Discharge to Recover and Assess (D2RA)

Surrey is well placed to deliver D2RA through improvements made in harnessing positive provider relationships, detailed market analysis and more consistent approaches to procuring and purchasing care as a result of the move to embed strategic commissioning. D2RA in Surrey has benefitted from jointly commissioned services, such as Care within the Home and Residential and Nursing Care 65+, led by the local authority in collaboration with NHS Continuing Healthcare for Frimley and Surrey Heartlands ICS.

In Surrey, D2RA formed a large part of the health and social care integration conversation prior to the pandemic but progress was accelerated during this period due to critical need and unprecedented demand. Two core assumptions stand at heart of DR2A:

- Reduce the time people spend in hospital; best for patients and for the NHS, increases availability of hospital beds and improves health outcomes.
- Assessing patients in a suitable environment when not in crisis, ideally at home, ensures better outcomes for residents, ideally returning home or entering health and care arrangements proportionate to their long-term needs.

Uncertainty during the pandemic relating to funding for D2RA and successive rounds of short term funding has seen D2RA being reactive as opposed to strategically embedding best practice. Initially funding was used to block purchase significant care home capacity and extend services such as reablement and home care without focusing on the principles of home first, step down, strength gain, reablement, rehabilitation and critically flow and move on from these services.

With both Frimley and Heartlands ICBs committing longer term funding these pathways will be enhanced and outcomes for both residents and the integrated system improved. Providers will be able to commit to new ways of working and support innovative approaches. Key learning that will ensure improved success include the following:

- **Understanding 'both sides'** - Social Care staff are (also) under significant pressure and resource is required to ensure successful D2RA referrals and future transition. This includes the reliance on ASC commissioning time.
- **Improved governance** - Clarity of decision making at place and County level.
- **Baselining need -** Ensure the right capacity is set up at the right time, avoiding the need to change services through the life of a contract.
- **Consistent discharge process and assessment** - (Impower work) increase provider confidence and reduce placement breakdown.
- **Clear goals** - D2RA must be used appropriately to ensure improved resident outcomes and reduced numbers of individuals remaining in inappropriate services through extended length of stay or even resulting in a long-term placement.
- **Primary Care must be involved** - The wider system needs to be able to respond to the changing landscape of resident need at place when new services are established.
- **Consistent, clear family communication** - D2RA is not optional, it is part of the core offer to improve outcomes for patients being discharged.
- **Complex needs** - Often hard to place in Surrey's market, work is underway to improve pathways for these individuals.

Case Study One – Equipment Delay (Step-down)

- Mrs K lives with a long-standing neurological condition. She was in contact with the ASC team in the locality looking at additional equipment for her home as she felt she was struggling with mobility. She had a fall and was not able to get up and was admitted to hospital.
- To support a safe discharge, she required a Sara Steady to support transfers and a high back chair. This was ordered by the neuro Occupational Therapist on the ward but there was a delay on the equipment availability. Mrs K could not return home safely without this equipment.
- Rather than remain in the acute hospital, Mrs K agreed to go to Priory Court to give time for her equipment to be delivered and to gain some strength with transfers. She spent almost four weeks in the care home.
- She was assessed as having goals on her return home and was supported by the ASC Reablement Team to settle back into her own home and regain her confidence.

Case Study 2 – Rehabilitation and returned home (Rehabilitation)

- Mrs X was discharged to a rehabilitation bed and staff at the care home actively engaged in a multi-disciplinary approach with ASC, GP and physiotherapist to help her achieve her rehabilitation goals.
- The ASC practitioner and the care home worked alongside the client's relatives to communicate the intentions of the service and the client's progress.
- She was discharged home after 21 days with a short-term reablement package, having regained her mobility and evidencing a continued upwards trajectory in terms of her independence.

Case Study 3 – Awaiting care agency availability (Step-down)

- Mrs C lived at home with a live in care worker funded through ASC via a Direct Payment. Her daughter was her main carer.
- Mrs C was housebound, visually impaired and had hearing loss, so conversations were challenging for her. She required full support with all personal care and home management.
- Mrs C had a fall at home and was found to have a chest infection; she was admitted to hospital for 12 days. The multidisciplinary team requested a restart to her care service, but they were unable to start immediately. As Mrs C no longer required care in an acute hospital, it was suggested she had a short stay in a care home whilst the agency arranged her regular care worker and confirmed that her needs were the same as prior to her admission. Mrs C and her daughter were happy with this.
- Mrs C then returned to her own home after 6 days in the nursing home with her regular care worker and her daughter supporting her.

Hospital Discharge and Flow – IMPOWER

IMPOWER were commissioned by Surrey County Council to support discharge and flow in East Surrey and Royal Surrey acute hospitals through winter and spring (November 22 - May 23). This work included supporting the identification of opportunities and delivery of interventions at three levels - i) on wards, ii) within each acute hospital and iii) across the wider system, including community hospitals. The work aimed to improve outcomes for patients, relieve pressure from the acutes by increasing discharges and reducing length of stay, and reduce avoidable adult social care long-term care and support costs.

Several critical considerations from a Surrey County Council lens were identified with regards to resident outcomes, maximising independence and reducing avoidable long-term care package costs:

1. Standardised approaches to hospital social work, notably social workers embedded on wards, with the right support and skills, enables holistic multidisciplinary team planning and consistent expectation setting. This drives faster decision making with more appropriate discharge destinations evidenced through the introduction of integrated working on East Surrey's Godstone Ward.
2. Optimised care and strengths-based approaches to assessing patients reduces the level of home-based care a person receives in the community, including consideration of short-term support and the use of Technology Enabled Care.
3. Commissioning the model that supports the system's home first ambition, enabling greater short-long term home care support, rehabilitation and reablement capacity and creating a home-first culture across frontline health and care teams. We have noted that a lack of community reablement capacity is a driver for over-referrals to long-term high-cost home care or risk-averse placements.
4. More effective use of short-term placements, embodying D2RA principles, enables faster discharge and more appropriate assessments of people's long-term needs, reducing avoidable, risk-averse decisions for long-term placements.
5. Empty community beds occur due to poor availability of provision for patients with particular / challenging needs, notably cognitive and behavioural, resulting in increased pressure on acutes, patient deterioration and challenges sourcing appropriate care and support long-term. This has informed Integrated Commissioning decision to develop the Enhanced Nursing Rate.
6. Systemic data and insight informed decision making is in development. Embedding this at speed is essential to informing commissioning requirements and matching patient needs to appropriate support.

The work delivered:

- Increased weekly discharges - 9% hospital wide and 25 additional from assessment areas and 17% reduction of failed no criteria to reside discharges.
- Reduced average length of stay (LOS) - 9% less inpatients with >= 21 day LOS hospital wide. 17% LOS reduction on older persons unit.
- Reduced discharges to long-term placements - 42% reduction from intermediate care ward.

- Increased staff understanding of best practice - 78% increase in staff understanding of best practice.

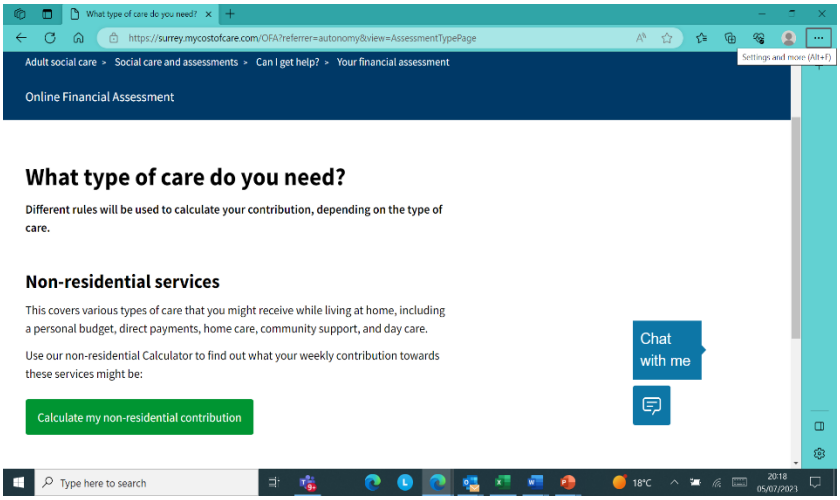
ASC Front Door

A Transformation Programme is underway to identify the opportunity for implementing the corporate SCC customer operating model to our Adult Social Care [ASC] directorate. The wider ambition is to understand the impact, design and approach to implementing the SCC customer operating model at a cross organisational level and we are starting this work with a focus on Adult Social Care by maximising current capabilities (including our accessible digital offer) and single point of access arrangement, as well as redesigning customer pathways to better shape demand for ASC services and deliver an improved experience.

The programme is currently in the discovery phase, the aim of which is to investigate and analyse the landscape of existing entry points to ASC services and undertake a demand management analysis of all ASC entry points, identifying who uses them, when, why and how, including associated pain points from a service delivery perspective and from a service user perspective. The outputs from this discovery phase will be explored further in the design phase to achieve closer alignment to the SCC Customer Experience Model.

The programme team will also be looking to expand on the existing digital initiatives for example, one such initiative is the widely used Online Financial Assessment portal. The portal enables residents to submit their financial details securely online and to upload supporting evidence. Using robotics, ASC can check whether evidence has been provided, send a letter requesting any missing information and acknowledge the application without intervention by a member of staff. In addition, chat bot and web chat services are available to support people through the application process. To this end, the chat bot was co-designed with support from colleagues from the Surrey Coalition for Disabled People. Over the last 6 months there have been 1,343 conversations via the chat bot and only 56 requests for a call back.

The illustration below shows where the chat bot can be found on the ASC web pages



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