Adults and Health Select Committee
Annex 1 Discharge to Assess data

Jan 24

(updated from the D2A evaluation completed in May 2023)

At the centre of D2A is the patient, the carer and the family which cannot be overstated and is reflected in the commitment that Surrey Heartlands presents through Home First principles.

Introduction

Scope: The following slide deck sets out the Surrey Heartlands Discharge to Assess data form January 2023 to December 2023 and data from 2020 to 2022 on a few of the slides for comparative purposes.

Two core assumptions stand at heart of D2A:

- Reducing the time people spend in hospital is best for patients and for the NHS, As it improves people's health outcome and increases the availability of beds in hospitals for those who need this care.

- Assessing people in their usual environment (e.g. at home) is preferable to assessing people in hospital.

Limits: The limitation of this data pack includes a lack of clear data to firmly support a robust review process. This is due to different organisations that are involved in the Discharge to Assess process using differing reporting systems and reporting data at different times. It is also important to note that any outputs do not purely reflect Discharge to Assess as the pathways are multifaceted and are dependent on other programmes contributing and influencing outcomes.

Acute Discharge Performance
Length of Stay

Acute Discharge Performance

Across the Integrated Care System Surrey Heartlands has seen 8% rise in population growth since 19/20 and a 7% decrease in unplanned admissions

	2019/20	2020/21	2021/22	2022/23	2023/24 (FOT)	Variance 19/30 to 23/24	Annual Total Trend Line 19/20 - 22/23
Non Elective Admissions	**39467**	**34598**	**42958**	**37271**	**36695**	**-7%**	
NHS East Surrey CCG	6242	5344	6043	5312	5766	-8%	
NHS Guildford and Waverley CCG	8702	8077	11428	9040	9261	6%	
NHS North West Surrey CCG	12246	11301	15436	14546	13509	10%	
NHS Surrey Downs CCG	12275	9876	10051	8373	8159	-34%	

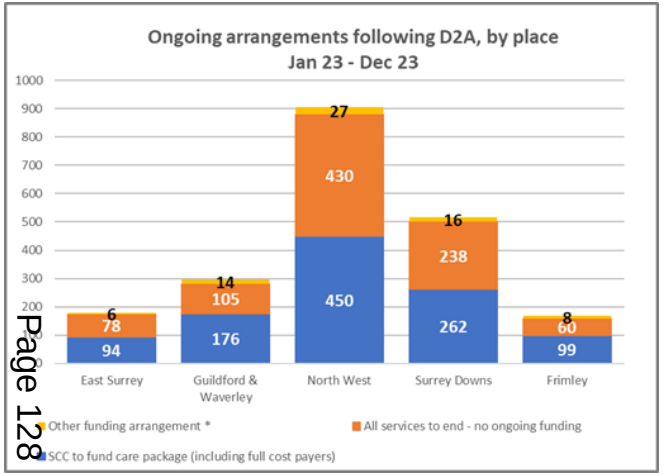
Overall, the average time a person spends in hospital has decreased by 4%.

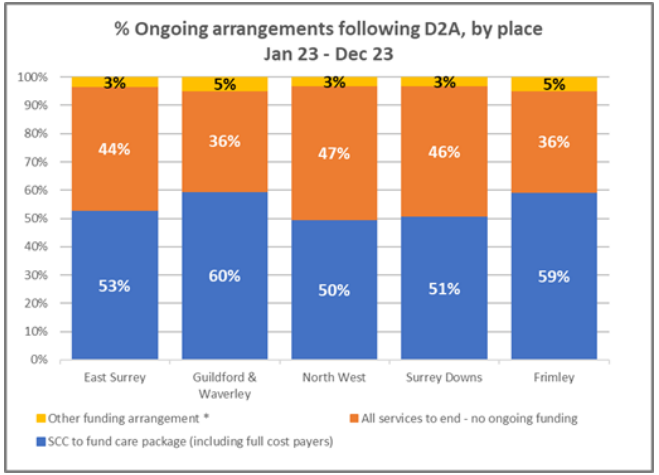
	2019/20	2020/21	2021/22	2022/23	2023/24 (FOT)	Variance 19/30 to 23/24	Annual Total Trend Line 19/20 - 22/23
Average Length of Stay	**8.03**	**6.48**	**7.17**	**7.89**	**7.73**	**-4%**	
NHS East Surrey CCG	9.03	7.39	8.64	9.92	9.40	4%	
NHS Guildford and Waverley CCG	7.33	6.01	6.49	8.16	7.56	3%	
NHS North West Surrey CCG	8.71	6.55	6.37	5.73	5.80	-33%	
NHS Surrey Downs CCG	7.35	6.34	8.27	10.19	9.98	36%	

NB: Length of stay is the calculated length of time from admission to discharge

D2A Activity

Discharge Volumes and funding arrangements after Discharge to Assess by Place





	East Surrey		Guildford & Waverley		North West Surrey		Surrey Downs		Frimley		Grand Total	
Ongoing Funding Arrangement	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**	**Total**	**%**
All services to end - no ongoing funding	78	44%	105	36%	430	47%	238	46%	60	36%	911	44%
SCC to fund care package (including full cost payers)	94	53%	176	60%	450	50%	262	51%	99	59%	1081	52%
The person will self fund their care package	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Other funding arrangement *	6	3%	14	5%	27	3%	16	3%	8	5%	71	3%
Total	**178**	**100%**	**295**	**100%**	**907**	**100%**	**516**	**100%**	**167**	**100%**	**2063**	**100%**

** Other funding arrangements include joint funding with SCC and Health, CHC, delirium, non-weight-bearing and S117*

- Data Includes all completed Discharge to Assess forms for discharges for the 12-month period between Jan 23 and Dec 23.
- In the last 12 months, 44% of discharges were for NW, 25% for Surrey Downs, 14% for Guildford and Waverley, 9% for East and 8% for Frimley.
- A larger proportion of discharges onto Discharge to Assess in NW Surrey (47%) and Surrey Downs (46%) resulted in people not requiring any ongoing care.

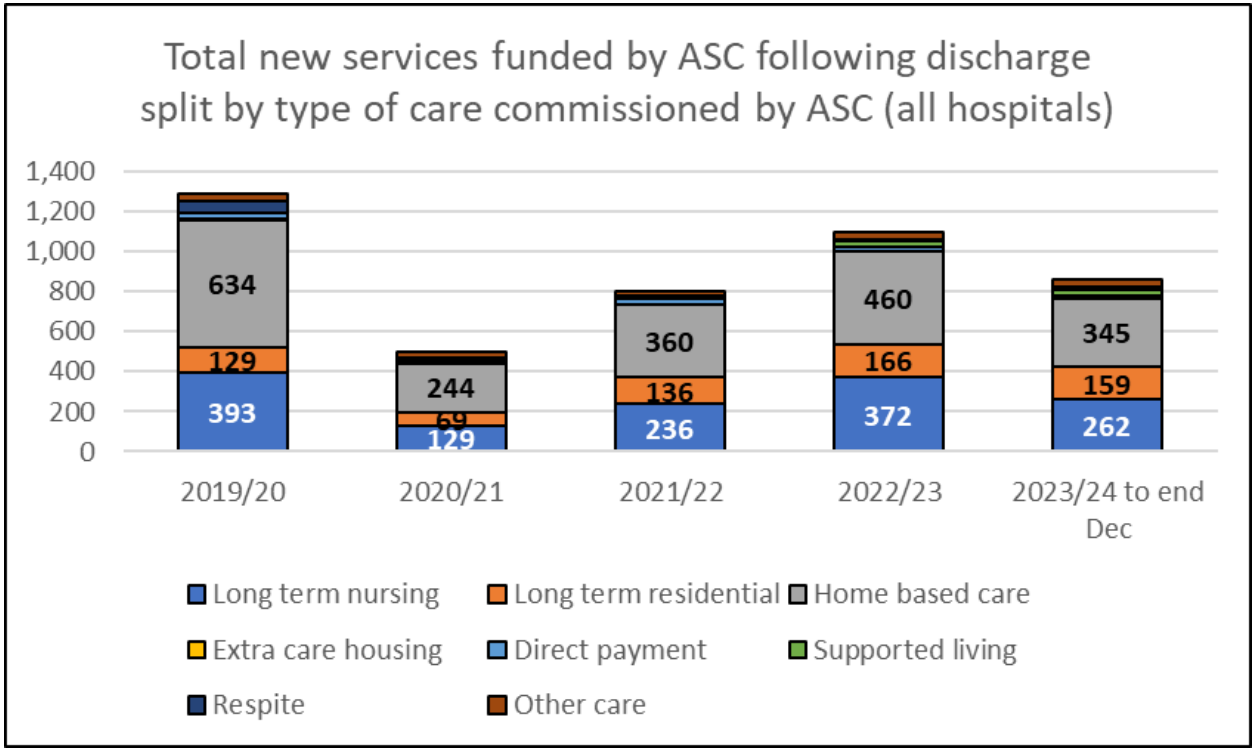
Data Source: LAS Hospital Discharge Forms as at 12/01/2024

Average Duration of Discharge to Assess Packages

ICP	Pathway 1 D2A Discharges		Pathway 2 D2A Discharges		Total D2A Discharges	
	Total	Avg duration (days)	Total	Avg duration (days)	Total	Avg duration (days)
North West Surrey	518	28.8	388	52.5	906	39.0
Surrey Downs	423	23.7	78	32.5	501	25.0
Guildford & Waverley	165	30.6	116	47.5	281	37.6
Frimley	90	33.7	70	46.2	160	39.1
East Surrey	95	24.3	77	43.1	172	32.8
Grand Total	**1291**	**27.3**	**729**	**47.9**	**2020**	**34.8**

- Data is based on completed Hospital Discharge Forms completed between Jan 2023 and Dec 2023.
- Average duration for Discharge to Assess Pathway 1 package is 27.3 days.
- Average duration for Discharge to Assess Pathway 2 package is 47.9 days.
- Surrey Downs has the shortest overall duration for all completed packages at 25 days.
- Surrey Downs and East Surrey had an average duration for Pathway 1 discharges of under 28 days. Pathway 2 discharges were all over 28 days.

Data Source: LAS Hospital Discharge Forms as at 12/01/2024

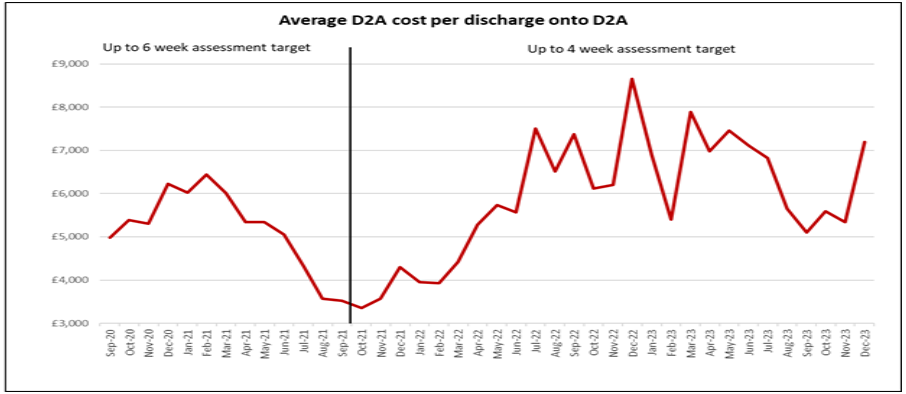


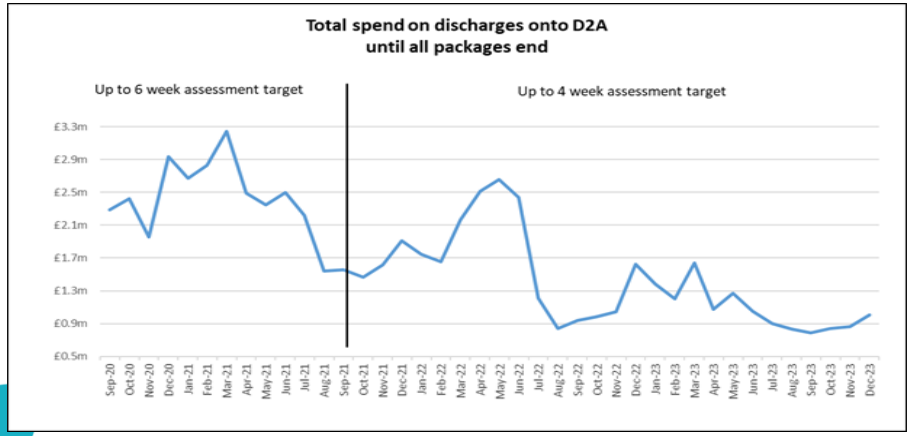
The above data suggests new services for patients funded by Adult Social Care largely require home-based care services.

Source SCC

D2A 23-24 Budget and 22-23 Spend

Discharge to Assess activity and cost Sept 2020-Dec 2023





Following an increase in spend for the first quarter in April-June 2022, both spend and discharges have reduced significantly, which is under review.

However, the average cost per package has increased, predominantly due to underutilisation of the care home and home care block arrangements which is now improving.

There has been an improvement in average cost since August bringing it closer to the April-June 2022 average.

The cost shown is the total cost per month of care packages (excludes staffing costs) and includes overrun costs as well as costs up to 4 weeks post discharge.

Discharge expenditure beyond 4 weeks

Discharge month (from when 4 week target started)	Estimated total spent until all packages end	Estimated total spend over 4 weeks from discharge date	% of expenditure more than 4 weeks after discharge
Total scheme 2	**£15.89m**	**£7.79m**	**49%**
Apr-22	£2.52m	£1.19m	47%
May-22	£2.66m	£1.30m	49%
Jun-22	£2.44m	£1.27m	52%
Jul-22	£1.21m	£0.44m	36%
Aug-22	£0.84m	£0.06m	7%
Sep-22	£0.94m	£0.11m	12%
Oct-22	£0.98m	£0.16m	17%
Nov-22	£1.04m	£0.18m	17%
Dec-22	£1.63m	£0.60m	37%
Jan-23	£1.38m	£0.50m	36%
Feb-23	£1.20m	£0.28m	24%
Mar-23	£1.64m	£0.71m	44%
Apr-23	£1.07m	£0.33m	31%
May-23	£1.27m	£0.44m	35%
Jun-23	£1.05m	£0.31m	30%
Jul-23	£0.90m	£0.22m	25%
Aug-23	£0.84m	£0.13m	15%
Sep-23	£0.79m	£0.11m	14%
Oct-23	£0.84m	£0.03m	4%
Total scheme 3	**£25.23m**	**£8.39m**	**33%**

Spend for people that have been on a Discharge to Assess pathway for more than 4 weeks has been a significant issue and accounted for almost 50% of the total prior to July 2022.

Since July 22 this position seems to has improved significantly, with overall spend over 4 weeks in the last 12 months at 26%.

It should be noted that for the later months more packages remain open, and therefore there may be some increase to the proportion of spend over 4 weeks. October looks particularly low; however, a number of packages were still open at period end and therefore this will increase to some extent.

Financial Summary 2023-24

The December forecast for the 2023/24 core Discharge to Assess expenditure is an overspend against all available funding of £0.5m. Available funding includes £6.4m Adult Social Care Discharge Funding, £2.5m recurrent Better Care Fund, £4m additional capacity and £1.5m winter capacity. This funding totals £14.4m and the current 2023/24 forecast is £14.9m. The current year forecast includes £2m of costs from 2022/23 that were carried forward to the current year.

When viewed by area the current forecast is an overspend of £1.5m in North West Surrey and underspends in all other Places, against the per capita allocated Adult Social Care funding, additional capacity and winter capacity, and the Better Care Fund allocated in each Place. However, North West spend has begun to decrease to some extent in recent months.

Current utilisation of block home care is low at around 75% in quarter 3 of 2024/25. Care home blocks however have had much improved utilisation in recent months, and occupancy was over 90% on average in quarter 3.

Expenditure / funding category	East Surrey £000	Guildford & Waverley £000	North West Surrey £000	Surrey Downs £000	TOTAL £000
Total D2A forecast 2023/24	**2,322**	**1,988**	**6,513**	**4,061**	**14,884**
Discharge Fund ICB contribution	886	1,001	1,687	1,426	5,000
Discharge Fund SCC contribution	246	278	468	396	1,389
Recurrent BCF budget contribution	472	194	1,036	791	2,493
Additional Capacity 23/24	708	800	1,348	1,140	3,996
Winter Capacity	269	304	512	433	1,518
Total funding available	**2,581**	**2,577**	**5,051**	**4,186**	**14,396**
Cost pressure / (surplus) vs available funding 2023/24	**-259**	**-589**	**1,461**	**-125**	**488**

Guildford and Waverley Place

D2A and Discharge Models

Discharge Models

One team approach :

- Agile models of Multi agency response that allows spot purchasing, utilisation of home based block care hours and additional rehab models
- Flexible approach to family support including Trusted Assessor roles, Care Home matrons, D2A assessment support and discharge liaison
- Integrated Neighbourhood teams work to provide wrap around support and care to complex care cohorts

Proactive

- Integrated Neighbourhood support
- Carers support
- Falls prevention
- Care Home support
- Proactive planning and support
- Virtual Wards
- Anticipatory Care
- Ageing Well
- High Intensity Users

Reactive

- Admission Avoidance Models of Care
- Virtual Wards
- Advice and Guidance
- Care Home Support
- Proactive clinical review processes
- Single team approach
- Care Coordination Centres

Workforce

Fuller Review – Neighbourhood Teams

Population Health

Clinical Models and new pathways

Community Engagement and Partnership

Carers Support

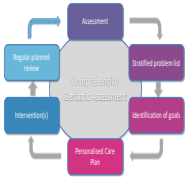
Surrey Downs Place

Our Integrated Care Pathway

Surrey Downs has developed a **single streamlined care pathway** that links preventative support, personalised & complex care, same-day urgent care at neighbourhood level with, place-based urgent care services. The pathway is **easily navigable** for patients and referring clinicians, focus at every step is on supporting people at home and **promoting independence**.

Living Well

Supporting people to live well for as long as possible and return to independence wherever possible. Enabling local communities through an asset-based approach.



Proactive Care

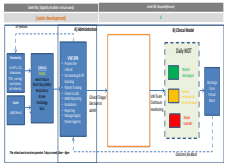
Proactive health and care, targeted at people living with frailty, multi-morbidity and/or complex needs to help them stay independent and healthy for as long as possible. Personalised care planning.

Same Day Urgent Care - Neighbourhood

Effective co-ordination and management of urgent on the day activity at Neighbourhood, PCN or primary care level.

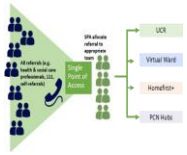
Urgent Community Response

Access to rapid assessment and provision of short term, intensive care packages for people at serious risk of admission to hospital



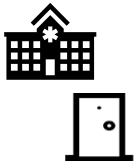
Virtual Wards

Support patients who would otherwise be in hospital to receive acute level care, monitoring and treatment in their home as an alternative to admission/ extended acute stay



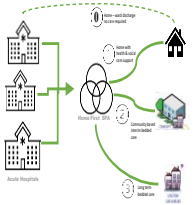
Urgent Care Co-ord. Hub

Provides coordination of system wide Urgent Care services by providing a single point of access and streamlined pathway for all patients



Urgent Care Front Door

Enhanced Front Door services within ED screening, streaming and redirecting to facilitate discharge out of the acute and to appropriate community support



HomeFirst Co-ord. Hub

Facilitating patient discharge from hospital to their place of residence as early as possible, with ongoing assessment and planning undertaken in their home

Integrated Neighbourhood teams

HomeFirst Service

Integrated Care Pathway maximising long term independence

Integrated Neighbourhood Teams model

Surrey Downs' INTs brings together primary care and community services to create truly integrated teams delivering personalised care to meet the needs of the local population and support people living as independently as possible.

Integrated leadership structure

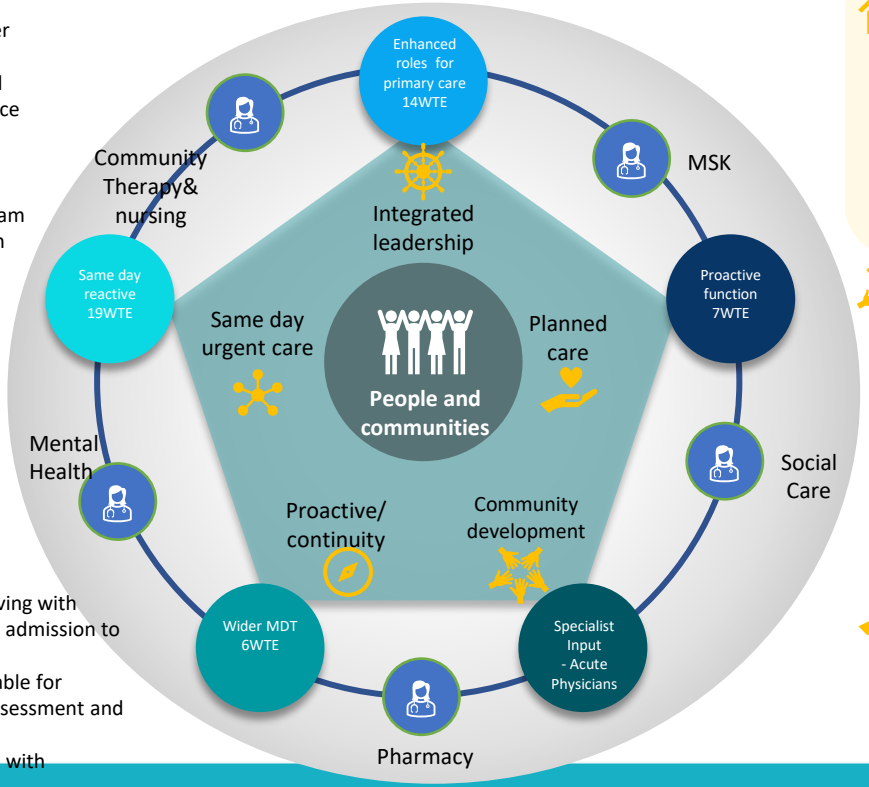
- Quadrumvirate leadership team consist of a Clinical Director, Lead GP, Operations Manager and Clinical (Nursing/Therapy) Lead.
- Leadership team manage Banstead integrated neighbourhood workforce, oversee local service delivery and play an active role in community development.
- Hold a devolved community service budget allowing them to shape the skill mix of the team to best meet the needs of the local population

Banstead same day urgent care

- Provide on the day support for patients at risk of admission or requiring urgent assessment in their place of residence.
- Consolidates GP home visiting, care home support and district nursing functions in to a single acute home visiting service interfacing with wider system UCR service.
- Roles funded from community, ARRS, acute budgets

Banstead Proactive & Continuity

- Provide proactive support to local residents living with complex needs and at risk of future decline or admission to hospital
- Utilises PHM tools to identify individuals suitable for support, provide care coordination, holistic assessment and personalised care planning
- Provides proactive frailty MDTs in partnership with Geriatricians / interface with virtual ward



Banstead Population

- **Population** - Banstead registered patients – 48000
- **Age profile** -Over 25% of residents >65, high number of care homes
- **Disease Prevalence** - Hypertension – 15.2%, Diabetes – 12.7%, Mental Health & Dementia 11.4%
- **Deprivation** – 1 of top 20 deprived wards in Surrey Heartlands

Community development

- Working partnership with citizens, voluntary orgs to develop and deliver community initiatives aimed at improving health and wellbeing of local population
- Include making Banstead dementia friendly, intergenerational community programmes - IMM , support initiatives for family and children
- Population health management used to support team understand local needs and schemes to support local people

Planned care

- Streamlined end to end pathways have been developed between Primary care & acute allowing residents to be supported in the most appropriate place by the most appropriate team
- Approach has led to development of integrated pathways for Diabetes MSK and now Respiratory incorporating ARRS, community, acute roles into integrated service

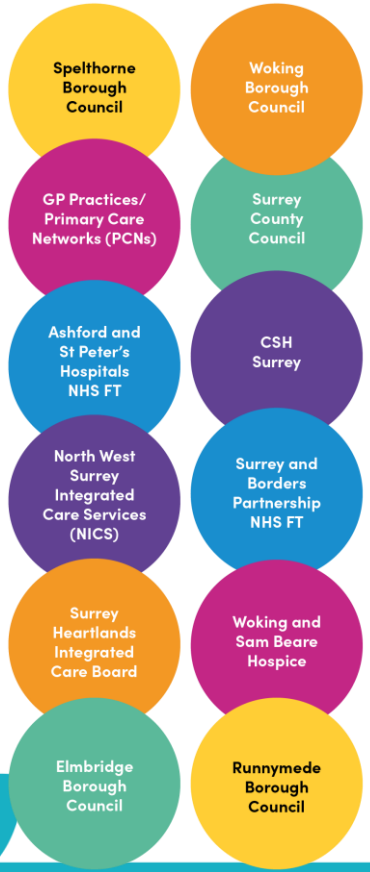
Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY COUNTY COUNCIL

NHS

North West Surrey Place

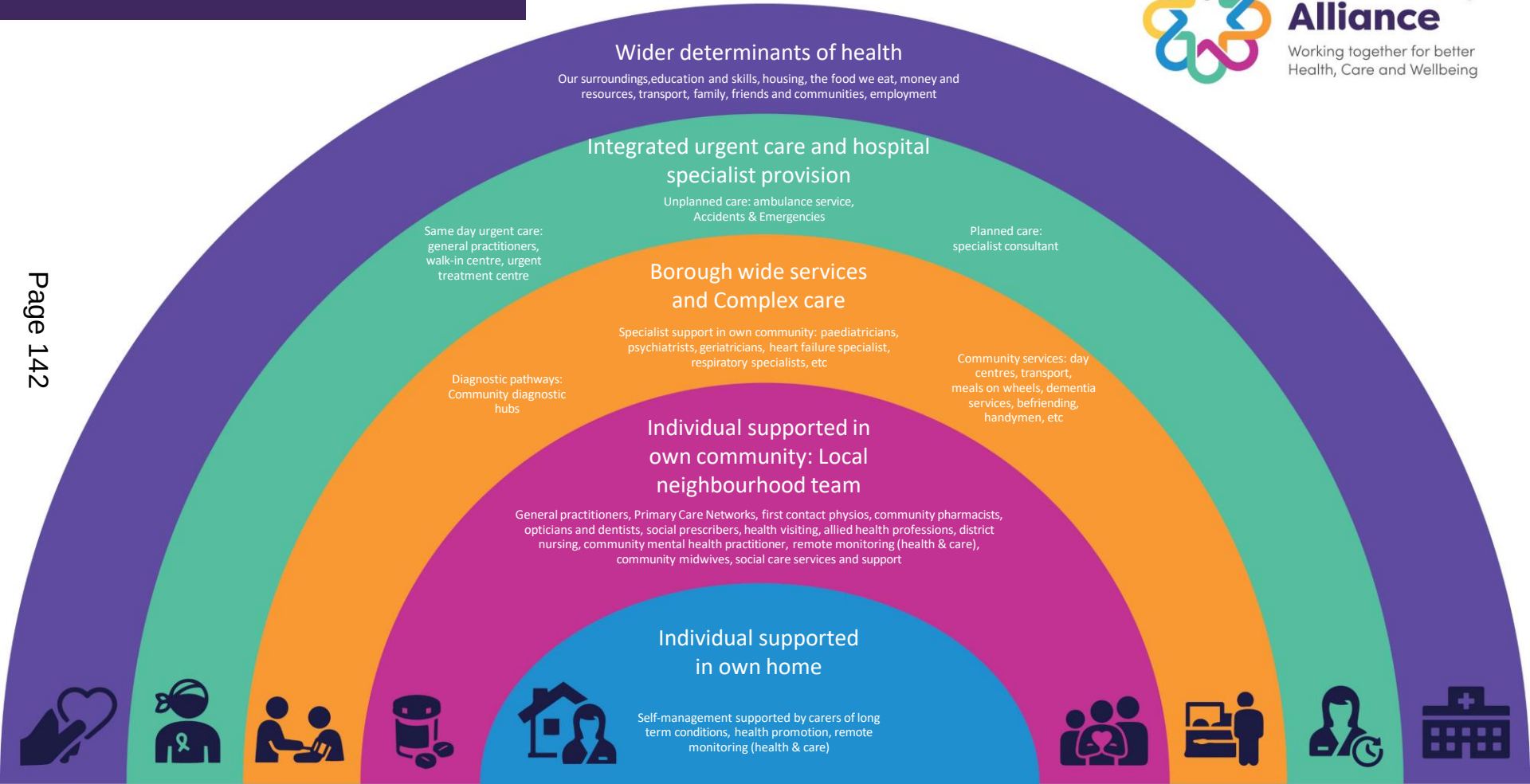
Who we are and why…



To achieve the total wellbeing of our community shifting our focus on health provision responding to sickness to prevention in the fullest sense.

Alliance offer

NW Surrey Alliance
Working together for better Health, Care and Wellbeing



Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

SURREY COUNTY COUNCIL

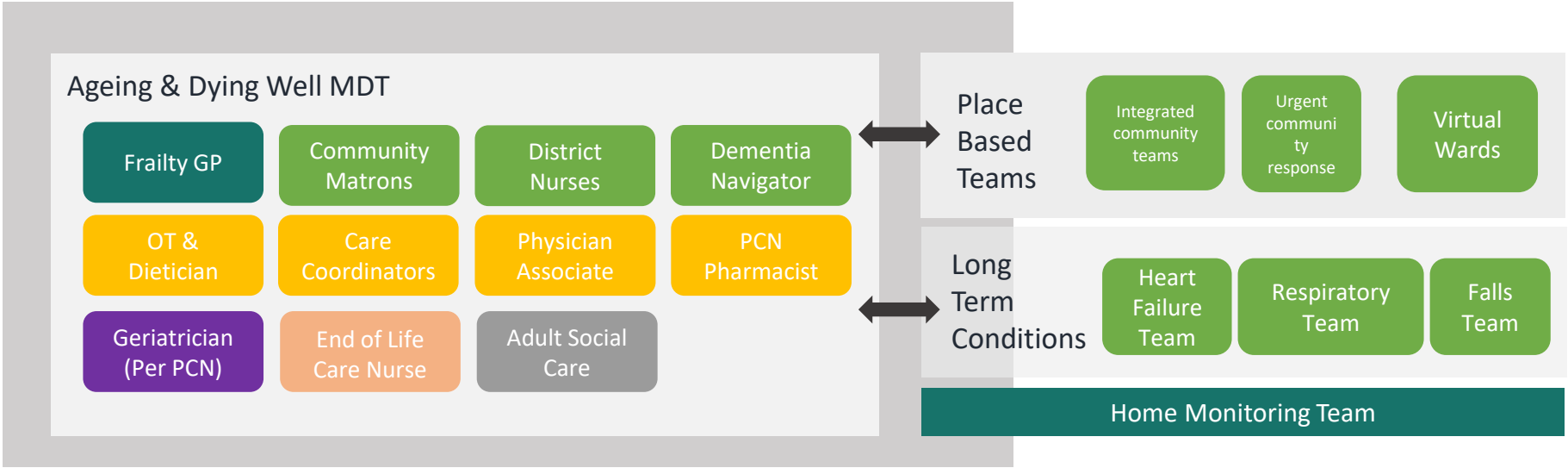
NHS

East Surrey Place

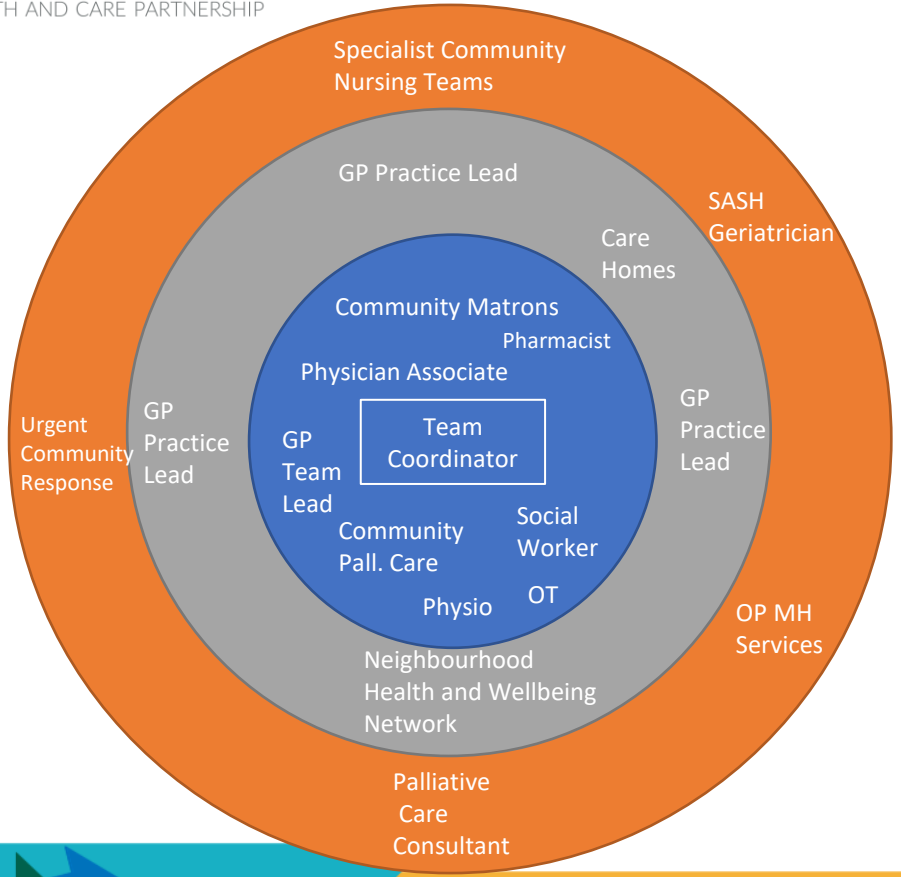
Surrey Heartlands
HEALTH AND CARE PARTNERSHIP

EAST SURREY

Integrated Neighbourhood Team



Integrated Neighbourhood Team Structure



Core Hub Team – identify as the Integrated Neighbourhood Team

Services / groups working only in that neighbourhood but across whole life course

Services working across East Surrey but with a named link to that neighbourhood

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