An update on reablement and the new Home First discharge to assess service

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1. Summary

1.1. The government introduced additional non-recurrent social care funding, under the title of the Improved Better Care Fund in 2017-18. Alongside this funding came some specific instructions on how it should be targeted and spent. One of these priority areas was "*reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready."* Somerset has chosen to do this by introducing a Home First discharge to assess service, incorporating joined up reablement and therapy services. These services were designed to reduce delays in transfers from acute hospital care and talking to the person about future plans in their own environment/not in an acute hospital setting.

1.2. One of the focuses for SCC was to upskill our social care reablement resource. As members will be aware, this has been an issue which we have wanted to address to improve the lives and prognosis of individuals and increase their ability to live at home, without the need for significant intrusion or repeated medical episodes. This piloted service provision has resulted in significant partnership working across the system with acute, community and social care providers linking to give better outcomes and staff who feel supported and empowered.

2. Issues for consideration / Recommendations

2.1. A PowerPoint is due to made available to members of Scrutiny who are asked to consider to understand and evaluate the new services provided. The approach to trialling a new reablement service within the plans should be noted.

2.2. Scrutiny feedback will be relayed to the Delayed Transfers of Care Board which is part of the Somerset STP.

3. Background

3.1. Discharge to Assess is emerging as a tried and tested model in other health communities and is one of the 8 high impact changes (HIC) recommended for improving the health and social care interface. In addition, it can facilitate another of those HIC's in introducing "trusted assessor" models to the system and using them effectively. The National Audit Office report '*Discharging older patients from*

hospital' May 2016 says:
Unnecessary delay in discharge (older people) from hospital is a known and long-standing issue…longer stays in hospital can lead to worse health outcomes and can increase long-term care needs…it is also an additional and avoidable pressure on the financial sustainability of the NHS and local government. Patients lose 5% of muscle mass each day they stay in hospital

3.2. Plans are in place and up to £3m will be used to support health and social care joint services including Discharge to Assess, Intermediate care options, admission avoidance and availability of responsive support after a hospital stay. This funding will supplement, not replace, existing social care resource for the benefit of the NHS, as well as funding joint initiatives which will include health staff being funded to work differently in the community.

3.3. The following will all be funded direct from the Improved BCF:

1. Additional therapy resource
2. Additional targeted and jointly upskilled reablement provision through social care providers
3. Step down reablement outside of a hospital setting in care homes
4. Additional social work resource (e.g. weekends)
5. Additional GP time to support community pathways
6. Additional equipment to enable people to stay at home
7. Trusted assessor posts in acute settings

The plan fully supports reducing delayed transfers of care but should also reduce NHS reliance on escalation beds and agency staffing in an acute setting. A different reablement offer will also reduce readmission and onward reliance on other NHS and non-NHS services.

4. Consultations undertaken

4.1. This work has been done across partnership organisations including Yeovil District Hospital Trust, Taunton and Somerset NHS Trust, Somerset Partnership, SCC and social care providers.

4.2. The finance implications under the Improved Better Care Fund remit have been evaluated by Directors of Finance from all the above organisations and outcomes for people and their feedback will form a crucial part of the initial test phase.

5. Implications

5.1. The spend on Home First is a significant amount of the Improved Better Care Fund allocation and must therefore address not only the health delays but also improve social care outcomes for people.

5.2. The increased development of the Discharge to Assess pathway will support outcomes from the NHS Outcomes Framework; the local authority Adult Service Plan; Somerset's STP as well as delivering some of the High Impact Changes required by system leaders:

- improved outcomes for patients by reducing length of stay in hospital beds where patients quickly become clinically decompensated and those with cognitive impairments can see their confusion increase
- reduced costs of on-going care packages and care home placements for individuals themselves, LAs and CCGs
- increased number of discharges through earlier discharge and assessments taking place outside of hospital
- avoidance of the current complex choice issue and provide a clear route for patients and staff to follow
- discharge planning that supports people to regain independence through effective reablement with increased system resource
- real time data tracking of flow and outcomes by using system data inside and outside of hospital
- reducing duplication and joining up health and social care by having one system, jointly owned across health and social care.

6. Background papers

6.1. Presentation to follow