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**Health and Adult Social Care**

 **Discharge Presentation**

* **Imagine leaving your home abruptly and never returning to it again.**
* **Imagine being told that you are moving house tomorrow and you have no control over where you are moving to and how much it will cost.**
* **This is what happens to people every day because we assess people in a place that is not their normal environment.**

**‘For older people in particular, we know that longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs. For people aged 80 years and over, 10 days spent in a hospital bed equates to 10 years of muscle wasting (NAO)’**

NHS England – Discharge to Assess & Improving Hospital Discharge

**The Role of the Local Authority – Health and Adult Social Care Assessments**

The Care Act 2014 was introduced to provide a coherent and consistent approach to adult social care in England. It replaced many different pieces of legislation (such as the NHS & Community Care Act 1990 and the National Assistance Act 1948). It introduced a number of principles which are key -

**Wellbeing**

The new statutory principle of individual **wellbeing** underpins the Act, and is the driving force behind care and support.

**Prevention**

Local authorities (and their partners in health, housing, welfare and employment services) must now take steps to **prevent, reduce or delay** the need for care and support for all local people.

**Integration**

The Act includes a statutory requirement for local authorities to **collaborate, cooperate and integrate** with other public authorities e.g. health and housing. It also requires seamless transitions for young people moving to adult social care services.

**The Ten Eligibility Outcomes for Adults with Care and Support Needs**

1. **Managing and maintaining nutrition**

### Maintaining personal hygiene

### Managing toilet needs

### Being appropriately clothed

### Being able to make use of the adult's home safely

1. **Maintaining a habitable home environment**

### Developing and maintaining family or other personal relationship

### Accessing and engaging in work, training, education or volunteering

### Making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services

### Carrying out any caring responsibilities the adult has for a child

**Strengths and Asset Based Approach**

**People have the right to decide how they wish to live. We all make individual choices in relation to activities such as when and how we undertake personal care, when and what we eat, when and where we go. Some of these choices may not be the ones we would make but people have the right to make informed choices about how they live.**

**People are resilient and often will have coping mechanisms and strategies. They are the experts on their lives. They have ambitions, skills and**

*Strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person’s strengths and assets.*

**Discharge Options**

**Return Home**

This could be because the person is independent and self-caring, because they have ongoing therapy or nursing needs that can be met in the community, because they require a low-level of care and support such as Age UK or Possability People, because their existing care and support needs remain unchanged and their current service provision can be restarted or because they have increased care and support needs but these can still be met in the community.

**Residential Care Home placement (including specialist dementia care)**

If it is felt that the person has increased care and support needs that mean they would not be safe overnight or between care calls then a Residential Care Home placement may be necessary.

**Nursing Care Home placement (including specialist dementia care)**

If it is felt that the person has increased care and support needs that mean they would not be safe overnight or between care calls and require registered nursing care then a Nursing Care Home placement may be necessary.

**DTOC’s**

‘As the population continues to age, demand for care will increase and the types of care needed will change. The Office for National Statistics predicts a 36% growth in persons aged 85+ between 2015 and 2025, from 1.5 million to 2 million. This is expected to lead to a substantial increase in demand for care home services’

‘The current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority[1](https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report#fn:1) (LA)-funded residents are unlikely to be sustainable at the current rates LAs pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs.’

(Competition and Markets Authority November 2017)

‘Despite 82 per cent of councils increasing fees paid to providers last year, our own survey reveals around two-thirds of councils have had residential and nursing home closures, and more than half have had care providers hand back contracts.’

(ADASS Care Home Funding Shortfall 2017)

The delay in discharging older patients from hospital is a systemic problem with a rising trend - the National Audit Office reported that between 2013 and 2015 recorded delayed transfers of care rose 31 per cent and in 2015 accounted for 1.15 million bed days. As we have just seen we know that for older people in particular longer stays in hospital can lead to worse health outcomes and can increase their long-term care needs.

**Discharge to Assess**

‘Put simply, discharge to assess (D2A) is about funding and supporting people to leave hospital, when safe and appropriate to do so, and continuing their care and assessment out of hospital. They can then be assessed for their longer-term needs in the right place.’ (Professor Vernon 2016)

**The Aims**

People’s health outcomes improve as more people will be able to live at home for longer if services are designed for discharge to home to be the default.

• People’s length of stay in a hospital bed decreases due to longer-term assessments taking place in a more appropriate situation and place. Evidence suggests this should reduce deconditioning and improve outcomes significantly since 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80.

• Encourages NHS and Adult Social Care leaders to work together for the best outcomes and experiences for people through joint approaches to discharge to assess. This may include joint commissioning or funding.

• Improves system flow by enabling patients to access urgent care at the time they need it.

• Reduces duplication and unnecessary time spent by people in the wrong place.

• Enhances working relationships between the health, social care and housing sectors and increases development opportunities for their staff.

**The Benefits for People**

* Putting people and their families at the centre of decisions, respecting their knowledge and opinions and working alongside them to get the best possible outcome.
* Taking steps to understand both the perspectives of the patient and their carers and the communities they live in, their needs, aspirations, values and their definition of quality of life.
* Ensuring the person and their family receive clear information about their care within the acute setting including what will happen on discharge and who to contact if there are any problems after discharge.
* Ensuring continuity of communication so all members of the team are working to the agreed care plan, until discharge from the pathway.
* Sharing responsibility, risks and skills across partners leads to innovative and creative solutions that deliver safe, effective care and support.

**Pathways from Discharge to Assess**

* 1. **Independent and Self-caring** – The aim is to try and enable as many people as possible to regain their independence and to be self-caring.
	2. **Short-term Care and Support** – If someone was previously independent or had a low level of care and support in place then could Age UK be appropriate? Perhaps they are still recovering or have a short-term need.
	3. **Ongoing Health needs** – If someone has ongoing health needs then could IPCT be appropriate?
	4. **Further Reablement** – If someone is improving and their care needs can continue to be reduced then could Independence at Home be appropriate? This could be to continue building confidence or
	5. **Ongoing Care and Support** – If someone previously had a care package in place or their situation has significantly changed then they are likely to need formal care and support and a social work assessment.

It gives local authorities a duty to carry out a needs assessment in order to determine whether an adult has needs for care and support. An assessment -