The Better Care Fund

Delivering Integrated Care Masterclass

Sharing responsibility for Transfers of Care

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NHS England

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PPL

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Summary

Transfers of care is one of the most challenging issues facing local health and social care systems. The number of bed days lost has increased despite the planned reductions targeted in 2016/17 BCF plans. The context is tough with cuts in local authority social care spend, budget pressures on NHS providers, fragility in care home and domiciliary care markets, and the unrelenting demand from demographics and increased morbidity.

However, the King's Fund found **no clear relationship between reductions in local authority funding levels and numbers of delayed transfers**. They concluded that **practice issues** must play their part. It is clear from the literature that systems most advanced in terms of the integration journey have better performance in managing transfers of care.

Housing, private providers and the voluntary and community sectors all have a key role in contributing to a sharing of responsibility for transfers and need to be at the table for both strategic and operational planning. Promoting personal independence and self-care through asset-based approaches and engagement with the public are essential to improving health and preventing hospital admissions.

A number of factors can be seen to get in the way of taking whole system responsibility for transfers. These can be grouped under the headings of **System, Cultural, Operational and Resources** (see handout).

Attendees at the workshops emphasised deficits in system leadership, silo working and a disconnect between strategic and operational managers as factors particularly influencing performance on transfers.

Summary (cont)

Given the imperative of getting to grips with the personal and financial cost of transfer delays, the new BCF guidance has included a national condition and metric linked to the new social care monies aimed at reducing the number of bed days lost. Health and social care systems will need to examine whether they have the foundations in place to enable whole system ownership of the problem as well as the ability to find creative solutions.

A number of detailed questions for systems to consider were posed in the workshops (see handout).These include examining:

- leadership and governance
- integrated programme management
- integrated commissioning arrangements and market development
- functioning of the A&E Delivery Boards
- integrated strategies and services to prevent hospital admissions
- collection, analysis and evaluation of data and benefit realisation
- adoption of best practice with a consistent Home First message
- and whole system approach to workforce planning and development.

The presentation includes examples of good and promising practice from more integrated systems who have successfully shared responsibility for transfers of care and seen an improvement in performance through a number of initiatives including discharge to assess.

Hannah Miller
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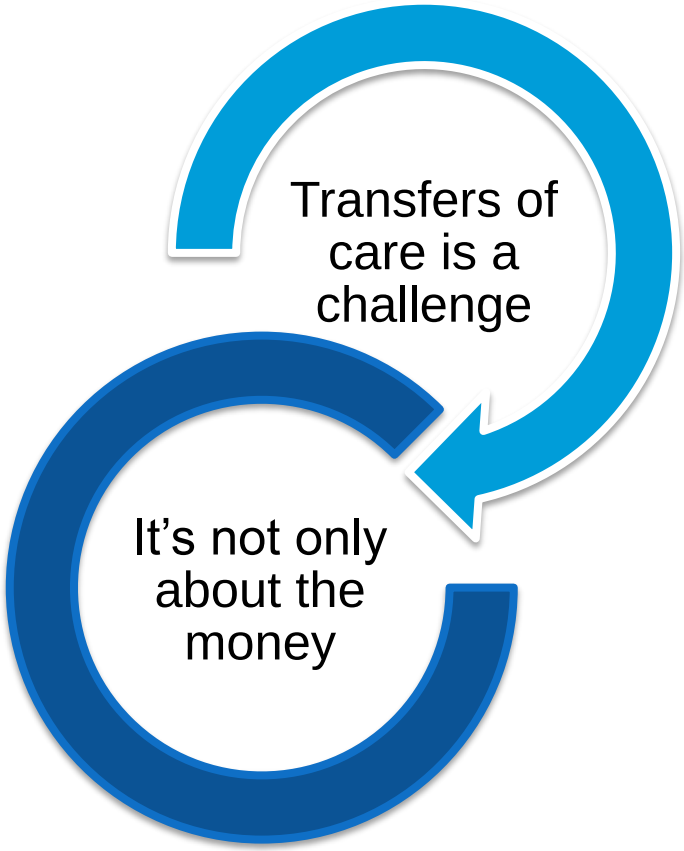
Transfers of care – a real challenge!



Finances: there is increasing pressure on NHS provider finances (particularly acute providers) reflecting the year-on-year downward pressure on prices paid for activity.

Local authorities' total service expenditure fell by 18% in real terms between 2010-11 and 2015-16. Over the same period, their spending on adult social care, excluding NHS transfers and the Better Care Fund, fell by 7% in real terms.

Who should be sharing responsibility for transfers of care?

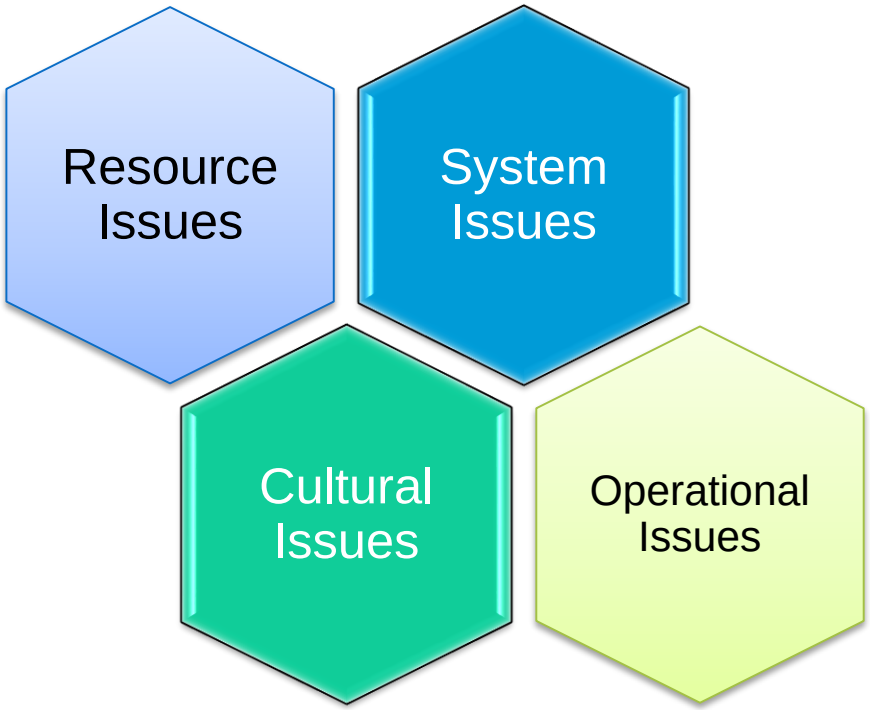
Usual Suspects

- **NHS partners**
- **Social Care**

Should include other key stakeholders?

- **Voluntary sector**
- **Private sector**
- **Housing**
- **Families/informal carers**
- **Citizens / wider community**

What gets in the way of taking shared responsibility for transfers of care?



A mature system can examine its performance critically and have difficult conversations without blame or falling out in order to find creative joint solutions

A whole system approach is essential for safe, timely transfers

- BCF planning guidance 16/17 included a national condition which required local areas to develop a clear, focused action plan for managing delayed transfers of care including locally agreed targets
- It also required CCGs to commission out of hospital services
- BCF guidance 17/18 includes a national condition and metric on DTOC with performance linked to new social care monies
- Role of the A&E Delivery Boards is very specific around managing transfers as a whole system

How do we achieve whole system ownership of transfers of care?

•Timely, safe discharges involve complex processes and interdependencies. They rely on the contribution and co-ordination of multi services across occupational and organisational boundaries and are a good illustration of the benefits of delivering integrated care

•A strong correlation of good performance on transfers with where systems are on the integration journey

Questions for the system include:

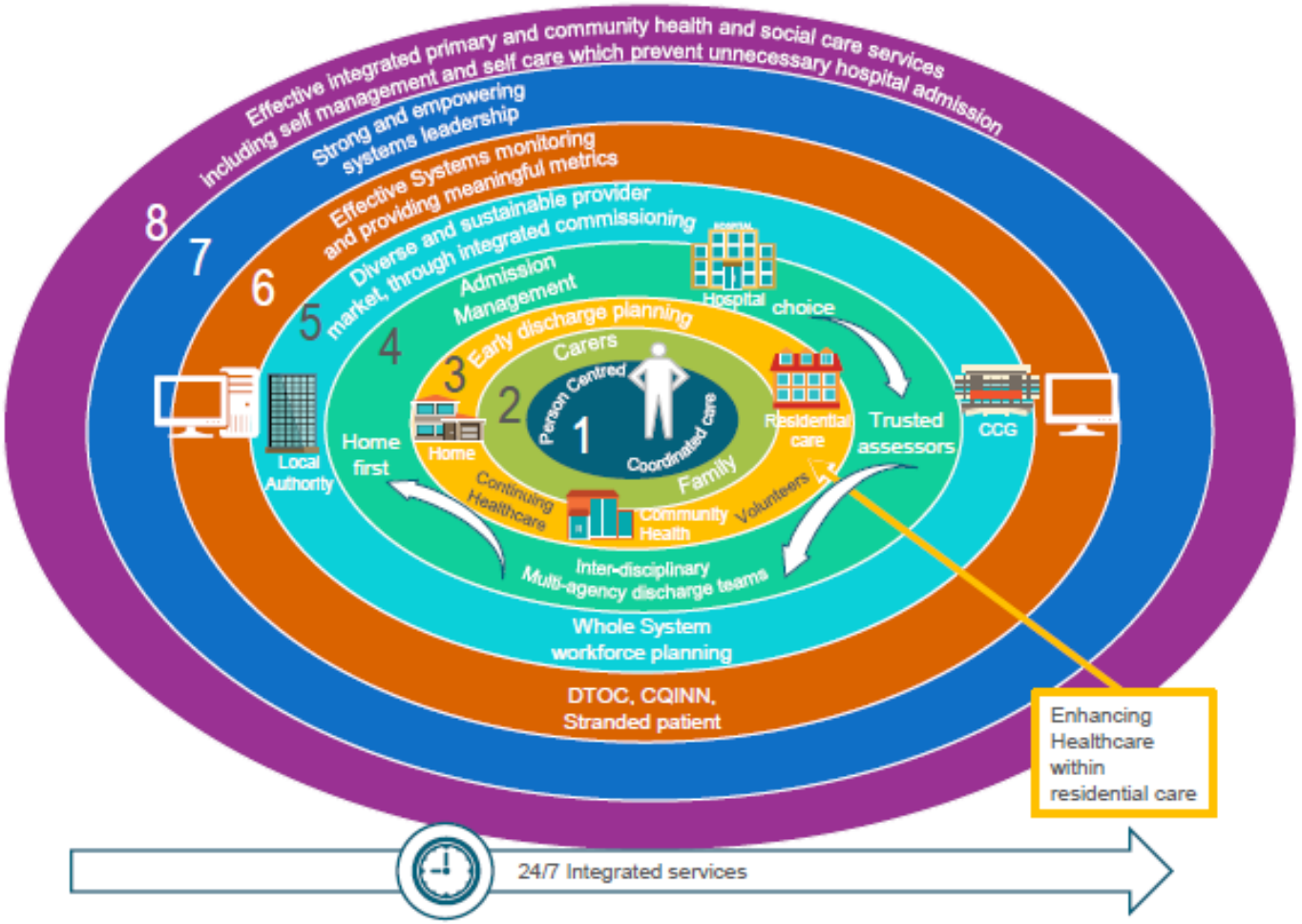
Have you honestly assessed where your system is on the integration journey using Stepping Up To Place: integration self assessment tool?

(LGA, ADASS, NHS Clinical Commissioners 2016)

Things that would be important to consider….

A whole system approach to transfers of care

1. Person-centred, coordinated care
2. Carers and families
3. Community
4. Management of patient flow
5. Diverse and sustainable provider market through integrated commissioning
6. Effective systems monitoring and providing meaningful metrics
7. Strong and empowering systems leadership
8. Integrated health and social care



KPMG/SCIE/PPL developed "Delayed Transfers of Care Signposting Resource" (March 2016)

Useful indicators to understand transfers of care

Helpful list of process and outcome measures embedded in Quick Guide: Discharge to Assess

BCF metric to align with A&E Delivery Board local targets

BCF metric based on total number of delayed transfers of care (delayed days) per 100,000 population v A&E Delivery Board metric based on total bed days lost

Other measures will be routinely collected or will need bespoke collection locally to reflect the current situation and reasons for delay e.g.

- LOS of stranded patients
- SAFER bundle implementation
- Tracking hospital stays in terms of “Red days” of no clinical value and “green days” where patients have valuable interventions

Patients able to access right service within 24 hours of “medically fit”

Admission to discharge ratios

Number of patients with access to D2A

Monitoring where patients are discharged to

Monitoring discharges to usual places of residence

Size and type of care package

Recording patient experience

Summary

Ultimately, a whole system approach to transfers of care depends on health and social care partners working together with all stakeholders to optimise patient flow throughout the system to prevent unnecessary admissions/readmissions to hospital and to enable a timely, safe discharge, ideally to the person's own home.

Further examples and initiatives

What can we learn from integrated systems to improve shared responsibility for transfers

More integrated the system, the better the performance

Hertfordshire Vanguard – Better care for home care residents

Croydon – Edgecombe Unit

Mid Notts Vanguard – Better Together 2017

Hertfordshire Vanguard – Better Care for Care Home Residents

- Co-ordinating care of the individual using a care outcomes framework
- Upskilling care home staff
- Enhanced GP input to care homes
- Home First MDT
- Community geriatric team
- Crisis response services
- Enhanced end of life care
- Integrated approach with care homes has reduced hospital admissions, facilitated easier transfers, resulted in fewer ambulance call outs, reduced falls, reduced reliance on crisis teams, improved advance care planning and has led to more confident care home staff teams

Mid-Notts Vanguard ‘Better Together 2017’

- Major DTOC/LOS issues identified 2015
- Addressed as whole system ‘wicked issue’
- New hospital discharge processes and community services (transfer to assess) developed
- Redesign of CHC assessment process
- Expansion of crisis response teams
- Care navigation advice for professionals
- Self care strategy/setting up health and well being hubs
- GP extended access
- MDTs
- Integration has resulted in top 10 performance nationally on DTOC and top quartile performance in people returning to their usual place of residence and length of stay of patients over 14 days now halved nationally on DTOC due to social care

Croydon Health Services NHS Trust/Croydon Council

- Total redesign of delivery of emergency care to over 65's
- Acute assessment, ambulatory care, comprehensive geriatric care and rapid response in one multi-disciplinary unit with direct access
- Senior consultant review in 2 hours
- Treatment/management plan in 4 hours
- 3 dedicated social workers
- Hot line for GPs to speak direct to consultants
- Age UK Croydon follows up lonely, isolated people
- Up to 25 patients avoid admission each day

Discharge/Transfer to Assess

- NHSE mandating A&E Delivery Boards to introduce trusted assessor and discharge to assess models
- Not a panacea by themselves – need the other elements of an integrated system for maximum effect on DTOC
- Mixed picture across the country on Discharge to assess as used to describe a range of schemes (Home First, Step Down, Reablement, etc.)
- Too much emphasis on bed based schemes?
- Too risk averse in scaling up and targeting high levels of dependency, e g. CHC?
- Evaluation hampered by data quality and need for better information sharing?
- Savings to acute trusts with risk of cost transfer to social care unless risk share agreements/pooled budgets?

Discharge/Transfer to Assess - Examples

Medway Council/Medway CCG

South Warwickshire NHS Foundation Trust/Warwickshire County Council

Doncaster Council/Rotherham, Doncaster and South Humber NHS Foundation Trust/Bassetlaw NHS Foundation Trust

Medway

- D2A plus co-ordinated discharge set up March 2016 in response to transfer performance issues
- Joint funded CCG/LA
- Realigned teams to provided single point of access for co-ordination of discharges
- Home First branding part of a ‘hearts and minds’ communications and marketing plan
- Positive experience reported by patients and staff
- Resulted in significant reduction of delayed transfers

Doncaster Council/Rotherham, Doncaster and South Humber NHS Foundation Trust/Bassetlaw NHS Foundation Trust:

- Redesign of discharge pathways
- Multi-agency rapid assessment team in ED/MAU
- Computerised i-tracker visible to GPs
- Joint health and social care simple assessments within 2 hours of discharge
- Support goes in same day
- Complex cases dealt with by Joint Integrated Discharge Team
- Reduction in direct admissions to care homes from hospital

South Warwickshire NHS Foundation Trust/Warwickshire County Council:

- Pathway 1- Home First for people who can go home with support from Reablement Service or Community Health Services
- Pathway 2- people needing rehabilitation/ reablement in a community or care home bed with view to return home
- Pathway 3- people likely to be assessed for CHC or care home provision
- Approx. 39 beds commissioned for Pathway 2/3
- Trusted assessment between health and social care, in-house reablement/rehabilitation. Care co-ordinators support patients and families throughout the discharge process
- Dedicated GP input into pathways 2/3

Useful tools and resources

Guidance/Tools/Practice (1)

- High Impact Change Model (managing transfers of care) developed from findings of the national helping people home team (DoH, NHSE, LGA, etc. 2016)
- Stepping up to the place: integration self assessment tool (LGA, ADASS, NHS Clinical Commissioners. 2016)
- NHSE Quick Guides:
  - Improving hospital discharge into the care sector
  - Discharge to Assess
  - Safer, Better, Faster ECIST good practice guide

Guidance/Tools/Practice (2)

- Signposting resource 2016/17 - Delayed transfers of care
- Right Place, Right Time: Better Transfers of Care: evidence guide (NHS Providers 2015)
- KPMG/SCIE/PPL developed "Delayed Transfers of Care Signposting Resource"(March 2016) which flags up guidance, tools and practice examples and provides a check list of issues to consider for transfer of care action plans. Resources are grouped around 8 key elements of an integrated health and social care system and can be used to identify local gaps
- Better Care Exchange (currently being refreshed)
- SCIE website www.scie.org.uk