Summary of Key Learning From The D2A Pilot

This report provides a summary of the key learning points and future recommendations associated with the pilot of the Discharge to Assess (D2A) scheme for complex patients/clients on Pathway 3 over the period 1 November 2017 – 31 December 2018.

The Joint Commissioning Board gave approval in September 2017 to fund a pilot of a D2A scheme specifically for Pathway 3 using a mix of bed based provision (provided by nursing and residential homes) and home care whilst people are assessed, underpinned by a pooled budget with equal contributions from the CCG and City Council. The pilot was established to test out a number of objectives on a small scale prior to moving to a permanent D2A scheme for all clients on Pathway 3:

- to test a mixed model of D2A placement for this client group, particularly the viability and impact of using a robust home care package for some clients/patients
- to evaluate the impact on costs of long term care package for this cohort of patients/clients, i.e. the extent to which assessment outside the hospital setting, and in particular in a person's home, can reduce their long term care package
- to evaluate the impact on DTOC overall in terms of both numbers and costs

The target group for the pilot were Pathway 3 patients/clients who are medically fit and able to leave hospital (UHS) but due to the complexity of their long term care needs, require further assessment and support in the community setting. Demand was estimated to be around 4 patients/clients a week (although the numbers that went onto the scheme were much less).

A nurse (1wte) and a social worker (1 WTE) were recruited fixed term to support hospital staff in identifying suitable patients, undertake the assessment in the community setting and ensure timely move on to long term care. A budget of £1,021,860 per annum was agreed for the pilot, funded 50:50 by the CCG and the Council (using improved Better Care Fund money) to cover the cost of these two staff members and a mixture of 13 assessment placements (nursing home beds, residential care beds and live in home care) which were initially commissioned using block contracts.

Following the initial evaluation which covered the period November 2017 - June 2018 a number of changes were made which have reduced the costs of the pilot:

- The budget for the assessment placements was reduced from £832,000 per annum to £421,200 and only one of the block contracts which was for 3 beds from one of the nursing homes was maintained, with the remainder of the budget held for spot purchasing (up to 3 placements at any one time). This decision was taken on the following grounds:
    - The original estimate of 4 patients/clients a week being discharged onto the D2A scheme proved to be an over-estimate and in reality there were only 1-2 discharges a week. This led to a high number of voids in the contracted beds. It was however acknowledged that to a certain extent this was down

to hospital processes not identifying suitable candidates early enough for D2A and some patients/families opting out of the scheme (primarily because they did not want to move twice) which would need to be addressed in any permanent scheme.

- A key reason for some patients/families opting out of the scheme was that they did not want to move twice and therefore by spot purchasing some of the assessment placements it allows for the possibility of assessing some people in their final destination. There is a risk however that the time it takes to source and spot purchase a bed will compromise any reduction in hospital length of stay.
- A positive relationship had been established with one of the nursing homes and therefore it was felt beneficial to continue to block purchase this resource. There have been very few voids in these beds.
- Owing to the complexity of the client group, the residential care beds were rarely able to meet client need and remained empty.

- The dedicated social worker for the scheme was removed and this function was absorbed by the Hospital Discharge Team with some additional hours funded. This decision was taken partly because the member of staff left but primarily with a view to the long term when it was felt that the Hospital Discharge Team should be managing D2A for Pathway 3 clients as part of their day to day operations. Having a separate team managing D2A over-complicates processes and risks duplication. The view was that in the long term the Hospital Discharge Team would manage the scheme exclusively from within its existing resources, drawing in support from CHC only when the patient requires a CHC assessment. However for this to happen a number of functions relating to Discharge Pathways 1 and 2 will need to be transferred back to the hospital and Rehab and Reablement Team and so a small budget was maintained to cover additional hours in HDT. Work is progressing to fully embed pathways 1 and 2 with a view that these functions will be handed over by end of the year 2019/20.

Summary of Pilot Activity

Metric	Assessment Bed/Package	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Operational													
No. of hospital readmissions from assessment beds		1		1	1		1	1	2				
No. of patients accessing the assessment beds/packages	complex nursing home	1						1					
	standard nursing home	6	7	5	5	4	4	5	3	3	1	4	6
	residential care	1						1			1	1	
	home care	1											
No. of placements extended beyond 4 weeks		1	2		3	1	2		1		1	1	1
No. of declines to pathway 3 D2A on grounds of patient choice		2	5	1	2	3		1	1	1		2	
No. of declines from the homes for pathway 3 patients					1	1	2						
No. deaths (within the 28 day placements)		3	2	2	1	1	1		1			1	

This shows that during the 12 month period there were:

- 60 patients/clients who went onto the pilot (an average of 5 a month) of whom the vast majority went into the standard nursing home placements (53 out of 60)
- 18 patients/clients who declined the pathway on the grounds of patient/client choice

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- About one fifth of assessments took longer than the scheduled 28 days
- There were 7 readmissions and 12 deaths which were reviewed and reflected the complexity of the client group
- It should be noted that less than 2% of patients/clients who went onto the scheme turned out to be CHC eligible.

Learning from the Pilot

Impact on Hospital Length of Stay

One of the key aims of the D2A scheme was to reduce hospital length of stay by undertaking the assessment of the client's needs for long term care outside of the hospital setting.

In order to measure the extent to which the pilot achieved a reduction, the length of stay in hospital for two groups with similar levels of need was compared:

- those patients/clients who were offered D2A and accepted (55 client records were available to review)
- those patients/clients who were offered D2A and declined. (18 clients)

The table below shows the length of stay in terms of the total average length of time in hospital, from admission to discharge. Those patients/clients who went onto the D2A scheme had shorter lengths of stay on average:

- by an average of 27 days from admission to discharge

Admission to Discharge

	Total LOS		Average LOS	
MMM YY	Declined	Accepted	Declined	Accepted
Dec-17	156	87	52	29
Jan-18	200	172	67	25
Feb-18	23	149	23	37
Mar-18	106	253	106	51
Apr-18	201	65	67	22
May-18	156	23	78	23
Jun-18	29	225	29	56
Jul-18		534		59
Aug-18		118		39
Sep-18	76	315	76	79
Oct-18	117	120	117	60
Nov-18		228		46
Dec-18	103	217	103	43
Jan-19	149		149	
Grand Total	**1,316**	**2,506**	**73**	**46**

Based on an estimate of three Pathway 3 clients a week (156 a year), this reduction in length of stay would equate to:

4,212 bed days per annum or 11.5 hospital beds (based on average reduction of 27 days between admission and discharge for clients on D2A)

Impact on national targets

In addition to impact on length of hospital stay, the pilot was shown to have also had a positive impact on achieving the CHC target to reduce the percentage of assessments carried out in an acute setting.

During the pilot period CHC assessments undertaken in the acute hospital decreased from 86% (pre pilot position) to 14% (December 2018 position). The pilot was only one factor in this reduction, but the overall additional focus it gave to assessing long term care needs in a non-acute (outside of hospital) setting was a major positive.

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
% CHC Assessments in acute setting	86%	56%	50%	29%	23%	19%	15%	15%	10%	20%	17%	20%	17%	15%	14%

Financial Impact

The table below compares the average inpatient tariff of those patients/clients who went onto the D2A scheme with those patients/clients who were offered the scheme and declined. Similar to the length of stay data, this shows that those patients/clients who went onto the D2A scheme went on to have a lower average tariff compared to those who declined the scheme:

- by an average of £4,220 less for total hospital length of stay

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PbR Final Tariff

* Tariff based on PbR Final Tariff (does include XBD costs)

Total LOS Tariff

			Average Tariff	
MMM YY	**Declined**	**Accepted**	**Declined**	**Accepted**
Dec-17	£24,247	£18,021	£8,082	£6,007
Jan-18	£32,447	£41,316	£10,816	£5,902
Feb-18	£6,483	£3,046	£6,483	£762
Mar-18	£21,889	£36,881	£21,889	£7,376
Apr-18	£25,704	£18,398	£8,568	£6,133
May-18	£44,254	£0	£22,127	£0
Jun-18	£5,852	£44,740	£5,852	£11,185
Jul-18		£61,222		£6,802
Aug-18		£21,334		£7,111
Sep-18	£12,755	£57,750	£12,755	£14,438
Oct-18	£22,442	£27,443	£22,442	£13,722
Nov-18		£38,056		£7,611
Dec-18	£13,634	£40,491	£13,634	£8,098
Jan-19	£0		£0	
Grand Total	**£209,707**	**£408,698**	**£11,650**	**£7,431**

Impact on reducing long term care costs was less evident. Given the complexity of clients, the majority of whom required a nursing home placement, it proved very unlikely that significant reductions would be achieved in reducing packages of care and most clients went into long term placements with similar levels of care provided at the time of assessment. The only client group where it is felt that there may be benefits in reducing long term care costs are those with delirium (based on evidence from elsewhere). There is a developing awareness that some patients with delirium are placed in long term residential care unnecessarily when a period of intensive care within a home environment may allow for the delirium to resolve. These patients could be managed on this pathway with a D2A or “bridging” type approach in any future model.

Patient/Client Experience: During the pilot a questionnaire was used to follow up with individual clients / families on their experience. The main feedback from clients who went onto the D2A pilot was:

- Assessment in placement was generally viewed as positive, particularly by those clients who went on to remain in the same home for their long term care.
- Assessment in placement was generally viewed as less pressured with more opportunity to ask questions and seek clarification from staff.

The main areas of more negative feedback came from people who declined the D2A pilot and related to:

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- Limited choice of placement, which was particularly related to those contracted homes at the beginning of the pilot which were outside of the city where travel distance was a concern to families
- Having to move on from placement (i.e. having to move twice, once into the assessment placement and then again into the long term care placement)

18 clients/families declined the D2A scheme for these reasons which will need to be taken into account for future implementation. Placement moves would be reduced by placing a client wherever possible in their long term placement directly from hospital and carrying out the assessment there.