GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Discharge to Assess – Standards for Greater Manchester

Ratified by Greater Manchester Health and Social Care Partnership, Strategic Partnership Board on the 28th of July 2017.

Contents

1. Introduction

The Discharge to Assess Model is a key element of the Eight High Impact Changes, developed by the Helping People Home Team in order to support the safe and timely discharge of patients from a hospital setting. It is recognised as best practice for all patients and supports the national indicator that 90% of all Continuing Healthcare Assessments are conducted outside of acute settings.

Across the conurbation, there are a significant number of people in acute beds, whose medical episode is complete, but who are awaiting further assessment to decide the best way forward for their long-term care needs. There is a degree of variation in the way in which this is being approached; this paper sets out the GM Standard for all providers of health and social care.

It is expected that all health and social care systems in Greater Manchester will adopt these Standards from September 2017. Robust plans to ensure that local arrangement meet or exceed these standards should be in place by September 2017 and monitoring of performance indicators identified in this document will commence at this stage.

2. Definition of Discharge to Assess

Discharge to Assess is an integrated person-centred approach to the safe and timely transfer of medically ready patients from an acute hospital to a community setting for the assessment of their health and/or social care needs.

No decision about long-term care needs should be taken in an acute setting and as such, all adult patients should have the opportunity to access a discharge to assess pathway.

Patients should be moved home or to identified community provision as soon as they are medically ready. They should be then given appropriate support until a full assessment can take place and a longer term care package can be implemented.

No patient should be discharged before they are medically ready and discharge to assess must add value to the patient pathway through improved outcomes or experience. It must not be used as a method of freeing up a bed.

Patients must not be transferred without considering the best interests and informed consent must be received.

3. Discharge to Assess Pathways

Four potential pathways are identified as part of the Discharge to Assess model:

Pathway 0

For patients who can go home with no support or with the continuation of their existing packages of care.
All patients may be able to return home without any additional support. This pathway should be made available as soon as the patient is ready for transfer.

Pathway 1

For patients who can return home with additional support

- The patient is discharged home and care and therapy are provided by a community support and reablement team in order to support the patient's recovery to independence.
- This support should be in place for a maximum of six weeks, with up to four visits per day from the identified team. It is anticipated however that the timescales will be shorter.
- During this time, the patient will be assessed and referred to the most appropriate ongoing care.
- The patient will be discharged from the service, and will move under their GP's care, self-funded care; local authority funded care or funded Continuing Health care, according to the outcome of the appropriate assessment.

Pathway 2

For Patients who could potentially return home after a period of additional rehabilitation (National evidence shows there is minimal need for this pathway- Rehabilitation and reablement deliver the best outcomes if they are done in the person's own home**)**

- Through this pathway, the patient is discharged to temporary residential care/intermediate care facility/community hospital/ supported accommodation setting for up to six weeks and are provided with rehabilitation and reablement services in this setting
- An assessment of their long-term care needs are completed in this setting and appropriate referrals made.

Pathway 3

- **For patients likely to need ongoing care in a residential setting**

  - Through this pathway the patient is referred to a nursing or care home facility with recovery and comprehensive assessment.

- These patients will have been assessed by the multi-disciplinary care team as having very complex care needs and are likely to require continuing care in a residential home.
- The pathway will be common for those whom CHC funding is likely.

Pathway 4

For patients who have a significantly specialist need and require a specialist placement and therefore cannot be discharged for assessment

4. Greater Manchester Standards for Discharge to Assess

The following key standards should be adhered to in the implementation of discharge to assess.

a. Pathways should be supported by a formal signed-off agreement between provider, CCG and Local Authority to ensure clear, effective agreements and processes including funding arrangements.
    i. NB: where hospital sites may need to bind in multiple CCGs and Adult Social Care organisations, individual agreements may be required to take account of repatriation across geographical boundaries
b. There is a clear "Discharge to Assess" implementation plan which has been agreed between all stakeholders, which has considered local barriers to implementation and appropriate capacity.
c. There is a communication and engagement plan in place for the Discharge to Assess model for system stakeholders and for patients and their carers.
d. Provision is free at the point of delivery, regardless of ongoing funding arrangements.
e. Agreed clinical criteria for each of the four pathways
f. Clear referral and assessment pathways for each of the four pathways
g. Provide rapid access to appropriate care arrangement outside of the hospital setting for each of the pathways.
h. Ensure that assessment is rapid, effective and able to mobilise the required services.
i. Each patient on the discharge to assess pathway must have an agreed care plan
j. Ensure that no patient is required to make decisions about their long-term care whilst in crisis.
k. Staffed by appropriate staff who are able to assess long-term care needs and whose roles and responsibilities are clear.
l. Ensure that assessments are not unnecessarily duplicated from the hospital to home.
m. Be delivered using process improvement methodologies ensuring that evaluation and feedback mechanisms are in place.
n. Any concerns regarding capacity to decide discharge planning must be dealt with appropriately and in line with the Mental Capacity Act.

5. Greater Manchester Benefits of Discharge to Assess

The benefits of Discharge to Assess can be defined as:

a. Assessment is 'context specific' and the patient's immediate and long term needs can be more appropriately evaluated at home or in another community setting
b. Issues which may have been developing for some time which precipitated an acute admission will be assessed and plans put in place while the patient is still at home or in a more appropriate care setting
c. Patient's needs reduce and may become less resource intensive than predicted in a hospital environment, saving demand on social care service resources.
d. Prevention of avoidable admission to long-term care settings
e. Increased patient and family satisfaction
f. Removal of steps, processes and delays in the discharge process which consume valuable resources and do not add value for the patient
g. Reduced length of stay
h. Reduced risks associated with vulnerable patients remaining in hospital
i. Increased discharge rates
j. Hospital beds are freed which reduces medical outliers
k. Increased patient flow through the hospital
l. Reduced delayed transfers of care and medically optimised patients remaining in an acute hospital setting
m. Improved performance with accident and emergency four hour standard
n. Reduced occupied beds

6. Greater Manchester Performance Indicators for Discharge to Assess

The following indicators for measuring the impact and success of the Discharge to Assess model need therefore to be put in place by systems:

a. Average patient length of stay
b. The total number and percentage of stranded patients
c. The total number and percentage of beds occupied by delayed transfers of care
d. The total number of patients discharged to a discharge to assess pathway (split by pathway)
e. The percentage of patients discharged from discharge to assess pathway within 6 weeks.
f. Patient and family experience (split by pathway)
g. The number of readmissions from discharge to assess pathways (split by pathway)
h. The percentage of patients who require ongoing care further to discharge from discharge to assess pathway

i. The percentage of CHC assessments that take place outside of an acute setting (target 85%)
j. Number of patients still at home after 30 days and 90 days.
k. Level of care still required on discharge from Discharge to Assess
l. Number of CHC placements to nursing homes and residential homes
m. The number of readmissions from discharge to assess pathway
n. Number of Council placements over 18 per 100'000

Systems will need to agree with GM Health & Social Care Partnership and locally how they will determine and achieve an improvement trajectory in respect of CHC assessment and social care assessments that are completed outside of the acute environment.