Discharge Case Study
University Hospital Southampton NHS Foundation Trust

Discharge 2 Assess (social care) – A partnership between University Hospital Southampton, Southampton City Social Services and Healthcare at Home

Overview and background

Our project was aimed at getting patients home whilst they were well, reducing the delay to care assessment and facilitating assessment in the patients home as this give a more accurate assessment of needs.

A team of enthusiastic supporters from Social Services (social workers), Healthcare at Home (managers and therapist) and University Hospital Southampton NHS Foundation Trust (UHS) (care group manager, project lead, therapists and lead therapist) formed a group to identify a patient pathway.

Understanding the problem and solutions

Early on in the pathway development it became clear that the best professional to assess a patient’s care needs in the home was an occupational therapist (OT) as they are able to make suggestions to the home environment as well as equipment recommendations that could reduce the care requirement and improve the patients’ independence. The OT visit was to take place within 48 hours of discharge.

UHS@home would support the patient in their home until the package of care was sourced and commenced. As UHS@home is an established service escalation procedures are in place should the patient become unwell at home.

For the pilot project the patient group was restricted to Medicine for Older People and only those requiring a restart of their package of care, or a small care package. “QDS Double ups” were excluded.

As an OT is unable to source care packages a link person within the Southampton City Social Services team was identified to work closely with the OT to recommence packages of care or advise care providers of the patient’s new requirements.

Particular challenges and solutions included:

- Multi agency working – required time to set up the pathway and understand all the complex interfaces. Our whole team believed in the project and wanted to see it succeed.

- Understanding the project – clear communication at the start with all stakeholders involved in the patients discharge.

- Launch – Ensuring everyone understood the pathway.
The following principles and themes emerged during the project:

- The skills of an OT are best suited to assessing the patient's current and ongoing needs within their home environment and translating this into care needs as a trusted assessor. They are ideally placed to fulfil the “navigator” role that is increasingly seen as pivotal if people are to access the right support at the right time.

- The partnership between the UHS OT, Social Services and Healthcare at home is an example of true integrated working and is key to the success and ensuring patients receive quick and effective transfer home.

- Patients require a period of adjustment back to the home environment; assessment 48 hours after transfer was too soon for the majority of patients. 72 hours is felt to be more appropriate unless the ward assessment identifies a need for earlier assessment.

- A key link in Social Services for the OT to liaise with meant that the needs identified at the home assessment could be sourced and implemented.

- Clear exit strategies are required for the patients so they don’t remain on service too long.

- Reablement services were more willing to accept patients as they had confidence in the home assessment.

- Self-funding patients felt more supported when sourcing their care.

**Impact and outcomes**

- Reduction in LOS on the Medicine for Older people wards.

- Higher quality needs assessments lead to improved outcomes (50% of patients had a reduction in the size of the care package, and 1 patient no longer had care needs once assessed in their own home environment).

- More appropriate access to, and better utilisation of equipment as a result of higher quality needs assessments.

- Improved patient satisfaction, (1 patient avoided a delayed discharge and was home to celebrate her 63rd Wedding anniversary).

- Empowered patients making informed decisions regarding their ongoing care needs within their own home environment.
• Greater efficiency in resource use, able to quickly prescribe equipment to meet patient needs at home that they would have ordinarily waited for via community teams. Able to identify redundant equipment in pts homes for recycling within the NHS.

• Highlighted areas of unnecessary duplication between services.

• Greater staff satisfaction, staff from all agencies. The following quote is from a UHS@home member of staff “I found the D2A project an excellent innovation that ensured quicker discharge home in a safe, efficient manner. It benefited the patients as they were able to get home sooner, and they were very happy with the service.” This was echoed by all staff involved.

• UHS@home was running at full commissioned capacity during the pilot.

• Further information can be found in the KPI table in Appendix 1 at the end of this case study.

Top Tips

• The fact that the OTs had organisational knowledge benefitted the project; they were able to pull patients through the process by signing the section 5, and able to highlight issues with key UHS staff for resolution and then refer on to UHS@home.

• Key link in Social service for the OT to liaise with meant the needs identified at the home assessment could be sourced and implemented.

• Clear exit strategies are required for the patients so they don’t remain on service too long

• Reablement services are more willing to accept patients once they have increased confidence in the home assessment.

• Clarity in communication at the launch.

For further information please contact:

Emma Bowyer,
Trust Lead for UHS@home,
University Hospitals Southampton NHS Foundation Trust
Emma.bowyer@uhs.nhs.uk
Themes

- Discharge Liaison Service
- **Policies and systems that link health and Social Care**
- Systems that involve patients in their care
- Systems to ensure information is acted on after discharge

Appendix 1 – Project KPIs

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<tr>
<th>KPI 1</th>
<th>KPI Description</th>
<th>Actual Performance</th>
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|       | Measurable improvements in patient outcomes. A Reduction in actual POC from original ward assessment | - 46% (5/12) of patients had no change in POC size (from estimated to LT POC prescribed) but did receive additional input e.g. equip prescription  
- 36% (4/12) had a reduction of x1 visit (from estimated POC to LT POC prescribed)  
- 9% (1/12) had a reduction of x3 visits (from estimated POC to LT POC prescribed)  
- 9% (1/12) had an increase in POC (from estimated to LT prescription) |

| KPI 2 | Reduction in MOP LOS bed days | - Reduction in LOS between S5 and transfer to UHS@home:  
Prior to the pilot delay between section 5 and transfer to UHS@home was 6.5 days (varying from 2 – 23) this was reduced to an average of 3.5 days (varying from 2 – 9 days)  
- Reduction in LOS from S5 to final discharge. Prior to the pilot ALOS from S5 to final discharge was 17 days, during the pilot this reduced to 9.5 days. |

| KPI 3 | Home assessment visits to be undertaken within 48 hours of discharge | 10/12 (interesting to note 4 were within 24hrs)  
Those not within 48 were at 72. |

| KPI 4 | To improve patient experience | 4 randomly selected patients, all made positive statements about the service. All were very pleased to get home. All comments received were complimentary of the service and the care they received. |

| KPI 5 | Readmission rates | There were no transfers back during the pilot |