Agenda Item No. 7

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.

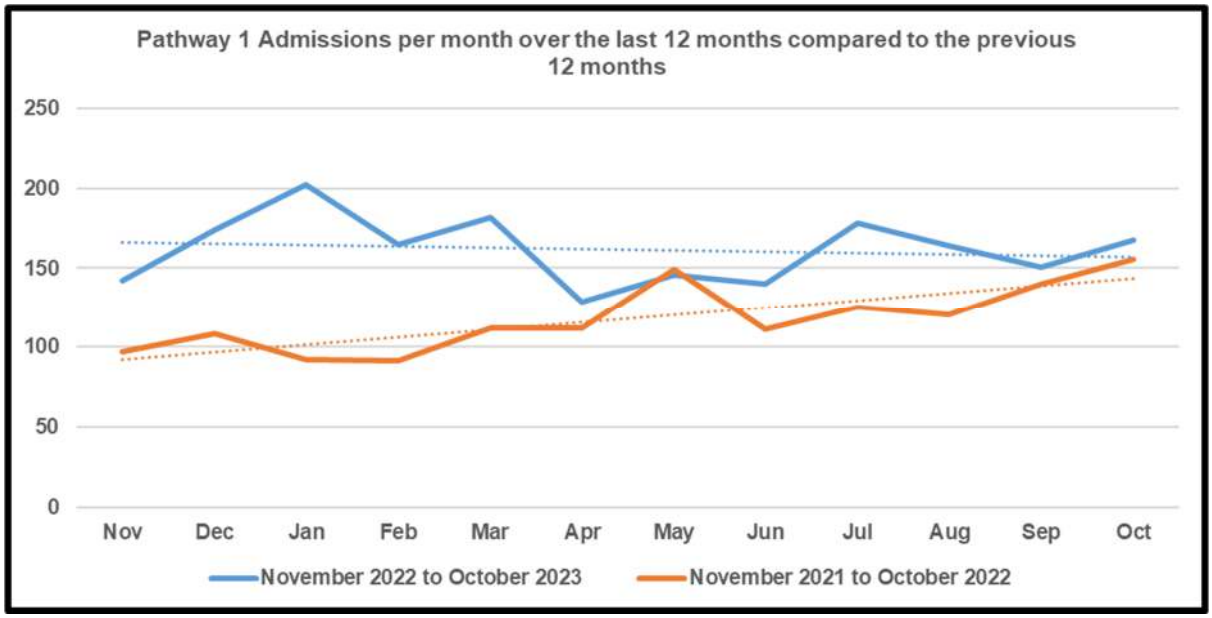
8. Under the approach of discharge to assess most people are expected to go home. Also on national evidence, the most effective way to support people is to ensure they are discharged safely when they are clinically ready, with timely and appropriate recovery support if needed.

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.

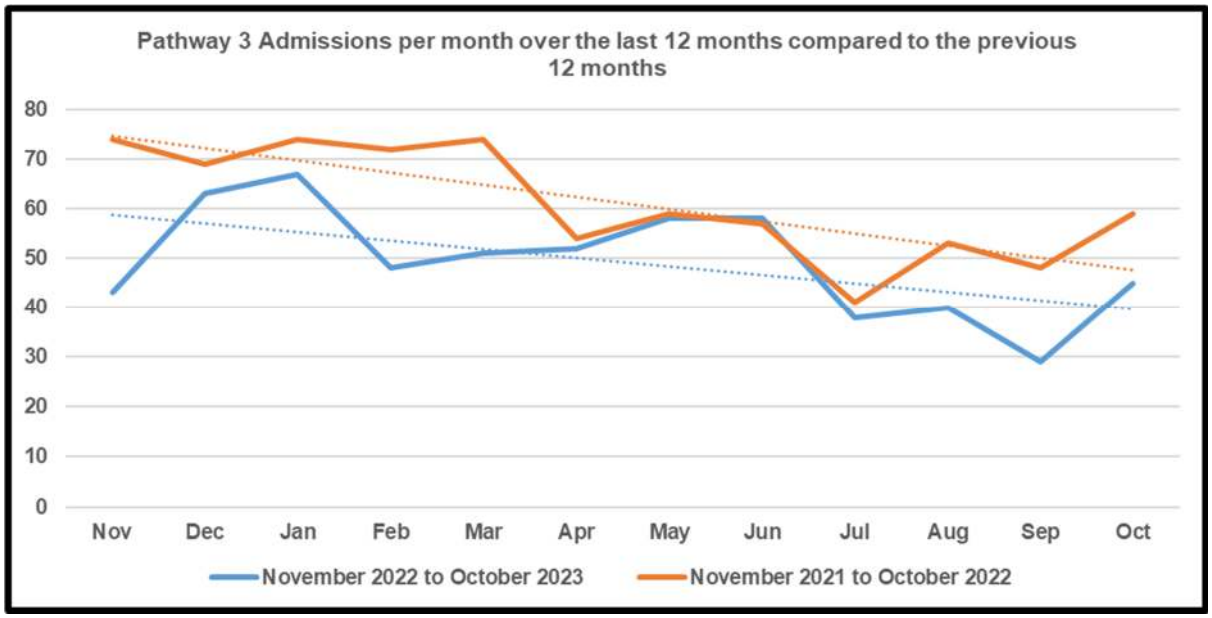
10. Activity of supported discharges from Nov 2022 to Oct 2023

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)

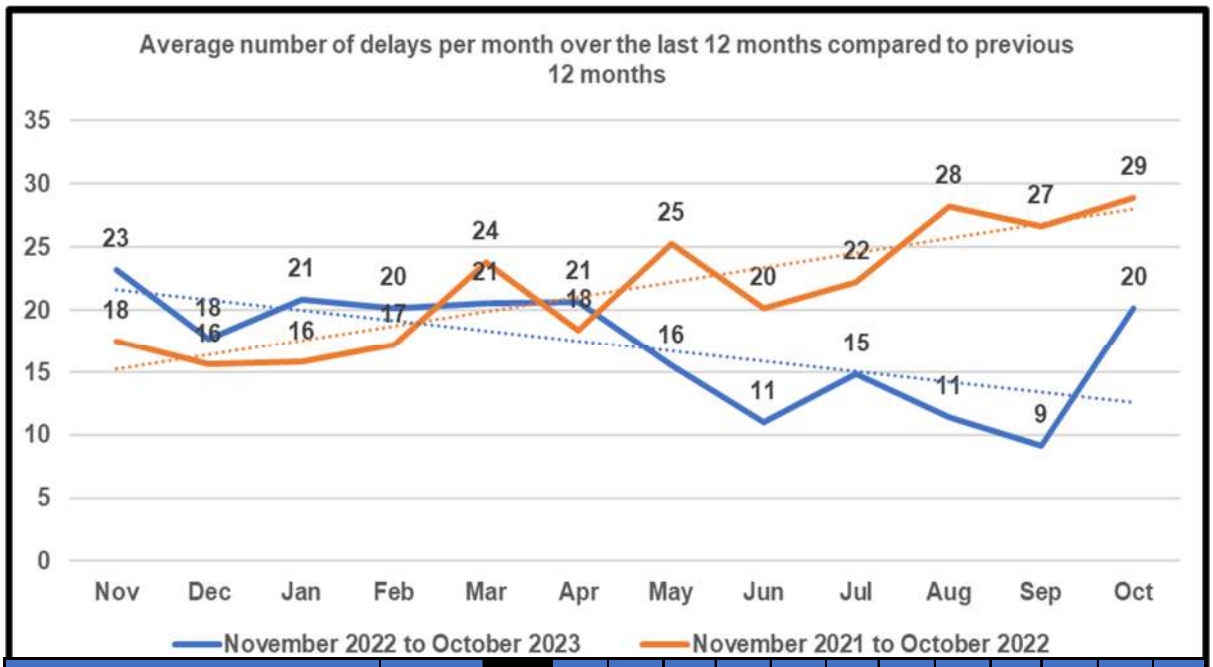
Pathway 1 Delays	Average	Total	11/2022	12/2022	1/2023	2/2023	3/2023	4/2023	5/2023	6/2023	7/2023	8/2023	9/2023	10/2023
Total	152	1820	140	123	205	153	169	146	156	146	158	123	124	177
Care Package	112	1342	85	77	165	111	143	99	102	94	131	99	79	157
Brokerage	1	5	1		1	1			1				1	
Equipment	4	43	4	2	2	9	5	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

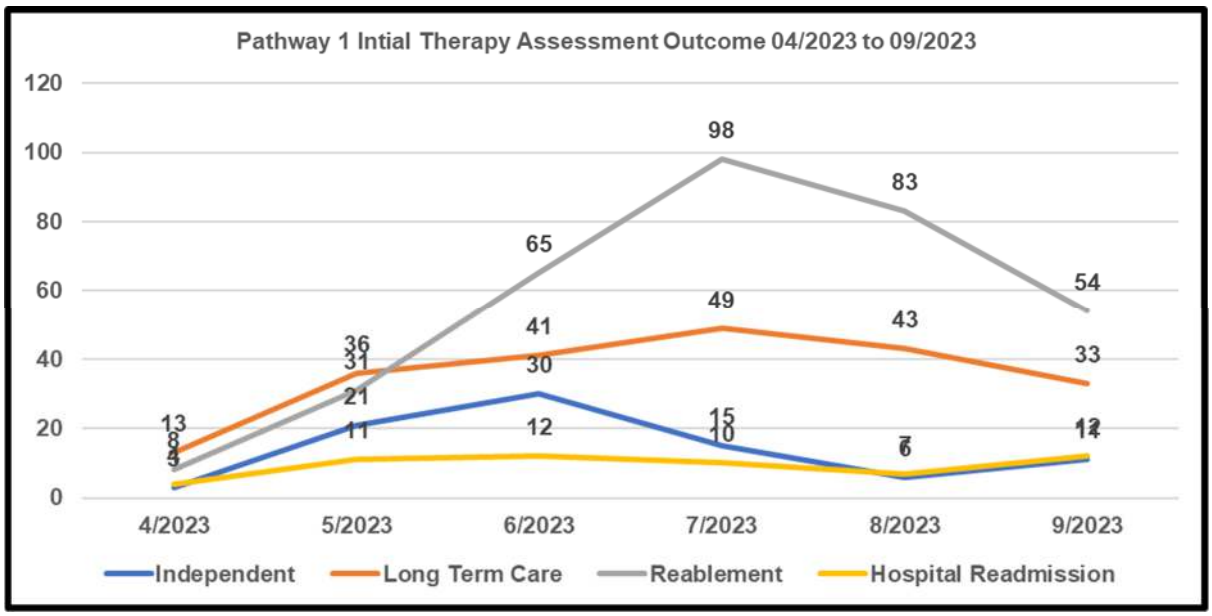
16. The main source of delay for placements was awaiting homes to be identified. Since April 2023 we have introduced a brokerage team which provides identified placements within 2 days.



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.

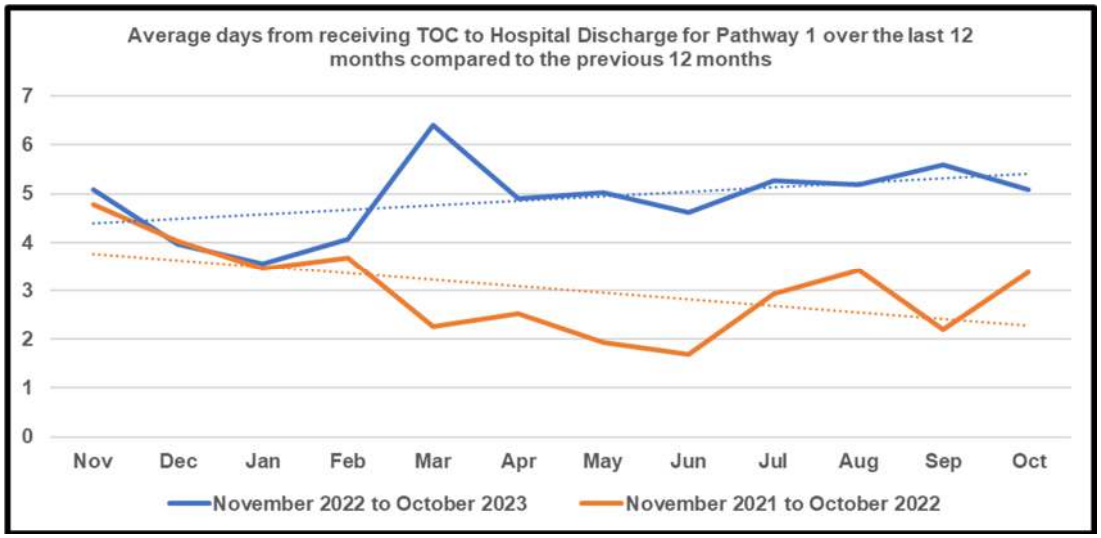
29. We support the person’s confidence building, to regain independence without need of formal care or back to baseline independence levels.

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

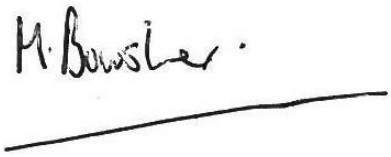
41. There are no perceived impacts on the environment or climate change.

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.



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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