ADULTS AND HEALTH SELECT COMMITTEE

DATE 7 **March 2024**

Surrey Heartlands & Surrey County Council Discharge to Assess Report

1. Purpose of report:

1.1 To inform Surrey County Council's Health Select Committee of the current Discharge to Assess arrangements in Surrey and to set out challenges and work underway to enable improved outcomes for people who are being discharged from hospital.

1.2 The Committee is asked to note the important part that Discharge to Assess plays as a contributor to resident/patient flow in discharge, as well as the commitment given to Discharge to Assess by Surrey Heartlands Integrated Care System.

2. Scope of report:

2.1 This report sets out the Surrey Heartlands Discharge to Assess position and is supported by data incorporated in Annex 1.

2.2 Challenges and recommendations that support Discharge to Assess are set out below and the Committee is asked to consider and scrutinise the report.

2.3 What is Discharge to Assess?

Discharge to Assess refers to the process when people who no longer need to remain in hospital (i.e. who no longer need acute hospital services) but who may still require ongoing care, are provided with short-term, funded support so they can be discharged to their own home (where appropriate) or another community setting where they can then be assessed for their longer-term care needs. This assessment can then be undertaken in the most appropriate setting and at the right time for the individual.

Challenges in Discharge to Assess.

Carers, families, and patients can be forgotten or receive poor communication when a patient is being discharged from hospital.

Budget setting for Discharge to Assess has been short-term which has inhibited creativity and reduced certainty for care providers.

Discharge to Assess is sometimes more associated with hospitals rather than the wider context of community care. Discharge to Assess by its nature is about getting home safely, which requires coordination and communication between the relevant health and social care professionals.

The workforce resource (including unpaid carers) is stretched and under increasing pressure and stress, especially during times of increased demand.

The complexity of acute or chronic presentation is increasing and people are living with multiple conditions in poor health for longer. This means that admission and discharge arrangements require careful organisation to ensure all aspects of care are considered.

As an Integrated Care System, we need to ensure consistent experience and outcomes for people, irrespective of where they live in Surrey. There is a risk of variation in the Discharge to Assess service offer, depending on where a person lives.

We have more work to do regarding measuring experiences and outcomes for people and carers.

We need to continually engage with care providers regarding their views and experiences of Discharge to Assess and improve the market provision for Surrey residents.

1.1 **Recommendations**

Key recommendations include:

- Work with Healthwatch Surrey and Action for Carers to continue to ensure carer and resident voices are heard and action taken to make positive change.

- Surrey Place Partnerships to continue to develop a consistent discharge process supported by models of care which look at prevention and admission avoidance in the first instance, with a Discharge to Assess offer focused on Home First with the resident/patient, carer, and family at the centre of care. NHS England » Principle 5: Encourage a supported 'Home First' approach

- On-going evaluation, review and learning, supported by the quality review cycle of discharge outcomes and the Discharge to Assess Task and 100 Day Challenge Group (a structured innovation method that creates the conditions for change and action in complex systems).

- To continue to collaborate with providers and workforce, ensuring that risks are understood, and duplication is minimised.

- Surrey County Council commissioners to continue to positively engage with and shape the market appropriately, with continued close working with Surrey Care Association, providers, and Place Partnerships, supporting the right provision at the right time, with the right system balance.

- Engagement, education and understanding of discharge process for patients, carers, and staff and to review and take forward the Carers and Hospital Toolkit (2023).

Background and Context

There is a rising demand for health services due to an ageing population with increasingly complex healthcare needs. People are living longer and, as they age, their healthcare needs change. The number of people living with long-term conditions is set to increase, with more individuals managing multiple health conditions. This changing need in our population is placing increasing demand upon carers and families who are the backbone of care in the community and needs to be central in planning care.

Home or hospital – the evidence

At first glance it might seem obvious that hospital would be the best place to look after someone, but in fact there is evidence to show that this may not be the case.

Small studies have suggested that admitting frail older people to hospital can lead to a decline in their physical ability. There's also a risk of picking up a hospital-acquired infection, which can cause serious complications or even death. And if someone is already receiving regular care at home, sending someone into hospital can interrupt the relationship with their carer. This bond can be hard to re-establish.

Older people are also at significantly increased risk of developing a condition called delirium if they are admitted to hospital. A little-known but common condition in the elderly, delirium is a state of acute confusion. It can have serious effects, such as accelerating or triggering dementia, and often leads to people spending a longer time in hospital and possibly going into residential care. It's not known exactly why hospital admissions should lead to delirium, but the unfamiliar and stressful surroundings of the ward and loss of a comforting home routine doubtless plays a part.

There are also financial as well as personal costs associated with hospital care. Keeping people in hospital is costly, and people over 85 account for a quarter of all

bed days in the NHS. Avoiding this would be better for older people, reduce admission to residential care and keep people living at home longer, and also save money.

Source:

Hospital or 'hospital at home' – what's best for older people? — Nuffield Department of Population Health (ox.ac.uk)

3.3. To support frail and older residents, Surrey Heartlands has implemented a range of community services to optimise care in the community and prevent hospital admission. These services include Urgent Community Response, Virtual Wards, Urgent Care Centres, Walk-In Centres as well as proactive and preventative community models of care which wrap care around patients and their carers when required.

A good example of this are the Frailty Hubs in each 'Place' whereby care is provided by integrated neighbourhood teams who identify the top high priority frail patients, develop personalised care plans and provide support and review. East Surrey Place Anticipatory Care Hubs - YouTube

The Walk-In Centres in Ashford and Woking, the Urgent Treatment Centre at St Peter's in Chertsey, and the Minor Injury Units in Haslemere and Caterham are also helping prevent hospital admission. Further information on out of hospital urgent treatment centres can be found at the following link. Urgent care services - ICS (surreyheartlands.org).

3.4. Community 'Virtual Ward' care has also been implemented which steps up care in the community to prevent admission to hospital or to support early discharge. Further information about virtual wards can be found in the following link which profiles an example in Surrey Downs: Virtual Wards - Surrey Downs Health and Care Partnership (surreydowns-hcp.org).

3.5. For communities, families, and carers to feel empowered, ideally, they need to be digitally enabled and have access to the internet to support care and ensure access to information. Supporting community digital needs is included in our Place-based plans and is a central pillar of ICS Strategy, whilst also recognising this won't be right for everyone.

Surrey Heartlands Integrated Care System is focused on minimising the time that people stay in hospital (often called Length of Stay) because a prolonged hospital stay does not support good outcomes. This means that timely and inclusive assessments need to be completed in hospital and as soon as appropriate outside hospital, to prevent people staying in hospital and to support successful recovery. This is often called Discharge to Assess.

Supporting carers and families

National guidance now specifies that NHS bodies and local authorities should ensure that, where appropriate, unpaid carers and family members are involved in discharge decisions. This reflects the amendment to section 74(1) of the 2014 Care Act made by the Health and Care Act 2022.

In Surrey Heartlands, Healthwatch Surrey and Action for Carers carried out a review in 2021 to understand carers' experience of hospital discharge and Discharge to Assess. Key findings suggest that even during the restrictions of COVID-19, there were positive stories of safe, patient-centred discharges but also recognised that poor communication and engagement also featured. The findings from this review suggest that 54% of carers felt communication was poor, 58% felt carers' views were not taken into account and 56% didn't feel consulted. Further information can be found in the following link: Carers experience of hospital discharge.

In 2022, to follow up on the review, Healthwatch Surrey and Action for Carers published a response to the recommendations. The findings suggest the review prompted re-evaluation of existing approaches in hospitals and suggested fresh initiatives such as a review of the hospital compassionate communication policy, working with Hospital Carer Advisers to help raise awareness of the needs of carers and better information for carers pre-admission and post discharge on what to expect which was published by Surrey County Council. Further information on implementing the recommendations can be found at the following link Responses to recommendations

NHS England has also recently developed a Carers and Hospital Discharge toolkit which needs to be reviewed by our Place Partnerships and taken forward to improve discharge outcomes. Further information on the toolkit can be found at the following link: TOOLKIT.pdf (mcusercontent.com).

Definition of Discharge to Assess

5.1 Discharge to Assess refers to the process when people who no longer need to remain in hospital but who may still require ongoing care, are provided with short-term, funded support so they can be discharged to their own home as stated in 2.3 above

This does not detract in any way from the need for agreed multi-professional assessment or from the requirement to ensure safe discharge, and it may work alongside time for recuperation and recovery, on-going rehabilitation or reablement. There are four Discharge to Assess Pathways.

5.2 **Discharge to Assess Pathways**

Pathway 0: Discharges home or to usual place of residence with no new or additional health or social care needs

Pathway 1: Likely to be minimum of 45% of people discharged; able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home. Every effort should be made to follow home first principles, allowing people to recover, reable, rehabilitate or die in their own home as appropriate.

Pathway 2: Discharges to a community bed-based setting which has dedicated recovery support. New or additional health or social care support is required in the short term to help the individual in this setting before they are ready to either live independently at home or receive longer-term or ongoing care and support. Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, before returning home.

Pathway 3: Discharges to a new residential or nursing home setting, for people who are considered likely to need long term residential or nursing home care. Should be used only in exceptional circumstances. For people who require bed-based 24-hour care; this includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged). Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

5.3 The National Hospital discharge and community support guidance - GOV.UK (www.gov.uk) has been updated in January 2024 and includes the following summary changes:

- The 'Duty to co-operate' that sets out that NHS bodies and local authorities should agree the discharge models that best meet local needs and that they are effective and affordable within the budgets available to NHS commissioners and local authorities. This reflects the amendment to section 82 of the NHS Act 2006 made by the Health and Care Act 2022.

- Involving families and carers, which specifies that NHS bodies and local authorities should ensure that where appropriate, unpaid carers and family members are involved in discharge decisions. This reflects the amendment made to section 74(1) of the 2014 Care Act made by the Health and Care Act 2022

- The guidance now also includes more specific information on Transfer of Care Hubs to manage discharges for people with complex needs.

5.4 As highlighted above, it is recognised that delayed hospital discharges are an increasing trend in the NHS. Longer stays in hospital can lead to worse health outcomes and heightened care needs, especially for older or frail people. Discharge to Assess was established in 2019/20 as part of the response to the COVID-19 pandemic when the government issued emergency funding in August 2020 for a new Discharge to Assess programme. This funding covered the costs of post-discharge care for up to six weeks. While aspects of Discharge to Assess had been in use in some areas prior to the COVID-19 pandemic, the policy issued in March 2020 put Discharge to Assess at the centre of discharge plans for patients who required support to leave hospital. National guidance was revised in August 2020, and this extra funding was made available. While current policy remains the same, national Discharge to Assess ringfenced NHS funding was withdrawn in April 2022 and was replaced by the National Discharge Fund. Surrey Heartlands and Surrey County Council Adults Well Being and Health Partnerships Directorate (AWHP, the renamed Adult Social Care Directorate) are committed to continue Discharge to Assess funding in 2024/25 and beyond, led by our Place Partnerships, working closely with Surrey County Council AWHP. Since 2022, Discharge to Assess pathways in Surrey Heartlands are focused on Pathway 1 and Pathway 2 as Pathway 3 involves long term residential care in a care home and follows a different process.

5.5. People who are discharged and require end of life care are reviewed individually where community care is tailored to meet need which generally follows Pathway 1. Unpaid carers play an important role in delivering end of life care at home so it is important to take into account the Healthwatch Surrey and Action for Carers review and response highlighted above, and the requirement to involve families and carers under the NHS Act 2006 made by the Health and Care Act 2022.

There are two core assumptions that stand at the heart of Discharge to Assess:

1. Reducing the time people spend in hospital is best for patients and for the NHS, as it increases the availability of beds in hospitals while improving people's health outcomes.

2. Assessing patients in a suitable environment (e.g., people's home) is preferable to assessing them in hospital.

Discharge to Assess arrangements in Surrey.

Surrey Heartlands and Surrey County Council AWHP Discharge to Assess arrangements are led by the four Surrey Heartlands Place Partnerships: Guildford and Waverley, Surrey Downs, North West Surrey, and East Surrey. Each Place has a close

relationship with their acute hospital trust, Surrey County Council AWHP, community providers, primary care networks, and the local voluntary, community, and faith sector.

To take forward Discharge to Assess and community models of care, Places have taken a tailored population health-based approach to understand trends and build models of care that focus on prevention and rehabilitation. Taking a proactive preventative approach to target populations who are at risk of hospital admission ensures the risk of admission is reduced as community wrap-around care is more focused, collaborative, and targeted. Community engagement is embedded in the models of care that supports access to care and helps residents know where to go for help and advice. Annex 1 provides more detail on the Place approach in each area.

Places are also implementing Transfer of Care Hub models to ensure streamlined processes for Discharge to Assess and to ensure a multidisciplinary approach to care planning. Transfer of Care Hubs are at different stages of development. Further information of Transfer of Care Hubs can be found at the following link Managing transfers of care – A High Impact Change Model: Changes 1-10 | Local Government Association as well the Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

In May 2023, Surrey Heartlands ICB completed a Discharge to Assess evaluation which recommended the creation of the Surrey Discharge to Assess Task Group. The Discharge to Assess Task Group is led by Surrey County Council, is collaborative and includes acute hospital partners, primary care, Places, and others to ensure value and learning is shared as a system and is monitored through the Urgent Care and Elective Care Committee. The purpose of the Task Group is to take a system view of Discharge to Assess across Surrey sharing experiences, challenges, good practice, identifying solutions and bringing together a consistent approach where appropriate. A key agenda item is collectively exploring the monthly Discharge to Assess finance and performance activity that is produced by our ICS Finance and Business Intelligence Teams, there is also work to develop a workplan that captures the recommendations from the evaluation and will include Healthwatch Surrey and Action for Carers review/ recommendations.

As well as the Discharge to Assess Task Group, Surrey County Council are undertaking an additional exercise to build a clear picture of existing work taking place across three key joint transformation priority areas (Mental Health, Children and Young People, and Older People and Frailty) with a view to identifying specific support needed to move each of the programmes into an accelerated phase of delivery.

As a result, work is now taking place to explore whether the 100 Day Challenge methodology (a structured innovation method that creates the conditions for change and action in complex systems) can be used to match the appetite across Surrey's system leadership to support new ideas and ways of working, to improve outcomes for people.

A cross-system leadership group has begun work to explore the methodology, agree the potential focus for the challenge, and co-create a learning agenda which includes the following in relation to Discharge to Assess.

- How should we deliver rehab/reablement to support a return to home?
- How should we monitor and review people more effectively to ensure that they remain at home and independent?
- How should we make use of technology to maintain independence?
- How should we support unpaid carers to continue to care for their loved ones effectively?

This work will help drive and provide focus to improve Discharge to Assess and resident outcomes.

8. Surrey Heartlands Acute non-elective or unplanned admissions and discharge performance

8.1 Noting the definition of Discharge to Assess above and the data presented in Annex 1 the following key finding are noted:

8.2 To understand hospital discharge and Discharge to Assess in Surrey it is important to explain the context of flow into hospital (non-elective admissions or unplanned admissions) and out of hospital, as well as how long people stay in hospital (Length of Stay).

9. Discharge to Assess activity

9.1. Annex 1 suggests that there has been an 8% rise in population growth since 2019/20 but there has been a reduction of 7 % in unplanned admissions compared with 2022/23, length of stay has also reduced overall by 4%. This data supports the population health preventative work implemented by Place as well as effective discharge processes.

9.2. In the last 12 months, 44% of Discharge to Assess discharges were from North West Surrey, 25% for Surrey Downs, 14% for Guildford and Waverley, 9% for East Surrey and 8% for Frimley. This data is representative of the population served by each Place.

9.3. The average duration people stay in Discharge to Assess Pathway 1 is 27.3 days and 47.9 days for Pathway 2. Surrey Downs has the shortest overall duration at 25 days and a larger proportion of discharges in North West Surrey (47%) and Surrey Downs (46%) have resulted in people not requiring any ongoing funded care. This potentially reflects improved outcomes for residents recovering sooner and indicates that people are getting the right level of care to recover well. For all of Surrey, it is

noted that most people requiring ongoing care after completing their discharge to assess pathway need home care which is material to the principles of Home First and the Integrated Care System Strategy.

10. Discharge to Assess spend

10.1. Annex 1 suggests that, following an increase in spend for the first quarter from April-June 2022, both spend and discharges have reduced significantly. However, the average cost per package has increased, predominantly due to under-utilisation of the Surrey County Council block care home and home care arrangements which is now improving. There has been a reduction in average cost since August bring it closer to the April-June 2022 average.

10.2. Discharge to Assess spend for people that have been on a pathway for more than 4 weeks has been a significant issue and accounted for almost 50% of the total spend prior to July 2022. Since July 2022 this position seems to have improved significantly, with overall spend over 4 weeks in the last 12 months at 26%.

10.3. The December forecast for the 2023/24 core expenditure is an overspend position against all available funding of £0.5m. Available funding includes £6.4m Adult Social Care Discharge Funding, £2.5m recurrent Better Care Funding, £4m additional capacity funding and £1.5m winter capacity funding. This funding totals £14.4m and the current 2023/24 forecast is £14.9m.

10.4 When viewed by Place, the current forecast is an overspend of £1.5m in North West Surrey and underspend in all other Places, against the per capita allocated funding in each Place. However, North West spend has begun to decrease to some extent in recent months which shows control measures are being well managed.

Current utilisation of Surrey County Council care home and home care block arrangements is low at around 75% in quarter 3 of 2024/25. However, this is an improving picture in recent months, and utilisation is now over 90% on average.

11. Workforce

11.1 Surrey Heartlands health and social care system have worked hard, within an ethos of ongoing improvement, to ensure that people can be properly identified for Discharge to Assess, that home first always come first, and that the assessments that people require are available and timely. To achieve this the workforce resource needs to be focused on discharge and Discharge to Assess and needs to be committed to achieving good outcomes in hospital and in community settings.

11.2 Based on the Discharge to Assess work completed by Place and the development of Transfer of Care Hub models, the risk of duplication has been minimised, with clinical and operational roles working across boundaries. Each hospital has their own strategy for supporting their workforce with greater emphasis being applied to

collaborative working across providers. Nevertheless, an awareness of workforce issues and concerns are highted at the daily System Operational Call and risks and concerns reported into the Urgent and Emergency Care governance system.

11.3 To take account of provider views from the Surrey care market, Surrey Care Association was asked to contribute to the ICB Discharge to Assess evaluation which highlighted the following:

- 4 weeks funding is too little to be confident of an accurate and holistic assessment of need and to agree funding for an ongoing package of care and is not person centred.
- Providers can be left without confidence, clarity, and surety about who will pay for continued levels of need.
- A fragmented homecare sector makes it harder to communicate and develop innovative and sustainable models to promote continuity of care and reablement.
- There is no long-term investment to create capacity and to build skills and capability.
- It can be difficult to meet the needs of a small number of people within the Pathway 3 cohort, who have particularly complex needs, and commissioners will work with providers to better understand the needs identified, so that we are better placed to meet these needs.

12 . Discharge to Assess Governance

12.1 Discharge to Assess governance in Surrey is part of a joint approach with Surrey County Council, which reports into the Urgent Care and Elective Care Committee and the Integrated Care Board and is reflected in respective Trust A&E Delivery Boards, led by Place.

Conclusion and recommendations

Discharge to Assess in Surrey has been an evolving journey and has needed to flex to account for national funding and local funding. Places have been at the forefront in leading this transition and the Integrated Care System has been instrumental in adjusting and varying the service offer, based on fluid, and changing needs of the population.

Highlights

- Discharge to Assess is now firmly embedded within the local Surrey system.
- There is an improving picture on spending within the Discharge to Assess financial envelope and reducing block contract voids.
- Work is underway with through the 100 Day Challenge that will drive forward improvement and support the Discharge to Assess Task Group workplan and Place.

Recommendations

- Work with Healthwatch Surrey and Action for Carers to continue to ensure Cares and resident voices are heard and action taken to make positive change.
- Surrey Places to continue to develop a consistent discharge process supported by models of care which look at prevention and admission avoidance in the first instance, with a Discharge to Assess offer focused upon Home First with the resident, carer, and family at the centre of care supported by Transfer of Care Hubs and national policy.
- On-going evaluation, review and learning supported by the quality review cycle and outcomes generated by the 100 Day Challenge work.
- To continue to collaborate with providers including workforce strategies, ensuring that risks are understood, and duplication is minimized.
- Commissioners to continue to positively engage with and shape the market appropriately, with continued close working with Surrey Care Association and Place, supporting the right provision at the right time with the right system balance.
- Engagement, education and understanding of discharge process for patients, carers, and staff and to take forward the Carers and Hospital Toolkit (2023).

Contact details

Lorna Hart - SHICB lornahart@nhs.net

Paul Morgan – SCC AWHP paul.morgan@surreycc.gov.uk

Sources and background papers

Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

Carers experience of hospital discharge.

Responses to recommendations

TOOLKIT.pdf (mcusercontent.com).Urgent care services - ICS (surreyheartlands.org).

Virtual Wards - Surrey Downs Health and Care Partnership (surreydowns-hcp.org).

Managing transfers of care – A High Impact Change Model: Changes 1-10 | Local Government Association

Annex 1 (separate power point)

This page is intentionally left blank