Report for: **Adults and Health Scrutiny Panel – 9th September 2021**

Title: **Current and Future Arrangements for NHS Continuning Healthcare, Hospital Discharge and Out-of-Hospital Services in Haringey**

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Ward(s) affected: **All**

Report for Key/ Non Key Decision: N/A

1. Describe the issue under consideration

1.1 This report describes the hospital discharge arrangements currently in place across North Central London to support Haringey residents to return home, and in particular to support those individuals who have additional care needs out-of-hospital. It also discusses the impact of these changes on patients and on the care system as a whole and the plans for future sustainability beyond the pandemic.

1.2 This report also sets out NHS Continuing Health Care (CHC) arrangements in North Central London and how this is joined up with social care services.

2. Recommendations

2.1 The Scrutiny Committee to note and discuss the contents of this report.

3. Background and Discussion

3.1 *Changes to Hospital Discharge Processes During the COVID Pandemic*

3.2 Prior to and during the pandemic, staff in each hospital in North Central London, in community health services, CHC teams, and Councils worked together to triage the needs of those hospital patients approaching discharge who were identified as needing care and support to return home. This network of support included North Middlesex University Hospital (NMUH) and Whittington Hospital, the two acute hospitals which admit the significant majority (>90%) of emergency patients who are Haringey residents; as well community health, mental health and adult social care.

3.3 Two aims of partners working together to facilitate hospital discharge are to:

- Ensure as many patients as possible can return directly home in a timely and safe way as soon as they are fit to do so – 'Home First';
- Ensure as few decisions as possible about a patient's long-term care needs are made when the patient is in the hospital bed and at a low ebb. Instead, a patient should be discharged out-of-hospital and then their long-term care needs assessed (an approach called 'Discharge-to-Assess' (D2A)). An individual who might need need care and support should be given every chance to recover post-discharge by accessing out-of-hospital short-term care in people's home or in bedded care.

3.4 Typically 75-85% of hospital patients go directly home without help from statutory care and health care to do so, though they may get help to return and settle home from the Bridge Renewal Trust's Hospital to Home voluntary service the CCG and Council fund. Hospital patients are followed up, if clinically required, when they return home by their GP practices, who will be alerted to the spell in hospital via a discharge summary sent from the acute hospital.

3.5 The remaining 15-25% of discharged patients have health conditions, additional needs or social circumstances that need be resolved or supported out-of-hospital, at least in the short-term. In Haringey, the options for such patients are:

a) To return home and receive short-term reablement and/or a package of care/NHS community health support. 'Reablement' is the term describing short-term intensive, time-limited therapeutic intervention typically over a 2-3 week period with the aim of improving an individual's ability to undertake daily tasks, such as getting around and about, washing, bathing etc. as part of their recovery;
b) To be discharged to a community bed supported by nurses and therapists typically for up to 6 weeks to rehabilitate, i.e. to to recover health and ability to undertake daily tasks. In Haringey, the majority of these patients (60%) are able to return home with support after this episode;
c) To return or be admitted to directly to long-term care homes or alternative setting (e.g. a hospice) because their potential for rehabilitation is agreed by partners to be very limited. Given the above aims, option (c) should be avoided if possible.

3.6 The above aims, D2A approach and out-of-hospital support services were in place pre-pandemic. What has changed in the pandemic is the process by which discharges are administered, the configuration of some of the services across North Central London and additional funding available to support these processes in 2020/21 and 2021/22.

3.7 In August 2020 – during the pandemic - the Government set a target that at least 95% of people discharged from hospital would return home with or without out-of-hospital services, and that no more than 1% would be admitted or re-admitted to care homes as long-term placements. Generally, Haringey complies well against these targets: 94% of Haringey patients were discharged home between Aug-20 and Jul-21; and 1.8% were placed in long-term care home placements, slightly higher than national expectations.

3.8 New national Hospital Guidance was issued in March 2020 and subsequently revised in August 2020 and June 2021. These changes included:

- *Establishment of acute-based and multi-agency Integrated Discharge Teams (IDT)* - one per hospital including at Whittington and North Middlesex University Hospital;
- *Re-focus on 'D2A'* and deferring formal CHC or Care Act assessments until the individual is out-of-hospital if at all possible. This had less of an impact on Haringey as Borough partners promoted D2A for several years, together with a focus on providing jointly-funded short-term interventions for patients who need it. Doing so helps patients recover their health and function as far as they can – and helps mitigate the costs of long-term care for the NHS and adult social care that would otherwise arise;
- *National investment for community health and adult social care to fund additional short-term out-of-hospital placement and care costs* incurred during the pandemic. Partners in Haringey utilised this funding to ensure more patients were discharged in a timely and safe way to meet their needs and recover. This funding was needed to meet demand-led pressures during the pandemic: the number of reablement cases the Council worked with more than doubled at the height of Wave 2 (Winter 2020/21) compared to pre-pandemic levels. This would not have been possible to meet this demand without the support of partners (particularly WHT) and access to the national funding scheme. This support for recovery is not only beneficial and valued by patients but also mitigates the need or the level of statutory Council or CCG-funded long-term. For example, over 75% of discharged patients who had a short spell of reablement in their home subsequently did not need long-term care.

- *Revised expectations on reporting* and targets including suspension of statutory monitoring of delayed transfers of care ('delayed discharges') since April 2020 – this is the reason no analysis of delays is included in this report.

  One of the new measures is the number of people who have length of stays of 21 or more days in hospital. The proportion of people (all ages and 65+) who stayed 21+ days in hospital decreased by 23% and 35%, respectively, between 2019/20 and 2020/21, far greater than the reduction in emergency admissions (both 15%). This means people, particularly those with complex needs, were typically discharged more quickly in hospital during the pandemic.

3.9 *Post-Pandemic Discharge and Out-of-Hospital Planning*

3.10 The expectation is that the IDT and post-discharge arrangements will continue for Haringey residents throughout 2021/22. Partners have recommitted themselves to the underlying aims to discharge people in a safe and timely way with an emphasis on Home First and recovery before deciding on long-term needs. Our objective is therefore to provide high-quality patient care in and out-of-hospital, discharging patients as quickly as possible from hospital once they are medically fit to do so to avoid the risk of deconditioning. Doing so will also help partners manage the flow of all patients from A&E to discharge and into the community during what is anticipated to be a challenging winter period as the NHS continues to recover from the pandemic.

3.11 To do so, partners in NCL are currently planning 'post-pandemic' discharge arrangements. This has already resulted in NCL CCG and its partners receiving funding from NHSE as part of an accelerator programme to strengthen IDTs and post-

discharge services in the remainder of 2021/22. This includes investing in both adult social care and community health services to continue to plan and deliver out-of-hospital services with acute colleagues.

3.12 The Council and CCG are currently reviewing the implications of the end of the additional national Hospital Discharge funding to support additional packages of care and placements. Findings so far suggest the legacy of the pandemic may result in demand-led financial pressures on Council and CCG budgets in terms of short-term and long-term care and support. NMUH, in particular, is already seeing increased presentation and admission rates during the last month. Partners are working together to review if there is likely to be any material difference in the overall level of patients' care and support needs pre and post-pandemic and if so, how the system works together to address the implication of these changes.

3.13 The NHS and Council is currently planning investment in joint out-of-hospital services for the autumn and winter as part of the Better Care Fund Plan and system resilence requirements. There will be a particular emphasis on services to facilitate hospital discharge and aid recovery in the short-term, e.g. further expanding short-term recovery and support at home or better supporting those patients whose housing environment may not be suitable for them. NCL CCG and its Council and acute hospital partners were also recently successful in securing additional funding for a short-term recovery facility for those hospital patients who at risk of homelessness/rough sleeping, and expanding the team to support their health, well-being and move-on within Haringey.

3.14 NCL CCG is also planning to increase resourcing and investment in Haringey's urgent care services to prevent hospital presentation and admission in the first place through its WHT-led Rapid Response service. This service, linked to 111, supports people identified as 'nearing crisis' in their own homes and can respond within 2 hours for the most urgent cases. Patients' conditions are stabilised and their cases subsequently transferred to suitable health services, including the patient's own GP practice. During the pandemic, the number of people the service was able to see increased by nearly 50% of pre-pandemic levels and partners are committed to building on this success story.

3.15 ***NHS Continuing Health Care Process***

3.16 NHS Continuing Healthcare (CHC) is a package of care, provided to an individual over the age of 18, which is solely funded by the NHS. To be eligible for CHC an individual must be assessed and found to have a "primary health need". Once eligible CCGs will commissioning a package of care to meet health and associated social care needs that have arisen as a result of disability, accident or illness. The Standing Rules Regulations require CCGs to have regard to the National Framework for Continuing Healthcare and Funded Nursing Care, October 2018 revised. (Henceforth referred to as "the Framework").

3.17 Eligibility for CHC is based on the totality of assessed needs rather than a diagnosis, setting of care or the ability of a provider to manage the care needs. Screening for CHC

is completed via a Checklist. This can be completed by the Council and / or CHC working together to establish whether an individual's needs are of the level that a full CHC assessment is required.

3.18 An individual's and / or their representative must be aware and engaged in the assessment processes, receiving advice and information as required. NCL CCG will seek appropriate consent prior to the assessment taking place. An individual's needs will be assessed by a multidisciplinary team, which will include at least one representative from both the CCG commissioned CHC service and the Council, who will collate all necessary evidence and, together with the completion of a Decision Support Tool, present the recommendation to NCL CCG who is responsible for the decision making in regards to eligibility for CHC.

3.19 Once an eligibility decision has been made and an individual is found to have a primary health need and therefore eligible for CHC NCL CCG will commission a care package to meet their assessed needs. When commissioning a care package the CCG will take into account the wishes of the individual and / or their representative in regards to how the care will be delivered alongside the ability to deliver the care package safely.

3.20 Care packages will be reviewed at minimum during the first 12 weeks of provision and subsequently annually or earlier if required. During the care package review, if it is found that care needs have changed then the individual will be subject to a repeat CHC assessment, completed, as previously, jointly with the Council representative, to establish on going eligibility. If the individual no longer demonstrates a primary health need then they will no longer be eligible for CHC.

3.21 For those individuals resident in a care home with nursing who have been assessed as not eligible for CHC a Funded Nurse (FNC) assessment will be considered. FNC is funding provided by the CCG to care homes with nursing to support the provision of nursing care by a registered nurse. Since 2007 FNC has been a nationally set flat weekly rate.

3.22 There are circumstances in which an individual, who has been assessed as not eligible for CHC, may receive CCG funding for an element of their care, if it has been identified as beyond that which the Council can legally provide. This funding will only be considered if it is more than incidental or ancillary to the care needs provided by the Council and above current CCG commissioned services. The CHC commissioned service will work closely with the Council to establish a joint package of care, clearly identifying who is responsible for commissioning particular elements of the care package.

3.23 Individuals and / or their representatives can appeal against the eligibility decision made by the CCG. Details on how to appeal will be provided in the CHC outcome letters sent to the individuals / representatives. The appeal process is detailed in the NCL CCG CHC Appeals Policy.

3.24 Individuals who are not eligible for Continuing Healthcare may still be eligible for Council-funded care and support, subject to a Care Act Assessment.

3.25 As Haringey's established approach has always been to promote "D2A" the principle and practice of discharging people out of hospital, ideally home, and supporting recovery prior to a CHC / Care Act assessments this will continue. There is no change to this approach as a result of the pandemic

4. Contribution to strategic outcomes

4.1 The approach contribute to objectives within both the Place and People Themes of the Borough Plan.

Place Theme; *A place with strong, resilient & connected communities where people can lead active and healthy lives in an environment that is safe, clean and green.*

People Theme; *Our vision is a Haringey where strong families, strong networks and strong communities nurture all residents to live well and achieve their potential.*

5. Background Papers

5.1 Department of Health & Social Care: Hospital discharge and community support: policy and operating model, August 2020
Hospital discharge and community support: policy and operating model - GOV.UK (www.gov.uk)

5.2 Department of Health & Social Care: National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, October 2018 (Revised)
National framework for NHS continuing healthcare and NHS-funded nursing care - GOV.UK (www.gov.uk)