GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

Llywodraeth Cymru
Welsh Government

A Healthier Wales:
our Plan for Health and Social Care

Delivering Home First

Hospital to Home Community of Practice: key learning and practice examples

May 2021

Content

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.

This document is also available in Welsh.

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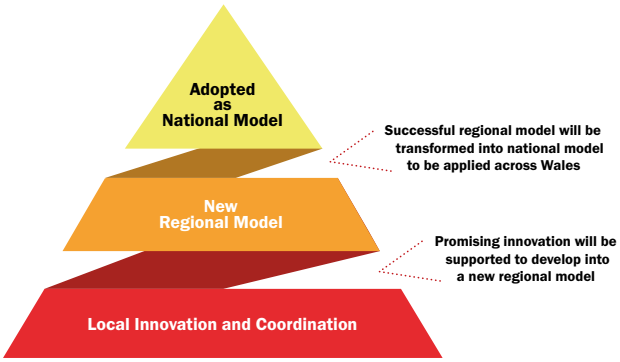
Introduction

'A Healthier Wales: Our Plan for Health and Social Care'[1] (AHW), published in June 2018, set out a long-term future vision of a 'whole system approach to health and social care'. This vision outlined a shift over time from the reliance on traditional hospital services to a seamless approach of integrated care including health, local authority and third sector services; facilitated by collaboration and consultation that empowers local communities.

Figure 1: Scaling transformational change and new models of care



To achieve the AHW actions the Welsh Government has funded a number of services through the Integrated Care Fund (ICF)[2] and Transformation Fund (TF)[3] to explore new models of care.

The longer term objective of these funds is for health and social care providers to implement and scale services from a local and regional level to a national level, eventually sustaining them from their own resources.

As part of this work, health, social care and third sector teams have been developing new partnerships and implementing new models of Home First and 'Hospital to Home' (H2H)[4] services in Wales.

'Hospital to Home' refers to the care and support offered to patients to leave hospital for ongoing assessment and recovery with an aim of limiting unnecessary time in hospital settings.

Since 2018 the development and implementation of Home First and H2H activity has been supported by the NHS Wales Delivery Unit (DU), and the importance of it was further highlighted as part of the Transformation Fund's National Mid-Term Evaluation.[5]

The process of discharge from hospital is a key factor of rehabilitation and has shown that the support that an individual receives both leading up to discharge and post-discharge will impact the likelihood of them requiring care in the future.

Based on the evaluation evidence and the actions set out in AHW, a Community of Practice (CoP) was introduced in Wales in summer 2020 and jointly run by Welsh Government and the DU. The purpose of the CoP is to support shared learning and scaling of models of care and good practice across regions for those delivering Home First and H2H services.

A Community of Practice is a group of people who share a concern or passion for something they do and learn how to do it better as they interact regularly.

The findings and next steps for the CoP are explored at greater length in this report, including case studies of the 'Discharge to Recover then Assess'[6] (D2RA) projects in Wales.

1. A Healthier Wales (gov.wales) https://gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-pl
2. Integrated care fund revenue capital and dementia guidance.pdf (gov.wales) https://gov.wales/sites/default/files/publications/2020-02/integrated-care-fund-revenue-capital-and-dementia-guidance.pdf
3. Health and social services transformation fund: projects | GOV.WALES https://gov.wales/health-and-social-services-transformation-fund-projects
4. COVID-19-hospital discharge service requirements (gov.wales) https://gov.wales/sites/default/files/publications/2020-04/COVID-19-hospital-discharge-service-requirements.pdf
5. Mid-point evaluation of a healthier wales transformation fund (gov.wales) https://gov.wales/sites/default/files/publications/2020-09/mid-point-evaluation-of-a-healthier-wales-transformation-fund_0.pdf
6. Right Sizing Community Services to Support Discharge from Hospital (ADSS Cymru) https://www.adss.cymru/image/blog/COVID-19%20Resources/28-05-20/Right-sizing%20Community%20Services%20for%20Discharge.pdf

Background

The Welsh Government and NHS Wales has been developing ways to improve discharge planning since 'Passing the Baton'[7] was published in 2008, with the Discharge to Assess (D2A) model supported by NHS in England since 2015[8]. The implementation of AHW is building on this work to further transform care that is already in place to improve outcomes in Wales. As part of this, the DU have been actively supporting the development and implementation of D2RA, refining a model that is adapted to the needs of the individual.

One of the core components that underpinned the development of a Welsh H2H model was the academic research and several reviews centred on examining Welsh hospital services and exploring opportunities to improve the discharge process.

In 2018 the Health Inspectorate Wales found that health boards and the Velindre NHS Trust had the correct policies in place regarding discharge generally, however there was a lack of awareness and understanding of the discharge processes amongst ward staff.

These findings demonstrated some positive foundations but also a clear need for an overhaul, re-education and re-evaluation of the discharge processes[9].

This was corroborated by the findings of the Wales Audit Office who found that only a third of Welsh NHS bodies recorded the date a patient was declared medically fit for discharge. Some areas for acute attention were identified such as[10]:

- Less people were assessed as requiring support on discharge from hospital
- Too many older people were assessed in an acute hospital bed for longer term care packages or new care home placement
- More people were placed in a bedded facility than might be expected.

The findings of these reviews were then applied in the context of the existing work on H2H; most specifically 'The Model' by Professor John Bolton and the D2A model helped to form the foundations for the development of D2RA[11].

Figure 2: Rapid discharge terminology in England and Wales

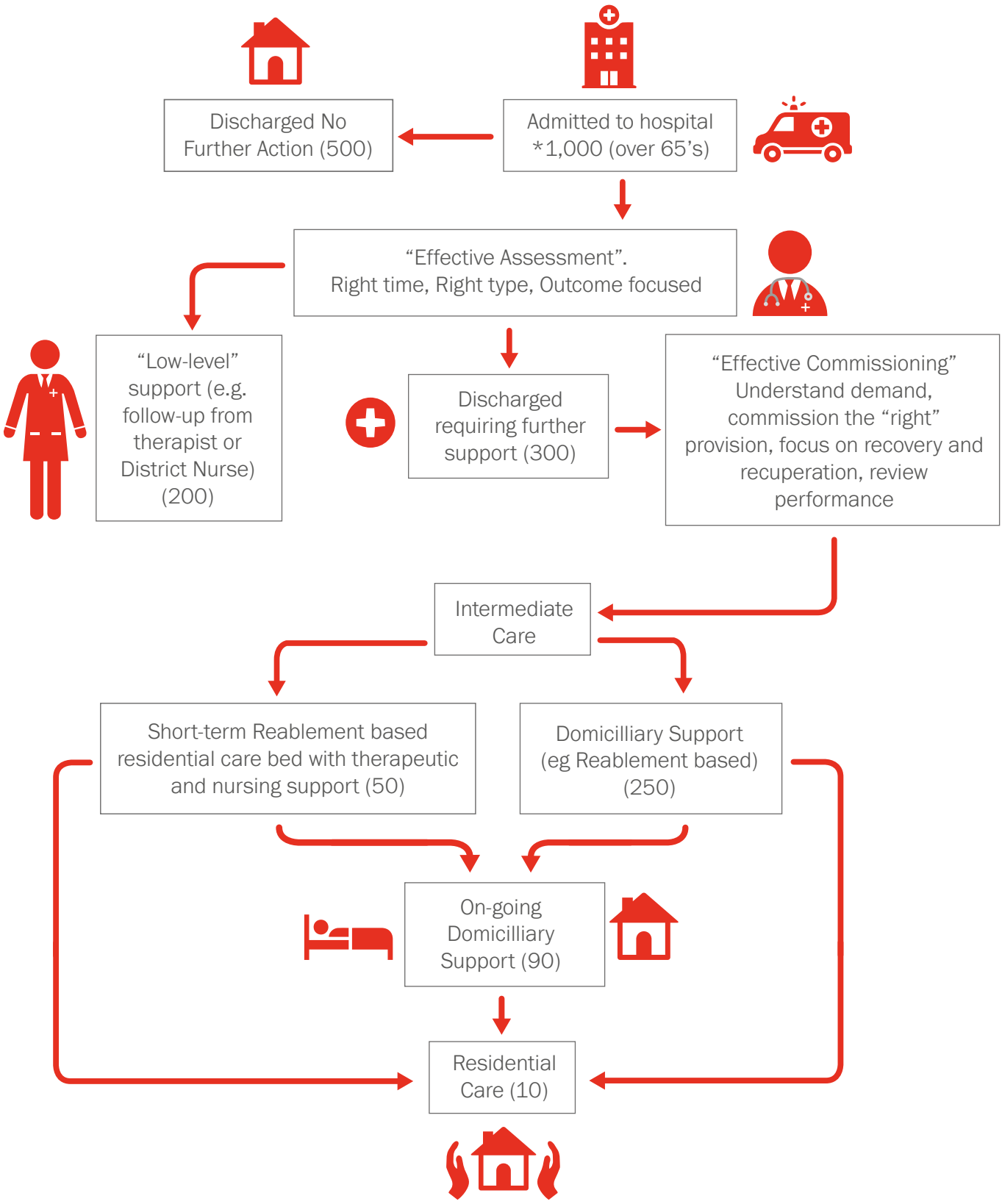
Discharge to Recover then Assess (D2RA)
The Welsh model, introduced in 2018. Based on the English model with the addition of recovery principles.

Discharge to Assess (D2A)
The English discharge model introduced in 2015.

7. Passing the Baton: A Practical Guide to Effective Discharge Planning
   https://www.adss.cymru/en/blog/post/passing-the-baton-a-practical-guide-to-effective-discharge-planning
8. Quick Guide: Discharge to Assess (pdf)
   https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
9. Patient Discharge from Hospital to General Practice: Thematic report 2017-18 (pdf)
   https://hiw.org.uk/sites/default/files/2019-06/180808dischargeen.pdf
10. What's the hold up? Discharging patients in Wales (pdf)
    https://www.audit.wales/sites/default/files/discharge-planning-leaflet-2019-english_5.pdf
11. Reducing Delays in Hospital Transfers of Care for Older People (pdf)
    https://ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf

Foundational Models

Figure 3: 'The Model' by Professor John Bolton



*Numbers in diagram demonstrate good practice based on the admittance of 1000 people.

In 'The Model', the numbers in the diagram illustrate what good practice could look like and map out provisional pathways. Professor John Bolton has highlighted that "the key message conveyed by the illustration, is that each component of the model needs to understand the flow of patients, the outcomes achieved and the overall performance of the health and social care system."[12]

This model has since been adopted by some UK local authorities to best capture their current performance in Home First and H2H services and identify where improvements can be made; with the overall aim of reducing delays in transfers of care for older people. It is worth noting that the H2H models in Wales have recovery and rehabilitation pathways that care for all types of patients, not just focusing on elderly patient care.

This foundational H2H work from 'The Model' and the English D2A informed the DU's 'Home First: Cartref yn Gyntaf' national conference in September 2018 where they brought together the successful elements from each model with the lessons being taken on board. Hence the founding principles of focussing on patient outcomes is paramount in D2RA, whilst the addition of the Recovery principles reflects some evolution of Home First and H2H in D2RA.

The principles of D2RA are focussing on achieving the best outcomes for the people, whilst at the same time making the most efficient and effective use of scarce resource.

The model is designed to support people to recover at home before being assessed for any ongoing need, in order to:

- Focus on what matters to them;
- Avoid deconditioning and loss of confidence in hospital;
- Minimise exposure to in-patient infection risk;
- Maximise recovery and independence;
- Provide a seamless transfer to longer-term support in the community, if required;
- Reduce over-prescription of statutory services 'to be on the safe side'.

Both the English D2A and 'The Model' were also presented during the CoP workshops, facilitating discussion on how this could be applied to D2RA in Wales and specifically what the creation of bespoke pathways that focused on recovery would look like.

12. Reducing Delays in Hospital Transfers of Care for Older People
https://ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf

Discharge to Recover then Assess: the Welsh Model

The Welsh D2RA Model has been designed through consultation by the DU with stakeholders and Regional Partnership Boards (RPBs), tailoring some of the work of Professor John Bolton and the English D2A model to suit the needs of the Welsh health and social care landscape. D2RA been specifically designed to be adaptable, and as such it has been implemented by all RPBs across Wales and continues to be adapted to respond to COVID-19.

Figure 4: D2RA Pathways

Pathway 0	Pathway 1	Pathway 2	Pathway 4	Pathway 3
				
Discharge or admission avoidance through short-term third sector support	Is this person fit to admit?	Why not home? Why not today?	Home first when your home is a care home	Support to recover in a bedded intermediate care facility
Preventative services delivered in collaboration with third and voluntary sector organisations. Aim to avoid further referral and admission.	Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission. Arrange treatment and supported recovery at home, whenever it is clinically safe to do so.	Initiated as soon as treatment, which can only be delivered within an acute hospital environment, is completed. Supports people to recover at home before being assessed for any ongoing need.	Similar to Pathway 2, but acknowledges specific considerations to be addressed in the existing care home environment. Individuals should be allowed a period of recovery, followed by assessment in their usual environment.	Should only be considered where the needs of the individual rule out recovery & assessment at home. Review and transfer to Pathway 2 wherever, and as soon as, possible.

The D2RA model is now becoming established as the national model for Home First and H2H and in order to reflect the AHW ambitions to have adaptable national services at local levels, there still remains some differences across regions. The five pathways were developed to maintain an emphasis on the 'Home First' principle and incorporate recovery. They have been designed as a focus for all H2H services in Wales, allowing RPBs to utilise the pathways and coordinate the right level and types of services to effectively deliver the best outcomes for people in their area.

These pathways are the result of regional and national workshops conducted by the DU, and an 'Every Day Counts' Guide is now available for four of the five D2RA Pathways.[13] These guides detail the principles of each pathway and 'What Good Looks Like'.[14]

The success of these pathways can be seen in the case studies (see page 12) where the use of D2RA pathways is delivering improved outcomes for people.

The services are now being encouraged to implement the pathway structure as part of their progression and sustainability planning.

13. Links to these 'Every Day Counts' are included in the annexes.
14. Pathway 0 'Every Day Counts' is currently under development.

The outcomes and performance measures for D2RA were a key element in the CoP discussions and resulted in a set of draft performance measures and indicators.

These evaluation methods will facilitate the continual improvement of the pathways and H2H approaches, focussing on how much, how well and was anyone better off (impact).

As with the pathways, and in line with AHW aims, the performance measures have also been designed to be adapted so that each region or service can use them appropriately.

D2RA in COVID-19

The roll out of the D2RA model was accelerated to address the challenges caused by COVID-19 and the model has become a vital tool in the Welsh Government's response.

In April 2020, £10m of funding was announced for RPBs to support recovered COVID-19 patients to return home. The fund is providing help for:

- the expansion of discharge from hospital services
- additional capacity within the community to care for people discharged from hospital
- maximising patients' independence post COVID-19, including the purchasing of equipment for their home
- enhanced community based services to reduce pressure on primary and secondary care.

Furthermore, additional funding of £10m was provided in May 2020 to accelerate the roll out of D2RA. This accelerated roll out helped to protect urgent care from the exacerbated hospital discharge requirements caused by COVID-19.[15]

In addition Pathway 0 was added to the D2RA model as a response to COVID-19 to help expedite and improve discharge services, utilising existing services as well as creating a platform for collaborative community working.

This has since been expanded and the Welsh Government have announced a further £6m in funding in March 2021 to enable the sustainable scaling of D2RA Pathways 0, 1, 2 and 4 and facilitate a greater place-based care focus on the delivery of care and support post COVID-19.

15. COVID-19 Hospital-to-Home Discharge Requirements
https://gov.wales/sites/default/files/publications/2020-04/COVID-19-hospital-discharge-service-requirements.pdf
The impact and subsequent actions mandated in response to COVID-19 are discussed at greater length later on in this report.

Figure 5: **Timeline of Home First and Hospital to Home in Wales**

Bringing 'Home First' and 'Hospital to Home' to Wales – D2RA Timeline

Home First: Cartref yn Gyntaf' national conference (September 2018) identified the pathways for D2RA.

Drawing on the work of D2A in NHS England and in conjunction with the Institute of Public Care the DU held a national event in September 2018 to analyse how the D2A principle could be brought to Wales.

The finding of this events informed the creation of the four Pathways which are the foundation of D2RA. Notably 'Recovery' was embedded as a core component to the Welsh Model for D2A, hence D2RA.

DU Review of Complex Discharge: 'Why not Home: Every Day Counts' – November 2018.

This gave D2RA the impetus for change that it needed in Wales and the project forged connections with the A Healthier Wales ambitions for patient focused, seamless and integrated models of care.

DU Regional and National Workshops held throughout 2019.

These workshops facilitated input from experts as the pathways were being developed to ensure that they suited needs of the H2H landscape in Wales. Additionally this allowed the DU to understand what existing infrastructure there was that could be built on.

The workshops produced 'what good looks like' documents for D2RA Pathways 2, 3 and 4. They also identified the barriers and challenges to D2RA implementation and demonstrated the need to determine how to achieve right sized communities services.

'Every Day Counts' – building a social movement.

The 2019 workshops and conferences helped to create a social movement of over 500 D2RA champion practitioners including health and social care practitioners, managers, commissioners, providers and support agencies.

Embedding D2RA Services across Wales.

With continued engagement through the DU, D2RA workshops and CoP were held. Funding was allocated via RPBs via the Integrated Care Fund (ICF) and later the Transformation Fund (TF) to support D2RA.

Support, guidance and evaluation was offered to these services by the DU, and as part of the ICF and TF. (Some of these service are included as part of the case studies within this document).

Right Sizing Communities project delivered by the DU, in collaboration with Professor John Bolton and the Institute of Public Care.

The 'Every Day Counts' sessions helped examine the barriers and challenges to D2RA and one of the key themes picked up was having the right sized community services. To tackle this the DU facilitated a national project on 'Right-size Community Services for Discharge'.

The findings supported the RPBs in the continued formation of the D2RA model. Two CoPs have since been established to support ongoing capacity and demand modelling for discharge and, more recently, admission avoidance.

Hospital to Home Community of Practice (2020-21).

As part of WG's evaluation of new models of care, a H2H CoP was established in conjunction with the DU to consider best practice; challenges and opportunities; and to help identify key performance measures.

The CoP continued during 2020 and into 2021 which has meant the impact of the pandemic on services and partnership working could be captured. This was instrumental in the identification of the need to create a Pathway 0 and the later expansion of D2RA as part of the COVID-19 response.

COVID-19 additional funding (2020/21)

In 2020/21 WG provided an additional £10million to support the expansion of the surge capacity required to meet the potential demand for D2RA Pathways, arising as a result of the pandemic. As such D2RA is now a key asset in the WG's toolkit and the discharge arrangements are embedded in to the COVID Response.

The roll out has shown to be broadly successful and as a result D2RA will now be a 2 year project designed to align existing services and continue to develop the pathways based on the feedback from the staff on the ground so that the focus stays on patient care.

Transformation Scaling Fund (2021/22)

The WG announced the Transformation Scaling Fund in March 2021, committing £6m in 2021/22 to assist with the scaling of hospital to home models at a regional level to help embed a national model of working.

The purpose of Scaling Fund is to build on existing H2H/ D2RA activity in order to scale within and across regions specifically supporting and enhancing the delivery of Pathways 0, 1, 2 and 4, with a view to ensuring there is a regional approach across the RPB in delivering the agreed D2RA model.

There will be an increasing emphasis on prevention and early intervention; supporting independence at home; and maximising community assets and third sector services to reduce demand on primary and secondary care.

Community of Practice: Hospital to Home

Communities of Practice are a way of bringing together groups of people who share a common passion, interest, concern or goal. They encourage productive discussion around mutual points of interest, facilitate the sharing of best practiceand support collaborative learning to overcome common challenges.

Figure 6: Community of Practice objectives

To promote shared learning

To develop networks

To share best practice

To overcome barriers

In line with the actions set out in AHW, the Welsh Government worked alongside the DU to develop a CoP centred on Home First and H2H services in Wales.

Throughout 2020 and into 2021, representatives from each of the seven RPBs (including health boards, local authorities and the third sector) were invited to attend a series of group sessions, intended to promote shared learning across regions and to support a joined-up approach toward improving outcomes for the people of Wales.

Four workshops were held, with discussions and content directed by, and tailored to, the needs of participants.

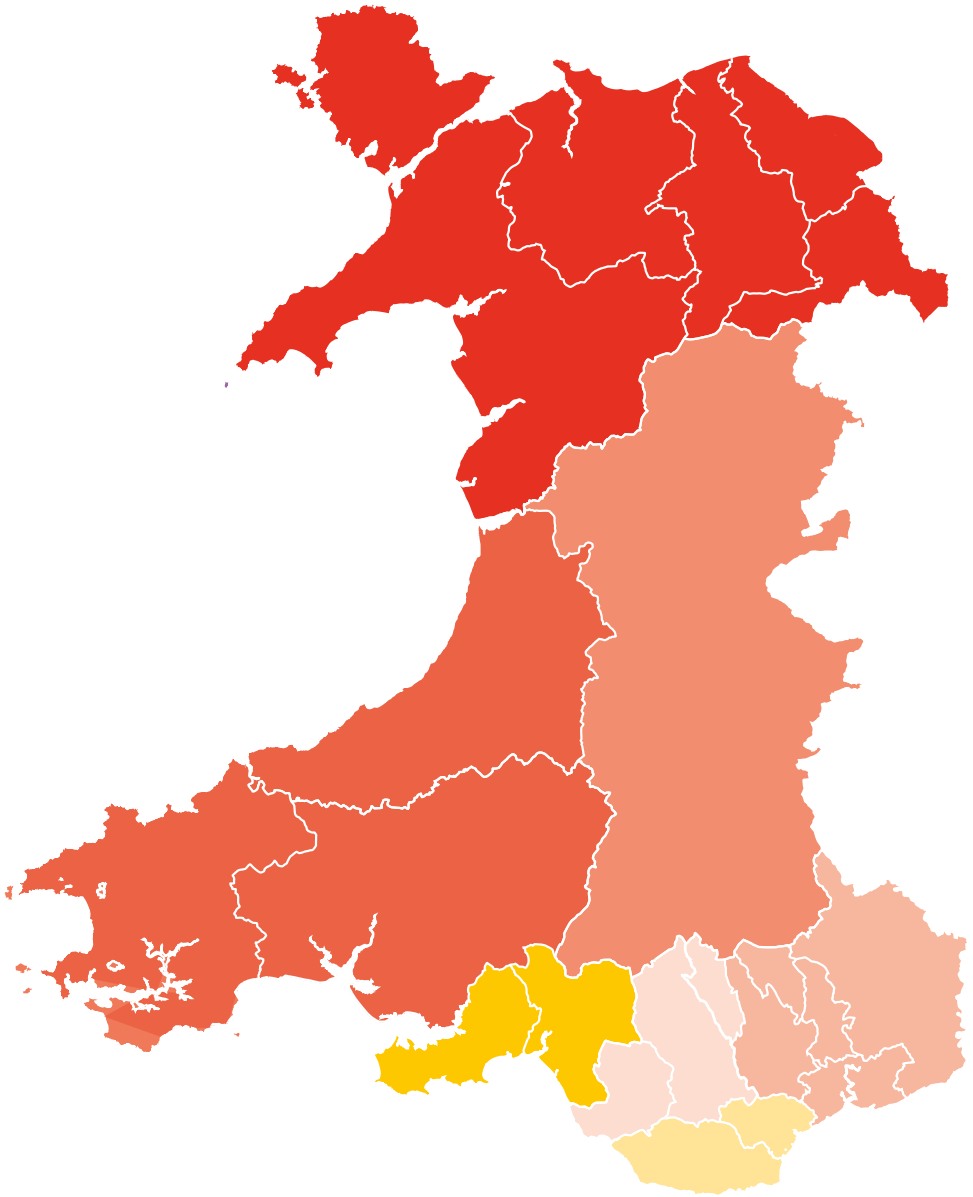
As a result, the workshops focussed on: existing models from Wales and the UK; developing a positive culture for managing risk; building an evidence base for demonstrating success; a reflective approach to future planning; and next steps for H2H in Wales.

Summaries of the key themes and outcomes from each session, as well as case studies strategies for managing risk and proposed performance indicators and outcomes are detailed further in the next sections of this report.

Key Learning – Session 1: Existing models across Wales

During the first workshop, participants shared examples of existing Home First and H2H models in place throughout their respective regions. Discussion was encouraged around service delivery, achievements to date, potential challenges and next steps. These examples have been developed into case studies (as mapped in Figure 7 below), to demonstrate the national picture of H2H services across Wales.

Figure 7: Home First and H2H models across Wales



1. Get me Home and Get me Home Plus
2. Stay Well @Home 2
3. Home First
4. Community Services Transformation
5. Discharge to Recover then Assess
6. Optimal Model of Care
7. PIVOT

D2RA in action across Wales: Case studies

Figure 8: D2RA case studies mapped to pathways

Bringing Hospital to Home to Wales – D2RA Timeline

Pathway 0	Pathway 1	Pathway 2	Pathway 4	Pathway 3
				
Discharge or admission avoidance through short-term third sector support	Is this person fit to admit?	Why not home? Why not today?	Home first when your home is a care home	Support to recover in a bedded intermediate care facility
Preventative services delivered in collaboration with third and voluntary sector organisations. Aim to avoid further referral and admission.	Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission. Arrange treatment and supported recovery at home, whenever it is clinically safe to do so.	Initiated as soon as treatment, which can only be delivered within an acute hospital environment, is completed. Supports people to recover at home before being assessed for any ongoing need.	Similar to Pathway 2, but acknowledges specific considerations to be addressed in the existing care home environment. Individuals should be allowed a period of recovery, followed by assessment in their usual environment.	Should only be considered where the needs of the individual rule out recovery & assessment at home. Review and transfer to Pathway 2 wherever, and as soon as, possible.

	Pathway 0 (example models)	Pathway 1 (example models)	Pathway 2 (example models)	Pathway 4 (example models)	Pathway 3 (example models)
Get Me Home (Cardiff & Vale)		X	X	X	
Stay Well@ Home2 (Cwm Taf)	X	X	X		
Home First (Gwent)	X	X	X		X
Community Services Transformation (North Wales)	X	X			
D2RA (Powys)	X	X	X	X	X
Optimal Model (West Glamorgan)	X	X	X		
PIVOT (West Wales)	X	X	X		

Get Me Home & Get Me Home Plus

Administration

Cardiff & Vale of Glamorgan Regional Partnership Board

Transformation Fund

Covering the Cardiff locality.

Description

Get Me Home Plus: A model of care centred on assessment from a home environment to reduce deconditioning and the risk of hospital-acquired infections.

Get Me Home Preventative Services: A single access point within the hospital that gives support to provide preventative interventions and support independent living.

Summary

Get Me Home Plus has established a fast track pathway where a multi-disciplinary team works with a cohort of patients who are more impaired and require a more intense package of re-ablement and homecare support. This service extends to includes a night-service where required and can offer wrap-around care and an enhanced focus on Occupational Therapist solutions.

The Get Me Home Plus team links in with the Preventative Services ensuring a holistic assessment of needs. This includes benefits advice, other community services and signposting to other third sector support with the aim of preventing further admissions and providing individuals with support to maintain their well-being within their own home.

Known locally as 'the pink army',
Get Me Home Preventative Services is a single access point within the hospital for all community based services. The team use 'What Matters' conversations to provide holistic tailored support that meets the well-being needs of the individual, providing preventative interventions and supporting independent living.

Outcomes

- Get Me Home Prevention has been vital to the COVID-19 response and was accelerated allowing the MDT to directly resolve issues thus reducing red tape, supporting 541 with discharges in just 3 months.
- The improved relationships and broader connections have encouraged better support for patients and better patient flow. This has been key in showcasing the value of the project to fellow health colleagues, with 100% of staff reporting that they feel the services facilitates faster discharge.
- The Get Me Home Plus model has been integrated into the community service, specifically connecting with the Community Response Team. However due to COVID-19 continued patient engagement has been difficult as there has not been consistent access to IT during the shift to enable virtual communication.

Next Steps

- Improve IT difficulties and move to virtual delivery, including improving Wi-Fi connection across the Vale of Glamorgan.
- Developing the training of staff to react to the changing needs of the service. This means that as the demands on project staff are now more specialist, a higher level of clinical knowledge is required.

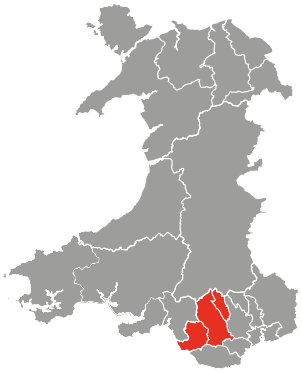
Further Information

Contact (Get Me Home):
C.Palmer@cardiff.gov.uk

Contact (Get Me Home Plus):
Judith.A.Hill@wales.nhs.uk

Video:
https://www.youtube.com/watch?v=eJM_eVU1FIY

Stay Well @Home 2 – Single Point of Access



Administration

Cwm Taf Morgannwg Regional Partnership Board

Transformation Fund

Covering the Rhondda Cynon Taf (RCT) and Merthyr Tydfil (MT) localities.

Description

Stay Well @Home is a two phase initiative designed to help people stay at home. Phase 1 established multi-disciplinary teams in the two District General hospitals at Accident and Emergency to avoid admission and shorten lengthof stay. This has been extended in phase 2 where the aim has been to offer an alternative to conveying or admitting people to hospital by putting in place community services quickly.

Summary

Phase 1 of SW@H established multi-disciplinary teams in the region's district general hospitals, working together to create bespoke care packages so that people could leave hospital sooner and be cared for at home instead.

Building on this, phase 2 of SW@H expanded the Single Points of Access (SPA) in each Local Authority, extending their opening hours to 7 days a week and up to 8pm – taking referrals over the telephone – from community professionals such as District Nurses, GP's and Welsh Ambulance Service for them to access rapid response community services to support people to stay safely at home and avoid them going into hospital.

The SPA agrees an appropriate community service response for the citizen within 4 hours based on their presenting need, determined following a single "what matters" conversation with a trusted assessor, reducing the number of steps and assessments required between referral and response.

Outcomes

- Phase 1 of SW@H of establishing multi-disciplinary teams (MDT) across RCT and MT was completed in 2017.
- Phase 2 of SW@H is now active across both in RCT and MT, with extended opening hours for SPA's established in RCT in January 2020 and MT in July 2020.
- As a measure of performance for phase 2, as of February 2021 96% of referrals hit the 4 hour target for a response being agreed. Whilst in RCT the extended hours were paused during the first two lockdowns due to staff shortage pressure these services are now running again.

Next Steps

- Review the progress and performance to assess next steps and acquire a sustainable source of funding.
- Create a plan to responding to a potential increase in demand for re-ablement services following COVID-19.

Further Information

Contact:
Sarah.J.Evans2@rctcbc.gov.uk

Article:
www.cwmtafmorgannwg.wales/hundreds-patients-avoid-hospital-stays-thanks-home-service/

Home First

Administration

Gwent Regional Partnership Board

Transformation Funding

Covering the Newport, Caerphilly, Monmouthshire, Blaenau Gwent and Torfaen localities.

Description

The aim of Home First is to develop an integrated approach between the 5 local authorities and Aneurin Bevan University Health Board to prevent avoidable hospital admission and support timely and effective discharge. It can be summarised as a seamless system of support to facilitate hospital discharge at the earliest opportunity for individuals with a focus on short stay wards and those who do not require admission.

Summary

Home First operates with the D2RA pathways and principles, providing a MDT that liaises between five local authority services and the acute hospital sites and operates complementary to existing services.

Patients appropriate to Home First are identified and support offered to discharge them back home as rapidly as possible with whatever support is relevant to their need. Home First staff initially operate a simple triage; patients known to community/social services and those not known. The Home First assessment facilitates discharge at the earliest opportunity by involving the patient, their family and carers and all relevant health colleagues.

Outcomes

- Home First has been operational at the Nevill Hall Hospital in Abergavenny and at the Royal Gwent Hospital in Newport since late 2018.
- Home First has begun to track 'Assessed Out' (admissions avoided) as a performance measure and the long-term trend is that the overall 'Assessed Out' rate is 60%. In 2019 it was 62%, this is significant and the best performance ever.
- There has been a strong focus on compiling qualitative performance data; and case study evidence illustrates that the admission avoidance facilitated by Home First can be hugely beneficial to the individual patients, to quote staff "Home First is working really well at the front door alongside physiotherapy and occupational therapy and improves confidence to discharge".
- However, survey feedback also indicates that consistency of team members' responses to other services (and perhaps training) is an important element of operating an effective admission avoidance service and more training in line with the services development is being explored.

Next Steps

Home First has outlined several next steps, some of which can be generalised for D2RA:

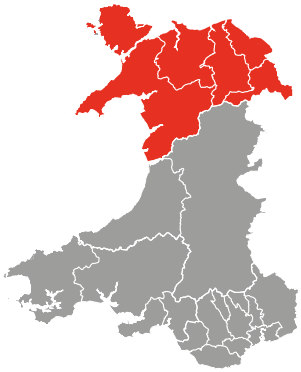
- Build admission avoidance into the wider patient wellbeing agenda (specifically as the Grange Hospital is being operationalised).
- Incorporate 'assessed out' into future performance data and recast 'patient centred care as close to home as possible' as a key commodity like that of hospital beds.
- Continue the collaboration with local authorities, health and third sector as part of wider transformation towards admission avoidance.

Further Information

Contact:
Joanne.Ascott@newport.gov.uk

Video:
www.youtube.com/watch?v=1sC_lr5Nxnl

Community Services Transformation



Administration

North Wales Regional Partnership Board

Transformation Fund

Covering the Gwynedd, Conwy, Anglesey, Flintshire, Denbighshire & Wrexham localities.

Description

The Community Services Transformation Programme aims to increase capacity and skills within community health and social care in order to deliver seamless integrated services on a locality footprint. By developing a place-based model for care and support, the programme seeks to shift the focus of care away from acute hospitals/ illness towards the community/ well-being.

Improving access to preventative services, delivering therapeutic interventions and community support; ensuring equality of access to services; simplifying navigation of the health and social care system; providing a model for digitally enabled care; and developing a sustainable workforce stand as the cornerstones of the programme.

Summary

The Community Service Transformation programme brings together primary care, community health, social care and the third sector to deliver care and support through Community Resource Teams (CRTs) within integrated health and social care localities.

Health, well-being and social care professionals are being brought together into CRT's, equipped with the skills and resources required to meet the needs of their local population through the provision of out-of-hospital services. These teams deliver multidisciplinary assessments, rehabilitation, carer and social care support, and clinical observations, as well as providing advice on health, nutrition, medication and wellbeing.

Outcomes

- A model for integrating independent sector providers into CRTs is being implemented in the West of the region.
- 14 integrated health and social care 'localities' are being established, which respect local resources and geographies.
- The localities, when fully mature, shall be responsible for the commissioning and deployment of resources, with leadership teams in place to ensure the appropriate level of accountability and governance is achieved.
- 19 CRTs are working across the region, and work is being undertaken to ensure that they are not only co-located (either physically or virtually), but that they operate as integrated entities.
- Information sharing is central to the ability of services and teams to integrate. Work is taking place to develop a regional information sharing agreement, and locally, initiatives such as SharePoint sites have been developed which functions as a platform available to all partners to share information about CRTs and the Transformation Programme more generally.
- Systems have been developed in south Wrexham to enable district nurses to access and record on the primary care record.

Next Steps

- D2RA Pathways are being embedded and implemented across the region.
- A single point of access is being established for each CRT within Anglesey.
- 'Right Sizing Communities Services for Discharge' work is underway to understand the whole of the health and social care system to get a complete and intelligent picture of demand and capacity, flow. This work is being extended in Conwy and Denbighshire, through work to undertake a whole systems analysis.

Further Information

Contact:
Jo.Flannery@denbighshire.gov.uk

Website:
www.northwalescollaborative.wales/transformation-programme/community-services/

Discharge to Recover then Assess (D2RA)

Administration

Powys Regional Partnership Board

Transformation Funding

Piloted in the North Powys locality.

Description

The aim of Discharge to Recover and Assess (D2RA) in Powys is to provide more rapid access to community based health and care and therefore reduce length of stay, ensure timely discharge and avoid inappropriate admissions using the Virtual Ward.

Summary

The D2RA Home First pathway (DU Pathway one and two) supports patients to return to their own home following an acute or community hospital admission. The 'Home First' therapy led team provides wrap-around support for individuals for up to 10 days following discharge whilst assessing an individual at home to determine what support or intervention is required.

This was done through the development of the Integrated Community Team which helps to keep people at home without reliance of social services in a combination of the discharge to assess pilot and neighbourhood nursing initiatives.

Outcomes

- There has been increased engagement from staff in acute settings, making direct contact with the Home First team to discuss suitability of patients.
- A Community Sector Emergency Response has been developed - co-ordinating multiple networks to deliver advice, information and practical support during the COVID-19 pandemic through 3rd sector organisations and community groups.
- The success can be measured as 50% of patients discharged from hospital requiring no ongoing statutory service e.g. reablement, community therapy.
- There have been some challenges, most notably staff sickness, redeployment, and recruitment of appropriate staff and funding.

Next Steps

- Identified as an 'acceleration for change priority' the discharge to assess and neighbourhood nursing initiatives will form part of work on the Integrated Community Team.
- The aim of integrating the teams is to create a more sustainable workforce model that will avoid unnecessary admissions and support the 2 hour response target from hospital discharge.
- This will include embedding new ways of working via digital technology.

Further information

Contact:
joanne.williams17@wales.nhs.uk

Article:
https://pthb.nhs.wales/news/health-board-news/an-occupational-therapy-led-discharge-to-recover-and-assess-model-in-powys-is-supporting-people-to-return-home-promptly-and-safely-from-hospital/

Optimal Model of Care

Administration

West Glamorgan Regional Partnership Board ICF

Covering the Swansea & Neath Port Talbot localities.

Description

Initially launched as a regional Optimal Model of Care in 2016, the key aim of the service is to help older people who become unwell to remain in the comfort of their own home, avoiding a hospital stay unless it is absolutely necessary and to assist them in living independently for as long as possible, using a "what matters to me" approach. If hospital admission becomes necessary, the service aims to support older people in returning to their home as soon as they are well enough to be discharged. This model was further enhanced by the launch of a bespoke H2H Service incorporating a "Home First" ethos first launched in December 2019.

Summary

A community based service to support people over 65 at home when they are unwell, to either stay at home or help them return home from hospital as quickly as possible, providing support in their own home and helping them to remain or regain independence.

The service is made up of various components, including:

- **a Common Access Point:** a single contact point for referrals to adult social care which provides rapid assessments and clinical interventions to avoid admission, through services including an Acute Clinical Team;
- **a Reablement service:** short-term home based or residential support provision to maximise daily living and enable continued independence;
- **a care placement pathway:** for those with more complex needs,
- **a third sector service:** which offers advice and assistance through a range of organisations to support people to get home after being in hospital.

Outcomes

- As an outcome of this model there has been a reduction in both the numbers of people supported in residential care homes and the number of residential care home admissions across the region since reporting began in 2016.
- Whilst there was a significant drop in demand due to COVID-19, from April-August 2020 682 older people have been supported by the Acute Clinical team, maintaining their independence at home and avoiding admission into hospital, with a total cost avoidance of £712,640.
- In this same period there were 286 reablement discharges facilitated, helping older people maximize their wellbeing and independence.
- The Community Resource Team have supported 234 individuals with therapy and interventions to aid them to remain at home as long as possible.
- The third sector led Community Wellbeing Service launched on 1st July 2020 has received and actioned 90 referrals between 1st July and 31st December 2020, this pathway is continuing to be developed with referrals increasing as the service is embedded.

Next Steps

The project is focussed on returning to full capacity following the reduced capacity for services due to COVID-19.

Further Information

Contact:
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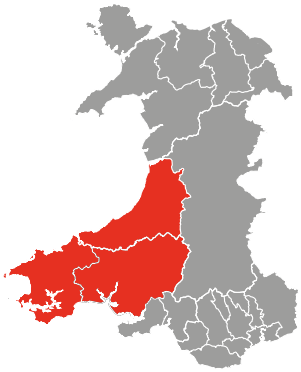
PIVOT



Administration

West Wales Regional Partnership Board ICF

Covering the Pembrokeshire locality

Description

The main aim of Pembrokeshire Intermediate Voluntary Organisations Team (PIVOT) was to help older people who become unwell to remain independent, in the comfort of their own home, avoiding a hospital admission unless absolutely necessary. In addition it aims to add value to a number of existing schemes by filling gaps in more formal provision depending on the needs of each client, joining up with other local and national services.

Summary

PIVOT is a collaborative working arrangement with the Multi-Agency Support Team (MAST) and other community schemes such as Care and Repair and lunch clubs, to deliver “wrap around” support for those wanting to remain independent in or repatriated to their own communities.

If an older person does need to go into hospital, PIVOT supports them to return home as soon as they are well enough to do so, providing a timely and effective discharge. People are also given support to live independently in their own homes for as long as possible, with opportunities provided to improve independence and reduce social isolation.

Services offered through the PIVOT service include: transport out of hours for those being repatriated; the provision of basic groceries; ensuring utilities are fully functioning and minor repairs addressed on return home; liaising with families; and following up with befriending and other services that address isolation where appropriate.

PIVOT acts as an access point and works in tandem with other local services, bringing together the most appropriate services to improve the outcomes for patients and help them remain independent.

Outcomes

PIVOT services were vital for saving bed days and improving the wellbeing and outcomes for patients. Before COVID-19 during Quarters 1 and2 of 2020-21 PIVOT provided services for 474 people:

- 31 people assisted during an Accident and Emergency discharge.
- 157 people provided with transport home from hospital.
- 109 people supported at home after a hospital stay.
- 177 people supported to avoid a hospital admission.
- PIVOT services were also an integral part of the COVID-19 response, building on the integration they had established with other services in West Wales, notably with the Community Response Team to establish joined up working with the third sector.

Next Steps

Developing and implementing an exit strategy to navigate the conclusion of ICF funding.

Further Information

Contact:
MJPalfreman@carmarthenshire.gov.uk

Video:
www.youtube.com/watch?v=qpWdABCkuyY&feature=emb_logo

Key Learning – CoP Session 1: Existing models across the UK

Examples of the English D2A model, alongside other H2H models from across the rest of the UK, were also discussed during Session 1 of the CoP. While it was acknowledged that the operation and delivery of services will inevitably differ depending on the set up of host organisations and the needs of the target population, the fundamental principles of the models presented remain consistent regardless of location.

A summary of discharge to assess models in England can be found on the Local Government Association website[16].

North Staffordshire: Track and Triage

The system in North Staffordshire faced a number of issues, including risk-averse practice and fragmented services in the community.

My Care, My Way, Home First
www.healthservicesnorthstaffs.nhs.uk/our-journey/my-care-my-way/my-care-my-way-home-first

CQC Local System Review Report
www.cqc.org.uk/sites/default/files/20181214_local_system_review_staffordshire.pdf

LGA Case Study: Track and Triage
local.gov.uk/north-staffordshire-track-and-triage

Medway: Home First

Home First is an initiative developed through the partnership of Medway Foundation Trust Hospital, Medway Clinical Commissioning Group, Medway Council and Medway Community Healthcare. It provides support for patients medically fit to be discharged, but who still require additional home support.

Medway Home First Pledge
www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/3-medway-D2A-model.docx

LGA Case Study: Medway Home First
www.local.gov.uk/medway-home-first

16 www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/overall-approach/discharge-to-assess

Surrey: discharge to assess

In East Surrey, adult social care and the Clinical Commissioning Group are working together to pilot the use of discharge to assess for all continuing healthcare (CHC) assessments.

LGA Case Study: Surrey Discharge to Assess
www.local.gov.uk/surrey-discharge-assess

Tower Hamlets: admission avoidance and discharge service (AADS) and discharge to assess

A Clinical Commissioning Group funded pilot was initiated in 2015, starting with 15 patients and running in parallel to other winter resilience schemes, including an admission avoidance team, H2H service and out of hours social work.

UCL Tower Hamlets Pathways: Admission Avoidance and Discharge
www.ucl.ac.uk/epidemiology-health-care/sites/epidemiology-health-care/files/pathway_th.pdf

Presentation: Discharge to Assess in Tower Hamlets
londonadass.org.uk/wp-content/uploads/2016/10/DToC-Roadshow-18.10.16-D2A.pdf

LGA Case Study: Tower Hamlets Admission Avoidance and Discharge Service (AADS) and Discharge To Asses
www.local.gov.uk/tower-hamlets-admission-avoidance-and-discharge-service-aads-and-discharge-assess

COVID-19 good practice case study: Discharge to assess in Warwickshire

The health and care system in Warwickshire has maintained, and strengthened, its 'discharge to assess' model through the COVID-19 period by remaining aligned to its core principle of maintaining a person centred Home First approach.

NHS Quick Guide: Discharge to Assess in Warwickshire
www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/1-south-warwickshire-D2A-model.pdf

Cost Impact of the D2A Pathway Acute Spell in Warwickshire
www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/1-south-warwickshire-D2A-model.pdf

Presentation: Discharge to assess in Warwickshire for Kings Fund
www.kingsfund.org.uk/sites/default/files/media/Bie%20Grobet%20-%20Discharge%20to%20assess%20Warwickshire%20model.pdf

LGA Case Study: Discharge to assess in Warwickshire
https://www.local.gov.uk/COVID-19-good-practice-case-study-discharge-assess-warwickshire

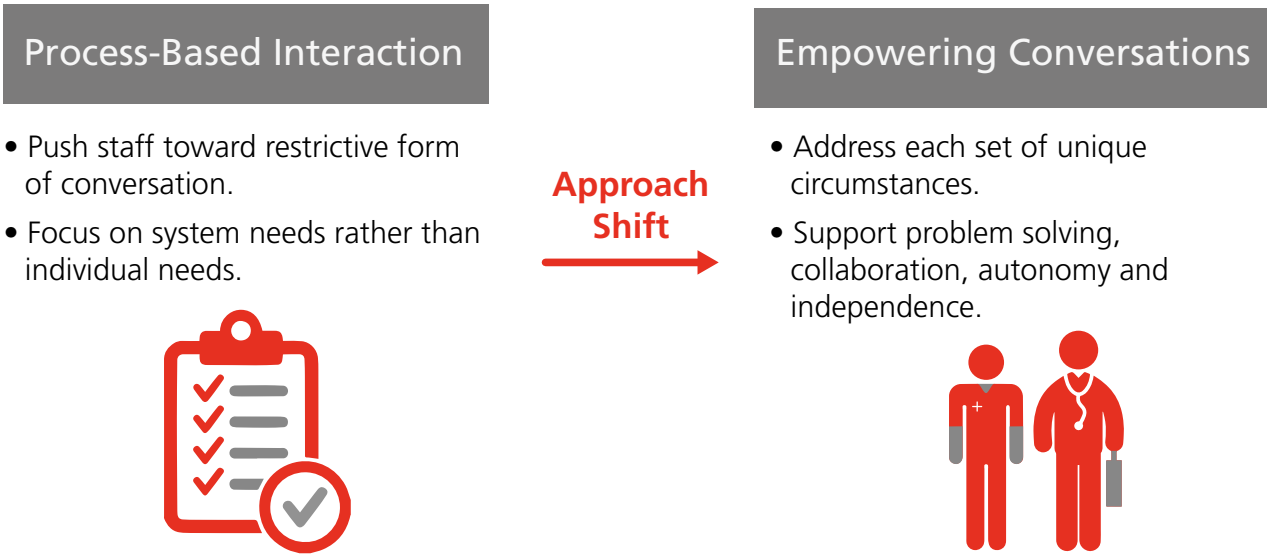
Key Learning – Session 2: Developing a positive culture for managing risk

The CoP Session 2 centred on risk management and how to improve service user outcomes by adopting a more positive risk culture, particularly when contemplating discharge decisions.

Current processes in place within acute hospital settings intend to minimise patient risk through a series of set procedures, checks and assessments. However, an increasing reliance on rigid process-driven interactions can often dominate staff time (up to 80%), result in restrictive patient interactions, cause unnecessary discharge delays and ultimately consequent in unintended harm caused by unnecessary discharge delays.

Moving from these heavily process-driven interactions, which focus on the needs of the system, toward a series of empowering conversations that address unique circumstances can help to refocus interactions toward the needs of the service user. This will reduce negative consequences, maximising patient autonomy and supporting sustainable outcomes. Moreover, while process led-interactions attempt to minimise physical harm, a more open and intuitive approach allows for the consideration of wider well-being needs, such as: compassion, respect, purpose, involvement and the need for outside relationships.

Figure 9: Benefits of a positive risk management approach



To enable the shift toward a more empowering approach, the workforce should be supported in developing the relevant 'listen to understand' skills. These include:

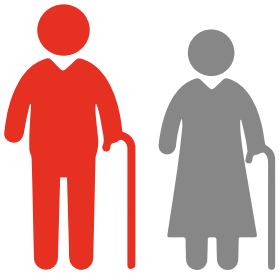
- Active listening – hearing what is being said, rather than listening for expected answers.
- Reflective statements – encouraging people to reflect on the wider situation.
- Open questioning – avoiding uniform questions that lead to restrictive responses.

Changing the way in which interactions are approached will also help to liberate ways of thinking.

This supports the development of a dynamic and skilled workforce, who seek more creative ways of working to understand and resolve specific dilemmas, using an awareness of strengths, challenges and perceived risk to establish sustainable outcomes that maximise benefits to the service user.

Case Study

The following case study was presented to the CoP to illustrate how negative risk culture and the following of process-heavy approaches can lead to negative outcomes, despite the best intentions of everyone involved.



Situation

Mr. X is an elderly gentleman who is on the ward within an acute hospital setting.

A ward nurse has referred Mr. X from rapid discharge to community services for medication only. He is otherwise medically fit at the time of referral.

Context

Mr. X lives at home with his wife, Mrs. X, who has been diagnosed with advanced dementia and has an existing care package in place.

Both Mr. and Mrs. X have expressed their wishes to stay at home, however both have been reluctant to receive care at home in the past.

Members of Mr X's family are aware of the situation and remain in support of his wish to remain in his own home.

Action

Mr. X's case is discussed at the next MDT meeting, with district nurses, GPs, social workers, physiotherapists and other allied health professionals present.

Discussions consider whether to offer Mr. X therapy-led re-ablement or a long-term brokerage service, right-sized through a therapist.

The following questions are raised:

- Is the need physical or cognitive?
- Does the individual have the capacity to manage medication without prompt?
- Given the individual's history, would care be accepted at home?
- Are other activities of daily living possible?
- Does the individual have re-ablement needs?

Outcome

- It takes 11 days from the time of referral for conversations and assessments relating to Mr. X's case to conclude. He is eventually discharged to home.
- During this time Mr. X is transferred between hospitals, leading to further frustration and confusion.

Conclusion

A negative risk culture based on assumptive conversations and over-reliance on process led to unnecessary delays in Mr. X's discharge decision.

With care services currently being delivered to the home and an existing family support network, mechanisms were already in place to discharge Mr. X earlier, while appropriately managing the identified risks.

Despite the best intentions, staff decisions went against Mr. X's wishes and contributed to his distress. This could have been avoided by adopting a 'home first' mind-set across the health board and instilling a more positive approach to risk culture.

Key Learning – CoP Session 3: Building an evidence base for demonstrating success

Performance Measures provide a systematic and standardised means of collecting data for a project or service, through which performance may be analysed and measured against pre-determined benchmarks. They are essential in ensuring that services are delivered as intended, objectives are achieved and issues are identified before they escalate into more serious problems.

Discussion on the requirements of H2H service measurement resulted in the following conclusions from participants:

Standardization of measures and processes: It was agreed that the processes used and data collected to measure service performance should be standardised across regions where possible, to allow for uniform implementation and accurate comparison between programmes.

Outcome-focussed measures: While it was acknowledged that process measures are necessary to ensure that services are delivered efficiently and as planned, participants urged focus on outcome based measures, rather than output, to ensure that emphasis remains on maximising benefit to the service user.

Skills and Resources: Participants noted that ample time, capacity and education on collection/reporting processes were essential to the accurate representation of service performance. Simplifying the way in which data is collected and reported, while maximising value to the individual, was seen as a fundamental requirement of measuring service performance.

Further discussion, informed by the measures proposed by Professor John Bolton (Figure 10 below), aimed to begin the development of a core set of indicators that can be used across services for each of the D2RA pathways.

Figure 10: Performance measurement for projects and services

Process Measures

Ask "How much has been done?" and "How well have we done it?".

Focus on the inputs, outputs, and implementation of the delivery.

Examples from Prof. John Bolton:

- What percentage of older people require formal help (pathways 1, 2 or 3) from a care service post discharge?
- What percentage of these older people require bedded facilities?
- What percentage of older people are waiting for the service for which they have been assessed?
- What percentage of older people are ready for discharge but have not yet been assessed for the support they might need?
- What proportion of older people are delayed in hospital when they are medically fit for discharge?
- What proportion of older people received long term support (as a new service) post hospital without being offered a period of recovery/support?

Outcome Measures

Ask "Is anyone better off?".

Focus on the impacts and outcomes for those affected by the service delivery.

Examples from Prof. John Bolton:

- What percentage of those who go to short-term bedded facilities return home?
- What percentage of those who are offered domiciliary care reablement or similar services need no further help or a reduced level of help after three months?
- What percentage of older people go direct to a residential or nursing home from hospital as a new place to live?

As part of the discussions, a number of performance measures were proposed by the participants as areas for potential data development over time (see Figure 12).

It was agreed that these measures were areas of interest for understanding the effectiveness of the system but further work would be needed to agree national definitions to ensure consistency and to develop systems to enable data collection.

This work will continue in the future but in the interim, five national D2RA measures have been agreed as a pilot (Figure 11) to share learning regarding data collection and to start the process for improving business intelligence in relation to the implementation of the D2RA Model. A Task and Finish Group involving all Regional Partnership Boards has been established to collect, monitor and review these measures with a view to refining them as appropriate.

Figure 11: National D2RA measures

Numbers	Focus	Measure
Measure 1	How much?	Number of people transferred on to each D2RA pathway
Measure 2	How well?	% of those transfers that took place within 48 hours of the decision being made (that they were ready for transfer from hospital to this pathway for supported recovery and assessment)
Measure 3	How well?	% people transferred to a D2RA pathway with a co-produced recovery plan in place
Measure 4	Is anyone better off?	% people transferred out of the D2RA pathway to their usual place of residence
Measure 5	How well?	% people readmitted to hospital within 28 days

Potential D2RA Performance Measures for Future Data Development

Figure 12: Potential D2RA performance measures by pathway

Pathway 1	Pathway 2 & 4	Pathway 3
		
MDT Front Door Turn Around	D2RA at home or at an existing care facility	D2RA in an intermediate bedded care facility
How much?		
% of people 'turned-around' at front door	% of people admitted on Pathway	% of people admitted on Pathway
Patient origin (i.e. self-presenting, WAST etc.)	% of patients receiving each support service	Number of people discharged to each facility
Number of individuals discharged to each service	Number of support plans put in place	Number of people transferred to Pathway 2 follwowing time in bedded facility
How well?		
% of avoidable admissions	Number of service providers between referral & discharge	Average time between referral to care facility and transfer
Number of discharge plans put in place	Time elapsed between referral and discharge	Average length of time spent in bedded facility
Re-admission rate (within X time)	Re-admission rate (within X time)	% patients returning home following admission to bedded facility
Is anyone better off?		
Number of 'bed days' avoided	% of individuals returning to original place of residence at time of admission	% of admitted individuals reporting improved wellbeing
Satisfaction of discharged individual	Satisfaction of discharged individual	Satisfaction of discharged individual
Level of independence upon return to home	Level of independence upon return to home	Level of independence upon return to home

Key Learning – CoP Session 4: A reflective approach to future planning

The fourth session of the Hospital to Home CoP aimed to gather views on the current Integrated Care Fund (ICF) and Transformation Fund (TF), with the intention of using participant feedback to inform the development of future funding programmes post March 2022.

Participants were asked to reflect on their experiences of using ICF and TF to support service delivery; identify successes and areas for improvement; suggest priorities for future funding programmes; and highlight potential areas in need of further support and investment.

Key Points from Discussions

Q1. What has worked well and not so well in the existing ICF and TF Programmes?

✓ **Service integration –**
The programmes have facilitated a move toward more integrated systems and services, particularly across the third sector and local authorities.

✗ **Temporary recruitment –**
Short-term funding has resulted in issues recruiting and retaining staff. Contracts are often only able to be offered on a temporary basis and are failing to attract the required levels of interest. This is compounded where numerous regions are competing for staff within the same talent pool.

✓ **Partnership working –**
Joint working and relationship development have been hugely successful, helping to improve understanding of the whole system.

✗ **Time limitations –**
The short timeframe of the programmes has made it difficult to demonstrate the impact of new services. Participants noted that planning services, agreeing funding between partners, putting in place governance arrangements and preparing for data collection all take up a significant amount of time, leaving very little time to establish services and deliver outcomes.

✓ **Double funding –**
The Transformation Fund's 'double funding' ability has allowed partners to develop new services that would not have been possible otherwise.

✗ **Multiple funding pots –**
Multiple, misaligned funding streams have become over-complicated, leading to considerable time and resource constraints among partners. Applying for, reporting to and delivering on numerous different funding programmes takes up valuable time and resources and results in both the duplication of work and layering of services.

✓ **Flexibility –**
A degree of flexibility has allowed organisations to continually adapt and develop, while supporting the implementation of local solutions for local problems.

✗ **Sustainability –**
Participants raised concerns over the sustainability of TF and ICF projects, with core budgets unable to maintain services once the funding programmes end. Moreover, following the recent period of austerity, additional funding is being used to manage increasing pressures and therefore the full effect cannot be realised.

✓ **Outcome focus –** Rigour around outcomes was positively received, though participants suggested moving toward a smaller number of consistent 'golden nugget' outcomes in the future.	✗ **Fragmented regional approach –** Some regions reported difficulty maintaining a consistent regional approach at a strategic level. Frustrations have arisen among regions covering disparate localities, occasionally hindering partnership working and the co-production of services.
✓ **Stability –** The programmes have provided the stability and capacity needed to support more creativity and to trial new ways of working, despite the uncertain environment.	✗ **Data collection –** A whole-system approach to data collection has not been achieved. Complexities in the system require a collaborative approach to analytical support, with existing local solutions often relying on the efforts of individual enthusiasts.
✓ **Culture change –** Moving from a model focussed exclusively on staffing needs to a service-oriented model, shifting focus toward patient and co-ordinated approaches and moving focus away from delayed transfers of care were all noted as positive shifts in culture.	✗ **Secondary care interaction –** Uncertainties remain in understanding how ICF and TF interacts and overlaps with secondary care.
✓ **Recognition of community services –** The programmes have helped recognise the value of community services and enables a move away from the existing secondary care centric approach.	✗ **Co-operation with acute services –** There have been difficulties reported in engaging with acute services and establishing a wider discussion around community services.
✓ **Therapy-led teams –** Both funds helped to advance the establishment of therapy-led teams in delivering D2RA.	

Q2. How do we develop a programme which enables a national model of Home First / D2RA to be embedded whilst still enabling local flexibility?

The following themes were common across groups when discussing elements they would like to see in future programmes:

- **Continued cultural shift –**
  While participants acknowledged that the ICF and TF programmes had achieved a certain degree of cultural change, it was suggested that greater cultural shift at ground level is required to embed D2RA going forward. Suggested mechanisms included:
  - Incorporating into undergraduate training across disciplines, so people come out knowing that this is what is expected in practice;
  - Developing a national training package for D2RA in Wales and making sure this includes a focus on positive outcomes and patient stories;
  - Ensuring the leadership is in place to support staff with positive risk-taking in line with the individual's wishes;
  - Improving the use of community-based advocacy in resolving tensions between MDT and individuals risk appetite;
  - Celebrating successful discharges and sharing positive learning.
- **Levelling-out –**
  It was noted that all regions and organisations across Wales are starting from different points in terms of capacity, resource, resident needs and geography, making a 'one-size-fits-all' approach ineffective. Further work needs to be done to 'level-out' these discrepancies where possible, while future programmes should accommodate for certain unavoidable differences.
- **Uniform agreement and understanding –**
  Collaboration continues to be hindered by varied terminologies, cultures and levels of risk adversity across regions, organisations and communities. Participants agreed that universal agreement needs to be achieved before a national model can be implemented, with a set of guiding principles established to support understanding.
- **Local variance –**
  Participants praised the development of the current D2RA national framework, but encouraged greater autonomy to introduce local variance where appropriate. One suggestion proposed that local authorities are given greater input, adding that the current approach is predominantly health board oriented.
- **Data collection –**
  The need for a full commitment to data collection and reporting was discussed, while noting that improved standardisation would relieve the current pressures placed upon informatics teams. It was recommended that well-defined, national 'golden nugget' outcomes should be agreed and made a condition of continued funding. These outcomes should be aligned across funding programmes and submitted to a single Welsh Government department to reduce reporting burdens.
- **Balanced prescription –**
  Some opinions voiced in the discussions called for greater levels of prescription from the Welsh Government, citing a need for more structure and guidance. Others however, felt that overly specific requirements can become counter-productive, limiting creativity and innovation. Participants recommended that future programmes work to find the right balance between structure and autonomy. The danger of a flexible of approach can often be confused with something being optional and RPBs can opt out – there needs to be a balance to avoid this happening.
- **Legislation –**
  Participants discussed a need for the joining up of legislation above SSWBA, noting that outcomes are often missed or deemed unimportant. Outcomes can also conflict, resulting in different approaches from the health board and social care, which is not conducive to collaborative working.

- **The bigger picture –**
  Although in full support of D2RA, a number of participants noted that it was only one element of a larger programme of work being undertaken by their region. Consideration should be given to how D2RA fits within wider bodies of work and its interaction with other home care models, as well as urgent and intermediate care
- **.Clarity of funding –**
  Numerous discussions emphasised the need for fewer funding streams and reporting requirements, noting that the existing arrangements have led to confusion and duplication of work. Future programmes should aim to align funding streams and provide greater clarity on both the intended use and desired outcome of funding.
- **Resource access –**
  It was recommended that more work is done to ensure that resources are in the right place to deliver services. Equity of access needs to be improved to ensure that the right bodies are able to draw upon the resources necessary to benefit citizens.
- **Relationships and co-production –**
  Participants highlighted the importance of co-production in any new programme, citing recent 'rightsizing' work as an example of an initiative that was done *with* RPBs, not *to* RPBs. There was also a call for greater clarity regarding the relationships and drivers between regions health boards, local authorities footprints and Clusters, while existing addressing any existing 'us vs. them' attitudes.
- **Future learning platforms –**
  It was generally agreed that the Communities of Practice have worked well in facilitating the sharing of best practice and promoting collaborative learning. Participants welcomed the prospect of implementing similar mechanisms in any future funding programmes.
- **Terminology –**
  Some questions were raised regarding the current terminology used, particularly 'Hospital to Home'. There was some concern that too much focus was given to step-down services and not enough on building community models of care. It was suggested that better terminology would improve communication, remove ambiguity and provide clarity on the intended outcome of services.

Q3. How do we ensure grant funding becomes mainstreamed with core funding across the partner organisations?

Topics discussed in response to the above question were categorised into the following four themes:

- **Sustainability –**
  Much of the discussion relating to the mainstreaming of funding centred on the sustainability of grant funded projects. It was noted that the continued reduction of core budgets due to a period of austerity have made it near impossible to replace project funding once a grant ends. Participants did not agree that this could be avoided through the use of tapered funding, instead recommending that exit strategies are planned for at the outset (i.e. within the proposal) and suggesting that the funding of long-term projects should become core funding if and when they can demonstrate sustained impact and success.
- **Length of funding –**
  Participants also discussed issues caused by the short timescales of funding, reaching the general consensus that a three-year period is too short to allow for sufficient planning, recruitment and delivery. While some agreed that temporary funding is beneficial in determining what changes have worked, it was agreed that a minimum period of five years is necessary to accurately implement and evidence a successful project or service.
- **Structure –**
  Further discussion addressed current funding structures and contemplated how funding should look in the future. Participants recommended reviewing the use of core funding alongside grant funding, noting that the two should not be viewed in isolation of each other. Additional suggestions included: separate mainstream and transformation funds; the allocation of funding to outcomes rather than projects; and the introduction of a 'summer pressures' fund to account for the knock-on effects of COVID-19.
- **Pooling –**
  Participants noted that grant funding is currently relied upon as the only 'truly integrated' funding source. It was suggested that this pooling needs to be protected, with many raising concerns over the inefficacy of voluntarily pooled budgets.

Q4. There will be a strong focus on evaluation and review of performance in the new programme – what support and infrastructure is needed to help you do this?

Topics discussed in response to the above question were categorised into the following four themes:

- **Analytical capacity –**
  Across each of the discussions, participants frequently mentioned the need to improve the analytical capacity and capability of their respective workforces. It was noted that existing systems and workforces have not been set up for data collection or analysis, with greater investment required to recruit the necessary staff, while repurposing and reskilling existing resources. Furthermore, participants noted that retaining skilled staff was again difficult due to temporary funding and that all regions were competing for the same staff within a limited talent pool.
- **Review of structures –**
  Additional to the upskilling of staff, participants noted that the current systems for collecting and reporting data within their respective organisations required significant improvement. Concerns were raised over disconnects between fragmented internal structures, with inconsistent processes for collecting, storing and reporting data leading to considerable difficulties in data communication and analysis.
- **Resources –**
  There needs to be sufficient resource allocated to capacity within the regions to support evaluation and performance monitoring. The additional resources allocated to TF Evaluation have been helpful to work alongside the regions.
- **Defined measures –**
  Participants recommended that future programmes should aim to define national outcome measures at the outset, which may be supplemented by tailored project-level measures where necessary. It was largely agreed that all regions should be working toward a common set of pre-determined outcomes, focusing primarily on the wider benefits to individuals and communities. However, it was also noted that the use of funding will vary between projects, therefore necessitating the use of some project-level measures.
- **Accountability –**
  Further discussions covered the topic of accountability, raising the need to tie funding to outcomes. It was suggested that future programmes are tied to a core set of requirements, with consequences for non-compliance; such as withheld funding.
- **Simplified reporting processes –**
  Echoing points previously mentioned, participants recommended that future reporting processes should be simplified, with particular emphasis on aligning the requirements of different funding streams. It was also suggested that the frequency of reporting should be reduced; requirements should remain consistent throughout the duration of the grant; and that more focus and support should be given to sustainability reporting, enabling regions to better plan for the future.

Impact of COVID-19 on Hospital to Home Services in Wales

COVID-19 brought significant challenges to the health and social care services in Wales, and impacted Home First and H2H services in numerous ways. One of the impacts was to accelerate the delivery of the D2RA. This was reflected in the case studies as well as in the COVID-19 hospital discharge requirements in Wales and supported by the additional funding provided by Welsh Government.[17]

The CoP's have provided a platform for feedback on the impact of COVID-19 and some of the observations and changes that have been made as a result of the upscaling of the model will be fed back into the further development of D2RA in Wales. Some of the feedback captured during the CoP includes

Positive outcomes of the COVID-19 response:

- **Reductions in bureaucracy and red tape:** More assessments are now being facilitated at home, while over complicated processes have been simplified and the speed of discharge planning has been accelerated.
- **Positive culture shift:** Including less complexity and improved communication in partnership working. The need to respond to COVID-19 pressures helped develop more team-based approaches and facilitated progression toward a more flexible and dynamic system.
- **Third sector integration:** An increase in volunteer and third sector involvement with H2H pathways has helped strengthen relationships between the hospitals and community staff and raise staff awareness of services available in the community.
- **Improved digital services:** Virtual working has acted as a catalyst to digital service development, resulting in greater engagement from GPs and an increase in remote assessments.
- **Flexible working relationships:** COVID-19 response has necessitated more flexibility between commissioners and providers, creating the opportunity for new working arrangements.
- **Capacity and planning:** The need to increase the availability of beds has improved capacity across the system, easing pressures on planning and helping to reduce delayed discharges.
- **Closer family involvement:** Reluctance to adopt care packages due to the risk of transmission, coupled with greater numbers working from home, has seen closer involvement and more support from families.
- **Profile and recognition:** Health, social care and third sector staff have received greater visibility due to their role at the forefront of the COVID-19 response.

17. Hospital discharge service requirements: COVID-19 https://gov.wales/hospital-discharge-service-requirements-COVID-19

Negative outcomes of the COVID-19 response:

- **Workforce fatigue:**
  Unprecedented pressures have taken a significant toll on the physical and mental health of staff. The momentum for change cannot be sustained as staff become more fatigued.
- **Service sustainability:**
  The speed at which certain changes have been made (i.e. increased service provision) has raised concerns over future sustainability and a lack of planning for the 'new normal'.
- **Process divergence:**
  Consultation with staff has been more lenient during the pandemic, resulting in a divergence from expected standards and practices. For example, involving fewer people in decision making.
- **Logistical challenges:**
  The '28 day rule' implemented within care homes to stop the spread of COVID-19 has created ongoing issues for moving residents throughout the system.
- **Eligibility and finance:**
  Issues remain around who pays for care in some areas and disagreements persist regarding Continuing Health Care eligibility.
- **Funding uncertainty:**
  H2H projects throughout the COVID-19 pandemic have been financed predominantly via both the ICF and Transformation Fund. This has caused uncertainty over sustainability and the availability of future funding.
- **Unequal awareness:**
  While certain community services have been stepped up during the COVID-19 response, others have been reduced or put on hold. Work needs to be done to support struggling services and ensure awareness is improved across all areas.

Community of Practice – Key learning summary and next steps

This section captures some of the strengths, key challenges and areas for improvement from the findings of the CoP. There have been a number of themes that were prominent throughout and which have been fed into the DU's further development of D2RA.

Strengths of Hospital to Home:

- **Focus on the patient –**
  There is a common goal of focusing on a 'Home First', with outcomes for patients and families and building in recovery as a core component to each pathway.
- **D2RA Development –**
  It is important that stakeholders have the capacity and ability to be part on conversations about the development of the D2RA model as this has helped to build ownership.
- **Flexibility –**
  The D2RA model allows for flexibility with roles and shared responsibilities, encouraging the opportunity to consider working differently.
- **Partnership working –**
  H2H has encouraged health and social care services to work in better partnership. Collaborative working has grown particularly fast due to the resourcing pressures of COVID-19.
- **Optimism –**
  There is enthusiasm and positivity around future opportunities for service integration.

Key challenges:

- **Risk dichotomy –**
  There are different risk cultures between hospitals and community services.
- **Practitioner buy in –**
  Getting full involvement from people who have not attended the CoP will be challenging. This has been exacerbated by the increased demand placed on health and social care staff by the pandemic, both in terms of workload and of staff illness.
- **Rebuild, not revert –**
  Maintaining the positive change within D2RA and preventing slippage back to old practices as the health and care system rebuilds post COVID-19 will require structure, collaborative working and development of evaluation measures.

Areas for improvement:

- **Shared learning –**
  There needs to be more learning both within local authorities, health boards and nationally. Specifically sharing examples of best practice and making sure that the D2RA model is constantly adapting and developing to suit the changing health and social care landscape. This is even more important in a COVID-19 context.
- **Focus on the patient –**
  Partners need to ensure that that patient voice is not lost within processes and the main focus is the patient choice. This means continually evaluating measures and outcomes to ensure that they are suited to patients.
- **Streamline procedures –**
  Work needs to continue to remove process time, red tape and bureaucracy to make the service more patient focused. This has happened to a limited extent due to COVID-19, but needs to remain a long term goal.
- **Build a 'Home First' mind-set –**
  Need to build the Home First mind-set throughout all staff, engaging people to be more involved at an early stage to create ownership at all levels.

To conclude the CoP session, participants were asked to provide a word which described the Community of Practice (see below).

It was agreed that CoP had proved useful to people and that further opportunities for informal learning and sharing barriers and best practice should be promoted.

A discussion with participants regarding next steps recognised that there are a number of complementary pieces of work being taken forward which includes the Community of Practice for the 'rightsizing' of community services; a Health and Social Care Capacity Modelling & Monitoring Group; and the D2RA Task and Finish Group.

Each of these Groups had enabled a stronger collective focus on Home First and H2H and is enabling the accelerated implementation of a national D2RA model.

The new, re-energised Home First/D2RA Implementation Programme will be co-ordinated by the DU, in continued collaboration with Welsh Government and all the stakeholders highlighted in this Briefing.

There is a firm commitment to continue the work with this CoP and to action the key learning highlighted. Initial thoughts are that the programme will have 3 key areas of focus:

1. **Right Community Services –** incorporating the various right-sizing pieces of work;
2. **Right Mind-Set –** incorporating the culture shift and training required to further embed the Home First/ D2RA ethos;
3. **Continuous Improvement –** incorporating monitoring, evaluation and shared learning.

Going forward, and within the context of new funding programmes being developed as a successor to ICF and TF, it was important that the separate elements are brought together within a collective governance structure to deliver a more powerful agenda for change and to reduce the complexity of current funding and reporting processes.

Further work will take place over coming months to shape these proposals and which will be shared with the CoP participants for their views and ongoing input.

Appendix 1: Acronym Guide

AADS	Admission Avoidance and Discharge Service
AHW	A Healthier Wales
CCG	Clinical Commissioning Group
CHC	Continuing Healthcare
CQC	Care Quality Commission
D2RA	Discharge to Recover then Assess
DU	NHS Wales Delivery Unit
GP	General Practitioner
H2H	Hospital to Home
ICF	Integrated Care Fund
LGA	Local Government Association
MDT	Multi-Disciplinary Team
NHS	National Health Service
RPB	Regional Partnership Board
TF	Transformation Fund

Appendix 2: Table of Figures

Appendix 3: Quick Resource List

Strategic Documents

A Healthier Wales: Our Plan for Health and Social Care
gov.wales/sites/default/files/publications/2019-10/a-healthier-wales-action-plan.pdf

NHS Wales Framework 2020/23
gov.wales/nhs-wales-planning-framework-2020-2023-whc2019029

Project Funds

Integrated Care Fund (ICF)
gov.wales/sites/default/files/publications/2020-02/integrated-care-fund-revenue-capital-and-dementia-guidance.pdf

Transformation Fund (TF)
gov.wales/health-and-social-services-transformation-fund-projects

Discharge Models

Discharge to Assess (D2A)
www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

Discharge to Recover then Assess (D2RA)
www.adss.cymru/image/blog/COVID-19%20Resources/28-05-20/Right-sizing%20Community%20Services%20for%20Discharge.pdf

COVID-19 Hospital-to-Home Discharge Requirements
gov.wales/sites/default/files/publications/2020-04/COVID-19-hospital-discharge-service-requirements.pdf

Bed Management toolkit
www.adss.cymru/en/blog/post/bed-management

Case Studies from Wales

Cwm Taf Morgannwg: Stay Well @Home
cwmtafmorgannwg.wales/hundreds-patients-avoid-hospital-stays-thanks-home-service/

Cardiff: Get Me Home
www.youtube.com/watch?v=eJM_eVU1FIY

West Wales: PIVOT
www.youtube.com/watch?v=qpWdABCkuyY

West Glamorgan: Optimal Models of Care (p.61)
gov.wales/sites/default/files/publications/2020-01/integrated-care-fund-annual-report-2018-2019_0.pdf

North Wales: Community Services Transformation
www.northwalescollaborative.wales/transformation-programme/community-services/

Gwent: Home First
www.youtube.com/watch?v=1sC_lr5Nxnl

Powys: Discharge to Recover then Assess
pthb.nhs.wales/news/health-board-news/an-occupational-therapy-led-discharge-to-recover-and-assess-model-in-powys-is-supporting-people-to-return-home-promptly-and-safely-from-hospital/

Case Studies from Across the UK

LGA Case Study: Track and Triage
local.gov.uk/north-staffordshire-track-and-triage

LGA Case Study: Medway Home First
www.local.gov.uk/medway-home-first

LGA Case Study: Surrey Discharge to Assess
www.local.gov.uk/surrey-discharge-assess

LGA Case Study: Tower Hamlets Admission Avoidance and Discharge Service (AADS) and Discharge to Assess
www.local.gov.uk/tower-hamlets-admission-avoidance-and-discharge-service-aads-and-discharge-assess

LGA Case Study: Discharge to assess in Warwickshire
www.local.gov.uk/COVID-19-good-practice-case-study-discharge-assess-warwickshire

Institute of Public Care Publications

Commissioning Out of Hospital Care to reduce delays
ipc.brookes.ac.uk/files/publications/Commissioning_Out_of_Hospital_Care_Services_to_reduce_delay_(Final%20March%202020).pdf

New Developments in Social Care
ipc.brookes.ac.uk/files/publications/New_Developments_in_Adult_Social_Care.pdf

Reducing Delays in hospital transfers in the care of older people: key messages in planning and commissioning
ipc.brookes.ac.uk/files/publications/Some_key_messages_around_hospital_transfers_of_care.pdf

Extra care housing in Wales: A state of the nation report
ipc.brookes.ac.uk/files/publications/HousingLIN_Wales_ECH_report_Dec15.pdf