Discharge to Assess (D2A)

To:	Adults Committee
Meeting Date:	10 December 2020
From:	Charlotte Black, Director of Adults and Safeguarding; and Will Patten, Director of Commissioning
Electoral division(s):	All
Forward Plan ref:	N/A
Key decision:	No
Outcome:	The report provides an update and progress in relation to the new Discharge to Assess hospital discharge pathway. The potential and predicted outcomes are: a. ensure the local implementation of Discharge to Assess requirements in line with nationally mandated conditions b. Ensure that vulnerable adults and older people are supported to have safe discharges from hospital c. Reduction in unnecessary delays in hospital discharges d. Ensure that vulnerable adults and older people receive the right care and support, in the right setting at the right time
Recommendation:	To note and comment on the contents of this report.

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1. Background

1.1 Following on from the publication of the NHS England (NHSE) COVID Hospital Discharge Service Requirements on the 19th March 2020, the local system rapidly mobilised and implemented a discharge to assess (D2A) model to deliver the nationally mandated requirements. This has been further refined and embedded, based on learning to date and to ensure long term embedding of D2A in line with the revised 21st August 2020 NHSE Hospital Discharge: Policy and Operating Model Guidance.

1.2 This report provides an update on progress of implementing the D2A model locally and the impact of the new pathways.

2. Main Issues

2.1 National D2A Guidance

2.1.1 The NHSE Hospital Discharge: Policy and Operating Model Guidance published on the 21st August 2020 (which replaces the NHS COVID Hospital Discharge Service Requirements which were published on the 19th March 2020) sets out the nationally mandated conditions that are required to be implemented locally.

2.1.2 The Government has provided funding, via the NHS, to help cover the cost of post-discharge recovery and support services, rehabilitation and reablement care for up to six weeks following discharge from acute hospital to enable a safe, swift discharge from hospital until 31st March 2021.

2.1.3 The D2A model supports people returning to their own home wherever possible for assessment post hospital discharge, with alternative pathways for people who cannot go straight home. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person. This does not detract in any way from the need for agreed multi professional assessment or from the requirement to ensure safe discharge and it is intended to support and encourage rehabilitation in a community setting.

2.1.4 The D2A process includes four potential pathways for people being discharged from the hospital setting.

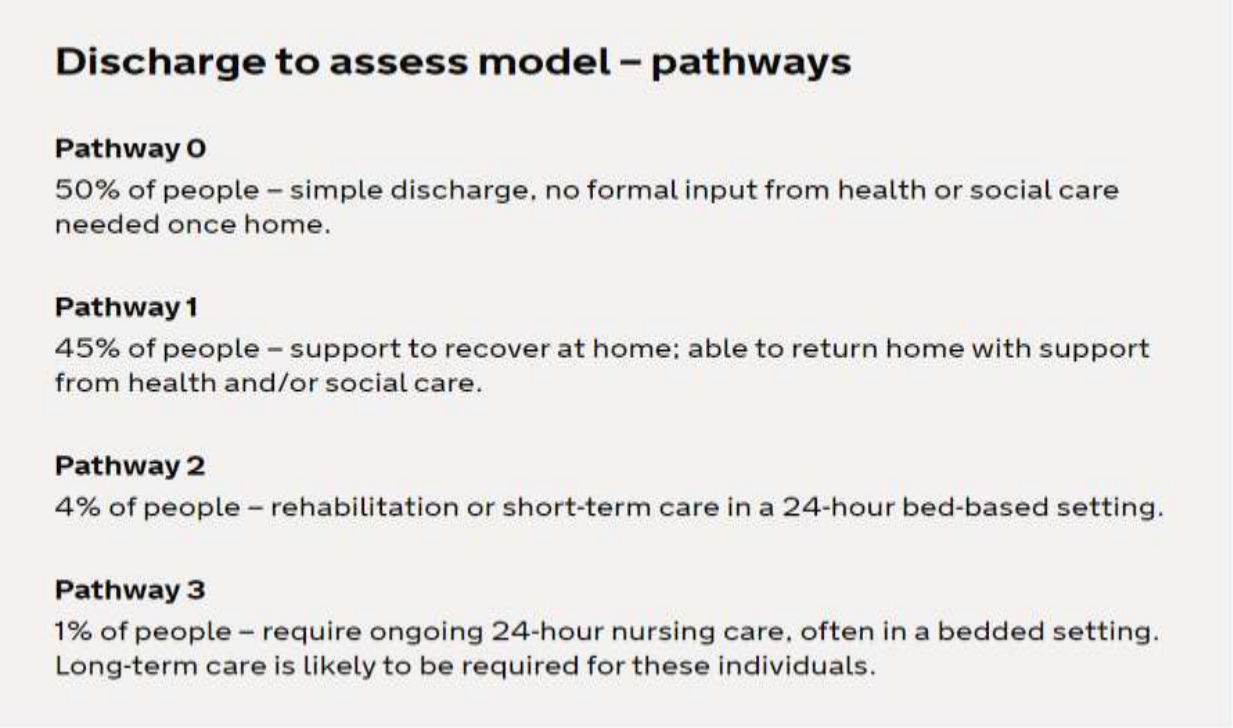

Figure 1 - Discharge to assess model - pathways

2.2 Local D2A Implementation

2.2.1 The D2A model adopted locally aims to achieve the following outcomes:

- Avoiding unnecessary hospital admissions;
- Improving patient flow through the system and particularly on discharge;
- Improving outcomes for individuals, with the right care and support being offered in the right setting at the right time, with long term care needs being determined once patients recovery and health has been maximised;
- Maximising opportunities for reablement and rehabilitation to promote independence and recovery, promoting the 'home first' model;
- Resources and capacity are commissioned based on flow and utilised effectively

2.2.2 The below table summarises the local landscape pre COVID and D2A implementation, compared to the new process landscape:

Landscape pre-COVID	Changes introduced in March 2020

• Slow patient flow, challenges re length of stay and delayed transfers of care (DTOCs)
• Assessments completed in hospital prior to discharge
• Referrals sent to multiple services depending on discharge pathway
• Determination of social or health pathway required in acute prior to discharge
• Delays for self-funders and patient choice
	• Implementation of national guidance on discharges:
	  ○ Simplified processes (discharge notices only)
	  ○ No assessment in acute – true D2A
	  ○ Single point of access in the community for all referrals
	• Reviewed and increased commissioned capacity to support discharges
	• Redeployment and alignment of staff to support D2A in the community (local

Landscape pre-COVID	Changes introduced in March 2020
	authority, Continuing Health Care (CHC) and Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). • All patients leave through D2A including self-funders. • The legal requirement to allow patient choice at discharge was removed, although the discharge to assess pathway does allow for decision on permanent/long term care to be taken in the 6 weeks post discharge where they can be better informed.

2.2.3 The following pathway definitions describe how the pathways have been implemented in Cambridgeshire:

- **Pathway 0:** this pathway applies to all people being discharged where no further intervention is needed to support a safe discharge. This includes anyone being discharged with no identified need for further support, or those who have existing packages of care (including residential, supported living or nursing home placements) which will be reinstated. This also includes those going home with a recommission or 'restart' of their existing package of care. Acute hospitals are the responsible organisation for discharge of all persons on pathway 0.
- **Pathway 1:** this pathway applies to people where reablement services or short-term health support in the community (i.e. Intermediate Care Team) have been identified as required to support the person's discharge from hospital.
- **Pathway 2:** this pathway applies to people who require an interim or inpatient rehabiltation bed.
- **Pathway 3:** this pathway is required when a new care package or an increase to an existing care package, envisaged to be an ongoing need, has been identified.

2.2.4 A single Point of Access (SPA) has been established by CPFT on behalf of the system, for all discharges on pathways 1-3, to ensure a coordinated and multi-disciplinary approach to triage, supporting people to ensure they get the right care in the right setting at the right time to support a safe discharge. Social care staff have been reconfigured to align with the new model, shifting the majority of the social care discharge planning resource out of the hospital and locating them in the community. In addition, to support the requirement to deliver D2A 7 days per week, from 8am-8pm, we have extended brokerage provision to cover these new operating hours.

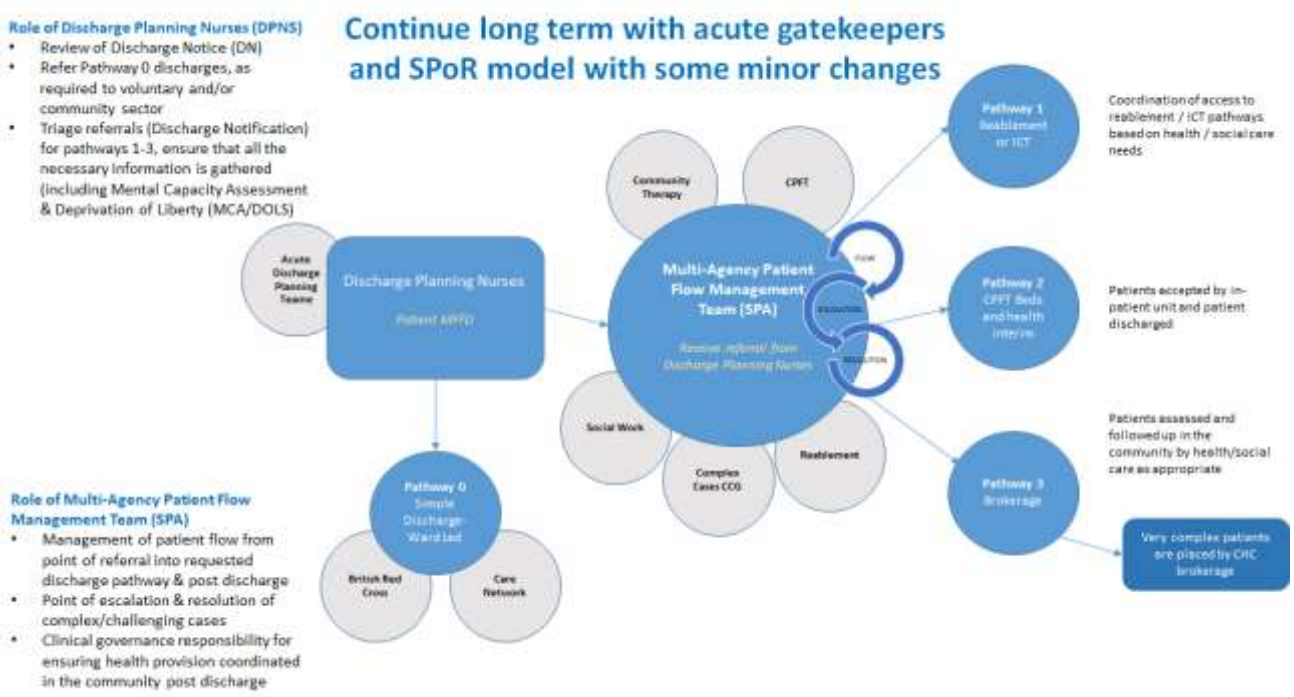

Figure 2 - Continue long term with acute gatekeepers and SPoR model with minor changes

2.2.5 Recognising the added complexities associated with learning disabilities (LD), the discharge process operates slightly differently for this client group, with the wards liaising with an LD Link Worker, via the LD Liaison Nurse from the hospital.

2.2.6 A number of system wide workshops were held throughout July and August 2020 to review the impact of the changes, identify learning and refine the D2A model going forward. There was full engagement from operational leads and teams across health and social care to ensure the approach was grounded in what will work best for patients and front line staff. Some of the further changes that have been implemented as a result of this review include:

- New referral form: a new form has been developed and launched on 14th September 2020. This has replaced the discharge notice and contains all the relevant fields of information required. Alongside the roll out of the new form, a programme of training is being undertaken with ward staff within the acute and community hospitals in order to successfully implement the referral form, thereby reducing quality issues and the flow of referrals.
- The SPA function has been redesigned and launched on the 14th September. This will embed a multi-disciplinary (MDT) triage function within the SPA, enabling an element of quality control and triage.
- The provision of 7-day working has improved since D2A commenced with brokerage, acute discharge planning and social care transfer of care teams all now working 7 days, building on 7-day provision from ICT and reablement. This is expected to achieve a smoother flow and smooth out peaks and troughs in demand, with acute hospitals ensuring that there is a consistent impetus of clinical led decision making to enable discharges throughout the week and weekends. Further work is required to build confidence with the provider market for both care homes and home care to enable them to process referrals over the weekend. We are engaging with local care associations to inform the approach to this. This includes provision of primary care, robust discharges which include take home medication, transport and equipment all of which have been

issues and affected the confidence of social care providers in taking weekend referrals. Once in place, work will be required by the Council contract management teams to manage the performance of contracted weekend flow. This will enable a consistent flow of discharges, enabling even more effective resource utilisation and reducing delays associated with peak times.

- A review of capacity, both operational resources and commissioned capacity has been undertaken to identify capacity gaps. Following system wide and CCG approval, NHS Discharge funding has been agreed to increase capacity in a number of service areas identified across the system, including:
  - Brokerage capacity
  - Social worker capacity
  - Expansion of the Enhanced Response Service to Peterborough (Reablement)
  - Therapy capacity
  - Intermediate Care capacity
  - SPA administration support

2.3 D2A Pathway Commissioned Capacity

2.3.1 A system wide review of demand and capacity is being undertaken to inform the commissioned capacity that is required to effectively support the D2A model. This work is being undertaken for Pathways 1, 2 and 3. This work has been completed for Pathway 2, in relation to community bed-based provision for a temporary period of time.

2.3.2 As D2A is a new process, it is not possible to predict demand using pre-Covid bed-utilisation data. However, a demand model has been developed by Council Business Intelligence team using a range of sources including current hospital discharge statistics. This model has been developed in conjunction with Business Intelligence colleagues from the CCG and CPFT, other NHS system partners and with input from Health and LA commissioners. The forecast model indicates that, in order to meet peak demand, 161 D2A short stay beds are needed. In response, the CCG recently commissioning an additional 20 health interim beds and we currently have 167 beds commissioned across health and social care to meet this forecast demand.

2.3.3 The commissioned beds will be categorised as outlined below, with triaging of people leaving hospital under Pathway 2 into the appropriate bed according to their needs.

- High level support for people with Physio/OT therapy requirements - Health Interim beds and in-patient rehab beds
- Middle level, needs “convalescence” type of approach - local authority interim beds
- Low level – reablement flats

2.3.4 People will be matched by the SPA to the most appropriate setting rather than whether they are following a health or social care pathway. It is paramount that, in order for people’s independence to be optimised, they are placed in the D2A setting which best meets their needs, and that wrap around services are in place to support them effectively. The D2A process needs to be person centred and there needs to be a robust focus on preventing people from deconditioning and ending up in permanent care. Close monitoring of these beds is being undertaken to continue to inform future commissioning arrangements. Spot

purchasing of further beds will be undertaken if there is insufficient capacity to support a discharge.

2.4 Links to the voluntary and community sector

2.4.1 The Voluntary and Community Sector (VCS) offers dedicated support for older people and adults aged 18+ (with physical disabilities, sensory impairments, learning disabilities and/or autism, mental health issues, and/or their carers) when coming home from hospital, which is fundamental to support Pathway 0. Age UK Cambridgeshire and Peterborough and Care Network Cambridgeshire offer discharge support services with the aim of helping people to return home from hospital in a safe and timely manner and to prevent readmission through a range of practical support and information and advice activities such as:

- One-to-one support
- Telephone support/welfare check-ins
- Collecting prescriptions and shopping
- Installing grab rails and key safes
- Food parcels
- Information and advice
- Support for discharge planning
- Wellbeing activities
- Triage into other local voluntary sector support

Examples of triage into other local voluntary and community sector services could include:

- Carers support offered by Caring Together and Making Space (who support people looking after someone with mental illness)
- Support for people with sensory impairments, for example Cambridgeshire Hearing Help, Camsight, etc.
- Homes support services (offering help with general domestic tasks including cleaning) and shopping services (such as those provided by Age UK Cambridgeshire and Peterborough)
- Referrals into local strength and balance exercise classes (promoted by Public Health's 'Stay Stronger for Longer' campaign) to reduce people's risk of falls
- Putting people in touch with local community groups and schemes where they live, such as Timebanks, Good Neighbour Schemes, etc.

2.4.2 These services complement our existing Reablement offer and provide localised support to people, enabling them to rebuild networks and establish support within their communities.

2.4.3 In addition, Age UK Cambridgeshire and Peterborough has had national funding extended until 31 March 2021 for their hospital discharge support.

2.4.4 The VCS and local community groups are also establishing links with the newly appointed Social Prescribers working in all the Primary Care Networks (PCN) across the county. These Social Prescribers take a holistic approach to people's health and wellbeing, focusing on 'what matters to me'. Social Prescribers are also known as link workers who

can connect people to community groups and statutory services for practical and emotional support.

2.4.5 For example a volunteer can via the Social Prescriber ensure a person's medication is correct following a discharge from hospital and ensure that a circle of support is in place for the person and their family, including conversations with carers about the support available to them (and referrals to Caring Together for the registering of 'What if?' contingency plans). With the PCNs that have been the earlier adopters of the Integrated Neighbourhoods approach (such as Ely South and Granta), Social Prescribers have established wellbeing hubs that are demonstrating the benefits of a person-centred preventative approach.

2.4.6 Think Communities have identified, support for older people, support for carers, and increased take up of Technology Enabled Care as three of their eight priorities and as this work develops this will provide further opportunity for links being made with communities to support people at home following discharge from hospital.

2.5 Designated Settings

2.5.1 Government guidance places responsibility upon local authorities to ensure sufficient alternative accommodation is available to quarantine and isolate residents (including those at the point of hospital discharge who require community bed-based care). The government has made £1.3 billion available to support enhanced discharge from the NHS, and this funding can be drawn on for this alternative provision. Local authorities are expected to work together with the NHS to put this approach into practice, in accordance with the D2A guidance.

2.5.2 The LA needs to ensure that "Designated Settings" are Homes that have the policies, procedures, equipment and training in place to maintain infection control and support the care needs of residents and who are cared for there for the remainder of the required isolation period. These designated settings have been notified to CQC and the local authority is working with CQC to ensure settings are inspected and assured in line with the CQC infection prevention control standards.

2.5.3 To ensure system preparedness for surges in COVID-19 cases and other demand during the winter and to maintain flow out from acute settings, the Council has worked with the CCG commission additional provision in the community to ensure individuals who are Covid positive or unable to comply with self-isolation requirements can be safely cared for upon discharge from hospital. This capacity is constantly being reviewed to ensure we have the right provision to meet demand.

2.6 Funding to Support D2A

2.6.1 **NHS Discharge Support Fund (DSF):** The government has provided funding, via the NHS, to help cover the cost of post discharge recovery support services, rehabilitation and reablement care for up to 6 weeks following discharge from hospital. The funding can also

be used for urgent community response provided within 2 hours to prevent an acute admission. This funding is available until 31st March 2021.

2.6.2 Where a new care package is arranged, this will be free for up to 6 weeks, and the customer will not need to pay towards the cost of their care until a full assessment has taken place and identified an ongoing need. This is applicable to those self-funding their care also.

2.6.3 Where the customer has an existing package of care and has been paying a client contribution, they will continue to pay the client contribution, and will not be charged for any additional support.

2.6.4 The DSF is also funding £3.2m of additional capacity in the following identified areas across health and social care until the end of March 2021. This funding will plug identified D2A capacity gaps and increase daily discharge rates.

D2A Pathway	**Investment**	**Responsible Organisation**
Pathway 1	Intermediate Care Workers – increase intermediate care provision	CPFT
	Therapists and Assistant Therapists – increase wraparound therapy to support enablement	CPFT
	Business Support – increase capacity in intermediate care to manage increased capacity	CPFT
	Social Workers – increased capacity to manage assessment flow	Local Authority
Pathway 2	Additional health interim bed capacity	CPFT
	Discretionary fund to spot purchase additional capacity during winter if required when the system experiences significant challenge and pressures	CCG
	GP cover for all pathway 2 capacity including weekends	CCG
Pathway 3	Brokerage capacity to cover 7 day working	Local Authority
All Pathways	Administrative capacity for the single point of access (SPA) to cover 7 day working	CPFT
	Emergency service response (to enhance 2 hour response in the community) - Peterborough	Local Authority

2.6.5 This funding replaces the previous NHS COVID 19 funding. In response to the initial stage of the pandemic, we jointly commissioned c.340 COVID block beds to clear up acute hospital capacity. These beds were contracted until the 20th September 2020 and were funded by the original NHS COVID 19 funding. Following the announcement of the new hospital discharge guidance, assessments and plans have been put in place for all people in those beds to transition to their long term care arrangements. This has created a significant financial pressure for the Council, with the local authority responsible for the ongoing care of c. 67% of these people.

2.7 Deferred Assessment Funding for additional workforce capacity for Continuing Health Care (CHC)

In line with the NHSE Hospital Discharge: Policy and Guidance, CHC and social care financial assessments recommenced on the 1st September 2020. The local authority is working jointly with the CCG to ensure that the backlog of assessments are completed, alongside new business as usual assessments, prior to the end of March 2021. To support this, the CCG received £600k of one-off 'Deferred Assessment Funding' to enable sufficient local capacity. The local authority has jointly agreed with the CCG that funding will be used to employ 6 additional social workers for the local authority, alongside 10 additional CHC nurses to be employed by the CCG between now and the end of March 2021.

2.8 Infection Control Funding

2.8.1 On the 1st October, the Government announced an extension to Infection Control Funding until the end of March 2021. £546m of additional one-off funding to support infection control (taking the total allocation to £1.146bn) across adult social care providers. For Cambridgeshire, this equates to an allocation of £5,429,954. The primary purpose of this fund is to support adult social care providers, including those with whom the local authority does not have a contract, to reduce the rate of COVID-19 transmission in and between care homes and support wider workforce resilience. 80% of the funding is to be passed to care homes and CQC registered providers. The local authority has discretion on the use of the remaining 20%, and the current proposal is that we use this to develop infection control measures in housing related support, by personal assistants and by day service providers, subject to internal governance approvals.

2.8.2 The continuation of this funding will enable providers to support safe hospital discharges and reduce unnecessary hospital admissions, through embedding effective infection and prevention controls and in turn minimising the risk of outbreaks within these settings.

2.9 Performance

2.9.1 National reporting on Delayed Transfers of Care (DTOCs) was suspended in March 2020. It is not envisaged that reporting on DTOCs will be reinstated in the same way, with a greater emphasis being placed on patient flow through the system.

2.9.2 Due to the relatively new nature of the D2A model and the rapid pace with which it was implemented, we are in the process of developing a set of KPIs and also waiting to hear about any national plans in order for us to be able to accurately report on the effectiveness of D2A implementation locally.

2.9.3 Across the system, we aim to maximise the number of daily discharges, with the aim of achieving 90% of the maximum possible daily discharges following the additional DSF investment that has just been agreed. Joint health and social care modelling was completed in early October, which was based on:

- All 65+ non elective hospital admissions that lasted 1 day or more
- An above average number of daily discharges to ensure we have sufficient capacity to meet peaks in demand (see figure below)

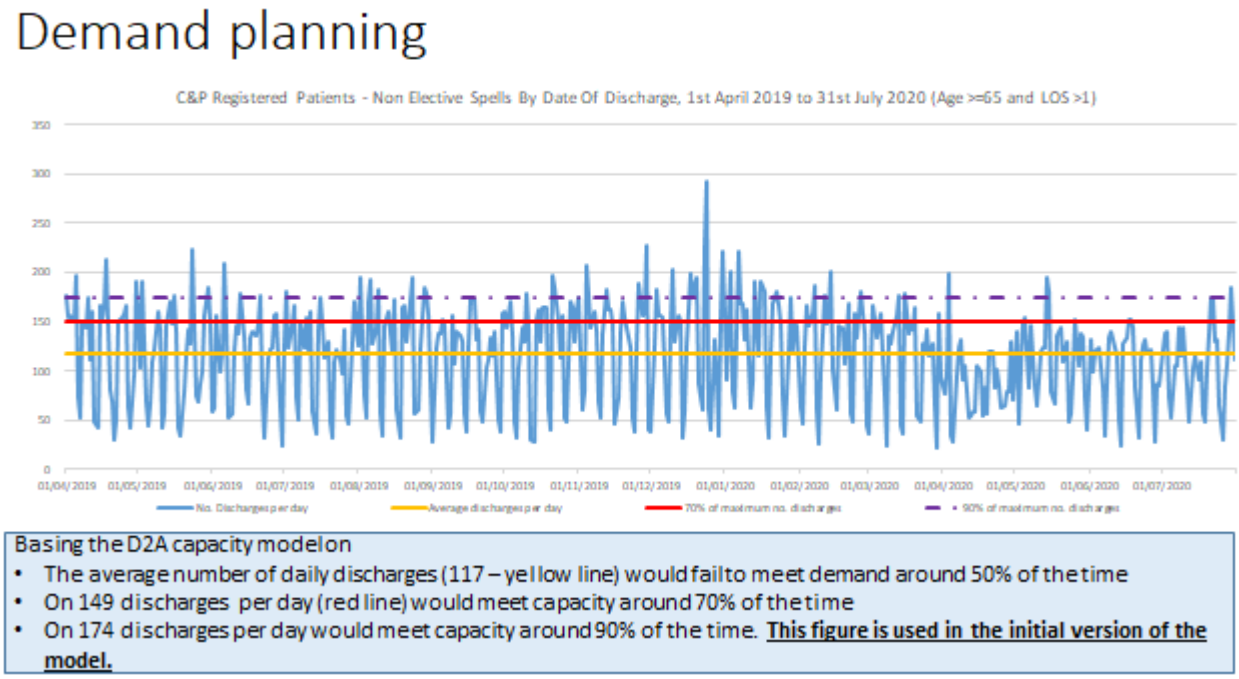

Figure 3 - Demand Planning - C&P Registered Patients - Non-Elective Spells by date of discharge, 1 April 2019 - 31st July 2020. (Age >=65 and LOS .1)

2.9.4 This modelling has given us the optimum level of **daily** discharges we are working to of **174** patients. If we apply the local D2A pathway flows to this number, the system should be able to achieve the following:

- 75% (or **131** patients a day) should be simple discharges
- The remaining 25% (**44** patients a day) will be complex discharges split as follows:

Proportion of total daily complex discharges	**Pathway**	**Current performance (average)**	**90% target**
15%	D2A Pathway 1	16 patients a day	27 patients a day
3%	D2A Pathway 2	2 patients a day	5 patients a day
7%	D2A Pathway 3	5 patients a day	12 patients a day

2.9.5 It is worth noting that in the Cambridgeshire and Peterborough system the percentage for Pathway 3 includes people going home with domiciliary care. Whilst the number for this pathway may seem higher than other systems in the country, it is because in other systems domiciliary care is classed as care at home and therefore counted under Pathway 1. Locally we have agreed to keep D2A Pathway 1 to short term rehab services, which is why we incorporate discharges home with long term domiciliary care under Pathway 3 instead and therefore our figures for this pathway look a little higher.

2.9.6 The local authority is working with health partners to develop a set of measurable D2A performance indicators, which enable us to effectively monitor patient flow across the system. These will aim to incorporate existing reportable data wherever possible, to minimise the reporting burden on system partners, and is likely to incorporate some of the following potential elements:

- Percentage of people moved off the medically fit/optimised list per day
- Percentage of weekend discharges
- Number of people who return homes / reduction in bed-based admissions
- Percentage of social care and CHC assessments completed in the community
- Return to independence following reablement / intermediate care
- Patient satisfaction / experience

2.9.7 Healthwatch recently undertook a national survey with 590 people to understand people's experiences of the new discharge arrangements. The full report can be found here. In addition, locally, the Council has commissioned Healthwatch to undertake a local review of experiences, with a representative sample of 35 people who experienced the discharge process locally. We will be working with Healthwatch and the Partnership Boards to respond to any issues that are identified from a patient perspective.

2.10 Winter Planning

2.10.1 Working closely with wider system partners we continue to implement effective D2A processes and pathways before the winter, so that we can maintain an optimum level of discharge 7 days a week.

2.10.2 In response to the publication of the national Adult Social Care: COVID-19 Winter Plan 2020-21 on the 18th September 2020, as a local authority we were required to ensure we have a robust local winter plan in place, which meets the key national recommendations. In addition, we have also completed the ADASS Service Continuity and Care Market Review: Self-Assessment prior to the deadline of the 21st October 2020, which reinforces our assured position locally.

2.10.3 Our local Health and Social Care Out of Hospital Recovery Plan (Appendix 1) sets out our vision and approach over the next 18-24 months, as we believe our level of ambition needs to go beyond the immediate short-term 'recovery' process and maximise the opportunity for transformation. Alongside this plan, sits our Care Home Support Plan, which can be found here. This provides a more detailed overview of our local approach to supporting care

homes to embed infection and prevention control measures, with the aim of minimising outbreaks within these settings.

2.10.4 Our approach to winter planning is the continued implementation and embedding of these plans, alongside specific short-term measures to ensure appropriate capacity to respond to the challenges of winter and a second surge of COVID. This includes, ensuring a clear approach over the winter period to continue to embed discharge to assess pathways; supporting workforce capacity to meet demand; continued embedding of infection and prevention control; practical and financial support to providers (including the roll out and oversight of the Infection Control Funding extension). It also includes a focus on mobilisation of the community sector and embedding our Think Communities principles, to support low level prevention and early intervention provision.

2.10.5 Our local Winter Plan builds on the strong partnership foundations we already have in place across our health and care system. The local response to the pandemic and our current plans incorporate the enhanced understanding provided through local data, feedback, demand and support needs we have identified as a result of COVID.

2.10.6 We continue to work collaboratively with the system and provider market to manage our local response to COVID. All partners are working extremely closely together to ensure we are maximising the capacity in the system, sharing intelligence and targeting our resources effectively. This is to ensure early identification of issues or support needs including COVID outbreaks and infections in care settings and in the community. We have a good relationship with local providers and liaise with them frequently to identify any issues at the earliest opportunity. This includes via regular online and telephone-based forums, coordinated communication channels and a regular social care presence in care homes working alongside and supporting them. Continued collaboration with providers has been central to the development and delivery of our local plans.

2.10.7 As a local system, we are committed to ensuring delivery of the three overarching priorities, as outlined in the national Adult Social Care: COVID-19 Winter Plan 2020-21, which was published on the 18th September 2020:

- Ensuring everyone who needs care and support can get high quality, timely and safe care throughout the autumn and winter period.
- Protecting people who need care, support or safeguards, the social care workforce, and carers from infections including COVID-19
- Making sure that people who need care, support or safeguards remain connected to essential services and their loved ones whilst protecting individuals from infections including COVID 19

2.10.8 We have reviewed our local winter plans alongside the recommendations in the national Adult Social Care: COVID-19 Winter Plan 2020-21 and are confident that our local plans are robust.

3. Alignment with corporate priorities

3.1 A good quality of life for everyone
Good quality, effective and appropriate services are provided to adults which are personalised and deliver care in the right setting at the right time supporting a good quality of life for people.

3.2 Thriving places for people to live
There are no significant implications for this priority.

3.3 The best start for Cambridgeshire's children
There are no significant implications for this priority.

3.4 Net zero carbon emissions for Cambridgeshire by 2050
There are no significant implications for this priority.

4. Significant Implications

4.1 Resource Implications
Additional funding has been agreed by the NHS to ensure that we have appropriate Discharge and Deferred Assessment Capacity. The capacity outlined within this report is being recruited to, but will be fully funded by the CCG.

4.2 Procurement/Contractual/Council Contract Procedure Rules Implications
There are no significant implications within this category.

4.3 Statutory, Legal and Risk Implications
There are no significant implications within this category.

4.4 Equality and Diversity Implications
There are no significant implications within this category.

4.5 Engagement and Communications Implications
There are no significant implications within this category.

4.6 Localism and Local Member Involvement
There are no significant implications within this category.

4.7 Public Health Implications
There are no significant implications within this category.

Implications	**Officer Clearance**
Have the resource implications been cleared by Finance?	N/A

Have the procurement/contractual/ Council Contract Procedure Rules implications been cleared by the LGSS Head of Procurement?	N/A
Has the impact on statutory, legal and risk implications been cleared by the Council's Monitoring Officer or LGSS Law?	N/A
Have the equality and diversity implications been cleared by your Service Contact?	N/A
Have any engagement and communication implications been cleared by Communications?	N/A
Have any localism and Local Member involvement issues been cleared by your Service Contact?	N/A
Have any Public Health implications been cleared by Public Health	N/A

5. Source documents guidance

5.1 Source documents

- Hospital Discharge Service: Policy and Operating Model
- Infection Control Fund
- Care Home Support Plan

5.2 Location

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

https://www.gov.uk/government/publications/adult-social-care-infection-control-fund-round-2/adult-social-care-infection-control-fund-round-2-guidance

https://www.cambridgeshire.gov.uk/asset-library/Peterborough-and-Cambridgeshire-Care-Home-Support-Plan.pdf