CARE

NHS

The Discharge to Assess pathways

in Bristol, North Somerset and South Gloucestershire

People recover best at home after a stay in hospital because they:

- Can maintain independence and muscle strength
- Avoid increased risk of infections, pressure sores and incontinence
- Are able to do more for themselves and be more active in familiar surroundings
- Enjoy better sleep and better mood among home comforts, family and friends

In addition, assessments in a person's home environment give a clearer picture of their needs.

That's why we always think 'Home First' and do all we can to enable people to recover in the place they call home, supported with any necessary monitoring or rehabilitation.

The pathways

Pathway 0: Home without formal support needs
Most people will go home on this pathway

Person discharged to the place they call home with no new NHS or social care support, but may receive informal support from friends, family or VCSE.

Pathway 1: Recovery and rehab at home
The vast majority of people who need formal support at discharge will go home on this pathway

Person supported to rehabilitate at home with tailored package of therapy and any other support needed.

Pathway 2: Rehab to home
Only a few people will leave hospital on this pathway

Person needs high level of support or rehabilitation that cannot be provided at home and continues recovery in community rehabilitation unit before returning home.

Pathway 3: Community bed
Very few people will leave hospital on this pathway

Person needs 24-hour bed-based care which is likely to be ongoing. They are cared for in a community assessment bed while long term needs are assessed and arranged.

See the glossary of key terms overleaf

Identifying the **best way** to get each person home

1. Person admitted and discharge planning begins
2. Discharge needs described in Transfer of Care Document
3. Community Transfer of Care Hub professionals identify the best pathway
4. Ward staff updated and discharge arrangements put in place
5. Ward staff discuss complex cases or any concerns with case manager

Pathway 1:
Recovery and rehab at home

1. Person allocated date for discharge
2. Community practitioner assesses person at home
3. Individual rehabilitation plan and any other support put in place as necessary
4. Longer term support needs assessed and put in place if needed

Pathway 2:
Rehab to home

1. Person transferred to community rehabilitation unit
2. Care and rehabilitation needs assessed
3. Ongoing rehabilitation while discharge planned
4. Further recovery at home or other setting

Pathway 3:
Community bed

1. Person waits for an appropriate placement
2. Therapy assessment and plan put in place
3. Social care practitioner supports longer term care planning
4. Person remains in community bed until next steps are in place

Voluntary and community sector support

Many people going home on Pathway 1 could go home on Pathway 0 with VCSE support. This would reduce waiting times for people who do need rehabilitation at home. The range and accessibility of local VCSE services is expanding and there are lots of ways you can access this support for the people in your care.

Acute hospital link workers

We are introducing link workers in each of our acute hospitals. They know the VCSE sector well and can ensure that people get the support they need for a smooth and timely return home. Case managers and therapists can refer people who may need additional support for discharge to their local link workers.
This includes:

- Advice on housing, social care, power of attorney
- Support with benefits, allowances and grants
- Home adaptations, decluttering, handyperson services
- Help around the home, cleaning, shopping
- Support for carers
- Local activities like befriending, walking clubs and social groups
- Tech enabled care
- Transport.

The link worker will review the information and discuss with the referrer, if necessary, before visiting the person for a friendly chat to discuss the range of support available. They can provide signposting and make arrangements for additional support as appropriate.

Contact your link worker:

- Southmead Hospital: linkworkers@nbt.nhs.uk, 0117 928 1557
- Bristol Royal Infirmary and Weston Hospital: referral processes will become available - please check the Trust intranet in due course. Please note, in North Somerset link workers are known as community navigators.

British Red Cross

Among other organisations, the British Red Cross offer valuable services to help support people being discharged home. These include:

- Help to get home and settled in
- Daily visits for a few days to check welfare and make lunch, to prevent readmission
- Practical support such as shopping
- Emotional support such as telephone befriending.

To make a referral for British Red Cross home support services, call 0117 301 2601 or email firstcallbristol@redcross.org.uk

Discharge Support Grant

A grant scheme offering one-off payments of up to £1,200 is available to help people return home following a hospital stay. It is available to cover some of the costs that might be a barrier to returning home, for example:

- Expenses that enable a friend or family member to help, such as the costs of:
  - childcare
  - a dog walker
  - fuel, taxi or other travelling costs
  - taking time off work
- Equipment not covered by other schemes
- Short term personal care support.

Once approved, payment can be made to the person, a family member, carer or voluntary supporter within two days of discharge. They grant does not need to be repaid and will not impact on Universal Credit or any other benefits.

Referrals should be made to Sirona's Partner2Care team who will work with the person and their family or carers to develop an individualised package of support.
Call 0800 111 4167 or email sirona.partnertocare@nhs.net

Key terms

There are some common terms used throughout the Discharge to Assess pathways:

- **ToC Doc:** Transfer of Care Document – enables ward staff to describes a person's functional abilities and recovery needs. It is used to identify the right discharge pathway and to support handover to the team receiving the person.
- **CToCH:** Community Transfer of Care Hub – a team of clinicians and social care professionals that match a person's needs as described in the Toc Doc to the pathway that will best meet those needs, with a focus on 'home first'.
- **IDS:** Integrated Discharge Service – hospital team, bringing together health and local authority colleagues, to coordinate arrangements for a person's discharge.
- **VCSE:** Voluntary, community and social enterprise organisations.

Version 2.1 April 2023 produced on behalf of Bristol City Council; Bristol, North Somerset, South Gloucestershire Integrated Care Board; North Bristol NHS Trust; North Somerset Council; Sirona care & health; South Gloucestershire Council; University Hospitals Bristol and Weston NHS Foundation Trust; and local voluntary, community and social enterprise organisations

For more information on the D2A pathways and up to date patient information materials, visit bnssghealthiertogether.org.uk/d2a