Discharge to Assess (D2A) newsletter – March 2019

Special focus – pathway one progress in Derby City

Colleagues working across health and social care on Discharge to Assess (D2A) pathway one in Derby have been widely praised by those involved in developing the services.

Following a period of ongoing change in developing and refining the new joined up service, managers and team leaders have congratulated all involved on a successful transition.

Rebecca Spray, Integrated Community Manager, says: “The new pathway was set up in the city in December 2017 and since then we have worked continually to improve the service. Both staff from Home First and Derbyshire Community Health Services have embraced the changes, and provided valuable input into making them work for everyone, and we have seen health and social care work together for the benefit of patients.”

Lauren Williams, Team Leader, says: “I think the thing that makes us most proud is the way the staff have handled all the changes. They’ve come along with it, and if they can see the patient benefit, they have adapted how they work. They’re incredibly busy in their work but have been able to change processes and work in different ways. We’re very lucky in Derby City to have that.”

Pictured (from left to right): Elaine Wesley, Karen Cooper, Lauren Williams and Rebecca Spray

This view is supported in social care. Karen Cooper, Team Leader of Home First, adds: “It’s certainly better than where we were a few years ago. Social care and health are talking to each other, understanding each other, and we’re showing real joint working. Our work is now really customer focused.”

D2A is the process of transferring patients from acute hospital at the point where they no longer require acute hospital care through different care pathways. NHS England define D2A as: *“Where people who are clinically optimised 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."

In Derby and Derbyshire, there are three D2A pathways with Pathway One being a transfer to home for further assessment to determine a person's ongoing care needs. As well as an assessment in the home, there may be a period of rehabilitation provided by the community health and social care teams. The assessment period is expected to last approximately 14 days.

D2A pathway one in the city has been seen to be working well and there is general acceptance among team leaders that community services have coped better these past few months than in previous winters. However, challenges still remain. One perennial issue is that of determining capacity, about when or how the community can say it is 'full'.

Elaine Wesley, Team Leader Rapid Response, explains: "In hospital this is easy to say – a ward has walls and beds – and when it is full, it is full. It is not so easy to say that when it comes to the community. When our staff have all their visits that are full, and we see numbers of patients rising, and their level of acuity rising, we have no way currently of saying that we are 'full'. It is more of a feeling. We have looked in the past at demand and capacity in therapy and nursing but we know we would benefit from a clearer model that states when peak capacity is reached."

Karen adds: "In the community we have improved our customer flow. Our community care workers are at the centre of the customer journey working to assess, signpost and transfer any of our customers requiring long-term support quickly."

On-going evaluation whether through Friends and Family feedback cards, Home First quality questionnaires or through the new capacity tool is helping leaders assess how D2A Pathway One is being received in the city and where improvements need to be made.

Elaine says: "We've had a lot of change within the services so I think over the next six to 12 months we'll be looking at consolidating what we've got within our services and making sure that our processes are a lot better. We haven't had a huge amount of time to do that through this winter because business has taken over, but now that we are separated into Place and Rapid Response teams, we have got the time to look at our processes and streamline things."

Another challenge is one of a legacy of the previous six-week

service provided. With the change from six weeks to two weeks, with a different type of integrated service provided, both patients and staff need to be accurately informed about how services are delivered today. Indeed, the issue of improved patient communication is going to be taken up by Rebecca and colleagues as one of their improvement challenges for the year ahead.

Rebecca adds: “There are challenges and patient communication is just one of them. In other areas we need to integrate our IT systems better between health and social care. But what we are seeing is health and social care working together better than ever before, and we’re seeing colleagues delivering the services being receptive to change and helping improve the processes so patients experience an improved service.

“We’re getting better at monitoring flow within the service and responding to demand. There’s a lot for everyone to be really proud of about what we’re achieving here. Our goal is to stop patients having a long stay in hospital and getting them back into their own environment so they can rehab quicker, we’re achieving that and improving how we do it all the time.”

Better care closer to home – the Derbyshire way

How does integrated care make a real difference to patients? How can services work together in new ways to help patients return home from hospital quicker? And how does this all feel for patients? In Derbyshire a new initiative is helping people get back on their feet quicker after a period of illness or injury.

Joined Up Care Derbyshire has teamed up with NHS England to show in a new video how local people are benefitting from community support beds placed in two care homes. The beds are for patients who are medically well enough to leave hospital but are not quite ready to return home or to the place they will call home.

In this video, patient Jean and her daughter, as well as members of the health and care team, explain how services are wrapped around the patient, providing rehabilitation and reablement support.

Video weblink
YouTube video weblink
Joined Up Care Derbyshire – further information on community support beds

Using a tried and tested model to make improvements

A meeting of the teams involved in Discharge to Assess (D2A) at Chesterfield Royal, featuring hospital and community health and social care staff, has considered how the system is currently working – and where improvements could be made. In a process called Plan, Do, Study, Act (PDSA) the team members have been discussing what is working well and areas where difficulties remain.

The team was pleased to note that:

- Pathway one was felt to be good, with improved uptake and more people going straight home
- There has been increased use of pathway two beds
- There is good communication between Chesterfield Royal and integrated community teams to follow up queries on documentation. Therapy-to-therapy conversations are happening when required
- There is felt to be timely discharges for therapy
- Chesterfield Royal has adopted the 'home first' mentality and patients are generally being discharged onto the correct pathway
- Less people are being transferred straight into long term care
- The flexibility of community carer response was good
- Trusted assessments have been adopted and documentation was perceived to be 'good', with clear information on referrals
- Community Support Bed Standard Operating Procedure is straightforward for acute admissions
- The majority of patients are going on the right pathway first time
- There have been very few complaints.

The team noted that among areas requiring improvement was the need for some form of written communication for patients and their relatives. A first draft has been circulated to the group members. The group plans to report back to the D2A implementation group on further issues.

For further information, please contact Gill Burrows, System Resilience Lead, Derbyshire Community Health Services, on email gillianburrows@nhs.net and phone 07776 490079.

Latest numbers

The March 2019 executive board of Discharge to Assess (D2A) heard that in January there were 5,546 people discharged from acute hospitals across Derbyshire. Of these, 508 were discharged via the D2A route (meaning that 9.2% of all acute hospital discharges are via D2A). The board heard that the average length of stay for D2A patients while in the acute was 15.4 days. In terms of the different pathways taken, 50.8% of all D2A patients were discharged for further assessment onto pathway one, 14.4% were pathway two, and 34.8% were pathway three.

Find us on the Joined Up Care website

This D2A newsletter and past copies of the newsletter are now all available on the Joined Up Care Derbyshire website at: https://bit.ly/2EvL4ny

The website D2A section also has general information on the D2A process. Please contact us if you think there are useful links or documents which we can add to the site which would be of general interest to a public audience. Thank you.

Feedback

We are always looking to improve the content of our newsletters so if you would like anything including in future additions, please email: anne.wilson31@nhs.net

Joined Up Care Derbyshire

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