| | | | | |
|---|---|---|---|---|
| **DECISION-MAKER:** | | **CABINET MEMBER FOR ADULT SOCIAL CARE FOLLOWING CONSULTATION WITH THE JOINT COMMISSIONING BOARD** | | |
| **SUBJECT:** | | **PROPOSAL FOR THE MAINSTREAMING OF HOSPITAL DISCHARGE PATHWAY 3 FOR PATIENTS/CLIENTS WITH COMPLEX NEEDS.** | | |
| **DATE OF DECISION:** | | **17 OCTOBER 2019** | | |
| **REPORT OF:** | | **DIRECTOR OF QUALITY AND INTEGRATION** | | |
| **CONTACT DETAILS** | | | | |
| **AUTHOR**: | **Name:** | **Jamie Schofield** | **Tel:** | **023 80296004** |
| | **E-mail:** | **Jamie.schofield1@nhs.net** | | |
| **Director** | **Name:** | **Stephanie Ramsey** | **Tel:** | **023 80296941** |
| | **E-mail:** | **Stephanie.Ramsey@southampton.gov.uk** | | |

**STATEMENT OF CONFIDENTIALITY**

**NOT APPLICABLE**

**BRIEF SUMMARY**

This report seeks approval to proceed with a proposal to mainstream hospital discharge Pathway 3 for patients/clients with complex needs. This follows a substantial pilot period and a further subsequent redevelopment of the model based on the learning from the pilot which was outlined in a report presented to the Joint Commissioning Board (JCB) in February 2019. See Appendix 1 for brief summary of the pilot.

**RECOMMENDATIONS:**

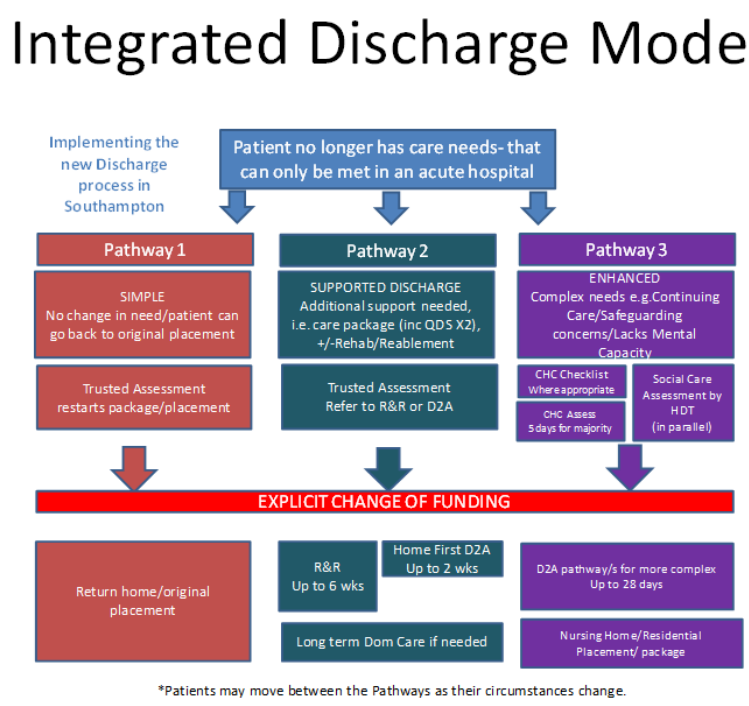
| | | |
|---|---|---|
| | **(i)** | To give approval to proceed with the preferred future Pathway 3 Discharge to Assess option for potential Continuing Health Care (CHC) patients/clients and those with complex social care needs leaving hospital who require a period of assessment. |
| | **(ii)** | To approve establishment of a pooled fund under S75 partnership arrangements of the Health Act with contributions of £229,183 per annum from Southampton City Council and £421,041 per annum from Southampton City Clinical Commissioning Group to fund the assessment placements required for the operation of the Discharge to Assess scheme. |

**REASONS FOR REPORT RECOMMENDATIONS**

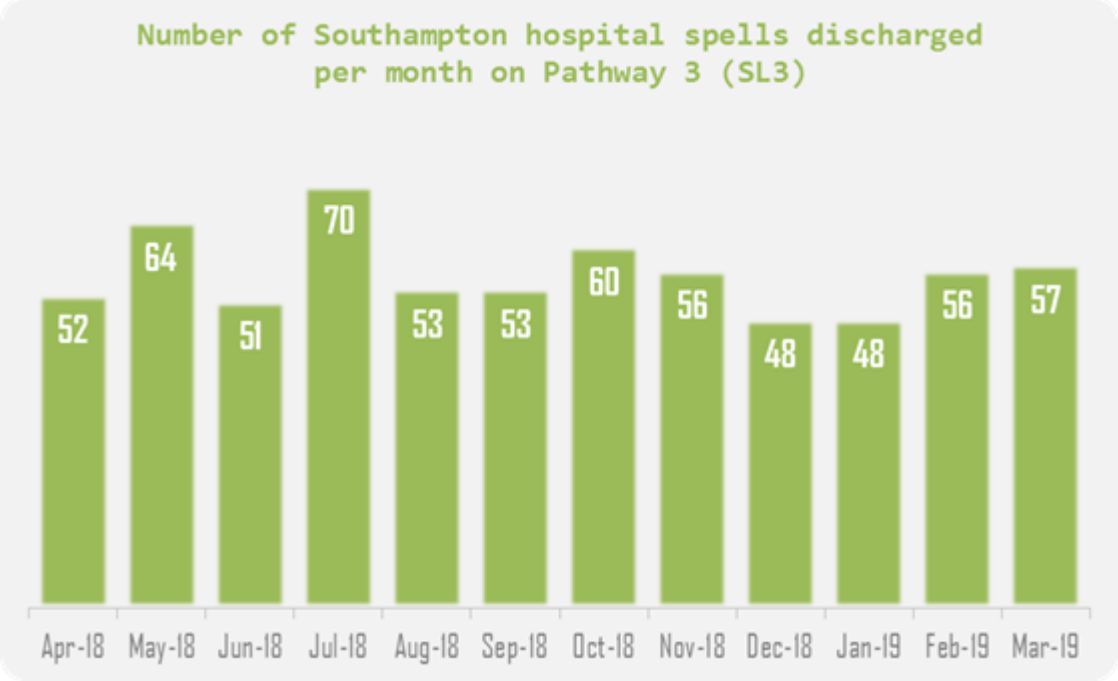
| | |
|---|---|
| 1. | The consistent delivery of safe, appropriate and timely discharge from the acute hospital setting continues to challenge the majority of health and social care systems, particularly where the needs involved are complex. |
| 2. | This report concerns the mainstreaming of Discharge to Assess (D2A) as a core part of Pathway 3 for those complex patients/clients requiring a period of assessment, following the original Discharge to Assess (D2A) pilot which commenced in November 2017 and subsequent amendments to the pilot to |

| | |
|---|---|
| | respond to the learning. 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 Local Government Association (LGA), Department of Health (DH), Monitor, NHS England and Association of Directors of Adult Social Services (ADASS) in 2015. Southampton has a significant challenge to achieve the nationally set target for reducing DTOC and is currently under national scrutiny for having one of the highest rates in the country. Ceasing this approach that the pilot has evidenced as being effective, could negatively impact DToC further. Assessment of long term health and social care needs outside of the acute setting is better for our population and the health and care 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** | |
| 4. | In the report presented to JCB in February 2019, five options were considered in relation to D2A for Pathway 3 as follows:<br>• Option One – Continue as is with the current Pathway 3 D2A model<br>• Option Two – Abandon D2A for Pathway 3<br>• Option Three – Separate D2A pathways for health and social care clients<br>• Option Four – Use of Transitional Care Unit for D2A on the University Hospital Southampton (UHS) site<br>• Option Five – CHC only D2A scheme |
| 5. | A detailed options appraisal was undertaken and the preferred option in February 2019 was Option 3: Two separate D2A pathways – one for CHC patients and one for Social Care clients, with a pooled budget to cover the placement costs for the period of assessment for those clients/patients where it is difficult to predict whether they will be health or social care responsibility. The other options were rejected for the following reasons:<br>• Option One – the costs of this were considered too high and are artificially inflated above the Council's average placement costs owing to the assessment placement attracting CHC rates, given the potential the client could meet CHC eligibility criteria. There had also been a high rate of families refusing D2A because they are not happy for their relative to be moved twice.<br>• Option Two – this would increase the DTOC rate and length of hospital stay. It is also not in line with national policy which promotes assessment taking place outside the hospital setting and does not comply with the 8 High Impact Change Model for improving hospital discharge.<br>• Option Four – this is likely to be high cost and does not comply with the general principle of assessing people in their own home or at least a setting which replicates a homely environment.<br>• Option Five – this option would have little impact for the majority of patients/clients as CHC patients account for a very small proportion of Pathway 3 overall numbers (less than 2%). |
| 6. | Since February 2019 and following further work at the request of the JCB to |

| | |
|---|---|
| | develop the preferred option and how it could be implemented, Option 3 has been discounted on the basis that it was found from a live audit of Pathway 3 patients/clients conducted by the Integrated Discharge Bureau (IDB) that very few are clearly CHC or social care clients prior to assessment and that the majority require a period of assessment to determine this. In addition the tool being proposed to determine this (which other areas had adopted to determine if a client was likely to meet CHC eligibility or not without a full assessment) has been discredited nationally because it is not felt to be accurate enough to determine likely future need. |
| 7. | Option one (Continue as is with the current model) - with some modifications to make this affordable to the Council (reflective of average council rates) and include an element of spot purchasing to enable clients to go straight to their final placement where possible - is now the preferred model. |
| **DETAIL (Including consultation carried out)** | |
| 8. | **Background**<br>Three pathways for discharge have been developed to provide a standardised approach, which is now recognised across the whole South West Hampshire System.<br>• **Pathway 1 Simple discharges** – these are managed by the hospital 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/clients and refer onto the discharge officers within the hospital to organise discharge.<br>• **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 or reablement. Ward staff are responsible for identifying and directing these patients/clients to the URS which will then facilitate discharge.<br>• **Pathway 3 Enhanced discharges** – these discharges are managed by the IDB and Hospital Discharge Team (HDT). This involves those patients/clients 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/clients to the IDB which will then facilitate discharge. |
| 9. | These 3 pathways are illustrated in the diagram below. |

| | |
|---|---|
| |  |
| 10 | Discharge to Assess (D2A) is recognised nationally as best practice for ensuring timely discharge and is defined as:<br>“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 or if not possible a setting as homely as possible”. |
| 11. | The benefits of assessing people's long term care needs outside of 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 a less acute setting leading to a more informed and accurate assessment of their needs. This can reduce ongoing requirements and care costs. |
| 12. | 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 embed 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. |
| 13. | **Pathway 3**<br>Pathway 3 involves those patients/clients requiring complex assessment and/or or those that have complex long term care needs. Within Pathway 3 there are currently a number of patient/client sub-groups:-<br>• End Of Life (EOL) – These are patients identified as close to end of life where the sourcing of care and the discharge process is sped up (i.e. “Fast tracked”) to support them to die in the place of their choosing |

| | |
|---|---|
| | wherever possible. A fast track pathway exists for this group of patients.<br>• Specialist Rehabilitation – Patients requiring bed based care in a specialist environment for example following a stroke. These patients are easily identified and follow a health pathway into specialist rehab care.<br>• **Clients with complex needs including those who are potentially Continuing Health Care (CHC) patients– These are patients/clients that are medically fit enough to be discharged from hospital but need further assessment in the community to determine their long term needs. This is the group for whom D2A has been piloted and that this proposal relates to.**<br>• "Bespoke Care" – Patients/clients requiring case by case funding arrangements between agencies for a specific need or intervention e.g. bariatric/non-weight bearing care, specialist support for people with mental health needs or learning disabilities and patients/clients with delirium with the potential for resolution. These arrangements would effectively be time limited "bridging" arrangements (which could be for a lengthier period than standard D2A arrangements which tend to be 28 days) giving the opportunity for longer term planning once community based stabilisation is achieved. This group of patients/clients can experience delays whilst needs and funding arrangements are clarified as it is sometimes unclear as to whether their needs are the responsibility of health, social or both. This group could potentially benefit from a pooled budget arrangement in future with the appropriate level of contributions from each agency.<br>❖ There are patients/clients that start out on Pathway 3 because they need further hospital based specialist assessment before they can safely be discharged e.g. "safeguarding" concerns, mental capacity assessment, best interest meetings however they then may be discharged on a different pathway once these issues are resolved. |
| 14. | The End of Life and Specialist Rehabilitation Pathways work effectively as patients have clearly identified health needs; however patients/clients with complex needs/potential CHC eligibility and patients/clients requiring time-limited "bespoke care" require complex specialist assessment in the community and are more likely to require negotiated interagency funding arrangements. As described below these last two groups account for approximately 40 patients/clients a month on average. |
| 15. | The average number of patients/clients discharged overall across the whole of Pathway 3 between April 2018 and March 2019 was 14 a week. |




16. Based on data produced from the first quarter 2019/20, these numbers breakdown into the patient/client subgroups as follows:-

- End of Life - 24% (14 per month av.)
- Specialist rehabilitation - 5% (3 per month av.)
- Complex needs including potentially CHC eligible clients - 13% (8 per month av.)
- "Bespoke Care" - 58% (35 per month av.)

17. This paper is proposing to continue with D2A supported by a pooled fund for the group of clients who have complex needs, including those who are potentially CHC eligible (13% of the Pathway 3 patients/clients – approximately 8 a month) with the funding contributions adjusted to ensure that the Council only pays the equivalent of its average care home rates (as opposed to CHC rates) for the placement during the period of assessment.

18. In future there may be benefits in expanding the pooled budget to also include the group of clients described above with "bespoke" care needs (58% of Pathway 3 patients/clients – approx 35 a month); however further work would need to be done to model the costs and contributions of this and so this is currently not included in this proposal.

**RESOURCE IMPLICATIONS**

**Capital/Revenue**

19. This paper is proposing to continue with the current D2A model for CHC and Complex Care client groups in Pathway 3 to enable assessment of their long term care needs to take place in a more homely setting outside of hospital. In order to facilitate this, it is estimated that up to 10 nursing home beds will be required at any one time for the period during which clients are assessed, based on 2 clients a week and an average assessment period of 5 weeks. It is proposed that the assessment beds comprise a mix of block contracted beds

(6 beds) and spot purchased beds (4 beds), thereby enabling some clients to go straight to their long term destination where possible whilst also maintaining the positive relationship that has been developed with the current contracted nursing home provider for this scheme.

20. It is proposed that a pooled budget with contributions from the CCG and Council is established to cover the costs of the 10 assessment beds (6 contracted beds and 4 spot purchased beds). The pilot has been funded via iBCF monies but this funding route will be ending. These are clients/patients that the council/CCG would be paying packages for if not included as part of the pooled budget. This model has been agreed with University Hospital Southampton NHS Trust as SCC investment to reduce DToC in lieu of a fines approach.In recognition of the Council's concern that the potential for patients/clients to be CHC artificially raises the rates paid, it is proposed that the Council's contribution to the pooled fund is set at the level at which it would be if the Council were paying its own average rates for adult nursing home care (i.e. £879.06 per week).

21. This has been modelled as follows:

| PROVIDER | UNITS | UNIT PRICE PER WEEK | NO OF WEEKS | TOTAL 2020-2021 COST |
|---|---|---|---|---|
| The Hawthorns | 6 | 1,145.00 | 52.143 | 358,222 |
| Spot Purchased - estimated cost | 4 | 1,400.00 | 52.143 | 292,001 |
| | | | | |
| **TOTAL COST** | | | | **650,223** |
| | | | | |
| TOTAL NUMBER OF DAYS AVAILABLE | 3,650 | | | |
| AVERAGE STAY PER CLIENT IN DAYS | 35 | | | |
| | | | | |
| POTENTIAL NUMBER OF PATHWAY 3 CLIENTS | 104 | | | |
| AVERAGE NUMBER OF PATHWAY 3 CLIENTS PER WEEK | 2 | | | |

22. Based on the Council paying its average adult nursing home rate of £879.06 per week, the contributions would therefore be:

| CCG CONTRIBUTION | SCC CONTRIBUTION |
|---|---|
| **421,041** | **229,183** |

**Property/Other**

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

**LEGAL IMPLICATIONS**

**Statutory power to undertake proposals in the report:**

24. This paper includes a proposed pooled fund the statutory powers for which are described in Section 75 of the National Health Service Act 2006.

**Other Legal Implications:**

| | |
|---|---|
| 25.. | None |
| **CONFLICT OF INTEREST IMPLICATIOINS** | |
| 26.. | None |
| **POLICY FRAMEWORK IMPLICATIONS** | |
| 27.. | 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?** | **Yes** |
| **WARDS/COMMUNITIES AFFECTED:** | **All** |
| | |
| SUPPORTING DOCUMENTATION | |
| **Appendices** | |
| 1. | Summary of learning from pilot |
| 2. | Implementation Plan for mainstreaming Discharge to Assess for Pathway 3 |
| 3. | ESIA |
| 4. | |

**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.** | **Yes** |
| **Privacy Impact Assessment** | |
| **Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.** | **No** |
| **Other Background Documents**<br>**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** | |
| **2.** | | |