Bristol Health and Wellbeing Board

Title of Paper:	Home First Discharge to Assess Transformation Programme
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Date of Board meeting:	7 September 2022
Purpose:	Information and discussion

1. Executive Summary

1.1 The Health and Wellbeing Board is asked to note and support the actions being taken via the Healthier Together Discharge to Assess (D2A) Transformation Programme and wider Home First Portfolio. The programme aims to support people to leave hospital and move to the right place for their recovery, care and support needs, in the place they call home, as soon as clinically possible. The programme will also support work to maintain hospital flow, reduce ambulance delays, deliver elective care recovery, and ensure that people receive the right long-term support at home to support their ongoing health and wellbeing.

1.2 Currently too many people across Bristol, North Somerset and South Gloucestershire spend too long in both acute and community hospital beds, which evidence shows leads to worsening physical and mental health. Similarly, too many people are discharged into community beds, rather than at home, further slowing their rehabilitation and recovery and leading to more people needing long term social care and reducing their opportunity to live independently.

1.3 The Home First D2A Programme brings together partners involved in Health & Social care together across the system. This includes NHS and Local Authorities partners, as well as care providers, Voluntary sector & Community organisations and organisations representing carers. This is to help:

- Tackle the immediate pressures facing staff and the people we care for throughout acute hospital, community, and social care.
- Develop short and medium term solutions which are sustainable for all partners, with joined up pathways of care outside of hospital as much as possible.
- Develop a long-term implementation plan for integrating/aligning health and care services based on an understanding of the elements where consistency across BNSSG is important and where local variation is critical to deliver the best service.

1.4 This is in the context of and in response to the 100 Day Challenge set by NHS England (https://www.england.nhs.uk/publication/acute-hospital-discharge-100-day-challenge/) to deliver against the 10 best practice initiatives that have been identified that demonstrably improve flow and should be implemented in every Trust and system to improve discharge. It also includes the delivery of recommendations that were made as part of the Local Government Association (LGA) peer review which took place in April 2022 and support provided by the LGA to deliver this.

2. Purpose of the Paper

2.1 The purpose of this paper is to:

- Brief the Board on the D2A Transformation Programme and wider Home First Transformation Portfolio

- Request that the Board input to and support delivery of the immediate and longer-term actions being taken via the 100 Day Challenge and current system transformation work.
- Request that the Board agree to consider in the Autumn the LGA's recommendations on the long-term implementation plan for an aligned/integrated model across health and care.
- Ensure that the principles of the Home First Portfolio align with the Health & Wellbeing Board's priorities.

3. Background, evidence base, and what needs to happen

3.1 The Healthier Together Home First Portfolio is a group of change programmes that bring health and care partners together across the ICS to either keep people at home when they need extra support; or get people back home as quickly as possible if they need to be displaced from their home environment for their needs to be met. This might be unplanned and needed in response to managing an existing condition or a change in the home circumstances (e.g. carer or housing), as an alternative to being admitted to hospital, or to support an earlier discharge from hospital.

The Home First Portfolio includes 3 major transformation programmes: Discharge to Assess, Ageing Well and Healthier Together at Home (virtual wards). It also brings together a range of programmes focused on specific conditions, for example CVD and end of life care.

3.2 The D2A Programme and Home First Portfolio are closely linked to the One City Plan 2050 vision of strong communities formed of resilient and independent people, integrated health and social care which seamlessly meets the ever-changing needs of our communities with a focus on early help, prevention, and person-centred support.

3.3 The aim of the D2A Programme is to address the significant and urgent pressures on the health and social care system across BNSSG. These include:

- Too many people in the BNSSG system being discharged from hospital into community beds. There are also too many people in hospital beds who no longer require acute medical care.

- Delays and the high number of people in post-acute care beds is having a significant impact on our ability as a system to maintain hospital flow, reduce ambulance delays, and deliver elective recovery.

- A number of areas to improve integration across D2A pathways in BNSSG and joint working between health and care services have been identified.

- A recent audit found that up to 38% of the current P3 waiting list could be treated in a home first setting with wrap around support, depending on available resources.

- Average length of stay remains significantly higher than targeted across all D2A pathways.

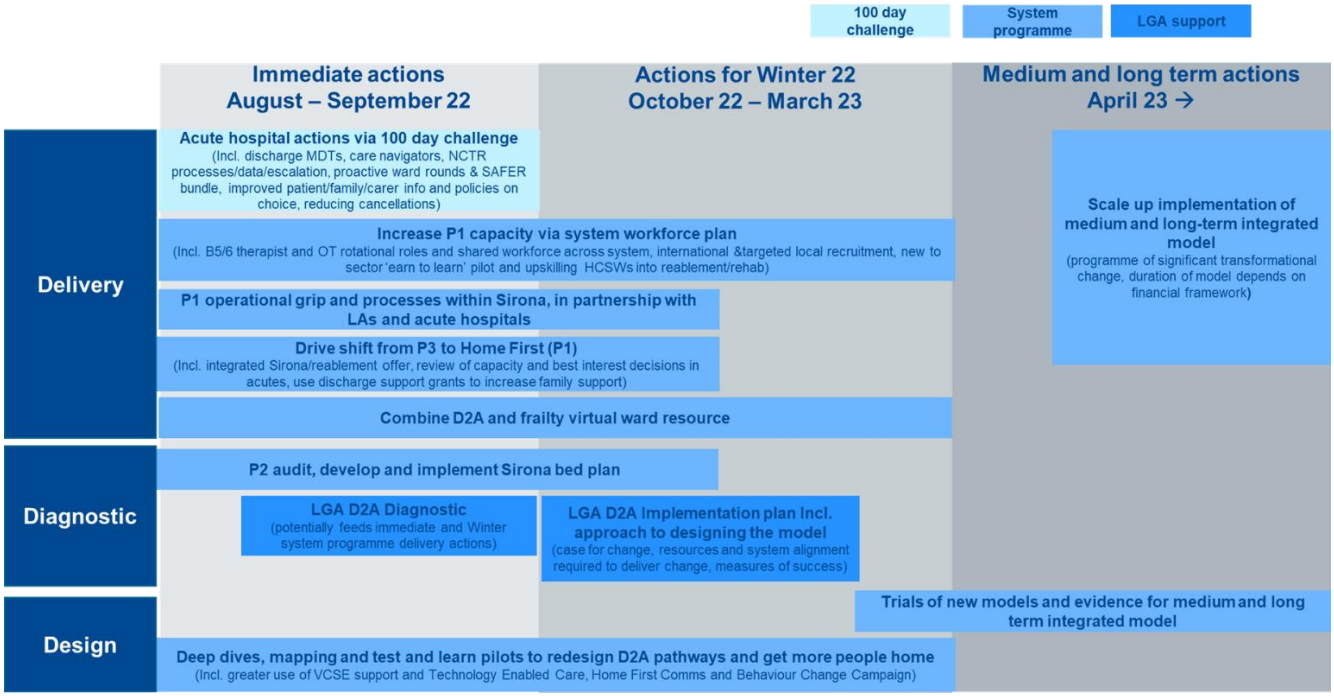
3.4 The diagram below sets out the key actions we are taking through the D2A Programme including:

- Immediate actions via the nationally mandated 100 day challenge to tackle the pressures before Winter 22.

- Short term transformation actions to address the immediate pressures in Winter 22 by increasing community capacity and reducing waiting times and overall length of stay on all pathways.

- Developing medium and longer-term solutions which are sustainable for all partners with joined up pathways of care outside of hospital as much as possible: including more clinical staff working in community roles to support recovery and prevention of re-admission to hospital; shared clinical decision making; earlier involvement of VCSE to assess and plan recovery and future care; and greater use of technology enabled care.

- Strategic support via the LGA review with three objectives: to develop an implementation plan for greater integration and alignment across health and care; to understand elements of the offer where consistency is important and where local variation is critical to deliver the best service; and to focus on the long-term solution but ensure this is mapped coherently with short term actions in one plan.



4. Community/stakeholder engagement

4.1 Across the Home First Portfolio, Ethical Healthcare Consultancy have been undertaking engagement and gathering insights from citizens and frontline staff across the system to better understand the challenges.

4.2 The D2A Programme Steering Group has met with the Bristol Healthwatch team and incorporated action to address their recommendations into the programme.

4.3 The D2A Programme is being delivered via several task and finish groups that allow changes to be co-designed with frontline staff from across the system.

5. Recommendations

5.1 It is recommended that the Health and Wellbeing Board:

- Notes and supports the immediate and short-term actions being taken to improve outcomes and flow through D2A pathways in Winter 22/23 via the 100 day challenge and system transformation programme.
- Supports and feeds into the development of an implementation plan for a longer-term aligned and integrated model across health and care via the LGA support offer
- Considers the LGA's recommended implementation plan once their support offer has concluded. This is likely to include recommendations on: models, funding and approaches to greater alignment and integration across health, social care and the VCSE sector to improve outcomes in ways that are sustainable for all partners.

6. City Benefits

6.1 The end goal of the D2A Programme and Home First Portfolio is that people are supported to stay well, in their own communities and independent for as long as possible.

6.2 In May 22, Bristol Healthwatch collated the experiences of 141 patients, families, carers and NHS staff involved in the hospital discharge process with a specific focus on Pathway 3. They identified that more than 75% of respondents felt delays in admission or discharge had a negative psychological effect and identified transition from one care location to another as the biggest area of concern.

6.3 The D2A Programme is expected to benefit Bristol citizens by:

- Reducing the amount of time people spend in hospital and supporting more people to go home first on Pathway 0 or Pathway 1 and regain their independence rather than going into P2/P3 beds, making use of Technology Enabled care to increase independence.
- Improving support for people and their families/carers to remain independent and avoid hospital admissions.
- Reducing waiting lists and delays going into and exiting hospital discharge pathways
- Freeing up acute hospital capacity and improving ambulance response times for other citizens who need urgent and emergency care
- Reducing the number of people receiving a Tier 3 (long term) care service, and increasing the percentage of these people being supported in their own home or tenancy.

7. Financial and Legal Implications

7.1 No immediate financial or legal implications for the Board to consider at this time.