Home First update to People Scrutiny Committee (January 2022)

1. Summary

This briefing provides an update on the Dorset Home First Programme, which was established in response to the national mandate to mobilise a system-wide discharge to assess pathway for all individuals requiring additional support on leaving hospital.

The programme mobilised in March 2020, as part of the response to the first wave of the pandemic, with a focus on reducing avoidable delays in hospital, and providing appropriate support and care to enable people to recover in their own homes wherever possible. The 'home first' model has continued to evolve and develop over the past two years, albeit in a persistently challenging operating environment.

The current phase of the programme is centred on how it can effectively transition from an 'incident response' approach to a sustainable health and care offer that is centred on reducing the length of stay for people in acute care, improving people's outcomes following a period of rehabilitation and recovery, and minimising the need for long-term care wherever possible

2. National Operating Model for Discharge to Assess

The COVID 19 Hospital Discharge Requirements (March 2020) set out actions for each health and care system to take immediately in to organise the safe and rapid discharge of people who no longer need to be in a hospital bed.

The primary objective in this initial wave of the pandemic was to ensure that acute bed capacity was created and maintained; but it also provided an opportunity for local systems to accelerate and extend work already in train to support a comprehensive discharge to assess approach.

Key features of this accelerated model were

- Daily review of all patients in hospital to identify those who are suitable to leave hospital that day (people who no longer meet the criteria to reside in hospital)
- On the day discharge facilitated by acute, community and social care teams working together with patients and families to transfer people to the right place for the next stage of their care. This should be home for the majority (95%) of individuals

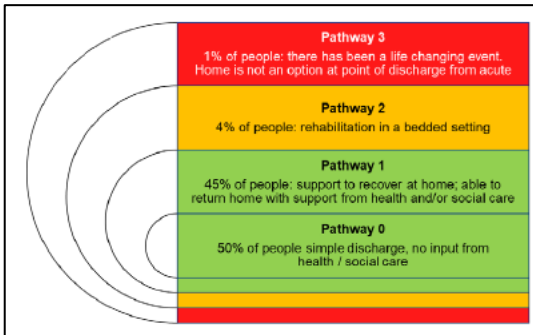
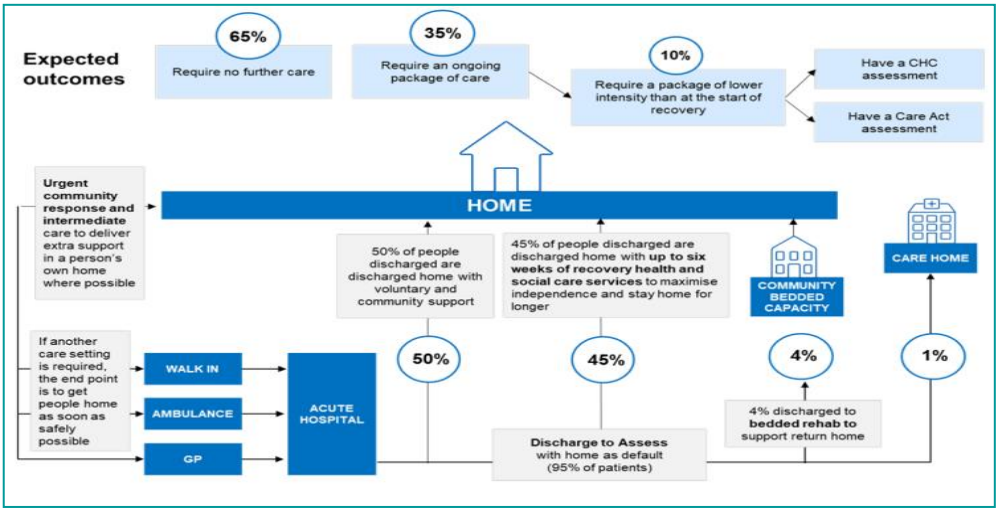


Figure 1: Discharge to Assess model

- Central co-ordination of all referrals for people requiring discharges on Pathways 1-3 via a system-wide single point of access and a co-ordinated 'discharge to assess' offer available seven days per week across health and social care
- No assessment for long-term care to take place in hospital, enabled by up to 6 weeks of national hospital discharge funding for post -discharge recovery and support services following discharge from hospital.

This guidance was superseded in August 2020 by the NHS Hospital Discharge and Community Support operating model which sought to embed the 'discharge to assess' model into system operating arrangements. This has been further updated in 2022 but with few material changes.

Fig 2: National operating model



National funding has been maintained over this period, tapering to four weeks funding support from July 2021 and is expected to end on March 31 2022. Local health and care systems are required to put in place a commissioning and operating arrangement to sustain the model after this period as part of ongoing delivery arrangements.

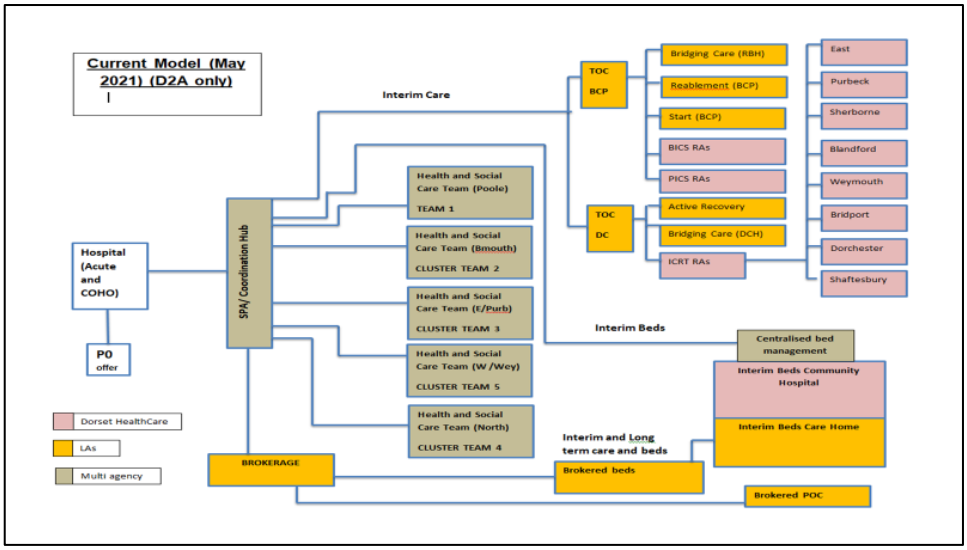
3. The Dorset Home First model

Health and care partners responded quickly to mobilise a Dorset-wide 'discharge to assess' offer. Key features included:

- A 7-day single point of access for all patients no longer meeting the criteria to reside and which tracks all discharges from acute and community hospitals on Pathway 1-3
- Centralised brokerage function for allocation to a Pathway 2-3 community bed and ensuring care requirements in place for those discharges to home on Pathway 1.
- Integrated Multi-Disciplinary Team (MDT) arrangement across acute, community and social care to facilitate rapid discharge of people onto Discharge to Access (D2A) pathways. This is organised into five geographical clusters to enable better local management with appropriate leadership and co-ordination from each partner.
- Investment in additional short-term care offers (home and bedded care) to enable rapid discharge from hospital, and a centralised approach to community hospital bed management
- Oversight and governance via a Dorset Home First Programme Board with executive representation from all health and care organisations in Dorset to drive delivery and support effective decision making

This infrastructure has largely been maintained since this initial period, but there is evidence of increasing pressure over the last six to nine months as the health and care system returns to usual activity levels. This is exacerbated by the ongoing impact of COVID as well as the negative impacts of delayed treatment and support over the last two years.

Fig 3: Dorset Discharge to Assess pathway



This winter is particularly challenging for all agencies involved in home first delivery: the numbers of people waiting in hospital and at home for care is persistently high and with increasing need. This is by compounded workforce shortages in health and care (sickness and vacancies), and the increasing fragility of the care market which is contributing to reduced capacity and flow across the system.

The impact of this is increased delays for people waiting for care, people not receiving the optimum care they need and the risk to long-term outcomes which may result in a high level of dependency and need for ongoing care. This latter impact is particularly challenging for local authorities.

Additional non-recurrent national funding has been made available over the winter period to help systems to address these challenges. In Dorset, this has included:

- Investment in additional short-term home and bedded care to provide more capacity for people requiring supported discharge, including those at end of life. However, this is limited by market availability and impact of Omicron on the care workforce.
- Investment in working with the voluntary sector to extend the support offer for people with low level needs (Pathway 0 and Pathway 1) to enable people to return home without formal care where appropriate
- Investment in supporting local authorities to address adults social workforce capacity pressures through recruitment and retention activity this winter, working with local providers.

This investment is underpinned by ongoing work across partners, in line with the Home First approach, to review and refine discharge to assess processes and pathways to reduce avoidable delays and hand-offs; and to optimise the use of available capacity (homecare and beds) to ensure a continued focus on improving recovery outcomes.

Looking ahead to 2022/23 and beyond, the Home First programme board is focused on how the current model can be stabilised, refined, and embedded to ensure that Dorset people can consistently receive the best care and support options to meet their needs. A strategic partner (IMPOWER) was appointed in August 2020 to assist system partners in evaluating the current approach, setting the ambition for future delivery, and developing a system business case that describes how this can be delivered. The Board is currently reviewing this proposal.

4. Work to date – evaluation, impact and learning

The Home First model is largely premised on delivering the following outcomes

Better outcomes for individuals	Improved system flow
• Reduced LOS in hospital bed on account of fewer assessments in hospital reducing risk of decompensation	• Reduced acute LOS and delays in discharge on account of better discharge planning and fewer assessments in hospital
• Assessment of needs is undertaken at home in familiar surrounding resulting in improved health and wellbeing	• Reduced duplication of assessment and unnecessary time spent managing people in the wrong place
• May require less ongoing care and support because they have left hospital at a time when they are best able to recover	• Reduced cost of long-term care as individuals more likely to require less ongoing care if assessment made at right time and place.
• Increase confidence and capability to manage health and well-being, contributing to fewer hospital admissions	• Reduced reliance on beds as default solution – more flex and efficiency in non-bed based options
• Allows individuals and families to be involved in process from the very beginning	• Create space for recovery and flow – improved bed occupancy
• Better experience – joined-up-care, reduced hand-offs, involvement in care plans	• Greater partnership working - benefits for capacity, planning and experience

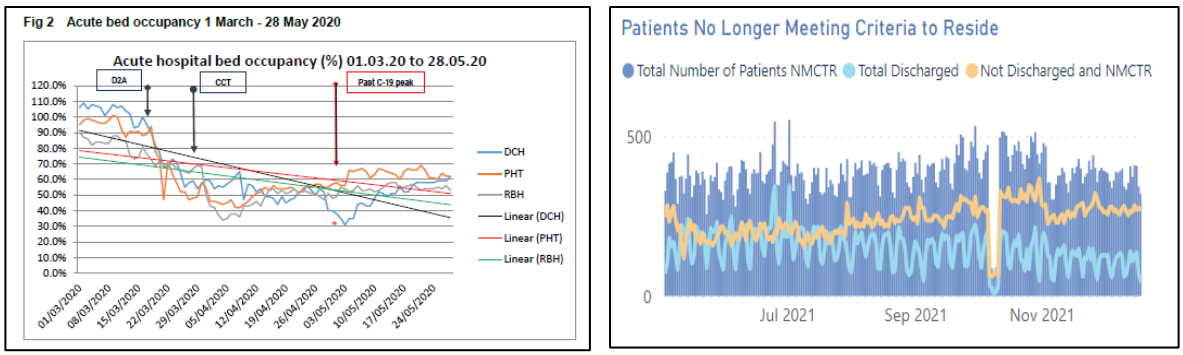
Much of the emphasis in the first phase of the programme has been centred on improving and maintaining system flow, in line with the requirements of the national pandemic response. Working with our strategic partner we have looked at overall system performance and flow over the last year. Key headlines

- Non-elective admissions for over 65s have remained relatively static for both Dorset County Hospital (DCH) and University Hospitals Dorset (UHD) since March 2021. These levels are higher than seen in 2020/21 and demonstrate 'winter' levels of demand through the summer of 2021.
- Average stay length for non-elective admissions had remained static for the 18-64 age group but has been rising since May 2021 for the over 75s (and over 65s at UHD).
- Supported discharges represent just over 20% of acute discharges and referrals to local authority adult social care.
- Despite falling referrals, the number of cases held by the SPA has increased since May 2021.
- Since November 2020 the time taken from SPA referral to discharge has increased for P1 – suggesting supply side challenges, as there has been a reduction for P2 and P3 during the same period.
- The hours of home care required on discharge has remained constant, but the number of clients supported has increased –suggesting that individuals are receiving support following discharge for longer.
- Utilisation of key Pathway 1 contracts has remained relatively consistent averaging around 64-67%.

- Establishing a reliable data picture of the system is challenging. Much of our data is fragmented and often incomplete. There is noy yet a regular, easily accessible system overview to enable strategic and day-to-day management.

Reducing the number of people delayed in hospital (people with no criteria to reside) has been a key system metric and achieved some success during the first twelve months of the programme. This position has deteriorated since last summer, in line with growing demand and capacity pressures in health and care. There are currently circa 300 people in hospital waiting for discharge.

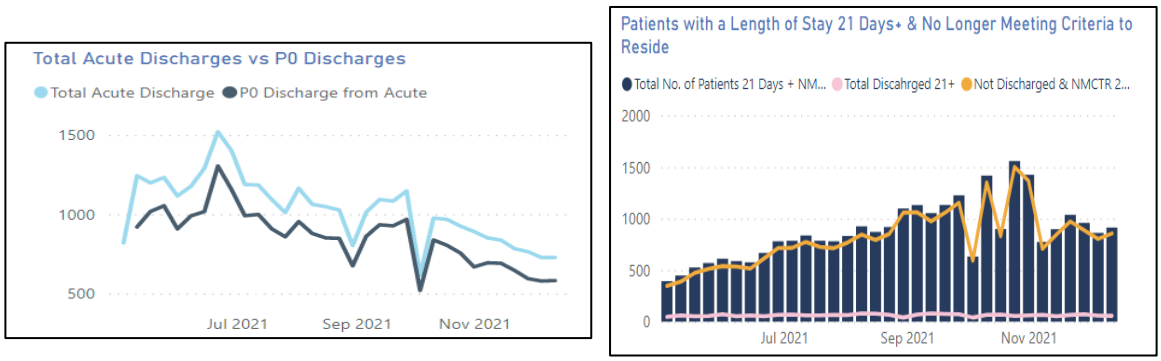
Fig 4: Acute bed occupancy and people not meeting criteria to reside[1]



An additional area of focus has been to increase the number of people discharged to home on Pathway 0 and Pathway 1. The national ambition is 95% of people should go directly home (with appropriate support) on discharge from hospital. In the Dorset system, circa 92% are discharged on P0 and P1 (all ages[2]) with circa 7% going to short-term bedded care (Pathway 2). Very few people (1%) are discharged directly to a long-term placement on discharge (Pathway 3). The number of people discharged to bedded care has increased in recent months, due largely to constraints in the home care market.

The overall rate of discharge has been in continual decline across all pathways over recent months, reflective of wider operational pressures. This means that more people are being delayed in hospital for longer.

Fig 5: Rate of acute discharge and numbers delate over 21 days



[1] No of people who are not discharged but are ready to leave hospital is represented by the yellow line

[2] The national ambition was premised on over 65s data only. Local data is currently premised all age discharge so may be skewed to higher levels of P0 discharges). Work continue to refine this analysis

5. Next steps – greater focus on outcomes and sustainability

The next phase of the programme is centred on how the system can effectively transition the home first model from an 'incident response' approach to a sustainable health and care intermediate care offer that is focused on reducing delays and improving the experience and outcomes for people following a period of acute care

An outline business case has been agreed by the Home First Board with sets the ambition for a reshaped intermediate care offer in Dorset over the next two to three years . This is centred around the following working vision:

We will enable people in Dorset to lead independent lives in their own homes, avoiding admitting them to hospital unless necessary and getting them back home with the right support following an admission.

We will identify the outcomes which matter to the people we serve, and we will be committed to achieving them through a clearly defined intermediate care offer

We will offer a timely and seamless journey through high quality services."

As part of this, there are a range of tactical opportunities that will be taken forward at pace over the next 6-12 months that will support the stabilisation and optimisation of the current model, and address some of the challenge in demand, capacity, and flow management. These include :

	Opportunities
1	A clear offer and accountability for **Admission avoidance** both from the community and at ED
2	Commitment to **processes and paperwork that reduce handoffs, with staff roles and responsibilities** that enable this
3	A **staff training programme** that focuses on the core knowledge and skills they need to enable effective discharges
4	A vision and enablers in place for a **daily rhythm and stimulation for patients on our wards** that promotes their wellbeing as well as their physical independence.
5	**Options for our more complex patients who don't fit into the standard D2A process** that empower staff to be creative
6	**Consolidation of and commitment to our providers** using our understanding of Home First demand to better match it to our supply
7	**System wide contract management** that maximises use of the resources we have available
8	A defined **advice and information offer and pathways to access universal services**

Delivery of the 'tactical opportunities' in 2022/23 will enable some rapid wins in intermediate care, showing the benefits of partnership working, whilst delivering clear benefits to the Home First vision and outcomes. A stronger platform will then enable the programme to confidently move into a more ambitious delivery phase – this may be possible during the second half of the 2022/23 financial year.

The following delivery schedule would be possible over the next 3 years with each year building further ambition into the foundations laid by the pervious activity and enabling full embedding of the change.