Delivering Integrated Care
Masterclass

Sharing responsibility for Transfers of Care

Hannah Miller, OBE, Senior Associate SCIE
Contents

Summary of key messages

Presentation

Handouts:
• Summary of key transfers of care issues
• What gets in the way
• Key issues to consider

Evaluated model
• Cost Impact of the Discharge to Assess (D2A) Pathway

Notes from workshop discussions
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.
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
SCIE Associate
Transfers of care – a real challenge!

It’s not only about the money

Transfers of care is a 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

<table>
<thead>
<tr>
<th>Helpful list of process and outcome measures embedded in Quick Guide: Discharge to Assess</th>
<th>BCF metric to align with A&amp;E Delivery Board local targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCF metric based on total number of delayed transfers of care (delayed days) per 100,000 population</td>
<td>A&amp;E Delivery Board metric based on total bed days lost</td>
</tr>
<tr>
<td>Other measures will be routinely collected or will need bespoke collection locally to reflect the current situation and reasons for delay e.g.</td>
<td></td>
</tr>
<tr>
<td>• LOS of stranded patients</td>
<td></td>
</tr>
<tr>
<td>• SAFER bundle implementation</td>
<td></td>
</tr>
<tr>
<td>• Tracking hospital stays in terms of “Red days” of no clinical value and “green days” where patients have valuable interventions</td>
<td></td>
</tr>
<tr>
<td>Patients able to access right service within 24 hours of “medically fit”</td>
<td>Admission to discharge ratios</td>
</tr>
<tr>
<td>Number of patients with access to D2A</td>
<td>Monitoring where patients are discharged to</td>
</tr>
<tr>
<td>Monitoring discharges to usual places of residence</td>
<td>Size and type of care package</td>
</tr>
<tr>
<td>Recording patient experience</td>
<td></td>
</tr>
</tbody>
</table>
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
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](#)
The Better Care Fund

Sharing responsibility for transfers of care
Workshop handout

1.15m bed days lost 2015:
- 26% increase Nov 15 – Nov 16
- (42% increase social care, 16% increase NHS)

2.7m estimated bed days occupied by older patients no longer in need of acute treatment

820m estimated cost of delays to NHS

BCF planned reduction of 293,000 days 15/16 but actual increase in days lost by 185,000 costing 148m more than planned

(NAO report 2016, Kings Fund 2016)

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

26% less people receiving social care since 2010

1/3rd care homes at risk of financial failure. (loss of 5,000 beds in last 18 months)

50% councils had a home care provider hand back their contract as not financially viable

Demographics – 18% increase in emergency admissions of older people 2010-15

Increased activity/co-morbidity

Kings Fund 2017

50% of delayed transfers in 24 areas

So not just funding but practice issues?

Wide variation in social care delays

Ranges from 0-25 days per 1,000 pop over 65

No clear relationship between reduction in funding levels and numbers of delays

Variation in NHS delays even wider

2-33 days per 1,000 pop over 65

Long delays for both Heath and Social Care tend to correspond in same areas
What gets in the way of taking shared responsibility for transfers of care?

System issues
- Weak leadership – lack of vision/ambition/slow to embrace new ideas/ways of working
- Silo working/blame culture
- Fear of challenge/loss of relationships
- Poor system governance and accountability
- Disconnect of strategic and operational managers
- Lack of risk sharing agreements

Cultural issues
- Different histories and language
- Different organisational and professional cultures
- Fear of organisational and personal change due to integration
- Proactive v reactive discharge planning
- Solutions being promised prior to assessment

Operational issues
- Lack of consistent or efficient approach to engaging patients and their carers in discharge
- Disagreement over criteria used for discharge notices
- Lack of clarity about process and protocol across agencies
- Reticence on personal information sharing
- Poor data on comparable costs across different care settings

Resource issues
- Financial challenge across all agencies
- Lack of good quality care home places and domiciliary care packages
- Workforce challenges around recruitment/retention of staff – nurses, doctors, social workers, care home staff and domiciliary care workers
- Lack of investment in out of hospital services
Things to consider....

Leadership and governance
- Do you have strong, integrated programme planning, programme interdependencies and monitoring of progress?
- Is there a strong message from system leadership on priority of safe transfers and their acceptance of collective responsibility?
- Is there mutually holding of organisations to account for the effectiveness of their role in transfers?

A&E Delivery Boards
- Are they on streaming, flow and discharge planning reflecting the joint responsibility of the system to operate optimally?
- Do they have a joined up plan with BCF?

Commissioning
- How integrated is your commissioning?
- Do you have a joint co-production approach to market management and development including a joint market position statement?

Admissions
- Do you have a strong emphasis on prevention of admissions? (MDTs, rapid response, risk stratification, self-care strategy, social prescribing, support to care homes, population based and micro outcome based commissioning)

Data- collection, analysis and evaluation
- Is analysis of DTOC data clear and jointly owned?
- Do you have a clear understanding of where delays fit in the wider system of care, including avoiding admissions in the first place?
- Is the evaluation of BCF schemes robust, does it clearly state benefits and are these targeted to the highest impact areas?

Targets/ best practice
- Do you have in place an agreement on a target for reducing delays that is realistic but ambitious?
- Has there been whole-scale adoption of best practice with a consistent Home First message? (SAFER bundle; discharge to assess and trusted assessor
models; integrated discharge teams; integrated reablement/intermediate treatment; support to care homes; integrated ICT; use of the voluntary sector; housing protocols; speedy ordering and delivery of equipment including assistive technology; choice protocol and good publicity and information for discharge arrangements.)

- How do you optimise what is seen to work well? Are pilots scaled up in a timely fashion?

**Workforce**

- Do you have whole system workforce planning and development?
Sharing responsibility for transfers of care
Workshop handout: Model shared by South Warwickshire

Cost Impact of the Discharge to Assess (D2A) Pathway
Acute Spell, D2A and Overall Costs - Data Collection and Cost Impact Analysis

Summary
An analysis was conducted to quantify the cost impact of a cohort of patients admitted to South Warwickshire Foundation Trust (SWFT) between July 2013 and December 2014. The analysis compared those accepting the D2A pathway to those not accepting the pathway prior to their acute discharge.

The D2A pathway is comprised of nursing home beds that patients move into for assessment of their on-going care needs at the right time for the patient. The analysis incorporates pathway 2 for patients who required rehabilitation and pathway 3 for the most complex needs patients.

The comparison between the accepted and non-accepted group is not a ‘randomised controlled trial’ standard of evidence and there may be differences between the two groups that affected their eventual outcome. However, it is a large cohort of patients tracked over a significant period and so does add to the evidence base on the impact of this model of care.

South Warwickshire is a generally affluent region and therefore some averted costs to health and social care are attributable to a higher proportion of patients being ‘self funding’ for on-going care.

The cost impact prior to discharge is reported here and considers the relative activity and costs associated with acute spells of both groups of patients and the activity and costs associated with D2A for the accepted group.

Cost impact post discharge from acute and/or D2A is identified, evaluated and set out separately in the report ‘Post Discharge Cost Impact of the D2A Pathway’ and is summarised here within the context of the overall cost impact. Post discharge cost impact considered the relative costs between the accepted and Non-accepted D2A groups of patients allocated Continuing Healthcare, Funded Nursing Care and Social Care. The CHC and social care averted costs equate only to year 1 averted costs, any on-going averted costs have not been calculated in the model because patients were only followed for 1 year.
Acute spell costs were quantified for the accepted and Non-accepted groups on a comparative basis, but not case mix adjusted. It was found that, for patients accepting D2A, the lengths of acute care spells were shorter than for those not accepting D2A. This resulted on average in lower acute spells costs for this group.

Correspondingly, it was also found that discharge below the HRG trim point was more common in the D2A accepted group, resulting in a greater potential averted cost to the provider as a result of D2A. This has been adjusted for within the cost calculations of the acute spells, based on an estimate per bed day cost below the trim point of £94 per day. (This potentially underestimates the provider averted cost as acute bed capacity was removed as a result of this service alongside other service improvement along the emergency pathway)

The cost of D2A itself is reflected in the cost impact and applies only to those patients accepting D2A.

Incorporating the results from the post discharge cost impact analysis, base averted cost in the D2A accepted group is summarised in the table below for each of pathways 2 and 3.

### D2A Accepted Averted Cost Summary

<table>
<thead>
<tr>
<th>Provider/Commissioner averted costs</th>
<th>D2A2</th>
<th>D2A3</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Acute bed averted costs (reduction in excess bed days)</td>
<td>£121,169</td>
<td>£782,857</td>
<td>£904,026</td>
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<tr>
<td>Social Care averted costs (long term care provision)</td>
<td>-£5345</td>
<td>£162,506</td>
<td>£157,161</td>
</tr>
<tr>
<td>Continuing Health Care averted costs (long term care)</td>
<td>0</td>
<td>£866,927</td>
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</tr>
<tr>
<td>Funded Nursing Care averted costs (long term care)</td>
<td>£14,190</td>
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<td>Provider averted costs (reduced bed base)</td>
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<td>Cost of D2A provision (including transport and GP)</td>
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<td>-£1,323,669</td>
<td>-£1,682,286</td>
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### Commissioner/Provider Summary

<table>
<thead>
<tr>
<th>CCG averted cost (SWCCG)</th>
<th>£223,259</th>
<th>£265,102</th>
<th>£41,844</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Care averted cost (WCC)*</td>
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<td>£62,718</td>
<td>£168,063</td>
<td>£230,782</td>
</tr>
<tr>
<td>Total System Averted Costs</td>
<td>-£165,885</td>
<td>£595,671</td>
<td>£429,786</td>
</tr>
</tbody>
</table>

A sensitivity analysis of the post discharge impact indicate a range of potential averted costs around the base averted costs. These are not shown here and are set out separately in the report ‘Post Discharge Cost Impact of the D2A Pathway’.
Introduction
An analysis was conducted to quantify the cost impact of patients at South Warwickshire Foundation Trust (SWFT) accepting the D2A pathway compared to patients not accepting the pathway.

This report sets out an analysis focussing on costs associated with the acute spell and the D2A element of the pathway for those patients accepting D2A compared to those Not Accepting D2A. The report describes the D2A dataset in order to quantify the impact of D2A and the use of the dataset within the analysis. The cost impact associated with acute and D2A spells is assessed and in combination with the post discharge impact an overall assessment of costs is presented.

Cost impact post discharge from acute and/or D2A is identified, evaluated and set out separately in the report ‘Post Discharge Cost Impact of the D2A Pathway’ and is summarised here within the context of the overall cost impact.

The pathway commissioned was for pathway 3 (this means patient who were a positive CHC checklist and were assessed as likely to need on-going residential care). When operationally there was spare capacity in the commissioned beds pathway 2 patients (those requiring rehabilitation and reablement and whose intended destination was home) were discharged into the homes and rehabilitation was provided by SWFT services at no additional commissioner cost.

It will be possible to commission pathway 2 beds at lower cost.

The D2A Dataset - Acute Spells and D2A Stay details
A D2A dataset was established by South Warwickshire Foundation Trust containing the acute stay details of a cohort of patients admitted between July 2013 and December 2014 and offered the choice of the D2A pathway. For those patients accepting the D2A pathway, details of their D2A were collected and reported, along with details of their acute stay. For patients not accepting D2A, acute stay details only were collected.

Data items were collected on each patient including their pathway i.e. 2 or 3 and their acceptance or non-acceptance of the D2A pathway. Details collected relating to each of the acute and D2A spells are set out below and were used to inform the metrics quantified in Tables 1 and 2.

2.1 Acute Spells Details
Data items collected and reported within the D2A dataset for the acute spell included:

Patient Identifier
Admission Date
Discharge Date and associated length of stay
Discharge Destination including RIP
Date of subsequent death following discharge (if known, applies to Non-accepted group only)

Healthcare Resource Group (HRG) relating to the stay.

HRG associated trim point days, cost up to the trim point, excess bed day cost.

Length of stay beyond Trim Point

Length of stay before Trim Point

2.2 D2A Stay Details
For patients accepting the D2A pathway, items collected and reported within the D2A dataset included:

Patient identifier

D2A Accepted/ Non-accepted Flag (Y/N)

D2A Pathway (applies to those not accepting D2A also)

Reason for D2A Refusal (non-acceptance)

Date of Admission into D2A

Date of Discharge from D2A and associated length of stay

Discharge Destination from D2A, including RIP

Cost per day of D2A stay

Analysis and Cost Impact
The metrics developed to assess the activity and costs associated with acute spells and D2A are set out in Tables 1 (accepted group) and 2 (Non-accepted group)

For acute spells, total and average lengths of stay were quantified, along with cost relating to the overall stay and any excess bed day element. For patients accepting the D2A pathway the total and average length of stay within D2A were additionally quantified, along with associated costs.

3.1 Cost of Acute Spells
The results from Tables 1 and 2 were then used to determine the cost impact of the Acute/ D2A stay element of D2A as follows:

Based on the numbers accepting and not accepting D2A a model was established in order to compare Acute/ D2A spell costs between the accepted and Non-accepted groups on a like for like basis.

The model, shown in table 3a sets out to compare costs of the D2A accepted patients with comparative costs which may have been incurred, had D2A been Non-accepted.
Three groups of columns are shown, each split by pathway type 2 and 3, as follows:

- Observed numbers of packages and related costs of the D2A accepted group (D2A Accepted Group).
- Observed numbers of packages and related costs of the D2A Non-accepted group (Non-D2A Group).
- Synthesised numbers of packages and related costs assumed for the accepted group, had D2A been Non-accepted (Non-D2A-Synthesised Group).

This shows that the acute care costs of D2A accepted patients were £1.43m compared to what they would have been had they Non-accepted i.e. £2.33m. Notwithstanding differences in case mix between the accepted and non-accepted groups, the key driver for this difference is the longer lengths of acute stay experienced by patients not accepting D2A.

Therefore an adjustment has been made as follows:

- Total beds days below the HRG trim point has been identified for each of the accepted and non-accepted groups.
- A per bed day averted cost to the provider has then been estimated by dividing the HRG Trim point cost by the HRG trim point bed day threshold for a subset of the patients within the cohort. This was calculated at £94 per bed day.

It is noted that this adjustment does not take into account any reductions in acute bed capacity following implementation of D2A and may therefore understate the provider capacity to benefit from the reduced average lengths of stay associated with D2A patients.

As D2A accepted patients tend to have shorter acute lengths of stay, discharge below the trim point more likely to occur in these patients than in the non-accepted group. If bed capacity is not removed there is financial risk to the Commissioner that additional cases are treated through the freed up capacity. This is not reflected in the model – nor potential additional income to the provider as the purpose of the evaluation is to derive the system cost benefit as well as specific commissioner and provider benefit.

### 3.2 Cost of D2A

These costs apply to patients following the D2A pathway only and are set out in Table 3a.

The costing has been adjusted to reflect additional patient journeys undertaken by patients accepting D2A. It would be anticipated that D2A patients would take 2 journeys or one journey over and above those not accepting. A £66 cost per journey (Stretcher cost) has been applied to the 321 patients accepting the D2A pathway.
**4.0 Results**
The model in table 3 outputs the key results of averted costs identified in relation to patients accepting the D2A pathway and is summarised in Table 6 below:

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| Provider averted cost (SWFT) | 62,718   | 168,063  | 230,782 |
| Total System Averted Costs | -£165885 | £595671  | £429786 |
Sharing responsibility for transfers of care
Workshop handout: Model shared by South Warwickshire

Post Discharge Cost Impact of the D2A Pathway
Associated Health and Social Care Packages and Costs
Identification Methods and Cost Impact Analysis

Summary
Discharge to Assess (D2A) is a programme that began in summer 2013 that looked to improve the experience of older patients being discharged from hospital. Involving NHS South Warwickshire CCG, South Warwickshire NHS Foundation Trust, local GPs and Warwickshire County Council Social Care, it is an example of health and social care teams working together to benefit patients who are unable to return home unsupported and who, previously, would have stayed in hospital longer than they needed to.

As part of the project D2A pathway 3 patients, who after assessment by the SWFT Discharge Team are deemed most likely to require continuing healthcare (CHC), are moved out of hospital and into care homes once their treatment is complete in order to have their longer-term needs assessed by a multidisciplinary team. This promotes smoother, more joined-up working, which in turn improves patients’ outcomes, while all professionals working on a patients care share the same knowledge and understanding of each case.

Whilst the funding for the pathway was joint between provider and commissioner at commencement of the project, for the period of the analysis the D2A pathway was funded by NHS South Warwickshire Clinical Commissioning Group (CCG) at an annual cost of £1.6m.

An analysis was conducted to quantify the cost impact of a cohort of patients admitted to South Warwickshire Foundation Trust (SWFT) between July 2013 and December 2014. The analysis compared those accepting the D2A pathway post discharge to those not accepting the pathway prior to their acute discharge.

To conduct the analysis it was first necessary to identify and quantify the Health and Social Care packages (and related costs) allocated to patients post discharge, encompassing Social Care (SC), Continuing Health Care (CHC) and Funded Nursing Care (FNC).
Following identification, numbers of patients allocated packages and their related average weekly costs were quantified for each type of package received (SC, CHC, FNC). For pathway 3 patients, numbers still receiving CHC packages at monthly intervals up to 12 month post discharge were identified and quantified.

An analytical model was developed to calculate and determine the cost impact of patients following the D2A pathway compared to patients not accepting the pathway. After consultation with all parties involved it was agreed this model would cover a 12 month period.

A one and two way sensitivity analysis was conducted on key parameters within the model in order to assess the impact relating to pathway 2 and 3 patients.

Results indicate an overall impact of averted costs in respect of Social Care and Continuing Health Care for patients following the D2A pathway, with a slight reverse impact in respect of Funded Nursing Care. A sensitivity analysis of the averted costs identified indicate that a plausible two way 5-25% adjustment in key parameters result in around a 200k averted costs adjustment from base in Social Care and Continuing Health Care.

Based on the agreed approach to analysis by all involved parties overall accrued 12 month averted costs and their sensitivity ranges can be stated as follows:

Social Care    157K (Range -76K – 428K)
Continuing Health Care  867K (Range 667K – 1073K)
Funded Nursing Care -47K (Range -62K to -32K)

Introduction

This report sets out an analysis of the impact of patients accepting the D2A pathway post discharge, compared to patients not accepting the pathway prior to their acute discharge.

To conduct the analysis it was first necessary to identify and quantify the Health and Social Care packages (and related costs) allocated to patients post discharge, encompassing Continuing Health Care (CHC), Funded Nursing Care (FNC) and Social Care (SC). The methods for identification of these packages and the assumptions adopted in the patient record matching work are set out in Section 2 below.

Following identification, the patients receiving packages were quantified in terms of both numbers and average weekly cost of each type of package received (CHC, FNC, SC). These results were then used to establish the overall post discharge costs relating to the D2A Accepted and D2A Non-accepted groups. Costs were then modelled to ensure that those relating to the accepted group were compared to the non-accepted group on a like for like basis, from which relative averted costs resulting from patients following the D2A pathway could be identified.

The description of the methods and assumptions underpinning the modelling and analysis are set out in section 3 and the results from the analytical model are presented in section
4. This includes a sensitivity analysis on the financial impact dependent upon key parameters within the model.

All identification and analysis carried out relates to a cohort of patients admitted to South Warwickshire Foundation Trust (SWFT) in the period July 2013 – December 2014 and offered D2A. Within each group (accepted and non-accepted) patients are identified according to two separate pathways P2 and P3 which are analysed separately within the model.

Activity and costs shown relating to acute care for this cohort have previously been analysed and is outside of the scope of this report.

Identification of Health and Social Care Packages

2.1 Background and Introduction

A D2A dataset was established by SWFT containing details of the cohort of patients including their acute/ D2A stay, their discharge date and status (including death) and NHS Number. By means of a data exchange agreements this dataset was shared between SWFT, the Arden and GEM Commissioning Support Unit (AGCSU), on behalf of the CCG, and Warwickshire County Council (WCC) in order to facilitate the matching work required to identify allocation of packages across Health and Social Care. Under the terms of the data exchange agreement, whilst it was possible to provide patient level data to WCC, data could only be returned in aggregate form to AGCSU, where the analysis was being conducted.

Following the initial identification process, set out below in section 2.2, a further process was then undertaken to identify patients still receiving CHC/ FNC packages up to and including 12 months post discharge. This process was conducted in order to refine the assumptions within the costing model and analysis and is described in section 2.3.

2.2 Identification of packages at discharge

NHS numbers of patients discharged from acute/ D2A were matched to CHC and FNC records within the ACSU, as recorded within the CHC budget expenditure extract (CHCBEE). For matching to Social Care records, key data items were provided to WCC to allow for the identification of Social Care packages.

A key data item for matching patient records is the NHS number. NHS number completeness on both Social Care records and on the CHCBEE was high and approaching 100%. As such, completeness of NHS number on Health and Social Care package records is not thought to be an issue within the analysis conducted.

For each patient and for each type of package i.e. CHC and FNC, it was assessed, for each patient, if they were in receipt of a package of care.

Within 7 days of their acute admission, for all patients

Within 7 days of their D2A discharge date, for surviving patients in the accepted group
Within 7 days of their acute discharge date, for surviving patients in the D2A non-accepted group.

For patients receiving Social Care packages patients were identified if they receiving a package at 2 month post discharge.

Further observations and assumptions within the identification process are set out as follows:

For patients with social care packages anyone with a zero cost package (e.g. reablement, low level support, etc) were excluded from counts. Numbers and related costs reported relate only to funded packages.

Similarly, for patients identified as in receipt of CHC/ FNC package, a small number of patients were excluded from the calculations where the cost of a package was not stated within CHC/ FNC records. However, these related to patients with packages prior to admission and did not affect this analysis.

Where patients were identified with packages beyond 7 days post discharge these packages were similarly excluded from CHC/ FNC counts and related costs. In reality, this excluded only a small number of patients (<2%) for whom packages were allocated at least 2 and up to 12 months after discharge.

Information supplied back to AGCSU from WCC was necessarily received in aggregated form as no data exchange agreement is currently in place for information to be received back to the CSU at the individual level. It was therefore not possible to cross reference this information at the individual level with patient level data relating to acute hospital/ D2A stay or CHC/ FNC packages.

2.3 Identification of packages 12 months post discharge

2.3.1 Continuing Health Care Packages (CHC)

For patients identified as receiving CHC packages at discharge in section 2.2 above, patients were identified if they continued to receive a package at the end of each subsequent month post their discharge date (up to a period of 12 months).

As indicated in section 2.2 the CHCBEE was utilised to identify patients receiving packages following their initial allocation. This is possible within the CHCBEE by the recording of the date from which the patient was allocated a package to the end date. These dates were utilised in order to cross reference with the discharge date of surviving patients from acute/ D2A.

Within the CHCBEE it should be noted that CHC reviews are not explicitly identified and there may be multiple records relating to the same patient, due to

A patients package straddling a financial year or

A change to the package being received by the patient within a financial year
The CHCBEE patient records were therefore necessarily manipulated to ensure a continuous record for each patient was available prior to analysis of their package status at each month post discharge. This then allowed for the quantification of packages and related costs at discharge and at each month thereafter up to and including 12 months post discharge.

2.3.2 Social Care Packages (SC)

Patients receiving Social Care packages were similarly identified at monthly intervals post discharge from acute/ D2A. Identification took into account the patient discharge date from acute/ D2A and if they were receiving a social care package at each month subsequent to this date.

For the cost evaluation, the quantification of packages and their average costs were extended up to a period of 14 months post discharge. This was to allow for a cost evaluation to be conducted on a 12 month period commencing from 2 months post discharge. This was in order to allow for an assessment of Social Care needs which would typically become apparent within 6 weeks of discharge.

For patients receiving Social Care packages the term ‘Service User Uptake’ is adopted within the cost evaluation, in order to reflect that where patients stop receiving Social Care packages, this may be due to reasons other than death.

2.4 Outputs from the Identification Process

The number of patients identified as allocated funded packages prior to admission and post discharge are set out in tables 1 and 2 attached. Table 3b additionally shows post discharge survival numbers of pathway 3 patients allocated CHC packages.

Table 3c shows service user uptake of patients receiving Social Care Packages from months 2 to 14 post discharge.

3 Analytical Model

The model described below sets out to provide an estimate of the potential impact of D2A in relation to packages received by individuals and the costs of these packages.

The overall model, shown in table 3a1 sets out to compare costs of the D2A accepted patients with comparative costs which may have been incurred, had D2A been not accepted.

In table 3a, three groups of columns are shown, each split by pathway type 2 and 3, as follows :

- Observed numbers of packages and related costs of the D2A accepted group (D2A Accepted Group i.e. group 1).
- Observed numbers of packages and related costs of the D2A non-accepted group (Non-D2A Group i.e. group 2).
- Synthesised numbers of packages and related costs assumed for the accepted group, had D2A been non-accepted (Non-D2A-Synthesised Group i.e. group 3).
As shown in table 3a, the actual numbers of packages received at discharge are reported for groups 1 and 2, along with the probability of the package being received, expressed as a percentage of numbers alive at discharge. Average weekly costs of those receiving packages are also shown.

For group 3, synthesised numbers are then calculated by applying the probabilities of patients receiving packages in the Non-D2A group by the numbers surviving post discharge in the D2A accepted. This calculation was applied to each type of package i.e. CHC/ FNC/ SC and for each of pathway 2 and 3. The average weekly cost per package of this group was assumed to inherit the average weekly costs of group 2 (the Non-D2A group).

### 3.1 Refinement of the Model – Post Discharge Packages Received

#### 3.1.1 Continuing Health Care

Observed monthly values (numbers and average weekly cost) for groups 1 and 2 are set out in table 3b from discharge to month 12. Total costs in each month are calculated by applying the number of people receiving packages, averaged from the beginning to the end of the month multiplied by the average weekly cost (also averaged from the beginning to the end of the month) multiplied by the number of weeks (4.35) in the month.

Synthesised monthly values were then calculated for group 3 patients according to two methods. In both methods, a synthesised number of patients is calculated at discharge as per the Non-D2A synthesised group described in section 3.0 above.

Monthly costs for group 3 were then calculated in method 1, assuming that the survival profile, post discharge reflected that of the D2A accepted group, whilst for method 2 the survival profile of the D2A non-accepted group was assumed.

Total accrued costs over the 12 months were calculated and compared for groups 1 and 3 in respect of each method. The averted cost pertaining to the D2A accepted patients is identified in table 3b and highlighted in table 3a as a comparison to the initial method which quantified costs over the six month time horizon.

#### 3.1.2 Social Care

The social care model was based on service user uptake from 2 months post discharge (M2) to 14 months (M14) and the acceptor survival rate. So we agreed a comparable 12 month reporting period and used the same methodology for survival rate as that based on CHC. i.e. Individuals were tracked monthly in order to quantify numbers receiving packages and the average weekly costs of packages.

As within the CHC refined model a synthesised group (group 3) of patients was quantified which could be compared to numbers and average weekly costs in the accepted group (group 1). Accrued costs over the Month 2 to 14 period was then calculated in each group and compared in order to derive an estimate of averted costs. The quantification and modelling of packages and related costs are set out in tables 3c.
4 Results including Sensitivity Analysis

4.1 Key Results

The model outputs the key results of averted costs accrued in each of SC/ CHC and FNC, as highlighted in Table 3a and are summarised in Table 4 below for pathway 2 (D2A2) and Pathway 3 (D2A3):

<table>
<thead>
<tr>
<th>D2A2 Accepted averted cost - SC - 12 Month - Accepted Profile - Months 2-14</th>
<th>D2A3 Accepted averted cost - SC - 12 Month - Accepted Profile - Months 2-14</th>
<th>Total Accepted averted cost - SC - 12 Month - Accepted Profile - Months 2-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>£5,345</td>
<td>£162,506</td>
<td>£157,161</td>
</tr>
<tr>
<td>D2A Accepted averted cost - CHC (26 Weeks)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£0,000</td>
<td>£763,058</td>
<td>£763,058</td>
</tr>
<tr>
<td>D2A Accepted averted cost - CHC - 12 month, Accepted Survival Profile, Mthd1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£0,000</td>
<td>£866,927</td>
<td>£866,927</td>
</tr>
<tr>
<td>D2A Accepted averted cost - CHC - 12 month, Non-Accepted Survival Profile, Mthd2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£0,000</td>
<td>£789,515</td>
<td>£789,515</td>
</tr>
<tr>
<td>D2A Accepted averted cost - FNC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>£14,190</td>
<td>-£61,013</td>
<td>-£46,824</td>
</tr>
</tbody>
</table>

Table 4

As shown, the pre-dominant post discharge cost impact of patients following D2A is of averted costs in CHC (763K - 867K depending on the method chosen), followed by averted costs in Social Care (157K). There is a reverse effect in FNC (-46K), however this is relatively small in comparison to averted costs accrued in CHC and Social Care. The FNC increase is a direct result of CHC decrease.

In both SC and CHC, the averted costs are primarily as a result of an increased probability of Non-D2A patients receiving these packages post discharge. In Social Care, the probability of a D2A patient being allocated a package in pathway 3 is 0.324 (32.4%), however this rises to 0.357 (35.7%) where D2A was not accepted.

In CHC, the increased probability is greater still, rising from 0.277 (27.7%) to 0.44 (44%). In combination with a greater average weekly cost per package, this results in a substantially greater averted cost overall when compared to SC.

4.2 Sensitivity Analysis (SA) - Pathway 3 for SC/CHC/ FNC and Pathway 2 for SC

The sensitivity of the financial impact on the pathways were tested by varying key parameters within the model i.e. the probability of individuals being allocated a package at discharge.

Each probability of receiving a package in relation to pathway 3 Social Care and CHC were varied by +/- 5% and for FNC by +/- 10%. These probability ranges were chosen on an arbitrary but plausible basis, set around the actual probabilities that did occur within each group of patients.

For the purposes of the sensitivity analysis, the base averted cost applied to CHC reflected the 12 month, accepted survival profile (method 1).

A sensitivity analysis was also conducted on pathway 2 patients allocated Social Care packages. A 25% variation in probability of receiving a package was applied here to Non
D2A patients due to the smaller numbers involved, compared to pathway 3 patients. For D2A patients receiving Social Care packages a 10% variation was applied because of the higher numbers compared to Non D2A.

Table 5 below sets out the results sensitivity analysis (SA). The one way SA shows the effect on averted cost effect by varying each probability in turn, whilst the two way SA shows the effect of varying D2A probabilities in one direction and Non D2A probabilities in the other direction.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Probability Range</th>
<th>Averted Cost (One Way SA)</th>
<th>Averted Cost (Two Way SA)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Base Probability</td>
<td>Lower</td>
<td>Upper</td>
</tr>
<tr>
<td>D2A3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2A with Funded Packages - SC*</td>
<td>0.324</td>
<td>0.308</td>
<td>0.340</td>
</tr>
<tr>
<td>Non - D2A with Funded Packages - SC*</td>
<td>0.357</td>
<td>0.339</td>
<td>0.375</td>
</tr>
<tr>
<td>D2A with Funded Packages - CHC*</td>
<td>0.277</td>
<td>0.303</td>
<td>0.291</td>
</tr>
<tr>
<td>Non - D2A with Funded Packages - CHC*</td>
<td>0.440</td>
<td>0.418</td>
<td>0.462</td>
</tr>
<tr>
<td>D2A with Funded Packages - FNC**</td>
<td>0.197</td>
<td>0.177</td>
<td>0.217</td>
</tr>
<tr>
<td>Non - D2A with Funded Packages - FNC**</td>
<td>0.083</td>
<td>0.075</td>
<td>0.091</td>
</tr>
<tr>
<td>D2A2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2A with Funded Packages - SC**</td>
<td>0.301</td>
<td>0.271</td>
<td>0.331</td>
</tr>
<tr>
<td>Non - D2A with Funded Packages - SC***</td>
<td>0.333</td>
<td>0.290</td>
<td>0.416</td>
</tr>
</tbody>
</table>

* Variation in probability +/-5%
** Variation in probability +/-10%
*** Variation in probability +/-25%

Table 5

This shows how a small variation in assumed probabilities can affect averted costs within the model. This is particularly the case in SC and CHC where a two way 5% adjustment in probabilities result in an approximate £100K to £200K difference from baseline averted costs.

4.3 Results Summary

In combination with averted costs results identified for pathway 2, total overall averted costs were calculated for each SC, CHC and FNC. These are set out in the chart below, incorporating the pathways 2 (Social Care only) and 3 sensitivity analysis to indicate a range of potential impact resulting from patients following the D2A pathway.
The Better Care Fund

Sharing responsibility for transfers of care
Collated notes from all workshops

Local initiatives to consider

- Wirral, ‘avoiding double-ups’
  - Currently working on transformation
  - “Evidence shows that if you remove patients from a stay in hospital quickly they would have not deteriorated as quickly.”
  - If patients are assessed at the ‘right point’ in the pathway, their care is more tailored to their needs, i.e. removing the double-ups. Such as now in the community, there is service provision for: IV ABX in the community, rapid response teams, etc.
  - This offer has improved integration in the BCF through working together

- Risk aversion in healthcare professionals, ‘avoiding double-ups’
  - The different attitudes to risk in the medical vs. community view
  - In Liverpool, they are working with OT’s in the early stages of D2A
  - One quick output was that hospital discharge delays were due to the ‘double-up’ package of care. Whereas, when patients are assessed at home they are assessed in a more efficient manner
  - Currently looking at rotations for healthcare professionals here – therefore will practice both in hospital and community settings.

- St Helens are ‘doing’ well in leadership governance and approach. Other localities are progressing, and have joint posts they are achieving in health and social care.

- Hertfordshire – different situations in East and West. The key is that there is better leadership which is a necessary foundation for integration in the East, therefore the same model is not working in the West.

- Hounslow – There is a social worker who can put in place a package straight away when discharge is necessary. This is done jointly with health.
  - Meetings to understand and prevent re-admissions on regular basis
  - Preventative work to get GPs on board
  - They identified transport as an issue, and they have got Red Cross on board

- Medway - Home First.
  - Discharges are directly to the individual’s home. Within two hours of discharge an OT will carry out an assessment at home and up to 6 weeks enablement is provided.
  - Some issues with professional boundaries and protection of work
  - Two strands: home first and step down to home (reablement). Currently working on strand 3 for CHC and end of life
- Outcomes based commissioning
- 1000 people from April to December.

- Warwickshire - Discharge team in the hospital that is allowed to make decisions on behalf of other organisations.
  - There is a trusted assessor who is also a trusted referrer.
  - Their next step will be to do across Coventry to deal with cross borders
  - They have found that it is easier to deal with people with complex needs on discharge
  - Discharge to assess model – there are clear pathways that relate to different level of needs
  - Home first
  - Task and finish group - operational people that during a week had lots of communication and understanding of each other
  - Suggested action plan – focus on few things at first:
    - Focus on what brings more back
    - Use assets you have (i.e. operational teams)
    - Discharge to assess
  - LA has redesigned how they arrange and re-commission care packages after discharge
  - Market position statement – managing the market is key. LA is better at it, but has to be thought through with others
  - Important to get all parties involved in the very beginning, to plan and shape, not only to deliver
  - Information governance is a barrier to measure and evaluate. There are work arounds in some parts of the country, but are not necessarily helping

- Wigan example includes:
  - Integrated discharge team – group of coordinators, social workers, nurses, home and residential care professionals etc all working together in one location and under one manager, one IT system
  - Agreed shared pathways:
    - designed new systems together
    - information refreshed three times on a daily basis
    - team huddles – unblock barriers etc
  - Agreed purpose – end to end
  - Holistic approach – strength and asset based
  - Integrated community services team includes social workers etc
  - Community book scheme – linking people into things they want to do
  - Wider system support – longer term
  - Redesigning assessments
  - Integrated spaces
  - Positive outcomes include:
    - anticipate discharge process
    - learning – ability to sit together to talk about same patient
    - conversation with patient and family
    - support system in place
    - Personalised
    - Flexibility – individual provision, geographical provision
Social workers have been on this journey for 5 years and are biggest advocates despite being sceptics to begin with

Need to translate into the NHS

Staff more energised, creative and feel able to change the system

Be accountable, be positive, be creative

Has impacted system, staff and patients in a positive way – 81 less people went into residential care and went home in 2016

**Identified useful tools or resources**

Evaluation report published on the NHSE website (within the Quick Guide to Discharge to Assess).

High Impact Change Model Managing Transfers of Care

**Identified challenges**

- **Social care challenges:**
  - Lack of understanding of self-responsibility and clarity on roles.
  - Issues delegating responsibilities to staff
  - Data sharing
  - Lack of clear leadership
  - Inability to communicate effectively across different systems and workstreams

- **Technical issues:**
  - Technical infrastructure to support information sharing is difficult
  - Not all areas are starting out at the same point in terms of ability and capability
  - No control over the whole system
  - Metrics not universal or standardised

- **Removing strict criteria for teams**
  - Consensus to want to move towards having patients assessed then stratified in to the appropriate service(s)

- **Lack of equality** in care home places and home care packages.
  - This area is completely saturated and is directly interlinked to workforce challenges
  - There is current activity to look for a different model of home care. i.e. people going back into their homes, rather than care homes
  - Fragility of the care market

- **Processes and procedures**
  - “There is so much going on with health and social care, it is difficult to have a joined up, consistent, embedded and running system– before it changes again.”
  - Lack of seven day service in providers/acute trusts
  - When and where the assessment takes place to facilitate effective transfers
- Person centred customer journey – one size does not fit all
- NHS is free and LAs have chargeable services
- Urban vs rural infrastructure creates variation

- **Resources and cultural challenges**
  - Behavioural changes
  - No honest or frank conversations between partners

- **False expectations and risk aversion**
  - Sharing the responsibility is a challenge, as each organisation has a different risk threshold and understanding of risks
  - GPs and consultants contribute to create ‘false’ expectations that can’t be or should not be met at discharge by social care.

- **Intermittent resource, system, cultural and operational issues**
  - “However, during these, we will be focused on our problems then forget everyone else”

- **Earlier management without using DTOC.**
  - D2A can be used in earlier instances, therefore will lose the DTOC metric. This area is cloudy as there are no clear pathways

- **Definition of DTOC** – Suggested that TOC should be used instead of DTOC or ‘length of stay’
  - “Sometimes we will be bogged down in the definition of what the DTOC is”

- **Risk incentives involved for managing transfers of care**
  - Consensus is to want to shift resource from one location to another.
  - Who picks up costs in the system?
  - Major transformation needs investment

- **Changing demographics**
  - There are more people needing certain types of care. This can put pressures on to the system if the services are not there. This will also interlink with the equipment budget. Some budgets are pooled some are not.

- **Need to link with housing** as every discharge has a housing element

- **Lack of understanding and focus on the big picture is a challenge.**
  - There is a general willingness to integrate, but there is a point when the individual responsibility kicks in, particularly if one has to defend their budget. So some people are withdrawn and onto silos
  - Sometimes when the big picture is lost, the issues are not solved but shifted into another areas. i.e. some discharge to assess models put too much pressure in the community teams

- **Workforce development** – upskilling in already pressurised budgets/economy

- **Limited provision**
Sufficient intermediate care capacity – both in terms of ‘step up’ and ‘step down’.
- Lack of EMI and/or specialist residential and nursing home availability.
- Poor infrastructure for MH and substance misuse
- Over-reliance of discharge on specialists

- Decision making: national policy disconnect and constant shifting.

Areas or types of further support needed
- How to achieve shared ownership to gain change in the system
- How to achieve consensus to understand DTOC, its phases and the challenges
- How to understanding DTOC from a financial perspective
- Tools to use to take away the atmosphere of blame
- Lack of understanding of the transfer to assess approach
- Need to focus on the ‘ready for discharge’ list. DTOC to be a subset of this.
- DTOC metrics:
  - More effort should be spent on the correct coding, measuring and counting DTOC
  - Currently, this is not applied consistently, and could be used as a political tool to manipulate organisations to work in a certain way: “what seniors see on paper is different to what is happening” i.e. example where policy and legislation can contradict.
  - Focus is on points in systems rather than whole picture and measuring all indicators in system
- Incorporate a co-production approach in integrated commissioning
- System Leadership and Governance
  - There can be many schemes/ programmes (including BCF) that are feeding into integrated care strategy and planning. “It is confusion in system leadership which leads to not knowing who is the chair. We want to avoid everyone being at every meeting.” System leadership needs to be more pragmatic, i.e. A and E delivery board integration teams also sit under different boards.
  - System leaders not taking responsibility. eg Home First Scheme: This scheme was promising, however could not secure a collective buy-in of resources as leaders did not know where to locate the money

“Siloed approach to governance and accountability is challenging to manage and break down”

Further information
All presentation materials and notes for Delivering Integrated Care Masterclasses March 2017 are available on the SCIE website