EVALUATING DISCHARGE TO ASSESS PATHWAYS

FEBRUARY 2023

Surrey Downs Health and Social Care Partnership

Contents

ACKNOWLEDGEMENTS

We would like to express our sincere thanks to the people in community, social and health care who took the time to take part.

This evaluation was funded by NHS England as part of the National Insights Priority Programme. It was conducted by the Kent, Surrey, Sussex Academic Health Science Network and the Applied Research Collaboration Kent, Surrey, Sussex.

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 places, Health and Care Partnerships (HCPs), were identified to act as case studies for evaluation in order to meet the aims of the overall project. Surrey Downs 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 pathways 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. An evidence review of patients' and informal carers' experience and outcomes is underway however this will not be specific to Surrey Downs 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.

The Surrey Downs HCP identified D2A pathways 1 and 2 as key service change and priority which contributes to system sustainability, improvement of flow and access, improvement of processes and outcomes, and supporting post-pandemic (and intra-pandemic) working.

This report provides Surrey Downs HCP with place-based findings based upon the staff interviews conducted across the HCP. 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 across Kent, Surrey and Sussex:

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, a shared vision for person-centered care, and sustainability of commissioning of all providers involved within the D2A pathway delivery.

KEY FINDINGS

- Surrey Downs demonstrates some core strengths within the delivery of D2A:
  - There is overall consensus that D2A has the potential to improve **person-centered** health and care outcomes and care transition.
  - There is a consensus 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
  - **The Home first principle is strongly held with all services,** community teams work hard to implement this principle as well as patient-centered care.
  - Community organisations involved in D2A are beginning to feel more involved.

- There are currently some **barriers** to the implementation of D2A. The most reported are:
  - **Concerns around capacity to deliver D2A** mainly due to workforce crisis in Homecare.
  - **Social care's removed involvement** within the wards creates a barrier to knowledge exchange and skill sharing.
  - **Different teams working in silos** (e.g., ward, physios, OTs, social care). This 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.
  - **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.
  - **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.
  - There is a strong need have **consistent measures and outcomes across all services** to evaluate D2A's effectiveness and implementation.
  - **There is a need for better service provision for patients with challenging behaviour, reduced capacity or serious mental illness across the system.**

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 (e.g., patients being discharged to the right service).

KEY RECOMMENDATIONS

- Creative and consistent commissioning: centralised administrative support; 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.
- A better focus on collaborative and multi-disciplinary working; Third sector capacity and involvement/ scope; a directory of community resources is needed for all providers; single points of contacts needed across all services involved within D2A service deliver
- D2A training needs to be rolled out across all providers 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 -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:

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** – 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

Interviews with staff (n=8) within services that are involved across the D2A pathways within the Surrey Downs HCP 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 the Surrey Downs area 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 interviews included staff members in the following roles: social care, commissioning, operation manager and clinical.

2.2 DATA ANALYSIS

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. 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.

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

National funding made has made it easier to deliver D2A, to increase capacity and initiate joint working needed for the pathway to be implemented at its best. Community Services within the Surrey Downs area seem to be working well particularly within sourcing equipment and home adjustments, enabling a safer return to the home:

> *'So actually, one of the outcomes from us I suppose is that they come home, they're then put into our support and then we're able to build up or build them up to be more supported by empowering them to make their decisions, so we link them into the social centre or we link them in to befriending services or you know we try and find out about local knitting clubs or things like that that the person can join to kind of create a kind of wider support network for themselves, especially when they may be isolated and lonely. So, I think that's 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.'*

Barriers between teams have begun to blur and there is some concept of the pathway being a whole team approach:

> *"it created blurred boundaries and I think, you know, the blurred boundaries are good, some people can work with that but then others can't"*
>
> *" I think you have to look at all the pathways together, you can't look at one thing in isolation"*
>
> *"even before D2A... there was a part of that team that were integrated already... there was a lot of ground broken I think, you know, the managers that I had in the hospital team were talking to the managers of Health every day "*
>
> *"we had cross-competencies trainings in terms of ability to do some of the basic task historically done by other disciplines and also a more diverse workforce so we used to have like therapy assistants, now they all are changed into rehab support workers so they could do the care element as well as the therapy element "*

The Home first principle and a holistic approach to patient centred care is becoming embedded well in all services involved in the D2A pathways:

> *'I think will show, that's a really clear indication of what, how were they managing before, what their current needs, what are expected, how they think they're going to be and then, actually, where are they? And I think I was saying before, it's around, it's that holistic view to them, sort of what other options, I suppose we all do still, because I try and think holistically, you do think within your silos a little bit around what, you know, I can look at it from a physical, functional perspective and I've seen the social care assessments, it's much more around asking the person how they're managing, what they feel they want and how do we pull those together to get that?'*

"you're all part of that patient's journey and so you have to be really working well together. And I think my observation around that is that's not just at manager's level, that's all the way down to the rest of the team as well so you can have really good collaboration going on"

"we are a team now, are quite passionate about this approach, this Home First"

Staff have committed to the principles behind D2A, and as a whole it is seen as a cost-effective way of delivering integrated care within the community:

" I think the concept of it is really, really good, if they just got it right at the very, very beginning, I think it would be, yeah, I think it'd be brilliant, I really do, I do like the concept of it"

"Discharge to Assess really is that it's that step out of the hospital with a bit more of a wrap-round support that allows the social care teams or the health teams, predominately health I suppose really but, that ability to monitor somebody and support them that little bit longer, supporting the discharge process."

5.1.2 CAPACITY

Reasonable follow-on capacity for service users was reported as well as capacity to bridge care:

"we don't have anyone over 6 weeks, and we haven't had an issue with having somebody on for longer than's needed because we haven't been able to find an agency"

"We do try and aim to get them to bridge some of the care as well, so, actually, they can support the discharge a day or two earlier"

Despite some staff embracing the concept of D2A there are still cultural hurdles to overcome:

"it has been a cultural shift for many teams and that has been, you know, challenging"

"Sounds horrid but our older staff came into care, ... they've just seen too many changes."

"we're actually losing staff, because they didn't sign up to being reablement"

Despite some blurring of the boundaries noted above, there are concerns about the fragmented aspects of the D2A pathway with barriers between points in the pathway still being in place:

"we're not there yet as an, we're still, you know, it's quite partnership and we're not quite fully integrated yet"

"although we've tried to work together and break down those barriers ultimately, we are different organisations and ultimately, we do have different pressures"

5.1.3 OUTCOMES

There is an agreement that there is a lack of consensus of the financing of D2A across all providers, and that by agreeing continuity and longevity of the service will ensure it can embed producing stability:

"So that's there. And then there are some of the responsibility metrics moved from Acute into the community, so therefore equipment ordering and those kind of things in some places has shifted to the Discharge to Assess teams because that seems to be more efficient and faster and the other thing is, Discharge to Assess teams seems to be working 8 to 8, you know, 7 days whereas the Acute is, well in our case the Acute is not and there is no weekend provision so I don't think it helped with the Acute team's morale but then the community teams, maybe they became more powerful but then also it could be seen as, you know, more of work for them without having enough capacity to do the work"

"I think it could be better, I think that whole kind of referral pathway and then how the information is passed on, I think it can be a bit, the problem with hospitals is obviously they're working full stop around the clock so it can be a bit chaotic sometimes and you tend to, and there's always that Friday push which is then difficult to kind of manage as they try and sort of clear out for the weekend"

"but then that's because we work daytime hours I think from that side, and what we've talked about with this responder service that I mentioned, one of the, because we've only been running it for two months now but that, at the moment that's a 16-hour service, seven-days-a-week, so it runs from 6 o'clock in the morning till 10 o'clock at night and we hope once we've got through the pilot we can extend it to 24 hours"

While there seem to be some audits to provide assurance that the pathway is doing what it should, the data collection seems to be cumbersome and there is little responsive / live information to provide feedback to staff and managers:

"Once they're out, we try as part of an assurance that we do, just to ensure that we know that they have gone to the place that they said they were going, with the right level. So, but that's not an easy process to do for all patients, so it's quite admin heavy on our data, on our discharge tracker in terms of them just ensuring that all the bits are completed with, you know, rather than, and there is a clear plan of care, that, actually, they have gone with that live-in carer and they're at home, safe, done, but, again, that's, you know, I'm talking sort of within a day or two of discharge, that's the level we have'.

"we don't really know what happens after that and they go somewhere else and, unless they happen to come back into hospital or back onto our list"

"from the coordination point ... once they leave, the further on information and feedback isn't readily available to us"

Getting the right level of care in place to get the patients on the right pathway the community is challenging, resulting in difficulty managing risk:

'And then therefore you end up having more patients going through Pathway 2 and then Pathway 3 become again, maybe the capacity to see them at home, say 24-hour care is not enough so therefore they go to residential or nursing home placement. So to me, I think the biggest issue is the capacity in Pathway 1, mainly in social care capacity, once we are able to address that as a system then we should be able to manage the other two or at least Pathway 2 much, much more effectively'.

5.2 MULTIDISCIPLINARY WORKING

5.2.1 CONNECTIONS

The pathway is person centred and staff feel that it brings together all the aspects of the care from acute to home:

> *"D2A has really helped [a much closer partnership] because it's looking at that whole pathway and bringing everything together"*

> *"from a management point of view ... influencing and negotiating and being able to keep ourselves on track as to, even though we come from different organisations actually, what's the right thing for the patient?"*

Staff report that the service is flexible and able to quickly adapt to patients' needs:

> *"I think we've had to create some capacity ourselves by looking at different ways that we can work and the fact that we've been able to do that to some success, you can't really go back from that can you?"*

> *"our middle name is change, and we will look at ways to make it easier to make it better for the patient, and we're always open to new ideas and whatever, and to work with partners"*

> *"as long as you're making decisions quickly and you're getting that information quickly from the wards or whoever it might be I think that's where the pathway bit really works"*

> *"it's about that to-do attitude, ability to communicate, working together and then ability to quickly respond to any changes, those kind of things is more and more important and if you are a standard, you know, bog standard therapist or a nurse, I think they will struggle to survive in Discharge to Assess pathways."*

Cross disciplinary understand was strong and has helped increase a whole person approach to care:

> *"we had cross-competencies trainings in terms of... ability to do some of the basic task historically done by other disciplines and also a more diverse workforce"*

> *"now they all are changed into rehab support workers so they could do the care element as well as the therapy element or they could do multiple therapy components and the nursing components and the care element because it doesn't make sense for you to go and only do the therapy while the patient need a support with going into the toilet and maybe getting off the bed and there is no social care capacity"*

> *"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"*

Commitment to working together, sharing information and creative solutions through discussions, huddles and MDT's is a major strength identified through the interviews within Surrey Downs:

> *"in this huddle you'll have like, you'll have doctors, you'll have nurses, you'll have therapists, you'll have Social Care, etc, etc, I mean there's you know a wide membership so you don't feel alone in having to make the next decision about what that patient needs and that's really helped us I think with things"*

> *"we have the MDTs people or staff members who have gone out to see that patient will come back and report back their findings and of course, and/or raise concerns if they have any around the visit that's just taken place"*

'but if they notice something that's of a concern they need to have a huddle or a meeting that they can come back to and raise those concerns and we've worked really hard to have that in place and that's the huddles that I spoke about before'.

This results in a positive approach to patient centered care and robust responsibilities towards risk management:

"So there is a kind of whole load of, you know, are we going to manage these risks, is this going to be safe, is this going to be doable, is this going to be okay. And is everybody on board with it, and if not then sometimes you have much bigger conversations about what's going to happen. So that's what the team spend a lot of their days doing is reading the Trusted Assessments, making sure that everybody knows what they're doing and then waiting for the care to, you know, to come along so they can have the next conversation".

"And then in terms of, I think, onward support, so if somebody is ready to be discharged, we do have a number of different options available to us. So, for example, like, the At Home team that actually can pick up some care, they'll bridge a few days of care, plus provide a multidisciplinary input. So they could provide some therapy, equipment, there's nurses, we've got doctors involved, frailty support. So, actually, there is this really strong team that can support these patients on the day that they've gone home, to ensure that we can keep them home rather than dancing straight back in again. Yeah, and then, as I say, onward links within community services from there on. As I say, we've got access to the system, we know who's already involved and how to, you know, sort of support that onward referrals, monitoring".

"the other thing from a management point of view I think is, and this is around sort of working cross-organisationally… is influencing and negotiating and being able to keep ourselves on track as to why, even though we come from different organisations actually what's the right thing for the patient? So, I will often take part in steering groups where we've got senior managers from Social Care and other organisations, voluntary sector, whatever, you have to, you're loyal to your organisation of course but you have to try and work together at supporting patient's".

"I can do the honest answer which is they're too risk averse in hospital so they're actually sent out with a higher package than what they need, what they need to be, so we would then reduce those through, what I would like to see is that, is for them to be having the, that conversation with the person and with the family, agree on what they feel is sufficient for them to be discharged on"

"So I think that shared ability to take that shared risk between the pathways is really important".

5.2.2 CO-ORDINATION

A single point of access has helped facilitate good working relationships between the hospital and out of hospital teams:

"having a key contact in a hospital team... for us that really helps because it builds the relationship"

"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."

While interdisciplinary training was noted, training in the principles and nuances of D2A was felt to be missing:

'Yeah, and I mean, actually, a good point, because if I think about the staff members within the team now, actually, we've never had that opportunity to say, do you understand what D2A is, do you understand what we're looking at and how and why?'

'so I think how it could be improved is generally, 1) awareness could be improved, you know, there could be patient awareness improved, the family's awareness improved, staff awareness, all those things, you know, I think that might go with the training as well. In other ways, you know, it's about having clear pathway and you know, which is agreed by everyone, that's really useful. And then always case studies and examples would help'.
"Is there any specific D2A training available for new staff?" "No. No. It's conversation, it's teaching them."

5.2.3 CULTURE AND SKILLS

Different perspectives on care and need through Health and Social Care. Prescence of Social care within hospitals creates disconnect between professionals working with the same patients. Care providers and health community services perceive a lack of connection with hospital staff in care transition. They feel that there is more a 'stepping down' of responsibility than sharing responsibilities. This perception is interlinked to difficulties in communication, coordination, and information sharing discussed in section 3.3:

'Yeah, and I think it works with social care in the hospitals, but I also think there needs to be a presence, needs to be reablement in there as well, so when you do get these cases where you think actually we really don't know what's going on with this patient, […] well hang on a minute, let's take him, assess him for a few days, see what he's going to do and then actually see whether he needs to go onto something else'.

"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".

"'I think D2A from the ward perspective is, not this is just my view, don't quote me on this, [laughs] but my view is the ward don't really get D2A and or what all the nuances of it, so when they say to someone oh, you can go there self-funding or yes, you can increase your care they, I don't think they've got the breakdown of what that means in D2A that you should, you know, we need to offer D2A, and we need to make sure that these increases are looked at under D2A because that's when we end up unpicking things and having to look at them retrospectively, so it is about that message from the time they go into the hospital, us all saying the same message and all understanding what D2A is. That would help a lot".

Many places are struggling to provide D2A to patients with challenging behaviour, that have diagnosed or undiagnosed mental health needs, or have cognitive impairments or conditions such as dementia. There is a general lack of provision for these groups of patients and some of the skills required are missing from general teams:

> *" if it's somebody who needs one-to-one because of delirium or confusion […] you're then looking to community beds and the care home beds to take these people.."*

> *"It depends on how you see mental health… everyone was sort of sat there going oh I can't deal with mental health, I don't understand mental health, but your person with dementia, your person with Alzheimer's, your person with a cognitive decline are all mental health, so explaining it to them in that way works, so for us our Alzheimer's cognitive impairment, if we can see that we can work and actually get them into a better routine then we will take those in-house, so for our mental health specialist pathway, the person needs to be known to mental health team but they cannot be in an episode crisis, so they have to be stable and just wanting to learn maybe something new."*

> *"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"*

> *"…people with dementia, I think particularly the families have been quite defensive about swift moves out of hospital to a temporary placement. It's not so much people going home, that's not so much of an issue but when there's a placement involved that usually means that somebody is quite, quite badly affected and therefore another move is not something that they can cope with very well"*

5.3 INFORMATION AND KNOWLEDGE EXCHANGE

5.3.1 ASSESSMENT

Staff described a good initial assessment tool that is generally completed well however there were some concerns that the information is not always accurate.

> *"one of the ways that we've tried to look at this and tried to do it well within Surrey Downs is having a, what we call a joint assessment so this is a document that has been developed by a number of teams and services so that includes acute, community services, Social Services, continuing healthcare, etc. so lots have people have come together and devised one document so that will follow that patient from the point that they're in hospital"*

> *" the form is working, it's got all the information"*

> *"So I think one of the biggest barriers is just, as I say, it's that getting the right information, at the right time, in the right format"*

The transfer of information between points in the pathway was felt to work well, particularly with the use of both written information and verbal handovers. Commitment to working together, sharing information and creative solutions is a significant strength identified through the interviews, resulting in a positive approach to patient centered care:

> *"get that communication really slick between all of us so when they're on the ward they're being seen by the therapist, you know whatever they are discussing and communicating with the patient that then comes to us and we have that information and we pass that information on"*

"it's normally backed up with a conversation as well from that side especially on the quicker discharges where they want us to kind of come in quickly from there"

There is disagreement on the process and principles of assessment and concern about the accuracy of the service user assessments:

'Ideally there should just be a seamless, they've been assessed, this is what's agreed within a multidisciplinary approach, and they're discharged into it. Realistically, I think there are sort of levels within that… yeah, so there probably are still some steps along the way and some challenges in terms of the transition from acute, from health to social care or into, even into a community hospital in terms of what information has been provided, what are they using, you know, how are they planning for onward planning within those.

'I've always said D2A is around that ongoing assessment, and that definitely has been lacking'.
"So I think one of the biggest barriers is just, as I say, it's that getting the right information, at the right time, in the right format"

IT access and access to patient systems across the HCP's providers. There is a need for a single electronic patient record to support the joint assessment / trusted assessor approach, which is shared and accessible throughout the pathway:

"we get a paper form which some are typed up, and has full information, and some are handwritten that you can't even read, got loads of abbreviations"

" in the Acute... they still use the paper records"

'how much it is trusted across the different organisations is, doubtful'
PARTICIPANT:

4.3.2 MANAGEMENT

There was some difference of opinion around the nature of the transfer of information which evidences a positive attitude to improve the system i.e., whether information sharing is electronic or not, yet there was some evidence of shared systems and a desire to widen this:

"a live document that follows that patient through and you know if I'm going in to see that patient I will input into the same document as would my colleague going in the next day or the day after"

"we use EMIS where we are, now not everybody has access to EMIS but what we try to do is have sight of each other's systems"

"it could be electronic which will make the lives easier and avoid duplication and repetition"

Oversight of the pathway in real time was manually collected and shared, while a more automated system would clearly be beneficial, the manual system seemed to be useful. The acute trust appears to have better business intelligence based around collection of national metrics:

" I keep a spreadsheet just because I do, I like to know where they've all gone and what timeliness, so I've got a little clock that tells me when they're coming towards the end of their D2A so it, for me there's probably a lot of control that I have about the D2As and where they go and when"

"it's quite a manual calculation in terms of numbers, where are the challenges, where are the delays, you know, how is that information being shared"

"there's lots of tools that we use to look at utilisation of the pathway, the delays, blockages and why those are happening along each pathway and that's information that's shared twice a day"

"our integrated dashboards have information like the number of medically fit patients in the acute because you work specifically with that acute, so that's one of the areas and the super stranded and stranded data comes to the dashboard"

Managing patient, carer and family expectations works well in the community however ensuring that they are provided with correct and timely information across the pathway is always difficult and requires continued focus for it to work well enough:

"it's going through all of the paperwork again with the person, all of the paperwork with the family, so that could take up two visits where you're not actually assessing that person, it's just re-explaining what they should have been informed at the start of the service"

"Xxxx hasn't really got to grip with the fact that she's going to be self-funding her package of care from tomorrow or her family and it's all a bit last minute."

"when they go into hospital they're supposed to be given brochures, you know, documents that tell them about D2A, what the pathway is, and, you know, the right to reside and all that is meant to be explained to them and I don't think that happens, so often when we're talking to them they're not really understanding D2A and you spend a lot of time I think with families explaining what D2A is and what it isn't and what the funding is and what it isn't"

'My experience is that the hospitals do not give out the correct information for what that refer, for that particular person and for that particular family, so we go out, we explain that the referral has come through via this Pathway, this is what we will be providing, and they get oh well, I was told that I'll have carers and it'll be 6 weeks free care'

"if the information hasn't been given in the correct format people don't get it, and then their families don't get it"

'between the hospital and coming home actually understanding what services that patient is going to receive, is not given to the patients, so a patient will be told that they're going to come home with reablement, they're going to have it free for six weeks and you're going to have four times a day, so the communication between them and them coming out to us is not right so then we have the uphill battle of actually then turning around and saying to that patient, actually no that's not our service, this is our service. Whereas before when we had social care on the wards didn't have that, because they knew our service'.

Enhanced capacity management and consistency in monitoring across the system to ensure that management information is as live as possible would help improve utilisation and responsiveness:

"'I think capacity in the community though it changes so quickly, it's like, you know, what, you know, you can, and even for Xxxxxx in reablement, they can have no capacity in the morning and then they

can have capacity in the afternoon because things have changed and it's, I think it's quite hard for any system to keep up with that, with that kind of level of change, that's really hard"

"quite a lot of it's quite a manual calculation in terms of numbers, where are the challenges, where are the delays"

"we have spreadsheets upon spreadsheets"

There seems to be a further need to focus on making the pathway person centred:

"'There's been a lot of benefits in terms of more open discussions around what is available and what sort of person-centred, what they really would benefit from right now, but at the same time, because it got to the point where, well, you have to have this when you leave, to try and then find the capacity all the time, and some of the challenges, family saying, well, actually, no, it's fine, I'm just going to take them home, or, we'll pay, it then delayed it because there's an extra step in the process where we have to ensure that that information is clearly given to everybody, and we do know there have been some issues that have come because complaints and queries come back saying, but why wasn't I offered it?"

'With all the right people there, they should be a multidisciplinary team to do that, to make sure that those 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.'

6.0 CONCLUSION AND RECOMMENDATIONS

The Surrey Downs pathway 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 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, the funding doesn't directly translate into additional capacity or skills.

In terms of key recommendations:

6.1 COMMISSIONING

- A continued focus to embed and champion the D2A culture and strategy.
- A further blurring of boundaries to create a sense of virtual team which should assist with better information and referral flows and continue to build trust along the pathway.
- 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 can embed and have stability.
- Improved automation of data capture and information generation to assist with both the operational deliver of the pathway and to provide assurance to commissioners.

- Continued training and improvement in the skills for assessing and managing patient risk, particularly between the acute and community teams where often quite different understandings and approached to risk are evident.
- Building in weekend capacity across all services involved in the D2A Pathway, including GP services would help re-admissions

6.2 MULTIDISCIPLINARY WORKING

- There is a need for better service provision for patients with challenging behaviour, reduced capacity, or serious mental illness across the system. Specialist mental health workers are needed (advice and treatment) across health and social care providers within the D2A provision.
- D2A training needs to be rolled out across all providers working within the pathways to ensure everyone is on the same page. Surrey Downs has a strong internal and cross-competencies training for staff, however social care is somewhat left to figure it out for themselves
- In conjunction with the recommendation on risk above, there is a need to ensure that patient / service users care is transferred from one setting to another rather than being discharged from one place and admitted to another.
- Third sector capacity and involvement/ scope. A Directory of Community Resources is needed for all staff.
- Single points of contacts needed across all services involved within D2A service delivery, Key workers or coordinators, plus better administrative support for families and patients. This will improve knowledge across services, patient, and carer involvement, empower patients and carers with the knowledge they seek and will overall impact a patient's holistic care.

6.3 INFORMATION AND KNOWLEDGE EXCHANGE

- Continued improvement work on assessments and their accuracy to minimise risks to staff and service users.
- Improving service user and family expectations of the pathway:
    - Patient information / leaflets to improve information about what service users (and families) can expect from different services.
    - Produce clear guidelines on what information should be included in the referral, especially for conditions such as fractures and cognitive impairment. Ensure that patients and families receive this information and that it is reiterated accurately and often.
    - Patient Centred Single points of contact needed (to help patients, carers and family members to understand who to talk to for information and advice.
- Accelerate actions designed to integrate different IT systems / service user record systems, preferably working towards a single electronic patient record.
- 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.
- Staff single point of access needed to improve information flow, capacity management knowledge between all providers within the D2A pathways.

REFERENCES

Department of Health and Social Care, 2020. Hospital Discharge Service: Policy and Operating Model. Department of Health and Social Care.

NHS England, n.d. Quick Guide: Discharge to Assess. https://www.nhs.uk/nhsengland/keogh-review/documents/quick-guides/quick-guide-discharge-to-access.pdf