Warwickshire Hospital Discharge Community Recovery Programme

Version date: 18.11.22

Warwickshire Health and Wellbeing

How have we got to this point?

Warwickshire Health and Wellbeing

National Integration Frontrunner Objectives

- Our national frontrunner proposal ambition would be realised by a partnership between NHS and Social Care providing care and support at the point of discharge linked to each of our acute centres; injecting new capacity into the system by enabling an NHS provider to become a registered domiciliary care provision; and seeking to exploit the new visa opportunities for bringing overseas working into domiciliary care which are currently difficult for SMEs providing this care to support
- We would also
  - Seek to strengthen our relationships with the voluntary and community sector and to understand new or enhanced opportunities
  - Realise further benefit from initiatives and partnerships we currently have in place e.g. levelling up, using technology such as DOCABO, Tribe and MySense as enablers
  - Support recovery post discharge
  - Continue working closely with our hospices
  - Use the opportunity to explore our role in preventing admission linked to ambulatory care and frailty assessment pathways

Intermediate Care – vision and key principles (1)

- The transformation of out-of-hospital services is a key element of the NHS' recovery. We are working with systems to increase overall capacity of community services to provide care for more patients at home and develop new models of care such as a new community recovery service.
- **Our vision is that within 5 years ALL people in an acute hospital, who need further support to recover, will have access to effective therapeutic intermediate care services within 24 hours of no longer meeting the criteria to reside.**
- We intend to test and evaluate a new model of intermediate care services post-discharge that would effectively see:

Commissioning of recovery services as one single intermediate care step-down (post-discharge from acute hospital) service at Place through one lead commissioner

National common professional and performance standards, including a 24 hour standard from no longer meeting the criteria to reside to being in receipt of the New Community Recovery Services

Single data architecture, pulling data from clinical systems

Intermediate Care - Key principles summary (2)

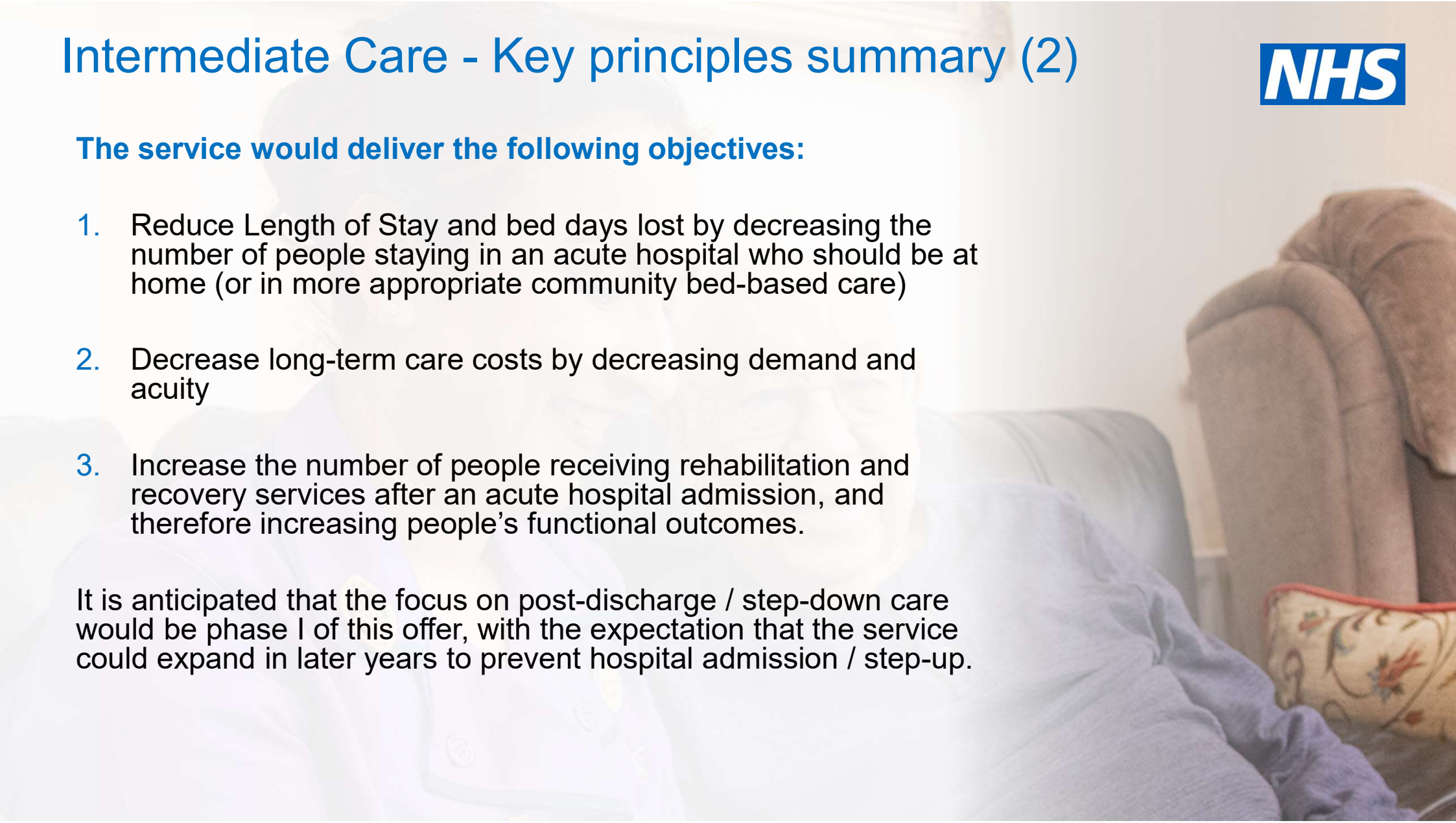
The service would deliver the following objectives:

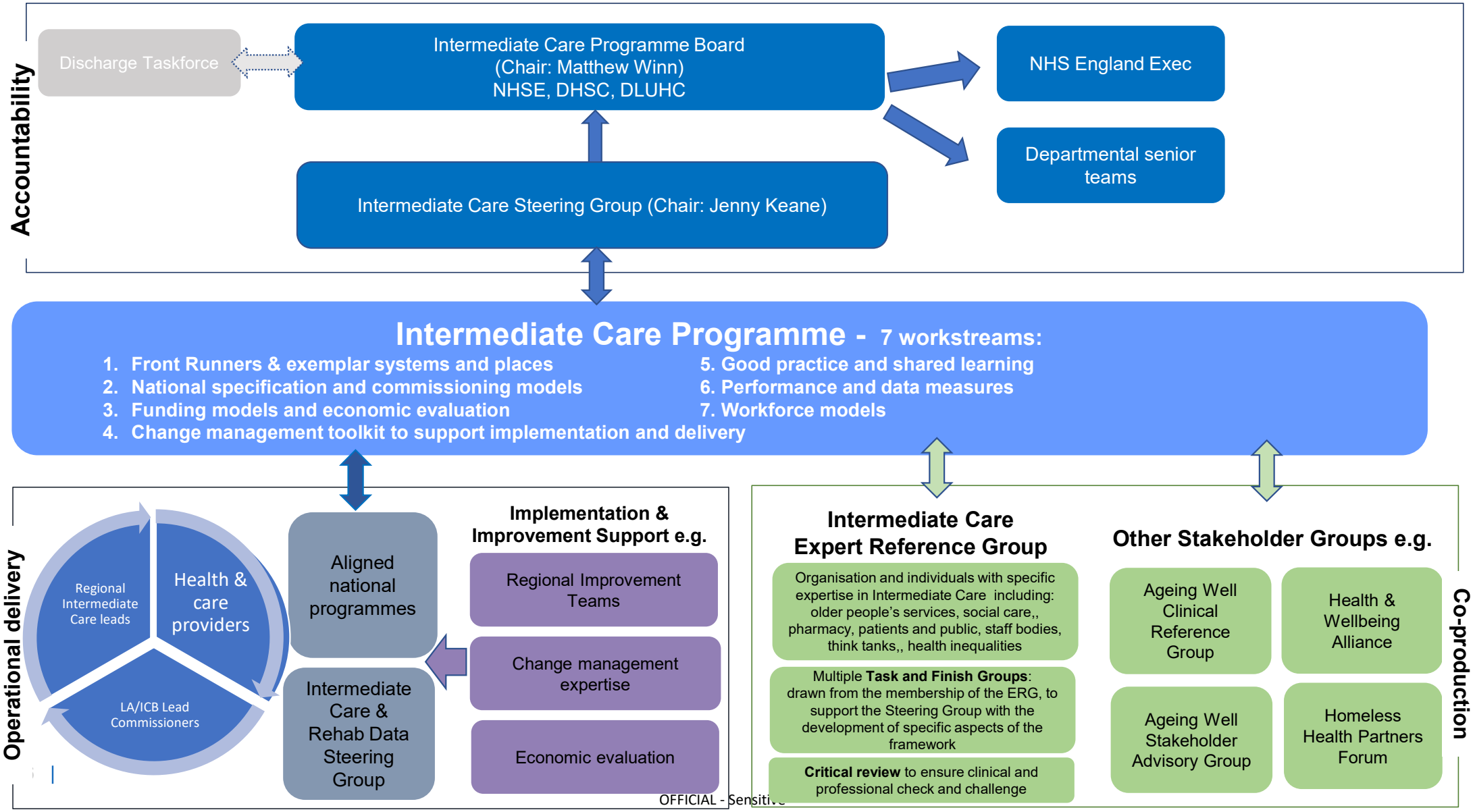
1. Reduce Length of Stay and bed days lost by decreasing the number of people staying in an acute hospital who should be at home (or in more appropriate community bed-based care)

2. Decrease long-term care costs by decreasing demand and acuity

3. Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission, and therefore increasing people's functional outcomes.

It is anticipated that the focus on post-discharge / step-down care would be phase I of this offer, with the expectation that the service could expand in later years to prevent hospital admission / step-up.





What are we committed to?

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Warwickshire Hospital Discharge Community Recovery Programme
National Pilot — SRO: Becky Hale

Purpose:

Aim

To further develop pathway 1 discharge to assess services in Warwickshire to enable **all** people in an acute hospital, who need further support, to access timely therapeutic intermediate care services on discharge.

Objectives

- Develop a Hospital Discharge Community Support Service building on existing arrangements and ensuring compliance with Hospital Discharge Guidance
- Reduce Length of Stay and bed days lost by decreasing the number of individuals staying in an acute hospital who should be at home.
- Decrease long-term care costs by decreasing demand and acuity
- Increase the number of people receiving rehabilitation and recovery services after an acute hospital admission.
- Develop integrated commissioning and delivery arrangements for hospital discharge

Outcomes

Individuals are supported to recover and re-able to maximise their individual outcomes.

Key Stakeholders:

Patients, Acute Providers, Community Providers, Primary Care, ICB, Social Care, Independent Care Sector, VCSE

Key Workstreams and proposed leads:

Service Design and Commissioning Arrangements – Zoe Mayhew
Integrated Discharge Operational Arrangements – Rachael Hayter
Finance – Adam Philips / Vicki Forrester / Ravi Basi
Redesign of Continuing Healthcare – Paul Smith
NHS care provider development – TBC SWFT
Data – Steve Jarman-Davies

Key Enablers:

NHSE Pilot Funding
System Resource including PMO
OD and Comms
Data and performance monitoring

Risks

Ceasing of hospital discharge grant; resource; market and workforce capacity

Interdependencies

Ageing Well, Coventry Improving Lives Programme, existing programmes of work across Warwickshire

Governance:

ICB commissioning responsibility delegated to SWFT integrated out of hospital function.
Programme Board reporting to Warwickshire Care Collaborative (and Place Partnerships)

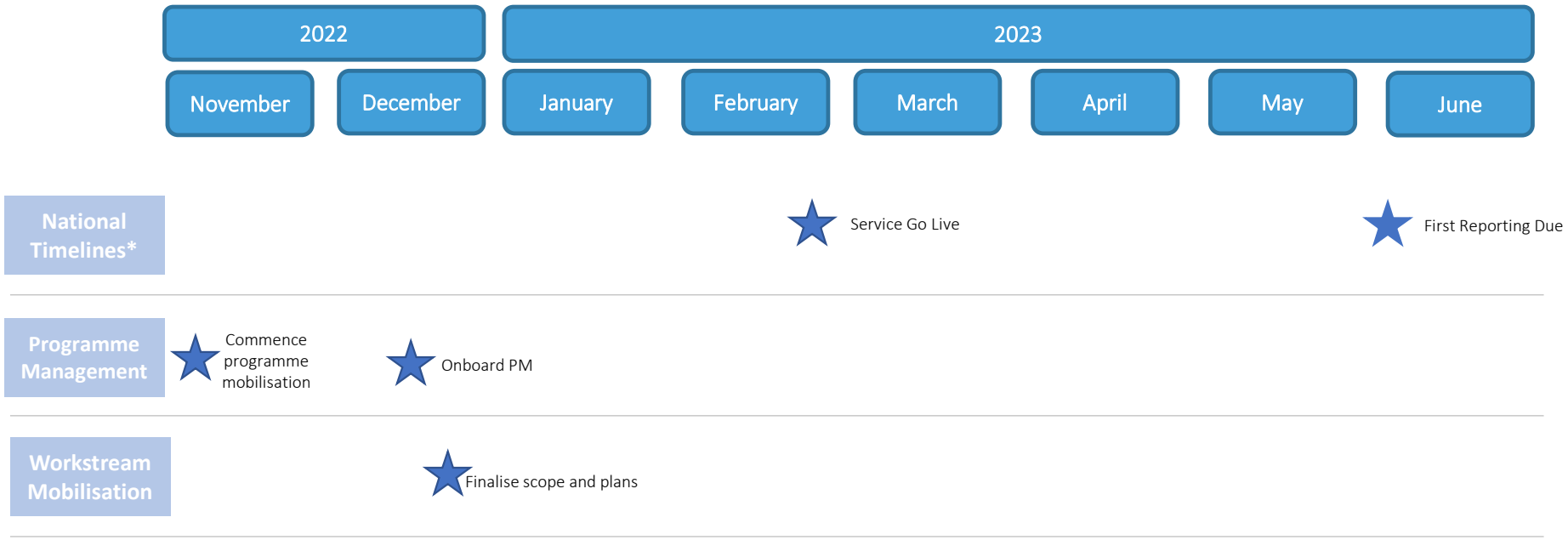
What are we testing?

Project area	Hypothesis	Pilot Site Actions	Supporting National/Regional Actions
Workforce	If systems understand the staffing levels and skills mix in an engaged and motivated workforce, they can redesign and plan a flexible approach across system partners to meet demand.	Review current staffing levels in all related roles and locations to fully understand resource capacity	Workforce modelling tool including staffing level principles
Workforce		Workforce capacity planning based on flexible approach to meeting system-wide demand by discharge pathway underpinned by robust workforce data collection	New role definitions with all roles supported by a professionally-endorsed skills and capabilities framework
Workforce		Develop a staff engagement and wellbeing strategy	HEE/partner-endorsed enhancements to create advanced practitioner roles
Workforce		Local recruitment and retention strategy including new support worker role	National recruitment campaign for therapy staff including initiatives to support international recruitment
Commissioning	If there is a lead commissioner model, then responsibility to commission the Community Recovery Service against national standards will be clear, duplication of services will be reduced, patient flow across the system will be improved and services will become more effective and personalised	Identify a lead commissioner across the ICS / Place footprint and test the impact of a singular approach to commissioning intermediate care post-discharge	Development of national service specification(s) for intermediate care working with experts and stakeholders across health and care
Commissioning		Review leadership arrangements across health and care, develop integrated system cultures and promote integration (at all levels) within the current system architecture	Professional standards developed in partnership with national bodies
Commissioning		Consider the effectiveness of services for often excluded health populations – and test innovations to ensure equitable access to recovery services	Demand and capacity modelling toolkit
Commissioning		Create a culture of collaboration with the independent care sector. This should look to improve communications and lead to a joint workforce approach	Stakeholder relationship management of key national bodies and lead independent sector providers to ensure consistency of message
Commissioning		Work with new market sectors such as personalised care delivered via personal assistants and live-in care and expanding care provision to include working-age adults	Peer support and community of practice for lead commissioners
Performance Measures & Data	If systems have a single data architecture across health and social care will enable them to evidence the impact of the 24 hour standard on reducing LoS and improving patients functional outcomes.	Systems should review their current data and its effectiveness as business/planning intelligence to support commissioning, assessing if the right data is being collected and agreeing the actions required to drive up quality and completeness	TBC - we propose to design the performance measures alongside the service and will come back as soon as is appropriate with these recommendations. However, we intend to measure customer experience – ensuring the right support at the right time, supporting independence and choice

Key Pilot Site Actions

Project area	Hypothesis	Pilot Site Actions	Supporting National/Regional Actions
Funding	If the new Community Recovery Service is commissioned through a lead commissioner model it will show a return on investment by reducing the long term costs to Health and Social Care.	Baselining existing expenditure on post-discharge services (health and social care)	Expert input from national partners to develop the economic case for investment
Funding		Develop estimates for the cost of delivering an NHS Community Recovery Service	National modelling to provide a framework for anticipated costs to deliver the recovery service and the resulting savings on long term care and support needs
Funding		Consider the impact of recovery service expenditure on long term care costs (health and social care), within the context of the impending Fair Cost of Care exercise	Bespoke support for pilot sites in evaluating costs and impact
Funding		Support the development of assumptions regarding demand levels, period of need and at which point a recovery service breaks even and delivers efficiencies (return on investment)?	National stakeholder relationship management to ensure support across national health and social care bodies and maintain consistency of message
Capacity and Demand	If systems commission effective recovery services they will release acute bed capacity and reduce the overall adult social care capacity required to support flow across the system.	Ensure there is system-wide demand and capacity modelling for intermediate care/Community Recovery Service	Support systems to build capacity by providing input to a national workforce strategy
Capacity and Demand		Transition D2A therapy staff into the community to meet the demand within the recovery service.	Work with pilot sites and partners to develop an optimum process for assessment practices
Capacity and Demand		Assess the impact on domiciliary care capacity (volume and acuity)	Targeted improvement support and expertise
Capacity and Demand		Demonstrate the impact on NHS acute and community bed capacity	Demonstrate the impact on NHS acute and community bed capacity

Implementation timelines (still in discussion)



*Subject to national funding being made available by end November

Next Steps at Pace

- Ensuring effective engagement in programme development and delivery – People, Place and Collaboratives (including links to Coventry Improving Lives Programme)
- Baseline finance, performance and operational processes
- Specify the HD Community Recovery Service including feasibility of scaling up the Home-Based Therapy pathway
- Finalise workstreams and develop plans
- Incorporate areas of the model for local 'testing' in plans (workforce, commissioning, performance measurement, funding, capacity)
- Confirm funding including SDF
- Confirm people resource to support delivery
- Progress project management and domiciliary development support (in train)

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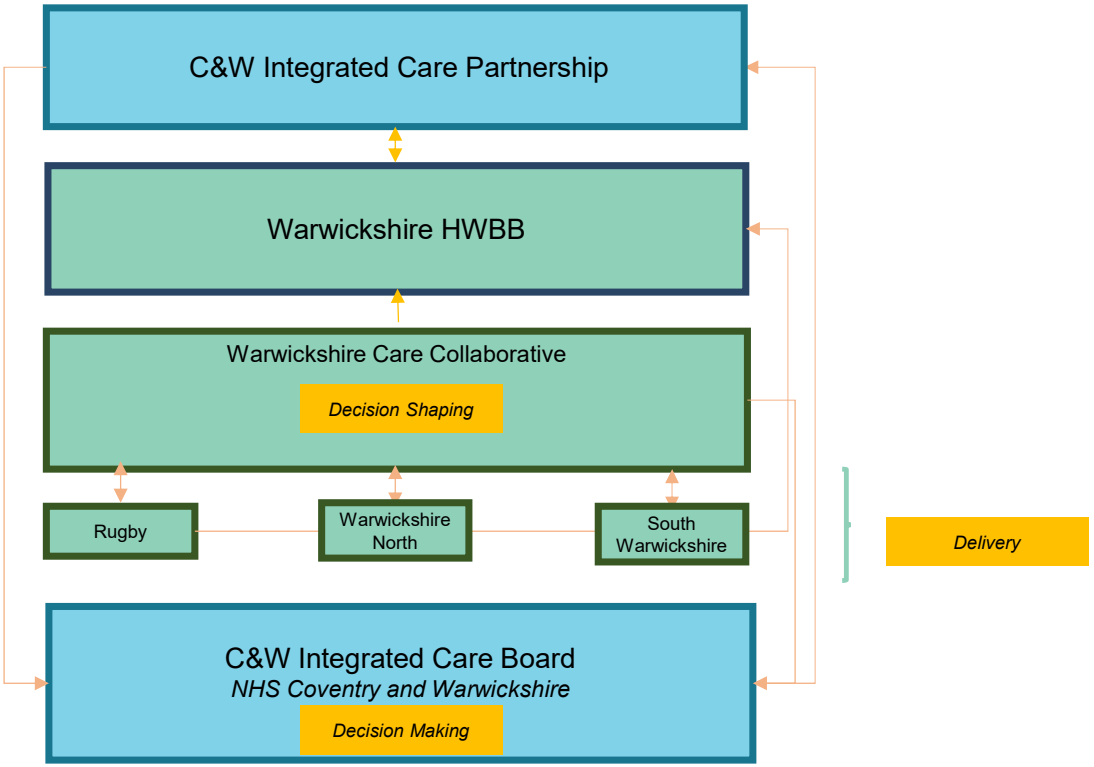
Proposed Governance



Discharge Governance | Place | System

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