ANNEX B

Effective Commissioning for a Home First Approach

Supporting the delivery of positive outcomes and experiences for people who are discharged from hospital

Insights from the evaluation of the Hospital Discharge Policy and Discharge to Assess*

*Commissioned from RSM UK consulting (RSM) working with The Institute of Public Care (IPC), Oxford Brookes University by NHS England and NHS Improvement, 2021

Introduction

The promotion of a ‘Home First’ approach and planned timely discharge from hospital have been established as best practice over the last decade or more, although this is still far from being universal in implementation. ‘Home First’ is the default pathway when implementing a Discharge to Assess (D2A) model, although there are alternative pathways for people who cannot go directly home. The aim is to provide support or intermediate care at home for the majority of people, with assessments of longer-term needs taking place after discharge.

The COVID-19 pandemic introduced a powerful new dynamic and drive for rapid progress including hospital discharge service requirements to discharge all patients as soon as clinically safe to do so. This has led to considerable learning from the experience of implementing the discharge to assess model, and the wider implications for good commissioning practice.

The D2A model uses four Pathways:
Pathway 0 – Simple discharges with no input from health / social care.
Pathway 1 – Support to recover at home, with input from health and / or social care.
Pathway 2 – Rehabilitation in a bedded setting.
Pathway 3 – Following a life changing event; home is not an option at point of discharge.

Evaluation

RSM and IPC were commissioned in March 2021 by NHS England and NHS Improvement to evaluate the implementation of the Hospital Discharge Policy and Discharge to Assess (D2A) model, undertaking qualitative and quantitative research and analysis. Ten health and social care systems in England were selected to take part in this evaluation, to give a wide range of geographies, demographic profiles and D2A experiences. Systems participated in focus groups and provided data. In total, approximately 160 people were engaged in discussions.

As a follow up to that work, the systems that had made significant progression with implementing a home first approach were brought together to explore in more depth the factors for success.

This overview summarises the key elements of ‘what good looks like’ in the principles, processes and practices to underpin good D2A implementation and outcomes.

Focus of this resource

This paper highlights further examples of effective commissioning to support the delivery of good outcomes and experience for people who are discharged from hospital, and also complements other publications including Top tips for implementing a collaborative commissioning approach to Home First.

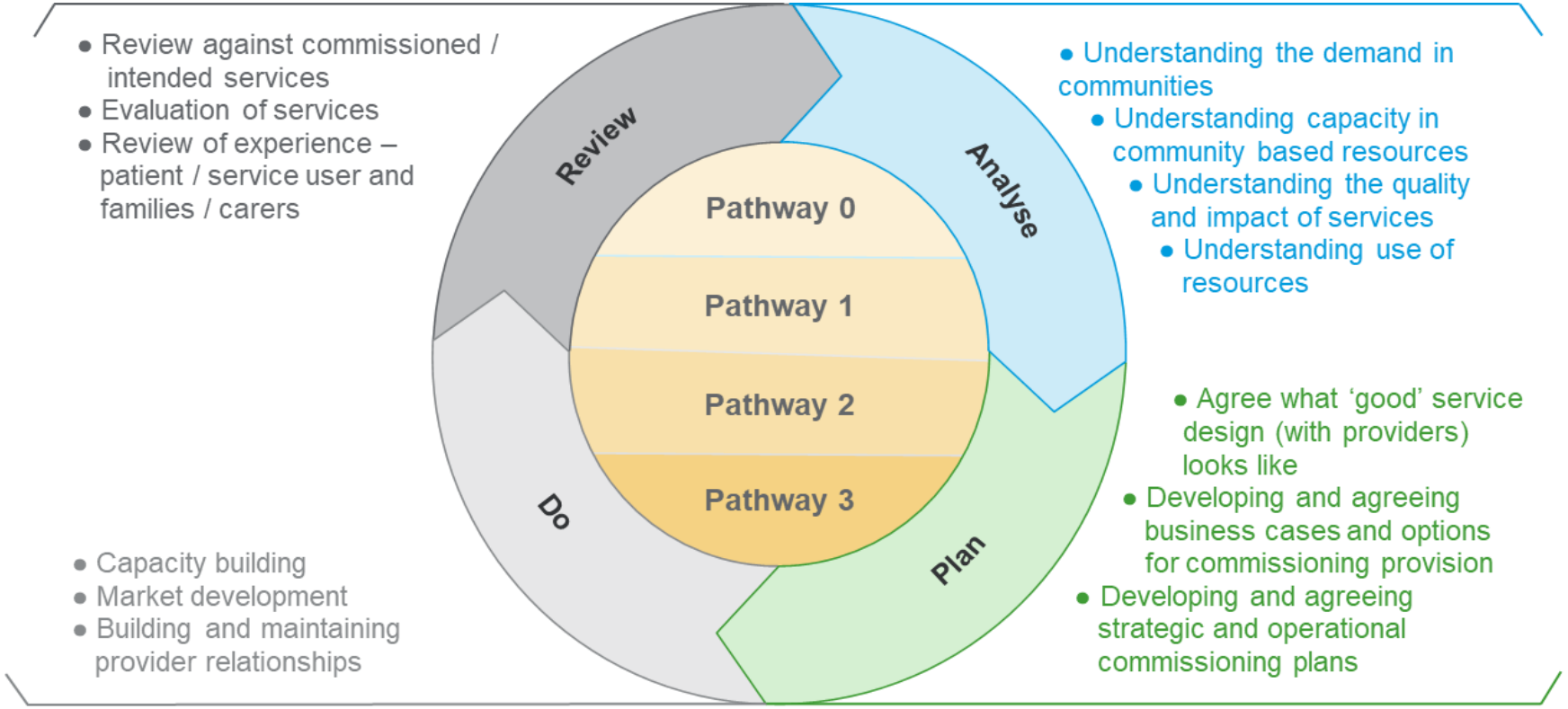
We have drawn together the messages from the evaluation, and in particular have built on the experience and insights of those systems that appeared to have achieved better practice. We explored some examples through a further workshop and follow up discussions with these systems. We describe the arrangements, experiences, conclusions and future developments by aligning the analysis to a typical set of strategic and operational commissioning activities – presented in an 'analyse, plan, do and review' cycle.

While the specific circumstances and experience are different across all health and care systems, we have focused on identifying the key principles, processes and practices that should be universally applicable, and which need to underpin good practice in a D2A approach.

D2A and the Commissioning Cycle

The ‘analyse, plan, do and review’ cycle describes a range of activities and their inter-relationships and is underpinned by some key principles including:

- a focus on need across agencies
- all four activities in the cycle are of equal importance and follow sequentially
- commissioning is developed strategically and jointly, and adapted as necessary in response to evidence.



ANALYSE: Characteristics of effective arrangements to analyse a D2A model will typically include:

- Understanding of current and potential demand and capacity across the system.
- Regular monitoring to understand the flow of people discharged on all D2A pathways.
- Understanding demand and capacity around Intermediate Care, including implications for therapists.
- Understanding the flows of patients through the acute hospital and the pathways that are needed to support recovery over time. Different types of people require different periods for their recovery.
- Calculating the predictable demands on the intermediate care services and planning accordingly.

"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."

Good practice examples from the D2A evaluation identified the following features of ANALYSE:

- Good understanding of capacity and potential increases in demand enables a focus on the right areas of delivery.
- Ability to review and understand demands for particular pathways**.** *"Some [pathways] are populated better than others and it was initially a bit rough and ready but served a purpose, and we are now working on getting this into a consistent format and more automatic process."*
- Having a regularly updated dashboard and one set of metrics that provides a *'single version of the truth'* across the system. *"Very painful to get that right – think our dashboard is good now; the figures tally up without too many discrepancies, we're now able to look at our pipeline coming in, we know how many people we've got waiting for pathways, we've got a view of all of the beds. We can see how long people are on the pathways for, we can see what their outcomes are (…) we've got all those metrics now."*
- Good understanding where capacity exists, where there are gaps and overlaps.
- Good range of data enables systems to understand the interdependencies of health and care and to look beyond acute bed days and discharging patients in isolation. *"It was a challenge to bring consistent data together across different acute trusts. They had different recording systems, documented things in different ways."*
- Understanding the pathways and proportions/ numbers of patients being discharged onto each, and why. *"We have brought together information on how many [people] would need to go down each pathway. This was reviewed on a weekly basis and escalated in between if appropriate."*
- Developing predictive modelling of capacity requirements across beds and Intermediate Care services.

PLAN: Characteristics of effective arrangements to undertake strategic planning for a D2A model will typically include:

- Agreed commissioning strategy across the whole health and care system focusing on 'Home First'.
- Agreement on which Intermediate Care services need to be commissioned to support recovery post-discharge.
- "Right-sizing" the intermediate care services so that there is sufficient support for the known needs of
- the population including understanding the demands on therapists and how they can be met.
- Focus on assessment for long-term needs after a period of recuperation and recovery from an
- intermediate care service – move assessment services into/ alongside the Intermediate Care Services.
- Stronger investment in community health services with virtual wards and high-quality nursing supporting
- GPs in the community.

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

Good practice examples from the D2A evaluation identified the following features of PLAN:

- Home First approach underpinned by the principle that 'the best bed is your own bed' and Discharge to Assess will give people the best chance of recovery. Agreement to move away from making decisions in hospital about long-term care.
- Focus on early intervention and timely discharge – to reduce delayed transfers of care. Making better use of community hospital beds and ensuring a whole system Intermediate Care offer. *"Pre-pandemic there were differences in approach in our different patches rather than a system-wide offer. Now it is a county-wide intermediate care offer."*
- Wider use of Voluntary and Community Sector support for Pathway Zero (P0) but building on this and extending to other pathways.
- Commissioning of new services addressing identified gaps including rapid response/ admission avoidance and using small, community-based care and support services (micro-providers) delivering *"practical solutions to problems or gaps that had been identified that came from common vision and a big sense of trust between people."*
- Not just commissioning more of the same and avoiding seeing beds as the solution *"we stuck to our principles when we looked at investing rather than just thinking how we can do this quicker and just buying beds."*
- *"De-militarising DTOC"* – removing health and care blame-shifting over discharge responsibilities through developing a new model based on: clear structure, governance arrangements and leadership roles; community posts embedded into services; trusted assessors.
- Involving all key partners including independent providers, and collaboration with hospice partners to support End of Life care at home. *"What it taught me was the importance of having a very clear vision that had sign-off at the top of the shop from all organisations was absolutely critical."*

DO: Characteristics of effective arrangements to undertake implementation and delivery of a D2A model will typically include:

- Work to ensure that everyone in the system fully understands the ethos and principles of D2A.
- Capacity building and more collaborative commissioning between NHS and social care.
- Market development and shaping – including the role of providers as strategic partners.
- Building and maintaining provider relationships and establishing trust between organisations.

"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."

Good practice examples from the D2A evaluation identified the following features of DO:

- Positive relationship with providers as more of a 'strategic partner'. *"What helps the provider is the way it is commissioned (…) the system has enabled me to make long term investments: technology costs, recruitment (…) the way it has been commissioned has enabled growth of capacity through investment."*
- Increasing trust between organisations and the voluntary and community sector being seen as key partners. *"The increase in trust between organisations, particularly in statutory organisations towards the voluntary sector and what they are able to deliver."*
- Worked to develop right culture and common goals - a no blame culture, collective problem solving. "*No longer seeing money as ours or theirs but a post that needs to be used as effectively as possible, how do we support communities to keep people at home, to do anticipatory care (…) to stop them bouncing back in."*
- Multi-disciplinary team working, getting professionals together to case manage in new ways has shown to lead to improved working between therapists and other teams. Redeployment of therapy staff to the community enabled better patient flow through the system.
- Detailed decision-making regarding discharge pathways is moved away from wards to the discharge lounge/team – an integrated care hub referral is made. Taking decisions away from acute settings allowed informed person-centred decisions to be made with creative multi-disciplinary approaches focused on community resources – in this model, the person's needs are described, rather than prescribed.
- Developing an integrated discharge hub is central to getting people out of hospital: *"to pull people out into the community resources along Pathway 1, 2 or 3 and that really joined up those teams on the ground in terms of decision making and rationale (…) and resolved some of these 'wicked issues' in ways that we might not have done in the past."*
- Developing creative solutions helps reduce the number of people going into 'low-level' beds and creates the opportunity to reconfigure bed provision. *"We are thinking differently about what we need to commission, especially our community beds that are being commissioned for people with higher complexity, cognitive impairment, challenging mobility issues."*
- Being creative in a crisis to get people home by creating a 'test and learn' approach in 'live' situations - able to reduce the number of people who needed bedded care, e.g. introducing 24-hour support through a wraparound service.

REVIEW: Characteristics of effective arrangements to review a D2A model will typically include:

- Work to ensure that everyone in the system fully understands the ethos and principles of D2A.
- Capacity building and more collaborative commissioning between NHS and social care.
- Market development and shaping – including the role of providers as strategic partners.
- Building and maintaining provider relationships and establishing trust between organisations.

"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."

Good practice examples from the D2A evaluation identified the following features of REVIEW:

- Having a 'single version of the truth' in the data builds confidence of the system and develops trust between partners*: "We had a daily SITREP where we could see these people are waiting for these pathways; these are the referrals we've got; this is the capacity today (…) helped to bring us together and trust each other that we were talking the same story."*
- Data needs to be used to feed back into commissioning and market-shaping activity*: "We used insight from data to shape provision. The intelligence that came through was crucial (…) we were able to develop the market to create greater flexibility."*
- The focus of Intermediate Care is opportunities for recovery*: "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."*
- Ensure metrics enable the system to see outcomes for people and make the case for continued investment. *"As a system we've got all our performance metrics – we know what the plan was in terms of the pathways; we know what we're doing in terms of numbers of pathways, length of stay and outcome in terms of where they go next."*
- Ensure patient experience is collected. *"Feedback from patients – the qualitative bit is so important as well as the quantitative, it is about patients (…) patient stories, the patient journey – looking back not just at acute length of stay, but at when someone came into the system to when they step off, and what's that journey been like is really important."*
- Understanding the purpose of D2A is vital and must be reflected in the data and metrics. What is measured matters: *"We can show that we've improved flow and we've freed up capacity and we've coped with COVID, but actually how do we demonstrate that further down the line that has benefits for those residents, and I think that's the bit that we're all interested in."*

Conclusions

This document has distilled some of the key messages and reflections to emerge from the national evaluation of implementation of the Hospital Discharge Policy and Discharge to Assess requirements. We have highlighted the elements that seemed to be particularly important in enabling better practice to develop. This has included:

- Understanding demand and capacity
- Planning for Home First and Intermediate Care services to support this
- Removing assessment from inside hospital, and ensuring it follows a period of recovery and support
- Commissioning what is needed 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
- Focusing on outcomes achieved for patients

Although we have not presented this as a checklist for developing good practice, we would strongly encourage other systems to examine their own approaches against the dimensions we have identified, and to make use of the commissioning cycle stages of: analyse; plan; do; review, in exploring their practice.

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