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Developing Buckinghamshire together

Discharge to Assess in Buckinghamshire

The discharge to assess service (D2A) helps patients be discharged earlier from hospital by co-ordinating and providing care from other providers, in non acute settings. It is for those people whose care can safely be continued elsewhere but may still require some interventions from our services. They are provided with short-term, funded support in their own home or another community setting. Assessment for any longer term care and support is carried out in the most appropriate setting and at the right time for the person.

It incorporates various health and care activities allowing effective management of demand across Buckinghamshire's integrated care system (ICS).

Reablement and rehabiliatation to support patients to regain their independence is an important feature of D2A. A multi-disciplinary team, including discharge co-ordinators will support patients and their families throughout the discharge process.

The service gets its name from its focus on assessing patients for their ongoing care needs outside the hospital rather than waiting in a acute hospital bed to be assessed. The ICS vision is that no decisions about long-term care should be made in an acute setting.

Our Aims

Patients on a D2A pathway are discharged from hospital into nursing or residential homes or into their own home, sometimes with live in care. This care and support is for a defined period of time and has a rehabilitation and reablement focus.

Our objectives are:

- Promote the independence of adults on D2A by placing them at the centre of any decisions that impact their lives
- Allow people, with their carers and families, to take a full and active part in planning their long-term care and support
- Reduce the need for long-term packages of care by assessing people's long term care needs outside of the acute hospital, in settings which can maximise their ongoing independence
- Review plans regularly to make sure they are appropriate and effective
- Work together across the ICS to improve patient flow, reduce delayed transfers of care and increase health outcomes

Characteristics

- Assessment for care needs take place at home or in residential care, not hospital
- Three pathways for three groups of patients – no patient is excluded
- Multidisciplinary team assesses and provides patient care
- Independent brokerage available in hospital

- Deliver quality care to vulnerable adults in safe environments
- Use telecare solutions where appropriate to promote and improve independence

Our Values

Privacy	Your rights to expect sensitivity and confidentiality in dealing with your personal information.
Dignity	Respecting your uniqueness, your personal needs and your right to be treated with respect.
Independence	Your right to choose and control the way care is delivered to you and supporting your right to independence.
Competence	D2A services will be delivered by appropriately qualified managers, nurses and care and support workers who are competent to do their job.
Reliability	We will deliver what has been specified, providing information about the services. We will keep you and your carers informed of any changes in services.
Equality	We will be responsive and sensitive to ethnicity, gender, disability, sexual identity, age, religion, sexual orientation, marital/civil partnership status, culture, lifestyle, values and social circumstance. We will ensure we do not disciminate against you on any of these grounds.
Courtesy	We will ensure you and your carers are treated with respect.

Our Structure

In the Buckinghamshire integrated care system and through the Better Care Fund, we already have initiatives underway to reduce length of stay in acute inpatients wards, reduce delayed transfers of care (DToC) and manage bed occupancy.

We also want to improve business as usual through effective multi agency team planning and communication across the health and social care system and to always reinforce the “home first” philosophy.

Home care

Providing time limited home care and live in care focussing on reablement. This allows safe and timely discharge from hospital to peoples own home, then allowing assessment of longer term care and support in their home

Bed-based intermediate care (including step up, step down capacity)

Providing a residential or nusing care home bed to provide time limited care and support with a reablement focus. The aim is to either:

- Allow safe and timely discharge to allow an assessment of longer term care and support; or
- Prevent admission to hospital through timely intervention

ENABLER – Multidisciplinary team (MDT)

The MDT is made up of nurses, OT's physios and social workers from BCC and BHT. They are involved in planning for patient discharge when medically fit and identify suitable patients for the D2A pathway.

They refer patients to providers identified as being able to provide short term discharge to assess packages. This could be home care, live-in care or a care home.

Key personnel act as a trusted assessor completing referrals. The trusted assessor refers to D2A beds without the care home needing to carry out an assessment.

Brokerage in hospitals

Buckinghamshire County Council independent broker service is located in hospital, alongside discharge co-ordinators. They will support self-funders with options for when they are discharged to ensure they are taking up care and support options proportionate to their needs.

Red Cross Care Navigators

This has been aligned to Buckinghamshire's Home from Hospital support, where the Red Cross provides transport and a settling in service for people discharged to their home. The Care Navigator will work with long length of stay patients on the ward to motivate and encourage them to make plans to go home. They will then provide at home support to help with the discharge.

Also available as part of discharge to assess:

- Home from Hospital service
- Support for carers
- Seven day service from BCC social care
- Reablement
- Community Health care teams
- Assistive technology
- Airedale Video consultation for Care Homes

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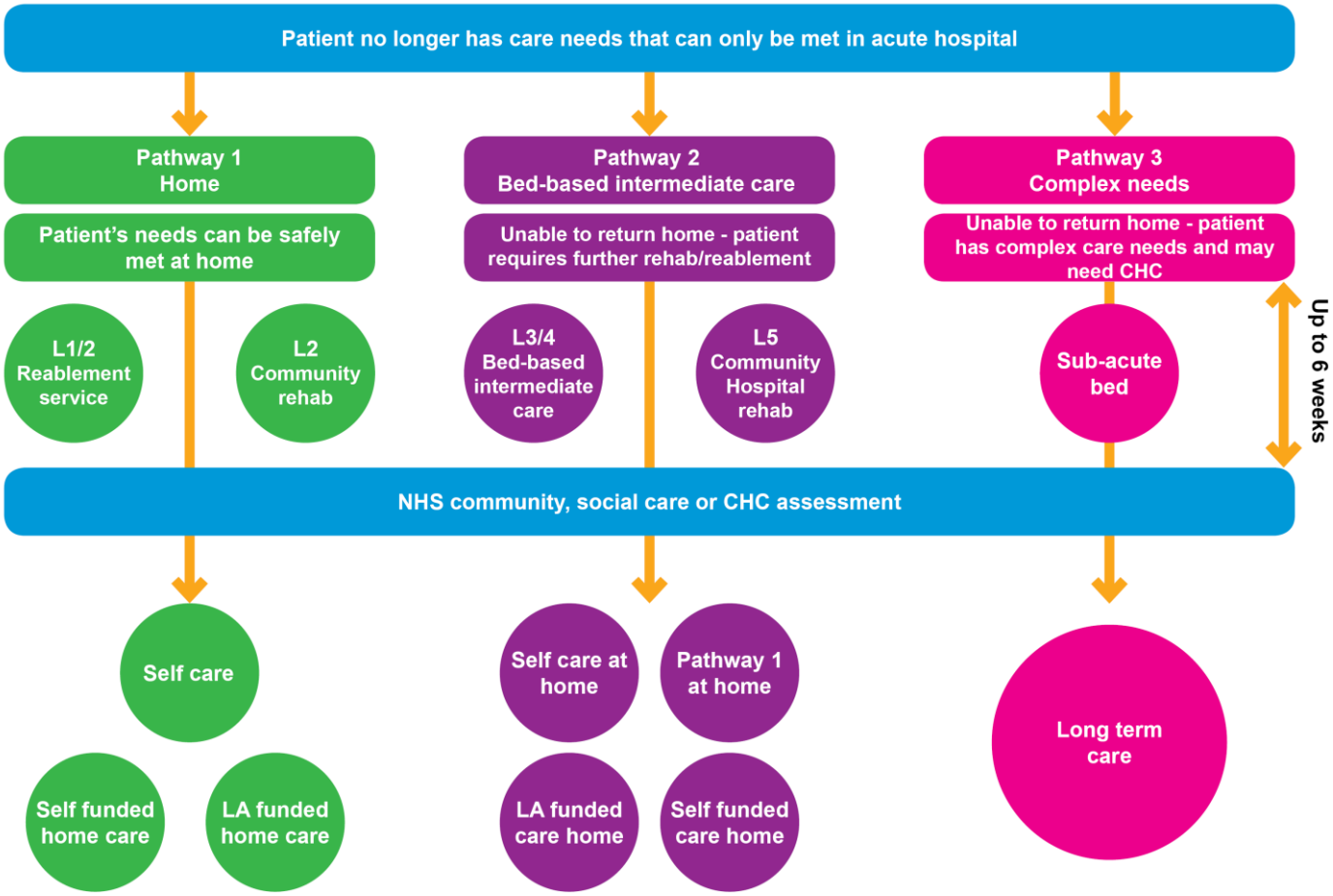
How patients benefit

The three pathways allow patients to be discharged from hospital in a timely way and support patients to rehabilitate fully in their own home or the community.



Pathway 1 for patients on a hospital ward who can return home with additional support from the reablement team or with community rehabilitation. They will remain on this pathway for up to six weeks.

Pathway 2 for patients who cannot be discharged home directly but could return there with additional rehabilitation

Patients are discharged to residential care or community hospitals for up to two weeks.

Pathway 3 for patients likely to need ongoing, long-term care and may be eligible for continuing healthcare funding.

Working together, Buckinghamshire's integrated care system has:

- **Access to short term care home beds**. These beds have been commissioned from providers the County Council has recognised as capable of high quality care for this model.
- **Access to additional domiciliary care support**. Extra hours have been commissioned from providers to enable people to be assessed in their own homes.
- **Built in links with primary care**. GP practices have been commissioned to provide clinical input to these beds. GP cover of a high quality is essential to allow the patient to move along the pathway within six weeks.

Enabler: Working with Buckinghamshire Reablement Service

Joint working across the Buckinghamshire integrated care system has been essential. Collaboration allows for a rapid and smooth transition between different services avoiding delays as patients wait for social care packages or a care home place.

The reablement service is crucial for Pathway 1. Staff have been retrained using a strengths-based approach focussing on what the patient can do for themselves rather than what they cannot, working with the patient for six weeks. The aim is to reduce the cost of expensive long-term care packages and help patients live independently in their own home.

Intensive support during the six week period of the reablement package means that at the end patients require significantly less home care.

What this means?

The service aims to offer patients the ability to return home more rapidly and improve their recovery from periods of illness or after an accident. All discharges should be appropriate and safe and it should demonstrate that it has not led to an increase in readmissions despite an earlier discharge home. The ICS is also working to establish a sustainable long-term D2A service.

Challenges

To understand the effectiveness of the D2A service we will examine key performance areas and any gaps in data. This will include evaluation of the impact of interventions in reducing unnecessary hospital admissions, delayed transfers of care and long length of stay for patients to support patient flow.

Challenges and lessons learned will need to be recorded to support planning for the following year.

Evaluation

An evaluation report will be produced and shared in May 2019