East Lothian Community Care Forum

Evaluation of the East Lothian Discharge to Assess Service

Community Action Research

"We have substantial evidence that this form of research has built the capacity of individuals and communities to evidence the need for and achieve positive change in the services or support provided to their community.

By community led we mean research defined, undertaken, analysed and evidenced by members of the community themselves. It is therefore research of and by the community and not, as is traditional, on and to the community."

East Lothian Community Care forum is the independent voice of service users that, among other duties, acts to provide the local authority with an independent service users' point of view of the services provided.

In November 2016 the East Lothian Integrated Health and Social Care Partnership commissioned East Lothian Community Care Forum to carry out independent research to evaluate the first year of the Discharge to Assess service. The research was carried out between April - June 2017.

Letters were sent out to 309 patients who had used the D2A service. All were invited to give their feedback on the service through telephone or face to face interviews. 26 people responded and formed the basis of the patient report. This was a 'talking points' survey (an approved Scottish Government research approach), using a questionnaire designed by the community researchers. This approach attracts fewer respondents but gives much more qualitative information.

In order to get a more complete picture of the D2A service we also approached all staff who had referred to the service to fill in an online questionnaire. 39 NHS staff responded.

Contents		Page
Report summary With Findings, Conclusion and Recommendations		3
Context		5
The Data		6
Patient Feedback		6
Stakeholder Feedback		14
Appendices		
Appendix 1	Statistics/Graphs – Patient Data	21
Appendix 2	Statistics/Graphs – Stakeholder Data	25
Appendix 3	Discharge to Assess Referral Criteria	27
Glossary		28

Findings

- The evidence from patient respondents shows that the Discharge to Assess service is a well-run, accessible, friendly service in delivering positive outcomes for its patients. It provides assessment and support to manage at home following hospital discharge. Patient respondents identified safety, increased confidence, resolving issues specific to their home environment and boosting moral as key benefits that helped their recovery.
- The D2A staff team was highly valued by patients for their personal approach, professionalism, flexibility and commitment to their work. They were also able to use their own local knowledge to successfully refer patients on to services that could offer specific longer term support.
- Most NHS staff who referred to the service found that it worked well for them and their patients. Staff referring to this service appreciated the education sessions that were delivered about the service. They found the informal referral approach, where they could discuss cases and make referrals by telephone directly with the D2A staff, particularly helpful as they didn't always have access to a computer, nor indeed time to fill out forms.
- As the name suggests the D2A service is designed to accept referrals for in-patients. It is no surprise that comments from A&E department staff highlighted difficulties referring patients who had not yet been admitted. Success with A&E referrals was dependent on whether one got to speak directly to a member of the D2A team who did try to accept such referrals if they met all the other criteria. If not, their request was refused by the Hub receptionist on the basis that it did not meet the written criteria.
- All patient respondents said that the service shortened hospital stays. Evidence from this evaluation showed that most patients want as short a stay in hospital as possible and very much appreciated services that help get them back home more quickly and, above all, safely and with support.

  Of the NHS staff referring to the service, most agreed that the service shortened hospital stays. Staff who worked with patients with more complex conditions and had longer stays in hospital reported that referral to the D2A service lessened patients' and their family carers' anxiety about discharge. Furthermore NHS Staff said that the provision of the service also notably reduced the risk of early re-admission.

- D2A criteria clearly states that the service cannot accept in-patients who require *new* packages of care. NHS Staff recognised that the D2A service offered patients, whose need for a package of care have been assessed as borderline, a further opportunity to see how they could manage independently in their own familiar surroundings.
- However, many staff also commented that not providing short term, episodic social care is a short coming of the service as it limits the number of patients who can take up the opportunity to return to live independently in their own homes, excluding those who might only require short term 'care at home' support.
- A leaflet was given to patients on the first visit. A few patients who contacted the service by phone reported difficulty getting through because the number 'did not take incoming calls'. One patient reported that they were able to leave a message on an answer machine but there was a delay in getting a response.

- Staff referring to this service commented about the benefit of having a D2A information sheet and criteria for referral on their systems particularly for new staff or infrequent referrers.

Conclusion

The statistics and comments both show that this service achieves its intended outcomes. In an era where pressure on hospital beds is critical and the Health Service is looking to expedite people more quickly and safely back home, the D2A service supports that objective well.

Recommendations

Any further development of this service should consider the feedback from this document:

- Provide a more extensive service that broadens its remit to formally consider patients from A&E who have not yet been admitted but otherwise meet the criteria, thereby preventing possible admissions. A&E staff also reported that extension to provide a weekend service would benefit their patients and further reduce possible admissions.
- Consider options/opportunities of accessing episodic, very short term social care to support borderline package of care cases. This would also support and give reassurance to patients and family members, especially those who are older, who could potentially face an increased caring role.
- Develop the D2A telephone system to provide a consistently available answering service.
- This research has identified the difficulty that service users and carers have in returning health and social care equipment after use. The East Lothian Community Care Forum knows this issue is wider than the D2A service and should be addressed at a strategic level.

Context

The integration of Health and Social Care services is set out in the Public Bodies (Joint Working) (Scotland) Act 2014[1], in addition to the establishment of a local health and social care partnership as a single management system, the adult health and social care services are managed though a single budget.

As part of this approach, Discharge to Assess, under the umbrella term ELSIE (East Lothian Service for Integrated Care of Elderly People) facilitates early discharge from hospital settings for patients who no longer require medical support from the hospital.

In East Lothian Discharge to Assess define their service as:

'An Occupational Therapy (OT) and Physiotherapy (PT) led service facilitating discharge from hospital where there is an element of therapy assessment remaining that would otherwise delay the discharge of the patient home.'

Discharge to Assess (D2A) in East Lothian has been operating since May 2015. It currently operates Monday to Friday, 8am – 4pm.

It has a staff team of Occupational Therapists (OTs) and Physiotherapists (PTs) who cover East Lothian. These staff teams also cover other teams under the ELSIE umbrella such as Hospital at Home. The Occupational Therapy Teams are structured differently from the Physiotherapy teams: OTs work in hospital settings with inpatients or in the community. Physiotherapists cover a geographical patch where they work in domiciliary settings with referrals from Hospital at Home, D2A, GPs etc.

A leaflet with referral information has been cascaded to all hospital referring sites. Awareness sessions were delivered and information is on their shared drive. Staff in the inpatient setting can refer by telephone.

Guiding criteria for this service are:

- The patient can transfer and mobilise (with or without equipment).
- The patient has an outstanding area of urgent therapy assessment that would otherwise keep them in hospital to be completed.

309 patients have used the service since it began in May 2015. A small percentage is re-referred (no statistic available). The team has since gained additional winter monies to increase staffing which has enabled it to develop further.

[1] http://www.legislation.gov.uk/asp/2014/9/pdfs/asp_20140009_en.pdf

The Data

Patient data

Referrals from Hospital and length of stay in hospital

All patients were referred from hospitals, mainly the Edinburgh Royal Infirmary, some from the Western General, and other local hospitals such as Roodlands and Belhaven.

Two of the patients were in hospital for a brief time – a few hours to an overnight stay. Of the rest, a third of patients were in hospital for up to a week, a third up to 3 weeks, and a third from 4 weeks to several months. The longest stay was 6 months in various hospitals. The spectrum of responses reflects the length of stay. Those who were in hospital briefly required less input from the service than respondents who were in for a longer time with more complex health issues and who required more support in place when they got home.

The findings below show combined views of respondents under the themes:

- **Patient understanding of the service,**
- **Personal Outcomes,**
- **Service Performance.**

Patient understanding of service and referral process

Question 2a & b: Did the person referring you explain about the D2A service?
Did they explain why you were being referred?
Question 4: How well did the D2A staff member explain what to expect from the service?

In response to **questions 2a & 2b about getting clear information about the service from staff referring to the service**, patients were, on the whole, clear that they were being referred to a service that would help them settle in, ensure they were safe in their home environment and were equipped and supported to manage day to day living. Although many didn't understand that this was a separate service or knew the name of the service they understood that help would be at hand when they got home.

1. *We never heard the phrase Discharge to Assess. They said someone would look after us when we got home. They went to assess the house before my partner came home to make sure it was safe and had the things my partner needed because she had other health issues, particularly balance issues as well as recovering from a broken shoulder.*
2. *I'm not really sure about this. I came home from hospital at a later date than planned. I had a mini stroke. I did get home visit from an OT and a Physio. Your letter was the first time I heard the term D2A.*
3. *Yes they said the furniture would be raised and I would have some equipment to help me.*

In a few cases, either the explanation was very brief or the patient was unable to take it in.

4. *They probably did but I didn't take everything in I was quite ill in hospital.*

5. *Discharge was all agreed but no explanation was given. Then when I came home there were seven people in my home and this upset me. There were people fitting a deep freeze and delivering food.*
6. *It was a quick conversation so not really knowing what to expect.*
7. *I was in a confused state due to an infection.*
8. *I can't recollect.*

One particular quote showed that staff were frank about the consequences of a longer stay.

9. *They explained to my family, get out now or lose your care package*

In response to question 4 about how well the Discharge to Assess service communicated with patients when they arrived home and what to expect from the service, two thirds of respondents scored 4 or 5 out of 5 stars.

1. *They were very clear about how they could help and support me.*
2. *The staff were very good at explaining things to me.*
3. *They were very clear and helpful about making me safe at home.*
4. *I felt I got a lot of support coming home. They gave me lots of equipment and explained everything really well. Most importantly they helped boost my moral.*
5. *It was very clear and we knew it was a time limited service.*
6. *Jo and Ali came they were great. They identified things which would make it easier for me around the house - stick, raised step for shower, handrail for stairs.*

Of the few respondents who gave lower scores most said it was because they were not feeling fully alert at the time:

1. *I have no recollection of visits.*
2. *Must admit my capability to digest the information afforded was limited at the time!*
3. *Mind you I wasn't feeling my best and might have missed stuff.*

One patient did not really understand what they were there to do.

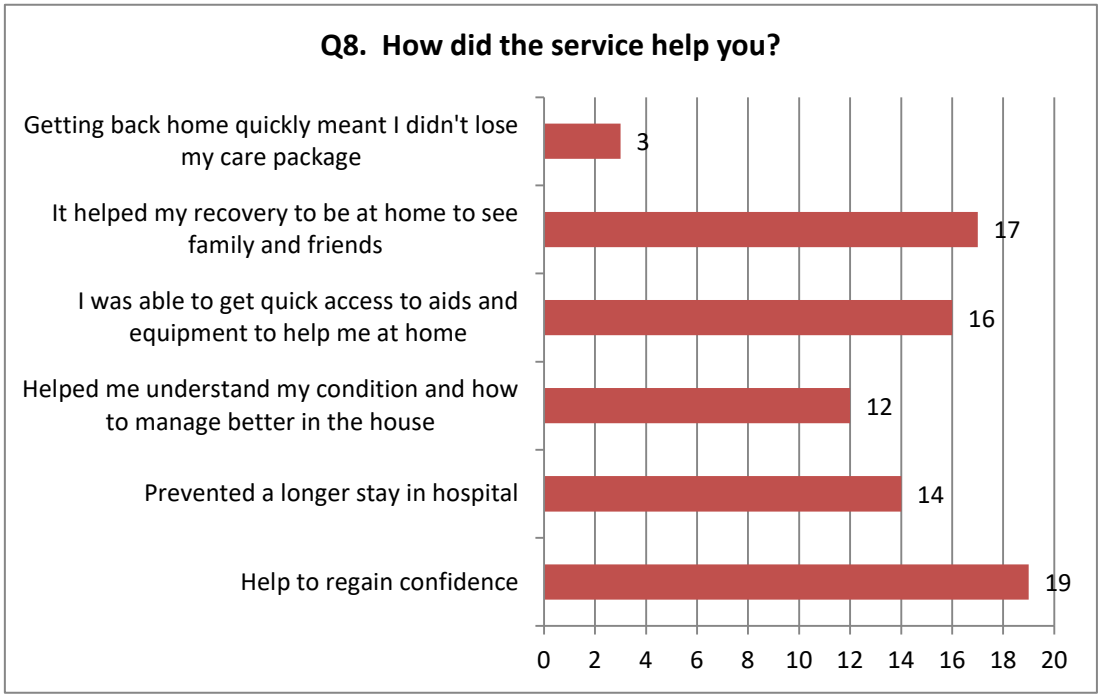
Reflections:

The evidence shows that most respondents were happy with the information they got from referrers and Discharge to Assess Team.

Our sample indicated that there was a still a degree of confusion for some respondents. This was due to some patients reporting that they were not feeling their best. A small leaflet to refer to later, outlining what the service does and how to contact them is left on the first visit. It may be helpful to those patients and also their carers, particularly if they are not present at the time of the D2A team visit, to check that the information has been absorbed and shared.

Personal Outcomes

Question 8: How did the service help you?
Question 9: What would have happened if this service hadn't been there?
Question 6: Did the service refer you on to other services that could offer support?



Help to regain confidence was the most important outcome cited.

1. *Without their help I wouldn't have been able to go anywhere and would be prisoner in my house. They gave me confidence to get around.*
2. *It was important to know that someone cares and is looking after my wellbeing at a vulnerable time. They didn't just say 'you've had a stroke so carry on'…it was very positive in that they said 'you've had a stroke and we can help you manage it….and they did!' It was all perfect except the drop at the end.*
3. *Their support with exercises really helped me to manage better and I feel more confident at home as a result. I didn't like being in hospital so getting home really helped my recovery. They had an alarm fitted at home and it makes me feel so much safer to know that help is at hand when I need it.*

Interestingly, **it helped my recovery to be at home and to be amongst family and friends** was cited as a close second benefit to the above.

4. *It definitely helped her recovery to be at home and be able to see her family and friends.*

Getting access to aids and equipment was another of the main benefits of this service followed by **help to understand my condition better.**

For those who had longer stays in hospital and who had more complex health issues **help to understand my condition and how to manage better in the house** was an important benefit of this service.

5. *Their encouragement was reinforcing my recovery.*
6. *They were able to identify fast gains.*
7. *All of the above were so important. I'm usually stoical but after my stroke I was very vulnerable and the visits were really helpful and a lifeline.*

About half of respondents felt that the service **prevented a longer stay** in hospital.

This concurs with responses from **question 9: What would have happened if this service hadn't been there?**

8. *She would definitely have had a longer stay in hospital without the support of this team. Especially the equipment provided helped her manage around the house.*
9. *Definitely I would have been much longer in hospital which I didn't want. I was so glad to get home*
10. *Once it was established that home staircase was suitable, early discharge was possible/encouraged.*
11. *Mum would have gone into a care home.*

For others the outcomes were not necessarily a shortened stay in hospital but, as mentioned above, the confidence to manage at home after a spell in hospital. The quote below gives a clear illustration of a before the service existed and an after viewpoint.

12. *We felt so much better supported because of this service. Having access to this team straight away compared to the last time when we felt very much in the dark. It is a night and day situation.*

Longer term support.

In response to **question 6**: **Did the service refer you on to other services that could offer support?** A third of respondents said they were referred on or told about other services that could support them over a longer term.

1. *Speech therapy which Mum received for a while and helped.*
2. *Chest, Heart and Stroke support group.*
3. *Support for stopping smoking.*
4. *8 weeks of exercise classes at the Loch Centre.*
5. *Home care support 4 times per day up to 45 mins per visit.*
6. *They were fantastic. They helped us make the appointments that we needed to see a consultant. They referred my partner onto organisations that could help her with smoking cessation and her alcohol intake.*
7. *The East Lothian exercise class.*
8. *They got carers in to visit me after my stay in hospital and increased my visits to twice a day.*
9. *The Stroke Liaison Nurse.*
10. *The Frozen Food Service.*
11. *The Community Alarm system.*

A third of respondents said 'no' to this question, many because they said they did not require further help at that time. However, some respondents said they could have benefited from support of a more social care nature.

Evidence from this was backed up by responses from **Q. 11: Was there anything else the team could have helped you with?**

1. *Help around the house.*
2. *I have a sore back and sore legs that I can hardly walk. Although they couldn't help with that it would have been helpful if the care was more holistic and I could get support with my other complaints.*
3. *My 84 year old neighbour gives me a lot of care and support and she sometimes finds it too much.*
4. *Biggest problem is the phone. The alarm is in the hall and because there was only a partial re-wire carried out there are no electrical sockets in the living room for an extension. I have fallen twice getting up to answer the phone.*
5. *I have neuropathy and may fall over. I am in a wheelchair and no longer able to self-propel. I would value assistance to get out more.*
6. *Longer term support for OT..or easier access to OT as and when Mum required.*

Reflections:

All respondents' personal outcomes were positive – the service does what is says on the tin – assessment to manage at home following hospital discharge. Respondents identified safety, confidence, resolving issues specific to their home environment and boosting moral as keystones to their recovery.

It is also important to understand the spectrum of need - respondents who had longer stays in hospital appreciated the help to understand their condition and how to manage safely in their home environment. For those with shorter stays, a visit from the team was sufficient to give reassurance and was much appreciated.

The staff team was very diligent in helping people to access other services that could support recovery or ongoing self-management. The comments from the question: 'Was there anything else the team could have done for you?' reflect expectations that were outwith the capacity of the D2A team. However, the D2A team's visit may be the first opportunity for health service providers to assess the complexity of an individual's ability to manage their health condition at home. The D2A team is not necessarily able to meet the full range of needs identified, as shown in the comments above.

Evidence from this evaluation show that people want as a short a stay in hospital as possible and, very much appreciate services that expedite them back home quickly and safely. Many respondents who had more complex conditions said that the service definitely prevented a longer stay in hospital.

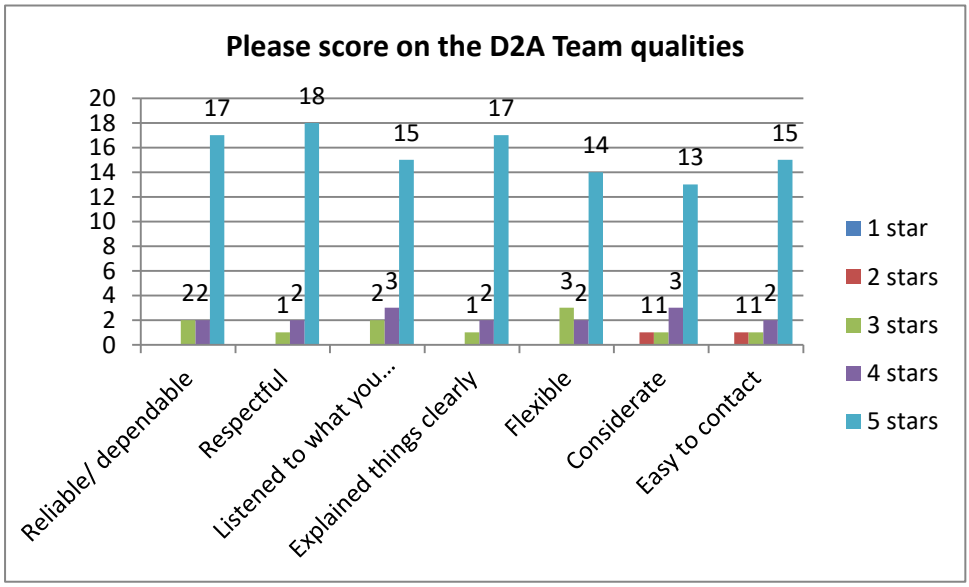
Service performance

Question 5: What support did you receive and please score out of 5 stars.
Question 10: Did you feel you were supported in the way that you wanted?
Question 12: Please give an overall score and thoughts on the service?

Question 5 asked respondents what service they received and to score them out of 5 stars. Over two thirds said they received Occupational Therapy support and scored highly most giving 4 and 5 stars. Nearly all respondents said they received Physiotherapy support and gave similar high scores.

1. *They got me handrails for my bathroom so I was safe to use it. They looked around the house and made sure that I couldn't trip - they sorted out the wires of my oxygen tank. They got me a new alarm system that goes off if I fall. I live alone.*
2. *Very good service from Jo and Ali. Anything you asked and they were able to help. Nothing was any bother to them. 5 stars to them both very professional.*
3. *They supplied me with a zimmer to manage at home and a bath seat. It all came after I arrived home and they fitted a rail as well*
4. *They were both perfect. They were very kind and seemed to know what I would need, so I felt much safer having had this service. The physio came several times to make sure I was managing with my walker.*
5. *The OT brought me equipment to help me and helped me shower and the Physio came and helped with exercise and getting my arm back to normal. They were fantastic. They also gave me an alarm system which changed things a lot and it is there if I need it.*

Question 10. Did you feel you were supported in the way that you wanted? Respondents were asked to score on **reliability, respect, listening, explaining things clearly, flexibility, considerate if needs changed and easy to contact**.



High scores were given to all 7 areas of service performance. The Blues in the graph represent 5 stars. Nobody scored a one star.

1. *In our opinion it is a very good service. It is very important in helping people to get back home more quickly from hospital and we think it is money well spent.*
2. *One day at the beginning the OT came in for a visit and dropped everything to help me shower even though it wasn't scheduled.*
3. *They were exceptionally good. They made me feel comfortable about what had happened and positive about my future.*
4. *Approachable - you could ask them anything.*
5. *The staff were excellent.*
6. *5 stars for everything.*

Comments showed that the area found least favourable was 'easy to contact'. Four respondents did not find the service easy to contact. Unfortunately, the data does not show how many contacted the service successfully.

7. *They were not easy to contact. When I rang their number at Roodlands it didn't take incoming calls. They did not leave a direct contact number. It was difficult to make contact. It was an answering machine that didn't get back to us quickly.*
8. *They were absolutely fantastic. However, not easy to contact. I could get through on their number but it didn't take incoming calls. They did not leave a specific contact number.*
9. *No number was left.*

One respondent, who was enthusiastic about the quality of the service, would have liked *'a final visit for closure. The service just stopped without notification'.*

Reflections:

The quotes from respondents show that staff were highly valued for their personal approach, professionalism, flexibility and commitment to their work. Clarification is required as to how patients contact the service if they need to, and to ensure that there is final sign off. This could give a further boost to their confidence that they could manage on their own. Comments also reflected that this generation of patients valued the service in terms of 'money well spent'.

Question 12 asked respondents to give an overall score and thought on the service.

Evidence from this report reflects an excellent service. Overall scores given for the service are mostly 4 and 5 stars. The quotes below sum up not only the versatility of this service but the quality of the staff.

1. *Top marks! I like to be as independent as I can. I have always been that way, now more than ever even if it's small things. The service helped me to do that. It's very important for me to do things for myself.*
2. *Fantastic service during a time of emotional uncertainty. The service also helped the family understand what was happening and they were very happy knowing that I was being well looked after. The service that is provided is invaluable to families and also the patient.*
3. *It was a safety net. If I had needed more I knew I could contact them.*
4. *I was really well taken care of. They could only come so many times. It was a challenging time for me and they were a great support.*
5. *I was very happy with the service I received all round. It is very good getting support like this at home.*

Whilst this service has been praised for quick and easy access to equipment, we did receive comments about the difficulty of exchanging or returning equipment. The contact telephone number does not seem to be well advertised.

Data from Stakeholders

(Health professionals who referred to the service, predominantly occupational and physiotherapists in both acute hospitals and community settings)

A questionnaire was sent out via an online survey and 39 staff responded. Similarly to the report on patients' views we have sectioned this report under the three headings:

- **Communication,**
- **Outcomes**
- **Service performance.**

Communication

Question 1: Have you attended a D2A education session?
Question 2: Is the referral criteria for his service clear to you?
Question 3: How often have you made a referral?
Question 4: How easy was it to refer to this service?

Question 1 asked how many people had attended a D2A Education Session. Two thirds said they had and a third hadn't. Of the respondents who said yes, they found the session helpful and informative.

1. *The education session was very informative and helpful. It's nice to put faces to names.*
2. *Very informative and sounds like an excellent initiative in order to facilitate a safe discharge home for patients*

Question 2 asked if the referral criteria was clear. The majority of respondents said yes.

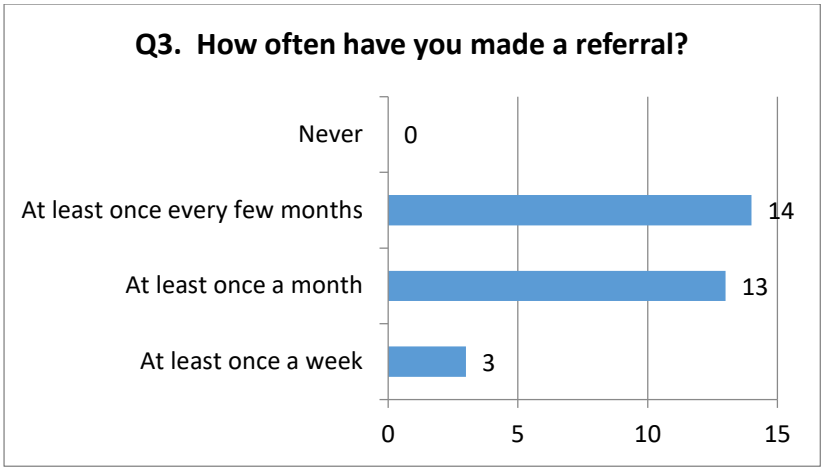
1. *The referral criteria is clear and the therapists are always very happy to discuss referrals if there is any uncertainty. The information leaflets are also helpful for staff, patients and relatives.*
2. *Found the leaflet helpful – I did find that once I had actually come out and spent time with the team for a day it gave me a much clearer understanding too.*

However the comments show that the criteria is not always cut and dried and that sometimes further explanation was required. The comments also illustrate the team's availability and approachability to provide further information:

3. *Initially I thought it had to be clear OT and PT goals (as Edinburgh ICT criteria) but once this was clarified, all fine. Good that lines of communication are open and I have often phoned to discuss a patient.*
4. *My team has made a few referrals where we thought was quite appropriate but had been declined.*

Reflections:

Comments show that the criteria is clear and, if further clarification is required, staff considering referring are appreciative of the ability to ring up and discuss that particular case with a member of the D2A team. They are also open to workplace shadowing. However, staff from the A&E Dept. feel that some of their patients are considered ineligible for this service, despite fitting the criteria, because they have not been formally admitted.



Comments show that referrals are varied depending on circumstances.

1. *Varies, at times I have had not for a month or so and others I have had 3 in one week.*

For patients who do not require a care package for discharge and who have been signed up as medically fit to return home this service works very well. Most respondents were able to identify patients from East Lothian who would benefit from the service.

2. *I refer to this service as often as I can as they are an excellent service which save bed days.*

Question 4 asked how easy was it to refer to this service? This question was scored highly by the majority of respondents. Comments show that the team was approachable and informative and timely on their call backs. Above all no paper work is required - many appreciated the ease of making a verbal referral.

1. *Very easy. Therapists always phone back in a timely manner and it is very helpful that there is no paperwork to be done. Therapist's always give an immediate decision as to whether the patient is being accepted on to the caseload and also an indication of when they will be seen. It is helpful that the team have access to TRAK and therefore can read all the electronic patient records which saves time and prevents duplication of work.*
2. *The fact that I can discuss the referral and give information verbally is excellent. At RIE it can be a challenge to get a computer and completing written referrals is timely. I cannot fault this process at all, even when unable to speak to a therapist, they have phoned back quickly.*

However, a couple of respondents did not find the process so straight forward.

1. *I have attempted to make several referrals (from A&E), some of which have been accepted and some haven't….. I would find it easier if we could always speak to a therapist after giving the basic demographic details to the receptionist. On the occasions when the receptionist at the hub has told me my referral was not appropriate, despite asking, I have not been given the opportunity to discuss this further with a therapist. This leaves us wondering in the hospital why are referrals are not appropriate as the receptionist does not generally expand.*
2. *The only issue I have at times is getting through to the Hub at Roodlands- when the line is engaged there is no option to leave a message.*

There seems to be an inconsistency regarding getting through to the D2A team and receiving call backs.

Reflections:

Overall comments show that it is easy to refer to this service. Respondents appreciate the ability to make verbal referrals directly to a D2A staff member, as this saves time especially as hospital staff do not always have immediate access to a computer. It assists them to meet the deadline of a 12pm referral for discharge that same day.

Two respondents from the A&E Dept. reported not being able to '*get past the receptionist*' at the hub to speak with a practitioner. We think this may refer to comments made earlier in the document about the referral criteria for A&E patients.

Outcomes

Question 5: Please tell us how you think the service helped?
Question 6: Did the D2A service deliver what you expected?

Question 5 asked how the service helped. Top of the list for nearly all respondents was that the service **helped facilitate a quicker discharge**.

1. *Pressure on hospital beds is so intense that consultants are reluctant to keep patients in hospital until a full assessment can be done, so D2A has helped to facilitate safe and early discharges.*
2. *I have made numerous referrals since the service has been set up and I have found that the team are able/prioritise effectively and it has facilitated quicker discharges from the front door- not always same day but that is not always essential.*
3. *At the time I don't think I fully understood from that session how it (the service) would benefit me….however as time went on and I did more referrals I saw how this service can really benefit even downstream wards.*

Respondents pointed out that the service the D2A team can provide person-centred assessments that can only be done effectively in the home setting.

4. *Really where the D2A has benefited my patient group, hasn't been to expedite discharge - but has been essential in preventing a re-admission for at risk patients; or confirmation whether someone will manage when we are unable to assess without the hassle of a home visit (i.e. a blind patient we can't assess in an unfamiliar environment).*
5. *To assess individuals who will be best assessed within their own environment, e.g. due to scanning, vision or cognition deficits.*

To provide a rapid assessment and provision of equipment came a close second.

6. *Useful referral to facilitate discharge of a patient who was keen to go home and unlikely to have long term issues but required further assessment and rehab with meal preparation, stairs and assessment of bathing equipment.*
7. *This has been a revelation in terms of supporting discharges from hospital. There is a huge gap in services in Edinburgh for providing a discharge assessment. Having this in East Lothian has meant when there are uncertainties about how the person may actually function at home we can reassure family that it will be looked at ASAP.*

Two thirds of respondents agreed on the benefits of a same day assessment when the patient arrives home and that the service prevents a longer stay in hospital.

8. *To increase the confidence of patient in their ability to manage at home. Often able to pick up patients the day after referrals which is very time efficient.*

Question 6 asked if the service delivered what was expected.

Overwhelmingly nearly all respondents replied 'yes' to this answer.

1. *They are a very efficient and effective service. Their timescales for responding to referrals are excellent as there is almost never a delay. The therapists are proactive and always looking to accept the referral rather than looking for reasons not to which can sometimes be the case with other services. The therapists are always happy to discuss referrals and signpost to other services if required.*
2. *The team are excellent at supporting hospital discharge, they have a great understanding of requirements for hospital discharge and what aspects are essential for discharge and what they can follow up in the community. They are a significant source of support to alleviate some of the hospital pressures.*

Quite a few comments highlighted that the question could not be fully answered because feedback was not given on patient outcomes.

3. *I have always found the planned input by the D2A team to be beneficial although it would be useful to receive feedback on the referral and outcome.*
4. *Although I would say we don't really get any follow-up; so I assumed there were no issues when they went out.*
5. *Didn't get feedback but presume everything went to plan.*
6. *Not sure of what actually happened on discharge however I know referral accepted.*

However, one respondent did ask for feedback:

7. *'The PT I spoke with took the referral easily after discussing the case. I asked for feedback a few days later and had a detailed response – D2A's assessment had ensured that this lady was safe at home and also had followed up on several areas that I did not identify in my own assessment (i.e. small aids, fire safety check).*

Reflections:

The statistics and comments both show that this service achieves its outcomes and delivers what is expected of it. In an era where demand on hospital beds is ever increasing and the Health Service is looking to expedite people more quickly and safely back home, the D2A service supports that objective well.

The data from patients overwhelmingly demonstrates positive outcomes. As feedback to referrers is not given as standard, we would hope that the positive feedback from this survey is included as part of any future awareness sessions.

This service can provide benefits for patients, who have no need for further medical interventions, irrespective of hospital ward or service.

Service performance

Question 7: Have you had any thoughts/ideas on how the D2A service could be improved?
Question 8: Do you think D2A shortens stays in hospital?

The data from the questions so far evidence that stakeholders think highly of the service in terms of the outcomes it achieves in helping hospital services expedite patient discharge from hospital efficiently and with ease.

Question 7 asked about thoughts and ideas on how the service could be improved?

Referral pathways

The following quotes offer suggestions where referrals could be more efficiently streamed.

1. *a) We would find it extremely useful if we could refer directly from the Emergency Department to prevent hospital admission. I do not understand why patients who are fit for home from ED but require further assessment are not appropriate for the service. On occasions I have noted on TRAK that the patients we send home from ED are eventually referred to hospital@home by their GP and are then ultimately seen by therapists. If we could have referred at point of d/c from ED that would be extremely beneficial and avoid a delay for the patients and then the GP's getting involved when the patients are not coping.*

2. *I know it is difficult but may be worth looking at not being so specific about 12pm discharge as this can be problematic at RIE for various reasons - wider criteria to give option of following day, this can be therapist's discretion and discussed?*
3. *Very difficult to access from A&E on basis that patients have not been admitted, however in an environment where only a minimal assessment is conducted to determine suitability for D/c further rapid access to therapy assessment at home to facilitate D/c home from A&E as an alternative to admission/prevent deterioration in community would be helpful, provided over 7 days. Also no Medical day hospital service in EL.*
4. *Possible in reach into RIE if service expanded targeting above patient group 24/48 hour discharges.*

Packages of Care

Many of the quotes highlight that they could not refer to this service if the patient required a package of care.

5. *If there was a way in which those awaiting a POC could be d/c with the team, however aware this would require significant additional resource & funding.*
6. *Would be great if D2A had access to some care for circumstances where it is a fine line knowing whether that patient would require a POC at home.*
7. *To potentially have support workers linked to team that could provide a small amount of care or assistance to patients at home on discharge to support the transition from hospital to home.*
8. *Scope to provide short term care packages to facilitate discharges further.*

Information

9. *As I don't refer to this service often, I forget the criteria. Also unsure of other services in East Lothian. Would be good to have a reminder of services/referral criteria we can keep on our shared drive especially as we have so many new staff coming through.*
10. *Make educational sessions (power point/in-services) available to new staff members*

Capacity & Development

11. *Inpatient OTs can be asked to provide input into the D2A team. This takes away from the time available for inpatient rehab and potentially slows patient's recovery. For D2A to be more effective in speeding up overall patient flow, the team needs to have dedicated staff to give them sufficient capacity to handle their workload without drawing on inpatient staff.*
12. *Is the volume of D2A impacting of the waiting list for DOMI?*
13. *Expand to include a weekend service and public holidays.*

Reflections:

- Comments show that the D2A referral criteria cannot always take on referrals that are made from the Accident and Emergency ward. It would be helpful if patients from A&E had access to this service thus avoiding possible readmissions because they are not coping following discharge. Can the criteria be amended to work better for referrals from this department?
- Many comments highlighted the limitations of the service if patients require packages of care. These limitations result in marginal cases having extended stays in hospital where patients' confidence and ability to manage independently is compromised from where it will be harder to recover.
- The education sessions were found to be very helpful to understand what the service does and how to refer. However, they weren't always able to access the referral criteria when they needed it. Is there a way to embed information/leaflet/referral criteria in the hospital IT systems as a reminder to those who don't use it very often or for new staff.
- Queries were raised regarding capacity, whether the D2A project encroached upon pre-existing resources available to inpatient or general community services.

Question 8 asked if respondents think the D2A service shortens stays in hospital.

In response to the question - Do you think D2A shortens stays in hospital? the majority of respondents said 'yes' to this question.

1. *Yes when the team has availability to accept referrals, I think this can shorten the admission.*
2. *Assessment can be completed within home environment which is more meaningful and beneficial to patients, practices can be completed at home instead of in hospital*
3. *Patients who are waiting for a home visit but who don't need to wait for care can often be discharged straight away with D2A.*
4. *It allows us to send people home quicker if we think they just need further assessment in their own home without having to arrange a home visit and then discussing it with the MDT before decision is made for patient to go home.*
5. *We have recently had several inpatients in the past weeks who we have discharged through D2A…… A culture change is required, and nurses, GPs and the wider multidisciplinary team, including families and carers, need to embrace this exciting initiative.*
6. *Absolutely, it has really supported us here in hospital, where before we might have had to put in POC as a "just in case" and the person would have spent days/weeks more in hospital. And anxious families can also have a significant effect on the d/c plan.*
7. *Quicker than community OT/PT and with less bureaucracy/written referrals.*
8. *I have had numerous patients who have been discharged much earlier than they would have been if D2A was not in place. They also prevented any quick re-admissions that may have been likely.*

9. *D2A has facilitated the rapid discharge of two patients from my ward in the last 2 weeks, made possible by the next-day visits the service provides which both pre-empted any potential issues on discharge and reassured the patients and their families.*
10. *…challenges borderline package of care patients to promote rehab at home.*

Whilst 'yes' was the overwhelming response to this question as borne out in the above quotes, other quotes highlighted some limitations preventing speedy discharges and consequent poor outcomes for the patient.

11. *Pts are all waiting a POC*
12. *Another patient was safe and keen for discharge but family members concerned re patient and felt needed 'POC' - D2A service allowed d/c to go ahead but ensure concerns were being addressed in home environment.*
13. *Not for my area. Only because for most patient's we still need to go through the same assessments as before to assure/clinically reason they are safe for d/c. D2A helps with the transition home, but I don't think for my own area it reduces any hospital days.*

Reflections:

It is clear that this service shortens hospital stays. Furthermore, some referrers report that for their patient group it is valued particularly because it prevents early re-admissions. The quotes reflect that the service provides a personal approach to patients and their families and offers thorough assessment and targeted support.

Currently the service is working for those patients who don't require any personal care. Can a case be made for patients requiring only episodic personal care to be able to access the Emergency Care Service for defined, very short term need? This would also support and give reassurance to family members, especially those who are older, in their caring role.

Acknowledgements

East Lothian Community Care Forum (ELCCF) gratefully acknowledges the opportunity given to ELCCF to carry out this research on behalf of the Integrated Health and Social Care Partnership. Thanks especially go to the community volunteers involved in the research and producing the end report. The Authors of the report:

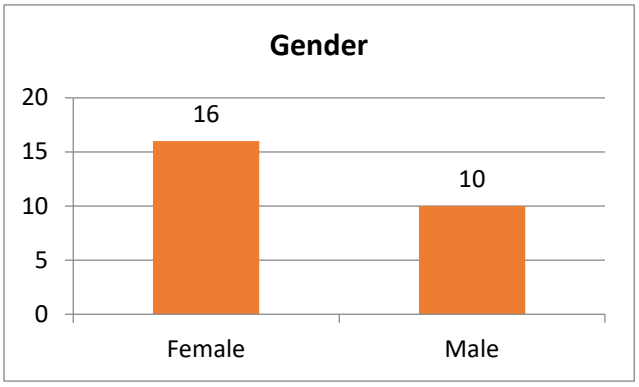
Ann McCarthy (Community Volunteer)
Janice Thomson (Community Volunteer)
Lesley Aitkenhead (ELCCF)

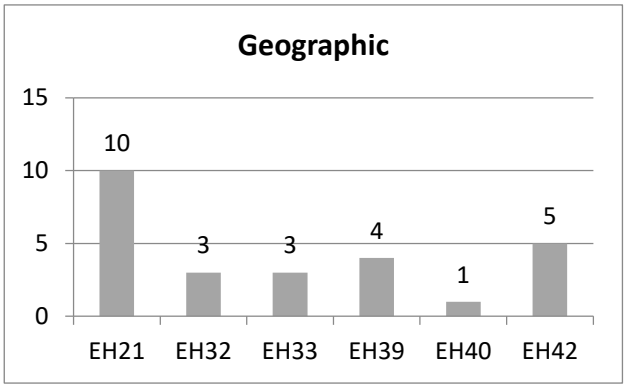
Appendix 1

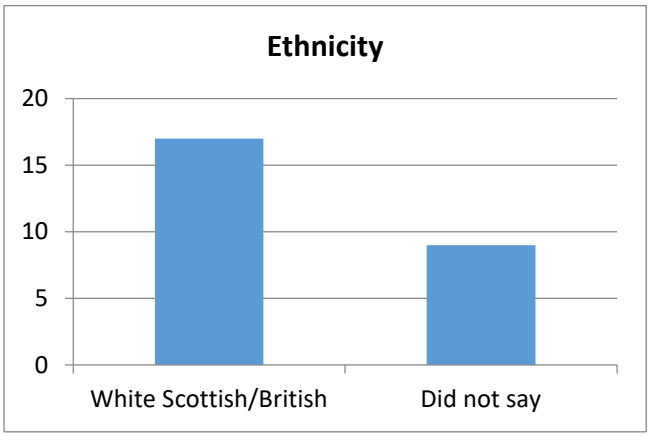
Statistics/Graphs - Patient Data

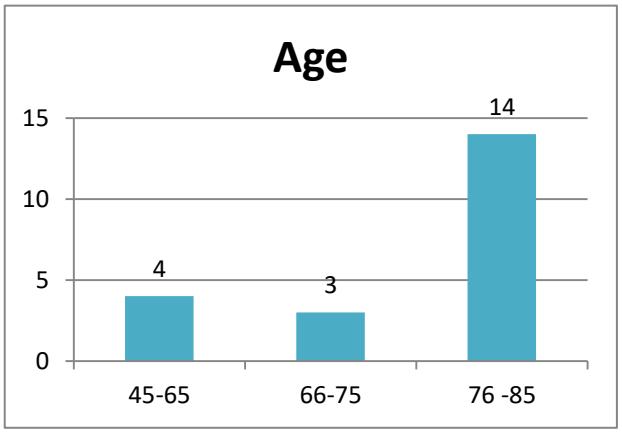
26 Patients

Equality information





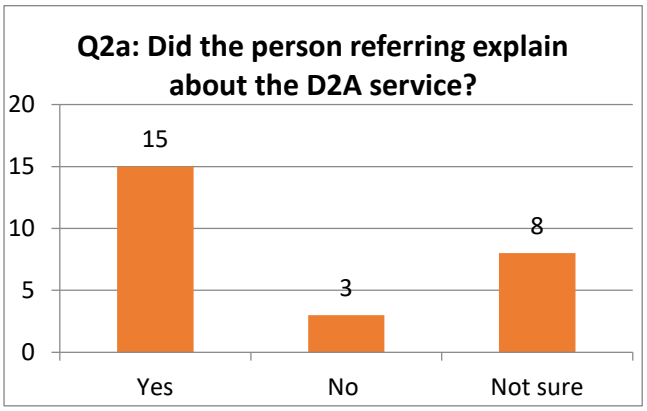


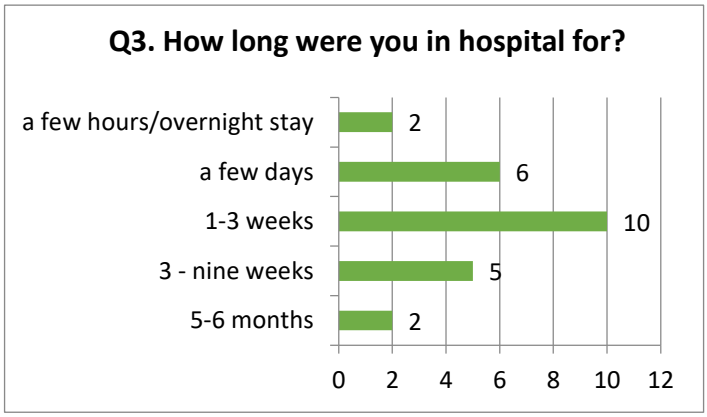


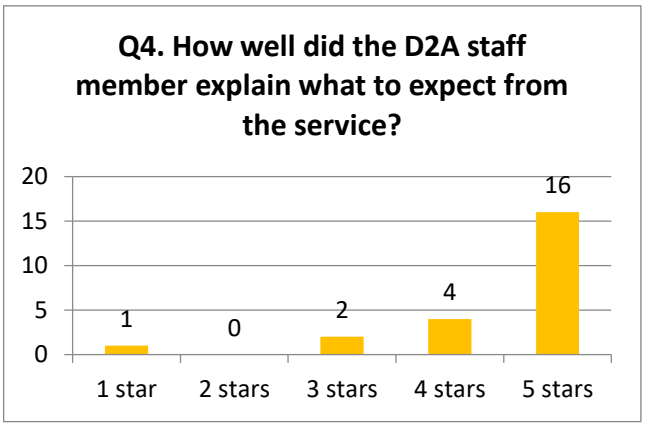
Q1. Where were you when you when you were referred to this service?

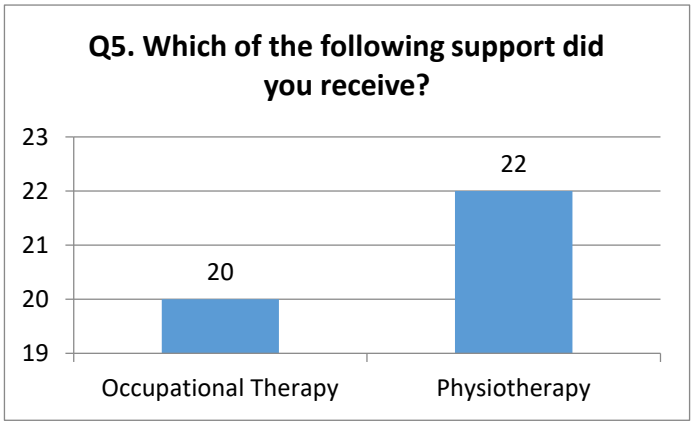
Referrals came from the following hospitals:

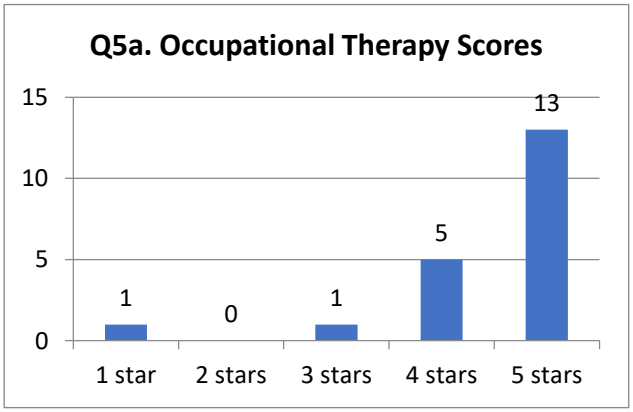
- The Edinburgh Royal Infirmary – Ward 101, Assessment Ward, A&E Department, Orthopaedic Ward, Stroke Ward, Dermatology Ward,
- The Western General Hospital,
- Roodlands Hospital,
- Edington & Belhaven Hospitals.

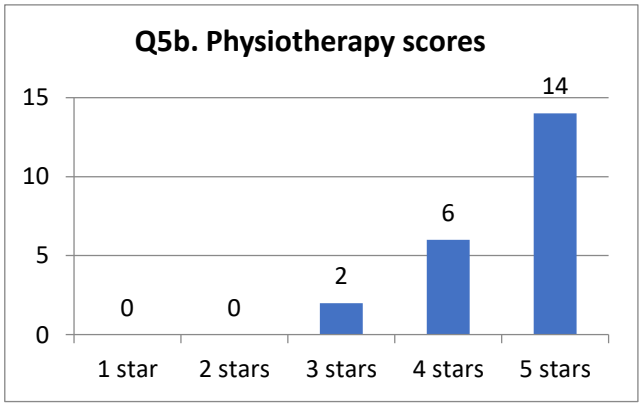

Q2a: Did the person referring explain about the D2A service?
20
15
10
5
0
15
3
8
Yes
No
Not sure

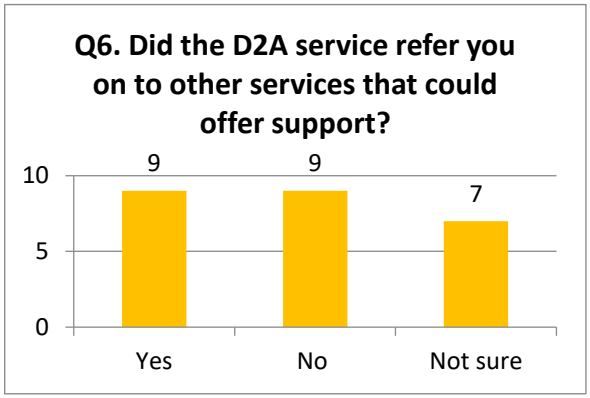

Q3. How long were you in hospital for?
a few hours/overnight stay
a few days
1-3 weeks
3 - nine weeks
5-6 months
2
6
10
5
2
0 2 4 6 8 10 12

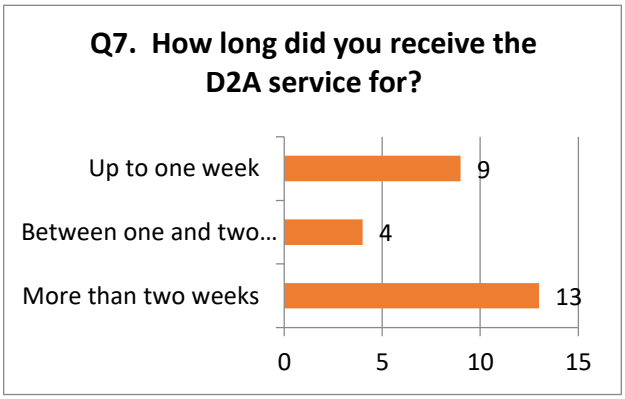

Q4. How well did the D2A staff member explain what to expect from the service?
20
15
10
5
0
1
0
2
4
16
1 star
2 stars
3 stars
4 stars
5 stars

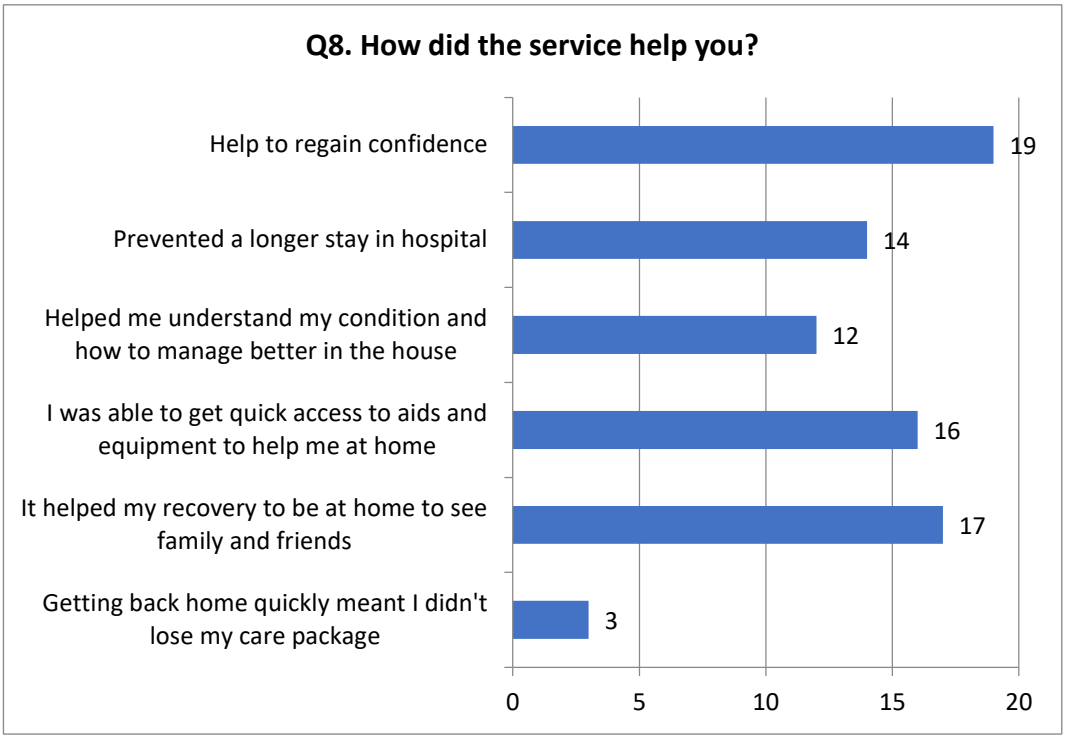

Q5. Which of the following support did you receive?
23
22
21
20
19
20
22
Occupational Therapy
Physiotherapy

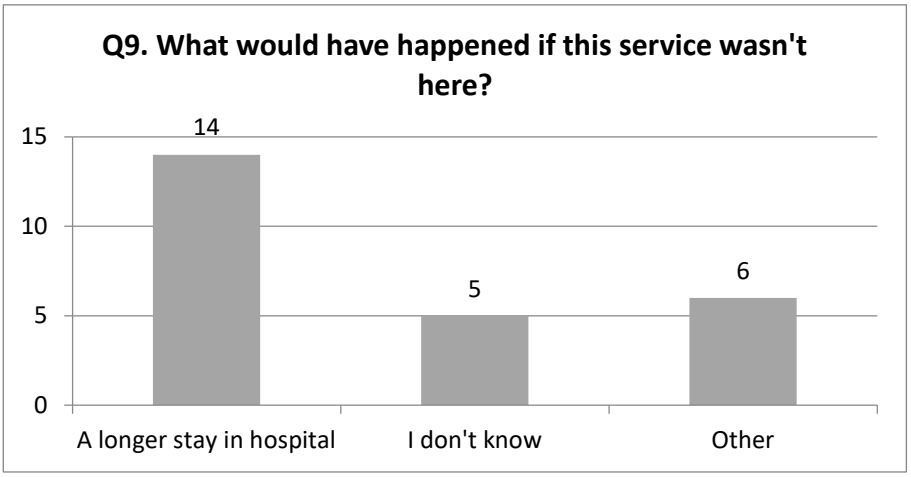

Q5a. Occupational Therapy Scores
15
10
5
0
1
0
1
5
13
1 star
2 stars
3 stars
4 stars
5 stars

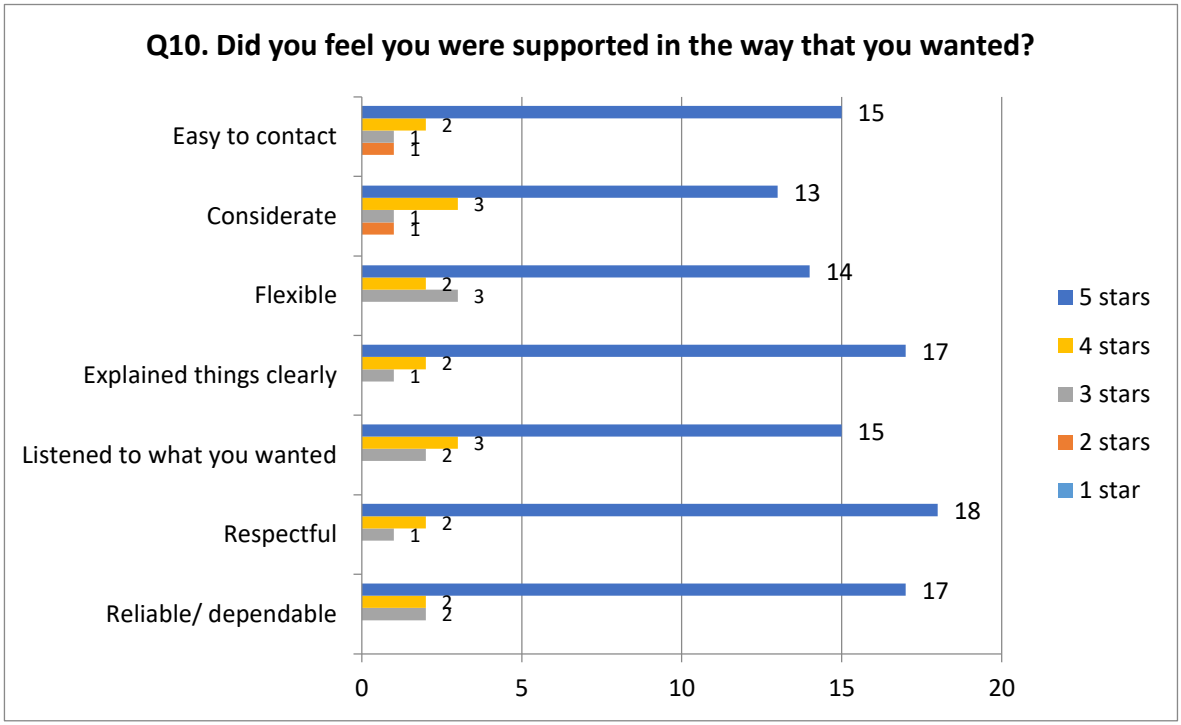

Q5b. Physiotherapy scores
15
10
5
0
0
0
2
6
14
1 star
2 stars
3 stars
4 stars
5 stars

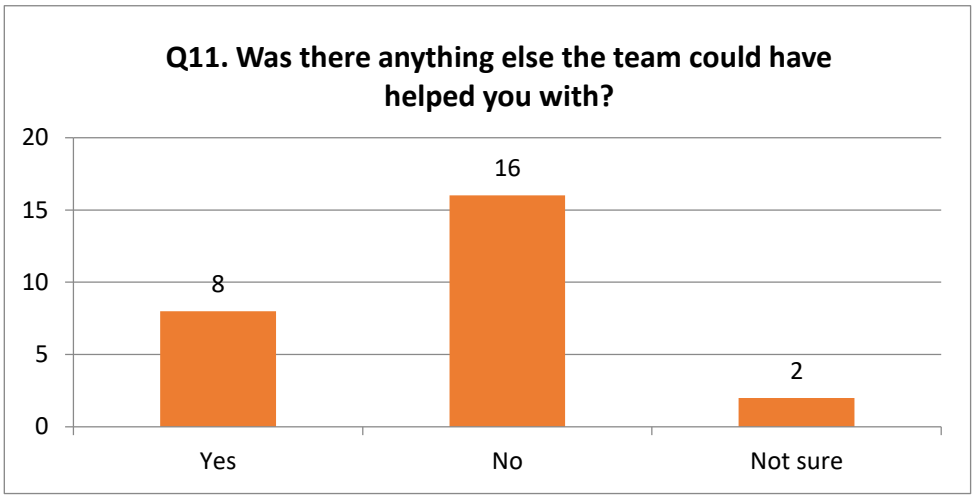

Q6. Did the D2A service refer you on to other services that could offer support?
10
5
0
9
9
7
Yes
No
Not sure

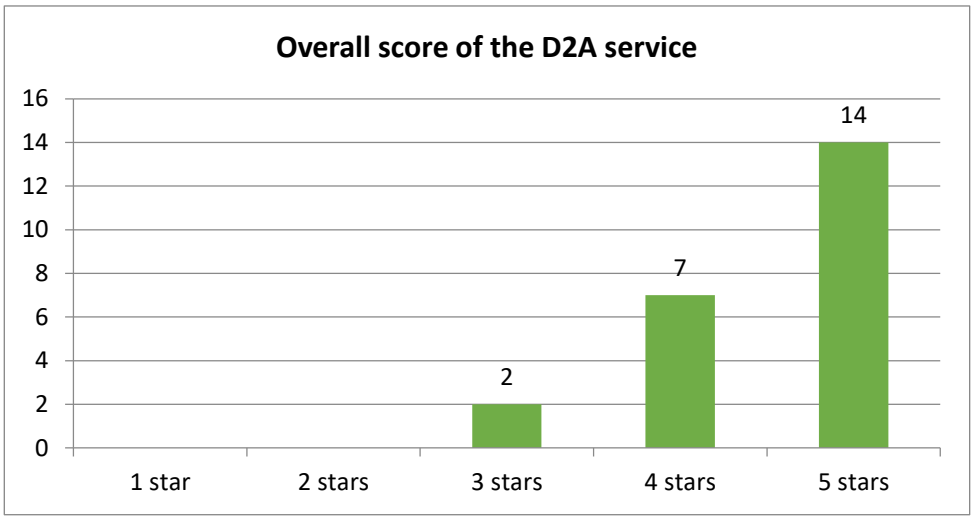

Q7. How long did you receive the D2A service for?
Up to one week
Between one and two...
More than two weeks
9
4
13
0
5
10
15


Q8. How did the service help you?
Help to regain confidence
Prevented a longer stay in hospital
Helped me understand my condition and how to manage better in the house
I was able to get quick access to aids and equipment to help me at home
It helped my recovery to be at home to see family and friends
Getting back home quickly meant I didn't lose my care package
19
14
12
16
17
3
0
5
10
15
20


Q9. What would have happened if this service wasn't here?
15
10
5
0
14
5
6
A longer stay in hospital
I don't know
Other

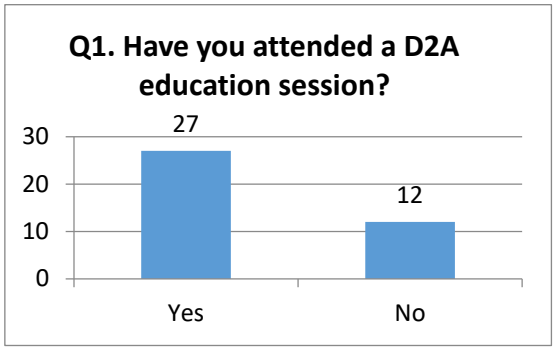

Q10. Did you feel you were supported in the way that you wanted?
Easy to contact
Considerate
Flexible
Explained things clearly
Listened to what you wanted
Respectful
Reliable/ dependable
15
2
1
1
13
3
1
1
14
2
3
17
2
1
15
3
2
18
2
1
17
2
2
0
5
10
15
20
5 stars
4 stars
3 stars
2 stars
1 star

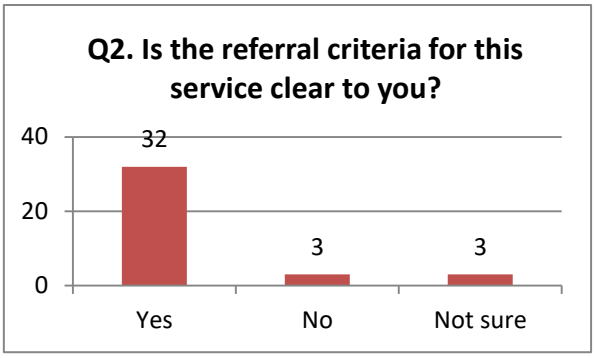

Q11. Was there anything else the team could have helped you with?
20
15
10
5
0
8
16
2
Yes
No
Not sure

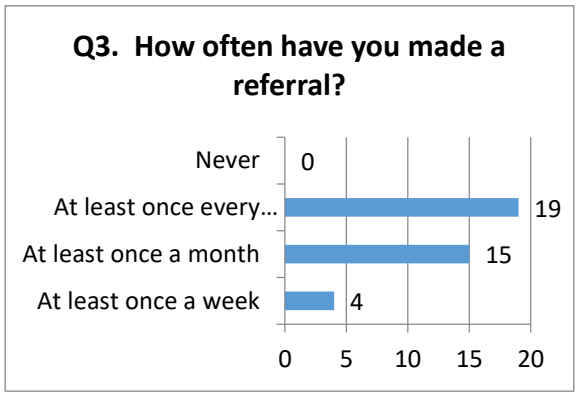

Overall score of the D2A service
16
14
12
10
8
6
4
2
0
2
7
14
1 star
2 stars
3 stars
4 stars
5 stars

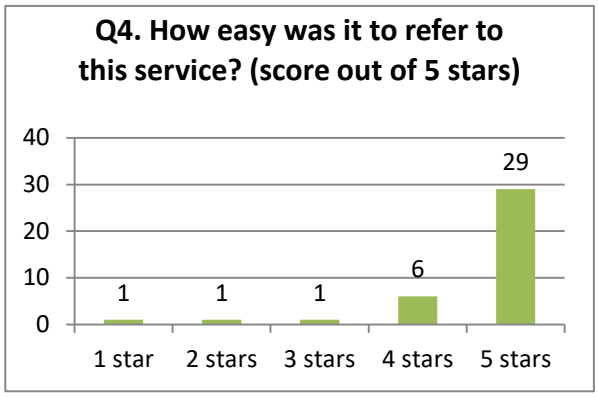
Appendix 2.

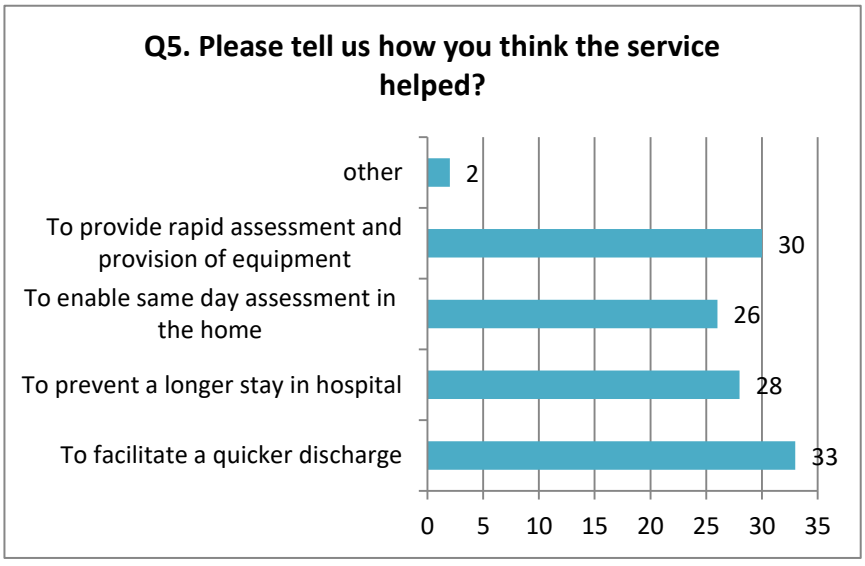
Statistics/Graphs - Stakeholder Data

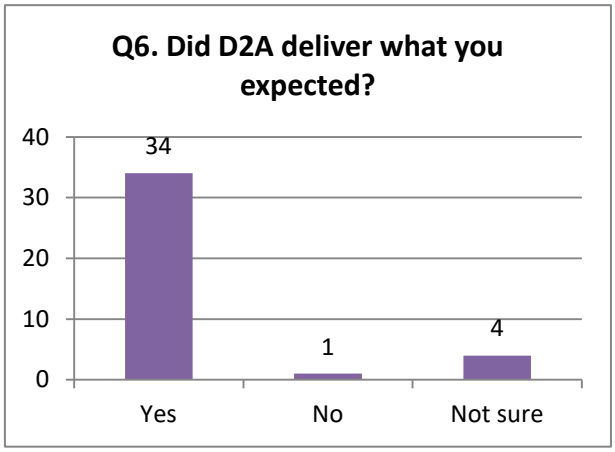


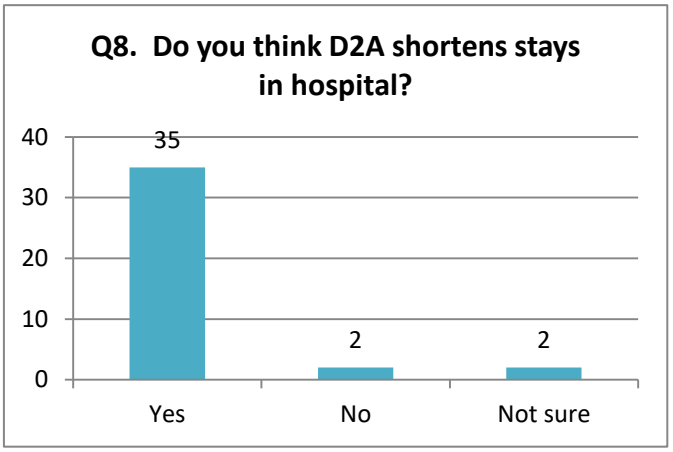









Q6. Did D2A deliver what you expected?
40
30
20
10
0
34
1
4
Yes
No
Not sure


Q8. Do you think D2A shortens stays in hospital?
40
30
20
10
0
35
2
2
Yes
No
Not sure

Appendix 3. East Lothian Discharge to Assess Referral Process

"Discharge to Assess" is a service for patients in hospital who have not been fully assessed by the inpatient AHP's and who require urgent input at home to complete the assessment process and facilitate discharge. A joint PT/OT Ax will be completed on the day of discharge (or the day after). Any identified equipment, minor adaptations and rehabilitation will be provided.

General Criteria for Discharge to Assess:

- Patient must be aged 18+ years of age, be a resident of East Lothian and be registered with an East Lothian GP
- Patient is an inpatient, is medically fit for an **imminent** discharge but is awaiting further PT/OT Ax prior to discharge; the referring therapist feels this could take place at home to negate a longer hospital stay
- The patient is not requiring a **new** package of care; we will accept referrals for patients with existing packages
- Patient can mobilise and manage basic sit to stand transfers (+/- equipment as required)
- Patient is deemed safe to be left alone at home or with family support
- Patient in cognitively able to understand the role of D2A and have the capacity to agree to assessment
- Medication dispensing has been considered in terms of patient's cognitive and physical ability
- If patient is being discharged late in the day, that they have sufficient support in place to manage overnight prior to the joint PT/OT Ax

Same Day Ax will be prioritised for patients who require:

- Urgent Ax of transfers (chair, bed, toilet)
- Urgent Ax of patient on the stairs
- Urgent Ax with a new piece of mobility equipment
- Significant anxiety around the discharge from the patient or family

Criteria for Ax the day after discharge would include:

- Ax of a functional activity (such as kitchen based tasks or personal care)
- Ax of outdoor mobility

Once an appropriate patient has been identified please call
The Hub at Roodlands on 0131 536 8674
Monday – Friday, 8.00am - 4.00pm
To be seen the same day patients should be at home by 12pm midday
(We'd encourage you to email the Discharge Hub if patient is going home via hospital transport to ensure priority given)

Our single point of contact will take your details and the details of the patient (name, CHI number, address and reason for referral). They will arrange for a PT or OT to call you back within 30mins to discuss the referral further and agree a plan.

If your patient requires a new PoC with further OT Ax, **please refer to DRRT via the ELC Contact Centre – 01875 824309.**

For PT input only, please refer to Domiciliary Physiotherapy Service – physioreferralsEAM@nhslothian.scot.nhs.uk

Glossary

Ax – Assessment

A&E – Accident & Emergency Dept.

AHP – Allied Health Professionals

D/c – Discharge

D2A – Discharge to Assess

DDRT – Duty Response and Rehabilitation Team

ED **???**

EL – East Lothian

ELCCF – East Lothian Community Care Forum

ELSIE - East Lothian Service for Integrated Care of Elderly People

GP – General Practitioner

IT – Information Technology

OT – Occupational Therapist

PT – Physiotherapist

POC – Package of Care

RIE – Royal Infirmary Edinburgh

WGH – Western General Hospital

ASAP – As soon as possible