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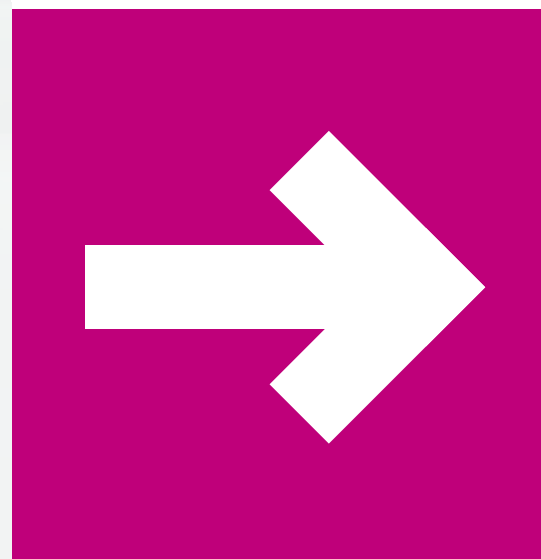
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QUICK GUIDE: DISCHARGE TO ASSESS

TRANSFORMING URGENT AND EMERGENCY CARE SERVICES IN ENGLAND

This is one of a series
of quick, online guides
providing practical tips and
case studies to support
health and care systems.



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INTRODUCTION

- Imagine leaving your home abruptly and never returning to it again.
- Imagine being told that you are moving house tomorrow and you have no control over where you are moving to and how much it will cost.

This is what happens to people every day because we assess people in a place that is not their normal environment.

This quick guide aims to support local health and social care systems to reduce the time people spend in hospital, at the point that they no longer need acute care. It provides practical tips and advice to commissioners and providers on discharge to assess (D2A) models, including best practice from across the country and should be read alongside the 2015 NICE guideline, [Transition between inpatient hospital settings and community or care home settings for adults with social care needs](#).

Unnecessary delay in discharging older patients from hospital is a systemic problem with a rising trend - the [National Audit Office reported](#) that between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days. For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs.

Wherever possible, people should be supported to return to their home for assessment. Implementing a discharge to assess model where going home is the default pathway, with alternative pathways for people who cannot go straight home, is more than good practice, it is the right thing to do.

The first two scenarios require commissioners and providers within health and care systems to challenge current practice and change mind-sets. Collaboration between health and care locally is vital to ensure sufficient quality of service, demonstrable change and agreement on how best to allocate resources and funds.

DEFINITION OF 'DISCHARGE TO ASSESS'

Where people who are clinically optimised¹ and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

Commonly used terms for this are: 'discharge to assess', 'home first', 'safely home', 'step down'.

This does not detract in any way from the need for agreed multi professional assessment or from the requirement to ensure safe discharge and it may work alongside time for recuperation and recovery, on-going rehabilitation or reablement.

MYTH BUSTING

It is the responsibility of all local stakeholders to make sure patients, carers and their representatives understand that this is NOT about:

- Discharging people from hospital before they are clinically ready.
- Discharging people without assessment for services required for their safety at home or another community setting.
- Moving people home from hospital without the right support and without their consent or a best interests decision.
- Creating an additional transfer in a person's care pathway in order to free up a hospital bed, without adding value to their experience of care or meeting good outcomes for the person.
- Moving people without clear pathways and processes, including an agreed care plan.
- Denying people the right to an assessment for NHS Continuing Healthcare (NHS CHC) if they may have a need for this.
- Charging people for care they should receive free from the NHS.
- Moving costs from health to social care or vice versa.
- Working only with people with low level or specific needs.

¹ Clinically optimised is described as the point at which care and assessment can safely be continued in a non-acute setting. This is also known as 'medically fit for discharge' 'medically optimised.' NHS England (2015). [Monthly Delayed Transfer of Care Situation Reports Definitions and Guidance London p.6-7](#).

PRINCIPLES

There is no 'one' model that will deliver discharge to assess. What is required is described as working as a 'complex adaptive system' which involves simple rules in order to function rather than rigid inflexible criteria.

The simple rules/principles below are evidence based - they can be used to assess existing services and should be the design principles that underpin a discharge to assess model:

Principles for D2A model	What does this mean?
Essential criteria	<ul style="list-style-type: none"> • Supporting people to go home should be the default pathway², with alternative pathways for people who cannot go straight home. • Free at the point of delivery, regardless of ongoing funding arrangements. • To be safe if the person is going home, the assessment should be done promptly (within 2 hours), with rapid (on the day) access to care and support if it is required. • Support services should be time limited - up to 6 weeks, in the best systems the average appears to be 2 weeks and can be longer than 6 weeks in exceptional cases. • Non selective, a service that tries to always say 'yes' - to include support for end of life care.
User focus/patient centred care	<ul style="list-style-type: none"> • Put people and their families at the centre of decisions, respecting their knowledge and opinions and working alongside them to get the best possible outcome. • Take steps to understand both the perspectives of the patient and their carers and the communities they live in, their needs, aspirations, values and their definition of quality of life. • Ensure the person and their family receive clear information about their care within the acute setting including what will happen on discharge and who to contact if there are any problems after discharge. • Ensure continuity of communication so all members of the team are working to the agreed care plan, until discharge from the pathway. • Where the patient may not have capacity for a decision about discharge placement/assessment, apply the Mental Capacity Act 2005 (MCA), informed by the MCA Code of Practice and relevant case law.
Easy access to services	<ul style="list-style-type: none"> • Provide simple access to information, advice and services; including support and access to information to enable self-care and self-management. This will ideally be a one-stop shop, always available when needed, with the ability to provide a timely and responsive service for the people needing services and practitioners.

² 'Default pathway' - providing this is in the line with an individual's wishes, where they have capacity to make this decision, or with a best interests decision in accordance with the Mental Capacity Act 2005 where they do not.

Principles for D2A model	What does this mean?
Effective assessment	<ul style="list-style-type: none"> • Ensure that assessment is rapid, effective and able to mobilise the required services. • Assess long-term care needs when the actual level of care required can be more accurately assessed. • Take steps to ensure there is no duplication in assessments throughout the patient's journey from hospital to home. • At the end of assessment and at transition to long-term support (if required) develop proactive/advance care plans where appropriate, with people and their carers, to help to mitigate the risk of crisis. • Ensure that people do not have to make decisions about long term residential or nursing care while they are in crisis.
Easy information flow	<ul style="list-style-type: none"> • Enable information to move with the person - create a system where once something is known about a person, everyone that needs to know within the system is informed (within the constraints of confidentiality/information governance). • Ensure consent is sought from people at the earliest opportunity to facilitate the sharing of information across partners, as appropriate.
Networks of care	<ul style="list-style-type: none"> • Build networks of service that place more emphasis on the person's needs rather than on organisational boundaries. This will encompass multi/cross disciplinary learning and planning. • Where it exists, ensure input from existing health and social care services including non-paid circles of support such as family and friends along with paid support from carers/volunteers from the voluntary and community sector.
Blurred boundaries	<ul style="list-style-type: none"> • Find ways to use money, resources and skills across organisational boundaries. • Empower staff with the right skills to offer what is needed and find new ways to manage actual and perceived risks. • Develop a competency based/trusted assessor approach, enabling interdisciplinary and cross disciplinary working.
Continuous evaluation and feedback	<ul style="list-style-type: none"> • Plan, Do, Study, Act (PDSA) cycles³ are recommended to test new ideas rapidly, closely monitor, learn and develop. Starting small and growing is more effective than trying to change the entire system all at once. • Sustain a dynamic system that is changing and will continue to change and improve. • Build in evaluation and feedback loops to review the whole system and allow flexibility of practice to create, contain and sustain change.

³ EPICS, (1998) The Great Missenden Group - work group on the older people's integrated care system.

LOCAL EXAMPLES OF DISCHARGE TO ASSESS

These local examples of discharge to assess showcase how improvements can be made as part of ongoing changes in ways of working and in response to issues with performance.

South Warwickshire

- Headline outcome: **Reported 0.5m net long-term costs averted in year 1 for pathway 3.**
- Funding arrangement: Funded by Clinical Commissioning Group (CCG) and Hospital Trust.
- **D2A pathway** operates across the whole hospital and has been running for 3 years.
- Patients are discharged from hospital via three pathways for care and rehabilitation support for up to 6 weeks:
Pathway 1 - to intermediate care and reablement services provided in their own homes.
Pathway 2 - to residential care within the independent and community sector.
Pathway 3 - to nursing care within the independent sector.
- The trusted assessment between health and social care, in-house reablement and rehabilitation, and care co-ordinators support patients and their families throughout the discharge process.
- D2A pathways have built-in links with primary care- two GP practices have been commissioned to provide clinical input for 30 nursing home beds.

Top tip

- Use a trusted assessor model.

Sheffield

- Headline outcome: The Health Foundation reported a **37% increase in patients who can be discharged on their day of admission or the following day.**
- Funding arrangement: No additional funding.
- The **D2A pathway** operates across the whole hospital and has been running for 5 years - to watch a presentation from the lead geriatrician please [click here](#).
- The patient's immediate needs are assessed by the ward MDT. Further on-going needs are assessed in the community by an integrated health and social care team called 'Active Recovery'.
- A micro system service improvement approach has been used to change ways of working - starting initially with one patient per week building up to 185 on average.
- Staff are released to attend training and the 'Big Room' meeting (see top tip).
- A trusted assessor arrangement is in place with a jointly agreed **transfer of care form**.
- A '**Generic Assessment**' model is used following training developed with Sheffield Hallam University.

Top Tip

- The cultural and behavioural challenges associated with new ways of working, were overcome through the weekly multi-agency and multidisciplinary 'Big Room' meetings, which are seen as an open place in which people are supported to contribute and share.

Medway

- Headline outcome: Delayed Transfer of Care (DTOC) rates were down by 25% in 3 months.
- Funding arrangement: small cash injection from CCG/ Local Authority.
- Quickly set up in response to performance issues - in 8 weeks.
- **D2A pathway** operates across the whole hospital and has been running from March 2016.
- Discharging on average 32 patients per week.
- Used existing team and directed all care via that route - removing historical 'territories'.
- Created one single point of access for all coordination of the patients' discharge.
- Created a communications and marketing plan for roll out using Home First branding for **banners** and **posters** across the hospital.
- Positive experience reported by **patients** and **staff**.

Top Tips

- Do not underestimate the significant engagement and communications which need to take place to enable systematic changes.
- Explore using existing staff structures and re-align teams.



LOCALLY REPORTED BENEFITS

The benefits of a fully mature, integrated system that has the right capacity in the right place are outlined below:

- People's health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default.
- People's length of stay in a hospital bed decreases due to longer-term assessments taking place in a more appropriate situation and place. Evidence suggests this should reduce deconditioning and improve outcomes significantly since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80⁴.
- Encourages NHS and Adult Social Care leaders to work together for the best outcomes and experiences for people through joint approaches to discharge to assess. This may include joint commissioning or funding.
- Improves system flow by enabling patients to access urgent care at the time they need it.
- Reduces duplication and unnecessary time spent by people in the wrong place.
- Enhances working relationships between the health, social care and housing sectors and increases development opportunities for their staff.
- Sharing responsibility, risks and skills across partners leads to innovative and creative solutions that deliver safe, effective care and support.

“Without the D2A pathway it is very likely that patient X would have entered permanent residential care, possibly with NHS Continuing Healthcare funded package of care. Instead the patient went home with a care package consisting of visits 4 times a day.” Staff from South Warwickshire

Mrs D has now returned to the activities she was doing prior to her fall and says of the Discharge to Assess service: “Being home helped prevent a potentially long recovery period, many thanks for your support and patience in getting me back to normal.”

Patient from North Bristol

HOW TO EVALUATE

Metrics

These [metrics](#) are suggested to evaluate the effectiveness and outcomes of the change in ways of working. These are intended to encompass the whole system and provide a starting point for local systems to measure their improvement.

Patient engagement

Listening to the views of patients is important to provide an understanding of how services can be improved through learning from the patient voice.

Healthwatch has been commissioned by [Southwark and Lambeth Integrated Care](#) to gather feedback from people taking part in a test scheme using extra care flats after discharge from St Thomas' and King's hospitals. [Feedback from participants](#) and family members takes place on a weekly basis in face-to-face or telephone interviews about the services they receive and their recovery journey.

Clinical Audit

Undertaking a clinical audit is useful in helping to identify people that are appropriate for D2A and a template can be accessed [here](#).

⁴ Kortebein P, Symons TB, Ferrando A, et al. (2008) Functional impact of 10 days of bed rest in healthy older adults. *J Gerontol A Biol Sci Med Sci.* 2;63:1076-1081.

COMMON CHALLENGES AND LOCAL SOLUTIONS

Biggest challenges	Examples of practical documents and local solutions
Sharing patient and professional risks across organisations	<p>Partners in South Warwickshire use a Memorandum of Understanding (MoU) to manage risk, roles and responsibilities.</p> <p>Medway uses an escalation plan if a patient is not met by community staff at home, due to any miscommunication or error.</p>
Identifying people who are appropriate for D2A	<p>South Warwickshire has developed guidance to help clinicians improve identification of the right patients for the D2A pathway. The guidance also includes a clinical audit template to ensure appropriate referrals to the D2A pathway.</p> <p>Brighton's Hospital Rapid Discharge Team complete an assessment form at the 'front door/ ED' and follows the patient through the hospital.</p>
Building trust between teams	<p>Many local health systems have introduced 'trusted assessment' or 'generic assessment' where one person/team appointed to undertake health and social care assessments on behalf of multiple teams, using agreed criteria and protocols.</p> <ul style="list-style-type: none"> • Sheffield Teaching Hospitals and Sheffield Hallam University have developed a 2 day generic assessor course. • South Warwickshire's trusted assessment form has enabled direct referral to reablement without the hospital social work team's involvement. • East and North Hertfordshire Care Home Vanguard is piloting a trusted assessor model and has developed the Complex Care Premium which is paid to the care home, for residents who have 'complex needs'.
Culture change	<p>Many local health economies have introduced new ways of working to embed culture change:</p> <p>Sheffield has coached nurses, managers and doctors through a micro-system coaching academy. This has encouraged leadership and the testing out of new ideas on a small scale.</p> <p>Brighton has introduced weekly multi-provider and multidisciplinary Discharge Improvement Group (DIG) meetings to escalate issues, develop jointly owned solutions and prevent a culture from developing where decision making is deferred and/or referrals are rejected.</p> <p>Medway has branded and marketed their D2A model (which streamlined multiple different pathways into 4) across all hospital wards to staff, patients and relatives to ensure processes, timescales and expectations are understood. The D2A pathway has also been translated into plain English for patients, relatives and carers.</p> <p>Liverpool has introduced the D2A model in the Frailty Unit where clinicians from the wider out of hospital services rotate through the Integrated Frailty Team to ensure that skills are maintained and enhanced across the community pathway.</p>

Biggest challenges	Examples of practical documents and local solutions
Awareness of services available at home	<p>In Greenwich, the Greenwich Integrated Volunteer Network offers volunteering opportunities for people wanting to give practical help to vulnerable adults including befriending, advocacy and signposting to other services.</p> <p>Medway's directory of services helps to signpost all the services available in one place.</p> <p>FirstStop Advice offers an impartial, free service, providing advice and information to older people, their families and carers about housing and care options for later life.</p> <p>Age UK Norfolk provide an advice and information service, including housing and care options at Norfolk and Norwich University Hospital to help with timely discharge and independence at home.</p>
Information technology systems	<p>Many areas are embracing technological solutions to reshape how care is delivered and how information is exchanged:</p> <ul style="list-style-type: none"> • South Warwickshire NHS Foundation Trust has implemented trusted assessment by eCAT (an in-house technology solution) which enables direct referral to reablement without the hospital social work team's involvement, facilitating timely discharge. • Doncaster has introduced an integrated solution where patients admitted into hospital have their details put into a computerised 'i-tracker' system, with an expected date of discharge set within 24 hours. • Medway has hand held devices to undertake assessments/referrals and Telecare/Telehealth support has been arranged to respond within two hours.
Pooled funding/savings	<p>Joint working has resulted in the transformation of Warwickshire County Council's (WCC) traditional domiciliary care service into a reablement service. Now 51% of patients need no home care one year after reablement and the savings are visible to the system through the better care fund. Funding of D2A beds is a joint arrangement between the CCG and South Warwickshire Foundation Trust.</p> <p>North Bristol's D2A service is funded by the CCG and the Hospital Trust, with resource for additional reablement from the Better Care Fund. The business case can be found here.</p>

Biggest challenges	Examples of practical documents and local solutions
<p>Mapping and capacity of community health, social care and housing sectors</p>	<p>Almost all systems already have a number of services preventing admission and supporting discharge. These are often currently delivered as many separate services with each service having specific criteria. These services across health and social care need to be mapped and redesigned into an Intermediate Tier of services as described in 'Intermediate Care - Halfway Home'.</p> <p>South Warwickshire's acute and community audit tool identifies the care that the patient needs including where that care should take place, once acute care is no longer needed.</p> <p>Hampshire has developed a Complementary Commissioning pathway which encourages the use of a single agency to provide a joint health and care package.</p> <p>Brighton has a joint social care and care agency assessment in community within 24 hours which ensures clarity regarding needs and capacity.</p> <p>Leeds CCG(s) has undertaken a 'hospital to home' pilot in collaboration with Age UK. This includes Age UK assisting in identifying suitable care home placements where these are required.</p> <p>Medway has ensured that there are back up options for every part of the service where possible (for example, a two hour response time has been agreed for transport services and where this is not possible, access to local day centre vehicles has been negotiated).</p> <p>Examples showing the use of extra care and sheltered housing to meet short term needs such as reablement can be found here.</p>
<p>NHS Continuing Health Care (CHC) assessment happening at the right place at the right time</p>	<p>Assessment for eligibility for NHS CHC that takes place in an acute hospital may not always reflect an individual's capacity to maximise their potential⁵ - and from 1 April 2017, CCGs will be required to report how many NHS CHC assessments are conducted outside of hospital. It is vital that health and social care agencies collaborate to develop effective arrangements, which facilitate timely and accurate NHS CHC assessments, remembering that where a patient requires an assessment for NHS CHC as part of the hospital discharge pathway, their care and support arrangements remain the responsibility of the NHS until the eligibility decision has been made.</p> <ul style="list-style-type: none"> • West Norfolk has introduced a D2A pathway where NHS CHC assessments are no longer carried out in hospital but conducted instead in the community, once the patient has reached their optimal recovery. • South Warwickshire discharge co-ordinators are responsible for all CHC assessments as a trusted assessor. This has enabled a 'straight to Decision Support Tool' model (i.e. without the need for a Checklist, where it is clear that a full assessment is required) where it is in the patient's interest, which reduces delay.

⁵ Sections 64 and 65 of the [National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, November 2012 \(Revised\)](#).

Biggest challenges	Examples of practical documents and local solutions
Medicines	<p>Liverpool has solved delays in TTO's (To Take Out) by operating a fast track pharmacy service, where requests for TTO's are prioritised. TTOs are processed and available within 30 minutes - 60 minutes of completion on Electronic Prescribing and Medicine Administration and 60 minutes for large blister packs.</p> <p>East Lancashire Hospitals NHS Trust has developed an electronic referral system, Refer to Pharmacy which allows pharmacists and pharmacy technicians to refer people from the hospital bedside to their community pharmacist for various post- hospital discharge support with their medication.</p> <p>West Hertfordshire has developed a Delirium Recovery Programme⁶ where patients assessed as requiring support are discharged home with 24 hour live in care, two weeks of regular and 'as required' medication on a medication policy and their individual plan of care for cognitive enablement.</p> <p>London North West Healthcare (LNWH) NHS Trust has piloted a pharmacist within the rapid response team to reduce medicines related admissions using a locally developed, evidence-based tool (PREVENT) to identify patients at risk of preventable medicines related problems.</p>
Adaptations in the home/Availability of equipment	<p>Adaptations in the home:</p> <ul style="list-style-type: none"> • West of England Care and Repair provides services such as fitting key safes, grab rails, electrical safety and heating repairs to enable an early return home for patients in Bristol and North Somerset hospitals. • Manchester Care and Repair runs a home from hospital service that is co-located within integrated discharge teams working closely with NHS and Manchester City Council staff. • Revival Home Improvement Agency's Hospital Discharge Service is able to provide continuous housing related support from ward for to up to 30 days after the patient's return to home. <p>Availability of equipment:</p> <p>Medway has a two hour turn around built into the contract with the community equipment supplier and has stores on site.</p>

⁶ Delirium is a term used to describe an acute confusional state. It is characterised by fluctuating features of inattention, altered perception, and disturbances of memory, cognition, perception, behaviour, and consciousness. Delirium can affect up to 60% of frail older people in acute hospitals.

TIPS FOR GETTING STARTED

This section contains tips for success from local areas who have put a discharge to assess model in place.

Consider set up	Support integrated working
Use the principles outlined on pages 3-4 as a basis for adapting the D2A model to ensure a tailored and effective solution	Set up systems/processes/agreements/pathways that allow information sharing
Review the Local Examples of Discharge to Assess highlighted on page 5 to find an option that would fit best to local circumstances and existing services	Adopt a trusted assessor model/generic assessor model
Start small - many areas have started identifying patients suitable for D2A on Frailty Wards and those identified as being in the last 12 months of life	Adopt risk sharing protocols - or be clear about where risk ownership lies
Use existing staff and re-align teams - many areas have found it helpful to utilise existing joint health and social care teams	Make sure the team has the ability to start both health and social care packages
Map demand/supply and size pathways according to local need	Invest in staff competencies to allow maximum flexibility in model
Pool resources between organisations to optimise services (e.g. joint business cases). North Bristol's D2A service is funded by the CCG and the Hospital Trust, with resource for additional reablement from the Better Care Fund and the business case can be found here	Include housing and occupational therapists (OTs) in any Multi-Disciplinary Team (MDT) working/ care co-ordination
It is critical to explore how the model will work at weekends, including alternative contingency plans	Include training for staff within MDTs on dementia and the Mental Capacity Act 2005
Make sure pathways are streamlined and simplified	Consider night-time services - housing associations could share or contract their out-of-hours repairs and homecare services
Consider how the D2A pathway can operate at the front door of the hospital - Bristol has found that assessment on entry helps to support 72 hour stay and reduces duplication	Ensure there is an up-to-date directory of services with all partners
Community demand and capacity modelling and costings need to be undertaken in advance and reviewed throughout the build up/implementation phase	Engage directly with local GP practices to ensure they are linked in
Embed new ways of working	Build bed base slowly and agree referral criteria and number of daily referrals with residential care homes
Have a senior leader with appropriate permissions and senior organisational support to drive the new ways of working in order to sustain them	Know how you will evaluate
Involve staff and patients in service re-design and process map pathways - here is Brighton's example	Think about how you will measure success and the impact of change before you start, to allow for consistent and comparable data to evaluate across the whole system - see suggested metrics
Use a Plan Do Study Act (PDSA) approach - to constantly refine your model	Consider how you will measure staff and patient feedback
Have a robust communication and engagement strategy (including consideration of specific branding) for staff, patients and families	Introduce a system to track and ensure appropriate referrals
Consider freeing staff up to work as a multi-disciplinary team to review new or past cases	
Use ambassadors to continually encourage referrals from wards within hospital and challenge practice	
Employ early frailty screening for all people with anticipated complex needs followed by targeted and assertive comprehensive needs assessment (using for example Comprehensive Geriatric Assessment) to find those people most likely to benefit from D2A	
Make sure you are not assessing patients twice - avoid 'assess to assess'	

To share or discover more case study examples in this area please use the BetterCareExchange. Create an account [here](#).

Special thanks goes to [these organisations](#) for their support, time, effort and commitment during the development of this Quick Guide.

Did you find this Quick Guide useful?

