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NHS

ANNEX A

Planning for sustainable improvements in discharge services in 2022/23:

Six areas of good practice and examples of discharge services that could be funded where affordable from health and social care resources (including the Better Care Fund)

Six actions to embed sustainable good practice in 2022/23 (1)

Action	Description	Supporting resources
1. Establish the relationships, system-wide vision and agreed operating model	• Establish joint commissioning priorities to underpin the vision based on the needs of your local community drawn from an analysis of your current demand and capacity plans • Involve wider partners – especially the voluntary and community sector – as strategic partners not just delivery agents • Agree funding models for sustainable delivery of post-discharge support, fully utilising the pooling of money in the Better Care Fund	• LGA Top tips for implementing a collaborative commissioning approach to Home First • Better Care Fund support • LGA peer review

2. Set in place the core operational infrastructure	• System-wide single-coordinator role (exec level)
	• Exec level oversight within the system
	• Establish a discharge hub (also known as transfer hub and single point of access)
	• Embed systems to monitor patient flow including:
	  • Length of stay in acute units and length of stay in step down/rehabilitation bedded care units
	  • Delay reasons for people not being discharged from rehabilitation bedded units and from home-based teams
	• Agree performance expectations for discharge to pathways 1, 2 and 3 when an individual is ready to leave their bedded care
		• Case studies
		• LGA High Impact Change Model
		• Better Care Fund plans - longer term actions
		• Staff action cards
		• Better Care Fund support
		• LGA peer review
		• ECIST podcasts and rapid improvement guides
		• ECIST targeted support offer accessed via regional teams

3. Jointly plan for demand on discharge pathways 0-3 - 0 – e.g. voluntary sector services - 1 – e.g. therapy; domiciliary care; equipment; home-based end of life care; virtual wards - 2 – e.g. short-term community bedded capacity; community based therapy; - 3 – e.g. care home provision	• Take a place-based approach, developing co-located and/or coterminous arrangements for commissioning and delivery arrangements, where appropriate; and where not, agree effective working arrangements • Embed system-wide models of care and support that promote health and wellbeing, independence, community support and self-care • Build on joint or pooled funding agreements, including sections 75s or 113 • Establish accountability arrangements including the role of overview and scrutiny committees	• Planning Guidance 2022/23 • LGA – out of hospital guidance on capacity and demand modelling • ECIST targeted support offer accessed via regional teams

Six actions to embed sustainable good practice in 2022/23 (2)

Action	Description	Supporting resources
4. Create a joint analysis of current capacity	• Review of what's already in place across the system based on the four discharge pathways • Analysed against identified demand	• Designated settings guidance • LGA – out of hospital guidance on capacity and demand modelling • Demand and capacity tutorials, training and models • ECIST targeted support offer accessed via regional teams
5. Develop a flexible joint workforce plan for care closer to home	• Shared posts, across commissioners in council and CCG as well as providers, such as council and NHS trust • Joint planning to support competitive workforce packages that grow capacity across health and care organisations	• eLearning module for nurses, AHPs and social care • Staff action cards for discharge services • NHS England job planning guidance for clinical workforce • ECIST targeted support offer accessed via regional teams
6. Jointly commission further capacity where appropriate	• Collaboration and joint risk-sharing • Shared responsibility for delivery of integrated services • Market-shaping to meet need	• LGA - Integrated commissioning for better outcomes

In 2022/23 systems can fund good discharge practice from existing health and social care budgets, including the Better Care Fund, where affordable within local arrangements

Type of Activity	Examples
Core operational infrastructure for good discharge practices	The infrastructure to underpin streamlined and collaborative discharge services: • Single co-ordinator role (exec level) • Discharge hub/transfer hub/single point of access
Commissioning acute capacity where appropriate to local plans	• Follow up capacity within acute discharge team • Complex discharge liaison team (working across health and care) • Discharge lounges & capacity to manage complex bedded discharges
Jointly commissioning community capacity where appropriate to local plans	• Intermediate care/reablement provision in peoples own homes for all people with new or extended care needs on discharge from hospital • Assessment capacity in community (including reviews of care provision) & trusted assessor schemes • Therapy capacity for rehab and reablement • Intermediate bed capacity for rehab and reablement • Domiciliary care capacity • Community palliative care capacity (end of life care) • Community social care capacity (day working) • Voluntary sector capacity in acute & community • Occupational therapy equipment in community – e.g. hospital beds for home
Flexible joint workforce planning for care closer to home	• Workforce transformation schemes • Single health and social care reablement/intermediate care teams working in peoples own homes