NHS
Hambleton, Richmondshire and Whitby
Clinical Commissioning Group

HRW Integrated Discharge Pathways

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Background

- Consultation – 'Transforming our Communities' provided a mandate to develop new models of care closer to home

- Poor performance against NHS England target of no more than 15% of DSTs undertaken in an acute trust

THE D2A Model

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Patient no longer has care needs that can only be met in an acute hospital

Pathway 1 Home	Pathway 1 Home with Support	Pathway 2	Pathway 3
	Patient needs can be safely met at home	Unable to return home- Patient requires further rehabilitation/reablement	Unable to return home- Patient has very complex care needs and may need continuing care
	Integrated Locality Team Up to 6 weeks	Community Based Beds	DTA/Nursing Home bed

TA

TA

Transport: 365 Response

DST TO ESTABLISH EXPLICIT CHANGE OF FUNDING

Self Fund/Self Care	LA Funded Home Care	Pathway 1	LA Funded Residential Care	CHC Funded Care	LA Funded Care
		Self Fund Residential Care	Self Fund/ Self Care at home	Self Funded Care	FNC

Pathway 1 Home

For patients on a hospital ward who can return home.

- Patient discharged through the‘ Home from Hospital’ service.
- They receive a Patient Centred Care Plan to support their continued independence and self-care management.

For patients on a hospital ward who can return home with additional support from their local Integrated Locality Team.

- Patient discharged through the ‘ Home from Hospital’ service.
- They receive ongoing support at home and stay on the pathway for up to six weeks.
- The ward multidisciplinary team completes a single Trusted Assessment for ongoing care needs in the patient’s home, which is shared between social care and community health teams (trusted assessment). Intermediate Care Team 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.
- Daily review process required

Pathway 1 Home with support

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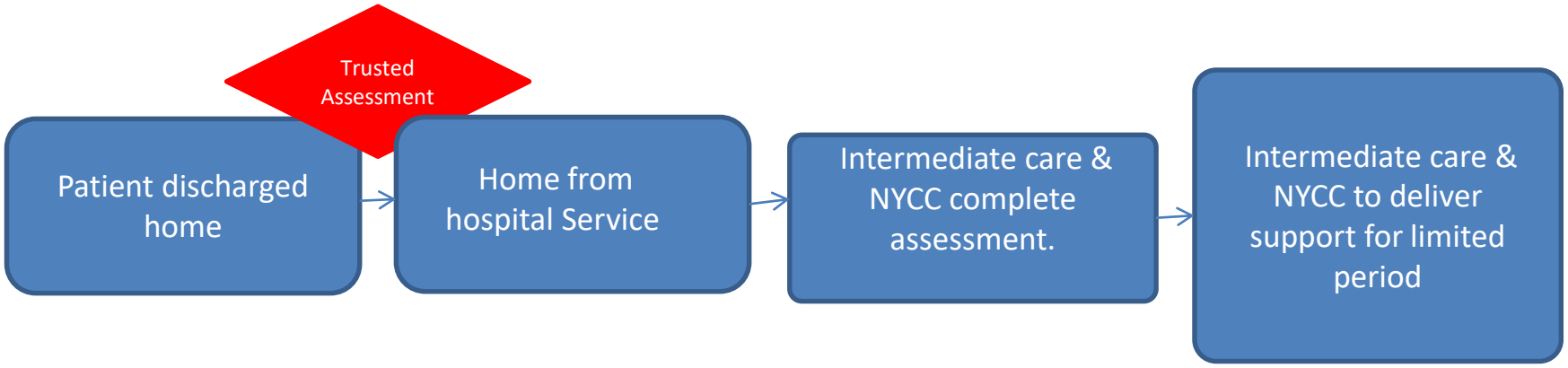
Patient medically optimised for discharge

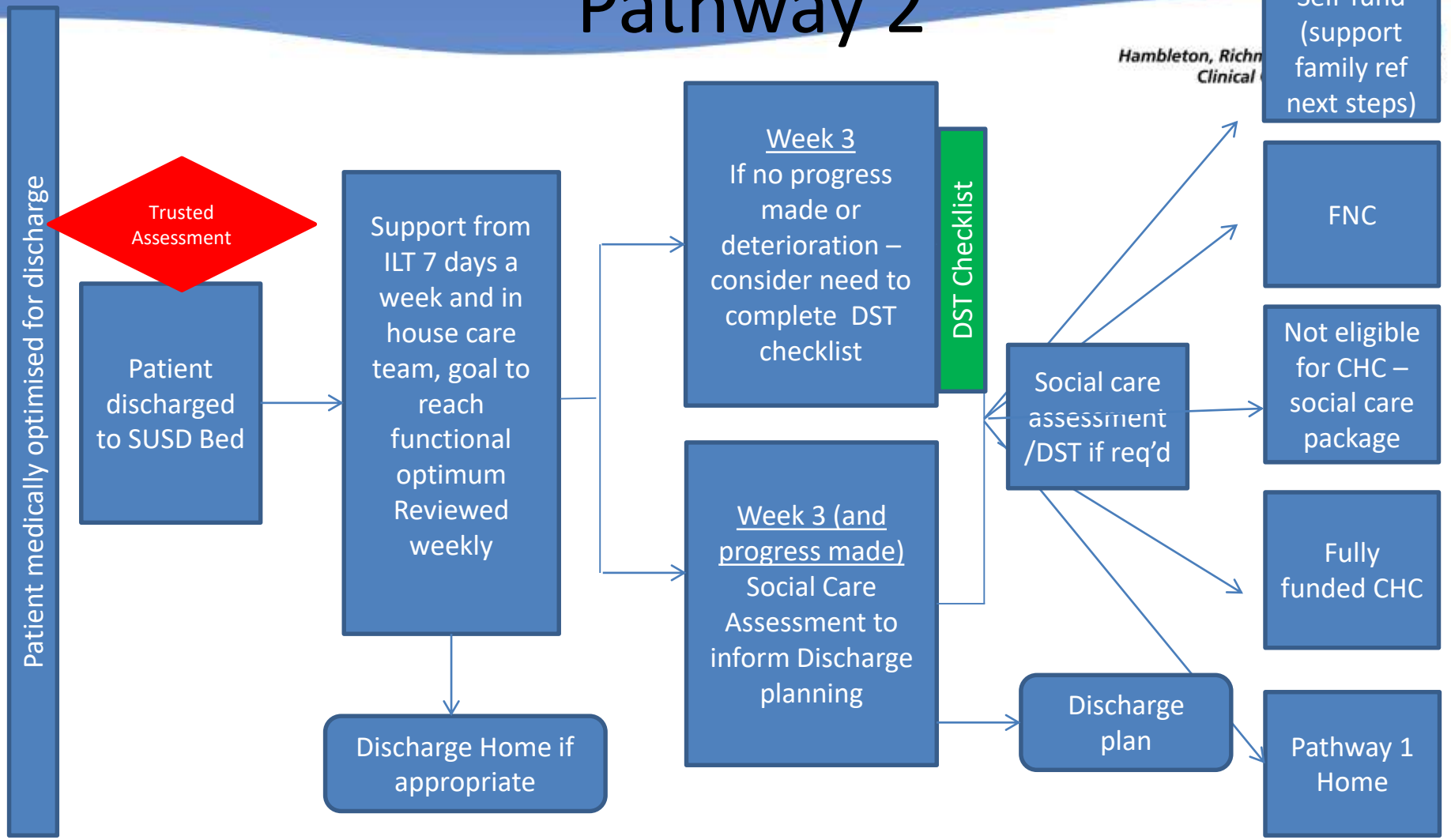


Pathway 2

For patients who cannot be discharged home directly but could return there with additional rehabilitation and reablement

- Patients are discharged to a community bed or temporary residential care via trusted assessment for up to 6 weeks.
- The local Integrated Locality Team manage the discharge home during the 6 week temporary placement.
- Daily assessments

Pathway 2



Funding

6 Weeks Health Funding

DST/ Social Care Assessment to determine onward funding responsibility

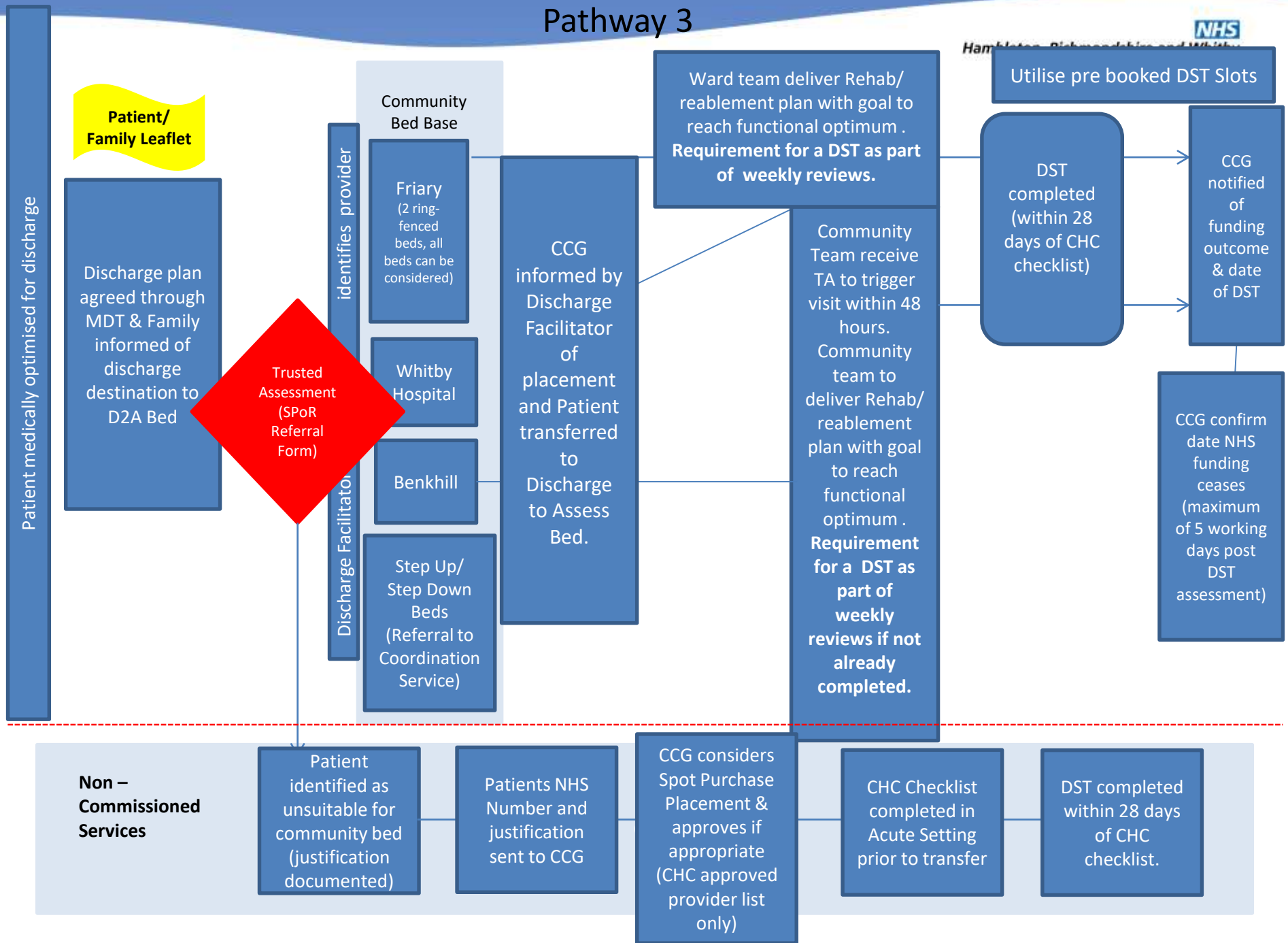
Monitoring in place

Pathway 3

For patients likely to need ongoing care in a Care Home or Residential setting, who may be eligible for continuing healthcare funding.

- The hospital-based team has assessed these patients as having complex care needs and likely to require daily care at a higher level than pathway 2.
- Patients suffering a delirium episode and require daily care until they are fit for assessment.

Pathway 3


Patient medically optimised for discharge
Patient/ Family Leaflet
Discharge plan agreed through MDT & Family informed of discharge destination to D2A Bed
Trusted Assessment (SPoR Referral Form)
Discharge Facilitator identifies provider
Community Bed Base
Friary (2 ring-fenced beds, all beds can be considered)
Whitby Hospital
Benkhill
Step Up/ Step Down Beds (Referral to Coordination Service)
CCG informed by Discharge Facilitator of placement and Patient transferred to Discharge to Assess Bed.
Ward team deliver Rehab/ reablement plan with goal to reach functional optimum . Requirement for a DST as part of weekly reviews.
Community Team receive TA to trigger visit within 48 hours. Community team to deliver Rehab/ reablement plan with goal to reach functional optimum . Requirement for a DST as part of weekly reviews if not already completed.
Utilise pre booked DST Slots
DST completed (within 28 days of CHC checklist)
CCG notified of funding outcome & date of DST
CCG confirm date NHS funding ceases (maximum of 5 working days post DST assessment)
Non – Commissioned Services
Patient identified as unsuitable for community bed (justification documented)
Patients NHS Number and justification sent to CCG
CCG considers Spot Purchase Placement & approves if appropriate (CHC approved provider list only)
CHC Checklist completed in Acute Setting prior to transfer
DST completed within 28 days of CHC checklist.

DST Assessments

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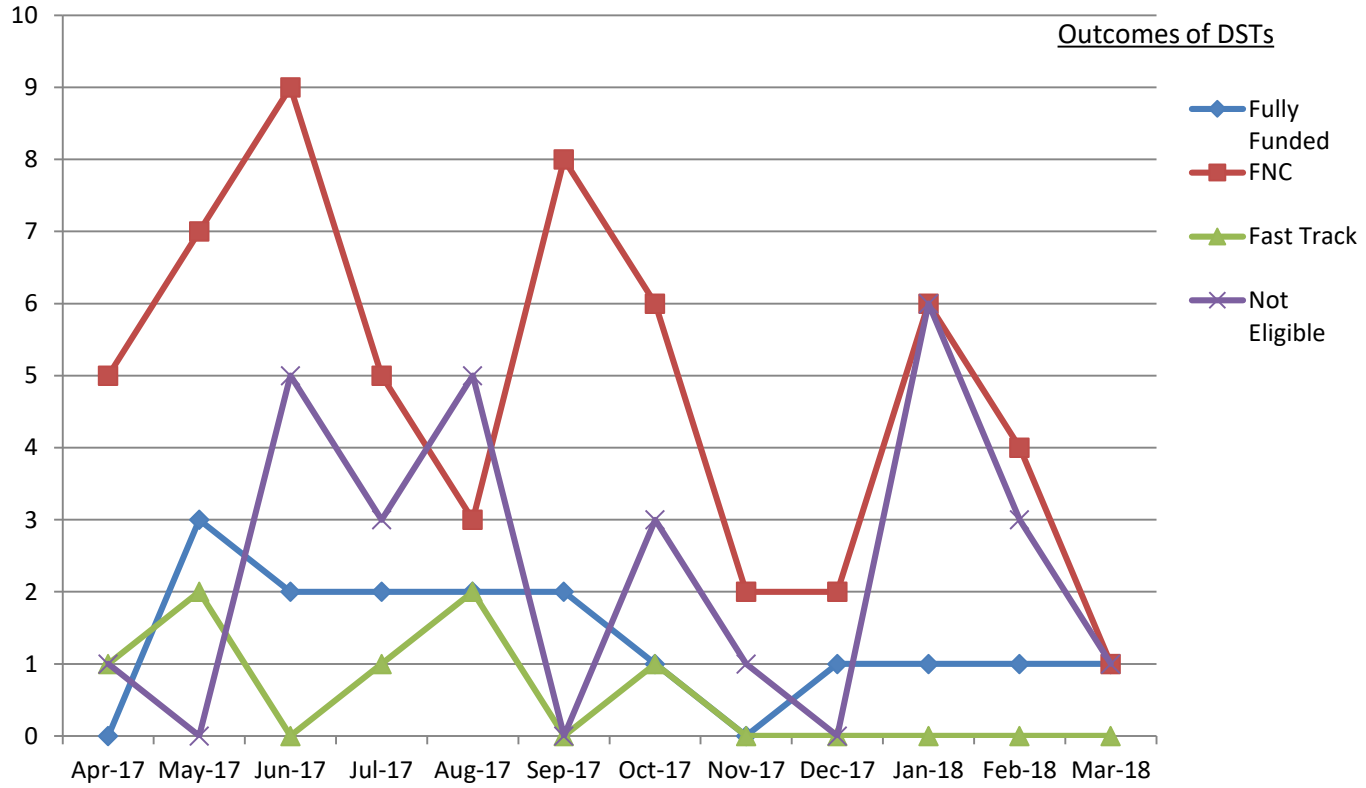
- Since the introduction of D2A (mid August 2017) the average number of referrals for DST's have reduced by 30%.
- The outcomes of DST assessments has changed (monthly averages):
  - 14% reduction in fully funded patients
  - 37% reduction in patients awarded Full Nursing Care
  - 100% reduction in patients fast tracked following assessment
  - 38% reduction in patients identified as not eligible for funding once assessed



Conclusion

- Enables a period of recuperation within a homelike environment
- Better outcomes for patients
- Reduced level of need for long term funding
- Fewer patients are going through the CHC assessment process
- Patients who are transferred to a Spot Purchase bed are high need patients who require complex care packages - 85% of patients qualified for funding
- Packages brokered through North Yorkshire County Council on behalf of health
- Use of SUSD prevents the requirement for ongoing social care needs
- Savings to the whole system
- Reduced Delayed Transfers of Care
- 0% DST in acute setting

Learning

- Requires good working relationships
- Pragmatic approach
- Clear clinical leadership
- Wide ranging and ongoing engagement as a system