CARE

NHS

Your guide to the Discharge to Assess pathways

in Bristol, North Somerset and South Gloucestershire

Why Home First?

We know that people recover best at home after a stay in hospital.

Staying in hospital any longer than necessary reduces a person's independence, leads to muscle loss and increases the risk of healthcare associated infections, pressure sores and becoming incontinent. People remain more active and do more for themselves in familiar surroundings. In addition, people enjoy better sleep and better mood among friends, family and their usual home comforts.

That's why we always think 'Home First' and do all we can to enable people to recover in the place they call home, supported with any necessary monitoring and rehabilitation.

For those people who no longer need hospital care, but may need further support while they recover, it is better to assess their rehabilitation and other needs outside of hospital, ideally in their home environment. Rehabilitation at home empowers people to do more for themselves and to be actively involved in their recovery, so their actual needs can be better assessed.

Experienced clinicians and social care professionals in our Community Transfer of Care Hubs are skilled at working in collaboration with the expertise of ward staff to identify the best way to get each person to the place they call home as quickly as possible, once they are medically ready for discharge.

Glossary of key terms on the back page

The pathways

Pathway 0:
Home without formal support needs
Most people will go home on this pathway

If no new formal health or social care support is required, the person can go straight to the place they call home as soon as they are medically ready. They may receive support from friends, family, the voluntary and community sector, or the continuation of a pre-existing package of health or social care. Rehabilitation may be offered as an outpatient, for example through physio or balance groups.

Pathway 1:
Recovery and rehab at home
The vast majority of people who need formal support at discharge will go home on this pathway

People are supported to return home with a tailored package of rehabilitation and any other necessary support. The person's longer term needs are assessed in their home environment so that any further support from health, social care or the voluntary and community sector can be put in place.

Pathway 2:
Rehab to home
Only a few people will leave hospital on this pathway

For people who are medically ready to leave hospital but have a high level of care or rehabilitation needs that cannot yet be met at home. These people continue their rehabilitation in a community rehabilitation unit. They will be assessed regularly and will return home as soon as they are ready. This could be with support from friends, family or the voluntary and community sector, on Pathway 1, or with a package of social care.

Pathway 3:
Community bed
Very few people will leave hospital on this pathway

For people who are medically ready to leave hospital but have complex needs that cannot be met in their home environment. While some may return home later, many are likely to need ongoing 24-hour bedded care. These people are cared for in a community assessment bed. A social care practitioner will help the person and their family and carers to identify and plan their long-term care and next steps.

Identifying the best way to get each person home

Person admitted to hospital ward

Discharge planning begins as soon as possible and an expected discharge date is established, usually within 24 hours of admission.

Discharge needs described and ToC Doc sent to IDS

The ToC Doc describes a person's functional abilities and recovery needs. Filling in the ToC Doc can begin when the person is admitted and should be sent by ward staff to the IDS as soon as the person's discharge needs are confirmed. The Toc Doc should be completed by the clinician who knows the person best, linking in with other professionals where more detail is required. A revised Toc Doc should be sent if a person's circumstances change.

CToCH identify the most appropriate pathway

The IDS review and process the ToC Doc, passing it to CToCH. Experienced clinicians and social care professionals assess the information about each person provided in the ToC Doc to decide on the best place to meet their needs. They will ask for more information from the ward staff if necessary and acute staff and CToCH clinicians can discuss the best pathway for people with complex needs.

Ward notified of pathway decision

The pathway decision will be communicated back to the ward via the IDS within 24 hours, along with any requests for further documentation, so that ward staff can make necessary preparations for discharge. Ward staff can discuss any concerns with the IDS or CToCH case manager.

CToCH begin process to support discharge

At the same time the decision is communicated back to the ward, CToCH make the necessary arrangements to begin the person's transfer of care and they are placed on the appropriate waiting list for their pathway. If the person's needs change while they are waiting the pathway decision will be reviewed with an updated Toc Doc.

Pathway 1: Recovery and rehab at home

Person allocated a date for discharge

Sirona locality teams book a date for the person to be assessed at home. This is communicated to the ward through the IDS so that discharge arrangements can be made in good time, including transport and any immediate VCSE support. If nightsitting is needed for the person to be able to go home, this will be arranged by CtoCH.

Community practitioner assesses person at home

The person is assessed by a Sirona community practitioner shortly after they return home, in person or by telephone or video call. The practitioner will check the person is safe, clinically well and has all necessary medication and equipment. They will assess the person's needs, including mobility, personal care, medication, meals and toileting. Any further support or care needed will be put in place, including from VCSEs.

Individual rehabilitation plan put in place along with any other necessary support

Following the initial assessment, Sirona work closely with community partners to best support the person's ongoing needs, with the right treatment, care and support at the right time. This may include local authority reablement and support from the voluntary and community sector. Over the first few visits a tailored rehabilitation plan will be developed, based on the individual's needs and goals, including an exercise and activity plan. The frequency and schedule for rehabilitation visits and additional support are revised as necessary.

Longer term support established, if needed

Once the person has progressed as far as possible towards their functional goals, they will be discharged from the service or, if a longer term care need is established, referred to social care for a care needs assessment. The person may also seek self-funded support.

Pathway 2:
Rehab to home

Person referred to community rehabilitation unit

The person is placed on the waiting list for an appropriate rehabilitation unit or dedicated bed in a care home, based on both geography and the specific needs of the individual. If the person's needs change while they are waiting, an updated ToC Doc should be submitted as a more appropriate unit could be available sooner.

Admission, assessment and rehabilitation planning

Once admitted, the unit assess the person and agree a care and support plan. The person is also assessed by a therapist within 48 hours. The therapist will discuss their goals and agree a rehabilitation plan with the person. An expected discharge date will be established.

Rehabilitation and discharge planning

The person receives regular rehabilitation from their therapist and support workers, with a focus on active involvement in rehabilitation throughout their daily routine. Discharge planning takes place with the person and their family and carers and this may include social workers and a care needs assessment. Regular discussions with the wider care team ensure plans are on track.

Further recovery at home or other setting

Once the person's care and support needs can be met at home, the person may return home on Pathway 1, or with the support of family, friends or VCSEs. Alternatively, for people who have progressed as far as possible with their rehabilitation and still require further care, they will go home or to another setting with appropriate support such as reablement, a package of social care or NHS continuing health care.

Pathway 3:
Community bed

Person waits for an appropriate placement

The person is placed on the local waiting list for an appropriate bed to suit their care needs. Pathway 3 beds are usually in residential and nursing homes run by care home providers, with some supported housing. When an appropriate bed becomes available the provider receives the ToC Doc to check they are suitable for the person and may contact the ward for more information.

Therapy assessment and plan

A Sirona practitioner visits the person within the first few days to assess their therapy and equipment needs. If appropriate, a therapy plan is put in place so that care home staff know how to support the person to maintain functional ability and this will include visits from a Sirona therapist if appropriate.

Social care practitioner supports longer term planning

The person is allocated a social care practitioner to assess and help plan their longer term care requirements, in discussion with family and carers. These discussions are conducted with the person's consent, or in their best interests if they do not have capacity to make these decisions. It will usually involve a care needs assessment to identify what social care support is needed, or it could involve NHS continuing healthcare.

Remain in community bed until next steps are in place

The person will usually remain in their community bed until the completion of a care needs assessment and care plan. Wherever possible this is completed within 28 days. This will identify their longer term care needs and enable appropriate support or next steps to be arranged. Usually this is a long term placement but a person may be able to return home or transfer to another pathway. Once the assessment, plan and means test have been carried out, the person will need to start paying the agreed contribution to the costs of their social care, including their Pathway 3 bed while they remain in it.

What's the difference between rehabilitation and reablement?

There can be considerable cross-over between NHS rehabilitation and social care reablement services, and they are often coordinated together, however there is a distinction.

Discharge to assess rehabilitation services focus on therapy, activities of daily living and exercises to help a person to improve their strength, mobility and functional ability. Often therapy plans are focused on particular personal goals, such as improving balance to reduce the risk of falling or improving upper limb strength in order to carry out daily tasks.

Social care reablement services focus on helping a person to regain skills to in order to live as independently as possible at home, for example following illness or a hospital stay. These could include getting dressed, having a wash or preparing a meal.

When do people need to pay for care at home?

It can be complicated to understand and explain the different types of care that someone may receive at home after discharge and how they might be funded. However, there are some key principles that underpin most situations.

Discharge to assess rehabilitation – If someone needs rehabilitation therapy after they are discharged from hospital, this will be provided for free by the NHS and the treating clinicians will work with the person around their specific goals and recovery timeframe.

Social care reablement services – Some people may be referred for reablement following a period of rehabilitation at home and some may receive a combination of NHS rehabilitation and reablement. Reablement is provided through the local council. Councils will fund reablement while it is shown to be making a difference to a person's functional abilities, usually for a period of one to six weeks.

Social care at home – Social care at home, such as regular visits from home carers, is not free and everyone needs to pay for at least some of their care. How much each individual needs to pay depends on a means test that takes into account their income and savings. It is important to note that while means tests for care home costs include the value of a person's house, means tests for care provided in a person's home do not.

NHS continuing healthcare – Some people with ongoing significant health needs can have their care paid for through NHS continuing healthcare. People are only eligible if the majority of their care requirements are focused on managing or preventing health needs. The assessment is a two-step process. An initial checklist is completed with the person by a health or social care professional to determine if they might quality for NHS continuing care. If they do, a full assessment is carried is carried out by two or more professionals involved in the person's care, using a detailed decision support tool. A fast track process is available for people who are terminally ill.

What is a care needs assessment?

A care needs assessment, also known as a Care Act assessment, is carried out by a social care practitioner. They are not usually carried out while a person is in hospital. The exact process varies between councils, but all follow the same national criteria.

The social care practitioner will talk to the person to identify their care needs based on their ability to manage everyday tasks, health, circumstances, living arrangements and personal goals for wellbeing. With the person's permission, family, carers and other health professionals can also be involved in these discussions.

The assessment will identify if the person is eligible for social care support from the local authority. If so, a care plan will be agreed with the person, detailing their needs and what could help to meet them. A means test will be carried out to determine how much the person needs to contribute to their care and support before the plan is put in place.

Once the assessment, plan and means test have been carried out, the person will need to start paying the agreed contribution to the costs of their social care. If the person is not eligible for social care support from their local authority, they may choose to organise and fund care support themselves.

Voluntary and community sector support

Many people going home on Pathway 1 could go home on Pathway 0 with VCSE support. This would reduce waiting times for people who do need rehabilitation at home. The range and accessibility of local VCSE services is expanding and there are lots of ways you can access this support for the people in your care.

Acute hospital link workers

We are introducing link workers in each of our acute hospitals. They know the VCSE sector well and can ensure that people get the support they need for a smooth and timely return home. Case managers and therapists can refer people who may need additional support for discharge to their local link workers. This includes:

- Advice on housing, social care, power of attorney
- Support with benefits, allowances and grants
- Home adaptations, decluttering, handyperson services
- Help around the home, cleaning, shopping
- Support for carers
- Local activities like befriending, walking clubs and social groups
- Tech enabled care
- Transport.

The link worker will review the information and discuss with the referrer, if necessary, before visiting the person for a friendly chat to discuss the range of support available. They can provide signposting and make arrangements for additional support as appropriate.

Contact your link worker:

- BRI – TBC
- NBT – linkworkers@nbt.nhs.uk, 0117 928 1557
- Weston General – TBC

British Red Cross

Among other organisations, the British Red Cross offer valuable services to help support people being discharged home. These include:

- Help to get home and settled in
- Daily visits for a few days to check welfare and make lunch, to prevent readmission
- Practical support such as shopping
- Emotional support such as telephone befriending.

To make a referral for British Red Cross home support services, call 0117 301 2601 or email firstcallbristol@redcross.org.uk

Discharge support grant

A grant scheme offering one-off payments of up to £1,200 is available to help people return home following a hospital stay. It is available to cover some of the costs that might be a barrier to returning home, for example:

- Expenses that enable a friend or family member to help, such as the costs of:
  - childcare
  - a dog walker
  - fuel, taxi or other travelling costs
  - taking time off work
- Equipment not covered by other schemes
- Short term personal care support.

Once approved, payment can be made to the person, a family member, carer or voluntary supporter within two days of discharge. They grant does not need to be repaid and will not impact on Universal Credit or any other benefits.

Referrals should be made to Sirona's Partner2Care team who will work with the person and their family or carers to develop an individualised package of support. Call 0800 111 4167 or email sirona.partnertocare@nhs.net

Key terms

There are some common terms used throughout the Discharge to Assess pathways:

- **ToC Doc:** Transfer of Care Document – enables ward staff to describes a person's functional abilities and recovery needs. It is used to identify the right discharge pathway and to support handover to the team receiving the person.
- **CToCH:** Community Transfer of Care Hub – a team of clinicians and social care professionals that match a person's needs as described in the Toc Doc to the pathway that will best meet those needs, with a focus on 'home first'.
- **IDS:** Integrated Discharge Service – hospital team, bringing together health and local authority colleagues, to coordinate arrangements for a person's discharge.
- **VCSE:** Voluntary, community and social enterprise organisations.

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For more information on the D2A pathways and up to date patient information materials, visit bnssghealthiertogether.org.uk/d2a