Delayed Transfers of Care
Signposting resource

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The Better Care Fund

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Contents

About this resource

The Better Care Fund (BCF) supports the integration of health and care in order to deliver more person-centred, co-ordinated care.

The transfer of care – from hospital to home, or between any other part of the system – represents major pinch points where services and processes often struggle to be truly integrated around the needs of individuals. The Better Care Fund is being used to drive system-wide integration, including improving local areas' approaches to managing delayed transfers of care (DTOC).

The 2016/17 Better Care Fund Policy Framework and the 2016/17 Better Care Fund Plan requirements now include a new national condition which requires local areas to:

- Fund NHS commissioned out-of-hospital services
- Develop a clear, focused action plan for managing delayed transfers of care, including locally agreed targets.

There are several national, regional and local initiatives related to reducing avoidable hospital admissions and delayed transfers of care (DTOC) out of hospital. This short document complements that work and signposts planners to useful information to help them with those action plans.

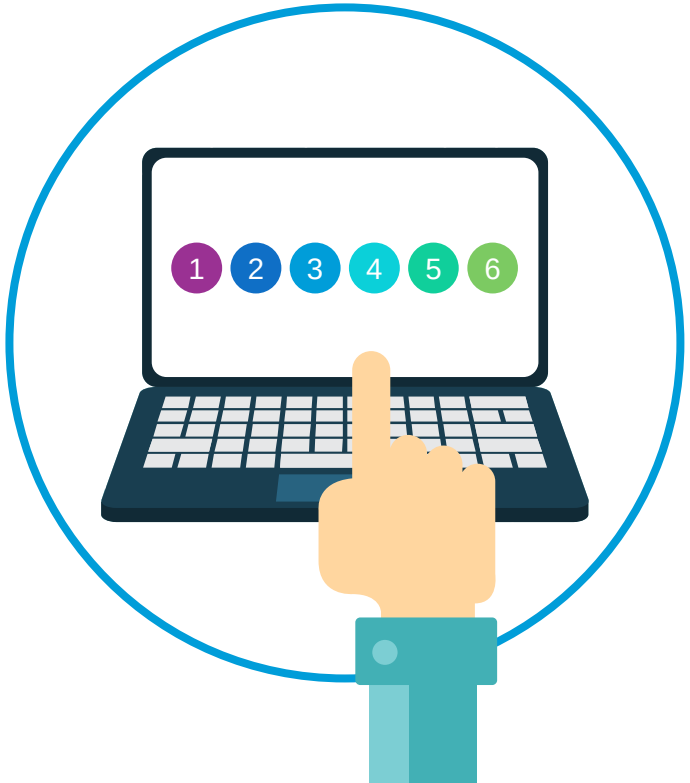
In particular, it can help Better Care Fund leads to meet the new 2016/17 Better Care Fund Plan Requirements regarding DTOCs.

It takes a person-centred, whole-systems approach and includes:

- Signposting to the most up-to-date guidance, tools and practice examples;
- A checklist of issues to consider when developing DTOC plans;
- Sources of additional support on DTOC planning and delivery.

The resource is based on a review of existing literature and guidance and consultation across the health and care system, including people who use services and carers (see Appendix 1).

To guide readers through the different types of resources we have created a simple diagram of the whole system of care and grouped resources into eight main groups of resources – plus one set of key overarching resources.



Delayed transfers of care target and metrics

In developing their plan, local partners are expected to agree a target for reducing DTOC that is realistic but ambitious. The metric for the target should be based on the DTOC measure in the BCF which is nationally reported, but they should also consider local approaches which can help to identify issues across the whole of the patient pathway and help to target interventions which should lead to improvements in the DTOC measures. See DTOC monthly reporting.

Within the BCF Plans for 2016/17, local areas should also consider the range of metrics that measure people's experiences and journeys through the system. These could include metrics on: length of stay and stranded patient; admission to discharge ratio; Red/Green Days (which involves staff tracking patients' hospital stays in terms of the 'red days', which are of no clinical value, and the 'green days', where patients have valuable interventions); and time spent at home. More information on use of metrics can be found on the Emergency Care Improvement Programme website.

A Local CQUIN (Commissioning for Quality and Innovation) incentivising improvement in patient flow has also been included in the NHS contract for 2016/17. This provides a mechanism for local areas to reward improvements in the proportion of patients discharged to their usual place of residence within 7 days of admission. The CQUIN could be used with acute providers only, or could be expanded to include other local providers (e.g. community providers and care homes) to support system improvements in patient flow and discharge.

Context

Helping people to transfer smoothly and appropriately through the health and care system is one of the most complex tasks that the system faces. Frontline care and health staff have been dealing with this challenge for many years, but the pressure is increasing as our population ages and resources are stretched. And of course many of us have personal experience of the stress that avoidable hospital admissions and delays in transferring to the next level of care can cause.

This is difficult territory, involving many organisations, processes and individuals. Every area of the country and every agency involved – from home care providers and residential services, to A&E departments and community health services – is working incredibly hard to tackle this issue.

As planners, you know better than anyone that this involves system-wide cooperation, risk sharing and a relentless, collective focus on improving the experience of the people you support. The BCF seeks to drive this system-wide transformation of local services to ensure that people receive better and more integrated care and support.

Health and care staff are clearly committed to the objective of preventing delayed transfers of care. Four benefits are consistently articulated:

- Benefits to the individual, including minimising deterioration and faster reablement.
- Smoother, person-centred pathways ensuring the right interventions at the right time.
- A clearer and faster focus on recovery and promoting independence.
- Proper use of resources and value for money.

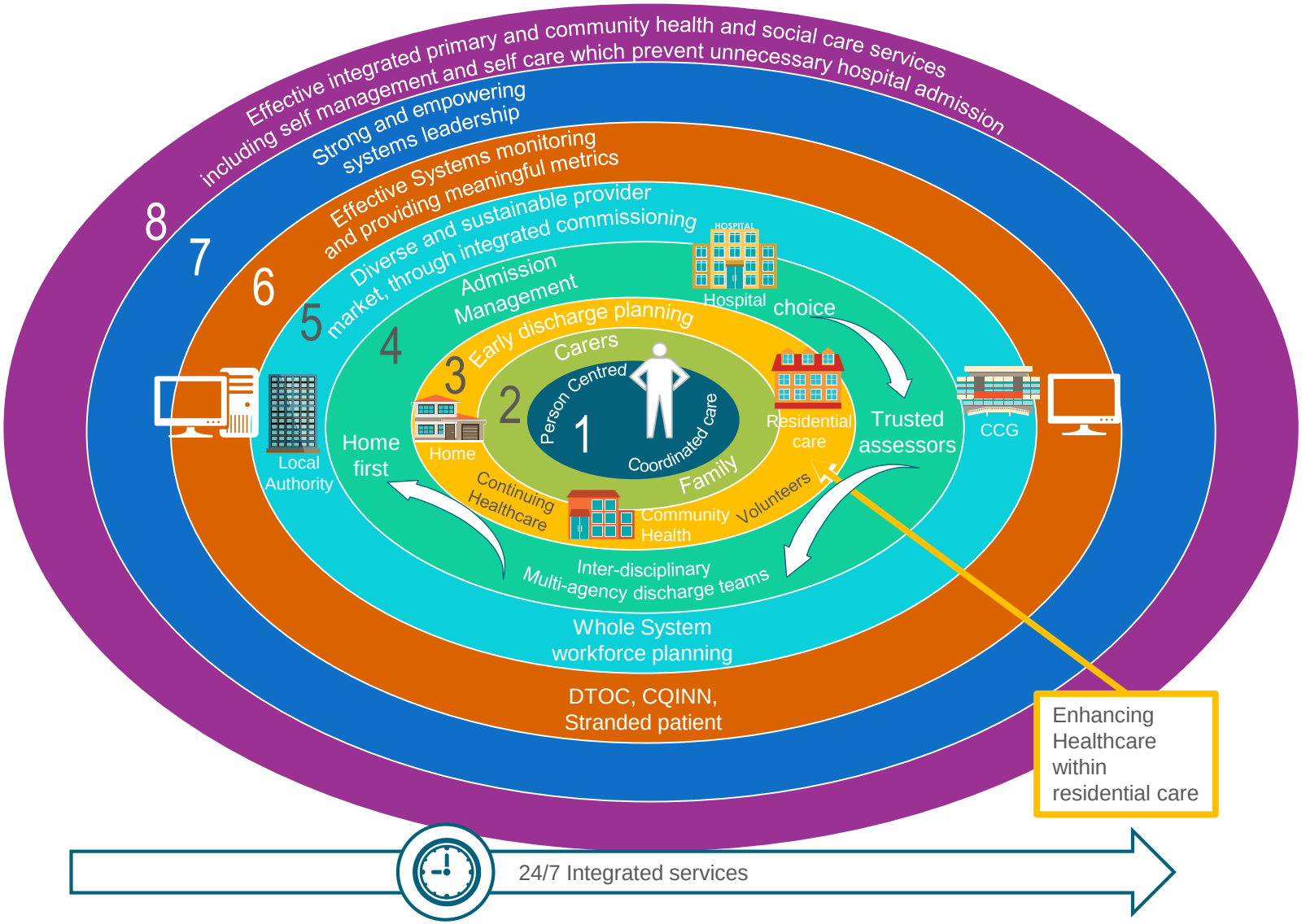
The focus on delayed transfers of care is a necessary, but not a sufficient, means of achieving these benefits. Supported by the BCF, systems that work well have:

- **Personalised arrangements**: Ensuring that people using services and their families and carers are well-informed and in control, and retain the confidence essential to resuming independent living as quickly as possible after periods in hospital. Arrangements are personalised to support those with, for example, dementia, learning disabilities, mental health problems and/or physical disabilities.
- **Systems leadership**: With senior organisational leaders who: see and tell a compelling story about why things need to be different; work together on the basis of trust and strong relationships; know when to cede (as well when to exercise) control; know each other's priorities and constraints, and who model and reward collaborative style and behaviours.
- **Effective hospitals**: With highly efficient hospitals where beds are used to maximum effect, patient flows are effectively managed, discharge planning starts on admission, and care is planned and delivered in focused and co-ordinated ways.
- **Effective community services**: With effective joint commissioning and delivery of community health and social care services.
- **Effective joint working**: Having effective information sharing, improvement in processes across agencies, clear accountabilities and strong partnerships with all providers, so that all partners know about options and availability of services.
- **Health promotion and prevention**: Ensuring that health and well being boards champion strategies which allocate time, energy and resources to avoiding (or at least delaying) the need for more intensive care and support solutions. This requires cross-sector commitment to understanding, absorbing and sharing risk.
- **Asset-based approaches in communities**: Identifying, publicising and sharing support projects and initiatives in stronger and more self-sustaining communities which promote people's active participation in community life and use the knowledge and experiences of people who use services.

Delayed transfers of care
Resource groups

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

Resources are grouped to make it easier to find the information you require. Fig. One illustrates the systems and areas covered by each group of resources on the following pages.



Checklist – Delayed transfers of care local plan

To help local planners deliver on the goals described above, we have developed a simple checklist that can be used to inform the planning process. You can refer to this checklist when developing your local DTOC plans. We want to avoid people duplicating effort when developing their plans, so if these actions are covered in the main BCF Plan or other local strategic plans it is fine to use them rather than reproduce them in the local action plan.

- ✓ Ensure all partners understand and agree the approach to measuring DTOC (as per DTOC situation reporting guidance). Review this as a system.
- ✓ Think broadly about the patient flow through the full system. Think about preventing unnecessary admissions, contingency planning, self-management, self-care and asset-based approaches to keeping people well and independent in their communities.
- ✓ Ensure that service users/patients and carers are involved in the development of the action plan and are represented on any decision making forums that support the plan's implementation.
- ✓ Ensure that there are strong governance structures in place with clear accountabilities in place to deliver the action plan. Ensure that this includes representatives from the whole system including: acute and community trusts, social care providers, hospital social workers, NHS discharge teams, GPs, pharmacists, district nurses, therapists, ambulance services, supported housing, voluntary and private sector providers, community groups, and people who use services and carers.
- ✓ Work with this governance structure to agree a stretching target for DTOC – using the agreed national definition: (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. But also work with partners to agree local operational measures that can help to target local interventions.
- ✓ Consider colocation of hospital social workers and NHS discharge teams.
- ✓ If your area is considering using a risk sharing agreement in relation to DTOC, please refer to the BCF Risk Sharing Agreement Guide
- ✓ Ensure that the plan clearly sets out how care homes, nursing homes and home care providers will be engaged in reducing unnecessary admissions and DTOC for example, put in place a clear plan to support enhanced care in care homes.
- ✓ Think through what needs to be done to support different cohorts of patients/service users, for example:
  - People with long-term conditions who may be at greatest risk of readmission (e.g. through in-reach teams that support people when they are admitted)
  - Younger people with physical disabilities, mental health, learning disabilities – where housing related support may be a bigger issue
  - Older people including those with dementia or other complex needs
  - People with mental health issues
  - Carers.
- ✓ Ensure that the plan includes a single, agreed cross-sector workforce strategy. This should set out: how multi-disciplinary teams are led and managed; how immediate and future capacity is jointly managed, identified and covered across health and social care sectors (e.g. via Joint strategy needs assessment); how all main workforce groups (including private, voluntary, community and statutory sectors) are developed to support reductions in DTOC.
- ✓ Ensure that the plan sets out how patients/service users journey through the admissions and discharge process are co-ordinated by a single person (e.g. a care navigator) who understands their needs, preferences and personal outcomes.
- ✓ Ensure that the plan includes a single agreed approach to commissioning services which support effective management of DTOC, such as preventative care services, voluntary sector care services and rapid response teams.

Better Care Fund – Additional support

The Better Care Support Team's role is to provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice.

If you require support in developing local action plans or implementing changes that aim to reduce DTOC please contact your local Better Care Manager.

More good practice and discussion about DTOC can also be found on the Better Care Exchange: https://bettercare.tibbr.com/tibbr/web/login

Key overarching resources

Organisation	Resource	Type
Association of Directors of Adult Social Services, Local Government Association, NHS Trust Development Authority, Monitor, Department of Health, and NHS England	High Impact Change Model	Toolkit
Care and Support Reform Programme	Care Act 2014 – Implementation support	Guides, elearning etc
Emergency Care Improvement Programme	Safer, better, faster care for patients	Guide
HM Government	Care Act 2014	Legislation
NHS England	2016/17 Better Care Fund Policy Framework	Framework
NHS England	2016/17 Better Care Fund Plan requirements	Guide
NHS England	Quick guide: Sharing patient information	Quick Guide
NHS England	Quick guide: Identifying local care home placements	Quick guide
NHS England	Quick guide: Better use of care at home	Quick Guide
NHS England	Monthly Delayed Transfers of Care Situation Reports – Definitions and Guidance	Guide

Delayed transfers of care
Key overarching resources (cont.)

Organisation	Resource	Type
NHS England	Better Care Exchange	Resources and case studies
NHS England	Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care - A guide for local health and social care communities (Keogh urgent care review)	Guide
NHS Interim Management and Support	ECIST resources and the ECIST network	Resources
NHS Providers	Right place, right time: better transfers of care	Report
National Institute for Health and Care Excellence (NICE)	Transition between inpatient hospital settings and community or care home settings for adults with social care needs (NG27) See also the associated costing statement and the scope which has useful contextual information.	Guide
Royal College of Physicians	Integrated care – taking specialist medical care beyond the hospital walls	Report

Care must be centred around the needs of the person using the services rather than the services themselves. Good coordination of care will enable informed choice and meaningful integration of services for people

Organisation	Resource	Type
NHS England	Personalised care and support planning handbook: The journey to person-centred care. Core Information	Guide
Health Foundation	Ideas into action: person-centred care in practice. What to consider when implementing shared decision making and self-management support	Toolkit
Health Foundation	Person-centred care made simple. What everyone should know about person-centred care	Toolkit
Health Foundation	My Discharge - A proactive case management for discharging patients with dementia	Case study report
Think Local, Act Personal and National Voices	A Narrative for Person-Centred Coordinated Care	Guide
Think Local, Act Personal	Personalised care and support planning	Toolkit
Public Health England	Working together 2: Easy steps to improve support for people with learning disabilities in hospital Guidance for hospitals, families and paid support staff	Guide
Joint Commissioning Panel for Mental Health	Guidance for commissioners of liaison mental health services to acute hospitals	Guide
Alzheimer's Society	Guidance for NHS continuing healthcare assessors - Evaluating emotional and psychological needs for people in the later stages of dementia	Guide
Alzheimer's Society	Fix Dementia Care Hospitals	Report

Carers and family members should be engaged in the discharge planning to ensure they are kept informed, and can contribute to plans, and that their own needs are considered

Organisation	Resource	Type
National Institute for Health Research	Understanding and improving transitions of older people: a user and carer centred approach - Ellins J, Glasby J, Tanner D et al.	Report
Association of Directors of Adult Social Services	Carers as partners in hospital discharge - Improving carer recognition, support and outcomes within timely and supported discharge processes. A review	Review

Ensuring the best outcomes from enhancing care in residential settings, using community assets and continuing health care

Organisation	Resource	Type
National Institute for Health and Care Excellence	NICE SC1 Managing medicines in care homes (including support for commissioning and a checklist for care home medicines policy)	Guideline
NHS England	Quick guide: clinical input into care homes	Quick guide
King's Fund	Developing Enhanced Primary Care Services for Residents of Nursing Homes in North Staffordshire	Report
NHS England	Quick guide: Technology in care homes	Quick guide
NHS England	Quick Guide: Better use of care at home	Quick guide
NHS England	Quick guide: Identifying care home placements	Quick guide
NHS England	Continuing healthcare	Framework and regulations
Think Local Act Personal	Developing the power of strong, inclusive communities	Toolkit
Social Care Institute for Excellence	Strength-based approaches	Toolkit
Housing Learning and Improvement Network	Hospital 2 Home Resource Pack	Toolkit
Age UK, British Red Cross and Royal Voluntary Service	Working with the Voluntary and Community Sector: collaborating to achieve better patient outcomes	Presentation

Management of patient flow, using early discharge planning for elective and emergency admissions, inter-disciplinary/multi-agency discharge teams and home first/discharge to assess combined with the S.A.F.E.R. patient flow bundle – (Senior review, All Patients, Flow of patients, Early discharge, Review)

Organisation	Resource	Type
NHS Interim Management and Support	SAFER Patient Flow Bundle	Guide
Peter Gordon	The SAFER Patient Flow Bundle	Resource
Monitor	Moving healthcare closer to home case studies: Enabling early discharge	Case studies
NHS England	Quick guide: improving hospital discharge into the care sector	Quick Guide
Health Foundation	Safer Clinical Systems: East Kent Hospitals University NHS Foundation Trust	Evaluation
Age UK	Personalised Integrated Care Programme	Case Study
Local Government Association	Case study: Kent – Operating an integrated discharge team	Case Study
University Hospitals Birmingham NHS Foundation Trust	Discharge Case Study - University Hospitals Birmingham NHS Foundation Trust	Case Study
London Health Programmes NHS	Preventing Delayed Transfer of Care and accessing settled Housing: Good practice for inpatient mental health services	Guidelines
Doncaster Metropolitan Borough Council, Rotherham, Doncaster and South Humber NHS Foundation Trust and Doncaster and Bassetlaw NHS Foundation Trust	Urgent and emergency care - integrated 'Discharge to Assess' model reduces admissions to hospital	Case study

Organisation	Resource	Type
University Hospital Southampton NHS Foundation Trust	Discharge Case Study - University Hospital Southampton NHS Foundation Trust. Discharge 2 Assess (social care) – A partnership between University Hospital Southampton, Southampton City Social Services and Healthcare at Home	Case study
The Academy of Fabulous NHS Stuff	Developing a Home First Mindset - Liz Sargeant	Guide
Epsom and St Helier University Hospitals NHS Trust and Surrey County Council Adult Social Care	Social care presence on the acute medical unit, seven days a week, improves discharges from hospital	Case study
Emergency Care Improvement Programme	Lincolnshire Care Home Trusted Assessor Project	Case study

Market shaping and integrated commissioning creates a diverse and sustainable health and care provider market, and includes system wide workforce planning. This includes CCGs, community health services, local authorities and the voluntary and private sectors.

Organisation	Resource	Type
Institute of Public Care	Market shaping toolkit (MaST): supporting local authority and SME care provider innovation and collaboration	Tool Kit
Local Government Association	Commissioning for better outcomes: a route map	Resource
Skills for Care	The principles of workforce integration	Guide
Centre for Workforce Intelligence	Think integration, think workforce: Three steps to workforce integration	Guide

These should enable early identification of risk across the whole health and social care system (i.e. capacity and demand issues). Where appropriate, selection of alternative metrics should be considered as means of setting local priorities for change.

Organisation	Resource	Type
NHS England	Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care - A guide for local health and social care communities (Keogh urgent care review)	Guide
Health Foundation	Improving patient flow (Sheffield Teaching Hospital NHS Trust and South Warwickshire NHS Foundation Trust)	Case Studies
The Academy of Fabulous NHS Stuff	Creating 'Predictable Recovery for the Emergency Pathway' (PREP) – Dr Ian Sturgess	Resources

Strong and empowering leadership that is accountable. This should include systems leadership.

Organisation	Resource	Type
Leadership Centre	The Revolution will be improvised	Guide
Leadership Centre	The revolution will be improvised Part 2	Guide
Local Government Association - Towards Excellence in Adult Social Care	Sector Led Improvement in Health and Social Care 2015	Resource
NHS England, Local Government Association and Department of Health	How to Lead and Manager Better Care	Toolkit

Integrated health and social care services that are community based and available 24/7. These should be responsive to individual needs and support people to manage their own health in the community. These services should actively engage with people living in care homes.

Organisation	Resource	Type
Skills for Health and Skills for Care	Right place, right time, right team - Thurrock Rapid Response Assessment Service	Case study
King's Fund	Avoiding hospital admissions - Lessons from evidence and experience	Report
Essex Cares and the King's Fund	Essex Cares Rapid Response teams	Case study
Nottingham City Care Partnership and East Midlands Ambulance Service NHS Trust	Falls Rapid Response Team: The integrated Ambulance and Urgent Care Service Model in Nottingham	Case study
NHS England	Case study: Cheshire – Developing transitional care models - Short Term Assessment Intervention Recovery & Rehabilitation Service (STAIRRS) (Integrated Care Pioneer Programme Annual Report 2014 - Pioneer Profiles and Case Study Examples, p 22)	Case study
NHS England	Transforming urgent and emergency care services in England. Safer, faster, better: good practice in delivering urgent and emergency care - A guide for local health and social care communities (Keogh urgent care review)	Guide
National Institute for Health and Care Excellence	NICE SC1 Managing medicines in care homes (including support for commissioning and a checklist for care home medicines policy)	Guidance
NHS England	Quick guide: clinical input into care homes	Quick guide
King's Fund	Developing Enhanced Primary Care Services for Residents of Nursing Homes in North Staffordshire	Report
Social Care Institute for Excellence	Avoiding Unnecessary Hospital Admissions videos on Social Care TV	Videos
National Institute for Health and Care Excellence	Mental wellbeing of older people in care homes	Guidance

Appendix 1
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