Kent Surrey Sussex Academic Health Science Network

NIHR | Applied Research Collaboration Kent, Surrey and Sussex

Unity Insights

Part of TheAHSNNetwork

Office for Life Sciences

NHS

# Evaluating Discharge to Assess across Kent, Surrey and Sussex

## Findings and Recommendations for Good Practice

Transforming lives through innovation

# The Core Team

Kent Surrey Sussex Academic Health Science Network



Please drop your name, organisation and job role in the chat.

Please note, this session will be recorded for internal purposes. It will not be made public, but will be shared on request for people unable to attend.

Please check your microphone is muted. Please feel free to turn off your camera during the presentations – which can help preserve bandwidth and improve sound/vision quality

We have time for discussion at the end, and please use the 'raise hand' function if you want to ask a question or comment.

If you have any comments about what you are hearing, or questions during the sessions, please write them in the chat (and 'like' others).

# Agenda

Kent Surrey Sussex Academic Health Science Network



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|---|---|---|
| Welcome and Introductions | **Rebecca Sharp**<br>Senior Programme Manager (KSS AHSN)<br>Implementation Lead – Social Care (ARC KSS) | 15 mins |
| | | |
| Evaluating Discharge to Assess in Kent Surrey & Sussex<br>Findings and Recommendations for Good Practice | **Stuart Jeffery**<br>Senior Research Fellow<br>University of Kent<br><br>**Conor Briant**<br>Lead Analyst<br>Unity Insights | 25 mins |
| | | |
| Introduction to Service Improvement Tool | **Stuart Jeffrey** | 10 mins |
| | | |
| Question Time and Discussion | **Rebecca Sharp** | 30 mins |
| | | |
| Final Comments & Close | **Stuart Jeffrey** | 10 mins |

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# D2A introduction video

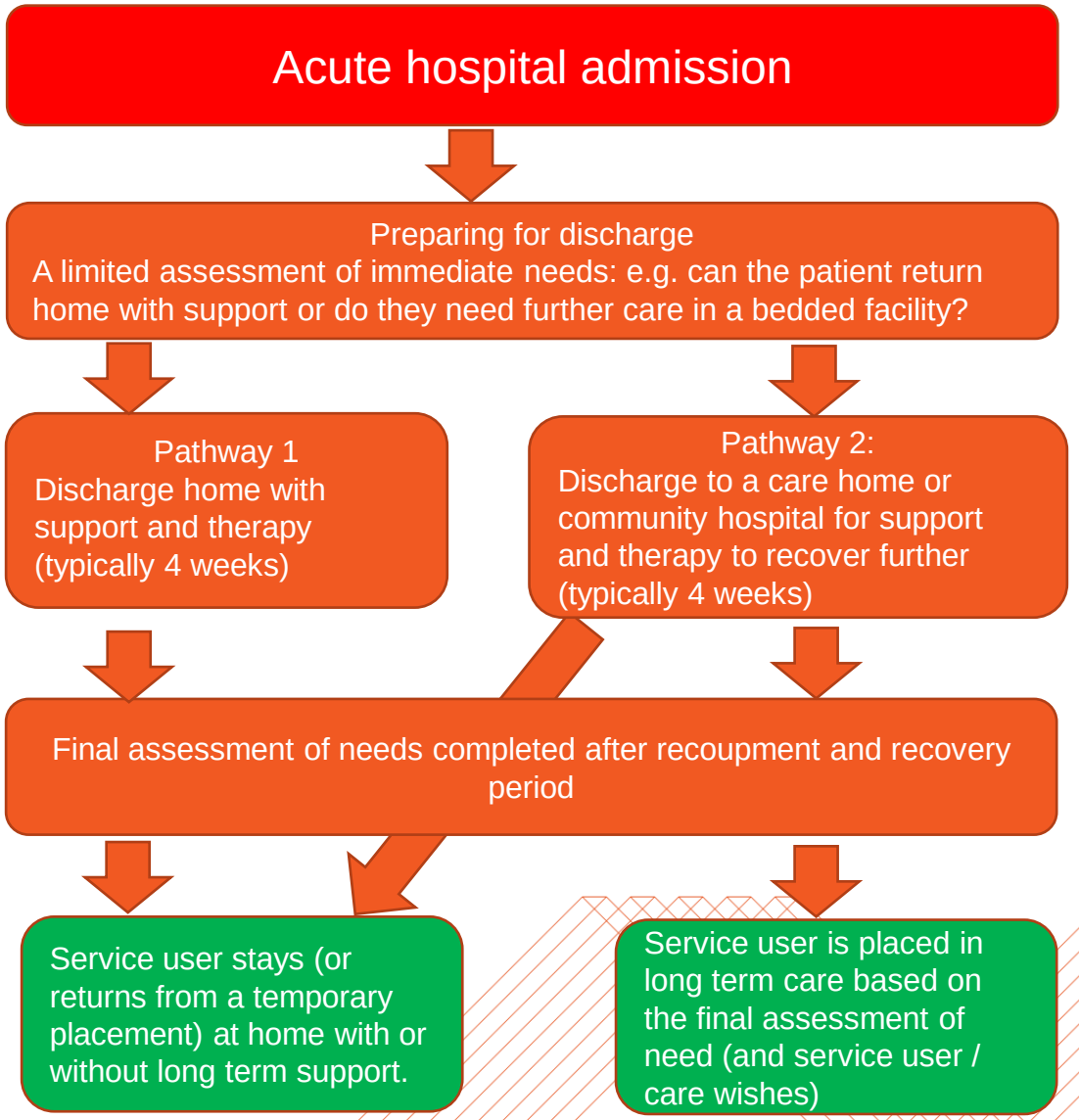


Reducing hospital stays and improving patient care - YouTube

# The Discharge to Assess Pathway



- D2A is based on the four pathway model for discharge from hospital.
- It's aim is for a rapid discharge followed by a period of support and therapy to allow the service user to maximise their recovery and independence and to minimise their long term care needs.
- The pathway involves health and social care workers from a variety of providers, settings and disciplines including the third sector.
- Support and therapy post discharge is funded by the NHS for up to four weeks. Onward support is means tested in line with local authority rules.



# Background to the evaluation



- Discharge to Assess rolled out / extended during COVID-19 with additional resources and effort across all systems.
- NHS England's Accelerated Access Collaborative funded evaluation of new pathways via its National Insights Prioritisation Programme (NIPP for short)
- NIPP v1 was 17 months and brought together Academic Health Science Networks and Applied Research Collaborations across England to provide these evaluations.
- Kent Surrey Sussex Academic Health Science Network (KSS AHSN) and the Applied Research Collaboration Kent Surrey Sussex (ARC KSS) met with ICS/ICB executives to find out what areas of evaluation would be of most value to systems. They decided on D2A.

# What we did…



- Chose three ‘places’ to evaluate – a real mix of demographics and one from each Integrated Care Board (ICB).
- Focused on the post acute / community / social care part of the pathways.
- Interviewed staff from community NHS services, social care – including homecare and care home providers, commissioners, acute hospitals and also the voluntary sector.
- Tried to recruit patients to interview but COVID-19 surges and acute pressures meant that we relied on Healthwatch and Carers UK data to understand the user experience
- Analysed and considered data flows and metrics.
- Involved a patient group of advisors throughout

# What we found ... and ca...

*"Nearly two ... felt that ... felt ...*

*"61% didn't receive information about the new discharge process during their hospital stay." and ...dents (61%) did not ...he process had ... in the ... 42 ...re*

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

Maintai...

Ensuri... patient/ca... involvement in decisions.

Difficulties in understanding the discharge process caused anxiety and distress.

...or safe care

...d shortfalls in the D2A process commonly led to feelings of confusion, anxiety and distress

# What we found out from staff



- A lack of local operational policies in place.
- The national policy on D2A had been helpful in bringing some consistency of approach, and…
- We identified a range of understanding on the purpose of D2A expressed by staff. These were close to the national policy but there were nuances. These included:
  - Improving acute patient flow
  - Improved outcomes and experience for patients and informal carers
  - Reduced readmissions
  - Reduced ongoing care needs
  - Improved staff satisfaction

# Our analysis



Three core themes were identified from the staff and patient interviews, these act as either barriers or enablers depending on their presence and delivery:

- **Commissioning:** how the pathway is funded, its structure and culture and the outcomes that are expected.
- **Multidisciplinary working:** the skills, knowledge and understanding of the staff, the connections between the teams, and how the pathway and teams are coordinated.
- **Information and knowledge exchange:** the way assessments are made, the management of the records and the availability of information to provide an operational oversight of the pathway.

# Commissioning



## Finance

- Is the funding sufficient to provide capacity to meet the demand?
- Is there agreement for longevity to ensure that the service is stable?
- Have out of area agreements been made?
- Is there capacity to provide care after the D2A period?
- Is there support for recruitment?
- Has weekend support been commissioned?
- Has capacity to bridge care been commissioned?

## Structure and culture

- Is there a clear strategy for the service?
- Has the team been built with a clear culture?
- Does the team operate as a single (or virtual single) team across the length and breadth of the pathway?
- Is there administrative support to ensure that there are good processes in place for the smooth running of the service and facilitate the flows of information?
- Have barriers between teams been removed ensuring that the team works as a whole rather than passing patients and requests between silos?
- Is there access to equipment and home changing / furniture moving?
- Does the team understand the purpose and principles of D2A.

## Outcomes

- Is the home first principle being met?
- Have outcome requirements for the service and their monitoring been built in?
- Is there a process for accountability and assurance?
- Is there transparency of outcomes, process and need across the system?

# Multidisciplinary working



## Connections

- Are the different players in the pathway connected?
- Do health and social care in the community work together or are there boundaries?
- How does one part of the pathway know what others are doing?
- Have silos been broken down and does the team work as a virtual team?
- Do community services have a strong voice?
- Is there a culture of development and integration?
- Is the service flexible and agile?

## Skills, knowledge and understanding

- Does the team include a range of therapists?
- Has the team been trained in therapy and rehab skills?
- Does the team know what other disciplines do?
- Do they understand the principles of D2A?
- Does the team have access to resolve housing problems (e.g. homelessness and hoarding)?
- Is specialist mental health support available?
- Have there been assessments of the risks in care homes and at home for service users with challenging behaviour?
- Are the needs of people with dementia understood?
- How are carers' needs addressed?

## Coordination

- Are there single points of contacts for key workers / coordinators?
- Is there a single source for knowledge and contacts?
- Are there huddles and MDT meetings?
- Is there a hub and spoke model for the coordination of the service and care?
- How are different perspectives on care and need managed?
- Is there continuity of care as patient moves through pathway?
- Is there knowledge and information sharing between team members?
- How is the third sector capacity and involvement managed.
- Is there a directory of resources?

# Information flows



## Assessments

- Do assessments start with essentials for discharge and increase in detail during the pathway?
- Is the assessment tool agreed by all parties? Do people have the skills to complete it?
- Does the information flow through the pathway? How is it shared?
- How are service users, carers and family expectations discussed? What information are they given? Is there an agreed set of information / leaflets?
- Do discussions with service users, carers and staff bring forward creative solutions? Is there an understanding of the benefit of not being in hospital?
- How is risk assessed and managed? Are risks understood by both acute and community staff? What level of experience and skill sharing is in place?
- How is the initial level of care needed identified and agreed? Is that level of care able to be changed quickly after discharge? How is this communicated with the service user and carer?
- Is there autonomy of decisions? How does the accountability work? Is a key worker assigned to each service user?

## Management

- How are service user records managed? Where are they kept? Who has access?
- Is there a single dynamic patient record? Is there a single assessment and recording process?
- Are records electronic and shared?
- Do all staff involved in the pathway have access to the electronic record? Can they both read the information and write to the record?
- How are the languages of different teams managed as the service user moves through the pathway? Are acronyms managed or banned?
- How are new staff inducted and trained in the use of the information? Can temporary staff access records?

## Oversight and outcomes

- Do key workers and managers know who is doing what and when?
- Are service managers, system managers and commissioners sighted on available capacity and the flow of service users through the pathway?
- Are service managers, system managers and commissioners able to monitor the pathway across system including waiting lists and capacity?
- Are outcomes for the service defined? Are they monitored? Are they reported?
- Is information on outcomes used to drive improvements?

# What the analytics team thought…

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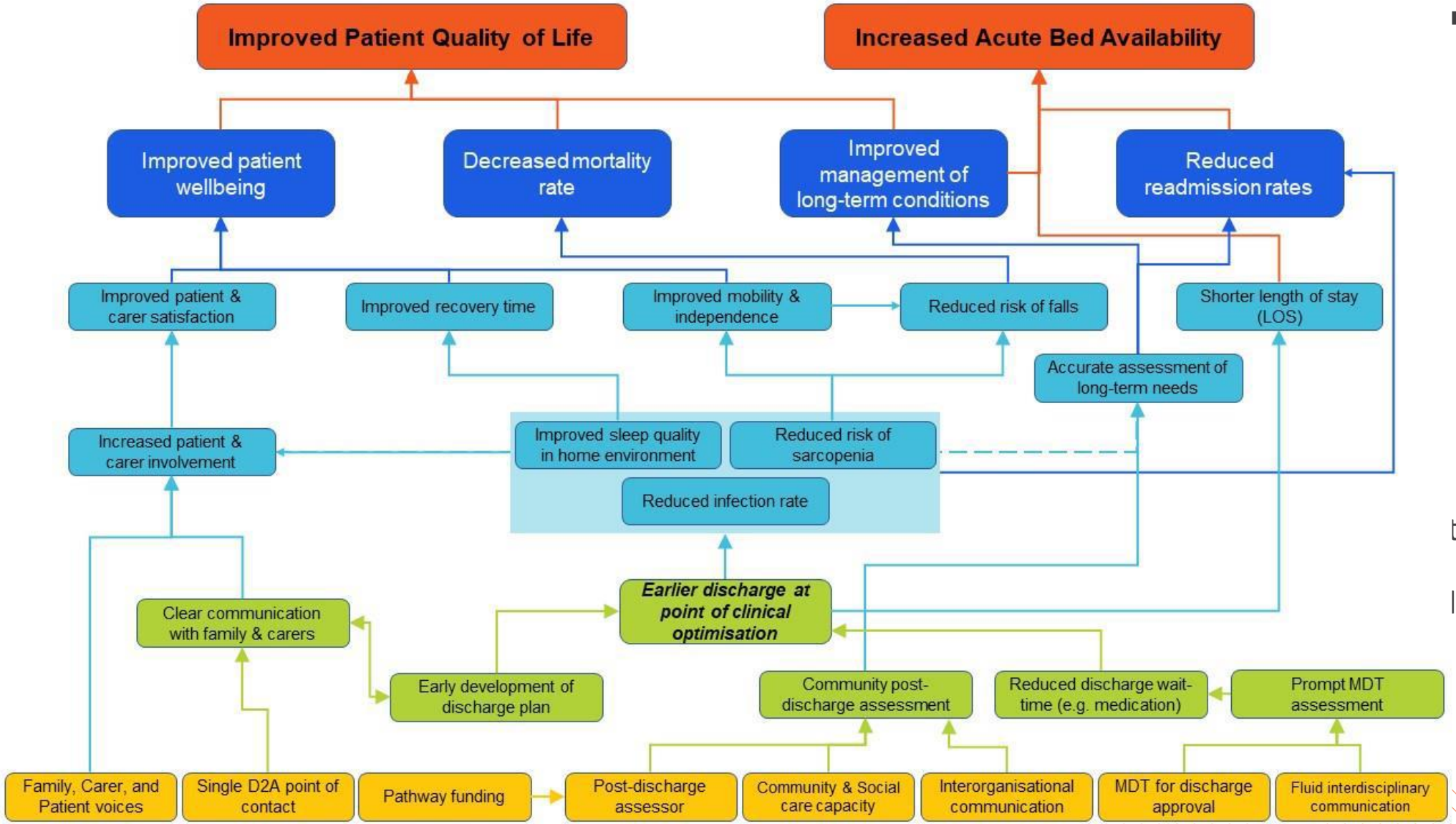


# The main findings

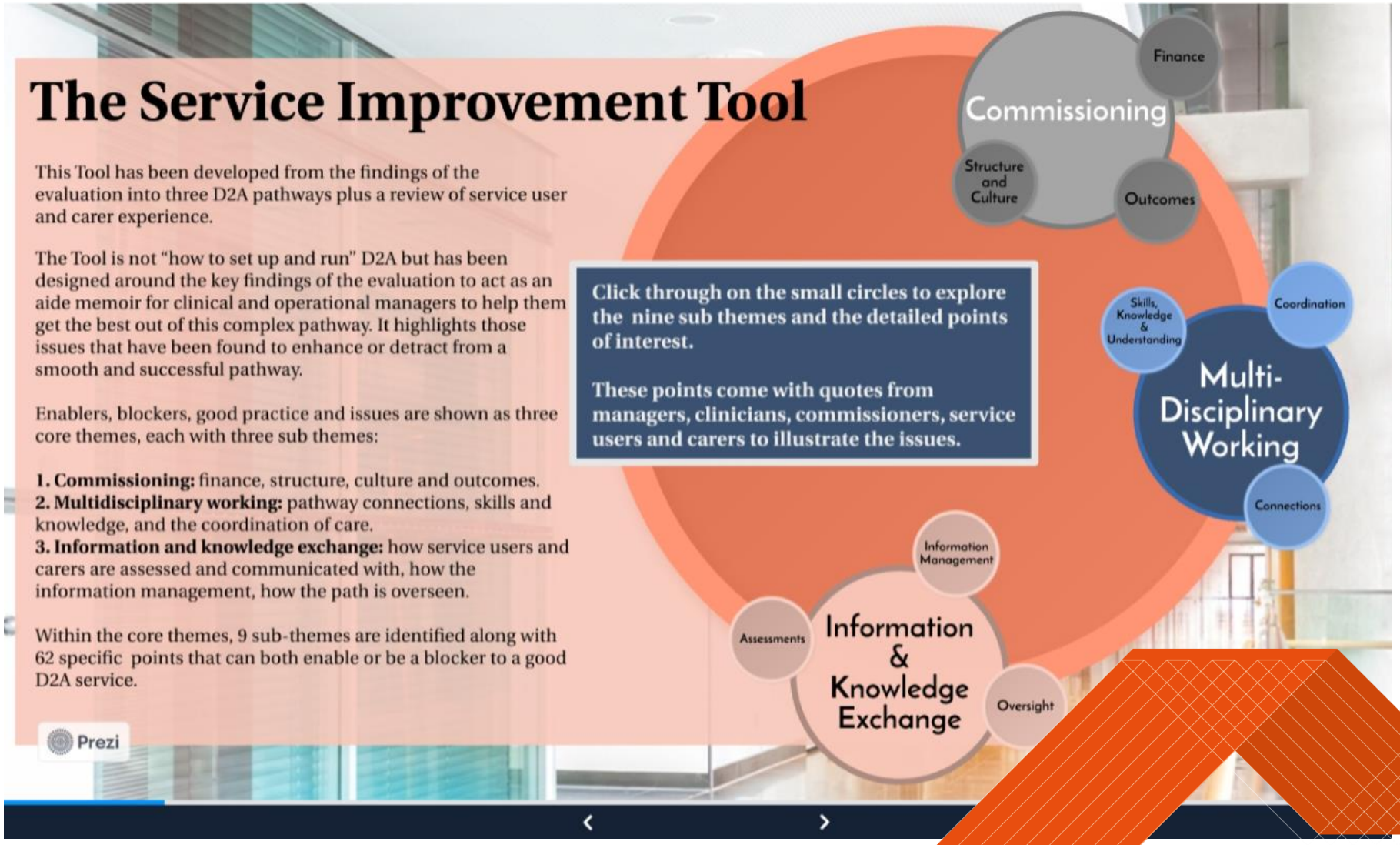


**The top six recommendations from this evaluation are:**

- The use of the D2A Service Improvement Toolkit to help identify and resolve blocks in the pathway.
- Ensuring a local operational policy for the pathway is available to all providers on the pathway.
- That co-ordination and communication across all service providers, and with patients and their carers, requires improvement.
- Carers can be forgotten within the overall care of the service-user, therefore assessment and involvement of the carer should be considered throughout the process.
- Oversight of the flow of service users needs development.
- To develop a consistent Patient Reported Outcomes Measure for people discharged from an urgent care pathway to aid feedback and service development.

# Pulling it all together





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# Menti – Question 1



**In terms of having the greatest impact, please rank the following six recommendations in priority order for implementation:**

- Greater collaboration between multi-disciplinary teams and use of the Service Improvement Tool to help identify & resolve blocks in the pathway.
- Development of a co-produced local operational policy that is available to all service providers along the pathway.
- A project focused on improved co-ordination & communication in and between teams, and with service users and their family & friend carers.
- An improvement project focused on ensuring assessment, support and involvement of family and friend carers throughout the process.
- Improved oversight of the flow of service users along the whole pathway.
- Development of consistent Patient Reported Outcomes Measure (PROMs) to aid feedback and service improvement.

# Menti – Question 2



## Please provide:

1. **Details of "other" priority areas for improvement (& why?)**
   **OR**
2. **Examples of good practice (& where?) that could be evaluated and shared.**

(Please note: Multiple responses are allowed, so you can provide multiple examples and/ or answer both questions).

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# MENTI RESULTS AND QUESTION TIME