North Yorkshire and York Care System

Safe Discharge – Winter Planning
15 October 2020

North Yorkshire County Council

NHS Bradford District and Craven Clinical Commissioning Group

NHS North Yorkshire Clinical Commissioning Group

NHS Vale of York Clinical Commissioning Group

City of York Council

YORLMC Limited Established 2007

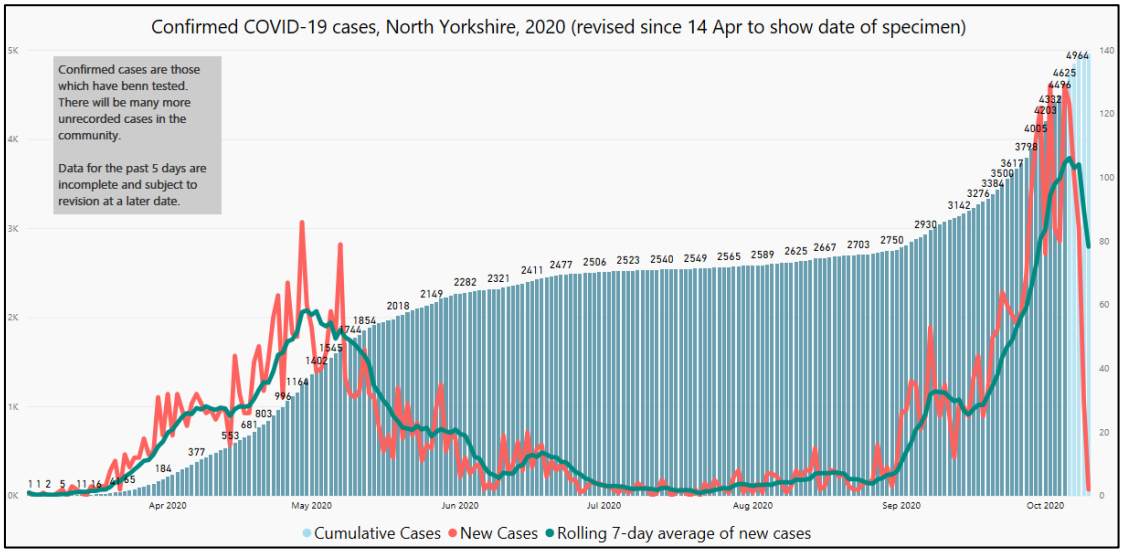
DHSC Requirements

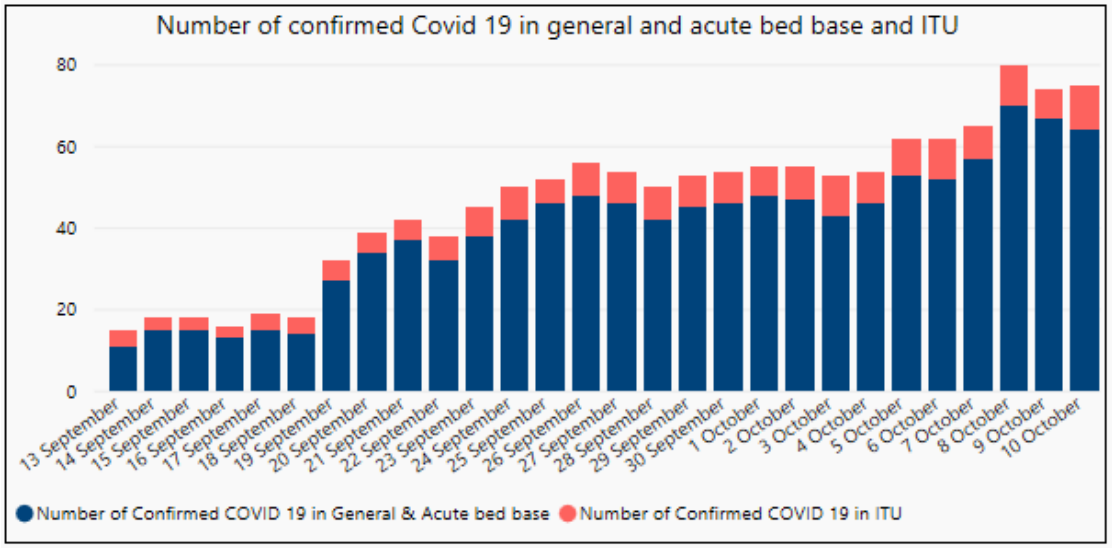
- Anyone with a Covid-19 positive test result being discharged into or back into a registered care home setting must be discharged into appropriate designated setting (i.e., that has the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents) and cared for there for the remainder of the required isolation period.
- These designated accommodations will need to be inspected by CQC to meet the latest CQC infection prevention control standards.
- 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 preceding their discharge.
- Everyone must have a reported COVID test result and this must be communicated to the care home prior to the person being discharged from hospital.
- Some settings might also be designated CQC assured alternative settings, where people may be discharged to designated accommodation within a registered residential setting. For example, a care home with a designated safe zone for COVID-19 positive people.
- Some people will be able to go back to their residential care home, where they are usually resident, **if** that care home is assured as designated accommodation.

Discharge Model April – Oct Lessons learned

5 x discharge command centres linked to key acute trusts and Local Response and delivery teams	• Effective management of discharges with improved communication between teams • Trusted assessment process not always effective with gaps in information
Block contract beds widely in place for Covid + and non-covid discharges (Apr – Aug)	• Enabled the system to quickly respond to discharge service requirements (7 days 8am-8pm) • Low occupancy rates average 60% • Heavy reliance upon pathway 3
Block beds reduction (Sept – Oct)	• Reflected reduction in Covid-19 and pressure on acute trusts based on best case bed modelling Covid secure premises (verified by HAS Quality Improvement Team) • Provided clearer pathway for Covid+ discharges • Concerns about community team capacity to manage an increase in activity going through home first pathway 1 • Require surge plans with ability to step up in the event of increase in activity • Require close monitoring of data across NYCC/CCGs

Summary of Covid-19 cases to date





Discharge Model principles going into Winter

- 7 day Discharge Command Centre in each of the system's Acute Hospitals with appropriate capacity
- Clear flow into discharge pathways 1-4 (including EoL fast track)
- Covid Secure premises for Covid+ discharges agreed and verified by CQC
- Sufficient capacity for spot purchase residential and nursing to meet discharge requirements for non-covid discharges
- Sufficient community team capacity across H&SC to meet demand and support Home First principle
- Surge plan for breach of community capacity
- System dashboard to monitor position weekly
- Clear route of escalation to SLE in the event of surge
- Technology and digital support (Immedicare)
- Commissioning/contracting arrangements for Domiciliary care with Rapid response to facilitate discharge

Discharge Model principles Pathway 1

Acute Trust Discharge Trusted Assessment to Command Centres

Pathway 1 - Home First

Interventions

- Community health and social care wrap around teams
  - Reablement
  - District nursing
  - Community therapy
  - Community equipment
  - Home from Hospital Service
  - Unpaid carer support
- Known discharge capacity of all teams with surge plan and financial resource identified
- Assistive Technology
- Adequate access to package of care from Dom care providers

Actions Community Tactical Group

- Clarity on team capacity to manage discharges with limits identified
- Modelling of resource requirements across teams for surge plan with costings
- Identify opportunities for shared community workforce across H&SC
- Identify funding streams to support enhanced team or surge
- Pursue further AT opportunities
- 7 day rapid approval of Community equipment
- Rapid access to dom care

Activity

Tracking of discharges to pathway 1 based on national targets and anticipated NY activity

Actions Tactical data sub-group

- Week by week review of admission and discharge data
- Process to review team capacity week by week to identify surge
- PW1 activity vs national average

Discharge Model principles Pathway 2

Acute Trust Discharge Trusted Assessment to Command Centres

Pathway 2

Interventions

- Non Covid locality specific SUSD/iBCF beds and adequate access to timely spot purchase in independent sector
- Covid secure discharge pathway to designated block beds with appropriate CQC sign off
- Sufficient community in reach support for rapid rehabilitation
- Known discharge capacity of all teams with surge plan and financial resource identified
- Assistive Technology

Actions Community Tactical Group

- Consider discharge premium to enable DSR
- Clarity on command centre/community team capacity to manage discharges rapid rehabilitation with limits identified
- Understand and overcome TA challenges
- Modelling of resource requirements across teams for surge plan with costings
- Pursue further AT opportunities/immedicare
- Determine covid secure pathway for Craven

Activity

Tracking of discharges to pathway 2 based on national targets and anticipated NY activity
Tracking of acute admissions
Block purchase occupancy
Wider market occupancy

Actions Tactical data sub-group

- Week by week review of admission and discharge data
- Process to review team capacity week by week to identify surge
- PW2 activity vs national average

Discharge Model principles Pathway 3

Acute Trust Discharge Trusted Assessment to Command Centres

Pathway 3

Interventions

- Adequate access to timely spot purchase in independent sector
- Covid secure discharge pathway to designated block beds with appropriate CQC sign off
- Block purchased winter resilience beds
- Sufficient community in reach support for rapid rehabilitation
- Known discharge capacity of all teams with bed based Surge plan and financial resource identified
- Assistive Technology/Immedicare

Activity

Tracking of discharges to pathway 3 based on national targets and anticipated NY activity
Tracking of acute admissions
Block purchase occupancy
Wider market occupancy

Actions Community Tactical Group

- Consider discharge premium to enable DSR
- Clarity on command centre/community team capacity to support discharge/rapid rehab with limits identified
- Understand and overcome TA challenges
- Modelling of resource requirements across teams for surge plan with costings
- Pursue further AT opportunities/immedicare
- Determine covid secure pathway for Craven and VoY Nursing

Actions Tactical data sub-group

- Week by week review of admission and discharge data
- Process to review team capacity week by week to identify surge
- PW3 activity vs national average

NYCCG Discharge Command Centres

Capacity Challenges
Require safe discharge pathway for Covid+ nursing/res to be confirmed post October
Current market occupancy – Nursing 91% Residential 89%
Scarborough nursing bed pressures due to bed reduction as a result of home closures
Poor Dom care availability in Scarborough
Limited reablement capacity in Scarborough
Community Services Humber at Opel 3, South Tees at Opel 2

Pathway	Actions for agreement
Pathway 1	Review of community nursing and therapy capacity in Harrogate (underway)
	Enhanced Reablement offer (Scar, HR)
	Enhanced dom care (pursue alternative contracting arrangements, linked to command Centres, poss. 72 hour post discharge packages)
Pathway 2	Covid + Residential blocks x 8 beds (Springfield Garth, Larpool Lane)
Pathway 3	Covid + Nursing blocks x 10 beds (Scorton Care Village, St Cecilia's) – clinical cover confirmation required for St C
	Non Covid Winter pressure blocks (exact bed numbers to be confirmed), pursue extra care opportunities

VoYCCG Discharge Command Centre

Capacity Challenges
Require safe discharge pathway for covid+ Nursing
Current market occupancy Nursing 94% Residential 95%
Selby nursing bed pressures due to bed reduction as a result of home closures
Poor Dom care availability - Framework provider recruitment challenges
Limited reablement capacity in Selby
Community Services York at Opel 3
VoY Draft Community prioritisation plan in place

Pathway	Actions for agreement
Pathway 1	Review of community team capacity in South Hamb/Ryedale and Selby ? Additional resource
	Enhanced Reablement offer
	Enhanced Dom care (pursue alternative contracting arrangements, linked to command Centres, poss. 72 hour post discharge packages)
Pathway 2	Covid + Residential block in place at Peppermill Court
Pathway 3	Covid + Nursing block TBD, option for Malton Hospital but alternative non covid blocks will need to be determined to backfill loss of Malton
	Agreement with CYC for non-covid spot nursing provision for Selby residents however CYC at 96% occupancy

BDCCG Discharge Command Centre

Capacity Challenges
Require safe discharge pathway for Covid+ nursing and residential
Market Occupancy Nursing 90% Residential 79%
Poor Dom care availability in Craven
Reablement capacity
Community team capacity to support home first

Pathway	Actions for agreement
Pathway 1	Community team capacity to meet needs of home first
	Enhanced Reablement offer
	Enhanced dom care (pursue alternative contracting arrangements, linked to command Centres, poss. 72 hour post discharge packages)
Pathway 2	Covid + Residential block TBD
Pathway 3	Covid + Nursing block TBD

Recommendations

•1. Agreement of Covid-19 + discharge arrangements including outstanding arrangements to meet DHSC requirements for CQC inspection:

- - Malton Hospital (possible Covid+ site for Y&NY)
- - GP Cover for remote support in place, confirmation of GP visit arrangements to be clarified'
- - Craven discharge pathway

NY CCG	Nursing	St Cecilia's Nursing Home x 5 Scorton Care Village x 5
	Residential	Springfield Garth x 5 Larpool Lane x 3
VoY CCG	Nursing	Malton Hospital TBD
	Residential	Peppermill Court
BD CCG	Nursing	TBD
	Residential	TBD

•2. Review of H&SC community team capacity to support home first principle

•3. Develop bed based and community team surge plans with contingency funding in place to step up if required

•4. Develop a clear data set via Community workstream tactical group to monitor position

SLE Silver update and actions 14.10.20

- Silver to track and make key decisions relation to designated beds and community team capacity, including transferring designated beds from covid+ to non-covid to respond to escalating acute activity
- Review of all discharges to ensure that assessments are completed within 6 weeks to support improved outcomes for individuals and improved use of resources with oversight from Silver
- Provide a key link to A&E Delivery Boards and develop communications on safe discharge to system partners
- CCGs to confirm clinical cover for designated beds
- NYCCG and VoYCCG to consider reciprocal usage of Peppermill Court and Springfield Garth
- Further discussions with provider colleagues to take place relating to Malton Hospital beds
- Confirmation of designated discharge arrangements in Craven
- Oversight of capacity across Domiciliary care/community health/primary care/ASC teams to support *home first* approach with clear integrated surge plans