Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Reference: FOI.ICB-2223/136

Subject: Discharge to Assess

*I can confirm that the ICB **does hold the information requested**; please see responses below:*

QUESTION	RESPONSE
I request that you provide me with a copy of the BNSSG ICB Discharge to Assess business case and any policy that has been adopted related to this.	Please see documents enclosed. Please note that FOI requests and responses are publicly available and therefore personal information has been redacted. The ICB considers the names included in these documents to be personal information and therefore has applied a section 40 (Personal Information) exemption to this information.

The information provided in this response is accurate as of 5 January 2022 and has been approved for release by Lisa Manson, Director of Performance and Delivery for NHS Bristol, North Somerset and South Gloucestershire ICB.

Healthier Together

Improving health and care in Bristol,
North Somerset and South Gloucestershire

Discharge to Assess Business Case

Update - October 21

Lisa Manson Director of Commissioning BNSSG CCG
Jon Lund Deputy Director of Finance BNSSG CCG
Julie Kell Head of Performance Integrated Care BNSSG CCG

Background

- Following the implementation of Hospital Discharge Scheme in March 2020 and further revisions in July/Sept 2021, the discharge to assess process has been refined in order that the virtual ICB has been moved into the community and all assessment processes including social care are conducted out of acute settings. Revised capacity modelling has been completed to support these functions.

- Discharge to assess business case was developed to transform the D2A pathway - which is funded non-recurrently until March 2022.

- The objective of the business case is to achieve the following outcomes:-
  - Development of PO supported by VSCE
  - 70% of complex discharges are P1 (maximising Home First)
  - Right size P2 and P3 bedded capacity
  - Reduce LoS in acute settings
  - Reduce time between Single Referral Form and Discharge
  - LoS in the following pathways
    - P1 = 10 days
    - P2= 21 days
    - P3= 28 days

Progress to date

- Agreed Implementation plan, including transformation areas for all partners – with the exception of the UHBW discharge team – all currently funded
- Agreed LoS targets for all partners
- Agreed LOS Saving from Acute Sector
- Opportunity to reshape the Care Market
- Recurrent funding agreed for Sirona – therapists and Re-ablement Support Workers (RSW)

Table 1 Impact of delays within Communty pathways by patient (slot/bed)

Pathway	Current Average wait Oct 21	Winter stretch March 22	Full business case implementation March 23
P1 (slot)	50	26	3
P2 (bed)	22	12	1
P3 (bed)	59	27	6
total capacity (Change to Total patients waiting)	161	65	10

Table 2 Changes in community capacity following implementation of business case.

Complex Pathway Patient Proportions (P1/P2/P3)	***LOS (days) (P1/P2/P3)***	***P1 (slots) split by % caseload of complex discharges***	***P2 beds by % case load***	***P3 beds by % caseload***
Baseline Oct 21	*P1 13* *P2 29* *P3 43*	*164 54%*	*166 20%*	*163 17%*
Winter target March 22	*P1 10* *P2 21* *P3 28*	*183 54%*	*136 20%*	*146 17%*
B Case Target March 23	*P1 10* *P2 21* *P3 28*	*221 70%*	*78 10%*	*99 10%*

Table 3 Impact of bed reductions based on reducing time from single referral to discharge to support acute bed deficit

UHBW BRI	Bed savings by March 22	Combined bed savings by March 23	UHBW WGH	Bed savings by March 22	Combined bed savings by March 23
P1	30	47	P1	9	18
P2	9	21	P2	8	17
P3	14	25	P3	1	7
Total	53 beds	94 beds	Total	18 beds	42 beds

NBT -	Bed savings by March 22	Combined bed saving by March 23
P1	24	54
P2	10	25
P3	13	28
Total	47 beds	107 beds

Current Challenges

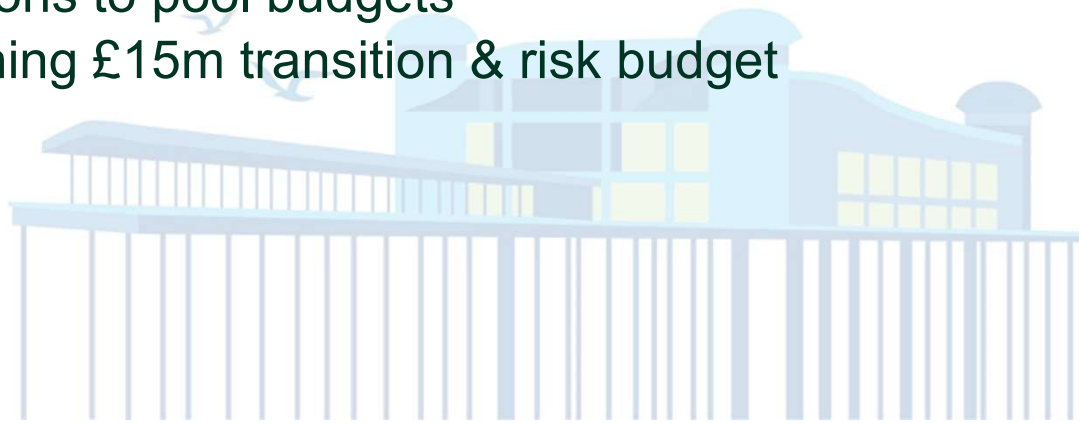
- Lack of Consensus in achieving an agreed funding model
  - Which includes –
    - Identification of Benefits Realisation
    - sources of funds e.g. better care fund, NHS Growth
    - which Local Authority services should be funded
    - Pace of transformation funded by non-recurrent funding
    - Balance of Sirona Community resources between P1 capacity and P3 therapy support

- Workforce – Recruitment
  - The business case delivery is predicated on recruitment across all sectors
  - Despite recurrent funding being available Sirona has been unable to recruit therapists and RSW
  - Continued pressure in the Domiciliary Care market with packages being handed back due to staffing constraints.

Proposed Next Steps

- Final Business Case to Healthier Together Executive Group – in 4 Weeks

- To achieve this the following actions are proposed
  - Finalise 21/22 H1 and H2 funding arrangements from HDP and S256
  - Workforce Review of all recruitment plans
  - Funding of the UHBW discharge team to support the delivery of LoS reductions
  - Bilateral meetings with Local Authority Partners – sponsored by CE's
  - Agree governance model and options to pool budgets
  - Agree financial model for establishing £15m transition & risk budget



Key Decisions

- Understanding the savings assumptions in acute beds
- Mandate for decision to spend NHS budget on LA reablement services
- Agree how to ‘carry forward’ money from 21/22 to future years re: risk reserve assumptions
- Mandate for approach to pooled budget with CCG, Sirona and LAs
- Understand the transition between current HDP spend and bed use, to future state model

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Business Case

Project Overview

Project Code	Verto Auto Generate		
Start Date	October 2022	End Date	March 2023
Programme Area	Out of Hospital Discharge to Assess		
Project Manager / Lead	Julie Kell Head of Performance Integrated Care BNSSG CCG Jon Lund Deputy Director of Finance BNSSG CCG		

Project Information

Executive Summary

This paper is formally requesting the Healthier Together approve the Discharge to Assess (D2A) model on a permanent basis and align funds to ensure the transition over the next eighteen months to March 2023.

The paper sets out the agreed vision and proposed deliverables, which are to transform how the transfer of people from hospital to community based support will be managed through a Discharge-to-Assess approach. The paper should be seen in the wider context of supporting health and social care transformation.

The business case is presented at a time of significant challenge across the system. There is currently insufficient workforce capacity in Social Care and Sirona to meet demand, all partners are struggling to recruit, and is one cause of the current sub-optimal performance. The business case presents a range of initiatives to re-shape the Discharge to Assess model that support better outcomes and mitigate the workforce challenges. Failure to invest risks a deteriorating situation and a delay in effecting transformational change.

In March 2020 and refreshed in August 2020 and July 2021, the Government set out the Hospital Discharge Service Operating model for all National Health Service (NHS) Trusts, community interest companies, and private care providers of NHS commissioned acute, community beds, community health services and social care staff in England. **July 21 Updated Hospital Discharge Service Policy and Operating Model:**

https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

The government has provided funding up to £9.6m as per H1, via the National Health Service, to help cover the cost of post-discharge recovery and support services; rehabilitation and reablement care for up to 28 days following discharge from hospital up to September 2021. Additional financial settlements have been agreed up to March 22 The funding period will be available from 1st Oct 2021 to March 31st 2022 with no extension past this date.
Despite further funding being discussed as part of the Spending Review (2022- 25) it is unlikely monies will be offered for discharge as this will be expected to be modelled in sustainable modelling in systems

Leaders across both health and social care recognise the successes achieved to date within the D2A model and that the funds from the centre will cease in March 2022. They now want to be able to embed these changes permanently and see recurrent funding included in the discharge to assess budgets across the Healthier Together footprint. This includes an uplift in system funding to close the modelled capacity gap and reduce delayed bed days in hospital.

The Urgent Care Oversight Board (September 2020) and Clinical Executive (December 2020) have reviewed the clinical model. A further modelling workshop attended by all partners was held in February 2021 and the action plan was signed off by the Integrated Steering Group and Planning and Oversight Group in March 2021. The financial plan was reviewed by Healthier Together Finance Group Oct 21 and supported. A separate meeting was also supported by Local Authority directors and Chief Executives in Oct 21.

They approved the use of a stochastic demand and capacity tool (the IPACS model). This enables realistic variation to be modelled for the Out of Hospital Discharge to Assess pathways from acute Trusts to community D2A providers.

The detail to support these priorities are contained in the implementation and investment plans (see **Appendices 1 and 2**), which have been developed jointly across key partners. These reflect the separate arrangements and service compositions in each area but deliver against the same shared outcomes and objectives from a D2A approach to hospital discharge.

Appendix 1 Implementation plan including trajectories

Appendix 2 Investment plan

Aims & Objectives

The BNSSG joint vision for the implementation of a Discharge to assess approach is:

> *Sharing the responsibility, risk and skills across organisations, leading to innovative and creative solutions; thereby achieving a seamless transfer for local residents from acute to community setting through the provision of integrated safe and effective assessment and support closer to home.*

This vision will be realised through working together with a single identified Executive lead for discharge requirements and single coordination to:

- Improve pre-discharge planning in the hospital through further development of the hospital integrated discharge team that manages patient flow from point ofadmission
- Invest the resources to deliver a '*Home first* 'model for all transfers from hospital to support safe transfer out of hospital, and reducing over time the need for community beds
- Establish new ways of working to deliver an integrated approach to the commissioning, delivery and co-ordination of intermediate care services in the community, supported by flow management models to use finite resources more effectively.
- Review the workforce resources and skills required to meet the changing needs of a discharge to assess approach.
- Build community resilience through closer partnership work with colleagues in the voluntary sector to grow neighbourhood networks ofsupport
- Support the best use of estates
- Build on existing work of assistive technology

The Hospital Discharge Service Operating Model introduced Discharge to Assess (D2A) for all providers of NHS commissioned acute, community beds, community health services and social care staff in England. Discharge-to-assess has been a vital policy during the COVID crisis and helped local health and care services to increase the numbers of people being discharged, as well reducing delays and, crucially, the length of stay in hospital. However, without uplift in capacity it is evident that these improvements are unsustainable, with numbers of individual delays and associated bed days in Bristol North Somerset and South Gloucestershire (BNSSG) now back at pre pandemic levels

D2A is a process designed to rapidly discharge 95% people from hospital once it is medically optimal and safe for them to return home.

With this model, there is limited assessment of rehabilitation within the acute hospital. Once someone has returned home, detailed functional assessments take place and ongoing care and equipment are organised.

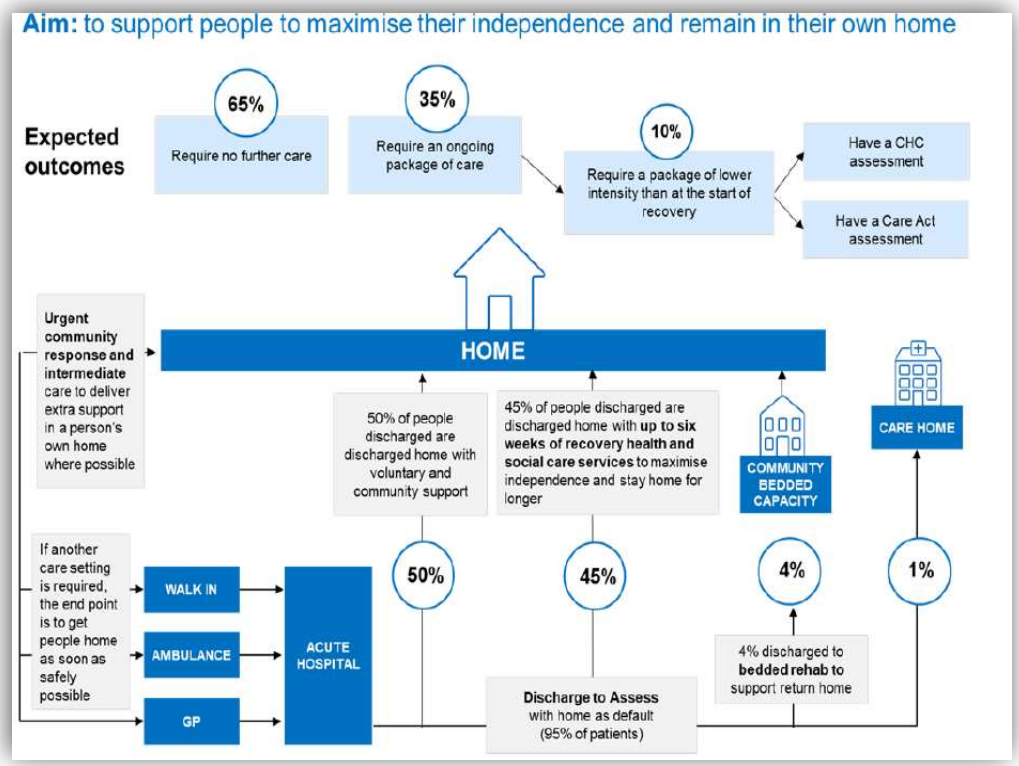
It anticipates that half of this group need simple discharge and no more formal NHS or social care support on

returning home and that 45% require a package of support including rehabilitation

A package of out-of-hospital assessment, rehabilitation, and re-enablement as part of this model is provided for a period of up to 28 days.

The D2A model is not new. BNSSG have been working to deliver a rapid hospital discharge approach for years.

The below diagram describes the model:



The D2A vision is shared by all partners, the investment bids from all partners focus on achieving the best outcomes for the system across the Discharge to Assess pathways. The main performance indicator being reduction in length of stay within the acute's, achieved through investment in the community to; ensure flow and that individuals exit the pathways optimising independence thereby reducing the risk of re-admission and/or need for extended community health support.

The bids presented differ, this reflects the different; start points, ways of working with Sirona, market challenges and opportunities of each authority.

Acute bid

United Hospital Bristol Weston (UHBW) will strengthen its discharge function by recruiting three additional B6 Case Manager roles with an additional five B4 patient flow coordinators to support complex discharges. This will ensure the team is equitable to the team in North Bristol Trust (NBT).

UHBW and North Bristol Trust (NBT) are focusing their improvement work on a number of key areas. This includes working collaboratively across BNSSG to create a fit for purpose Single Referral Form (SRF) to minimise delays and implement a process to review SRF's at key points along the patient journey, thus ensuring any changes are captured in a timely manner. Review of internal processes across multiple workstreams with input from partner organisations to maximise efficiencies, for example:

- CHC fast track, assisted technology, voluntary services
- Reducing delays between the moment the patient has no right to reside to submission of the SRF with KPIs to support this process

Education sessions and use of media provided by community partners to support staff in discharge planning

to reduce delays. Specialist input for example Safeguarding team to ward staff to North Bristol NHS Trust (NBT) and University Hospitals Bristol NHS Foundation Trust (UHBW).

Community bid

Sirona

The Sirona care & health bids share the themes of;

- Increasing capacity and flow through Pathway P1 including being able to provide four visits a day to more complex patients.
- Increasing capacity and flow through Pathway P2 in North Somerset
- Increasing capacity and flow through Pathway P3 with additional therapy provision
- Development of Assistive Technology to support D2A pathways
- Working closely with the Voluntary sector

Local Authority

The vison for the future is based on strong, integrated workforce, place-based care in localities; less bed-based reliance but where this is required a reduction of Length of Stay (LOS) and increase in people returning home from this pathway.

The Local Authority bids share the themes of:

- Closer partnership working with Sirona
- Increasing capacity and flow through Pathway 0, P1 and P1+. Home First
- Optimising use of Technology Enabled Care and Reablement in pathways and on exit from Pathways
- Extending role of Voluntary Care Sector and Extra Care Housing
- Increasing resilience across the social care provider workforce
- Review of Estates and new opportunities i.e. Frenchay site.
- Building on developing a different approach to workforce and calling out new integrated roles and teams
- Reducing number of residential placements.

Alongside D2A investment bids, each local authority is working to and investing in broader plans aligned to D2A and Integrated Steering Board strategic priorities.

Working with the Voluntary Sector (VSCE)

The D2A model has recognised the role of the VSCE in supporting discharge and preventing further admissions to hospital. The model has clear accountability and escalation with local processes for lead VSCE organisations within each locality and agreed pathways to support both pathways O and 1.

Expected Outcome and Overview of Benefits

The following benefits and outcomes described below are expected as part of the model:

Improvements in patient led outcomes

- Integrated, timely, personalised care- not care that is most convenient for individual organisations.
- Maximising Independence – The goal for everyone receiving support should be to maximise their long-term independence.
- Although funded support will be available for up to six weeks, many people will benefit more from a shorter, intensive period aimed at enablement
- Reducing or eliminating longer term needs for care.
- Home is best for 95% of older people leaving hospitals – for recovery and any further assessment of need.
- Communication and information-sharing with the individual and their family/ careers and between those organisations, assessing, commissioning and providing care and support.
- Operating Strengths based assessment proportionate to the stage of recovery the individual has reached; involving the individual (and/ or others as appropriate); appropriate to the level of decision required; done at the right time and in the right place to get an accurate picture of what is needed. Describing the needs of the individual – not prescribing.

Increased D2A capacity;

Leading to reduced hospital length of stay;

- Leading to reduction in use of high cost escalation capacity;
- Lower hospital bed occupancy rates
- Free up funded planned care bed capacity

Increase in proportion of discharges on Homefirst pathway (i.e. Pathway 1 Home with Support);

- Leading to reduced D2A length of stay and better patient experience & outcomes; leading to reduced cost and volume of long term care packages and reduced need for D2A bedded capacity

Increase in rehabilitation & reablement therapy staffing; and shorter assessment times

- Leading to reduced D2A length of stay and better patient experience & outcomes;
- Leading to reduced cost and volume of long term care packages and reduced need for D2A bedded capacity

In order to achieve these goals a clear partner implementation plan has been agreed.

Appendix 1 Implementation plan including trajectories

Background and Evidence Base

Health and social care systems are expected to build upon the hospital discharge service developed during the COVID-19 response, incorporate learning from this phase, and ensure discharge to assess processes are fully embedded for all people aged 18+. Therefore, we have used the guidance from the following evidence base:

Hospital Discharge Service Policy July 2021

https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model
This document sets out the Hospital Discharge Service operating model for all NHS trusts, community interest companies, and private care providers of NHS commissioned acute, community beds, community health services and social care staff in England. It replaces the Hospital Discharge Service Requirements.

Discharge to assess also forms part of the High Impact Change Model (HICM) for hospital discharge

Shared guidance to local authority commissioners from the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Care Provider Alliance (CPA).
COVID-19 action plan for adult social care.

Scope, Interdependencies and Assumptions

What is within scope?

Processes to ensure discharge to assess services are fully embedded for people aged over 18 focusing particularly on those aged 65+

What is outside of scope?

This work does not include people who require stroke services as a separate business case out currently to consultation has been developed. However, learning from the D2A model is being used to develop this model.

Dependencies and Interdependencies

Please detail all dependencies and interdependencies

The D2A process is dependent on the delivery of the D2A Implementation plan including trajectory (**Appendix 1)** and D2A action cards **(Appendix 3**) these outline the roles and responsibilities of each of the following organisations

Appendix 1 Implementation Plan including trajectory

Appendix 3 Action Card

- Community services
- Acute clinical staff
- Local authorities and Adult Social Care
- Clinical Commissioning Groups and Care Providers.

Although there are no direct actions within the D2A action cards, the Out of Hospital Delivery Group has linked with the work of the Care Provider, Primary Care and Voluntary Sector cells.

Within the costings enablers such as transport, assistive technology and medical equipment have also been described.

It is expected that that the action cards, implementation plan and pooled investment plan will be reviewed monthly by the D2A Implementation Board reporting into Planning and Oversight Group monthly. This group will be chaired by the Lead Executive Director for BNSSG.

Assumptions

There are six main pathways that support the discharge of individuals from all hospital beds throughout BNSSG these are:

1. **Home First DTA Pathway 1** –home for short term rehabilitation for Sirona services for up to 10 days this has used existing P1 staff but now an expectation for step down which is why Extra Care Housing model included to support P1+.

2. **Community Bed Pathways 2 and 3** – discharge to a community bed for short term rehabilitation (Pathway 2 bed for up to 21 days) and assessment in a community bed for up to 28 days

3. **MDT complex cases** co-ordinated by the acute for the most complex patients that do not fit any of our standardised pathways and require a multiagency support plan to exit hospital

4. **End of Life care pathway**

5. **Voluntary Care Support (VCS) Pathway 0** including advice, signposting or mutual aid support including shopping, pharmacy support etc.

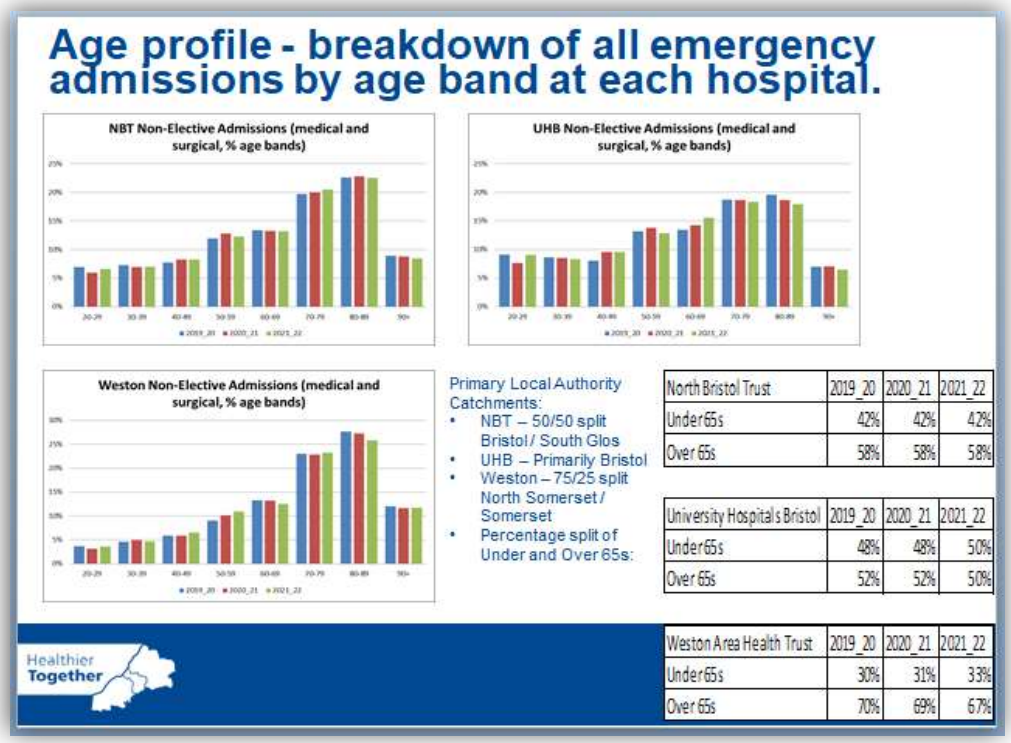
Pathways 1-3 are for ‘complex’ patients (who are over 65 and require additional, more intensive care support, while an assessment for their long-term care is carried out). The IPACS model supports assessment of the projected demand for these three pathways and the potential implications for associated resource requirements.

The following assumptions are taken from our current system performance indicators within the patient pathway, capacity and demand tool for ‘business as usual’ and illustrate the potential implications for resources for the D2A model.

Acute Flow

Percentage split of Under and Over 65s by primary Local Authority Catchments:

- NBT – 50/50 split Bristol / South Gloucestershire
- UHB – Primarily Bristol
- Weston – 75/25 split North Somerset / Somerset



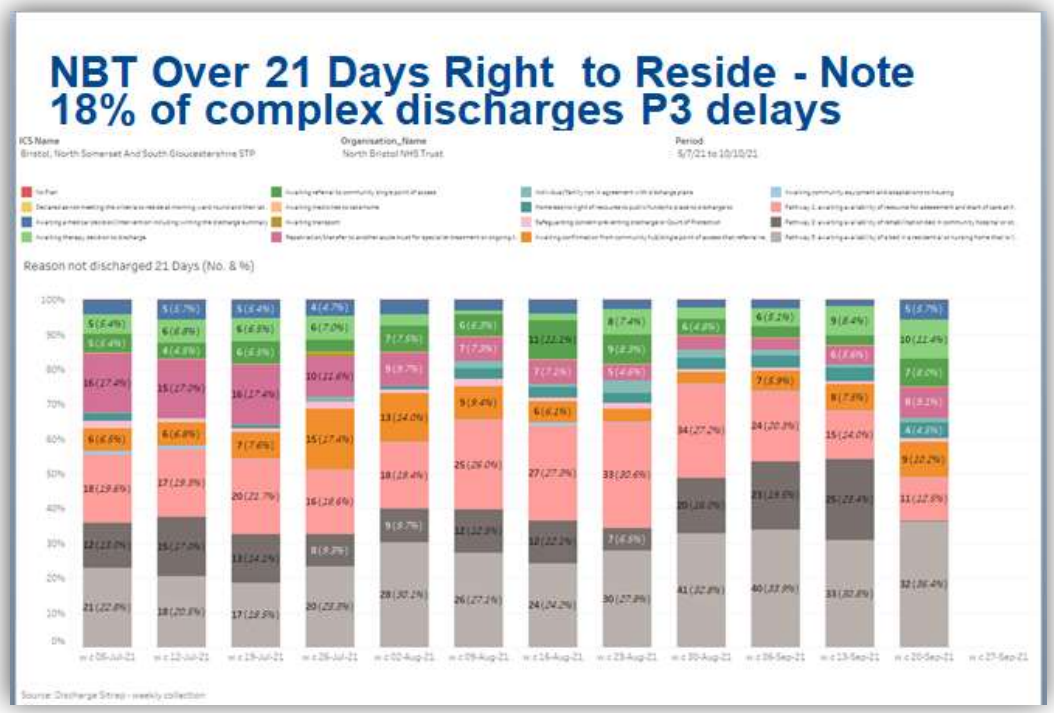
Right to Reside

The acute right to reside data which profiles all age groups shows in NBT approximately 51% of patients are waiting for a D2A pathway and 49% are patients that are still the responsibility of the acute trust. In UHBW 64% of the delays are patients waiting for a D2A pathway and 36% are still the responsibility of the acute trust

Current demand is exceeding capacity with current delays in community pathways. If we could improve our flow, then the community could take from the acute waiting list in a more timely way.

Both NBT and UHBW are undertaking internal projects to improve the completion of the Single Referral Form (SRF) and the time from admission to successful submission and acceptance by the Sirona Community Integrated Care Bureaus (CICBs).

There are around 200 people at any one time which ties in with acute delays. UHBW and NBT internal work programs are in place to improve admission to SRF, Sirona operational action plan looks at improvements from SRF to discharge.


NBT Over 21 Days Right to Reside - Note 18% of complex discharges P3 delays
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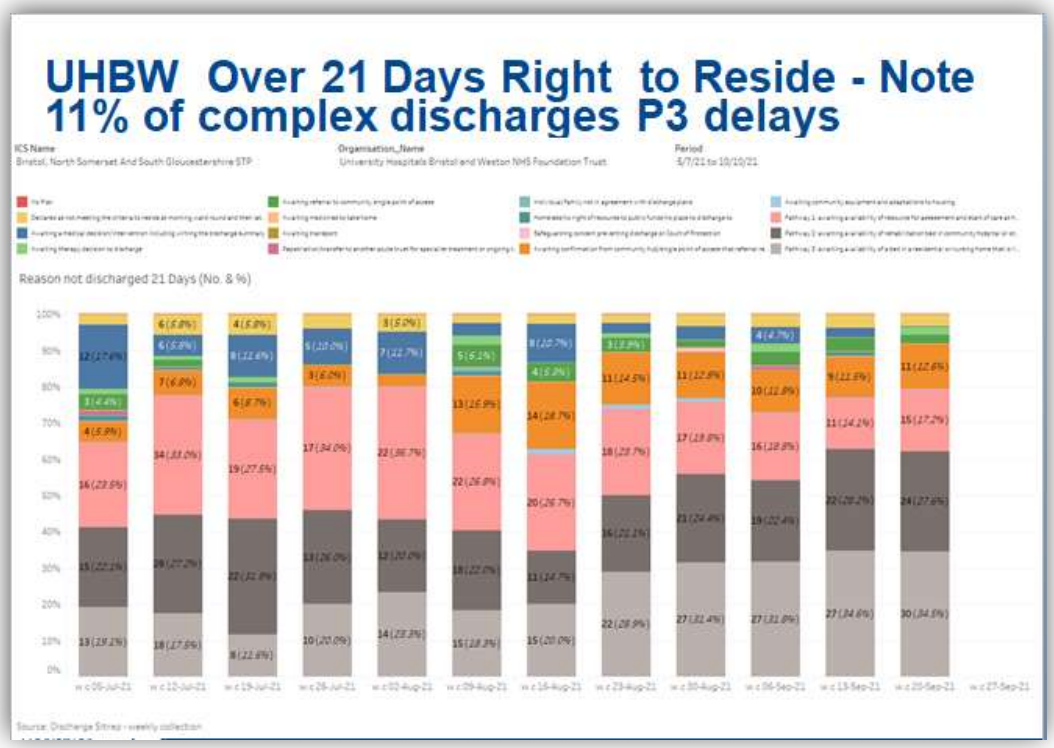
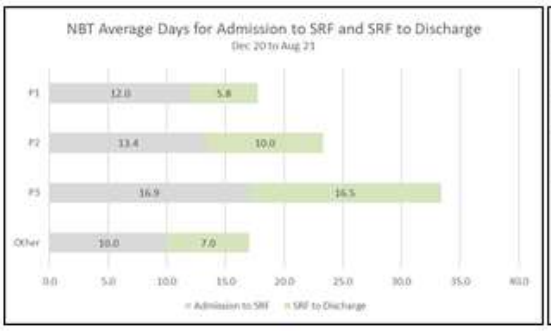
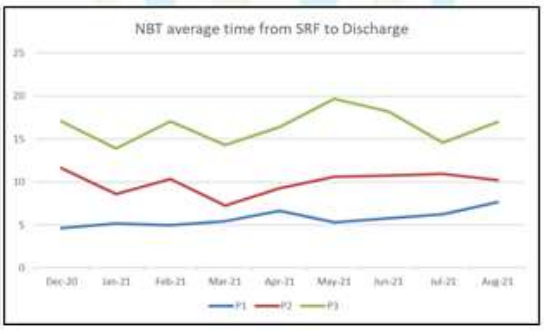
Bristol, North Somerset And South Gloucestershire STP
Organisation_Name
North Bristol NHS Trust
Period
5/7/21 to 10/10/21
Reason not discharged 21 Days (No. & %)


UHBW Over 21 Days Right to Reside - Note 11% of complex discharges P3 delays
ICS Name
Bristol, North Somerset And South Gloucestershire STP
Organisation_Name
University Hospitals Bristol and Weston NHS Foundation Trust
Period
5/7/21 to 10/10/21
Reason not discharged 21 Days (No. & %)

NBT Average days on Pathway

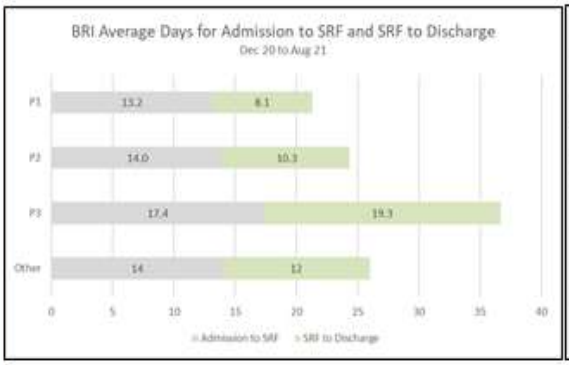
Admission to SRF and SRF to Discharge

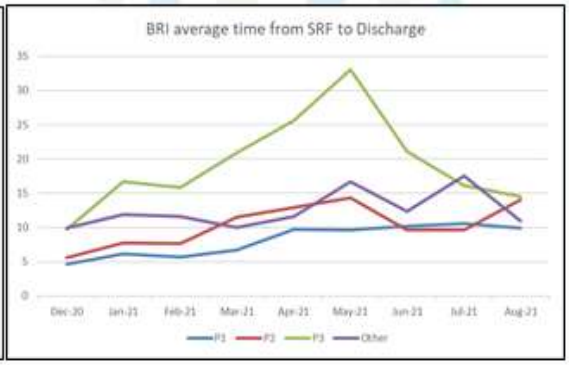




UHB Average days on Pathway

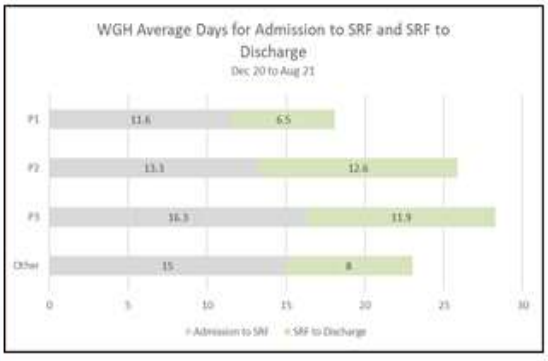
Admission to Single Referral Form (SRF) and SRF to Discharge

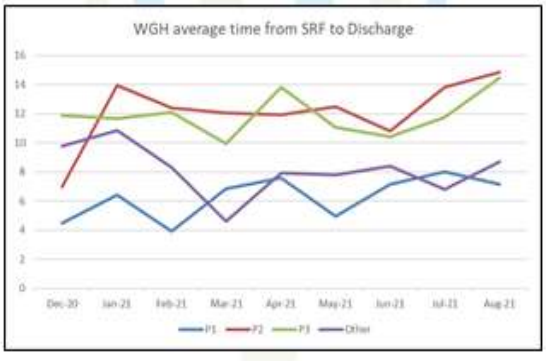




Weston Average days on Pathway

Admission to SRF and SRF to Discharge





Bed Deficit: That UHBW and NBT bed modelling show a bed deficit without mitigation. The deficit for

UHBW is circa 105 beds across Bristol Royal Infirmary (BRI) and Weston. NBT has a bed deficit of 129 beds. Before the pandemic, all hospitals consistently ran at above 92% occupancy rates, frequently have funded & unfunded escalation capacity open, poor A&E 4hr performance, high levels of delayed transfers of care.

In terms of summarising the impact of the bed savings for NBT

As of Sept 2021, only 4% vs. a pre-Covid allocation of 12% of the General & Acute bed base is dedicated to elective care.

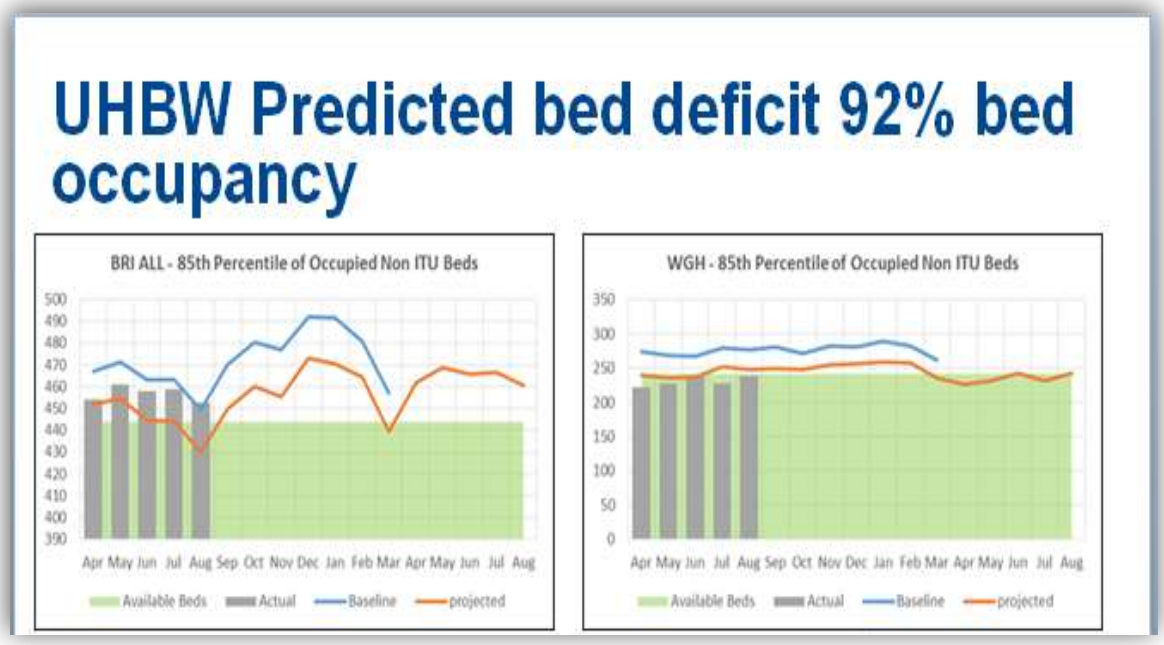
47 beds saved in 21/22 and a further 60 beds saved for NBT in 2022/23 = 107 beds across 18 months.
The 47 beds targeted (5.5% of our bed base) for 21/22 are already in the Trusts bed model and H2 assumptions. Our plan is to increase our elective bed base from 4% to 8% over this period, this will not eliminate the risk of 104week waits but we are currently modelling the overall impact based on case mix requirements.

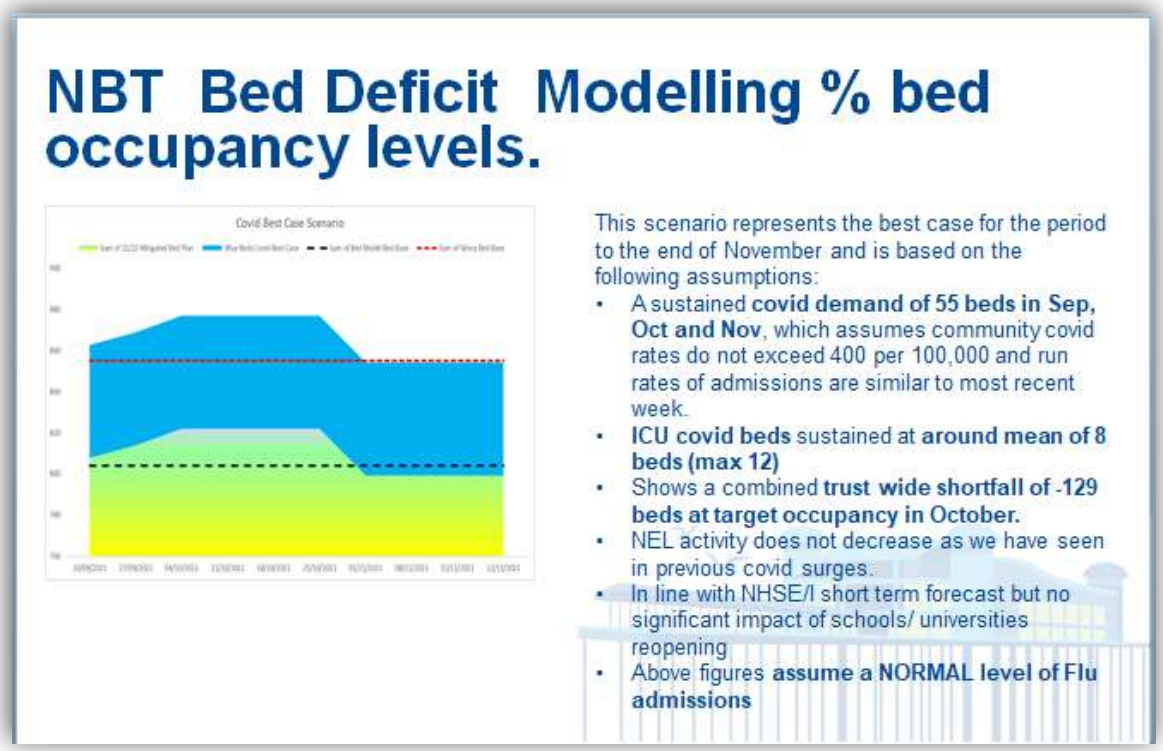
Into 2022/23 a further reduction of 60 beds = 7.5% occupancy reduction is likely to result in a 92% occupancy overall (we are yet to run our activity assumptions for next year). Whilst this remains about the ideal 85% NHS E/I recommended bed occupancy, the reduction would significantly improve hospital flow and eliminate Ambulance queuing and offload pressures.

Within UHBW Medicine in BRI is operating above its pre-pandemic baseline and forecast to grow. Extremely high levels of medical outlying have meant for example circa 50% of BHI beddays in August were consumed by medical patients. This has a significant impact on maintaining urgent elective work and leaves no ability for elective backlog recovery.

There are also significant implications for system partners such as NBT who cannot get their patients into BHI as tertiary transfers in a timely way. Same applies in Division of Surgery which lost 15 beds in August to medical outlying. Lots of the medical outlying is driven by the MFFD position.
The BRI all graph shows this will get worse over the Winter and into next year.

BRHC and Weston are for the time being managing within their allocated bed base – but it must be noted that for Weston this is only because we are bringing large numbers of blue pathway patients up to Bristol, and across the system (including Musgrove) do not repatriate overnight closure patients back to Weston in a timely way.

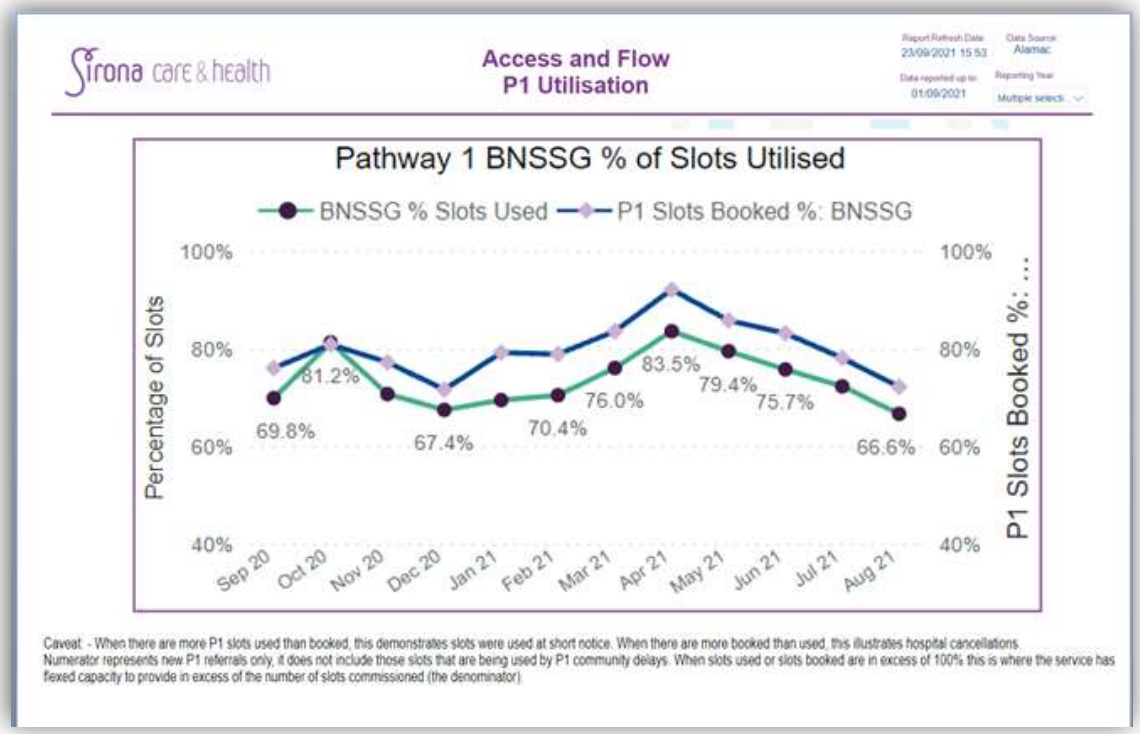




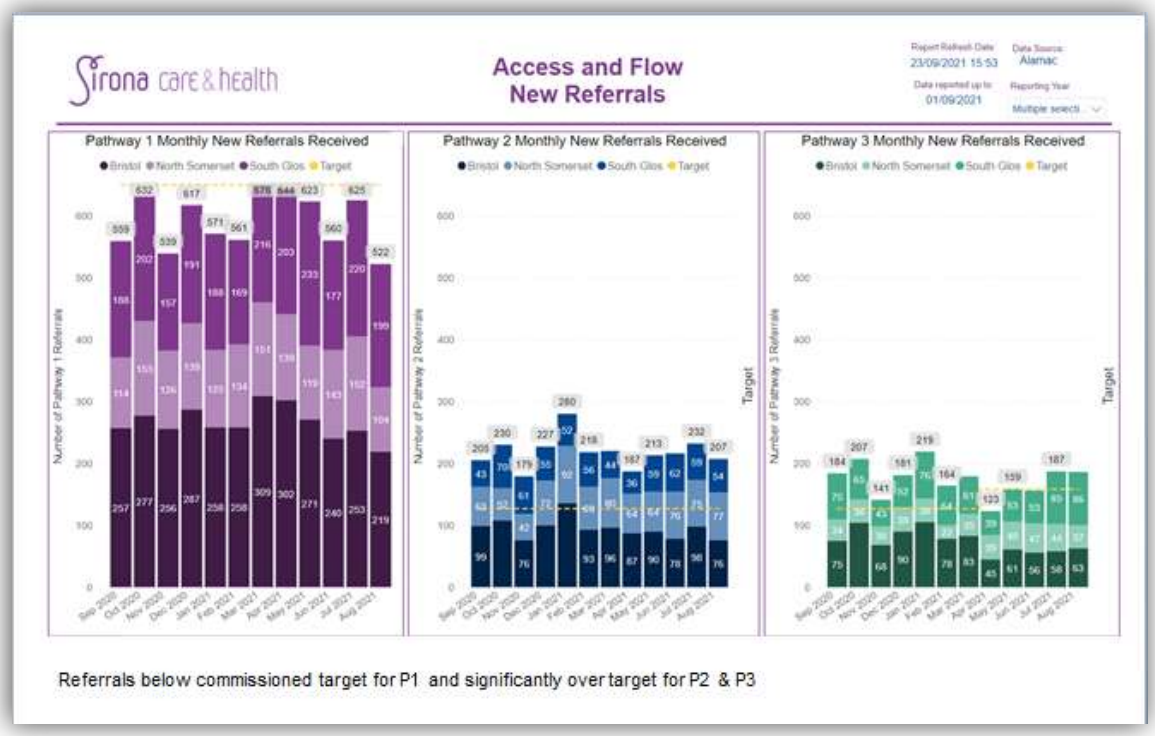
Community flow within Sirona

- The referral demand for P1 is mostly at or below commissioned capacity whilst that for P2 and P3 is consistently above contracted capacity.
- The slot utilisation for P1 is below commissioned capacity and is compromised by flow through pathways including a build-up of delays in exiting pathways, a requirement to match available capacity with the demand (both therapy and rehab support worker) and workforce recruitment challenges. In addition to this, utilisation is also compromised by last minute cancellation of planned discharges and the difficulty in reallocating this capacity to a hospital-discharge slot at short notice. As a result of this there has been growth in the waiting list
- P2 bed occupancy is 88% and P3 99.9% and with the demand above commissioned capacity, there is an increasing waiting list of patients to enter these pathways.
- Average LOS is above target for all pathways, impacted also by delays exiting the pathways and the complexity of the patients requiring support.

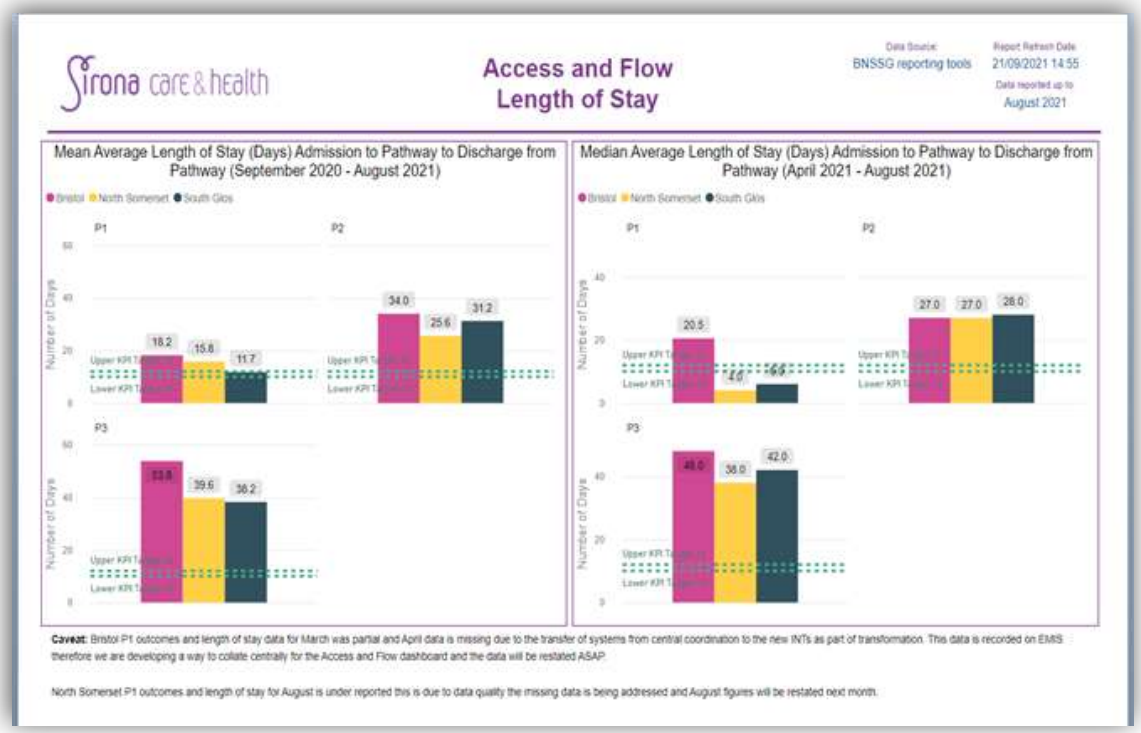
During 21/22 a new Information Technology system to support the D2A system was introduced.

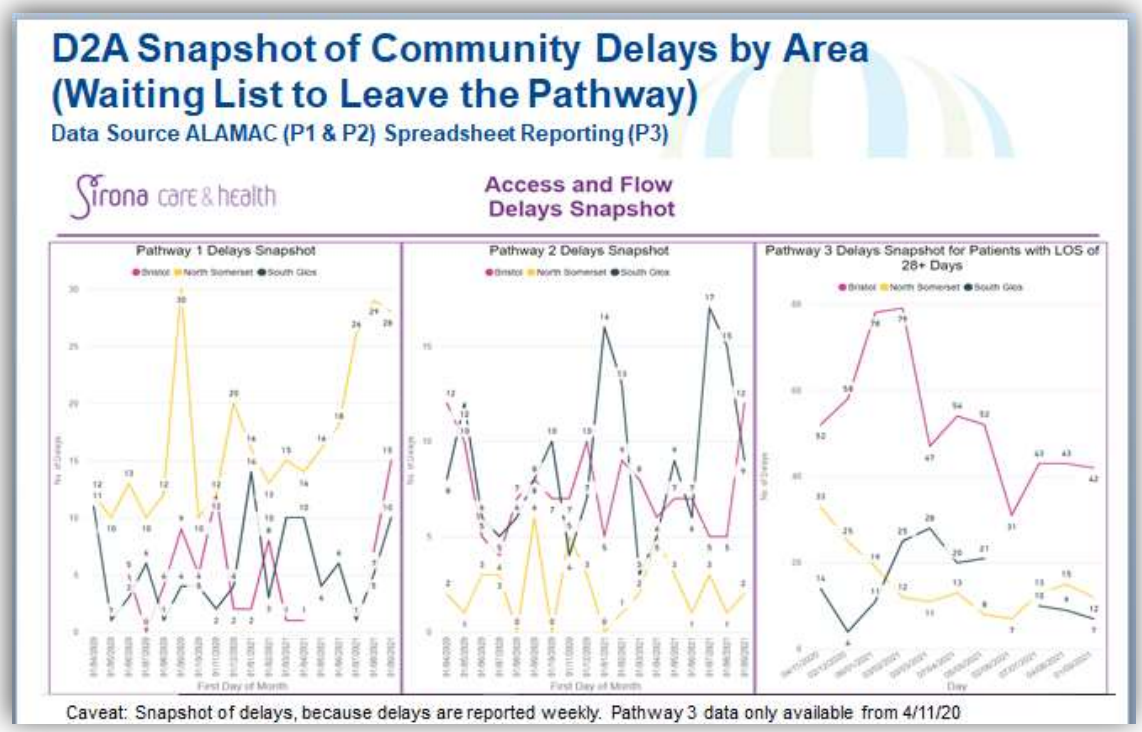


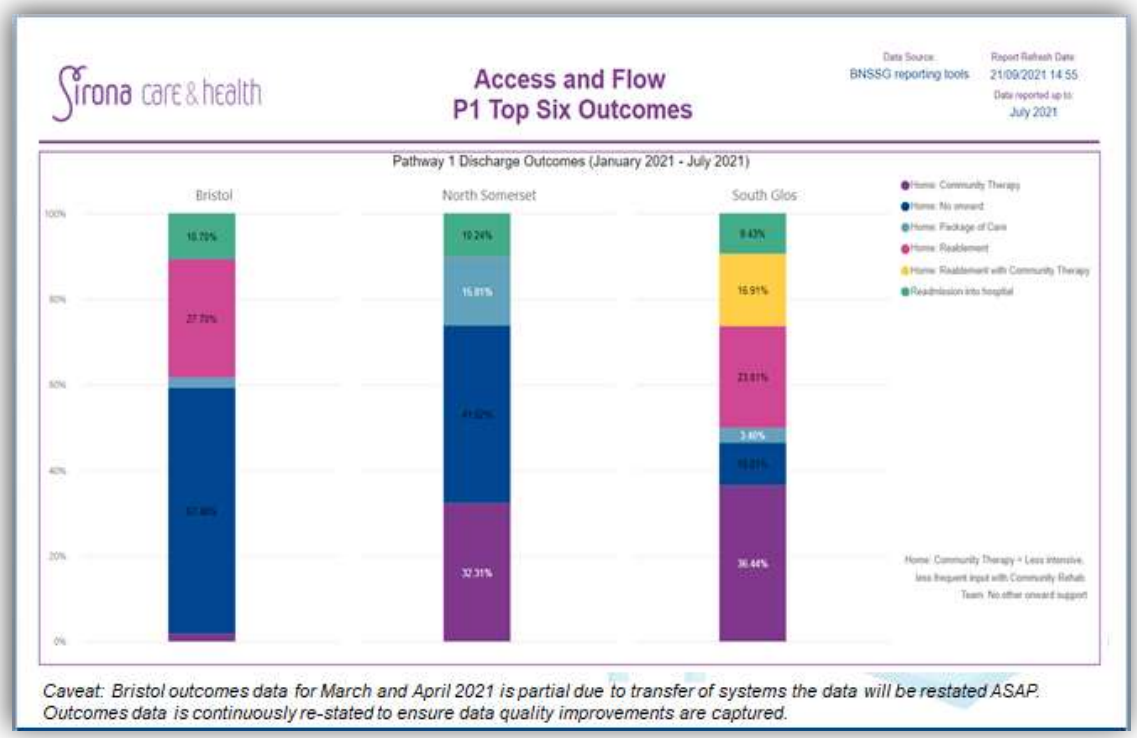
Caveat: - When there are more P1 slots used than booked, this demonstrates slots were used at short notice. When there are more booked than used, this illustrates hospital cancellations. Numerator represents new P1 referrals only, it does not include those slots that are being used by P1 community delays. When slots used or slots booked are in excess of 100% this is where the service has flexed capacity to provide in excess of the number of slots commissioned (the denominator).



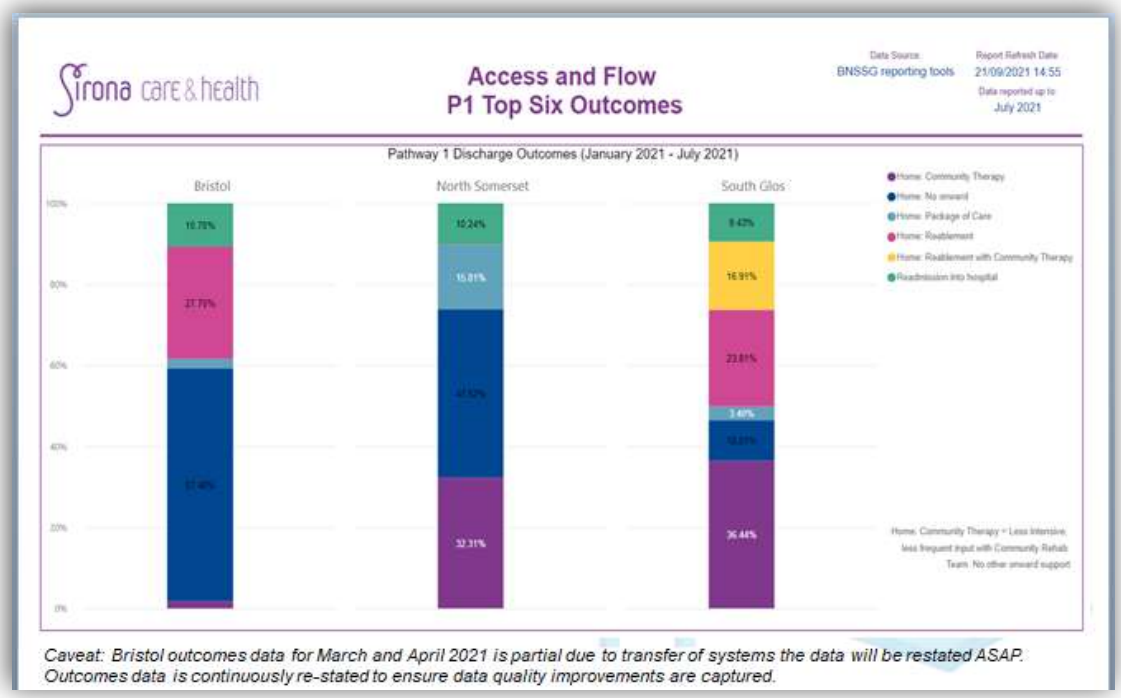
Referrals below commissioned target for P1 and significantly over target for P2 & P3


Sirona care & health
Access and Flow
Length of Stay
Data Source:
BNSSG reporting tools
Report Refresh Date:
21/09/2021 14:55
Data reported up to
August 2021
Mean Average Length of Stay (Days) Admission to Pathway to Discharge from Pathway (September 2020 - August 2021)
Bristol North Somerset South Glos
P1
P2
P3
Number of Days
18.2
15.8
11.7
34.0
25.6
31.2
53.8
39.6
36.2
Median Average Length of Stay (Days) Admission to Pathway to Discharge from Pathway (April 2021 - August 2021)
20.5
27.0
27.0
28.0
48.0
36.0
42.0
Caveat: Bristol P1 outcomes and length of stay data for March was partial and April data is missing due to the transfer of systems from central coordination to the new INTs as part of transformation. This data is recorded on EMIS therefore we are developing a way to collate centrally for the Access and Flow dashboard and the data will be restated ASAP
North Somerset P1 outcomes and length of stay for August is under reported this is due to data quality the missing data is being addressed and August figures will be restated next month.


D2A Snapshot of Community Delays by Area
(Waiting List to Leave the Pathway)
Data Source ALAMAC (P1 & P2) Spreadsheet Reporting (P3)
Sirona care & health
Access and Flow
Delays Snapshot
Pathway 1 Delays Snapshot
Bristol North Somerset South Glos
No of Delays
First Day of Month
Pathway 2 Delays Snapshot
Bristol North Somerset South Glos
No of Delays
First Day of Month
Pathway 3 Delays Snapshot for Patients with LOS of 28+ Days
Bristol North Somerset South Glos
No of Delays
Day
Caveat: Snapshot of delays, because delays are reported weekly. Pathway 3 data only available from 4/11/20



Caveat: Bristol outcomes data for March and April 2021 is partial due to transfer of systems the data will be restated ASAP. Outcomes data is continuously re-stated to ensure data quality improvements are captured.



Caveat: Bristol outcomes data for March and April 2021 is partial due to transfer of systems the data will be restated ASAP. Outcomes data is continuously re-stated to ensure data quality improvements are captured.

Flow into Local Authority

Of the patients referred from P1 to LAs most are supported with Packages of care or reablement N Somerset LA have the highest number of P1 delays. Most patients leaving P1 in Bristol and N Somerset require no ongoing care. All LA's have experienced high delays for POC in all D2A services Bristol LA has seen significant improvements in pts over 28 days from its peak in Feb 21. South Gloucestershire LA have consistently had low numbers of patients over 28 days. Patients are being discharged home from P3 beds with no onward care but approx. 50% still receiving ongoing long-term care. Patients exiting to social care pathways on average require higher level of care need than prior to D2A approach

North Somerset does not have a home to decide or home first model and limited reablement service D2A action plan includes costing to bolster reablement in North Somerset.
Since summer increased difficulties across all areas, recruiting to direct care social care roles, Sirona therapy and nursing to meet increased.
Active action plan to deliver improvements stranded community reviews held weekly

South Gloucestershire

The bid from South Gloucestershire represents a transitional position. The council's response to Discharge to assess was implemented at speed to meet the system requirements for pace and flow. Over the last 18 months they have learnt at speed in the context of COVID 19. They are now clearer about their performance, outcomes for individuals and the ability of their market to support the approach. They have used and learnt from other systems, Local Government Association research and independent consultancy.

In South Gloucestershire, their challenge to achieve effective D2A includes; capacity in the domiciliary care market, a sub optimal reablement model and an over reliance on bedded provision in pathways.

South Glos recognise that they are some way yet from where they need to be. The number and complexity of people using P3 beds has increased from pre-COVID. The acuity and complexity of P3 cases has seen an increase in the numbers of assessments and social work input required per person.

North Somerset

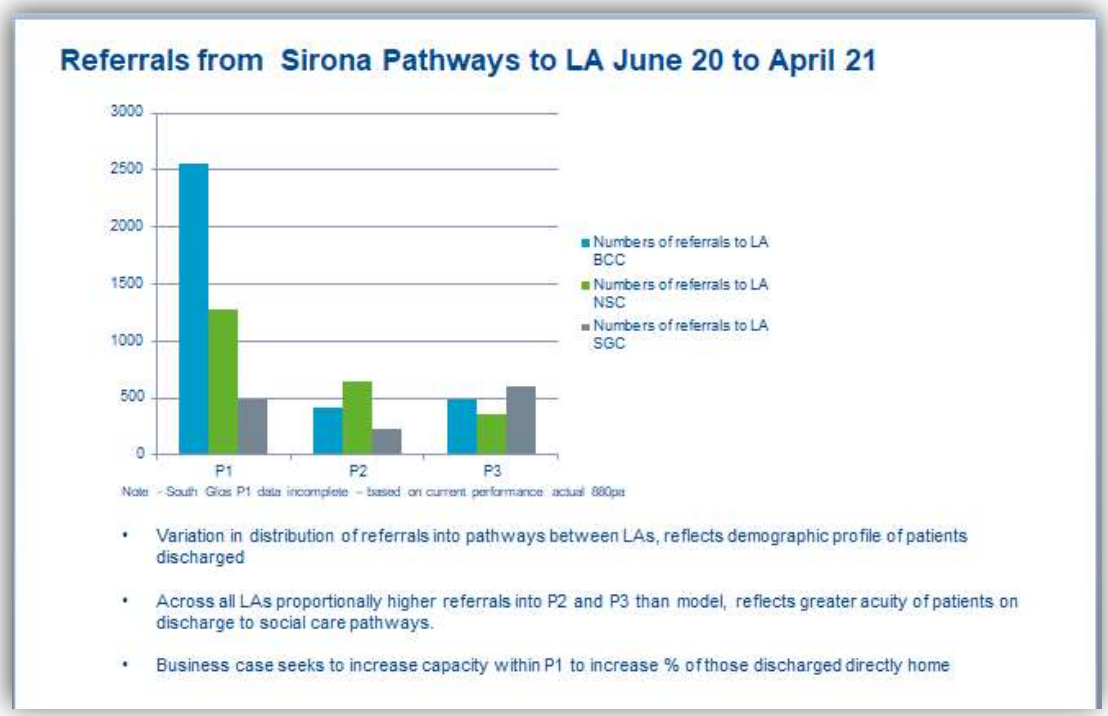
Intrinsically the North Somerset business case proposals seek to address the historic under investment in capacity in reablement which has been supported previously in South Gloucestershire and Bristol. It was prepared during the ongoing difficulties at Weston General Hospital and has received the support of the local Ageing Well bid and supported by Sirona as we seek to align local pathways and move more patients to P0+.

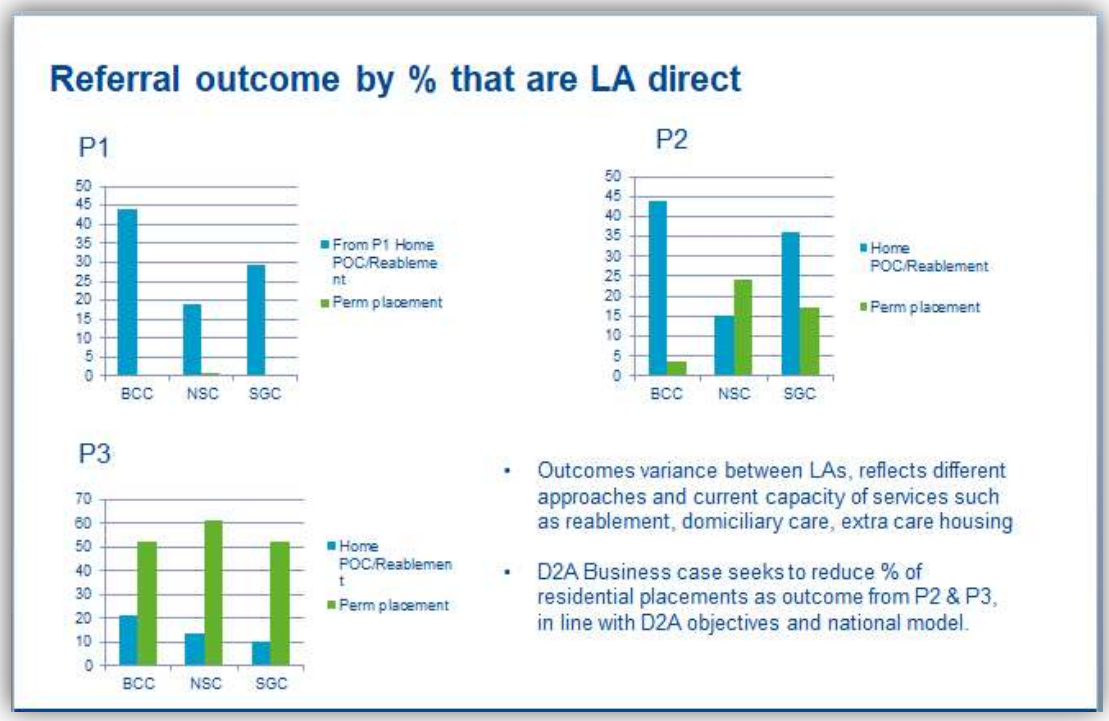
This investment is all the more necessary given the relatively low level of planned bed-based care in P2 and P3. The investment in reablement services and associated TEC pathways will significantly improve flow which aligned with proposals to delay the Care Act assessments and allow our care provider to take direct flow from Sirona, will lead to LOS reductions to P1 pathways currently 62% above national targets that have a hospital bed day value of Circa £4M if subsequently national targets are met.

The proposals also develop capacity to support a shift from P1 to P0 pathways with the work on TEC, Wellness service and Home from Hospital providing a P0+ capacity that will complement the local VCSE offer to shift the P0 pathway in North Somerset from C 35% to closer to 50%, the financial benefit to the CCG is obvious financially and perhaps most convincingly is this supports addressing the inability of Sirona to recruit sufficiently to the level of P1 required.

Bristol

The Bristol case for change as set out in our proposal builds on redesigned D2A pathways. As shown in the pathway analysis, there is good flow and outcomes from most Out of Hospital pathways as a result of reorganised D2A social work teams, key P1 Sirona pathways and the key P2 funnel through the Council reablement service. However, the data does show particularly with the high number of P3 beds as a result of some over - development of this bed-based pathway. Current workforce pressures and supply issues across the Bristol.





Modelling assumptions

The bed modelling reviews community capacity profiled March 2020 onwards noting numbers of commissioned capacity this also included all extra beds commissioned within that process. This noted changes in North Somerset P2 capacity and 48 beds commissioned in July to support the planned elective programme.

The use of the stochastic demand and capacity tool (the IPACS model) has enabled realistic variation to be modelled for the Out of Hospital Discharge to Assess pathways from acute Trusts to community D2A providers. Model will continue to have further work to draw in long term outcomes from D2A model.

The model provides an assessment of D2A service occupancy and the number of potentially delayed patients in the system.

It is based on:

- Arrivals into complex care pathways (P1-3) (taken from Covid and non/Covid demand projections);
- Proportions of patients going into these complex pathways (current and target);
- Length of stay on these complex pathways (current and target);
- Capacity (unlimited, or according to current/ target levels).
- The model which explores the following main pathways was supported by all partners to support the discharge of individuals from all hospital beds throughout BNSSG, these are:
- Home First DTA Pathway 1
- Community Bed Pathways 2 and 3
- Voluntary Care Support (VCS) Pathway 0.

Gap to close based on 5 week average activity and scenario outputs

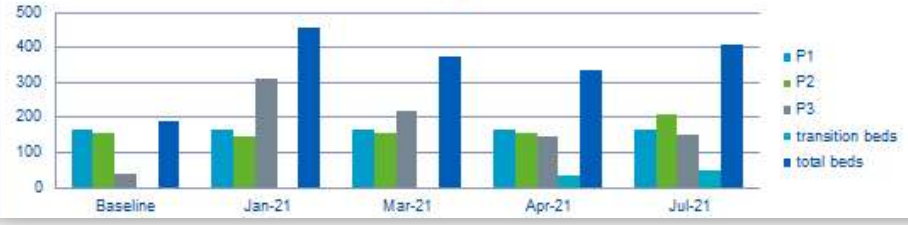
P1	Activity	Difference to Scenarios
P1 Activity	117	
Scenario 1	221	-104
Scenario 3	170	-53
Scenario 5	287	-170
Scenario 6	221	-104

P2	Activity	Difference to Scenarios
P2 Activity	189	
Scenario 1	185	4
Scenario 3	137	52
Scenario 5	100	89
Scenario 6	73	116

P3	Activity	Difference to Scenarios
P3 Activity	168	
Scenario 1	226	-58
Scenario 3	155	13
Scenario 5	142	26
Scenario 6	96	72

Scenarios	Complex pathway split	Length of Stay
Scenario 1	54/20/17	13/29/43
Scenario 3	54/20/17	10/21/28
Scenario 5	70/10/10	13/29/43
Scenario 6	70/10/10	10/21/28

BNSSG Pathway Capacity Funded baseline up to July 21



Sirona average number of slots / patients discharged into pathways per week (28/06/21 – 01/08/21)

Current capacity and gap to close

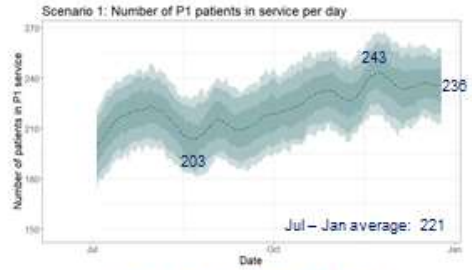
P1	Slots Used: Bristol	Slots Used: North Somerset	Slots Used: South Glos	Total Slots used: BNSSG	Difference to Target (150 slots per week for BNSSG)	Business Case Total (Daily Discharge figures) - Trust Discharges to P1	Variance between Trust Discharges to Alamac Slots Used
P1 5 week average	43	33	41	117	33	55	63

P2 5 week average	Sirona Admissions to P2 (Discharge from Acute)	Business Case Total P2 Trust Discharges	Variance between Trust Discharges to Sirona Admissions	Difference to weekly target (using Sirona admissions data)	Designated Capacity
NBT (weekly target 21)	14	8	6	7	65
UHBW (weekly target 35)	13	17	5	22	107

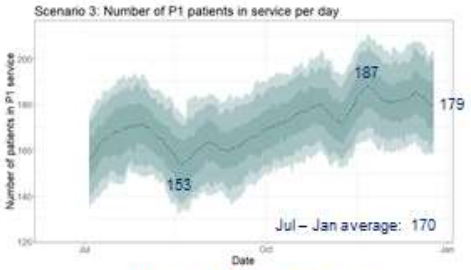
P3 5 week average	Business Case Total P3 Trust Discharges	Difference to weekly target (using Trust Discharges data)	Designated Capacity
NBT (weekly target 12)	14	-3	77
UHBW (weekly target 11)	10	-1	67

P1 – Estimated number of patients in service per day July 21 to Jan 22 (no capacity limit)

P1:P2:P3 split – 54:20:17

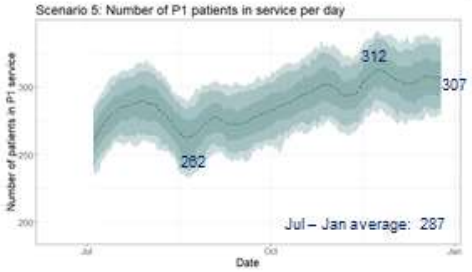


Current LoS – 13 days

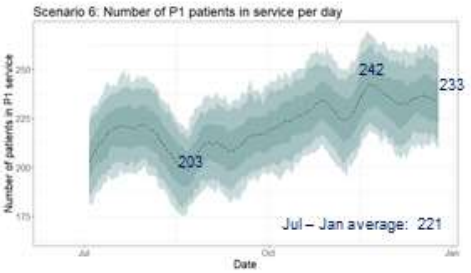


Target LoS – 10 days

P1:P2:P3 split – 70:10:10



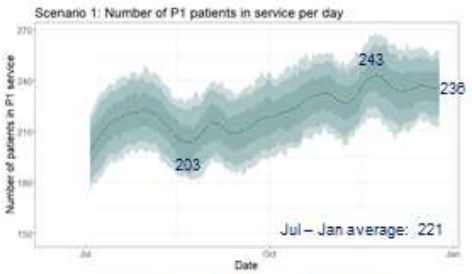
Current LoS – 13 days



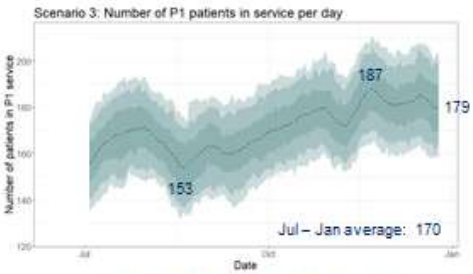
Target LoS – 10 days

P1 – Estimated number of patients in service per day July 21 to Jan 22 (no capacity limit)

P1:P2:P3 split – 54:20:17

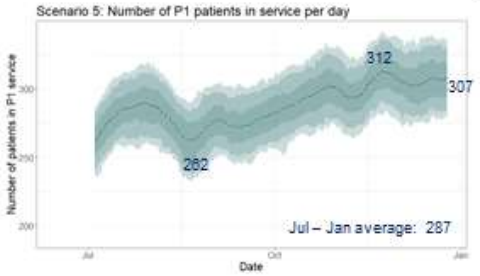


Current LoS – 13 days

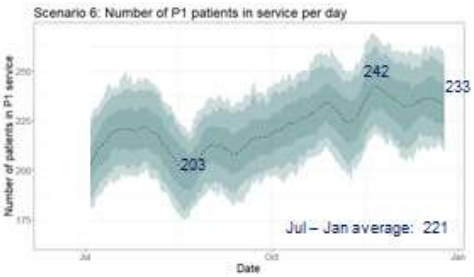


Target LoS – 10 days

P1:P2:P3 split – 70:10:10



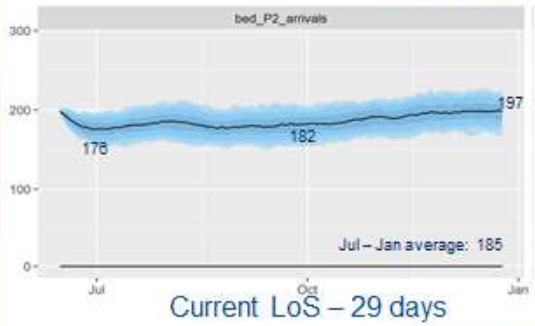
Current LoS – 13 days



Target LoS – 10 days

P2 – Estimated number of patients in service Jul 21 to Jan 22 (no capacity limit)

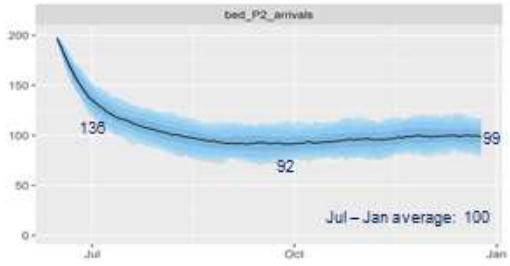
P1:P2:P3 split – 54:20:17



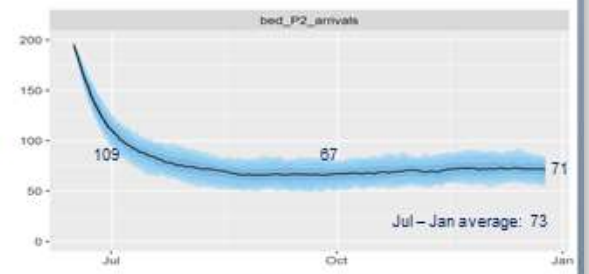
Current LoS – 29 days

Target LoS – 21 days

P1:P2:P3 split – 70:10:10



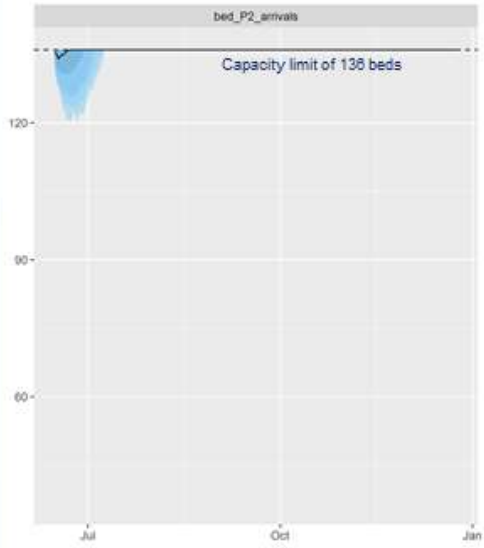
Current LoS – 29 days

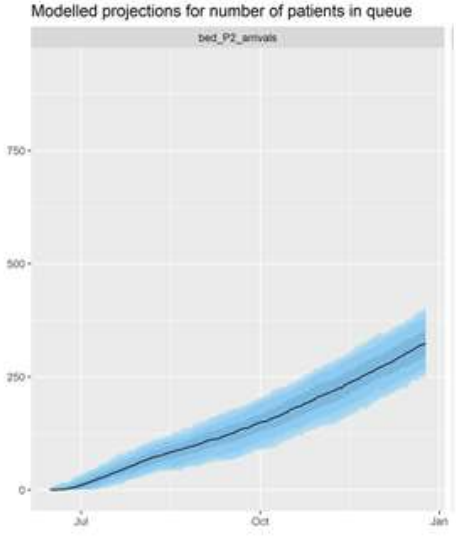


Target LoS – 21 days

P2 – Estimated number of patients in service and acute queue Jul 21 to Jan 22 (Capacity limit of 136 beds)

P1:P2:P3 split – 54:20:17; Current LoS – 29 days





Once the capacity limit on the left hand plot (136 beds) is reached then a queue for P2 will result in the acute sector if no other options are available

Workforce Delivery

Our current model is not sustainable due to insufficient workforce to resource. The business case supports different approaches across the system using staff in different ways. This case supports workforce supporting care in the community and D2A – focused on all areas of delivery, particularly the non-registered workforce. It has reviewed how care can be delivered differently that meets system needs and best outcomes for residents/ patients. Exploring; what work is done where and by whom. This includes:

- Sirona therapy & nursing
- Social Care - Dom Care
- Vol sector
- Social prescribing
- Social Worker/ OT
- Health and Care Technology Enabled Care (TEC)

Success of the D2A business case is heavily dependent on the ability of partners to recruit at the level identified within the business case.

New posts identified within business case to be funded on recurrent basis

Provider	Role type	WTE In post	WTE vacancy	Timeline date required in post	Currently identified at risk
Acute UHBW	Band 4 managers Band 6 flow facilitators Co-ordinators	5	8	Feb 22	At risk 3x 4 (12)
Sirona	Therapists, RSWs	43	92	April 22 - filled over 18 months	At risk 3x 4 (12)
NSC	Reablement workers	2	33	Nov/Dec 22	At risk 3x 4 (12)
BCC	Reablement workers	8.5		Feb 22	In post
SGC	Reablement workers	24.8		Feb 22	In post
Total		83.3 in post	**133 to fill**		

The Sirona and North Somerset posts are to be filled over an 18 months period, which provides mitigation in challenging employment market. There is confidence that roles can be filled however retention also needs to be managed to ensure capacity is retained, this is dependent on D2A transformation being achieved as outlined in the paper and sufficient capacity in social care; assessment and dom care to enable flow. The risk for NS reablement worker recruitment, is in the potential impact on the wider provider workforce, if workers transfer employers rather than being new to the sector.

Posts identified within the business case to be funded for 12 months

Provider	Role type	WTE In post	WTE vacancy	Timeline – date required in post	Currently identified at risk
BCC	– assessment	-	6	Feb 22	At risk 3x4 (12)
SGC	Social work – assessment capacity	22	-	Feb 22	At risk 3x4 (12)
SC providers	Dom Care	tbc	tbc	Feb 22	At risk 4x4 (16) * Note – amber in NS
Total			**6 to fill** (excluding dom care)		

The additional assessment capacity identified within the business case is short term funded. For unfilled

posts it will be challenging to attract on the short-term basis. The current agency market for social work is currently stretched and it may not be possible to fill within the timescales required. As, it is likely that the majority of these roles will be filled from agency, there is a risk that current agency workers will seek alternative placements.

The success of the business case is also dependent of sufficiency of supply within the Domiciliary Care market across BNSSG. D2A increased dom care demand as acuity of patients is resulting in higher level of individual need at pathway exit. The level of additional capacity required within the Dom Care market to support flow is not specified within the business case. The business case identifies short term (12 month) funding to support mitigation measures. Currently providers are experiencing significant challenges in filling current vacancies to cover existing work and are expecting this trend to continue. This is currently impacting the ability to providers to pick up packages of care at point of exit in Pathways 1 & 2. The flow modelled at a reduced length of stay will increase demand into Domiciliary Care. Short term measures proposed to support market resilience, retention bonuses and recruitment campaigns, will mitigate to an extent.

Mitigating actions such as short term support by way of retention bonuses are having a positive impact will support, however if current trends continue are unlikely to achieve the capacity levels required. Long term support to build domiciliary care workforce resilience is not funded as part of the business case. Inability to recruit additional capacity in domiciliary care will impact the ability of the D2A model to achieve targets and timeline outlined, as it will not be possible to achieve flow modelled at the target length of stay.

Workforce recruitment and retention within care services is reaching crisis point across the UK, with almost all care providers reporting an inability to recruit and retain workers even where increased pay rates are offered. This is affecting health services including community health services, as well as community care work. Care work has traditionally been the choice of dedicated few, with terms and conditions of employment making other careers much more attractive. Following the demands that the covid-19 pandemic has made on care workforce, together with workforce shortages in many sectors that offer better terms and conditions, the care market is losing workers at unprecedented levels. In addition, the potential inclusion of the domiciliary care workforce for mandatory vaccinations is likely to lead to a further quantum of staff leaving the market. There is a real risk that, despite D2A and other government funding being provided to progress workforce initiatives, public commissioning bodies are unable to secure the capacity required in the domiciliary care market to match demand. The impact on the care workforce may be exacerbated by the recruitment and expansion of health community services. This risk is a threat to the D2A business case demand modelling assumptions to support improved flow through the pathways. Whilst workforce measures such as the Proud to Care Retention bonuses have mitigated some of the pressure, solutions need to embrace demand management issues which involve the use of assistive technology, and remote monitoring, working with the voluntary sector to offer a blended care model, and challenge expectations and opportunities to maximise independence, deliver care as flexibly and efficiently as possible. Whilst these will help mitigate the workforce shortages, the risk will remain to a substantial degree.

A programme of work already sponsored by Healthier Together is exploring the longer term challenges that will need different solutions. The programme workstream builds on existing best practice across BNSSG and includes workstreams such as;

- Attraction research – what makes care/ therapies an attractive option – to different segments (YP, work returners, older workforce)?
- What skills are needed where?
- Accredited skills and development - to enable career progression
- Terms and conditions
- Career pathways – entry point to careers in SW, therapies, nursing
- Extended use of Assistive Tech
- Working differently; hybrid roles

Approaches are being co-produced with; providers, voluntary sectors, BNSSG partners, TEC partners
This does not replace or impact the current best practice proposals including D2A and Frailty. Offering a range of support worker roles to enable career progression for this sector

Costs		
Description of Costs	Estimation of Planned Costs (£000s)	Confidence Level of Spend
Appendix 2 Provides a breakdown of all costs the details of which are described within the financial summary	The Discharge to Assess business case plans to invest £13m recurrently to deliver the implementation plan	Currently there is a transitional plan to deliver and actual non-recurring spend is approx. £15m (£3m 21/22 and £12m 22/23 onwards)

Savings Summary		
Description of Saving	Estimate of Savings (£000s)	Confidence Level of Savings
The model is forecast to release c200 beds from acute sector, which will generate cash savings of £16.6m which contribute to delivery of emerging NHS ICS medium term financial plan. In the next 3 years savings will be realised by re-utilising capacity for elective backlog recovery and earning associated Elective Recovery Fund income. Beyond that it is expected that capacity will be reduced and costs released	£16.m per annum	Medium

Contract and Activity Implications

Which Contract and Provider will be impacted (if known)?

Acute providers, Community providers (Sirona as well as Medical Equipment, Red Cross), Local Authority reablement services (and associated sub-contracts)

When will the contract change come into effect?

We would expect the contract changes to start in November 2021. The funding flows will be phased to align with the deliverables in year 1 to the pace of change and realigned for year 2/3 up to March 2023.

Please provide a summary of activity implications

The following tables show the impacts of the implementation plan **(Appendix 1 Implementation Plan**)
All the detail including required action, whom, impact and trajectory for delivery are included and will be monitored by the D2A Delivery Implementation Board.

The tables below summarise those changes**.**

Table 1 Acute bed days released demonstrating impact on single referral form and discharge changes.

NBT - Admission to SRF	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	12	88	10	14.7	9.5	3.7	18.3
P2	13.4	29	12	3.1	11	2.2	5.2
P3	16.9	29	15	3.3	13	3.4	6.7

NBT - SRF to Discharge	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	5.8	43	4.5	9.5	1	25.7	35.2
P2	10	22	7	6.6	1	13.1	19.7
P3	16.5	28	11	9.5	4	12.1	21.6

NBT - Total Savings	Bed savings with implementation of full D2A business case
P1	53.5
P2	24.9
P3	28.3

BRI - Admission to SRF	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	13.2	58	10	14.0	9.5	2.2	16.1
P2	14	24	12	3.5	11	1.7	5.2
P3	17.4	22	15	3.1	13	2.6	5.7

BRI- SRF to Discharge	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	8.1	35	4.5	15.7	1	15.3	31.0
P2	10.3	18	7	5.8	1	10.5	16.2
P3	19.3	25	11	10.7	4	9.0	19.8

BRI - Total Savings	Bed savings with implementation of full D2A business case
P1	47.1
P2	21.5
P3	25.5

WGH - Admission to SRF	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	11.6	27	10	3.8	9.5	1.2	5.0
P2	13.3	16	12	1.6	11	1.2	2.8
P3	16.3	10	15	0.8	13	1.2	2.0

WGH- SRF to Discharge	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	6.5	15	4.5	4.7	1	8.3	13.0
P2	12.6	16	7	6.9	1	7.4	14.3
P3	11.9	7	11	0.6	4	4.3	4.9

WGH - Total Savings	Bed savings with implementation of full D2A business case
P1	17.9
P2	17.2
P3	6.9

Community Activity

The following tables demonstrate changes in capacity generated in the community to support flow

Table 2 P0 activity expected

PO Weekly discharges per week	Total	Over 65
NBT	435	252
UHBW	476	262

Table 3 Projected capacity within pathways

This table describes the pathway changes and capacity required as the model

Complex Pathway Patient Proportions (P1/P2/P3)	LOS (days) (P1/P2/P3)	P1 (slots) By % caseload	P2 beds by % case load	P3 beds by % caseload
Baseline	P1 13 P2 29 P3 43	164 54%	166 20%	163 17%
Winter target	P1 10 P2 21 P3 28	170 54%	136	146
B Case Target	P1 10 P2 21 P3 28	221 70%	78 10%	99 10%

Table 3 Capacity created by reducing community delays and achieving LOS of 10 days for P1, 21 days P2 and 28 days P3.

The following table describes average delay within community pathways.

P1	Average delays in Community patients over 10 says	Winter target March 22	Stretch Target March 23
Bristol	11.4	4	0
North Somerset	27.1	13	1
South Glos	11.1	8	1

P2	Average delays in Community patients over 21 days	Winter target March 22	Stretch Target March 23
Bristol	8.6	3	0
North Somerset	2	1	0
South Glos	11.4	9	1

P3	Average delays in Community patients over 28 days	Winter target March 22	Stretch Target March 23
Bristol	38.6	15	4
North Somerset	11.8	6	1
South Glos	8.2	6	1

Overall Financial Summary

The financial model has been developed by working closely with both Sirona, and each of the three LA's and the acute trusts. These meetings have included both operational and financial colleagues.

The new model has been overlaid across those budgets identifying the gaps both in operational staff and enablers to deliver the model and the capacity deficits on beds.

The Discharge to Assess business case plans to invest £12.9m recurrently to deliver the implementation plan.

Business Case / Application of funding	**£**		**Commissioning responsibility**
Acute Discharge Teams (UHBW)	320,303		NHS responsibility
GP support	62,000		NHS responsibility
	382,303	3%	
P0 capacity (Red Cross & N Som Wellness)	512,739		joint NHS and ASC responsibility
P1 capacity (Sirona)	6,479,348		joint NHS and ASC responsibility
Transport, Equipment & Technology (CCG & LA)	299,770		joint NHS and ASC responsibility
P2 & P3 beds incl Extra Care Housing (CCG & LA)	804,836		joint NHS and ASC responsibility
P2 & P3 therapy (Sirona)	816,503		joint NHS and ASC responsibility
	8,913,197	69%	
Home First / Reablement teams (LAs)	3,551,180	28%	ASC responsibility
TOTAL	**12,846,680**	**100%**	

NB. 2021/22 prices

As per implementation plan (Appendix 2) this investment will deliver:

- P1 54% discharge with average length of stay 13 days to 70% with av. LoS 10days
- P2 20% discharge with average length of stay 29 days to 10% P2 with av. LoS 21 days
- P3 17% discharge with average length of stay 43 days to 10% P3 with average LoS 28days
- As a consequence there will also need to be an increase in Social Care reablement/home first capacity due to earlier home first discharge with more complex needs
- Increased capacity is also required in enabling services such as Patient Transport, Community Equipment and P0 voluntary sector support to prevent delays in discharge
- Increased capacity is also required in acute hospital discharge teams to ensure SRF process and discharges planned as early as possible

This would be funded from:

- £11.9m CCG Long Term Plan Acute & Community Services allocation growth
- £ 0.1m Reprioritisation of CCG Primary Care Locally Enhanced Services budget
- £ 0.9m Adult Social Care budget contribution [this could include funding from real-terms growth in CCG contribution to Protection of Adult Social Care Better Care Fund 22/23 and 23/24]

Local Authority budget contributions pro-rata to adult social care re-ablement services increases as below:

		BCC	N Som	S Glos	TOTAL
Investment in Recurrent Reablement Services	£k	1,402	1,435	854	3,691
Share of BNSSG resources	%	38%	39%	23%	100%
Local Authority budget contribution	£k	336	344	205	885
Pro-rata share of LA investment	%	24%	24%	24%	24%

The implementation plan (Appendix 2) describes what the investment will deliver and how all partners will achieve the required actions to reduce length of stay in the community to increase flow, reduce the need for bedded pathways by increasing home first, and reduce length of stay in the acute trusts by improving the process for earlier facilitated discharge.

Financial Benefits
This investment identifies the following financial benefits:

Cash-Releasing
£16.6m Acute beds reduced length of stay reducing demand by 200 beds – cash realised through combination of Elective Recovery Fund income generation; reduced bed capacity and reduced escalation and winter pressures costs due to improved operational flow.

Non-Cash Releasing
Increase in independent living; reduced de-conditioning and reliance of residential/nursing care
Optimal Care Act and CHC assessment model leading to lower readmissions and lower level of failed care packages
Avoid need for capital investment in beds

Risks & Mitigations
The urgent care system remains under considerable operational pressure and is not currently optimised; temporary funding is currently provided from Hospital Discharge Fund to support the system, there are significant workforce gaps in domiciliary care market caused by wage inflation, Covid pressures and Brexit. The improvements set out in the implementation plan are profiled to deliver by March 2023.

Recognising these risks it is also proposed to use NHS budget surpluses in 2021/22 to create a non-recurrent £15.1m transitional cost & risk pool, as envisaged under the principles of the 2020/21 S256 agreements.

£2.8m is forecast to be drawn down in financial year 2021/22 and therefore £12.2m available to mitigate future risks.

Risks will include:

Risk - Health Care	£ estimated annual value	£ current financial cost	£ six month (estimated minimum time to release current costs)	Mitigation
Stranded costs arising from acute bed reductions (25%)	4.1	N		Could be funded from additional income or other cash releasing savings committed in NHS LTP. Note. Current unsustainable performance for ambulance handovers, ED performance and elective activity
P2 & P3 beds demand due to lower than expected reductions in length of stay Scenario 3	5.7	Y	2.9	Requires robust operational management & implementation
Price of D2A care home and	0.6	N		Est. 5% of gross cost incl NI rates, pension rates, Covid cost premiums

dom care capacity				
Total	**10.4**			
Risk - Social Care (including costs currently funded from non-recurrent Hospital Discharge Fund and S256 agreement)				
Social Care cost risks - assessment 22/23	1.0	Y	0.5	Non recurrent – the delivery board will need to deliver transformational change to redesign services and likely to take until 30 Sept 2022, as per timeline in Appendix 2
Social Care cost risks - dom care market incentives 22/23	0.8	Y	0.4	Non recurrent – the delivery board will need to deliver transformational change to redesign services and likely to take until 30 Sept 2022, as per timeline in Appendix 2
Social Care risks - BCC/Sirona RSW capacity 22/23	1.0	Y	0.5	Non recurrent – the delivery board will need to deliver transformational change to redesign services and likely to take until 30 Sept 2022, as per timeline in Appendix 2
Total	**2.8**			
	13.2			

It should be noted that £13.2m annualised risks already exceed the £12.2m available transition pool; and most of these costs are already been incurred now. So concerted, immediate action will need to be taken to mitigate these risks and reduce costs where appropriate

£12.8m recurrent investment plus £12.2m non recurrent investment would be lower than forecast gross investment incurred during 2021/22 for Hospital Discharge. The key gains required in operational flow will come from robust operational management to match capacity and demand, remove avoidable delays in the pathway and reducing handover delays, and recruiting to substantive staffing model and using strategic provider partners.

All partners are committed that these risks could be further mitigated in the future by additional NHS or local authority budget growth not yet notified, such as continued Covid Hospital Discharge Funds, Comprehensive Spending Reviews announcements and understanding of recurrent impact of Health & Social Care Levy beyond 2024/25.

Discharge to Assess Pooled Budget/Governance Options

Under the recommendations of the latest Discharge to Assess Business Case the NHS will commit an additional recurrent funds of £12.0m per annum (93%) from April 2022 and also and additional £15.1m (£2.9m 21/22 and £12.2m 22/23) non recurrent transitional funding (as set out above), including all P1 – P3 'discharge to assess' capacity during the intermediate phase of care where NHS hospital capacity is not required but the assessment of need of statutory social care has not been completed; as well as net £2.6m for additional local authority social care commissioned reablement capacity. This is acknowledged as value for money as it mitigates the biggest clinical and operational risk facing the NHS and could help realise cash releasing savings to the NHS in the medium term. Local Authorities are requested to contribute a further £0.9m per annum (7%) from April 2022.

In order to maximise the likelihood of delivering the benefits set out in the case, and also to further the Healthier Together Partnership vision of integrated care to improve outcomes that matter to people, a new governance approach will be required. There have been some early conversations on the possibility of pooling budgets but these conversations need to continue and involve the Directors of Finance and Commissioning who can take a view on the benefits, risks and consider how future governance might operate. This would need to go through organisational decision pathways for sign off.

Acknowledging different current service configurations in the 3 main acute hospitals in BNSSG and 3 adult social care services in 3 local authorities, a pooled budget could be the best mechanism to balance risk and maximise impact across hospital discharge care in BNSSG.

The purpose would be to support:

- flexing resources between the different stages of the pathway eg. more P0 and P1 home first care leading to reduced P2 & P3 bed based care or vice-versa; depending on demand and

capacity
- flexing resources between different service need within the pathway eg. qualified therapy capacity, social worker capacity, rehab support capacity; as well as between in-house or externally commissioned capacity
- flexing resource between places as demand changes due to both hospital capacity & demand; and population need changes
- ensuring best practise is shared through the BNSSG partnership
- holding each other to account for delivering actions and benefits identified in the Discharge to Assess Business Case
- enabling transparent and fair sharing of financial risks between partners

Discharge services and pathways directly correlate the majority of the key metrics within the 21/22 Better Care Fund:

- Avoidable Admissions (out of scope of D2A, other than avoidable readmissions)
- Acute Hospital length of stay of 14days (in scope)
- Discharge to Normal Place of Residence (in scope)
- Residential Admissions (in scope)
- Reablement (in scope)

Therefore it will important to consider how any future governance interacts and aligns with existing Better Care Fund governance arrangements to align with the option, rather than develop an alternative form of governance.

Services within scope

A pooled budget/governance arrangement could include existing P0 budgets; P1-P3 budgets managed by Sirona, CCG and Bristol City Council; and adult social care reablement capacity managed by local authorities. It would not be envisaged to include long term domiciliary and residential and nursing care placements in adult social care and NHS CHC. The pooled budget could be for £12.2m transition/risk pool fund, or the baseline budget also. Consideration should also be given to transferring responsibility for provision of P3 beds from CCG to Sirona, to align with majority of P2 beds and ICB ways of working and offer maximum flexibility.

Timeframe

To provide certainty for procurement and recruitment, but also provide an opportunity for evaluation and exit, it is proposed to formalise an appropriate governance arrangement for 3years with effect from 1st January 2022, with a break clause at 1st April 2023.

Membership

Senior Responsible Officer from CCG.

Membership from senior Finance and Commissioning Teams from CCG, NSC, BCC and SGC; together with Sirona and Acute Hospital Operational Teams

The CCG will contribute the majority of funds, however the financial, clinical and operational risks and benefits impact Acute hospitals and therefore the CCG would require Acute hospital membership of a joint commissioning arrangement.

Measurement Framework

Evaluation and Measurement Framework

- An evaluation process was completed in Feb included as appendix 4.

Appendix 4 system evaluation

- Set of discharge guidance action cards has been developed to summarise responsibilities for key roles within the hospital discharge process. A self-assessment has been completed and allocated actions reviewed at OOHDG. These alongside the performance measures described within the key performance indicators will be reviewed monthly.

Appendix 3 action cards

- Implementation plan reviewed by Discharge B Case Review Group monthly.

Appendix 1 System Implementation plan

- Review of pooled budget monthly

Appendix 2 investment plan

Key Performance Indicators

Lead Indicators / Key Performance

The following key indicators have been agreed and included within Investment plan trajectory . The table below shows data sets completed and used within performance management.

Table 4 data sources

Data Set	Measurement	Status
Single Referral Form (SRF) targets weekly	Admission to SRF SRF to discharge	Agreed completed
MFFD daily, daily criteria to reside	Numbers of pts MFFD Number of pts over 21 days	Agreed completed
Right to Reside	Number of patients	Agreed completed
Alamac daily Sirona report on capacity	Numbers of D2A referrals and slots allocated	Agreed completed
Weekly Sirona D2A outcomes report LA p3 bed occupancy report	Bed occupancy Referrals taken Outcomes LOS Delays	Agreed completed
LA outcomes	LA outcomes	Work in progress

Timescales (Tasks and Milestones)		
Milestones and Tasks Verto includes a list of milestones and targets for each of the task groups that sit under Out of Hospital delivery group. Appendix 1 implementation plan The below list draws out the key milestones required for delivery.	Start date	End date
Complete PPI following sign off of QIA and EIA meeting held and actions agreed	July 21	Nov 21
Funding agreed historical gaps identified within BCC and BCF and Sirona transfer	May 21	Oct 21
Managing workforce and therapy acute/community balance supported by NHSI	March 21	Dec 21
review options for the creation of a single/ pooled budget and review how we prioritise	Sept 21	Dec 21
Acute bed release and what these will be reused for; what the long term plan allocations are likely to be	July 21	Oct 21
Development of Dom care market for the system – including who funds it	July 21	Jan 22
Acute improvements on admission to SRF	July 21	Dec 21
Review of community Strategic estates to include current beds e.g. Clevedon	Sept 21	March 22
Recovery/recuperation and resilience verses rehabilitation of older people leaving hospital needs consideration (realism and expectation)	April 21	Dec 21
Commissioning of specialist Mental Health Services for post hospital care is a critical gap	July 21	Dec 21

Risks and Issues		
Please describe how risks and issues have been identified and the relevant mitigating actions as appropriate.		
Description of risk / issue	Mitigating Action (Inc. date due)	Impact if not mitigated
Delays in the community due to extended delays over 10 days P1, 21 days P2 and 28 days P3	Standard Operating procedure agreed across all partners Weekly stranded reviews Ongoing	LOS increased in community causing a backlog of delays in pathways
Recruitment of staff to support D2A model both in health and social care services	Staff adverts rolling programme Training posts offered. Work with BNSSG workforce cell. Ongoing	vacancies within services to support flow
Risks of community outbreaks	ensure flexibility remains with a list of preferred providers	Loss of capacity
long term care package costs not reduced	Work with LAs to support with government social care investment	Long term savings not released
Need further harmonisation of Sirona pathway delivery including CICCBs	robust operational plan with reporting to oversight group on progress or escalation of issues	Lack of efficiency within pathways

Resourcing Requirement	
Name	Role
Julie Kell	Programme Manager
Jon Lund	Finance Lead
Xxxxx xxxxx, xxxxx xxxxx, xxxxx xxxxx	Business Intelligence Lead

Paul Forte	IPACS modelling
Xxxxx xxxxx, Anne Clarke, xxxxx xxxxx,xxxxx xxxxx, xxxxx xxxxx, xxxxx xxxxx, xxxxx xxxxx	LA leads
xxxxx xxxxx, xxxxx xxxxx	Acute Leads
Lisa Manson	Executive Lead

Stakeholder Analysis

Stakeholders

- Community services
- Acute clinical staff
- Local Authorities and Adult Social Care
- Clinical Commissioning Group
- Care Providers
- Primary Care
- Pharmacy Leads
- Voluntary sector

Communications Plan on Engagement and Frequency

The table below identifies key stakeholder groups and frequency of engagement

Governance

Project Governance

The D2A Delivery Board will be chaired by the Executive Lead reporting into Planning and Oversight and Integrated Steering Group

Group	Includes	Frequency
D2A Delivery Board	Acute, Community partners, CCG, Social Care	Monthly
OOHDG	Acute, Community partners, Continuing Healthy Care, Social Care and Voluntary Sector, BI	Weekly
Capacity and demand	As above	Twice a month
Healthier Together including Integrated Steering Group and transformation.	As above	Attended March 21
Finance and Analytics	Finance colleagues across system	Attended July 21
Planning and Oversight Group	Senior leads across the system	Monthly
Primary Care Cell	Primary Care Colleagues across BNSSG	Attend every 3/12

Project Impact *(Please attach the relevant completed Impact Assessment form to fully support this Business Case).*

Equality Impact Assessment
The Equality impact assessment has been completed and signed off and noted that the implementation of the Out of Hospital programme of work should not discriminate against people of protected characteristics

BNSSG OOH EIA SIGNED OFF.docx

Quality Impact Assessment

The enclosed QIA clarified that People should expect to receive high quality care from acute and community hospitals, including regular and open sharing of information on the next steps for their care and treatment, as well as clarity on plans and joint decision making processes for post-discharge care.

00. OOH QIA V1.0 SIGNED OFF.docx

PPI Assessment form

Work has been completed on the PPI and meetings held. However, the form cannot be submitted until the QIA signed. This is expected in 2/52. Health Watch will be starting a patient and staff review of P3 beds at the end of October 2021 which we will include within our assessment.

Legal and other Implications

The Out of Hospital Delivery Group has refreshed the Managing Expectation and Choice Policy. Although developed using the guidance of the Discharge Requirements documentation, the system is requesting that oversight is provided by one lead across BNSSG.

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Equality Impact Assessment

Programme name:

Out Of Hospital (OOH)

Follow the steps in this document and complete all the fields as fully and accurately as you can, and you will have a comprehensive equality impact assessment. By completing this template you will have assessed the impact on people protected characteristics and those who experience health inequalities and socio-economic deprivation; this is a key part of your project and it will be used to inform the decision making process.

Please Note: As a standalone document this Equality Impact Assessment (EIA) should have an overview of what the service is, including its purpose and benefits, it should make reference to studies, record what engagement has taken place (can be meetings, focus groups, clinical advice, patient feedback, stakeholder review, national studies, JNSA data), and include impact on each protected characteristic etc.

To comply, the project manager and the decision maker has to demonstrate at the time of planning/decision they had due regard to eliminating discrimination, advancing equality and fostering good relations for all protected characteristics, this can best be demonstrated if the writer includes:

1. A statement of the evidence/ information used for choosing the characteristics to focus on and identifying relevant equality issues (summary section – i.e. there might be a group/s that need more focus than others due to their challenges and likely impact)
2. A statement of people who you consulted/engaged with in completing the EIA
3. A brief description of the project, policy or practice which your EIA is concerned with
4. Some assessment of whether the issues you have identified represent (actually or potentially) positive, negative or neutral impacts in relation to the Public Sector Equality Duty (PSED) - Section 149 of the Equality Act 2010
5. A statement of how the project, policy or practice has been designed or amended to date in response to the equality issues identified (or not)
6. Some assessment of the legality of the project, policy or practice in relation to the PSED (could it discriminate unlawfully or help to advance equality of opportunity, foster good relations - Relevance to the Public Sector Equality Duty section Q7-9)
7. Some recommendations for the decision-maker in response to your findings eg: No major change, adjust the policy or practice, continue it, stop and remove it – and name the decision maker (e.g. Governing Body)

Part 1 and Step 1 – Initial Equality Impact Assessment Form

- When completing this form, please use simple and accessible language – NO JARGON
- Please complete all the fields in this section with the relevant information
- Complete all the fields in the form. If you are missing some information, include reference to that and come back to complete that section when you have more details

- Extend acronyms to full the first time you reference them in your text. For example, Clinical Commissioning Group (CCG)
- Revisit this EIA throughout the project to update it and ensure it reflects any changes or amendments to the original proposal

Introduction

Healthier Together partners must discharge the Public Sector Equality Duty by ensuring that all 'policies' including commissioning decisions, policy, service design and practices do not directly or indirectly discriminate against individuals with one or more protected characteristics outlined in the Equality Act 2020. They are age, disability including physical and mental impairment, gender reassignment, marriage and civil partnership, pregnancy and maternity, race including nationality and ethnicity, religion or belief, sex, sexual orientation.

There are three aims under the PSED, which public sector organisations must have due regard to:-

- Eliminate conduct that is prohibited by the Act, including discrimination, victimisation and harassment
- Advance equality of opportunity between persons who share a relevant protected characteristics and those who do not share it and to
- Foster good relationships between persons who share a protected characteristic and those who do not (particularly to the need to tackle prejudice and promote understanding)

In addition, under the NHS Constitution, the Equality Act and Health & Social Care Act 2012 the health service must also have due regard to the need to reduce health inequalities.

The CCG's duties extend to the rights of the public to have the ability to access information on an equal basis and to have reasonable adjustments made to cater for a disability.

The purpose of this EIA is to enable the CCG to assess the effects that our policies, projects, practices and decisions are likely to have on vulnerable and seldom heard communities and/or our workforce during the COVID-19 pandemic. This template is partially completed to help the writer; but it must be amended and further developed to suit their needs.

This exercise acknowledges that the COVID-19 outbreak will affect people and their communities differently, and for some groups the impact will be more severe than that experienced by the general population as a whole; and that there is the potential of worsening health inequalities. Equitable decision-making is still a key priority for Bristol, North Somerset and South Gloucestershire (BNSSG) CCG.

Research evidence

Organisations have conducted a number of studies into the disproportionate impact of COVID-19, which have been referenced in the EIA, two notable bodies of work are:-

Bristol City Council's rapid review report brings together insight from a number of studies to date.

The Public Health England report Disparities in the risk and outcomes of COVID-19 corroborates what has already been recorded and identifies the following groups as being disproportionately impacted – males, those aged 80 or older, those living in more deprived areas and those from Black, Asian and Minority Ethnic (BAME) communities. The report highlights challenges including language barriers, cultural differences, the link to comorbidities, socio-economic factors (housing, employment, education etc). However, the study was not able to control for pre-existing conditions like diabetes and hypertension nor did it control for age, location, role etc. for staff such as nurses. Therefore, there could be other risk factors at play. The writer is advised to consult local demographic data and other sources of data to build a picture for the cohort they are assessing when completing this EIA template (please refer to the appendix).

Follow the steps in this document and complete all the fields as fully and accurately as you can, and you will have a comprehensive equality impact assessment which will be used to inform the decision making process.

Completing the screening EIA

1. What are the main aims, purpose and outcomes of the proposal?

Describe the policy/practice being developed and reviewed. Think about: What is the purpose of the policy or practice? In what context will it operate? Who is it intended to benefit? What results are intended and why is it needed.

The purpose of this EIA is to enable the CCG to assess the effects that our policies, projects, practices and decisions are likely to have on vulnerable and seldom heard communities and/or our workforce during the COVID-19 pandemic.

This proposal will assess the impact of projects under the OOH Programme to ensure that there is no direct or indirect discrimination against individuals with one or more protected characteristics and advance equality of opportunity and foster relationships between on group and another where possible, as outlined in the Equality Act 2020. This proposal will also highlight any potential risks for protected groups and specify mitigating actions for resolution.

As a result of the COVID-19 pandemic, the aim of the Out of Hospital programme of work under Integrated Care is to enable a safe and timely hospital discharge of patients to the most appropriate discharge destinations. This includes COVID positive patients.

There are many workstreams to the Out of Hospital Programme of work but there are common themes to each of these and this EIA will be the overarching EIA for these workstreams. The current workstreams include:

- Pathway redesign
- Capacity & modelling work
- Implementation of the patient testing guidance
- Reporting
- Development of financial agreements for COVID 19 expenditure
- Supporting the work of care homes

COVID-19 Hospital Discharge Service Requirement sets out requirements for all NHS trusts, private care providers of acute, community beds & community health services and social care staff in England around discharge. This includes pathway redesign of some services to free up at least 15,000 beds, identifying extra capacity, changes in funding arrangements of new or extended out of hospital care and social care support packages and change in reporting of hospital delays.

This document can be found here:

COVID-19_hospital_
discharge_service_re

Patient Testing Discharge Guidance into Out of Hospital Care Provision on testing ALL residents prior to admission to care homes is described here:

covid-19-adult-soci
al-care-action-plan.p

BNSSG system has developed local guidance on patient testing, which is described in this document:

Discharging to care providers (002).pptx

2. Does this Proposal relate to a new or existing programme, project, policy or service?

This proposal relates to existing programme of work under Integrated Care.

3. If existing, please provide more detail

What results are intended and why is it needed?

- To support the discharge of ALL individuals from all hospital beds throughout BNSSG
- Voluntary care support for people leaving hospital including advice, signposting or mutual aid support including shopping, pharmacy support will be accessed based on need
- Standardised approach for all to COVID testing across community in BNSSG
- Safe & clinically led criteria for zoning of patients leaving hospital
- Radical reduction in Medically Fit For Discharge and stranded patients both within acute and community services
- Sharing of capacity right across BNSSG
- Movement of teams out to community (Integrated Care Bureau, Continuing Healthcare Teams) to support discharge process across the patch
- Identify gaps in service provision across BNSSG
- Joint pathway redesigns to enable standardised approach

4. Outline the key decision that will be informed by this EIA

The implementation of the Out of Hospital programme of work should not discriminate against people of protected characteristics

5. Does this proposal affect service users, employees and/or the wider community?

Provide more information on: Potential number of people affected, potential severity of impact, equality issues from previous audits and complaints. The key decision that will be informed by this EIA

Yes

6. Could the proposal impact differently in relation to different characteristics protected by the Equality Act 2010?

Assess whether the service/policy has a positive, negative or neutral impact in relation to the Protected Characteristics.

- **Positive** impact means reducing inequality, promoting equal opportunities or improving relations between people who share a protected characteristic and those who do not
- **Negative** impact means that individuals could be disadvantaged or discriminated against in relation to a particular protected characteristic
- **Neutral** impact means that there is no differential effect in relation to any particular protected characteristic

Age (Positive, Negative, Neutral)
Is the impact positive, negative or neutral?

Negative & positive:

- Shielding based on clinical evidence only. However older people may find social isolation more challenging than younger generation

Please provide reasons for your answer and any mitigation required

Some older people may have multiple health and care needs; this could include physical disability, long-term health conditions, a history of dementia, Alzheimer's or stroke; they might not speak English or limited English and live alone or in care homes or environments where they are at greater risk. This group might find it difficult to cope with change and adhere to restrictions due to poor memory or lack of understanding. It is important to have support from family, carers or the health and care system to help share information, encourage hand hygiene and social distancing and support from voluntary groups who are delivering medicines and groceries. Information in easy read format and large print, and information targeted at their support and care network is important. AgeUK has identified a digital divide in later life, only 33% of adults over 75 use digital technology "Three out of ten people aged 65 to 74 and two-thirds of those aged 75 and over are not online. There is also a link to socioeconomic disadvantage. For example, while only 15 per cent of people aged 65 to 74 in socio-economic group AB* do not use the internet, this rises to 45 per cent in group DE**". Therefore, enlisting the support of other media like newspapers, radio and television is important for this group.

Social Economic Classification:

*AB: Higher & intermediate managerial, administrative, professional occupations

**DE: Semi-skilled & unskilled manual occupations, Unemployed and lowest grade occupations

Health and care staffing levels are reduced due to sickness and mobilisation of workforce into different areas could lead to leaving the older and disabled populations vulnerable in other ways.

Bristol & South Gloucestershire have a high student population, however many students will have returned to their permanent homes and back to parents but there are some who are still living in student accommodation. Messaging regarding Covid-19 needs to consider how young people are responding to public campaigns particularly as this is seen to be a disease that is predominately affecting older people.

Young families, particularly children who rely on school meals may be worse off now that the schools have been closed, and families will be in a poorer economic position where parents have been furloughed or made redundant. This is further negatively impacted by the reduction in food supplies available at Foodbanks.

Children with special educational needs and their families will be particularly challenged due to the closure of schools.

A number of schools have remained open to support key workers, this could be a route to disseminating information to parents of young children.

* Under-18s are only protected against age discrimination in relation to work, not in access to services, housing, etc. Children's rights are protected by several other laws and treaties, such as: The Children Act; the Human Rights Act 1998; the UN Convention on the Rights of the Child; the European Convention on Human Rights; the UN Convention on the Rights of Persons with Disabilities; and the UN Convention on the Elimination of Discrimination against Women

Disability (Positive, Negative, Neutral)

Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty/ Disability; Long-Term Condition

Is the impact positive, negative or neutral?

Negative & Positive:

- Ability / capacity to understand risk discussion
- Ability to self-isolate
- Ability to comply with Infection & Prevention Control (IPC)
- Identified gap in service provision for highly complex patients, which has been addressed ; whilst recognising the need for further assessment of available provision for this specific cohort of patients

- All care home providers have access to the national guide and are capable of interpreting the guide in a way that does not discriminate against anyone
- Care home providers are monitored by CQC to ensure they remain well led
- For any pathway redesign Trusts are party to the NHS Full Standard Contract which duplicates the law – Section 13 of the Service Condition states the provider must:

  ✓ Not discriminate between or against service users, carers or legal guardians on the grounds of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, sexual orientation, or any other non-medical characteristics, except as permitted by Law.

  ✓ Must provide appropriate assistance and make reasonable adjustments.
  ✓ In performing its obligations under this Contract the Provider must comply with the obligations contained in section 149 of the Equality Act 2010 (General Duties), the Equality Act 2010 (Specific Duties) Regulations and section 6 of the HRA. If the Provider is not a public authority for the purposes of those sections it must comply with them as if it were.
  ✓ In performing its obligations under this Contract, the Provider must use all reasonable endeavours to support the Commissioners in carrying out their duties under the 2012 Act in respect of the reduction of inequalities in access to health services and in the outcomes achieved from the delivery of health services.

  - The BNSSG system has identified an increase in the number of patients with a high level of need during COVID pandemic. As a result of that the Out Of Hospital Group has agreed to undertake a deep dive exercise to gain a better understanding of the pre-COVID flow for this specific cohort of patients & to ensure that there is the right level of wrap around in the teams to improve the flow.

Please provide reasons for your answer and any mitigation required

Those with disabilities, particularly sensory impairment, learning disabilities and poor mental health are also at great risk. Health and care staff must consider their organisation's legal duty to provide reasonable adjustments

People who are deaf or who have a hearing impairment

Deaf people may have a limited understanding of spoken English and will require information in British Sign Language. In comparison to mainstream information, there is very little available in BSL to support this group. In addition, not all deaf people, particularly older people, will have access to digital media or the skills to navigate devices. Deaf people could have less direct access to family and friends who would usually assist with communication due to social distancing, particularly when engaging with key support and health and care workers. People who are profoundly deaf rely entirely on ball and there must be interpreter services easily and quickly available if necessary. As a result, this group

could be at increased risk of isolation and loneliness. People with a hearing impairment will struggle with communication with people who are wearing face coverings as lip reading and reading facial expressions is a major method of communication. Equally having to be 2 metre from someone may limit what they can hear even with hearing aids. Many people with a hearing impairment who are older also do not access digital technology and cannot access forms of media and communication such as radio and television. For both Deaf people and people with a hearing impairment care needs to be given in communicating the C19 testing process if required as it is difficult and invasive.

Resources like InterpreterNOW app can assist with communication with services like NHS111. Health and care staff are likely to be wearing PPE during appointments which will prevent Deaf or deaf people from being able to lip read, clear face masks suitable for clinical use are being developed.

People with a visual impairment

Three-quarters of people with a visual impairment are over 65 and are partially-sighted not blind. A significant number of people with a visual impairment do not access digital technology. Their preferred form of communication is either in written format in large-print – font-size 14 and above – or by telephone. Much of their access to information is through the television, radio and the local newspaper. Most people with visual impairments live independently supported by friends or family, but this is not possible during COVID-19. There is therefore significant increase in mental and emotional distress and social isolation. Many people with visual impairment struggle with social distancing not being able to judge distances or not being able to be guided physically. This is leading to many people refusing to go outside and losing confidence. Information in braille, audio and electronically may be required. Care needs to be taken in communicating the C19 test as it is stressful and invasive.

Learning Disabilities & Neuro-diversity (Autism/ADHD)

COVID-19 information is complex and rapidly changing, this can be difficult to comprehend and keep track of. Inconsistent messaging from various sources, lack of direct instructions and use of metaphors adds complexity. This group has communication support needs and information in large print, easy read and Makaton can support as well as targeted messaging to family and carers.

People with learning difficulties or neuro-diversity may not cope well with change and the disruption might cause long-term negative impact to their emotional wellbeing and mental health beyond the pandemic. Many will be following the news and social media but will not have the coping mechanism to process this. Our Covid Voices has published a collection of first-person accounts that provides some indication of how this group is feeling.

Gender Reassignment (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Neutral:

- There is no gender differentiation when planning onward care out of hospital

Please provide reasons for your answer and any mitigation required
Gender reassignment refers to people who have either undergone, intend to undergo or are currently undergoing gender reassignment (the medical and surgical treatment to alter their body) and also individuals who do not intend to undergo surgery but wish to live as a different gender than their gender at birth. These people self-identify as transgender or trans. Transgender people are protected under the Equality Act 2010 on the basis of gender reassignment or disability. Some transgender people have applied to receive a Gender Recognition Certificate (GRC) under the Gender Recognition Act which gives them legal recognition according to their acquired gender in most situations.

Transgender people face health inequalities and have poor health outcomes when compared to the non-transgender population. According to the LANCET Journal inequalities faced by transgender individuals in societal aspects and policy making based on binary gender norms could increase the risk of illness and mortality during the COVID-19 pandemic. In addition, most hospitals are likely to have cancelled elective procedures due to capacity issues and resource allocation because of the pandemic and there may be a lack of access to specialised drugs, hormone therapy or delayed surgery which may lead to increased anxiety. The report goes on to say it is likely that transgender individuals are also facing mental health challenges.

Some members of this community may have no links with their family, thus exacerbating a sense of isolation. Bristol City Council report Social isolation, gender and sexual orientation cited that transgender youth were vulnerable, not because they were transgender; they were unable to cope with the social shame and isolation; the report went on to say that elderly transgender people were twice as likely to live alone and many are estranged from their biological family.

Stonewall stated in their LGBT in Britain Trans report (2018) that transgender people are also likely to face discrimination because of their gender identify and feel unsafe in public. They are also less likely to have a positive experience in a health and care setting; 2 in 5 transgender people felt healthcare staff lacked understanding of trans health needs.

Race Including nationality and ethnicity (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Neutral & positive:

- There is no racial differentiation when planning onward care out of hospital
- BAME people are more adversely affected by COVID-19 therefore the use of the translation services / advocacy has been implemented across all 3 trusts & by Sirona, as required.

Please provide reasons for your answer and any mitigation required

Public Health England have published their report which supports the initial data which indicated that the BAME community are at greater risk of contracting the virus. This could be linked to health factors such as comorbidities (prevalence of underlying health conditions like diabetes, cardiovascular disease, obesity); socio-economic factors (housing, education, employment/low paid work, built environment, lack of wealth) and cultural vulnerabilities (multi-generational housing, faith gatherings). The number of BAME people who hold frontline jobs (and experience increased viral loading) is a factor, 1 in 5 NHS staff are BAME. NHSE have released data on people who have died as a result of COVID-19 as at 17.04.2020. Of the 13,918 people recorded, the ethnicity 12,593 is known. 81% are white and 19% white mixed and BAME.

Loss of self-employed income will also impact the BAME business community who will have smaller businesses and will have challenges around communication needs and timely access to useful accurate information and alternative sources of aid.

Some BAME communities, particularly those who speak English as a second language or don't speak English at all, will have limited or no access to key health and care messaging. Some people may be seeking information from other sources in their own language, potentially abroad to compensate for the lack of information from official sources in a format they can understand.

Religion or Belief (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Positive:

- Providers are expected to make reasonable steps to enable patients and their families to observe their religious practices, the following mechanism provides some assurance to the CCG:
- Under Section 14 of the Service Condition the Provider must take account of the spiritual, religious, pastoral and cultural needs of Service Users. Section 15 and 16 sets down conditions for mental health needs and managing complaints

- Consideration must be given in terms of accessing technology to enable non face to face appointments & the ability to use them

Please provide reasons for your answer and any mitigation required
For all groups irrespective of ethnic or religious background, there will be challenges around funeral arrangements, registering deaths if self-isolating, paying funeral costs and any restrictions placed around attending. There is a role for pastoral or similar care to play in supporting all groups.

Race and religion may be closely linked, these communities often have some form of religious association. Health and care staff must be aware of cultural norms around last rites, burial and funeral arrangements amongst different cultures and religions and support the family and their religious leader to navigate any changes in practice or to clarify any 'transmission based precautions'.

Lastly, religious gatherings are currently suspended and therefore cultural and religious norms have been disrupted. There will be other major religious events in the coming months (Jewish Lag B'omer in May, Eid in June, Hindu festival of Diwali in November, etc.).

Sex (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Neutral:

- Sex is not a factor when designing / planning onward hospital care

Please provide reasons for your answer and any mitigation required
Women – Women are more likely than men to have part time or casual employment due to care responsibilities. There is a potential for discrimination if women are furloughed or redeployed based on their caring responsibilities.

Men – As a result of loss of income, a limited number of self-employed individuals will not qualify for aid, for households where men are the primary or only income earner this will result in hardship. National and international evidence is emerging that the mortality / morbidity rate for men is greater than for women.

Both men and women may experience mental health issues including stress, anxiety and depression because of their unique challenges. COVID-19 affects the mental health of men and women in different ways the intervention must also be gender specific.

Sexual Orientation (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Neutral:

- Sexual orientation is not a factor when designing / planning onward hospital care
- People who are LGB can experience prejudice in many spheres of public life including the health and care sector from members of the public and potentially from staff. Providers have policy in place to support staff and patients who might face discrimination.
- Under the NHS Standard Contract providers must have due regard to the Public Sector Equality Duty (general and specific duties) and must therefore eliminate unlawful direct and indirect discrimination, there is also a duty to foster good relationships between one group and another.

Please provide reasons for your answer and any mitigation required
Neutral direct impact for this group compared with others, research has shown people who identify as lesbian, gay, and bisexual (LGB) are more likely to experience some common mental health challenges, possibly due to a history of discriminatory experiences. The Government national survey indicates that 24% of respondents had accessed mental services in the 12 months leading to the survey.

Pregnancy and Maternity (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Positive & neutral:

- There is no differential effect in relation to pregnancy & maternity by the proposed changes in the Out of Hospital Programme of Work
- Consideration must be given in terms of accessing technology to enable non face to face assessments / consultations

Please provide reasons for your answer and any mitigation required
According to the Royal College of Obstetricians and Gynaecologists guidelines pregnant women are not at greater risk if they contract COVID-19, however pregnancy alters the body's immune system and response to viral infections in general; there is no evidence that there would be adverse sickness or death in this group, compared to non-pregnant women. This group may be vulnerable when needing access to healthcare, midwifery and travelling to hospital appointments, e.g. intermittent appointments for scans.

There may be additional concerns about options for delivery (e.g. birthing pools) and about the safety of delivery rooms and other birthing environments. Women are potentially uncertain about the risks to themselves and their baby in the absence of strong evidence.

Marriage & Civil Partnership (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Neutral:

- There is no differential effect in relation to marriage and civil partnership by the proposed changes in the Out of Hospital Programme of Work

Please provide reasons for your answer and any mitigation required
Neutral impact when compared to the rest of the population. Cancellation of ceremonies is primary concern for this group.

Health Inequalities (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Positive & Negative:

- Identified gap in service provision for highly complex patients, which has been addressed ; whilst recognising the need for further assessment of available provision for this specific cohort of patients
- There are known health inequalities in terms of access to health services e.g. socio-economic factors , deprivation
- Consideration is being given to the prioritisation of people with known health inequalities e.g. learning difficulties and severe and enduring mental health

Please provide reasons for your answer and any mitigation required
Women, low waged workers, micro-sized businesses, and the casual employment sector (e.g. gig economy) will be significantly impacted. Some businesses will benefit from financial relief schemes, however not all may qualify; unemployment figures have risen and staff have been furloughed. It is anticipated as lockdown eases those who have needed to take a freeze in mortgage payments and rent may have subsequent financial difficulties and may face losing their home. As employers are asked to contribute to furlough payments from August, this might result in further job losses.

There are historic health inequalities that still exist. Poor housing conditions, low income and access to food and healthy nutritious food remains a challenge. The health and wellbeing of people in deprivation are negatively impacted by the wider determinants of health including housing, employment, education, access to social networks and lifestyles. Smoking, higher level of alcohol consumption, obesity and chronic health conditions are risk factors; in addition people with more limited financial means may use more public transport, and may therefore be at greater risk of contracting and spreading the virus.

Other groups to consider (Positive, Negative, Neutral)

Is the impact positive, negative or neutral?

Neutral & Positive:

- There is no differential effect in relation to other groups by the proposed changes in the Out of Hospital Programme of Work
- Consideration must be given to those other groups prior to discharge to ensure any housing or safeguarding concerns are raised & resolved in a timely manner

Please provide reasons for your answer and any mitigation required

Other groups that could be impacted by your decisions include:

- The homeless – high risk due to prevailing health issues (respiratory and cardiovascular disease, HIV, hepatitis, musculoskeletal disorders, poor mental health), lack of physical shelter, or living in temporary accommodation which prohibits shielding, low levels of literacy, substance dependency and other chaotic lifestyle factors, early death due to suicide.
- The traveller community – low levels of literacy, poor housing conditions, disengagement from mainstream services, poorer health outcomes, prevalence of lung/cardiovascular disease, service reduction due to COVID-19 that will impact wellbeing and health (schools, community centres, grass root organisations).
- Refugee/Failed Asylum seekers – Challenges include language barriers, insecure and poor housing, mental health problems and issues related to the process of seeking refuge. This group faces cultural challenges, prejudice and hostility; multiple support needs including access to legal advice might not be met. Failed asylum seekers can live in overcrowded and otherwise unsuitable accommodation, work illegally, are impoverished and on a low income; and are not registered in the health and care system. This group is particularly hard to reach as they are under the radar and fear ‘authority’ and risk of deportation. There is a risk of this group not seeking medical attention and difficulty self-isolating or shielding and very few agencies/organisations will have access to support messaging to this group.

- Domestic abuse victims – this is a particularly vulnerable group, there will still be a need for access to emergency accommodation, shelters, social service support and medical care. There is an increased risk of harm for victims who still live with perpetrators (individuals might be more reluctant to leave abusive relationships during this time of uncertainty and potential lack of alternatives).
- Prison population - The virus poses significant risk to the prison population. Prisons tend to be overcrowded environments; around 10% of the workforce are ill or self-isolating. Some low risk prisoners were released on ROTL (released on temporary licence) or early release to ease prison numbers. Mental health issues, respiratory disease, diabetes and substance dependency can prevail in this group. There may also be challenges around the level of literacy. Ex-prisoners will have likely experienced trauma, discrimination and social deprivation and will need community-based health and care.
- Carers - Carers will have added pressure because of reduced access to support systems (family, health professionals, care assistants and so on). Those with caring responsibility, potentially sandwiched adults (looking after children and older family members) who work remotely will be at a greater risk of developing poor mental health. Many people in the "Gig economy" are carers, this creates challenges around the continued need to support relatives, loss of income during self-isolation, loss of employment altogether or continuing to work with an increased risk of exposure.

Relevance to the Public Sector Equality Duty

Please select which of the three points are relevant to your proposal. There is a general duty which requires the system to have due regard to the need to:

7. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010?

Does this proposal address risk in relation to any particular characteristics? (Yes/No)

No

8. Advance equality of opportunity between people who share a protected characteristic and those who do not?

Will this proposal facilitate equality of opportunity in relation to particular characteristics? (Yes/No)

Please explain your reasons

Yes. This is by taking into account of the needs of those with protected characteristics when making the proposed changes and ensuring that their needs are met we will ensure that access to out of hospital services are the same for everyone.

9. Foster good relations between people who share a protected characteristic and those who do not

Will this proposal foster good relations between people who share a protected characteristic and those who do not? (Yes/No)

Yes. This is by taking into account of the needs of those with protected characteristics when making the proposed changes and ensuring that their needs are met we will ensure that access to out of hospital services are the same for everyone.

Please explain your reasons

Thank you for completing the screening EIA, by the end of the Screening you will have:

- Gathered and briefly analysed relevant data
- Decided if the policy will differentially impact any protected group
- Identified gaps in the data or the writer's knowledge that need to be addressed
- Completed the screening form and noted further actions to be taken
- Established if a Full EIA is required and the level of priority.

If there is at least one negative outcome or major change (e.g. to existing service, planning a new service, strategic planning) a FULL impact assessment is required and you must complete Part 2 of this document. This will also require some form of engage with stakeholders to test the policy or process including impact on those with protected characteristics and you will share the findings in the EIA. Online platforms can be used in a number of ways including focus groups, meetings and surveys.

Is a full Equality Impact Assessment required?

No

10. EIA Impact Assessment Approver(s)

Full Name: xxxxx xxxxx

Comments from Equality Lead
Date Approved

Email this document to the inclusion lead xxxxx.xxxxx@nhs.net for approval

Part 2: FULL EQUALITY IMPACT ASSESSMENT

Step 2: Scoping of the Equality Impact Assessment

This section of the form is about understanding how this proposal will impact different groups and individuals. A full EIA is likely to

EIA Status (New, Existing, Other, None)

What aspects of the project are particularly relevant to equality?
E.g. Policy statement or referral or access criteria, communication with patients, equity of access to service, patients experience or stakeholder engagement

What evidence is already available that will help in the development of both the project and the EIA?
Sources of data and information may include: Equality Monitoring Data, Demographic Data (Inc. Census), Recent and previous engagement work, Annual reports, Ad-hoc audits, Joint Strategic Needs Assessment (JNSA), Healthwatch reports, Patient Advice & Liaison Service (PALS), Complaints/Feedback, Equality Delivery System (EDS2) and similar work elsewhere.

Do you require further information to gauge the probability and / or extent of any adverse impact on protected groups? (Yes/No)
Think about how you might get this information. E.g. New consultation activities or benchmarking.

Which communities and groups have been or will need to be consulted or involved in the development /review of the project/service?
This will help to identify engagement opportunities set out in the Patient and Public Involvement Plan

Step 3: Equality Analysis

This section is about bringing together all of your equality information in order to make a judgement about what the likely effect of the policy, practice or service will be on the equality duty and whether you need to make any changes to the policy, practice or service.

Be wary of general conclusions. It is not acceptable to simply conclude that a policy will universally benefit all patients, service users or employees regardless of any protected characteristic, without having evidence to support that conclusion.
This section will detail the following:

- Actual or potential positive outcomes/impacts in relation to the public sector equality duty?
- Actual or potential negative outcomes/impacts?
- Actual or potential neutral outcomes/impacts?

Please state actions which have already been taken to remove or minimise the potential for adverse outcomes/impacts and to maximise positive outcomes/ impacts:
Consider the following questions in your response:

- Could the proposal disadvantage people from a particular group?
- Could any part of the proposal discriminate unlawfully?
- How does the proposal advance equality and foster good relations, including participation in public life?
- Are there other projects or policies that need to change to support the effectiveness of this proposal?
- Actual or potential neutral outcomes/impacts?

Assessment of the legality of the proposal - Consider the following questions in your response:

- Could the proposal disadvantage people with a particular protected characteristic?
- Could any part of the proposal discriminate unlawfully?
- Are there other proposals, projects or policies that need to change to support the effectiveness of this proposal?

What is the outcome of the Equality Impact Assessment?

No major change (Yes/No)
The EIA demonstrates the project plan is robust. The evidence shows no potential for discrimination and opportunities to promote equality have been identified and implemented

Adjust the project proposals/plan (Yes/No)
To remove barriers or to better promote equalities.
This might mean to introducing measures to mitigate the potential effect.

Continue the project (Yes/No)
Despite potential for adverse impact or missed opportunities to promote equality, provided you have satisfied yourself that is does not unlawfully discriminate

The EIA identified actual or potential unlawful discrimination (Yes/No)

Changes have been made to the project to remove unlawful discrimination.

Step 4: Monitoring, Evaluation and Review

This section is about looking at how the actual impact of the proposal will be reviewed regularly throughout the project life-cycle.

Provide details of how the actual impact of the project will be monitored?
Consider the following questions in your response:

- How you will measure the effects of the project?
- When the policy/ practice will be reviewed and what could trigger an early revision
- Who will be responsible for monitoring and review?
- What type of information is needed for monitoring and how often it will be analysed?
- How to engage relevant stakeholders in implementation, monitoring and review

Step 5: Decision Making

This EIA will be used to inform the decision making process. Use this section to record the relevant decision making information

Provide an outline of the decisions made relating to this proposal
Is the proposal going ahead as planned? If not, what is different?

How was this Equality Impact Assessment referred to in the final decision?
The system must demonstrate it has paid due regard to the conclusions drawn from this EIA, regardless of whether the impact is positive, negative or neutral. Please provide an explanation to accompany your response

Date the decision was made

Will this personal data include sensitive personal data? (Yes/No)

Full EIA Impact Assessment Approval – Please email xxxxx.xxxxx@nhs.net for approval

Full Name
Comments from Equality Lead
Date Approved

Appendix

The communities we serve

Bristol, North Somerset and South Gloucestershire has an estimated resident population of 915,500 people with 441,300 of this total living in Bristol which is the largest city in the South West, and currently the 8th largest city in England. Since 2001, the population of Bristol is estimated to have increased by 13.2%. This growth is double the average estimated increase for England.

The population of North Somerset at the 2011 Census was record as 202, 600 people. This represents an increase of 13, 766 (7.3%) from the 2001 Census. The current resident population of South Gloucestershire is around 271,600 people according to a 2014 mid-year estimate from the Office of National Statistics.

The CCG serves a diverse population across Bristol, North Somerset and South Gloucestershire, with some population highlights as follows:

Age:
Bristol's Joint Strategic Needs Assessment shows that Bristol has a relatively young age profile compared to the national average with higher proportions of people aged 16-24 years and lower proportions of people aged 45 and over. By contrast North Somerset and South Gloucestershire's population is slightly older when compared to the rest of England which currently stands at 17.6%.

Ethnicity:
BME (Black and Minority Ethnic) communities in Bristol make up 17% of the total population, with 28% of all school pupils coming from BME backgrounds. For North Somerset and South Gloucestershire, BME communities make up 2.7% and 5% of the population respectively.

Religion & Belief:
Christians represent the largest religious group in Bristol (46.8%), North Somerset (61%) and South Gloucestershire (59.6%). The second largest group stated that they have no religion making up 37.4% of the population of Bristol, 30% of North Somerset and a third of the South Gloucestershire population.

Disability:
The proportion of people with life limiting long term illness or disability make up 17.6% of the population of Bristol, 19.2% of the population of North Somerset, and18% of the population of South Gloucestershire.

Other useful resources

Organisation	Website
Healthwatch National Reports Library	https://www.healthwatch.co.uk/reports-library
Joint Strategic (JSNA)	Bristol: https://www.bristol.gov.uk/policies-plans-strategies/joint-strategic-needs-assessment South Glos: https://www.southglos.gov.uk/community-and-living/stronger-communities/community-strategy/joint-strategic-needs-assessment-jsna/ N Somerset: https://www.n-somerset.gov.uk/my-council/statistics-data/jsna/joint-strategic-needs-assessment/
Public Health England	https://www.gov.uk/guidance/phe-data-and-analysis-tools https://healthierlives.phe.org.uk/topic/public-health-dashboard#par/cat-39-4/sim/cat-39-4/are/E06000023/ati/102
NHS National Staff Survey	http://www.nhsstaffsurveyresults.com/national-trend-questions/ http://www.nhsstaffsurveyresults.com/national-breakdowns-questions/
King's Fund Future Trends	https://www.kingsfund.org.uk/projects/time-think-differently#trends
NHS Digital UK population's health	https://digital.nhs.uk/data-and-information/data-insights-and-statistics/population-health-team
Bristol City Council	https://www.bristol.gov.uk/statistics-census-information/new-wards-data-profiles https://bristol.opendatasoft.com/pages/homepage/
Bristol Race Equality Manifesto Leadership Group Public Sector Data	https://www.bristol.gov.uk/documents/20182/2979159/Race+Equality+Data+Report.pdf/c17dd489-3149-0660-609b-b3995cd2c2f0

System and Organisation resources

The following groups and sources of data can also add rich evidence to your work:-

- Comparison of similar policies
- Recommendations from Inspections and Audits
- Service uptake, level of DNAs etc
- Ethnic monitoring, collection and analysis
- Disability monitoring, collection and analysis
- Service monitoring reports
- Patient satisfaction surveys
- User feedback e.g. exit interviews for patients and staff
- Complaints, Comments and Incidents
- Workforce data including staff surveys
- Staff networks, or All staff
- HR function
- Equalities Lead
- CCG Board members
- Citizen Panel survey results
- Suppliers and contractors
- Outcome from consultations with different stakeholder groups
- Feedback from focus groups
- Feedback from representative organisations like unions, Age Concern, VSO etc.
- Reports by other organisations, academic studies and research teams
- Pilot projects

Contact us:

Healthier Together PMO Office, Level 4, South Plaza, Marlborough Street, Bristol, BS1 3NX

bnssg.htpmo@nhs.net

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Quality Impact Assessment Discharge to Assess Model

Programme's name: Out of Hospital Delivery Group

November 2021

Review Date: May 2022

Quality is defined in terms of three domains:

- Patient safety (doing no harm to patients)
- Patient experience (care should be characterised by compassion, dignity and respect);
- Effectiveness of care (to be measured using survival rates, complication rates, measures of clinical improvement, and patient-reported outcome measures)

The quality and safety domains should be used to outline the details of the potential impacts of the plans on quality.

Version Control			
Version Number	Author	Purpose/Change	Date
V 0.1	xxxxx xxxxx	Version 0.1 created	01/10/2020
V 0.2 – V 0.11	xxxxx xxxxx	Initial updates included from xxxxx xxxxx & Julie Kell	
V 0.12	xxxxx xxxxx	Update to incidents section from xxxxx xxxxx	17/11/2020
V 0.13	xxxxx xxxxx	Update provided to section 3 & risks	19/11/2020
V 0.14	xxxxx xxxxx	P3 provider Letter added	23/11/2020
V 0.15	xxxxx xxxxx	Inclusion of comments relating to the Managing Expectations protocol & infection control	21/11/2020
V 0.16	xxxxx xxxxx	Inclusion of P3 leaflets and action log updated	26/11/2020
V 0.17	xxxxx xxxxx	Updates included to question 16 from xxxxx xxxxx	26/11/2020
V 0.18 – V 0.21	xxxxx xxxxx	Updated to include comments from xxxxx xxxxx, xxxxx xxxxx & Julie Kell	
V 0.22	xxxxx xxxxx	Updated to include comments from xxxxx xxxxx	23/11/2020
V 0.23	xxxxx xxxxx	Updated to include comments from xxxxx xxxxx	02/03/2021
V 0.24	xxxxx xxxxx	Updated to include comments from xxxxx xxxxx relating to the serious incidents & complaints sections	22/03/2021
V 0.25	xxxxx xxxxx	Updated to include comments from xxxxx xxxxx concerning the complaints section	02/07/2021
V 0.26	xxxxx xxxxx	Sirona Quality Schedule added	21/07/2021
V 0.27	xxxxx xxxxx	Updated to include comments from xxxxx xxxxx relating to the complaints section	06/10/2021
V 0.28 – V 0.32	xxxxx xxxxx & xxxxx xxxxx	Inclusion of the Exec Summary & updated appendices	08/10/2021 15/10/2021
V 0.34	xxxxx xxxxx & xxxxx xxxxx	Appendix 7 – BNSSG CCG Managing Expectations of Patient Choice v15.	25/10/2021
V 0.35	xxxxx xxxxx	Comments included by xxxxx xxxxx	01/11/2021
V 0.36	xxxxx xxxxx	Final comments from Julie Kell included	01/11/2021
V 0.37	xxxxx xxxxx	Embedding of policies within document	04/11/2021
V1.0	xxxxx xxxxx	Version signed off by the Out of Hospital Group	12/11/2021

Executive Summary

As a result of the COVID-19 pandemic, the aim of the Out of Hospital (OOH) programme of work is to enable a safe and timely hospital discharge of patients to the most appropriate discharge destinations. This includes COVID positive patients.

Health and social care systems are expected to build upon the hospital discharge service developed during the COVID-19 response, incorporate learning from this phase, and ensure discharge to assess processes are fully embedded for all people aged 18+.

A Discharge to Assess (D2A) Business Case *(please refer to* ***Appendix 1 – Discharge to Assess Business Case*** *for more details) is* being developed to formally request the Healthier Together to approve the D2A model on a permanent basis and align funds to ensure the transition to March 2023. The paper sets out the agreed vision and proposed deliverables, which are to transform how the transfer of people from hospital to community based support will be managed through a discharge-to-assess approach.

This assessment highlights that patients 'safety & clinical outcomes may be at risk due to the organic nature of the pandemic and other external factors delaying discharge process on a D2A pathway.

The Out Of Hospital Programme provides reassurance that any recent or future changes in discharge process underpinned by the national legislation are implemented accurately ensuring safe discharges.

This document demonstrates the need to produce a QIA Action Plan to tackle some key challenges and to undertake a full Patient & Public Involvement exercise. The QIA Action Plan will be added to the OOH Action Plan for monitoring purposes.

The OOH QIA Action Plan would cover the following actions:

- To agree a plan that requires a robust agreement on provider responsibility for patient and incident reporting throughout discharge
- Thematic review of top complaints around patient discharge from UHBW & NBT, which will be part of the PPI exercise
- To ensure that patient letters & P3 leaflets from the Managing Expectations protocol are available and handed out in different languages to reach our Black, Asian & Minority Ethnic) BAME communities
- Clear timeframes to be identified when risks to patients will be reduced
- QIA to be reviewed in 6 months' time

Introduction

D2A is a process designed to rapidly discharge 95% people from hospital once it is medically optimal and safe for them to return home.

With this model, there is limited assessment of rehabilitation within the acute hospital. Once someone has returned home, detailed functional assessments take place and ongoing care and equipment are organised.

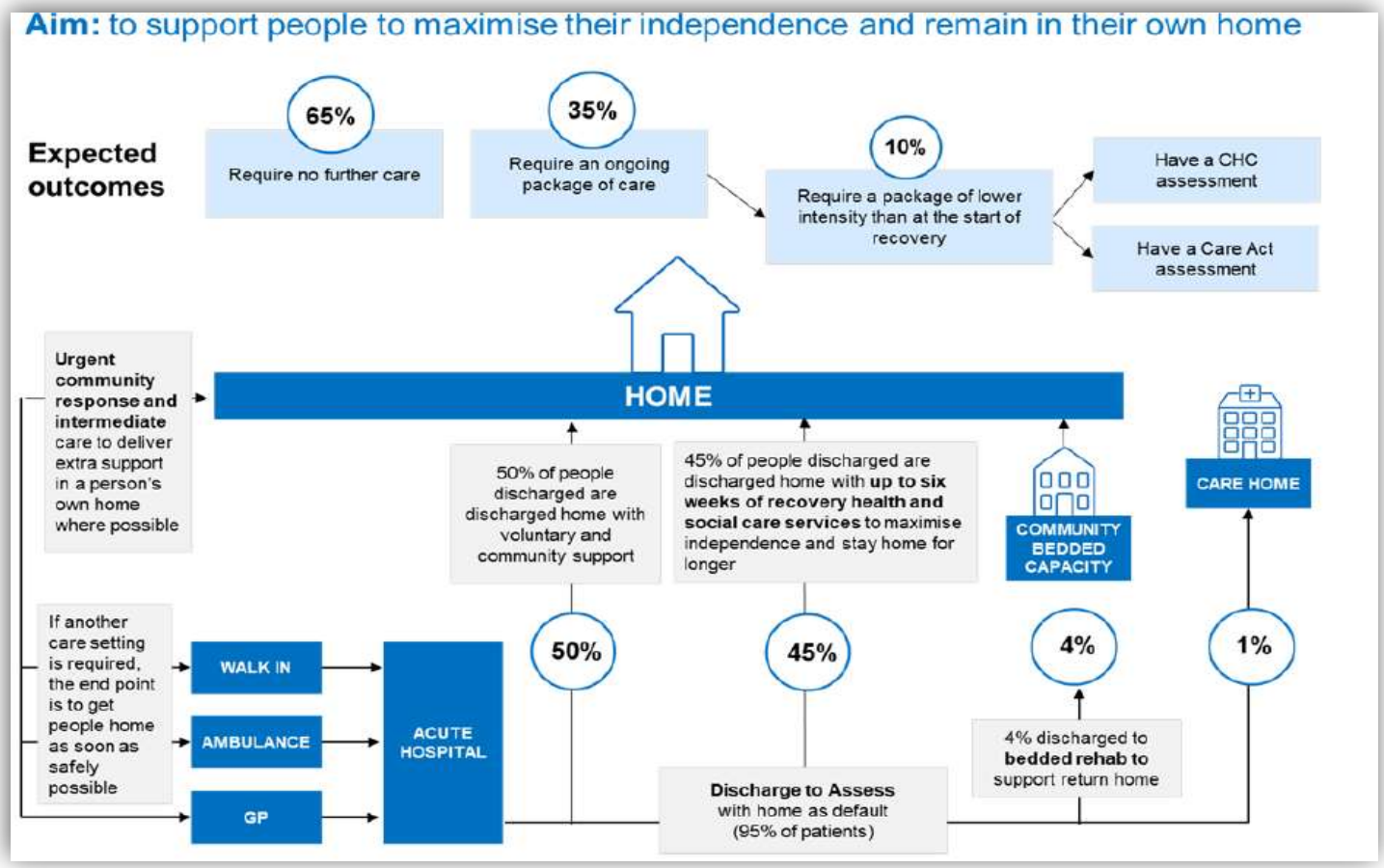
It anticipates that half of this group need simple discharge and no more formal NHS or social care support on returning home and that 45% require a package of support including rehabilitation.

A package of out-of-hospital assessment, rehabilitation and re-enablement as part of this model is provided for a period of up to 28 days.

The D2A model is not new. BNSSG have been working to deliver a rapid hospital discharge approach for years. The BNSSG joint vision for the implementation of a Discharge to assess approach is:

> *Sharing the responsibility, risk and skills across organisations, leading to innovative and creative solutions; thereby achieving a seamless transfer for local residents from acute to community setting through the provision of integrated safe and effective assessment and support closer to home.*

The below diagram describes the model:



Please refer to the D2A Business Case ***(Appendix 1 – Discharge to Assess Business Case)*** for more information relating to the BNSSG D2A model.

The BNSSG D2A Model has been jointly developed in accordance with the following guidance:

- ✓ In March 2020 and refreshed in August, the Government set out the Hospital Discharge Service Operating model for all National Health Service (NHS) trusts, community interest companies, and private care providers of NHS- commissioned acute, community beds, community health services and social care staff in England. This document sets out how health & care systems should support the safe and timely discharge of people who no longer need to stay in hospital. Discharge-to-assess has been a vital policy during the COVID crisis and helped local health and care services to increase the number of people being discharged, as well reducing delays and, crucially, the length of stay in hospital. Health and Social Care Systems are expected to build upon the hospital discharge service developed during the COVID-19 response, incorporate learning from this phase,

and ensure discharge to assess processes are fully embedded for all people aged 18+. The latest version of this document can be found here:

https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model

The government has provided funding up to £9.6m as per H1, via the National Health Service, to help cover the cost of post-discharge recovery and support services; rehabilitation and reablement care for up to 28 days following discharge from hospital up to September 2021. Additional financial settlements have been agreed up to March 22 The funding period will be available from 1st Oct 2021 to March 31st 2022 with no extension past this date.

Leaders across both health and social care recognise the successes achieved to date within the D2A model and that the funds from the centre will cease in March 2022. They now want to be able to embed these changes permanently and see recurrent funding included in the discharge to assess budgets across the Healthier Together footprint.

- ✓ Shared guidance to local authority commissioners from the Association of Directors of Adult Social Services (ADASS), the Local Government Association (LGA) and the Care Provider Alliance (CPA).

  https://www.cosla.gov.uk/__data/assets/pdf_file/0026/15569/coslaguidanceforcommissionedservices170420.pdf

- ✓ COVID-19 action plan for adult social care:

  https://www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan/covid-19-our-action-plan-for-adult-social-care

- ✓ Discharge to assess also forms part of the High Impact Change Model (HICM) for hospital discharge: *(Please refer to **Appendix 02 – HICM Refresh July 20**)*

- ✓ BNSSG response to testing: *(Please refer to **Appendix 03 – Testing Guidance**)*

This Quality Impact Assessment explains how the D2A model may affect patients' safety; clinical outcomes and patients experience for all people aged 18+.

Stroke patients & Avon & Wiltshire Partnership Trust (AWP) patients are outside of scope of this assessment.

Part 1: Screening Tool

1.1 Does your plan affect patient safety?

The following screening questions relate to both positive and negative impact.

1. Is there an impact on patient safety? (Yes / No)

Yes. This mainly applies when patients are discharged to Care Homes, where COVID-19 infection rates are considerably higher. There is also a risk of delayed discharge if care homes are closed and cannot take any patients or when wards have been exposed and patient are forced to stay prolonged period of time in isolation in a hospital. Safety of patients may also be compromised if too rapid discharges take place in order to improve flow in a hospital.

Patients being transferred to a nursing home must have a COVID test 48 hours before they are discharged. The result whether positive or negative should not stop their discharge but the nursing home must be aware of the result in order for them to manage their resident. The new document that came out in December 2020 says that any patient with a positive result must only go to a CQC registered home. *(Please refer **Appendix 4 - Admission and Care of Residents in a Care Home during COVID-19**).*

This has been added as a risk.

2. Is there an impact on delivery of national standards? (Yes / No)

   Yes. Some of our metrics are nationally mandated, such as criteria to reside or LOS data. This data is regularly reviewed and monitored by the System Flow T&F Group, OOH DG, Integrated Care Performance Team Meetings and at the Right to Reside Meetings with the national team.

3. Is there an impact on the provider's duty to protect people? (Yes / No)

   Yes. There is an impact on providers duty to risk assess discharge, including discharge to care homes with COVID-19. The CCG's responsibility is to oversee this process and ensure that providers have very clear risk assessments in place. Each of the providers have completed a service specification document highlighting the level of need that can be offered (please refer to ***Appendix 5 - Provider Criteria Spreadsheet*** *for more information*). This information is collected & reviewed on a regular basis by the OOH DG.

   National NHS contracts are used for monitoring.

4. Is there an impact on clinical workforce capability and skills? (Yes / No)

   Yes. Additional skills in assessing safe discharge may be required. This may relate to COVID-19 or changes in communicating and liaising with a wider system. The CCG's responsibility is to ensure that the providers have upskilled workforce, where needed. This is covered within the NHS contract with each provider.

   There is currently insufficient workforce capacity in Social Care and Sirona to meet demand, all partners are struggling to recruit, and is one cause of the current sub-optimal performance. The D2A business case ***(Appendix 1 – Discharge to Assess Business Case)*** presents a range of initiatives to re-shape the Discharge to Assess model that support better outcomes and mitigate the workforce challenges.

5. Does the plan create an impact on the prevention of violence and aggression; or contribute to service users feeling less safe? (Yes / No)

Yes. Several safeguarding measures is already in place ensuring all patients discharged from a hospital are discharged to a safe environment to prevent violence and aggression, such as MDT meetings, completion of a Single Referral Form, which identifies risk.

National & local submission of hospital delays also identifies any service users, whose discharge is delayed due to safeguarding concerns.

6. Is there an impact on partner organisations and any aspect of shared risk? (Yes / No)

Yes. Partnership working is a significant enabler in implementing above changes. This particularly applies to work around trusted assessment model & work with the care home providers. If there are no care homes available due to COVID-19 infection rates or when homes are closed, contingency plan includes a risk assessment of other providers.

Supporting these providers with wrap around support has enabled stronger working relationships with providers. This could be support with training, PPE or 1-1 if necessary. Working closely with PHE in the event of an outbreak with providers to ensure any outbreak is managed efficiently and effectively.

7. Provide a rationale for assessing the impact on Patient Safety
(A summary narrative to explain the answers to all of the above questions)

Patient safety on D2A discharge pathway may be at risk due to some unknowns (i.e., COVID-19 impact) as safe discharge from acute and community hospitals is heavily reliant on other services having beds/staff capacity and maintaining level of patient care/care pathway that meets patients' needs through any COVID-19 impact. The Out of Hospital Programme provides reassurance that any recent or future changes in discharge pathway underpinned by the national legislation are implemented accurately ensuring safe discharges. This has been added as a risk along with the mitigating actions.

1.2 Does your plan affect clinical outcomes?

The following screening questions relate to both positive and negative impact.

8. Does your plan comply with the best evidence guidance including NICE? (Yes / No)

Yes, the OOH Group uses evidence based approach in decision-making process in accordance with the NHSE/I requirements.

Please refer to the Part 1 Screening Tool section for more details.

9. Does your plan impact on the delivery of services in line with national clinical and quality standards? (Yes / No)

Yes.
The OOH group has taken into consideration quality standards as per Standard Contract and quality schedule (appendix 6) used by the CCG in partnership with its providers. In addition the Government guidance Hospital discharge service policy and operating model:

https://www.gov.uk/government/publications/hospital-discharge-service-policy-and-operating-model/hospital-discharge-service-policy-and-operating-model#annex-a provides overarching quality standards. NICE guidance NG 27 (2015) Transition between hospital inpatient settings and community and care settings for patients with social care needs and NG 94 Chapter 35 discharge planning provides further quality standards guidance.

Please refer to ***Appendix 6 - Sirona Quality Schedule 20-21 Q2 Position Statement V4*** for more details.

10. Does your plan lead to a change in care pathways? (Yes / No)

    No. This will not change pathway just route of assessment, which will be undertaken out of acute hospital out to community. Patients will also be tested for COVID-19 when discharged to a care home, in advance of a timely discharge.

11. Is there an impact on the delivery of clinical outcomes? (Yes / No)

    Yes, delays in discharge may lead to different clinical outcomes. There is also a risk of too rapid discharge process at times of escalation / increase in COVID-19 cases. This process is closely monitored by the OOH DG and actions are in place to ensure timely discharge from a hospital and managed within weekly Bronze Call.

    This has been added as a risk.

12. Provide a rationale for assessing the impact on Clinical Outcomes
    (A summary narrative to explain answers to questions above)

    Patients' clinical outcomes may also be at risk due to the impact of COVID-19 as well as other external factors (provider delays in assessment, delays in accessing services in the community etc.). Timely discharges and compliance with the national legislation is at the heart of the OOH DG programme of work. This includes a formulation of a BNSSG wide Stranded Action Plan for all patients delayed in a hospital, monitoring of Serious Untoward Incidents for failed discharges to ensure patients are not discharged too early. This has been added as a risk along with the mitigating actions.

1.3 Does your plan affect patient experience?

The following screening questions relate to both positive and negative impact.

13. Does your plan have an impact on service user experience? (Yes / No)

    Yes. Partnership working improves service user's experience, which includes receiving regular and open sharing of information on the next steps for patients care and treatment, as well as clarity on plans and joint decision-making processes for pre & post-discharge care.

This also relates to managing patients expectations post discharge. The Out of Hospital Delivery Group is working closely with the national team as it is recognised that patients' choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge (particularly if moving to an alternate setting that is not their usual place of residence). This may have a negative impact on patient's experience.

The Out of Hospital Delivery Group also refreshed and signed off the Managing Expectation and Choice Policy on 08 October 2021 which is being reviewed on a regular basis. Please refer to ***07. Appendix 7 – BNSSG CCG Managing Expectations of Patient Choice v15.***

Patient Pathway 3 leaflets ***(Appendix 8 – Bristol P3 leaflet v0.3.1, Appendix 9 – North Somerset P3 leaflet v0.3.1 & Appendix 10 – South Glos P3 leaflet v0.3.1)*** have also been developed across the 3 areas. The leaflets aim to provide clear and concise information explaining what a Pathway 3 bed is, why they have been navigated to a P3 bed and what to expect once they are in the bed. The leaflet aims to reassure patients that discharge to a P3 bed is part of agreed discharge planning to support the assessment of their longer term needs outside of hospital. The leaflet has been developed with input from the system e.g., local authorities, the acutes and Sirona. The leaflets have been shared with CCG PPI colleagues and supported by the CCG Comms team.

14. Does your plan have an impact on carer experience? (Yes / No)

    Yes. Carers are closely involved in a decision making process about patients onward care. This involves risk assessment to carer, their wellbeing, experience, choice & risk of exposure to COVID – 19 as part of the MDT.

15. Does your plan support the choice agenda? (Yes / No)

    Yes. Please see above (point 13)

16. Does your plan address concerns and issues identified through PALs, complaints, and national and local service user and carer surveys?
    Yes. This includes close monitoring of the number and topics of complaints which is done by the CCG Customer Services Team and includes:

    - those made directly to the CCG
    - those copied into the CCG
    - those which come to the CCG but it are not appropriate to be handled by the CCG and they are therefore passed to the provider in question
    - those complaints made via a Members of Parliament (who are based within our localities) which are directed / copied to the CCG

    All of the above information is recorded and communicated to the relevant department to monitor trends & activity. This data is reported quarterly to the Quality Committee and Governing Body. The reports include an overview of the numbers and trends, highlighting areas of concern, for example a large number of complaints for a particular area, i.e. mental health.

    In addition to this, the Customer Services Team will also include an overview of other information they have received, such as reports from Healthwatch.

Action trackers & learnings logs are kept by each department that assists Customer Services with investigations. These departments will use these learnings to feed into quarterly reporting to evidence improvements. The Customer Services Team is also working to gather feedback from complainants who have been through the CCG complaints process to gain additional insight and further develop our services.

The complaints process is explained on the CCG website and assistance is offered by the CCG Customer Services Team for all service users who need help navigating the care system.

Any complaints would be expected to come through the usual trust processes, found on the website and any compliments would usually come through the Friends and Family survey or letters sent to the trusts.

The Nursing and Quality Directorate Patient Safety Team monitor all serious incidents under STEIS process reported by providers and would provide information on trends to reporting providers and escalate within CCG. If there was an increase of incidents relating from discharges then this would be highlighted as a concern for further learning for all providers to be taken in OOH discharge pathway. This is reliant on robust reporting mechanism, which is not currently in place. This has been added as a risk along with the mitigating actions for resolution.

At the UHBW site there are 3 major risks around patient discharges. This is monitored weekly from an operational perspective by the IDS management team and quarterly through the Trust Board. Any member of staff in the BRI can report an incident relating to patient discharge and associated delays via Datix. All such incidents are monitored and responded to within 72 hours of reporting. If appropriate and required, incidents are also linked to the overarching risks.

With regards to complaints, they are managed through the PSCT and any outcomes are shared with the IDS team for learning at monthly team meetings. A very common theme is communication between the wards, patients and their families around discharge plans. As a result the team is working with the Trust Communication team to improve information that we have available to share with patients and their families. The HDT team are also working to improve communication around discharge at an operational level as well.

NBT monitor the patient experience of discharges through internal concerns raised on DATIX; external concerns raised by partner organisations including the use of the hospital discharge concerns form, please refer to ***Appendix 11 - Hospital Discharge Concerns Form***

Verbal and written complaints are monitored too, as well as readmissions, which are monitored. Work is ongoing to understand readmissions in more detail, which includes one of the band 7 team leads reviewing patients admitted frequently and the potential service gaps that result in an admission. Recently the following information was relayed to SIRONA front line teams to help prevent avoidable admissions:

> *In the event of a concerns about safety of a patient to remain at home following a P1 discharge from North Bristol Trust, please ensure Sirona ACPs are contacted first to determine whether an appropriate community intervention to support the patient can be found.*
> *In the event the ACP confirm return to hospital is the safest thing for the patient please contact:*
> *The IDS direct on 0117 414 4444 or the Trust Operations matrons on 0117 414 8884 who will arrange DIRECT ADMISSION and avoid the patient waiting to be admitted again via ED.*
> *Unfortunately, at the present time due to system pressures it is likely a patient sent to ED will have an extended wait.*

17. Provide a rationale for assessing the impact on Patient Experience
(A summary narrative to explain answers to questions above)

People should expect to receive high quality care from acute and community hospitals, including regular and open sharing of information on the next steps for their care and treatment, as well as clarity on plans and joint decision-making processes for pre & post-discharge care by making decisions in partnership with patients & carers. However, patients' experience may be compromised at times due to some delays in discharge, communication issues or other factors. It is recommendation of this paper that a thematic review of top complaints around patient discharge from UHBW & NBT should be undertaken as part of the PPI exercise.

1.4 Risk Scoring

Please add the risks identified for your project (copy and paste to add more if needed)

Scoring: The scoring is based on a standard risk matrix scoring system. The score will therefore, reflect the potential risk to quality and is summarised below. The overall risk score should be the highest score from the individual quality domains.

The ***probability*** of the risk	The ***impact*** of the risk
1. Rare	1. Very low impact
2. Unlikely	2. Low impact
3. Possible	3. Medium impact
4. Likely	4. High/Serious Impact
5. Almost certain	5. Very Serious Impact

Quality Domain: Patient Experience & Clinical Outcomes

Risk description: Delays in hospital discharge may have a negative impact on patients experience and clinical outcomes. 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80. Patients who are medically optimised for discharge may not be able to be discharged on the day they are ready to go due to other external delays, such as care provider assessments, packages of care, closure of a care home due to COVID-19 outbreak etc. This mainly applies to complex discharges, which is around 2% of a total number of hospital discharges in BNSSG, the majority of these patients would be awaiting P3.

There are also delays in discharge of patients already in a P3 bed.

Probability: Likely

Impact: Very High Impact
Total score: 20

Mitigating actions:

The OOH DG has undertaken a number of initiatives, which aim to reduce the number of hospital & P3 delays. This involves having a robust reporting mechanism in place to capture every delay,

so issues can be proactively managed, early discharge planning which helps to identify complex patients sooner, MDT process for complex patients (please refer to ***Appendix 12 - MDT Review SOP***), fully embedded D2A model, well-established stranded & escalation process in all 3 areas, ongoing review of the beds commissioned amongst other ad hoc initiatives. A BNSSG Stranded action plan (**Appendix 13- *BNSSG Stranded Action Plan 02 Oct 2020)*** has also been developed and signed off by the OOH DG to reduce the number of patients whose discharge may be delayed.

Alternative provision is being identified at times of escalation to reduce hospital delays for patients awaiting P3, this may include using transitional ("holding beds") for patients awaiting P3. Any additional capacity is subject to quality checks to always ensure safety of all patients and QIA are completed when required. (Please refer to ***Appendix 14 - Transitional Beds QIA***). Our ambition is to use existing providers when we can to increase this provision to ensure not only quality and consistency but to ensure we are working with providers that are experienced in the P3 process. Please refer to ***Appendix 15 – v8 bed tracker*** for more details.

Action plans are developed as required to improve flow into these beds to reduce delays by the following T&F Groups reporting to the wider OOH DG:

- System Flow T&F Group
- Models of Care T&F Group
- Commissioning T&F Group
- Therapy T&F Group

Weekly community Escalation meetings are held with CCG performance to ensure oversight of bed flow and to identify any emerging things which may impact on the patient experience/clinical outcomes. (Please see ***Appendix 16 - D2A P3 Community Escalation Standard Operating Procedure v6*** for more details).

Public & Patient Involvement work has commenced to gain a better understanding of the discharge process from the patients 'perspective in order to improve patients experience during on a D2A discharge pathway even further and tackle the issues that are important for the patients, which will include development of metrics that matter to patients.

Quality Domain: Patient Experience

Risk description: Issues of individual's choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge; particularly if moving to a residential, nursing home or transitional beds (transitional beds do not have therapy, Social Worker or CHC input and no onward care coordination).

Probability: Possible

Impact: High Impact

Total score: 12

Mitigating actions:

A new Managing Expectations Guidance has been signed off and is being implemented across BNSSG to tackle the issues associated with choice & engagement. Please refer to ***Appendix 7 – BNSSG CCG Managing Expectations of Patient Choice v15*** for more information. A set of leaflets have been produced to support the communication of this message.

Patient leaflet for D2A Pathway 3 to explain the process and to provide rationale for discharge to a P3 bed. Please see ***Appendix 8 – Bristol P3 leaflet v0.3.1, Appendix 9 – North Somerset P3 leaflet v0.3.1 & Appendix 10 – South Glos P3 leaflet v0.3.1*** for more information.

QIA for transitional beds are being completed as and when required. (Please refer to ***Appendix 14 - Transitional Beds QIA*** for more details***).***

Quality Domain: Clinical Outcomes

Risk description: Some patients are being discharged to care homes with COVID-19 cases (both other residents and staff), which may put patients discharged from a hospital at risk. There is also a risk of spreading the infection in care homes by patients discharged from a hospital.

Probability: Unlikely

Impact: Very serious

Total score: 10

Mitigating actions:

A robust plan is in place to ensure that all discharges are safe, which is the priority of the OOH DG agenda now. Care homes ensure that any positive cases are isolated and barrier nursed where possible this is in a completely separate part of the home and with separate and consistent staffing.

Care homes are offered an 'incident management meeting' when taking Covid positive admissions to ensure the ability to safely isolate and meet the person's needs. Where a care home is still with 28 days of last admission, a meeting is held and a full risk assessment of the home and the individual being admitted to ensure IPC measures are in place for the safe admission and transmission prevention.

There is regular testing in homes of staff and residents. Full PPE is always used and there are less concerns about supply due to adequate stock and supply from acutes.

In line with the new requirements set out in the letter from the DHSC to LAs, CCG, PH and Acute Trust, the following actions are in place to minimise cross infection:

• No-one will be discharged into or back into a registered care home setting with a COVID- 19 test result outstanding or without having been tested within the 48 hours prior to the person preceding their discharge
• Everyone being discharged into a care home must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital

In addition to this a provider letter has been sent to all P3 providers setting out the requirements for hospital discharges, notifications relating to staffing levels, referrals etc, please refer to ***Appendix 17 - Provider Letter V3.2*** for more information.

Weekly community Escalation meetings are held with CCG performance to ensure oversight of bed flow and to identify any emerging things which may impact on the patient experience/clinical outcomes. (Please see ***Appendix 16 - D2A P3 Community Escalation*** **SOP** for more details).

Fully rolled out vaccination programme reducing the risk of serious effects of COVID-19 for those who are fully vaccinated.

Quality Domain: Clinical Outcomes, patients experience & safety.

Risk description: There is a risk of too rapid discharge of patients from hospitals at times of escalation & significant pressures on the system caused by the increase in the number of COVID-19 patients. This may have a very serious impact on patients experience, their safety and clinical outcomes and increase the spread of the virus amongst others.

Probability: Unlikely

Impact: Very serious

Total score: 10

Mitigating actions:

The BNSSG system has learnt from the first wave about the implications of too rapid discharge from a hospital into bedded facilities with inadequate failsafe mechanism in place to protect patients, other residents & staff.

Care homes are now able to regularly test their staff and residents. They also follow strict infection control measures. All new admissions are isolated for 14 days. Other Service uses are tested before they are transferred from care home to care home.
Professional visits are restricted to when it cannot be achieved virtually, limiting the number of sites that professions visit

In line with the new requirements set out in the letter from the DHSC to LAs, CCG, PH and Acute Trust, the following actions are in place to minimise cross infection:

- No-one will be discharged into or back into a registered care home setting with a COVID-19 test result outstanding or without having been tested within the 48 hours prior to the person preceding their discharge

- Everyone being discharged into a care home must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital

This process is closely monitored by the OOH DG and actions are in place to ensure timely discharge from a hospital and managed within weekly Bronze Call.

Weekly community Escalation meetings are held with CCG performance to ensure oversight of bed flow and to identify any emerging things which may impact on the patient experience/clinical outcomes.

Quality Domain: Patient Safety

Risk description: The Nursing and Quality Directorate Patient Safety Team monitor all serious incidents under STEIS process reported by providers and would provide information on trends to reporting providers and escalate within CCG. If there was an increase of incidents relating from discharges then this would be highlighted as a concern for further learning for all providers to be taken in OOH discharge pathway. This is reliant on robust reporting mechanism, which is not currently in place. The risk here is potential lack of reporting as the incident may happen after discharge from hospital, for example the hospitals may report delayed discharge but may not know of the incident if it happens after patient is in care home/home etc. There is also a risk that care home may not use STEIS or datix.

Probability: Unlikely

Impact: Medium Impact

Total score: 6

Mitigating actions:

The OOH DG to agree a plan that requires a robust agreement on provider responsibility for patient and incident reporting throughout discharge.

1.5 Conclusion of Screening Tool - Project Lead to confirm

18. Based on answers to the screening questions above, do you think this project needs to proceed to full QIA? (Yes / No)

    Yes

19. Please explain your reasons:

    High impact risks & issues have been identified as part of this assessment and it is the OOH DG responsibility to ensure that mitigating actions are in place to address these.
    OOH Programme is responsible for all aspects of the discharge pathway, including patients experience, safety & clinical outcomes. It is essential to ensure that the OOH DG has robust plans in place to ensure safe & timely discharges from hospitals.

1.6 Approval – Quality Lead to complete

20. QIA Approver(s): Jenny Thompson
21. Date of Quality Assurance: Initial review 20/10/20 and completion 26/10/21

22. Comments from QIA lead: All aspects of the 3 quality domains have been reviewed and adapted during implementation of the project. The quality impact is being considered as an ongoing process by the OOH group.

Appendices

No	Name
Appendix 1	Discharge to Assess (D2A) Business Case
Appendix 2	HICM refresh July 2020 - Consultation PDF
Appendix 3	Testing Guidance
Appendix 4	Admission and Care of Residents in a Care Home during COVID-19
Appendix 5	Provider Criteria Spreadsheet
Appendix 6	Sirona Quality Schedule 20-21 Q2 Position Statement v4 (2)
Appendix 7	BNSSG CCG Managing Expectations of Patient Choice v15
Appendix 8	Bristol P3 leaflet v0.3.1
Appendix 9	North Somerset P3 leaflet v0.3.1.
Appendix 10	South Glos P3 leaflet v0.3.1
Appendix 11	Hospital Discharge Concerns Form
Appendix 12	MDT Review SOP
Appendix 13	BNSSG Stranded Action Plan 02 Oct 2020
Appendix 14	Transitional Beds QIA Template v2
Appendix 15	v8 Bed Tracker
Appendix 16	D2A Pathway 3 Community Escalation Standard Operating Procedure v6
Appendix 17	Provider Letter v3.2

Part 2: FULL Quality Impact Assessment

Full QIA has been answered in the Part 1 sections above.

Full QIA Approval

23. QIA Lead approval: The OOH discharge plans have considered quality throughout its implementation of changes to discharge pathways during the Covid pandemic and evolved its processes and mitigated risk. The QIA recognises that this has been an evolving project and will continue to evolve. QIA approval is agreed with recommendation that timeframes are agreed for the outstanding risks to be mitigated and reduced. It is recognised that the project remains under the OOH group to mitigate risk in ongoing process to ensure that the three quality domains are addressed.

Contact us:

Healthier Together PMO Office, Level 4, South Plaza, Marlborough Street, Bristol, BS1 3NX

bnssg.htpmo@nhs.net

Some actions may be merged to group together with the impact

Yellow - action
Green - impact starting
Red - risk

Area to be impacted	Overall objective	Responsibility	Impact	Key actions / KPIs	Apr 2021	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2022	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan 2023	Feb	Mar	Current performance (as of D2A business case slides)	Risks
Right to reside / admission to SRF	Successfully delivered an UHBW proactive hospital programme focusing on complex discharge processes	UHBW	UHBW Admission to SRF LoS reductions: Winter target LoS (by March 2022): 10 days P1, 12 days P2 and 15 days P3 Stretch target (by March 2023): 9.5 days P1, 11 days P2 and 13 days P3	1. 95% of patients discharged by 5PM on day patient no longer meets criteria to reside											Phase 1						Phase 2								30% (BNSSG)	
				2. 95 % of patients awaiting P1 have a completed SRF within 24 hours from becoming MFFD											Phase 1						Phase 2								BRI P1 15 days Weston P1 12 days	Changing staff and high use of agency
				3. 95% of patients awaiting P2 have a completed SRF within 24 hours of becoming assessment fit											Phase 1						Phase 2								BRI P2 16.4 days Weston P2 21.2 days	Changing staff and high use of agency
				4. 95% of patients awaiting P3 have a completed SRF within 24 hours of becoming assessment fit											Phase 1						Phase 2								BRI P3 21.2 days Weston P3 21.8 days	New IDS Lead to start and using NBT assumptions
				5. 95% of staff completed the new SRF training											Phase 1						Phase 2				Phase 3				Training not yet started	Changing staff and high use of agency
	Time to Care Programme delivered focusing on P0 discharges, safer bundles use of discharge lounge	UHBW	90-95% of "simple" daily discharges, not diverted to D2A:	6. Audit completed by the registered nurses to identify tasks done on the wards which could be done by a different staff group or could potentially stop altogether											Phase 1						Phase 2				Phase 3				No audit	Working with new DON
				7. 95 % of P0 patients discharged to the discharge lounge within 2 hours of no longer meeting criteria to reside											Phase 1						Phase 2				Phase 3				Trust data required	Changing staff and high use of agency
	IDS workforce recruitment support	UHBW		8. 2 additional WTE B6 Acute Trust case Managers in Bristol & 1 in Weston recruited into posts											Phase 1						Phase 2				Phase 3				N/A	Dependant on active recruitment program
				9. 5 FTE B4 Patient Flow Facilitators recruited into posts in Bristol											Phase 1						Phase 2				Phase 3				N/A	Dependant on active recruitment program
				10. Replacement of 0.60 FTE Speciality Manager Role with 1.00 FTE BI Coordinator (cross site) Band TBC											Phase 1						Phase 2				Phase 3				N/A	Dependant on active recruitment program
	NBT internal programme implemented to reduce LOS (this also includes staff education programme)	NBT	NBT Admission to SRF LoS reductions: Winter target LoS (by March 2022): 10 days P1, 12 days P2 and 15 days P3 Stretch target (by March 2023): 9.5 days P1, 11 days P2 and 13 days P3 Rejection rate reduced to below 5%	11. 95% of patients discharged by 5PM on day patient no longer meets criteria to reside								Phase 1						Phase 2				Phase 3							31%	Changing staff and high use of agency
				12. 95% of patients awaiting P1 have a completed SRF within 24 hours from becoming MFFD								Phase 1						Phase 2				Phase 3							P1 - 12.3 days	Changing staff and high use of agency
				13. 95% of patients awaiting P2 have a completed SRF within 24 hours of becoming assessment fit								Phase 1						Phase 2				Phase 3							P2 - 15.1	Changing staff and high use of agency
				14. 95% of patients awaiting P3 have a completed SRF within 24 hours of becoming assessment fit								Phase 1						Phase 2				Phase 3							P3 - 16.5	Changing staff and high use of agency
				15. 95% of staff completed the new SRF training								Phase 1						Phase 2				Phase 3							Training started in July	Changing staff and high use of agency
SRF to discharge	Successful recruitment of therapists across Sirona to support ICCB and capacity	Sirona	SRF to discharge: Winter target LoS (by March 2022): 4.5 days P1, 7 days P2 and 11 days P3 Stretch target (by March 2023): 1 day P1, 1 day P2 and 4 days P3	16. 30 WTE additional therapists and RSWs to be recruited into posts across BNSSG. Increase the capabilities of ECH																									30 WTE	Recruitment vacancy rate
	Reduce variability in system for 7 day working, to maximise opportunity.											Phase 1			Phase 1			Phase 2				Phase 3								Reliant on LAs managing flow
	Reduced time from care home assessment to admission	CCG	24 hours target of assessment to admission	17. 95% patients awaiting P3 admitted to a care home within 24 hours of completion of assessment								Phase 1			Phase 1			Phase 2				Phase 3							70%	Potential outbreaks in care homes
Supporting LOS and reducing patients delayed into ongoing care	Supported MDT process in P3 beds	Sirona	Reduce LOS in P3 beds to 28 days	18. Wrap around support to support community MDT approach - 100% of all care homes supported							Phase 1					Phase 1		Phase 2				Phase 3							Sirona P3 LoS June mean / median days Bristol - 48.8 / 40 NS - 29.9 / 25 SG - 38.5 / 42	Resolving GP payment
	Strengthened reablement service. Work with the market to re-shape our community-based services model, including reablement, to develop a sustainable market.	LAs	Reducing LOS from P1 to 10 days, P2 21 and P3 28 days	19. 95% of patients awaiting P2 discharged within 48 hours of LA assessment											Phase 1				Phase 2				Phase 3				Sirona P1 LoS June mean / median days Bristol - 27.2 / 20 NS - 13.4 / 4 SG - 13.8 / 8 Sirona P2 LoS June mean / median days Bristol - 31.1 / 26 NS - 39.9 / 27 SG - 32.3 / 28	Recruitment into new N Somerset service required
	Digital reablement pathway, immediate access to TEC assessment and support with connection and equipment during reablement pathway to maximise independence and reduce ongoing care packages.	LAs	Over 50% into P0 from D2A community pathways	20. reduction in Dom care packages up to 10%								Phase 1				Phase 2				Phase 3							Under 50% currently referred from P0 to LA	
	Development of P0+ pathway building on success of Home from Hospital and Wellness service & linking to voluntary sector offer to maximise independence	LAs		21. Working with VSC partners on delivery of a local pathway. 50% of patients in complex D2A discharge to P0.									Phase 1					Phase 2				Phase 3								
	Delivery of sustainable community based care by building on ongoing domiciliary care capacity though Proud to Care	LAs	Reduce P1/P2 delays to 0 pts waiting over 10 days P1 and P2 28 from approx. 27	22. 100% awaiting P1 with a LOS no longer than 10 days										Phase 1				Phase 2				Phase 3							Sirona delay data in P1, P2 and P3	Recruitment of staff
				23. 100% awaiting P2 with a LOS no longer than 27 days										Phase 1				Phase 2				Phase 3							Sirona delay data in P1, P2 and P3	Recruitment of staff
	Consideration of how we move therapy support to the community, with the risk transfer – link to CICB and policies with better risk share across the system	Acute Trusts	To support full establishment of Sirona therapy	24. Review the amount of therapist support / can we increase / do differently? Review the amount of therapist support / can we increase / do differently?												Phase 1						Phase 2						Phase 3	Sirona vacancy rate - 30 whole time equivalent	Potential TUPE and management of change
	Review of community Strategic estates to include current beds e.g. Clevedon	CCG	To ensure right bedbase of (number to be taken from IPACs model)	25. Strategic group to be set up to explore alternative solutions for community bedbase												Phase 1						Phase 2						Phase 3	155 beds for P2 currently commissioned 73 beds for P3 currently commissioned	
	Reduction in number of long term placements in care homes	LAs	Reduction of placements by 20%	26. Supporting P1 model with reablement and supported care												Phase 1						Phase 2						Phase 3		

Transformational work to support pathways and all performance	re-shape BNSSG brokerage model, which would lead to a reduction in social Work capacity required to support assessments in pathways	LAs	To reduce number of SW undertaking brokearge activity	27. Support P3 flow to 28 days												**Phase 1**				**Phase 2**				**Phase 3**					4 separate brokerage models	
	Work with all partners to develop the 'community workforce' required moving forward. Able to meet individual's needs, operate as trusted assessors, with the skills & career pathways to attract and retain most efficiently.	ALL	Able to meet individual's needs, operate as trusted assessors, with the skills & career pathways to attract and retain most efficiently.	28. Review the amount of support / can we increase / do differently? Review the amount of therapist support / can we increase / do differently?															**Phase 1**						**Phase 2**			>450 WTE vacancies across BNSSG	Dependent on ability to recruit to community workforce
	Work with the voluntary sector to increase number supported in P0 and increase number remaining at home post 90 days.	ALL	Increase number remaining at home post 90 days.	29. Develop a supportive PO model								**Phase 1**						**Phase 2**						**Phase 3**					Under 50% currently referred from P0 to LA	
	to increase use of supportive technology to undertake SW assessments	LAs	reduce number of SW assessments to support LOS in pathways	30. Develop a digital tool to support SW assessments												phase 2														
	Commissioning of specialist Mental Health Services for post hospital care is a critical gap	CCG	To ensure all patients with dementia and dual diagnosis supported in P3 bedbase to support flow	31. Reduction in P3 LoS									**Phase 1**				**Phase 2**				**Phase 3**									Sirona P3 LoS June mean / median days Bristol - 48.8 / 40 NS - 29.9 / 25 SG - 38.5 / 42	

NBT - Admission to SRF	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	12	88	10	14.7	9.5	3.7	18.3
P2	13.4	29	12	3.1	11	2.2	5.2
P3	16.9	29	15	3.3	13	3.4	6.7

NBT - SRF to Discharge	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	5.8	43	4.5	9.5	1	25.7	35.2
P2	10	22	7	6.6	1	13.1	19.7
P3	16.5	28	11	9.5	4	12.1	21.6

NBT - Total Savings	Bed savings with implementation of full D2A business case
P1	53.5
P2	24.9
P3	28.3

BRI - Admission to SRF	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	13.2	58	10	14.0	9.5	2.2	16.1
P2	14	24	12	3.5	11	1.7	5.2
P3	17.4	22	15	3.1	13	2.6	5.7

BRI- SRF to Discharge	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	8.1	35	4.5	15.7	1	15.3	31.0
P2	10.3	18	7	5.8	1	10.5	16.2
P3	19.3	25	11	10.7	4	9.0	19.8

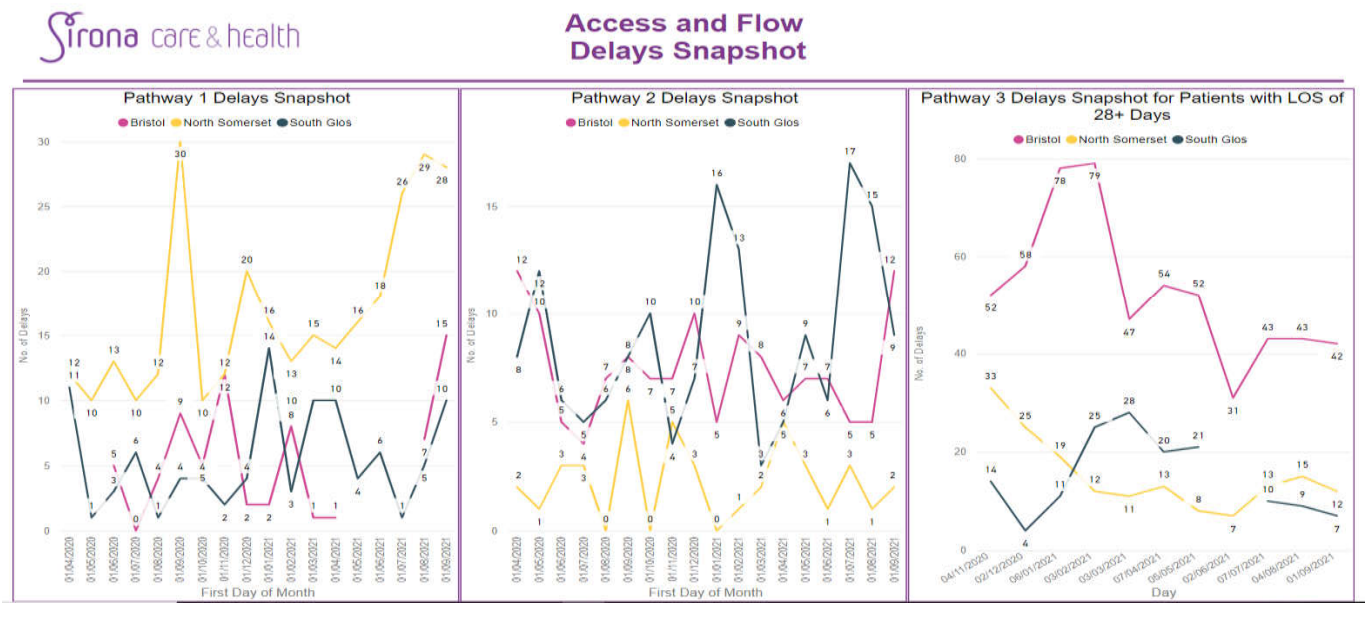
BRI - Total Savings	Bed savings with implementation of full D2A business case
P1	47.1
P2	21.5
P3	25.5

WGH - Admission to SRF	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	11.6	27	10	3.8	9.5	1.2	5.0
P2	13.3	16	12	1.6	11	1.2	2.8
P3	16.3	10	15	0.8	13	1.2	2.0

WGH- SRF to Discharge	Baseline LoS	Baseline Beds (90% occupancy)	Winter Target LoS (by March 22)	Winter Target Bed Savings	Stretch Target LoS (by March 23)	Stretch Target Additional Bed Savings	Bed savings with implementation of full D2A business case
P1	6.5	15	4.5	4.7	1	8.3	13.0
P2	12.6	16	7	6.9	1	7.4	14.3
P3	11.9	7	11	0.6	4	4.3	4.9

WGH - Total Savings	Bed savings with implementation of full D2A business case
P1	17.9
P2	17.2
P3	6.9

Current Baseline



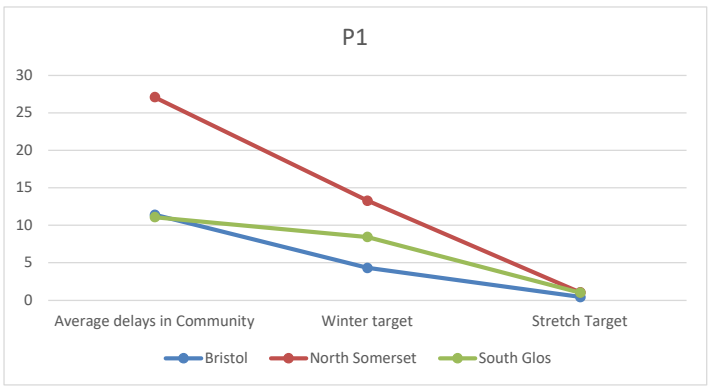
Trajectory changes

P1	Average waiting list in acutes	Average delays in Community	Winter target	Stretch Target
Bristol	0.0	11.4	4	0
North Somerset	0.0	27.1	13	1
South Glos	0.0	11.1	8	1

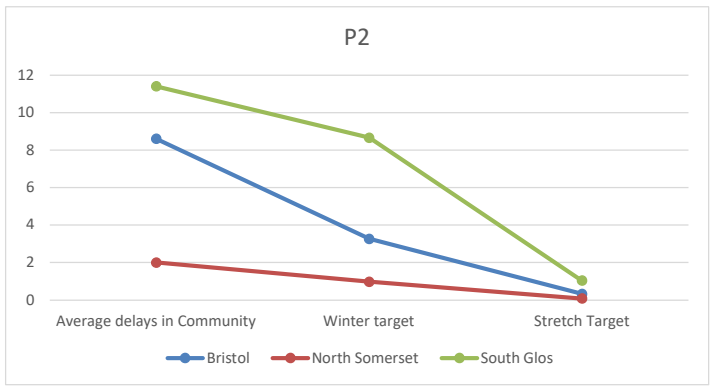
29.9
19.2
15.6

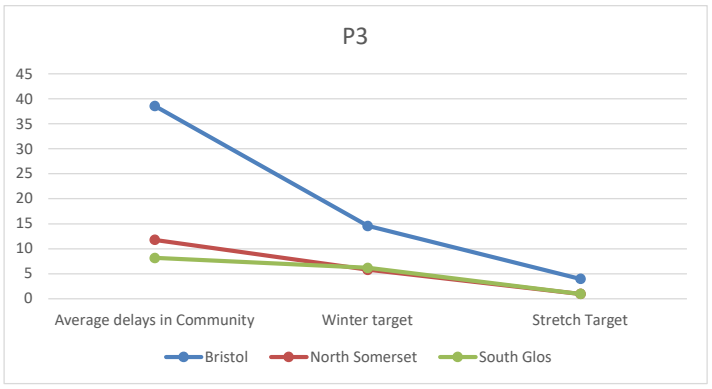
P2	Average waiting list in acutes	Average delays in Community	Winter target	Stretch Target
Bristol	0	8.6	3.268	0
North Somerset	0	2	0.98	0
South Glos	0	11.4	8.664	1

P3	Average waiting list in acutes	Average delays in Community	Winter target	Stretch Target
Bristol	0	38.6	14.6	4
North Somerset	0	11.8	5.8	1
South Glos	0	8.2	6.2	1



P3 winter target - removes all over 42 days delays





NBT	Total Patients on pathway (Dec 20 - Aug 21)***	Current Average Length of Stay from admission to SRF (Dec 20 - Aug 21)	Current Average LOS from SRF to Discharge (Dec 20- Aug 21)	Total bed days for Adm to SRF	Total bed days for SRF to d/c	Total bed days (patients x Total pathway average LoS)	Total Bed requirement at 90% occupancy	Adm to SRF Bed requirement at 90% occupancy	SRF to discharge Bed requirement at 90% occupancy	LoS Winter Target - Acute (Admission to SRF)	Total bed days using reduced LoS from winter acute target (patients x average LoS)	Total Beds if LoS winter acute target met (90% occupancy)	Savings for winter "adm to SRF" Acute target	Total bed days using reduced LoS from winter "SRF to d/c" community target (patients x average LoS)	Winter Target - Sirona (SRF to discharge)	Total Beds if "SRF to d/c" target met (90% occupancy)	Bed savings associated with SRF to D/C	Stretch internal Acute Improvement ADM to SRF	Total bed days using reduced LoS from stretch "adm to SRF" acute target (patients x average LoS)	Total Beds if LoS winter acute target met (90% occupancy)	Savings for stretch "adm to SRF" Acute target	Additional savings for stretch "adm to SRF" Acute target	Stretch Target - Sirona (SRF to discharge)	Total bed days using reduced LoS from stretch "SRF to d/c" community target (patients x average LoS)	Total Beds if "SRF to d/c" stretch target met (90% occupancy)	Bed savings associated with SRF to D/C stretch target	Additional savings associated with SRF to D/C stretch target	Bed savings with implementation of full D2A business case
P1	2224	12	5.8	26688	12899	39587	131	88	43	10	22240	73	15	10008	4.5	33	10	9.5	21128.0	70	18	4	1	2224	7	35	26	53.5
P2	663	13.4	10	8884	6630	15514	51	29	22	12	7956	26	3	4641	7	15	7	11	7293.0	24	5	2	1	663	2	20	13	24.9
P3	523	16.9	16.5	8839	8630	17468	58	29	28	15	7845	26	3	5753	11	19	9	13	6799.0	22	7	3	4	2092	7	22	12	28.3
Total	3410			44411	28159	72570	239	**146**	93				**21**	**20402**		**67**	**26**				**30**							**106.7**
								By March 22													Additional 9							
																		By March 23										
																		47										

BRI	Total Patients on pathway (Dec 20 - Aug 21)	Average Length of Stay from admission to SRF	Average LOS from SRF to Discharge	Total bed days for Adm to SRF	Total bed days for SRF to d/c	Total bed days (patients x average LoS)	Total Bed requirement at 90% occupancy	Adm to SRF Bed requirement at 90% occupancy	SRF to discharge Bed requirement at 90% occupancy	LoS Winter Target - Acute (Admission to SRF)	Total bed days using reduced LoS from winter acute target (patients x average LoS)	Total Beds if LoS winter acute target met (90% occupancy)	Savings for winter "adm to SRF" Acute target	Total bed days using reduced LoS from winter "SRF to d/c" community target (patients x average LoS)	Winter Target - Sirona (SRF to discharge)	Total Beds if "SRF to d/c" target met (90% occupancy)	Bed savings associated with SRF to D/C	Stretch internal Acute Improvement ADM to SRF	Total bed days using reduced LoS from stretch "adm to SRF" acute target (patients x average LoS)	Total Beds if LoS winter acute target met (90% occupancy)	Savings for stretch "adm to SRF" Acute target	Additional savings for stretch "adm to SRF" Acute target	Stretch Target - Sirona (SRF to discharge)	Total bed days using reduced LoS from stretch "SRF to d/c" community target (patients x average LoS)	Total Beds if "SRF to d/c" stretch target met (90% occupancy)	Bed savings associated with SRF to D/C stretch target	Additional savings associated with SRF to D/C stretch target	Implementation of full D2A business case
P1	1323	13.2	8.1	17463.6	10716.3	28180	93	58	35	10	13230	44	14	5954	4.5	20	16	9.5	12568.5	41	16	2	1	1323	4	31	15	47.1
P2	529	14	10.3	7406	5448.7	12855	42	24	18	12	6348	21	3	3703	7	12	6	11	5819.0	19	5	2	1	529	2	16	10	21.5
P3	392	17.4	19.3	6820.8	7565.6	14386	47	22	25	15	5880	19	3	4312	11	14	11	13	5096.0	17	6	3	4	1568	5	20	9	25.5
							183	**104**	78				**21**			**46**	**32**				**27**							**94.0**

Weston	Total Patients on pathway (Dec 20 - Aug 21)	Average Length of Stay from admission to SRF	Average LOS from SRF to Discharge	Total bed days for Adm to SRF	Total bed days for SRF to d/c	Total bed days (patients x average LoS)	Total Bed requirement at 90% occupancy	Adm to SRF Bed requirement at 90% occupancy	SRF to discharge Bed requirement at 90% occupancy	LoS Winter Target - Acute (Admission to SRF)	Total bed days using reduced LoS from winter acute target (patients x average LoS)	Total Beds if LoS winter acute target met (90% occupancy)	Savings for winter "adm to SRF" Acute target	Total bed days using reduced LoS from winter "SRF to d/c" community target (patients x average LoS)	Winter Target - Sirona (SRF to discharge)	Total Beds if "SRF to d/c" target met (90% occupancy)	Bed savings associated with SRF to D/C	Stretch internal Acute Improvement ADM to SRF	Total bed days using reduced LoS from stretch "adm to SRF" acute target (patients x average LoS)	Total Beds if LoS winter acute target met (90% occupancy)	Savings for stretch "adm to SRF" Acute target	Additional savings for stretch "adm to SRF" Acute target	Stretch Target - Sirona (SRF to discharge)	Total bed days using reduced LoS from stretch "SRF to d/c" community target (patients x average LoS)	Total Beds if "SRF to d/c" stretch target met (90% occupancy)	Bed savings associated with SRF to D/C stretch target	Additional savings associated with SRF to D/C stretch target	Implementation of full D2A business case
P1	715	11.6	6.5	8294	4647.5	12942	43	27	15	10	7150	24	4	3218	4.5	11	5	9.5	6792.5	22	5	1	1	715	2	13	8	17.9
P2	375	13.3	12.6	4987.5	4725	9713	32	16	16	12	4500	15	2	2625	7	9	7	11	4125.0	14	3	1	1	375	1	14	7	17.2
P3	188	16.3	11.9	3064.4	2237.2	5302	17	10	7	15	2820	9	1	2068	11	7	1	13	2444.0	8	2	1	4	752	2	5	4	6.9
							92	**54**	38				**6**			**26**	**12**				**10**							**42.0**

D2A Business Case - Summary Financials

Programme	Pathway	Additional P2 & P3 beds	GP Support	Red Cross	Sirona	Acute IDS teams	Community Equipment & Patient Transport	NHS Sub-total	Bristol	N Somerset	S Glos	LA Sub-total	TOTAL
Acute discharge support						**320,303**		**320,303**					**320,303**
Health D2A													
	P0			422,739			50,000	472,739					472,739
	P1				6,479,348			6,479,348					6,479,348
	P2 & P3 beds	263,800						263,800					263,800
	P2 and P3 therapy & pharmacist				816,503			816,503					816,503
	P3 GP support		62,000					62,000					62,000
	Patient Transport						100,000	100,000					100,000
NHS Sub Total - D2A		**263,800**	**62,000**	**422,739**	**7,295,852**	**0**	**150,000**	**8,194,391**					**8,194,391**
Social Care													
	Homefirst / reablement						100,000	100,000	1,402,002	1,022,000	775,400	3,199,402	3,299,402
	Live in carers							0		272,738	79,040	351,778	351,778
	ECH (and Redfield & Bariatric)	332,800						332,800				0	332,800
	Brokerage	208,236						208,236				0	208,236
	Connecting Care - Rec							0		25,000		25,000	25,000
	N Som Wellness							0		180,000		180,000	180,000
	Equipment set up							0		24,770		24,770	24,770
Sub Total - Social Care		**541,036**	**0**	**0**	**0**	**0**	**100,000**	**641,036**	**1,402,002**	**1,524,508**	**854,440**	**3,780,950**	**4,421,986**
Total		**804,836**	**62,000**	**422,739**	**7,295,852**	**320,303**	**250,000**	**9,155,730**	**1,402,002**	**1,524,508**	**854,440**	**3,780,950**	**12,936,680**
										6months			**6,468,340**
Other costs													
	Connecting Care							0		25,000		25,000	25,000
Total		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**25,000**	**0**	**25,000**	**25,000**

No.	Provider	Reference	Description	Actioned
1	LA - Bristol	N/A	Update Bristol Tab	19-Aug
2	LA - North Somerset	NS13	Query - NS13 Value difference	
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

	£	Commentary	
Business Case / Application of funding	**£**		
Acute Discharge Teams (UHBW)	320,303	NHS cost	
P0 capacity (Red Cross & N Som Wellness)	512,739	split NHS/LA cost	50% Red Cross
P1 capacity (Sirona)	3,174,560	split NHS/LA cost	
Transport, Equipment & Technology (CCG & LA)	299,770	split NHS/LA cost	
P2 & P3 beds incl Extra Care Housing (CCG & LA)	2,056,036	split NHS/LA cost	
P2 & P3 therapy (Sirona)	3,081,560	split NHS/LA cost	
Home First / Reablement teams (LAs)	3,551,180	split NHS/LA cost	
	12,996,148		
Sources of Funding			
NHS LTP investment	11,900,000	as per previous business case and included in LTP	
Ageing Well contribution	59,846		
BCF 21/22 uplift (2.3% = 5.3% uplift net 3% inflation)	518,151	to be validated	
BCF 22/23 uplift	518,151		
	12,996,148		
NHS LTP & Risk			
Risk - Health Care			
Acute savings stranded costs (25%)	-4,065,188	could be funded from additional income or other cash releasing savings committed in NHS LTP	
P2 & P3 beds Scenario 3	-5,733,000	requires robust operational management & implementation	
	-9,798,188		
Risk - Social Care			
Social Care cost risks - assessment 22/23	-1,046,761	could be funded from redesigning assessment process	
Social Care cost risks - dom care 22/23	-827,500	could be funded by workforce redesign or future national government funding for social care pay rates	
HDP 21/22 risks	-1,375,000	non recurent 21/22 only S Glos CICB & BCC/Sirona RSWs	
Social Care risks - BCC/Sirona RSWs 22/23	-500,000	non recurent - service redesign	
	-3,749,261		
	-13,547,449	c£15m S256 funding into S75 risk reserve	

D2A Business Case - Summary Financials

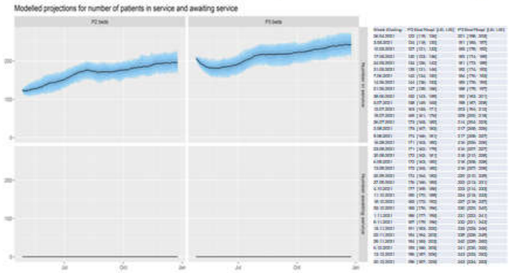
Programme	Pathway	Additional P2 & P3 beds	Red Cross	Sirona	Acute IDS teams	Community Equipment & Patient Transport	NHS Sub-total	Bristol	N Somerset	S Glos	LA Sub-total	TOTAL	Comments	HDP	Variance	Commentary
Acute discharge support					**320,303**		**320,303**					**320,303**				
Health D2A																
50%	P0		422,739			50,000	472,739					472,739	Red Cross costs need to be checked			
	P1			3,174,560			3,174,560					3,174,560	overlap?			
Scenario 4 (25)	P2 & P3 beds	1,465,000					1,465,000					1,465,000	capacity correct?, Brokerage had been included x2			
	P2 and P3 therapy & pharmacist			3,081,560			3,081,560					3,081,560	overlap?			
	P3 GP support	62,000					62,000					62,000				
	GP support LES funding	-62,000					-62,000					-62,000				
	CCG brokerage	50,000					50,000					50,000				
	Patient Transport					100,000	100,000					100,000				
							0									
NHS Sub Total - D2A		**1,515,000**	**422,739**	**6,256,120**	**0**	**150,000**	**8,343,859**					**8,343,859**				
Social Care																
Exclude	Assessment						0	0	0	0	0	0	why so much more assessment? No more patients? Are SG over assessing patients			
	Homefirst / reablement					100,000	100,000	1,402,002	1,022,000	775,400	3,199,402	3,299,402	overlap?			
	Live in carers						0	0	272,738	79,040	351,778	351,778	overlap?			
Revised	ECH (and Redfield & Bariatric)	332,800					332,800	0	0	0	0	332,800	Bristol Cost suggests a unit cost of £1,400 which is greater than a bed cost - Agreed £400/wk for all			
Revised	Brokerage	208,236					208,236	0	0	0	0	208,236	capacity correct?			
	Connecting Care - Rec						0		25,000		25,000	25,000				
Exclude	Dom Care Additional Capacity						0			0	0	0	Pay Rate			
Exclude	Dom Care incentives & recruitment						0		0	0	0	0	Proud to Care Bonus			
	N Som Wellness						0		90,000		90,000	90,000	50/50 LA/CCG Ageing Well??			
	Equipment set up						0		24,770		24,770	24,770				
	Reporting TBC						**0**	0	0	0	**0**	**0**	**Reconciling line**			
Sub Total - Social Care		**541,036**	**0**	**0**	**0**	**100,000**	**641,036**	**1,402,002**	**1,434,508**	**854,440**	**3,690,950**	**4,331,986**				
							0				0					
Total		**2,056,036**	**422,739**	**6,256,120**	**320,303**	**250,000**	**9,305,198**	**1,402,002**	**1,434,508**	**854,440**	**3,690,950**	**12,996,148**				
									6months			6,498,074				
Other costs																
	Connecting Care						0		25,000		25,000	25,000	NHS X			
	Brunel Elective Accelerator						0				0	0	Accelerator			
	Reporting TBC						**0**				**0**	**0**	**Reconciling Line**			
Total		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**25,000**	**0**	**25,000**	**25,000**				
HDP		**13,150,784**	**0**	**3,550,720**	**0**	**0**	**16,701,504**	**3,168,710**	**1,149,424**	**1,429,404**	**5,747,538**	**22,449,042**				
Variance		**-11,094,748**	**422,739**	**2,705,400**	**320,303**	**250,000**	**-7,396,306**	**-1,766,708**	**285,084**	**-574,964**	**-2,056,588**	**-9,452,894**				

Activity???
Requirement to realign

BNSSG - Acute Bed capacity

Cost per bedday	225	
Beds saved (from Implemetation Plan)	198	
Beddays saved	72,270	
Quantified saving	16,260,750	4065188
Cash saving	10,000,000	
Reinvestment in reduced occupancy rate	6,260,750	
	16,260,750	

54:20:17 Headline results – Scenario 1
P2 LoS = 29, P3 LoS = 43 (Actual Sirona Data)



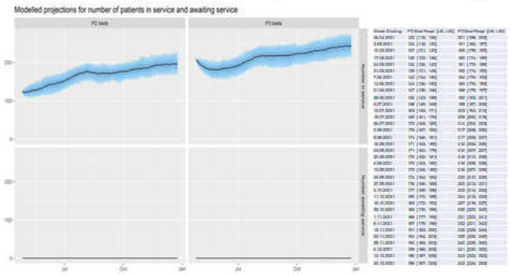
- Left plot is P2 beds; right plot P3 beds – using the LoS data from Sirona and assumptions as spreadsheet model
- Black line is the average; 95% of possible values lie within the blue shaded area
- Weekly reqs. and 50% of possible values around reqs. in the table

BNSSG - P2 & P3 Capacity

Description	No.	No.	Original (94)	Scenario 1 (177)	Scenario 2 (130)	Scenario 3 (93)	Scenario 4 (25)
P2 & P3 Capacity Provided							
P2	110			166	136	104	78
P3	143			163	146	141	99
Total Capacity Provided			**253**	**329**	**282**	**245**	**177**
Community Provider (CP) Capacity							
Clevedon	8						
SBCH	60	(includes Stroke)					
Henderson	20						
Skylark	30						
CP Baseline		**118**		118	118	118	118
Orchard Grove Capacity							
East Bristol Rehab	18						
South Bristol rehab	16						
Orchard Grove Baseline		**34**		34	34	34	34
Existing Capacity - before step up beds		152		152	152	152	152
less: Step Up beds		-16		-16	-16	-16	-16
Total Existing Capacity			**136**	**136**	**136**	**136**	**136**
Net Increase to Existing Capacity			**117**	**193**	**146**	**109**	**41**
Additional Provision							
less: ECH	16						
less: Redfield							
Less - Addn Provision			**16**	**16**	**16**	**16**	**16**
Absolute additional P2 and P3 beds required			**101**	**177**	**130**	**93**	**25**
Total Cost of Original & x4 Scenario's			**5,514,600**	**9,664,200**	**7,098,000**	**5,077,800**	**1,365,000**

Cost of P2 or P3 bed per week (excluding therapy, incl Bariatric beds)	1050	5,733,000
Cost of ECH bed per week (includes 10hrs therapy excl Bariatric bids)	400	
Total cost of ECH	**332,800**	
of which,		
N Som	41600	
Bristol	187200	
S Glos	104000	
	332,800	

54:20:17 Headline results – Scenario 1
P2 LoS = 29, P3 LoS = 43 (Actual Sirona Data)



- Left plot is P2 beds; right plot P3 beds – using the LoS data from Sirona and assumptions as spreadsheet model
- Black line is the average; 95% of possible values lie within the blue shaded area
- Weekly reqs. and 50% of possible values around reqs. in the table

Social Care Services

	2	6	7	8	9	22	23	24	25	
No.	**Reporting Category**	**Activity**	**Existing Resource**	**Baseline spend (BAU for LA)**	**Additional Resource Required**	**21/22 In-Year Actuals / Forecast**	**LA Contribution**	**Total 21/22 Contribution to HDP**	**BC Costs (FYE)**	
BS06	Assessment	Critical posts to inreach into acutes for MDT's and discharge dependent safeguarding.	Two social work posts in CICB to undertake MDTs, in-reach assessments and disclosure dependent safeguarding	1,934,924	BG11 posts x2 44,318 per post per annum. 6 months for two posts is £44,318 total	0	0	0	88,636	Bristol
BS15	Assessment	Fund an VCSE organisation in the City to provide this service. Either fund existing service (such as Red Cross) or new service to be developed	Funding to VCSE offer to support people after discharge. This offer could be telephone support, or practical support for food shopping etc.	0	Estimate - £40k TBC with market	0	0	0	40,000	Bristol
										N Som
NS12	Assessment	0	0	0	Refresher training - £120 plus VAT – approx. 4 people = £562.52 Level 2 training - £250 plus VAT – approx. 2 people = £562.50	0	0	0	1,125	N Som
NS14	Assessment	0	0	828,000	Social worker x 4 at £40k = £160k	0	0	0	160,000	N Som
NS15	Assessment	0	0	353,000	Care Navigator x 2 at £35k = £70k	0	0	0	70,000	N Som
NS18	Dom Care incentives & recruitment	0	0	185,000	Based on previous 6 months x 2 payments approx. £261k	0	0	0	261,000	N Som
NS19	Dom Care incentives & recruitment	0	0	0	Approx. £16.5k	0	0	0	66,000	N Som
NS20	Dom Care incentives & recruitment	0	0	45,000	Proud to Care Post £35k – Promotional budget £10k	0	0	0	45,000	N Som
SG01	Assessment	Social Work and OT – Care Act assessments and plans. Notes Assumes a P3 bed base of 50 (includes spot purchases). Impact of LoS. Based on optimal model of MDT work into each setting &Pro-active early decision making & taking account of reduced LoS.	(staff budget 22fte)	1,022,603	2 x Senior Practitioner, 8 x Social Worker, 1 x OT, 1 x SW Assistant, 1x OT Assistant, 2 x Coordinators.	750,716	515,040	1,265,756	608,000	S Glos
SG07	Dom Care incentives & recruitment	Enable flow – reducing wait times for dom care pick up	100,000 pa additional commissioned hours of Dom Care attriubtable to D2A	1,900,000	recruitment and retention incentive - a weeks average pay to each worker at strategic care providers if existing staff stay in place for each 3 month period Q3 & Q4. £31,875 per quarter, total £127,500pa	127,500	0	127,500	127,500	S Glos

SG09	Dom Care Additional Capacity	Enable flow – reducing wait times for dom care pick up	Per SG07	0	financial support to create additional worker capacity. Analysis of the difference in size of packages across referrals show that hospital discharge packages are 2 hours bigger per week than community referrals (12 hours per week instead of 10). The 20% difference equates 2,102 per week (109,321 hours pa) additional burden from D2A channels. Providers need a £3 premium per hour to create capacity, this equates to 328,000. This represents 11% of the additional cost. The remainder will be met by the local authourity.	328,000	2,982,000	3,310,000	328,000	S Glos
SG11	Dom Care incentives & recruitment	0	0	0	Funding further 3 months for Q4 recruitment incentive (50% of £40,500 in row 7) = £20,250 pq	60,750	0	60,750	81,000	S Glos
TOTALS				**6,268,527**		**£1,266,966**	**£3,497,040**	**£4,764,006**	**1,876,261**	

Sirona - Additional DTA Funding (All posts include weekend working)

Pathway / Reporting	Service	Band	WTE	WTE with Cover	Original Costing £	LATEST Revised costing (NS P2 and Rev Corp Costs)	Comments	In Year Actuals / Forecast Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 In-Year Actuals / Forecast
	P1 Expansion					**£**														
P1	Nursing	5	2	2.46	107,277	107,277														0
P1	Therapists	6	5	6.15	333,958	333,958														0
P1	RSW's	3	51.7	63.6	1,970,595	1,970,595														0
P1	Admin	2	3	3	87,026	87,026														0
	Non Pay																			0
P1	Travel				52,830	52,830														0
P1	Equipment				17,610	17,610														0
P1	Medical Consumables				205,450	205,450														0
																				0
P1	Corporate Costs including IT				471,707	399,814	Revised	194,443	194,443	194,443	230,677	230,677	230,677							1,275,360
	Sub Total - P1 Expansion				**3,246,453**	**3,174,560**		**194,443**	**194,443**	**194,443**	**230,677**	**230,677**	**230,677**	**0**	**0**	**0**	**0**	**0**	**0**	**1,275,360**
	P3 Therapy 128 Beds																			
P2 and P3 therapy & pharmacist	Therapists	5	4	4.9	214,556	214,556														0
P2 and P3 therapy & pharmacist	Therapists	12	22.5	27.5	1,363,023	1,363,023														0
P2 and P3 therapy & pharmacist	RSW's	6	18.5	22.7	706,025	706,025														0
	Non Pay					-														0
P2 and P3 therapy & pharmacist	Travel				40,500	40,500														0
P2 and P3 therapy & pharmacist	Equipment				13,500	13,500														0
P2 and P3 therapy & pharmacist	Medical Consumables				157,500	157,500														0
																				0
P2 and P3 therapy & pharmacist	Corporate Costs including IT				374,255	317,214	Revised													0
	Sub Total - P3 Therapy				**2,869,359**	**2,812,318**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
	Total - P1 Expansion & P3 Therapy				**6,115,812**	**5,986,878**		**194,443**	**194,443**	**194,443**	**230,677**	**230,677**	**230,677**	**0**	**0**	**0**	**0**	**0**	**0**	**1,275,360**
P2 and P3 therapy & pharmacist	***Add Pharmacist***				60,326	60,326														0
	Total - P1 Expansion & P3 Therapy				**6,176,138**	**6,047,204**	**Revised Original Scheme Total**	**194,443**	**194,443**	**194,443**	**230,677**	**230,677**	**230,677**	**0**	**0**	**0**	**0**	**0**	**0**	**1,275,360**
	NS P2 Therapy Cover for additional Beds																			
P2 and P3 therapy & pharmacist	Physio	6	1	1.2	56,289	56,289														0
P2 and P3 therapy & pharmacist	OT	5	1	1.2	47,350	47,350														0
P2 and P3 therapy & pharmacist	AP	4	1	1.2	36,898	36,898														0
P2 and P3 therapy & pharmacist	RSW	3	1	1.2	34,975	34,975														0
																				0
P2 and P3 therapy & pharmacist	Direct Costs				9,040	9,040	Non pay(Travel, Medical Consumables, Uniform													0
P2 and P3 therapy & pharmacist	Indirect Costs				12,579	12,579	Laptops, Phones, Postage etc													0
P2 and P3 therapy & pharmacist	Corporate Costs				11,785	11,785	Payroll, HR, Apprentice Levy, BI, Insurance													0
	Sub Total - NS P2 Therapy Cover for Additional Beds				**208,916**	**208,916**		**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total - Revised Sirona Contribution					**6,385,054**	**6,256,120**		**194,443**	**194,443**	**194,443**	**230,677**	**230,677**	**230,677**	**0**	**0**	**0**	**0**	**0**	**0**	**1,275,360**

Acute Discharge Support

Pathway / Reporting	Area	Role	Costs
Acute Discharge Support	Clinical	Band 6 nurses x FTE IDS Case Managers (Mon- Fri 8 -4pm including 7 days per year on a Bank holiday or weekend.) x1 Weston, x2 Bristol	£125,214
Acute Discharge Support	A&C	Band 6 FTE Performance Manager x1 (Mon – Fri 8 -4pm no weekends or BHs) n.b this replaces 0.6 FTE Band 7 Speciality Manager.	£11,074
Acute Discharge Support	A&C	Band 4 Patient Flow Coordinators (A&C) x5 (Mon- Fri 8 -4pm including 7 days per year on a Bank holiday or weekend)	£153,500
Acute Discharge Support		Bristol only	
Acute Discharge Support	A&C	Uplift for Weston B2 x2 FTE	£4,628
Acute Discharge Support	A&C	Additional 1.0 FTW B3 for Bristol	£25,887
Total - Acute IDS Team			**£320,303**

CCG Costs

Pathway / Reporting	Description	Cost	
CCG brokerage	Brokerage	50,000	
P3 GP support	GPs for P2 & P3	62,000	funded from DES
GP support LES funding	GPs for P2 & P3	-62,000	
Patient Transport	Patient Transport	100,000	
P2 & P3 beds	Community Equipment	100,000	
	Total	**250,000**	

Bristol

No.	Reporting Category	Pathway	Pathway enabler	Service	Activity	Existing Resource	Baseline spend (BAU for LA)	Additional Resource Required	21/22 In-Year Actuals / Forecast	LA Contribution	Total 21/22 Contribution to HDP	BC Costs (FYE)	Q2 Accelerator or Q3/4 D2A	Lead in time	Total by Service
BS01	Homefirst / reablement		Interim Bed Co-ordinator (x1 post) and an Assistant Bed Co-ordinator post BG9 (X1 post)	DTA recurring funding	Oversight of P3 pathway beds; flow, link upstream to P1 and P2 and link across BCC and CCG and with providers. To facilitate meetings and relationships with providers and contract assurance. Production of activity data.	Post to oversee all Pathway beds and flow. Dominique Hills post part time.	55,236	This is a BG13 support post for a year to increase this oversight/ brokerage/ placement capacity.	0		0	55,236			110,472
BS02	Homefirst / reablement		OT Post	DTA recurring funding	One post to continue working with P1, 2 and 3 and rapid response referrals.	To continue to provide OT support across the D2A service, which has been in place via agency worker since 2020.	265,908		0		0	44,318			
BS03	Homefirst / reablement		OT Technician and AT Technician (x2 posts)	DTA recurring funding	Posts will work on sustainable, VFM solutions to care and support. AT to in-reach to acutes for simple discharge . Reduction in bed days and time in reablement.	Two posts to expedite discharge from all pathways including P0.	246,624	£35,232 (6 months for both posts) BG9 posts x2 at annual cost of £35, 232 per post.	0		0	70,464			317,088
BS05	Homefirst / reablement		Social Care Practitioner SCP post for front door to pick up PO discharges	DTA recurring funding	Dedicated post to pick up P0 individuals' where level of needs have not been identified in hospital. Potential to in-reach to E.D. Will have access to admission avoidance beds for Older People.	One post to manage P0 discharges at social care front door .	852,848	X1 BG9 post £17,650 (six months salary)	0		0	35,232			888,080
BS06	Assessment		CICB social worker posts	DTA recurring funding	Critical posts to inreach into acutes for MDT's and discharge dependent safeguarding.	Two social work posts in CICB to undertake MDTs, in-reach assessments and disclosure dependent safeguarding	1,934,924	BG11 posts x2 44,318 per post per annum. 6 months for two posts is £44,318 total	0		0	88,636			2,023,560
BS07	Homefirst / reablement		Re-ablement posts	DTA recurring funding	Critical reablement capacity to maintain P2 capacity as additional 30 packages a week into re-ablement from Sirona. And need for additional Mental Heath re-ablement capacity due to MH surge.	P2 re-ablement capacity X12 BG7 posts (£323.5k) and one senior reablement post BG9 (£35.2k)	3,616,922	£161,748 x12 reablement posts for 6 months And £17,650 BG9 senior re-ablement post for six months and	0		0	358,728			3,975,650
BS09	Homefirst / reablement		Homecare	DTA recurring funding	Extension of Bristol's currently successful block contract rounds taking from re-ablement. Due to increased activity from P1, P2 and P3 BCC has seen an increase in double up packages.	Homecare double up block rounds Previous surge funding Extension of current block contracts (single round) to all Framework providers to maintain supply and flow and keep DTOCs from re-ablement down.	17,837,000	£606,696 *for 12 months* *£81,328 for 12 months*	0		0	688,024			18,525,024
BS10	Homefirst / reablement		We Care and Repair	DTA recurring funding	Funding for this service and extension of contract enables direct discharge on P0.	Support people to return to own home – help when it is needed tier 2 service to support with PO, P1, P2 and P3	0	£75k	0		0	150,000			150,000
BS12	Brokerage		One additional commissioner to work on all D2A related initiatives	DTA recurring	Set up, manage and negotiate new block contracts for double up round and live in care and to manage additional brokerage, contact and commissioning deliverables from this business case.	Need for extra capacity to develop and contact manage blocks	662,832	£55,236 for a year	0		0	55,236			
BS13	ECH (and Redfield & Bariatric)		ECH OOH flats and training	DTA recurring	Continue successful ECH as pathway out of hospital -Brunel Care and Guinness Care	Continuation of x9 OOH ECH flats and care and support	5,300,000	£397,298 including 10k training for providers on managing complex clients (Mental health, substance misuse etc)	0		0	794,596			6,094,596
BS14	ECH (and Redfield & Bariatric)		Redfield beds	DTA recurring	Redfield Lodge beds as capacity	Redfield lodge as an OOH pathway (TBC)	1,834,720	£179,319 for six months	0		0	358,638			2,193,358
BS15	Assessment		VCSE Community Officer	DTA recurring	Fund an VCSE organisation in the City to provide this service. Either fund existing service (such as Red Cross) or new service to be developed	Funding to VCSE offer to support people after discharge. This offer could be telephone support, or practical support for food shopping etc.	0	Estimate - £40k TBC with market	0		0	40,000			40,000
TOTALS							**32,607,014**	**£1,481, 970 for six months 1/10/2021 to 31/03/2022.**	**£0**	**£0**	**£0**	**2,739,108**			**34,317,828**

North Somerset

No.	Reporting Category	Pathway	Pathway Enabler	Service	Activity	Existing Resource	Baseline spend (BAU for LA)	Resource Required	21/22 In-Year Actuals / Forecast	LA Contribution	Total 21/22 Contribution to HDP	BC Costs (FYE)	Q2 Accelerator or Q3/4 D2A	Lead in time	Total by Service
NS12	Assessment			Trusted assessor				Refresher training - £120 plus VAT – approx. 4 people = £562.52 Level 2 training - £250 plus VAT – approx. 2 people = £562.50	0		0	1,125			1,125
NS14	Assessment			Social Care staff			828,000	Social worker x 4 at £40k = £160k	0		0	160,000			988,000
NS15	Assessment			Care Navigator /Home First Co-ordinator			353,000	Care Navigator x 2 at £35k = £70k	0		0	70,000			423,000
NS18	Dom Care incentives & recruitment			Proud to Care Bonus			185,000	Based on previous 6 months x 2 payments approx. £261k	0		0	261,000			446,000
NS19	Dom Care incentives & recruitment			Golden Hello			0	Approx. £16.5k	0		0	66,000			66,000
NS20	Dom Care incentives & recruitment			Proud to Care Post and Promotional Activities			45,000	Proud to Care Post £35k – Promotional budget £10k	0		0	45,000			90,000

South Gloucestershire

No.	Reporting Cetegory	Pathway	Pathway enabler	Service	Activity	Existing Resource	Baseline spend (BAU for LA)	Additional Resource Required	21/22 In-Year Actuals / Forecast	LA Contribution	Total 21/22 Contribution to HDP	BC Costs (FYE)	Q2 Accelerator or Q3/4 D2A	Lead in time	Total by Service
SG01	Assessment		Support to ICCB	Additional Capacity required to enable flow from Pathway 2 & 3 from 01/10/21 to 31/03/22	Social Work and OT – Care Act assessments and plans. *Notes* *Assumes a P3 bed base of 50 (includes spot purchases). Impact of LoS. Based on optimal model of MDT work into each setting &Pro-active early decision making & taking account of reduced LoS.*	(staff budget 22fte)	1,022,603	2 x Senior Practitioner, 8 x Social Worker, 1 x OT, 1 x SW Assistant, 1x OT Assistant, 2 x Coordinators.	750,716	515,040	1,265,756	608,000	Q3/4 D2A	In post	1,630,603
SG07	Dom Care incentives & recruitment		P1,2,3	Dom Care	Enable flow – reducing wait times for dom care pick up	100,000 pa additional commissioned hours of Dom Care attriubtable to D2A	1,900,000	recruitment and retention incentive - a weeks average pay to each worker at strategic care providers if existing staff stay in place for each 3 month period Q3 & Q4. £31,875 per quarter, total £127,500pa	127,500	0	127,500	127,500	Q3/4 D2A	Paid to those in post	2,027,500
SG09	Dom Care Additional Capacity		P1, P2, P3	Dom Care	Enable flow – reducing wait times for dom care pick up	Per SG07		financial support to create additional worker capacity. Analysis of the difference in size of packages across referrals show that hospital discharge packages are 2 hours bigger per week than community referrals (12 hours per week instead of 10). The 20% difference equates 2,102 per week (109,321 hours pa) additional burden from D2A channels. Providers need a £3 premium per hour to create capacity, this equates to 328,000. This represents 11% of the additional cost. The remainder will be met by the local authourity.	328,000	2982000	3,310,000	328,000	Q3/4 D2A	Time to Implement TBC	328,000
SG11	Dom Care incentives & recruitment							Funding further 3 months for Q4 recruitment incentive (50% of £40,500 in row 7) = £20,250 pq	60,750	0	60,750	81,000			81,000

Pathway	Service Description	Total	Comments
	First Call		Financial Breakdown not provided
	Longer Length of Stay		Financial Breakdown not provided
	Pathway 0		Financial Breakdown not provided
	High Intensity use		Financial Breakdown not provided
P0	**Total Cost - Red Cross**	**845,478**	

From: ANTHWAL, Rachel (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
Sent: 23 July 2021 08:55
To: KELL, Julie (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
Cc: ROBERTSON, Keith (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG); PENLINGTON, Greg (NHS BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE CCG)
Subject: Red Cross costsing for D2A case

Apologies as this has only just come in from Red Cross. Having discussed with them, we are keen to include a wider offer than Home First into the package as we envisage it will bring wider benefits and reduce costs across the system. As a result we would propose the VCS element be £845, 478. This would include the following elements ran as a block:

Happy to discuss if you feel different about inclusion of these costs.

Best wishes,
Rachel

HM Government

NHS

Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and adult social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- Transfer from the ward to a designated discharge area should happen promptly; for persons on pathway 0 this should be within one hour of that decision being made, and the same day for people on all other pathways. Discharge from the discharge area should happen as soon as possible and appropriate, preferably before 5pm.
- Due to COVID-19, everyone being discharged to a care home must be tested for Coronavirus and, irrespective of test result, will need to be isolated in that setting.

MEDICAL STAFF (DOCTORS)

What will I be able to stop doing?

- **Detailed functional inpatient assessments prior to discharge (describe need not provision)**
- **Making decisions about the care people will need after discharge**

All people who no longer meet the criteria to reside for inpatient care in acute hospitals should be discharged home or to a non-acute setting.

Reviews and discharge co-ordination

- At least twice daily multi-disciplinary review (consultant review at least daily) of all people in acute beds to agree who no longer meets the clinical criteria to require inpatient care and will therefore be discharged.
- Ensure clear clinical plans in medical notes to enable criteria-led discharge.
- Request immediate arrangements for discharge with a plan for virtual follow up where needed.
- Limited functional assessments should take place in an acute setting once people no longer have a medical need for inpatient care. People requiring on-going support will be discharged to assess.
- The multi-disciplinary team need to clearly describe the support people will require when they are discharged or transferred.
- Ensure that the discharge summary includes the date that COVID-19 testing was conducted and the results, if known.

Safety netting

- Patient initiated follow up. Give people the direct number of the ward they are discharged from to call back for advice. Do not suggest going back to their GP or going to the emergency department.
- If required, telephone people the following day after discharge to check on them for reassurance.
- If required, call people after discharge with the results of investigations and their management plan.
- Manage people virtually in outpatient clinics care under the same team/ speciality.
- Request community nursing follow up where appropriate.
- Request GPs to follow up in some selected cases.

Criteria led discharge

- Document clear clinical criteria for discharge that can be enacted by the appropriate junior doctor, qualified nurse or allied health professional without further consultant review.
- Ensure arrangements are in place to contact the consultant directly for clarification about small variances from the documented clinical criteria.

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Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.
- Due to COVID-19, everyone being discharged to a care home must be tested for Coronavirus and, irrespective of test result, will need to be isolated in that setting.

MATRON, WARD MANAGER (NURSE IN CHARGE)

What will I be able to stop doing?

- **Detailed functional inpatient assessments prior to discharge (describe need not provision)**

All people who no longer meet the criteria to reside for inpatient care in acute hospitals should be discharged home or to a non-acute setting.

What do I need to do?

- Ensure at least twice daily multi-disciplinary review (consultant review at least daily) of all people in acute beds to agree who no longer meets the clinical criteria to require inpatient care in an acute hospital and will therefore be discharged.
- Ensure every person has a clearly written plan which includes clinical and functional criteria for discharge. Make sure the plan is communicated to all multi-disciplinary team members, the person and their loved ones.
- Limited functional assessments should take place in an acute setting once people no longer meet the criteria to reside in an acute hospital. People requiring on-going support will be discharged to assess. The multi-disciplinary team need to clearly describe the support, i.e. the discharge to assess pathway, people will require when they are discharged or transferred.
- Liaise with managers of the discharge team for pathway 0 (where the person is discharged home without any support needs/requirements).
- Ensure that testing follows the latest national infection control and testing guidance and is planned in advance so that, where possible, results are available before discharge.
- Follow the system to share testing results with individuals and receiving care homes where applicable.
- During every ward round, board round or case discussion ensure the following questions are asked:
  - Does the person require the level of care that they are receiving, or can it be provided in another setting?
  - What value are we adding for the person staying in an acute hospital balanced against the risks of them being discharged home or to a non-acute setting?
  - What do they need next and what action is required?
  - ‘Why not home, why not today?’ for those who have not reached a point where long-term 24-hour care is required.
  - If not for discharge today, then when? Ensure there is an expected date of discharge.
  - Can a nurse or allied healthcare professional discharge the person without a further review if documented clinical criteria are met?

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Hospital Discharge Service Requirements

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Key messages for all staff

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- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.

ACUTE THERAPY TEAMS

What will I be able to stop doing?

- **Detailed functional assessments for discharge**
- **Equipment ordering for anyone requiring ongoing input**

A significant part of your work will now be in non-acute settings (mainly in people's homes)

What will I do differently?

- Limited assessments for discharge will be undertaken within a ward or other hospital environments/designated therapy assessment areas.

Roles could include (this is not an exhaustive list and will depend on individual skillsets):

- A single coordinator role will direct (for each person) who will take on the case management role and undertake the first assessment at home.
- Acute therapists will assess people in their own home/usual place of residence at the request of the single coordinator and agree a recovery and support plan with the person including reablement support and/or equipment.
- This will be a trusted assessment which will be accepted by the receiving care provider (agreement as to universal document to be used across acute and community services).

When and where will I do my work?

- You will work much more fluidly between community settings, people's homes and within the acute trust, depending on the capacity demands and learning from the COVID-19 Level 4 emergency.
- Cover will continue to be required over 7 days so you may find your hours of work are adjusted.

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Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.

BEDDED REHABILITATION (THERAPIES)

What will I be able to stop doing?

- **Assessments on the acute wards**
- **Detailed functional assessments for discharge**
- **Equipment ordering for anyone requiring ongoing input**
- **Assessment and discharge notification processes**

You will need to decrease the overall length of stay to create more capacity and allow more people to benefit from rehabilitation.

How will I need to work differently with colleagues?

- There will be a case manager based in the acute hospital who will be liaising directly with your unit to facilitate the transfer.
- There will be an increase in the availability of recovery and support services within the community. They will start quicker and help people to regain autonomy at home.
- The national Capacity Tracker Tool needs to be updated with your bed status to help manage overall NHS bed capacity.

What will I do differently?

- Start a daily clinical review (10-20 mins) of the plan for every person. Focussing on the key questions; Why not home? What needs to be different? Why not today?
- You will use discharge to assess pathways as a discharge route from community rehabilitation beds.
- You will act as trusted assessor for onward referrals. You should not expect to have to re-do assessments, or to use lengthy referral forms.
- You may need to use technology for outreach and follow up to reduce travel time.
- All equipment and care needs will be assessed within the person's home using the locally agreed routes.

When and where will I do my work?

- Cover will continue to be required over 7 days so you may find your hours of work are adjusted.
- You may be required to outreach to support your patient home. The single co-ordinator will direct the process.

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Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.
- Due to COVID-19, everyone being discharged to a care home must be tested for Coronavirus and, irrespective of test result, will need to be isolated in that setting. If their destination cannot do so, the local authority is responsible for providing suitable alternative accommodation.

SOCIAL CARE

A significant part of your work will now be in non-acute settings (mainly in people's homes).

What will I be able to stop doing?

- **Assessment and discharge notification processes**
- **Assessment of needs in the acute setting**
- **Funding panel requests**
- **Attendance at board rounds**

How will I need to work differently with colleagues?

- In general, no social care or funding assessments will be undertaken in hospital.
- Safeguarding investigations should continue to take place in a hospital setting if necessary.
- People will be discharged from hospital as soon as possible after the decision to discharge has been made.
- Most people will be discharged home or to the place they lived prior to hospital admission.
- Align with reablement/ intermediate care services to ensure that the support provided within the initial recovery period is reviewed as soon as practical, continually adjusting as the individual progresses.
- Conduct Care Act assessments, if appropriate, within the 6-week period as the need for a long-term package becomes clear.
- No one will be discharged to a care home without local authority involvement.

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Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.

CCGs & LOCAL SYSTEM COMMISSIONERS

What will I be able to stop doing?

- **Intensive contract monitoring**

If your CCG and local authority currently commission domiciliary care and care homes in relation to discharge in your locality separately you will establish a single commissioning route with one accountable lead organisation, and share performance and other data with regard to your local care providers single relationship management routes.

How will I need to work differently with colleagues?

- You will determine a lead commissioning organisation and lead commissioner.
- Ordinary financial controls are to be maintained with respect to invoicing, raising of purchase orders and authorising payments.
- The lead commissioner will work closely with the single discharge co-ordinator to ensure that issues in relation to flow through commissioned services are promptly addressed.

What will I do differently?

- You will expand the use of telecare and telehealth where possible.
- Support greater use of personal health budgets and individual service funds to support mainstream care at home, provided by directly employed carers.
- Establish contractual options to maintain continuity of care from providers supporting pathway 1 people at home when the discharge to assess period of free care is completed.

When and where will I do my work?

- You are likely to work much more closely with people engaged in different elements of the commissioning process from other organisations.
- You are likely to need to work more flexibly to support requirements. Cover will continue to be required over 7 days, so you may find your hours of work are adjusted.

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NHS

Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.

MANAGERS OF THE DISCHARGE TEAM

A significant part of your work will now be co-ordinating care input and oversight in non-acute settings (mainly in people's homes).

What will I be able to stop doing?

- **The guidance reduces current requirements to collect and report various forms of activity**

How will I need to work differently with colleagues?

- Effective liaison with wards for pathway 0 (where the person is discharged home without any support needs / requirements).
- Close collaboration with the role of single co-ordinator for pathways 1,2 and 3.

What will I do differently?

- Ensuring that people are assessed for short term care needs as they arrive home.
- Ensuring assessment and tracking capacity for pathways 1, 2 and 3 to ensure people are tracked and followed up to assess for long term needs at the end of the period of recovery.
- Arranging dedicated staff to support and manage people on pathway 0.

When and where will I do my work?

- You will work much more fluidly between community settings, and within the acute trust, depending on the capacity demands and learning from during the COVID-19 emergency period.
- Cover will continue to be required over 7 days, so you may find your hours of work are adjusted.

HM Government

NHS

Hospital Discharge Service Requirements

This document outlines how your role will alter in line with the overarching discharge framework. These changes will ensure that people who need care receive it in the right setting.

Key messages for all staff

- Once someone no longer meets the clinical criteria to require inpatient care in an acute hospital, they will be discharged **as soon as possible today**, and any further assessment required will be done in a community setting. Discharge to assess will be the default for all people who require assessment of their care needs. Community health providers and social care will operate with a single co-ordinator in each acute centre, accountable to a named Executive Board director.
- You will prioritise time to identify and agree which people can be discharged home or transferred to a non-acute setting.
- People on pathway 0 will be discharged from the ward / unit within 1 hour after a medical decision to discharge has been confirmed. Discharge home should be the default pathway. If people are not able to go home immediately, they will be transferred to a safe place to await discharge, which should happen as soon as possible.

MEMBERS OF THE DISCHARGE TEAM

What will I be able to stop doing?

- **Processing assessment and discharge notices because there will be none**
- **Arranging discharges of people on pathways 1-3**

You will continue discharging people on pathway 0 (straight home with no required support) and a significant part of your work will be focused on pathways 1-3, in partnership with reablement and intermediate care services.

How will I need to work differently with colleagues?

Staff from discharge teams will be using their skills to supplement capacity in the discharge to assess service and will be directed by the single co-ordinator role and supported by their line manager.

What will I do differently?

Roles could include (this is not exhaustive and will depend on individual skillsets):

- Case manager in the acute trust (every person will be allocated a case manager as soon as the decision to discharge is made by the consultant).
- Accompanying people to the discharge lounge.
- Accompanying people home or to another setting when discharged.
- Carrying out reviews and assessments of people who are on the discharge to assess pathways.
- Acting as trusted assessor for care homes and community beds.
- Other non-clinical roles within the hospital and community as required to support effective flow of patients.

When and where will I do my work?

- You will work much more fluidly between community settings, people's homes and within the acute trust, depending on the capacity demands and learning during the COVID-19 emergency period.
- Cover will continue to be required over 7 days, so you may find your hours of work are adjusted.

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

D2A Business Case Review

24th February 2021

Authors

Julie Kell Head of Performance Integrated Care

xxxxx xxxxx Project Officer (Integrated Care)
NHS Bristol, North Somerset & South Gloucestershire CCG

Microsoft Teams

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

List of Attendees

Attendee	Organisation	Job Title
Xxxxx xxxxx - Chair	**BNSSG CCG**	Deputy Director of Commissioning (Contracting & Procurement)
Julie Kell	**BNSSG CCG**	Head of Performance (Integrated Care)
xxxxx xxxxx - Facilitator	**BNSSG CCG**	Deputy Director of Commissioning (Planning & Performance)
Xxxxx xxxxx – Note taker	**BNSSG CCG**	Urgent Care Support Coordinator
xxxxx xxxxx	**Sirona**	Director of Operations
Xxxxx xxxxx	**NSC**	Head of Commissioning People & Communities
xxxxx xxxxx	**NSC**	Finance Business Partner (Adults and Children's Services)
xxxxx xxxxx	**NSC**	Service Leader-Adults' Support & Safeguarding
xxxxx xxxxx	**UHBW Weston**	Head of Patient Flow & IDS Weston Division
Xxxxx xxxxx	**BNSSG CCG**	Associate Director of Quality
Xxxxx xxxxx - Facilitator	**BNSSG CCG**	Deputy Director of Transformation
xxxxx xxxxx – Note Taker	**BNSSG CCG**	Project Officer (Integrated Care)
xxxxx xxxxx	**BCC**	Deputy Director – Adult Social Care
xxxxx xxxxx	**BCC**	Acting Head of Service Front Door and Discharge to Assess Services
xxxxx xxxxx	**Sirona**	Access and Flow Lead Bristol
Jon Lund	**BNSSG CCG**	Deputy Chief Finance Officer
xxxxx xxxxx	**NBT**	Deputy Chief Operating Officer
Xxxxx xxxxx	**BCC**	Deputy Director Integration, Transformation and Partnerships

Xxxxx xxxxx	**BCC**	Head of Adult Care Commissioning Care and Support Adults
xxxxx xxxxx	**UHBW**	General Manager Complex Discharge & South Bristol Community Hospital
xxxxx xxxxx	**BNSSG CCG**	Contract Manager Non Acute
xxxxx xxxxx	**BCC**	Head of Finance
xxxxx xxxxx	**BCC**	Principal Commissioning Manager Adult Social Care
xxxxx xxxxx	**UHBW**	Head of Commissioning & Planning
Xxxxx xxxxx - Facilitator	**BNSSG CCG**	Head of Contracts (Non- Acute)
xxxxx xxxxx – Note Taker	**BNSSG CCG**	Team Administrator (Integrated Care)
Xxxxx xxxxx	**BNSSG CCG**	BI Manager – Transformation
xxxxx xxxxx	**SGC**	Adult Social Care Service Manager
Anne Clarke	**SGC**	Director for Adult Social Care and Housing Department for Children, Adults and Health
Julie Sharma	**Sirona**	Director of Transformation
Rebecca Harrold	**SGC**	Partnerships and Commissioning Service Manager
xxxxx xxxxx	**SGC**	Head of Financial Management and Business Support Department for Children, Adults and Health
Sian Barry	**NBT**	Associate Director of Contracts
xxxxx xxxxx	**NBT**	Assistant Director of Finance

List of Presenters:

Attendee	Organisation	Job Title
Xxxxx xxxxx	**BNSSG CCG**	Deputy Director of Commissioning (Contracting & Procurement)
Julie Kell	**BNSSG CCG**	Head of Performance Integrated Care
xxxxx xxxxx	**Sirona**	Access and Flow Lead Bristol
xxxxx xxxxx	**NBT**	Assistant Director of Operations (Integrated Discharge)
xxxxx xxxxx	**NSC**	Adults' Support and Safeguarding & Strategic Lead for Occupational Therapy
Xxxxx xxxxx	**BNSSG CCG**	BI Manager – Transformation
xxxxx xxxxx	**Sirona**	Interim Lead BI Business Partner
Jon Lund	**BNSSG CCG**	Deputy Chief Finance Officer
Xxxxx xxxxx	**BCC**	Head of Adult Care Commissioning Care and Support Adults
xxxxx xxxxx	**BCC**	Principal Commissioning Manager Adult Social Care
xxxxx xxxxx	**BCC**	Acting Head of Service Front Door and Discharge to Assess Services
Rebecca Harrold	**SGC**	Partnerships and Commissioning Service Manager
Xxxxx xxxxx	**NSC**	Head of Commissioning People & Communities
xxxxx xxxxx	**UHBW**	General Manager Complex Discharge & South Bristol Community Hospital
xxxxx xxxxx	**NBT**	Deputy Chief Operating Officer

List of Apologies:

Attendee	Organisation	Job Title
xxxxx xxxxx	**NSC**	Assistant Director Adults' Support & Safeguarding
xxxxx xxxxx	**BNSSG CCG**	Senior Performance Improvement Manager – Integrated care
xxxxx xxxxx	**UHBW**	Deputy Chief Operating Officer – Urgent Care

Objectives:

Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Discharge to Assess is an integrated person-centred approach to the safe and timely transfer of medically ready patients from an acute hospital to a community setting for the assessment of their health and/or social care needs.

- Is the model right - If it's not what do we do
- What are the barriers to achieving the model
- To agree next steps as a system to ensure this model is implemented and funded in the most appropriate manner

Summary of Presentations

	Name	Summary
		Welcome & Introduction
1.	**Xxxxx xxxxx** **BNSSG CCG** **Chair**	**Objective of the day** • Is the model right and if it's not right what do we do? • Bring everyone up to the same position • Agree next steps
2.	**Julie Kell** **BNSSG CCG**	**Executive Summary of Model** Key points to draw in Model a national model Done at pace Expected to see significant pressure throughout Feb and March within community services Capacity and demand model forecasts improved efficiency reduces required need for community beds. Flow mapped into ongoing LA services  2.1 Model Executive Summary.pptx
3.	xxxxx xxxxx **NBT** xxxxx xxxxx **Sirona** xxxxx xxxxx **NSC**	**Operation Scene Setting** Presentation gave examples on what it feels like within operational services both acute, Sirona and LA services.  3.1 Operational Scene Setting v1.5.p|
4.	**Xxxxx xxxxx** **BNSSG CCG** xxxxx xxxxx **and**	**What does the data tell us?** This presentation took us through data following the impact of D2A on the pathway from acute, community and onward pathways. It was

	xxxxx xxxxx **Sirona**	noted that this slide deck contains data that was not available in the previous financial year; therefore it cannot be directly compared to previously held data. The data is collected from numerus sources, therefore will not always be a validated position, but does provide baselines. The data will feed into the Digital ICB going forward and improve accuracy. This data, although still having ongoing work, does correlate with the narrative that is understood as a system. 4.1 What does the data tell us 2402 v0.(
5	**Jon Lund BNSSG CCG**	**Finance update** Presentation ready for workshop gave a briefing on actual costs of D2A model alongside potential sources and applications for ongoing funding. Within the presentation and in the chat box concern was raised about ensuring assumptions within the finances met the performance position i.e. LOS, bed closures in acute trusts and expectation of ongoing long term care currently within the local authorities. 5.1 D2A Exec Summary - Finance U
6	**Xxxxx xxxxx NSC Xxxxx xxxxx,** xxxxx xxxxx **and** xxxxx xxxxx **BCC, Rebecca Harrold SGC.** xxxxx xxxxx **Sirona.** xxxxx xxxxx **and** xxxxx xxxxx **NBT and UHBW**	**Key lines of enquiry/ risks and issues** • Local Authority perspective • Sirona perspective • Acute perspective Within each of these presentations each area as per slide decks highlighted the key issues and risks per organisation in order that these could be discussed and noted as we broke into the breakout groups. Particular issues noted across the organisations were the impact on not going forward with the model i.e. high numbers of MFFD, capacity issues in the community and financial risks per organisation. 6.1 Local Authority key lines of enquiry ri 6.2 Sirona key lines of enquiry risks and is 6.3 Acute Trusts key lines of enquiry risks a

List of Q&As and responses including comments

Q/A	Name	Question/Answer
Q	xxxxx xxxxx NBT	How is the occupancy of acute beds data calculated with the requirement for reduced bed bases to manage infection control?
A	Xxxxx xxxxx CCG	The occupancy of acute beds were taken from ALAMAC and the average per week was taken. I can share the exact ALAMAC metrics if helpful.
Q	xxxxx xxxxx Sirona	Where has the LOS data come from for Social Care Ax in 2020? Social Care assessments are no longer completed in acute settings and should be moved into the P3 data section which explains the increase in that pathway.
A	Xxxxx xxxxx CCG	This data has been taken from Trust data but may be showing an average of Social Care Ax and P3 combined would show a better comparison.
C	xxxxx xxxxx Sirona	As digital CIC becomes online, more data will be available to us. We must be mindful and ensure data aligns with what's happening on the ground.
C	Xxxxx xxxxx NSC	The data has not shown any evidence around the reduction of long term care. Reducing 209 beds in hospitals has had a significant impact on social care.
C	Anne Clarke SGC	We must look at admissions and work to understand more about patient experiences rather than focus on reducing bed days.
C	Stephen Beet BCC	We need more time to understand/explore those financial assumptions across the whole system to help us design the most efficient model and ensure best outcomes/experience for patients/citizens.
C	xxxxx xxxxx SGC	The transfer of resources referred to so far in the presentations seem to have only identified a transfer to Sirona, but the current model has required extra spend by LAs funded by the D2A grant so that impact on LAs spend would need to be explored and funded.
C	Jon Lund CCG	Lower demand for care homes have been referred to by local authority colleagues, this would assume there is a saving on care packages in the long term. Presumably LAs have increased dom care spend and decreased care home spend, this could be seen as beneficial for patients and LA finances?

C	xxxxx xxxxx NSC	POC alternatives to placements can be more expensive than placements but it would be interesting to look at comparable spend.
C	Xxxxx xxxxx BCC	An evidenced lower demand for care homes would provide these benefits but this needs to be evidenced in each LA. We very much support that, but has to be done strategically otherwise we get unforeseen consequences, e.g. if a home suddenly finds itself unsustainable because we increase and decrease beds, that cost comes back on LA.
Q	Xxxxx xxxxx BCC	In the longer term is there room for the system to look for opportunities to plan/develop different P2/3 facilities, as part of larger ECH developments?
A	Julie Kell CCG	It is expected to pick this up within the bed review
C	Anne Clarke SGC	We must give more consideration to the environment different care settings offer and look towards estates that enable the most IPC measures to taken place.
C	xxxxx xxxxx NBT	The profile of patient wait has shifted we must take any actions needed to ensure elective throughput is as high as possible for the next year.
C	xxxxx xxxxx Sirona	There is a need to review the business case in isolation and across all partners. This workshop is an opportunity to check and challenge with each other and agree next steps.

Developing the action plan moving forwards breakout session:

Group 1 – Bristol

List of Attendees

Attendee	Organisation	Job Title
Xxxxx xxxxx - Facilitator	**BNSSG CCG**	Deputy Director of Transformation
xxxxx xxxxx – Note Taker	**BNSSG CCG**	Project Officer (Integrated Care)
xxxxx xxxxx	**BCC**	Deputy Director – Adult Social Care
xxxxx xxxxx	**BCC**	Acting Head of Service Front Door and Discharge to Assess Services
xxxxx xxxxx	**Sirona Care and Health**	Access and Flow Lead Bristol
Jon Lund	**BNSSG CCG**	Deputy Chief Finance Officer
Xxxxx xxxxx	**BNSSG CCG**	Deputy Director of Commissioning (Contracting & Procurement)
xxxxx xxxxx	**NBT**	Deputy Chief Operating Officer
Xxxxx xxxxx	**BCC**	Deputy Director Integration, Transformation and Partnerships Adult Care
Xxxxx xxxxx	**BCC**	Head of Adult Care Commissioning Care and Support Adults
xxxxx xxxxx	**UHBW**	General Manager Complex Discharge & South Bristol Community Hospital
xxxxx xxxxx	**BNSSG CCG**	Contract Manager Non Acute
xxxxx xxxxx	**BCC**	Head of Finance
xxxxx xxxxx	**BCC**	Principal Commissioning Manager Adult Social Care
xxxxx xxxxx	**UHBW**	Head of Commissioning & Planning

1. What the model looks like

- Acknowledgement of complexities of system and the huge amount of work it has

taken to get us as a system to this stage.

- Comfortable and signed up to the D2A model, the modelling of pathways and outcomes for patients as they move on to onward support is where the focus is needed.
- BNSSG has a high number of P3 beds in comparison to other systems, (115 in Bristol currently, not including surge beds).
- Our definition of P3 differs to other systems.
- Keen to develop a P3 model that flex's and adapts alongside promoting as much P1 as possible.
- Key to promote when people can go home they should go home. There is a lot more as a system that can be done around P0 and admission avoidance.
- CICBs have become the community front door for admission avoidance, these needs to be factored into the model more.
- The D2A model isn't just a discharge from hospital it is the continuation of support for an individual across health and social care.
- A key need for the model to work is an agreed, sustained long term funding plan.
- Whatever we design long term needs to align to things like the Better Care Fund.

2. Barriers

- Unpredictability around the long term consequences of Covid.
- How do you project forward accurately with such fluctuations in activity across the system
- Key risks include the loss of key services we heavily rely on
- Finances have been set up in the short term to progress the model as a response to Covid, this may create barriers in the future development of a joint funding approach
- What is our stretch, what is our aim and how do we future proof this?
- Culture shifts are needed to allow us to respond to the here and now. A culture is needed where we are all on the same page and can be flexible enough to move patients into the right place for them.
- Complications of P3 due to the complexity and variety of people in P3 beds
- The D2A model is the right first step but there is more work to be done around holding people in the community & understanding their journey within the system
- Therapy provision and rehab provision difference in pathways
- We need to understand why we still have so many people in the P3 beds to allow us to make the necessary changes
- Issues with brokering onward care
- Boundaries around the care provision model creates are outdated, we need to look

at what the future looks like

- We need to focus on what a person needs rather than working towards time limits of 28 days/ 42 days etc.
- Disconnect between the view that we are taking more people into P3 than we should be from national modelling
- A critical barrier will be workforce and how we ensure we have the workforce needed across all partners - There is a risk we are duplicating work and competing for workforce.
- how do we build needed capacity in the longer term, and think what capacity means - it's not just beds, it's the input needed for the output

3. Actions to ensure model is implemented and funded in the most appropriate manner

Action	Recommended group to pick up action e.g. OOHDG/ Capacity and Impact
- Consideration of how we move therapy support to the community, with the risk transfer – link to CICB and policies with better risk share across the system	**OOHDG – Operational work stream**
- Short term funding needs resolving to consider current investment, short term funding and costs after March – Short life task and finish	**OOHDG - Finance work stream**
- Longer term ambitions and trajectories for improvement to be determined, including transformational change needed to deliver the trajectories/ambitions and home first goals.	**ICSG work programme working alongside OOHDG**
- Disaggregation of the D2A Business Case into LA areas	**OOHDG - Finance work stream**
- Acute bed release and what these will be reused for; what the long term plan allocations are likely to be	**System DOFs and planners sub group to consider impact on acute and alternate funding streams (needs to include stroke released capacity)**
- Deep dive into why we still have so many people in the P3 beds to allow us to make the necessary changes and why we are so different to other areas – benchmarking and best practice information from other areas as part of BCC Care	**OOHDG – Operational work stream**

- Ladder work	
- Completing the LA outflow from D2A pathways and outcomes	**OOHDG – Commissioning Arrangements work steam**
- System targets for different parts of pathways – linked to longer term trajectories to help management and delivery	**OOHDG – Operational work stream**
- Workforce modelling based on needs	**Healthier Together - BNSSG workforce modelling**
- Need to confirm governance and alignment to ICSG rather than urgent care steering group	**Xxxxx xxxxx with Julie Kell and xxxxx xxxxx**
- Longer term goal for Bristol to be agreed, transformation support from Sirona needed to support this.	**Local meeting to be organised between BCC and Sirona**

4. Other Comments

Success factors while working through Covid using the D2A model –

- Joint working
- Good relationships
- Good focused task groups to tackle key issues e.g cell structure
- We stopped thinking about LA responsibility vs health responsibility as we weren't focused on money

Group 2 – South Gloucestershire

List of Attendees

Attendee	Organisation	Job Title
Xxxxx xxxxx - Facilitator	**BNSSG CCG**	Head of Contracts (Non- Acute)
xxxxx xxxxx – Note Taker	**BNSSG CCG**	Team Administrator (Integrated Care)
Xxxxx xxxxx	**BNSSG CCG**	BI Manager – Transformation
xxxxx xxxxx	**SGC**	Adult Social Care Service Manager
Anne Clarke	**SGC**	Director for Adult Social Care and Housing Department for Children, Adults and Health
Julie Sharma	**Sirona care and health**	Director of Transformation
Rebecca Harrold	**SGC**	Partnerships and Commissioning Service Manager
xxxxx xxxxx	**SGC**	Head of Financial Management and Business Support Department for Children, Adults and Health
Julie Kell	**BNSSG CCG**	Head of Performance (Integrated Care)
Sian Barry	**NBT**	Contracting Lead
xxxxx xxxxx	**NBT**	Assistant Director of Finance

1. **What the model looks like**

- Had and have a very proactive approach to discharge planning and way we have worked within the CICB, complexity of work sometimes not reflected in the numbers, to try and retain if we can. Basis of model is relationships, how do we build on these relationships. Bear in mind needs of patient.
- What is model trying to do, is very fixed on data, difficult to model for the future, to model on real life, development to be done on it, some elements time-intensive, to keep providers reassured, hidden demands on model.
- One spec for all care homes has added value.

2. **Barriers**

- Dispersed P3 capacity across a large geography.
- Relied on spot purchasing of P3 beds even before COVID.
- The need to handhold providers who are not performing – this takes time to address and involves all stakeholders.
- Market capacity in general, dom care capacity constrained in recruiting and retaining staff, strategic approach on hold in dealing with here and now.
- Demand and capacity model – still some concern, how do more actually reflect what we are doing and predict what will happen.
- Ongoing finances behind the model, what is financial and resource gap as a system? Need transparency around costs.
- Funding challenge been solved by additional money – take funding away then no ability for LAs to continue that level of support, becomes unsustainable.
- As new community provider, Sirona keen to have time to build relationships in North Somerset and Bristol with relevant stakeholders.
- The belief that you can remove beds to fund the D2A model is false.
- If current funding levels stop, the model can't operate.

3. Actions to ensure model is implemented and funded in the most appropriate manner

Action	Recommended group to pick up action e.g. OOHDG/ Capacity and Impact
Short Term	
Conduct and review a risk assessment on funding and staffing stopping in April	Silver /Gold
Develop plan on how to de-escalate current capacity to BAU levels	OOHDG alongside Capacity & Impact Cell
Medium Term	
Identify hidden costs from current service model	OOHDG – Finance Work stream
Refresh the cost (including line above) and resources involved in the current D2A model. Assess this against: • Outcomes achieved • Demand and capacity • Financial envelope	OOHDG – Finance Work stream – feeding into system planners and DDOFs

• Strategic plan From this, then agree future model.	
Assess how additionally commissioned services fit with the model, e.g. extra care housing, live in care, etc.	OOHDG – Operational work stream
Resolve 7 day working in South Glos Council – needs a long term solution.	OOHDG – Operational work stream
Reduce variability in system for 7 day working, to maximise opportunity.	OOHDG– Operational work stream
Maximise use of available capacity and reduce number of slots lost across the system.	OOHDG - Operational work stream
Long Term	
Strategic estates discussion for OOHC	Strategic Planning Group
Development of dom care market for the system – including who funds it	OOHDG – Commissioning Work stream

4. Other comments

- Use of agency staff – need to move away from the use of these.
- Funding on D2A requirements – Reviewing LAs shared finances and comparing across model.
- Funding – if money removed from acute to fund, impacts on income and expenditure, can't carry out elective work, what happens to acute beds? What has been shared on the finances? Realign future investment rather than a reduction in current funding allocations.
- Waiting lists – how do they interconnect across acutes, community and LAs.

Group 3 - North Somerset

List of Attendees

Attendee	Organisation	Job Title
xxxxx xxxxx - Facilitator	**BNSSG CCG**	Deputy Director of Commissioning (Planning & Performance)
Xxxxx xxxxx – Note taker	**BNSSG CCG**	Urgent Care Support Coordinator
xxxxx xxxxx	**Sirona**	Director of Operations
Xxxxx xxxxx	**NSC**	Head of Commissioning People & Communities
xxxxx xxxxx	**NSC**	Finance Business Partner (Adults and Children's Services)
xxxxx xxxxx	**NSC**	Service Leader-Adults' Support & Safeguarding
xxxxx xxxxx	**UHBW Weston**	Head of Patient Flow & IDS Weston Division
Xxxxx xxxxx	**BNSSG CCG**	Associate Director of Quality

1. **What the model looks like**

- Source of funding is the concern, rather than challenging the application of the model.
- All evidence suggests a non-bedded model is way forward.
- Need to understand how resources move around in this model and to answer the question- What is the impact on social care of this model and the evidence? We cannot lose pre-existing social care services. Can we look at entire services from Sirona and ALL council areas and prioritise these?
- During Covid did confidence in P1 decrease? Yes, staff absence = loss of specialists, Ratios change and priorities are not always focused around SRFs.
- Guides would help with SRFs; a better quality of SRF would save time and better communication with wards. We should then see an increase in P1 referrals after Covid pressures have reduced.
- P2 and P3 blurring and gaps in P1 in terms of complexity of needs and a higher domiciliary offer is required.
- LoS for P1- varies over area and data changes, the average is 10 days and majority of patients stay home after 10 days. Increased therapy will reduce LoS, should we move the

target?

- Risks in social care and acute care differ.

- Could P1 % be higher? Should we look at 21/22 stretching?
- Possibly a step up process for Sirona for P1 patients, using services to stop patients going into hospital.
- Some P1s come in as an emergency now and then require more complex needs, pre planning required with a multi-disciplinary focus. If we don't do this now then will be issues around P0 in the future.
- Sirona are re-opening planned rehab pathways
- N. Somerset spot purchasing has helped but has been intensive on therapists. Need to use spots for specialist care.
- We have had a short term increase in deaths in care homes and this has been built into a long term model, we don't know if this is a recurring cycle.
- Have patients expectations changed around being in hospital or being at home? Also, families at home are more able to care for relatives at home currently (suppressed demand) – this could change.
- Fast track and 24 hrs at home show behavioural change.
- Big spike in end of life care at home now – need to understand at what scale.
- If we agree the model after lots of hard work this year, are we clear on mapping and long term ramifications. We don't have all of the data only that feeding the model - we don't know the true picture.
- Covid funding focused on leaving hospitals rather than going in, the whole picture of a patient's journey through BNSSG services is not taken into account.
- Scenario modelling required - around reducing hospitalisation due to LARC, wellness service INTs what are the outcomes.

2. Barriers

- Funding
- Specific needs and behaviours costing the council a lot to keep patient in their residence and out of hospital
- Only 8 community beds
- Is Elton too small, do we need a different future for Clevedon?

3. Actions to ensure model is implemented and funded in the most appropriate manner

Action	Recommended group to pick up action e.g. OOHDG/ Capacity and Impact
Increasing P1s (aiming for 70% in 21/22 but stretching further in future years) Review the target for LOS of P1 – currently running at 12 days.	OOHDG – Operational work stream
SRF improvement workstream. Less reliant on therapists, simpler to complete	OOHDG – Operational work stream
Management of QDS patients	OOHDG – Operational work stream
Review the amount of therapist support / can we increase / do differently?	OOHDG – Operational work stream
How can we support developing more capacity within dom care?	OOHDG – Operational work stream
Risk assessment to be completed about the services that might not exist if the money is removed – prioritising out of hospital requirements	OOHDG – Finance work stream
Review the totality of where money is going and prioritise	OOHDG – Finance work stream
Reduction in numbers of spot purchase. Aim for 80/20 split	OOHDG – Commissioning Arrangements work stream
Review of Clevedon community hospital	Strategic Planners and Integrated Steering Group
Review of complex patients i.e. looking at if the 2% of total discharges being complex the right level and is more support possible around	OOHDG – Operational work stream
Review of demand and capacity within Fast track services	OOHDG – Operational work stream

Start to review options for the creation of a single/ pooled budget and review how we prioritise	Strategic Planners and Integrated Steering Group

4. Other Comments

Existing budget to be reviewed prior to agreement of funding model moving forward.

Closure Summary:

Today's workshop has confirmed support from the D2A model from partners across the system. Actions have been identified on a short, medium and long term basis to inform the D2A process moving forward. Feedback gained from the system has shown the need for an accelerated response around short term issues that are a significant cause of concern for Local Authority colleagues in particular.

All information collected today will be used to inform and take forward actions and next steps agreed as a system and will be shared and taken through the relevant governance streams.