EVLUATE DISCHARGE TO ASSESS PATHWAYS

D2A LITERATURE REVIEW (FEB 2023

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D2A LITERATURE REVIEW

Hospital discharge refers to transfer of patient care and recovery from an in-patient acute to a community, social care or domestic setting (Waring et al., 2016). Discharge from hospital is "a necessary process experienced by each living patient" (Kripalani et al., 2007) and a critical and vulnerable stage in patient care (Lilleheie et al., 2019; Waring et al., 2016). As such, safe and timely hospital discharge is a priority for healthcare systems.

Health care professionals, policymakers and researchers agree that hospital discharge should not be considered a single event but rather a complex process of care transition that require effective communication and coordination between heterogenous groups (Bishop and Waring, 2019; Urbanski et al., 2021) across health and care settings, such as hospital teams, general practitioners, community nurses, social care workers, patients and families (Oikonomou et al., 2019). Within this complex process, planning has an important role to guarantee safe and timely hospital discharge and continuity of care. Discharge planning, defined as "an individualised plan for a patient prior to them leaving hospital for home" (Gonçalves-Bradley et al., 2016) or other community services, aims to improve the coordination of services and care after a patient's discharge from hospital (Katikireddi and Cloud, 2008).

Mortality, infections, depression, reductions in patients' mobility and their daily activities are associated with delays to discharge (Rojas-García et al., 2018), suggesting a need to ensure that patients are discharged quickly for reasons of outcome as well as to improve acute inpatient flow. Landeiro et al., (2019) highlighted the financial costs of delays to discharge.

WHAT IS D2A?

While various forms of discharge to assess have been utilised for a number of decades under different descriptions such as early supported discharge and home first, the Department of Health and Social Care introduced the national policy for D2A initially in March 2020 and then with a full update in August 2020 and in subsequent years (Department of Health and Social Care, 2020 and Department of Health and Social Care, 2022). The national policy initially included funding for six weeks of NHS paid support post discharge however the national funding ended in March 2022 and the decision on the funding was given to local health and social care systems (Social Care Institute for Excellence, 2022).

Two core assumptions stand at heart of D2A:

a) 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.

b) assessing patients in a suitable environment (e.g., people's home) is preferable to assessing them in hospital.

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** – "Put people and their families at the centre of decisions" i.e. their needs are key. People should be given options and support to be discharged to the right place and in a timely manner.
- **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.)

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.

Pathways 1 and 2 are therefore those that D2A sits within, i.e. those are the two pathways where there is a possibility of improvement function and therefore a change in support needs that would benefit from assessment once function improves.

OTHER EVALUATIONS OF D2A

Gadsby et al., (2022) evaluated the implementation of D2A in Swale in Kent. They found that issues around the selection of patients for the pathway by staff, power imbalances that hampered service improvements, a disjointed service, and a lack of delivery of anticipated benefits. The motivation to reduce length of stay was felt to override the need for person centred care.

A wider evaluation by RSM Consulting for NHS England (RSM Consulting and Institute of Public Care, 2021) reviewed 10 systems across England and found significant variation in approach and focus although generally there was agreement on the need for single points of access, a shift of resources into the community, a need for integrated teams and the need for additional community capacity. They highlighted problems with data management (knowing what was happening / oversight), uncertainty of funding, demand for community resources and problems with communication with families. They suggested that the funding of care for the initial post discharge period was helpful, partnership working enabled good relationships, adaptability of workforce was present and that systems were less risk averse than before.

The pilot study to this work (Jeffery et al., 2022) showed benefits to the quad aims of healthcare improvement but particularly around staff satisfaction and conditions with staff reporting enhanced autonomy and widening skill sets.

EFFECTIVENESS OF D2A

Shepperd et al., (2009) found insufficient evidence that hospital at home services / supported early discharge were cheaper, reduced readmissions or any impact on mortality, although those with stroke or elderly with a mix of conditions were less likely to be in residential care. They did, however, find increased satisfaction for the patients. In a more recent study based in New Zealand, Parsons et al., (2018) showed in an RCT with 183 older people that early supported discharge reduce average acute

length of stay by 6 days and overall cost of care by around a third. Hernández et al. (2018) found a similar reduction in length of stay in a Spanish study, Offord et al., (2017) found a similar reduction in length of stay (4.3 days) in a study based in England and Lawlor et al., (2019) concluded that D2A both reduced acute length of stay and improved patient satisfaction.

COMMUNICATION AND PLANNING DISCHARGE

In the literature on hospital discharge and discharge planning, a few studies have focused on the coordination of professional groups (Bishop and Waring, 2019; Corrado et al., 2015; Hammad et al., 2014; Katikireddi and Cloud, 2008; Waring et al., 2015) and professionals' perspectives (Atwal et al., 2014; Kripalani et al., 2007; Waring et al., 2016).

These studies concur that effective communication between hospital and community care settings is an important element for quality discharge (Gonçalves-Bradley et al., 2016) and identifies barriers and enablers to coordination and communication across groups and settings. Waring, Marshall, and Bishop (2015) looked at the organisational and professional boundaries that "define and separate professional groups" (p.41) to understand their effect on the safety and quality of discharge. They concluded that professional boundaries are a threat to safe discharge and that promoting a culture of collaboration improved the quality of discharge and resulted in further satisfaction for the different occupational groups involved. Data showed that professional groups that collaborated at the different stages of the discharge process, shared a common understanding of the importance of discharge planning and of their responsibility in the discharge process, had better results.

A recurring recommendation from these studies is that hospitalists should not see discharge as the end of their responsibility to care, on the contrary they should attempt to guarantee a safe transition of care (Hardicre et al., 2017; Kripalani et al., 2007; Waring et al., 2016). At this end, it is recognised that discharge documentation plays an important role for continuity of care and safe transition from hospital to community care. For example, Hammand et al. (2014) evaluated discharge summaries received by primary care practices for patients hospitalised for 24hs or longer and found relevant differences among wards, with orthopaedic wards demonstrating the lowest adherence to national guidance on information to be communicated upon hospital discharge. Corrado et al. (2015) looked at electronic discharge notes completed by junior doctors at Leeds Teaching Hospitals NHS Trust. Discharge notes take up time to complete and need inputs from multiple professionals for information to be complete and appropriate. A lack of communication and collaboration makes discharge notes difficult to complete for junior doctors, who are often responsible for coordinating discharge, however it has recently become more common for hospital to hire a discharge coordinator (Katikireddi and Cloud, 2008). Corrado revealed that integrating discharge briefings into the daily multi-disciplinary

team meetings improved the quality of discharge notes and diminished the time to complete them for junior doctors.

Waring, Bishop and Marshall (2016) investigated the views of healthcare professional, patients and carers about the threats to safe hospital discharge and identified contributory and latent factors that impact on safety of discharge. Inadequate assessment of patients' needs and follow-up care (e.g., lack of proper communication or access to medications, equipment at home) were identified as direct factors related to discharge safety. These were in turn informed by proximal and latent factors including a) discharge planning, referral and communication (e.g., fragmented communication systems) across settings; b) resources constraints; c) lack of shared responsibility.

These studies of hospital professionals' perspectives on hospital discharge reiterate the importance of multi-disciplinary collaboration and effective communication with community health and care services and patients and families (Kripalani et al., 2007; Waring et al., 2016).

PATIENT EXPERIENCE

The experiences of patients and carers is the focus of consistent body of literature on hospital discharge (Cain et al., 2012; Ewing et al., 2018; Hardicre et al., 2017; Heaton et al., 1999; Knight et al., 2013; Swinkels and Mitchell, 2009; Uhrenfeldt et al., 2018; Webster et al., 2002; Wright et al., 2017).

Cain et al. (2012) found that Patients and caregivers faced many challenges in the transition from hospital to home and the main challenges related to a) translation of medical care in to home settings (e.g., taking medications, medicating wounds, etc.); b) knowing who to call for help and support; c) practical organizations of everyday life (e.g., looking after pets, going grocery shopping, cleaning, etc.).

Similarly, Wright et al. (2017) found that communication to patients about discharge plans, changes to discharge plan (e.g., delays, postponed date, etc.) and medications could be improved. The management of medication in the post-discharge stage is identified as key challenge for safe discharge in various studies (Altfeld et al., 2013; King et al., 2018a; Knight et al., 2013; Wright et al., 2017), this is particularly important considering that 30% to 50% patients do not take medication as intended (Wright et al. 2017). Improving communication between hospital discharge teams, general practitioners and community pharmacists is a valid way to address this issue (Ibid.). Moreover, the majority of these studies conclude that both patients and carers should be involved in discharge planning.

Some of these studies has focused particularly on carers' and significant others' experiences and needs, recognising that they play an important role in care transition and post-discharge but are not

always involved in the process. For example, Ewing et al. (2018) evaluated the use of the Carer Support Needs Assessment Tool (CSNAT) Approach to support carers of people at end-of-life post discharge. Three main issues emerged from this research: organisational focus on patients' needs, carers' unrealistic expectation of caregiving at home and lack of awareness from carers that patients are at end of life. Uhrenfeldt et al. (2018) systematic review of significant others' experience of hospital patients' transfer to home shows that significant others' confidence in taking care of patients back home was strengthened by their involvement during their loved one's hospitalization. The study concludes that involvement in the discharge planning, including discharge planning meetings and learning-by-doing care activities led by health care providers during hospitalizations, have a positive impact on significant others' strength and confidence in assisting after discharge.

A common conclusion and recommendation of these studies is that carers should be involved and independently consulted in discharge planning and that carers' needs should be given more weigh in the process (Ewing et al., 2018; Heaton et al., 1999; Uhrenfeldt et al., 2018; Waring et al., 2016). Also, carers should be instructed and advised in their role post-discharge (Heaton et al., 1999; Uhrenfeldt et al., 2018)

A large part of literature on hospital discharge and patients' and carers' involvement has focused on older patients (Allen et al., 2016; King et al., 2018b; Knight et al., 2013; Lilleheie et al., 2019; Oikonomou et al., 2020, 2019; Swinkels and Mitchell, 2009; Waters et al., 2001) . "For older patients, who are more likely to have complex health and social needs, and who may be anxious, confused and disorientated, the risks associated with transitions of care may be greater than that of the general population" (Hardicre et al., 2017, p. 2).

INTEGRATION OF CARE

"Discharge management is thus a multidisciplinary process focusing on many aspects of a patient's life." (Urbanski et al., 2021).

Integrated care helps facilitate the transitions across organisational boundaries (The Kings Fund, 2016) and the wide variety of players and complexity that can exist in a person's transfer of care from an acute setting to a long term place, either at home or in a care home, requires coordination and integration. This coordination can be facilitated through information flows that support decision making and through co-location (Alidina et al., 2016).

Integrated documentation improves interprofessional, integrated and multidisciplinary working (e.g. Atwal and Caldwell 2002; Fitzpatrick, 2004; Øvretveit, 2017; World Health Organization, 2019), however funding and interoperability difficulties can prove to be barriers (e.g. Melchiorre et al., 2018;

Waterson et al., 2012). The Kings Fund also warn of "over zealous interpretation" of information governance (The Kings Fund, 2013); this is a particular issue between providers of care (MacInnes et al., 2020; Litchfield et al., 2022) and across the health and social care divide (Douglas et al., 2022).

PROCESS

Important also to look at hospital discharge and post discharge as a process where patients, carers and heath and care providers navigate and negotiate their independence and dependence. See also Friedrich (2020) who posits the same point on dependence form a bioethical angle. Hardicre et al. (2021) important reflection on what involvement is. They see involvement as a labour-intensive process that can be analysed as "work", "including decision making, undertaking activities, and completing tasks" (p.4). This helps to look at patients' and carers' involvement as resource rather than an attribute of the patient. Involvement is dynamic and dependent on relational, contextual and material circumstances. Data from this study show that patients might prefer to be less involved during the hospital stay but want to be involved again in the post-discharge. It is important to look at active involvement as a resource that is mediated by access and ability to leverage multiple resources and as such, subject to unequal distribution, p.10). Important point to avoid neoliberal and moral understandings of patient involvement that overlook inequalities. It follows that it is Important to investigate the contextual, organisational and sociocultural aspects of care transitions (Aase and Waring, 2020).

The literature also suggest that older studies were concerned more with the issues of delayed discharges (see Webster et al. 2002; Heaton et al., 1999) and possible negative effects of shorter stays. More recent research instead shows that shorter stays are now accepted as desirable and positive outcomes of proper discharge planning. This suggests that there has been improvement in addressing delayed discharge and discharge process. However, some of the key issues of discharge planning – poor communication, lack of notice of discharge, inadequate consultation with carers and patients, over reliance on informal care - remain relevant to current assessments of good hospital discharge.

To conclude, some key themes emerge from this review of literature. Difficulties in discharge and post discharge care due to inconsistent coordination between health providers, community services, older people and carers. Issues of unmet needs and self-management post-discharge, due to factors including inadequate follow-ups and understanding of care needs for older people at home, lack of adequate funding for community services. Factors that impact positively on discharge and continuing care: multidisciplinary discharge team, involvement of patients and carers in discharge planning (Allen et al., 2017).

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