EVALUATING DISCHARGE TO ASSESS PATHWAYS

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ACKNOWLEDGEMENTS

EXECUTIVE SUMMARY

Kent, Surrey and Sussex ICSs identified Discharge to Assess (D2A) as a key service change and priority which can contribute to system sustainability, improve flow and access, improve processes and outcomes, and support post-pandemic (and intra-pandemic) working. D2A was funded by the government during wave 1 of COVID-19 as a mechanism to reducing hospital stays and improving patients' assessment.

Across Kent, Surrey and Sussex (KSS) three Health and Care Partnerships (HCPs) were identified to act as case studies for evaluation in order to meet the aims of the overall project. Dartford, Gravesham and Swanley HCP was chosen as one of those three and this report provides detail on the findings relating to this HCP only.

This project had three aims:

a) Evaluate the impacts, capacity, processes and barriers across primary, community, Voluntary, Community & Social Enterprise (VCSE) sector, and social care and other stakeholders
b) Evaluate the experiences and outcomes of service users and informal carers
c) Develop outcome and process measures as part of the evaluation for use in ongoing monitoring and management of the pathway

D2A uses discharge pathways 1 and 2 only, therefore service users discharged under pathway 0 and 3 were excluded.

System pressures resulted in staff being unable to support the recruitment of service users and attempts to recruit them through alternative routes failed. A revised review of experience and outcomes is underway however this will not be specific to DGS and is therefore not included in the report. Outcome measures have been developed and will be applicable across all areas; they are therefore not contained in this report but will be covered in the final rapid insights report.

This report provides DGS with place-based findings based upon the staff interviews conducted across its HCP and social care aspects such as communication, roles and relationships, coordinated and person-centred care, the nature of impacts and effectiveness, sustainability and information sharing were explored within the interviews which may be use in future improvement cycles within the HCP.

Interviews with commissioners and staff in social care, community and acute services were conducted between March and June 2022. Interviews were carried out via MS Teams to understand staff's experiences of being involved in delivering D2A.

From the interviews three core themes were identified:

1. Commissioning: how the service is financed, the structure and culture of the service, and what outcomes are services working towards.

2. Multidisciplinary working: how the services in the pathway connected, the skills and knowledge of the teams, how care is coordinated along the pathway.
3. Information and knowledge exchange: how service users and carers are assessed and communicated with, how the information is managed and flows between teams, how the path is overseen.

'Active ingredients' for success included: integrated working across the HCP effective communication across the HCP, a shared vision for person-centered care, and sustainability of commissioning of all providers involved within the D2A pathway delivery.

We have presented our findings and recommendations here for your use should you feel this is appropriate.

KEY FINDINGS

- DGS demonstrates some core strengths within the delivery of D2A:
  - There is a consensus that for D2A to work there has to be **coordination and collaboration at a commissioning level** and between acute, community health and social care services.
  - **The Home first principle is strongly held within the community services,** community teams work hard to implement this principle as well as patient-centered care.
  - **DGS has a very strong community care offer** (Community healthcare and social care as well as VCSE organisations and commissioned housing services). Community organisations involved within the delivery of D2A are integral to the success of how patients settle at home, and stay ay home supported by their surrounding

- There are currently some **barriers** to the implementation of D2A. The most reported are:
  - **Concerns around capacity to deliver D2A** mainly due to care home capacity and step-down beds, bridging of care is costly and happening across the sector, as well as specific staffing shortages (OT's, Community nurses and GP's, home care workers) that cause blockages within pathways.
  - **IT access and access to care records across the HCP's providers** is a large barrier across the system to effective workflows, patient flows. Single dynamic patient records, single assessment and recording process, shared electronic record, trusted assessors were all discussed as priority needs within the staff interviews.
  - **Lack of one point of contact** to collect information on D2A patient. This results in poor communication (see above), difficult and delayed discharges, added workload for community-based providers and NHS services (e.g., GPs) to collect relevant information and dealing with complaints, safeguarding issues, backlogs.
  - **There is a need for a single point of contact for** patients and carers/family members to ease duplication of information sharing, tighten assessment and referral processes and keep the patient and their family informed without relying on particular community staff to relay this information which can be timely, occasionally resulting in complaint management.
  - **There is a need for creative, collaborative and consistent commissioning processes** of all community services across the D2A pathways. An uncertainty within the **longevity of**

funding makes it difficult to initiate the changes and have the flex in capacity needed across the year and across boroughs.

o There is a strong need have **consistent measures and outcomes across all services** to evaluate D2A's effectiveness and implementation.

o **There is a priority need for better health and social care provision for patients with serious mental illness, cognitive impairment and / or challenging behaviour to appropriately assess their needs and move them into community care.**

Whilst capacity to deliver the pathway are affected by wider issues (e.g., workforce crisis in homecare, overworked NHS or social care staff staff), a better coordination would address some of these issues by reducing time spent to collect information, more accurate assessment, and optimized use of current capacity and skills (e.g., patients being discharged to the right service) and funding (i.e., reduce bridging care of costly services)

KEY RECOMMENDATIONS

- Creative and consistent commissioning: Centralised administrative support and contact; building in consistent outcome requirements for all providers on the pathways; determine how the programme will be funded long-term across all HCP providers; building in weekend capacity across all services involved in the D2A Pathway; commissioning of specialist support for patients with complex needs.
- A better focus on collaborative and multi-disciplinary working including third sector capacity and involvement. A Directory of Community Resources is needed for all providers
- D2A training needs to be rolled out across all teams working within the pathways
- Specialist mental health workers are needed (advice and treatment) across health and social care providers within the D2A provision. Possibly a specialist D2A pathway.
- Single points of contact for patients and carers, a patient centred point of access (Hub and spoke model)
- Patient information / leaflets: Improve information about what service users (and families) can expect from different services. To produce clear guidelines on what information should be included in the referral, especially for conditions such as fractures and cognitive impairment.
- Capacity management and monitoring across system including waiting lists to enable tracking, monitoring of outcomes, improve effective working capacity and faster patient/bed allocation. Accelerate actions designed to integrate different IT systems

1.0 BACKGROUND

1.1 POLICY CONTEXT

Delayed hospital discharges are an increasing trend in the NHS. Longer stays in hospital can lead to worse health outcomes and heightened care needs, especially for older people. During a major incident, keeping acute beds free is essential and to assist with this in March 2020, during wave 1 of COVID-19, the government issued emergency funding up to August 2020 from NHS England for a new D2A programme. The funding covered the costs of post-discharge care for up to six weeks. While aspects of D2A had been in use in some areas prior to the COVID-19 pandemic, the policy issued in March 2020 put D2A at the centre of discharge processes for patients who required support to leave hospital for the first time. National guidance was revised in August 2020, and extra

funding was made available. While current policy maintains the same D2A model ringfenced NHS funding for D2A was withdrawn in April 2022.

Two core assumptions stand at heart of D2A:

1. reducing the time people spend in hospital is best for patients and for the NHS, as it increases the availability of beds in hospitals while improving people's health outcomes.
2. assessing patients in a suitable environment (e.g., people's home) is preferable to assessing them in hospital. D2A is described as a flexible, complex and adaptive model that can and must be adapted to local needs and resources (i.e., NHS and local authorities' budget).

D2A needs to work as a "complex adaptive system" adapted to local needs and resources (NHS England, n.d.). It is underpinned by the following principles:

- **Home first** – supporting people to go back home (or previous place of residency) should be the default. Post-discharge care packages should also aim to aid people to be able to go back home where possible.

- **Person-centred care** – patients' needs should drive the process. People should be given options and support to be discharged to the right place and in a timely manner. Family and informal carers should also be involved in the process.

- **Easy access** – to information, advice and services.

- **Effective assessment** – rapid initial assessment in hospital followed by a short period of rehabilitation and recuperation before long-term care needs are assessed.

- **Information flow** – information should follow the person across services and should be easy to access, both from patients/family and health and care professionals.

- **Networks of care** – build networks of services that focus on the person's needs instead of organisational or disciplinary boundaries.

- **Blurred boundaries** – using resources across boundaries and having a trusted assessor model.

- **Continuous evaluation** – have feedback loops to review and improve the pathway.

(from NHS England, n.d.)

To summarise, D2A aims to reduce the length of stay in hospital for patients medically fit for discharge and improve patient's assessment by moving the point of detailed assessment for ongoing care from the acute hospital into the community, with the funding allowing for a full assessment 4-6 weeks post discharge. It is based on the idea that discharge is a process and not a single event, and hence it requires co-ordination and co-operation across health and social care services and staff at a local level.

The D2A model is based on the following four pathways model for discharging (Department of Health and Social Care, 2020):

Pathway 0: Simple discharge – no additional support needed. The patient is able to return to their normal life with no need for additional health and social care.

Pathway 1: Home with additional support. The patient can return home but will require support. This could be either or both of; (a) Community based rehabilitation via an Intermediate Care Service, rapid community response services or other community agencies; or (b) b. A short- or long-term package of care. If this is under D2A, the patient will receive a single trusted assessment in hospital followed by a period of support / rehab at home and then a full assessment after 4/6 weeks to establish long term needs.

Pathway 2: Community rehabilitation in a non-acute in-patient bed the patient is unable to return home in the short term and requires support in a non-acute bed, either a community hospital or a care home. The patient will receive rehabilitation with the aim of returning home in 4/6 weeks. Under D2A, the patient will receive a single trusted assessment in hospital followed by transfer to the non-acute bed. A full assessment is completed at the end of the period to establish ongoing needs.

Pathway 3: Complex patients and End of Life Care Patients.

2.0 METHODS

Staff Interviews:

Interviews with staff (n=10) within services that are involved with the D2A pathways in DGS were interviewed between March – June 2022 on MS Teams to determine their experiences, thoughts and opinions on a) barriers and enablers to delivering D2A and b) its effectiveness and sustainability. Areas and recommendations for improvement were also discussed.

Interviews were carried out on Zoom or MS Teams and lasted about 1hour. They were audio-recorded, transcribed and anonymised.

2.1 RECRUITMENT

Potential interviewees were identified by NHS and Social Care leads in DGS HCP who had agreed to be part of the evaluation. Those elected to take part in an interview, were provided with a Participant Information Sheet and contacted via email by the researcher to agree a day and time for the interview.

The interviews were conducted with staff from providers along the D2A pathway from the acute trust, community healthcare services, social workers, home care providers, care home providers and the voluntary / third sector plus health and social care commissioners.

The staff included representatives from the following groups: Commissioning (health and social care), housing, support workers, service managers and the discharge team.

2.2 DATA ANALYSIS

Interview data were analysed using framework analysis which consist of five stages: familiarisation, identification of a thematic framework based on the interview topic guide, indexing, charting and mapping, and interpretation across the research team. Analysis was conducted using the qualitative data analysis software QSR NVivo.

3.0 FINDINGS -PATIENT AND CARER PERSPECTIVE

A grey-literature evidence synthesis conducted to gauge the perspectives of patients, informal carers and advocates on their experience of 'Discharge to Assess' identified key areas for improvement:

Communication, including the use of clear verbal and written information (particularly when describing what to expect of D2A, and discharge summaries), establishing points of contact, maintaining interdisciplinary dialogue, and ensuring patient/carer involvement in decisions;

Carer Involvement, including early recognition of those in carer roles for assessment and ongoing communication, consideration of those individuals as partners in care, respecting carer knowledge of a patient and their medical history and providing adequate information for safe care;

Unmet Needs, caused by issues such as insufficient home support at the point of discharge onwards, a lack of equipment, medication and transport, and often complicated in patients with multiple, sometimes competing, requirements.
Perceived shortfalls in the D2A process commonly led to feelings of **distress**.

4. MEASURES

A measurement framework was developed for the Discharge to Assess pathway based on information from the place-based and patient voice reports, existing health and social care datasets, a literature review and stakeholder engagement. A logic model was created and corresponding measures to capture implementation and outcomes from the pathway have been identified.

In addition to the measurement framework and measures, the following key recommendations were also highlighted:

Develop a nationally standardised post-discharge outcome survey for patients and carers, to be used to support local quality improvement and demonstrate impact of the pathway in different regions.

Capture management information data to track the implementation of the pathway and patient flow through each of the relevant services.

Produce a national quality improvement dashboard, capturing and presenting information at sub-ICB level to provide system and place-based leadership the information to engage in quality improvement activities at the local level while encouraging the sharing of learning and best practice nationally.

5.0 FINDINGS – STAFF INTERVIEWS

Three core themes were identified by the research team. These are not the only considerations when setting up a D2A service but the aspects that the teams considered most likely to be both an enabler and a blocker to its smooth running.

The three core themes and eight sub – themes are laid out in table 1:

Theme	Sub Theme
Commissioning. *How the pathway is funded, its structure and culture and the outcomes that are expected.*	1. Finance 2. Capacity to Deliver D2A 3. Outcomes
Multidisciplinary working. *The skills, knowledge and understanding of the staff, the connections between the teams, and how the pathway and teams are coordinated.*	1. Connections 2. Co-ordination 3. Culture and Skills
Information and knowledge exchange. *The way assessments are made, the management of the records and the availability of information to provide an operational oversight of the pathway.*	1. Assessment 2. Management

We asked for documents or a policy that described the local pathway but none were provided and some suggested that they were not aware of such a document which is concerning.

5.1 COMMISSIONING

5.1.1 FINANCE

A lack of continuity and commitment to the D2A approach and principles across all providers involved in the pathways creates staff capacity issues within the community

> *"it needs … the funding arrangements are clear …, it's that long term look as opposed to… a panic about capacity because of winter pressures"*

> *'so we can't forward plan appropriately'*

> *"I think as a system we need to develop that joint approach moving forward and that be clear and whatever we do that commission arrangements need to be for a substantial enough period to provide stability for whoever's delivering them"*

> *'Don't talk to organisations in November, at the end of November about winter, winter's happening by then. And then what they want you to do is scale up, "we've got this pot of money, it's here til the end of March, who can scale up and help deliver?" No one. I'm telling you now, no one can recruit that quickly, DBS check someone, you know, induct them into delivering a role that's care-centred to deliver this, and I just think they get it so wrong.'*

5.1.2 CAPACITY

Training and development, particularly around the culture and principles of D2A seems to be lacking in some parts of the pathway.

> *'I think if training was available, I would like to attend because from my operational role I would be able to steer or discuss with my own staff delivering frontline, or support them, you know, those delivering the frontline services for sure.'*

> *'I think what would help us is to have a mandate around Discharge to Assess and a 'you must do' centrally, coming down the line from government and health and social care to get a must do.'*

> *'So I think as a minimum we need some sort of induction there, a couple of hours induction, these are the areas and key things you should be looking out for as you work with family or patients, there should be linked contacts in there, who to go to for a bit of advice or support as a one-to-one mentoring frontline staff, there should be some sort of training on how to make best interest decisions and what that looks like before we discharge'.*

It was heavily emphasized within the interviews with community providers of care that the lack of weekend support across the services that offer D2A is a significant barrier to not only capacity to discharge, but also quality of care and the ability to remain patient focused:

> *'because we would be available to assist with them discharges over the weekends for instance or on bank holidays, got bank holiday coming up, haven't we? So you think them 3 days, the Saturday, the Sunday, the Monday, we're not picking up any of them referrals, yeah, we might come back with, going to pick them up like on the first thing on the Tuesday morning and start dealing with them but that's 3 days lost'*

> *"It's only Monday to Friday, working days only, not bank holidays, and certainly not the weekends. So, yeah, so it would be great if we could extend the service and, again, but it's all down to the funding"*

Capacity constraints are fairly universal, however there was perceived to be less bridging of care following the introduction of the D2A pathway:

> *INTERVIEWER: 'So what is your view of the local capacity, staff, community beds, care homes, care providers, and its ability to meet the demands of the D2A pathways?'*
> *PARTICIPANT: 'Woefully inadequate … There's real pressures on the workforce, there's a limited workforce and there's issues with recruitment and retention as well, which means that the ongoing packages aren't available in the same timely manner as they have been in the past. So it's, a lot more people getting held within the Discharge to Assess pathway on temporary arrangements. Timeframes for assessments are ever increasing due to, you know, pressures on staffing levels and workforce levels'*

> *'There is still bridging, but I have not reached the numbers I was before Covid. So that area has improved, I would say, for the bridging. It's consistently sort of at a number, but it's not gone up to the really high numbers I was experiencing before Covid'.*

There is a lot of evidence throughout the interviews that supports the notion that many teams working across the DGS D2A pathways practice excellent management techniques which in turn supports staff retention and increases capacity of care post D2A

> 'when I am supporting with training the supervisors I always use the example of it could be that, I don't know, Betty wants to walk to the end of the road and back and that's what we're supporting her with, or it could be that Betty wants to independently wash and dress and with the rest of her time that's allocated learn how to use her new mobile phone, then that's what we would do. So it is those successes that make it worthwhile.'

> "we have managers that look at short term pathways and directly interlink with our colleagues on a daily basis, on an hourly basis looking at those people that are transferring, being discharged, transferring services, so we have the operational teams to do that."

> "we know what people are waiting for, we know the different areas of pressure and why people have been delayed, especially for more complicated ones"

5.1.3 OUTCOMES

Joined up approach to D2A delivery and outcomes - concerns that teams are disjointed and do not operate as a single (or virtual single) team across the length and breadth of the pathway:

> "we just don't always connect the dots on it, on what we gather between organisations. "

> "I don't think anyone's got a collective ownership of it, and that's our challenge at the moment is a disjointed system"

Accountability and assurance: knowing what is happening, what the outcomes are and what needs improving:

> "it's been very difficult for us to actually … assess whether we've improved discharge or not"

> "Even with the clunky counting you could imagine … you get different interpretations and understanding of why things have gone wrong, or no explanation whatsoever … so there's a lot of work still to do there in terms of tracking monitoring reporting"

Individual teams seem to be working well, although there was still a sense of separateness between them. There was significant positivity around team managers / supervisors supporting their staff with capacity and workload issues, change management and support to deliver patient centred care.

5.2 MULTIDISCIPLINARY WORKING

5.2.1 CONNECTIONS

Despite capacity and resourcing issues, staff are committed to ensuring connection between services, and working out how health and social care in the community should work together:

'I think we all now are utilising technology and working together, so I do feel that whereas before there was more of a them and us, whereas now I kind of see it as a we, […] I think we've realised that we're better together than we are as separate.

'I understand from the staff level, the problems that they have, as well as up within the hospitals and the issues that they have. So, […] I'm in the very lucky position that I did start from the beginning, because I've formed lots of relationships, which, especially over the last couple of years, has really helped. The key to what we're doing at the moment is the communication. We're all struggling, but if we keep that communication going then it has helped. It doesn't mean I've got more capacity, but it means that everybody knows what's going on.'

Social and primary care staff reported that D2A has strengthened communication, collaboration, knowledge, and information sharing across community health and care services: working within and across services has become stronger with the implementation of D2A:

'and I would always say, we're not trained in kind of that mental health services but we work very closely with our mental health team, so from a Social Services perspective we have these triage calls for the Discharge to Assess but we also have triage calls where we meet daily to discuss other referrals and that is with myself, a senior practitioner OT and someone in the promoting independence team, so a registered practitioner. And I think kind of having those conversations with them I think you kind of marry your skills across and you build up those experiences and knowledge from my colleagues within KCC'.

A lack of mental health provision within the community, in particular with step down beds, causes delays in the pathway:

'From our challenging behaviour patients perspective there is no care home, especially in these times, that are willing to take on patients who are more challenging. So we have two patients stuck in the hospital for a very long time because of their challenging behaviour'
'where do we send the more complex patients, so particularly for dementia, delirium, challenging behaviour, aggressive behaviour, verbally aggressive, no care home wants these patients, some of these patients are so extreme that they have been known in the past to community mental health services, or psychiatric liaison services, but actually they no longer meet needs for those services, so they're effectively closed on the books, therefore what do you do with these patients and how do you manage them, there is no one plan which is… so there's nobody owning that one plan'.

5.2.2 CO-ORDINATION

Community services integral to the delivery of patient centred care and timely discharge can struggle to get their voices heard :

'because we've tried to get round the table for, you know, the budget holders, etc, to say, look, if we didn't deliver the service, your staff would actually have to do that.'

Continuity of care as patient moves through pathway can be difficult and there is a need for greater coordination and understanding of patient centred needs.:

'how do you keep an eye and look after these patients, a caseload if you like, and who's looking after them, because obviously needs will change, it'll either be a health need or a social care need, or a bit of both, and what do you do for that person who's just bored or lonely actually, and with finding things to use as groups and all of that, and people that rock up frequently we try to have plans, but again it's putting all of that information isn't it and understanding that patient journey all the time'

5.2.3 CULTURE AND SKILLS

Kent has a strong commitment to the culture shift that D2A has presented all teams with. This is addressed by commitment to regular, supportive and informative huddles and MDTs:

'We have a daily conference call where we discuss these patients and move them from one pathway to another, which is really, really good. It's with health, it's with therapy, it's with KEaH it's with Social Services. So every patient is discussed every day and because of that communication, it does mean we move people on, or try to move people on, a bit quicker, because they're having these conversations daily.'

'so within that board round there will be a discussion as to how the patient is and what they feel the pathway should be, and if it's not very clear to us that that is the right pathway then we will ask for evidence around behaviours, we will read the nursing notes and medical notes, we will liaise with the occupational therapist if we feel that this patient needs to have an assessment around what falls equipment or stuff, we'll obviously work closely with the physiotherapist, and most importantly we will have a discussion with the patient and the next of kin.'

Knowledge and skill sharing is seen as an important aspect of collaborative working across D2A. Understanding the principles of D2A, understanding what other services do, their skills and what they provide is seen as lacking from community providers of care:

'And I think it's like I said understanding that client journey from start to finish and it's those sorts of things that we've kind of introduced from a KEaH perspective on our KEaH training but there isn't any formal Discharge to Assess training'.

'I think if training was available, I would like to attend because from my operational role I would be able to steer or discuss with my own staff delivering frontline, or support them, you know, those delivering the frontline services for sure. I think also if staff leave, my own staff leave and when you recruit, if I've got oversight of a service I can at least embed the principles to a new employee coming in as part of their induction programme around expectation'.

D2A can be a difficult pathway for patients with cognitive impairments, acute mental illness and/or behaviour that is challenging, mainly due to the complexity of involving multiple partners along the pathway and frequent changes in care, creating inconsistency and the patient or family not being in control or be able to predict the care offered:

'The patient may have been really settled in a bay and they've got dementia and of course you move them then to a care home and then you start getting unhappiness back from the care home that they're trying to climb out of bed, that they're doing all this different behaviour, but obviously we can only give the information as they're presented in the hospital.'

'we do sometimes have delayed discharges because we are doing mental capacity or best interest decisions or seeking advice on what we do in particular cases and I know that people say well they're going under D2A, they're just, there's no, they're just moving from one place to another but actually going from a hospital bed where you didn't choose'

'someone who had mental health needs, they were receiving the Hilton support, previously self-neglecting, alcohol abuse, and then came to us, was being referred into us and my query is if she's now engaging in services is it right to transition her to another assessment service? Would she be more appropriate to have a long-term care package so that way she's not transitioning, transitioning, transitioning?'

It is evident that Kent has strong community focused delivery partners, working to ensure the patient centred approach is maintained:

'so I work closely with Peabody, I've got all their mobile numbers, I call them my hotlines. Yeah, Imago, if I feel anything is urgent I put that in my title, urgent visit needed, in block capitals and then they do normally go out within a day or two'

'I think you need to have quite a good knowledge base of the sector and particularly as you said the voluntary sector. We lean heavily and call heavily upon people delivering, you know, those voluntary sector type services out there and I think to understand that, to understand the welfare benefits system because it really is great if you can support a person if they're not receiving the right benefit to increase their income and take control of their own sort of managing that and making the choice to buy a cleaner in if you want or, you know, do whatever. So for us we do look for people that come with a certain knowledge in that background or within a housing sector type background because we are all about sort of making sure someone can go back home. Home is best for someone without a doubt but unless you sort of understand the sector you might struggle a bit, so our skills are always around someone with kind of knowledge around welfare benefits, knowledge around the sector generally and knowledge around housing.'

'So we do have sort of local directories that are for each area. They signpost in the community, and it all comes back in here and we manage all the signposting, so we do all the referrals, so like Imago. We also have these people come to our team meetings. So last week we had a West Kent one where Involve came, they explained all the services, and it really opens your eyes to how much they actually do and what's out there.'

DGS have services and staff that offer creative and flexible solutions to challenging situations, both through internal team discussions and within the community providers involved in the pathways. This improves patient centred outcomes, reduces re-admissions and reduces potential perceived risks:

'Generally, after a good night's sleep they are, you know, you're getting a different assessment. But I would see, if the time allows, for us to get therapy out, what equipment can we get in place quickly? It might be that we have to ask family to become involved for that night, look, you know, we don't want to readmit mum or dad or whoever, but, you know, this is what we need to do. Can you bring a bed down? You know, the bed's upstairs, we've realised

they've come home, they can't, what, okay, they can sleep in the chair tonight because they've got a riser recliner, we risk assess them for that point, and then we can then do the reassessment the next morning.'

5.3 INFORMATION AND KNOWLEDGE EXCHANGE

5.3.1 ASSESSMENT

Good examples of coordinated care were demonstrated, particularly in terms of responsiveness to changes in functional ability and the home situation, through internal team discussions and from community providers involved in the pathways.

'So after every visit the support workers feedback to the supervisor the individual's progression, so what was done at the call, what needed support with, what were they independent with, and then that supports the supervisor in we have weekly supervisor meetings where they discuss clients that potentially may need ongoing care and in those discussions looks at also, and that's got a senior practitioner OT and a registered practitioner at those meetings so it's a bit like an MDT meeting, where they would discuss and see if there's any further ways to reduce that individual kind of from all different, kind of putting our brains together and kind of seeing what we can do best to support that individual'

'I go through all the process of the service and it's just making sure that they're going to receive the care that they need because as I said, sometimes it might come across for just a personal care need but it might be they can't do their own medication, they're struggling in the kitchen, you know, and a lot of these haven't been assessed in hospital. I mean they send everybody home from hospital saying that they are self-medicating but how would they know that when they automatically take their medication away from 'em and administer it themselves.'

'So, you know, there may be simple things like, we need a safe pathway to get them discharged, through to the kitchen and bathroom, but ultimately when we do a visit, there might be some health and safety issues. So they need a grab rail, simple things like that, or they may need, you know, a caring provider, so we refer there as well. So, yes, it is, it's the more holistic approach, not just being medically fit'.

Incomplete referrals from hospital to home, poor communication between services involved and staff management and capacity can create delays in assessment time within the community:

"so depending on who's filling it in, whether you're going to get that information right"

"we don't get all the information that we need"

'I feel there's a delay in the assessment so it's up to four weeks and sometimes we have patients come back and we hear that KCC have not picked up the patient. We get, sometimes we get emails from families saying, 'well they've been there this many weeks and nobody's

contacted us', so even though the patient's already been discharged we're still having to follow things up'

There have been many changes within the past few years that directly affect staffing changes, sometimes this can make consistency within the assessment and/or referral process harder, exacerbating any existing issues around capacity:

'you have a care home ring up to do a phone assessment with a nurse on the ward who probably doesn't know the patient very well, even though they're on the ward, or doesn't look after that particular patient or, and then they just say random stuff and you're like, 'where has that even come from? That's never been raised. There's no evidence of this. Why have you said this to the care home'? So yes, unless one person does the whole thing then you'll always have that. The more people you introduce to the process I feel the muddier it becomes'.

Flow and volume of information exchange and documentation creates increased workloads for all services working across the D2A pathways, this was seen by many interviewed as a barrier within DGS to effective service delivery:

'if we can support them to fill [the assessments] in, and we've had to put things in place, because the referrals are not necessarily completed correctly, we've had to put a checklist, which is also a little bit of a delay in getting someone home, because we have to get the ward to complete a checklist over the phone with us, and I'd like to get rid of that, I'd like to get rid of that layer, but I can't until we've worked on the completion of the referrals and got that information.'

'sometimes there can be discrepancies in the information we're given on the referral, I mean it doesn't happen a lot but sometimes it does but obviously then we then go in and we find out that, truly what's going on and are able to rectify it but yeah, sometimes there can be a bit of misinformation on the referral.'

5.3.2 MANAGEMENT

Managing Risk: Flexing approaches to discharge and care. Staff reported that D2A has favored a shift in culture where it was implemented, particularly in community staff's ability to being creative and flexing care and support once patient has moved and settled:

'I mean it does vary. Some people we do have a lot longer, I've been with the company for about 7 or 8 years now. It used to be 3 weeks, but I think it's now 6 weeks. But it also depends, so if somebody's like broke their shoulder and for 8 weeks they're unable to use their shoulder, then we would be with them the whole-time kind of thing'.

'so maybe there's a bit more opportunity to do more there with social prescribing and other needs are outside of health. It's trying not to look at it from a health perspective per se alone, it's getting all that other stuff in, I can do more of that as a Discharge to Assess model, and good model, and some places do it in fairness really well'.

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'they will often send referrals out to link people in and just generally involve other, we can't hold their hand forever and a day once they're discharged because our role is to support the hospital and not so much the community, so wherever we can sort of do wraparound with other community services they will try to do that.'

IT access and access to patient systems across HCP providers is a large barrier across the system to effective workflows and patient flows. Single dynamic patient records, single assessment and recording process, shared electronic record, trusted assessors were all discussed as needs within the staff interviews:

'An information management system, patient records, electronic, that this is all there …it's the one that the GP's use, so it's community-based, but the useful bit about that is it's GP but it's also all our community matrons and district nurses and community therapy teams. So within that you can see who else is going in and when they last saw their GP, so from a community perspective, actually, there's quite a lot of information there, but… social care and then acute are completely separate from that. I don't know, is there an option of something like, I don't know, some sort of case management system where an individual is holding onto some … and it wouldn't be everybody…I suppose we're looking now at virtual ward work, is there a cohort of patients that then fit in that bit and whether it's active and whether that's the virtual monitoring to make sure that they've stayed out for that length of time, so, actually, if they are readmitted it's completely new'.

'All the right disciplines, all the right people there, there should be a multidisciplinary team to do that, to make sure that them conversations happen, so that person only does have to tell the story once, not three, not four times, as it is doing now at the moment'.

Additionally, capacity management and consistency in monitoring across the system to enable tracking, monitoring of outcomes, improvement effective working capacity is seen as behind in development causing problems across the pathways:

'On the face of it, it should be an easy process, but given I've had an email today asking for paperwork for patients that were discharged about a month ago, because it's either not being given to KCC or they've had it and they can't find it, so the process sounds easy but sometimes it doesn't work, and then we have to scrabble around looking for it'.

'So the hospital themselves never ask for any data off of us, so that's interesting in itself I think, never. We collate data and we do quarterly and annual reports on the service that go directly back to the people that fund and commission us so that they see what they're buying because not only do they need to know but they actually have to have member, Council member buy-in for these services, they can't just think "ooh we've got a lot of money, we'll do this", they have to go past the scrutiny panel and have member buy-in for it, so you've always got to keep members sweet about the money in their district is supporting their, you know, people'.

"Even with the clunky counting you could imagine ... you get different interpretations and understanding of why things have gone wrong, or no explanation whatsoever ... so there's a lot of work still to do there in terms of tracking monitoring reporting"

> *'I just know that it's, it's how do we make sure that our information gives us a picture as opposed to, you know, a couple of pieces of jigsaw on opposite sides as it were. So yeah that's, I think that's the bit we need to get right, is making sure that, you know, that whichever, whatever set of data we're looking at that is related to that system and how, you know, it all interlinks is actually what we require to, you know, that they do match up and we're not looking at apples and pears as it were'*

> *'So yeah in terms of what we, the information we get from the provider, whether that's kind of standard information shared that we collect on a regular and then anecdotal reports come through as well where there's no kind of, it's not fixed and it's stuff they're picking up and then there's kind of the, the other kind of style of reporting which isn't, which isn't based on the figures which we kind of, well I get a weekly update from an operations manager with one of our providers that just gives a bit of a general, this is what's going on, which is kind of helpful as well and leads into, informs the wider picture. But yeah so we do gather a lot, we just don't always connect the dots on it, on what we gather between organisations'.*

Managing patient, carer and family expectations is difficult and leads to difficulties further down the pathway:

> *'other barriers would be patients' expectations, families' expectations and sometimes to be honest that is supported by wards and what they say but that's an internal issue that we are trying to address'*

6.0 CONCLUSION AND RECOMMENDATIONS

There seemed to be a significant amount of positivity among staff about D2A. The three high level themes were common to all areas that we evaluated although the there were different points of emphasis within each as would be expected.

The national policy that has driven D2A since the start of Covid has been helpful, both to ensure that there was funding directed at the pathway and to provide some level of consistency of approach. However, the funding doesn't directly translate into additional capacity or skills.

In terms of key recommendations:

6.1 COMMISSIONING

- Building consistent outcome requirements for all providers on the pathways, ensuring that the team(s) know and understand them, to enable commissioners to accurately see where funding needs to be directed if there are blockages in the D2A processes.

- Removing barriers between and across teams: ensuring that the team works as a whole rather than passing patients and requests between silos

- Determine how the programme will be funded long-term across all H&SC providers, helping to avoid competing priorities and agreeing on the longevity to ensure that the service has the opportunity to embed and have stability.

- Building in weekend capacity across all services involved in the D2A Pathway, including GP services would help re-admissions

- Increasing step down bed capacity within communities and having an understanding of whom has capacity and where needs to be a priority.

- A document that describes simply the pathway so that all staff and service users understand it.

- Training on D2A to ensure that staff are aware of the principles and culture of D2A as well as having knowledge about the specific local pathway and where to source support for service users.

6.2 MULTIDISCIPLINARY WORKING

- Explore how provision for service users with mental health problems or cognitive impairment can be expanded and integrated further into the D2A pathway.

- Specialist mental health workers are needed, both for (advice and treatment. Patients presenting with a diagnosed or undiagnosed mental health condition or have cognitive decline are seen to present risk within care homes, leaving these patients using beds and staff resources within the Acute Wards that can be utilised by incoming patients. Additionally, it is identified that Alzheimer's and Dementia problems can increase with continual moves and changes in routine (including changes in carers, and times or visits) potentially increasing behaviour that is challenging to manage. It is proposed that D2A has a specific Mental Health pathway that can address these concerns, this could potentially help to alleviate the lack of services within the community for patients with Dementia (for example) as the pathway could be commissioned separately.

- Ensure that skills are shared across and among the teams working within the D2A pathway. This will help with better assessments and improved access to support.

- Continuity of care needs to be improved as service users pass between the various points along the pathway.

- Third sector capacity and involvement, scope; a Directory of resource needed, this possibly currently exists within the community (social prescribing services?)

- Single points of contacts (key workers or co-ordinators) needed to not only improve communication and continuity of information flow, but also to increase the capacity to deliver holistic patient centred care and ensure that all services and organisations involved in the pathways are used, informed and understood. Key points of contact would also benefit the

carers and family members and reduce the number of complaints, information finding and explanations which can take up a lot of staff time, in particular within the community.

- Include community providers involved in the delivery of D2A delivery in both the operational MDTs and in commissioning and development of services, giving them knowledge, information, and the ability to share their expertise and own information on need.

6.3 INFORMATION AND KNOWLEDGE EXCHANGE

- Improvements in the initial assessment of service users to ensure that information can be relied on.

- Reduce the turnover of staff to increase consistency and skills of those completing assessments.

- An electronic patient / service user record that follows the person through each stage of care from home to hospital and back again and that is accessible and used by all involved in that person's care.

- Patient information / leaflets - Improve information about what service users (and families) can expect from different services. To produce clear guidelines on what information should be included in the referral, especially for conditions such as fractures and cognitive impairment.

- Capacity management and monitoring needed across the system including waiting lists, enabling tracking and monitoring of outcomes, improve effective working capacity and faster patient/bed allocation.

- Administrative support: to ensure that there are good processes in place for the smooth running of the service and facilitate the flows of information.

- Staff single point of access needed to improve information flow, capacity management knowledge between all providers within the D2A pathways

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