EVALUATING DISCHARGE TO ASSESS PATHWAYS

THE DEVELOPMENT OF A SERVICE IMPROVEMENT TOOL

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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.

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

Across Kent, Surrey and Sussex (KSS) three places (Health and Care Partnerships - HCPs), were identified to act as case studies for evaluation. These were chosen to cover a range of different demographics including a mix of rural/coastal and urban, a mix of levels of deprivation and inequality, a range of life expectancy and somewhere with a high ethnic population; Appendix 1 provides full details of the decision. The three HCPs chosen to act as case studies were:

- Dartford, Gravesham and Swanley
- East Sussex
- Surrey Downs

In each case site interviews with commissioners and staff in social care, community and acute services were conducted between March and June 2022. In addition, grey literature from Healthwatch organisations and Carer's UK relating to discharge experience from acute hospitals were analysed. Enablers, blockers, good practice and issues were analysed with three core themes, each with three subthemes, identified and subsequently developed into a service improvement toolkit:

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.

The highest impact requirements for success that were identified from interviews with staff were:

- Adequate funding and capacity for care during and after the D2A period
- Communication, connections and coordination across the pathway
- A strong culture of enablement and a clear understanding of the strategy and deliver of D2A
- An understanding of the outcomes of the service and a tailoring of these to patient need
- Broad range of skills held by individuals and across teams
- Accurate initial assessment and evolving assessments as service users travel the pathway
- Joined up information systems
- Clear and transparent management information

The service user and carer perspectives were analysed using primarily grey literature from Healthwatch organisations around the country. Four themes were identified:

- Carers: carers and their needs were not considered or assessed and communication with health and care services was a problem.
- Communication: the need for a single point of contact, clear verbal and written information is needed, and ensuring service users are involved in decisions. Difficulties in understanding the discharge process caused anxiety and distress.
- Unmet needs: support was not in place or insufficient, equipment was missing, there was little help to navigate the system for either carers or service users.

Key performance indicators and measures have been recommended.

- Outcomes: Patient Reported Outcome Measures (PROMs) are urgently needed to provide clarity on parts of HCPs' discharge pathways to establish where it works well and where there is need for improvement.
- Control: Live information on capacity and flow is not visible to managers along the pathway.
- Improvement: There are no specific measures in use and pathway specific data needs to be reported to inform service improvement cycles.

The top six recommendations from this evaluation are:

- The use of the D2A service improvement toolkit to help identify and resolve blocks in the pathway.
- Ensuring a local operational policy for the pathway is available to all providers on the pathway.
- That communication, in all senses, requires improvement.
- Carers seem to be often forgotten and therefore need to be assessed and considered in the care of the service user.
- Oversight of the flow of service users needs development.
- Development a patient reported outcomes measure for people discharged from an urgent care pathway to aid feedback and service development.

1.0 BACKGROUND

Discussions with directors from the three ICSs in Kent, Surrey and Sussex had led to the identification of discharge from acute hospitals as being a key area of concern and one that they were keen for support on.

Delayed hospital discharges are an increasing trend across 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:

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[1]. 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, A Quick Guide to Discharge to Assess[1])

It should be noted that "a system must consist of three kinds of things: elements, interconnections, and a function or purpose"[2], i.e. it is greater than the sum of its parts and the interconnections and function need to be considered along with its elements.

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[1] https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
[2] Meadows, DH (2008) Thinking in Systems, A Primer. Chelsea Green Publishers (p12)

New legislation in 2022 requires hospitals to involve patients and carers in the plans for discharge, where support is likely to be required after discharge, as soon as it is feasible to do so (Health and Care Act, 2022; Section 91)[3]. This needs to be considered in regard to the principle of home first so that both can be met.

The D2A model is based on the following four pathways model for discharging from the Department of Health and Social Care[4]:
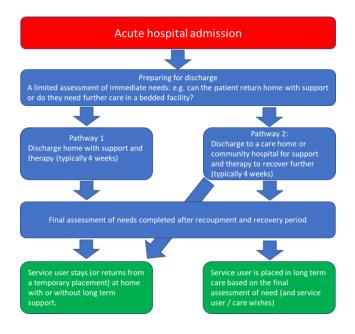
Pathway 0: Simple discharge – no additional support needed. The patient is able to return to their normal life with no need for additional health and social care.

Pathway 1: 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) 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 or rehab at home and then a full assessment after 4 to 6 weeks to establish long term needs.

Pathway 2: Community rehabilitation in a non-acute in-patient bed because 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 to 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.

The D2A model covers pathways 1 and 2 only, i.e. people who require some support following an acute episode of hospital care but not those who are at the most complex end of long term care or those requiring end of life care. The D2A pathway can be expressed as:

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[3] HM Government : Health and Care Act 2022 https://www.legislation.gov.uk/ukpga/2022/31/section/91/enacted
[4] Department of Health and Social Care, 2020. Hospital Discharge Service: Policy and Operating Model. Department of Health and Social Care.

To summarise, D2A aims to reduce the length of stay in hospital for patients who are 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 to 6 weeks post discharge. This process utilizes pathways 1 and 2, i.e. those patient who need additional support to leave hospital. 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 project was set up with 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.

A wider review of the academic literature on hospital discharge (see Appendix 2) plus a pilot evaluation in 2021 informed the approach to the evaluation of the three HCPs. The literature highlighted the needs for communication and collaboration between health care professionals, the need to involve patients and the need to see discharge as a transition of care rather than completion.

A mixed methods approach was used with three of the workstreams based around the three project aims and a fourth workstream focused on dissemination and implementation.

As part of their Accelerated Access Collaborative's NHS Insights Prioritisation Programme (NIPP), NHS England provided funding for the 17 month evaluation project. This evaluation project was delivered by the KSS AHSN and ARC KSS with the support of the three ICSs across Kent, Surrey and Sussex.

2.0 METHODS

The evaluation was managed using five work packages which covered the three aims of the study plus its setting up and the implementation of the findings. The evaluation was conducted over a 17 month period (six quarters) and the table below shows a summary of these work packages and broad timing of their delivery. The overall approach used mixed methods with a qualitative analysis of multiple case studies, an evidence review and logic modelling to develop metrics requirement.

Q1 Q2	**Work Package 0:** Approvals and recruitment: • Contracts • Team and PPI recruitment • Protocol and ethics • Place agreement			**Outputs**
Q3 Q4	**Work Package 1** Mixed methods evaluation of the impacts, capacity, processes and barriers across community settings. Data: • Interviews / focus groups • Outcome measures developed in tandem	**Work Package 2** Mixed method analysis of the experiences of patients and carers. Data: • Interviews • Outcome measures developed in tandem	**Work Package 3** Development of outcome and process measures to facilitate the evaluations and for use in ongoing monitoring and management of the pathway .	Outcome measures
Q5	Analysis of data, insight generation, report writing commenced			Detailed insights
Q6	**Work Package 4:** Dissemination and implementation • Rapid insights, final document • Implementation of findings facilitated by AHSN			Final insights to ICSs

2.1 PATIENT AND PUBLIC INVOLVEMENT

Patient and public involvement was central to the evaluation from the start. We recruited a Patient Advisory Panel to guide and advise the team. This panel met each quarter with the project team and reported into the project board. They were also provided with monthly updates between meetings.

The panel was comprised of four experienced patient advisors with interest and experience in the transfer of care from acute to home settings. They were recruited via an existing network of providers and then supported by the ARC KSS's Public & Community Involvement and Engagement Team.

The panel provided support for the co-production throughout the evaluation. They were involved from the outset to ensure the service user and carer voice was heard and understood.

The panel ensured that the service user and carer voice was accurately described in the outputs of the evaluation, that the outputs captured the wider implications of the pathway and that they were as jargon free as possible.

2.1 WORK PACKAGE ZERO (WP0: SET UP)

The evaluation was governed by a newly convened Project Board, chaired by the Chief Officer of the AHSN, and delivered by a project team that included staff from two universities, the KSS Academic Health Science Network and Unity Insights. A detailed protocol for the evaluation (Appendix 3) was developed and agreed with the Project Board. A Public Advisory Board was set up to ensure the public voice was heard at all

stages of the evaluation and to provide co-design and some aspects of co-production, particularly around the analysis and implementation of the findings.

The setting up of the evaluation required the selection of three places including "at least one *[Place / HCP]* in a coastal community and one in an area with above average levels of ethnic diversity for use as case studies."

To establish three sites the Project Board has suggested a number of aspects were taken into consideration:

- What data is available, e.g. 'unplaced hours', Delayed Transfers Of Care and other metrics, to help identify characteristics of places.
- Both rural vs urban HCPs to be included.
- Differences in social care providers
- Deprivation differences and health inequalities
- The preferences of ICSs
- Avoid places that are too similar in terms of demographics.
- Which places want to be involved
- One site from each ICS

2.2 WORK PACKAGE ONE (WP1: STAFF EXPERIENCES)

Leads for each HCP were identified and workshops held with staff across local pathways to inform them of the evaluation, to ensure that the research team understood the structure and processes of D2A within each HCP, to allow for questions and clarifications, and to develop the lines of questions to be used in the interviews, i.e. co-design based on a consensus of the three sites.

Potential interviewees were identified by NHS and Social Care leads in the HCPs 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.

Around ten members of staff from across each of the three pathways (total n=29) were interviewed using a semi-structured set of questions. Interviews were conducted 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.

Data were analysed using framework analysis[5] 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. The data from each case site were first analysed separately followed by a comparison and discussion of themes across the three case sites. The charting and mapping were conducted using the qualitative data analysis software QSR NVivo.

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[5] See Ritchie, J. & Spencer, L. 1994. Qualitative data analysis for applied policy research" by Jane Ritchie and Liz Spencer in A.Bryman and R. G. Burgess [eds.] "Analyzing qualitative data", 1994, pp.173- 194; and Srivastava, Aashish & Thomson, Stanley. (2008). Framework Analysis: A Qualitative Methodology for Applied Policy Research. JOAAG. 4.

Individual HCP reports (Appendices 4 to 6) were drafted and discussed with HCP lead prior to finalisation.

2.3 WORK PACKAGE TWO (WP2: SERVICE USER AND CARER EXPERIENCES)

The project team attempted to recruit around 10 service users and 2 carers who had experienced D2A in each HCP (i.e. 36 in total). Recruitment attempts were made between April and October 2022:

- Acute staff were asked to actively recruit patients awaiting discharge and with their consent provide contact details to the project team.
- Acute staff gave information sheets to patients and asked them to contact the project team after discharge.
- Posters asking for user volunteers were displayed around acute, community and primary care providers.
- Healthwatches covering all three HCPs were contacted and asked to advertise the study in their regularly newsletters.
- Letters were sent to each D2A user in two HCPs covering a 12 month period.
- Facebook paid for adverts were trialed focused on a radius around one HCP.
- Posts were made in Facebook community groups in each HCP.
- Acute Trusts included these posts in their own Facebook feeds.
- £20 gift vouchers were offered for participating people.
- A £50 prize draw was offered to staff who recruited participants.

Despite these measures, no service users or carers were recruited during this period and an alternative approach to establishing the service user and carer experience and needs was used.

In November the project team therefore commenced an evidence review of grey literature:

Inclusion criteria: Grey and academic literature reporting on patients or family, informal carers and advocates of patients discharged from NHS acute hospital services since March 2020, when Discharge to Assess guidance was implemented, until the present.

Exclusion criteria: Academic literature, grey literature with no division between pre- and post- March 2020 discharges, literature with findings already included in another piece of literature, research exploring the views of people that have not experienced discharge, and research specifically focused on pathway 3.

Search terms: ("virtual ward" OR "home first" OR "step down" OR "bridging" OR "hospital at home" OR "early discharge" OR "virtual ward AND ("patient" OR "service user" OR "Carer(s)" OR "family" OR "relatives"

Following the search, it was found that 11 Healthwatch organisations across the country had interviewed and reported on service user and carer experience of discharge and along with a survey published by Carers UK, these seemed to provide a cohesive cluster of reports that could be used for the review. While this was not specific to the three HCPs nor specific to D2A, the experiences and needs were felt to be useful in the development of recommendations for pathway development and for the development of metrics in WP3. In addition, one academic study was found.

The data from these 13 reports / papers were therefore used and they were drawn together in a thematic analysis in a similar methodology to WP1, i.e. using a framework analysis.

2.4 WORK PACKAGE THREE (WP3: METRIC DEVELOPMENT)

In addition to official guidance and research, the insights, learnings, and recommendations captured through WP1 and WP2 were used to shape development of process and outcome measures within an evaluation framework for the D2A pathway.

Fours steps were taken:

1. Findings from the pilot evaluation and research conducted by the University of Kent team were reviewed
2. A literature review was conducted
3. A dataset review was conducted
4. Stakeholder engagement with information and operational teams was conducted

A logic model was produced to highlight interdependencies and both causes and effects.

Drawing from the data the team, identified key areas for consideration and where existing data can be utilised. Recommendations for additional development were considered.

2.5 WORK PACKAGE FOUR (WP4: IMPLEMENTATION)

Implementation has been considered throughout the project:

- Initial workshop to scope the approach
- Public advisor involvement, including plans for outputs, dissemination and implementation
- NHS England involvement
- Feedback to HCPs via workshops / discussions

The following outputs were developed. These will all be available online from the KSS AHSN and ARC KSS websites, and downloadable / printable as appropriate:

- D2A Service Improvement Tool outlining the key themes that emerged to support a successful D2A pathway and the barriers and enablers to achieving this (available via Prezi)
- Project Reports
    - Full Report
    - HCP Place-based Reports
    - Service User and Carer Perspective Evidence Review Report
    - Process and Outcome Measures Report
- Short-read Project Summary, with links to on-line resources
- Short video
- Podcast
- Policy Briefing
- Website
- Academic publications

A series of briefing and discussion events will also be offered to colleagues working across the discharge pathway in Kent, Surrey and Sussex, to support mobilisation of service/ system improvement.

3 FINDINGS/RESULTS/OUTCOMES

3.0 WORK PACKAGE ZERO (WP0: SET UP)

Eleven HCPs across the three KSS ICSs were considered using the aspects above to arrive at a choice of three HCPs for evaluation. Appendix 1 provides full detail on the methods and decision.

Across Kent, Surrey and Sussex three HCPs were identified to act as case studies for evaluation. These were chosen to cover the suggested range of different demographics including a mix of rural/coastal and urban, a mix of levels of deprivation, a range of life expectancy and somewhere with a high ethnic population using data from the ONS and HM Government (see Appendix 1 for full details of the decision).

- Dartford, Gravesham and Swanley (DGS) has the highest level of ethnicity of all of the HCPs, it has the second worst life expectancy in KSS, it has stated its interest in participating in the project and it is one of the few (mostly) urban populations in KSS. It was therefore chosen as the Kent HCP.
- East Sussex has the area with the highest level of deprivation in KSS, it is a coastal community and had expressed an interest in the evaluation – it was therefore chosen as the Sussex HCP.
- Surrey Downs was chosen for Surrey. There were few differences between the four Surrey HCPs however, Surrey County Council were keen that Surrey Downs be used.

Ethics approval for WP1 to WP4 were obtained from the University of Kent (Ref 566) as the evaluation did not meet the criteria to need NHS Ethics / HRA approval according to the HRA checklist.

3.1 WORK PACKAGE ONE (WP1: STAFF EXPERIENCES)

The first study aim, to assess the impacts, capacity, processes and barriers across primary, community, Voluntary, Community & Social Enterprise (VCSE) sector, and social care and other stakeholders were focused on through work package 1. The three detailed reports based on the findings from the HCPs are shown in Appendices 4 to 6. Summaries of findings are shown at the end of this section but using a cross case analysis to consider at the data as a whole, the following points are highlighted.

Firstly, as part of our evaluation 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. This suggests a potential issue with operational understanding along the pathways.

Secondly, while there was an acknowledgement that the national policy on D2A had been helpful in bringing some consistency, we also identified a range of understanding on the purpose of D2A expressed by staff. These were close to the national policy but there were nuances. These included:

- Improving acute patient flow
- Improved outcomes and experience for patients and informal carers
- Reduced readmissions
- Reduced ongoing care needs
- Staff satisfaction

Thirdly, three core themes were identified by the research team in the cross-case analysis; each core theme had three sub-themes and each sub-theme had a range of issues that related to enablers or barriers to the running of a D2A service.

The three core themes were:

- Commissioning: how the pathway is funded, its structure and culture and the outcomes that are expected.
- Multidisciplinary working: the skills, knowledge and understanding of the staff, the connections between the teams, and how the pathway and teams are coordinated.
- 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.

A detailed list of the enablers and barriers were identified within the themes. These have been expressed as questions that services can ask themselves as part of the Service Improvement Tool (Appendix 9). These were felt to be substantial findings and should be of use to commissioners and operational managers when reviewing D2A services for the purpose of service improvement.

Commissioning

Ensuring that the right level of resource was provided to the service to meet demand is an obvious need but there were other aspects to the financing and resourcing of the pathway (including staff and equipment) that we found. The D2A pathway does not exist in isolation and it usually requires services to pass the care of the service user on to; these follow on services need to have sufficient capacity and this is further complicated by those services often using the same cohort of staff for long term care and D2A. The pathway was felt to ideally operate seven day a week in line with the rest of urgent care. Agreements and processes for invoicing were found too difficult for some providers and for patients who live out of the area of the Local Authority (LA) a need for a working arrangement with neighbouring LAs was expressed. Finally, ensuring contracts have longevity would provide stability for team members and providers.

A clear structure and embedded culture were found to be enablers (or lack of: a blocker) to a good D2A pathway. As noted above, we were unable to find an operational policy or strategy for any of the three services reviewed. This combined with low levels of training was felt to be problematic. While the high level principles of D2A were broadly understood, staff generally felt more training and a move towards working as a single or virtual team would help with removing barriers and enhancing discussions. Broadly people understood the home first principle which they tried to follow.

Understanding outcomes is essential: "one of the key outcomes from what we do is support them individually but then try and open up their own kind of network and build that."

Outcome requirements for the service and their monitoring has not been considered in significant depth and while there were some aspects of reporting, it was generally felt that this is an area that could be improved. In particular, the use of service user and carer feedback was not widely utilised in service improvement work.

Key points on commissioning:

- Sufficient financial and staff resources for the D2A pathway and to support care after the pathway.
- Seven day service
- Out of area agreements and clear payment routes for providers
- Certainty of continuity of service
- Clear service strategy, structure and culture
- Training on D2A including purpose and principles
- Single or virtual teams
- Clear outcome requirements plus transparency
- Patient centred service and the use of service user feedback

Multi Disciplinary Working

The need for robust connections between teams and stages in the pathway was noted, particularly as the pathway crosses from acute care, often into community health and then into social care. Removing boundaries and ensuring that teams know what each other does and are doing was felt to be important. A culture of integration was desired with the removal of siloed working. Community and social care services wanted a stronger say in the development of the pathway rather than be passive recipients. There was a feeling that a flexible and agile culture was helpful on this pathway.

Skills, knowledge and understanding both through having access to and having included in the pathway a range of therapists, was felt to be helpful. Access to mental health support was problematic in most teams particularly around the support of those with dementia. Also, unsurprisingly, service users with complex needs required a significant amount and range of resources. It was felt risk assessments in care homes could be reviewed particularly for service users with challenging behaviours. Being able to manage complex housing needs was discussed by many, specifically homelessness and hoarding. Concerns about the assessment of carers needs were noted.

Multi-disciplinary working at the heart of D2A: "That cross-competency bit is really, really important, getting people to understand each other's roles and responsibilities and what they can offer I think it cuts down this whole stuff about I've got to, you know I'm going to refer my patient on to my colleague that's sat next to me. Why don't you just have a conversation, why don't you both go and do a joint assessment together? I know that's easier said than done but actually in a lot of circumstances we've done that exact thing and it's really, really helped so I think however you put that into a training package I think it's really important".

Coordinating care on D2A is essential: "having one coordination point to have access to all those services has been positive, setting up information management systems, provision of information on a daily basis, monthly reporting, so that's all been relatively good. Communication between them, so multidisciplinary huddles, meetings, daily."

The coordination of care was felt to be essential. Generally pathways had some form of hub / discharge team that facilitated the initial move from the acute hospital and most pathways had some for of huddle or MDT meeting to discuss and coordinate care. Single points of contact (SPOC) existed to some extent but there was a feeling that these could provide better communication for both team members and for service users / carers. A SPOC might be combined with a directory of resources given the variability and complexity of needs, this may support access to third sector community support. Finally, there were many concerns about continuity of care as service users move through the pathway.

Key points on multidisciplinary working:

- Robust connections between teams and stages in the pathway and the continuity of care
- A culture of integration
- A stronger say for community and social care services
- A flexible and agile culture
- Skills, knowledge and understanding across the range of therapies and services
- Mental health expertise and support
- Ability manage complex care arrangements including housing
- Coordination of care, via hubs and MDTs
- Single point of contact for staff, service users and carers
- A directory of resources
- Person centred care

Information

Assessments that start with essentials for discharge and increase in detail during the pathway were felt to be inline with the principles of the pathway however this and the assessment documentation need to be agreed by all parties. Those completing it were considered, sometimes, not to have completed it correctly either through a lack of understanding of the key information needed or lack of time. The information on a service user was felt to need to flow and grow along the pathway. Service users and their carers expectations, or what the D2A pathway was going to provide and what happens when it ends, were sometimes not discussed with them. It was felt that good discussions with service users and carers can help bring forward creative solutions. There was a disparity in the understanding of risk and its assessment and a felt need to ensure that skills on risk assessment are shared. This manifested sometimes in the wrong level of care being provided at the start of the pathway.

Single dynamic service user records were broadly lacking although there were some aspects of a single record in place. This was felt to be needed to ensure that records are available and able to be written by all teams across the boundaries between health and social care.

There were concerns that teams do not have oversight of the whole pathway. There was an expressed need for key workers and managers to know who is doing what and when and for service managers, system managers and commissioners to be sighted on available capacity and the flow of service users through the pathway. There was a desire to use this information and information on outcomes to drive improvements.

Key points on information:

- Robust and agreed assessment process
- Strong involvement of the service user and carer from the start
- Ensuring that service users and carers are given information and involved in discussions.
- Information flows through the pathway and is dynamic, i.e. it is used by all and it evolves along the pathway, preferrable through a shared electronic record.
- A shared understanding of risk
- Oversight of the pathway including the demand and capacity of services
- Using information to drive service improvements

3.1.1 Summary from the Dartford, Gravesham and Swanley (DGS) D2A pathway

There is a consensus that for D2A to work there must 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, and community teams work hard to implement this principle as well as patient centred care. Additionally 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.

However, there are currently some barriers to the implementation of D2A within DGS.

There are concerns around capacity to deliver D2A mainly due to care home capacity and step-down beds, bridging of care (short term home care support for those waiting for long term provision) is costly and happening across the sector, as well as specific staffing shortages (OT's, community nurses, GP's and home care workers) that cause blockages within pathways. There is also a 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.

IT access and access to care records across the HCP's 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.

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 to keep the patient and their family informed.

There is an understanding at all levels that 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. There is also a strong need to have consistent measures and outcomes across all services in order to evaluate D2A's implementation and effectiveness.

3.1.2 Summary from the Surrey Downs D2A pathway

Surrey Downs and associated providers involved in delivering D2A pathways 1 and 2 demonstrate some core strengths within the delivery of D2A.

There is consensus that D2A has the potential to improve person centred health and care outcomes and care transition, and that for D2A to work there must be coordination at a commissioning level and between different players in acute and community health and social care services.

It was evident that the home first principle is strongly held within all services and community teams work hard to implement this principle as well as patient centred care. Community organisations involved in D2A are beginning to feel more involved.

However there are currently some barriers to the implementation of D2A. There are concerns around capacity to deliver D2A mainly due to workforce crisis in homecare. A lack of a single point of contact to collect information on D2A patients leads to poor communication, 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, and backlogs. Similarly there appears to be a need for a single point of contact for patients and carers/family members.

Different teams working in silos (e.g., ward, physios, OTs, social care) results in poor information sharing, poor assessment (especially in the transition from acute to social care), and a lack of inter and intra disciplinary skills and processes hindering multidisciplinary working which the pathway relies on. Additionally social care's removed involvement within the wards creates a barrier to knowledge exchange and skill sharing.

Similar to the other case sites, there is a consensus that there is a need for better and more consistent commissioning processes of community services across the D2A pathways - an uncertainty within the longevity of funding makes it difficult to initiate the changes needed, as well as aligning all services involved along the D2A pathways in terms of capacity (for example commissioning weekends). Implementing tighter and more consistent measures and outcomes across all services to evaluate D2A's effectiveness and implementation would provide useful insights that would benefit capacity management, help understand blockages along the pathway and where funding is needed most.

3.1.3 Summary from the East Sussex D2A pathway

Overall, there was consensus that the D2A pathway had the potential to improve person-centred care and outcomes both for patients and staff. Some strengths were identified across services in East Sussex. It was recognised that the implementation of D2A had fostered better coordination and communication across services at a commissioning level and encouraged multi-disciplinary working.

In terms of enablers, it was recognised that national funding for D2A made it easier to initiate changes needed to implement the pathway, i.e. coordination at commissioning level, sharing accountability, multi-disciplinary working. Discharge hubs were felt to have improved multi-disciplinary working and information sharing across services.

Despite these improvements, some barriers were also identified. There was a perceived power imbalance toward acute settings who were felt to be driving the pathway. Poor assessment and understanding of social care from hospitals was felt to result in difficult and delayed discharges, added workload for community-based providers and NHS services (e.g. GPs) who had to collect relevant information and deal with complaints, safeguarding issues, and backlogs.

Different teams working in silos (e.g., ward, physios, OTs, social care) resulting in poor information sharing, poor assessment (especially in the transition from acute to social care) was also identified as a main barrier to a well-functioning pathway.

Issues around capacity due to workforce crisis in homecare, limited number of district nurses and O.Ts. and specialised services (e.g., mental health) as well as limited availability of acute staff for care handover were reported as a main barrier to deliver D2A.

Finally, there was an expressed need to have consistent measures and outcomes across services to evaluate D2A.

3.2 WORK PACKAGE TWO (WP2: SERVICE USER AND CARER EXPERIENCES)

The second study aim, to evaluate the experiences and outcomes of service users and informal carers, was the focus of work package 2.

System pressures resulted in staff being unable to support the recruitment of service users and attempts to recruit them through alternative routes were unsuccessful. An scoping review of academic and grey literature on patients' and informal carers' experiences and outcomes relating to discharge from acute hospital was therefore undertaken. The full report is shown in Appendix 7.

The 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. Difficulties in understanding the discharge process caused anxiety and distress.

"61% didn't receive information about the new discharge process during their hospital stay." and "[…] most survey respondents (61%) did not receive any information on how the process had changed. There was little variation in the provision of information throughout the 42 STP/ICS areas, suggesting that people were consistently not receiving this information, regardless of their location."- National Healthwatch.

Carers: 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.

"If only I had been recognised as his carer and been given the information as well, we would have known what to do from the start. I was completely omitted from the discharge process and received no communication which made the experience more challenging than it needed to be". - Carer's UK

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 for patients with multiple, sometimes competing, requirements. Perceived shortfalls in the D2A process commonly led to feelings of confusion, anxiety and distress.

"Nearly two thirds of respondents (62%) … felt that they were supported, however 38% felt that they were not." - Healthwatch Bedfordshire

3.3 WORK PACKAGE THREE (WP3: METRIC DEVELOPMENT)

The third study aim, to develop outcome and process measures as part of the evaluation for use in ongoing monitoring and management of the pathway, was the focus of work package 3.

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.

The following key recommendations were 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.

The full report from this work package is shown in Appendix 8.

3.4 WORK PACKAGE FOUR (WP4: IMPLEMENTATION)

A series of reports have been written and will be shared across all three Integrated Care Systems: Kent and Medway, Surrey and Sussex. The reports will also be shared with NHS England, more specifically the Discharge Team, to support dissemination nationally.

A Service Improvement Tool has been developed which pulls together the findings from:

Work Package 1 – Staff Experiences

Work Package 2 – Service User and Carer Experiences

Work Package 3 – Process and Outcome Measures

This tool outlines the three key themes that emerged from the study – Commissioning, Multi-Disciplinary Working and Knowledge and Information Exchange. It allows the user to click through and seek more granularity within these themes. It sets out the key questions to ask when implementing a successful D2A pathway, with examples of the enablers and barriers that were identified throughout the research.

A short-read project summary, with links to all on-line resources including the Service Improvement Tool, will be disseminated through the AHSN Network and the NIHR ARC network and via social media including Linked-In and Twitter.

Similarly a short video and podcast will be developed to support dissemination of the project findings in alternative formats in order to reach a wider audience.

Policy briefings will also be developed and shared with NHSE/ DHSC/ LGA.

Finally a series of on-line briefings will be held for stakeholders across Kent, Surrey and Sussex to outline the findings, introduce the Service Improvement Tool and to support mobilisation of service/ system improvement. These events will be open to those interested in or working across the discharge pathway, including those with lived experience.

A plan to measure impact includes the numbers accessing the Service Improvement Tool, feedback from commissioners, and the number of improvement projects implemented.

4.0 DISCUSSION AND RECOMENDATIONS

The first two aims of the study, i.e. staff experiences and identification of barriers and enablers plus the experiences of service users and carers, has driven a significant proportion of the analysis and discussions. These have supported the third aim, that of developing metrics designed to support the working and development of the pathway.

Overall, the three pathways in the case sites felt evolved and developed with positive interactions noted throughout and a reasonably good approach to information sharing plus a significant amount of skill sharing to help both understanding of roles and the assessment of service users. The three high level themes (commissioning, multidisciplinary working and information) were common to all areas that we evaluated although 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 there seemed to be a need to further embed both the consistency and the understanding of the pathway in the teams providing them with, for example, local operational policies for the pathway; these would seem to be of likely benefit to the local understanding of D2A particularly given the complexity of this pathway.

There was generally good recognition of the benefits of D2A and good alignment with the national policy in terms of understanding by staff but the detail of delivery seems to need further work. In particular, the need for communication in all senses, requires improvement. Whether this is information to service users, a single point of contact for staff and services users, ensuring that all had access to a directory of services or the use of single shared records, communication seemed to be a strong theme that came through in staff, service user and carer data.

The service user and carer data suggest that the impact of poor communication and poor pathway processes cannot be underestimated. There were significant levels of distress and anxiety noted by service users and their families. Carers seem to be often forgotten in the process of care transition from acute settings which is deeply concerning given their role in the ongoing support of the person being discharged and the impact that it has on the ability for that person to return home in the longer term. The difficulty the project team had in accessing the views of the service users and carers was mirrored by comments from managers and commissioners that those views are not properly fed into improvement work for the services. In addition, the outcomes that the service users achieve and their experience remain largely unknown to local commissioners and managers. There is therefore a need to consider how these missing experiences can be captured and used.

Clearly capacity constraints need to be addressed but given that is a huge problem across health and social care currently and while it requires identifying within this report, addressing the substantive aspects of these capacity problems is likely to be resolved at a national level rather than be something local systems can make significant inroads into. However, managers and commissioners reported that they were not sighted on what capacity was available and where blockages were suggesting that the oversight of the flow of service users needs development.

Therefore our core recommendations from the evaluation of the three HCP's pathways, the service user experience and the development of the metrics that cover both processes and outcomes, have been built into a Service Improvement Tool for D2A services to consider. The Service Improvement Tool has been

designed to act as an aide memoire for clinical and operational managers to help them get the best out of this complex pathway. It highlights those issues that have been found to enhance or detract from a smooth and successful pathway.

The findings are broken down into the three themes (commissioning, multidisciplinary working and information), nine sub-themes and then into 62 key points that came out of the analysis. These points are enablers when done well or barriers when not. We have set these points as questions and they form the basis of the recommendations of this report. These questions help identify where pathways may be enabled to operate more effectively and comments from the evaluation from commissioners and operational managers plus quotes from the service user and carer report are included where they are relevant to the question.

Outside of the recommendations to HCPs for their commissioners and managers to consider we feel that specific further development work is need to develop a patient reported outcomes measure for people discharged from an urgent care pathway, one that provides a report on the outcome of the care both during and after the acute stay. Should this be developed across a wider area than individual HCPs then the data would be increasingly useful in the improvement of services and the understanding of more systemic issues.

We also suggest that at a wider level than individual HCPs there is work to integrate live data on flow and capacity into existing oversight tools to ensure operational oversight is possible across not just HCPs but ICBs too.

The D2A Service Improvement Tool is therefore recommended as a key way to establish areas in current services that may benefit from review and that the development of PROMs and live data are recommended to enhance broader oversight of multiple services and to enhance improvement work.

4.1 LIMITATIONS

This study was based on case studies of three D2A services and while the recommendations from the evaluation of these provide a reasonable level of consistency, they may not be reflected in other D2A pathways and those other pathways may have different areas needing to be developed. That said, we believe these findings should be helpful for most pathways in most HCPs.

The evaluation was clearly limited by the inability to recruit service users and carers to be interviewed. We hope that by the use of Healthwatch and Carers UK data that we have captured patient and carer experience and although it is not specific to our three HCPs, it does have a greater breadth of relevance.

APPENDICES

1. Health & Care Partnership (HCP) Selection
2. D2A literature review
3. Project Protocol
4. Sussex HCP report
5. Kent HCP report
6. Surrey HCP report
7. User and carer evidence review report
8. Metrics report
9. D2A Service Improvement Tool