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NHS providers

RIGHT PLACE, RIGHT TIME
COMMISSION INTO TRANSFERS OF CARE

EVIDENCE REVIEW

December 2015

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INTRODUCTION

Getting transfers of care right is critical for patients' experience of care, and their health outcomes. The effective management of transfers of care (ToC) between services has been a longstanding challenge for the NHS and care system. Too many patients and service users still spend too long in the wrong care setting for their needs. It is clearly a whole system issue which must be addressed through partnerships of NHS providers, with commissioners, social care services, the voluntary sector and other interdependent services such as housing, and providers recognise this. That is why a wealth of activity is underway at local levels to target the problem and develop collaborative ways of working which put the patient first, and cross organisational boundaries. The *Right place, right time* commission will analyse and explore the issues involved in improving transfers of care with a specific focus on sharing 'what works' widely across the sector.

The available evidence suggests that improving ToC within and between health, social care and other services offers the opportunity to make efficiencies in different parts of the system, and crucially, to improve the experience of people who use services as well as their long term health outcomes. Although experience tells us this will not be a simple undertaking, and will need time and investment in local relationships to implement, it is a shared goal worth maintaining. The need for all players in the system to continue working together to address the inherent difficulties in ensuring smooth transfers of care across the complexity of the NHS and care system is clear. In the long term, a large-scale, systematic and coordinated approach will be required in order to achieve this goal.

THE CONTEXT

In 2015, demand for health and care services continues to rise; we have an ageing population and the number of people with long term conditions is increasing. In parallel, financial constraints are becoming ever tighter across the sector, with unprecedented cuts falling on local authority budgets and impacting social care provision. In this context, NHS providers must work harder than ever to find solutions to the challenges posed by ToC within and between services, to ensure that ultimately, the people who use their services receive the best care possible, in the right place and at the right time.

The problem

At the end of June 2015, 4,999 people were delayed in hospitals in England; 15 per cent more than at the same time last year.[1] In the last 12 months, delayed transfers of care (DToC) have increased more sharply in acute care than non-acute care (by 15 per cent compared with 12 per cent). Over this period, the NHS has lost over 1.5 million bed days due to DToC. What is more, official figures are believed routinely to underestimate the real number of people who remain in hospital when their needs could be met elsewhere.[2] Delayed discharges are a measure not just of hospital performance, but of how well the wider health and care system is working.

In 2012 the NHS Confederation estimated that DToC cost the NHS approximately £200m each year,[3] and it is among the top four issues of greatest concern for trust finance directors and clinical commissioners.[4] The quantitative evidence is strongest for transfers from acute hospitals, but the problem is equally well-recognised within ambulance, community and mental health settings and the interdependencies between these and other services such as social care and housing are well known.

We know that delayed discharges and ToC can have a significant negative impact on people's experiences of care and their health outcomes, as too can transfers which are premature or poorly handled, for example when the right information is not passed on, or the right support is not in place. Equally, when transitions between services are smooth across a person's whole pathway, their experience can be immeasurably improved.

Despite the consensus about the need to improve ToC for patients and service users, and a growing focus on pathways rather than organisational boundaries, colleagues from primary care, secondary care, social care, housing and other public services all report a need to free up leadership time and 'headspace' to invest in new ways of working. In an environment of growing demand and cost pressure, this remains a difficult but essential task if we are to deliver the 21st century services which the public want and deserve.

The causes

More often than not, queues of patients in hospitals are the result of a lack of capacity in community-based provision, or insufficient coordination between services. In the third national audit of intermediate care published in November 2014, the average waiting time from referral to assessment for home based intermediate care services was six days, with a third of people waiting in a hospital bed.[5] In a survey of nurses by the Royal Voluntary Service, almost 70 per cent said they frequently had to delay discharging patients because no support was in place for them once they left hospital.[6] The vast majority of respondents believe the three key factors behind delayed discharges are lack of social care support or home care; waiting for a final assessment before discharge; or for non-acute care to become available elsewhere in the NHS.[7] This chimes with recent data from NHS England, which shows that of the nearly 1.5 million delayed days in the last year, the majority were due to waits for public funding, residential or nursing home places or for other care arrangements to be in place, such as assessments or equipment or care packages in the home.[8] Interestingly though, survey respondents appear to over-estimate the impact of insufficient availability of social care. A recent report by Monitor on A&E delays echoed this, concluding that the problem lay primarily in other parts of the health and social care system.

An audit of 324 admissions to a hospital, carried out by the Oak Group[A] in January 2015, found that in 36 per cent of cases where a patient could have been treated by an alternative service, this care was available but was not taken up because an assessment had not been carried out or it was not considered.[9] This raises the question of whether practitioners are giving full consideration to all the available options in 100 per cent of cases, before admitting a patient to hospital or delaying a ToC if that is the only alternative.

The way services are paid for also contributes to the problem, since patients on a care pathway often have to cross over between services which are paid for in different ways. This makes aligning ways of working to improve ToC more challenging. For example, within the urgent and emergency care (UEC) pathway, acute and specialist facilities are predominately funded through the national tariff whereas UEC services offered by mental health and community trusts, such as rapid response, crisis teams and psychiatry liaison services, are paid for predominately through block contracts. For commissioners and providers attempting to improve ToC through a system-wide redesign of UEC services, this patchwork of payment approaches presents a barrier.[B] National payment mechanisms need to enable a coordinated, system wide approach to improving ToC.

The impact on patients and service users

The impact of delays in ToC on patient experience and outcomes is widely acknowledged to be significant. A recent special inquiry by Healthwatch England reflects this consensus. It found that 46 per cent of people in England did not think they were fully involved in decisions about their discharge from hospital. Frequently, GPs did not receive discharge summaries in a timely manner or did not always act upon them.

A The Oak Group supplies medical intelligence to increase efficiency in providing healthcare by ensuring that patients receive the right care in the most appropriate care setting, and is the leading provider of solutions for 'Care Setting Management' in both medical/surgical and mental health.

B For further information on alternative payment approaches, see Phillippa Hentsch's blog on the NHS Providers website: A new way of paying for urgent and emergency care services. https://www.nhsproviders.org/news-blogs/blogs/a-new-way-of-paying-for-uec

Service users reported stressful experiences due to huge variation nationally in how assessments for NHS Continuing Care are undertaken. In many cases, a lack of support following discharge leads to readmission.[10]

Eighty per cent of all delayed discharges and ToC happen to people aged over 70. For this group, a delay of more than two days negates any additional benefit that could be gained from intermediate care, and a seven day wait is linked to a 10 per cent decline in muscle strength. This can have an irreversible effect on health. In the past decade, emergency readmissions for those aged 75 or over have increased by 88 per cent.[11] A survey of older people across the UK found that a quarter of those who had been readmitted within three months felt they had been discharged before they were ready, with only 6 in 10 saying they got all the support they needed afterwards.[12] This is of great concern given that older people at the end of their lives are more likely to die in hospital against their wishes if community- or home-based support is not available when they need it.[13]

One in five mental health patients does not receive follow up within seven days of a hospital discharge. The first one to two weeks are a time of elevated suicide risk for these patients, so the risks associated with not following up are substantial. Demand for mental health beds could also be leading to unnecessary detentions under the Mental Health Act. A survey of junior psychiatric doctors found that a quarter had been told that no bed would be available for their patient unless they were sectioned.[14] Similarly, limited capacity for housing authorities to meet the needs of vulnerable and homeless people leaving hospital can lead to a cycle of discharge and readmission as they are not able to fully recover.

The cost to the public purse

In June 2014, Age UK released an estimate that in four years, the NHS had lost almost two million bed days due to patients waiting for a social care assessment, care home place, care package or adaptations to their own home, at a cost to the system of up to £526 million.[15] Based on reference costs, they calculated that an NHS bed costs around £1,900 a week, compared to about £530 for a place in residential care; acute care being 3.5 times more expensive than residential care. The opportunity cost of keeping patients in hospital for longer than necessary is therefore clear.

Even after people are discharged, Healthwatch England has estimated that emergency readmissions cost the NHS more than £2 billion every year.[16] NHS providers are not reimbursed for avoidable readmissions within 30 days of discharge, so the consequences of people being discharged without adequate support in place to recover can be costly. A Channel 4 investigation using figures provided by hospital trusts and clinical commissioning groups (CCGs) found that over £390 million had been withheld between 2011 and 2014.[C]

It is estimated that at least a fifth of NHS costs are spent on end-of-life care.[17] A day of community care at the end of life costs about £145, compared with £425 for a specialist palliative care bed day in hospital.[18] The cost of a DToC at the end of an individual's life is therefore substantial to the system, as well as to that person's wellbeing.

Mental health perspective

Though existing research has largely focused on transfers from acute physical health settings, people with mental health problems regularly face delays and other issues when they move between services. People delayed in a mental health setting account for an estimated 1 in 20 bed days in the NHS.[19] Every year, 6,000 mental health patients remain in hospital longer than they need to, with each additional day costing the NHS more than £2 million a year.[20] In 2013/14, delayed transfers accounted for four per cent of all working age adult mental health bed days.[21]

The current fragmented approach to commissioning mental healthcare, where responsibility for different services is divided between NHS England, local authorities and CCGs, has contributed in no small measure to this. Split commissioning and block contracts have sometimes acted as significant barriers to pathway redesign. Designing models of care for a locality is made more difficult by bed data which is insufficiently detailed or broken down to understand the service demand within a population, meaning that the appropriate step down and ongoing support services are not always being

C For information see the Channel 4 Dispatches programme A&E's Missing Millions (2014) and accompanying press release http://www.channel4.com/info/press/news/1-billion-nhs-funds-withheld-dispatches

commissioned. NHS England's mental health taskforce reported that "People gave a strong message that within mental health settings, particularly within inpatient and secure care, all aspects of a person's life, including healthy relationships, education, employment etc. needed to be actively supported through collaborative care planning".[D] These needs are not always being met under the current arrangements.

Lord Crisp's interim report into acute adult psychiatric care reflected these concerns. It found that the inability of adult inpatient mental health services to meet demand is largely a problem of discharge and alternatives to admission. Ninety-two per cent of wards surveyed reported treating some patients who could have been cared for by other services had they been available. A lack of suitable housing was found to be a key driver.[22] The effect of funding pressures upon support services in the community has been particularly visible in the reduced accommodation provision by local authorities, whose budgets have seen deep cuts.

It is important to recognise in a mental health context that adequate length of stay can be as important as short length of stay, and support after discharge is crucial for people to remain independent. For example, the lack of availability of crisis home treatment teams is being reflected in increased rates of suicide among users of those services.[E] Equally, in cases where an admission is required, beds are frequently not available when they are needed. Too many people, including adolescents, are currently transported hundreds of miles across the country to the nearest available acute bed.[23] Detention rates are also increasing as doctors are told their patients will only get a bed if they have been sectioned.[24] Clearly, all of these issues can have a substantial impact on some of the most vulnerable people, and may lead to long-term consequences for their mental health.

The ambulance service

Recent guidance from NHS England highlighted the central role of ambulance services in delivering urgent and emergency care.[25] The challenge of transfers of care for ambulance providers is unique in the health and care system, in that they have to undertake transfers which are often unplanned and urgent in nature. Staff may have limited information about a patient's history, conditions and preferences and have to make critical decisions quickly, based on the information they have. Developing systems for sharing information about service users with ambulance teams is therefore essential.

Delays moving people into community, residential and home care services lead to backlogs in hospitals, which in turn has an effect outside the hospital doors. In January 2015, instances of ambulances queuing outside A&E departments were almost double that for the same period of the previous year. The Guardian reported that ambulances had to wait outside A&E departments for at least half an hour on 72,911 occasions during the last winter to date.[26] Monitor confirmed the challenge in the last quarter of 2014/15 for foundation trust ambulance services which experienced a monthly average of 13,000 handover delays (over 30 minutes).[27] A recent report by Monitor into A&E delays also found that an increase of seven per cent in the number of people coming to hospital by ambulance contributed to delays in A&E.[28] Such delays result in ambulance trusts breaching their targets, and put patients at risk while they await admission into hospital.

In this context and to help address these issues, 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.[29]

D The taskforce received more than 20,000 responses from its engagement with stakeholders and service users. The full report is available at http://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf

E University of Manchester, National confidential inquiry into suicide and homicide by people with mental illness, July 2014. http://www.bbmh.manchester.ac.uk/cmhs/centreforsuicideprevention/nci/reports/Annualreport2014.pdf

TACKLING THE ISSUE

In this section, we provide an overview of what individual organisations and local health partners have done to improve transfers of care and discharge processes, and how these solutions might be applied across the wider health and care sector. We have deliberately focused within this review on initiatives which have been evaluated. Additional case studies of interesting work that is underway but at an earlier stage will also be included in the body of the report.

Inefficient flow of patients and service users into, through and out of hospital is widely recognised as a key driver of DToC, both between services within the hospital and from the hospital into other provider organisations.[30] Several organisations have undertaken holistic reviews of their processes to identify where improvements can be made to support the timely transfer and discharge of patients who are ready to move on. In doing so, some have found it helpful to take a 'lean' approach, adapted from industry, to engage staff to identify waste and inefficiency within their systems and optimise their processes to eliminate this.[31] Some of these methods are outlined later in this document.

Many providers have taken steps to equip multidisciplinary teams, both in hospitals and the community, to take ownership of discharge processes and work more effectively together. In the majority of cases, this includes the appointment of a discharge coordinator or care navigator who 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 the creation of 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.[32]

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 delays down the line. In addition, providers seeking to address growing numbers of delayed discharges and DToC are increasingly piloting 'discharge to assess' or 'early supported discharge' models. 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. A number of these case studies are referenced later in this document. From the early evidence, these may prove helpful models for other providers to consider adopting as we move towards addressing delayed transfers in a coordinated way across the health and care system.

A growing number of organisations are also 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.

A more detailed, thematic analysis of approaches and solutions to improve transfers of care is provided below.

Reviewing patient flow and 'lean' approaches

Providers are increasingly working to streamline their processes and develop more effective pathways which utilise their resources as efficiently as possible and prevent 'blockages' in the system which result in delayed transfers and discharges for patients. This is known as 'patient flow'. A number of organisations have carried out comprehensive reviews of flow across all of their services and departments, some of them adopting a 'lean' approach, adapted from industry, to facilitate this.

Lean is an improvement approach developed by Toyota to improve flow and eliminate waste. Lean is about 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. Lean thinking focuses on what the customer (the patient or 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. In healthcare,

activities with value might be anything which helps patients and service users get better and/or manage their symptoms and comfort.[F 33]

In reviewing the existing literature and evidence put to the commission, it emerged that when implementing large-scale change across a whole organisation, having a bold vision and a focus on processes, rather than structures, was critical to success. Similarly important was staff ownership of the work and gaining a full understanding of internal systems and where process delays exist.

The examples of Sheffield Teaching Hospitals NHS Foundation Trust and South Warwickshire NHS Foundation Trust are well known within the health sector. Supported by the Health Foundation as part of the 'Flow Cost Quality' improvement programme, drawing on lean principles, the two organisations 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 participating trusts were encouraged to question the most fundamental aspects of how they delivered services, such as "why do we separate outpatient and emergency?" or "do departmental priorities pull the organisation in different directions?"

As a result of this process, Sheffield Teaching Hospitals saw improvements in the timeliness of assessment and treatment; 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). The raw mortality rate also decreased, suggesting a link between improved flow and patient safety. In south Warwickshire, the trust was able to maintain A&E performance and reduce average length of stay and bed occupancy during a challenging period of increased emergency admissions. Raw mortality and patient satisfaction also improved. Both trusts agreed that in addition to the technical insights into service design acquired through this process, organisational culture and the approach to change were crucial to embedding improvements across their services.[34]

Doncaster and Bassetlaw Hospitals NHS Foundation Trust also undertook a two year review and redesign of its processes to improve the safety of discharge between health and social care.[G] The discharge service, in place since 2012, has been nominated for a number of health and social care awards. Doncaster Royal Infirmary faced particular problems with extended length of stay and delayed discharges from hospital to social care, impacting on elective capacity and emergency admissions. A working group of representatives from the hospital, CCG, community provider and Doncaster Borough Council used process mapping and data analysis to gain a better understanding of the problems causing delays. This identified a need for proactive discharge planning, including better management of patient assessments and initial placement.

An integrated discharge team was established, with specific pathways for key patient groups, as well as a community team including community social workers. A rapid assessment team was also set up within the emergency department, operating seven days a week and providing short term equipment for discharge when required, as well as following up with patients at home. In addition, the trust put in place a joint assessment document, 'discharge passport' for patients and an electronic tracking tool to flag patients whose expected discharge date has passed. These changes have resulted in better use of existing resources, improved discharge outcomes and quality of post-discharge care, reduced delays (to one of the lowest rates in the country), a reduction in length of stay of 1.5 days, lower continuing health spend for the CCG and a 40 per cent reduction in the number of patients going directly into long term care.

East Kent Hospitals University NHS Foundation Trust took a systems approach to improvement to address high readmission rates within 30 days of discharge for frail and elderly care home residents. The team mapped clinical pathways and sought to understand external influences before identifying risks and testing potential solutions. Staff were encouraged to step back and question their assumptions about where problems might lie. They concluded that the key issue, contrary to their expectations, was one of communication between

F For further information on lean and its underpinning principles, see the Lean Enterprise Academy website http://www.leanuk.org/what-is-lean.aspx

G For more information, please contact David Purdue, Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

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. To address the communication difficulties, the team 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 a geriatrician, to case-manage patients in the care home and act as first point of contact upon discharge. These initiatives have led to a clear reduction in unnecessary readmissions within 30 days of around 30 per cent across the board, and up to 50 per cent in some months. It has also strengthened relationships between professionals and improved sharing of good and bad practice as an opportunity to learn.[35]

The lean approach to reviewing processes has also proven successful further afield. The 'Redesigning Care' programme at Flinders Medical Centre, Australia, used a similar method to those adopted by NHS organisations, with well-documented outcomes, including an overall saving of 15,000 bed days over five years, or 3,000 on average per year. The report in the *Medical Journal of Australia* helpfully breaks down the key factors to its success:

- mapping processes and identifying opportunities for redesign
- evaluating according to relevant measures
- stabilising high-volume flows
- identifying 'short' and 'long' patient care families
- 'pull' rather than 'push' bed management
- standardising and sustaining
- ward rounds and discharge summaries.[36]

Providers in Bolton, Leicester, Wirral and Worcestershire have used the same fundamental approach to redesign their services, producing robust evidence which, together with the examples outlined above, makes a strong case for organisations to carry out holistic reviews of their systems and processes from a lean perspective. Bolton NHS Foundation Trust was able to reduce the number of steps its staff needed to take to process a blood sample from 309 to 57 following a lean review, saving vast amounts of staff time and energy.[37] A value stream mapping exercise for a specific treatment undertaken by Wirral University Teaching Hospital NHS Foundation Trust found that while the time required to deliver the treatment was 610 minutes for the patient, and 330 minutes for the hospital, the process was actually taking 31 weeks, most of which was time spent waiting or on tasks not directly related to the treatment.[38] Through a similar programme, University Hospitals of Leicester NHS Trust has reduced avoidable delays and admissions, and improved the timely discharge of patients. In Worcestershire, partners in the health and care system have implemented a patient flow centre dedicated to collecting, reviewing and acting upon all whole-system data relating to bed and service capacity and demand to ensure optimal use of resources.[39]

It is clear from the work these organisations have undertaken in this area that there is potential for all providers to increase their efficiency and reduce blockages and delays through taking an overview of how things work across the organisation, service or department and identifying where improvements can be made or processes streamlined. Given current pressures, this could be a helpful approach to address the imperative to work together across the whole health and care system to improve discharges and DToC.

Targeting the problem

Across the country, individual organisations and local partners have undertaken a wide range of work to optimise transfers of care within and between their services and improve patients' experiences. There is some consistency in the types of approaches that different providers have adopted in their local areas, which can be grouped broadly into the following categories:

FRONT LOADING DISCHARGE PROCESSES THROUGH MULTIDISCIPLINARY WORKING

University Hospital Southampton NHS Foundation Trust (UHS) has developed a comprehensive discharge plan to commence in time for winter pressures. Key partners in the local area have signed a memorandum of understanding to establish a single discharge team, which will include senior discharge managers who case manage complex patients to ensure smooth transitions. Discharge pathways are being overhauled to front load the discharge process to the point of admission, supported by changes to discharge IT systems. Also in scope is 'CHC in 5 days' - a drive to undertake fewer

unnecessary continuing healthcare (CHC) checklists and to move from CHC checklist positive to full outcome within five days. The UHS CHC coordination team will seek 'CHC trusted assessor' status, allowing them to ratify CHC applications on behalf of the CCGs without the need to go to panel. Backed by a £100,000 investment, the trust expects this programmer of work will help to halt the trend of rising DToCs and help meet quality and financial targets.[40]

Sheffield Teaching Hospitals NHS Foundation Trust established a single transfer of care team, including community and hospital staff, which facilitates front door turnaround in the emergency department, medical assessment units and the frailty unit (which focuses on early senior review to avoid admissions when appropriate), utilising appropriate community pathways. Experienced transfer of care nurses work with each specialty area to facilitate the discharge of complex patients. As a result, the average length of stay decreased by 9.3 per cent between 2007/8 and 2012/13, ahead of the overall figure nationally.[41] Nottingham University Hospitals NHS Trust has implemented consultant geriatrician review for frail older people, to formulate rapid admission plans and facilitate discharge, saving 260 bed days over a month and helping direct resources to those most in need.[42] The *Health Service Journal's* commission on hospital care for frail older people cited early care planning decisions by senior clinicians as a key factor in achieving the right treatment followed by timely discharge.[43]

Doncaster and Bassetlaw Hospitals NHS Foundation Trust has introduced an integrated discharge team, working with the local council, CCG and other providers to ensure that patients with complex needs receive an initial assessment in hospital to establish the required next steps. In some cases, patients are able to go home or transfer to social care beds for further assessment outside hospital. This has minimised delays in transfers and substantially increased the number of people still at home 91 days after discharge. In Swindon, the not for profit social enterprise SEQOL[H] operates a similar discharge assessment referral team (DART) for complex cases, to front end discharge processes from the point of admission and stream patients to the right service. DART has helped reduce length of stay by an average of 2.5 days and cut referrals to local authority funded services by 50 per cent.[44]

King's College Hospital NHS Foundation Trust designed the 'community peace document' for use with nursing home residents with severe frailty and/or advanced dementia. The documents help prevent unnecessary admissions and better plan palliative care through the use of structured care plans, developed before the need arises to admit a person to hospital. Patients who received a peace document had a 50 per cent lower risk of admission compared to the previous year.[45]

Providers in Kent, Leeds and West Norfolk have adopted approaches to discharge planning at the point of admission, including through the establishment of integrated multidisciplinary teams, with a range of positive results including reduced length of stay and delayed discharges, lower costs due to excess bed days, less reliance on local authority services and most importantly, improved patient experiences and health outcomes.[46]

Recent guidance from NHS England provides further helpful approaches for planning transfers from hospital into the community.[47]

TRANSITION MODELS FOR REHABILITATION AND RE-ABLEMENT AT HOME

Sheffield Teaching Hospitals NHS Foundation Trust provides an active recovery service jointly with social care, which facilitates the timely discharge of complex patients from hospital through providing continued assessment, rehabilitation and recovery at home. The service receives referrals from GPs and community teams, with a two hour response time target and assessment in the patient's home.[48] In August 2014, 90 per cent of patients were assessed within 24 hours of discharge. Previously, patients waited up to two weeks. As part of the integration pioneers programme, providers in Leeds have established a joint recovery centre offering rehabilitative care to prevent hospital admission, facilitate earlier discharge and promote independence. In its first month of operation, the centre saw a 50 per cent reduction in length of stay at hospital.[49]

Yeovil District Hospital NHS Foundation Trust made the decision to begin caring for medically fit patients on a 30-bed nurse led ward, having identified a lack of places where elderly people could stay to continue their recovery once fit, resulting in a large number of medically fit patients on wards. The trust uses a defined protocol

H www.seqol.org

to determine who should be transferred to the ward, and the move has seen average length of stay cut from 14 to nine days, with 98 per cent of patients cared for on the ward reporting they were treated with respect and dignity. It has also freed space in community hospitals through providing an alternative setting for rehabilitation.[50]

On a smaller scale, St Catherine's Hospice in Scarborough is piloting four nurse-led end of life care beds so that patients at the end of their lives can be discharged from Scarborough Hospital as quickly as possible, in line with patient choice. The initiative has enabled more discharges into the community and made support more readily accessible, while delivering high quality care for patients and allowing people to die in their place of choice.[51]

In response to increased pressure on beds, Nottinghamshire Healthcare NHS Foundation Trust and its local partners set up the Transfer Action Group, in which the hospital and community providers from health and social care meet daily to discuss how best they can prepare patients with a length of stay of seven days or more, in particular those requiring ongoing support, for transition back into the community. The group aims to agree responsive, flexible solutions to meet individual needs and share available capacity within services. This has reduced length of stay for patients requiring supported discharge from 23.9 days to 16.8 days over a period of four months to January 2015. It has also improved the timeliness of assessments and expedited simple discharges where appropriate.[52]

LIAISON BETWEEN SERVICES

Effective working across different services and organisations is fundamental to improving transfers of care and reducing delays. Often, it is a lack of alignment or communication between services involved in a patient's care which is the main cause of delays. Several of the reviews of 'flow' outlined in the previous section included a focus on improving communication between health and social care providers. Increasingly, these organisations are also seeking to work with other public services including housing and homelessness services, benefits and welfare or employment advice, in order to improve their offer to patients.

Greenwich Coordinated Care (GCC) partnership has worked to align services in Greenwich, including care homes, A&E and GP surgeries to provide care and treatment at home when possible, or through short term residential care. GCC has extended rapid response and intermediate care services to selected residents with complex needs, introducing a care navigator role to coordinate individuals' care. Mental health, as well as the voluntary and community sectors and other key services, such as housing, are an integral part of the model.[53]

Kings Health Partners' Pathway project aims to improve care for homeless patients and reduce delayed or premature discharges. The team works with the patient to address their homelessness by liaising with local authorities and other agencies and providing skilled advocacy at Homeless Persons Units. They offer advice about homelessness, health and housing law, as well as practical support such as clothing and canteen tokens. The project has shown a 30 per cent reduction in annual bed days for homeless patient admissions. StreetMed, a nurse-led health outreach project, provides similar liaison and advice including benefits, employment and mental health and substance misuse services.[54]

St Giles Hospice, in the Staffordshire area, has worked with Bromford[l] to offer support with benefits and welfare, adaptation and navigation of services. My Home Support makes best use of the skills and expertise across both organisations to enhance the care provided by St Giles and help service users build independence and resilience. Bromford Support Workers conduct a holistic assessment using a framework commonly used in the housing sector. Outcomes include a range of wellbeing benefits and improved independence in the home, as well as avoidance of hospital admissions and reduced need for social care packages.[55]

The Royal Free London NHS Foundation Trust's My Discharge project focuses on dementia patients, aiming to assess for discharge within 24 hours of referral to ensure a safe transition out of hospital. As well as working with family members to prepare them for their relative's return home, the service liaises with social care and voluntary sector organisations to arrange care visits and ensure equipment is in place for discharge.[56]

l Bromford is a social enterprise which provides affordable housing and support services. http://www.bromford.co.uk/

DISCHARGE TO ASSESS AND ACCELERATED DISCHARGE MODELS

NHS England recently published new guidance on urgent and emergency care which recommends that discharge to assess, where post-acute care planning takes place in the community as soon as the acute episode is complete, should become the default pathway. Many areas have committed to developing their pathways based on this principal.[57] 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.[58]

Delays often occur when a patient has been confirmed ready for discharge but a social care package is not yet available for them. To address this, Heart of England NHS Foundation Trust funds St Giles Care Agency[J] to provide an accelerated discharge service. St Giles responds to deliver the care required to allow a patient to return home, on an interim basis until statutory services are able to take over (typically between 5.5 and 7 days). A package of care per patient costs on average £72 per day, compared with an estimated £300 on an acute ward. After 18 months, the service had saved in excess of 4,500 bed days.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust also operates a successful discharge to assess model, outlined above in the section on 'front loading discharge processes through multidisciplinary working'. The trust has increased the options available to people leaving hospital – for simple discharges, a social worker and nurse meet the patient at home to arrange follow up care, while more complex patients are assigned a discharge facilitator to case manage their long term needs.[59] In Sheffield and Leeds, the recovery models described previously facilitate earlier discharge from hospital.[60]

South Warwickshire NHS Foundation Trust employs early discharge coordinators to help frail older patients navigate through the system towards re-ablement at home, rather than in a bedded facility. Taking advantage of ambulatory care in A&E and short stay wards has enabled earlier discharge from wards, leading to reductions in length of stay and bed days lost due to DToC.[61]

Approaches in mental health

Though much less well documented, patients in mental health settings also experience delayed transfers of care, and providers recognise the impact this can have in such a setting. Due to the relatively small number of inpatient beds, and with services in the community dependent on a mixture of funding sources, these patients are particularly susceptible to being discharged without adequate ongoing support in place. Furthermore, research has shown that more than a quarter of patients in general hospitals have a mental health issue as well as physical illness.[62] However, mental health problems are not always recognised or addressed in physical health settings, which can lead to patients being discharged without adequate support in place to recover. When the root causes of mental ill health are left unattended, problems often recur and may lead to repeat admissions which could have been prevented. Effective links with other services are critical in this respect.

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, seven 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. For referrals from A&E, the team aims to conduct an assessment within one hour. For other referrals, the target is 24 hours. Once a diagnosis has been made, patients are either transferred to the out patient clinic in the hospital or support is arranged in the community.[63] In addition to reducing daily bed use, discharge of older people to institutional care has decreased by 50 per cent, leading to an estimated saving for local authorities of £3 million per year.[64]

Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) has built on the successful RAID model

J A wholly owned subsidiary of St Giles Hospice registered charity.

to provide an additional alternative setting where more prolonged assessments can take place when immediate discharge is not possible. The psychiatric decision unit (PDU) 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 through RAID. Mental health nurses and psychiatrists can take time to help individuals manage crisis in a positive, proactive way and to identify the most appropriate care pathways. The unit currently sees about 80 users per month. Evaluation is ongoing, and has shown a reduced need for mental health beds and positive feedback from service users.[65] Following this success, other acute trusts in the area are now setting up their own PDUs.

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. The navigator ensures they attend primary care appointments to monitor their health and discuss their treatment and supports them to reduce their dependency on services. The close relationship enables the navigator to identify early signs of mental health crisis. If this occurs, they can arrange an urgent out patient appointment, re-referral, or a recovery plan. 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.[66]

Appropriate housing is fundamental to a successful discharge for mental health service users with specific accommodation needs, and is frequently a driver of delays. 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 need and prevent delayed discharges due to housing issues. A key aim of the gateway was to ensure that service users are actively engaged in the decision and have genuine choice. A coordinator with knowledge of both mental health needs and housing provision works with the trust, Leeds City Council housing services and accommodation providers to find people the best placement for them. The trust has seen a marked reduction in delayed discharges due to accommodation issues and out of area placements. The expertise of gateway coordinators has released clinical time to plan and provide care, and service users have reported a positive and more seamless experience when moving between providers.

NHS England's recent guidance on urgent and emergency care provides further helpful recommendations to improve transfers of care for mental health service users.[67]

Approaches in ambulance services

Ambulance services provide planned transfers between settings and emergency transfer to hospital, among other services. They face unique challenges in that they often find themselves responding with very limited information about the person's condition, history, and preferences, and often have to make difficult decisions quickly. Ambulance services have developed positive ways of addressing these challenges.

North West Ambulance Service NHS Trust and other key partners use a web-based electronic referral and information sharing system (ERISS) to improve awareness of and access to care planning documents. A warning flag can be placed against a person's address to alert ambulance staff to the presence of an end of life care plan. The system uses a built-in tracking function to keep up to date.[68] Since its introduction in 2012, ERISS has reduced unnecessary hospital admissions and demand for specific clinical areas and has contributed to improved clinical decision making and information, including the quality of information.[69]

Coordinate my Care (CmC) allows people with chronic conditions to create a personalised care plan which is stored electronically and can be viewed by the range of professionals involved in their care. The system provides an up-to-date record, ensures key data is entered and allows professionals in acute and community settings to update the record as the person's needs and wishes change.[70] CmC works with London Ambulance Service NHS Trust, South East Coast Ambulance Service NHS Foundation Trust and NHS 111 to deliver a single solution for the whole of London.[71]

Yorkshire Ambulance Service NHS Foundation Trust (YAS) worked with district nurse managers to develop referral pathways for nine areas via a clinical hub, providing a single point of access to community nursing teams. When an ambulance crew is called to a person known to be on an end of life care pathway, they can connect to the relevant community nursing service to agree a care

plan. The initiative has enabled more people to avoid inappropriate admissions and remain at home. The leads have carried out case reviews to learn lessons about why the 999 service needed to become involved.[72]

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 practitioners before transporting the patient to hospital, in order to identify alternative solutions. In many cases admissions are avoided through arranging appointments, home visits or a GP prescribing medication over the phone.[73]

Recent guidance published by NHS England provides further helpful approaches to managing transfers of care to and from ambulance services, including a recommendation to maintain clinical hubs in ambulance control rooms, developing alternatives to conveyance to hospital, and real time access to patient care plans for ambulance teams. The guidance highlights the importance of active cooperation of local health communities to achieve improvements.[74]

Approaches to medicines management

Problems often arise when patients transfer between different providers and clinicians are not aware of changes to their medication elsewhere in the pathway, or when patients themselves are not fully aware of how and when to take their medication. This can lead to adverse effects which may result in readmissions that could have been avoided and negatively affect patient outcomes. The Royal Pharmaceutical Society (RPS) has developed core principles to support the safe transfer of information about medicines across all care settings and reduce avoidable harm to patients.[75] A number of providers have successfully applied these principles to reduce the issues associated with medicines management.

Isle of Wight NHS Trust conducted a re-ablement 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.

East Lancashire Hospitals NHS Trust was an early adopter of the RPS guidance. The trust uses its electronic patient tracking system to identify patients in need of medicines reconciliation on admission to hospital, linked to the patient's location. The system records whether a pharmacy technician has verified the patient's drug history and checked that the current prescription matches that on admission, and any changes have been dealt with. It also shows when a patient is overdue for medicines reconciliation. The trust also adapted its paper prescription chart to make is easier to identify at what point a patient began taking a particular medicine – before admission or in hospital – and whether the dose was changed. The new prescription chart also facilitates 'friendly' e-discharge letters which are easier to interpret. Several other organisations have since adopted the approach. A care homes hospital admission check list specifically supports the transfer of information with patients entering hospital from a care home.

A new approach to data collection

A number of studies have noted that the data that is currently collected for delayed discharges and ToC routinely underestimates the actual incidence of delays, and some experts have recommended a new approach to collecting this data nationally. Currently, two measures are used: a census of patients delayed taken on the last Thursday of each month (number of patients delayed), and a total of all days that patients were delayed in the month, including those not counted in the census (total days delayed).

It has been suggested that it would be useful to have a record of the number of delayed days for each patient across the whole month, which is likely already to be collected locally. This could be used for regional benchmarking and to identify best practice. Additionally, more information on the characteristics of those patients who experience delays, such as age and details of conditions, would help identify where there is unmet need.[76] For example, an audit of acute bed usage carried out by the Oak Group on behalf of a trust allowed them to identify what types of patient were occupying each type of bed, and where those patients could be more appropriately cared for elsewhere.[77] The NHS Benchmarking Network has also collected a wider range of data for mental health services, which has helped to enable benchmarking, tracking performance against targets and sharing of best practice within the sector.[78]

What works?

As health and care providers have sought to address the causes of delayed discharges and ToC, consensus has emerged around some of the changes that have been found to be successful in reducing delays in a range of contexts and circumstances around the country. These are the kind of approaches providers may wish to consider applying in their own local areas as we seek to reduce DToC nationally. Options which have been applied around the country and have achieved consistent positive impacts include:[K]

- Strategic planning and cross-organisational working:
  - predictive modelling and risk stratification
  - using population-based approaches to plan services
  - single or shared care records to ensure key information follows the patient through the system
  - benchmarking of bed-based capacity, occupancy case mix and patient flow and monitoring performance
  - strong collaboration and flexible ways of working between organisations involved in transfers
  - comprehensive case management of the most frequent service users and those with complex needs
  - use of tools to systematically determine and regularly re-assess the minimum levels of care required by individual patients, to ensure they are being treated at the most appropriate level at all times
  - reducing variation in how service models are described and evaluated around the country to facilitate benchmarking
  - systematic sharing of documents and templates to support discharge planning, to reduce duplication across the sector
  - systematically embedding successful changes across the local health economy.
- Point of admission:
  - making senior clinical decision makers available at the hospital front door
  - processes to ensure patients are admitted to the right ward first time
  - early specialist assessment has been associated with reduced length of stay[79]
  - increased use of standardised assessment tools to support early assessment.
- Discharge planning:
  - comprehensive joint assessments and joint care planning
  - daily structured decision making for discharge planning
  - minimising internal delays, such as waits for investigation or second opinions
  - appointment of care navigators and/or discharge coordinators in both in and out patient settings.
- Bed management:
  - maintaining a real time bed state accessible to all staff
  - named leads for patient flow
  - agreed full capacity protocols
  - managing patients in a short stay rather than a specialist unit where a shorter stay is anticipated
  - managing frail older people in a short stay unit for older people wherever possible
  - avoiding transfers of patients or handovers between consultants for non-clinical reasons.

K These examples are taken from across the range of publications listed in the bibliography to this evidence review.

- Community provision:
  - in-reach, discharge to assess and early supported discharge provided by rapid response community teams
  - availability of appropriate therapies, rehabilitation, re-ablement and intermediate care
  - increased provision of supported living environments e.g. assisted living, residential care. In some localities other facilities have been re-purposed to meet this need.

Government and national initiatives to address DToC

At the national level, government departments and statutory organisations have implemented a number of initiatives aimed at supporting health and social care organisations to improve ToC and reduce delays:

- the Department of Health is looking at transfers of care as part of wider policy work around integration and out of hospital care, and as part of work to support healthcare systems through winter[L]
- the NHS England mental health taskforce is focusing on transfers of care as part of its review of mental health services
- Monitor has published a report looking at the four hour emergency care standard - *A&E delays: why did patients wait longer last winter?*
- NHS England has published its *Transforming urgent and emergency care services in England* guidance which includes recommendations around transfers of care
- NHS England is currently reviewing and updating its guidance and definitions of DToC in acute and mental health settings, to better support providers in addressing them
- quick guides to get ready for winter
- NHS England and partners have published six quick guides to bring clarity on how best to work with the care sector to reduce delays[80]
- NICE will shortly be publishing guidelines on transition between inpatient settings and community or care home settings for both physical and mental health
- in January 2015 the Department for Communities and Local Government and the Department of Health released £37 million to support councils in preventing avoidable admissions to hospital and getting people home from hospital more quickly. The Department for Communities and Local Government also provided £12 million to help join up health and social care services to reduce delayed discharges[M]
- the Monitor integrated care licence condition supports the effective provision of healthcare across care settings
- DToC reductions is one of the metrics used in evaluating better care fund plans.

Useful ongoing research into transfers of care

In addition to NHS Providers' *Right place, right time* commission, other national organisations are also undertaking work to examine the causes of DToC and assess the various approaches which organisations have adopted to address them:

- The King's Fund is conducting a study to look at how DToC data is collected, identify any gaps and long-term trends, and understand the pressures on providers which are driving the current increase in delays[N]
- the National Audit Office is examining delayed transfers from acute to community and social care settings, with a focus on how providers monitor, measure and attempt to minimise delays, and what arm's length bodies are doing to facilitate this[O]

L For more information or to contribute to this work, please contact Charlotte Buckley at the Department of Health.

M For more information, see the government press release: https://www.gov.uk/government/news/new-funds-to-kickstart-joint-working-with-nhs-and-councils-this-winter

N For more information or to contribute to this work, please contact James Thompson at The King's Fund.

O For more information or to contribute to this work, please contact James Beveridge at the National Audit Office.

- Monitor currently has various work streams related to ToC, including a study led by the economics team of the financial impact of moving care into the community, work on improving DToC guidance, intelligence gathering to better understand the social and community care issues and ongoing work by the UEC improvement support team, including the Helping People Home team.[P] Monitor's (2015) report on moving care closer to home examined telehealth, enhanced step-up, rapid response, early supported discharge and reablement schemes. They concluded that well-designed schemes to move healthcare closer to home can deliver benefits in the long term, but it is difficult to reduce costs across a local health economy in the short run, and that these schemes needed to be better supported and incentivised through local and national costing and pricing systems
- the Queen's Nursing Institute is conducting a nurse-led review to identify best practice in hospital discharge arrangements for community staff, to be published later this year.

P For more information or to contribute to this work, please contact Amy Caldwell-Nichols at Monitor.

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For further information

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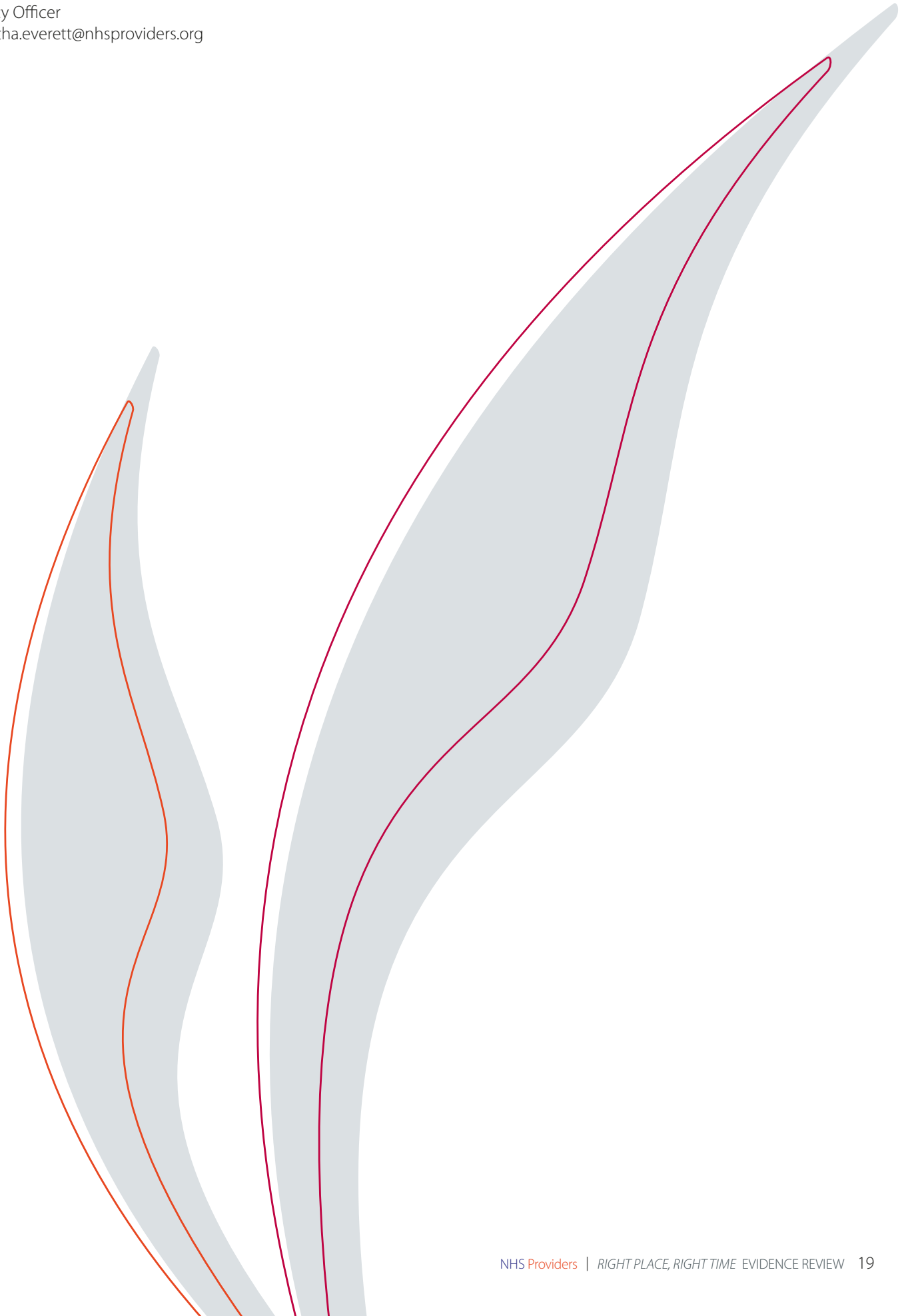

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high quality, patient focused, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has more than 90 per cent of all NHS foundation trusts and aspirant trusts in membership, collectively accounting for £65 billion of annual expenditure and employing more than 928,000 staff.

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