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HELPING THE NHS WITH... 1

Acting without delay –

How the independent sector is working with the NHS to reduce delayed discharge

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Introduction

Reducing delayed discharge – where often frail and elderly patients are unable to leave hospital due to necessary care, support or accommodation in the community being unavailable – is arguably one of the biggest priorities for the NHS.

Delayed discharges and transfers of care (DTOCs) have a significant impact on the ability of NHS acute trusts to provide routine treatment such as elective surgery. It is vital, both for the patient and the trust, to be able to discharge patients speedily to avoid adverse effects to patient flow.

While delayed transfers of care are not a new issue for the NHS, the problem has been worsening in recent years. There has been a 60 per cent increase in DTOCs from 2011 to 2015 and in the past year alone there was a rise of over 28 per cent. By October 2016, this meant more than 4,500 acute beds and 2,200 non-acute beds were occupied by these patients at any one time – equivalent to ten 650 bed hospitals. The National Audit Office (NAO) estimates the annual figure may be as high as 2.7 million lost bed days.

These delays have a significant impact on patients who are at increased risk of infection and pressure wounds. However, there is also an impact on patients attending A&E who are forced to wait significantly longer than the four-hour waiting target for a bed as a result – the number of which rose by 66 per cent in the last 12 months.

Equally, there is a severe financial impact associated with the inability to free up much needed NHS beds. The estimated annual direct cost of DTOCs is estimated to reach £169 million for 2016/17, £24 million more than 2015/16. In reality, the full costs associated with DTOCs are likely to be much higher, with the NAO assessing the cost of delays to the NHS as upwards of £820 million every year.

Clearly the scale of the problem is significant, however the causes of delayed discharges are complex. Much of the focus has been on the continuing cuts to local social care provision – and indeed there has been a 172 per cent increase in the number of days delayed due to patients waiting for a care package at home and a 110 per cent increase in patients waiting for a care package for a nursing home since 2010.

However,recent analysis by auditors at the Oak Group found that over half of all delayed discharges are related to issues with hospitals' own processes, almost 20 per cent around shared issues of planning, documentation and transport and other issues such as delays in having drugs ready for patients to take home, delays in diagnostic results or a lack of therapy services at weekends also being a key factor.

The complexity of this issue means there is no one-size-fits-all model to tackling the rise in DTOCs. Much can be learned from a number of innovative partnerships between the independent sector and the NHS and this report, the first in a series, will look at a range of partnerships which are helping some of the most vulnerable NHS patients to get the right care in the right place at the right time.

What does improvement look like?

Eradicating variation in standards of care is a major focus for the NHS so it is inevitable delayed discharges and transfers of care will be in the spotlight. The problems faced by NHS trusts are not universal and the King's Fund points out 50 per cent of delayed discharges are occurring in only 24 local authority areas. Figures from November 2016 show a wide variation between council areas in the number of days delayed for social care. Councils that have cut spending on social care over the past few years have fared no worse than councils that have maintained or increased spending.

NHS England has been working on practical ways NHS trusts can address delayed transfers of care into the care home sector and highlighting examples of success. This looks at specific areas where improvement should be focused. A culture of awareness is one of these areas and NHS England believes improvement is needed in how the care sector, NHS and social care work together. This means having an understanding of the role and responsibilities of care sector providers, the independent sector and factors that can lead to delays.

How the independent sector is helping to reduce delayed discharge

Since universal healthcare was established in the UK in 1948, the independent sector, as well as charities, social enterprises and staff-led mutuals, have supported the NHS in the delivery of free at the point of use services for NHS patients. For many years independent sector providers have provided capital, capacity and capability to the NHS to help meet the increasing demands it faces and currently the sector provides:

- over 22 per cent of all NHS gastroenterology, trauma and orthopaedic services;
- over half a million NHS elective surgical procedures annually;
- almost 10 per cent of all NHS MRI scans; and
- almost half of all NHS community services.

Publicly acknowledging the importance of NHS/private partnerships, the government recently set out in the 2015 Spending Review settlement a commitment to encouraging long-term partnerships between the NHS and the private sector – notably to modernise buildings, equipment and services, and deliver efficiencies, especially where these partnerships support the upgrade of diagnostics capabilities and the development of new models of care.

The independent sector has been working with the NHS to help reduce delayed discharge through providing access to community care, extra bed capacity, step down units, virtual wards and rehabilitation services for those who need it.

The following case studies demonstrate how strong partnerships between the NHS and the independent sector are successfully enabling patients to be treated in the most appropriate setting and for NHS hospitals to make the most efficient use of their capacity.

CASE STUDY 1

Virtual ward schemes to improve patient flow save the NHS half a million inpatient stays

Ensuring that patients can be treated in their own home where appropriate has significant benefits not only for patients and their families but also helps free up capacity within NHS trusts, allowing them to focus on developing patient services rather than constantly 'fire-fighting' due to a lack of beds.

How does it work?

Healthcare at Home works with 13 NHS trusts to provide a supported discharge service which aids patient flow throughout hospitals and allows patients to receive complex clinical care in their home via 'virtual wards', rather than as in-patients in a hospital.

Healthcare at Home's expertise lies in providing care for people with cancer, the frail elderly as well as re-ablement, pre- and post-operative surgery and inflammatory disease services. Appropriate NHS patients are identified and then the referring clinical team works with the homecare team and the patient to agree on a fully personalised care plan.

While in their own home the patient is closely monitored by a clinical team and a home care team through a 24/7 telephone based care bureau which has access to electronic patient records, with the patient remaining under the clinical responsibility of the hospital consultant or GP.

What does success looks like?

Lewisham and Greenwich NHS Trust has been working with Healthcare at Home for just over two years. Patients who need sub-acute care, for example an IV drip or a regime of antibiotics, can recover in their own home under the care of Healthcare at Home nurses. Consultants from the trust continue to oversee the care and are responsible for discharge, but the model of care helps to increase bed capacity and enables greater patient flow. Staff work alongside clinicians within the hospital to identify appropriate patients for the service.

Patient flow had initially been a challenge at the hospital with large numbers unable to leave the emergency department and in 2015, trust leaders agreed with commissioners that a different way of working was required to bring about improvement. Lee McPhail, director of service delivery for the trust says: "We took time to set up the service. Our relationship with Healthcare at Home has evolved over time; they know what we want and we can establish a more bespoke service when we need one. For it to be successful it was vital to engage the trust and support of the clinicians, some of whom had had a negative experience with different models of care in the past."

Over a nine-month trial period, there was a significant focus on learning from feedback from clinicians with junior doctors becoming powerful advocates of the new model of

care as they were able to see a reduction in their workload which enabled them to spend more time treating the patients who needed hospital care. The quick response of the service is also key to the success of the model, both to the patient and in financial terms. McPhail says: "Their responsiveness has really added value to the contract."

In working with NHS trusts, Heathcare at Home has created 379 virtual beds, the equivalent to a small district general hospital. Data from 2016 showed that all participating trusts saved £490 per inpatient spell and that the NHS could save half a million inpatient stays a year if the virtual ward scheme was introduced across all its organisations, saving at least £120 million.

Other successes include:

- University Hospital Southampton NHS FT which started using the service in 2010. It has saved more than 17,000 bed nights, which, by releasing capacity has enabled the trust to become a major trauma centre.
- King's College Hospital NHS FT became involved in April 2014 and since then has had a 97 per cent reduction in the need to send patients to other hospitals due to lack of capacity. The trust has seen a 100 per cent patient satisfaction rate and a 33 per cent reduction in paediatric emergency department four hour breaches.

CASE STUDY 2

Nursing homes can provide complex care needed to free up hospital beds

Four Seasons Health Care has 300 care homes across the UK. For the last two and a half years the organisation has been working with the NHS and local authorities to provide extra capacity for acute trusts, helping to reduce delayed discharges of care, as well as helping to prevent admissions in the first place.

How does it work?

Four Seasons Health Care works with 100 local authorities and 120 CCGs, as well as a number of Vanguards, operating a discharge-to-assess service along with rehabilitation and intermediate care. This service helps to prevent admission as well as providing 500 extra beds across England to help acute trusts discharge older patients who still need extra care but not necessarily in a trust setting.

Commissioning operations director, Paul Hayes, says: "There can be a lack of understanding about the level of complexity and acuity of the kind of people who we

are now caring for in care homes. I have been working in senior care for about a decade and the acuity of people coming to us now is very high. They are very poorly, some are requiring end of life care, but there is often the perception that care homes don't have the ability to care for these types of patient, but we can and we do."

Initially the service worked on a more piecemeal basis, depending on local demand. However, the organisation is now starting to provide dedicated units to meet the needs of trusts. Hayes says: "By having dedicated units we have the right staff in place all the time to provide capacity when it is needed."

The focus on the unit is very much on working the patient towards discharge. Hayes says: "Sometimes there are concerns from social care that nursing homes just want to keep patients so that their beds can be filled. But, in the nicest possible way, all the work we do, from the minute the patient comes to us, is work to make sure that they can leave us again, whether it's to their own home or another care home."

Hayes says: "The care we provide is a good step-down between hospital and home. It's not just the practical side but also the emotional and confidence side. Quite often the person will have had an event that's quite traumatic and the thought of going home alone is a huge thing. That extra time and attention in an intermediary setting really does help."

CASE STUDY 3

Spare capacity in independent hospitals can improve patient flow in struggling NHS trusts

BMI Healthcare is the UK's largest independent hospital provider with a network of more than 59 hospitals across England, Wales and Scotland, providing both medical and surgical services and one of its hospitals in Windsor is now able to act as a 'back-up service' for its local NHS trust providing extra capacity when needed.

How does it work?

BMI Healthcare has ring-fenced four beds at BMI The Princess Margaret Hospital in Windsor for use by Wexham Park NHS Hospital in Slough. By helping just three patients it has already saved the NHS 49 bed days so far this year. What began as an emergency arrangement is now being developed into a more permanent option allowing the NHS trust to discharge a greater number of patients who are medically well, but cannot return home until their community care package is in place.

The service works by having an agreement drawn up with the trust to ensure that a community package for the patient has already been arranged, enabling a time limit to be agreed on the length of the patient stay – usually about two to three weeks. Having an agreed time limit such as this, rather than an open-ended arrangement, allows BMI

Healthcare to plan for the patient's care and put appropriate staffing in place. Staff will then provide care and safety and anything extra that has been agreed as part of the pathway, until they can return to their own home, being able to take advantage of BMI Healthcare's 24-hour consultant care and doctors on an on-call rota.

What does success looks like?

The partnership has so far saved the NHS seven weeks' worth of bed days – just by caring for three patients. The three patients (two in their early 90s and one in their late 90s) had already spent about two weeks in hospital before being transferred to the BMI The Princess Margaret Hospital for extra care.

To ensure the success of the project Jayne Cassidy, executive director of BMI The Princess Margaret Hospital, says it was vital to build up strong relationships between the two organisations. In particular, good communication was needed to agree the right criteria regarding the acuity of patients the hospital was able to accommodate, ensuring patient safety and an efficient discharge to the BMI Healthcare-run facility.

She says: "Once the patient has been triaged within the criteria that is laid down then the trust will know that they can send them to us straight away when they need to increase capacity." ●

CASE STUDY 4

Pooling resources and reducing organisational boundaries in intermediate care

In Luton, Virgin Care is leading a collaboration between its intermediate care for rehabilitation team, Luton and Dunstable NHS Trust, Luton Borough Council's social workers, the local GP provider and Moorland Gardens Nursing Home, to improve the referral pathways and admission criteria for patients who no longer needed acute care, but needed extra support until they are fully ready to return home.

How does it work?

Suitable patients are admitted to the nursing home following a stay in an acute setting and are given occupational therapy and physiotherapy by Virgin Care. The Moorland Gardens staff provide nursing care the patients require, GPs provide daily medical cover and social workers can put in place measures needed for when the patient returns home.

By working together, the organisations have set up an agreed criteria and pathways to ensure appropriate patients were being referred to the service by the acute trust. Previously, a lack of integrated working had resulted in a number of inappropriate

referrals because no-one in the acute or community sector was really sure what the service provided. Such referrals often resulted in more complex care being needed and therefore the length of stay would increase which in turn would impact on the ability of the acute trust to refer the patients who would benefit the most. The newly-designed pathway ensures everyone works together to identify who will benefit from the service.

Under a different collaboration, Virgin Care is also helping to prevent admission in the first place. A rapid response team was set up as part of the At Home First programme. The programme ensures NHS and social care organisations work together across Luton to provide integrated adult services, identifying high risk patients and offering wrap around care to prevent them needing to be admitted to hospital.

Virgin Care service manager Anne Adams helped to set up the rapid response team, working with Cambridge Community Services, GPs, Luton and Dunstable NHS Trust, Luton Borough Council and mental health services. She says: "If a patient suddenly experienced a change in their condition and needed nursing therapy or increased care, then the rapid response collaboration would step in to help."

For the programme to work properly it was vital that everyone worked together rather than just having interfacing organisations. Members from each organisation came together on a Kings Fund programme – Improving Leadership Collaboration.

Anne says: "It really helped us to thrash out the tiny details, like "who receives the first phone call" and at the end of it we got the pilot up and running. "The key difference is that the intermediate care service that Virgin Care can deliver works in an integrated way with social care and at the end of the pilot that integration had become embedded. "We would have daily multi-disciplinary meetings and you would hear nurses saying to social workers 'oh I didn't realise you could do that.'"

Anne believes success depends upon creating frameworks and models of working.

She says: "You can't just tell people to work together, you have to put the framework in place to help them do it." ●

CASE STUDY 5

An international perspective – Specialist rehabilitation to improve patient recovery

A significant proportion of patients who experience delayed discharge would benefit from rehabilitation in a less costly environment than an acute hospital. Circle has teamed up with European rehabilitation provider Vamed to offer a high-speed solution which could save upwards of £10m per NHS acute hospital each year. Not only does rehabilitation help reduce the length of stay needed, but there are also fewer complications and a reduced likelihood of readmission.

How it works

Offering a sustainable solution for patients with complex conditions who are not well enough to be sent home, this rehabilitation model creates a link between acute hospitals and community settings, such as nursing homes or care at home, and allows frail and elderly patients with multiple needs to access orthopaedic, neurology and cardiac rehab, served by a large, multi-disciplinary team of dedicated consultants, GPs, nurses and therapists.

Hip and knee patients are transferred to rehabilitation within 24 hours, with all other patients given a maximum waiting time of five-days. This improves bed flow, potentially freeing up 44,000 bed days and enabling NHS trusts to boost income through elective surgery or closing wards, as well as saving money on readmissions.

In each of the neurological centres currently found in Europe, four types of care are delivered by 10 doctors (three neurologists and seven GPs) and 50 therapists (physio, speech, psychologists, occupational therapists and massage). On average patients get about two hours of physical, social and psychological therapies per day, enabling them to get back to independent living or work.

Dr Hermann Moser, neurologist and medical Director at Vamed says: "We cooperate closely with acute hospitals so that a patient who has had a stroke, for example, can be discharged within 24 to 48 hours to reduce pressure in the acute hospital." He believes this model can work well in other healthcare systems. "From a neurological point of view this type of rehabilitation could be adopted in the NHS. It depends on patient acuity and as long as you have appropriately trained staff in the sub-acute setting, the patient can start intensive rehabilitation. The Vamed model has a range of different centres and can be flexed in terms of the staffing model to meet the acuity and timing required."

High-level modelling suggests around 70 rehabilitation facilities could be supported in the UK, creating savings of more than £700m a year for the NHS. In 2010, a report by the Royal College of Physicians (RCP) and the British Society of Rehabilitation Medicine (BSRM) found that while current initiatives on acute stroke care, critical illness rehabilitation and trauma care networks all highlight the need for early specialist rehabilitation intervention, the priority of acute provider units is often too focused on clearing beds at the expense of supporting a fully staffed acute rehabilitation service as part of the early continuum of care.

What does success looks like?

The Gmundnerberg Neurological Centre, in Austria, has 150 beds for patients who are mobile or can be mobilised, but need help with dressing or bathing. Many of its patients are aged between 46 and 85 years and have significant comorbidities; 80 per cent of patients have CVA, Parkinson's or MS. With medically-led, focused and high intensity care, 80 per cent of patients go home, 10 per cent into residential care and 10 per cent into a nursing home. Only two patients per month are readmitted to hospital.

Developing successful partnerships between the NHS and independent providers to reduce delayed discharge

With delayed discharge figures worsening every year, it is vital that every effort is made to tackle this issue and ensure patients can access the care they need in the most appropriate setting. While the causes of delayed transfers of care are complex and there will be no-one-size-fits-all model to tackle the issue, this report clearly demonstrates that NHS/independent sector partnerships can help reduce delayed discharge with a number of key principles for developing successful partnerships.

Understanding local capacity – With unprecedented levels of demand on the health service, it is vital that all available local resources are utilised to ensure NHS patients get the care they need. Key to achieving this is NHS trust leaders knowing the full capacity and capability available in their local area, both in the NHS as well as the independent sector. Engaging with all local providers should therefore be a key priority for Sustainability and Transformation Partnerships and is something the NHS Partners Network can offer footprint areas support with.

Building relationships – As Healthcare at Home's case study illustrates, the key to making their service in Greenwich work was the ability to have open and honest conversations with staff to ensure patients were getting the best possible care, modifying the service as needed. Engaging with clinicians and involving them in the service design, with a focus on constant improvement, is a must. Equally, putting the right frameworks in place so that organisations working together have clear lines of repsonsibilities is vital in ensuring patients get the best possible care.

Thinking big – A fear of working with the independent sector can often impede potential successful partnerships in the NHS. But developing truly collaborative service models can provide real benefits to patients as well as efficiencies across the sector. NHS trusts also shouldn't be afraid to look outside their local area – both domestically and internationally, independent sector providers have considerable experience in improving patient pathways and outcomes which could easily be adopted by the NHS. ●

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