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RIGHT PLACE, RIGHT TIME
BETTER TRANSFERS OF CARE: A CALL TO ACTION

'Doing the obvious thing is the radical thing'

INTRODUCTION

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There is no simple solution to delays in transfers of care: no one individual to blame nor a magic bullet that will solve everything. Everyone in the health and social care system needs to act: commissioners and providers, physical and mental health, national and local organisations. However there are a number of practical steps we can take to understand the root causes of delayed transfers of care and build the partnerships needed to tackle them. Our starting point is three calls to action addressed to every part of the health and care system.

1. Start with the person (the patient or service user). They are your common cause.
2. Ask yourself how do we help this person get back to where they want to be?
3. Agree what the data tells you. A shared understanding of the numbers can help with tracking down the root causes.

No one working in the NHS or social care sets out to do harm. Having seen first hand the day to day pressures on a hospital ward and across different care settings what was most striking was the importance of these three calls to action in both professional practice and system design.

Hospitals, community, ambulance and mental health providers sit within a wider ecology of the health and social care system and the interplay between people's circumstances, for example, their housing, their family and community and the social support they have. To reduce delays managers and clinicians must work with partners to manage these interplays within the system as a whole. To find solutions we need to start with the patient experience, in order to design pathways that fit more closely around the needs and lives of patients and service users.

Delayed Transfers of Care (DToC) can harm patients and create massive increased and avoidable costs for both the NHS and social services, as well as the wider public sector. Much serious avoidable harm to patients, such as hospital acquired infection and injurious falls, occur when patients are experiencing a delayed transfer of care to their own home or a post-acute setting.

Unplanned delays can also have a catastrophic impact on a person's pre-admission functional ability. In a mental health setting extended length of stay can lead to deconditioning, functional relapse and a loss of confidence. In an acute setting, at its most basic, time is muscle; older people can lose significant muscle power in as little as half a day in hospital. This can be the difference between being able to stand unaided and having the confidence to return to independent living.

DToC is often seen as a simple equation: delays equal longer waits in A&E as the hospital fills up. This is a gross over simplification, which can misdirect efforts to address delays in transfer of care.

The long-term trend in delayed transfers of care had been reducing but over recent years it has started to increase again. There were 145,100 total delayed days in August 2015, up from 137,600 last year[1]. According to a recent audit of acute care of older people by NHS Benchmarking, five per cent of stays in hospital of 21 days or more account for a staggering 41 per cent of total bed days[2]. In that finding alone is a very big pointer to understanding why so many of our hospitals and the wider system hit gridlock.

All NHS providers face the challenge of ensuring timely patient discharge and managing the 'flow' of patients through their organisations. An increase in patients with high acuity and complex needs has piled on the pressure, with rising admissions, and more complex discharges. Historically in the NHS, the winter heralds an increase in pressure which then levels off in the summer months. Worryingly, figures for delayed transfers of care during the spring and summer of this year show that the delays have not gone away. Winter is coming, and a perfect storm is brewing. Hospitals are struggling financially and greatly increased capacity is often simply not an option. There are real concerns that another NHS bed crisis is just around the corner.

The situation looks bleak, but there is cause for hope. In some areas commissioners and providers are managing these pressures better than others. There are examples of excellent innovation across the country. This progress, nevertheless, remains patchy, with many trusts struggling to identify solutions to increased demand.

The *Right place, right time* commission has analysed and explored the issues involved in improving transfers of care. We have explored delayed transfers of care within the within the mental health and community sectors and between mental health and physical health providers. The two sectors can learn much from each other and need to work more effectively together: acute and emergency care can learn lessons from mental health on ambulatory and home based care; many of the issues facing acute providers are highly relevant for mental health providers as well, including lessons from best practice in patient flow.

Services need to plan ahead across their whole populations and proactively manage those patients most at risk of admission, seeking to maintain people's independence and protect them from the risk of hospital or inpatient admission. Commissioners, managers and the frontline must engage with other types of providers in their area, from social care, general practice, community services and the independent and third sectors. More open and honest conversations must be had between staff and with patients and their families. This must not be about blame. The imperative now is to address the barriers in the system that are causing delays.

MESSAGES FOR NATIONAL ORGANISATIONS

Mobilising action around the individual and their personal physical and psychological recovery should be the touchstone of both redesigning systems and managing flow through them. Effective change requires national system leaders to act differently too. These are the messages our commissioners, our research and our visits highlighted.

Messages for the Department of Health

Planning for demand – at the highest level the Department of Health must set the framework to ensure that NHS capacity meets the level of demand in future years.

Social care – The Department of Health must assess the costs of a sustainable social care market including implementation of the national living wage.

Health and Wellbeing Boards – The Department of Health should look to further strengthen Health and Wellbeing Boards to promote their role and encourage joined up commissioning, as well as reinforcing its support programme for Health and Wellbeing Boards by reviewing its policy and promoting the role in oversight and local systems leadership.

Shared care records – The Department of Health must continue to spearhead the introduction of shared care records ,as the current difficulties many providers experience sharing records is limiting their ability to join up care. Information governance arrangements should support information sharing as the norm, rather than by exception.

Housing – The availability of appropriate housing support is clearly a factor in a significant number of DToCs. This is a particular issue in mental health. There is a shortage of the specialist housing which can prevent people needing acute services. The Department of Health, and all policy makers, should factor this into their decision making.

NHS Continuing Healthcare Assessments – The Department of Health should produce further guidance for trusts and CCGs in order to speed up the process of Continuing Healthcare assessments, including these assessments in arrangements for assess to discharge.

Messages for NHS England

Local government and the third sector – NHS England should encourage commissioners to collaborate with local authorities and understand the capacity of the independent and voluntary sector in their health economies.

Use of technology – In particular, in many areas there has been poor adoption of telehealth and telecare services to enable preventative care, avoid admissions and support transfers of care. NHS England should work with technology providers to facilitate a better understanding and dialogue with commissioners.

'A new approach to data collection and reporting of DToC in acute and mental health settings' – NHS England needs to make clear that health and social care delays should be counted using the same notification process and timescales.

Definitions of DToC and OATs – There remains an urgent need for NHS England to agree and issue clear definitions for DToC and Out of Area Treatments (OATs) in mental health settings.

Messages for NHS Improvement (Monitor and the TDA)

Data capacity – As Monitor and TDA come together to form NHS Improvement they should work with trusts and their representative bodies to build and source this data and analysis capacity to support service improvement.

Payment mechanisms – National payment mechanisms need to enable a coordinated, system-wide approach to improving transfers of care, including an end to block contract payments.

Housing and NHS estates – NHS Improvement should work with NHS England to ensure that NHS land and estates can be used effectively in partnership with housing providers to develop innovative supported housing provision.

Messages for Health Education England

Staff shortages – Health Education England should ensure concerns about shortages of staff, in particular occupational therapists and other allied healthcare professionals are taken into account in planning for future workforce provision.

Skills mix and developing transferrable skills – Health Education England should consider how it can assess and meet the skill mix demand in the short to medium term.

Messages for Communities and Local Government and the Local Government Association

Capacity mapping – CLG and the LGA should ensure local authorities are enabled to learn from the best practice across the country in providing preventative approaches to social care commissioning, and integrated programmes to improve transfers of care.

An asset based approach – Greater use should be made of third sector organisations for asset-based community development, including developing information/advice and care navigation services.

Wider investment, including in housing – A local Transformation Fund should be established to support the investment necessary to implement new models of care that integrate services and drive community based approaches to health and social care.

A CALL TO ACTION

There is a compelling need for local action. Across health and social care commissioners and providers should work together to identify the root causes of delayed transfers of care and act to ensure people receive the right care in the right place at the right time.

Calls to action	Providers	Local councils	Clinical commissioning groups	Health and wellbeing boards
Test your assumptions about root causes of poor and delayed transfers of care. Accept that tackling delayed transfers of care is a system problem and not simply the responsibility of the local trust.	✓	✓	✓	✓
Understand the needs of your local population. Successful organisations are focused on understanding population health, and adopting and making better use of risk stratification tools in order to plan effectively the services to meet those needs.	✓	✓	✓	✓
Ensure that people in your area who are at risk of admission into hospital, for example older people, those with mental health problems, or homeless people, are supported with proactive, integrated and preventative services. This should include appropriate therapies, rehabilitation, re-ablement and intermediate care. This provision should be available before admission and upon discharge to prevent readmission.	✓	✓	✓	
Listen to your staff. They will know where the bottlenecks occur. It is vital to fully involve the whole staff team in the process of change.	✓	✓		
Listen to your patients, service users and carers. Case notes, Friends and Family Test scores and conversations with patients and their relatives are all key pieces of the puzzle to help understand where delays occur and identify what needs to change.	✓	✓	✓	✓
Inform and involve patients, service users and families in decisions about transfers of care.	✓	✓	✓	
Gather and interrogate the data you have. Benchmark performance against other providers and within the provider down to team and individual decision-maker level.	✓	✓	✓	
Build your capacity to undertake process engineering and analytics. Seek external help, for example from local academic institutions.	✓	✓	✓	

Retain focus once changes have been implemented to ensure sustainability.	✓	✓	✓	
Work together to tackle the problem. Establish effective face-to-face meetings.	✓	✓	✓	✓
Involve the local independent, voluntary and community sectors in local planning and accountability arrangements.		✓	✓	
Ensure providers in your area are able to share records about patients and service users transferring between them, while maintaining safeguards and appropriate levels of consent.	✓	✓	✓	
Consider making senior clinical decision makers available at the hospital 'front door' to prevent unnecessary admissions. This can include primary and social care staff.	✓	✓	✓	
Prevent unnecessary medicalisation and ensure everyone in the trust is focused on helping older people maintain and recover their independence and mobility.	✓	✓	✓	
Conduct **full assessments of functional ability upon admission**, and set an evidence-based estimated date of discharge.	✓			
Ensure staff discharging patients are aware that it is not their role to duplicate or second guess decisions about the **most appropriate support arrangements in the community.**	✓			
Talk to your local NHS providers to ensure that they are confident that social workers understand the **full menu of community based services to support discharge**.		✓		
Acute and mental health providers to ensure an i**ntegrated and seamless approach** to people's social, mental and physical health needs.	✓	✓	✓	
Recognise that delayed transfers of care are not just a problem in physical health. Mental health patients are often delayed inappropriately in inpatient settings. Commissioners need to tackle this issue and ensure the right mix of capacity in their community to provide ongoing support and avoid out of area placement.	✓	✓	✓	
Explore how **technology** can help people in your community retain their independence	✓	✓	✓	
Work with **ambulance providers to develop a mobile urgent treatment** service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital.	✓		✓	

Explore **better use of your community workforce**; in particular how community nurse services can be further integrated with primary and social care provision. Consider how care navigators could help patients understand and access care services in the community.		✓	✓	
Consider the introduction of a 'Discharge to Assess' model if this service is not already being provided in your area with the aim of promoting people's wellbeing and independence.	✓	✓	✓	
Consider **increased provision of supported living environments** e.g. assisted living, residential care.		✓	✓	✓

THE CAUSES OF DELAY

The commission's work looked at the causes of delay in order to identify the solutions. At the highest level it showed us that:

Delays are preventable and although patients do not always register the boundaries between interdependent health and social care bodies, all too often the delays they experience are as a result of the barriers that prevent these organisations working effectively as one system.

There are many causes of delays – there is a complex range of reasons why delays occur both inside organisations and across the wider health and social care system. This is not just about demand rising but a growth in particular in frail, elderly patients with complex needs suffering because of the lack of integration between the NHS and care services. Workforce recruitment and retention challenges at all levels contribute, in particular care homes fishing in the same limited pool for staff and few pay incentives due to stretched social care budgets.

Care sector capacity is increasingly causing delay not just because of delays in sourcing a care package but also availability of staff to assess social care packages. Sometimes delays are simply a matter of organisation within the hospital itself, such as managing the supply of medicines.

Delays and poorly managed transfers have many impacts. It is fundamental to understand the impact of delays on the individual and their potential to slow or undermine recovery. The full report gives examples of this. Delays also impact the wider organization, in terms of course of flow and capacity, but also on staff morale. And beyond the moral obligation to benefit patients there is strong economic reason to tackle delays . In 2012, the King's Fund estimated that DToCs cost the NHS approximately £200m each year[3]. That is an extra cost of more than £550,000 per day, the equivalent of treating 60,000 patients[4]. Delays are a symptom of wider transfers of care not being well managed. Sometimes discharges are rushed and patients are transferred without the right support in place – these are premature transfers of care. This can result in patients not being fully involved in decisions about their discharge, an inability to cope once home, and of course an increased potential for readmission.

MENTAL HEALTH

Though often seen to be an issue primarily for acute physical health care, delayed transfers of care are an equally significant problem in mental health settings or for those experiencing mental health problems. There is much common ground between the factors contributing to delayed transfers of care in acute and mental health settings. However it is also worth understanding the specific challenges facing mental health service users and providers.

Some straightforward international comparisons are helpful here: England is the only country with no mental health beds in general acute hospitals and one of the few countries that does not have integrated alcohol, drug and mental health services. In mental health, DToCs are part of a wider problem around lack of hospital and community capacity which can result in people being taken to an inappropriate setting such as a police cell, being sent miles away from their home to the only available bed, or being denied care at all.

Over and above the conditions they live with, mental health service users can also face extended stays due to their individual circumstances and characteristics. They may be homeless, live alone, have no recourse to public funds, or be part of a mobile or migrant community. The first three months after discharge are a time of particularly high suicide risk[5]. Mental health service users will often suffer complicating factors or comorbidities in terms of physical health problems such as diabetes, thyroid and respiratory conditions. A further factor lengthening stay in mental health is the use of the Mental Health Act, the use of which has increased in recent years.

Children and young people can face delays to transfer or discharge due to a lack of appropriate or supported care on leaving an inpatient setting, conditions with increased risk, or a more fragmented care pathway due to receiving treatment far away from home with a lack of local support. Looked after children will spend longer in inpatient care because of the amount of time it takes to agree their care plan.

Delays and problems therefore occur both in discharge from inpatient mental health settings and for inpatients in acute hospitals with both physical and mental health needs. For mental health services there is not a clear definition of 'delayed transfer of care' or 'out of area treatment'. This makes vital activities such as accurate data collection and service benchmarking extremely challenging.

Healthwatch England's research[6] unfortunately sets out some shocking examples of the experiences of patients with mental health problems. Transfer of care between inpatient and community settings is clearly a vital area of focus to improve the level of care offered to people with mental health problems.

An estimated one in 20 bed days are used by people experiencing a delayed discharge in a mental health setting[7]. Healthwatch England estimates that over 6,000 service users stay in inpatient care longer than is clinically necessary with every additional day they spend in hospital costing the NHS in excess of £2m a year[8].

In addition to the negative experience and outcomes for patients, the lack of appropriate care for patients was clearly also generating a cost to the system due to repeat attendances, inappropriate discharge and problems becoming more severe. Homeless people are particularly vulnerable to the repeat cycle of admission and discharge without appropriate available support[9].

These experiences demonstrate the failure of services on some occasions to treat the whole person and to understand their individual circumstances. Such accounts make uncomfortable reading. However, there are encouraging examples of innovative, integrated care being developed:

- Patients in Birmingham who may be suffering from mental health problems can access assessment, support and advice from any of the acute hospitals, 24 hours a day, 7 days a week. The rapid assessment, interface and discharge (RAID) model was first piloted by Sandwell and West Birmingham Hospitals NHS Trust and has since been replicated around the country[10].
- Birmingham and Solihull Mental Health Foundation Trust has built on the successful RAID model with a Psychiatric Decision Unit which provides a responsive seven-day service in a supportive environment to people whose complex presentations and/or social issues mean they cannot be immediately discharged. Evaluation is ongoing, and has shown a reduced need for mental health beds and positive feedback from service users[11].
- Northumberland, Tyne and Wear NHS Foundation Trust introduced a bed management and transfers system to tackle out of area treatment and delayed transfers of care. The system has been in place for almost 12 months and has reduced out of area admissions, improved transfers between primary and secondary community care mental health services and introduced rapid response and triage for people who feel they need urgent help[12].
- Care navigators can provide help to reduce problems in transfers of care for mental health patients. In the London Borough of Waltham Forest, upon discharge from a mental health service, people are allocated a navigator to support them for a period of 12-18 months, ensuring they attend primary care appointments to monitor their health and discuss their treatment. The pilot showed a reduction in crises where regular contact with the navigator was maintained, as well as shorter crisis episodes and less time in secondary care[13].
- Leeds and York Partnership NHS Foundation Trust and Community Links set up the Accommodation Gateway to ensure service users are connected with the housing service that best meets their needs and prevent delayed discharges due to housing issues. The trust has seen a marked reduction in delayed discharges due to accommodation issues and out of area placements.
- One Housing Group forged a joint venture with the Camden and Islington NHS Foundation Trust and the London Borough of Camden for the Tile House development which provides a service to 15 people with complex mental health needs, who may otherwise be in hospital wards or expensive out of borough placements. One Housing Group estimates this model could make over £1 billion in efficiency savings for the NHS per year if the model was applied across the country[14].

QUALITY IMPROVEMENT CAPACITY

Quality improvement for both physical and mental health[15] requires a systematic approach to working together, using methods, tools, data, measurement, curiosity and open mindsets to consistently strive for improvement in both physical and mental health care. Quality improvement techniques can help make healthcare safer, more effective, timely, efficient and equitable. It can also make services more person-centred, recovery-focused and better at ensuring people with experience of mental illness are at the heart of service design and involved in the co-production of services.

The use of quality improvement science not only helps to create the conditions for new ways of thinking about flow across and between organisations, but can also measure whether a change really is an improvement, tracking the intended and unintended consequences to ensure that an improvement in one part of the system does not unbalance another.

The commission has been told that at present quality improvement science is not reliably integrated into mental health training at undergraduate, postgraduate and doctoral level, and that it is a technique which could be much better understood in the sector and helpfully applied to mental health pathways.

However some deaneries have managed to include quality improvement in the training of junior doctors and the Royal Colleges are recommending ways that quality improvement science can be incorporated into the education and practice of healthcare professionals. NHS Wales, NHS Scotland, NHSIQ, the Institute of Healthcare Improvement Open School and BMJ Learning offer some helpful introductory materials for quality improvement, but have very few UK examples from mental health services. To address this gap a national mental health quality improvement toolkit is to be launched in 2016. It will use case studies from five clinical areas to show how quality improvement can work in mental health settings, illustrating the main methodologies and tools.

Some provider trusts, including East London NHS Foundation Trust, Academic Health Science Networks (Yorkshire and Humber, West of England, UCL Partners) and Patient Safety Collaboratives teach quality improvement science and develop local improvement coaches, through 'improvement academies' and introduce ways of working collaboratively in regions to achieve key outcomes. This quality improvement methodology is called a 'collaborative breakthrough series' and if a national series could be introduced for delayed transfers of care, then knowledge and resources could be pooled and data could be collected to help drive improvement at local and national levels.

WHAT WORKS?

> *Doing the obvious thing is the radical thing*

From the literature review, submissions, discussions, visits and formal meetings the commission has been able to identify and isolate a number of common factors that can help to overcome the seemingly intractable challenge of delayed transfers of care. We have set these out below.

Create a compelling story

In orchestrating any major organisational change it is essential to create a compelling story to ensure everyone is clear as to why change is necessary. The research in this report clearly shows the massive impact delayed transfers of care have on patient care, staff morale and an organisation's bottom line. Nevertheless each organisation must paint this picture for its staff at all levels before embarking on any major operational changes, so that each individual is sufficiently motivated to go on the journey together and understands where his or her contribution fits. This helps ensure everyone in the team shares the commitment to implementing sustainable change. It is difficult to change practice and behaviour if staff cannot see why such change is necessary[16].

Planning and preparation: really understand the problem

> *I have spent all week fire-fighting, isn't it time I found the cause of the fires?*[17]

To improve the flow of patients it is first vital to understand what is causing delays in the first place.

It sounds simple enough but all too often managers and staff assume they understand the underlying causes of delays. Assumptions can lead to further problems: if nurses on a ward assume that delays are caused by a lack of capacity in the community sector they may feel absolved of the responsibility for tackling factors in delays that they can control.

Or managers may rush to 'bolt on' solutions from another organisation without recognising that such solutions do not match their own problems. For example, adding extra capacity in the form of an assessment ward to relieve pressure on A&E. This may work in the short term, but the extra ward eventually fills up as the underlying process problem of the flow of patients through the hospital has not been addressed.

> *If you have a blocked pipe it is not enough just to mop the floor.*
>
> **Michael Wilson, CEO Surrey and Sussex NHS Trust.**

Expanding capacity is not always the answer:

> *Some hospitals have chosen to expand the capacity in their A&E department or with assessment units in response to a demand problem. Rather than relieving the situation, it can make matters worse. It is like widening the large end of a funnel without increasing the size or capacity of the neck*[18].

Understanding the problem means exploring the patient journey in detail and identifying where and when delays and problems can occur. This should involve::

- Communication with staff
- Patient and relative feedback
- Data collection and analysis
- Internal and external benchmarking

Talking to staff is fundamental. This needs to involve all staff teams, from consultants to hospital porters, A&E nurses to ward administrators, pharmacists to physiotherapists. Many of these people are actively involved in discharge out of hospital, preparing reports or assessing patients for their ongoing care needs. Each staff team will hold one piece of the jigsaw and be able to identify bottlenecks and roadblocks from their own perspective. It is important to gather this information from all corners and to involve all staff members in the process of exploring the problem, as they will be vital to the implementation of any solution

Data

Data is a vital tool for understanding what causes delays – and needs to be used as such. Data alone is not enough and evidence is sometimes a poor substitute for common sense and good practice. However it can help to pinpoint where the problems are and provide a starting point for discussions with staff and patients.

First of all it is important to understand what data is available, what it shows, and what remains unknown. Information on delayed transfers of care, inpatient length of stay, bed occupancy rates, discharge times and A&E four hour target times are all helpful indicators. The next stage is to explore the variation in this data. It must be examined in granular detail. For example, on which days and at which times of day are bed occupancy rates highest? How does this align with available capacity? When does capacity dip (staff leave, weekend rotas, clinic times)? What is this information saying about where bottlenecks are occurring? Data is not the only tool available, and it is important to use it as a starting point for wider discussions. Without the right data it will be impossible to understand the root causes of delays.

Benchmarking

Data can be used to benchmark performance against other trusts, to find out areas of excellence and where improvement is needed. It can also be used within organisations: comparing wards and consultant teams to highlight inefficiencies and potential problems which warrant further exploration. This benchmarking can help to identify and challenge variation in decision-making and outcomes. Some studies suggest that consistency of decision making by practitioners is far more important to patient experience and outcomes than creating new services[19].

The causes of backlogs

According to NHS Improving Quality[20], there are usually three main reasons why backlogs develop:

1. Demand (referrals) exceeds capacity (staff, equipment and space). This is in practice rarely the reason for delays within hospitals.
2. There is a mismatch between demand and capacity because of variation, for example shift patterns, clinics or theatre sessions do not match times of peak demand
3. Perverse incentives to create queues, for example queues can create the appearance of being highly utilised which is rewarded with extra resources for initiatives to reduce queues.

Understanding where peaks and troughs in capacity do not effectively meet peaks and troughs in demand can help identify bottlenecks and wasted capacity. Where activity does not keep pace with demand, backlogs develop. This in turn creates more problems within providers and elsewhere in the system. In response managers introduce triage systems and carve out slots for urgent patients. Two queues are created which reduces efficiency and capacity: even more staff time is taken up designing and implementing solutions to tackle backlogs. The only permanent solution is to identify what part of the process is causing backlogs in the first place and address it

Explore the whole patient journey

In seeking to understand the problem of DToC it is important to look at the whole patient journey. For example, after extensive and detailed improvement work in ultrasound, the service improvement lead in an acute NHS trust realised that 'Without improving transport we can go no further to improve ultrasound services'. As a result, the hospital decided to review porter services[21].

The patient should be at the centre of system diagnosis and design. In order to understand their experience, map patient flows over time. How many steps are there in the patient pathway, how long does it take to move between steps? Are there any unnecessary steps? Make the best possible use of the data to gain insight and make decision-making visible and accountable at every stage of the pathway. Ask as many questions as possible about the process with the team. Which patients have the

longest stays in hospital and why? Who discharges our patients? Who stops discharges? Why? How do we know this? Are we just guessing? The more these questions are posed, the more detailed the diagnosis of the problem.

A thorough analysis will of course include a wider look at the local population. Successful organisations are focused on understanding population health, and adopting and making better use of risk stratification tools in order to plan effectively the services to meet those needs.

Many providers could benefit from augmenting their management's capacity to undertake this kind of analytics and process engineering. Organisations can also source support from supply chain partners, local SMEs, and academic institutions.

Engage staff

It is important to involve staff at all stages in the journey of transforming services. As set out above, all staff need to have a shared commitment to change, and this can be achieved by setting out a clear story for them as to why change is necessary. Secondly, it is crucial to involve staff in the preparation stage, to collectively develop a diagnosis of the individual problems facing a trust and local health economy. Thirdly, setting out a structure will ensure that everyone involved is clear as to what is happening and how the changes will be introduced.

Listen to patients and service users

Just as important as communication with staff is listening to and communicating with patients and service users. Healthwatch England's research underpins how important the feedback of patients is in order to identify where care has gone well and when they have been let down. Poor communication with patients and their families is a leading cause of problems with transfers of care. For example, a patient whose family has not been consulted is sent home without the right support in place and ends up being readmitted in an emergency. We know that in a mental health setting the relationship and communication with family members and social support networks is a critical part of preparing for effective, sustainable discharge.

It is important to learn the lessons of what has gone wrong from the patients and their relatives themselves. Case notes, friends and family test scores and other forms of generic patient feedback can help, as can detailed discussions with patients who have experienced unnecessarily long lengths of stay in hospital. Investing time in conversations with patients and their families will help diagnose where problems can occur but will also assist professionals to determine their preferences and manage their expectations.

Create a series of measured actions

Once problems are clearly understood and everyone is on board with the challenge of designing solutions, the next step is to set out a series of measured actions to implement change. This means success can be measured, and any drawbacks that may arise along the way can be identified early. Standardised good practice should be adopted based on external and internal benchmarking and adopting best practice models.

Make the good things stick

Spending time at the beginning of the process planning what needs to be done and really understanding the problems you are addressing will help ensure any solutions implemented will be sustainable in the long term. Engaging staff with a compelling vision for change and involving them in every step of the journey will also help to embed new ways of working. Once changes have been introduced, however, it is important to keep an eye on the process and ensure that the drive to make a difference does not tail off. Staff need to feel that the new ways of working are here to stay and have become business as usual.

> *A change is operationalised once people forget what they did before, it is no longer seen as an add on.*[22]

WORKING IN PARTNERSHIP

Remember you are only one piece of the jigsaw

Many successful providers told us that the key has been to understand their performance data internally and with partners, reaching a shared understanding of the complete patient journey before, during and after hospital/inpatient stays and how each part impacts on flow and outcomes. A number have set up regular meetings of all the systems players in relation to avoiding inappropriate admission and ensuring timely transfers of care.

Working effectively across organisational boundaries is never easy. There is a clear risk that additional pressures such as rising demand and tightening budgets can damage such relationships just when it is even more important to enhance them.

Nevertheless, it is vital that organisations avoid the pitfalls of wrangling over budgets and working in silos. The Care Quality Commission[23] has cited as a key success factor: 'visible, positive, engaged leadership. Providers work with patients and other groups and agencies to understand the needs of their population'.

Often delays can occur because hospital staff discharging patients have limited awareness of what other services are potentially available in their local community to help them:

> *I don't know half of what's on there [menu of options for ongoing support], the girls on the ward don't stand a chance*
>
> **Ward Staff team leader**[24]

Often problems occur because of communication difficulties between different organisations and staff teams:

> *We're all talking different languages and patients are totally confused*
>
> **Matron**[25]

Such confusion can mean nurses are reluctant to discharge patients at all, or that patients are discharged without the right package of support. It can mean patients languish on wards while they wait for social care assessments to be completed.

Single or shared care records to ensure key information follows the patient through the system are a key element in improving partnership working and avoid unnecessary delays to the flow of patients. All health economies should be working towards this. In the meantime, some areas are developing their own solutions to improve communications. Eden House care home has developed a 'hospital passport' for its residents being admitted as inpatients, detailing personal preferences and information about current treatments. Weston General Hospital, part of Weston Area Health NHS Trust, collaborated with a local care home so that a patient with a learning disability was carefully supported when admitted to hospital for an operation. Arrangements were put in place so that the patient could arrive early and no distressing delays would occur.

East Kent Hospitals University NHS Foundation Trust took a systems approach to **address high readmission rates** within 30 days of discharge for frail and elderly care home residents. They have cut their rate by 30 per cent across the board and up to 50 per cent in some months. The team mapped clinical pathways and sought to understand external influences before identifying risks and testing solutions. Staff were encouraged to question assumptions about where problems might lie. Contrary to their expectations, the key issue was communication between acute medical and care home professionals at the point of discharge, as well as a lack of specialist support for patients in the community, often resulting in emergency readmission. So they worked closely with emergency and care home staff to develop a new tool, the 'anticipatory care plan', written in simple, non-medical language and specifically designed for use by care homes when patients are discharged back to their care. They also won funding from the CCG for a new community team of a matron and geriatrician, to case-manage patients in the care home and act as the first point of contact upon discharge[26].

Kings College Hospital NHS Foundation trust has developed a 'bundle' for staff to follow when **transferring patients between hospital and care home**. It covers a range of issues associated with discharge including the things patients will need, such as medication, continence

products and dressings. It also covers protocols on transporting and escorting patients. It collates the different reports from speech and language therapists, occupational therapists and physiotherapists and information from nurses on ongoing care of conditions like pressure ulcers. It includes information about mental capacity and do not attempt resuscitation (DNAR) notices as well as the patient's personal preferences. This demonstrates the complexity of getting all aspects of a patient's discharge right first time[27].

Partnership working is essentially about building trust. It is important to have clear governance structures in place, with decision-makers at the right level meeting face to face to identify solutions and redesign services together, and to invest in the processes to support it. Dynamic, real time, integrated monitoring of patient flow through the whole health and social care system is one of the cornerstones to effectively managing DToC[28].

When inpatient or hospital care is not the answer

Partnership working can also help prevent people ending up in hospital or inpatient care in the first place. It is estimated that around a third of admissions through A&E could be prevented[29]. Clearly protecting the front door of the hospital so that unnecessary attendances and admissions are avoided is a crucial element in maximising capacity.

The Health Service Journal has produced a training video discussing the fictional case of 'Mrs Andrews'[30]. It highlights an example of how a patient's experience can go horribly wrong and suggests ways the whole health and care system can be improved to address this. It highlights the need for primary care clinicians to proactively identify patients at high risk of hospital admission. These patients should then have an assessment of their needs, and GPs and other community services should work together to prevent an escalation of their condition. Protocols should be in place with ambulance trusts to find ways of avoiding A&E admission if it is not necessary.

NHS England has recommended that ambulance providers and commissioners work together to develop a mobile urgent treatment service capable of dealing with more people at scene and avoiding unnecessary journeys to hospital. This would, in effect and where appropriate, reduce the number of transfers for people using ambulance services and could help deliver a better experience and avoid unnecessary admissions[31].

Lincolnshire Community Health Services NHS Trust and East Midlands Ambulance Service NHS Trust have worked together **to establish processes for avoiding unnecessary admissions to A&E for callers to ambulance services**. When appropriate, paramedics speak on the phone with other practitioners before transporting the patient to hospital, in order to identify alternative solutions. In many cases admissions are avoided through arranging appointments or home visits[32]. For example, a 78 year old woman was attended by paramedics regarding concerns of a returning urinary infection. Instead of taking her into hospital, the team arranged for an out of hours GP to prescribe antibiotics over the phone. The patient was able to remain at home rather than be transported to hospital, with the attendant wait in A&E and possible admission.

Avoiding hospital admission is also possible in elective services which can increase capacity. For example, research by the British Heart Foundation has explored the **adaptation of a routine procedure for heart failure patients so that they can be treated in their own home**. 100 per cent of patients preferred this and in 79 per cent of cases hospital admission was avoided. 1,040 bed days and £162,740 were saved during the pilot. The treatment cost was around £783 per intervention compared to £3,796 in hospital[33].

Within the hospital setting, successful organisations have made senior clinical decision makers available at the front door to prevent unnecessary admissions and implemented processes to ensure that patients are admitted to the right ward first time. Salford Royal NHS Foundation Trust relocated its minor injury unit and worked alongside the CCG and council **to employ a 'deflector' to organise GP appointments, steering patients away from A&E when appropriate**[34]. Some areas are now considering social care and reablement services at the front door of the hospital to avoid unnecessary admissions.

The Nottinghamshire Emergency Pathway Taskforce **introduced an advice telephone line for GPs to contact hospital doctors**. This reduced GP emergency admissions by 23 per cent. They also placed primary care staff at the A&E front door to triage and divert patients where appropriate. The Royal Free London NHS Foundation Trust piloted the placement of a senior primary care clinician

to undertake triage in A&E. Patients who made their own way to A&E were seen by a GP within ten minutes of arrival at any time between 10am and 10pm seven days a week. 20 per cent were signposted to the emergency department, 30 per cent went home or to their own GP, and 50 per cent were referred to an on-site urgent care centre. The Nottingham pilot ensured that 54 per cent of all adult self-presenters were redirected away from the emergency department. The vast majority went home. This reduced average length of stay to 50 minutes and significantly improved Friends and Family Test scores[35].

As soon as they have arrived, start planning when they will leave

There is a growing move to conduct full assessments upon admission, so that patients get to the right services when they come into hospital, and a focus on discharge planning from the earliest stages to avoid delaysdown the line. While a patient's condition can remain unpredictable, having an evidence based estimated date of discharge will concentrate minds and enable staff to identify patients whose discharge has been unnecessarily delayed.

Early discharge planning has been shown to help reduce length of stay but research by NHS England has found variable evidence of effective discharge planning[36]:

"Many areas that the team had contact with still did not have single integrated discharge planning teams, sharing information and intelligence and proactively engaging in daily board rounds. Where there was evidence of estimated dates of discharge (EDD) set on the day of admission these were not always realistic and patients and families were not consistently advised about the date and the discharge process."

Avoid over medicalising

The Health Service Journal example of Mrs Andrews[37] demonstrates dramatically how older people can be unnecessarily medicalised when they are admitted into hospital.

So, **it is important to question automatic procedures**. Does the patient really need to be changed into a gown? Does their risk of falls mean they need to be in a bed with cot sides or would they be better off in a chair? Are they able to move about and what can be done to encourage them to keep active? Is it necessary for them to be on intravenous antibiotics (which care providers after discharge are often unable to continue)?

Some hospitals are exploring introducing chair-based clinics as a better model for these patients. Moving elderly patients between wards should be avoided wherever possible as it can have a dramatic impact on their health, leading to further risk of falls and increased frailty and confusion[38].

Housing partners can help

Working in partnership with housing associations can help to ease the pressure on acute services. In addition to the good quality affordable housing and green space which avoids ill health, housing associations also provide innovative and tailored solutions to help meet a whole range of particular needs.

They provide specialist housing and support for older people and those with health conditions, both mental and physical, which helps people live independently, reduces the likelihood of hospitalisation, and facilitates smoother discharge from hospital. Housing associations' work improves health outcomes and wellbeing for people with learning disabilities, people with mental health problems, homeless people, older people and many more.

They do this by providing:

- 'Integrated housing and care for older people'
- 'Community-based support services for older people' – such as falls prevention, reablement or primary care delivered nearer to home
- 'Supported housing for people with mental health problems or learning disabilities' – as well as aids and adaptations in people's existing homes
- 'Specialist support services for people with mental health problems, people at risk of homelessness and other vulnerable people' – including employment support or speeding up hospital discharge
- 'An innovative approach to delivering integrated priorities in devolved arrangements'

This work can help to reduce costs too, with supported housing estimated to deliver net savings of around £640m to the public purse overall. This includes a saving of £4,136 per person per year to health services and £10,988 to social care for people with learning disabilities[39].

As shown in the examples below, the impact of housing associations' work can be maximised where health partners are able to take a transformational approach to service delivery, or use NHS land in innovative ways.

Innovative solutions to hospital discharge

Housing and care provider Midland Heart has worked with **both acute and community trusts to develop reablement units**. Each of the units are refurbished wards, created to reflect a more homely and less clinical environment. Through a joint and trusted assessment team, older individuals deemed medically fit for discharge and who do not require an acute bed, are placed into the service. The reablement team then create a personalised support plan, to meet the social care needs of the customer whilst continuing their discharge journey home. Midland Heart's team of reablement workers deliver a programme of activities that focus on wellbeing, confidence building and independence, as well as ensuring that an ongoing care package is arranged or necessary adaptations are fitted to make the transition home smooth.

For example, Ward D47 at Sandwell and West Birmingham City Hospital provides a step-up and step down refurbished ward within the main City Hospital building. It has 20 flexible community care beds for customers aged 18 or over – with the vast majority aged 65 and over. Midland Heart's reablement workers focus on working to achieve the reablement goals outlined in care and support plans.

WHAT WE SAW

During the course of the project the commission saw many examples of great practice. Here we have selected a number of themed examples drawn from the submissions to the call for evidence, the literature review and the field visits undertaken by Paul Burstow.

Adopting a lean approach

Lean is a widely used improvement approach developed by Toyota to improve flow and eliminate waste, focusing on getting the right things in the right place, at the right time and in the right quantities, while minimising waste and being flexible and open to change. It is about what the customer (the service user in the NHS) values and regards any activity that is not valued as waste. If you remove the waste, the customer receives a more value added service[40].

Supported by the Health Foundation, Sheffield Teaching Hospitals NHS Foundation Trust examined flow through emergency care pathways to address delays and better match capacity with demand. The 'lean' approach provides a structured framework for examining processes and use of resources to identify inefficiencies or blockages, critical to understanding flow. The first ward to implement the scheme achieved a reduction of seven days in the average length of stay and reduced the number of falls. The trust achieved a 37 per cent increase in discharges on the day of or the day after admission (equal to two additional discharges per day); and a reduction in bed occupancy from a mean of 312 in January to a mean of 246 in September (a full year saving of £3.2m from ward closures and reduced staffing requirements)[41].

When examining patient flow through the hospital it is important to look at elective as well as emergency inpatient journeys. As one hospital told us:

> *If you only consider the emergency flow it is a bit like running Heathrow but only looking at one of the runways*[42].

There is a difference in the narrative and expectations between emergency and elective care. The latter starts with the presumption of return home and independence. There are lessons to be learned from the elective care enhanced recovery approach with empowered patients.

Monitor has examined best practice in this area and concluded:

> *The critical steps are: timeliness of first consultant review; the completeness of the case management plan, which should include an expected date of discharge and clinical criteria for discharge; then ensuring the tempo of the case management plan is delivered, highlighting potential bottlenecks or constraints and designing them out of the process. The ambition should be to remove all unnecessary waits along a patient journey*[43].

According to one manager we spoke to, part of the approach to timely discharge is not to 'let go' of the patient. Their service risk stratifies patients at risk of delayed transfers of care and escalates their priority if they are not seen within 72 hours[44]. Another contributor emphasised the need for all staff to focus on efficient discharge processes, ensuring patients were up, had breakfast and were dressed and ready to go. Likening the process of discharge to hotel checkout times, this contributor explained that there is a need for all teams to work proactively to ensure discharges happen smoothly[45].

At our visit to one hospital we heard how easy it is for a discharge to be stopped, with multiple staff members having the power to do this. This trust is now looking at nurse led discharge with agreed discharge criteria, and has introduced a rule that no one is permitted to stop a discharge without going back to the consultant who originally signed it off[46].

Beyond the hospital

Getting a grip of flow, managing transfers of care to ensure people end up in the most appropriate place is a shared endeavour. In Kent the county council's adult social services department has been working to redesign the way it manages demand for support. It has focused on achieving the most independent outcome possible for the person. The council has used detailed examination of case files to understand the real world flow of people through adult social services and has supported the redesign of the pathways to support self-management and greater choice and control.

This granular understanding of how people moved through the system has enabled Kent to unearth and challenge variation in decision-making, exposing both gaps in knowledge of the menu of support available and gaps in the menu.

One tool the council uses is SHREWD (Single Health Resilience Early Warning Database), a capacity planning tool, designed to be accessed and updated by partners within the local health system in Kent to share 'system critical' information. An evaluation of the system found it had made a significant contribution to sharing information across local partners resulting in shared understanding and action[47].

They undertook a detailed examination of the acute pathway at discharge to test the appropriateness of the destinations that people were going to. This found a large number of people ending up in the wrong place. By redesigning the pathway, improving the decision-making process and boosting the availability of alternative services Kent has cut the number of inappropriate placements. When implemented county-wide the changes would result in 200 fewer placements into long-term beds.

Eliminate Variation

Often it is not a lack of capacity that is the problem, but variation in the use of available capacity, and an inability to appropriately align peaks and troughs of capacity to peaks and troughs in demand.

According to NHS Improving Quality:

> *Improvement teams up and down the country have consistently shown that the main cause of queuing in the NHS is variation and the mismatch between demand and available capacity. This is contrary to the previously held belief that it was demand alone creating unmanageable queues. We therefore need to develop our understanding of variation, particularly variation in capacity, in order to prevent putting additional capacity at parts of the process that are not bottlenecks, e.g. medical assessment units*[48].

Examples of variation include staffing levels, availability of equipment, patients (acuity, motivation), and processes within the hospital (e.g. guidelines, protocols). It is not possible to eliminate all of this variation, but that which is related to systems and procedures within the hospital can be addressed. For example, where capacity is reduced out of hours but demand remains constant.

Staff at Epsom and St Helier University Hospitals NHS Trust noticed a significant variation in the rate of discharges from weekdays to weekends, creating a Monday backlog. They have now decided to pilot more normalised weekend working to see what impact it would have on flow. Called Super Saturday, the aim is to have senior social work input over the weekend. The goal is to eliminate variation in behaviours around discharge between weekdays and weekends[49].

Care Navigators

The *Right place, right time* commission has found that many successful organisations have put in place **care navigators to support patients through the system, thereby preventing delays**. TThe navigator acts as the point of contact for the patient and their family, sometimes supported by administrative assistants to avoid diverting too much clinical time away from the care of patients. NICE is expected to recommend this role in all hospitals as part of its forthcoming guideline for transitions between acute inpatient and community or social care settings for adults with social care needs[50].

Age UK Oxfordshire has placed two 'care navigators', supported by volunteers, on hospital wards at John Radcliffe Hospital, and at Witney and Abingdon Community Hospitals. The 'Care Navigators' help people and their families to understand the options available to them if they have care and support needs. They help them make choices about their future care and facilitate safe and effective discharge – be that to their own homes or to residential or nursing care – as soon as they are well enough[51].

It is vital that initiatives like care navigators or dedicated discharge teams are not 'bolted on'. To be sustainable they must be fully integrated into the work of a ward or department. As previously discussed all staff must be engaged in understanding the problem and identifying the solution. Otherwise a new initiative can simply be seen as taking away the shared responsibility for discharging patients at the right time.

Care navigators can also have a useful role to play in primary care settings, enabling more proactive care for vulnerable patients. Victoria Medical Centre has introduced a link worker for patients over 75 at risk of isolation or falls, aimed at improving personalised care and preventing hospital admission[52].

Medicines administration

The Royal Pharmaceutical Society has developed core principles to support the safe transfer of information about medicines across all care settings and reduce avoidable harm to patients[53]. A number of providers have successfully applied these principles to reduce the issues associated with medicines management.

Isle of Wight NHS Trust conducted a reablement project in which hospital pharmacists used the time when a patient was in hospital to help them understand their medicines, and supported them both in hospital and after they left, including addressing any concerns. Following discharge, community pharmacists were given the results of the patient's hospital assessments and visited them at home to reinforce previous advice, assess how they were doing and offer any further support they might need. My Medication Passport, designed by patients for patients, is a pocket-size booklet, also available as a smart phone app, which allows the user to record medications and other key medical information to ensure accurate transfer of information between care settings.

Involving pharmacy teams in tackling delayed transfers of care can produce significant results. **East Lancashire Hospitals NHS Trust piloted smoother discharge involving the pharmacy team at the heart of the project.** More than half of discharge letters were authorised by lunchtime (three times as many as the trust average). Seventy-five per cent of patients went home by 4pm (Again, three times as many as the trust average). All patients were discharged with accurate information about their ongoing medicines[54].

End of life care

When patients are nearing the end of life it is more important than ever that transfers of care go smoothly. It is often the case, however, that these transfers can be the most complicated to get right. According to Marie Curie Cancer Care around seven out of ten people in the UK want to die at home but currently over half die in hospital[55]. Findings by the National Audit Office suggest that 40 per cent of end of life care patients have no medical need to be in hospital[56]. The right care is, however, often not provided in their own homes or in care homes to deal with their needs.

St Giles Hospice has set up a service in partnership with Bromford[57], a social enterprise that provides housing support, called 'My Home Support'. So far nine out of ten patients using the service have been supported to die in the place of their choosing. The service teams build up a rapport with patients which can help them overcome a reluctance to engage with support:

"Mr C had been diagnosed with terminal lung cancer and lived alone in a two storey house[…] He had no care package and there was no District Nurse involvement and all hospice services were also declined… He was experiencing constant and increasing pain. The only toilet was upstairs and, as he became increasingly unsteady on his feet, he was at risk of falls. The pain and reduced mobility meant he was no longer able to visit the local pub and meet friends there, escalating his social isolation."

"'My Home Support' was accepted as it was seen as being outside of health and social care. Over time the support worker built up a rapport based on shared interests of birds and wildlife, and was able to also encourage discussion about his care wishes, pain relief and aids that might help. Eventually he agreed to let the District Nurse visit to better manage his pain. This improved his mobility significantly. He told her that he had met friends for a drink in the pub. His daughter said that she had noticed a big change in his physical and mental wellbeing. As it became easier to have conversations he agreed to an occupational health assessment, which led to a bath seat and a commode for downstairs. When Mr C deteriorated, Hospice at Home was put in place and he died at home as he wished."

Ongoing support

As is clear from the data available, many delays in transfers of care are caused by a lack of availability of ongoing support, or delays in the assessment process to establish support packages.

A number of health economies are now implementing 'Discharge to Assess' models, where a patient is discharged to their own home while ongoing support is arranged. We heard from several organisations which have experienced a positive impact on their services and succeeded in cutting the number of delays, or reducing the rate of growth where delays had been increasing steeply. For example, the Aintree at Home model has saved 327 bed days over six months – eight bed days on average per patient.

NHS England[58] recently published new guidance on urgent and emergency care which recommends that discharge to assess should become the default pathway. **University Hospital Southampton NHS Foundation Trust runs a therapy-led discharge to assess programme. Patients are assessed by a therapist in their usual place of residence and are then given an appropriate package of care.** Over a period of three weeks, 12 patients were discharged, saving an estimated 27 acute bed days. There has also been a reduction in the level of care required at home by patients assessed in this way[59].

Norfolk and Norwich University Hospitals NHS Foundation Trust introduced a proactive reablement service near to the acut site. It was run by a multi-disciplinary team and achieved very positive results with 90 per cent of patients returning home afterwards:

> *Mum was happy and we could really see she was progressing. I didn't notice there were different teams. It was exactly how it should be…We needed more than 4 days to get the bed downstairs. We all work. We talked to the people at [the unit] and agreed a day that gave mum time and gave us time to get organised*[60].

The future? Integrated, preventative, proactive care

A growing number of organisations are developing projects in partnership with social care, housing or the voluntary sector, often paid for through block contracts for a set level of provision, for example to deliver temporary care packages in the community as an interim solution where a person is ready to be discharged but a care package is not yet in place. This kind of approach can enable individuals to move to a more appropriate setting to receive ongoing care, when they may otherwise have had to remain in hospital. Many healthcare providers have also begun offering links into other relevant services such as housing and employment advice, to better support people upon discharge and avoid readmissions.

Hospital discharge should be seen as an opportunity to ensure that patients have the right package of preventative, proactive care to enable them to remain independent in future and prevent any further hospital admission. Too often this opportunity is missed. Approaches such as the **older persons advisory and liaison service at Epsom and St Helier University Hospitals NHS Trust**[61] can help to mitigate this risk.

OPAL – older persons advisory liaison service.
"The OPAL team picks people up from A&E, identifying those patients who need comprehensive geriatric assessments. The service has been in place at Epsom Hospital for four years. It reduces the numbers of people admitted to hospital and subject to a 'medical model' process."

"The OPAL model is also being used to identify patients at risk of admission and to have conversations about preferences around health treatment ahead of time. The Trust has employed a GP to engage with patients and their families."

"The team provides rapid assessment to discharge. An Occupational Therapist and care assessor go home with the patient, ensuring the assessment is done in context. They do a lot of work unpicking discharges to learn lessons. They found, for example, that some people were being bounced back into hospital by care workers. The care workers had not been involved in the change and when they went to a person's home and found them 'unwell' they triggered a readmission. This service enables the health economy to see the whole person story rather than fragmented investigations into individual presenting medical issues."

Forward thinking health economies are using technology to support more integrated working. For **example, Airedale NHS Foundation Trust has video links with ten nursing homes**, providing 24 hour support to the home staff and directly to residents in order to prevent emergency admissions.

In some places community and acute NHS services are already developing domiciliary care offerings of their own. With a strong focus on reablement, these services can be the difference between someone going home and regaining their independence or increasing in dependency and relying on formal care services.

Some areas are working in close partnership with housing providers to ensure reablement services focus on the whole person and their home circumstances rather than simply looking at their condition in isolation. Service like **Manchester Care & Repair** help transfer patients home. They arrange support like doing emergency shopping and making a patient's home safer, warmer and more habitable. This service has achieved a significant reduction in emergency readmissions.

Aster Living Somerset visits patients in hospital and at home to help plan their discharge. They move beds and other furniture; assemble new flat pack furniture, and repair trip hazards. They also check that benefits have not been stopped and that new benefits are applied for where relevant, check there is food in the house and that the gas and electricity are working. They refer patients on to long-term help.

Similarly, **Swale Staying Put** makes basic changes to people's homes to make them more suitable for their ongoing needs and to prevent falls, for example attaching grab rails and fixing loose carpet. **Croydon Staying Put** also provides similar support, including blitz cleans and the purchase of essential home equipment, such as a fridge, beds and bed linen or a microwave for meals on wheels[62].

Often the most effective services are not the most expensive, but are proactive in supporting people to remain independent and healthy for longer. **Southwark and Lambeth Older People's Information Directory** provides easily accessible information online about clinical, social and voluntary sector support available in the local community. Over 1,400 services are listed, including exercise classes, housing advice and social clubs. Hosted on the Age UK Lambeth website, it supports local statutory services to introduce social prescribing and signposting[63].

CONCLUSION

Delayed transfers of care can and must be reduced to ensure that NHS providers of all types can remain sustainable and continue to deliver high quality patient care. The *Right place, right time* commission has found that there is no single, simple solution to reducing delayed transfers of care. The key to success lies in focusing on what can be done in the hospital or inpatient setting and in partnership with other providers and those offering support across the health economy.

In this vein we have sought to highlight not only what providers and their partners can do, but also to identify where actions by national players need to change. Often it is their frameworks, systems and processes that can, unintentionally, undermine local progress.

It is important to keep patients, service users and carers at the heart of solving the problem and to work with staff across all levels, taking everyone with you on the improvement journey. Trusts should consider adopting process engineering and data analytics as valuable tools to help surface the root causes of problems with transfers of care and there needs to be a shared understanding across institutional boundaries of what the data is showing. Simply adding initiatives to already complex pathways is likely to exacerbate problems of flow.

In contrast, by making the process leaner, understanding it end to end, designing change in partnership with the frontline, and making sure the patient's perspective is held at the centre of everyone's practice we can reduce length of stay, speed up the process of discharge, ensure adequate ongoing support and most important, improve patient care and health outcomes.

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Nottinghamshire Healthcare NHS Foundation Trust

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One Housing Group

Oxford Health NHS Foundation Trust

Oxleas NHS Foundation Trust

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Royal Marsden NHS Foundation Trust

Sheffield Teaching Hospitals NHS Foundation Trust

South Warwickshire NHS Foundation Trust

Southern Health NHS Foundation Trust

St Giles Care Agency

St Giles Hospice

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The Christie NHS Foundation Trust

University College London NHS Foundation Trust

University Hospital Southampton NHS Foundation Trust

Footnotes

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