Urgent and Emergency Care support fund for local authorities: form for submitting proposals

Sent 8 September 2023

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This proposed funding is for the provision of support and interventions to be set up by the local authority in collaboration with the relevant integrated care board.

Please complete all sections of this form.

Proposals should be submitted to ascdischargelocalengagement@dhsc.gov.uk with the subject line: **LA UEC proposal – [local authority name]**

Deadline for submission of proposals – 29 September 2023

Local authorities should review the accompanying letter from the Department of Health and Social Care before completing this form.

Section 1: contact details

Lead local authority details

Name of local authority submitting the proposal

Kent County Council

Name of the responsible officer

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Job title or position in local authority

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Integrated care board (ICB) details

Name of ICB

Kent and Medway ICB

Name of the responsible officer within ICB

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Job title or position within ICB

Chief Delivery Officer

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Section 2: the proposal

How would you use this funding to go further in supporting the resilience of urgent and emergency care services this winter:

a) using up to 100% of the indicative allocation for your local authority? (250 words maximum)

This funding would have a significant impact on supporting the resilience of urgent and emergency services across Kent this winter. The funding would be targeted in areas of Kent with the most challenged performance (East Kent) of urgent and emergency care services and to address capacity gaps across the county.

1. Increase the Home First offer to provide services to support reablement and recovery for people leaving hospitals and for admission avoidance. This will support acute and community hospital "flow" and improved outcomes for people. In East Kent the Home First offer is focussed on jointly recruited posts KCHFT (Community Health Provider) and KCC with a focus on enablement and rehab.

2. Increase capacity in step-down provision for people with complex needs, including dementia, to enable further recovery, reablement and assessment period outside of acute hospital environments. This will include bed-based provision as well as more intensive homebased community provision.

3. Increase capacity in Rapid Transfers Dementia Service for East Kent to provide community support for people with dementia to support more people with dementia to return to their usual place of residence on discharge from hospital, and reducing risk of people with dementia being readmitted to hospital by providing more intensive support.

4. Additional social care staffing. This will focus on a) increased assessment services to reduce waiting times for assessment, including in step down facilities to support "flow"; b) support for the development of Integrated Transfer of Care Hubs across the county and c) Increased brokerage working with the market to identify appropriate longer term provision of care for people with complex needs including mental health, improving system flow.

5. Expand the Voluntary and Community Sector "Take Home and Settle" service to support people with lower levels of social care needs to settle back in their homes following discharge.

6. Extend acute hospital-based Technology Facilitators and technology devices that enable people to more independently manage their health and social care needs on discharge from hospital.

b) using up to 150% of the indicative allocation for your local authority? (250 words maximum)

Up to 150% of the indicative allocation would enable further scaling up of the schemes above as well as investment to provide additional support for Mental Health discharges. There are currently capacity pressures in the market to support with mental health discharges, and investment would reduce length of stay and increase bed availability for mental health admissions from community and acute hospitals.

1. Expansion of Mental Health enablement service to develop mental health enablement supported discharge function, reducing length of stay and supporting people to return to usual place of residence.

2. Investment in training and development for social care providers in mental health, increasing the capacity in existing market to support people with primary mental health need.

3. Establishment of a Mental Health Transfer of Care Hub with integrated health and social care team

4. Scaling up schemes that have been front loaded in East Kent due to the pressures and rolling out across the County (for example Rapid Transfer Dementia Service)

5. Scaling up schemes to enable additional discharges, for example further expansion of Home First services to incrementally increase the workforce and number of daily discharges.

Has this proposal been discussed and agreed with the Integrated Care Board?

Yes

Section 3: criteria

What is the anticipated impact of your proposals on urgent and emergency care resilience and performance over this winter period? (250 words maximum)

1. Increased Home First offer will increase the number of pathway 1 discharges from acute and community hospitals, reducing length of stay. The reablement focus will improve outcomes for people, promoting independence. Impacts have been modelled on current performance of services and incremental increase as service is scaled up.

   In East Kent expanding the Home First model of Jointly recruited (KCC & KCHFT) support worker posts from 25 to 50 will provide additional capacity to support **15 – 30 discharges per week** depending on Length of Stay. The reablement focus is anticipated to reduce the hours that people receive for long term home care, releasing capacity back into the market.

   The model will be rolled out into West Kent with same skill mix ethos to deliver personalised care and facilitate self-care aligned to therapy support

2. Increased capacity in step-down provision will increase the number of pathway 2 discharges and reduce length of stay. In Kent, long term admissions into care homes remain high and the investment will focus on cohorts of individuals where there are gaps in current provision (geographical and in relation to clinical/support needs) focused on recovery and reablement to support people to return home. This provision is scalable over the winter period as we will be focusing on using bed-based provision with capacity and where there is established integrated working across health and social care to deliver.

   This will fund **30 additional step-down beds, based on average length of stay of 21 days.** In addition to supporting discharge from hospital, the reablement focus is anticipated to reduce the number of people being permanently admitted to care homes from a hospital discharge pathway, as well as supporting the reduction of the risk of re admission to hospital within 90 days of being discharged. Staffing has been calculated on Safer Staffing levels.

3. Increase capacity in Rapid Transfers Dementia Service (East Kent) will reduce length of stay for people with dementia and will increase numbers of people discharged to their usual place of residence. There is evidence that people with dementia have longer length of stay in acute hospitals in Kent. This provision is scalable and will

build on the current service which supports people with dementia who are discharged on pathway 3.

Additional 2 x Band 7 Practitioners and 1 Support Worker to add capacity to the already existing team and enable an expansion of remit to also focus on pathway 1 discharges as well as those that have been deemed to be pathway 3.

As with the existing remit the aim is to reduce length of stay and support people home rather than to a Pathway 3 bed. Biggest impact will be on 21 day length of stay, which has already been evidenced with current staffing in place, with much less likelihood of re admission due to level of support on discharge.

Current caseload is 25. The aim will be to **increase this to 35**. Although this will of course be dependent on complexity of referrals.

In addition extra staffing will enable assessment response time to reduce from 72 hours to same day or next day

4. Additional social care staffing will provide additional assessment capacity to reduce waiting times for assessment and will support flow from step down and discharge to assess services. It will enable the rolling out of Transfer of Care Hubs which will improve discharge planning and reduce length of stay for people with complex needs. Transfer of Care Hubs in East Kent have evidenced that a true MDT approach with the right capacity ensures people go the right destination on discharge with the right care and support.

   Funding would support **10 additional social workers/occupational therapists** to work in integrated transfer of care hubs in hospitals across the county, and to provide social care assessment capacity to additional beds/discharge capacity enabled through this funding.

   It would also include **funding additional Commissioners/brokers** with a focus on supporting complex, including mental health, discharges reducing the no longer fit to reside numbers.

5. **"Take Home and Settle" service** will support pathway 0 discharges and will support people to build confidence on discharge from hospital and link people in with community and voluntary sector provision to promote wellbeing. It will create capacity in commissioned discharge to assess services and will support an increase in pathway 1 discharges as the Red Cross can support the less complicated discharges.

   Evidence from similar services that have been set up in other parts of Kent show reduction in NCTR beds days and admissions. In East Kent April 2022 to March 2023

there were 512 accepted referrals that will have all have supported more successful and quicker discharges home, reducing length of stay.

6. **Extension of Technology Facilitators** will enable pilot provision to be provided across the county throughout the whole of the winter provision (current pilot funded until end of December). There have been positive impacts from the pilot on use of technology devices to support people to manage health and social care needs at the point of discharge.

   People already supported, have been provided with wide range of equipment including motion sensors, smart speakers, hydration reminder mugs and ring doorbells. All supporting safer discharges and reducing risks of deterioration, falls and carer breakdown. Reduces length of stay and potential reliance on packages of care to enable discharge.

   Staffing: 2 Facilitators.

   Evidence of success: The service started in July 2023. There have been 128 referrals, of those 128 people only 2 have been re admitted to hospital. All supported timely discharges and no delayed discharges . Education also key part of role and facilitators have been regularly attending meetings and MDTs advising on use of technology and raising awareness.

The delivery and performance of schemes will be monitored through existing integrated governance including Better Care Fund and Joint Commissioning Management Group.

Is your proposal deliverable over the winter period (up to the end of March 2024)?

Yes

Are these proposals additional to your local authority's existing expenditure and capacity plans (for example existing expenditure and capacity plans for the Better Care Fund and the Market Sustainability and Improvement Fund)? (delete as applicable)

Yes

Section 4: wider adult social care funding

Please refer to the accompanying letter from the Department of Health and Social Care to determine whether your local authority needs to complete this section.

Please explain why you are unable to fund the activity included in this proposal from your existing adult social care budget. (250 words maximum)

Letter has advised that KCC do not need to complete this section as planned expenditure on adult social care in 2023/24 has increased significantly this year. However for completeness the latest forecast overspend on adult social care services is approximately £25m before management action and allocation of grants.

Section 5: spend profile

Please provide a high-level summary of your projected spend of the funding for each month of the funding period. This should be based on your proposal for up to 100% of your indicative allocation. A suggested table is set out below.

Area of spend	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
E.g., *Recruitment costs, fees paid to providers*	£	£	£	£	£	£
Home First	£0	£72k	£144k	£144k	£144k	£144k
Step down provision	£0	£163k	£326k	£326k	£326k	£163k
Rapid Dementia Transfer Service	£0	£27.4k	£27.4k	£27.4k	£27.4k	£27.4k
Adult Social Care Staffing	£0	£74k	£74k	£74k	£74k	£74k
Take Home and Settle	£0	£9.6k	£9.6k	£9.6k	£9.6k	£9.6k
Technology Facilitators and equipment	£0	£0	£0	£16.7	£16.7	£16.7

Has your Section 151 Officer agreed these plans?

Yes