Discharge To Assess

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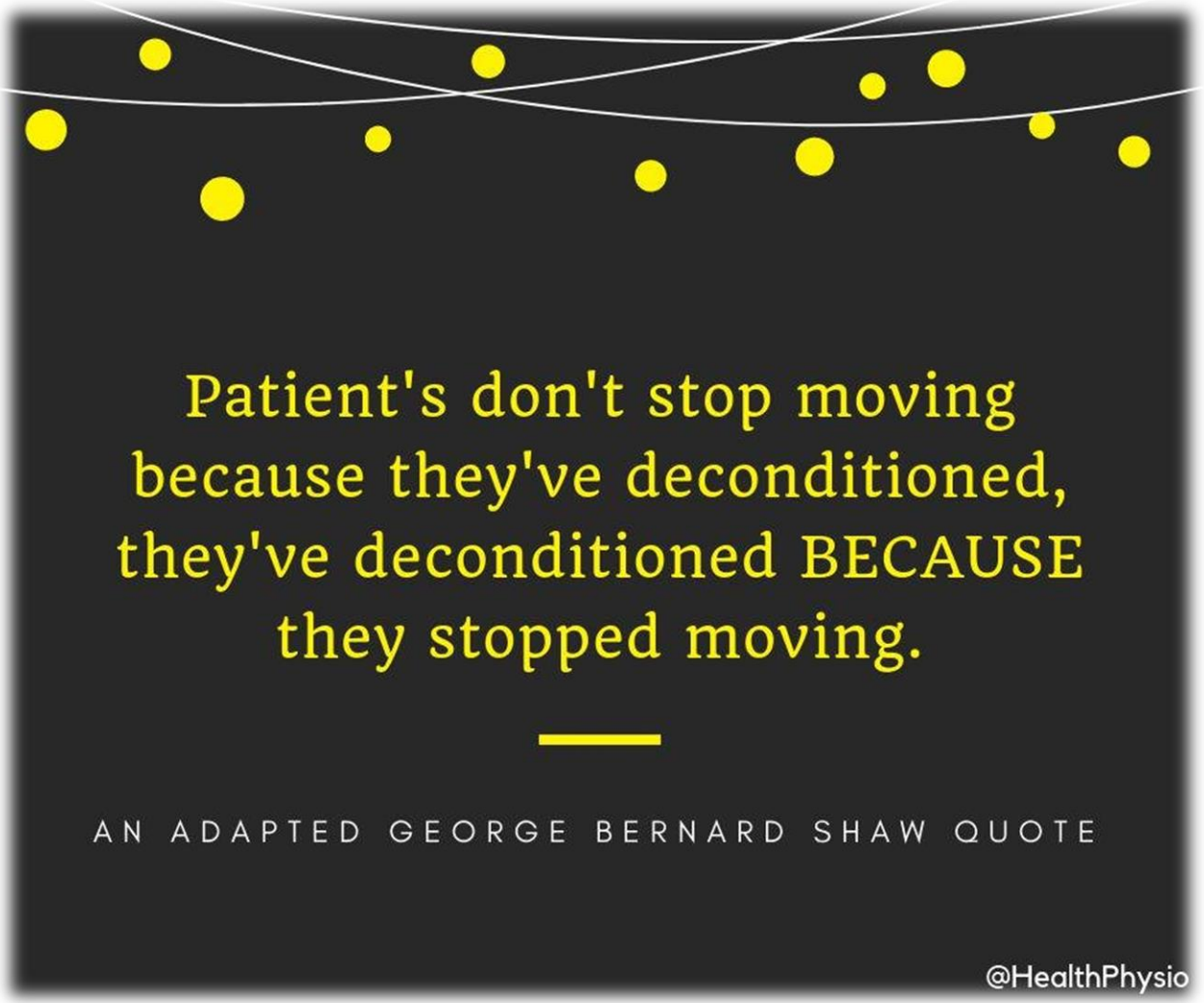

Patient's don't stop moving because they've deconditioned, they've deconditioned BECAUSE they stopped moving.
AN ADAPTED GEORGE BERNARD SHAW QUOTE
@HealthPhysio

Levels of activity in-inpatient settings

- The median age of inpatients is rising, with pre-existing mobility impairment prevalent on admission.
- Even in wards geared up for post-acute rehabilitation, many patients leave much less mobile than they were.
- A hospital day is spent in bed for up to 83% of the time with only 6% of the rest of the time is spent ‘active’.
    - If doing 10,000 steps a day this equates to 600 steps
    - If doing 2000 steps a day this equates to only 120 steps a day

- In the context of stroke, the inpatient rehabilitation environment does not appear to promote higher levels of physical activity than the acute hospital environment. (https://pubmed.ncbi.nlm.nih.gov/26851969/)
- Environmental change from hospital to home is associated with reduced sitting time and increased the time spent physically active. (https://pubmed.ncbi.nlm.nih.gov/29750901/)
- After early supported discharge to the community, participants took more than twice the number of steps. (https://pubmed.ncbi.nlm.nih.gov/26725003/)

Muscle Physiology - Sarcopenia

(Perkin et al 2016)

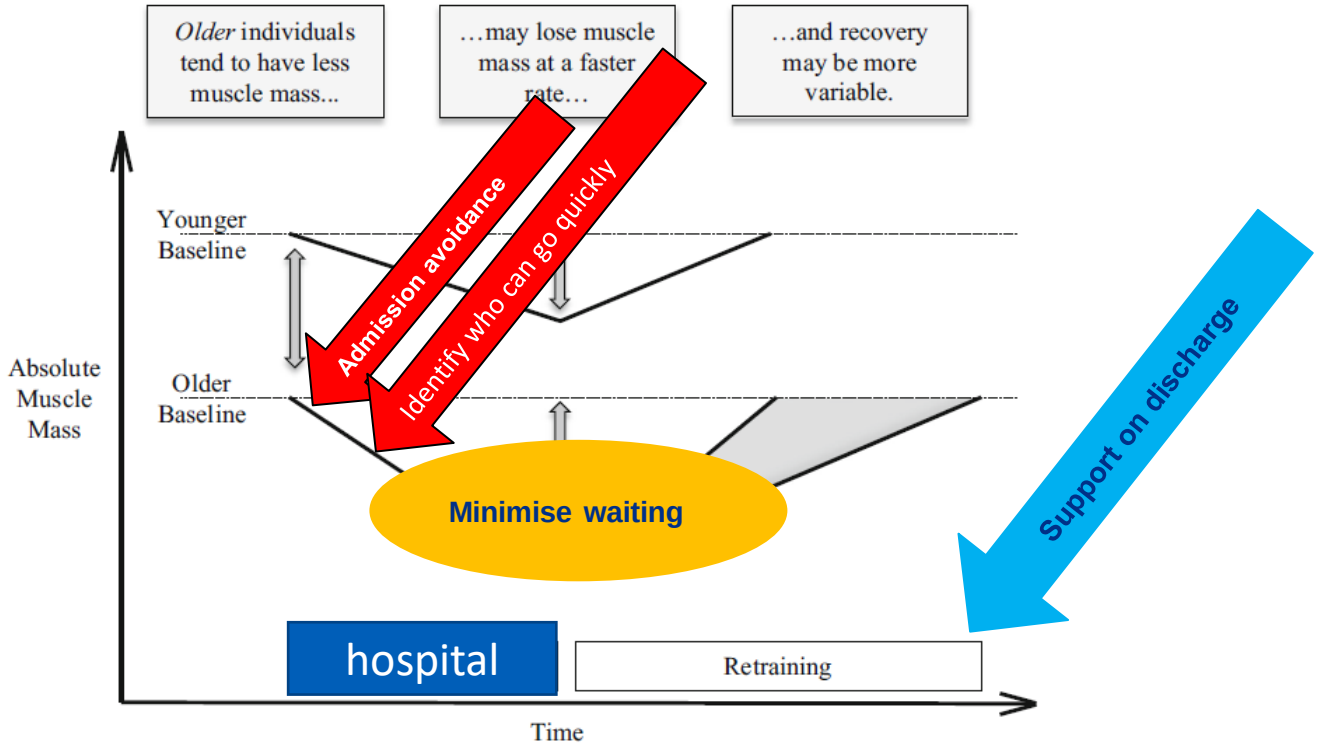


Fig. 1 Schematic of the differences in muscle mass changes in older compared to younger individuals in response to match unloading and retraining protocols

Why not home? Why not Today?

14 systems

14

10,400 patient journeys studied

10,400

Between 32% and 54% of the people delayed were discharged to a setting where the levels of care were not well-matched to their needs

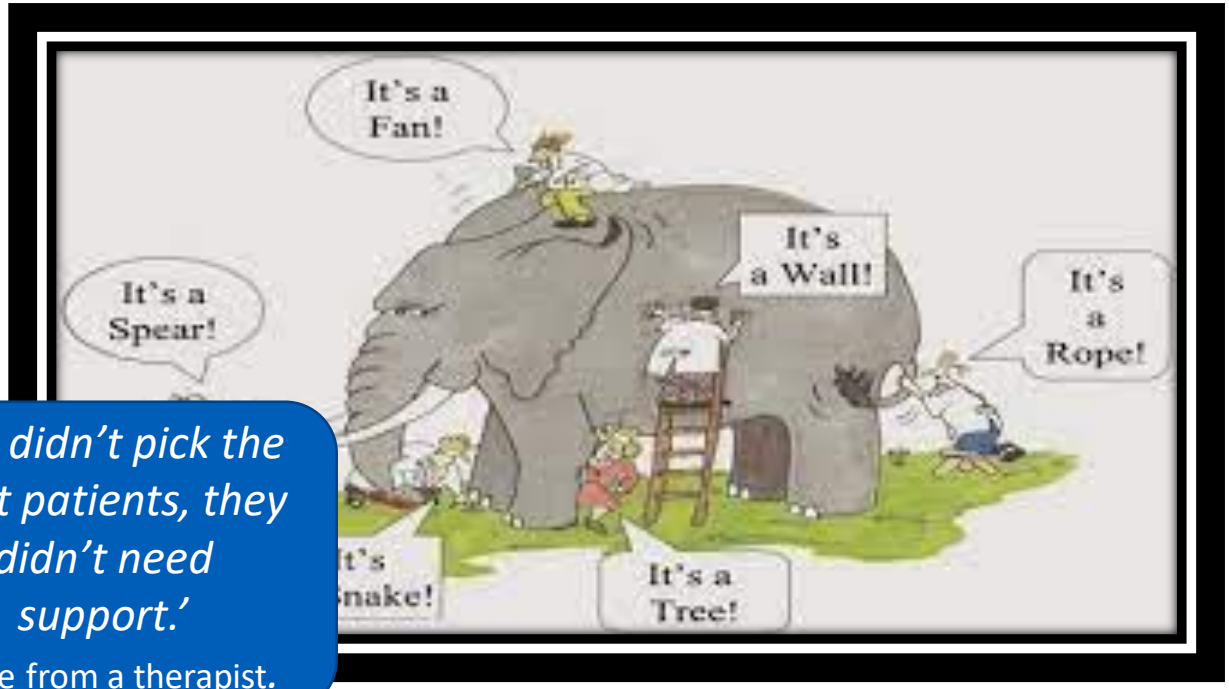
32-54%

In 92% of these cases, the setting was providing a more intense level of care than would have maximised the individual's independence

92%

https://reducingdtoc.com/

Discharge to assess



'We didn't pick the right patients, they didn't need support.'

quote from a therapist.

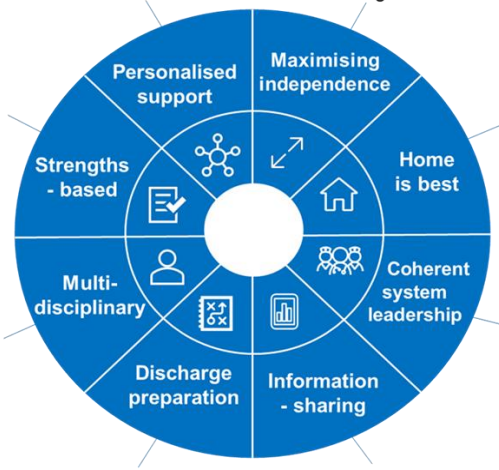
https://www.youtube.com/watch?v=KJEyZ1Y5O0w

Principles for discharge

Integrated, timely, personalised care - not care that is most convenient for individual organisations. Services that say 'yes' and tailor their response to the needs of the individual. People can access social care support via a personal budget as well as via commissioned services.

Maximising independence – The goal for everyone receiving support should be to maximise their long-term independence. Although funded support will be available for up to six weeks, many people will benefit more from a shorter, intensive period aimed at reducing or eliminating longer term needs for care.

Strengths-based assessment proportionate to the stage of recovery the individual has reached; involving the individual (and/or others as appropriate); appropriate to the level of decision required; done at the right time and in the right place to get an accurate picture of what is needed. Describing the needs of the individual – not prescribing.



Home is best for 95% of older people leaving hospital – for recovery and any further assessment of need.

Flexible multidisciplinary working involving health, social care, the independent sector, the voluntary sector and housing – creating a culture across organisations that enables personalised services to be wrapped round the individual.

Positive, collaborative system leadership with a clearly articulated vision; trust between partners; a sense of mutual endeavour to solve problems and blur boundaries as necessary; where success is judged as a system based on the outcomes achieved for individuals using services - not on individual organisational indicators.

Preparation for discharge begins at the point of admission – creating a culture which recognises multiple and complex needs, including a person-centred informed response. A culture of partnership working is in place to enable appropriate discharge planning and onward assessment.

Communication and information-sharing with the individual and their family/carers, and between those organisations, assessing, commissioning and providing care and support.

Discharge Pathways:

Pathway 0 (50%*)

- simple discharge home, no new or additional support is required to get the person home or such support constitutes only:
    - informal input from support agencies
    - a continuation of an existing health or social care support package that remained active while the person was in hospital

Pathway 1 (45%*)

- Able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.
- Every effort should be made to follow Home First principles, allowing people to recover, re-able, rehabilitate or die in their own home.

Pathway 2 (4%*)

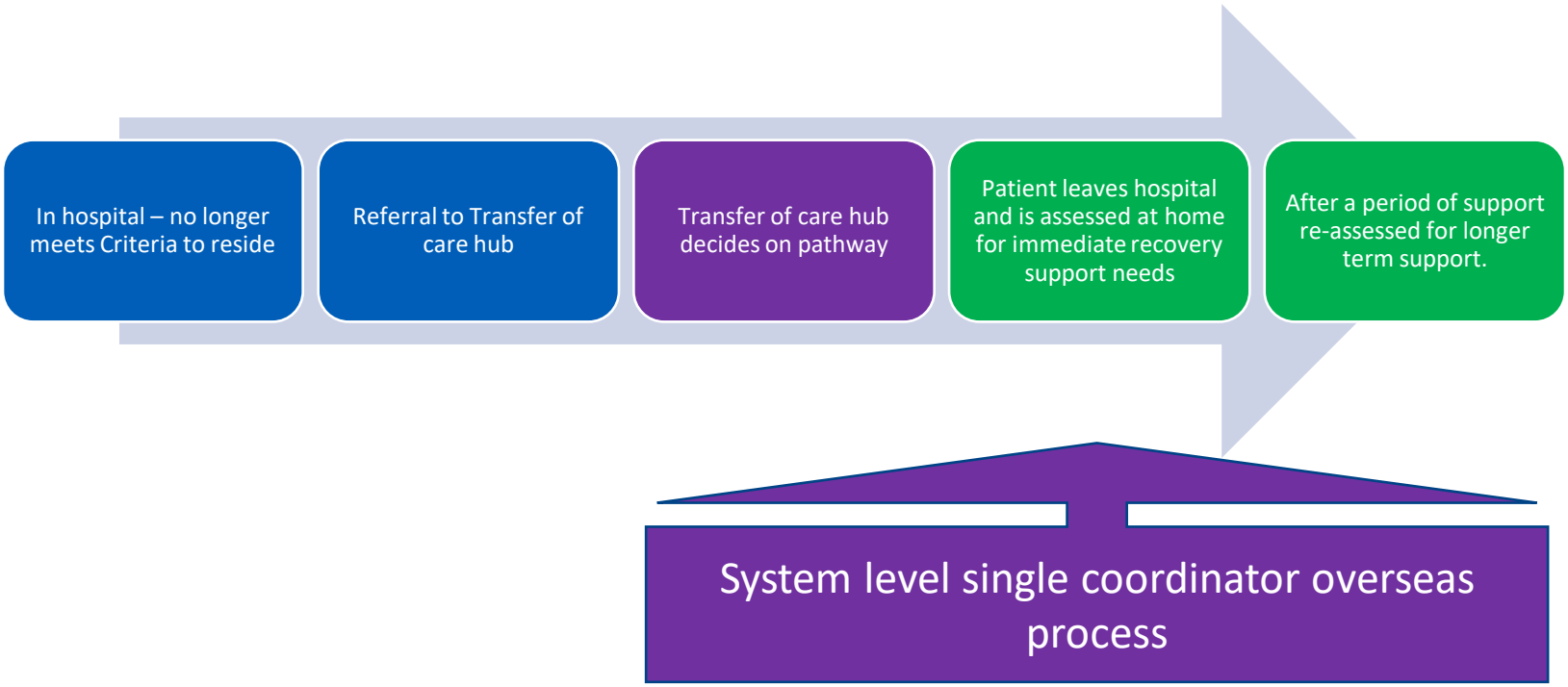
- recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home.

Pathway 3 (1%*)

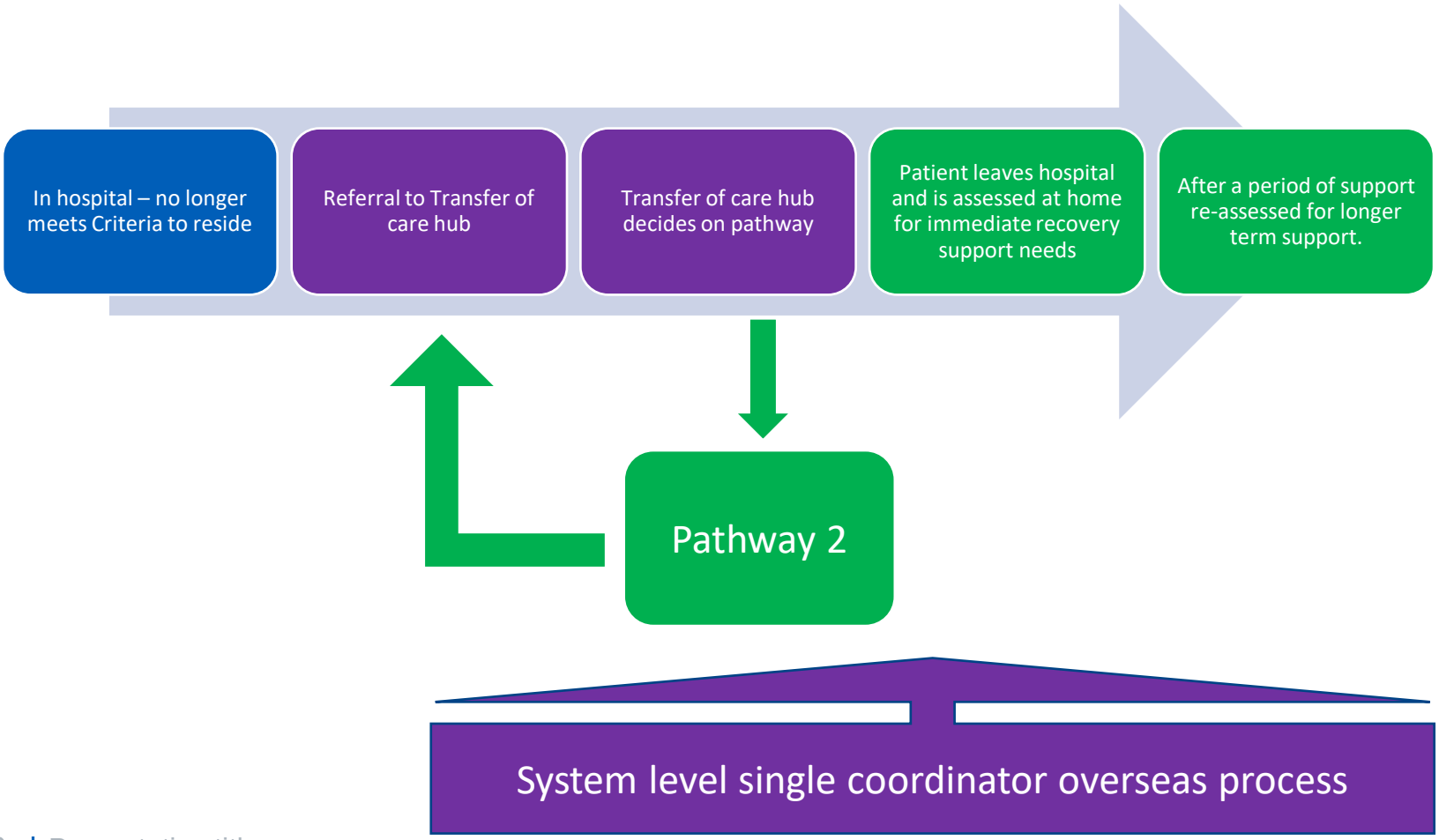
- For people who require bed-based 24-hour care: includes people discharged to a care home for the first time.
- Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

over 65

Pathway 1 - high level process



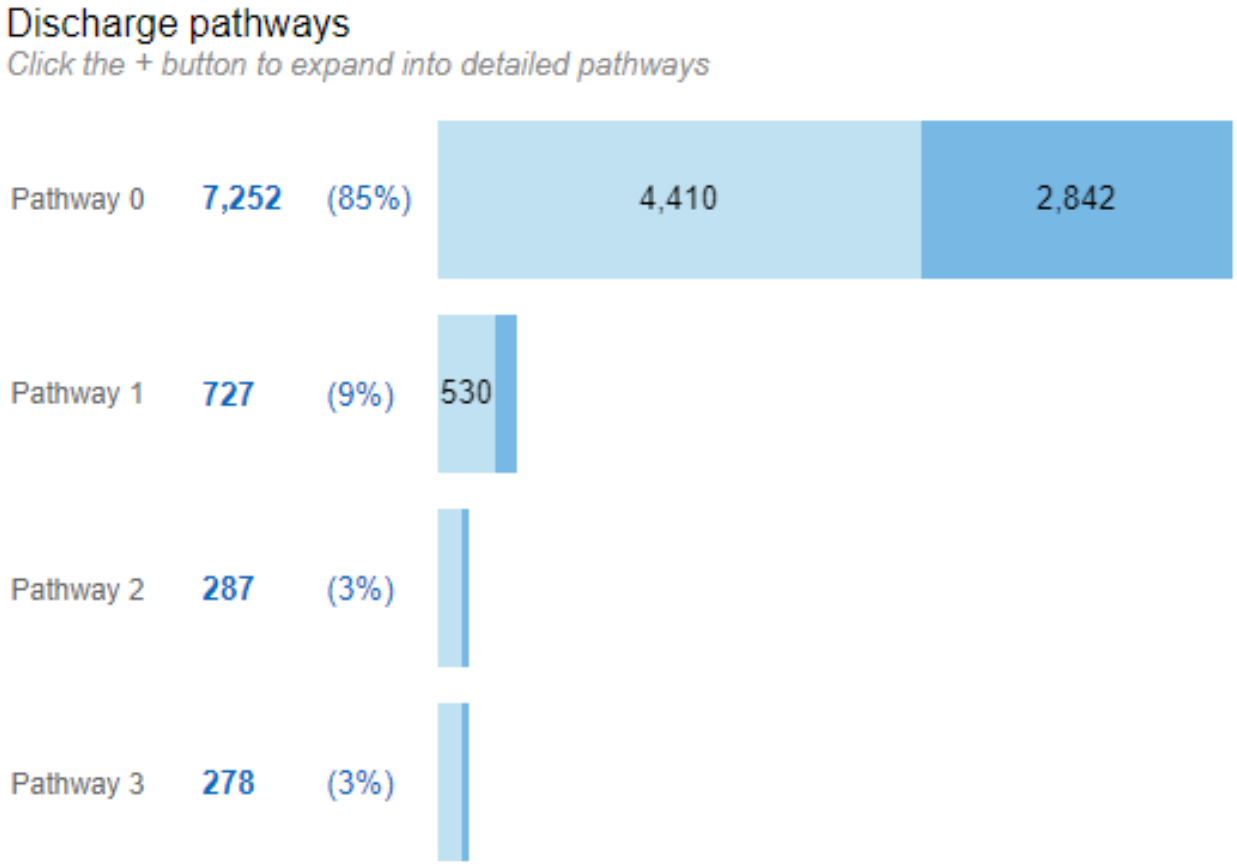
Pathway 2 - high level process



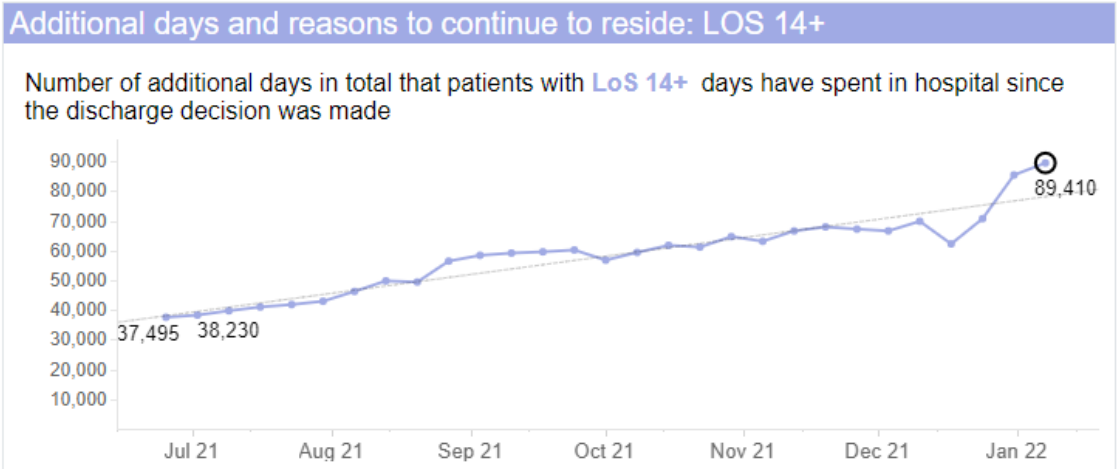
Key features

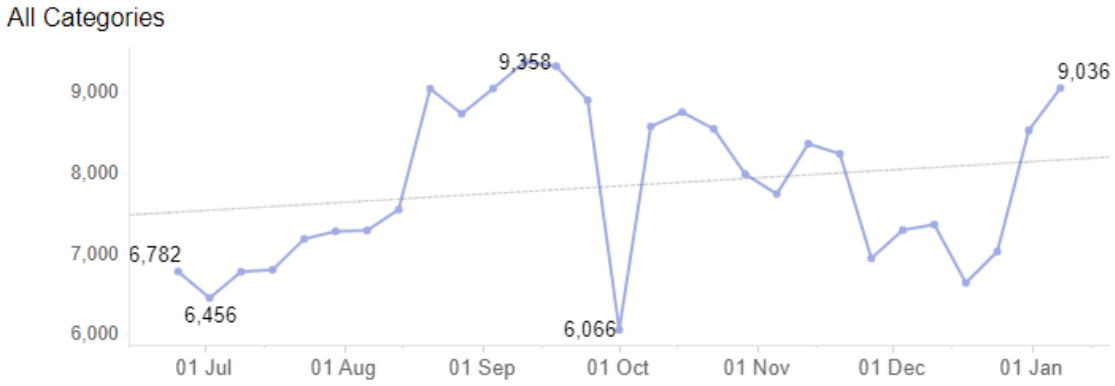
- If a person in hospital does not meet the Criteria to Reside (Annex A) they must be discharged as soon as they are clinically safe to do so. [2.3]
- No assessments of long-term needs whilst in hospital (NHS CHC and Social Care). [2.8]
- No delayed transfers of care recording or reporting. [2.5]
- Home is the default pathway for all patients. [3.1]
- **At least 95% of over 65's leaving hospital** should be going straight home/usual place of residence either on **Pathway 0 or Pathway 1.** [3.1]
- There must be close monitoring of progress when people are discharged on Pathways 1 and 2. Assessments of any on-going needs should be done as soon as it is possible by the appropriate lead professional. [3.8]
- Systems should coordinate the commissioning, provision and progress monitoring of people discharged on the pathways to create a system that says 'yes' and then personalises its responses and support as needs change over time.

So how are we doing?



But…..


Additional days and reasons to continue to reside: LOS 14+
Number of additional days in total that patients with LoS 14+ days have spent in hospital since the discharge decision was made
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
37,495
38,230
89,410
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22


All Categories
9,000
8,000
7,000
6,000
6,782
6,456
9,358
6,066
9,036
01 Jul
01 Aug
01 Sep
01 Oct
01 Nov
01 Dec
01 Jan

C.10%

What has worked well?

- **Funding:**
  - Additionality
  - De-weaponised conversations

- **Partnership working**
  - Joint working with Health and Social care
  - Clarity of leadership
  - Relationships with partners

- **Workforce**
  - Adaptability of the people we work with
  - Redeployment of people aligned to the system risk

- **Risk acceptance**
  - Guidance support positive risk taking
  - More creative in their solutions
  - Sharing the risk between health and social care

What hasn’t worked as well?

- **Funding uncertainty**
  - Short term funding = short term service investment – not transformation
  - Removing funding may have negative impact

- **Resources in the community**
  - Increased pressure on community services
  - On background of low priority for community capacity

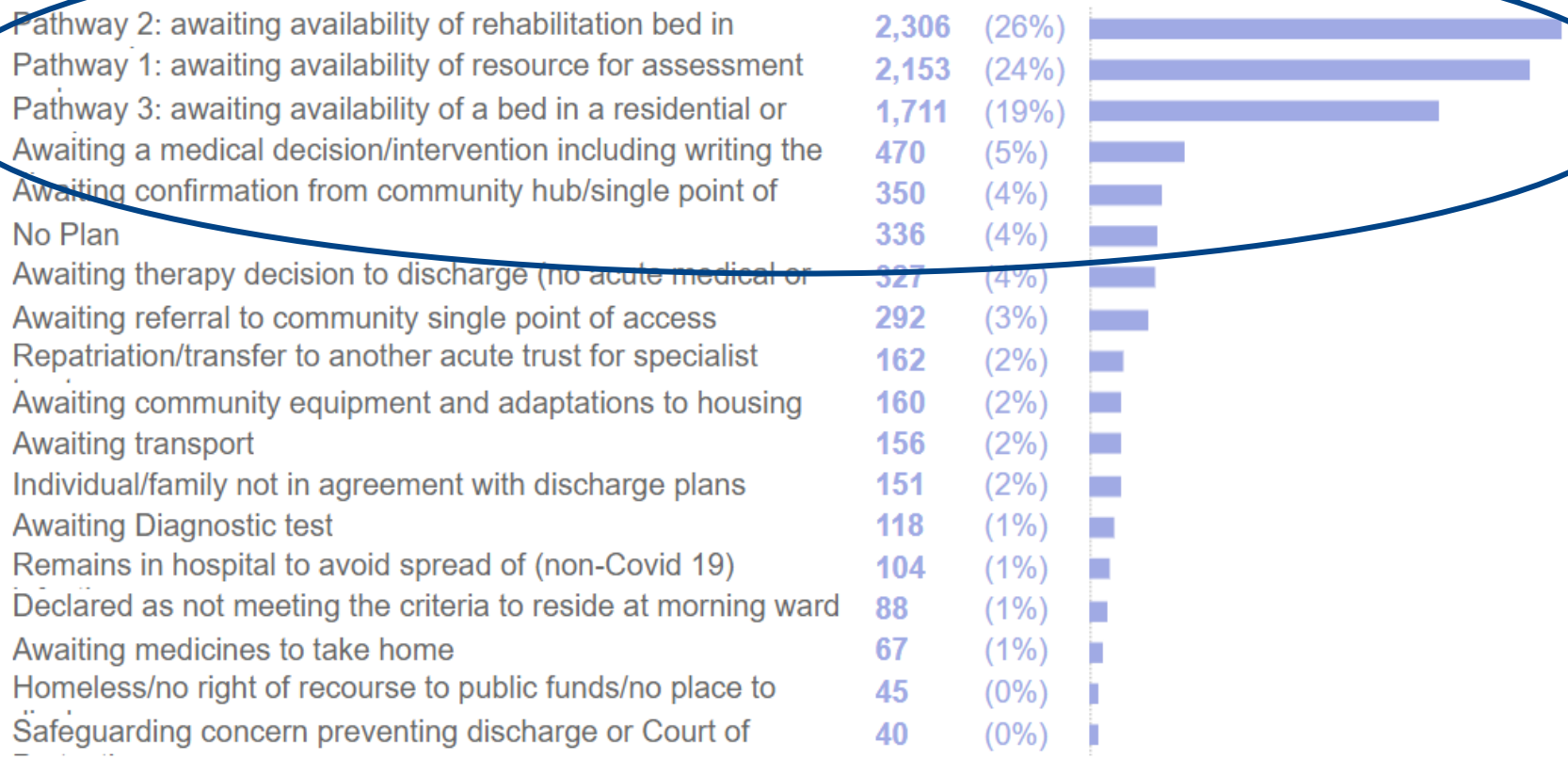
- **Data management**
  - Data identification and collection
  - National data didn't support local systems develop their single version of truth

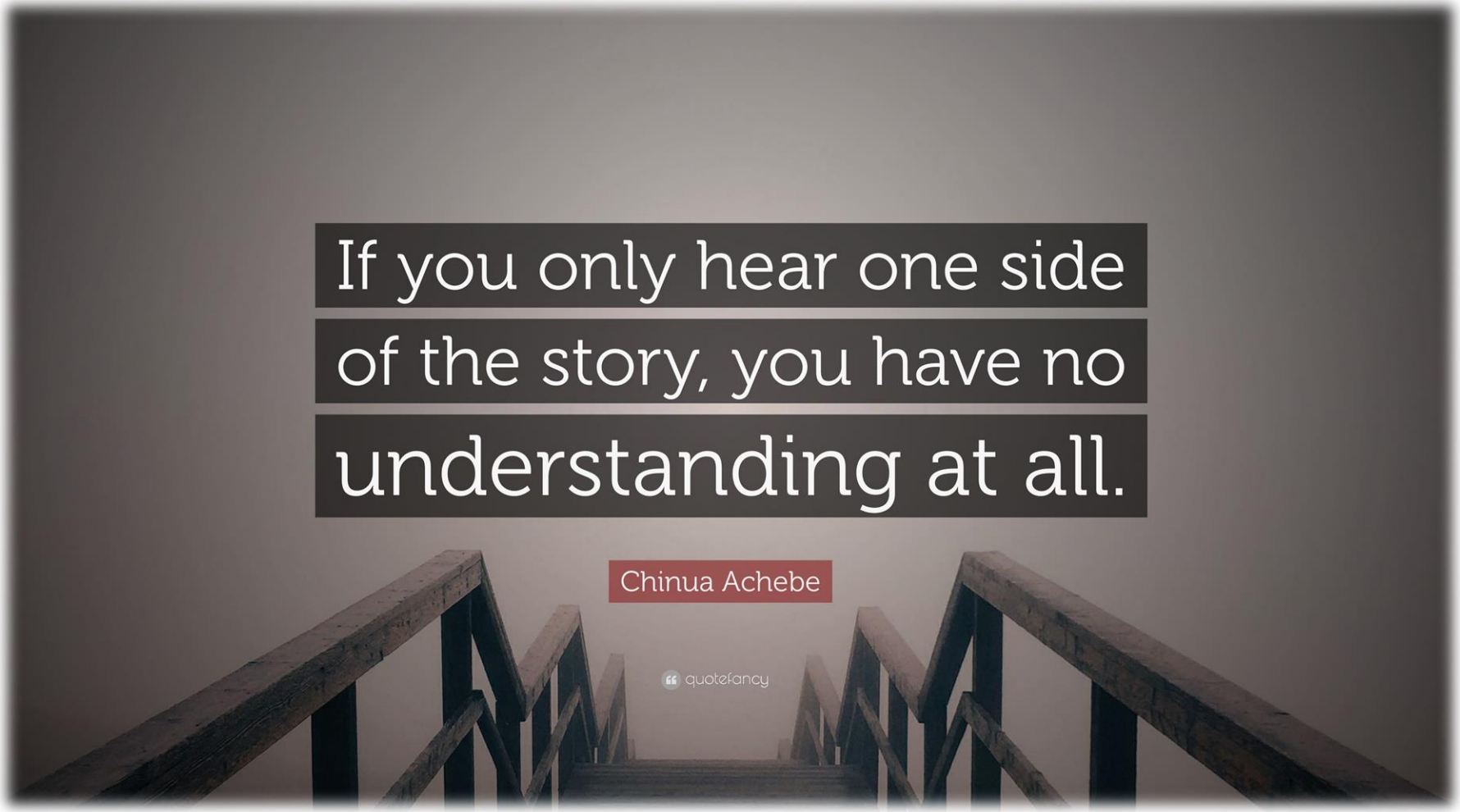
- **Communication with families**
  - Needs to be improved about expectations with the different pathways
  - Lack of understanding about the funding arrangements after the first 4-6 weeks.

What are we waiting for…

Reasons why patients continue to reside 14+ days: 07 January to 13 January 2022

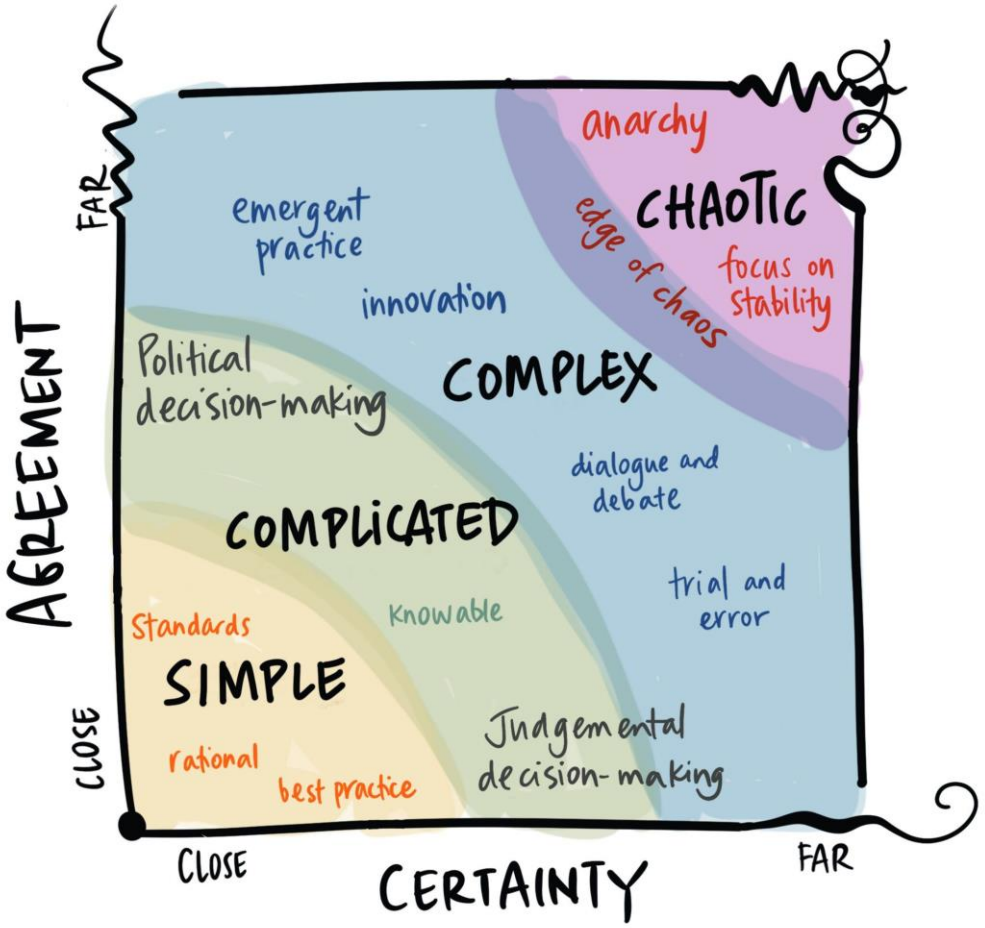
Please click on the reasons to filter time series below.




If you only hear one side
of the story, you have no
understanding at all.
Chinua Achebe
quotefancy

Do we recognise complexity in discharge?

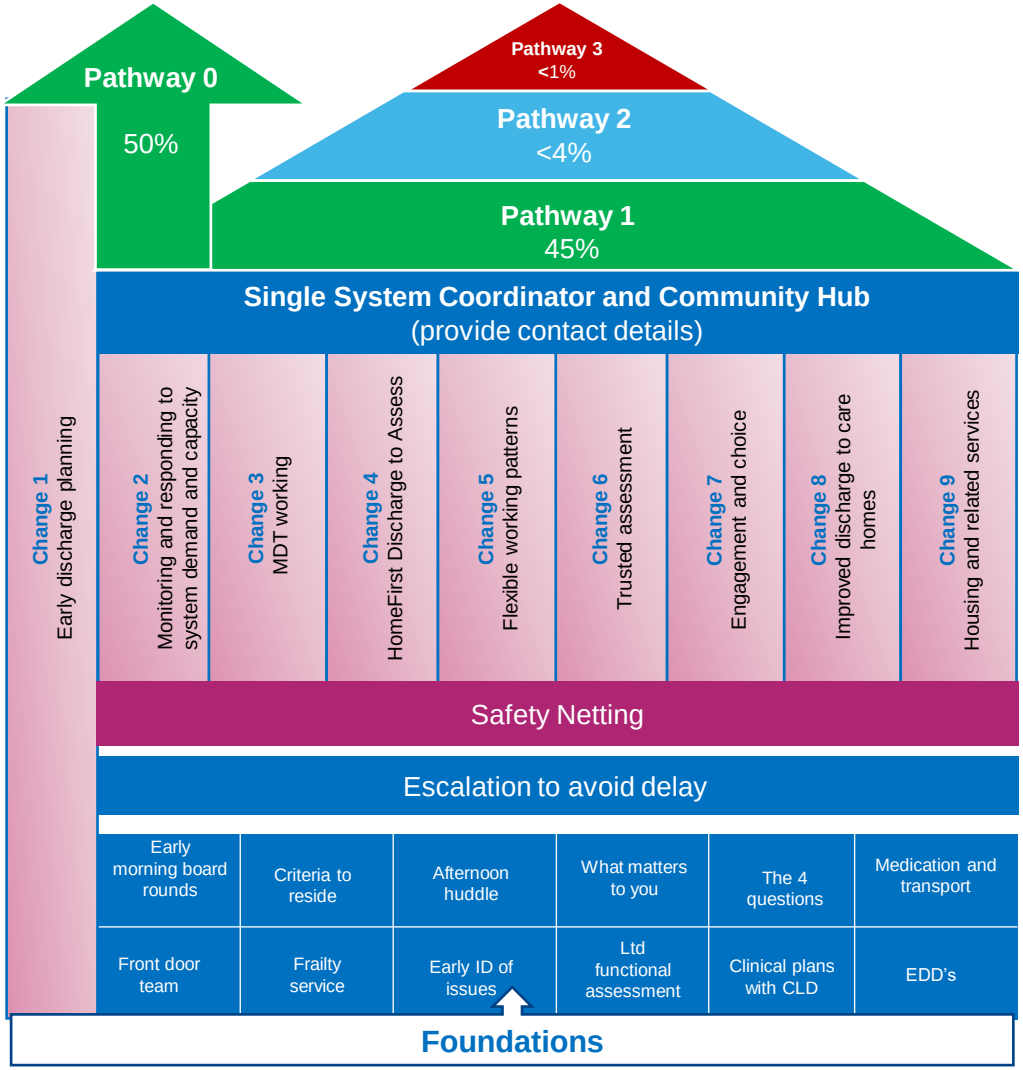
Not complex discharges!!



Stacey Matrix adapted by S. Bradd and D. Finegood

% apply to age 65+

HomeFirst



Percentages taken from John Bolton: Reducing delays in hospital transfers of care for older people (2018)

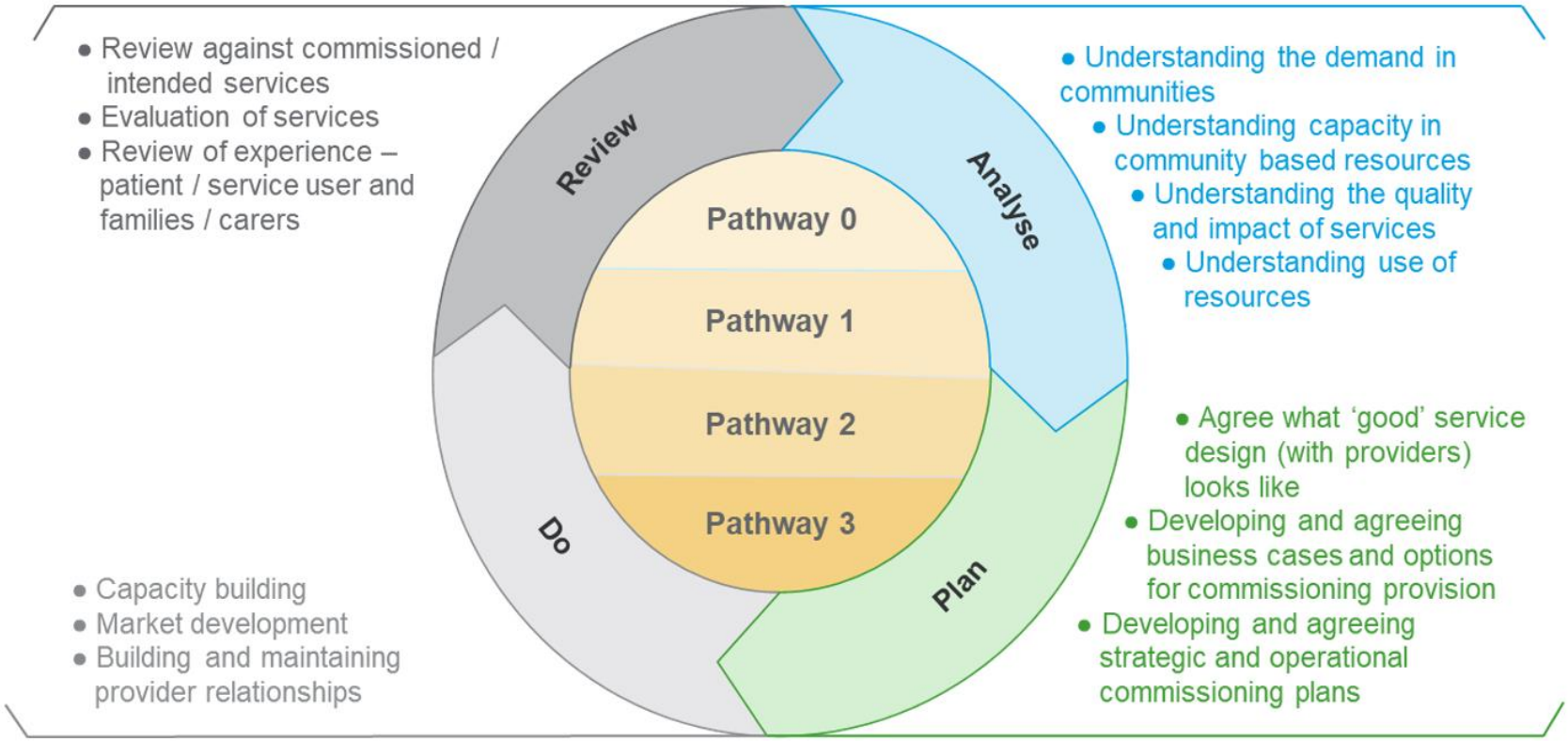
Commissioning out of hospital care services to reduce delays (2020)

Pillars from LGA:
High Impact Change Model: Changes 1-9 (July 2020)

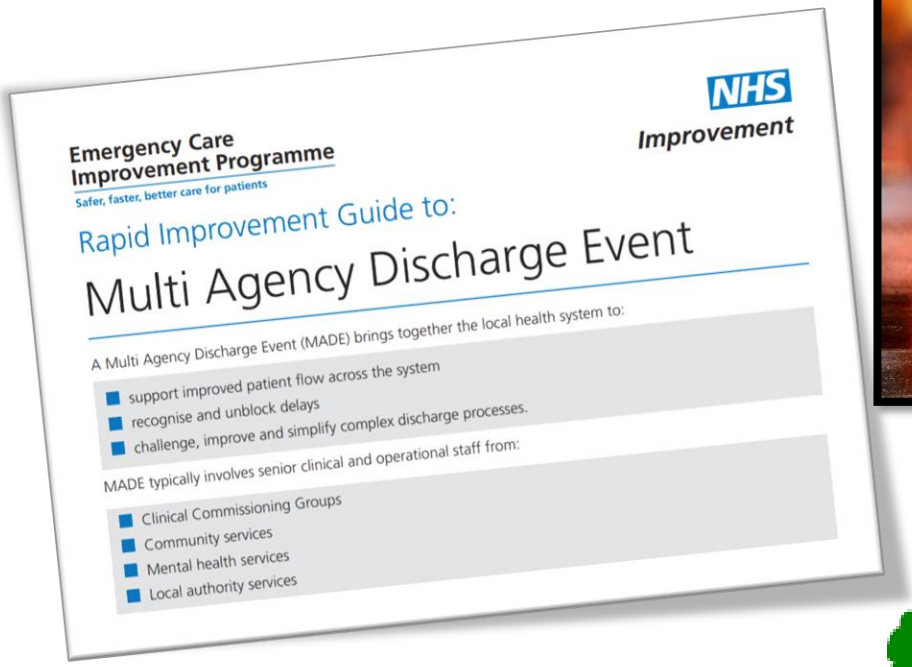
4

The D2A commissioning cycle

The 'analyse, plan, do and review' cycle describes a range of activities and their inter-relationships and is underpinned by some key principles including: a focus on need across agencies; all four activities in the cycle are of equal importance and follow sequentially; and commissioning is developed strategically and jointly, and adapted as necessary in response to evidence.



MADE's



Emergency Care Improvement Programme
Safer, faster, better care for patients

NHS Improvement

Rapid Improvement Guide to:

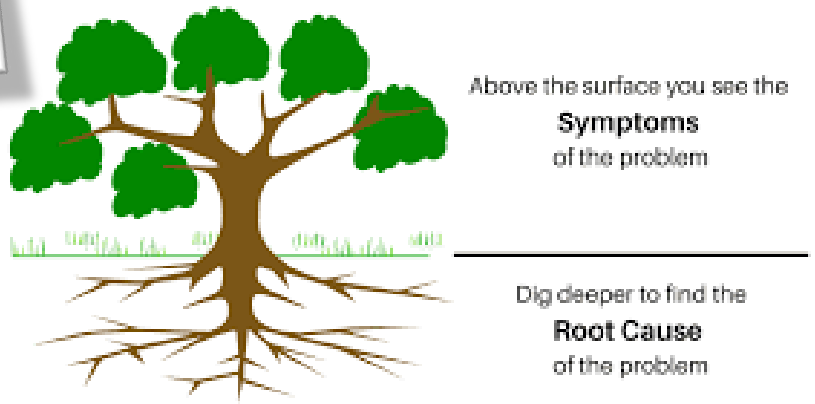
Multi Agency Discharge Event

A Multi Agency Discharge Event (MADE) brings together the local health system to:

- support improved patient flow across the system
- recognise and unblock delays
- challenge, improve and simplify complex discharge processes.

MADE typically involves senior clinical and operational staff from:

- Clinical Commissioning Groups
- Community services
- Mental health services
- Local authority services




WHERE
ARE WE
GOING?

What ‘good’ looks like….

Questions?

- For more information, resources and discussion please join our FutureNHS platform https://future.nhs.uk/ECISTnetwork/grouphome
- Follow us on twitter @ECISTNetwork