DECISION-MAKER:		**Joint Commissioning Board**		
SUBJECT:		**Pathway 3 Discharge to Assess Pilot – Evaluation Report & Recommendations**		
DATE OF DECISION:		**9 August 2018**		
REPORT OF:		**Stephanie Ramsey**		
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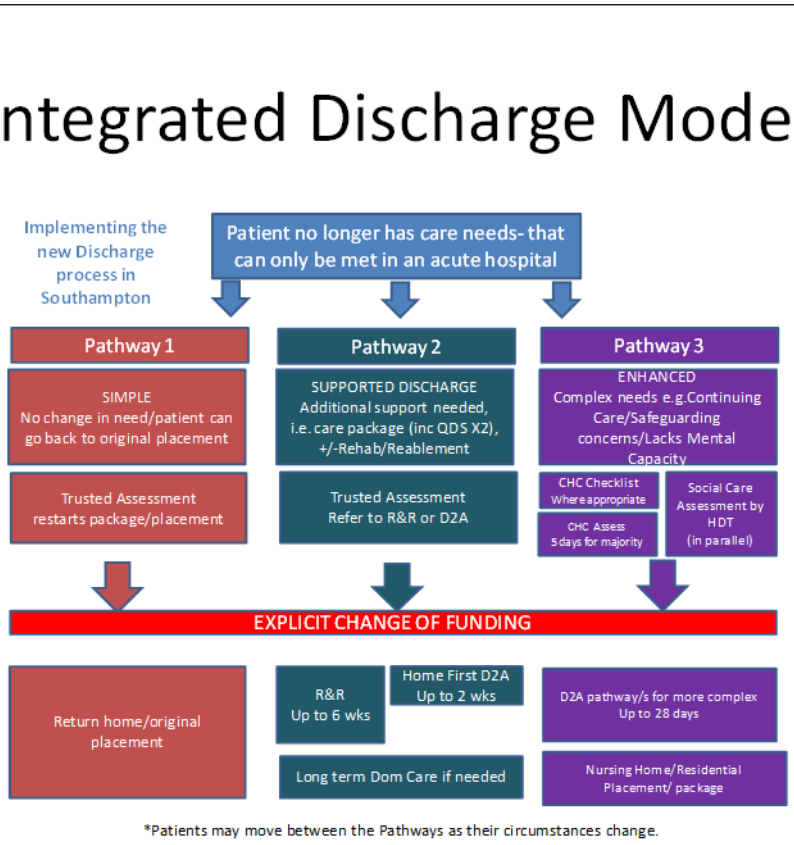
STATEMENT OF CONFIDENTIALITY
NOT APPLICABLE

BRIEF SUMMARY		
This report provides a summary of the key learning points and recommendations following the pilot of a Discharge to Assess scheme for patients on Pathway 3 over the period 1 November 2017 – 30 June 2018.		
RECOMMENDATIONS:		
	(i)	To note the findings and key learning points from the pilot.
	(ii)	To consider the recommendation that Discharge to Assess should be implemented for complex patients/clients as an intrinsic part of pathway 3, managed by the Integrated Discharge Bureau (IDB) and give support for this to be worked up in more detail.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The consistent delivery of safe, appropriate and timely discharge from the acute hospital setting continues to challenge the majority of health and social care systems, particularly where the needs involved are complex.	
2.	This report concerns the evaluation of a pilot to test a discharge to assess (D2A) scheme for clients/ patients with more complex needs (referred to as patients/clients on "Pathway 3") and recommendations for a future model. This is a key element of Southampton's action plan to reduce delayed transfers of care (DTOC) and part of the "8 high impact change model" for improving discharge published jointly by the LGA, DH, Monitor, NHS England and ADASS in 2015. Southampton has a significant challenge to achieve the nationally set target for reducing DTOC (26.6 delays per day by Sept 2018 from a baseline of 38.8) and failure to reduce social care attributable delays could directly impact the additional social care monies invested by Government via Better Care. Assessment of long term health and social care needs outside of the acute setting is better for our population, individual system partners and the system as a whole.	
3.	Alongside the nationally set target for reducing overall DTOC, there is a national target for reducing the percentage of assessments of eligibility for Continuing	

	Healthcare (CHC) undertaken in the acute setting to 15% or less.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	NOT APPLICABLE
DETAIL (Including consultation carried out)	
1.	**Background** Three pathways for discharge have been developed to provide a standardised approach, which is now recognised across the whole South West System. • **Pathway 1 Simple discharges** – these are managed by the hospital ward staff through trusted assessment with support as necessary from the Integrated Discharge Bureau (IDB) and strong links back to the patient's/client's community care team who will proactively work with the hospital. Primarily this includes care package re-starts and return to home or previous placement. Ward staff are responsible for identifying and assessing these patients and refer onto the discharge officers within the hospital to organise discharge. • **Pathway 2 Supported discharges** – these discharges are managed by the Southampton Urgent Response Service (URS) which is part of the Integrated Rehab and Reablement Service. A D2A scheme using home care is now well established and the URS will in-reach into the hospital to work with ward staff to facilitate discharge. This includes those situations where additional support in the community is required for example a long term care package, rehabilitation, reablement or bed based care. Ward staff are responsible for identifying and directing these patients to the URS which will then facilitate discharge. • **Pathway 3 Enhanced discharges** – these discharges are managed by the IDB and Hospital Discharge Team (HDT). This involves those patients requiring complex assessments or those with obviously complex long term care needs. This can include safeguarding concerns, those lacking mental capacity and those likely to be eligible for Continuing Healthcare. Ward staff are responsible for identifying and directing these patients to the IDB which will then facilitate discharge.
2.	These 3 pathways are illustrated in the diagram below.

	
3.	Discharge to assess (D2A) is recognised nationally as best practice for ensuring timely discharge and is defined as: "discharge to assess will involve people who have ongoing complex care need but have been clinically optimised such that they no longer require an acute hospital bed for this care and their assessment can take place outside the hospital setting, in their local community, ideally in their own home".
4.	The benefits of assessing people's long term care needs outside the hospital environment have been well documented and are predicated on the principle that people feel more empowered and are better able to function in their home setting leading to a more informed and accurate assessment of their needs. This can reduce ongoing requirements and costs of packages of care.
5.	Discharge to assess is now well embedded for patients/clients with less complex needs (but still requiring additional support post discharge) on pathway 2, where assessment takes place in their own homes and has evidenced a reduction in long term care needs. This has led to savings and cost avoidance in social care packages. The intention is to adopt a similar D2A approach for patients/clients with more complex needs (referred to as being on Pathway 3). However, owing to their complexity of need, a more intensive package of care is usually required to support their assessment in the community and opportunities for savings are limited.
6	The Joint Commissioning Board therefore gave approval in September 2017 to fund a pilot of a D2A scheme specifically for Pathway 3 using a mix of bed based provision (provided by nursing and residential homes) and home care whilst people are assessed, underpinned by a pooled budget with equal contributions from the CCG and City Council. The pilot was established to test out a number of objectives on a small scale prior to moving to a permanent D2A scheme for all clients on Pathway 3:

	• to test a mixed model of D2A placement for this client group, particularly the viability and impact of using a robust home care package for some clients/patients • to evaluate the impact on DTOC overall in terms of both numbers and costs • to test processes and how much assessment capacity is required to maintain throughput on this D2A pathway
7.	**Overview of Pilot** The pilot was a "discharge to assess" scheme for patients who are medically fit and able to leave hospital but due to the complexity or likely complexity of their long term care needs, require further assessment and support in the community setting.
8.	A mixture of assessment placements were commissioned:- • 4 x "standard" nursing home beds • 4 x "complex" nursing home beds • 4 x "residential" beds • 1 x "live in" home care placement The assessment placement was for a maximum of 28 days but with the aim of completing the majority of the work within a three week period (this allowing one week for arrangement of onward placement).
9.	For the purposes of the pilot the proposal was developed on a maximum demand level of 4 referrals a week.
10.	The pilot included the recruitment of 1 WTE nurse and 1 WTE social worker primarily to undertake assessment in the community setting and ensure timely move on to long term care. These posts were to additionally liaise with appropriate members of the IDB (both health and social care) in supporting the "pull" of appropriate patients from hospital. Overall responsibility for the identification of potential patients for this scheme and facilitating safe and appropriate discharge once agreed remained with UHS staff in the hospital.
11.	The pilot was initially scheduled to run from 1 November 2017 – 30 April 2018 but was extended to 30 June 2018 to enable a fuller evaluation.
12.	There was an established project group working on the delivery of Pathway 3 that continued to meet regularly throughout the pilot and beyond. A weekly teleconference was also established to support the process.
13.	**Summary of Pilot Activity** The table below presents the operational data from the pilot for the period 1 November 2017 – 30 June 2018.

Metric	Assessment Bed/Packag	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Operational													
No. of hospital readmissions from assessment beds							1	1		1	1		1
No. of patients accessing the assessment beds/packages	complex nursing home						1	1					
	standard nursing home					1	3	6	7	3	5	4	3
	residential care							1					
	home care							1					
No. of placements extended beyond 4 weeks							2	1	2		3	1	2
No. of declines to pathway 3 D2A on grounds of patient cho						4	6	2	5	1	2	3	
No. of declines from the homes for pathway 3 patients						1					1	1	2
No. deaths (within the 28 day placements)							2	3	2	2	1	1	1

14.	This shows that during the 8 month period there were: • 36 patients/clients who went onto the pilot (an average of 4-5 a month) of

	whom the vast majority went into the standard nursing home placements (32 out of the 36) • 23 patients/clients who declined the pathway on the grounds of patient choice • about one third of assessments took longer than the scheduled 28 days • there were 5 readmissions and 12 deaths which were reviewed and found to reflect the complexity of the client group The reasons behind this data are discussed in more detail in the following sections.
	<u>Learning from the Pilot</u>
15.	**Client group:** The pilot focussed on providing a D2A pathway for the more complex patients/clients whose needs are beyond those on Pathway 2 e.g. people who may be eligible for CHC, may lack mental capacity, may have safeguarding concerns. Typically this group are likely to require high levels of long term care, often in residential or nursing home provision, and are likely to have long stays in hospital prior to discharge. They are also those patients/clients most likely to be subject to discharge delays owing to complexity of assessment and difficulties sourcing long term care, delays in nursing home placements being one of the top reasons for DTOC. In Southampton, following significant developments within the rehabilitation and reablement pathway, including the embedding of D2A as the default position for any client on Pathway 2, the majority of delays now relate to patients/clients on Pathway 3 – they are relatively a small group in patient/client numbers, however with a high number of delayed days attributable to them. The pilot identified that on average there were 1-2 patients a week suitable for D2A on this pathway (as opposed to the initial estimate of 4 a week), although over time it is expected that this number will increase to 2-3 a week as staff become more familiar with D2A as an option for this client group. The pilot also identified that, whilst many would be eligible for an assessment of CHC, **less than 2%** would go on to be proven eligible for CHC and **the majority will be social care funded clients** (Self funders estimated to account for 5-15% of this client group) who will require social care funded nursing home placements.
16.	**Assessment Placement/Capacity:** An aim of the pilot was to test a mixed model of assessment placements including residential care, nursing care and support in a person's home. The pilot demonstrated that the vast majority of clients were only suitable for nursing home care, owing to their level of complexity, 32 out of the 36 clients being placed in standard nursing home provision. To support this client group at home required a level of live in and double up care which was generally at a cost that was prohibitive to the scheme and potentially raised expectations which were not sustainable in the long term. It is however considered that there could be some benefit in maintaining a home support option in future for the small group of patients/clients with delirium where (although not tested in this pilot) there is national evidence to show that a time limited period of assessment and reablement in their own homes can lead to the delirium resolving and improved outcomes. The pilot also demonstrated the need for flexibility to source assessment

placements from a wide range of nursing home providers. A small number of block contracts were initially set up for the pilot to enable the commissioner to build a relationship with particular providers; however this took time to set up and a number of the providers were outside the city (owing to the lack of nursing home capacity in Southampton) which was unpopular with some clients and their families because of travel distance. The decision was therefore taken mid pilot to decommission some placements in favour of spot purchasing which enabled greater flexibility and better value for money as it avoided voids. The only exception to this was a block contract with one nursing home in Southampton able to offer both standard and complex placements. The relationship with this particular home has proved positive and offers other opportunities for future relationship building including the possibility of trusted assessment (this would ultimately impact favourably on hospital delays).

Going forward, it is recommended that any future model sources the majority of its assessment placements through spot purchasing with a wide range of providers with perhaps just one small block contract arrangement with one nursing home provider to build on the positive relationships established through the pilot. It is recommended that this capacity is focussed on nursing home beds (mainly standard with some complex) with a small budget to spot purchase some flexible care to support some clients with resolvable conditions (i.e. delirium) in their own home.

In terms of placement capacity, the pilot also demonstrated that there was a need in some cases for a longer period of assessment. Around a third of the patients on the scheme remained in placement beyond 4 weeks because of the challenges associated with completing the more complex assessments. It is therefore recommended that sufficient capacity is built in to any future model to allow for an average period of 5 weeks assessment for all clients.

17. **Impact on national targets, length of hospital stay and long term care costs:** The pilot demonstrated that the use of D2A for patients/clients on Pathway 3 has a positive impact on reducing length of stay, reducing discharge delays for both the Council and CCG and contributing towards achievement of the CHC target to reduce the percentage of assessments carried out in an acute setting.

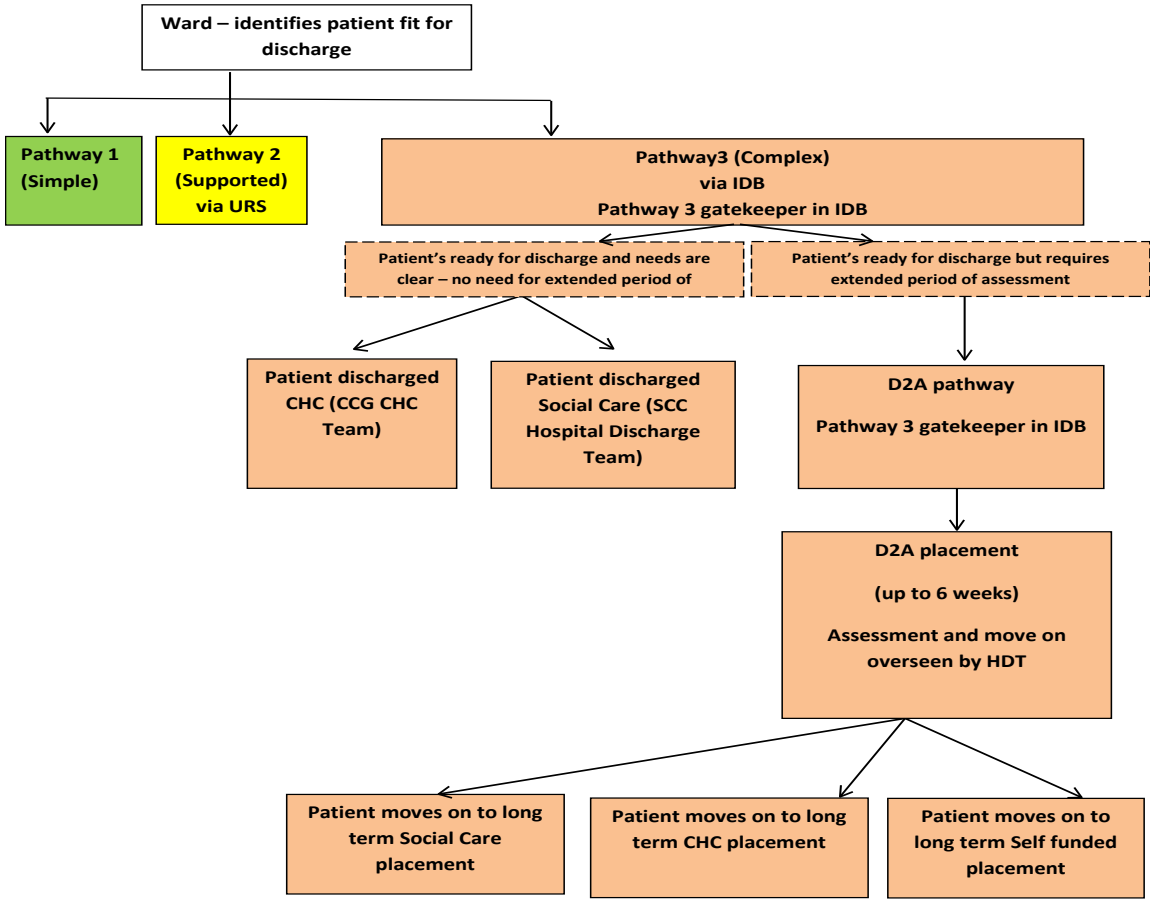
During the pilot period CHC assessments undertaken in the acute hospital decreased from 86% (pre pilot position) to 10% (June position). The pilot was only one factor in this reduction, but the overall additional focus it created on the assessment of long term care needs in a non-acute (outside of hospital) setting during the pilot period was a major positive. This is shown in the table below which shows the number and percentage of CHC assessments undertaken in hospital:

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
% CHC Assessments in acute setting	86%	56%	50%	29%	23%	19%	15%	15%	10%

Unfortunately, owing to the data analyst post becoming vacant within the Integrated Discharge Bureau, it was not possible to consistently monitor length of stay for the full duration of the pilot; however data for the period November 2017 – January

	2018 showed the **average length of hospital stay for patients on Pathway 3 D2A was 40 days, whereas it was 71 days for patients who were offered D2A but declined it.** This indicates the potential for a significant reduction in DTOC and possibly excess bed days.
18.	Impact on reducing costs was less evident. Given the complexity of clients, the majority of whom required a nursing home placement, it proved very unlikely that significant reductions would be achieved in reducing packages of care and most clients went into long term placements with similar levels of care provided at the time of assessment. The only client group where it is felt that there may be benefits in reducing long term care costs are those with delirium mentioned above in Paragraph16 (based on national research evidence). There is a developing awareness that some patients with delirium are placed in long term residential care unnecessarily when a period of intensive care within a home environment would allow for the delirium to resolve. These patients could be managed on this pathway with a D2A or "bridging" type approach in any future model.
19.	**Patient/Client Experience:** During the pilot a questionnaire was used to follow up with individual clients / families on their experience. The main feedback from clients who went onto the D2A pilot was: • Assessment in placement was viewed as positive, particularly by those clients who went on to remain in the same home for their long term care. • Assessment in placement was viewed as less pressured with more opportunity to ask questions and seek clarification from staff. The main areas of more negative feedback came from people who declined the D2A pilot and related to: • Limited choice of placement, which was particularly an issue in relation to those contracted homes which were outside of the city where travel distance was a concern to families • Having to move on from placement (i.e. having to move twice, once into the assessment placement and then again into the long term care placement) 23 clients/families declined the D2A scheme for these reasons which will need to be taken into account for future implementation. The issue around limited choice has already been discussed in Paragraph 16 and will be addressed through the greater flexibility in sourcing placements offered by a spot purchasing approach. Placement moves could be reduced by placing a client wherever possible in their long term placement directly from hospital and carrying out the assessment there. This should be considered wherever possible going forward; the use of spot purchasing arrangements with a wide range of providers to source placements (as opposed to block contracted beds) is more likely to support this.
20.	**Discharge Processes:** The pilot particularly highlighted the need for simple, standardised and high quality discharge processes. There were two key learning points with regard to process: • firstly that D2A needs to be seen as an integral part of the standardised

	discharge pathways, in this case Pathway 3, as opposed to anything separate. It is recommended going forward that D2A for Pathway 3 clients/patients is managed by the IDB as part of Pathway 3 and that a gate keeping function is identified in the IDB to work directly with the wards on a daily basis to appropriately target patients who would benefit from D2A and support the timely "pull" from the wards. • secondly that good quality discharge in terms of good communication with nursing homes, provision of comprehensive and accurate patient/client information, timely arrangement of transport, provision of the right medication and equipment is key to ensuring a timely and proactive response from care providers. The pilot highlighted some difficulties in this area which are being addressed by UHSFT. The relationship with the care market going forward is key to the success of rolling out D2A for this client group, particularly in progressing 7 day working.
21.	**<u>Summary and Recommendations</u>** In summary, the pilot demonstrated that D2A can be implemented for Pathway 3 clients and improves patient/client experience in terms of providing a less pressurised environment for assessment and reducing unnecessary long stays in hospital which are known to lead to poor outcomes for patients/clients. There are 2-3 clients a week in Southampton who would be eligible for D2A on Pathway 3 and the vast majority of these will require nursing home placements, the majority of whom will be social care clients. Needs are complex and most clients will go on to require nursing home care; however D2A provides an opportunity for any reablement and therefore cost reduction that is feasible. It is recommended that going forward D2A should be provided for complex patients/clients and that this should function as an intrinsic part of Pathway 3, managed by the IDB. In time, the long term aim would be to discharge clients wherever possible to their long term placement and assess there; however until this can be guaranteed for all clients, it is recommended that a joint budget split 50/50 between the CCG and SCC is held by the IDB for short term D2A placements.
22.	<u>Proposal for Pathway 3</u> Key principles for Pathway 3 should mirror those for all other pathways, namely: • discharge planning should commence as early as possible • decisions about long term care needs should wherever possible be made outside of the hospital setting • a strengths based approach should always be employed • trusted assessment should be promoted For any Pathway 3 discharge, there will be two key decisions: can the patient go straight to placement either funded by CHC or Social Care; or do they require a longer period of assessment, in which case they will go down the D2A route. It is proposed that there should be a new "gate keeping" function in the IDB to "pull"

	appropriate patients from the wards and to specifically oversee the D2A placements. It is proposed that assessment of the patient/client in their D2A placement, working with the CHC team if the patient checklists in for CHC assessment, and managing the move on of the patient/client at the end of their period of assessment is undertaken by the Hospital Discharge Team.
23.	This proposed model for Pathway 3 is illustrated in the diagram below. 
24.	With specific reference to Pathway 3 D2A, the following recommendations are made: • The pooled fund is maintained to the end of the 2018/19 financial year between the CCG and Council on a 50/50 split to fund a mix of bed based (standard and complex nursing home) and a small number of home care D2A placements for a 4-6 week period, taking on board the lessons from the pilot that 4 weeks is not always long enough to support a comprehensive assessment of a client's long term care needs. This is then reviewed at the end of the year to inform 2019/20 budget planning. • It is proposed that the assessment placements are sourced through a mix of block contracting (it is recommended that a trusted nursing home partner is commissioned to provide up to 3 standard and complex beds til the end of 2018/19, building on the relationship developed with one nursing home during the pilot) and spot purchasing. • Discharge to a D2A placement should be seen as the default position for any

	patient/client whose long term needs require a period of assessment. • As already stated, there should be a gatekeeper function within the IDB, responsible for "pulling" appropriate patients from the wards and accessing the D2A placements and overseeing capacity. • The undertaking of the D2A assessment would sit with the Hospital Discharge Team (with CHC and/or community nursing teams as appropriate) along with overseeing the client's eventual move on to long term care.
RESOURCE IMPLICATIONS	
<u>Capital/Revenue</u>	
25.	The total budget for the pilot was £463,465 for 6 months. This comprised: Assessment Placements • Standard Nursing Home x 4 beds x 26 weeks x £850 = £88,400 • Complex Nursing Home x 4 beds x 26 weeks x £1,500 = £156,000 • Home Care x 4 packages x 26 weeks x £950 = £98,800 • Residential home x 4 beds x 26 weeks x £700 = £72,800 • TOTAL £416,000 Assessment Team • 1 wte nurse at Band 6 for 26 weeks = £ 22,242 (including on costs, top of the band) • 1 wte social worker or care manager for 26 weeks = approx. £20,000 • 0.25 wte band 7 supervision for 26 weeks = £5,223 • TOTAL £47,465
26.	UHS made a contribution of £75,000 which left £388,465 which was split 50/50 between the Council and CCG and set up as a pooled fund within the Better Care S75.

27. For the 8 month period 1 November – 30 June (extended length of pilot), the actual spend on the pilot was £377,477. This is less than the 6 month budget of £463,465, leaving an unspent surplus of £85,988. The main reason for this underspend was because a number of the placement provisions commissioned were ceased mid pilot in favour of increasing capacity with one contracted nursing home provider in the city and establishing a budget for spot purchasing placements (for the reasons already discussed in this report) and demand was lower than expected (1-2 referrals a week as opposed to 4). The following table summarises the financial outturn of the pilot project.

Description	Budget for Pilot (£)	Actual spend for pilot up to end of June 2018 (£)	Forecast variance (£)
Placement Budget	416,000	285,273	(130,727)
1.0 wte Nurse Cost	22,242	55,083	32,841
1.0 wte Social Worker/Care Manager	20,000	37,121	17,121
0.25 wte B7 supervision	5,223	0	(5,223)
	463,465	**377,477**	**(85,988)**
Funded by:			
University Hospital Southampton	(75,000)	(75,000)	0
Southampton City CCG	(197,965)	(160,220)	37,745
Southampton City Council	(190,500)	(142,258)	48,243
	(463,465)	**(377,477)**	**85,988**

28. For the remainder of 2018/19, in line with the recommendations of this report, it is recommended that the pooled budget based on a 50/50 split between the CCG and Council is maintained to purchase Pathway 3 D2A placements.

The annual budget requirement would be £803,400, calculated as follows:

- Standard and Complex Nursing Home x 3 beds x 52 weeks x £1,200 = £187,200 pa
- Standard and Complex Nursing Home (spot purchasing budget) x 6 beds x 52 weeks x £1,500 = £468,000 pa
- Home Care (spot purchasing budget) x 3 packages x 52 weeks x £950 = £148,200
- Total = £803,400

29. A budget has already been allocated from iBCF which would cover the Council's 50% costs in 2018/19 and the Clinical Commissioning Group have identified funding for their element of the costs. After this date no budget will be available to proceed unless alternative funding is secured. The position will therefore need to be reviewed towards the end of 2018/19.

Property/Other

30. There are no specific property implications associated with these recommendations.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

31. Not applicable

Other Legal Implications:

32. None

CONFLICT OF INTEREST IMPLICATIOINS	
33.	None
RISK MANAGEMENT IMPLICATIONS	
34.	The pilot has enabled D2A to be tested with patients/clients on Pathway 3 in a managed way and this has informed the development of future recommendations and management of risks. In particular: • the primary use of spot purchasing with a wide range of providers for sourcing placements has been recommended going forward in order to maximise flexibility, increase choice and enable some clients, where appropriate, to move to their long term placement straight away (with assessment happening in this placement). This in turn reduces the risk of client/family choice impacting on ability to move clients into D2A and the risk of paying for unused capacity. • building in D2A as an integral part of Pathway 3, managed by the IDB, as outlined in the recommendations going forward will simplify processes for ward staff, reducing the risk of some patients/clients not being considered for D2A in a timely way. The gate keeping function described in the recommendations will further support timely identification and discharge of patients. • allowing a slightly longer period of 4-6 weeks (on average 5 weeks) for assessment in the community will greatly reduce the risk of assessment placement capacity becoming "blocked" as a result of assessments taking longer than planned. This leaves a smaller number of residual risks which will need to be managed going forward, as set out below: • Managing the ongoing risk of client/family choice - it will be important to ensure that D2A is seen as the default for any client on Pathway 3 requiring a period of assessment. This will require awareness raising and training amongst ward staff and clear messaging for patients and their families, highlighting the rationale and the benefits to patient outcomes of minimising the time spent unnecessarily in a hospital bed. • Managing the risk of insufficient capacity in the Hospital Discharge Team to support the gatekeeping function and carry out the assessment within the D2A scheme, such that Pathway 3 operates effectively - in order for this to be supported within existing IDB/Hospital Discharge Team resources, there will be a need to ensure that Pathways 1 and 2 are completely managed by the wards and hospital discharge facilitators and the Urgent Response Service respectively. This has always been the intention but will now require a concerted effort to get there in order to free up the capacity in the IDB/HDT required for Pathway 3. • Managing the risk of poor quality discharge impacting negatively on the willingness of the social care market to support D2A for more complex patients/clients - work is ongoing within UHSFT to improve the quality of hospital discharge.

POLICY FRAMEWORK IMPLICATIONS	
35.	The development of a D2A option for Pathway 3 clients supports the delivery of outcomes in the Council Strategy (particularly the priority outcomes that "People in Southampton live safe, healthy and independent lives" and CCG Operating Plan 2017-19, which in turn complement the delivery of the local HIOW STP, NHS 5 Year Forward View, Care Act 2014 and Local System Plan. It is also a key element of the 8 High Impact Change Model for managing transfers of care which all Local Authorities and CCGs are expected to implement.

KEY DECISION?	**Not Applicable - No decision required**
WARDS/COMMUNITIES AFFECTED:	**All**
SUPPORTING DOCUMENTATION	
Appendices	
1.	None

Documents In Members' Rooms

1.	**None**
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**No**
Privacy Impact Assessment	
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.	**No**
Other Background Documents **Other Background documents available for inspection at:**	

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	**None**	