Better Transfers of Care for Older People

The Role of Local Authorities in Improving Transfers of Care

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Preventing hospital admissions

• **Joint working between health & social care commissioners**
  – Understanding local need & planning effectively;
  – Joint commissioning of health and care services;
  – Joint monitoring of health & care services;
  – Understanding the data and reviewing effectiveness of interventions;

• **Enhanced out of hospital health & care services – integrated around the individual**
  – Joined up approaches to self care and management of long term conditions in the community;
  – Joined up approach to assessment & care planning – proactive support to assist people in managing conditions and care;
  – Increasing primary care MDT working and proactive interventions;
  – Integrated Rapid Response services in the community, clinical and social care support;
Current presenting issues

• Increasing number of people delayed in hospital due to health and social care;

• Main reasons for social care:
  – People waiting for assessment;
  – People waiting for packages of care in their own homes;
  – People waiting for placements;

• Increasing frailty of the provider market:
  – Sustainability of providers;
  – Inability to recruit sufficient workforce;

• Significant reduction in Local Authority Budgets since 2010 and set to continue:
  – Impact on the cost of care;

Essential that commissioners across health & care work together to maximise the use of system resources
Managing Transfers of Care

High Impact Changes

1. Early discharge planning
2. Systems to monitor patient flow
3. Multi-disciplinary / agency discharge teams
4. Discharge to Assess / Home first
5. 7 Day Services
6. Trusted Assessors
7. Focus on Choice
8. Enhanced care in care homes
High Impact Changes:

- **Change 1 : Early Discharge Planning.** In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.

- **Change 2 : Systems to Monitor Patient Flow.** Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

- **Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the community sector.** Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and outcomes.

- **Change 4 : Home First/Discharge to Access.** Providing short-term care and reablement in people’s homes or using ‘step-down’ beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital.
High Impact Changes:

• **Change 5 : Seven-Day Service.** Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people’s needs.

• **Change 6 : Trusted Assessors.** Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

• **Change 7 : Focus on Choice.** Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options.

• **Change 8 : Enhancing Health in Care Homes.** Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.
High Impact Changes

High Impact Change Model
Managing Transfers of Care

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Questions & Discussion

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