Local Government Association

directors of adass adult social services

Community health and care discharge and crisis care model

An investment in reablement

July 2020

Context

Supporting people at home (the ethos of Home First from hospital) and discharge to assess are approaches promoted through the COVID-19 Hospital Discharge Requirements first published in March 2020. It was initially funded through COVID emergency funding to support discharge from hospital so as to create acute and intensive care capacity in the context of the pandemic.

The funding and approach since March 2020 have had successes. There are also some concerns about implementation and the impact on people and across systems, not least in the context of the shortage of personal protective equipment (PPE) for adult social care in many parts of the country, inconsistencies in testing people being discharged from hospital, and whether discharge is safe and to the right place for the individual. We must learn from these concerns to build on the positive aspects of the initiative.

Health and care partners will want to look at intelligence and data about capacity in the context of sufficiency, suitability and sustainability across all provision, not just acute healthcare. They will want also to ensure that, as much as possible, arrangements to make sure that people who are most impacted by COVID-19 are protected and supported. ADASS consulted its regions and agreed a set of criteria for future discharge to assess and investment in reablement (see appendix).

Purpose

This paper sets out the view of the Local Government Association (LGA) and Association of Directors of Adult Social Care (ADASS) that the approach – which more appropriately should be called 'discharge to support recovery and then assess'[1] – is a key component of a person-centred community health and care model. The experience of responding to COVID-19 has demonstrated the importance of this care being centred on the individual, providing safe, proactive care that maximises independence and wellbeing.

[1] 'Commissioning Out of Hospital Care Services to Reduce Delay', a discussion paper Institute of Public Care, March 2020

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Themes

Home is the default – but not enough people do go home after hospital

People have the best outcomes when they are helped to avoid having to go to hospital or return home from hospital safely and without delay, with support targeted on their needs. Once settled back into their homes, and after a period of reablement or rehabilitation if needed, only then should they have a care and health assessment for any ongoing needs.

The evidence[2] is clear that home is the most appropriate place for resolving crises and recovery for nearly all people being discharged from hospital. This care and support must be personalised to enable people to live in dignity and in control. People should be able to recover at home, receive short-term reablement or rehabilitation at home, be assessed for any ongoing care needs from home, and be supported to avoid a hospital admission from home. This is not a new approach. Social care has a long history of delivering effective reablement and has much experience to share, working in partnership with healthcare colleagues to design and deliver home first locally. The High Impact Change Model for managing transfers of care[3] signals how health and care can best work together to support timely hospital discharge resulting in better outcomes for people.

To achieve this model, we need to extend best practice and re-orientate services and funding to help more people to get home when that is the most appropriate place for them – and to stay at home. We know, however, that too many people are not discharged to the best destination for them. The LGA found in 2016 that: 'Discharge planning to maximise independence would save money and improve outcomes. For nearly a quarter of people (24 per cent) who were discharged from hospital with a care package, a preferable pathway was identifiable that could have delivered better outcomes at lower cost. Given that a significant subset of these pathways results in costly long-term residential placements this is of particular significance. Practitioners taking part in the study estimated that 59 per cent of long-term residential placements resulting from an acute hospital admission could be delayed or avoided.'[4]

These findings were confirmed in 2019 by work commissioned by the Better Care Fund Team of delayed discharges in 14 systems covering over 10,000 patient journeys. This found that up to 54 per cent of those who were delayed were found to be discharged to a setting where the levels of care were not well-matched to their needs. Of these, 92 per cent of these cases, the setting was providing a more intense level of care than would have maximised the individual's independence.[5]

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[2] For example, https://www.local.gov.uk/shifting-centre-gravity-making-place-based-person-centred-health-and-care-reality

[3] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/refreshing-high

[4] https://www.local.gov.uk/sites/default/files/documents/Efficiency%20opportunities%20through%20health%20and%20social%20care%20integration.pdf

[5] https://reducingdtoc.com/People-first-manage-what-matters.pdf

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Home is the default – but there are not enough community-based services to support people at home

The underfunding of adult social care is well-documented. The 2020 ADASS Budget Survey[6] highlights that only 4 per cent of directors of adult social services are confident their budgets will enable them to meet statutory duties.

Further, as a response to COVID-19, a proportion of councils have increased their fee rates being paid temporarily by a further 5 per cent or more. Recognising huge cash-flow risks, most councils are also paying care providers more quickly than before, on the basis of planned care, or are paying for day/community services despite these being temporarily closed. LaingBuisson, however, has calculated that the care sector alone faces £6.6 billion extra costs by the end of September 2020, some £3 billion of which related to PPE alone[7].

During the rapid hospital discharge period since March, the ADASS survey finds that 11 per cent of people were moved to a place that did not meet their needs, often at a higher fee rate than councils would have normally paid. There are major concerns about these prices not being affordable for individuals and councils after the emergency NHS funding ends. In addition, 11 per cent of councils have experienced inappropriate block-booking of residential or nursing home places by the NHS from out of area. The current situation has further reinforced the need for appropriate housing provision to be central to health and care partnerships.

In addition, over one-third of directors either disagreed or strongly disagreed that there is sufficient mental health (40 per cent) and substance misuse services (30 per cent) available locally. This was closely followed by enhanced health in care homes (28 per cent). In addition, 15 per cent expressed concern about sufficient support for Discharge to Assess and 17 per cent for reablement and rehabilitation. Just over 30 per cent of directors also reported increases in the numbers presenting for social care support as a result of unavailable community or voluntary support.

The provision of COVID-19 emergency funding from 19 March, to support discharge and prevent hospital admission, has been welcomed. The funding has had positive impact in many ways and points to future joint working and funding opportunities. Our members also tell us:

- positive impact from upfront assurance, particularly for councils, as well as temporary cessation of funding discussions, disagreements and delays
- less than 20 per cent of the funding had been claimed by 31 May, in part from councils finding wide interpretation of the funding criteria, confusion and misunderstanding of council/clinical commissioning group (CCG) budgetary and accounting systems, and need for new pooled funds
- only 40 per cent of councils have financial risk-sharing arrangements in place with their CCGs.

[6] https://www.adass.org.uk/adass-budget-survey-2020-coronavirus-budgets
[7] https://www.local.gov.uk/sites/default/files/documents/COVID-19%20Financial%20pressures%20in%20adult%20social%20care.pdf

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It is too early to fully gauge how much additional ongoing funding nationally is needed to support the continuation of the most successful aspects of the emergency hospital discharge and prevention arrangements. It is already clear, however, that:

- Home First should be the focus, avoiding admissions to care homes direct from hospital
- ongoing spend and investment should be directed at effective 'wraparound' rapid discharge, crisis intervention, preventing hospital admission and reablement – including making available appropriate seven-day social work, therapy, pharmacy and transport support
- the Better Care Fund is the most appropriate joint vehicle to effectively roll out this model going forward
- the significant backlogs of continuing healthcare and financial assessments, which have built up as a consequence of the emergency arrangements, and the timescales and implications of a return to pre-COVID arrangements.

Partnership is best – with parity and autonomy to support individuals

Success is dependent on health, social care, housing and others working collaboratively, with parity between partners and recognising each other's strengths and experience. The experience of COVID-19 has cemented this. Local systems are reporting stronger joint working as a result of responding to the pandemic.

Many highlight also:

- a stronger shared purpose, underpinned by greater trust and deepened local relationships
- many examples of place-based leadership, of developing innovative, nimble solutions that address local need or concerns outside of national programmes or activity
- more autonomy and freedom to act, with decisions being taken closer to the individual
- more effective joint commissioning and service delivery and more sharing of risk and funding
- development of infrastructure to support shielded and vulnerable people, a growing attention on health inequalities, and on support from the community and volunteers
- the need for parity of esteem for the care sector with the NHS has never been greater, and the need for an explicit social care workforce strategy and new employment deal for the care workforce, including action on pay, training and development, career progression and professionalisation, and recognition
- concerns about unsafe discharge as speed has at times overridden safeguarding and person-centred care considerations, and can create more and costly problems elsewhere.

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Building a new model of health and care to support crisis and recovery

The past few months confirm the need to reshape health and care, embedding positive developments and preventing a return of fragmented and untimely care and support, especially on discharge from hospital. This will require government and national partners to support local place-based leadership, to continue to shift resources towards community-based services, and to support the recruitment, retention and retraining of the workforce. The key elements of the model are summarised below.

Prevention of admission

1. Joint crisis response service in the community, encompassing primary, community and social care and support, and available for all, including those in receipt of home care and those who are end of life to prevent unnecessary admissions to hospital or care homes. This includes clear step-up arrangements.
2. Simplified access in the community in relation to possible hospital admission and discharge; this must be local and place-based, and include health, social care, the voluntary and community sector, and ambulance services among others.
3. Social workers, with their expertise in managing and working with complexity, should be embedded within teams supporting people to stay well at home or return home, along with occupational therapy.

Hospital stay, discharge and post-discharge support

4. Discharge to assess and reablement should be primary objectives, with prioritisation given to providing care at home, personalisation and the use of direct payments or personal budgets.
5. The High Impact Change Model sets out elements to support a safe and timely discharge, including early discharge planning, multi-disciplinary working, trusted assessment, and providing timely information and choice, all of which must be in place, guided by the overriding principle that home is the default option.
6. There must be strong links with housing, as evidenced in the High Impact Change Model. This should include the work of home improvement agencies, sheltered and extra care provision, and housing support services both in relation to the physical environment but also the support to vulnerable people.
7. Family and carers must be supported, including with clear, timely advice and support to enable them to play their pivotal role in supporting recovery, particularly at home.
8. It is essential also that people's rights to assessment, information, advice, and care and support planning are in place and fulfilled, especially in relation to safeguarding, people returning home or without capacity. The Adult Social Care Ethical Framework[8] provides guidance and support in decision making.

[8] https://www.gov.uk/government/publications/covid-19-ethical-framework-for-adult-social-care/responding-to-covid-19-the-ethical-framework-for-adult-social-care

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9. There must be a consistent, well-understood response to COVID-19 status, including the use of testing prior to discharge to any social care service, with the result available before discharge, and testing resource should be prioritised for this purpose. This must include the ability of providers to isolate individuals, including the use of temporary alternative accommodation where appropriate.
10. The assessment of ongoing health and care needs, particularly continuing healthcare, should be undertaken holistically by professionals working in the community (not acute), ideally with a single, comprehensive assessment process operating out of integrated community teams or arrangements.

Commissioning and funding arrangements

11. This model will require investment in effective reablement and rehabilitation with clear measures regarding achievement of independence. The provision of funding for up to six weeks' reablement or rehabilitation is vital, as is investment to improve capacity of home-based and community health and care services.
12. A single point of contact with 'the market' across health and social care can support a more unified management of price, flow, quality and market shaping jointly. Councils should be lead commissioners and retain their Care Act duties in relation to assessment, planning, market management/shaping and safeguarding.
13. Reablement should be jointly funded and delivered. This could be delivered through the Better Care Fund arrangements or other aligned local arrangements. People's contributions to ongoing care must remain clear also.
14. Councils must continue to be able to use the monies allocated to the NHS for securing capacity, for example dedicated COVID-19 step-down or other alternative facilities to protect vulnerable adults and prevent the number of outbreaks and deaths in care homes.

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Appendix

ADASS criteria for extending NHS England and Improvement funding for Discharge to Assess and investment in reablement

- We want to support proposals for and extension for NHS England and Improvement funding of the for discharge to assess and an investment in reablement on the following basis:
- Where it has worked well it has worked well for whole systems and most critically for older and disabled people and their families. Carefully and jointly managed, it may well be extremely helpful over the next winter to cope with winter itself, further waves of COVID-19 and to manage, in a structured way, the stability of and managed exit from some forms of social care.
- It should have a big discharge to assess and reablement focus on care at home (home first), personalisation and the use of direct payments/personal budgets as well as in care homes.
- This should cover six weeks paid for by the NHS and align with pre-COVID council and BCF funded crisis intervention and reablement.
- It should focus on crisis response before the need for hospital as well as hospital discharge.
- It must have, as a pre-requisite, safety checks prior to discharge and, if to social care or family carers, that isolating is possible and that PPE, testing, tracing and tracking are in place.
- Home first is the default option.
- People must have full information and advice prior to discharge about assessment, crisis response, reablement, funding and possible future charges
- People (patients, clients and staff) should be assumed positive and the above taken account of unless they have a negative test.
- The scheme should not be portrayed as removing the right to information, advice, assessment, choice and charging, rather that people's Care Act and continuing healthcare rights will be enacted outside of hospital.
- Councils should be lead commissioners and will retain their duties in relation to assessment and planning, market management and safeguarding.
- Community services and primary care will support through EHCH, infection control and an equivalent for people with high needs and/ or who are at the end of life at home.
- Investment in and evidence of effective reablement is critical. Providers will need to demonstrate their track record in supporting people to achieve their maximum functioning and wellbeing in order to be commissioned. Some measure of this will need to replace delayed discharges and avoidable admissions.
- There needs to be seven-day social work, physiotherapy and occupational therapy available and funding for this should be intrinsic to the model.

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