Discharge to Assess

Christy Francis
Senior Operations Manager
City Health Care Partnership CIC
How do we define Discharge to Assess?

An integrated person-centred approach to the safe and timely transfer of medically stable patients from an acute hospital to a community setting for the assessment of their health and social care needs.

_Hull & East Riding Discharge to Assess Work stream (2015)_
Mrs Andrews deserve a better deal

Mrs Andrews’ story: Her failed care pathway
A study by Richardson found a 43% increase in mortality at 10 days after admission through a crowded A&E

Richardson DB. *Increase in patient mortality at 10 days associated with emergency department overcrowding*. Med J Aust 2006;184:213-6

For patients who are seen and discharged from an A&E, *the longer they have waited to be seen*, the higher the chance that they will die during the following 7 days

• 48% of people over 85 die within one year of hospital admission

Imminence of death among hospital inpatients: Prevalent cohort study
David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 Palliat Med

If you had 1000 days left to live how many would you chose to spend in hospital?

• 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80

Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.

Hospital is NOT a place of safety for people that are medically stable
These all make a compelling story?

- High numbers of outliers in hospitals – associated with patient risk
- Crowded emergency departments – associated with patient risk
- High and sustained levels of escalation across the system – abnormal now feels normal – new colours have emerged!
- High levels of acute hospital bed occupancy
An Integrated Health & Social Care Response: Our Shared Purpose

No decision about long term care needs need to be taken in an acute setting.

All adult patients should have the opportunity to access a D2A pathway.

- Support timely discharge from hospital
- Maintain independence where possible
- Reduce the level of long term care packages
- Net neutral impact on Social Care spend
Local Demographics Vs National picture

- 36,000 people aged 65+
- 22,000 living with a life limiting illness or disability
- Deprivation higher than England average
- Life expectancy for both men and women lower than England average
- Heavy reliance on acute hospital based care
- National outlier in respect of emergency admissions

*NHS Hull CCG (2015)*
DTOC Trend for the North of England over the past year

Delayed bed days for the North of England as a whole by responsible organisation by month over the past 12 months

Source – UNIFY national data collection
BCF scheme 4
Reablement & Rehabilitation

The overarching aim of this scheme is to maximise Reablement and rehabilitation pathways as an alternative to hospital and to maintain independence following a hospital stay, avoiding unnecessary admissions and delayed discharges.

The objectives are to:

• Sustain the current service and build on models of good practice
• Ensure integration and development across help at home services
• Integrate rehabilitation and therapy services
• Improve transfers of care
HULL DISCHARGE TO ASSESS PILOT REFERRAL PATHWAY

Criteria:
- 18+
- Medically fit Hull resident and Hull GP

Referral In from HRI ED/Ambulatory care/Frailty Unit

Patient/Client assessed for suitability by ICT nurses based in hospital via Bleep 496- response within 1 hour 8am-8pm 7days a week

BED REQUIRED

YES

Discharged facilitated to highfield (ICT transport)
Documentation as is for ICT

Further MDT assessment at highfield
Geriatrician, Pharmacist- meds management
Physio, OT, Social worker, Nurse
Reablement team
Patients/clients prioritised for D/c plan within 7 days

NO

Discharged facilitated to home (ICT transport)
Documentation as is for ICT

Further MDT assessment at home
GP, Physio, OT, Nurse
Social work-Reablement or Long term teams
Patients/clients prioritised for D/c plan within 7 days

Exclusion:
- Acute mental health needs that cannot be met in a community setting
- Patient/client at risk of harm to self and/or others in a community setting

Patient/client discharged fromDtoA caseload within 10 days with one of the following outcomes

1. Pt requires ongoing rehab-health needs only with/without medical input-appropriate for ICT bed or dc home with ICT support
2. Pt requires social package of care only- discharge to reablement/long term team as appropriate
3. Pt requires respite/short stay - residential placement- discharged to long term social care team
Why choose Intermediate care

Community bed based rehabilitation = 45 beds
Home based rehab = 30
Reablement flats = 18

<table>
<thead>
<tr>
<th>Workforce</th>
<th>WTE/Planned Activity per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Geriatrician</td>
<td>4.5 PA per week (for 45 beds)</td>
</tr>
<tr>
<td>GPwSI</td>
<td>2 PA per week (for 45 beds)</td>
</tr>
<tr>
<td>Senior Pharmacist</td>
<td>0.60</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>6.0</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>7.0</td>
</tr>
<tr>
<td>Therapy assistants</td>
<td>10.0</td>
</tr>
<tr>
<td>Nurses</td>
<td>18.0</td>
</tr>
<tr>
<td>Health Care Assistants</td>
<td>10.0</td>
</tr>
<tr>
<td>Social Workers</td>
<td>0.2</td>
</tr>
<tr>
<td>Admin Staff</td>
<td>3.0</td>
</tr>
</tbody>
</table>

TOTAL WTE = 56.0
7 Day Services 8am-8pm 365 days a year
National Audit of Intermediate Care (2014): “Best Practice” indicators

- Assessment by geriatrician within 72 hours of admission ✓
- Geriatrician-led multidisciplinary rehabilitation ✓
- Secondary prevention of falls ✓
- Bone health assessment ✓
- Referral to transfer time 2 days or less ✓
- Multidisciplinary care by 5 or more staff types ✓
- Average length of stay less than 21 days ❌
- *I was involved in discussions and decisions about my care* ✓
NAIC 2014

Improvement in independence with ADL for 87.5% of patients
Destination on discharge

- Own home
- National Avg: 64.47%
- Hull: 73.42%

- Relative’s home
- Residential home
- Nursing home
- Sheltered housing
- Acute hospital
- Community hospital
- IC bed based unit
- Mental health facility
- Hospice
- Died
- Not known

NAIC 2014
## EVALUATION

### DATA COLLECTED FROM APRIL TO SEPTEMBER 2015

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Total no: referrals</td>
<td>194</td>
</tr>
<tr>
<td>Discharge to assess Bed</td>
<td>83</td>
</tr>
<tr>
<td>Discharge to assess Home</td>
<td>106</td>
</tr>
<tr>
<td>No: of patients who declined the service</td>
<td>5</td>
</tr>
<tr>
<td>Average time from Referral to transfer</td>
<td>&lt;24hrs</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>11.88 days</td>
</tr>
<tr>
<td>Cost per patient per bed day</td>
<td>£118.14</td>
</tr>
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</table>
Evaluation continued...

<table>
<thead>
<tr>
<th>DISCHARGE OUTCOMES ON DAY 10</th>
<th>TOTAL FIGURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to Intermediate care bed</td>
<td>28</td>
</tr>
<tr>
<td>Discharged home with ICT or other community health support</td>
<td>63</td>
</tr>
<tr>
<td>Discharged home with social POC</td>
<td>4</td>
</tr>
<tr>
<td>Discharge home independent</td>
<td>5 (bed) + 27(home)</td>
</tr>
<tr>
<td>Permanent Residential Care</td>
<td>1</td>
</tr>
<tr>
<td>Readmitted to hospital</td>
<td>3</td>
</tr>
<tr>
<td>Died</td>
<td>1</td>
</tr>
</tbody>
</table>
## Discharge delays
### Activity per month

<table>
<thead>
<tr>
<th>Delayed Discharges Per Month - D2A 2015</th>
<th>Count of Delayed Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>1</td>
</tr>
<tr>
<td>May</td>
<td>3</td>
</tr>
<tr>
<td>Jun</td>
<td>3</td>
</tr>
<tr>
<td>Jul</td>
<td>4</td>
</tr>
<tr>
<td>Aug</td>
<td>3</td>
</tr>
<tr>
<td>Sep</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
</tr>
<tr>
<td>STAFF FEEDBACK</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Patient flow much better through assessment units</td>
<td></td>
</tr>
<tr>
<td>Easy access to beds without too much assessment in hospital</td>
<td></td>
</tr>
<tr>
<td>Flexibility with criteria WORKS really well</td>
<td></td>
</tr>
<tr>
<td>Reduced levels of duplication</td>
<td></td>
</tr>
<tr>
<td>Not much different from ICT</td>
<td></td>
</tr>
<tr>
<td>Inappropriate patients to ICT</td>
<td></td>
</tr>
<tr>
<td>Difficulty with patient flow in community</td>
<td></td>
</tr>
<tr>
<td>Confusion due to too many pathways</td>
<td></td>
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</tbody>
</table>
# NAIC PREM results

<table>
<thead>
<tr>
<th>PREM question</th>
<th>Hull Intermediate care</th>
<th>National average</th>
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</thead>
<tbody>
<tr>
<td>Information available to staff re: pt condition</td>
<td>100%</td>
<td>85.83%</td>
</tr>
<tr>
<td>Information given to pt</td>
<td>83.33%</td>
<td>85.17%</td>
</tr>
<tr>
<td>Pt awareness of goals</td>
<td>100%</td>
<td>96.5%</td>
</tr>
<tr>
<td>Pt involvement in goal setting</td>
<td>50%</td>
<td>62.8%</td>
</tr>
<tr>
<td>Trust &amp; confidence in staff</td>
<td>100%</td>
<td>87.21%</td>
</tr>
<tr>
<td>Pt involvement in discharge decision making</td>
<td>66.67%</td>
<td>62.24%</td>
</tr>
<tr>
<td>Pt feeling less anxious on discharge from service</td>
<td>83.33%</td>
<td>74.68%</td>
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</tbody>
</table>
Challenges

- Onward patient flow management
- Integration Vs Competition
- Multiple- agencies
- Resource- funding cuts
- Recruitment
- Health behaviour change for patients
What next?
NHS Five Year Forward View

New Care Models (NHS England)

“Secondary” care reaches into general practice
Primary & Acute Care Systems

“Primary” Care reaches into the hospital
Multispecialty Community Providers

Young, J. NAIC conference (2014)
Plans for Hull in line with NHS Five year forward view

- NHS Hull CCG strategic plan 2014-2020
- Lead provider model for community services
- Community Hubs (MCPs)
- Hull Integrated Care Centre (PACS)
- Urgent and Emergency care network
- Care Co-ordination by “expert generalists”
- Further expansion of pilot in line with BCF plans
- Additional social work resources for ICT