Royal College of Occupational Therapists

Discharge to Assess – The role of occupational therapy

Tuesday 8th December

13:00 – 15:00

Agenda

Time	Session
13:10	Hospital Discharge Service: National Policy and Operating Model **Kate Jackson, Tom Luckraft, Joanne Richardson**, NHS England & Improvement
13:25	Panel discussion
13:50	**Comfort break**
14:00	Discharge to Assess: Findings from Torbay and South Devon **Becky Harrison,** Torbay and South Devon NHSFT
14:10	Oxfordshire Home First: Discharge to Assess **Sally Steele**, Oxfordshire County Council and **Sarah Hamblin**, Oxford Health NHSFT
14:20	Collaborative Reablement **Amy Howard** and **Mikaela Ellingham**, Surrey County Council
14:30	Panel discussion

Additional panellists:
Liz Sargeant, ECIST – NHSEI, Austin Booth, Independent Occupational Therapist and Gemma Dorer, Sussex Partnership NHSFT

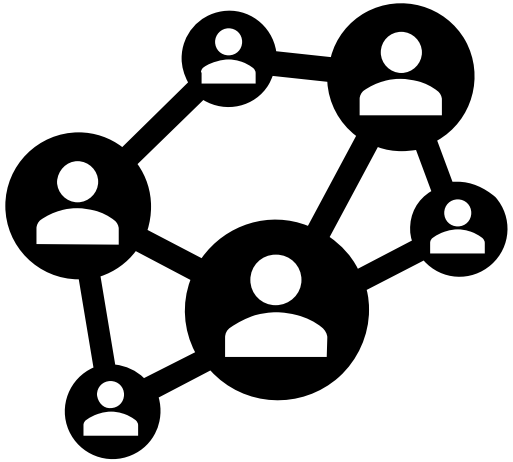
Networking after the event

FutureNHS collaboration platform – National AHP virtual hub

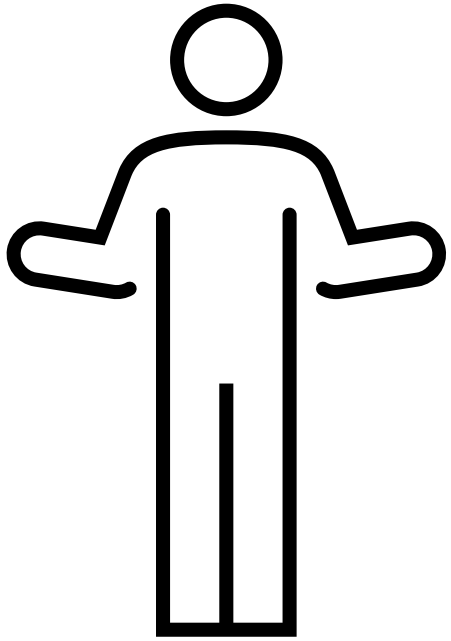
Email england.cahpo@nhs.net and ask for access to the AHP General Virtual Forum

AHP Discharge to Assess network

- www.source4networks.org.uk search for “D2A”



Who’s here?



Where do you work?

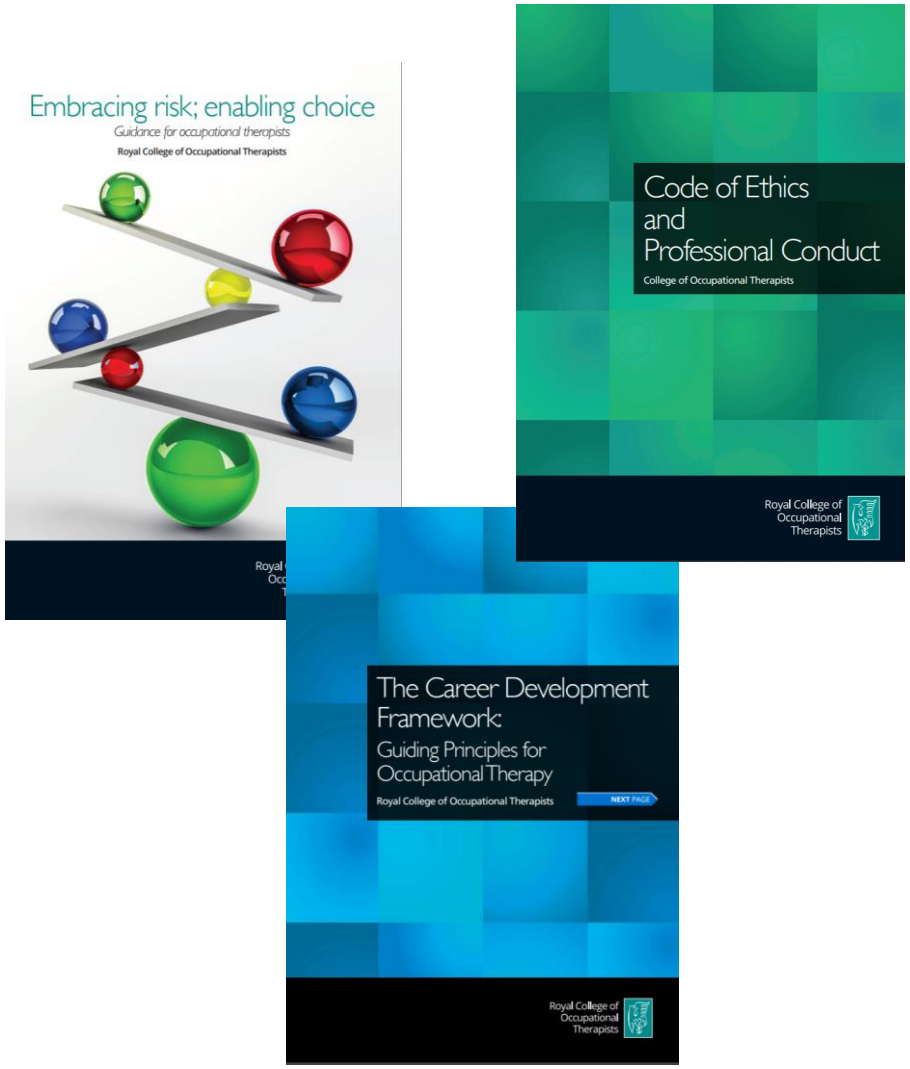
- 40% NHS acute setting
- 30% NHS community setting
- 20% local authority
- 5% integrated services
- 5% other

Where are you in the UK?

- Everywhere!
- All 4 UK nations

RCOT Resources

- Informed View – Hospital Discharge Service: Policy and Operating Model www.rcot.co.uk/about-occupational-therapy/rcot-informed-views
- Embracing Risk; enabling choice www.rcot.co.uk/practice-resources/rcot-publications/downloads/embracing-risk
- Career Development Framework www.rcot.co.uk/cpd-rcot
- Code of Ethics and Professional Conduct
- Professional Enquiries service – professional.enquiries@rcot.co.uk



Department of Health & Social Care

Ministry of Housing, Communities & Local Government

Local Government Association

NHS

Hospital Discharge Service: National Policy and Operating Model

'Achieving Discharge to Assess and a Home First Approach'

No more pilots – it's all about implementation

Emergency Care Improvement Support Team

Safer, faster, better care for patients

Policy Leads and Advisors

Jo Richardson
Improvement Manager (Therapies)
Emergency Care Improvement Support Team
NHS England & NHS Improvement

Kate Jackson
Professional Advisor(AHP)
Community Services & Ageing Well programme
NHS England & NHS Improvement

Tom Luckraft
Deputy Programme Lead – Discharge to Assess Programme
NHS England & Improvement

Liz Sargeant
Clinical Lead; Health and Social Care Integration
NHS England & NHS Improvement

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | Local Government Association | NHS

Policy Background (Pre-Covid)

- A high and increasing number of patients experiencing a **Long Length Of Stay (LLOS)**
- People trapped within the system disproportionately affect occupied bed days and therefore **occupancy**.
- Decreasing the numbers of people experiencing a LLOS leads to an increase **in Emergency Dept performance.**
- **Activity levels** within any bedded setting are **very low** even with therapy input – this is not a criticism of the therapists this has been well documented.
- When people are supported at home the **activity levels are higher** in these individuals.
- Assessment of function outside of a person's home (i.e., hospital kitchen) leads to a false assumption on ability – **over/under prescription of care**.
- Historically all assessments needed to take place before discharge – **this built-in delays** i.e., 48 hrs; start of services could be longer.

Vision for the patient journey through discharge, assessment and delivery of post-discharge care

Admission & acute care

- Undertake **admission assessment** to inform discharge planning. This take places in **Frailty units** for older patients with specialist trained teams
- **Preliminary discharge date** identified and shared with patient (and family)
- Receive urgent community response within **2hrs of a crisis** including if presenting to A&E

Decision to discharge

- Discharge is agreed by MDT when patient is medically fit according to **criteria to reside**
- **Communicate** discharge decision to patient and discussion of ongoing needs and care preferences
- **Care support information and knowledge** fully documented including specific ongoing need (including if end of life care is needed and what preferences are)
- Allocation to **discharge pathway** agreed according to patient need and **level of urgency** indicated

Discharge preparation, discharger & transfer

This stage is overseen by a single coordinator role across discharge & community teams

- Discharge referral form prepared outlining package of care and urgency of It being delivered (immediately, within 1hr, within 4hrs)
- Bed identified or necessary home-adjustments in place incl **equipment requests**
- **Transport** booked if required
- Transfer to home (pathway 0-1), community bed (2), alternative to home(3) and **patient informed of interim funding** arrangement by discharge team

Care Review

- Pathway 1: Patient arrives home and professionals conducts a care review **within time specified by urgency level (0,1 or 4 hrs).** This is conducted by health and social care staff as appropriate
- Pathway 2,3: Patient arrives at new care setting and there is a care review during the admission process (immediately)
- **Care review includes co-developing goals and care plan** with patient and carer including type of services, frequency of visits and medication schedule
- End of life patients are reviewed by **specialist palliative team**
- **Care plan document** is shared with patient and submitted to D2A community coordination team

Care package delivery

Following applies to pathway 1-3

- Deliver non means-tested, short term support (<6weeks) of **integrated and coordinated health and social care services** and record **progress and review goals** including:
- Pathway 1,2: Reablement: improve independent living through skills and confidence building; and/or Intermediate care: to build strength and mobility
- Pathway 3; Bed-based care
- All; crisis response (within 2hrs)
- Staff are deployed flexibly to ensure continuity of care
- Care packages should focus on optimise an individual's functioning, allowing self-management where possible and building personal-networks and/or carer skills to support that individual

Meeting ongoing care needs

- 2 weeks from end of interim care package delivery:
- Carry out **a single assessment** conducted by a health and social worker where the individual's **ongoing care needs are fully identified** and documented and options for **financing** care needs are agreed including whether they will be NHS funded **(CHC approved), Local authority funded under Care Act responsibilities (means tested),** and identification of other wrap around services such as voluntary sector input
- Ongoing care plan is written including whether **personal health budgets** will be used
- In some cases, if a continued short period of funded reablement will have a large impact of future independence – this can be suggested at review
- **For children and young people that are CHC funded** – make note in system to assess eligibility during transition

Principles for Discharge to Assess

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.

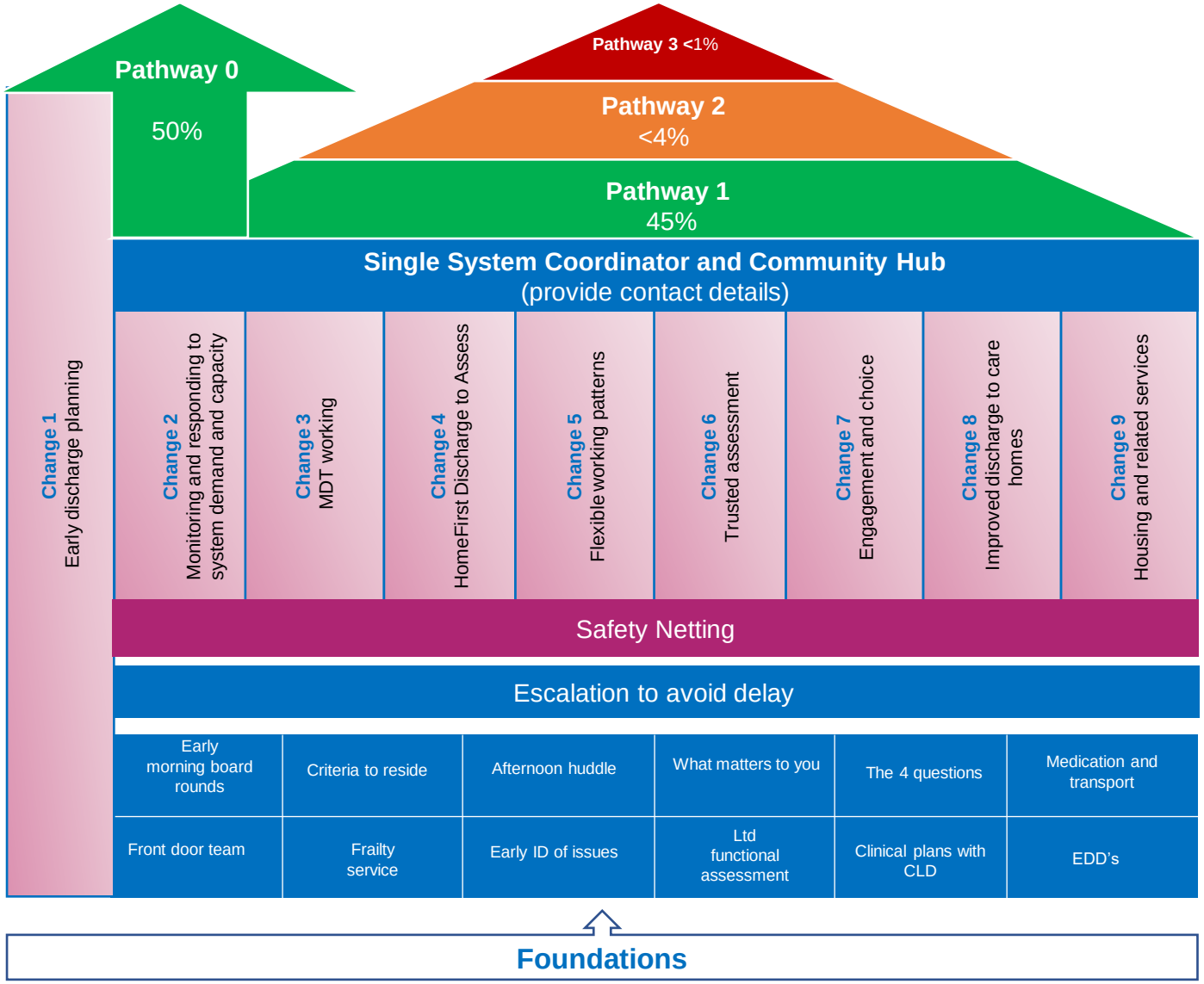
Flexible multidisciplinary working involving health, social care, the independent sector, the voluntary sector and housing – creating a culture across organisations that enables personalised services to be wrapped round the individual.

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.

HomeFirst



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

% apply to age 65+

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

Check and challenge; Myth Busters

✓It is not guidance, it is a policy.
✓D2A does not address all the rehab needs

- *"I have been told we need to move all acute therapists out of the hospital?"*
- *"We need to order equipment prior to d/c to ensure it is in place by the time a person gets home".*
- *"We have been told that we need to move therapists out to the community despite not having enough staff to cover areas such as ED, acute stroke units etc"*
- *"There should be no therapy work on the wards at all"*

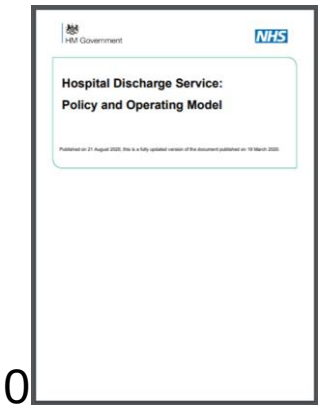
✓There will be increasing complexity within the community.
✓£588 million to support 'additionality'
✓The lead commissioner will work closely with the single discharge co-ordinator to ensure that issues in relation to flow through commissioned services are promptly addressed.

Policy Updates

- **Hospital Discharge Service: Policy and Operating Model** – published 21.08.20

  (Updated version of Discharge Requirements - published 19.03.20)

Hospital discharge service: policy and operating model



- **Action Cards –** published 21.08.20

Hospital discharge service requirements: action cards for staff

- **Reintroduction of NHS continuing healthcare (NHS CHC); guidance** – published 21.0

Reintroduction of NHS continuing healthcare (NHS CHC): guidance

Supporting Documents for AHP's

- https://improvement.nhs.uk/resources/allied-health-professions-ahps-supporting-patient-flow/
- https://improvement.nhs.uk/resources/allied-health-professionals-job-planning-best-practice-guide/
- https://improvement.nhs.uk/resources/clinical-leadership-framework-action/
- https://improvement.nhs.uk/resources/culture-leadership/

Torbay and South Devon
NHS Foundation Trust

Discharge to Assess

Findings from Torbay and South Devon

Becky Harrison

Torbay and South Devon
NHS Foundation Trust

1. Our D2A journey So Far

2. The Positives

3. The Challenges and What's Next

Torbay and South Devon
NHS Foundation Trust

Our D2A Journey …

Integrated – acute, community health and social care

Background

Torbay and South Devon NHS Foundation Trust

- Population approx. 268k
- Higher than the national average of older people (and increasing)
- Clear evidence once medically fit, people are better in their own bed
- Need to increase capacity and flow

How ?

Torbay and South Devon
NHS Foundation Trust

- Utilising existing infrastructure and network
- Upskilling of staff
- Expansion of community resource
- Campaigns with the public

Mrs Smith ….

- Admitted to hospital following a fall
- Diagnosed UTI with increased confusion
- Lives alone with limited support, no POC
- Risk assessment – Mrs Smith able to be left between care visits and has no night time needs

- OT met Mrs Smith at her property
- Vital observations
- Functional assessment around the home
- WZF, bed lever and commode issued
- Rapid response / reablement
- IC support worker

What Went Well …

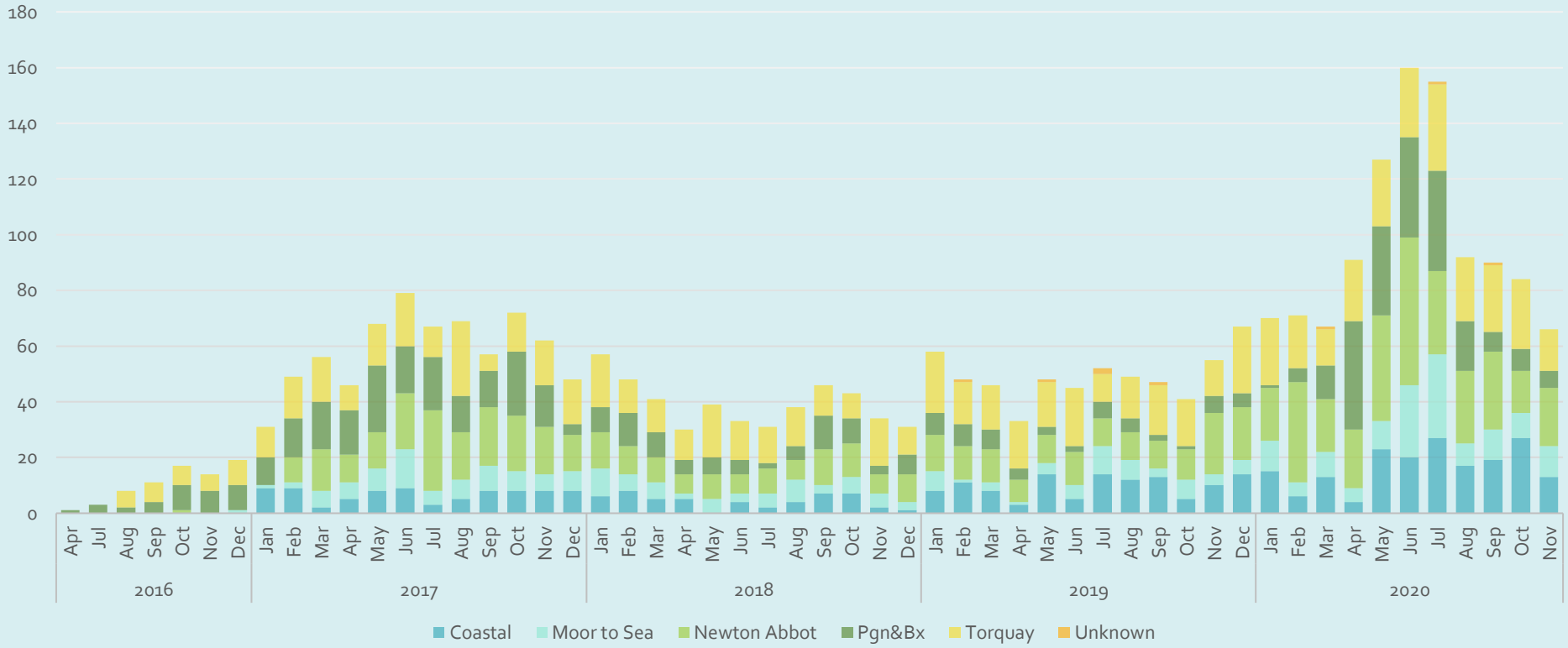
Torbay and South
NHS Foun

Torbay and South Devon
NHS Foundation Trust

- We found patients were keen to return home quickly
- Staff confidence increased – positive risk taking
- Acute and community teams working closely together
- Patients staying at home successfully

The Challenges and What's Next for Us

Torbay and South Devon NHS Foundation Trust



Torbay and South Devon
NHS Foundation Trust

- Establishing a more robust feedback loop
- Ringfencing support and care
- 7 day working and extending opening hours across the services
- Standardisation of services - ie, skills

What's Next for You...

NHS
Torbay and South Devon
NHS Foundation Trust

Oxfordshire Home First

Discharge to Assess

Sally Steele – *Oxfordshire County Council*
Sarah Hamblin – *Oxford Health NHS Foundation Trust*

Oxfordshire's D2A Journey

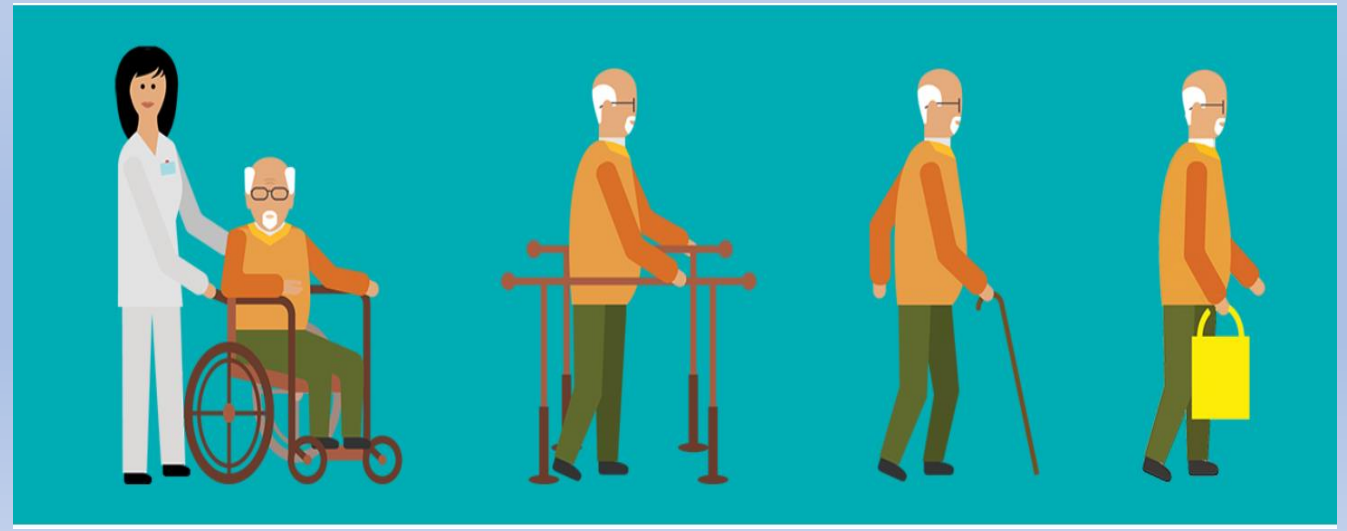
- **Home First System lead** appointed successful candidate from local authority
- System wide **project group established** with all partners including voluntary sector
- **Pathway designed** using National guidance and agreed at system level
- **Phased countywide roll out**
- **Cultural shift** supported by regular comms
- 2-way **weekly meetings** with system leaders
- Patient **information leaflet** developed
- **Patient feedback** questionnaire via 'I want great care'
- Patient **case studies**
- **Clinical Governance**
- **Virtual MDT** established

Where we are now:

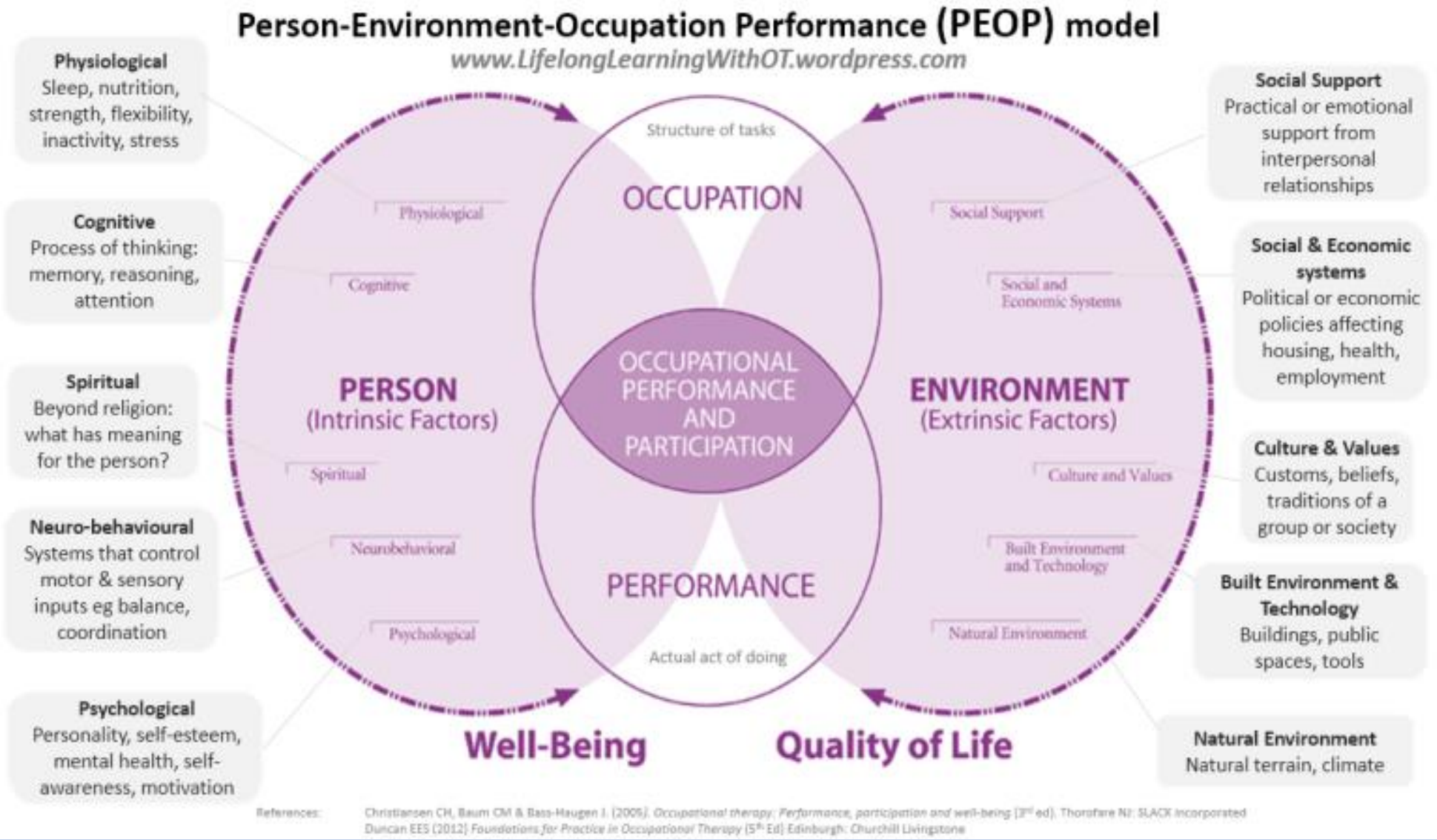
- County & system wide service
- Reablement and D2A pathway
- Broad MDT skill set including mental health practitioners and 3rd sector
- Integration with 2hr/ 48hr Aging well response
- Improved outcomes in independence- 86%
- Reduction in ongoing care provision -55%
- Developing single point of access
- Developing trusted assessor therapy model
- Increasing capacity with domiciliary care market
- Overcoming challenges with shared IT

Skills Occupational Therapists can offer to the D2A process

- Collaborative
- Wholistic approach – mental and physical health
- Reflective but proactive
- Problem solver – think outside the box
- Co-production
- Inclusive
- Positive cultural change
- Positive risk takers
- Enablers
- Risk assessment and prioritisation



Principles of Occupational Therapy related to Discharge to assess



Principles of Occupational Therapy used in D2A

- Occupation and activity are fundamental to a person's health and wellbeing within the context of their various environments.
- Discharge to assess focuses on enabling people to return to their home environment as early in their recovery journey as possible
- Focuses on occupational performance setting personalized treatment plans in collaboration with reablement partners
- Activity is used as the agent for change and motivation for the person to improve their function and achieve their goals.
- May require adaptation, new learning, positive risk taking, undertaking activity analysis so that those adaptations and progress can be made successfully

Occupational Therapists as System Leaders

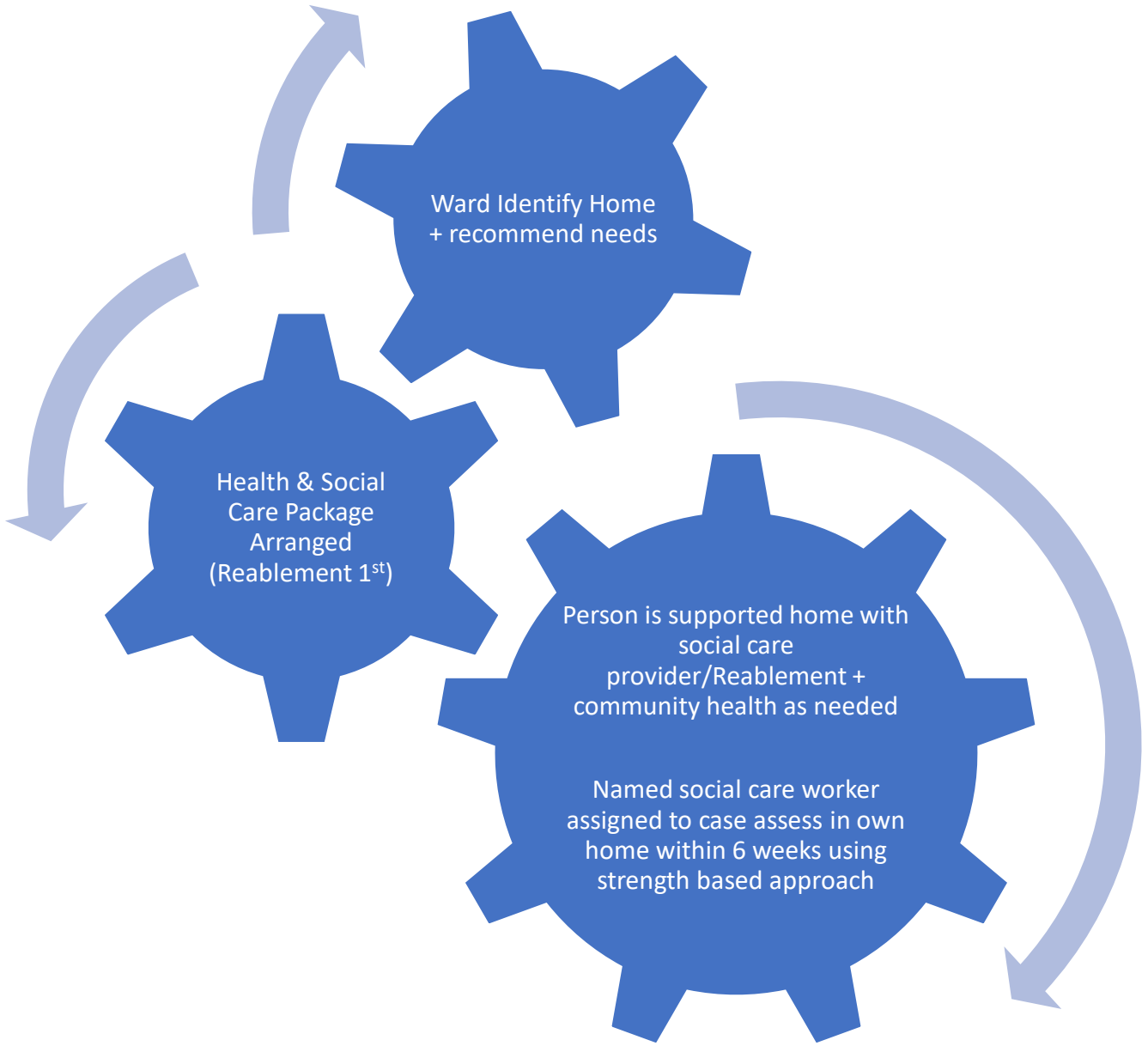
Passion and the belief to inspire	Collaboration	Shift in culture to wellbeing and holism.
Ability to bridge between health and social care	Positive Risk Taking	Ability to flex and respond to system demand and priorities
Skills & tools to add value to the individuals and systems.	Ability to self reflect and grow	Problem solvers – thinking outside of organisational boundaries

Collaborative Reablement Service

Amy Howard – Senior Manger Reablement Services
Mikaela Ellingham – Reablement Therapies Manager

SURREY COUNTY COUNCIL

Surrey's Approach to D2A Pathway 1 from a Social Care View



- ✓ Ward recommendations are trusted
- ✓ Hospital Social Care teams now community facing
- ✓ Reablement + Community Health always considered first
- ✓ No Social Care or Funding Assessments made at hospital
- ✓ OT support in community via Community Health or Reablement Services
- ✓ Regular system conversations to monitor flow and prevent blocks to discharge

SURREY COUNTY COUNCIL

Reablement Transformation Programme 2019 – 2022

A Reablement offer to ensure access for all who may benefit from short term interventions, providing the right support at the right time, increasing and promoting independence

Improved partner relationships

Equal offer for Reablement for both hospital and community referrals

The right people across all client groups accessing outcome focused Reablement

More people benefitting from targeted Reablement through increased capacity

Therapy Led Workforce

Commissioned services with Reablement vision

Technology enabled care included within Reablement offer

Background to Winter Pressures and the Creation of CRS

Use of block contracts each winter coordinated by hospital team = Good flow out of Acute but social care bottle neck

In-House Reablement Team well regarded but frequently unable to meet demand of the system, recruitment a challenge and LA contracts hard to flex

Reablement Team decided to be creative and work with a small number of providers to try something new: co-designed block contract hosted by Reablement where in-house and provider worked together.

Develop skills within the care sector workforce to work with residents in Surrey to improve outcomes and quality of life and promote independence

The Story So Far:

6 Providers

810 Extra hours per week

2019 supported over 400 extra people

7 New Therapy Posts

£1m Investment from Better Care funding

+

1 New Provider

5 Extra OT's

729 Extra Hours per week

£450K Investment from D2A system funding

SURREY COUNTY COUNCIL

Collaborative Reablement Service (CRS)

- ✓ Screen cases
- ✓ Set goals
- ✓ Support delivery
- ✓ Joint review
- ✓ OT support
- ✓ Joint Training
- ✓ Buddy systems
- ✓ Shared Risk
- ✓ Remain CQC compliant