BCF Support Programme - Discharge to recover and then assess

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DH(SC) Guidance in 2009
Half-Way Home

Don’t assess an older person in an acute hospital bed for longer term residential care
- this was the seed of D2A – Discharge to Assess Policy in England in 2020.

Why Discharge to Assess?

- The assessments of older people for long term care when they have been in an acute hospital bed for more than 5 days proved to be inaccurate and to overstate people's needs. (1/3rd unnecessary or premature admissions to residential or nursing care – still happening in some places)
- Work on home closures in Warwickshire found one third of the residents' admission to one home had been either premature or unnecessary – all these residents had been assessed as requiring residential care whilst in an acute hospital. They reported being "tricked" into the care home.
- Welsh Study – Right Sizing Community Services to support hospital discharge
- Commissioning Out of Hospital Care Services to reduce delays – Published by IPC March 2020 (follow up to 2018 paper)

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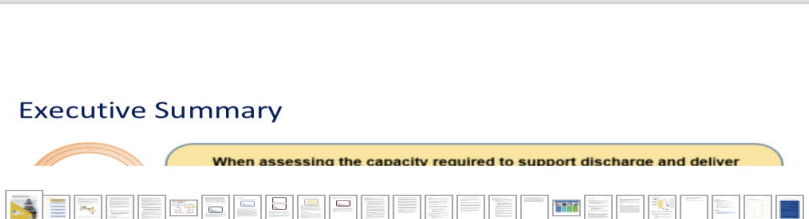
Right Sizing Community Services to Support Discharges from Hospital - national report

PDF - 1.8 MB



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Study in Wales 2019

- Tracked most older people leaving hospital in 2018.
- Found significant variation in outcomes for older people depending on where they lived and what Intermediate Care (IC) was available for them
- Long Term admissions to residential/nursing care were highest where IC was limited – not related to demography
- Where good IC services existed high percentage of partial or full recovery
- Significant shortage of services for those with dementia

Intermediate Care

- From the 1990s it was expected that older people would receive “intermediate care” after a period in an acute hospital
- Intermediate Care can be in a bedded setting (community Hospital or Care Home) or in a person’s own home – it must be therapy led and have a focus on recovery or rehabilitation.
- This is still patchy and insufficient is commissioned to meet local needs for recovery – 2 out of every 5 older people being discharged from hospital end up on the wrong care pathway – poor decisions and not enough of the “right” service.

Recovery/Rehabilitation/Reablement

- People require a period of recovery/rehabilitation after a period in an acute hospital – because of loss of muscle tissue, deterioration, frailty, mobility, confidence.
- Over two-thirds of older people leaving hospital and returning home will make sufficient recovery not to require on-going care.
- Over two thirds of older people leaving bedded care (where therapy is on offer) will return home.
- Where there is no therapy only 40% make a recovery at home and only 20% return home (D2A).

D2A not sufficient D2RA

- “Placing” an person out of an acute hospital bed into a service (bedded or in the community) which does not have a recovery support arrangement will lead to deterioration and the need for more care – “Discharge to Dump”.
- When a person is waiting for an assessment, they are likely to deteriorate and there is a risk that waiting for a full Care Act Assessments will be to the detriment of people for whom the Act was aimed to help.
- Full assessments should take place after a period of recovery.

Reablement Based Domiciliary Care

Each person leaving hospital should have a “recovery plan” – offering advice on what actions the person can take to help their own recovery from exercise to drug management

Each person referred to a Reablement Service should have a recovery-based plan, drawn up by the person with a therapist, both setting out the goals to be achieved and how they might get there – this should be followed by the Care Worker

The aim should be to enable the person to live as independently as is feasible and in their own home.

Demand and Capacity Plans

- Focus on what is driving the demand for intermediate care services – what percentage of older people require support at the point of discharge – varies from 12%- 40% of discharges for those over 65 years of age! Some places have no data on this!
- Look to manage (reduce) the demand e.g. mobilisation in acute hospitals or risk averse assessments
- Make sure the “right” capacity has been commissioned to meet the known demand – focus on community capacity and therapy led bedded care – quality and quantity
- Use P2 not P3!!
- Measure the levels of recovery made by older people

Assessments

- In hospital –assess if the person can be helped to recover at home (preferable) or will they require support from bedded provision?
- Part 1 of Care Act – Duty of Well-Being/ Duty of Prevention and Duty of Co-operation between NHS and Local Authority/ Promoting Diversity and Quality. This encourages the use of recovery-based services.
- At any point provider of Intermediate Care Service can assess that sufficient recovery has taken place to end the service – Trusted Assessor (Care Act 2008).
- Only those who need on-going support require an Assessment under Section 9 -13 of Care Act.
- Some complications with Mental Capacity assessments but these are better out of hospital (delirium vs dementia)

What makes the difference?

- It’s not the assessment that makes a difference to the outcomes for the person but the support they are offered – recovery, rehabilitation, recuperation.

Why isn’t this happening?

- Acute Hospitals don't prioritise the recovery programmes for older people whilst they are in hospital – mobilisation on wards
- There is still a strong focus on getting the person out of the hospital bed and less on their recovery (which happens best away from an acute hospital) – measuring delays
- Despite the evolution of the BCF there has not been sufficient investment in the “right kind of Intermediate Care”.
- Many Senior Medics and others still want to “assess” a person for their long-term care rather than develop a recovery plan
- Insufficient Intermediate Care to meet needs (let alone support admission avoidance)

Conclusion

- Many older people will make a full or partial recovery following an episode in an acute hospital with good of therapy led intermediate care – assess a person after this period of rehabilitation/recovery
- If a system had the right amount of Intermediate Care to meet the needs of their elderly population there would be speedier discharges and less long-term care needs for both NHS and Social Care
- If a health and care system was judged on the outcomes for the person there would be faster flow through the services and longer term reduced demand. (Shorten lengths of stay to improve outcomes for people).
- Discharge to Recover and then assess – D2RA

For more information, please contact

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Better Care Fund
Support Programme

How to access support

- **Email us:** BCFSupport@local.gov.uk with an outline of the request and system/place contact details:
- Please copy in your Better Care Manager (BCM) and your Care and Health Improvement Adviser (CHIA) for your area within your support request email. Initial support requests can also be discussed with your local Better Care Manager or Care and Health Improvement Adviser
- Local systems wanting to take up support can also access the support offer via ECIST regional or social care lead, or by directly contacting the BCF Support Programme team:
  - **Rahat Ahmed-Man**, Senior Adviser (rahat.ahmed-man@local.gov.uk)
- The BCF Support Programme team will get in touch to discuss and scope the support requirements with the system