Agenda Item No: 4

Optimising Hospital Discharges through the implementation of Discharge to Assess (D2A)

To: Cambridgeshire & Peterborough Health & Wellbeing Board Core Joint Sub-Committee

Meeting Date: 4 December 2020

From: Executive Director

Purpose: To provide an overview of the changes implemented across local health and social care teams from March 2020 to optimise patient outcomes and experience following a hospital admission, and improve the process of discharging patients from hospital to their own home or other appropriate care setting. These changes have been implemented observing the key principles of national Discharge to Assess guidance.

Recommendation: The Sub-Committee is asked to note progress in implementing Discharge to Assess principles and processes to support patient discharges from hospital in Cambridgeshire and Peterborough.

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1. Background

1.1 The Cambridgeshire and Peterborough system has faced some challenges in sustaining good patient flow out of hospitals and delivering national performance standards on Delayed Transfers of Care.

1.2 Discharge to Assess principles and pathways have been reviewed on a number of occasions and despite everyone's best efforts, several challenges remain regarding the pace of complex discharges, such as:

- Insufficient capacity to support home discharges and overreliance on bed-based community services.
- Most patients received health and/or social care assessments in hospital prior to discharge (contrary to D2A principles).
- Referrals for community services were sent from hospital to different services depending on discharge pathway, with "bounce" between some services often taking place and causing unnecessary delays to discharge.

1.3 At the end of March, and in response to the challenges posed by the covid 19 pandemic, national guidance about hospital discharges was issued setting out clear directives regarding the implementation of simplified processes and effective Discharge to Assess pathways.

1.4 In line with the national ask, the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and system partners mobilised very quickly to introduce the following changes:

- Simplified processes in hospitals with all patients referred to community services for discharge when they reach their Medically Fit for Discharge date (MFFD). No assessments take place in hospital with Mental Capacity Assessments being the only exception for safeguarding purposes.
- Established a Single Point of Access in community for all referrals to all health and local authority services supporting discharge.
- Redeployed 60 FTE CPFT staff and 5 FTE complex cases nurses to support D2A pathways, significantly increasing the capacity of intermediate care services in community, and proactively case managing patients following discharge from hospital.
- Increased commissioned capacity using national covid19 funding to include:
    - 346 beds in care homes providing a mixture of residential and nursing beds (including dementia care)
    - An additional 6 home care cars commissioned from the independent sector (2 had been commissioned during winter to cope with seasonal surges in demand and were extended, and a further 4 cars were added to increase pace of discharges from hospital in response to the covid 19 crisis).

1.5 The implementation of true D2A with all assessments taking place in community following discharge, paired up with the funnelling of all referrals through a single point of access and the availability of appropriate community capacity to support D2A pathways, delivered significant results in performance and patient flow.

1.6 This report is for the Cambridgeshire and Peterborough Health and Wellbeing Board Core Joint Sub-Committee to consider under its Terms of Reference.

2. Main Issues

2.1 In the summer the system received further national steer confirming we had to move to a “recovery” phase and start bringing back on line services that where paused in the midst of the pandemic and return to business as usual.

2.2 This provided system partners with an opportunity to discuss the impact and lessons from any changes implemented in the preceding months, to include the implementation of D2A and associated changes highlighted in point 1 of this report. It was agreed then that the system should find a way to sustain the achieved momentum even as the system downgraded the perceived “urgency” to free up acute capacity for critical care as covid19 admissions plateaued and subsequently decreased.

2.3 Further national steer was also received confirming the extension of additional funds linked to the pandemic that could be accessed to support hospital discharges, at least until the end of the March 2021.

2.4 As a result, D2A principles and processes have been consolidated establishing a long term framework that supports prompt patient discharges from hospital through a number of key health and social care pathways:

- **Pathway 0: Home with no support or minimal support / help**

  Patients leaving under this pathway are expected to recuperate with normal access to GP or some arranged follow up support from e.g. a District Nurse. Voluntary sector services and/or social prescribing are also used to support discharge and prevent further admissions to hospital. This should account for at least 50% of all hospital discharges.

- **Pathway 1: Home with Care**

  Patients go home with short term reablement or intermediate care services to help with their recovery. A case manager is allocated to every person on the pathway to actively monitor their progress. The support package will be flexed to match the progress of the individual and during this time assessment for long term need will take place to include any financial assessments if/as required. 45% of people discharged from hospital should leave under this pathway.

- **Pathway 2: Rehabilitation in a community in patient bedded facility**

  A proportion of patients for whom home is not an option will require rehabilitation in a community bedded facility or care home with therapeutic and nursing support to help their recovery. The goal is still to get the patient to their usual place of residence following the period of rehabilitation. A case is allocated to every person on the pathway to actively monitor their progress with assessment of longer-term needs, financial assessments and Continuing Health Care (CHC) eligibility made as soon as the case manager decides that an accurate assessment of future needs is possible. The national benchmark is for 4% of all discharged patients to go through this pathway.

- **Pathway 3: More complex patients with less potential to reable/rehabilitate**

  This pathway is for the small number of people whose needs are such that it is necessary for them to stay in a care home. It also includes patients who can be discharged home with domiciliary care support and who do not meet the clinical

criteria for D2A pathways 1 or 2. As with other pathways a case manager is allocated to every patient until assessments for long term care, including CHC eligibility, are completed and the case management can be handed over to the relevant organisation responsible for supporting the patient long term. This patient cohort is estimated to be the smallest with national guidance anticipating only 1% of hospital discharges to go through this pathway.

2.5 Significant investment has also been agreed in order to retain sufficient capacity in community to support discharges whilst also returning staff previously redeployed to D2A to their substantive roles and minimise risk of impacting negatively on other services at the expense of having sufficient capacity for D2A.

2.6 In September 2020 system partners agreed to invest £3.4m additional funds from the national covid 19 monies to the end of March 2021 to increase capacity levels in community. This funding is largely dedicated to the recruitment of staff such as care workers, therapists, and care coordinators; although a small proportion has also been used to enhance primary care cover of community in patient units at weekends, and additional designated beds in a few selected care homes to be added to the pool of capacity for D2A Pathway 2.

2.7 The challenges of recruiting additional staff particularly around key disciplines such as therapy are very much at the forefront of the local thinking. Therefore whenever possible system partners have opted for the sharing of capacity across organisational boundaries to increase efficiency and effectiveness. This has been one of the local success stories gaining recognition across the region as we have secured 9 therapists and 4 therapy assistants to redeploy from hospitals or other community services into D2A supporting true system working beyond organisational boundaries.

2.8 Furthermore, when additional capacity is required to meet increases in demand due to operational pressures system partners have devised a clear process to request additional funds to spot purchase capacity. Whilst the final decision for the approval of additional spend rests with Cambridgeshire and Peterborough CCG, the decision as to which patients warrant special consideration under this protocol is made by patient facing operational teams that understand the individual needs of the person best.

3. Consultation

3.1 Although all the changes that have taken place under D2A were driven by national mandate and formal consultation with service users or the wider public was not required, all system partners have been keen to ensure the patient / service user voice is taken into account in the commissioning of supporting services short, medium and long term.

3.2 During the first few months of the pandemic, patients discharged under D2A Pathways 1 through 3 were followed up by phone from the hospital Discharge Planning Teams to gather evidence of patient experience and ensure any issues from the patient perspective were promptly identified and followed up.

3.3 The CCG and local authority have also commissioned from Healthwatch Cambridgeshire and Peterborough a survey of a sample of people discharged from hospital. They are aiming to get the report published late November/early December, and we will be using the findings to further shape the future commissioning of relevant services.

4. Anticipated Outcomes or Impact

4.1 By retaining the processes and approach to D2A we will sustain the improvements and benefits we have seen to date, and we will also put the system into a much better footing to respond quickly and effectively to future pressures as we are seeing a second surge of covid19 cases alongside other additional seasonal pressures for the winter season.

The overarching principles that underpin the D2A model are aimed at optimising quality of outcomes of patients and patient experience. These are:

- Home First is an approach which expects people to return home as the preferred option, rather than end up by default in bed-based care.

- A hospital is not the right environment for people to make long-term decisions about their ongoing care and support needs. Home First and D2A enable assessments to be completed in community after reablement or rehabilitation if required.

- We will deliver integrated, timely, personalised care, not care that is most convenient for individual organisations. Flexible, multidisciplinary working involving health, social care and voluntary sector organisations to personalise services around individual need.

- The goal for everyone receiving support should be to maximise their long-term independence.

- It is key for the system to follow best practice in safeguarding, giving due consideration to deprivation of liberty, Mental Capacity Act (2005), and any other concerns that have been identified.

- The whole system response needs to enable local partners to develop creative solutions which meet local demand and capacity. Positive, collaborative system leadership supports the development of a shared vision, trust between partners and a sense of mutual endeavour to solve problems.

4.2 The increased capacity levels in community set out in point 3 of this report are expected to support an increase in the number of daily discharges and achieve 90% of maximum possible daily discharges from hospital.

5. Implications

Financial Implications

5.1 The national funding available to support discharges is only available to the end of March 2021. System partners will need to evaluate in January the full impact of the D2A programme in order to discuss options for the potential sustainability of this work should it be deemed the right way to proceed long term.

Legal Implications

5.2 None anticipated as all practice within D2A adheres to the necessary legal and operational frameworks for social care and health care teams.

Equalities Implications

5.3 A full Equality Impact Assessment has been completed on the D2A work programme with no concerns highlighted.

6. Appendices

6.1 None

7. Source documents guidance

7.1 Source documents

Hospital Discharge Service: Policy and Operating Model (August 2020)

7.2 Location

Hospital Discharge Policy