COVID 19 Hospital Service Discharge Requirements – Frequently asked Questions – Discharge to Assess and Therapy – 30 March.

Discharge to assess

Who will make the decision that someone is to be sent home?

- The consultant in charge of their care will decide. S/he should set individualised clinical criteria for discharge within a clear clinical plan which means that the patient can be discharged even if the particular consultant is not present.

Won't clinicians feel pressure to declare someone to be medically fit for discharge, putting patients at risk?

- The guidance sets out criteria, agreed with the Royal Colleges that specify the conditions that require a person to be in an acute hospital.
- If a person does not meet any of these criteria, then they must be discharged unless there are person-specific compelling clinical reasons why they cannot be discharged to prevent delay.

How do we identify the people who should be discharged?

- All patients in acute beds will be reviewed twice a day. Clear criteria to determine which patients should be in an acute hospital have been included in Annex B of the discharge guidance document. These provide the framework for decision-making.

What percentage of people can safely go home?

- Under the discharge to assess model, 95% of people over the age of 65 who are admitted to hospital can go straight home:
    - 50% can go home with minimal or no support
    - 45% can go home with social care support
- Around 4% will need short term rehabilitation in a bedded setting (step down)
- Only 1% require long term residential or nursing care

You reference 95%of people being discharged to their own homes (Pathways 0 and 1). What are these assumptions based on?

- Work by Professor John Bolton, looked at discharges of 1,000 people over the age of 65[1] and concluded that if the discharge to assess process was delivered in full and the pathways fully optimised, that this pattern of outcomes would be seen.
- We know that these are not the current pattern of outcomes, but they are deliverable if this process is followed, relevant local partners are engaged (including the VCS) and a balanced approach to managing risk is taken.

Who will make decisions about care?

- The single coordinator will be responsible

Adult social care are being asked to move assessment staff away from hospitals to support Discharge to assess – but surely some social work presence is still needed in hospital?

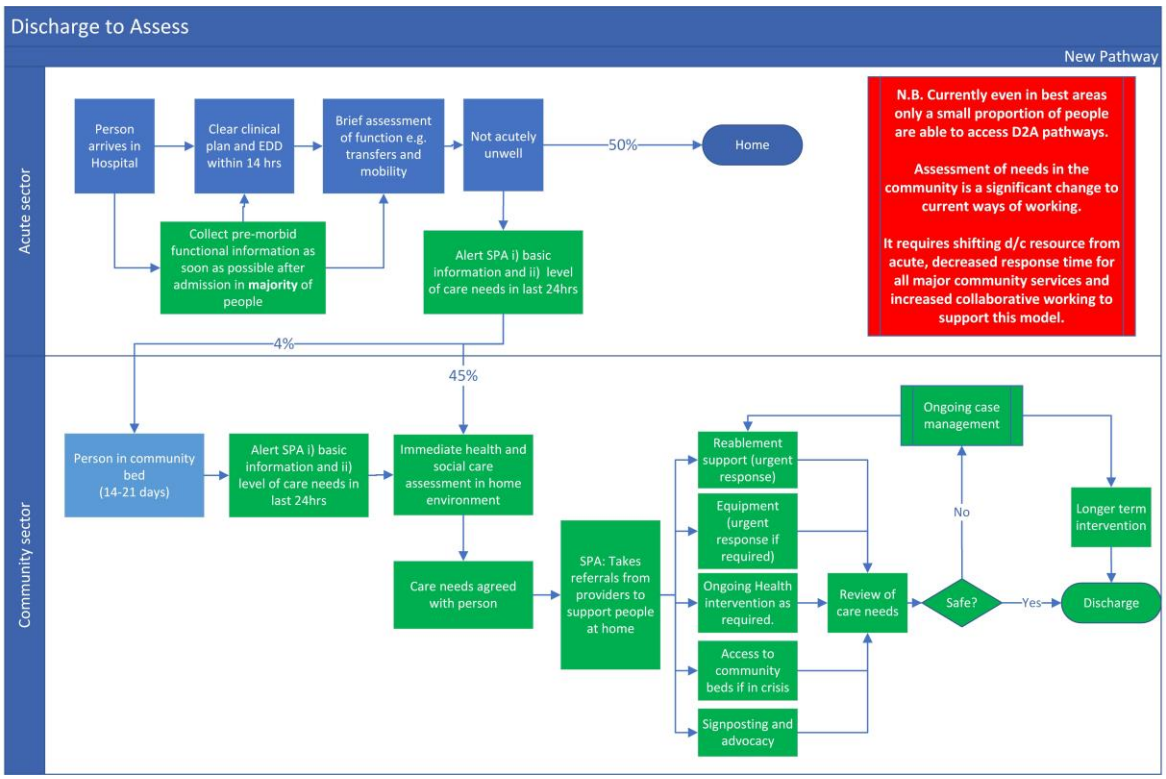
- Assessment will not be happening in acute hospitals, it will be happening once the person has been discharged. So social care staff will spend the vast majority of their time in the community reviewing placements and assessing for long term care needs. Social workers will only be required for safeguarding and Independent Mental Capacity Advocates (IMCA) cases.

[1] https://ipc.brookes.ac.uk/publications/pdf/Some_key_messages_around_hospital_transfers_of_care.pdf

How do you make sure that care packages are not over specified?

- There will be regular reviews of care packages once someone has been discharged. Needs frequently change as people recover. Adjustments will be made to decrease or increase support during the reablement/rehabilitation phase.
- The single coordinator will have appointed a case manager to every patient who should review care daily. This should be done virtually wherever possible.

An overview of the model is set out below



Therapy

Are there good practice examples of discharge to assess (D2A) around the country that we can base our service on?

- There are a number of good practice examples on the Better Care Exchange. Guidance is also available through the High Impact Change Model for managing transfers of care

What is the basic amount of information that we should collect on initial assessment?

- Use a describe model (not prescribe), to collect information on what the person is like today, in front of you. You will need to collect information on what the person was previously like two weeks prior to admission. This will help align the person to a pathway (0 – 3). Brief functional assessment of person during initial assessment to describe current function.
- The level of care over the last 24 hours will help to provide a relatively accurate picture of how a person has been functioning on the ward. But the assessment should be focussed on how a person functions in their home environment.

Do we have the backing of our professional bodies (OT and PT) in terms of positive risk taking and discharge?

- Yes they do. We have been in touch with both the Royal College of Occupational Therapists and the CSP in relation to this guidance. In principle they have supported discharge to assess and a move of services to the community for some time. The RCOT document *embracing risk; enabling choice* will help with some of the questions staff may have.
- It is about balancing the risk of sick patients who may die not being able to access acute care with the risks of sending people home. The safety netting described in the document will be key.
- The HCPC has written a position statement entitled 'Supporting allied health professionals and allied health professional support workers during the COVID-19 epidemic in the UK'. It is recommended that all AHP's read it to see how both regulatory and professional bodies are supporting us through this pandemic. it can be found here: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/letter-supporting-ahps-19-march-2020.pdf

If a person's normal place of residence is a care home, presumably this will be their default destination?

- Yes

Should we still collect data relating to patients we see? And if so, what data is important to collect?

- The Requirements set out basic information on the data that will be needed. Further guidance will be made available shortly. Systems should be recording details of agreed support that is funded under these arrangements.

Should we be discussing advanced care plans before discharge with our more vulnerable patients?

- It is good practice to talk generally about the need for this before discharge. The case manager should be informed of the need for this so that detailed planning can take place after discharge.

Will we need to update our contracts if we currently work for the acute Trust but are now expected to work for the community provider?

- Employment will stay with the current employer and they, or the overarching government insurance scheme, will cover you for the things you are doing differently. In times of Emergency this is acceptable. Your contracts will all have an overarching condition to meet the needs of the service as required, and at this difficult time, these changes are required.

For how long will discharge to assess (POC) be free for each individual?

- This will be kept under review. See the section on funding and funding flows

Will there be a limit to the amount of therapy sessions per day or per week for the people at home?

- There are no national limits for therapy, the key consideration is the balance of risk. As this pandemic unfolds it is highly likely that all services will come under extreme pressure. System leaders need to keep communicating to help manage the risk across the whole health and social care system. Individual clinical judgements will be needed to be made to ensure we keep people safe. If clinicians identify a patient safety risk, they should escalate through the locally agreed route.
- People in their own homes will derive therapeutic benefit from carrying out day to day tasks at home. Some interventions may therefore be reminders. Some people will require more specialist interventions (e.g. people recovering from a stroke).

Who will take ownership of the whole D2A pathway? Acute or community? Who will be the SRO?

- The delineation of responsibility to coordinate and manage the discharge arrangements are expected to be:
    - Pathway 0 – acute discharge staff lead
    - Pathways 1, 2 and 3 – community staff lead
- Community health, social care and acute staff need to work in absolute symmetry (and include housing professionals where necessary) to ensure all patients are discharged on time.

What do we say to patients and/or their relatives or carers if they do not agree with our decision regarding discharge, either to their own home or an interim bed?

- It is recognised that issues of patient choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge (particularly if moving to a residential or nursing home). During the COVID-19 response there will be suspension of all choice protocols. Patients will not have a choice about the package of care. The following leaflets have been produced to support the communication of this message (See also Annex J of the guidance).
    - Leaflet A – to be shared and explained to all patients on admission to hospital
    - Leaflet B – to be shared and explained to all patients prior to discharge, this is split into leaflets:
        - B1 for patients who are being discharged to their usual place of residence
        - B2 for patients moving on to further non-acute bedded care

Do we need special insurance if we are taking people and equipment home in our own vehicles?

- Using your own vehicle does require business insurance. Some insurance companies will have a small additional charge for this other companies provide for free. Any additional cost should be reimbursed by your trust.
- Although a simple solution transporting people home in your own vehicle does have a number of wider implications. You should review your local trust policy to ensure you can be reimbursed for any costs e.g. petrol and insurance and are not putting yourself or your patients at risk.

Can we get fast access to parking permits to allow us to park near to peoples' front doors on discharge (especially in cities where there are parking restrictions?)

- This should be agreed locally with senior executives. Local authority colleagues should be able to assist with this.

What do we need to do with regards to cleaning if we are in someone's home and they no longer need their walking aid?

- There are several equipment suppliers across the country. Each equipment supplier will have their own locally agreed process. Most suppliers are/have updated their guidance in regard to equipment collections and infection control.
- This has minor variations and so we cannot accurately answer this important question. Please look at and follow the updated local guidance. If you are unable to locate it please escalate locally.
- Consider having a supply of alcohol wipes in pool/fleet/own vehicles to allow for on-site cleaning as required

Is there an expectation that equipment services need to be able to deliver the critical equipment within 4 hours or is this in relation to a clinician/ OT visit within this time?

- The guidance outlines that:
    - The single coordinator needs to ensure there is access to sufficient equipment to support discharge of people with reablement or rehabilitation needs at home.
    - The local commissioner for NHS and Social Care Equipment must ensure:
        - Local equipment services (across the NHS and local government) have a sufficient supply of the more common items of equipment used to support people with reablement or rehabilitation or longer-term care needs.
        - Quick access to this (same day where needed) and that this is available seven days a week (supported through mutual aid with neighbouring areas or redeployment of community-based staff if required).

Is there any other national guidance coming soon relating to the way we work?

- Separate guidance on Community Health Service prioritisation is also being published, setting out the activities that can be stopped for the duration of this incident and those that must continue.
- Guidance will be published shortly on procedures for people carrying COVID-19 who are being discharged from hospital.

- Guidance has been published on actions for residential care, supported living and home care providers https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-on-residential-care-provision
- The COVID 19 Hospital Discharge Service Requirements set out amendments to the existing CQC guidance on operation of Trusted Assessment at annex C. Key changes from existing arrangements are:
    - All hospitals will train additional discharge staff to operate as 'Trusted assessors'. Trusted Assessors will continue to support care providers with discharge arrangements. The additional staff will supplement Trusted Assessors in existing schemes.
    - Most hospitals already use trusted assessor schemes for discharges to care homes and care at home services in their areas. These should be kept up to date in local NHS Discharge to Assess (D2A) arrangements. This should be prioritised.
    - Over this period CQC's priority is to continue to check that people are safe. Where we have serious concerns, we will use inspection and other processes to do so.
    - Registered providers and managers will need to have confidence that legal requirements for assessments will be met, and that particular consideration will be given to safety and infection control-related needs during this heightened period.