

Place Health and Adult Social Care Procedures

Discharge to Assess (D2A)

Hospital Social Work Team and Reablement



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Introduction

Discharge to Assess (D2A) model was implemented in Barnsley in March 2020 and this was on the back of Covid -19 Pandemic and followed the Hospital Discharge Service Requirements. Following the Pandemic this model of working has remained in place.

Discharge to Assess (D2A) model supports people to be discharged out of hospital and their assessment completed within their own home. That home could be the persons own home in the community or a care home. The model is founded upon research where evidence suggests that a person is best assessed within their own environment and not in hospital bed.

The model consists of 4 National pathways 0-4 and each pathway has its own description. Barnsley has broken pathway 1 down to differentiation between the discharge needs i.e., fast track, reinstatement, reablement.

Teams

RightCare Barnsley are based at Kendray Hospital they are the appointed lead in coordinating a timely and secure discharge onto the appropriate pathway. Their primary function is the oversight of coordination of the discharge arrangements for all people from community and acute bedded units on pathways 1, 2 and 3. The model operates 8am-8pm, 7 days a week.

Case Managers (Health Colleagues) are based in Barnsley Hospital and see people who have been referred to their team under D2A. The case managers will see people on the wards and will undertake an initial assessment, this includes completing Mental Capacity Assessments and Best Interest Decisions. They are responsible for ensuring that people and their advocate have full information and advice about what is going to happen on discharge and which pathway has been agreed. This includes information on how their needs will be assessed, provision of follow up support and if any changes will be applied to their care and support.

Hospital Social Work Team consists of both qualified and unqualified staff. The team completes Care Act Assessments for people outside of hospital. Some assessments are completed whilst a person is in hospital for people who are on the Stroke or Neuro wards or for people who have complex needs. The team supports peoples discharges from hospital, acorn unit, stroke and neuro unit, from D2A beds, Intermediate care beds and reablement service and Neighbourhood Rehabilitation Service.

Reablement Service supports peoples discharges from hospital, acorn unit and D2A beds/Intermediate care beds. Reablement is a preventative service that aims to support people in their own homes, to maximise their independence and remain healthier by regaining skills or learning new ways of doing things to develop confidence.

D2A Therapists complete initial assessments on the day the person is discharged from hospital to determine the type of support/service required for the person.

An agreed process has been implemented for people who screen in on a Continuing Health Care Checklist and for when 1:1 funding can be approved. See process map at the end of this policy.

The D2A is based on 4 clear pathways for discharging people.

<p>Pathway 0 Process</p>	<p>This is a simple discharge. No formal input from health or social care needed once home.</p> <p>Person should only be discharged on this pathway if they are considered to be well enough for self-care upon discharge.</p> <p>Ward arranges discharge direct.</p>
<p>Pathway 1 Process</p>	<p>Support to recover at home and return home with support from health and social care.</p> <p><u>Examples:</u></p> <p><i>Return home with reinstatement</i> of previous support with no changes. RightCare send request for reinstatement to Hospital Social Work Team Duty who will make the necessary arrangements and feed this back to RightCare to ensure that discharge and reinstatement is timely, and no one is left at home without support in place.</p> <p><i>Return home with reinstatement <u>and</u> D2A assessment.</i> This might be where there are concerns the original care package may not be enough. The person is discharged home with a full reinstatement and assessed by D2A team at home the same day. If they identify an increase is required from existing provider, RightCare will notify Hospital Social Work Team who will then try and increase existing services. If this is not possible, then an urgent referral is sent to the Brokerage Team. Person would need to be safe at home until an increase is possible – this might be speaking to family if they are able to cover, or to consider a place of safety if it is deemed unsafe for the person to be at home without appropriate support in place.</p> <p><i>D2A therapists will assess people in their own home and agree an outcome for on-going support.</i> This might include Reablement or Neighborhood Rehabilitation Services (NRS). This will be a trusted assessment which will be triaged by the receiving pathway / social care service.</p> <p>Reablement and Neighborhood Rehabilitation Services (which is NHS funded) are both free to the person for a short period of time not exceeding 6 weeks. These are not provisioned on ERICA.</p> <p>If / when a person completes their input from NRS a referral will be sent via RightCare to hospital social work team to complete a Care Act Assessment.</p> <p>If/When a person completes their input from Reablement, the Reablement team will refer direct into the Hospital Social Work</p>

	<p>Team. The hospital social work team will then complete a Care Act Assessment.</p> <p><i>D2A assessment at home to identify long term need for social care support via a care agency.</i> When this is identified, the D2A therapist will inform RightCare. If the person is unsafe to be left without support. Rightcare will look to bridge any gaps to secure support in the interim. Rightcare then send a referral to hospital social work team who will triage and identify the most appropriate support needed and will complete a Care Act Assessment.</p>
<p>Pathway 2 Process</p>	<p><u>Rehabilitation or short-term care in a 24-hour bed based setting.</u></p> <p>Acorn Unit is currently at Highstone Mews which is a Residential Home. They have 30 beds available for rehabilitation of people who go there from hospital. There are spot purchase beds available in care homes across the Borough.</p> <p>Therapy staff on Pathway 2 provide therapy for the person to try and regain their independence prior to hospital admission and reduce the need for further support services at home.</p> <p>When the person has reached their rehabilitation potential, a referral will come to the hospital social work team via RightCare to complete a Care Act assessment.</p> <p>When the person has reached their rehabilitation potential, a referral will come to Reablement service via Rightcare.</p> <p>When the person has reached their rehabilitation, a referral will be sent to NRS via Rightcare.</p> <p>Hospital social work team receives referrals from the Stroke Rehabilitation Unit and the Neuro Rehabilitation Unit at Kendray Hospital via RightCare for a Care Act Assessment.</p> <p>Early Supported Discharge Team (EDS) referrals will come via Rightcare into the Hospital Social Work Team for a Care Act Assessment.</p> <p>There is no cost to the person when they are accessing a rehabilitation bed. There is no provision put on ERICA as this is funded by the NHS.</p>
<p>Pathway 2 Process</p>	<p><u>Discharge to Assess Beds (D2A)</u></p> <p>Person is funded by ICB for 2 weeks on admission to the D2A bed. This is not provisioned on ERICA. This can be in any care home across the borough and RightCare will always strive to find a placement that suits family and financial situations (i.e., avoiding top up fees, homes near family etc.).</p>

	<p>Hospital social work team triage the D2A referrals, looking at evidence on ERICA and health notes to ascertain if they are eligible / suitable for this pathway. No one should be discharged from hospital directly to a care home without the involvement of the Local Authority (hospital social work team).</p> <p>RightCare Barnsley source the bed, liaising with the person and their advocate.</p> <p>Hospital social work team review within 2 weeks of a person being in a D2A bed.</p> <p>It may be that if the person is still not fit to return home, their placement may turn into a short stay. Hospital social work team will assess and provision this, then the review will be sent to the appropriate Locality Team to review further only if longer term case management is required, otherwise the case will be kept with the hospital social work team to progress.</p> <p>It could be that the person is deemed as requiring permanent care and the Hospital social work team will complete an assessment. This does not include a financial assessment in its entirety, but the hospital social worker team will send the financial paperwork to the person/ advocate to discuss the financial assessment process and the review will then be set with the appropriate locality team for them to follow this process through to completion. This includes the financial assessment, deputyship issues or deferred payment options. Locality teams will always be informed of any complex or outstanding issues via email by the allocated worker.</p> <p>Alongside this, any health professional can arrange a 'Step Up Bed' via RightCare from the community where a person is allocated a 24-hour bed in a care home for a place of safety. This is funded by the ICB for 72 hours only, the Hospital social work team will complete review / reassessment within the 72-hour timeframe.</p>
<p>Pathway 3 Process</p>	<p>People who require ongoing 24-hour placement in a care home setting other than an acute hospital ward. It is likely that long term care is to be required for the people on this pathway. Hospital social work team will receive a referral via RightCare who will then triage, for suitability for this pathway and complete a Care Act Assessment.</p> <p>People who are already in care, go to hospital and return to their permanent care placement.</p>

The impact on the D2A process aims to achieve:

- Improve quality and flow across the whole system.
- Person discharged same day with no delays.
- Assessed in own home and allocated to correct pathway based on individual need.
- Streamlined discharge approach for people.
- Positive person experience as people are assessed within their own home.
- People who are eligible for fast-track funding are streamlined and discharged in a timely manner.
- Reduces deconditioning for the person / reduced bed days.
- Improved collaborative working and communication between ICB, Adult Social Care, Reablement, Community and Acute health services.
- Correct Package of support, no over prescribing.

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Process for D2A pathway from 16th January 2023

The three pathways below follow the pathways as stated in the Barnsley Hospital NHS Foundation Trust and community partners Discharge to Assess Model <https://www.england.nhs.uk/urgent-emergency-care/improving-hospital-discharge/case-studies/implementation-of-a-discharge-to-assess-model/>

Pathway 1a	Pathway 2	Pathway 3
<p>From hospital with a community care package arranged by BMBC for new patients and existing patients who have an existing care package in place and needs have changed. All patients who have an existing care package in place with no change in needs will be discharged with existing package.</p> <p style="text-align: center;">↓</p> <p>Checklist completed 2 weeks post discharge and forwarded to CHC. All Positive checklists will need costings and completed CPA</p> <p style="text-align: center;">↓</p> <p>ICB funds care package from the date of the positive checklist until a DST can be completed within 28 days.</p> <p style="text-align: center;">↓</p> <p>Follows the CHC process with letter sent from CHC to the patient/ family or representative/ SW</p>	<p>From hospital into short term rehab bed in Intermediate Care setting (IMC)</p> <p style="text-align: center;">↓</p> <p>Funded by CCG</p> <p style="text-align: center;">↓</p> <p>If Checklist required prior to discharge follow standard CHC process - ensure patient has no further rehab / reablement potential that can be delivered by existing services</p> <p style="text-align: center;">↓</p> <p>If funding agreed from CHC it will be backdated to the 29th Day from receipt of the checklist</p> <p style="text-align: center;">↓</p> <p>Letter sent from CHC to patient family or representatives/ SW</p> <p>This includes stroke/neuro patients can discharge on a positive checklist</p>	<p>From hospital into 24 hour nursing / residential bed arranged by RCB</p> <p>NB the process applies only to new patients. Patients discharged with existing placements with no change in need do not follow this process – see Pathway 1a</p> <p style="text-align: center;">↓</p> <p>ICB fund for 2 weeks. SW to reviewed within the 2 weeks If 121 staffing is requested by the care home this can be agreed if the criteria at the foot of the page apply:</p> <p style="text-align: center;">↓</p> <p>RCB complete cost tracker and submit to ICB Finance Team.</p> <p>Checklist completed 2 weeks post discharge and forwarded to CHC</p> <p>All Positive checklist will need costings and completed CPA especially if 1t1 in place,</p> <p style="text-align: center;">↓</p> <p>CHC will fund the bed from the date of the positive checklist until a DST is completed within 28 days</p> <p style="text-align: center;">↓</p> <p>Follows the CHC process with letter sent from CHC to patient /family or representative / SW</p>

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121 funding can be agreed at the point of discharge in the following presentations:

- Heightened behaviours due to mental disorder / state (e.g Delirium Dementia) putting self and others at risk if not supervised
- High falls risk if not supervised
- Requires observations for soft signs of deterioration
- Patients requiring high level of input to maintain skin integrity
- Patients on constant invasive and non-invasive ventilation requiring constant supervision for risk of e.g. removal / blockage

The list is not exhaustive but represents the level of exceptionality to be evidenced.

The funding can be applied for a maximum of 14 days with a review of the need for 121 to be completed within 5 working days and the outcome communicated to the CHC Team.

A Care Package Agreement Form will need to be completed and sent to the CHC Team for approval (patients may be moved without delay in urgent circumstances and to avoid a DToC).

RCB to complete the patient tracker to enable the D2A funding spreadsheet to be completed accurately.