DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		**Hospital Discharge Operational model and Home First Discharge to Assess (D2A)**		
DATE OF DECISION:		**16 September 2021**		
REPORT OF:		**Director of Quality and Integration**		
CONTACT DETAILS				
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STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY

This report sets out a proposed Integrated Intermediate Care and Hospital Discharge to Assess (D2A) Model for Southampton that meets the national Hospital Discharge Operational Model requirements as per current government guidance most recently updated 5th July 2021.

It highlights the current position, illustrating some of the challenges, with a particular focus on the requirement to move from an over dependency on nursing/residential care home beds to discharging more patients home in line with “Home First” principles.

Parallel guidance has been published requiring the development of Urgent Community Response services (“step up” hospital avoidance), which also has a bearing on intermediate care provision. Although this is alluded to in this paper further detail will be provided at a later date on hospital avoidance.

RECOMMENDATIONS:

	(i)	Joint Commissioning Board is asked to support the overall direction of travel in relation to the proposed Hospital Discharge Operational Model, in particular the shift towards more care being delivered in people’s homes “Home First” – noting the breadth of change required to achieve this.
	(ii)	Joint Commissioning Board is asked to support the proposal to allocate the available NHS Hospital Discharge Programme (HDP) funds in 2021/22 in line with the proposed Home First Discharge to Assess model.
	(iii)	Joint Commissioning Board is asked to note the annual estimated costs of the proposed Home First Discharge to Assess Model going forward and that there will need to be a decision later in 2021/22, once the financial position regarding NHS Hospital Discharge Planning (HDP) funds beyond March 2022 is known, in relation to how these costs are met within the Southampton Health and Care System. This will be the subject of a separate report.

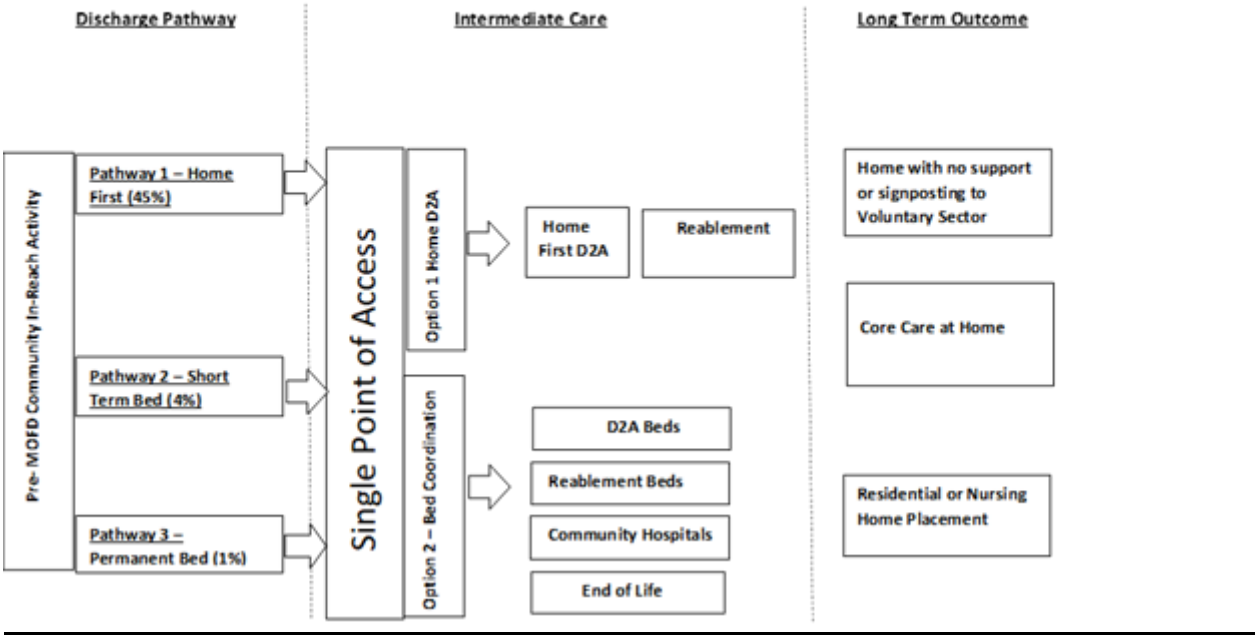
REASONS FOR REPORT RECOMMENDATIONS

1.	A primary government assumption at the outset of the COVID-19 crisis was that acute hospital beds would be in high demand and thus the optimisation of flow out of the hospital would be a priority. In

	March 2020 as part of the Government's response to COVID, legislation was introduced with immediate effect that changed the timescales and approaches associated with hospital discharge focussing on a "Home First Discharge to Assess (D2A) Operational Model". These changes have undergone further adaptation since their initial implementation and are now the expected ongoing Hospital Discharge and Community Support model as set out in the Government's Policy and Operating model published on 5 July 2021.
2.	The key features of the Hospital Discharge Operational Model are:- • An Expected Discharge Date should be established at the earliest point possible in a patient's journey to allow for pre-emptive planning and information sharing to take place. • A "Criteria to Reside" has been developed which describes the clinical scenarios in which a patient would require acute inpatient care. If the patient doesn't clinically meet these scenarios when assessed then the expectation is that they should be discharged from the bed on the same day. • Once a patient is ready for discharge they should be discharged as soon as possible on the same day. • A patient's home ("Home First") will be the default discharge destination even if intensive support or 24 hour care is required to achieve this. • "Discharge to Assess" should be the default approach which requires that functional assessment of need and long term care requirements should take place in the community not in a hospital setting. The expectation is that all patients, regardless of their final eligibility for funding, will follow this process and so the community health and social care system is now managing the assessment and care of self-funders in the same way as all other patients/clients from an earlier stage up to the point that their needs and eligibility for support is confirmed.
3.	In order to support this new discharge policy, the Government introduced a national Hospital Discharge Fund in March 2020 to cover the additional costs to the community health and social care system of supporting hospital discharge. In May 2021, the Government published its finance support and funding flows for 2021/22 which covered discharge funding for the first 6 months of this year as follows: • For the period 1 April – 30 June, eligible costs will be reimbursed from the NHS HDP for the period up to 6 weeks post discharge • For the period 1 July – 30 Sept, eligible costs will be reimbursed from the NHS HDP for the period up to 4 weeks post discharge The funding position for the second 6 months of the year and beyond has not been confirmed but is expected to mirror the first 6 months with continued eligible costs reimbursed for up to 4 weeks post discharge.
4.	In response to the new guidance, Southampton stood up a range of provisions and arrangements to deliver the new discharge requirements. This included: • The Community Discharge Hub which brought together the teams responsible for discharge across the Council (Complex Care and Hospital Discharge Team), CCG (Continuing Health Care Team) and Solent (Urgent Response and Community Independence Teams) to manage the discharge process, including triaging Onward Care Referrals completed by the hospital each day, initiating and overseeing the D2A process, case managing all patients and clients

	as they move through the D2A process, liaising and problem solving with the hospital and community services to maintain flow and capturing data that informs the system. A previous business case for maintaining the Community discharge hub was brought to and approved by the Joint Commissioning Board in April 2021. • A range of additional D2A capacity (over and above the 10 D2A beds the city already had in place under joint funding arrangements) to achieve the aim of assessing all patients, including self-funders, in a community setting. 38 block contract D2A beds are currently commissioned by the CCG from the independent sector. • Additional home care bridging hours to support the Home First principle • Additional spot purchased beds for those patients whose needs cannot be met in the D2A block contracted beds, either because of capacity or their complexity • Therapy support to the D2A process • Additional support to the Community Independence Service • Additional CHC staff to support D2A process • Additional social work staff to support the D2A process • Additional brokerage support
5.	The total costs of this additional provision have been met by the Hospital Discharge Fund. However there was a shortfall of approximately £1M for Southampton (£7.2M for Hampshire, Southampton and Isle of Wight CCG as a whole) between the amounts of funding allocated for the first 6 months of this year and the costs of this capacity.
6.	Whilst Southampton has succeeded in stepping up the additional capacity at pace to respond to the new guidance and has made significant improvements in the length of stay of patients who were previously significantly delayed in hospital (reducing the length of stay by an average of 14 days for those needing nursing home care and by an average of 5 days for those needing rehab and reablement in their own homes), the city has also experienced a number of risks and challenges with the new discharge arrangements, in particular: • **Achieving the 4 week timescale for D2A** which the national discharge fund can be used for – approx. 20% of clients are taking longer than 6 weeks to move on from their D2A placement and the average length of stay in a D2A bed is averaging 41 days (5.8 weeks) as achieving the assessments within current resources is proving challenging. • Delivering the Government expectations around **Home First** – which is that 95% of patients go straight home from hospital. In Southampton the figure is 89%. There is a strong over-reliance on bedded support and it has been estimated that to achieve the 95% expectation, approx. 7 patients a week would need to move from being admitted to a D2A bed to being discharged straight home with the necessary health and care support around them to enable this. This estimate does not account for any additional growth in discharge numbers/demand. • **Increased costs of onward care** which have been shown to be primarily linked to increased levels of complexity but also potentially the over-reliance on D2A beds which could mean that their capacity for reablement and independence is not being maximised. Patients are leaving hospital at a much earlier stage in their recovery than in previous hospital discharge models thus increasing the likely levels of complexity on discharge. The overall demand on community services has increased substantially particularly in relation to increased costs of residential and nursing home packages, “double up” care (both in terms of reablement and

	general homecare), use of equipment and increased therapy. For CHC, numbers of clients were broadly the same between 19/20 and 20/21 but average costs for placements/packages have increased by around 28% in 20/21 (26% increase for both home care and residential; 31% for nursing homes) and for Adult Social Care average unit costs for placements have increased since 19/20 by 20% for residential placements, 21% for nursing home placements and approx. 100% for home care packages. • **Lack of certainty regarding funding** resulting in short term planning
7.	There is therefore a need to both determine a more sustainable model moving forward into the second 6 months of the year and beyond which both complies with the Government's requirements for D2A and Home First and optimises people's independence and provides a positive experience, at the same time as better managing onward care costs.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
8.	The following alternative options have been considered and discarded: • **Do nothing** is not an option for the reasons outlined in Paragraph 6 above. The current over-reliance on bed based care does not meet the Government's expectations of Home First, does not offer best outcomes for local residents and is not sustainable in the long term • **Reverting back to the previous model of discharge** pre Covid where D2A was not the norm and people's long term care needs were assessed whilst still in hospital is also not an option because this would not comply with the Government's Discharge requirements and increased hospitalisation increases rapidity of deterioration and the potential for higher long term care costs.
DETAIL	
	<u>Proposed Hospital Discharge Operational Model</u>
9.	This report proposes a new more sustainable Hospital Discharge model to be implemented during the second half of this year and beyond.
10.	Its key aims are: • To reduce over-reliance on bed based placements with a view to achieving Home First wherever possible • To promote and support people to retain as much independence as possible at the earliest opportunity and maximise their potential for remaining in their own homes • To seek to reduce onward care costs by reducing dependence on bed based and more intensive care wherever possible
11.	The model described in this report aligns with the Home First D2A model being developed for the whole Southampton & South West Hampshire System with colleagues from across Southampton City Council, Commissioning, Hampshire County Council, University Hospital Southampton Trust, Solent NHS Trust and Southern Health Foundation Trust through a series of discussions and a whole system workshop held on 2 July 2021. This vision has also been agreed by the Southampton and South West Hampshire Operational Delivery Group (ODG) in July 2021 and is now in the process of being worked up in detail for both Southampton and Hampshire at place which will include input from the voluntary and community sector, patients and families.

12.	This new model will reflect the national model as outlined in the Hospital Discharge and Community Support: Policy and Operating Model below, which also demonstrates the expected proportion of hospital patients discharged through each of the pathways (45% Pathway 1: Home First; 4% Pathway 2: Short Term Bed and 1% Pathway 3: Permanent Bed) – the expectation being that 50% of patients leave hospital with no support on pathway 0. This new Home First D2A model is shown below. 
13.	Currently Southampton and South West Hampshire are discharging 89% patients straight home on Pathways 0 and 1 (73% and 16% respectively) against a national expectation of 95%, 6-7% into interim beds on Pathway 2 (against a national expectation of 4%) and 4-5% into long term beds on Pathway 3 (against a national expectation of 1%).
14.	The main issues with the current operating model which are driving this over-reliance on bed based discharges and which the new model will seek to address are summarised below: • A need to improve discharge planning – patient needs are not always known soon enough and sometimes there is insufficient information about them, thus driving more risk adverse discharge planning. Estimated dates of discharge (EDDs) are not routinely established or communicated and twice daily ward rounds/reviews are not in place on all wards. The lack of pre-discharge planning also means that patients with particular needs e.g. mental health problems, learning disabilities, homelessness potentially may not be flagged as needing extra support until the point that they are due to be discharged. • D2A capacity which is focussed on beds – whilst this was partly due to the need to step up a lot of capacity quickly to respond to the new guidance which came out in March 2020 and demanded immediate action, it has meant that the default position has been to discharge patients with more complex needs to a bedded environment as opposed to exploring alternative options. The majority of patients that access a D2A bed stay in residential/nursing home care following their D2A assessment. There could be a range of

	reasons for this, including that people tend to decondition whilst in a residential/nursing home environment or they get used to the residential/nursing home environment and do not want to leave (in many circumstances people have moved to non D2A beds in the same nursing homes). • Lack of capacity within the home care market – resulting in difficulties sourcing home care, particularly for people needing two-carer packages and multiple calls a day. The home care market has been under particular pressure in terms of recruiting and retaining workforce whilst other business sectors reopen following the lockdown. • Insufficient capacity in community health and care services to provide the level of support and immediacy of response required to support a more Home First D2A model. Currently the Urgent Response Service, Community Independence Teams, End of Life outreach services and the homecare framework are already challenged in meeting the current demand and would need increased resourcing to meet the demands of this model. 24/7 medical cover also isn't available currently.
15.	The new model will address these current issues by providing: • A stronger focus on earlier discharge planning, at the point of admission and within the first 12 hours: to be led by the hospital supported by In-reach from the community where appropriate (Adult Social Care, housing/homelessness support, Mental health and voluntary sector support) • Strengthened Single Point of Access/Community Discharge Hub with additional Social Work and CHC capacity: to more proactively promote and coordinate pre-discharge planning, receive and rapidly process onward care referrals, in-reach into the hospital as appropriate, rapidly mobilise the appropriate resources required to get people out of hospital and achieve the 4 week D2A timescales. . • Promotion of Home First principles with a strong focus on reablement and promoting independence: ensuring all patients are discharged back to their home whenever this is practicably possible with reablement support to meet their level of need. Once a patient has transferred out of hospital a rapid community assessment should determine the next steps e.g. D2A or CHC assessments, therapy, reablement, no further care required etc. A time limit will be established to support this (e.g. within 48 hours). • More flexible use of interim beds, particularly community hospital beds, to provide interim bed based care when a patient is unable to return straight home. The new model would require fewer interim beds; however those beds that remain will need to be more flexible according to the current needs in the system. This will include a review of the community hospital bed model with a view to managing a greater proportion of rehabilitation patients at home which will release community health beds to be used for direct rehabilitation pathways and for other reasons including higher acuity step down with unresolved social issues. • Strengthened health and care services in the community with the agility to respond quickly and flexibly to greater levels of complexity and acuity in people's own homes at any time of the day 24/7. This will require ready access to Reablement care, Homecare, Therapy, Overnight care, End of Life Care, and 24/7 medical cover.
	<u>Benefits of the Model</u>
16.	The non-financial benefits of the new model are outlined below<u>:</u> • Patient's needs are assessed from a person centred perspective with a view to maintaining

	them at home wherever possible. • Improved information sharing at an earlier stage of the discharge pathway will enable a more accurate understanding of a patient's needs, thereby ensuring that they are discharged to the most appropriate setting. • Long term health and functioning is improved through a greater focus on timely reablement particularly in a home environment that people are accustomed to and feel comfortable in. • A focus on home based care as the default position will reduce the numbers of people unnecessarily placed and subsequently remaining in bed based care. • Greater flexibility in the use of bed based interim care for those who need it will ensure that these resources are utilised more effectively. • There will be improved flow out of hospital as a result of earlier discharge planning, improved information and increased ability to mobilise resources rapidly into people's home across a full week. • Demand and Capacity are coordinated from a single hub - Opportunity to bring data together from system gives a shared version of the "truth". • Stronger Multi-Disciplinary Team approach and system wide ownership of hospital discharge
17.	In terms of financial benefits, there is an expectation that delivery of a Home First D2A model could potentially reduce the long term costs of onward care. The early feedback from areas that are further ahead in implementing the government guidance (Somerset, Swindon) is that getting patients on the right pathway early in their recovery has better outcomes in terms of the provision of long term care. Somerset, who are furthest ahead, audited their 2020/21 (April – April) cases and identified a 14% reduction in long term care packages and a 5% reduction in long term placements against their forecasted activity.
18.	Hampshire County Council undertook some analysis when developing their Home D2A and Single Point of Access business case and were projecting a 5% reduction in long term care costs. These were primarily associated with keeping people mobile in their own homes through timely reablement and therapy at the point of discharge and thus either negating or reducing the need for long term homecare and and/or residential care costs.
.	**Resourcing the New Model**
19.	The table below shows the average monthly discharges by pathway from University Hospital Southampton Trust based on the last two month period (May – June 2021). This is for all patients discharged from the Trust, around 50% of whom will be Southampton residents. The table also shows the percentages being discharged down each pathway and how this compares to the national expectation. It then goes on to calculate the distance from the national expectation in terms of how many patients a month would need to move onto or off each pathway. Focussing on pathway 2, there would be a need to shift approx. 70 patients each month from short term bed based care to support to recover in their own homes. This equates to roughly 2 patients a day and based on Southampton patients making up 50% of the overall numbers would mean 1 patient a day (7 a week) for Southampton.

DISCHARGES BY PATHWAYS - TOTAL DISCHARGES FROM UHS (REGARDLESS OF LOCAL AUTHORITY OR FUNDER)

Sum of Number	Column Labels				
Row Labels	0 - Simple Discharge	1 - Support to Recover at Home	2 - Short Term Bed Based	3 - 24 Hour Nursing Care	Grand Total
Average monthly discharges over last 2 months (May & June)	1992	438	180	123	2733
% Discharges by Pathway	73%	16%	7%	4%	
National Expectation	50%	45%	4%	1%	
Difference between acutal activity & national expectation	**-626**	**792**	**-71**	**-96**	

The table shows that we are above the national guidance on Pathway 0 (73% as opposed to the national expectation of 50%) which we would seek to maintain.

20. In order to resource the new model, there would need to be an increase in home care and wrap around health and care support to enable one additional patient a day (7 a week) with complex needs to return to their own home. Therefore the following additional support would need to be commissioned.

- 296 additional hours of home care a week
- 393 additional hours of night care a week
- 295 additional hours of reablement care a week
- 49 additional hours of therapy a week

Appendix 1. Shows how the Additional Resource was calculated.

21. In addition to the additional home care and wrap around health and care support identified above, it is proposed that the following are also developed to support the Home First approach:

- Voluntary Sector involvement at every stage of the hospital discharge process – including ongoing investment in the Welcome Home Scheme which is delivered by Communicare and has been funded up until now from a one off CCG grant which has now expired
- Additional capacity in the SPOA to support increased numbers of discharges home, increase in-reach into the hospital to pull patients out sooner and achieve the 4 week D2A timescale
    - Social work capacity 3 x wte social workers (these will be temporary appointments whilst funding is short term)
    - 2wte x Band 6 CHC nurses
    - Voluntary Sector – Communicare
- Ongoing increased costs for community equipment on discharge that directly relates to the increased complexity of patients being discharged from hospital will also need to be accounted for within the financial model.

22. <u>Shift in Resources from Bed Based Care</u>

The Southampton system currently has 37 community rehab beds at the Royal South Hants Hospital (average Length of Stay 3 weeks) and 38 D2A interim beds block contracted from the nursing home market (average length of stay 6 weeks), giving a total of 75 beds. Allowing for an optimum occupancy rate of 85%, this would give a capacity level of 64 beds. On top of this block commissioned capacity, we are also spot purchasing interim D2A placements in the care home

market – on average a further 10-25 beds at any one time.

The new model will require fewer D2A beds and it is proposed that the savings achieved from disinvesting in interim care home beds are reinvested in home care and community health and care wrap around support.

Based on the monthly discharges shown in the table at Paragraph 19 (2733 a month), of which approx. 50% will be Southampton City residents (1367 a month or 309 a week), the table below shows the total number of interim beds required with 7% going down pathway two (Short Term bed based care) as per the current model in comparison to the 4% going down Pathway Two as per the national expectation.

Patients on Pathway 2	**Numbers per week**	**Number of beds required based on 4 week LOS**
@7% (current position)	**21**	**84**
@ 4% (national expectation)	**13**	**52**

[*NB. The number of beds required in the above table is based on the national expectation of a 4 week D2A period. Based on the current proportion of patients being discharged on Pathway 2, 84 beds are required at any one time. Given that Southampton is currently block contracting 75 beds, 38 D2A beds from the care home sector and 37 community hospital beds from Solent NHS Trust, this would suggest we are only spot purchasing a further 9. However the number of spot purchased beds is in reality higher than this because the majority of the D2A care home patients are remaining up to 6 weeks in an interim bed*.]

By reducing the proportion of patients discharged on Pathway 2 to 4% as outlined in this report, the number of beds required would reduce to 52, a reduction of 32 beds. Using the average weekly nursing home bed rate of £1,200, this could generate savings of up to £38,400 per week, releasing as much as £1,996,800 per annum.

In practical terms, it would be recommended that most of this reduction is made from ceasing to use spot purchase beds and a smaller proportion from the block contracts, with double running built into the system initially whilst home care support is developed and the new ways of working embedded.

Mobilisation Timetable

23. The aim would be to move towards the Home First D2A model described in this report gradually over the next 12 months to avoid destabilising the current system. Particular care will need to be taken moving into the Autumn and then Winter period when demand is expected to increase and so it is recommended to commence gradually, working with the home care market over the next 6 months to develop capacity and capability, whilst commissioning some additional bridging hours and bolstering the reablement offer, with a view to de-commissioning the surplus bed based capacity and ramping up home care and wrap around community support from March 2022 onwards.

24. This is shown in the table below:

Mobilisation Period	Plan	Comments
Sept 2021 – January 2022	Focus on improving processes with particular focus on first 12 hours and earlier discharge planning Ensure that the data captured is	This would include increasing the level of in-reach into the hospital. Data should reflect the whole pathway including patient outcomes

		meaningful and owned by the system Maintain steady state with D2A capacity going into and over Winter period Work with Home Care sector to begin to develop capability and capacity – support with workforce challenges Commission some additional bridging capacity Commission some additional reablement capacity Work with Voluntary Sector to scope opportunities to support hospital discharge and ongoing care.	(not just length of stay (LOS and discharge delays). Maintaining Steady State D2A is likely to involve continued investment in nursing home care over the winter. Recruitment needs to be continuous – ideally this would be for permanent positions to attract staff. We need to include the voluntary sector in our pathway planning at the earliest opportunity.
	February – June 2022	Decommission surplus bed based capacity There needs to be a continuous effort to shift the culture to focus on "home first" and then ongoing assessment. Ramp up Home care capacity Ramp up Reablement and wrap around care and support	This is dependent on having adequate homecare/reablement therefore agreeing target capacity in line with decommissioning beds. A key element of this is ensuring that the community increasingly takes responsibility for determining the patient destination and "get home" requirements. Need to ensure that capacity is new and not shifting from elsewhere in the system. Continuous rolling programme of recruitment is required.
	July 2022 onwards	Further embed Home First D2A model	
	July 2022 onwards	Review ongoing financial impact on stakeholders, including the potential long term impact on social care, with a view to ensuring that ongoing funding is in place to financially support the new operational model.	

RESOURCE IMPLICATIONS

Revenue

25. The table below provides a comparison of the ongoing annual costs of the new Home First D2A model once fully implemented with the ongoing annual costs of the current predominantly bed based model. This shows that the costs are very similar with the Home first D2A model being only

marginally more expensive (£30.5K).

However this does not take into account the expected benefits of the Home First D2A model in reducing long term care costs through a more strengths based model of D2A – as outlined in Paragraphs 17 and 18.

26. Comparison of Annual Running Costs

Resource	Current bed based model £000	New Home First D2A Model £000	Difference £000	Comment
Spot purchased D2A placements/packages	2,904.0	907.2	(1,996.8)	Reduction in use of beds (see Paragraph 22)
Block contract D2A beds	2,500.2	2,500.2	0	
Brokerage	316.8	150.0	(166.8)	Review of current outsourced approach
SPOA & Assess capacity (CHC/SW)	624.7	989.7	365.0	Additional CHC & SW capacity for inreach and additional D2A assessment work to meet 4 week standard
Home Care D2A capacity	640.5	1,246.3	605.8	Increased capacity to support more complex patients at home
D2A Therapy support	455.0	818.3	363.3	Supporting rehab and reablement in people's own homes
Additional Reablement (incl health and care)	815.0	1,285.0	470.0	Increased reablement in people's own homes
Vol Sector support to D2A	0	90.0	90.0	
Additional equipment to support D2A	0	300.0	300.0	
TOTAL	**8,256.2**	**8,286.7**	**30.5**	

27. During 2020/21 and 2021/22 the Government has allocated additional funding to CCGs for delivery of the hospital discharge arrangements as set out in the national model. This has been outlined in Paragraph 3 of this report. Whilst the actual allocation for 1 October 2021 – 31 March 2022 is yet to be confirmed, the CCG is expecting an allocation of £2,701K for Southampton for this period, mirroring the allocation for the first 6 months of the year. Whilst this allocation was uplifted by NHS England in the first 6 months of the year – by approx. £1M for Southampton (to approx. £3,701K)– in recognition of cost pressures, it is not expected to change for the second 6 months of this year.

In addition the CCG has been allocated additional "Ageing Well funding" for hospital admission avoidance in 2021/22. Some of the increased investment in teams like the Urgent Response Service which provides both step up and step down urgent response and reablement has been badged against this budget - totalling £815k per annum.

Together these two streams make up the budget that is available in 2021/22 and comes to £6,217K (£5,402k HDP plus £815k Ageing Well) for the full year - £3,108.5K for a 6 month period.

The national position on NHS funding for discharge for 2022/23 is as yet unknown.

28. In addition to this, the CCG, in anticipation of a shortfall in 2021/22, transferred a non-recurring budget of £950K to the Council via the Better Care Fund Section 75 Agreement to be used as a one off investment to support delivery of the hospital discharge arrangements. This will support developments in the second 6 months of this year.

29. The table below shows the costs of mobilising the new Home First D2A model during the second 6 months of the year from 1 October – 31 March 2022 alongside the investment available in 2021/22 through the various funding sources outlined in paragraphs 27 and 28. It should be noted that the plan would be to phase in the new model, whilst still maintaining the same level of bed based capacity until the home care and additional wrap around support is fully in place – as per the mobilisation plan in Paragraph 24. This therefore assumes some double running of old and new models until at least February 2022, hence why the costs for this 6 month period are more than 50% of the full year costs shown in Paragraph 26.

	1 Oct 21 – 31 Mar 22 (6 months) **£000**	**Comment**
COSTS (Mobilising new Home First D2A model whilst still maintaining bedded capacity to ensure flow)	4,613.0	Includes most of the bedded capacity currently in place
BUDGET Assumed NHS HDP Budget NHS Ageing Well Budget **Budget Total**	 (2,701.0) (407.5) **(3,108.5)**	
SHORTFALL	1,504.5	
Non Recurring BUDGET CCG NR Hospital discharge transferred fund (in BCF)	 (950.0)	
REMAINING SHORTFALL	**554.5**	

30. The above table shows that for the financial year 2021/22 the majority of the costs are met by the NHS HDP funding and NHS Age Well funding with the £950k non recurrent budget transferred from the CCG into the Better Care Fund to support with any shortfall on the hospital discharge arrangements. This leaves a residual £554.5k shortfall (13.7%) which the CCG is expecting to pick up from additional "Surge investment" for surge cost pressures and slippage in recruitment.

31. The budget position for 2022/23 and beyond is however unclear and guidance on NHS investment is not expected until Quarter 4 of this year at the very earliest. There will therefore need to be further work undertaken later in the year when the future financial position is clearer to confirm how the ongoing annual costs as outlined in Paragraph 26 will be met in future years. This will be the subject of another report.

Property/Other

32. The main property implication relates to the base for the SPOA. The Urgent Response Service is currently working with SCC and Solent Estates Departments to identify a long term collocated base for the SPOA and the intermediate care teams.

LEGAL IMPLICATIONS

Statutory power to undertake proposals in the report:

33.

- In March 2020 many assessment and care planning duties that had previously applied to hospital discharge (as laid out in the Care Act 2014) were suspended as a result of the emergency Coronavirus Act 2020 and the Covid 19 Hospital Discharge Service Requirements.
- From 1st September 2020 the "Hospital Discharge: policy and operating model2 has been in place setting out mandatory "Discharge to Assess" (D2A) that must be followed by Health and Social Services
- July 5th 2020 the "Hospital Discharge: policy and operating model" was further updated.

Other Legal Implications:

34. NOT APPLICABLE

CONFLICT OF INTEREST IMPLICATIOINS

35. NOT APPLICABLE

RISK MANAGEMENT IMPLICATIONS

36. Learning from other areas and based on local intelligence, the table below sets out the key risks and challenges along with plans that would be put in place to mitigate them:

Key Risks and Challenges	**Plans for Mitigation**
Unanticipated increases in demand/surge at a time when the model is being implemented could outstrip the capacity.	Implement the new model gradually, ramping up from Spring 2022 onwards. Some "double running" along with closely monitoring and forecasting demand will help to ensure we don't decommission bed based capacity until we are confident that we have the required level of homecare and support in place to meet the demand.
Continued failure to turn D2A assessments around within 4 weeks resulting in cost pressures above those we have anticipated within our HDP spend.	Strengthening the SPOA to undertake CHC and social work assessments with the 4 week timescale.
Recruiting homecare, reablement and therapy staff is difficult in the current market therefore sourcing the necessary resources to progress the new model is challenging.	Gradually implementing the new model from Spring 2022 onwards and ensuring we don't decommission bed capacity until we have the appropriate support in place. Ensuring that we have recruitment and retention processes in place that attract and retain care and therapy staff which would include:- • Rolling recruitment drives • Recruiting reablement and therapy staff

		on permanent contracts • Supporting the homecare market through access to training and support, engagement in strategic development including helping to design flexible and sustainable commissioning arrangements and access to information and communication forums.
	Unless systems are in place for community staff to prioritise and identify potential "home first" patients at an early stage suitable patient planning won't have taken place and patients will still continue to be discharged to D2A beds by default resulting in continued use of spot purchase beds at the same level alongside increased investment in home based care.	There is a work stream in place, led by UHS, that is looking to ensure that all patients have an EDD in place to support appropriate pre-planning. Having community staff in-reaching into the hospital will also allow for more proactive planning identifying those patients requiring extra support at an early stage and also ensuring that patients are on the correct hospital discharge pathway wherever possible focussing on a return home.
	It is important that performance is measured not just in terms of numbers of discharges or length of stay but also in terms of outcomes. Unless this is measured effectively the effect of shifting focus, in terms of early discharge, increased early community activity and the concentration on keeping people in their own homes the full impact won't be understood	Shared data systems will be developed that equally capture whole system demand, capacity and outcome.

POLICY FRAMEWORK IMPLICATIONS

37. This proposal reflects national hospital discharge guidance (updated on 5th July 2021) and key principles associated with Better Care and the Southampton Health and Care Strategy by:-

- promoting person centred/strength based interventions that support people to remain be independent
- greater joined up whole person care
- proactive planning and intervention
- reducing permanent inappropriate admission to residential care
- ensuring people receive reablement care following discharge
- reducing unnecessary hospital delay

KEY DECISION?	**YES**
WARDS/COMMUNITIES AFFECTED:	**ALL**
SUPPORTING DOCUMENTATION	

Appendices	
38.	1. Calculating the additional Resource Requirements

Documents In Members' Rooms

39.	N/A	
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 **Other Background documents available for inspection at:**		
Title of Background Paper(s)		
40.	N/A	