17. Are discharge team use the mission “Home First” for every person they support, we believe that helping to return to their usual environment allows for greater recouperation and recovery results. Below is the activity of the people who have been supported home since April 2023.



Residents are supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible outcomes.

18. Over recent months there has been greater success for people to maintain their independence for daily living. We have provided two case studies Appendix 2 & 3 to highlight the positive impact our team can have on people's lives.

    NHS bodies and local Authority ensures that local funding arrangements are agreed by all partners and are aligned with existing duties, including those under the Care Act 2014 and Mental Health Act 1983.

19. The new Dudley Short Term and Reablement Service that assists clients to be discharged back home was approved to commence in October 2023 following sign off from Cabinet. Recruitment is underway to get the team running at full capacity, with an implementation deadline of February 2024.

20. The ICB additional investment of £545,891 is not yet confirmed as recurrent, following further communications of a final report and evaluation to the Integrated Commissioning Committee a decision will be made to whether this additional investment is made permanent.

    Annual cost of Dudley Short Term and Reablement Team based on 23/24 pay scales is £3,966,200.

    **Funded by:**

| | |
|---|---|
| Local Authority Base Budget | £1,188,400 |
| BCF NHS Minimum funding | £2,235,600 |
| ICB additional investment | £ 545,891 |
| Total Annual Funding | £3,969,891 |

21. Adult Social Care have access to £2.331m additional BCF Discharge Grant funding in 23/24. This is on track to be fully utilised and has enabled us to support timely discharge and the ongoing care needs above usual demand associated with discharged clients.

22. We provide a timely service to support discharge from the hospital and ensure people who need care continue to receive this after discharge in a place that is most appropriate for them to be.

23. We respond flexibly to escalating demand within our financial obligations.

24. We support the Health and Social Care economy in Dudley to meet the targets of the “Hospital Discharge Service: Policy and Operating Model

25. We participate in multi-disciplinary working with the Acute Trust, DIHC and the ICB

26. To build the new service on the successful pilot and projects

27. We offer up to 7 days recovery period to establish the best care to meet people’s need and avoid over prescribing care and increasing dependency at times of crisis to avoid hospital attendance and admission.

28. We support the provision of informal care and community engagement and appropriate signposting.

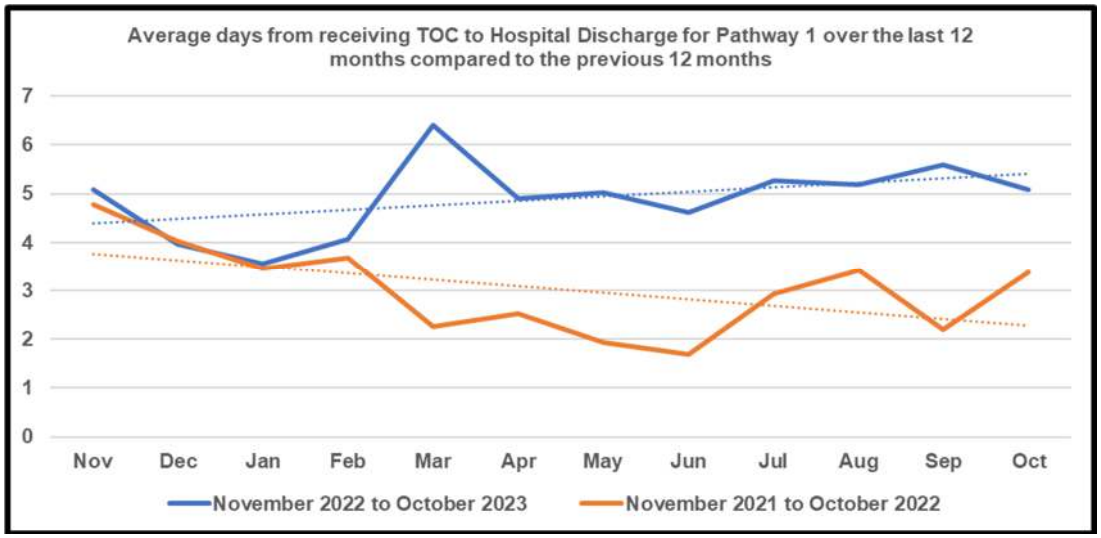
29. We support the person’s confidence building, to regain independence without need of formal care or back to baseline independence levels.

30. We identify promptly and prescribe intervention of therapy programs and equipment, integrating Therapy (OT & physio) within the Adult Recovery Team, to support person’s independence.

31. We respond at the appropriate time to the identified long term needs of the person by providing a personalised full care act compliant assessment focusing the person abilities personal goals and outcomes using community assets, neighbourhood support, falls prevention, we work with the clinical hub who offer support to us and the person if we require clinical support and guidance.

    <u>Integrated discharge infrastructure supports safe and timely discharges.</u>

32. We aim to meet our targets of supporting hospital discharges by providing care and support for 5 people a day. The below chart shows that are target that we are not meeting our target of planning discharges within the 48-hour period. The 528 extra people whom we have supported home over the last year has contributed to the longer planning process, are aim now that we have introduces our new short term and reablement service, plus our brokerage to return to discharge meeting the 48hr target.




## Finance

33. There are no financial implications arising from the contents of this report.

## Law

34. The adult social care discharge team is subject to the provisions of the Care Act 2014, The Mental Capacity Act 1983

## Risk Management

35. Risk of failure to deliver statutory service under the Care Act and Mental Capacity act. This is mitigated in accordance with the governance and control measures of the Section 75 agreement and Better Care Fund Conditions.

36. The Main risks are:
    - Not receiving adequate funds from BCF to meet demand.
    - Not having the care and assessment capacity to undertake discharge planning and long term need support.
    - Partners from health and social care not in agreement with the schemes currently in place.
    - Schemes from the BCF monies not performing.

37. Mitigation:
    - BCF plan is jointly agreed between health and social care and signed off by the health and wellbeing board.
    - A performance and activity data set is monitored each month by the Better Care Fund Committee and early intervention is provided to ensure any risk is minimised.

- Schemes, activity, and performance is overseen operationally by the Better Care Fund Committee where reps from all aspects of the business attend. There is then further governance and oversight from a strategic and senior governance point of view from the Integrated Commissioning Committee.
- Yearly evaluation and audit is conducted on the individual schemes to assess if they continue to be fit for purpose.

## Equality Impact

38. The Social Care Discharge is a regulated service under the Care Quality Commission. We make sure our services provide people with safe, effective, compassionate, high quality care.

## Human Resources/Organisational Development

39. The councils current budget spending control measures will be adhered to.

## Commercial/Procurement

40. There are no current commercial or procurement implications to be considered.

## Environment/Climate Change

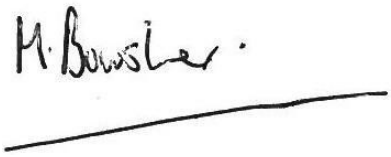
41. There are no perceived impacts on the environment or climate change.

## Council Priorities and Projects

42. This supports our Borough's ambitions of collaborating with our partners across the health and social care system and contributes to the wellbeing, independence, and prevention agenda.

43. It also aligns to our council plan outcomes by ensuring everyone, including our most vulnerable, have the choice, support, and control of the services they need to live independently, and all residents benefit from access to high quality, integrated health, and social care.

44. Cross agencies and Health professionals have been included in the impact proposal. As this is a development from an existing team, factors are already in motion.



**Matt Bowsher**
**Director of Adult Social Care**

Report Author:
Joanne Vaughan, Head of Assessment, and Independence
Telephone: 01384 817599
Email: joanne.vaughan@dudley.gov.uk

## Appendices

Appendix 1 Hospital Discharge and Community Support Guidance
Appendix 2 Case study 1
Appendix 3 Case study 2
Appendix 4 Section 75 Better Care Fund agreement

Department of Health & Social Care

# Hospital Discharge and Community Support Guidance

Published 31 March 2022

# Contents

Section 91 of the Health and Care Act comes into force on 1 July 2022. It revokes procedural requirements in Schedule 3 to the Care Act 2014 which require local authorities to carry out long-term health and care needs assessments, in relevant circumstances, before a patient is discharged from hospital.

Section 91 of the Act also introduces a new duty for NHS trusts and foundation trusts to involve patients and carers (including young carers) in discharge planning. This applies in situations where an adult patient is likely to need care and support after their hospital discharge, and the trust considers it appropriate to involve them or their carers in planning their hospital discharge. The new duty states that this should be done as soon as is feasible after the trust begins making any plans relating to the patient's discharge.

Under this duty, a carer is defined as an individual who provides or intends to provide care for an adult, otherwise than by virtue of a contract or as voluntary work.

More detail about this new duty will be set out in the next update to this guidance, which is expected in autumn 2022.

## About this guidance

This guidance sets out how NHS bodies (including commissioning bodies, NHS Trusts and NHS Foundation Trusts) and local authorities can plan and deliver hospital discharge and recovery services from acute and community hospital settings that are affordable within existing budgets available to NHS commissioners and local authorities. It applies to NHS bodies and local authorities exercising health and adult social care functions in England and should be used to inform local service planning and delivery.

This guidance applies in relation to adults being discharged from acute hospitals and community rehabilitation units in England, excluding maternity patients.

Discharges from mental health hospitals are not within the scope of this guidance. However mental health trusts are encouraged to embed some of the principles, adapted for mental health care pathways. Separate guidance will be published for those being discharged from mental health settings in due course.

This guidance is applicable from 1 April 2022.

# Introduction

From 1 April 2022, local areas[1] should adopt discharge processes that best meet the needs of the local population. This could include the Discharge to Assess, Home First approach. Systems should work together across health and social care to jointly plan, commission, and deliver discharge services that are affordable within existing budgets available to NHS commissioners and local authorities, pooling resources where appropriate.

Under the Discharge to Assess, Home First approach to hospital discharge, the vast majority of people are expected to go home (i.e. 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.

Multi-disciplinary hospital discharge teams and transfer of care hubs (see further below), comprising professionals from all relevant services across sectors (such as health, social care, housing and the voluntary sector), should work together so that, other than in exceptional circumstances, no one should transfer permanently into a care home for the first time directly following an acute hospital admission. 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[2]. It also supports hospital flow, maximising the availability of hospital beds for people requiring this level of inpatient care and elective surgery, such as hip replacements.

As health, care and other public services in England move towards more integrated, multi-disciplinary working, local areas have the opportunity to improve the experiences and outcomes of their local population. Local areas should work together to develop the model within existing resources. This should include agreeing any investment to reshape provision towards more home-based, strengths-based care and support, and with less reliance and expenditure on bed-based provision.

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[1] In this guidance, local areas is used as a collective term for NHS bodies (including commissioning bodies, NHS Trusts and NHS Foundation Trusts) and local authorities exercising functions in England.
2 Kortebein P, Symons TB, Ferrando A, et al. (2008) Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2;63:1076-1081

The principles in this guidance should form the foundation for local planning of arrangements for discharge from acute hospitals and community rehabilitation units. This can best be achieved by providing choice for individuals, who should be supported to make fully informed decisions, with input from their wider family or unpaid carers (where appropriate, and where the individual consents) or their Independent Advocate. This process should be person-centred, strengths based, and driven by choice, dignity and respect.

This guidance is based on the experiences of individuals, unpaid carers and organisations with health and care experience, as well as input from leaders of NHS and local government services. In particular, we are grateful for the contributions of Carers UK, the Carers Trust, Healthwatch England, the Local Government Association, the British Association of Social Workers, and the Principal Social Workers Network for their support in developing this guidance. The full list of organisations who have contributed to this guidance is in Annex A.

## How NHS and local authorities can work together to plan and implement hospital discharge, recovery and reablement in the community

This guidance has been themed according to:

- The care journey
- Roles and responsibilities
- Specific needs

## The care journey

### 1. NHS bodies and local authorities should agree the discharge models that best meet local needs that are affordable within existing budgets available to NHS commissioners and local authorities

NHS bodies and local authorities should adopt discharge processes that, in their judgement, best meet the choices and needs of the local population. This could include the Discharge to Assess, Home First approach. Funding to support discharge can be pooled across health and social care via an agreement under section 75 of the NHS Act 2006 to minimise delays, ensure effective use of available resources and ensure the decisions about an individual's care needs are made in their own environment. Local areas can choose the appropriate funding mechanisms to enable these processes, such as the Better Care Fund (BCF), or other means that are affordable within existing budgets available to NHS commissioners and local authorities. For example, the BCF can, subject to local agreement, continue to be used to fund services at the interface of the health and social care system, such as intermediate care and hospital discharge planning, as well as core adult social care services and breaks for unpaid carers.

This guidance seeks to support local areas as partners to jointly agree how to use their existing resources to best effect, to deliver the best possible outcomes for their population following the end of the hospital discharge funding. Care, when delivered at home, not only leads to better outcomes for the individual, but is also a better use of resources [3].

NHS bodies and local authorities should ensure that local funding arrangements are agreed by all partners and are aligned with existing duties, including those under the Care Act 2014 and the Mental Health Act 1983. These arrangements should also include clear

3 Why not home, why not today brochure (local.gov.uk)

information for self-funders of adult social care, so they can make informed choices about any onward care needs that do not fall under locally funded eligible costs.

Health and social care commissioners should consider how capacity across the system is being used to support people in their own homes and consider how resources can be best used to support this.

Where local areas agree to fund a period of care (pending a long-term needs assessment being carried out), agreements should be in place to ensure no one is left without care or – if needed – an assessment of long-term needs prior to the end of this period. This should also ensure that no carers are left without adequate support or an assessment of their longer-term needs (if needed) at the end of this period.

The case studies below set out how two local areas have agreed funding to facilitate best practice for their local hospital discharge services.

Regardless of the hospital discharge, community support and funding model that is adopted locally, people and, where relevant, their families, unpaid carers, and Independent Advocates, should expect to receive personalised support that meets their needs and maximises the person's independence[4]. People should not be routinely discharged to a community step-down bed simply to free a hospital bed, nor should they routinely be discharged to a community bed simply because home-based care is not available. Where relevant, the decision about when to discharge a person, and any support they might need before an assessment of their long-term needs, should take into account the views and circumstances of any unpaid carers as well as those of the individual. Hospital discharge teams should also consider unpaid carers' preferences and involve them to ascertain whether they are both willing and able to provide care and support post-discharge, before an assessment of longer-term needs. This should include an offer to refer to local carers' support services.

If a person's preferred placement or package is not available once they are clinically ready for discharge, they should be offered a suitable alternative whilst they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they do not need acute care, including to wait for their preferred option to become available.

Whilst NHS organisations should seek to offer choice to patients where such choice exists, in practice, there may be limited situations where an NHS organisation may decide to reduce the choice of services offered to people on discharge. Such situations include times of extreme operational pressures, for example, for the duration of the UK COVID-19 Level 4 National Incident. A record should be produced of the considerations of the

4 Individuals may be entitled to Independent Advocacy if they do not have a friend or family member to support them during the discharge process. More information is set out in section 13.

relevant discharging body in deciding to offer that patient a reduced choice, setting out all of the material considerations for and against doing so, and the balancing exercise between the patient choice duty in the NHS Act 2006, and relevant competing duties and countervailing factors. For further information on patient choice, see section 11.

Case Study: Surrey County Council (SCC)

Surrey County Council's footprint covers five acute hospitals, and multiple community services across health and care. These services support flow by providing rehabilitation and reablement support post-discharge, as well as directing services towards the prevention of admission. Outside of central hospital discharge funding, SCC have used a combination of the BCF, NHSE services and local authority core funding to deliver their hospital discharge and community services.

SCC have a history in investing in reablement services, and their main pooled funding arrangement is via the BCF. They have multiple place-based reablement teams, and demand is managed across footprints that are coterminous with their NHS commissioning bodies. They have increased capacity in these reablement services by setting them up in partnership with home care providers. Staff operate the same way regardless of who employs them, so the difference in providers is not felt by the individual.

From April 2022, SCC will be continuing their Discharge to Assess services, with some changes. In most cases, they expect ward staff to describe what the person might need, and for the multidisciplinary team in the transfer of care hub to decide which pathway is most appropriate for the person. The majority of funded services will be for people on Pathway 1 and Pathway 2 discharges.

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 have a need for 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 funded reablement pathway. People with health needs, and the potential for gaining skills, may also be supported by community health providers post-discharge.

SCC are exploring setting up a 'risk share fund' with the NHS, via the BCF. This would be used in exceptional circumstances to prevent discharge delays, where a decision cannot be reached about who should fund the individual's interim care support. Finally, they have plans to invest in bespoke hospital discharge services to manage demand. This includes investing in local authority funded step-down services, for people with interim care needs.

Case Study: South Warwickshire Foundation Trust

South Warwickshire Foundation Trust implemented the Discharge to Assess model as part of a wider system transformation that began in 2012/13 and included: ambulatory emergency care; a community integrated health and social care team; frailty services; trusted assessment; and early supported discharge. The Discharge to Assess approach was rolled out across Warwickshire following a successful pilot.

Joint working is essential to implement Discharge to Assess successfully. The Trust worked with the local authority, NHS Continuing Healthcare (CHC) and the local clinical commissioning groups (CCGs) to set up Discharge to Assess. Joint working between a Warwickshire County Council (WCC)-led Better Care Fund project and local NHS partners reduced delayed transfers of care and provided a strong foundation to respond to COVID-19.

Local authority commissioning expertise is utilised. WCC run the commissioning of Discharge to Assess pathways, with a Joint Executive Commissioning Lead for the local authority based within the trust. Pooled funding via section 75 partnership agreements and memorandums of understanding enable joint decision making, management of risk and clarification of roles and responsibilities.

The Discharge to Assess approach has led to savings for the local health economy with shorter hospital stays for emergency inpatient adults and people over 75, leading to reductions in ward capacity. Discharge to Assess can also lead to a reduction in CHC costs: the Trust's service statistics show that the proportion needing CHC funding with the approach is half that of the group who do not use it. The Trust also found reductions in local authority packages of care and saw less people going into long term care.

Point prevalence studies have proved to be a useful tool. These involve taking snapshot of people within hospitals and community services, asking whether they could be managed in a lower care setting, and calculating the cost-benefit of this.

## 2. Planning for discharge should start on admission, or before for elective procedures

Planning for discharge from hospital should begin on admission. Where people are undergoing elective procedures, this planning should start pre-admission, with plans reviewed before discharge. This will enable the person and their family or carers to ask questions, explore choices and receive timely information to make informed choices about the discharge pathway that best meets the person's needs. Further detail on the four Discharge to Assess pathways is set out in Annex C.

From the outset people should be asked who they wish to be involved and/or informed in discussions and decisions about their hospital discharge, and appropriate consent received. This may include a person's family members (including their next of kin), friends, or neighbours, some of whom would be considered unpaid carers. Paid care workers and personal assistants may also be included. The person or people identified at this stage, including any unpaid carers, may be wider than a person's next of kin. A person who does not have family or friends to help, or who may find it difficult to understand, communicate or speak up, should be informed of their right to an Independent Advocate.

Multi-disciplinary teams (see section 4) should work across hospital and community settings – including with services provided by community health, adult social care and social care providers – to plan post-discharge care, long-term needs assessments and, where appropriate, end of life care. Social workers, including children's social workers of young carers and young adult carers, should be involved at an early stage of the discharge planning process where appropriate, including where that planning takes place in a hospital setting. The multi-disciplinary team should also ensure that any mental capacity and safeguarding concerns have been considered alongside other support needs post-discharge.

Discharge planning should include information about post-hospital care, such as advice and information about community and voluntary sector organisations, housing options (such as home adaptations and possible alternative housing) and NHS/social care crisis response teams that can be contacted post-discharge.

Family members and unpaid carers providing care for the individual should be offered support where appropriate. For example, all unpaid carers may benefit from signposting to local carers' support services, and they should be made aware of their right to an assessment for their own needs by their local authority[5] (see section 12 for details). This includes young carers under the age of 18.

## 3. People should be supported to be discharged to the right place, at the right time, and with the right support that maximises their independence and leads to the best possible sustainable outcomes

Health and care professionals who are facilitating hospital discharges should work together with individuals, and – where relevant – families and unpaid carers, to discharge

[5] NICE Guideline 1.2.7: Practitioners involved in transferring people to and from hospital should seek to identify carers and refer them to appropriate services.

- Follow recommendations on support for families, parents and carers throughout admission in NICE's guideline on transition between inpatient mental health settings and community or care home settings **and**
- Follow recommendations on discharge from hospital in NICE's guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs.

people to the setting that best meets their needs. This process should be person-centred, strengths-based, and driven by choice, dignity and respect.

The vast majority of people being discharged should go home without the need for ongoing support. Of those that remain, the majority of supported discharges should be going home, with only a small proportion of people needing short-term bed-based intermediate care. Only in exceptional circumstances should someone be considered to need long-term care at the point of discharge. See Annex C for further details about discharge pathways.

Support should extend beyond discharge itself. Local areas should have agreed protocols for collaborating with onward care providers about the individual's hospital discharge through the transfer of care hub (see section 10 on information sharing). Community health and care services, including GPs and social care providers, should communicate with the individual and, where relevant, their unpaid carers, to track and manage the individual's recovery, and ensure that any change in the support needs of the individual (or their carer) takes place at an appropriate time.

People should be discharged to a familiar setting where possible, as they often respond well to the familiarity of their home environment when it is appropriate for supporting their needs. If required, they should receive rehabilitation or reablement support from NHS or social care services to enable them to regain their independence as far as possible. This can lead to a more accurate assessment of their future needs once they have reached an improved point of recovery. Practitioners within acute and community health and local authorities should consider a range of factors when supporting the individual and their family, unpaid carer(s) or Independent Advocate to decide an individual's care pathway and post-discharge support. This includes the individual's preferences, existing provision of care, and whether unpaid carers are willing and able to support an individual's recovery. Practitioners should be aware of young carers or young adult carers involved in unpaid support, working with them respectfully and appropriately and ensuring they have necessary support in place.

Discharging people to the most appropriate place to meet their needs requires active risk management across organisations to reach a reasonable balance between safety at all times, and independence. More detail is set out in section 8. Anyone requiring formal care and support to help them recover following hospital discharge should receive an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met and allow time for fuller assessments to take place as the person settles in their environment. This should be coordinated via the transfer of care hub (see section 4). People should not have to make decisions about long-term care while they are in crisis or in an acute hospital bed.

Local areas should draw upon a range of short and medium-term interim care services, depending on the severity of an individual's needs. For example, some people may benefit from voluntary sector support, or very short term 'hospital to home' services to get them settled back home. Short-term (72-hour) reablement or live-in care services may also be useful to ensure individuals have care available while they settle at home, rather than being discharged to a community or care home bed, but these should be organised and agreed as affordable within existing budgets available to NHS commissioners and local authorities.

People with ongoing mental health needs, a learning disability, dementia, those in the last few months of life, and a range of other factors and conditions may require specialised support in the community to ensure their needs continue to be met. Children and young people facing the loss of a family member, and anyone facing the loss of a loved one due to suicide, should be informed about how they can access specialist bereavement support. The needs of homeless people will also need to be considered (see section 14). Local commissioning plans should include the provision of specialised support that meets the local population's needs.

## Structure, roles and responsibilities

### 4. Local areas should develop a discharge infrastructure that supports safe and timely discharge to the right place and with the right treatment, care and support for individuals

Local areas should develop and implement the hospital discharge model that best meets the needs of their local population that are affordable within existing budgets available to NHS commissioners and local authorities. Discharging an individual onto the right care pathway when they no longer need to remain in hospital requires a whole system approach. NHS organisations should work closely with adult social care, children's social care, care providers, housing, the voluntary sector and others to ensure people's care and treatment is timely, optimal and coordinated, while also minimising delays when they are ready to be discharged.

Senior level support from NHS providers and local authorities should provide strategic leadership and oversight of the discharge process to monitor and eliminate the causes of unnecessary discharge delays and ensure that the agreed hospital discharge procedures are being followed consistently.

NHS bodies, local authorities and other relevant partners should develop local protocols. These should set out each organisation's role and how responsibilities should be exercised to ensure appropriate discussions and planning concerning a person's short and long-term care options happen at the appropriate time in their recovery.

To ensure hospital discharge processes are effective, NHS bodies and local authorities should also ensure local recovery, rehabilitation and reablement services are commissioned effectively and sustainably, and meet the needs of their local population in the short and long term that are affordable within existing budgets available to NHS commissioners and local authorities. This may be provided as part of intermediate care services, and should be done in collaboration with relevant organisations, including the voluntary and community sector and care providers.

The support needs of specific populations should be considered when commissioning local services (see section 14). This includes determining the type of specialist rehabilitation services needed for people with complex conditions and ensuring appropriate social work provision and other specialist support is in place for people in complex, abusive or neglectful relationships. The involvement of advocacy should also be a key consideration where appropriate. Local areas should also determine the best working arrangements of multi-disciplinary health and care teams who manage discharge from acute and community hospital settings, whether they choose to co-locate their staff, work together using virtual systems, or find other means of effective collaboration.

Commissioners should work with local voluntary and community sector organisations to develop and maintain capacity in the community to support people, including those who do not need specific reablement or rehabilitation, to retain links into the community and maintain their wellbeing.

Specific roles, structures, and responsibilities

Health and social care systems based around a hospital should have an identified executive lead, employed by any partner in the system, to provide strategic oversight of the discharge process. They should ensure that appropriate procedures are followed, including the inclusion and support of carers, and that there are no avoidable delays to discharge.

Every local health and social care system should have a single coordinator who acts on behalf of the system to secure safe and timely discharge on the appropriate pathway for all individuals. This system leadership role can be employed by any partner in the system. Their primary function is to develop a shared system view of discharge, hold all parts of the system to account and drive the actions that should be taken as a system to address shared challenges. The single coordinator is accountable to the executive lead.

Every local health and social care system based around an acute hospital footprint should have a transfer of care hub whereby (physically and / or virtually) all relevant services across sectors (such as health, social care, housing and voluntary sector) are linked together. The transfer of care hub should coordinate care for people who require formal care and support after discharge from hospital, and any support for unpaid carers

providing care. Hubs should be staffed by a small team, dedicated to ensuring people are discharged from hospital on the right pathways, with the right discharge information, and that they get the right onward care and support (if needed). Staff based in the transfer of care hub may also be the care givers and rehabilitation professionals for an individual. Decisions about what long-term support package is needed should not be taken on the hospital ward.

Case managers in transfer of care hubs should link relevant services to coordinate care and support the individual. The case manager can be from any discipline (such as social care, primary care or therapies) depending on the needs of the individual being supported. They should also make arrangements for all persons leaving hospital with ongoing health and care needs to have an initial safety and welfare check on the day of discharge to ensure basic safety and care needs are met and allow time for fuller assessments to take place as the person settles.

Hospital multidisciplinary teams should describe – with input from the person and their unpaid carer, advocate, or relevant community-based professionals – the needs that require support after discharge before an assessment of their long-term needs. This could include non-clinical factors like their physical, social, psychological, financial and practical needs, including home adaptations and equipment. This could determine whether the person's home is suitable for their needs upon discharge. Multidisciplinary teams may include social workers, clinicians, therapists, mental health practitioners, pharmacists, care workers, dietitians, housing representatives, volunteer and community services and any other specialists needed to coordinate care for the individual. They should adopt strengths-based and person-centred planning, working together to plan care and carry out joint assessments. These teams should be aware of carers' rights, and ensure carers are willing and able to care and that they have sufficient support to care safely. This helps to facilitate an integrated transition from hospital to the person's usual place of residence. Safety should be ensured from the day of discharge. They should refer those requiring support to the transfer of care hub.

Hospital-based social workers have a vital role as members of a multi-disciplinary team, ensuring a person-centred and strengths-based approach is adopted during pre-admission, hospital stays and planned safe discharge. Their role in hospital and assessment settings is essential for people whose social circumstances are complex. These social workers should be experienced in supporting people to make informed choices, weighing up the risks and benefits of options, and they should be familiar with mental health, mental capacity and safeguarding issues. They should also be knowledgeable about carers' rights. They should understand the full options available to people in community settings in order to offer people the best choice and understanding of their recovery pathway.

It is critical that General Practice and other primary care providers are directly linked into all discharge planning to ensure that health recovery support is available to the individual throughout their care journey.

Detailed guidance on accountability and roles can be found in staff action cards.

## 5. Joint accountability across health and social care leads to better outcomes

### Cooperation duties

Section 82 of the NHS Act 2006 requires NHS bodies and local authorities to cooperate with one another to secure and advance the health and welfare of their local population. NHS bodies and local authorities must also comply with duties in the Care Act 2014, which requires them to co-operate with each other in the exercise of their respective care and support functions, including those relating to carers and young carers (section 6 and 7).

### Best practice

To implement best practice, NHS bodies and local authorities should work together to:

- determine what an individual needs and wants after discharge, if anything, so that they are discharged onto the pathway that best meets their needs
- appropriately refer qualifying individuals to Independent Advocacy services on admission, so their voice is heard during the discharge planning process
- plan, commission and deliver appropriate care and support that meets population needs and is affordable within existing budgets available to NHS commissioners and local authorities
- understand the quality, cost and effectiveness of local treatment, care, and support to inform people of their options
- understand the role each organisation has in safeguarding and put appropriate safeguarding policies and procedures in place[6]

[6] The NHS Safeguarding App is available as a free resource and aims to keep you updated on safeguarding and trauma informed practice (Level 1 & 2).Further information on safeguarding can be found in the following intercollegiate documents:

- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff

- take joint responsibility for the individual's and unpaid carer's, including young carer's, welfare when making decisions about discharge and post-discharge support
- transfer people seamlessly and safely from hospital to their own home or new care setting with joined up care, via clear, evidence-based and accurate assessments that fully represent the medical and psychological needs and social preferences of the person
- transfer information between settings in a timely way
- identify any carers, including young carers, and determine whether any carer is willing and able to provide care and, if so, what support they might need (including through use of young carers' needs assessments)

### Planning, delivery and monitoring of discharge services

Local areas should agree governance structures that support clear planning, delivery and monitoring of performance and routes to escalate issues, where required. They should work together to:

- agree expected levels of performance, including the establishment of performance management mechanisms to monitor and improve outcomes
- use agreed, reliable and shared data to inform daily decision making, address issues and improve outcomes for people being discharged
- agree an executive lead and a single co-ordinator for the system
- establish and implement a joint vision and ambition for an approach, maximising the numbers who are discharged home
- implement mechanisms to plan, deliver and monitor the effectiveness of local discharge and recovery/rehabilitation arrangements
- Seek proactive feedback from providers of care post discharge on how the discharge went in practice, and identify areas for improvement
- identify joint commissioning responsibilities and leadership

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- Looked After Children: Roles and Competencies of Healthcare Staff
- Adult Safeguarding: Roles and Competencies for Health Care Staff

- establish how shared risk and resources will be managed in order to deliver improved outcomes for people being discharged from hospital in a way that is affordable within existing budgets available to NHS commissioners and local authorities

### Legal duties on health and social care bodies

Health and social care providers must meet the requirements set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 9 provides that the care and treatment of people using services must be appropriate, meet their needs and reflect their preferences.

- Regulation 12 provides that care and treatment must be provided in a safe way. To comply with this regulation, care providers must, amongst other things, assess the risk to people's health and safety of receiving any care or treatment.

Care Quality Commission (CQC) guidance for providers on meeting the 2014 Regulations states that providers must assess risk to people's health and safety, including during the discharge process, and that such risk assessments must be completed and reviewed regularly by people with the qualifications, skills, competence and experience to do so, and should include plans for managing risks.

The Care Act 2014 sets out a single route to establishing an entitlement to care and support for adults with eligible needs for care and support, and the entitlement to support for carers. The Act is also clear about the steps that local authorities must follow to work out this entitlement, and to help people understand the process. This includes a duty to assess and meet people's eligible care needs in relevant circumstances and to conduct a financial assessment where necessary.

Section 2 of the 2014 Act and section 3 of the 2014 Act require local authorities to take steps to prevent, reduce or delay needs for care and support for local people and with a view to ensuring integration of care and support services with health provision, including the provision of housing. Section 2 requires local authorities to have regard to identifying carers with needs for support that are not being met.

From 25 March 2022, the Coronavirus Act will be repealed. NHS bodies and local authorities should adopt discharge processes that best meet the needs of the local population. This includes assessing the person's longer-term needs at the right time, in the most appropriate setting. This should be achieved through joint working across health and social care including pooling of resources where appropriate. The government is working to underpin these principles through legislative changes being proposed within the Health and Care Bill by revoking Schedule 3 of the Care Act, which requires long-term health and

care needs assessments to take place before discharge from hospital, which can delay discharge.

NHS England and CCGs must comply with their duties in relation to NHS Continuing Healthcare and NHS-Funded Nursing Care, as set out in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, whilst having regard to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety. The fundamental standards set in law a clear baseline below which care must not fall, and the CQC will be able to take enforcement action against providers that do not meet these standards.

NHS bodies and local authorities should ensure all legal responsibilities are met in relation to mental capacity and best interest decision making, and in relation to people's entitlement to aftercare services following discharge from detention under the Mental Health Act 1983.

NHS bodies also have a duty to refer a person who is homeless, or may be threatened with homelessness, to local authority homelessness/housing options teams under the requirements of the Homelessness Reduction Act 2017. More detail is set out in section 14.

Specific responsibilities of NHS bodies and local authorities in relation to hospital discharge are set out in detail in Annex B.

### Escalation

Health and social care systems should have escalation mechanisms for people with concerns about care and support that are clearly communicated to people using services, their families, their unpaid carers and advocates, and service providers. These should clearly set out who is responsible for what and at which step of the process they should be engaged.

Concerns should be escalated via the locally agreed escalation mechanism, overseen by the single coordinator reporting to the executive lead. Areas will have flexibility over how this is implemented locally, but they should ensure mechanisms are agreed with all partners, and that there is a clearly identified responsible person at each stage of the discharge process. Escalation mechanisms should be co-designed with people, including carers, who have experience of escalating issues in the past to ensure they work.

Where a complaint needs to be raised against an NHS body, it should be made to them directly in the first instance. This can be done through the relevant body's complaints

department, or its Patient Advice and Liaison Service (PALS). PALS can also provide information about the NHS complaints procedure, including how to get independent help if needed. Where a complaint needs to be made by an individual or provider this should be raised directly with the NHS body providing the service in the first instance. A complaint can also be raised with the commissioner of the service. Where this does not yield satisfactory results, the complaint can be raised through the Parliamentary and Health Service Ombudsman.

Where a complaint needs to be raised against a local authority or care provider, it should be made to them in the first instance. If this does not yield satisfactory results, or the complaint is not answered within a reasonable time, a complaint can be raised through the Local Government and Social Care Ombudsman.

Individuals can also provide information to local Healthwatch organisations and the CQC, which may carry out a range of actions including inspecting the relevant body if it has the powers to do so.

## 6. Health and local authority social care partners should support people to be discharged in a timely and safe way as soon as they no longer require acute hospital care

Health and social care professionals should support and involve the individual to be discharged in a safe and timely way to ensure they are only hospitalised for as long as they require hospital care. Discharging people once they no longer need acute care improves their outcomes and reduces the risk of medical complications such as deep-vein thrombosis, hospital acquired infections, and loss of independence[7]. Evidence suggests that even 10 days of bedrest is associated with significant muscle loss in older adults[8].

The criteria to reside tool (see Annex D) was developed in March 2020, as a response to the first wave of the Coronavirus pandemic. It is being reviewed with the collaboration of the British Geriatric Society and a broad set of clinicians to ensure it supports clinical teams to have discussions and make decisions whether a person needs to stay in an acute bed to receive care.

No person should be discharged until it is safe to do so. This should include ensuring that, where relevant, any unpaid carers have been consulted on whether they are willing and

[7] Rosman, M., Rachminov, O., Segal, O., & Segal, G. (2015). Prolonged patients' In-Hospital Waiting Period after discharge eligibility is associated with increased risk of infection, morbidity and mortality: a retrospective cohort analysis. *BMC health services research*, *15*(1), 1-5. Tess, B. H., Glenister, H. M., Rodrigues, L. C., & Wagner, M. B. (1993). Incidence of hospital-acquired infection and length of hospital stay. *European Journal of Clinical Microbiology and Infectious Diseases*, *12*(2), 81-86.
[8] Kortebein, P., Symons, T. B., Ferrando, A., Paddon-Jones, D., Ronsen, O., Protas, E., ... & Evans, W. J. (2008). Functional impact of 10 days of bed rest in healthy older adults. The Journals of Gerontology Series A: Biological Sciences and Medical Sciences, 63(10), 1076-1081.

able to provide care and support. Young carers should be offered independent advocacy support if they want it, to support them to consider how they will be impacted.

The 2018 National Audit of Intermediate Care indicates that intermediate care recovery services over a 6-week period increases levels of people's independence and can reduce the number of preventable readmissions to hospital . The audit found that 71% of individuals reported an improved dependency score after a 6-week period of home-based care. 85% reported an improvement after 6 weeks of bed-based care, and 66% for reablement care. As a result of rising levels of independence, we would expect fewer emergency readmissions and long-term social care needs, including a reduction on cost pressures. Hospital readmissions are estimated to lead to additional costs of £1.6bn annually. While this figure indicates the total cost of hospital readmissions for all reasons, Discharge to Assess can help lower some of these costs if the necessary recovery services are in place after hospital discharge.

## 7. Assessing for long-term needs at an optimised point of recovery improves people's outcomes and is good value for money across the system

Individuals should be assessed for their long-term care needs following a period of recovery, rehabilitation and reablement (where required) when they are back in a familiar environment. The assessments should take place at a point of recovery when their long-term care needs are clearer.

Local authorities have duties to assess and meet people's eligible care needs in relevant circumstances and these assessments should be conducted in a timely manner, in accordance with their Care Act 2014 duties. Best practice is for these assessments to be undertaken in a person's home to determine long-term care needs.

If care, treatment or support is needed, the individual should be fully involved in considering what form that might take and in weighing up the risks and benefits of the options that are available. This includes, if required by the person, consultation with family members and any carers who are willing and able to provide care and support. If the individual does not have any friends or family members to consult with about these options, then an Independent Advocate should be consulted.

Social care expertise is a central part of the process to determine people's long-term care needs following a period of recovery and rehabilitation. It can maximise their independence, meet their needs and wishes and ensure they are fully aware of their options and the implications of each choice.

For individuals leaving the acute hospital environment it is best practice to screen for NHS Continuing Healthcare at the right time and in the right place for that individual. In the vast majority of cases this will be following discharge and after a period of recovery at home. Further information on how hospital discharge interacts with NHS Continuing Healthcare can be found in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

People with end of life needs will have additional considerations, which are set out in section 9.

## 8. Discharge requires active risk management across the system

Multi-disciplinary discharge teams should work together when discharging people to manage risk carefully with the individual, and their unpaid carer, representative or advocate, as there can be negative consequences from decisions that are either too risk averse, or do not sufficiently identify the level of risk. At one end of the scale, people may be discharged onto pathways which result in care being over-prescribed; and at the other end, individuals may not receive the care and support they need to recover. Any onward care providers should be included early in the person's discharge planning. This allows more time for local capacity to be managed and suitable support to be put in place. People's care needs may also change, and there should be processes in place to ensure these needs are continuously reviewed and that the person is receiving appropriate support (see section 4).

A study of 10,400 individuals' care pathways found that of the people who experienced a delayed discharge, 32-54% were discharged to a setting where the levels of care were not suitable for their needs. 92% of these people were receiving more intense care than they needed, suggesting a barrier to them maximising their independence.

Individuals and local factors will determine how best to manage risk. For example, in areas covering a broad geography, a virtual transfer of care hub may be one model that can facilitate multidisciplinary working to ensure information about individuals and any family or friends caring for them is shared effectively across organisations with their consent. Other areas may choose to co-locate key staff members from relevant organisations at a physical transfer of care hub, such as in a local acute hospital. Alongside ensuring integrated working across health, housing, social care and other key organisations, assigning a single point of contact ensures that the individual or the family can communicate with professionals in a timely manner. Unpaid carers, in particular young carers and young adult carers, should be told how to communicate their concerns to professionals. This could be particularly crucial if there were a change in the individual's care needs post-discharge, such as their condition worsening. Supporting multidisciplinary

working is also key to developing a shared approach to risk to support discharge. Huddles, trusted assessment, shadowing, and peer learning can all support this.

Health and social care professionals working in NHS bodies and local authorities should ensure that ‘safety netting’ is provided whereby the individual is provided with advice on discharge. The person should be given the contact details of their discharge team at the point of discharge and advised to make contact if they are concerned about anything. People should not be asked to see their GP or go to the emergency department following discharge, and they should only be followed up by a new team when the person’s relevant information has been handed over to the new team. Where appropriate, information provided to the person on discharge should be shared with their family, any unpaid carer(s) and providers of onward care services. Where a young carer is identified, or any professionals responsible for care planning have concerns about this, the local authority has a duty to conduct a needs assessment, where it appears that the young person may need support (see section 12).

# Specific needs

## 9. Palliative and end of life care needs should be anticipated and met as part of an individual’s discharge journey

Consideration should also be given to people who have palliative care needs, including those who are nearing the end of their life. Health and social care partners should work together to provide appropriate rehabilitation and reablement support from palliative and end of life specialist services and voluntary organisations. This may include support to maximise the individual’s independence or meet other personal goals.

People receiving palliative or end of life care should be supported to, where possible, recover from the incident that resulted in them being admitted to the acute hospital. They should receive appropriate and compassionate support from specialist organisations post-discharge to continue living the remainder of their time with dignity and as fully as possible. People who are recognised as likely to be in their last year of life may also benefit from further support such as benefits advice and equipment. Systems should have regard to the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care for those individuals where an appropriate clinician has decided that an individual has a primary health need arising from a rapidly deteriorating condition and the condition may be entering a terminal phase. The important role played by unpaid carers, including when they are an integral part of the care plan, and the need for carers’ breaks and for carers’ support is clearly set out in the NHS CHC and FNC guidance.

Health and care providers should collaborate to minimise common issues that may disrupt end of life care during the interim care period. This includes access to medication and

support, or trained professionals to administer them where necessary, and access to 24-hour nursing care and support to talk through the person's wishes and preferences. Each individual's care journey should be anticipated and mapped out, including advanced care planning, to ensure they can move through a seamless pathway to end of life care, without unnecessary disruption.

## 10. Information should be shared across relevant health and care teams and organisations across the system in a secure and timely way to support best outcomes

One of the purposes of integrating health and social care is to ensure smoother care pathways with care joined up around a person's life, needs and wishes, including an individual's information and data being shared between relevant organisations with their consent. Relevant care information should be discussed and communicated in a timely manner to the individual and the people who will provide ongoing support, such as domiciliary care teams, GPs, unpaid carers, advocates and family members.

Health and care professionals (such as clinicians, social workers and therapists) should share appropriate information early to support a safe and timely discharge – for example about medication (including whether medication has changed since hospital admission) and immediate support needs, including transport and equipment required.

Health and care professionals should share key information about an individual's communication needs (for example if they have a learning disability or dementia), specific care preferences and details about their carer or family member. There is an opportunity to ensure that the carer is identified on the person's health and care record as well as their own health and care record. If an individual experiences substantial difficulty in communicating their needs and does not have a friend or family member to support them, an Independent Advocate must be instructed.

Local areas should work to establish information sharing protocols and mechanisms to enable data about the discharge process to be shared in a timely and effective manner to facilitate safe and timely discharges. This could include developing a shared dashboard of key activity and performance metrics, which would provide accurate information to underpin service and management decisions.

## 11. Planning and implementation of discharge should respect an individual's choices and provide them with the maximum choice and control possible from suitable and available options

The NHS Act 2006 sets out in broad terms the general duty as to patient choice in the NHS. This requires relevant bodies to "act with a view to enabling patients to make choices".

On discharge from hospital, people who have new or additional needs should be offered choices of onward care and support to aid their recovery before any out of hospital assessment and arrangement of ongoing care and support (if needed). The choices offered should be suitable for their short-term recovery needs and available at the time of discharge.

Key to enabling choice whilst preventing delays is early and ongoing discharge planning conversations between healthcare professionals and people and their families and unpaid carers, following the principles of personalised care.

People in hospital should be supported to participate actively in making informed choices about their care, including, for people who fund their own care, the potential longer-term financial impact of different care options after discharge. These conversations should begin early in a hospital stay, and not when a person is ready to be discharged. This should also include, where appropriate, information about housing options (adaptation of the existing home and possible alternative housing, for example supported living).

Where there is disagreement between a person and their unpaid carers or family members, and the person is deemed by the appropriate professional to have capacity to make decisions relevant to their discharge, the person's right to make these decisions should be respected.

Where an individual wishes to return home and their family member or unpaid carer is unwilling or unable to provide the care needed, NHS bodies, local authorities and care providers should work together to assess and provide the appropriate health and care provision required to facilitate the individual's choice, where possible, and enable a safe discharge.

If a person's preferred care placement or package is not available once they are clinically ready for discharge, an available alternative or alternatives appropriate for their short-term recovery needs should be offered, whilst they await availability of their preferred choice. People do not have the right to remain in a hospital bed if they no longer require acute care, including to wait for their preferred option to become available.

Whilst NHS organisations should seek to offer choice to patients where such choice exists, in practice, there may be limited situations where an NHS organisation may decide to reduce the choice of services offered to people on discharge. Such situations include times of extreme operational pressures, for example, for the duration of the UK COVID-19 Level 4 National Incident. A record should be produced of the considerations of the relevant discharging body in deciding to offer that patient a reduced choice, setting out all of the material considerations for and against doing so, and the balancing exercise between the patient choice duty in the NHS Act 2006, and relevant competing duties and countervailing factors.

## 12. NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions

Family members, friends and other unpaid carers play a vital role in the care of people who are discharged from hospital. NHS bodies and local authorities should address local barriers to identifying and supporting carers throughout the hospital discharge process. This includes ensuring local authorities continue to adhere to their duties in existing legislation, for example, those outlined in the Care Act 2014, and the Children Act 1989.

A determination should be made as early as possible in discharge planning – or following a period of recovery – about the status and views of any carers who provide care, including that they are willing and able to do so. This will need to be age appropriate if this is a young carer under the age of 18.

In delivering sound discharge planning, NHS bodies and local authorities will need robust systems to identify carers, including young carers, early in the process.

A carer's assessment can be completed as soon as practicable after discharge, but should be undertaken before caring responsibilities begin if this is a new caring duty or if there are increased care needs. If the assessment needs to take place prior to discharge it should be organised in a timely manner so as not to delay discharge from hospital. Section 10 of the Care Act 2014 requires local authorities to carry out an assessment where it appears that an adult carer may have needs for support at that time, or in the future, and to draw up a support plan for how these needs will be met. Should carers have substantial difficulty engaging in their own assessment, they should be referred for independent advocacy support under the Care Act 2014. Young carers in particular may benefit from independent advocacy support.

Recording carers' details in electronic patient records can be one way to facilitate the identification and recognition of carers, particularly in cases where the individuals they are

caring for experience repeat admissions. There is also the opportunity to identify the carer on their own patient record.

Practitioners should note that not all individuals who are (or will be) providing ongoing care will identify as a ‘carer’. If the person is nevertheless acting in the role of a ‘carer’, they should be regarded as one and involved in key conversations about the care needs of an individual after their discharge from hospital, or in having their own needs assessed. In other cases, the person being discharged may themselves have caring duties, such as a parent of child with a disability. Parents in this situation should be made aware of their right to an assessment of their needs (as set out in section 97 of the Children and Families Act 2014) and any additional services the local authority may need to put in place to support them in fulfilling their caring role for their child. This could include, for example, the provision of a short break or respite care to support the family.

Consideration should be given to identifying any children or young people in the household who have caring responsibilities or may have new responsibilities at the point of discharge. This may include children or young people taking on a greater caring role in relation to a disabled sibling or other child in the family, as well as providing care to a parent following discharge.

Where a young carer is identified, or any professionals responsible for care planning have concerns that the person will be discharged into the care of a person under the age of 18, the local authority should be notified of this information. Upon notification, the local authority must carry out an assessment in accordance with their responsibilities under section 17 of the Children Act 1989 where it appears to the authority that the young person may need support or on request from the young carer or their parent. Any assessment should be conducted in accordance with the Young Carers (Needs Assessments) Regulations 2015 taking into account the young carer’s age, understanding and family circumstances. Local authority assessments must also consider whether it is appropriate or excessive for the young carer to provide care for the person in question, in light of the young carer’s needs and wishes. The Act also specifies that the NHS has a duty to cooperate with local authorities in exercising these responsibilities.

There are instances where relationships are abusive: the individual or their carer may be abused, may abuse or be neglectful, or may have key information about abusive others. Safeguarding protocols should be followed where abuse, or risk of abuse, is identified, or staff members have concerns about abuse.

## 13. Mental capacity, advocacy and special arrangements for discharge

Mental capacity should be assessed on a decision-specific basis. If there is a reason to believe a person may lack the mental capacity to make relevant decisions about their

discharge arrangements at the time the decisions need to be made, a capacity assessment should be carried out as part of the discharge planning process. Where the person is assessed to lack the relevant mental capacity to make a decision about discharge, a best interests decision must be made in line with the Mental Capacity Act 2005 and usual processes. No one should be discharged to somewhere assessed to be unsafe, and the decision maker must make the best interests decision.

Onward care and support options which are not suitable (for example, those not considered clinically appropriate) or available (for example, placements which are not available) at the time of hospital discharge should not be considered in either mental capacity assessments or 'best interests' decision making. Just as a person with capacity does not have a right to remain in a hospital bed if they no longer require acute care, neither is this an option for a person who lacks the mental capacity to make the discharge decision.

During discharge planning, health and care providers should continue to meet their responsibilities regarding Deprivation of Liberty Safeguards[9], where appropriate. This is especially the case for, but not limited to, people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment. This includes carrying out a capacity assessment before a decision about discharge is made, if there is reason to believe a person may lack the mental capacity to consent to their discharge arrangements which amount to a deprivation of liberty.

Any decision by the decision maker must be taken specifically for each person and not for groups of people. The Deprivation of Liberty Safeguards - Code of Practice outlines further information in relation to Mental Capacity.

It may be appropriate for an Independent Advocate to support an individual during the discharge planning process, and in some cases, this may be a legal requirement. Advocates are independent from the NHS and local authority and are trained to help people understand their rights and options, express their views and wishes, and help make sure their voice is heard. Advocates play a vital role for people including but not limited to people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment. Referrals to Independent Advocacy services should be made as soon as discharge planning begins and ideally upon admission.

[9] Liberty Protection Safeguards: what they are

## 14. NHS bodies and local authorities should ensure people receive support that is tailored to their specific needs and circumstances

Where there are ongoing health, housing or social care needs after discharge with different care options available, individuals (and, where relevant, their family, unpaid carers or advocates) should be empowered and supported to make the best choice for their individual circumstances.

Transfer of care hubs should incorporate appropriate safeguards for individuals who require this. For example, people who are homeless, at risk of homelessness or living in poor or unsuitable housing should be determined on admission to hospital; and individuals with a physical or learning disability and mental health needs have an increased probability of needing to use the social care system in their lifetime. Local areas should ensure that all legal responsibilities are met in relation to After-care in section 117 of the Mental Health Act 1983

Health and social care professionals should follow an ongoing commitment to reducing health disparities and inequalities and consider the needs of groups that might need specialised support. This includes, but is not limited to, understanding issues relevant to people from black, Asian and minority ethnic groups, LGBTQI, faith or cultural needs, people living with disabilities, autistic people, older people, unpaid carers, people who do not speak English, and those with specific communication needs.

Any local changes to discharge arrangements should ensure that care providers are continuing to meet their responsibilities regarding Deprivation of Liberty Safeguards. This is especially the case for, but not limited to, people with a learning disability, dementia, acquired brain injury or people currently lacking capacity to make decisions about their mental health treatment.

For people where new mental health concerns have arisen, psychiatric liaison teams should be contacted by case managers in the first instance to review and assess as appropriate. A care co-ordinator or relevant mental health clinician should be involved in the discharge planning for people with a pre-existing mental health concern who are known to mental health services, to ensure their mental health needs are considered. They should ensure that the proposed onward care provider, if relevant, is fully aware of the person's support needs. For those who are being discharged from an acute hospital following an episode of self-harm, the provider should consult NICE guidelines to ensure appropriate processes are being followed[10]. Where individuals present with mental

[10] Current self-harm guidelines: https://www.nice.org.uk/guidance/cg16 with new draft guidelines: https://www.nice.org.uk/guidance/gid-ng10148/documents/draft-guideline. New draft guidelines provide most up to date advice but are in draft form, with final guidelines expected to be published in July 2022.

distress but do not meet the criteria for secondary mental health services, a preventative mental health offer should be available.

All people who are homeless or threatened with homelessness should be determined on admission to hospital. During the hospital stay, the person should be referred by acute hospital staff to local authority homelessness or housing options teams, under the requirements of the Homelessness Reduction Act 2017, if the person consents. This duty to refer ensures services are working together effectively to prevent homelessness by ensuring peoples' housing needs are considered when they come into contact with public authorities. People who are homeless or at risk of homelessness should not be excluded from short-term post-discharge recovery and support because of their housing status. Further guidance on supporting people who are homeless when being discharged from hospital can be found in the LGA and ADASS high impact change model for managing transfers of care and the accompanying support tool.

For people living in poor or unsuitable housing the local housing authority has a duty to provide any necessary adaptations (as determined by legislation and regulations underpinning the Disabled Facilities Grant System) and assess housing needs. The local authority also has the power to implement fast track and integrated systems for such provision.

Many people admitted to acute medical units have a condition which makes them frail[11]. This is characterised as multiple physical, cognitive, and functional impairments resulting in longer stay in hospital, and higher rates of hospital acquired harms such as deconditioning, falls, infection, delirium, and adverse drug events. Research suggests that the average 30-day readmission rates are around 20% in this group, but many can be prevented by comprehensive geriatric assessment and discharge planning that includes a specific focus on:

- medicines reconciliation and optimisation
- patient and carer information, advice and support
- falls interventions
- provision of assistive technology to mitigate risk at home

The default pathway for people with frailty should be Home First, with intermediate care at home to regain functional ability after discharge. However, some people with more severe frailty may require a period of step-down bed-based care to support them to regain

[11] Conroy S, Dowsing T (2013) The ability of frailty to predict outcomes in older people attending an acute medical unit. Acute Med 12(2):74–6

confidence and independence in a homelike environment. For those individuals, care should adopt a reablement approach and be supported by the community intermediate care team in order to maximise recovery and delay progression to long term residential care.

**Terms used in this guidance**

Carers: all unpaid family members, friends and others who are providing care to the person being discharged. This includes (but is not limited to) adult carers, young carers, young adult carers and parent carers.

Local areas: collective term for NHS bodies (including commissioning bodies, NHS Trusts and NHS Foundation Trusts) and local authorities exercising functions in England.

**Key documents that have been drawn upon include:**

- This guidance should be read alongside the 2015 NICE guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs
- For further details on Discharge to Assess please see: NHS Quick Guide: Discharge to Assess
- CQC Guidance on Trusted Assessors Requirements when people are discharged from hospital to adult social care services under 'Trusted Assessor' schemes
- BASW England Health and Care Bill briefing
- BASW England policy response: Health and Social Care Bill
- ADASS snap survey findings
- Barnardo's report: Still Hidden Still Ignored Barnardo's young carers report
- Discharge to assess also forms part of the LGA and ADASS high impact change model for managing transfers of care

- Managing transfers of care – A High Impact Change Model: Changes 1-9 | Local Government Association

- Guidance to local authority commissioners is available from ADASS, the LGA and the Care Provider Alliance (CPA)

- Newton Europe publications: Why not home, Why not today? and People first: manage what matters

- Community health and care discharge and crisis care model: an investment in reablement

- The LGA and ADASS have produced 2 'tops tips' guides: Top tips guidance on implementing a home first approach to discharge from hospital and Top tips guidance on implementing a collaborative commissioning approach to home first

For queries relating to this guidance, please contact discharge@dhsc.gov.uk.

# Annex A - Contributing organisations

As well as local and national government and NHS departments, representatives from the following organisations have contributed to the development of this guidance:

- ADASS
- Age UK
- Barnardo's
- The British Association of Social Workers
- British Geriatrics Society
- The British Red Cross
- Care England
- Care & Repair England
- Carers UK
- The Carers Trust
- The Care Quality Commission
- Doris Jones Ltd.
- Healthwatch England
- Homecare Association
- Local Government Association
- Prof. John Bolton
- The National Care Forum
- NHS Providers
- The Patients Association
- Principal Social Workers Network
- The Royal College of Occupational Therapists

# Annex B – Specific responsibilities related to hospital discharge processes

The following lists existing duties and best practice for NHS bodies, local authorities and care providers to follow when planning and delivering hospital discharge services.

## Commissioners of health and care services should:

- Ensure that, where appropriate, onward health services and care packages for those discharged (including commissioning of care home beds) are jointly commissioned; and the local authority should be the lead commissioner unless otherwise agreed between the NHS body and the local authority. There should be clear agreement around who is responsible for paying for the package of care, including the use of pooled funding arrangements where appropriate in a way that is affordable within existing budgets available to NHS commissioners and local authorities

- provide adequate health and care discharge services, operating 7 days a week

- work in partnership to plan and commission sufficient provision to meet the needs of the population

- work in partnership to co-ordinate local financial flows for post-discharge care and support, including monitoring all local spend and co-ordinating local funding arrangements

- continue to build on recent learning and commissioning arrangements for community palliative care services, optimising the best use of all available financial resources including those currently allotted to CHC fast track. Enabling community palliative care services to provide palliative and end-of-life care for those people transferring to, or already in, the community requiring care and support within their own home or a hospice

- continue to promote the use and development of effective tracking tools for care homes, hospices and community rehabilitation bed providers. They should ensure that the operational potential of domiciliary and residential capacity trackers is realised, through their use in health and care system wide discharge planning, and that the effectiveness of reablement and rehabilitation is monitored

- work with system partners to ensure appropriate data collection and that its use supports the best outcomes for individuals

- give clear information to providers on which contract will be used, for example, NHS commissioning bodies must use the NHS Standard Contract

## Local authorities should:

- as outlined in the Care Act, take the lead on local care market shaping, including contracting responsibilities (for example, expanding the capacity in domiciliary care and reablement services in the local area, and ensuring that long term strategic provisions are developed, with surge capacity for winter pressure periods)

- work with CQC and other regulators to ensure safeguarding and quality of care, advising NHS colleagues where action is needed to make provision safe or alternatives are needed

- engage local housing authority services to provide housing support and advice for persons requiring housing assistance on discharge from hospital

- agree a single lead local authority or point of contact arrangement for each hospital system, ensuring each acute trust and single co-ordinator has a single point to approach when co-ordinating the discharge of all people, regardless of where that person lives

- work with partners to co-ordinate activity with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery

- In respect of young carers, local authorities must carry out an assessment upon the request or appearance of need, and this assessment must consider whether it is appropriate or excessive for the young carer to provide care

## Local authority adult social care teams should:

- make provision for Care Act assessments of need, financial assessments and longer-term care planning to take place following discharge

- ensure expert social work professionals can contribute to hospital based multidisciplinary discussions and decision making occurring before discharge

- ensure social care expertise is a central part of the process to determine the long-term care needs of and with people following a period of recovery and rehabilitation and that they are fully aware of their options and the implications of each choice

- continue to conduct safeguarding activities in a hospital setting if necessary

- provide capacity to review care provision and change if necessary, at an appropriate point, in line with good practice and legal responsibilities

- assess whether a carer has needs for support (or is likely to do so in the future) and, if the carer does, what those needs are (or are likely to be in the future)
- identify an executive lead for the leadership and delivery of hospital discharge processes
- provide social care capacity to work alongside local community health services via the transfer of care hub
- support real time communication between the hospital and the single coordinator, not just by email
- work with NHS bodies to ensure appropriate data collection and that its use supports the best outcomes for individuals

## Adult social care and care providers should:

- work in collaboration to plan and monitor local capacity to ensure there is appropriate social care support in place to support effective hospital discharges
- where possible, support 7-day working for community social care teams (commissioned by local authorities) and other care provision
- deploy adult social care staff flexibly to support best outcomes for people. This can include support to avoid any immediate bottlenecks in arranging step down care and support in the community, and at the same time focus on maintaining and building capacity in local systems
- provide feedback on hospital discharge commissioning and contracting arrangements and seek improvements, where relevant

## Acute Health Providers

### Hospital discharge teams should:

- arrange dedicated staff to support and facilitate hospital discharge. This will include:
    - making arrangements to ensure there is transport for people to return home from hospital. This should be via family/carers where appropriate/suitable, voluntary sector, or taxi and, only as a last resort, non-emergency patient transport services (NEPTS)
    - local voluntary sector and volunteering groups helping to ensure people are supported (where needed) actively for the first 48 hours after discharge

    - ensuring people have full information about the next steps of their care and be provided with a discharge summary which includes any changes to pre admission medication regime

    - ensuring ‘settle in’ support is provided where needed

    - in conjunction with local care home providers, develop trusted assessment arrangements to facilitate the prompt return of their own residents after a hospital stay

- ensure that required medication and essential equipment are provided at the point of discharge, and that information about this is provided to onward care providers, the individual and, where appropriate, their family and unpaid carers

**Hospital clinical and managerial leadership teams should:**

- create safe and comfortable discharge spaces for people to be transferred to from all ward areas

- maintain timely and high-quality transfer of information to primary care and all other relevant health and care professionals on all people discharged

- maintain provision for senior clinical staff to be available to support ward and discharge staff with appropriate risk-management and clinical advice arrangements

- engage with commissioning bodies and regional colleagues to support clinical and medical leaders in implementing discharge processes and culture

- closely monitor hospital discharge performance data to ensure discharge arrangements are operating effectively and safely across the system, including over seven days, and that a high proportion of people on the discharge list achieve a same-day discharge to the most suitable destination for their needs

- ensure that, as part of daily ward rounds, timely and accurate data is collected and submitted to the Acute Daily Discharge Situation Report. It is important this is a clinically driven data collection

- ensure a live list is available for all agencies to work from and include those suitable for discharge, the number and percentage of people on the list who have left the hospital, and reason of delay for those unable to be discharged in a timely way

**Community health service providers should work closely with other system partners to facilitate timely discharge of people. As part of this they should:**

- have an easily accessible contact within the transfer of care hub who will always accept referrals from staff in the hospital and source the care requested, in conjunction with local authorities

- monitor the effectiveness of reablement and rehabilitation, with local authority partners as appropriate

- use multi-disciplinary teams on the day a person goes home from hospital, to assess and arrange packages of support

- ensure provision of equipment to support discharge

- ensure individuals are closely tracked and followed up regularly to ensure their care support is appropriate

- take part in assessing the long-term needs of an individual at the end of the period of recovery

- maintain a focus on supporting timely onward transition of care for people receiving care in community beds (rehab and short-term care) and support them with reablement and rehabilitation packages in home settings following their discharge from a 24-hour bedded unit

- collect and submit data on the delivery of services to the Community Services Data Set (CSDS) and bed rehabilitation weekly SITREP

- use the Capacity Tracker tool for identifying the bed capacity in community rehabilitation bed providers

- for people identified as being in the last days or weeks of their life, the transfer of care hub will be responsible for co-ordinating liaison with primary care, community services and community palliative care services to co-ordinate and facilitate rapid discharge to the person's home or a hospice

Community Palliative Care teams will continue to co-ordinate and facilitate prompt discharge to home or hospice. End-of-life care, including palliative care, and pre- and post-bereavement support, must continue to be personalised and planned in a holistic way involving the person themselves and their families, social care, community nursing, general practice, occupational therapy, and others.

# Annex C – Pathways for the Discharge to Assess Model

Adapted from John Bolton model for persons aged 65 and over, and when used across all 18+ age groups, it is expected that a greater percentage than detailed will be allocated to pathways 0 and 1:

## 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
    - a continuation of an existing health or social care support package that remained active while the person was in hospital

## 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.

Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.

## 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, before returning home

## 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).

Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

# Annex D - 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.

## Review and challenge questions for the clinical team

Is the person medically optimised? Do not use ‘medically fit’ or ‘back to baseline’.

What management can be continued as ambulatory, for example heart failure treatment?

What management can be continued outside the hospital with community/district nurses? For example, IV antibiotics?

Persons with low NEWS (0-4) scores – can they be discharged with suitable follow up?

- if not scoring 3 on any one parameter – for example, pulse rate greater than 130
- if their oxygen needs can be met at home
- stable and not needing frequent observations every 4 hours or less
- not needing any medical/nursing care after 8pm:
    - people waiting for results – can they come back, or can they be phoned through?
    - repeat bloods – can they be done after discharge in an alternative setting?
    - people waiting for investigations – can they go home and come back as outpatients with the same waiting as inpatients?

## Criteria-led discharge

Can a nurse or allied health care professional discharge without a further review if criteria are well written out?

Can a junior doctor discharge without a further review if criteria are clearly documented?

How can we contact the consultant directly if criteria are only slightly out of range and require clarification?

www.gov.uk/dhsc



**Appendix 2**

Case study Mr H

Referral received 11th October 2023 via supported discharge from the acute setting via (Pathway 1 from the trust, which is home with a POC). This was following from a hospital admission from an infection Care commenced 13th October (the day of discharge) with support of 4 calls a day with the assistance of 1 carer.

Therapy attended post discharge to ascertain a therapy plan and person-centred goals. Mr H said he wanted to be supported to regain confidence in managing his own personal care, and bathing. A powered bath lift was supplied, and grabrails to give confidence. Personal care was supported by the care staff while Mr H gained improved confidence post discharge from the acute.

During Mr H recovery period his care and therapy plan were reviewed and amended as he improved. As Mr H recovery has stabilised a full care act assessment was completed on 2nd November 2023. Mr H was fully able to participate in the assessment and able to express his progress and care needs and wishes. The result was that Mr H had recovered to prehospital admission level and was now independent with his care needs and the forma package of care was able to stop, Mr H and the assessor felt that support with medication reminders would be an advantage so a referral to Telecare Services was made for pill dispenser. The outcome being that Mr H was independent and yet assured in the area of medication mitigating the need for ongoing medication monitoring calls from care staff. A very good result for Mr H. Reduction was 14 hours of care.

**Appendix 3**

Case study Mrs CE

Referral received 5th October 2023 via supported discharge from the acute setting via (Pathway 1 from the trust, which is home with a POC). This was following from a hospital admission from a longstanding medical condition. Care commenced 13th October (the day of discharge) with support of 4 calls a day with the assistance of 2 carers. (2 carers were needed due to mobility issues)

Occupation Therapy and Physiotherapy attended post discharge to ascertain a therapy plan and person-centred goals. Mrs CE said she wanted to be supported to regain confidence in going to the bathroom herself as she has done this herself prior to her hospital admission. Equipment was issued by the OT a Re-Turn (this is a piece of equipment that can be operated by 2 trained staff and Mrs CE for transfers, this is a more inclusive and mitigates the needs for hoisting)

When maximum therapy input and care staff support had stabilised a full care act assessment was undertaken. Mrs CE was fully able to participate in the assessment and able to express her progress and care needs and wishes. This assessment took place 26th October 2023. The outcome was that Mrs CE would need a long-term package of care but now with the intervention of therapy only 1 carer was needed for 30mins a call, a referral to voluntary services that offer socializing events. The care package had reduced from 28hrs per week to 3 ½ a week. Mrs CE was also delighted that she had regained her mobility and independence

**Dated 31 October 2024**

**DUDLEY METROPOLITAN BOROUGH COUNCIL**

**and**

**NHS BLACK COUNTRY INTEGRATED CARE BOARD**

# FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES UNDER THE BETTER CARE FUND

**CONTENTS**

**THIS AGREEMENT** is made on the 31 October2023

**PARTIES**

(1) **DUDLEY METROPOLITAN BOROUGH COUNCIL of** the Council House, Priory Road, Dudley. DY1 1HF

(2) **the "Council")**

(3) **NHS BLACK COUNTRY INTERGRATED CARE BOARD** of Civic Centre, St Peter's Square, Wolverhampton WV1 1RG (the "**ICB"**)

**BACKGROUND**

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the Borough of Dudley.

(B) The ICB has the responsibility for commissioning health services pursuant to the 2006 Act in the Borough of Dudley.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the ICB and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will be able to pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering into this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services and

d) support the delivery of the overall vision for the social care and health economy for Dudley of one ambition, working as one for everyone.

(G) The Partners will jointly be carrying out consultations on the services affected by proposals in this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

## 1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

**2018 Act** means the Data Protection Act 2018.

**2000 Act** means the Freedom of Information Act 2000.

**2004 Regulations** means the Environmental Information Regulations 2004.

**2006 Act** means the National Health Service Act 2006.

**Affected Partner** means, in the context of Clause 23, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event.

**Agreement** means this agreement including its Schedules and Appendices.

**Approved Expenditure** means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

**Authorised Officers** means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

**Better Care Fund** means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

**Better Care Fund Metrics** means the metrics specified in Part 1 to Schedule 9.

**Better Care Fund Plan** means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

**Better Care Pooled Fund** means the Pooled Fund as specified in Schedule 2.

**Better Care Fund Programme Director** means the member of staff appointed by the Council or jointly appointed by the Council and the ICB who is the Pooled Fund Manager;

**Care Act 2014** is the Act which places additional responsibilities upon Local Authorities to help to improve people's independence and wellbeing. It makes clear that local authorities must provide or arrange services that help prevent people developing needs for care and support or delay people deteriorating such that they would need ongoing care and support.

**ICB Statutory Duties** means the Duties of the ICB pursuant to Sections 14P to 14Z2 of the 2006 Act.

**Change in Law** means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement.

**Commencement Date** means 00:01 hrs on xxx

**Confidential Information** means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

**Contract Price** means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment.

**Default Liability** means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.

**Demographic Growth** means anticipated population changes including size, structure, and distribution

**Financial Contributions** means the financial contributions made by each Partner to the Better Care Pooled Fund for each Individual Scheme in any Financial Year.

**Financial Year** means each financial year running from 1 April in any year to 31 March in the following calendar year.

**Force Majeure Event** means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;
(b) acts of terrorism;
(c) acts of God;
(d) fire or flood
(e) industrial action;
(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;
(g) any form of contamination or virus outbreak; and
(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief.

**Functions** means the NHS Functions and the Health Related Functions.

**Health Related Functions** means health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification. This is subject to the exclusions listed in Regulation 6(a)(i) to
(vi) of the Regulations together with such exclusions and limitations as specified in the relevant Scheme Specification.

**Host Partner** means for the Better Care Pooled Fund, the Council.

**Health and Wellbeing Board** means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

**Indirect Losses** means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

**Individual Scheme** means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

**Integrated Commissioning** means arrangements by which both Partners commission Services in relation to an Individual Scheme on behalf of each other in exercise of both the NHS Functions and Council Functions through integrated structures.

**Law** means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

**Lead Commissioning Arrangements** means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

**Lead Commissioner** means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

**Local Performance Metrics** means those metrics for each scheme specified in Part 2 of Schedule 9.

**Losses** means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Loss and "Loss" shall be interpreted accordingly.

**Month** means a calendar month.

**National Conditions** mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

**NHS Functions** means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the ICB as are relevant to the commissioning of the Services and which may be further described in each Service Schedule.

**Non-Recurrent Payments** means funding provided by a Partner to the Better Care Pooled Fund in in respect of an Individual Scheme in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 9.4.

**Overspend** means any expenditure from the Better Care Pooled Fund in a Financial Year for any Individual Scheme which exceeds the Financial Contributions to the Better Care Pooled Fund for that Individual Scheme for that Financial Year save where such overspend results from Payment for Performance Fund payments not being available to the Better Care Pooled Fund.

**Partner** means each of the ICB and the Council, and references to "**Partners**" shall be construed accordingly.

**Partnership Board** means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 3;

**Pay for Performance Fund** means the ring-fenced element of the Better Care Fund Pooled Fund as specified in Schedule 2, paragraph 3 and Schedule 4 which shall be used for the purposes set out in Schedule 2, paragraph 3 and Schedule 4.

**Performance Measures** means the Better Care Fund Metrics and the Local Performance Metrics.

**Performance Payment Arrangement** means any arrangement agreed with a Provider and one or more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

**Performance Payments** means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

**Permitted Budget** means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

**Permitted Expenditure** has the meaning given in Clause 7.3.

**Personal Data** means Personal Data as defined by the 1998 Act.

**Pooled Fund** means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations.

**Pooled Fund Manager** means such officer of the Host Partner which includes a Section 113 Officer for the Better Care Pooled Fund as is nominated by the Host Partner from time to time to manage the Better Care Pooled Fund in accordance with Clause 7.6.4.

**Provider** means a provider of any Services commissioned under the arrangements set out in this Agreement.

**Public Health England** means the SOSH trading as Public Health England.

**Quarter** means each of the following periods in

a Financial Year: 1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March“

and "**Quarterly**" shall be interpreted accordingly.

**Regulations** means the means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

**Ring Fenced Capital Grants** means one or more of the grants specified at Schedule 2.

**Scheme Specification** means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement which shall, in all cases be agreed prior to any such scheme becoming operative.

**Sensitive Personal Data** means Sensitive Personal Data as defined in the 2018 Act.

**Services** means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

**Services Contract** means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

**Service Users** means those individuals for whom the Partners have a responsibility to commission the Services.

**SOSH** means the Secretary of State for Health and Social Care..

**Third Party Costs** means all such third-party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Partnership Board.

**Working Day** means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including“" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a

person includes a reference to that ’person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement,” staff“ and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

## 2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 21.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

## 3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 The Partners enter into this Agreement in order to support the delivery of the overall shared vision for the Dudley health and social care economy of one ambition, working as one for everybody.

3.4 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Specification.

## 4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Integrated Commissioning;

4.1.2 Lead Commissioning; and

4.1.3 the establishment of a Pooled Fund.

in relation to Individual Schemes“(the "Flexibilities")

4.2 The Council delegates to the ICB and the ICB agrees to exercise, on the Council’s behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The ICB delegates to the Council and the Council agrees to exercise on the ’ICB's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

## 5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners as outlined in the Better Care Fund plan agreed on an Annual basis by the Health and Wellbeing Board.

5.3 Following the agreement of the Better Care Fund Plan, the Partnership Board will develop and agree Schemes for the delivery of functions in line with the Plan. The Specification for each Individual Scheme shall be in the form set out in Schedule 1.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Partnership Board

## 6 COMMISSIONING ARRANGEMENTS

Integrated Commissioning

6.1 Where there are Integrated Commissioning arrangements in respect of an Individual Scheme, both Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Health Related Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall be responsible for compliance with and making payments of all sums due to a Provider pursuant to the terms of each Service Contract.

6.3 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.4 Each Partner shall keep the other Partners and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in respect of any Individual Scheme in the Better Care Pooled Fund.

6.5 The Partnership Board will report back to the Health and Wellbeing Board

as required by its Terms of Reference.

Appointment of a Lead Commissioner

6.6 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall:

6.6.1 exercise the NHS Functions in conjunction with the Health Related Functions as identified in the relevant Scheme Specification;

6.6.2 endeavour to ensure that the NHS Functions and the Health Related Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.6.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.6.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.6.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.6.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the "Commissioner" and "Co-ordinating Commissioner" with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.6.7 undertake performance management and contract monitoring of all Service Contracts, reporting on performance by exception to the Partnership Board;

6.6.8 in consultation with the programme director, undertaking any enforcement action pursuant to any Services Contract;

6.6.9 make payment of all sums due to a Provider pursuant to the terms of any Services Contract;

6.6.10 keep the other Partner and the Partnership Board regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend for any Individual Scheme in the Better Care Pooled Fund.

6.6.11 notify the other Partners if it receives or serves:

(i) a Change in Control Notice.

(ii) a Notice of an Event of Force Majeure.

(iii) a Contract Query.

(iv) Exception

Reports and provide

copies of the same.

6.6.12 provide the other Partners with copies of any and all:

(i) CQUIN Performance Reports.

(ii) Monthly Activity Reports.

(iii) Review Records; and

(iv) Remedial Action Plans.

(v) JI Reports.

(vi) Service Quality Performance Report;

6.6.13 shall consult with the other Partners before attending:

(i) an Activity Management Meeting.

(ii) Contract Management Meeting.

(iii) Review Meeting.

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

6.6.14 shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6.6.15 shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

6.6.16 shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports

6.7 The Lead Commissioner shall not:

6.7.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions.

6.7.2 vary any Provider Plans (excluding Remedial Action Plans).

6.7.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan.

6.7.4 give any approvals under the Service Contract.

6.7.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices).

6.7.6 suspend all or part of the Services.

6.7.7 serve any notice to terminate the Service Contract (in whole or in part).

6.7.8 serve any notice.

6.7.9 agree (or vary) the terms of a Succession Plan.

without the prior approval of the other Partners (acting through the Partnership Board) such approval not to be unreasonably withheld or delayed.

6.8 Each Partner shall (at its own cost) provide such cooperation, assistance, and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

6.8.1 resolve disputes pursuant to a Service Contract.

6.8.2 comply with its obligations pursuant to a Service Contract and this Agreement.

6.8.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract.

6.9 No Partner shall unreasonably withhold, or delay consent requested by the Lead Commissioner.

6.10 Each Partner (other than the Lead Commissioner) shall:

6.10.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners.

6.10.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

## 7 ESTABLISHMENT OF A POOLED FUND

7.1 In the exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain the Better Care Pooled Fund for revenue expenditure as set out in the Scheme Specifications.

7.2 The Better Care Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in the Better Care Pooled Fund may only be expended on the following:

7.3.1 the Contract Price.

7.3.2 where the Council is to be the Provider, the Permitted Budget.

7.3.3 Performance Payments.

7.3.4 Third Party Costs.

7.3.5 Approved Expenditure

*("Permitted Expenditure")*

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Better Care Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for the Better Care Pooled Fund. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Better Care Pooled Fund on behalf of itself and the other Partners.

7.6.2 providing the financial administrative systems for the Better Care Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager.

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

## 8 POOLED FUND MANAGEMENT

8.1 The Pooled Fund Manager in respect of the Better Care Pooled Fund shall have the following duties and responsibilities:

8.1.1 the day-to-day operation and management of the Better Care Pooled Fund;

8.1.2 ensuring that all expenditure from the Better Care Pooled Fund is in accordance with the provisions of this Agreement and the Scheme Specifications.

8.1.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Better Care Pooled Fund.

8.1.4 ensuring that full and proper records for accounting purposes are kept in respect of the Better Care Pooled Fund.

8.1.5 reporting to the Partnership Board as required by the Partnership Board and the relevant Scheme Specification;

8.1.6 ensuring action is taken to manage any projected under or overspends relating to any Individual Scheme within the Better Care Pooled Fund in accordance with this Agreement.

8.1.7 preparing and submitting to the Partnership Board Quarterly reports (or more frequent reports if required by the Partnership Board) and an annual return about the income and expenditure from the Better Care Pooled Fund for all Individual Schemes and the Better Care Pooled Fund together with such other information

as may be required by the Partners and the Partnership Board to monitor the effectiveness of the Better Care Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met; and

8.1.8 preparing and submitting reports to the individual partners or the Health and Wellbeing Board as required by them.

8.2 In carrying out their responsibilities as provided under Clause 8.1 the Pooled Fund Manager shall have regard to the recommendations of the Partnership Board and shall be accountable to the Partners.

8.3 Save where otherwise agreed by the Partnership Board, there shall be no vireing of funds between Individual Schemes within the Better Care Pooled Fund.

## 9 FINANCIAL CONTRIBUTIONS

9.1 The Financial Contribution of the ICB and the Council to the Better Care Pooled Fund will be set out in the Better Care Fund Plan.

9.2 The Pooled Fund Manager will be responsible for making proposals to the Partnership Board future years' Better Care Fund Plan to determine the Financial Contribution of the ICB and the Council to the Better Care Pooled Fund.

9.3 Financial Contributions will be paid as set out in Schedule 2.

9.4 With the exception of Clause 12, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Better Care Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in the Partnership Board minutes and recorded in the budget statement as a separate item.

## 10 NON FINANCIAL CONTRIBUTIONS

10.1 The non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Better Care Pooled Fund) will be set out in a separate agreement between the ICB and the Council to support wider integration across the Health and Social Care economy in Dudley.

## 11 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

### Risk share arrangements

11.1 The Partners have agreed risk share arrangements as set out in Schedule 4, which provide for financial risks arising within the commissioning of services from the Better Care Pooled Fund.

### Overspends in Pooled Fund

11.2 Subject to Clause 11.1, the relevant Partner for the Better Care Pooled Fund shall manage expenditure from the Better Care Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

11.3 The relevant Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from the Better Care Pooled Fund has been in accordance with Permitted Expenditure and it has informed the Partnership Board in accordance with Clause 11.4.

11.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Partnership Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 4 shall apply.

### Underspend

11.5 In the event that expenditure from the Better Care Pooled Fund for any Individual Scheme for which Financial Contributions within the Better Care Pooled Fund are made in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

## 12 CAPITAL EXPENDITURE

12.1 The Better Care Pooled Fund shall not (subject to any Ring Fenced Capital Grant) normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be

agreed by the Partners.

## 13 VAT

13.1 The Partners shall agree the treatment of the Better Care Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

13.2 Subject to Clause 13.1, Services commissioned by the Council will be subject to the VAT regime of the Council and Services commissioned by the ICB will be subject to the VAT regime of the National Health Service.

## 14 AUDIT AND RIGHT OF ACCESS

14.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998

14.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the relevant Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

14.3 The Partners shall comply with relevant NHS finance and accounting obligations as required by relevant Law and/or National Guidance

## 15 LIABILITIES AND INSURANCE AND INDEMNITY

15.1 Subject to Clause 15.2, and 15.3, if a Partner (“First Partner”) incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner (“Other Partner”) which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

15.2 Clause 15.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other

Partner acting in accordance with the instructions or requests of the First Partner or the Partnership Board.

15.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 13.4 the Partner that may claim against the other indemnifying Partner will:

15.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

15.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

15.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

15.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

15.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

## 16 STANDARDS OF CONDUCT AND SERVICE

16.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

16.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Better Care Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

16.3 The ICB is subject to the ICB Statutory Duties and these incorporate both a duty to act effectively, efficiently and economically and duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Better Care Pooled Fund is therefore subject to ensuring compliance with the ICB Statutory Duties and clinical governance obligations.

16.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

## 17 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in Schedule 5.

## 18 GOVERNANCE

18.1 Overall strategic oversight of partnership working across the health and social care economy is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

18.2 The Partners have established the Partnership Board to oversee the delivery of the Individual Schemes and Better Care Pooled Fund and their associated action plans and performance monitoring arrangements in accordance with the Better Care Fund Plan, this Agreement and any requirements of the Health and Wellbeing Board.

18.3 The Partnership Board is based on a joint working group structure. Each member of the Partnership Board shall be an officer of one of the Partners and will have responsibility to make decisions in accordance with the Governance arrangements of each Partner which enable the Partnership Board to carry out its objects, roles, duties and functions as set out in this Clause 18 and Schedule 3.

18.4 The terms of reference of the Partnership Board shall be as set out in Schedule 3.

18.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

18.6 The Partnership Board shall be responsible for the overall approval of the Individual Schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

18.7 Each Scheme's Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Service is reported to the Partnership Board and Health and Wellbeing Board.

## 19 REVIEW

19.1 Save where the Partnership Board agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement of the Better Care Pooled Fund or the Individual Schemes the subject of the Better Care Fund Plan and the provision of the Services within 3 Months of the end of each Financial Year.

19.2 Subject to any variations to this process required by the Partnership Board, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 3.

19.3 The Partnership Board shall within 20 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 19. A copy of this report shall be provided to both Partners and the Health and Wellbeing Board.

19.4 In the event that the Partners fail to meet either the requirements of the Better Care Fund Plan or any other relevant statutory requirement the Partners shall provide full co-operation with any regulatory bodies (including NHS England) to agree a recovery plan.

## 20 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

## 21 TERMINATION & DEFAULT

21.1 Subject to the statutory requirements of the Better Care Fund, this Agreement may be terminated by either Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes which are operational at the date of such notice being given.

21.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

21.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partners (acting jointly) may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partners may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 22.

21.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners' rights in respect of any antecedent breach and any terms of this Agreement that expressly or by implication survive termination of this Agreement.

21.5 Upon termination of this Agreement for any reason whatsoever the following shall apply:

21.5.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

21.5.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

21.5.3 where either Partner has entered into a Service Contract such Partner shall use all reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place that Partner in breach of the Service Contract) where the other Partner requests the same in writing provided that the Partner that has entered into such Service Contract shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

21.5.4 where a Service Contract held by either Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Partner holding the Service Contract assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

21.5.5 the Partnership Board shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

21.5.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

21.6 In the event of termination in relation to an Individual Scheme the provisions of Clause 21.5 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

## 22 DISPUTE RESOLUTION

22.1 The Partnership Board shall, in the first instance, operate as the forum for discussion of issues relating to this Agreement. This shall be based on the outlined principles of openness and treating Partners with equal esteem to resolve, as far as possible, any issues in a collective, consensual manner.

22.2 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

22.3 The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 22.1, at a meeting convened for the purpose of resolving the dispute.

22.4 If the dispute remains after the meeting detailed in Clause 22.3 has taken place, the Partners' respective chief executive and accountable officer or nominees shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

22.5 If the dispute remains after the meeting detailed in Clause 22.4 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a

mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

22.6 Nothing in the procedure set out in this Clause 22 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

## 23 FORCE MAJEURE

23.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs, and it is prevented from carrying out its obligations by that Force Majeure Event.

23.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

23.3 As soon as practicable, following notification as detailed in Clause 23.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 23.4, facilitate the continued performance of the Agreement.

23.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

## 24 CONFIDENTIALITY

24.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 24, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

24.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

24.1.2 the provisions of this Clause 24 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

24.2 Nothing in this Clause 24 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

24.3 Each Partner:

24.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees and advisors to carry out their duties under the Agreement;

24.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 24.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 24; and

24.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

## 25 FREEDOM OF INFORMATION AND ENVIRONMENTAL INFORMATION REGULATIONS

25.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

25.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 25 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

## 26 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

## 27 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in Schedule 6, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 2018 Act**.**

## 28 NOTICES

28.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 28.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

28.1.1 personally delivered, at the time of delivery;

28.1.2 posted, at the expiration of forty-eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

28.1.3 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the

recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

28.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

28.3 The address for service of notices as referred to in Clause 28 shall be as follows unless otherwise notified to the other Partner in writing:

28.3.1 if to the Council, addressed to the Director of Adult Services:

28.3.2

Tel: 01384 815805

E.Mail: Matt.Bowsher@dudley.gov.uk

and

28.3.3 if to the ICB, addressed to The Dudley Managing Director.

Tel: 01384 3219251.

E.Mail: neill.bucktin@nhs.net

## 29 VARIATION

29.1 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

29.2 The members of the Partnership Board shall have delegated authority from their respective organisations to agree the addition of schemes to the agreement following consideration of a detailed business case at a Partnership Board meeting.

29.3 Any other variation to the agreement, including any proposed variation following a review under the terms of Clause 19, will be subject to signed agreement from each of the Partners.

## 30 CHANGE IN LAW

30.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

30.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

30.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 22 (Dispute Resolution) shall apply.

## 31 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

## 32 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

## 33 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub-contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

## 34 EXCLUSION OF PARTNERSHIP AND AGENCY

34.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

34.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither

Partner will have authority to, or hold itself out as having authority to:

34.2.1 act as an agent of the other;

34.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

34.2.3 bind the other in any way.

## 35 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

## 36 ENTIRE AGREEMENT

36.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

36.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

## 37 COUNTERPARTS

37.1 This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

## 38 GOVERNING LAW AND JURISDICTION

38.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

38.2 Subject to Clause 22 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or

claims).

**IN WITNESS WHEREOF** this Agreement has been executed by the Partners on the date of this Agreement

Signed for and on behalf of
**DUDLEY METROPOLITAN BOROUGH COUNCIL** by:

_____

Authorised Officer

_____

Name

_____

Position

Signed for on behalf of **NHS BLACK COUNTRY INTEGRATED CARE BOARD** by:

_____

Authorised Signatory

_____

Name

_____

Position

## SCHEDULE 1 –SCHEME SPECIFICATIONS

The Schemes that are subject to this Agreement are as described in the Better Care Fund Plan as approved by the Dudley Health and Wellbeing Board.

The elements of the BCF Plan are set out below:-

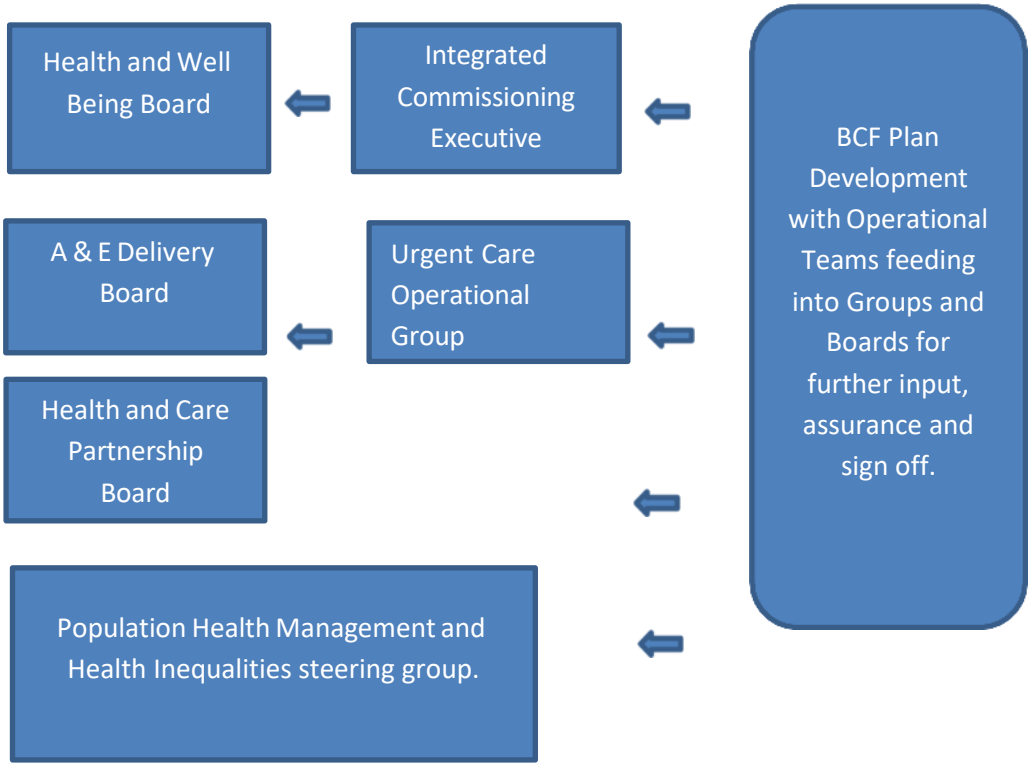
### BCF Narrative Plan Template 23-25

### Health and Wellbeing Board(s): Dudley

### Governance

The assurance and decision-making process for the implementation and continuation of the BCF is the responsibility of the Integrated Commissioning Executive, established through a Section 75 Agreement between Black Country Integrated Care Board and Dudley Metropolitan Borough Council.

Consultation on the plan has been undertaken through an iterative process with Dudley A and E Delivery Board, the Urgent Care Operational Group, and Dudley Health and Care Partnership Board prior to approval by the Health and Well Being Board. A timeline of these meetings can be found in Appendix 1 (page 25). All stakeholders are represented on these boards, including Local authority, voluntary sector organisations, housing, mental health organisations. All partners have had an opportunity to comment and inform the plan. The plan has been collectively agreed with all partners through the process described. Diagrammatically this is shown below:




At the beginning of 2023, a programme commenced to review the existing lines of the BCF plan with all stakeholders to inform the 2023/25 programme. For 2023/25, there will be enhanced robust monitoring of the plan throughout the year with areas for further review identified. Evaluations and progress will be governed through the Integrated Commissioning Executive and shared with other stakeholder forums. The development of a revised joint reporting framework is underway which is due to be implemented in July 2023.

## Executive summary

Our joint priorities for 2023/25 are: -

- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service
- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embedding the palliative care strategy and its recommendations,

alongside the development of a more integrated palliative care team.

- Further developing our Community Partnership Teams
- Exploring opportunities to merge pathways 2 and & 3 to create flexibility around resource and provision.
- Exploring further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in 2023.

Review of 2022/2023 programme

A light touch evaluation took place against the priorities within the 2022/23 plan. The outcome was that most of the investment areas were key in delivering the objectives laid down in the Better Care Fund Guidance, however it identified four areas of opportunity for efficiencies and transformation. An overarching review with comments against all schemes can be found in Appendix 2 (page 26). The review identified four areas for further transformation work to be undertaken during the next 2 years, as shown in Appendix 3: (page 31) -

- Transform palliative care services to ensure a truly integrated team across Health and Social care.
- Review of the existing Discharge to Assess Pathways to ensure that these are integrated and represent value for money, to provide D2A/reablement pathways that are the most cost effective and responsive to ensure flow through the urgent care system.
- Review medical cover within the plan for reablement services, particularly those whose function has changed post covid.
- Align rehabilitation investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere.

As we progress through the identified areas of transformation, we intend to make appropriate changes to our existing BCF Plan. This is to ensure delivery of tangible impacts in line with the vision and objectives set out int the Policy Framework.

The ICB commissioned a review of Discharge to Assess pathways in 2022, and the outcomes from this review will also inform changes to the BCF Plan over the next 12 months. Further areas have also been aligned to the Better Care Fund Plan for 2023/25 where they meet the criteria, these are: -

- Dudley Clinical Hub: This provides an admission avoidance function.
- Handyman investment: To support quick and efficient discharge for those people. with housing issues where a simple intervention can reduce delays.
- Further investment into Discharge to Assess pathways bringing schemes together to ensure the most effective use of resources.

The Adult Social Care Discharge Fund for 2023/25 will continue to enhance current schemes within the existing BCF Plan, notably provision around Pathways 1, 2 and 3. All partners have agreed to the allocation of funding.

## Dudley Insights

The information below provides an insight into the activity in the Dudley urgent and emergency care system. The data shows that there are significant peaks and troughs in activity and performance in Dudley and winter 2022/23 was particularly challenging.

Figure 1: ED attendances Type 1 at Dudley Group NHS Foundation Trust (DGFT).

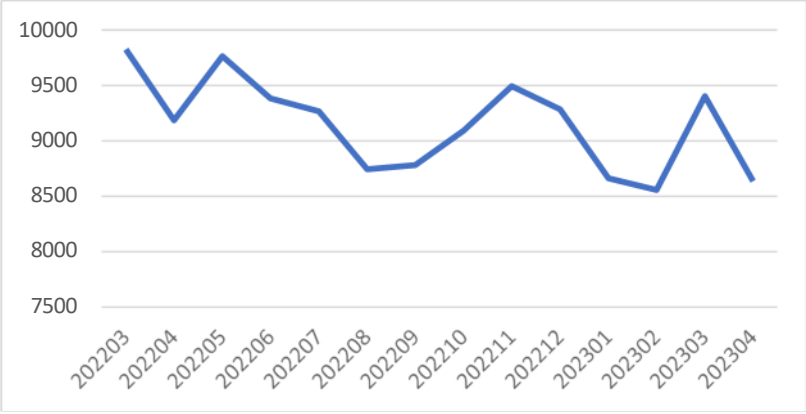



Figure 1 shows that over the last 12months we have seen a general reduction in the number of type 1 attendances at DGFT. We have not had a return to the peak in attendances we saw in March 2022.

Figure 2: Emergency admissions

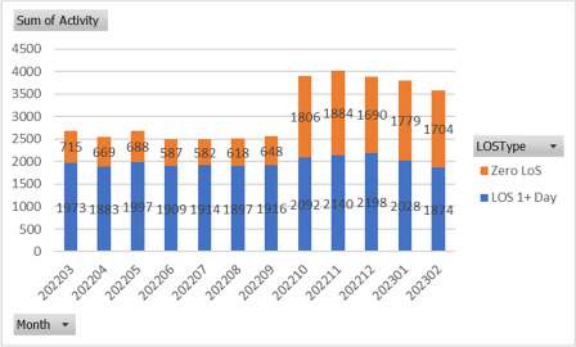
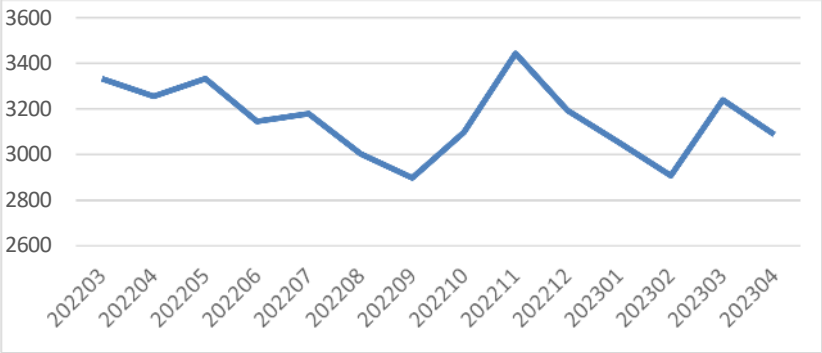



Figure 2 shows a change in activity around September/October of 2022. However, during this period DGFT changed the way Same Day Emergency Care (SDEC) activity was recorded and this is now coded as an emergency admission. The admissions have stayed relatively stable during this period.

Figure 3: Conveyances to DGFT




The admission avoidance activity has increased, and this may be why figure 3 shows a general reduction in ambulance conveyances during the previous 12 months despite the obvious peak during October – December 2022.

Figure 4: Care Home admissions:

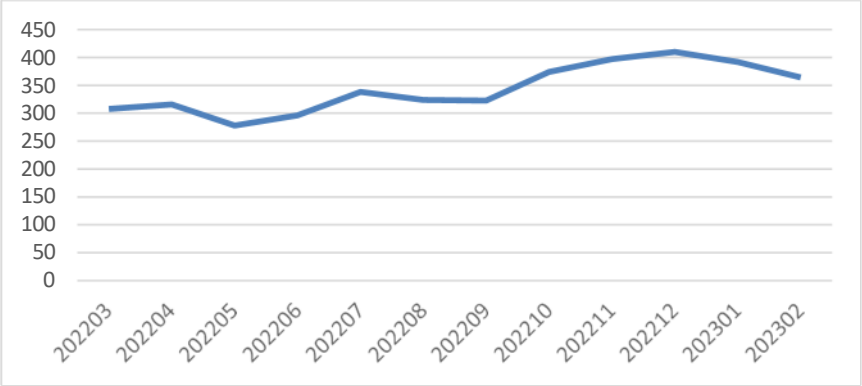


Figure 4 shows that despite an apparent reduction in the curve during recent months, care home admissions are still higher than they were in the same period last year. There is a focused piece of work with care homes working with staff on falls prevention and using appropriate admission avoidance interventions and we hope this will have a significant impact on care home admissions.

Figure 5: System wide A & E type 1 performance.

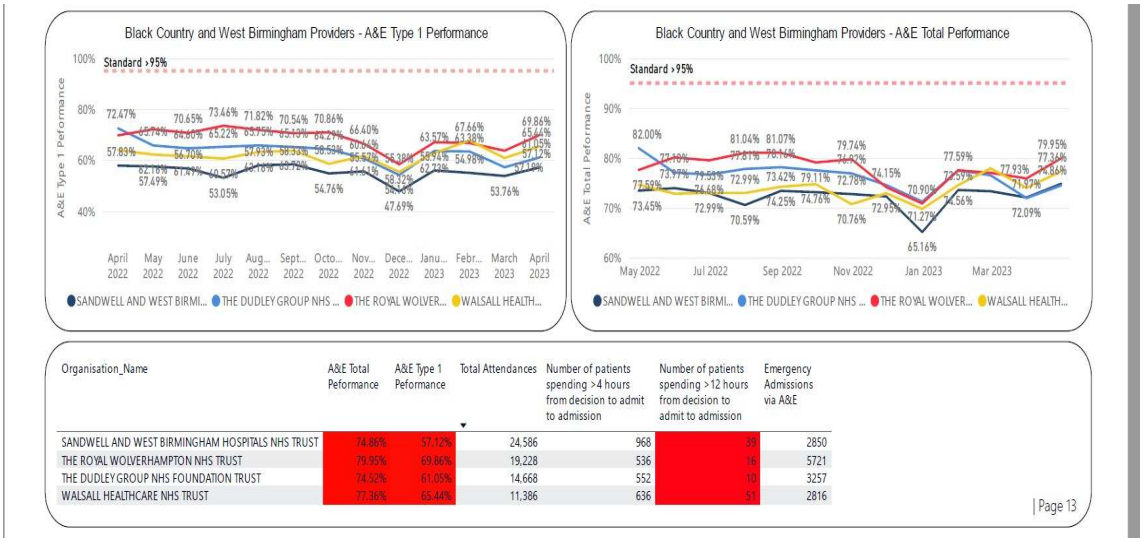



Figure 5 shows that Dudley's activity is about average compared to neighbouring places and operates along the same trajectory of demand.

Our current challenges in Dudley are: -

- Too many community beds within Dudley place.
- People within a community bed having a length of stay beyond national guidance.
- Lack of specialist neuro-rehabilitation capacity
- Lack of Pathway 1 domiciliary care capacity.
- People being conveyed to hospital that could be managed through admission avoidance teams.
- Lack of pathway capacity to ensure consistent and smooth flow from an acute bed.

This BCF Plan is intended to respond to these challenges.

## National Condition 1:

### Overall BCF plan and approach to integration

This plan is designed to support the Dudley health and care system through: _

- Preventing inappropriate admission to hospital, residential or nursing care
- Supporting timely discharge from hospital
- Enabling people to live independent lives in supportive and resilient local communities.
- Reducing wider inequalities by enabling appropriate access to services and embedding preventative measures

Our approach to commissioning is led by the Integrated Commissioning Executive, established under the provisions of a Section 75 Agreement which governs the operation of the Better Care Fund. There is no set approach to joint commissioning, rather a set of approaches based upon what is required to address an issue – singular commissioning by either partner, aligned commissioning where each partner is responsible for their element, joint commissioning where resources are brought together to deliver a joint response.

During the period of our 2022/23 BCF Plan, a number of factors have informed our approach to the 2023/25 BCF Plan: -

- A review of our Discharge to Assess Pathways by an external organisation with a set of recommendations.
- The advent of the Adult Social Care Discharge Fund
- Lessons learned from the winter of 2022/23
- A review of existing BCF schemes

As a result of these specific changes and the challenges we have faced, our priorities for 2023/25 are as follows: -

- Further developing our Community Partnership Teams
- Embedding our Clinical Hub as an alternative to 999 and ambulance conveyance through increasing referrals from GPs, care homes and the West Midlands Ambulance Service
- Further developing the role of Virtual Wards
- Re-commissioning the Enhanced Health in Care Homes Scheme
- Further development of the Reablement Service

- Enhancing the management of our D 2 A pathways, ensuring there is an appropriate level of capacity to meet demand, supported by timely flow through the system.
- Develop a more robust integrated discharge Hub and smoother transition through pathways.
- Embed the palliative care strategy and its recommendations, alongside development of a more integrated palliative care team.
- Explore opportunities to merge pathways 2 and 3 to create flexibility around resource and provision.
- Explore further opportunities to merge Pathway 1 and Own Bed Instead (OBI) provision.
- Development of the Carers' Hub working with Dudley Group NHS Foundation Trust due to open in the 2023.

The plan currently has both singular and aligned commissioned areas. Through the 23-25 planning term, we will be looking at opportunities to commission services through a joint commissioning approach, our priority area for 23-25 is palliative care.

## National Condition 2: Meeting BCF objective 1: Enabling people to stay well, safe and independent at home for longer.

Detailed below are some of the main schemes in our approach in Dudley to 'Enabling people to stay well, safe and independent at home for longer.'

Community Partnership Teams

Our Community Partnership Teams are at the heart of our approach to support people at home within supportive local communities. They operate within our six PCNs and bring together clinical and operational staff across primary and community care to wrap higher quality care and services around patients nearer their homes. These teams bring together Community Nursing (District and Long-Term Condition Nurses), Social Care, Voluntary Sector Social Prescribers, Mental Health Nurses as well as the GP Practice and wider PCN workforce, to have a weekly focused discussion around our most complex and vulnerable patients in our community. In the last 10 months a transformation programme has further developed these teams which fundamentally underpin the Integrated Model of Care within Dudley. This has included standardised and dedicated leadership, development of clear metrics and outcomes and the embedding of care co-ordination across primary and secondary care. Currently these teams focus on people with complex comorbidities and frailty, as well as palliative care and complex mental health patients on a monthly basis. We are also expanding the model to have a focus on complex respiratory and diabetes cases. The plan will have strong links with the virtual ward programme as part of the step up/step down pathways of care for frailty, heart failure, respiratory palliative care and care home patients. The Intermediate Care/NHS Continuing Healthcare teams have been further embedded into these Community Partnership Teams to maximise support/rehabilitation to patients within their own home, facilitate timely discharge and support the wider MDTs.

Admission Avoidance

The Clinical Hub provides Dudley with its admission avoidance function through a single point of contact. This service provides the 2-hour community response service triage through to Same Day Emergency Care

(SDEC), hospital avoidance to both care homes and people in their own homes, care home educational service and the falls response service. They receive referrals from all stakeholders including primary care, care homes, GPs, social care, and ambulance service. The Urgent Community Response Service (UCR) operates seven days a week 8am-9pm, and the Care Home Educational Team operates 9am-5pm five days a week.Activity has significantly increased over the latter part of the period. All GP referrals for medical admissions where possible come though this service so that admission avoidance interventions can be put in place if safe to do so.

Figure 6: 2-hour Community Response Activity

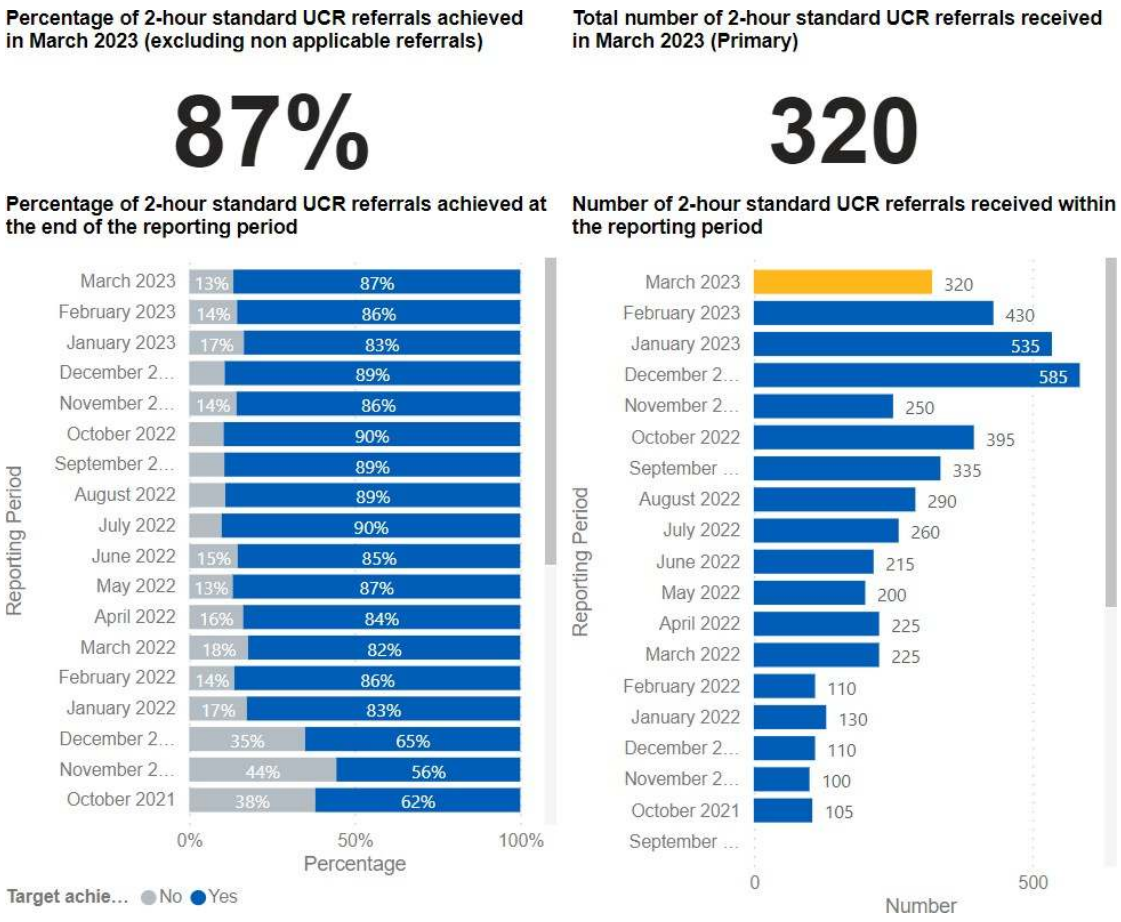



Figure 6 shows that the activity for 2 hour community response has increased over the last 12 months. We will contine to work with the Clinical Hub to ensure that the admisiosn avoidance function is maximised.

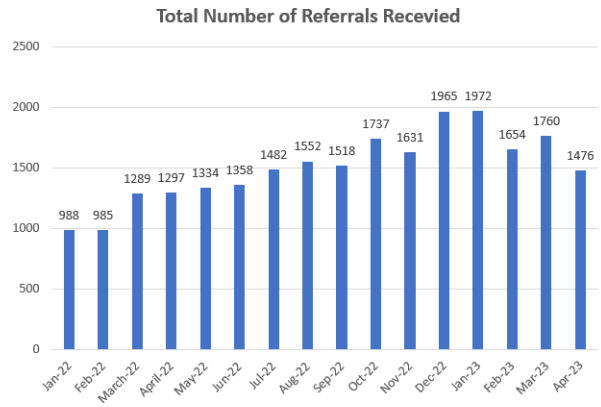
Education and oversight provision is provided for care homes by the Educational Care Home Team, focusing on 21 care homes identified as most in need. This supports care homes to ensure that a patient is not conveyed to

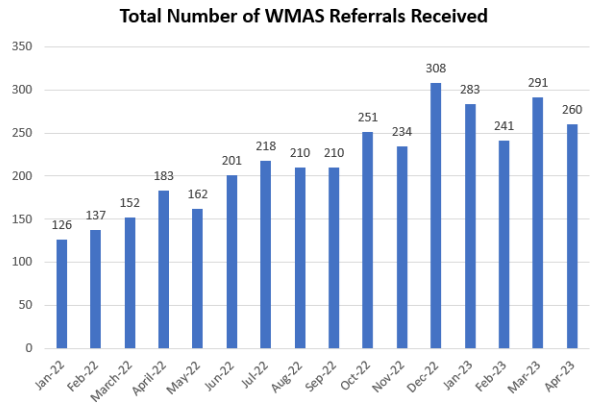
hospital unnecessarily and ensures that there is good quality of care delivered within care homes. The Clinical Hub also supports the ongoing Covid – 19 vaccination programme in care homes, and end of life provision. If necessary, the Clinical Hub, will provide carers over night to ensure that people can be cared for within their own environment rather than being admitted to hospital.

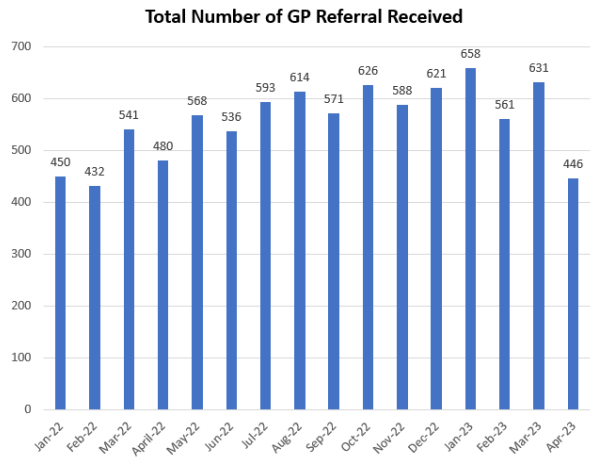
The Falls Service provides a same day response and is available to all care homes within Dudley. The teamwork with care homes and their residents to respond to the fall but also by providing interventions to prevent future falls. This team has only recently been set up but early data shows that they are reducing ED attendances for this cohort of people by 90%.

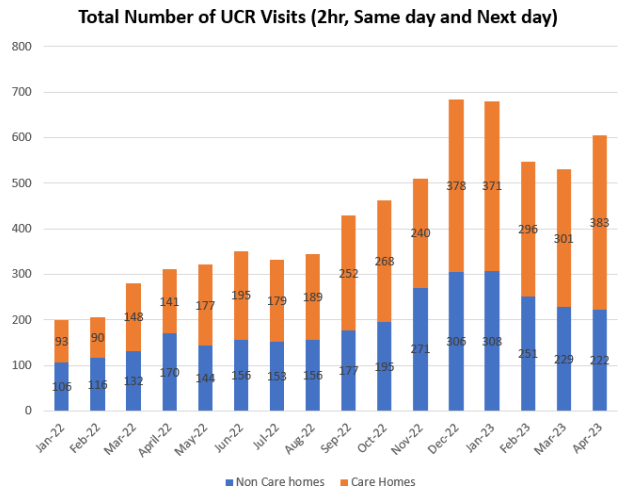
The Hub provides advice, guidance, and treatment around the 9 Core clinical pathways of the Enhanced Health and Care Home model, working in collaboration with the Care Home Education Team.

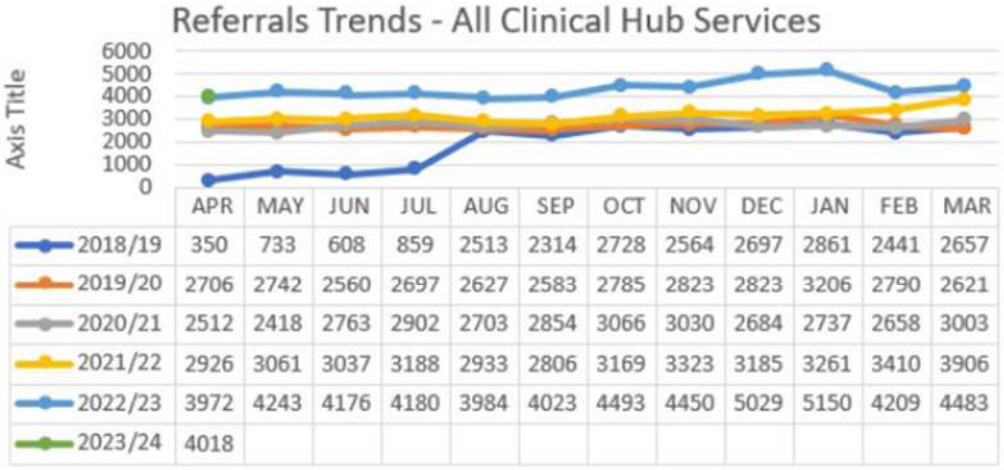
Figure 7 Clinical HUB activity from January 2022 – April 2023: again, showing the general increase in activity over the last 12 months.






| | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2018/19 | 350 | 733 | 608 | 859 | 2513 | 2314 | 2728 | 2564 | 2697 | 2861 | 2441 | 2657 |
| 2019/20 | 2706 | 2742 | 2560 | 2697 | 2627 | 2583 | 2785 | 2823 | 2823 | 3206 | 2790 | 2621 |
| 2020/21 | 2512 | 2418 | 2763 | 2902 | 2703 | 2854 | 3066 | 3030 | 2684 | 2737 | 2658 | 3003 |
| 2021/22 | 2926 | 3061 | 3037 | 3188 | 2933 | 2806 | 3169 | 3323 | 3185 | 3261 | 3410 | 3906 |
| 2022/23 | 3972 | 4243 | 4176 | 4180 | 3984 | 4023 | 4493 | 4450 | 5029 | 5150 | 4209 | 4483 |
| 2023/24 | 4018 | | | | | | | | | | | |

*Produced by: Community Informatics*

Admission avoidance functions within the social care community teams offer either step-up facilities or emergency care within a person's own home. Health and social care teams work in collaboration to ensure the person can access the right care at the right time with wrap around support. Where a step-up bed is required, the teams provide the appropriate intervention and support to secure timely discharge back into the community. The hospital avoidance function provides preventative care in the community, signposting is given on direct payments, interventions for falls prevention, administering of personal budgets and health and wellbeing interventions. Reablement is provided by Therapy Services to maximise a person's potential and ensure that desired outcomes are achieved.

Virtual Wards

Dudley Group NHS Foundation Trust lead on the virtual ward programme providing eight virtual wards. The most successful programmes have been respiratory and paediatrics and there is further work required around frailty, and how this links in with the admission avoidance function. The priority so far has been in discharging people from an acute bed to a virtual ward programme, but during the next period the admission avoidance function will be enhanced, so people can be maintained at home, within a virtual ward without entering an acute hospital bed.

Single handed Care

During 2022/23 we piloted a programme of ‘single handed care equipment’. This enabled a reduction in the number of carers required to keep people at home and prevent an admission but also facilitated discharge using fewer carers, hence ensuring the capacity of carers was greater. The programme involved training all staff in the use of single-handed equipment, both hospital staff and private providers, as well as a joint commitment to ensuring this is the default pathway for those people whose needs can be met using this system. Delivery of the equipment can be done at short notice and operates 7 days a week to support admission avoidance and hospital discharge.

Palliative Care Strategy

A palliative care strategy has recently been approved by the Health and Care Partnership Board which commits to developing a system wide approach so that citizens who are in the last stages of their life receive the care they need to preserve their integrity and wellbeing and are as comfortable as possible in the place of their choosing. Providing personalised care planning, shared records and involving the carer in all aspects of care when appropriate. The strategy will be embedded into all discharge plans to ensure that the ambitions of the plan are achieved.  Palliative care will be an area we hope to transform within the plan to provide joint a joint commissioned approach as opposed to the current aligned approach through the delivery of a new palliative care service.

Housing Adaptions

The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering Disabled Facilities Grants (DFGs) funded by the BCF, and public sector adaptations funded by the Council’s Housing Revenue Account (HRA). The Home Improvement Team have strong links with both the Council’s Adult Social Care team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre- vetted and approved contractors as part of a framework delivery. A handyman programme supports both admission avoidance and discharge, this can be something simple such as lock

changing, or furniture movement to something which requires a more substantial adaption or intervention.

We have positive relationships with our housing colleagues, and we are working together on homeless discharge pathways. We have regular meetings, with an upcoming focus on identifying patients with any housing issues at the point of admission and there is ongoing work on enhancing the transfer of care document to reflect those with specialist housing needs.

Demand and Capacity

Demand and capacity issues during the last term have been challenging due to several reasons including:

- Closure of 'block' units due to infection control issues
- Surges in referrals due to workforce issues in the local trust, such as reduced staff at weekends or due to staff sickness.
- Discharge planning issues within specialist units, such as specialist neurorehabilitation, which means length of stay is increased, which ultimately means more beds are utilised than actually needed if patients were discharged in a timely manner.
- Lack of capacity in pathways when surges occur.
- Service users having an increased length of stay in bed-based services due to lack of assessment capacity.

Some of the solutions include:

- Working with the local acute trust to have a consistent flow of referrals.
- Focused work with public health and quality teams around infection control issues and supporting homes due to infection control issues. Priority to re- opening facilities when safe to do so using a balanced approach to risk management.
- Focused work with specialist units to ensure discharge planning is proactive so no 'red' days (days without any action or progress).
- Utilisation of additional funding to procure additional social work assessment capacity in bed-based units.

More detailed information on some of the schemes is detailed below.

Pathway 2 (bedded rehabilitation) capacity and demand modelling has been embedded since the onset of the Covid pandemic and based on work completed through the National Audit for Intermediate Care. Learning from this analysis has highlighted demand trends and where increased capacity is required. Specifically, challenges arise when there are peaks in demand and where a community facility has beds closed due to, for example, infection control issues. Capacity has been used as flexibly as possible to ensure occupancy is maximised and an innovative project providing surge social work capacity funded through the Adult Social Care Discharge Fund (ASCDF) has significantly improved flow in all Discharge to Assess beds.

One area of potential unmet demand for 2023/24 is the gap in local service provision for patients requiring discharge to specialist Neuro-rehabilitation beds. To mitigate this, work is currently ongoing with system partners to develop referral pathways and improved responsiveness to decision making. A dedicated block commissioned specialist resource is being supported to ensure access and reduce delays.A further issue identified within the last 18 months activity data is the increased number of patients requiring 1:1 support from the acute setting into a Pathway 3 community bed.

Further work is being completed in this area to explore if this is a local assessment issue or a developing trend in the acuity of need. Comprehensive reviews of all patients referred with a 1:1 requirement is also being completed. The evidence and data from pathway 3 suggest a small proportion of patients once discharged from hospital and following a period of recouperation begin to improve and would benefit from rehabilitation. Linking pathway 2 and 3 units allows in this scenario rehabilitation to be delivered without moving the patients. Similarly having rehabilitation and therapy support across pathway 2 and 3 allows flexibility of the community bed base to meet surges in referrals to either pathway and deliver maintenance therapy support to those awaiting long term care assessments in pathway 3.

Pathway 1 capacity has improved during the later part of 2022/23 through ongoing work with the service providers. However, capacity does still not always meet demand. Again, this is challenging during ‘peaks,’ and capacity may be wasted when discharges are delayed due to reasons beyond Council control.

An implementation plan for a supported hospital discharge team will provide a home first approach to support patients with wrap around care and therapy support. There is ongoing work with DGFT to model the discharges that can be supported within the financial plan and ensure there are no wasted opportunities.

The demand and capacity analysis has highlighted the need to have at least between 3-5 Discharge to Assess Pathway 1 discharges every day. A priority for Pathway 1 teams in 2023/24 is to further develop links with bed-based intermediate care and community reablement/Own Bed Instead to ensure as many people can be supported in their own home as possible and improve flow through community beds.

Further work will be taking place during the next period to model a process where capacity is available to meet demand but also with partners to facilitate a system where there is a consistent flow of referrals rather than when resource is available within partner organisations.

The ongoing Discharge Funding allocated to ICBs, and Local authorities will be used to focus on the areas that have had the most demands through previous periods to ensure it has the greatest impact on delayed discharges. Plans for expenditure build on existing BCF plans and have been agreed with all partners.

**National Condition 3: Meeting BCF objective2: Provide the right care in the right place at the right time.**

We have described above our approach to admission avoidance and how our Community Partnership Teams function. This section will focus on how we deal with timely discharge and flow. Some of the areas previously discussed feature both within the admission avoidance and discharge flow plans, such as the single-handed equipment programme, the application of the palliative care strategy and housing adaptions.

In Dudley data shows that:

- There is on average about a 96% occupancy level of the acute beds.
- There are on average around 100 people at any one time who have been deemed medically fit for discharge, this includes those patients who are waiting for ward actions such as a therapy review.

- About 23% of discharges happen at weekends.
- The majority of those people on the list for meeting the criteria to be discharged are not discharged due to requiring therapy review, followed by a Pathway 1 provision and a small proportion on pathway 2.
- Those delayed on pathway 2 are mainly due to the availability of specialist neuro rehabilitation beds.

Discharge to Assess and Pathways 1,2 & 3.

The Discharge to Assess Policy is now embedded in operational teams with Home First always the starting point for conversations with patients, families, and carers around future destination. Own Bed Instead (OBI) dovetails into the discharge pathways with a commitment moving forward to integrate OBI into Pathway 1. Linking pathway 1 and 2 allows patients in community beds to be prioritised for discharge home earlier thereby improving flow in community bed capacity and ensuring people can return home as soon as possible. Where discharges do not happen and bed days are lost, we have a mechanism in place to record the reasons for this and themes and trends are used to develop a plan for improvement. For example, where one ward has a higher level of failed discharges then there is increased support to understand why, and further interventions are put in place.

There is a working group dedicated to the development of a robust Discharge to Assess programme, collaborating with all partners to ensure that bed days are used in the most effective way and that patients who are suitable enter the D2A programme.

During 2022/23, pathways 2 and 3 were used flexibly to allow for maximisation of capacity dependent on demand. This allowed flow to be maintained by changing the usage of beds in a fluid way dependent upon patient need.

Reablement programme

We have invested in a reablement programme across health and social care. This is a joint programme working across the teams to ensure that those entering pathway 1 on discharge have a robust reablement plan in place. This is a new programme and will be developed further over the coming year.

Home before Lunch

DGFT leads a ‘Home Before Lunch’ project with all partners supporting this principle. Many of the ‘failed’ discharges are due to losing daytime hours and therefore bringing even the most complex discharges out earlier in the day, allows time to facilitate smooth discharges. There is a KPI to ensure that 70% of discharges happen before lunch. On some wards this is being achieved and on other wards further work is required to improve their performance against this KPI.

System Developments

As a place we have bespoke schemes and programmes to meet the needs of our local population, however as Dudley is part of a wider Integrated Care System (ICS), we also look at opportunities to work at scale. For example, within the Black Country ICS the Adult Social Care Discharge Fund has been used to commission system wide schemes from Black Country Healthcare NHS Foundation Trust – the lead provider for mental health, learning disability and autism services. This includes providing housing support and a social prescribing service for mental health inpatients. During the next term, we will continue to look at opportunities to commission at scale where this makes sense.

Discharge HUB

There is currently a virtual Discharge HUB in Dudley with partners meeting several times during the day to discuss discharge pathways and the no criteria to reside lists, to ensure the maximum number of complex discharges are achieved. All teams use an integrated discharge database to manage discharges and ensure smooth lines of communicationwith all teams. Further work will take place during the next period to enhance how this database can accurately reflect discharge positions in real time.

In line with the NHSE targets for UEC discharge HUB developments we will continue to develop this team to ensure we are maximising its capability. A recently commissioned Integrated Brokerage Team, staffed through a collaborative model across organisations, delivers an integrated response to discharge into a bed-based service. This has functioned particularly well and allows people to naturally move from one pathway to another in a seamless manner if their needs change.

Handyman Programme

This was funded through the winter of 2022/23, and we will look to continue this programme during the next period. This was an excellent example of using a simple intervention to release acute bed days by using a personalised approach to discharge planning. For example, if a person had lost their keys, required house cleansing etc, the handyman programme was utilised to provide this personalised intervention to facilitate discharge.

High Impact Change Model

The High Impact Change Model has been reviewed for this financial year. A summary of the findings and opportunities for further development are detailed below. This table provides the key themes from the high impact assessment and identified key areas for development in the coming term. These areas focus on:

- Home for lunch.
- Development of the Integrated Discharge HUB.
- Better discharges to care homes.
- Improved BI system.
- Home First approach.

| Impact change | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| Change 1: Early discharge planning | Some wards achieving KPI of home for lunch | Bring decision making to earlier in the day. | September 2023 | Percentage increase of home for lunch |

| Impact change | Where are you now? | What do you need to do? | When will it be done by? | How will you know it has been successful? |
|---|---|---|---|---|
| Change 2: Monitoring and responding to system demand and capacity | Dudley place has a system for monitoring demand and capacity but does not align with system partners. | Further negotiation with system partners to align system and criteria for reporting. | July 2023 | All criteria across the system for reporting demand and capacity is consistent. |
| Change 3: Multi-disciplinary working | Good MDT working although further work to develop the discharge HUB | Benchmark current practice against standards and develop a plan for improvement. | Benchmarking has begun, action plan will be developed by August 2023. | Meet the UEC standards for an integrated discharge hub |
| Change 4: Home first | Dependent on ward and area of discharge, depends on home first approach. | Work with acute colleagues on messaging and upskilling discharge conversations | September 2023 | Default conversation for all discharges is 'Home first' |
| Change 5: Flexible working patterns | Flexible approach | | | |
| Change 6: Trusted assessment | In place | | | |
| Change 7: Engagement and choice | In place | | | |
| Change 8: Improved discharge to care homes | Performance is varied. | Work with acute colleagues and the care hone sector to agree what 'good' looks like. An existing work programme is in place to take this forward. | September 2023 | No incidents reported from care homes for poor discharges. |

| | | | | |
|---|---|---|---|---|
| Change 9: Housing and related services | Issues arise with complex discharges in housing related matters | Ensure housing and acute colleagues develop pathways and communication channels. This work has begun. | October 2023 | For discharges that require housing interventions to be smooth and zero 'wasted' bed days. |

How we support unpaid carers

BCF funding is used to fund the Carers Hub and Wellbeing Service. This is delivered by the Council's Carers Network Team and a commissioned provider, providing information, advice and support including peer support, welfare benefits advice and applications, young adult carers mentoring service (18 – 25), carers assessments and a preventative carer sitting service. Funding is used to ensure support is provided for the person receiving care at home. This includes support with social worker capacity to undertake Care Act compliant assessments.

The service operates from two HUBs, one in the south and one in the north of the borough.

•In 2022/23 the service engaged with approximately 3,500 carers.400 carers were referred for direct support to the Adult Carer Wellbeing Service They offer a range of services including: -

•

- Community-based delivery such as in local parks and libraries.
- Welfare benefits/allowance advice – supported new claims/appeals, raising £1,129,317.
- Peer Support – groups and activities
- Carers Rights and Awareness Sessions
- Young Adult Carer (18-25) Service.

The Hub delivered: -

- 244 Carers Assessments and 158 Carers Reviews.
- 113 Carers direct payments (via carers assessment) to support carers' health and wellbeing with a value £33,500.
- Provision of short-term preventative sitting service for carers. This service will be included as part of the commissioning of the

Adult Carers Wellbeing Service, to ensure it meets the current needs of carers.

- Support with ‘cost of living’ via Household Support Fund (HSF) payments to carers
- 1,200 carers aged 65 or above received a £150 voucher and 1,800 carers aged 18 – 64 received a £50 voucher.

Following its success, this service has extended a pilot digital carers service. The digital support targets the wider carer community who may not wish to access direct support from the Hub or need support outside of normal working hours. This includes information, advice, virtual chat, and peer group meetings.

Since the start of the pilot the service has achieved 19,751 hits to its website with 67% of this outside of normal working hours, ensuring support is available 24/7. In addition, it has engaged 2,306 carers and directly supported 641 carers.

Based on the success of the pilot, we plan to include a ‘digital offer’ within the next Carers Wellbeing Service tender. We are also continuing to work with ADASS Regional Carers to look at a possible regional digital offer for carers.

We are continuing to work with DGFT to establish a jointly funded Carers Information Hub within the hospital, to identify and support local carers. It is anticipated that this will open in summer 2023.
The Careers Strategy and Action Plan is currently being reviewed and refreshed, consultation and engagement with local carer organisations and groups has taken place with feedback now informing key priorities for the next strategy (2023 – 2026).

Following a review of the service and consultation with carers, the Adult and Young Carers Wellbeing Service will be recommissioned with services to commence from Autumn 2023.

## Disabled Facilities Grant (DFG) and wider services

Dudley Council has a published its commitment to deliver DFGs for its residents. The Council has its own in-house Home Improvement Team that provide a cross tenure approach to delivering DFGs funded by the BCF, and public sector adaptations funded by the Council's Housing Revenue Account (HRA). The Home Improvement Team has strong links with both the Council's Adult Social Care Team and Housing Occupational Therapy (for HRA funded adaptations) who work together to review and develop a seamless DFG service for residents, from assessment, through to referral, means testing, grant administration and delivery of works to site through a range of pre-vetted and approved contractors.

There is a joint Housing, Communities and Social Care Action Plan, currently under review, to monitor and improve the service provided, with a particular focus on waiting times.
There is a current Council policy for DFGs, which provides for discretion in awarding grants, incorporated into the latest Housing Assistance and Guidance Policy.

A revised Housing Assistance and Guidance Policy has now been approved following the publication of the Disabled Facilities Grant (DFG): Guidance for Local Authorities in England to ensure that the Council continues the work that has already been undertaken to develop a service to ensure flexibility of grant delivery that enables people to stay well, safe, and independent at home for longer.

Flexible use of resource has already enabled a less bureaucratic means test of resources and assisted in providing minor adaptations, hoisting equipment, and helping people to re- locate to more adaptable homes. For example, we have invested:

- £695,000 towards additional Community Equipment Service equipment for prescribers across the health and care economy to support people to maximise their independence, including bathing equipment, specialist chairs, mobility aids and hoists.

- £47,000 towards the Handyman Service for the capital expenditure on key safes and ironmongery, safety, security, and small adaptations

In future, increasing the flexibility of the grant further will enable more heating and energy saving support to be provided, help for children living in joint residency, closer working with other housing providers and a contribution to other projects.

How is Dudley Tackling Health Inequalities?

The Black Country is the second most deprived ICS in the country. Nationally, 20% of the population lives in the most deprived quintile, and each of our areas in the Black Country are above the national average.

- Sandwell - 60%
- Walsall - 52%
- Wolverhampton - 52%
- Dudley – 28%

In Dudley we have a higher number of people than average, with disabilities (physical, mental health, learning disability, autism) and people from socially excluded groups (homeless, vulnerable migrants, Gypsies and Travellers, sex workers), as well as a higher- than-average older population.

Tackling inequalities in health and wellbeing is one of the overarching purposes of integration. Each new or existing service funded by the BCF or IBCF must have regard to the need to reduce inequalities in access to health and care and improve health and care outcomes.

Dudley's approach to health inequalities is based upon addressing the three pillars of access, prevention and the wider determinants of health and wellbeing. This forms the focus of activity for all partnership bodies led by the Health and Wellbeing Board's Joint Health, Wellbeing, and Inequalities Strategy.

The Health and Care Partnership Board has jointly agreed to an evidence-based Outcomes Framework that lies at the heart of our approach to Population Health Management. A Population Health Management and Inequalities Group reports to the Health and Wellbeing Board and co-

ordinates this work across partners.

The Health and Wellbeing Board has agreed its outcomes for patients, organisations and systems and this plan supports delivery of these outcomes by: -

Providing Care Closer to home with Improved
Outcomes Longer life Expectancy
Personalised care and Improved Patient Experience.
Increase in people attending community services, reducing pressures on hospitals, primary care, and social care.
Timely discharge from hospital
Sustainable health and care system.

The Health and Wellbeing Board's priorities are: -

Improving school readiness
Reducing Circulatory disease deaths
Improving breast cancer screening coverage

With a focus on those neighbourhoods with the greatest need.

This involves focusing on access to services preventing illness at a neighbourhood level through the work of our multi-disciplinary Community Partnership Teams, supporting those at risk with the most complex needs. These teams will utilise risk stratification and other population health management methodologies to enable access to the most appropriate support and prevent unnecessary admission to hospital or care homes.

There has been significant learning since the last plan around health inequalities, and how these impact on both health maintenance and prevention. Whilst the overall uptake rate is the highest in the Black Country, Covid vaccine take-up has been significantly lower in some population groups in Dudley, and these populations are at higher risk of hospital admission. This continues to be an area of focus and the lessons learned in understanding the reasons behind "vaccine hesitancy" have an impact on how we can ensure wider issues preventing access to services are addressed.

Part of our approach to addressing health inequalities is the creation of strong and resilient communities through our work with the voluntary and community sector. This has included investment in community led projects to address inequalities, including support for carers. These schemes will be reviewed in 2023/24 and the ICB will seek to fund sustainably if evaluations prove positive.

Dudley Council for Voluntary Service – the local umbrella body for voluntary and community sector organisations – is a key partner. As well as providing our local High Intensity User Service, their Integrated Plus workers are embedded within our Community Partnership Teams and work to support the discharge and admission avoidance processes, through the facilitation of effective social prescribing interventions to avoid the medicalisation of problems.

As a Dudley place we have a clear process for commissioning and re-commissioning services which includes ensuring our involvement and engagement team participate in all stages of commissioning, and we ensure this is driven through the findings in the Equality and Impact Assessments.

We ensure services are accessible and fair for every client. We provide person centred care in a non-judgmental manner; care plans are tailored to meet the person's needs, including dislikes and beliefs, to ensure people can take part in whatever aspect of care they wish, whilst promoting their independence.

**APPENDIX 1**

| | |
|---|---|
| Informal discussions with all stakeholders | Ongoing throughout the period |
| Integrated Commissioning Executive | 3rd May 2023 |
| Health and Care Partnership Board | 18th May 2023 |
| Integrated Commissioning Executive | 7th June 2023 |
| A & E Delivery Board | 8th June 2023 |
| Dudley Health and Well-Being Board | 8th June 2023 |
| Health and Care Partnership Board | 15th May 2023 |

## APPENDIX 2 Evaluation of Better Care Fund 2022 – 2023

### BCF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign | To continue into 23-24 |
|---|---|---|---|---|---|
| **Tissue Viability Service** - Assistive Technologies and Equipment | ✓ | ✓ | ✓ | ✗ | ✓ |
| **Intermediate Care Team** - District Nursing | ✓ | ✓ | ✓ | ✗ | ✓ |
| **Step down** - Occupational Therapy provided by DGFT | | ✓ | ✓ | ✗ | ✓ |
| **Step down** - Physiotherapy provided by DGFT | | ✓ | ✓ | 💡 | ✓ |
| **LTC Nurses** | ✓ | ✓ | ✓ | ✗ | ✓ |
| **Own Bed Instead** | ✓ | ✓ | | ✗ | ✓ |
| **Medical Cover into Intermediate Care** Intermediate Care Support - Dr Plant | | ✓ | ✓ | ✗ | ✓ |

### BCF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign | To continue into 23-24 |
|---|---|---|---|---|---|
| **Admission Avoidance Service – Beds** Intermediate/ Stepdown Care - GP Respite | ✓ | ✓ | ✓ | ✗ | ✓ |
| **Nursing Home Beds** Intermediate/ Stepdown Care | | ✓ | ✓ | ✗ | ✓ |
| **Nursing Home Beds** Pathway 3 Beds | | ✓ | ✓ | ✗ | ✓ |
| **Nursing Home Beds** Intermediate/ Stepdown Care | | ✓ | ✓ | ✗ | ✓ |
| Joint **Palliative Care** Support Team | ✓ | ✓ | ✓ | 💡 | ✓ |

# BCF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign | To continue into 23-24 |
|---|---|---|---|---|---|
| **Intermediate/ Stepdown Care** - Physiotherapists | | ✓ | ✓ | 💡 | ✓ |
| **Medical Cover** - Saltwells Stepdown Cover – DGFT | | ✓ | ✓ | 💡 | ✓ |
| **Highest Care Needs** – coordinated palliative care community-based and inpatient care | ✓ | ✓ | ✓ | 💡 | ✓ |
| **Reablement** Highest Care Needs – coordinated community-based and inpatient care | ✓ | ✓ | ✓ | 💡 | ✓ |

Note: 💡 This symbol denotes a line within the plan where further transformation work will be undertaken

# ASC DF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign |
|---|---|---|---|---|
| Enhanced neuro-rehabilitation capacity | | ✓ | ✓ | ✗ |
| Additional Intermediate Care bed-based capacity | | ✓ | ✓ | ✗ |
| Social work capacity | | ✓ | ✓ | ✗ |
| Discharge to Assess – enhance model | | ✓ | ✓ | ✗ |

# ASC DF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign |
|---|---|---|---|---|
| Therapy capacity for pathway 3 and spot purchase beds | ✓ | ✓ | ✓ | ✗ |
| Bridging beds | | ✓ | ✓ | ✗ |
| Assessment capacity to review care packages in peoples own homes. | ✓ | ✓ | ✓ | ✗ |
| Therapy support in patents own homes | ✓ | ✓ | ✓ | ✗ |

# ASC DF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign |
|---|---|---|---|---|
| Additional social work capacity for mental health and LD patients | | ✓ | ✓ | ✗ |
| Additional equipment | ✓ | ✓ | ✓ | ✗ |
| Overtime for DOM care workers and social work staff | ✓ | ✓ | ✓ | ✗ |
| Additional Pathway 3 beds | | ✓ | ✓ | ✗ |

# ASC DF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign |
|---|---|---|---|---|
| Additional Pathway 1 | | ✓ | ✓ | ✗ |
| Additional back-office support | ✓ | ✓ | ✓ | ✗ |
| Administration time for planning and co-ordination | ✓ | ✓ | ✓ | ✗ |
| Additional Intermediate Care Nurse capacity | | ✓ | ✓ | ✗ |

# ASC DF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign |
|---|---|---|---|---|
| Additional discharge 2 Assess joint plan (townships) | ✓ | ✓ | ✓ |  |
| Support for pathway 0 | | ✓ | ✓ | ✗ |
| Top slice for administration | ✓ | ✓ | ✓ | ✗ |
| Additional beds to support discharge for those patients testing positive for covid | | ✓ | ✓ | ✗ |

# ASC DF 22-23 Schemes

| Scheme Name | Admission Avoidance | Supports Timely Discharge | Provides Care in the Most Appropriate Setting | Opportunity to Decommission / Redesign |
|---|---|---|---|---|
| Voluntary sector support for mental health inpatients | ✓ | ✓ | ✓ | ✗ |
| Additional pathway 3 beds managed by health teams, patients with nursing needs | | ✓ | ✓ | ✗ |

## APPENDIX 3 – BCF 23 – 24 Work Plan

| 4 areas for review | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|
| Transform **Palliative Care Services** to ensure a true integrated team across Health and Social care. | Set up Dudley Place Palliative Care Integration Working Group. Establish core members and develop TOR | Working group to explore opportunities and potential solutions for integration | Continue to collaborate to coproduce recommendations | Recommendations to be presented to the Integrated Care Executive |
| Review of the existing **Discharge to Assess Pathways**, ensuring integration, value for money and ensure patient flow. | D2A Steering Group established and in place. Need to determine action plan and timelines. | Continuation of D2A Steering Group and implementation of Action Plan. | Continue to collaborate to coproduce recommendations | Continue to collaborate to coproduce recommendations |
| Review **medical cover** within the plan for int care services, particularly those whose function has changed post covid. | Not a priority for Q1 | Review current position and recommendations taken to Integrated Commissioning Executive. | Implementation of recommendations | Complete |
| Align rehabilitation **(Step down physiotherapy)** investments to look at opportunities for transformation and release of funds to provide additional investment elsewhere. | Not a priority for Q1 | Discussion with existing provider to identify opportunities | Implementation | Complete |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 1001 | Whole Population Prevention / Population Health Management | Locality Based Prevention Hubs | Community Based Schemes | Charity / Voluntary Sector | Additional LA Contribution | Existing | £1,299,140 | £1,299,140 | 14% |
| 1001 | Whole Population Prevention / Population Health Management | Locality Based Prevention Hubs - Carer support | Carers Services | Charity / Voluntary Sector | Additional LA Contribution | Existing | £434,900 | £434,900 | 58% |
| 1002 | Whole Population Prevention / Population Health Management | Community Equipment Stores | Assistive Technologies and Equipment | Local Authority | Minimum NHS Contribution | Existing | £520,300 | £527,100 | 20% |
| 1002 | Whole Population Prevention / Population Health Management | Community Equipment Stores | Assistive Technologies and Equipment | Local Authority | Additional LA Contribution | Existing | £616,300 | £624,300 | 24% |
| 1003 | Whole Population Prevention / Population Health Management | Disabled Facilities Grant | DFG Related Schemes | Local Authority | DFG | Existing | £4,677,209 | £4,677,209 | 41% |
| 1003 | Whole Population Prevention / Population Health Management | DFG - ASC Equipment Capital Costs | DFG Related Schemes | Local Authority | DFG | New | £695,000 | £695,000 | 6% |
| 1003 | Whole Population Prevention / Population Health Management | DFG - Net Zero Neighbourhood Scheme | DFG Related Schemes | Local Authority | DFG | New | £500,000 | £500,000 | 4% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 1003 | Whole Population Prevention / Population Health Management | DFG - Housing Assistance | DFG Related Schemes | Local Authority | DFG | New | £150,000 | £150,000 | 1% |
| 1003 | Whole Population Prevention / Population Health Management | DFG - Minor Adaptations | DFG Related Schemes | Local Authority | DFG | New | £375,000 | £375,000 | 3% |
| 1003 | Whole Population Prevention / Population Health Management | DFG - Handypersons Capital Costs | DFG Related Schemes | Local Authority | DFG | New | £47,000 | £47,000 | 0% |
| 1003 | Whole Population Prevention / Population Health Management | DFG - Prior year carry forward | DFG Related Schemes | Local Authority | Additional LA Contribution | New | £5,024,000 | £0 | 44% |
| 1004 | Whole Population Prevention / Population Health Management | Falls Service | Prevention / Early Intervention | Local Authority | Additional LA Contribution | Existing | £54,200 | £58,400 | 4% |
| 1005 | Whole Population Prevention / Population Health Management | Careres Network Team | Carers Services | Local Authority | Minimum NHS Contribution | Existing | £219,400 | £223,400 | 30% |
| 2001 | Urgent Care Needs – Integrated Access & Rapid Response | Out of Hours | Home-based intermediate care services | Local Authority | Minimum NHS Contribution | Existing | £200,400 | £204,200 | 3% |
| 2001 | Urgent Care Needs – Integrated Access & Rapid Response | Out of Hours | Home-based intermediate care services | Local Authority | Additional LA Contribution | Existing | £34,200 | £34,800 | 1% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 2002 | Urgent Care Needs – Integrated Access & Rapid Response | Access - SPOA | Integrated Care Planning and Navigation | Local Authority | Additional LA Contribution | Existing | £1,691,900 | £1,819,400 | 20% |
| 3001 | Ongoing Care Needs - Enhanced Primary & Community Care | Homecare | Home Care or Domiciliary Care | Private Sector | Minimum NHS Contribution | Existing | £7,083,923 | £7,762,816 | 38% |
| 3001 | Ongoing Care Needs - Enhanced Primary & Community Care | Homecare | Home Care or Domiciliary Care | Private Sector | iBCF | Existing | £6,426,513 | £6,426,513 | 33% |
| 3001 | Ongoing Care Needs - Enhanced Primary & Community Care | Homecare | Home Care or Domiciliary Care | Private Sector | Additional LA Contribution | Existing | £1,638,664 | £1,638,664 | 8% |
| 3003 | Ongoing Care Needs - Enhanced Primary & Community Care | Direct Payments | Personalised Budgeting and Commissioning | Private Sector | Minimum NHS Contribution | Existing | £147,300 | £155,600 | 4% |
| 3003 | Ongoing Care Needs - Enhanced Primary & Community Care | Direct Payments | Personalised Budgeting and Commissioning | Private Sector | Additional LA Contribution | Existing | £3,582,900 | £3,582,900 | 96% |
| 3003 | Ongoing Care Needs - Enhanced Primary & Community Care | Direct Payments | Carers Services | Private Sector | Minimum NHS Contribution | Existing | £89,100 | £89,100 | 12% |
| 3004 | Ongoing Care Needs - Enhanced Primary & Community Care | Urgent care assessment and therapy | High Impact Change Model for Managing Transfer of Care | Local Authority | Additional LA Contribution | Existing | £936,450 | £965,150 | 27% |
| 3004 | Ongoing Care Needs - Enhanced Primary & Community Care | Urgent care assessment and therapy | Integrated Care Planning and Navigation | Local Authority | Additional LA Contribution | Existing | £936,450 | £965,150 | 11% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 4001 | Highest Care Needs – coordinated community-based and inpatient care | Living independentley Team - Community Reablement | Home-based intermediate care services | Local Authority | Minimum NHS Contribution | Existing | £724,400 | £738,500 | 11% |
| 4001 | Highest Care Needs – coordinated community-based and inpatient care | Living independently Team - Community Reablement | Home-based intermediate care services | Local Authority | Additional LA Contribution | Existing | £790,300 | £809,600 | 12% |
| 4002 | Highest Care Needs – coordinated community-based and inpatient care | Access & Prevention - Occupational Therapy | Prevention / Early Intervention | Local Authority | Minimum NHS Contribution | Existing | £228,100 | £232,700 | 18% |
| 4002 | Highest Care Needs – coordinated community-based and inpatient care | Access & Prevention - Occupational Therapy | Prevention / Early Intervention | Local Authority | Additional LA Contribution | Existing | £1,002,400 | £1,022,800 | 78% |
| 4003 | Highest Care Needs – coordinated community-based and inpatient care | Tiled House | Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery) | Local Authority | Minimum NHS Contribution | Existing | £2,983,600 | £3,031,600 | 53% |
| 4004 | Highest Care Needs – coordinated community-based and inpatient care | External reablement - packages of care | Home-based intermediate care services | Private Sector | Minimum NHS Contribution | Existing | £2,235,600 | £2,362,100 | 34% |
| 4004 | Highest Care Needs – coordinated community-based and inpatient care | Urgent Care - Homecare assistants | Urgent Community Response | Local Authority | Minimum NHS Contribution | Existing | £536,900 | £541,800 | 26% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 4004 | Highest Care Needs – coordinated community-based and inpatient care | Urgent Care - Homecare assistants | Urgent Community Response | Local Authority | Additional LA Contribution | Existing | £931,800 | £956,300 | 45% |
| 4005 | Highest Care Needs – coordinated community-based and inpatient care | Palliative - front end | Personalised Care at Home | Local Authority | Minimum NHS Contribution | Existing | £272,000 | £277,400 | 100% |
| 4006 | Highest Care Needs – coordinated community-based and inpatient care | Supported Living - MH | Home Care or Domiciliary Care | Private Sector | Minimum NHS Contribution | Existing | £246,100 | £260,000 | 1% |
| 4006 | Highest Care Needs – coordinated community-based and inpatient care | Supported Living - MH | Home Care or Domiciliary Care | Private Sector | Additional LA Contribution | Existing | £1,610,789 | £1,610,789 | 8% |
| 4007 | Highest Care Needs – coordinated community-based and inpatient care | Integrated Discharge Pathway | High Impact Change Model for Managing Transfer of Care | Private Sector | Minimum NHS Contribution | Existing | £1,063,600 | £1,123,800 | 31% |
| 4007 | Highest Care Needs – coordinated community-based and inpatient care | Short Term beds | Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery) | Private Sector | Minimum NHS Contribution | Existing | £204,300 | £215,900 | 4% |
| 4007 | Highest Care Needs – coordinated community-based and inpatient care | Short term beds | Bed based intermediate Care Services (Reablement, rehabilitation, wider | Private Sector | iBCF | Existing | £488,901 | £488,901 | 9% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| | | | short-term services supporting recovery) | | | | | | |
| 4008 | Highest Care Needs – coordinated community-based and inpatient care | Internal Day Care & Dementia Gateways | Community Based Schemes | Local Authority | Minimum NHS Contribution | Existing | £1,124,700 | £1,145,700 | 12% |
| 4009 | Highest Care Needs – coordinated community-based and inpatient care | Urgent Care enhanced offer | High Impact Change Model for Managing Transfer of Care | Local Authority | iBCF | Existing | £1,001,300 | £1,001,300 | 28% |
| 4010 | Highest Care Needs – coordinated community-based and inpatient care | Enhanced therapy offer | Home-based intermediate care services | Local Authority | iBCF | Existing | £998,700 | £998,700 | 15% |
| 4011 | Highest Care Needs – coordinated community-based and inpatient care | Enhanced review offer | Integrated Care Planning and Navigation | Local Authority | iBCF | Existing | £216,100 | £216,100 | 2% |
| 4012 | Highest Care Needs – coordinated community-based and inpatient care | Bed based Packages | Integrated Care Planning and Navigation | Private Sector | iBCF | Existing | £5,934,569 | £5,934,569 | 66% |
| 4013 | Highest Care Needs – coordinated community-based and inpatient care | DDS clients over 65 | Home Care or Domiciliary Care | Private Sector | iBCF | Existing | £1,561,621 | £1,561,621 | 8% |
| 5001 | Discharge to Assess | Enhance the discharge to Assess model and increase capacity | Home Care or Domiciliary Care | Private Sector | Local Authority Discharge Funding | Existing | £732,164 | £732,164 | 4% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 5001 | Discharge to Assess | Enhance the discharge to Assess model | Home-based intermediate care services | Local Authority | Local Authority Discharge Funding | New | £1,000,000 | £2,538,578 | 26% |
| 5002 | Additional Pathway 3 beds | To support discharge to assess to ensure that patients are transferred from hospital to an appropriate setting to assess their long term needs. Additional 43 beds already in place. | Residential Placements | Private Sector | Local Authority Discharge Funding | Existing | £262,718 | £262,718 | 8% |
| 5003 | Additional equipment | To reduce the number of resource for pathway 1 we require additional equipment for the single handed equipment initiative | Assistive Technologies and Equipment | Local Authority | Local Authority Discharge Funding | Existing | £200,000 | £200,000 | 8% |
| 5004 | Additional social work capacity for mental health and LD colleagues | Dedicated SW support for this cohort, recruitment commenced for 2 WTE | Integrated Care Planning and Navigation | Local Authority | Local Authority Discharge Funding | Existing | £136,296 | £136,296 | 2% |
| 232501 | Tissue Viability Service | Provision of equipment to enable discharge of patients to their own home, mattresses/beds etc. (Drive Devilbiss - equipment only) | Assistive Technologies and Equipment | NHS | Minimum NHS Contribution | Existing | £1,287,006 | £1,296,015 | 48% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 232502 | Clinical Hub - 2 Hour Response and Admission Avoidance | 2 Hour Response and Admission Avoidance Service | Urgent Community Response | NHS | Additional NHS Contribution | Existing | £619,057 | £623,390 | 29% |
| 232503 | PREVIOUSLY KNOWN AS<br>Clinical Hub - Palliative and End of Life Care - dedicated Domiciliary Care Teams<br><br>NEW SCHEME NAME<br>Clinical Hub - Rapid Response Team | Dedicated Domiciliary Care providing end of life care to people in own homes<br><br>NEW AMENDMENT<br>Also provide end of life care to people in care homes. | Community Based Schemes | NHS | Minimum NHS Contribution | Existing | £1,962,619 | £1,976,357 | 22% |
| 232504 | Clinical Hub - Own Bed Instead (OBI) | OBI is a rehab service to support people in their own homes | High Impact Change Model for Managing Transfer of Care | NHS | Minimum NHS Contribution | Existing | £487,055 | £490,464 | 14% |
| 232505 | Clinical Hub - Long Term Conditions Nurses - Hospital Avoidance Team | Long Term Conditions Nurses (Hospital Avoidance Team) | Community Based Schemes | NHS | Minimum NHS Contribution | Existing | £252,944 | £254,715 | 3% |
| 232506 | Pathway 2 Beds | Block Pathway 2 Capacity Intermediate/ Stepdown Care | Residential Placements | Private Sector | Minimum NHS Contribution | Existing | £2,063,159 | £2,399,204 | 63% |
| 232507 | Additional Pathway 2 Beds capacity (ASCDF - Line 1 and 2) | Additional bed based capacity to support acute discharges and maintain patient flow | Residential Placements | Private Sector | ICB Discharge Funding | Existing | £280,000 | £400,000 | 10% |
| 232508 | Pathway 3 Beds | Block Pathway 3 beds | Bed based intermediate Care Services | Private Sector | Minimum NHS Contribution | Existing | £1,093,476 | £1,101,130 | 19% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| | | | (Reablement, rehabilitation, wider short-term services supporting recovery) | | | | | | |
| 232509 | Pathway 2 Neuro Rehab Beds | Neuro-rehabilitation beds to aid discharge | Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery) | Private Sector | Minimum NHS Contribution | Existing | £550,000 | £755,250 | 13% |
| 232510 | Pathway 2 Neuro Rehab Beds ASCDF | Additional bed based capacity to support acute discharges and maintain patient flow (In addition to West Park) | Bed based intermediate Care Services (Reablement, rehabilitation, wider short-term services supporting recovery) | Private Sector | ICB Discharge Funding | Existing | £100,000 | £150,000 | 2% |
| 232511 | Intermediate Care Admision Avoidance Beds | Intermediate Care Admission Avoidance beds | Community Based Schemes | Private Sector | Minimum NHS Contribution | Existing | £1,632,835 | £1,644,265 | 18% |
| 232512 | District Nursing support into Intermediate Care | District Nursing support into Intermediate Care based at Tiled House. (Provider - DGFT) | Community Based Schemes | NHS | Minimum NHS Contribution | Existing | £231,958 | £233,582 | 3% |
| 232513 | Additional Social Work Capacity (ASCDF Line 3) | To underpin ongoing work and to support discharges from community beds | Community Based Schemes | NHS Community Provider | ICB Discharge Funding | New | £120,000 | £150,000 | 2% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 232514 | Extra Intermediate Care Nurse capacity to support Pathway 2 (Line 16 ASCDF) | To meet demand within the acute setting and to expedite discharge from P2 beds | Community Based Schemes | Private Sector | ICB Discharge Funding | New | £30,000 | £40,000 | 0% |
| 232515 | Pathway support | Working with partners across the system to provide capacity across all pathways including mental health services. | Community Based Schemes | NHS | ICB Discharge Funding | New | £220,000 | £250,000 | 3% |
| 232516 | Pathway 2 Medical Support - (Doctor cover) Summerhill | Doctor cover provision for patients in designated intermediate care homes. (Summerhill) | Other | NHS | Minimum NHS Contribution | Existing | £62,759 | £63,198 | 100% |
| 232517 | Medical input into stepdown facilities - Saltwells | Medical input into stepdown facilities provided by DGFT (Included in the block - previously Saltwells) | Community Based Schemes | NHS | Minimum NHS Contribution | Existing | £89,271 | £89,896 | 1% |
| 232519 | Pathway 2 Step Down Occupational Therapy | Pathway 2 Step down - Occupational Therapy Services based at Tiled House. (Provider - DGFT) | Community Based Schemes | NHS Acute Provider | Minimum NHS Contribution | Existing | £550,352 | £554,204 | 6% |
| 232520 | Pathway 2 Step Down Physiotherapy | Step Down Physiotherapy Services provided within Local Acute Community Trust | Community Based Schemes | NHS | Minimum NHS Contribution | Existing | £211,948 | £213,432 | 2% |
| 232521 | Pathway 2 Step Down Physiotherapy | Step Down Physiotherapy Services provided by private provider | Community Based Schemes | Private Sector | Minimum NHS Contribution | Existing | £69,045 | £69,528 | 1% |

| Scheme ID | Scheme Name | Brief Description of Scheme | Scheme Type | Provider | Source of Funding | New/ Existing Scheme | Expenditure 23/24 (£) | Expenditure 24/25 (£) | % of Overall Spend (Average) |
|---|---|---|---|---|---|---|---|---|---|
| 232522 | Support for discharge | To provide increased capacity in discharge pathways. | Community Based Schemes | Private Sector | ICB Discharge Funding | Existing | £739,628 | £1,790,140 | 14% |
| 232523 | Pathway 2 beds | Block pathway 2 capacity Intermediate/Stepdown Care | Residential Placements | Private Sector | Additional NHS Contribution | Existing | £805,598 | £489,634 | 20% |

## SCHEDULE 2– BETTER CARE POOLED FUND

The Better Care Pooled Fund is made up of contributions of the ICB and the Council as specified in the Better Care Fund Plan agreed by the Health and Wellbeing Board.

The Pooled Fund will include Ring Fenced Capital Grants which may only be paid out of the Better Care Pooled Fund for use by the Council in accordance with the conditions attached to those grants.

All monies in the Better Care Pooled Fund allocated to Individual Schemes may only be spent on those Individual Schemes and shall be accounted for and reported accordingly.

### 1. HOST PARTNER

1.1 The Host Partner for the Better Care Pooled Fund is the Council and the Better Care Pooled Fund Manager, being an officer of the Host Partner is the Better Care Fund Programme Director.

### 2. FINANCIAL GOVERNANCE ARRANGEMENTS

2.1 As in the Agreement with the

following changes: Management of the

Better Care Pooled Fund

2.2 The other Partner shall make monthly payments to the Host Partners

2.3 Each month in monthly closedown estimates for over or under performance will be shared for accruals purposes in line with the following closedown timetable:-

2.3.1 The relevant Partner to submit pooled budget figures for each Individual Scheme to the Host Partner by the 8th Working Day of the month. The First reconciliation point will be at the end of Q2 ( Month 6) to include any over/under performance to date but will not include assessment of performance payment

2.3.2 The Second reconciliation point will be the end of Q3 (Month 9) with potential to include assessment of performance payment preferred.

2.3.3 Over performance will be paid separately so as to keep a clear audit trail in line with Standard Financial Instructions and Standing Orders

2.3.4 Month 11 reporting will incorporate year end estimate on pooled budgets.

2.4 The year-end reporting will be shared in line with the following closedown timetable:-

2.4.1 The relevant Partner to submit draft figures for each Individual Scheme within the Better Care Pooled Fund to the Host Partner to enable the Host Partner to provide draft figures for the Better Care Pooled Fund by the 3rd Working Day following year end (to meet national accrual deadline)

2.4.2 The relevant Partner to submit budget information for each Individual Scheme within the Pooled Fund to the Host Partner to enable the Host Partner to submit budget information for inclusion in the annual accounts by the 10th Working Day following year end (to meet national deadline for submission of draft and audited accounts.)

2.5 The Host Partner financial system will be used for financial management purposes:

2.6 Budget holders will submit forecasts by the 10th Working Day of each month. These will then be reviewed by the appropriate Heads of Service and Service Directors by the 15th Working Day of the month.

2.7 A budget report will contain:

2.7.1 Financial codes and description of code

2.7.2 Original, revised and year to date budgets

2.7.3 Actual spend to date and commitments

2.7.4 Previous months and current forecasts

2.7.5 Comments

2.8 Budget Holders for each Individual Scheme will be detailed in each Scheme Specification and will be required to follow the established working rules and will be bound by the Host Partner's organisation's scheme of delegation.

2.9 Where budget holders are not employed by the Host Partner, they will need to sign an undertaking to abide by the established rules.

2.10 Training will be provided to budget holders and managers in the use of the Agresso financial system by the Host Partner.

2.11 Budget Holders for each Individual Scheme will be responsible for all financial transactions for their budget including raising invoices (sales notes) and authorising both pay and non-pay expenditure.

2.12 The fund will not include a contingency reserve; however this will be kept under review.

2.13 Means testing for any social care payments will be carried out by the Host Partner.

Changes to Contribution levels

2.14 The contribution levels to the Better Care Pooled Fund for each Individual Scheme have been agreed in principle as outlined above in Schedule 2.

2.15 Any changes to contribution levels will need to be agreed through the governance structure outlined in Schedule 3.

Audit Arrangements

2.16 The current Internal and External Auditors for both Partners will need to provide audit opinions on the operation of the pooled fund and sign off substantive audits.

2.17 Grant Thorntons have been appointed to manage the External Audit process for the Host Partner.

2.18 The Finance Department within the Host Partner will manage and act as the

point of liaison with the auditors.

2.19 The Audit arrangements for the Better Care Pooled Fund will comply with the external audit regimes of both parties.

## 3 REPORTING AND ASSURANCE ARRANGEMENTS

3.1 In line with the Better Care Fund Policy Framework the Host Partner in partnership with the relevant Partner shall provide quarterly and annual reports on the overall operation of the arrangements for the Better Care Pooled Fund.

3.2 The Quarterly and annual report shall include such information as will be specified in the Policy Framework and further guidance provided by NHS England and the Department of Health and Social Care to provide assurance to NHS England as to the appropriate use of the fund.

3.3 The Integrated Commissioning Committee, the arrangements for which are set out in Schedule 3, shall prepare the reports and (if required) submit them for approval to the Health and Wellbeing Board in order to meet the deadlines for the submission of the quarterly reports as set by NHS England and the Department of Health and Social Care.

## SCHEDULE 3– GOVERNANCE

### 1. Partnership Board

1.1 The Dudley Integrated Commissioning Committee established by the Partners will act as the Partnership Board.

### 2. Role of Integrated Commissioning Committee

2.1 The Integrated Commissioning Committee shall:

2.1.1 provide strategic direction on the BCF Plan, based on advice and recommendations received from its Better Care Fund Executive. .

2.1.2 receive the financial and activity information, including the Quarterly reports of the Pooled Fund Manager for each Individual Scheme and ensure that such Individual Schemes are being developed to meet the requirements of the Better Care Fund Plan;.

2.1.3 review and recommend the operation of this Agreement and performance manage the Individual Services.

2.1.4 agree such variations to this Agreement from time to time as it thinks fit, subject always to the governance arrangements of each Partner.

2.1.5 review and recommend annually a risk assessment and a Performance Payment protocol.

2.1.6 review and recommend annually revised Schedules as necessary.

2.1.7 request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Better Care Pooled Fund.

2.1.8 hold the Better Care Fund Programme Director to account for the delivery of the aims of the Agreement; and

2.1.9 provide regular reports to the Health and Well-Being Board on the operation of this Agreement.

### 3. Integrated Commissioning Committee Support

The Committee will be supported by officers from the Partners from time to

time. Administrative support will be provided by the ICB.

The Better Care Fund Executive will be responsible for the management of the Fund and will report to the Integrated Commissioning Committee.

## 4. Meetings

4.1 The arrangements for meetings of the Committee will be set out in its terms of reference. .

## 5. Delegated Authority

5.1 The Committee is authorised within the limits of the delegated authority given to either Partner, exercising by its members (which is received through their respective organisation's own financial scheme of delegation) to:

5.1.1 authorise commitments which exceed or are reasonably likely to lead to exceeding the contributions of the Partners to the aggregate contributions of the Partners to the Better Care Pooled Fund in respect of any Individual Scheme only where responsibility for that overrun has been determined under the procedures set out in Schedule 4 (but not further or otherwise); and

5.1.2 authorise a Lead Commissioner to enter into any contract for services necessary for the provision of Services under an Individual Scheme

## 6. Information and Reports

Each Pooled Fund Manager shall supply to the Committee on a Quarterly basis the financial and activity information as required under the Agreement.

## 7. Post-termination

The Committee shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

## SCHEDULE 4– RISK SHARE AND OVERSPENDS

Pooled Fund Management

1. Variances on expenditure will be identified through monthly monitoring processes undertaken by Budget Managers in conjunction with the Host's Strategic Finance. Financial performance will be reported to the Integrated Commissioning Committee on a monthly basis

Overspend

2. The Partners agree that overspends shall be apportioned in accordance with this Schedule 4.

3. The Committee shall consider what action to take in respect of any actual or potential overspends

4. The Committee shall acting reasonably, having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints, agree appropriate action in relation to overspends which may include the following:

4.1 whether there is any action that can be taken in order to contain expenditure;

4.2 whether there are any underspends that can be vired from any other fund maintained under this Agreement;

5. A cap will be set for each partner on the exposure to the other partners overspend in the pooled fund. This will be agreed by the Committee in line with the contributions from each partner agreed in the Better Care Fund Plan.

6. In the event that the overspend is below the total cap agreed, the overspend will be apportioned in accordance with their total revenue contribution to the pooled budget, taking into account specific arrangements for specific funding streams (for example Capital Grants) in the Better Care Fund Plan.

7. The Partners agree to co-operate fully to establish an agreed position in relation to any overspends.

8. Subject to any continuing obligations under any Service Contract entered into by either Partner, either Partner may give notice to terminate a Service or Individual Scheme where the Scheme Specification provides.

## SCHEDULE 5 – POLICY FOR THE MANAGEMENT OF CONFLICTS OF INTEREST

1. Governance shall comply with the Nolan principles on public life, the relevant provisions of the Council's Code of Conduct for members and the ICB Code of Conduct for Governing Body Members and policies for managing conflicts of interest to the extent relevant.

2. No person may sit on the Integrated Commissioning Committee or otherwise be engaged in a decision with regard to the entering into of a Contract for Services where he / she has any personal / pecuniary interest, such as any financial or ownership interest in any body providing services in accordance with the definition of "Pecuniary Interest" within the constitution of the Council or the ICB's Policy for Declaring and Managing Interests.

3. Where it became apparent that an individual has such a personal or pecuniary interest, he / she will immediately disclose it to the Chair of the Integrated Commissioning Committee and take no further part in the discussions or determination of such item, except to the extent that this has been agreed by all other members of the Committee in attendance.

## SCHEDULE 6 – INFORMATION GOVERNANCE PROTOCOL

1. The Information Governance arrangements for the agreement will follow the principles outlined in the Dudley Overarching Information Sharing Protocol to which both partners are signatories.

2. Information Sharing arrangements for individual schemes will be set out in the specification for each scheme and will include, as appropriate, information sharing agreements in line with the principles set out in the Overarching Information Sharing Protocol.

**Meeting of the Adult Social Care Select Committee - 17th January 2024**

**Report of the Director of Adult Social Care**

# Preparing for Adulthood (PFA)

## Purpose of report

1. To inform the Adult Social Care Select Committee of the development of the Preparing for Adulthood Team within Dudley Disability Service and how this is working to improve the outcomes of young people with disabilities and/or autism in Dudley.

## Recommendations

2. It is recommended for the Select Committee:

   - to review the contents of the report and refer to the relevant Service Director if any further information on Preparing for Adulthood is required.

## Background

3. The last 18 months have seen the development of Preparing for Adulthood in Dudley Council this was in response to the Preparing for Adulthood Strategy and Action Plan published in July 2021 and the recognition of the need to improve the pathway for young people with special educational needs and disabilities (SEND) who may need support as adults from Adult Social Care.

4. Preparing for Adulthood aims to support young people from the age of 14 to enable them to have a smooth and fulfilling transition from childhood to adulthood. The Preparing for Adulthood approach aims to demonstrate that, by intervening earlier and differently, outcomes for the young person can be improved. This will result in improved quality of life and life choices, based on enhanced and sustainable health and wellbeing,

independence, choice and control, where they are defined by their strengths and not by their diagnosis, condition or behaviour.

5. In summary, Preparing for Adulthood:

- Supports young people entering adulthood to be physically and mentally resilient so once they become an adult, they will have a connective, fulfilling and productive life.
- Build lifelong support networks.
- Increase the number of supportive and lasting relationships.
- Reduce the number of residential placements.
- Improve the emotional and mental wellbeing of our young people.
- Improve access to employment opportunities.
- Improve the support offer of re-accommodation.

6. Although led by Adult Social Care the development of Preparing for Adulthood has been a partnership approach with the process being fully supported by SEND, Health, Childrens Services, Connections, Schools and Colleges, young people and their parents and carers.

<u>How we have worked together to achieve the aims and objectives</u>

7. The Preparing for Adulthood strategy identified four underpinning pillars:

- Opportunities to access further education and employment.
- Independent living including access to supported living.
- Full inclusion and active participation in local communities as an equal citizen and to be supported to build relationships and friendships.
- To maintain health and wellbeing with reasonable adjustments in place as appropriate to support the access to mainstream health provision and services.

8. Under these 4 pillars a range of outcomes were agreed. Working groups were set up to drive forward the achievement of the outcomes. These have been extremely well attended by a wide range of stakeholders.

9. Outcomes will be achieved by:

- Promoting independence.
- Using a strengths-based approach.
- Prevention and early intervention.
- Whole system multi-disciplinary networks of support.
- Focusing on what the young person wants and to raise aspirations.
- Encouraging problem solving skills, resilience and independence.

- Supporting statutory teams by offering more time with the young person on Preparing for Adulthood related activities.
- Being a system 'connector' to champion the testing of a new practice model, including connection pathways, sharing information and two-way communication to discuss different roles and services.

10. The SEND Ofsted inspection also identified that provision to support young people who were moving into adulthood was not sufficient in Dudley so the Preparing for Adulthood work also focused on improving this. A post 19 high needs group was established to lead this work.

11. It was also recognised that operationally the existing transition pathway was not enabling young people to be appropriately supported especially those young people known to SEND but not known to Childrens services. This has led to a complete redesign and the team sitting in Dudley Disability Service now known as the Preparing for Adulthood team are able to support young people from age 14. There are 4 support workers who support young people and their families. They will soon be joined by a fifth worker whose focus will be on young people who are likely to need support from the Mental Health Team.

What has been achieved

12. Adult Social Care Commissioning Team supported the development of a Post 19 Complex Needs Development Plan. This plan was coproduced with a wide range of stakeholders including young people and parents/carers. It identified a range of areas where improvement and procurement were required. Feedback from the parent/carers involved in the development of the plan include:

    *"As the working groups have progressed, we do feel really included in the complex post 19 project. We feel valued and feel that our comments and suggestions are listened to and that we can ask lots of questions. We were involved in the draft plan and the finalised version of this".*

13. One key area that was identified for improvement was communication and information about what Adult Social Care Services and Preparing for Adulthood are. The working group reviewed existing information and helped develop new pages for the Dudley Council Website, including an animated video developed by young people that explains what Preparing for Adulthood is. They are also filming 'day in the life' videos to go on the website to show other young people what life can look like with a good support package. The group redesigned the information leaflets for Preparing for Adulthood and have designed new banners to use at events. The Preparing for Adulthood team have also been attending as many

events and meetings as possible to reach parent/carers and young people and share information about Preparing for Adulthood and Post 19 provision. Feedback includes:

*"Thank you so much for taking the time to come to Lifted Spirits this week. The feedback has been so good! Everyone has taken something from the morning and we have had lots of positive comments".*

14. Workshops have been set up with the Carers Network for Parent/Carers that focus on supporting them to prepare for their young person moving to adulthood. They choose the subject they would like to know more about and topics have included Mental Capacity; how this is assessed and what parents need to think about if their young person is deemed not to have capacity, and Welfare Benefits and how this will change when their young person turns age 18. The feedback from Parent/Carers has been fantastic and they all feel the sessions are extremely beneficial. Parent/Carers have stated that the sessions are *"really useful to get together and discuss issues"* and they value *"being listened to".* The sessions are held at the Brett Young Carers Hub so it also connects the parents/carers to this provision and again we have had excellent feedback about the range of support on offer to them when they move into this informal carer role (see Appendix 1 for feedback from one of the sessions).

15. Enabling Parent/Carers to visit examples of current provision and talk to young people who are accessing the services has also really helped to increase the knowledge of what Post 19 provision is and how it could work for their young person. We have been supported to do this by Sarah Offley at Dudley Voices for Choice who has played a huge part on the Preparing for Adulthood development and enabled us to involve young people all the way through. Feedback from parent/carers includes:

*"We have been welcomed into the community particularly by Sarah Offley and Dudley Voices for Choice. As a result of this new relationship, we have been out to see several community visits looking at social care micro provisions and we have spent a full day at Glasshouse college. There is some superb educational provision at glasshouse and other places out of the borough, and we still feel really strongly that the people involved in commissioning the education post 19 need to meet some young people who have complex needs, to understand the cohort. We also feel they would benefit from visiting a local good educational provision such as glasshouse. We are concerned that any offering is not just life skills and that there is real educational opportunities with outcomes, such as what we saw at glasshouse last week".*

16. The introduction of Preparing for Adulthood support workers into the operational team has enabled focused support to be provided to young people and their families where we feel transitioning to adulthood is likely to be complex. The workers support the parent/carers to navigate this change and work with the young person to identify how they would like to live their life. Feedback from parents supports that the workers are having a positive impact and improving their experience of transition (see Appendix 2 for PFA Support Worker Compliments and Feedback).

17. When working with young people the Preparing for Adulthood support workers use a new tool developed for the team called a PFA Personal Support Plan. This plan was designed by young people themselves and includes questions they want to be asked. The plan helps us to gain a detailed picture of the young person and what they would like their life to look like. The plan supports the assessment process and enables the young person's voice to be heard in the assessment and a real focus on their strengths and the outcomes they want to achieve. They also focus on building a picture with the young person of their circles of support and this enables us to see how we can support this to be more sustainable thus reducing the formal support they may require as adults and maintaining their independence.

18. The Housing Needs Analysis commissioned by Dudley Disability Service highlighted a lack of provision for young people with a learning disability and/or autism in Dudley. This combined with a need to increase provision to support young people gain skills for independent living led to the development of the vision of a Foyer for young people with a Learning disability and/or autism. This is an innovative idea and builds on the successful concept of Foyers for vulnerable young people experiencing homelessness, drug and alcohol issues, carer leavers etc. We are working closely on this exciting project with a local provider, the Foyer Federation and award-winning architects from Australia who have designed Foyers around the world. The vision and plans for the Foyer are being coproduced with young people and we hope to be able to share initial designs for the Foyer soon.

19. Dudley Disability Service has a new Independent Living team who will work with young people and their families to explore different types of accommodation enabling a smooth transition from parental home or residential college or care into more independent living. They will also support young people to identify community-based services and options that enable them to be a more active part of their community and develop interests and friendship groups.

20. The Preparing for Adulthood team within Dudley Disability Service has no waiting list for assessments a significant reduction from 48 waiting for assessments since 12 months ago, and the zero waiting has been sustained for 4 months now, the team is working hard to clear the waiting list for review, this will be achieved by March. We think it is extremely important that young people get a timely and consistent response from the team so they feel it is there to support them when they need it.

Impact of Preparing for Adulthood

21. Knowing that the changes we have been making are having a positive impact on young people and their parent/carers is extremely important to us. Parent/carers are telling us that they feel more informed and involved. They are excited about some of the new developments that they are involved in and have a greater understanding of what an independent life could look like for their young person.

22. Young people have more choice and are choosing alternatives to formal education which is enabling them to access their community, build confidence and skills that will enable them to be more independent (see Appendix 3 for case studies).

23. Dudley Disability and the SEND service have developed a much closer and effective working relationship. Communication is good and meetings take place regularly to discuss young people and their options. We have also been meeting with colleges from across Health and Social Care to share information about Preparing for Adulthood and how they can be involved. Recent feedback from a meeting with Educational Psychologists demonstrates the impact of this:

    *"The feedback was fantastic and really highlighted the value in connecting with our colleagues within the LA. I think most of us weren't aware of being able to signpost for self-referrals into PFA so that was really valuable information to know. Definitely information other colleagues will benefit from knowing so it's great to hear you're planning on more of these sessions, I think lots of people will really benefit from it".*

24. Schools and colleges are more informed about Adult Social Care and the options that are available for young people when they move into adulthood. This, together with the relationship with SEND colleagues and the Preparing for Adulthood support workers working with young people has enabled creative packages of mixed provision to be offered, the result being parents withdrawing from the tribunal process, accepting and now asking for mixed provision of locally provided education and social care instead of out of borough college. As well as enabling the achievement of better outcomes this has a wider impact. Although having financial

implications for Adult Social Care in the short term it is achieving significant financial savings for the wider council and should lead to long-term saving for Adult Social Care (see Appendix 3 for case studies).

25. We have been working with the provider market to increase their understanding of Preparing for Adulthood and the services young people will need as they move into adulthood. This is leading to a real sense of working together to improve the range of provision and choice for young people, and to think innovatively about how we can meet needs.

26. Co-production has been at the heart of everything we have developed within Preparing for Adulthood and this has delivered real benefits in terms of how we have responded to the challenges and the outcomes that have been achieved. Everyone involved say they feel listened to, they feel included, they are committed to achieving the outcomes and we are all working together to do this. Feedback from parent/carers includes:

    *"I welcomed being involved in this particular work stream as I have recent lived experience in this area in terms of my son's journey. The discussions that have taken place have highlighted how complicated this area is and how important it is to explore all options so that each young person can have their individual needs met. This inevitably takes time and whilst it has at times seemed to be slow progress I understand why this is the case. I have been really pleased to hear Emma's thoughts regarding challenging traditional models of learning and employment for our young people. She has some positive and ambitious ideas which she shares with the group and asks for feedback which parents and professionals have been happy to share. I am looking forward to continuing to be involved with this work moving forward".*

    *"We are happy to continue to be involved and are really enjoying learning more about post 19 to remove the fear and share the information with parents at Lifted Spirits going forward".*

<u>Future plans for Preparing for Adulthood</u>

27. The Preparing for Adulthood team and work will continue to grow, and the stakeholders are working hard to make sure outcomes are being achieved and the journey for young people into adulthood continues to improve future plans; including:

    - We are recruiting a Preparing for Adulthood support worker for Mental Health who will focus on supporting young people where Mental Health support is the predominate need. We believe this could prevent many young people needing support from Adult Social Care Mental Health team.

- We would also like to extend Preparing for Adulthood support for young people who could potentially become adults at risk but do not have a disability or need for secondary mental health support to prevent them needing Adult Social Care.
- The Foyer development will continue to take shape and will hopefully be delivered within the next 3 years.
- We are looking to improve access for young people to Direct Payments and have commitment to develop tri-funded personal budgets to include Adult Social Care, Education and Health funding. This will give young people with complex needs much more flexibility, choice and control over how their needs are met
- We are looking to develop Individual Service Funds (ISF) to fund innovative services to support young people.
- We are working with SEND to improve the pathway for young people not known to Childrens Services to enable easier identification and the ability for Adult Services to provide support from 14 yrs.
- Continue to improve the knowledge of Preparing for Adulthood and the needs of young people with the provider market so we can work with them to develop services that fill some of the gaps in the market.
- Continue to work with providers to develop innovative way to respond to demand.

## Finance

28. There are no financial implications arising from the contents of this report.

## Law

29. In the last couple of years there have been several policy changes that have affected the lives of disabled young people, those with Special Educational Needs and their families, and had an impact on the range and quality of support available to them as they prepare for adulthood.

30. Legislation gives local authorities a legal responsibility to co-operate, and to ensure that all the correct people work together to get the transition right for a young person.

31. The two pieces of legislation that have the greatest influence on support for disabled young people preparing for adulthood are Part 3 of the Children and Families Act 2014, which focuses on Special Educational Needs and Disability and Part 1 of the Care Act 2014, which focuses on the care and support of adults. Importantly, the Children and Families Act 2014 introduced a system of support which extends from birth to 25, while

the Care Act 2014 deals with adult social care for anyone over the age of 18.

32. This means there will be a group of young people aged 18-25 who will be entitled to support through both pieces of legislation. The two Acts have the same emphasis on outcomes, personalisation, and the integration of services. Preparing for Adulthood aims to join up these two pieces of legislation at a local level.

## Risk Management

33. There are no risk implications arising from the contents of this report.

## Equality Impact

34. The provision of the Dudley Disability service supports people with protected characteristics, primarily people with a disability.

## Human Resources/Organisational Development

35. There are no human resource implications arising from the contents of this report

## Commercial/Procurement

36. There are no commercial/procurement implications arising from the contents of this report.

## Environment/Climate Change

37. There are no environment/climate change implications arising from the contents of this report.

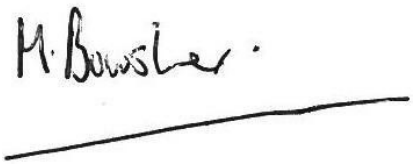
## Council Priorities and Projects

38. Through our People Strategy, this service change supports the council's strategic priorities by identifying what the workforce needs to look like and how it needs to operate to deliver outcomes for the residents of Dudley borough. It will not have any negative impact on current wider Council and borough activity and projects including but not limited to:

- Climate Change and our Net Zero target by 2041
- Digital and Information Technology (including Data Protection)
- GP and health provisions
- Public transport connectivity

- Local housing needs
- Local depravation and cost of living
- Green spaces and the safety of the community
- Corporate Parenting
- Asset and Property Management

39. This service change also aligns to our council plan outcomes by ensuring everyone, including our most vulnerable, have the choice, support and control of the services they need to live independently, and all residents benefit from access to high quality, integrated health and social care.



**Matt Bowsher**
**Director of Adult Social Care**

**Report Author:** Emma Matthews
Telephone: 01384 814869
Email: emma.matthews@dudley.gov.uk

**Appendices:**

Appendix 1 – PFA Carers Support Workshop Feedback Analysis.
Appendix 2 – PFA Support Worker Compliments and Feedback.
Appendix 3 – PFA Case Studies.

## PFA Carers Support Workshop – Feedback Form Analysis

| Feedback Question | Very Good | Good | Poor | Very Poor | Don't know |
|---|---|---|---|---|---|
| Overall how did you find the workshop? | 9 people | 1 person | 0 | 0 | 0 |
| How would you rate the accessibility and parking of the venue? | 9 people | 1 person | 0 | 0 | 0 |
| How would you rate the facilities of the venue? | 9 people | 1 person | 0 | 0 | 0 |
| Please can you tell us what you found good and what could have made it better? | - Really useful to get together and discuss issues.<br>- Lots of information, very positive.<br>- Being Listened to.<br>- So many issues that need addressing – so many questions to be answered.<br>- Chance to speak to other parents and to know so many people are struggling and need the information/support.<br>- Meeting other people with similar experiences and learning about help in the community.<br>- Lots of discussion.<br>- Too hot in room. | | | | |
| Which parts of the session did you find most useful? (tick all that apply):<br>a) What is Preparing for Adulthood.<br>b) Carers and the Care Act – how does this change things.<br>c) Dudley Carers Hub and Wellbeing Service.<br>d) Engagement Exercise.<br>e) Question and Answers. | a) 8 people chose this answer<br>b) 4 people chose this answer<br>c) 5 people chose this answer<br>d) 6 people chose this answer<br>e) 6 people chose this answer | | | | |
| Please can you tell us more: | - Hopefully these sessions can continue for other parents to engage in.<br>- More sessions please.<br>- My son is 21 with ASD so learning about support out there is useful. | | | | |
| Which parts of the session did you find least useful? (tick all that apply):<br>a) What is Preparing for Adulthood.<br>b) Carers and the Care Act – how does this change things.<br>c) Dudley Carers Hub and Wellbeing Service.<br>d) Engagement Exercise.<br>e) Question and Answers. | a) 0 people chose this answer<br>b) 1 person chose this answer<br>c) 0 people chose this answer<br>d) 0 people chose this answer<br>e) 0 people chose this answer | | | | |
| Please can you tell us more: | - It was all very useful.<br>- Trying to find options.<br>- All useful.<br>Not enough time available. | | | | |
| If we were to offer more workshops around Preparing for Adulthood and support for parent carers, would you be interested in attending?<br>a) Yes<br>b) No | a) 8 people chose this answer<br>b) 0 people chose this answer | | | | |
| If yes, how would you like to attend:<br>a) Webinar (i.e. MS Teams).<br>b) Face to Face.<br>c) Don't mind. | a) 0 people chose this answer<br>b) 7 people chose this answer<br>c) 1 person chose this answer | | | | |
| If yes, when would you prefer to attend:<br>a) am.<br>b) pm (afternoon).<br>c) pm (early evening). | a) 6 people chose this answer<br>b) 3 people chose this answer<br>c) 0 people chose this answer | | | | |
| Please share any further feedback you would like to make: | - More focussed sessions i.e. education, housing, law, benefits.<br>- More focussed workshops.<br>- Too many questions on feedback form. | | | | |

**Compliments and feedback received for PFA Support Workers:**

**Feedback for PFA Support Worker:**

"I just want to take time out to commend you on the support you have offered and continue to offer to XXX.

XXX can be quite a complicated young person and not the easiest to reach, but you have worked tirelessly to engage her and offer the support she needs. I know this is not easy but you persevere.

You evidence good multi-agency working, by liaising with all parties involved and keeping us up to date on what you are doing your end. I am aware that XXX has demanded you time beyond the call of duty, working even beyond 8pm, when you should be with your own family, which evidences your commitment to the young people you support. You are indeed a good advocate for XXX and she acknowledges this.

Andrew and Joseph, Renata Maciejewska is indeed a valuable asset to your service".

Regards,
Deidre Chin
Team Manager - Children in Care & Resources - Care Leavers

**Social Worker Feedback on the PFA Personal Support Plan:**

"From a social work perspective, it was felt that the PFA Personal Support Plan that was completed by the worker Lisa Stone was very helpful, relevant and factual regards to the information that had been collated and beneficial to the completion of Care Act assessment.

Information collated by the PFA worker allowed me to identify XXX's current level of need and the support provided to him, it helped identify his current needs, wishes and feeling alongside capturing his future aspirations.

The PFA workers involvement also reduced the time that I was to spend completing assessments and gathering information, through the support provided by contacting service provisions, both formal and informal and checking its appropriateness to the meet the young person's aspirations.

I feel that the PFA involvement supported me to build a good rapport with the family and individual through regular visits and contact made by herself and me throughout as the family could contact one of us or both.

I felt that this overall involvement from the PFA worker and the PFA plan completed, reduced the amount of work which I was / had to complete myself, alongside reduce the duplication questions being asked and explored with the individual, as this can sometimes be overwhelming for most families.
I feel that Lisa explored the PFA pathway and processes thoroughly with family very well which also allowed them to understand the next process where the Care Act assessment was to be completed, and support plans and referrals made.

Overall, a good piece of work!  It would be very beneficial if the PFA workers could remain involved throughout by helping with the sourcing of suitable services and be available for the family to contact if the allocated worker is absent".

Regards,
Nina OShaughnessy (DDS Social worker)

**Feedback for PFA Support Worker:**

"I just wanted to say that my professional feedback for you as an individual would be that I find you very professional, easy to get hold of, supportive and dedicated to young people, great team worker who keeps me fully updated, a pleasure to work with".

Regards,
Lisa Talbot
Young Persons Advisor Children in Care & Resources - Care Leavers

## Case Study 1

XXX recently turned eighteen and lives in accommodation provided by the residential college where he attends. He has a good sense of humour and likes to be around his family. His parents are main carers for his younger sister. He loves mountain biking and spending time by the local canals.

He likes having time to himself and space when he needs it. XXX likes to have control over when he sees people. He goes to college 5 days per week and has taxi transport provided to take him there. Conforming to a rigid timetable of provision poses challenges for XXX, where he is expected to comply.

### What are XXX's strengths

XXX loves being in the outdoors where he feels a sense of freedom and no external control. XXX can articulate his wishes about what he wishes to do and when, he finds it difficult being expected to attend classroom lessons at certain times and be punctual for the taxi transport. He often found himself not attending college and did not have any interests he was able to pursue in replacement due to the restrictive nature of residential college provision.

### XXX's experience

XXX has Autism and Fragile X Syndrome. He had been living in accommodation provided by the college until behaviours manifested and was moved to self-contained accommodation with his own care staff team. Sadly, the behaviours did not subside and in anticipation of his 18th birthday, a referral was made to the Preparing for Adulthood Team to plan his transition to adult social care.

With the Preparing for Adulthood approach, we were able to establish that he did not wish to be in college full time or conform to a timetable that had been set for him without consultation with him. It was clear he wanted to be in control of his life and choose what happens. However, a decision to cease education comes with the withdrawal of the accommodation he was living in and it was not an option to return to the family home.

The Preparing for Adulthood worker identified with XXX he would like to live in an area near countryside and canals so he was able to walk or get there by bike. He struggled to use public transport or be in vehicles due to a fear of closed spaces. Supported living accommodation was identified for XXX, which he viewed and agreed to take on the tenancy himself. A transition was carefully

planned with XXX reducing attendance to college 3 days per week and having introductory days/overnights at his new home with the current staff team.

**The support XXX will get to live his life**

Upon successful transition to his own accommodation close by to a canal which opens to the local park, XXX has now left college full time and works on a voluntary basis with a local charity who do bike repairs that are flexible whenever he is able to help.

Having his own tenancy means XXX is now able to invite family and friends over without the worry of conforming to college accommodation and behaviour rules. XXX is now able to better self-regulate and the incidents of behaviour have subsided considerably.

XXX is often out with support who cannot keep up with him on the mountain bike! He is now able to wake up and stay up late whenever he chooses to. His care support team are continuing to work and develop a plan, this is continually updated to ensure XXX does not lose out on potential opportunities. XXX had the opportunity to take up paid work but he wanted to continue on a voluntary basis, which he felt was more conducive to his health and wellbeing.

**Case Study 2**

XXX loves his family, especially his two younger brothers who have similar interests in gaming. He went to a local school up until the end of Year 13. With support from his brothers, he loves watching YouTube videos of professional ESport gamers talking through his favourite games. XXX has many interests including music, his mobile phone and watching the Wolves at Molineux.
His parents were very anxious about the next steps for XXX as he transitioned into adulthood and unclear about his education progression. XXX was clear he did not wish to continue with his education and wanted to be active in the community. His parents, who are his main carers supporting with all tasks of daily living outside of the school day, held down permanent jobs which suddenly appeared in jeopardy with XXX's future aspirations.

**What are XXX's strengths**

XXX can play on his gaming console independently and uses Amazon Echo to navigate through his music playlist at home. XXX goes with his father to watch the Wolves at weekends, but often misses the weekday games due to his father's work commitments. XXX chooses his own meals and often picks the ones that have a kick to them! XXX loves his mother's cooking, but would like to be supported to make his own meals occasionally with the spices to hand.

**XXX's experience**

XXX has a mild learning disability with a physical disability. He uses a wheeled frame to walk unassisted. After COVID, XXX has worked hard to maintain his mobility, considering he was not able to leave the family home to go outdoors, and he did this by doing exercises with his brothers and involvement from Occupational Therapists who did online demonstrations on Zoom initially.

XXX was referred to the Preparing for Adulthood Team by the Children's Disabilities Team who had set up a domiciliary care package to support him with personal care in the mornings. XXX did not like different carers coming to the family home in the morning.

A Preparing for Adulthood Plan was completed with XXX to identify his wishes and aspirations for the future. A Carers Assessment was also offered to his parents to identify how they can be supported in their roles, this included consideration for how they could maintain employment and sustain this alongside the caring role.

XXX was involved in discussions about his future. He wanted to be more independent from his parents and have a choice in how his care and support is provided, and he wanted his parents to continue supporting on the evenings. He understood why his parents felt staying in education was a good idea for him, but this was not his wish and he worked with his Preparing for Adulthood worker to create a Personal Support Plan that would meet his needs and ensure his parents were able to continue with their lives as usual.

**The support XXX will get to live his life**

XXX made the decision to leave college at the end of Year 13 and continues to live in the family home while his brothers are young. He hopes to build on independent living skills over the next two years and move out into accommodation of his own when he is 20.

XXX now has a Direct Payment, where he has recruited his own Personal Assistant to come each morning to support getting ready and dressed for the day ahead. He reached the decision to go without the domiciliary care package and opt for an arrangement which gives him more control and choice over his own support arrangements. The Personal Assistant works alongside XXX to build on independent living skills that his mother and father would have typically done for him. He is now chopping up vegetables with support to make his own spicy dishes, he makes enough for the family to have as their main meals some evenings.

XXX is now able to follow the Wolves midweek at their evening games with ad hoc support from his Personal Assistant and adding new widgets he can try out with his brother on his next family visit.

His parents remain in employment and are supported in their caring role because XXX has his own support independently of them. XXX is thinking about going to college 1 day per week to do a social media course to learn how to make his own gaming videos.

Over the next two years it is hoped XXX will build the confidence and acquire new independent living skills to move into his own accommodation in the future. He continues to have his Personal Assistant and the support of his family.

**Case Study 3**

XXX is a happy young adult and is well liked in school. It has been identified that XXX has reached his full potential in education as agreed by himself and his class teacher, his family are also on board with this. XXX's interests are the outdoors, he loves gardening and outdoor leisure where he visits football grounds, restaurants and gardening centres with his family and his PA.

XXX already had a PA in place before my involvement as parents both work full time. His PA enables him to access the community away from the family home and to spend time with adults around his age group where XXX has formed good relationships. XXX's needs were identified as 1-1 support as he has no road safety or danger's he could be exposed to. XXX needs 1-1 support with all aspects of his daily living activities in line with the Care Act, as he would not have capacity to do this solely on his own. XXX is the only sibling still living in the family home where it has been identified he needs a lot of stimulation to fulfil his needs.

PFA support involved using the PFA Personal Support Plan to work with XXX and his family to build a picture of his strengths, interests and needs. We then started looking together at possible activities XXX could do when he leaves school.

XXX had had some experience at Ashfield Gardens via his school and he enjoys his time there. After discussion with Ashfield Gardens they confirmed they could meet his needs and provide 1-1 support throughout XXX's stay. It was agreed that if everyone was in agreement on him leaving school, XXX could start by attending 2 days a week with a possible increase depending on how he copes with the 2 days.

XXX has expressed an interest in Riverside as it is outdoors where he is happiest. Riverside have confirmed that they could meet his need if XXX provides his own PA that can attend with him. XXX could attend Riverside up to 5 days a week. Discussions took place with mother and XXX's current PA to see if and how often they could provide support for XXX if it was agreed he would attend Riverside. They agreed they could provide this support in line with whatever was agreed in his plan.

XXX wanted to attend social activities in the community in gardening, music, gaming, football and swimming. XXX wants to continue living in the family home and is not wanting to move into his own accommodation or supporting living. Parents are happy that XXX can continue to live with them and are happy to continue supporting him. The PFA Personal Support Plan and all the information that was gathered, as well as options that had been explored, were passed to the social worker to inform his reassessment and support planning.

The overall outcome for XXX is to spend time with peers within his age group and away from the home environment, this will encourage XXX to be more social out in the community and keep him active, it will also improve his ability to interact with others and maintain friendships within his provisional groups. XXX's PA will encourage him to maintain his life skills with prompting on what and how to achieve them and XXX will also explore more of the outside world visiting new places around his interests.

**Case Study 4**

XXX lives with her mother and her dog (Jake) in a house in the Dudley borough area. XXX has autism spectrum disorder and learning disabilities. She attends Aspire college and her course is due to end on 15th of June 2023.

Information was collected through face-to-face visits, using the PFA Personal Support Plan with XXX, in addition to telephone calls made to XXX's SEND officer, EHCP Co-ordinator and college. XXX identified her aspiration and wishes within the community. XXX wished to live at home with her mother in the short term and in the foreseeable future. She also identified in her education and employment that she would like to increase her confidence and independent/daily living skills. In her hobbies and interests, XXX expresses her passions for arts and crafts, dancing, baking and animals. XXX has said she is hands-on and likes creating and making things. XXX identified that she would like to be a veterinarian or gain work experience/volunteering with animals.

Information regarding XXX's wishes and aspirations were recorded on a face-to-face visit. I discussed and explained there were informal services that offer activities in the community for free or a small fee. XXX and her mother

expressed their interest in the informal activities in the community and information was given to XXX and her parents about various activities within the community. Some of the charities that interested XXX were; Hope House, which offered XXX gardening and specialist cooking courses, Dudley Borough halls, music and dance, the theatre and cinema tickets, Himley Hall, outdoor events, charity fun runs and much more.

XXX's wishes in education were to increase her independence, build on her numeracy and literacy, independent/daily living skills and to keep a scheduled routine that she can become familiar with, alongside additional support within the community with the assistance of a PA. XXX is familiar with technology and had gadgets of her own for example; computer, tablet and Alexa which she uses with the assistance of Alexa (Voice search).

XXX's PFA has been completed along with her PFA Handover for allocation of a social worker. This will inform her Care Act assessment and future support planning ensuring that these are both strengths based and person centred.

# Adult Social Care Select Committee - Progress Tracker

| Subject (Date of Meeting) | Recommendation/action | Responsible Officer/Area | Status/Notes |
|---|---|---|---|
| Meeting on 13th July, 2023 - Progress Update with the Woodside Day Service | Resolution (3) - That a further report be submitted to a future meeting of the Select Committee, with consideration being given to ways of seeking service users' views on the service. | Director of Adult Social Care/Democratic Services | **Future meeting date to be confirmed** |

## Future Business 2023/24

| Date of Meeting | Work Programme | Responsible Officer/Area |
|---|---|---|
| 7th March, 2024 | Annual Report 2023/24 and potential items of business for 2024/25 | Steve Griffiths |
| | Telecare Update | Marie Spittle |