Health and Adult Social Care Overview and Scrutiny Committee

BRIEFING NOTE – No. 6/21

Date: 3 March 2021

Briefing paper to: All Members of the Health and Adult Social Care Overview and Scrutiny Committee

Purpose: At the January 2021 meeting of the Committee, Members asked to see the figures on hospital discharges and re-admissions in order to gauge the success of the Homecare Bridging Service, the Discharge to Assess Pilot and the 24-Hour Care at Home Model.

Feedback on the winter 19/20 initiatives funded by the Better Care Fund

Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means people no longer need to wait unnecessarily for assessments in hospital. In turn this reduces delayed discharges and improves patient flow.

People who are clinically optimised[i] and do not require an acute hospital bed but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting.

Assessment for longer-term care and support needs are then undertaken in the most appropriate setting. 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.

Wherever possible, people are supported to return to their home for assessment. Implementing a model, where going home is the default pathway, with alternative pathways for people who cannot go straight home, is more than good practice, it is the right thing to do.

- **Homecare Bridging service**

Hospital discharge services were further strengthened for the winter of 2018/19 and winter 2019/20 through the commissioning of a Home Care Bridging Service. This service facilitates the speedy discharge of people to their home with a package of support, whilst their long-term care arrangements are finalised.

The Home Care Bridging Service went live on the 9 December 2019. The service performed well and has enabled prompt discharges from the acute setting and improved the flow.

During the period between 9 December 2019 and March 2020, 88 patients were supported (110 referrals received). This averages 29 people a month. In terms of effectiveness, the majority of patients were supported to return home. Three patients needed alternative support following assessment.

- **Discharge to Assess**

This initiative started in January 2020 and aimed to test a new discharge pathway for patients who were unable to go home immediately following discharge from hospital. For example, they may have required a residential/ nursing bed to assess their longer-term needs and eligibility for health or social care funding support in a care setting.

Officers developed plans to test and scale a discharge to assess pathway to support Continuing Health Care (CHC) in Medway. It was anticipated that the pathway would improve performance in relation to CHC targets, which require 85% of assessments to take place in the community.

The successes of the initiative were

- Medway's Decision Support Tool (DST) assessments (undertaken in the acute hospital) rates were 41% in December and 23% in January and 0% February.
- Every patient placed on the pathway stayed in the initial home they were placed in after the assessment.
- As a result of the Covid pandemic, Discharge to Assess was introduced nationally for all discharges and the pilot placed Medway in a better position to take forward at pace to support hospital discharge. Placements and new packages of care are currently funded through NHS budgets for up to 6 weeks.

- **24 Hour Care at Home model**

This intervention was piloted in January 2020. The aim was to provide support to people who have night-time assistance needs, so they can return home following admission to hospital, instead of being admitted to a residential or nursing care home.

The 24-Hour Care at Home model provides intensive care and support over an initial 72-hour assessment period. This can be extended for up to two weeks. This enables patients who have just been recently been admitted to and cared

for in hospital, with the opportunity to have a holistic Health and/or Social Care Assessment in their own home environment.

The full care pathway and treatment protocols put in place enabled the service to support two patients on average each week, over a 12-week period.

The average daily cost of 24hr care was £600 per client. Of the 9 patients supported, 6 remained at home at the end of the pilot.

As an example of future costs avoided, for the patients who remained at home instead of being discharged into residential care, the cost difference in the care provided and residential care would suggest a saving of around £51k or an average of £10k per patient, per year, where residential care is delayed.

This initiative is being evaluated. Findings of the evaluation will inform any future commissioning decisions

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[i] **Clinically optimised is described as the point at which care, and assessment can safely be continued in a non-acute setting. This is also known as 'medically fit for discharge' 'medically optimised.'*