**Virtual Networking Event Themed Summary**

**Discharge to Assess: the role of occupational therapy**

The following is a themed summary of the online discussion between attendees of the RCOT Discharge to Assess: the role of occupational therapy virtual networking event held on 8th December 2020. The event was attended by over 260 RCOT members from across the UK, based in acute, community and social care settings.

The points below summarise the written comments shared using the ‘chat’ function. These reflect the opinions and experiences of individual participants and are not intended to represent a formal position from RCOT. An RCOT Informed View on the Hospital discharge service: Policy and operating model can be found [here](https://www.rcot.co.uk/about-occupational-therapy/rcot-informed-views).

During the event participants shared good practice and positive outcomes arising from implementation of D2A processes, as well as identifying approaches to overcoming challenges at a local level.

RCOT are keen to hear about examples of innovative and successful D2A practice that members would be willing to share to aid other occupational therapy teams in their implementation of D2A principles. Please share your experiences with Lauren Walker, Professional Adviser at [lauren.walker@rcot.co.uk](mailto:lauren.walker@rcot.co.uk)

**Key areas of discussion**

Effective practice:

* Opportunities for occupational therapy leadership
* Connecting acute and community occupational therapy teams
* Multi-disciplinary working and professional development
* The role of the single-coordinator
* Use of discharge hubs
* Assessments in the home
* Team structures
* Mental health
* Positive outcomes

Overcoming system challenges:

* Strategic leadership
* Embracing risk
* Changing cultures

**Opportunities for occupational therapy leadership**

* Those who have led on the development of D2A principles, such as John Bolton, note that D2A works well when it is therapy led.
* There are opportunities for occupational therapists to lead at all levels, for example, as Single-Coordinators across systems; leading discharge coordination in acute settings; developing workforce strategies within CCGs; managing reablement teams; supervising and upskilling un-registered colleagues.
* Therapists should not wait to be invited to local discussions about the implementation of D2A, they should seek out opportunities to influence.
* Strategic leadership is also vital in ensuring that longer term rehabilitation needs are identified and addressed, integrating appropriate health, care, and voluntary sector services. Occupational therapists have the skills and knowledge to lead this locally.

**Connecting acute and community occupational therapy teams**

* In a number of areas there is ‘in-reach’ from community teams to acute settings. This is effective in allowing therapists to talk through cases, encourage positive risk taking and make appropriate, timely discharge decisions.
* Community teams may already know patients who have been admitted to wards and can provide information about people’s strengths and needs in their home environment.
* In some areas acute occupational therapists have been deployed to work with community teams. Acute therapists are also taking patients out to meet community occupational therapists – particularly critical care, neurological and complex orthopaedic patients.
* One area has developed pictorial moving and handling guidance sheets as part of project work between acute and community teams, to share skills and expertise across settings.
* Thought needs to be given to where occupational therapy resource is best placed; there is a balance to be struck between acute and community.

**Multi-disciplinary working and professional development**

* Having an appropriate skill mix within the workforce is vital. This includes qualified allied health professionals (AHPs) and nurses, as well as appropriately trained band 3 and band 4 staff.
* Upskilling band 3 and band 4 staff as trusted assessors, e.g. providing equipment and assistive technology, allows registered level staff to focus more on coordination and supporting individuals with complex and specialist needs.
* D2A presents opportunities for un-registered staff to develop new skills, and for registered staff to work to the top of their license and move into areas of advanced practice.
* Blended roles across AHP and nursing can be effective in reducing clinical contacts and footfall in people’s homes, as well as offering an opportunity for professional development.
* Voluntary sector organisations are important partners, offering valuable community and social support.

**The role of the single-coordinator**

* The single-coordinator role is vital in facilitating communication and consensus building with the different organisations within a system.
* Where an acute trust links with multiple systems there should be a lead local authority or CCG for the trust. The co-ordinator for this system can then link in with the coordinator(s) from other systems that the trust works with.
* Currently, not all areas have a single-coordinator and this can be the source of local challenges e.g. ineffective communication and mismatched capacity.
* Occupational therapists are well suited to the role of single-coordinator, and there are already a number of occupational therapists holding and applying for these positions.

**Use of discharge hubs**

* Currently, not all areas have discharge hubs established and this can create challenges locally.
* Discharge hubs that include representation from acute, community and local authority services are essential to creating effective circular communication and feedback loops that allow pathways to work.
* Many areas have occupational therapists contributing to discharge hubs, through daily calls with system partners, and it was noted that there should be a multi-disciplinary approach to discharge decisions.
* Discharge decisions should be strengths-based, not problem-focused, and some areas have developed person-centred assessment forms to redefine the way that discharge questions are asked.
* Discharge planning should start at the point of admission. Areas that have applied this approach have found that it helps prevent delays once a person is medically optimised.

**Assessments in the home**

* Several areas reported that they are successfully achieving home assessments within 24-48 hours of discharge.
* One area reported meeting patients as they arrive home post-discharge and another area’s intermediate care team are visiting within 2 hours where needed.
* Decisions about the urgency of home assessment should be personalised, based on the needs of the person rather than a set of rigid rules.
* Ward teams should talk to patients and their carers about what they feel will be needed, and how quickly.
* As an example, a person living alone with no care may need a visit within two hours, whereas someone going home late in the day with a relative staying overnight may be better seen the following day – with their understanding and agreement.
* One team has found that some people need a day or two to settle back at home before starting an intervention.

**Team structures**

* There were different approaches to operating D2A pathways with most areas utilising existing intermediate care, reablement, rapid response and community teams, and others establishing specific D2A teams utilising acute and community staff.
* It was noted that the recommendation from NHS England and Improvement is that D2A is not a new service, but a reorganisation of existing services to ensure most effective use of the workforce.

**Mental health**

* It was noted that the existing policy for D2A is very focused on physical health needs. The national NHSEI Mental Health team are developing a D2A approach for people with mental health needs.
* One area is currently piloting a D2A approach to facilitate discharge of patients from acute older adult mental health wards. An occupational therapist will work with these individuals for four weeks to resettle them and support their occupational needs in the community.

**Positive outcomes**

* There are multiple opportunities for occupational therapists to develop their roles and take up positions of leadership as a result of D2A implementation.
* One area noted that they are encountering fewer issues with the provision of equipment due to people being assessed in their home environment.
* Another area noted that implementing D2A has positively transformed their entire system.
* Several areas are developing case studies that demonstrate the positive impact of D2A on patients’ personal experiences of discharge.

**Strategic leadership**

* Misinterpretation of D2A principles at a strategic leadership level (e.g. CCG and local authority) can seriously hamper effective integration and implementation across the system.
* Nurturing understanding and encouraging conversations is important. Creating supportive networks involving multiple agencies, involving more like-minded people, and sharing resources can all help to shift mind-sets and support change.
* D2A is working best in systems where senior leaders agree a strategic direction and frontline staff are empowered to work together to find approaches and solutions that work locally.
* Quality improvement tools such as driver diagrams can be effective ways of establishing change needs within a system and provide outcome metrics. Occupational therapists can lead on this work across acute and community settings.
* Systems should collect data on the outcomes of D2A, what is going well and what isn’t, and commissioners should work jointly to ensure appropriate capacity within pathways.
* It can be hard to challenge as a small voice in a big system. But lots of small voices make a choir.

**Embracing risk**

* It was noted that therapists, nurses, and medics in acute settings can sometimes feel concerned about perceived risks of patients being discharged sooner.
* The RCOT document [*Embracing risk; enabling choice*](https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/embracing-risk)(RCOT, 2017) can support conversations and decisions that focus on positive risk taking.
* Ensuring effective and regular communication between acute and community services helps to build mutual understanding and trust.
* Rotations for junior and senior therapy staff that include community and acute settings helps therapists to gain experience of various aspects of D2A pathways.
* In-reach of community therapists into acute settings also helps to develop positive, trusting relationships.
* Sharing patient stories and case studies that highlight the experience of the whole D2A pathway helps to support positive risk taking.
* One area that has been operating D2A pathways for several years noted that readmission rates due to unsuccessful discharges are very low. Within the first six months of operating D2A there were 2 readmissions, with an average of 20 patients discharged on a D2A pathway per month.
* One area reported operating a single point of access for people already know to services which they can call if they are deteriorating at home. This triggers a rapid response aimed at preventing readmission.

**Changing cultures**

* It was noted that fostering ‘enabling’ cultures in acute wards, for therapy, nursing and medical staff is important for shifting cultures that are very medically focused.
* The [Choosing Wisely](https://www.choosingwisely.co.uk/) initiative was flagged as a useful resource, developed by the Academy of Medical Royal Colleges, that aims to support shared decision making between clinicians and patients.
* Conversations focused on ‘why not home, why not today’ should begin at the point of admission.
* Effective communication and collaboration with social care and social work colleagues is an essential part of the picture.
* A mutual understanding of each profession and team’s role with patients as part of D2A, and how this impacts patients’ outcomes, is important.
* Quality improvement tools and principles can help to change culture, behaviours and improve patient experience in a positive, systematic way.
* Outcomes from quality improvement projects can also demonstrate the value of occupational therapists, as part of a MDT, in improving efficiency and patient experience through partnership working.
* Shifting away from terminology such as ‘medically fit’ and embedding the term ‘medically optimised’ can help in shifting perspectives.
* For most people, ‘functional optimisation’ happens most effectively at home and should rarely be a reason to keep someone in an acute hospital bed.