Evaluate Discharge to Assess Pathways

PLACE-BASED REPORT FOR EAST SUSSEX HEALTH AND CARE PARTNERSHIP (FEBRUARY 2023)

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EXECUTIVE SUMMARY

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

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

This project had three aims:

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

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

System pressures resulted in staff being unable to support the recruitment of service users and attempts to recruit them through alternative routes failed. We then opted to carry out an evidence review of patients' and informal carers' experience and outcomes however this is not specific to East Sussex. We include a short summary of key findings in this report; a more detailed presentation of the findings will be included in the final rapid insight report. Outcome measures have been developed and will be applicable across all areas; here we include a summary of key measures and a full presentation will be covered in the final rapid insights report.

Interviews with commissioners and staff in social care, community and acute services were conducted between April 2022 and July 2022. Interviews were carried out on Zoom or MS Teams to understand staff's experiences of being involved in delivering D2A.

From the interviews, three core themes were identified based on interviews across KSS:

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.

This report provides insight into these three core themes in relation to the D2A pathway in East Sussex and, particularly pertaining to barriers and enablers to effective service delivery.

KEY FINDINGS

- Consensus that D2A has the potential to improve **person-centred** health and care outcomes and care transition.
- Consensus that for D2A to work there has to be **coordination at a commissioning level** and between different players in acute and community health and social care services
- There are currently some **barriers** to the implementation of D2A. The most reported are:
  - **Concerns around capacity to deliver D2A** due to workforce crisis in Homecare, limited number of district nurses and O.Ts. and well as limited availability of acute staff for care handover.
  - **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 perceptions of power imbalances in who drives the process. This hinders 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. Whilst capacity to deliver the pathway are affected by wider issues (e.g., workforce crisis in homecare, overworked NHS 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).
  - **Perceived power imbalance** in driving the pathway. Care providers and NHS community practitioners (e.g., GPs) feel they need to be involved earlier on in the discharge process and commissioning.
  - Uncertainty of **duration of funding** makes it hard to initiate the changes needed.
  - Need to have **consistent measures and outcomes across services** to evaluate D2A's effectiveness and implementation.

1.0 POLICY CONTEXT

Delayed hospital discharges are an increasing trend in the NHS. Longer stays in hospital can lead to worse health outcomes and heightened care needs, especially for older people. During a major incident, keeping acute beds free is essential and to assist with this in March 2020, during wave 1 of COVID-19, the government issued emergency funding up to August 2020 from NHS England for a new D2A programme. The funding covered the costs of post-discharge care for up to six weeks. While aspects of D2A had been in use in some areas prior to the COVID-19 pandemic, the policy issued in March 2020 put D2A at the centre of discharge processes for patients who required support to leave hospital for the first time. National guidance was revised in August 2020, and extra funding was made available. While current policy maintains the same D2A model ringfenced NHS funding for D2A was withdrawn in April 2022.

Two core assumptions stand at heart of D2A:

1. reducing the time people spend in hospital is best for patients and for the NHS, as it increases the availability of beds in hospitals while improving people's health outcomes;
2. assessing patients in a suitable environment (e.g., people's home) is preferable to assessing them in hospital.

D2A 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 is able to 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. 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 (n=11) with staff within services involved in D2A pathways 1 and 2 were conducted between April 2022 and August 2022 to explore 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 East Sussex 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, primary care, social workers, home care providers, care home providers and the voluntary / third sector plus health and social care commissioners.

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. Analysis was conducted using the qualitative data analysis software QSR NVivo (Version March 2020).

3 PATIENTS AND CARERS' PERSPECTIVE- SUMMARY OF FINDINGS

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.

The three core themes and subthemes are presented in Table 1:

Table 1. Summary of themes and subthemes

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

These are categorised into strengths and barriers to effective service delivery and areas for further consideration (recommendations and best practice).

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.

5.1 COMMISSIONING

5.1.1 FINANCE

Strengths

Staff commented that national funding made it easier to deliver D2A, increase capacity and initiate joint working needed for the pathway to be implemented at its best. This was highlighted particularly by commissioners and social care providers:

> "[what] *was easy to deliver was additional capacity because we had national funding, the national money that came in through the response to the pandemic, which meant, you know, whether it was additional beds, additional home care hours, or what have you, you know, we were able to do it*"

Barriers

Staff reported that uncertainty around funding made it more difficult to build long-term changes that would improve joint work and shift culture at a system level. This issue was mostly reported by NHS and Local Authorities commissioners and managers:

"Because the funding was always quite short term, it was always being agreed really late, we've never come to that sort of settled place where people knew that that was going to continue so things like the [discharge] *hub has been run on a real shoestring, so think I it would be really useful that if we said, yeah, this is how we're going to work and these are the people who are going to work on it, then that's the bit where you would start to really upskill those people"*

"having had national money, you know, it's very easy to be good partners when there's money in the system but when the money runs out things get a bit more tricky"

5.1.2 CAPACITY TO DELIVER D2A

Strengths

Staff in social care services identified consistent throughput as a positive outcome of D2A, with the potential of attracting new workforce:

"The positives of it [D2A] *have been that you're getting a regular stream of referrals of clients"*

"We are in the process of recruiting additional staff into our teams to help us have a larger workforce with relation to Home First, there will always need to be that element of staffing in the acute to do the screening to get these patients out, so it's a fine balance of having the right decision makers in an acute setting and then having the ability then that there's that constant capacity in the community."

Barriers

Overall, staff reported concerns on the capacity to deliver D2A across hospital and social care services due to understaffed and overworked workforce:

"[D2A] *relies on a finite amount of resource and that resource is very, very fragile, you only need some sickness, absence not related to sickness, training, annual leave, and that fragility that sits round that service is almost compounded by the fact that actually you haven't got enough resource to respond."*

The majority of staff interviewed identified the workforce crisis in homecare as a barrier to deliver D2A. This is a long-standing national issue that was exacerbated as a result of COVID-19 and VISA regulations following Brexit. Even though limited homecare capacity is not caused by D2A, it has an important impact on the commissioning and delivery of D2A and the 'home first' principle:

"we've obviously got considerable (…) capacity issues within the care industry, specifically home care, and therefore to assist the D2A pathway and the momentum forward with throughput has been challenging simply because, you know, capacity is not necessarily there. (…) we haven't had capacity problems, it's a new thing for us, we hadn't had it for 6 and a half years and then it fell off the side of a cliff last September [2021]. *(…) Covid continues to be an issue because not only have we got leavers from the industry, we've also got a fairly high level of absence due to sick leave and Covid infection. So all the time overseas recruits come in and you think four and a half thousand additional hours, it's actually not, a lot of it is backfilling absenteeism at the moment."*

"what has been extremely limiting has been the ability to secure home care capacity and a lot of that is about the national market conditions of home care. You just can't buy it, you know, there's a critical shortage of home care hours and home care staff, so whilst we know that's what we need, we know that's the key part of our Discharge to Assess model, in the absence of that, you know, our sort of

discharge pipeline so to speak, the pathway blocks up and clogs up so that's been a perennial challenge to us"

"I have asked our service placement team why. They say since leaving EU the carers has problem in staying in UK to work. A lot of care agency lost their carers, that's why they don't have capacity, they don't have manpower to put a new pack of care, so it is mainly that reason."

There is also limited capacity in other key services and roles to deliver D2A. These include district nurses and OTs, and care homes. This can affect the timeliness of discharge and quality of post-discharge care packages, with care homes and home care providers having to find safe solutions to deliver specialised care that they wouldn't normally be equipped for:

"we actually did secure some money to get some more Adult Social Care assessors, for example, we couldn't get the assessors, it wasn't just about internally, you know, we couldn't even find agency staff. We know that OT and PT are really thin on the ground, so again, even if there was money for that we've really struggled for that."

"There aren't enough district nurses, they don't have the time, and one of the things we have found is that we are taking on more and more district nurse [type of clients] *and we're now pushing back because we're not trained to do it, we're not insured to do it and it's causing a big issue."*

"If we don't have the temporary support for the formal care package also take a very long time before the care agency is sourced, which has delayed a discharge not because of the assessing process, but because service is not available. For the D2A bed the situation is also the same, the availability in the community is also very limited, it's quite long time can be wait before a care home available for people to move to from the hospital."

Reablement, rehabilitation and specialised services (e.g., mental health or cognitive impairment support) are also described as scarce and sparse, with important consequences on the type of care available to people post-discharge. This can result in poor discharge outcomes for people and families, delayed discharges, and added work for staff and managers in social care services:

"The OTs and the physios, there wasn't enough of them and they weren't getting around until latest end of Week 2 which means officially by the end of Week 4 they've only had two weeks' worth of rehab, so the patients that could re-enable we've totally devalued through their medication, through their physicality and through their mental health just by D2A."

"I think there are particular gaps for us around more challenging mental health and that's because there's very little provision in the county and therefore of course that's reflected here too"

"The only issue is that the actual physical number of (…) dementia residential homes, dementia nursing homes, they're quite few and far between, so it's having the availability of the homes to then discharge people to if you get what I mean."

Social Care commissioners and providers relayed a more nuanced view on community capacity to deliver D2A. While they maintain that there is limited capacity in homecare due to national and systemic issues, **they suggest that community capacity is sufficient but is badly used as often patients are not discharged to the right service and the services needed are not available**. They identify poor assessment from hospital (see 3.3.1 for more details), limited availability of specialised services (see point above) and limited homecare as main causes for this to happen. This is a main barrier to 'effective discharge', a principle of D2A.

“makes it feel like there’s not enough beds but actually if the home care bit was working right, we believe we’ve got the right number of beds but we haven’t got it, it feels like we haven’t got enough beds because the home care’s not there to move people on from”

“So we’ve got capacity, as I say I’m sat here with an empty bed, assigned, paid for with the staff to look after a potential client to go in there but they don’t. And it would be a good tool, the D2A stream I think is a good idea but if they [hospital] *don’t have the staff at their end to facilitate it there’s always going to be a block in the system.”*

“So there’s a really interesting thing about what’s reported and what’s real about some of that stuff, so when you look at it we have not used our bed capacity very well throughout all of it, so often there’s been noise saying there aren’t any beds and it’s like but there are loads of beds, they’re all here and they’re empty, you know, then you get into ‘well are they the right beds?’”

“The classic comment I had from the discharge teams was we’ve got plenty of beds, we don’t need any more beds commissioned, we need the right beds at the right place.”

“Failed discharges [into the community] *are quite high, that’s slightly concerning, and (…) I’m going to say the level of support planning and assessment is questionable and results in quite a lot of complaint from the provider market.”*

“There have been patients that have got delayed at different places because at times the whole Discharge to Assess pathway has been clogged up and blocked for the want of social care and home care particularly. (…) There are people who’ve been stuck waiting in an acute ward for longer than we’d want because (…) they get assessed as needing a package of say home care but we can’t provide that for them so they end up in a care home bed instead.”

“I think there are particular gaps for us around more challenging mental health and that’s because there’s very little provision in the county and therefore of course that’s reflected here too”

5.1.3 OUTCOMES

Strengths

There is consensus among staff across acute and community health and care services that D2A has the potential to improve outcomes for people, by fostering person-centred care and a smoother transition of care. This is in line with the ‘home first’ and ‘person-centred care’ principles in D2A and shows common understanding of the pathway across organizations and professional roles:

“I think the outcome, the impact on service user is better. Why do I say that? Because when we set up the care package for people to go home we set it up temporary support. Of course when people have rehab potential there’s a rehab patient service for them to go, like go home with a reablement service, from joint rehabilitation service, so they can carry on improving, they are kept abilities and functioning abilities at home back to their normal level or independent level, and also go to, or go to an intermediate care centre to have a period of mobility rehabilitation before going home.”)

“there’s definitely something about moving people through from the acute environment having that sort of smooth transition from the acute environment, effectively something of a step down stay for up to 4 weeks. It, did seem to just work relatively well, you know, well received and I think in terms of outcomes, where we could move people on to what was the right longer term, you know, medium to long term setting or get people, more importantly, where we could get people back home then it worked very well”

Interviewees also recounted that D2A has the potential to have a beneficial effect on staff outcomes, by facilitating a smoother and timely transition of care:

"I think what should end up happening is that you increase the skillset of your workforce and you're increasing their knowledge because they've got a better knowledge of the acute and the community. So I think it would be a benefit to the workforce."

"I think if Discharge to Assess has got an aim of a higher quality and more accurate assessment behind it and therefore we can glean more information and paint a clearer picture for providers, I think it actually assists the team."

Barriers

Staff reported that the way D2A is currently implemented doesn't make it person centred. Some voiced the concern that since the COVID-19 pandemic there was more focus on hospitals' need to free up beds than on patients' needs. This is a major barrier as it hampers one of the core principles of D2A**:**

"We're pretty good at getting people out of hospital, what I don't think we've maximised is the whole person-centredness, the looking at that person and wrapping services around that to try and deliver that greater independence bit."
"[D2A] *it's for the hospital and to get the beds cleared, it's not for a patient, nobody is taking that patient's journey and considering the implications for it, with all the clunks that it is at the moment"*
"I think in terms of outcomes for the client, I think that's gotten lost in we just need to get them out of hospital, if you know what I mean."

Staff showed concerns for unequal outcomes for people with complex needs (comorbidity, mental health, cognitive impairment) and for older people. These result from lack of specialized services (see 3.1.2), sparse care homes, and poor assessment from hospital (see 3.3.1).

"It feels a bit like a monopoly at the moment, it's a bit of a lottery in terms of where you live and what your needs are. Because if your needs are low-level and you live in a certain postcode, you're going to get care because we've got carers there. If you live in a rural postcode and you have high-level needs, you're going to go into bedded care. Or, if you don't go into bedded care initially, you're going to stay in hospital a long time. And I think we need to think about the health inequalities that that brings and inequalities that brings to individuals based on where they live and their needs and presentation"

Social care staff also raised concerns about the fact that moving patients with cognitive impairment (e.g., dementia) to different places in a short frame of time can have negative impacts on their health. This can be addressed by improving capacity and assessment, but it also raises the question whether D2A as currently implemented is the preferable pathway for people with cognitive impairment:

"Maybe someone's got dementia, you know, actually moving them into a temporary bed for assessment and then moving them again isn't a person-centred approach, it's about getting them out of hospital, it's not about what would be the best thing for that person"

"The Pathway just doesn't work for people who have cognitive impairments, you know, because again you're moving them around so I think that they should be an exception to the Discharge to Assess Pathway, if it's to stay in place in some way I think they need to be considered completely outside of it because, you know, I don't think it's very fair to, you know, to be saying to a family member of someone with dementia that yeah, we're going to place them here and then we're going to decide and then move them again"

Staff also noted that current barriers to the delivery of D2A result in negative outcomes for staff in community health and care services. They described how issues such as poor assessment, complex post-discharge care needs, limited specialised services, increased services users' complaints, all resulted in added workload and pressures for staff managing and delivering health and care in the community:

"The amount of turnover and churn with having five dedicated blocked beds is enormous, so it's very hard work with your staff team with such a high turnover of clients. So [D2A] *it's certainly not a particularly easy option to go for"*

"We deliver the care calls for which we're paid for but all the ancillary work that goes around somebody being discharged who doesn't have the correct medication so we have to speak to the hospital, speak to the GP, try and get the pharmacy on-board to get that correct medication, make sure that the medication that the client, the patient went into hospital with is no longer there, make sure that the equipment's correct, go back to the hospital, try and speak to the OTs, the physios, what equipment do they think this person needs, it's just, um, be honest it's a complete mess and there isn't one Health Board who's better than another"

"I think overall providers have probably, you know, come to have less faith in hospital discharges as a result of this because I think they've probably picked up more difficult situations than they did beforehand."

Care providers have pointed out that CQC expect the same care planning and safeguarding process for D2A clients as for long-term clients. This is a long and laborious process and can be detrimental to a timely transition of care and assessment process expected in D2A, potentially resulting in worse outcomes for social care staff and patients:

"We have to go through all of the same rigmarole for somebody on the D2A as you would for a long-term potential client coming in, all of that care planning, all of those assessments, all of those man hours, you know, and somebody might only be with you a few days. (…) That is a barrier because it's labour-intensive. You always know that if it was a client coming in for a long-term placement, you know, it might take you 4-6 weeks if you've done a full care plan for somebody but actually you've got to develop all of that within a couple of days for somebody, you know. The expectation of Social Workers and the CQC doesn't go down just because the person has only been there for a very short period of time, so you're trying to reach an almost unattainable standard several times a week for different people."

5.2 MULTIDISCIPLINARY WORK

5.2.1 CONNECTIONS

Strengths

Staff reported that D2A has enabled strong connections between hospital and social care, especially at a commissioning and operational level, in East Sussex. This has fostered open and honest conversations, where issues can be raised and addressed timely:

> *"Long story short, is that, you know, there have been sort of challenges and bumps along the way but actually the partnership working, the joint approach, the Health and Social Care across all of Sussex work extremely closely together so that works really, really well."*

> *"I think we are in a really strong place in East Sussex in terms of our ability to influence some of the decisions that are made, I think that's a really strong partnership working with regards to us being able to have conversations with colleagues and quite frequently I have telephone calls that are not planned and somebody phones me up from the health or the CCG to talk through a situation and we try and troubleshoot and resolve that issue as it arises which is a really, which is really beneficial that rapport's there."*

Social and primary care staff reported that D2A has strengthened communication and collaboration across community health and care services. This includes regular communications, shared responsibilities, and joint work to address barriers:

> *"we use JCR which is Joint Community Reablement, they're like a short-term service of physios and OTs, so we've probably gotten better relationships with them because again we have a meeting every week and anybody that we can see needs their support in one of the D2A beds we have that meeting and they know to immediately respond and go into that person, so that's probably massively improved that joint working"*

> *"we've developed [a form] with our local GP surgery about accepting certain types of clients under a D2A. (…) We use it literally just so that we can pin down, make sure that somebody at the hospital is agreeing that the information that they've given is accurate."*

Barriers

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 4.2.2 and 4.3.1.

> *"What tends to happen is that the passing off of the patient between health and social care that's where it falls apart because I think once the hospital signs somebody off as medically fit to be discharged and discharges them, there's then no joined-up working to make sure that that person is safe at home"*

> *"I don't think that there's been much cross-organisational working together, it could improve, and only when I put my foot down we were able to get hold of the consultants from the hospital to talk to me"*

Despite the recognition of improved commissioning and communications, some staff reported the need for leadership to foster more open conversations between health and social care staff on what works and what doesn't work:

"In terms of leaders across the system, I think there is work needs to be done around our transparency in us being able to, in a safe environment have honest conversations with each other without the other one feeling that the other one's setting them up. And I think it kind of sometimes feels like there is the divide in how we're feeling, particularly saying one thing, doing another. So I'd welcome a more honest collaborative approach and being able to be honest with each other."

5.2.2 COORDINATION

Strengths

Staff reported that the Discharge hub set up during COVID-19 worked well as it fostered joined-up work across health and social care and operated as one point of contact for D2A:

"The discharge hubs, at the beginning of Covid because there was all of this big push to get the patients out, share Covid to the care home and all that jazz, they put local authority into an office, they put the hospital into an office, everybody came together to look at what they've got and it worked really well but then they took it all away again."

"Multi-agency discharge hubs so, and what that meant is that, you know, linked to the acute hospitals there's, you've got acute staff, community NHS staff, and Social Care staff all, you know, working together either virtually or on sites, you know, on the same patient lists (…) And that joint working, you know, it took a bit to establish that, get it right and get it going but it's been there through the pandemic and that's been, that's one of the sort of things that's really made a difference."

Barriers

Staff reported that different teams are still working in silos and this represent a major challenge to multi-disciplinary work required by D2A. They explain that this fragmentation hampers information sharing at the time of care transition, making the process 'clunky,' and has negative effects on patient-centred outcomes:

"It's a whole holistic pathway and people, if they aren't considering that then we're not supporting the patient but it is very segregated, the nurse will come in and do that, the OT will come in and do that and half the time never shall meet, whereas actually those experts could really support the care team to really empower that patient to go home."

"At the minute we're still very much probably an acute workforce and a community workforce so I think the change that is needed to happen is respect and knowledge of each other's challenges."

"[I think there is] *a lack of joined-up working and communication."*

Staff also reported that the lack of one point of contact in hospitals makes it difficult for staff in the community to gather information and being able to address issues timely. This has important consequences, including delayed discharges, poor discharge outcomes and increased workload for social care workers and providers.

"It's been extremely difficult to get hold of the hospitals because they haven't had dedicated personnel and staff to just handover to us about different residents." (SSX.S. 12)

5.2.3 CULTURE AND SKILLS

Strengths

Staff reported that D2A has promoted a shift in culture, particularly in hospital staff embracing the 'home first' principle:

"home should be the first option so that's probably been the biggest changes in people's thought processes related to it because they are thinking about it first now, saying actually let's try and get this patient home. So I think that's the mentality that, you know, that slow change of culture is probably starting to happen, I think has probably been the biggest change."

"I don't always think we're aligned in our values and ethics in regards to that, I think the social care role is more around advocacy for the patient and trying to advocate for what's right for them that's within their best interest or the least restrictive option or actually, these are the outcomes that they want to achieve and let's look at how we can support them."

Barriers

Staff, especially in commissioning and management roles, reported that the cultural shift needed to deliver D2A was slow and only happening in small pockets rather than at a system level. As seen in 3.1.1, this is partly due to uncertain funding which makes it difficult to plan and initiate system changes in the long term. Staff also recognize a different approach to care in acute and community services which could be a barrier to cross-disciplinary work and consistent understanding of D2A principles across services.

"I think the challenges are actually it's a completely new way of working and there's definitely some cultural challenges there, so for a ward nurse who maybe doesn't have quite the knowledge or the experience of discharging patients so early with that community support may feel anxious about almost releasing that patient early or booking the transport for the patient and that's something that we haven't really, I think fully implemented yet within this area because I don't think we've got the robust enough structure in the community to pull all of the patients that are using this model, we've been able to do it with pockets of patients rather than a consistent kind of every day we will pull 10 patients out, we're doing almost a small test of change because we don't have the infrastructure to do this for a large cohort of patients at this point"

Staff in social care identified a limited understanding of procedures and logistics of adult social care from acute staff as a main barrier to multidisciplinary work. This can be understood as an issue related to the skillset needed to deliver D2A as well as a wider barrier to promote the culture shift needed to meet core principles of D2A (i.e., multi/cross disciplinary work, effective assessment). The quality of assessment from acute staff is also linked to this barrier and will be discussed in more detail in 4.3.1.

"It's also that skillset about really understanding what community can do and thinks sort of is normal, so I don't think we've got the right skillset matching patients, I think it's too, we have people who are probably, you know, very experienced about acute services but don't understand community well enough"

"It's all about that transition and I think what we haven't seen is acute really understand what community need. I think there's been, there's something really important about, for example, acute understanding that when somebody gets into a home then all of that paperwork, all of that responsibility, that's quite a huge thing so if you send someone the wrong information, the wrong meds, you haven't done the right assessment, that's massive."

"I think it's just because not knowing how we work with community, what happens to somebody in the community, that's the lack of knowledge and information, you know, it's well that's the main thing. So their departments are different from ours, and I totally agree they are there to be acute, mainly acute illness, once that is sorted they would like to pass the patient back to the community, but in the case of D2A beds what they should realise is they're going to unknown surgeries, they're going to be cared for

by people who do not know them, at least for that period of time that they're going to be there, so as much as passing on as much information as they can would be helpful."

"It requires a lot of respect for one another and trying to point out where there's going to be challenges, so for example trying to do a medication round here, you staff your nursing home based on the clients that you have and their dependency level, if you get clients in who suddenly need lots and lots and lots of professional input and meetings and CHC assessments and social work reviews, and all of that takes huge amounts of time and they want to have those meetings at half past 9 in the morning or telephone review, you know, and that can take all your senior staff off the floor for a whole day. And that, you can't foresee that and you can't suddenly increase your budgeted staffing for that but then they need to be reasonable in the community that you can't just drop everything and give them 2 hours or 3 hours of your time."

In terms of skillset to deliver D2A, staff reported that skills to deliver reablement and rehabilitation services are essential to deliver the pathway. While they do not consider D2A to need different skills from other discharge and care pathways**, they expressed concerns for the fact that the limited availability of these services and roles (discussed in 3.2.1) results in limited availability of reablement and rehabilitation skills, which impacted negatively on the pathway.**

"As I say you could get somebody who is compos mentis as you and I who might just have a few mobility issues, you know, just waiting for the OT to, I don't know, put them a ramp in their toilet or something at home, or you could have somebody in the most advanced frail state who needs, who's got Grade 4 pressure damage needing tissue viability input and so on. So you need to have the full gambit of skills really because you just don't know what you're going to get."

"we've got a training team which is nurse-led so our head of training is a registered nurse and therefore has got really good knowledge about both domiciliary care and health and, you know, we're regulated by the CQC to do tasks and there are tasks that we're not regulated to do, so unless the CQC change their regulations we can't, there are a lot of things that we can't do. And I think, you know, if you're working in quite a specialised complex care environment like, you know, harping back to the spinal cord injury, your staff are highly trained but in a specific area. Within dom care because we cover so many different ailments and illnesses and conditions, you can't, there isn't a one size fits all. So we will give additional training for, which is client specific but again my fear with that always as I said earlier is it's great to have that training as long as we can guarantee that a trained person's going to go in and do that. And yes the district nurses can sign off our staff are competent but that competency needs to be re-evaluated annually, sometimes every 2 years, who's then going to resign them off as competent? District nurses don't have the bandwidth to be able to do that."

"There is gap around having a team which is all about that reablement stuff, that gets someone home and very quickly say, can do stuff with OT, can we do some PT stuff here, so I think we probably are missing and not just the skillset, that's a capacity thing"

"There was no education for re-enablement so they had it for domiciliary care but they didn't have it for care homes and nursing homes, so they've got these D2A patients comings through but they weren't considering the implications of how we can re-enable, support enablement and what does that look like"

"The issue is how do we pay for that? How do we pay for OTs? How do we pay for physios? You know, if health were to fund this then absolutely fine, but yeah, health can't fund their own physios or actually find them. So yeah, so we've, the skills that we have in-house are not there to be able to really assist with the discharge process. We can feedback and we can do a very basic assessment but we can, you know, we can assess somebody's mobility because we do, we do risk assessments for mobility, falls risk assessment and so on, but we don't have the in-house knowledge to advise what that person actually would need in terms of equipment, rehab."

5.3 INFORMATION FLOW

5.3.1 ASSESSMENT

Strengths

Staff involved in assessing patients reported that the introduction of D2A the paperwork is simpler and quicker to complete:

> *"since the discharge pathway the paperwork is simpler, quicker to complete."*

Barriers

The majority of staff reported poor assessment from hospital as a main barrier to effective assessment. Hospital discharge assessment were described as lacking key information needed to assess, accept, and care for patient in adult social care. This was considered to be a major barrier to an effective, safe and person-centred transition of care, as it resulted in delayed discharges, poor outcomes for patients, added workload for staff in the community (e.g., OT.s, care workers and GPs):

> *"it's been extremely difficult to get accurate information about individuals from the hospital."*

> *"When the temporary patients come in they do not come with a full history, full medical history, these are people with a lot of comorbidities, complications, and we only get a very fragmented discharge summary from the acute care, which is incomplete most of the time or with a lot of errors in it."*

> *"We've had a lot of cases where the information that we've gathered from the ward is not always a true reflection of that person, so when the care home who will be holding that patient under the Discharge to Assess Pathway, they'll call up the ward and do their own assessment and they may finally get different information."*

> *"There is big disparity between the medication summary what the GP holds, and what the patient comes out of the hospital, a lot are really missed."*

> *"*[Information sharing] *it's really poor and we often have people coming home with no paperwork whatsoever, so we actually have no information about this person because they've been deemed medically fit for discharge and they're discharged but nobody anywhere has taken the responsibility to actually liaise with us. We just get told, you know "Mary Jones will be home at 3 o'clock on Saturday afternoon", the weekends are particularly bad, and we've got no idea a lot of the time what we're walking into, we have no background on this person whatsoever."*

> *"When we do care planning the barriers we find is the proper documentation, proper contact with the right person, whether it's old GP or old carer, or old, or the person's relatives, knowledge about, they have any power of attorneys or people who are looking after, who have involved, these are the people, to find out where these people are, make sure that they are properly involved."*

Staff also reported that poor assessment can result in risk management and safeguarding issues. At this end, it is also important to note that social care providers require a verbal handover to meet CQC criteria:

> *"The communication around the clients has been very difficult and that leads to quite a few safeguarding sort of concerns where we've had to raise it with the hospital that this is not what we were expecting with this client."*

"The amount of admissions that have been delayed just because we can't get hold of the wards often, so I'm sat here with a fully paid for bed that is available but I have to be able to assess that client first and we cannot for love nor money get hold of somebody at the hospital on the ward to give us a verbal handover. I cannot accept that person without a verbal handover of what their current condition is because otherwise I will have CQC and my doctors surgery raising safeguarding all over me because I haven't done an up-to-date active assessment."

"It is the fact that you've been misinformed so your expectation is one thing and actually you end up with something else, which hasn't led to a client not getting the care they need. So if we were a residential home, for example, without nursing and without all that equipment to look after people, air mattresses and, you know, nurses on site, that could potentially be extremely problematic to not handover clients appropriately."

"But I think again when somebody's discharged from hospital with completely new medication GPs aren't always aware of that. It takes a while to filter down and that's where the exposure is and it's dangerous."

"Covid has made that particularly difficult because we've lost the face-to-face assessment, it's done remotely, and generally the quality of specification assessment for the client is on occasion quite poor."

5.3.2 INFORMATION MANAGEMENT

Barriers

Staff reported some barriers in information sharing and management at a system level. Overall, they relayed the benefits of having one information system to share information across services, which is currently missing. There are currently multiple systems to (a) capture and share information on capacity, (b) share information (e.g., assessment) across acute and community staff.

"We are really clunky in terms of understanding where there is capacity, so if you say, okay, here's a person and they've got this need, they can go home but they're going to need x, y and z, there's no easy way to see who has x, y and z and so I think, a guy who worked for me was saying, you know, I think there's 12 different referral routes, 8 different information systems."

"I think that [information sharing] *probably needs improving, I think there must, there needs to be something around being able to share information much better, so our community teams use SystmOne but in the acute setting it's still paper for patients' documentation, so I think that would be something that needs to be a real improvement in this process is that information sharing across."*

Another barrier to information sharing and management is the different organisation of the services involved, particularly the NHS and social care sector. This impacts particularly the sharing of information on the performance of the pathway for commissioning and evaluation purposes:

"The information sharing with the independent sector, so that home care providers and home care providers, that gets a little bit more challenging, it's far better than it ever, ever was but that just gets a little bit more challenging just because of the dispersed nature of it, you go from dealing with, you know, to all intents and purposes, a handful of NHS organisations and 3 local authority Adult Social Care to then suddenly hundreds, hundreds of care home providers and home care providers."

It is likely that there are potential differences on the preferred way of sharing information about patients across services, and social and care staff expresses preferences for verbal handovers, which are a CQC requirement in social care (see 3.3.1).

"We want a system that doesn't put anymore labour on anybody, so having the verbal handover is still by far the quickest, safest possible way communicating about how somebody is. We don't want to have to sign people up to writing reports and all that kind of thing and sending it off or emailing."

"The acute Trust is going through a process of changing all of its documentation to electronic so people won't be writing on paper now but actually what I haven't heard is if that will interface with SystemOne or whether actually you'd still have to log on to a separate system and whether you'd need read only access or something"

A lack of KPIs specific to D2A at the brokerage level is another barrier identified by staff. It is important that data on D2A is collected and shared consistently across the system to be able to commission, overview and improve the pathway.

"From a measurable perspective and on reflection from this interview, I think it would have been useful for the brokerage manager to be involved more heavily in the conversations. You know, thinking about it now and going back to the measures, I think it would have been useful to annotate purchasing the D2A pathway transfer as such simply because it gives the market, provider market, a chance to feed back and say yes, these are better or they're worse"

6.0 CONCLUSION AND RECOMMENDATIONS

Staff involved with D2A really like the concept and seem to want it to succeed. 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:

Commissioning

- Providing certainty of on-going funding and commitment to the D2A pathway so that skill, capacity and processes can be developed. Establishing the longevity of the pathway will also foster the embedding of D2A principles consistently across services.
- Consult with all the teams involved in the pathway, including occupational therapists, physiotherapists, care home and homecare providers, GPs, voluntary and community organisations, to map capacity and find feasible solutions to capacity issues, particularly in homecare and specialised services (e.g., mental health, rehabilitation, reablement)
- Build capacity, for example through supporting training and recruitment in all parts of the pathway.

- Consider specialist skills and capacity to support people such as those with cognitive impairment. Placing patients in the wrong environment causes the pathway to slow down, and hamper person-centred.
- Ensure that the pathway is patient focused rather than simply a route to increase acute capacity.
- Design and share a document that describes simply the pathway so that all staff and service users understand it.
- Ensure that an understanding of how the pathway can address health inequalities (e.g., worse outcomes for patients with complex needs, mental health and cognitive impairment, 'postcode lottery' in availability of social care services) is built into service commissioning.

Multidisciplinary Working

- Strengthen the connections between acute care and community and social care. This will enable better transfers of care and better assessments, and open communications will support a continuous improvement approach to the pathway.
- Proactive involvement of all the key actors in acute and community health and social care at the different stages of the process to foster joined-up work, shared responsibility and accountability.
- An increased focus on points of contact and coordination. Who is it that teams should talk to when there is a question and how can the right person be reached?
- Skills, culture and knowledge within the pathway needs to continue to be developed.

Information

- Hospital discharge assessments need to ensure that key information needed to assess, accept, and care for patient in adult social care is accurate and timely.
- Handovers, particularly into social care, need to be both verbal and written.
- Adopt one information sharing system across acute and community health and care services to ease information flow.
- Adopt an assessment form that include all necessary information for care providers and community NHS services (e.g., GPs).
- Initiate processes that foster multidisciplinary communication and involve care providers early on.

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