Monitor
Making the health sector work for patients

Moving healthcare closer to home case studies: Enabling early discharge

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Early Supported Discharge Service: Countess of Chester Hospital NHS Foundation Trust

The Early Supported Discharge (ESD) Service enables acute hospital patients to be discharged in a timely way by making sure care packages are in place to support their rehabilitation at home. An important feature of the service is the strong partnership with the local community trust.

The Countess of Chester Hospital NHS Foundation Trust is a large district general hospital in Chester with over 600 beds, providing services at an acute hospital site and at an intermediate care site.

Aims

ESD aims to allow patients to be discharged from hospital earlier and receive the rehabilitation they need in their own homes. By increasing the patient's functional independence at home, ESD also aims to help them avoid readmission. It is one of several schemes designed to support the trust's A&E performance.

Characteristics

- 7-day service
- nurse and therapy led
- patients stay up to 14 days on the ESD pathway and are referred to social care if applicable at day 3
- serves up to 90 patients a day
- supports 14 new discharges a day

Origins

The foundation trust and the local community trust set up ESD at the Countess of Chester acute site in November 2012 as a joint service for adult patients. Many patients aged over 65 were occupying Countess of Chester beds despite being able to receive care and support outside hospital.

Structure

Multidisciplinary team The team comprises nurses and therapists, including occupational therapists and physiotherapists, as well as a social care assessor. Increasing numbers of community support workers can provide care, rehabilitation and support in the patient's home while awaiting social care packages. Staff are employed by an integrated community and acute therapy service.

Acute-based Multidisciplinary meetings take place daily at the acute hospital to discuss patients on the ESD pathway and plan their care.

How patients benefit

The service takes patients who are medically stable but need further therapy. Patients are referred from A&E and intermediate care, and identified from medical wards. A typical patient has been hospitalised following a fall.

Enabler: single therapy lead across the locality

ESD relies on downstream services being available to which patients can transfer from the ESD pathway. The trust reports that joint working with the local community trust has enabled patient flow through the service. One person is responsible for therapy services across the local community and acute providers, which has particularly helped develop successful working relationships.

MDT meetings take place daily at the hospital where staff discuss patients on the virtual ward. The hospital-at-home team provides additional medical support to ESD.

Short-term input ESD can care for 90 patients in the community each day, offering therapy, bridging social care support and providing short-term medical care at home. Patients stay with the service 10 days on average, receiving a maximum of three visits a day before transferring into community care (eg ongoing community services, integrated care teams run by the local partnership trust, or primary care). Social care assessment is made on day 3 for patients who the team predict will need ongoing care.

The trust has responded to increasing demand on the service. Since it was set up, the service has supported 4,000 hospital spells and 3,000 unique patients. The trust has invested in additional staff for the service. ESD's length of stay has shortened due to the development of pathways with social care, which enable increased throughput.

Impact

The trust says ESD helps it cope with the pressures of increased demand. Specifically, it helps shorten length of stay, freeing beds for patients with acute health needs and relieving pressure on A&E.

ESD could save money as the trust, in partnership with the community trust, is now looking after three times as many patients in the community as it was in the acute hospital, for the same cost. The trust achieved this by reinvesting in community teams the savings made from bed closures.

More information

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Discharge to Assess: South Warwickshire NHS Foundation Trust

The Discharge to Assess (D2A) service enables patients to be discharged earlier from acute inpatient wards by co-ordinating care in alternative settings. Important features include the trusted assessment between health and social care, in-house reablement and rehabilitation, and care co-ordinators to support patients and their families throughout the discharge process.

South Warwickshire NHS Foundation Trust became an integrated trust in 2011. It provides community services across the whole of Warwickshire and acute services to south Warwickshire at Warwick Hospital.

Aims

Patients on a D2A pathway are discharged from hospital into nursing or residential homes, community hospitals or their own homes with care and rehabilitation support for up to six weeks. The service derives its name from its focus on assessing patients for ongoing care needs outside the acute hospital rather than patients waiting in acute beds to be assessed. The local health economy's shared vision for the service is that no decision about long-term care needs will be made in an acute setting.

The service aims to:

- support timely discharge from hospital
- maintain patients' independence where possible
- reduce requirements for long-term care packages
- have a net neutral impact on social care spend.

Characteristics

- assessment for care and therapy needs at home, not in hospital
- three pathways for three distinct cohorts of patients – but no patient is excluded
- multidisciplinary team assessing and providing patient care
- patients referred on within four to six weeks
- discharge care co-ordinators facilitating patient journey

D2A aims to minimise hospital stay and maximise independence by taking longer than usual to assess patients for ongoing care needs outside the acute hospital and providing care at home wherever possible.

Origins

Pressures to improve patient flow across the hospital included accident and emergency underperformance, high levels of delayed transfers of care, suboptimal health outcomes and bed crises.

South Warwickshire Foundation Trust's plan for system transformation began in 2012/13 and comprised initiatives on ambulatory emergency care, a community integrated health and social care team, frailty services, trusted assessment and early supported discharge. Implementing the D2A model has been a significant part of the system transformation.

The trust worked with the local authority, including NHS continuing healthcare (CHC) and the local clinical commissioning groups (CCGs) to set up the service.

Structure

Care seven days a week The multidisciplinary team can provide 7/7 care in the patient's own home and 24-hour care in residential settings for patient rehabilitation. This allows the patient to leave hospital and complete their recovery at home or in the community when they no longer require acute hospital care.

Assessments for continuing care needs take place at home or in residential care. Assessing the patient at the right time for them and in the right environment reduces delayed transfers of care, allows more time to assess them for ongoing care and reduces overall spending on continuing healthcare.

Multidisciplinary team The care co-ordination team comprises mostly nurses but includes occupational therapists (OTs) and social workers. The rehabilitation and reablement teams include GPs, nurses, OTs, physiotherapists, social workers and support workers.

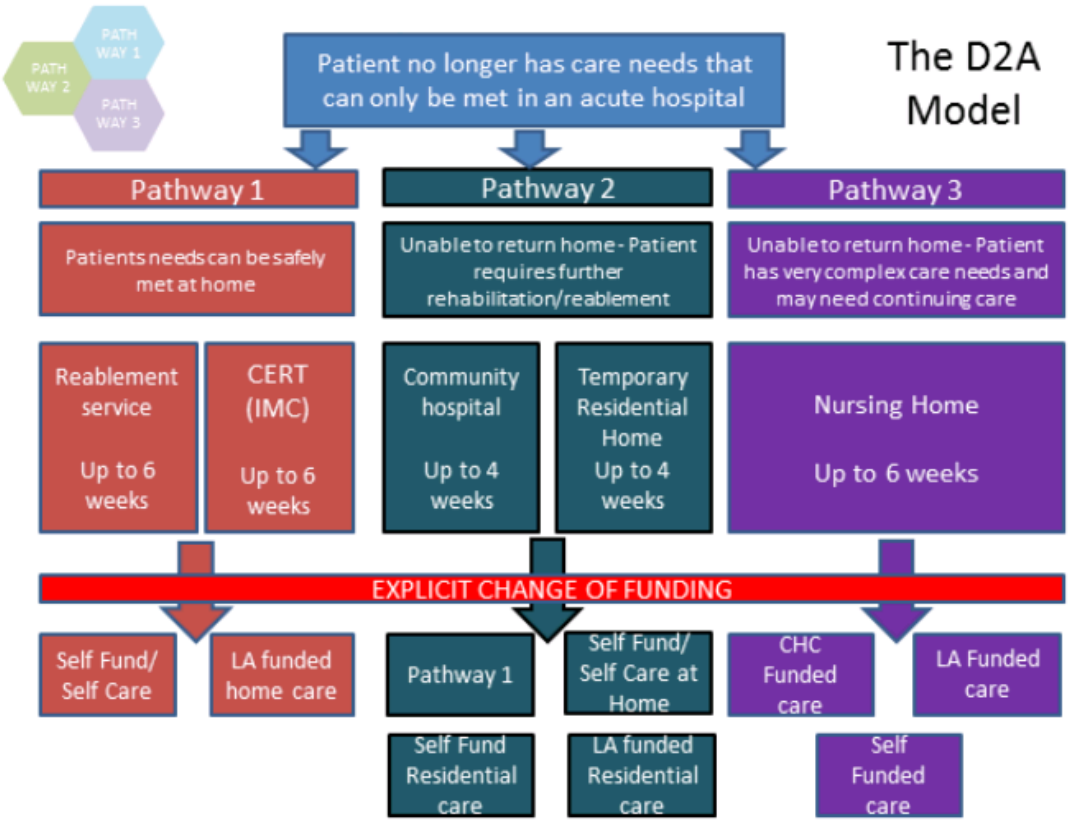
Enabler: care co-ordinators

D2A runs on the explicit assumption that the pathways are only for six weeks; after that, the way the patient's care is funded must change. Care co-ordinators are crucial to achieving this. They follow the patient through the pathway and complete ongoing care assessments at the end of the pathway. These practitioners ensure continuous and appropriate care for patients. By December 2014, only one patient out of 300 who had been through the service had been significantly delayed.

How patients benefit

Three pathways enable patients to be discharged from hospital in a timely way and support patients to rehabilitate fully in their own home or the community.

The average age of the service's patients is 80 years old.



Pathway 1 is for patients on a hospital ward who can return home with additional support from the Community Emergency and Response Team (CERT) or reablement service. They receive ongoing support at home through CERT and Warwickshire Reablement Service, and stay on the pathway up to six weeks.

The ward multidisciplinary team completes a single assessment for ongoing care needs in the patient's home, which is shared between social care and community health teams (trusted assessment). CERT or the reablement service provides care and therapy at home to support patients' recovery to independence. The intensity of the service depends on patients' needs: they can be seen up to four times a day.

The trust discharges about 40 patients a week through this pathway.

Pathway 2 is for patients who cannot be discharged home directly but could return there with additional rehabilitation. Patients are discharged to temporary residential care or community hospital settings for up to four weeks. About 23 patients a week are discharged through this pathway.

Pathway 3 is for patients likely to need ongoing care in a residential setting, who may be eligible for continuing healthcare funding. The hospital-based multidisciplinary team has assessed these patients as having very complex care needs and likely to require continuing care in a residential home for the rest of their lives. Around 40% of these patients have dementia. This pathway takes patients into a residential home, where the assessment for their ongoing care need is completed. About five patients a week follow this pathway.

The trust has access to 30 temporary community nursing home beds. Patients on Pathway 3 are discharged from Warwick Hospital to one of these for up to six weeks. The beds are funded by the CCG, commissioned by the local authority and case-managed by the trust. The local authority commissioned beds from providers it deemed capable of high quality care under the intensity of developing such a complex pathway.

D2A pathways have built-in links with primary care. Two GP practices have been commissioned to provide clinical input to these 30 nursing home beds. GP cover for nursing homes is deemed critical to high quality care and to enabling the patient to move along the D2A pathway within six weeks.

The average length of stay on the pathways is four to six weeks. Following discharge from the pathway, patients move under their GP's care or to self-funded care, local authority funded care or funded CHC.

Enabler: trusted assessment between health and social care

- trusted assessment enables direct referral to reablement without the hospital social work team's involvement
- assessments are sent electronically to the service to which the patient has been triaged, facilitating timely discharge
- trusted assessments are helped by eCAT (an in-house technology solution for trusted assessment referrals)
- the trust reports this has enabled improved flow through the hospital

Enabler: working with Warwickshire Reablement Service

Joint working with the local authority has been essential to developing D2A. Close collaboration allows for a rapid and smooth transition between different services, avoiding delays as patients await social care packages or a nursing home place.

The transformation of the local authority's traditional domiciliary care service into a reablement service was crucial to developing Pathway 1. Over 200 staff were retrained to change their way of working – from doing things *for* the patient to doing things *with* the patient, for six weeks. The aim was to reduce the cost of expensive long-term care packages and help patients live independently in their own homes.

Before this, a typical patient's domiciliary care package was about 14 hours a week. Now, support initially intensifies during the six weeks of the reablement package, although by the end patients on average need only 10 hours of care a week. Those who need ongoing home care support average five hours a week, with 51% of patients needing no home care one year after reablement. Savings are shared among the trust, CCG and local authority commissioner.

Impact

The service offers patients the choice of returning home and D2A has not led to an increase in readmissions despite earlier discharge home.

The trust reports that streamlined internal processes have produced more effective services and enabled it to improve A&E performance against rising activity. Increasing the number of D2A beds ensures that acute medical beds are more often used only by patients who need acute clinical care.

From 2011 to 2014, the trust believes that D2A and other work areas resulted in:

- improved A&E performance
- shorter length of stay for emergency inpatient adults
- shorter length of stay for people over 75 from:
    - fewer emergency readmissions
    - fewer patients affected by three ward moves.

The scheme may save money for the local health economy. For instance, the trust reports that 2014/15 data show the proportion of patients on Pathway 3 receiving CHC funds has fallen from 40% of eligible patients to 20% in a year (when

compared to patients who refused the pathway). The trust's service statistics show that the proportion needing CHC funding after a D2A programme is half that of the group who do not use D2A.

Challenges

Waiting times for community nursing home beds can be two to three days. This results in:

- excess hospital stays for some patients who cannot be discharged to a community bed on the day they are clinically able to be so
- some patients still having decisions about their long-term care needs made in hospital.

D2A has a 27% refusal rate by patients. The trust believes this may be due to the geographical location of the Pathway 3 nursing homes; the families of some patients with dementia may not want them to move.

More information

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These case studies are part of a suite designed to increase awareness of the impact of moving healthcare out of hospital. For more materials see Moving healthcare closer to home