Institute of Public Care
Show me the way to go home

Briefing Paper

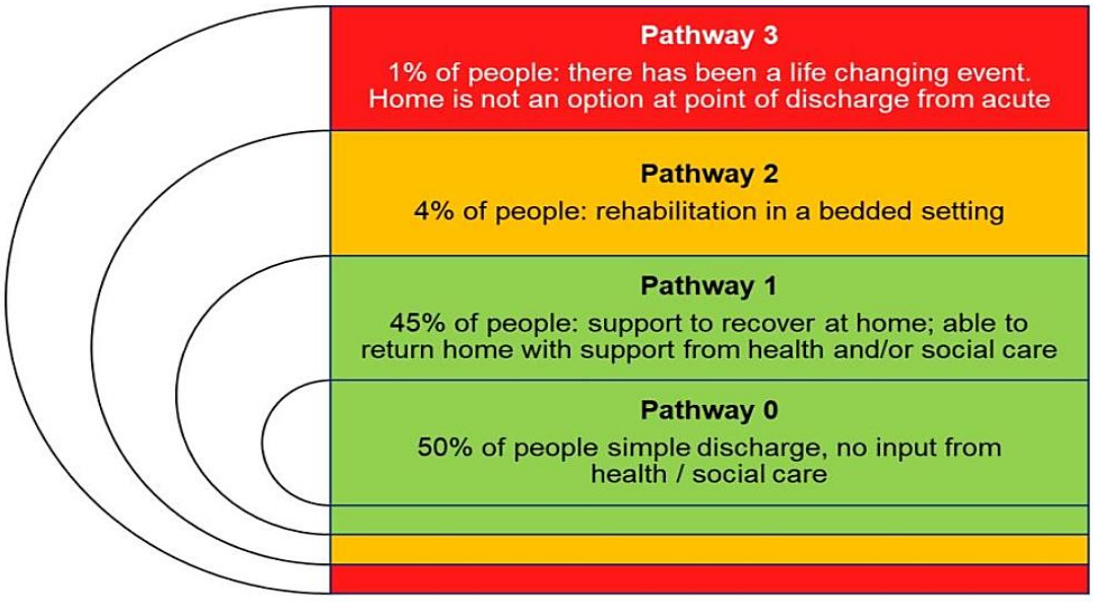
April 2022

Institute of Public Care
Show me the way to go home

Briefing Paper

More than two years on from the start of the Covid-19 pandemic, and despite continued high rates of community transmission, there is increasing emphasis on the move towards 'living with' Covid. For the NHS and social care this return to a pattern of the 'new normal' has been underlined by the ending from 31 March 2022 of the ring-fenced NHS money to support people post hospital discharge. What happens next, and what systems need to do to continue to support a Home First model, should be informed by the experience gained from the Discharge to Assess policy implementation. Below we reflect on the conclusions and insights gathered from a range of work with different health and care systems, and the factors associated with greater success.

From the start of the Covid-19 pandemic in March 2020, the policy response was targeted on protecting the NHS from being overwhelmed and maintaining the capacity of hospitals. Just prior to the emergence of the pandemic the Government announced some changes to the arrangements for the discharge of patients from hospital. This became a key component of the strategy through the implementation of Discharge to Assess (D2A). The initial emphasis was on releasing up to 15,000 acute beds within a week, and maintaining the timely flow of people through hospitals and discharge thereafter. This was never intended to be seen simply as a bed management policy, and the discharge pathways model embedded in the guidance (see below) was designed to ensure people received the right care, in the right place and at the right time, building on a framework developed by Professor John Bolton that focused on helping older people to recover following a stay in hospital. Systems were encouraged to understand the demands that they were likely to experience for each of the 4 defined care pathways by measuring their current resource use and by reviewing the suitability of the services that were provided to deliver a recovery-based model of practice.



As the March 2020 guidance (and subsequent iterations of it) made clear, discharge home should be the 'default pathway'. Getting people 'Home First' and assessing their needs only after they have a chance to recover in familiar surroundings, rather than assessing their needs in hospital was to be the key to both shorter hospital stays and enhanced outcomes for people enabled to regain independence. Importantly, a National Discharge Fund was established to support the costs of care packages (paid via the NHS) and providing a mechanism to circumnavigate the familiar contested financial responsibilities between health, social care, and individual patients and their families.

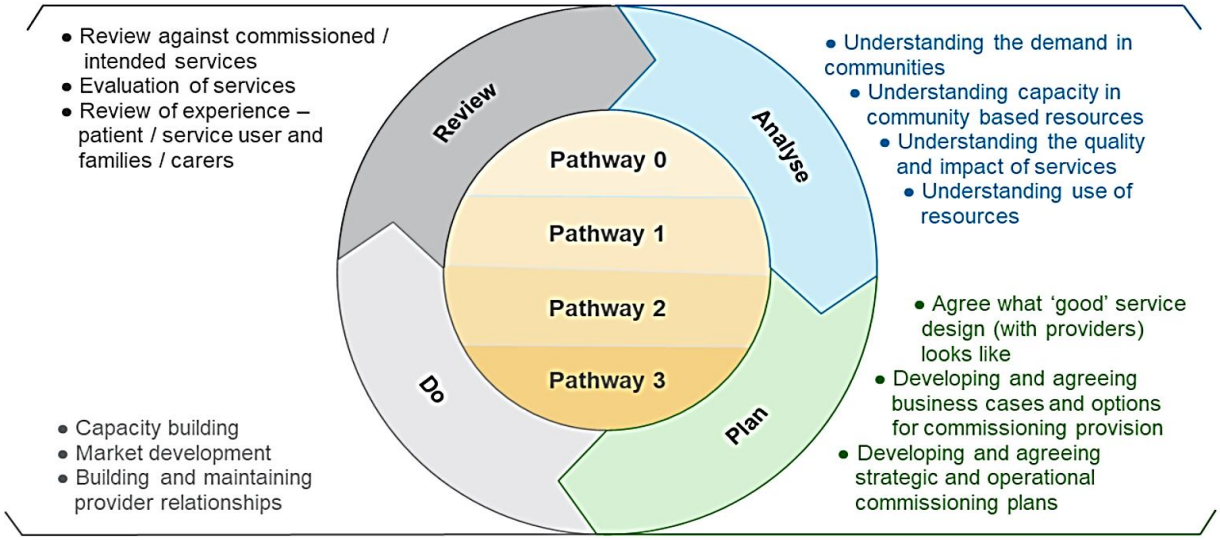
What has been achieved by the D2A approach throughout the country to-date is a mixed picture, but understanding the factors that appear to be associated with greater success is vital if good practice is to be more widely adopted, and the potential of D2A to transform care and deliver improved outcomes for people enabled to return to a level of independence is to be grasped. Such lessons are highly relevant to the government's White Paper for health and care integration and 'joining up care', and the aspirations to move beyond a compartmentalised and fragmented health and care system.

The Institute of Public Care (IPC) and colleagues at RSM were commissioned in 2021 by NHS England & Improvement (NHSE/I) to assess the impact of D2A through qualitative and quantitative analysis. We worked with a range of 10 health and care systems throughout England, and concluded that the policy and guidance gave a clear mandate and was a catalyst for local development and implementation. We found that the most important factors influencing the success of D2A include:

- **Intelligent market-shaping and commissioning strategies** ensure there are sufficient and appropriate community-based services commissioned or provided to meet demands, including low level support from the voluntary and community sector (and ensuring that people don't default to bedded provision for lack of these services).
- There is a focus in all **Intermediate Care services**, including bedded services, on getting people back home after a short-term episode of care, and these services do not lead inexorably to permanent residential admissions.
- The weekly demands on both community-based services and bedded services are understood and the **flow of patients** through these services is well managed (there should not be delays waiting for the next longer-term services); and
- The **performance measures** used to monitor the service adequately capture the above activity as well as individual and aggregated outcomes.

We have drawn together the key messages, building especially on the experiences and insights of those systems that seemed to have achieved better practice. These might usefully be analysed against a set of strategic and operational commissioning activities, organised around the cycle of:

- analyse;
- plan;
- do;
- and review.



Systems that have effective arrangements to analyse a D2A model will understand their current and potential demand and capacity across the system, and will monitor and understand the flow of people discharged on the D2A pathways, with an appropriate and regularly updated dashboard of metrics. Understanding the flow of people through the acute hospital enables systems to identify and predict the demand and capacity around intermediate care requirements.

It was evident that systems with an established model of Home First that pre-dated the D2A requirements started from a stronger position, as this participant described:

> "Because we had been in the Home First part of the story for quite some time, we were able to do some really accurate forecasting, which I think is a really important element of commissioning – getting that forecasting right."

Effective arrangements for D2A are contingent on a strategic planning approach that focuses on Home First across the whole health and care system, and making decisions about the intermediate care services that need to support recovery following discharge from hospital. Changes in the pattern of commissioning will typically be required, focused on early intervention, rapid response/admission avoidance and community-based support to maximise people's recovery and resumption of valued roles and activities.

The change in the balance of support is likely to see a reduction in reliance on beds, as this person commented:

> "We very quickly took strong decisions on not commissioning more beds, but actually commissioning much more into our home pathways."

Implementation and delivery of D2A requires everyone involved to sign up to and be committed to the ethos and principles of the policy. In addition to the importance of strategic leadership are the changes required in market shaping and capacity building, and developing more collaborative commissioning relationships with providers.

A crucial element of better practice has been the 'de-weaponising' of money; the availability of a National Discharge Fund to support D2A implementation effectively

removed contested decision making about funding responsibilities that have long been at the centre of difficulties in achieving timely discharges. This comment highlights the transformation of approach:

> "We trusted the people around us (…) also the money didn't get in the way (…) you didn't think 'that's my money, that's your money,' you thought – that's system money."

New ways of working need to sit within a changed no-blame and collaborative culture; examples of such practices include: engaging differently with the community and voluntary sector, building trust and recognising their contribution in supporting people particularly on Pathways 0 and 1; developing effective multi-disciplinary team working and enabling therapist-led teams to transform intermediate care services; and developing creative solutions to reconfigure bed-based approaches for complex needs, rather than it being a default offer for too many people leaving hospital.

Reviewing D2A implementation closes the loop and ensures that experience feeds back to data collection and use, and to commissioning and market-shaping activity. Indeed, data is the key to understanding and adjusting the system, as this comment underlines:

> "The data – it's not just something we have to do for a national return, but something that comes alive operationally day to day and is relevant."

The national requirements of D2A brought their own data collection and reporting requirements, but among better performing systems we found it was vital that there was local understanding and ownership of data in establishing a 'single version of the truth' across the system that all partners recognised and validated, and where they did not inappropriately challenge or mistrust the information.

Collecting the right metrics across the system is about much more than tracking hospital flow, and is crucially about monitoring performance and outcomes, as this person observed:

> "The whole premise of moving to the intermediate care model was to test and demonstrate that we could significantly reduce long-term care costs as a consequence of putting in that single reablement team. And that is one of our core metrics and we look at that week in and week out (..) we are demonstrating that we are giving people more opportunities to get home."

Furthermore, whether D2A is successful will reflect the shared understanding and commitment to change across health and care systems, and – fundamentally – how this is underpinned by creative commissioning and capacity building. Systems that have relied heavily on the availability of care home beds and community beds that are not used specifically for reablement will have met their objectives of emptying hospitals, but will fail miserably to support people's independence or enable their recovery and rehabilitation.

Supporting a genuine and properly commissioned D2A service can break the cycle of simply cost-shunting from hospital to community, but it takes time to fully realise the benefits. Where the approach was found to be working well the benefits realised

included shorter lengths of stay in hospital; lower permanent admissions to residential and nursing care, and fewer older people needing on-going health and care support. People needing support following hospital care should be discharged to their own home wherever possible in order to recover, or to a community-bedded service that will specifically support their recovery (i.e., it has the right staffing and ethos of recovery and provides the necessary therapy inputs). It should then be the case that the need for longer term health and care support is reduced for this cohort of people when their needs are assessed at the end of four to six weeks of recovery. This is likely to be the way to deliver both financial benefit to the system and also – most importantly – to secure better outcomes for people. However, achieving these outcomes requires a system-wide approach that looks at the overall benefits rather than attempting to apportion costs and benefits between health and care in a binary manner. There will always be a grey area at the interface of the NHS and social care and an integrated model of commissioning and provision is essential, underpinned by joint and pooled resources including the Better Care Fund and Section 75 arrangements.

The case for funding a properly implemented, recovery and outcome focused D2A model is that it allows people to be in the best place to support their recovery, and reduces the long-term care costs overall. We know that it can be done; but it is equally clear that not all systems are addressing all aspects of the D2A equation holistically, nor doing so in genuine partnership across organisational boundaries.

Systems that have made better progress are typically those that were already well advanced in their thinking and practices prior to the D2A guidance and had – at least – the foundations of a Home First model of support on which to build. Similarly, having good inter-organisational and multi-disciplinary relationships and clear strategic leadership appear to be necessary conditions for successful implementation.

The continued pressures on health and care services cannot be denied, as the systems begin to emerge from the worst impacts of Covid-19 it is not a return to a pre-pandemic world. But it is vital to capitalise on the D2A lessons of the past 2 years; D2A is not a temporary policy response to the demands of Covid-19, but must become the ‘new normal’ in managing transfers of care and optimising opportunities for recovery so people can return home and resume their lives without requiring high-cost long-term care. In highlighting the key elements that seem to be particularly important in enabling better practice to develop, we are not advocating a ‘one size fits all’ approach. However, it is worth systems paying attention to:

- understanding demand and capacity;
- planning for Home First and intermediate care;
- removing assessment from the hospital and ensuring it follows a period of recovery and support;
- commissioning what is needs and shaping the market to enable new models of care;
- developing strong strategic leadership and governance;
- having a single version of the truth around data and metrics;
- and focusing on outcomes achieved for patients and their carers.

Following this approach should not be seen as a passive checklist, but examining practice against these dimensions may be valuable for other systems seeking to improve their D2A performance, reduce long term costs and residential bed use, and achieve better outcomes and quality of life for people leaving hospital.

Philip Provenzano, John Bolton and Melanie Henwood worked with colleagues at RSM in undertaking the evaluation of D2A, and have continued to work with other systems in supporting Home First approaches. Systems needing support in managing their D2A strategy are welcome to contact IPC for further information pprovenzano@brookes.ac.uk