NHS Improvement

Flow in providers of community health services: good practice guidance

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collaboration trust respect innovation courage compassion

We support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable.

Contents

Introduction

Good patient flow across health and social care systems is crucial for the NHS to run an effective and sustainable service. If patient flow is poor hospitals become congested,[1] clinical outcomes are poorer,[2] financial performance deteriorates[3] and staff will be overstretched.[4]

Delayed transfers of care (DToC) clog system flow. Between August 2015 and August 2017, DToC rose by 24% in both non-acute settings and acute settings. As non-acute DToC currently make up about one-third of all delays, good flow to and from community providers is essential to achieving the target of reducing DToC beds to no more than 3.5% of occupied beds and delivering the extra beds we need ahead of winter. Providers of community health services need both to take action in their own organisations and to work with their local systems to improve flow along the entire patient pathway.

This guidance sets out good practice for providers of community health services, and our expectations of them over the next six months. We recognise that implementing these measures will not resolve all the problems around flow and that patient flow issues are broader than DToC, but are also clear that progress can be made in the short-term.

While we recognise that providers of physical and mental health services face distinct challenges, we have observed similar successful approaches across these sectors, and this good practice guidance is directed at all providers of community health services. This guidance also applies equally to inpatient services and those delivered in the community.

[1] Hoot NR, Aronsky D (2008) Systematic review of emergency department crowding: Causes, effects, and solutions. *Ann Emerg Med* 52(2): 126–136. www.annemergmed.com/article/S0196-0644(08)00606-9/fulltext
[2] Campbell CS (2011) Deconditioning: The consequence of bed rest. Institute on Aging. http://aging.ufl.edu/files/2011/01/deconditioning_campbell.pdf
[3] The Nuffield Trust (2016) *Understanding patient flow in hospitals*. www.nuffieldtrust.org.uk/files/2017-01/understanding-patient-flow-in-hospitals-web-final.pdf
[4] Fillingham D, Jones B, Pereira P (2016) The challenge and potential of whole system flow. The Health Foundation. www.health.org.uk/sites/health/files/ChallengeAndPotentialOfWholeSystemFlow.pdf

Expectations of providers of community health services over winter

In visits to providers of community health services across England we have observed several areas of good practice in managing flow, but also significant variation. To start to address this inconsistency in the short term, and the key barriers to good patient flow, we have identified nine measures. We divide these between:

- six essential measures we expect all providers of community health services to consistently implement (where not already in place) over the coming months
- three wider measures of good practice for consideration.

We recognise that in the medium term there are further issues to address that are the subject of other work programmes across national bodies. This guidance supports providers in initiating immediate steps to improve patient flow in their organisation. We are committed to tackling and support trusts to deal with the longer-term issues. We will maintain our focus on these as part of our work on performance improvement and flow across the system more generally, and on productivity and efficiency through our extensive retention support programme (more information available here) and the extension of the operational productivity programme to community services.[5].

Cross-system working

The barrier: Underdeveloped relationships between staff in acute, community, mental health, primary and social care organisations can lead to lack of organisational collaboration. This can result in limited understanding of what neighbouring services offer, hesitation in transferring patients across different

[5] NHS Improvement provider bulletin, 8 February 2017: https://improvement.nhs.uk/news-alerts/provider-bulletin-8-february/. The team focusing on community and mental health trusts can be reached at nhsi.sectordevelopment@nhs.net for any further information.

settings, inappropriate referrals and the evolution of very disparate models of care. Most patients are not interested in which local organisation delivers their care but instead care about its quality and timeliness. It is incumbent on us to provide a seamless service.

To address this barrier, providers of community health services should take steps to integrate their service offer with local partners. Changing mindsets is challenging but particularly important. To do this, providers should introduce processes that encourage strong working relationships and a feeling of joint responsibility over the entire patient pathway.

Over this winter (within six months), we expect providers of community health services to:

1. Facilitate system-wide data-sharing

IT system incompatibility between most health and social care services is a barrier to collaboration. Nevertheless we expect providers of community health services to:

- engage with acute, mental health and social care partners to agree the process of sharing relevant patient data while meeting information governance standards, to enable better, more rounded decisions about patient care
- work with partners to initiate the development of a joint dashboard that monitors flow through the entire system, allows bottlenecks to be identified and is in a format that shares progress, motivates clinical staff and drives measurable improvement
- in addition to sharing data locally, submit accurate daily flow data to the daily situation reports (SitReps) for providers of community services, with the first day's data collected on 7 November 2017. NHS Improvement has been working with providers of community services to make sure they are ready to start submitting this data, which will enable a better understanding of community services at a national level.

Case study: Epsom Health and Care (EHC)

Epsom Health and Care (EHC) is an alliance of Epsom and St Helier University Hospitals NHS Trust, GP Health Partners, CSH Surrey and Surrey County Council. These four organisations are collaborating to share data – administrative patient data and relevant medical history – with each partner organisation acting as a joint data controller and information governance jointly overseen through a steering committee. The arrangement informs personalised health and care plans and reduces the need for the patient to repeat 'their story'.

This system took five months to implement in conjunction with wider work to integrate services. It took two months for the four partner organisations to draft a data-sharing agreement, and their sign-off took a further two months. Creation of an integrated care record on the IT system then took a further month.

Signing off the agreement with partners was a significant challenge. The GP partner was a federation of 20 practices, with each practice being the data controller of its own information. This required commitment and leadership from the medical director of the GP federation, to sign off of the agreement in each GP practice. The commitment from each of the four partner's chief executives also helped to progress the agreement.

The alliance recognised that data-sharing is key to shaping integrated ways of working and set aside funds to allow this, covering costs of licences for EMIS (the IT system that shares the data), the resources to write the data-sharing agreement and laptops to allow clinicians remote access.

The alliance considers data-sharing has played a key role in its success, including in the development of its services in the community.

In addition to sharing appropriate data to manage flow, providers should submit data to the Community Services Data Set (CSDS). These submissions will increase local, regional and national understanding of community services for all patients, helping to drive future decision-making around community services. For more information about CSDS data submissions please visit *www.digital.nhs.uk/Community-Services-Data-Set*.

2. Actively engage in the operational management of discharge across all local organisations

To enable local systems to jointly assess the discharge pathway for each patient, we expect all providers of community health services to engage with the operational management of discharges across their local system (this case study focuses on the use of calls for this purpose although we acknowledge there are a range of ways to manage discharges across the system). This will involve:

- ensuring they are an active partner in discharge calls (or equivalent communications) hosted by the local acute provider
- where necessary, running their own daily joint calls (or equivalent communications) to manage the discharges of patients based in community care, with appropriate inclusion of the local acute provider and social care. Each patient who is medically fit for discharge or on a complex discharge list should be discussed in these calls.

Case study: Buckinghamshire Healthcare NHS Trust

The trust successfully runs a discharge conference call between the urgent care representative at the local clinical commissioning group (CCG), the team manager for hospital-based and community-based adult social care, the locality managers for the therapy and nursing community teams, ward managers for acute and community hospital teams, the triage nurse or duty desk for the provider of continuing healthcare (CHC) assessments and the team lead for the trust's single point of access referral service. Calls initially ran three times a week for 45 minutes, but this was adjusted to reflect the system's needs. The CCG representative was chosen to chair and co-ordinate the call as they were considered to be impartial and able to hold the system to account. The calls discuss all patients in Buckinghamshire Healthcare who are medically fit or on the trust's complex discharge list.

The trust and local system started running the calls after experiencing an increase in DToC and wider 'medically fit for discharge' patients, and rising patient length of stay. The calls sought to address the view that lack of system engagement was hindering patient flow.

The trust introduced the system over a week, using existing teleconferencing services. Each organisation committed to the A&E delivery board chair that they would devote a senior member of staff to support the calls and provide visibility at an appropriate level. Although the calls refocused resources, by improving efficiency they saved time for those participating.

The calls allow everyone to work together on supporting patients and ensuring a clear solution for each patient. Since the local system implemented the calls, and in conjunction with wider efforts at the trust, numbers of DToC have been low, length of stay has fallen for medically stable patients and working relations between organisations have improved.

Over this winter and beyond, we also expect providers of community health services to:

3. Develop a 'discharge hub' referral and co-ordination service as part of an integrated discharge team

Providers of community services, working with local partners, should start to develop a 'discharge hub' that:

- acts as a single point of access for patients moving to and from both acute and community services, including those being referred directly from NHS 111 and ambulance services
- has teams to facilitate admission avoidance, and support the early discharge of patients, where possible, for both physical and mental health
- is run by both administrative and clinical staff who are co-located, where possible, to ensure the best care co-ordination.

Case study: Royal Devon and Exeter NHS Foundation Trust

The trust successfully implemented ‘Community Connect’, a single point of access for triaging referrals and co-ordinating short-term care. The hub focuses on preventing avoidable admissions and enabling patients to return home after admission to hospital, so that they receive appropriate care and support. Referrals come from several clinical sources, including local GP community services, the acute hospital’s emergency department or acute medical unit and other hospital ward referrals. If further care is needed, the hub can refer the patient on for community intervention, social care assessment or to the acute hospital’s complex discharge team.

Following a phone call or online submission to the single point of access, the triage service, staffed by band 5 and 6 nurses and therapists, discusses the patient’s needs to determine the appropriate care pathway to prevent admission or support discharge. Co-ordinators then organise the right short term care offer as required by the patient. The service runs 365 days a year between 7.30am and 11.00pm.

The hub came about from services in the local system needing a number of different discharge pathways to come together under a single point of access. There was also an appetite for greater focus on ‘home first’ and admission avoidance. From start to finish, implementation took five months.

Since the service started, DToC have reduced and the trust has seen a financial benefit that has contributed to the successful delivery of its cost improvement programme.

Addressing challenges in resolving patient choice

The barrier: Several providers of community services find it challenging to discharge patients who wish to remain in their community hospital even after a medically appropriate care pathway has been identified. Problems often arise as a result of unreasonable patient expectations, the feeling among some patients that they are safer in hospital or ward staff finding it difficult to talk about discharge with some patients.

Over this winter (within six months), we expect providers of community health services to:

4. Effectively implement their patient choice policy

Providers of community services should implement a robust choice policy that is aligned with their local acute provider, with clear contribution from legal experts and endorsement from the executive teams of local partners. This will require providers to:

- support and train staff, including senior staff, to use and escalate this policy
- train staff to have effective discussions with patients about their ongoing needs, such as beginning conversations that highlight the benefits of moving a patient's care towards their place of residence.

For further details on how to manage patient choice see *Support patient choices to avoid long hospital stays*.

Case study: Worcestershire Health and Care NHS Trust

The trust uses its legal team to help manage its patient choice policy. This is a small in-house team, led by the company secretary who is an experienced solicitor.

Over a few weeks, the legal team developed and finalised standards templates and leaflets for staff to use on the wards. These templates help manage patient and family expectations and avoid misunderstandings.

The legal team becomes involved either when the trust has escalated a case, or at an early stage when ward staff sense that there may be a complex discharge issue. The company secretary is available to explore these issues at an early stage. If a case goes on for a long time, the legal team will support ward staff and matrons with meetings and correspondence. While staff do not attend regular operational meetings, junior legal staff will periodically attend meetings, such as matron's meetings, to share learning and discuss key issues.

The trust has found anecdotally that staff now feel more supported in cases that historically may have left them feeling vulnerable to complaints.

5. Ensure the services they deliver are well understood

To manage their visibility in the wider health and social care system, providers of community health services should:

- make sure that local partners, at senior managerial and clinical level, know exactly what services they offer for patients, including ensuring all this information is embedded in the local NHS 111 service menus and their own trust website. This will help local partners refer the right patients into community services and set appropriate expectations for patients who are to receive community healthcare
- hold regular discussions with their local acute and social care partners to maintain awareness of demand and capacity throughout the wider system, which may have an impact in the community setting.

Case study: Epsom Health and Care (EHC)

The Epsom Health and Care alliance provides clear updates on community capacity through its internal communication channels every day and every week, reaching each of its member organisations. Every morning the community service provider circulates throughout the alliance its current and expected future community hospital bed capacity, current and future issues for delivering care, and collective actions to address them. The internal channels used for this include:

- daily ‘discharge huddles’ in the acute hospital, attended by continuing healthcare, social care, mental health, community care colleagues and the alliance’s ‘@home’ service which delivers enhanced packages of care across acute and community settings to reduce the number of necessary attendances
- a weekly ‘whole system call’ hosted by commissioners to discuss capacity across the system
- daily community multidisciplinary team meetings at the ‘@home’ discharge hub.

Although community services provided in the Epsom area are reasonably well understood, disagreements between organisations can arise at times of high demand. The establishment of the alliance and the communication channels help to manage these effectively. The close working between operational managers across the alliance's four partner organisations has also improved ways of working and allows issues to be addressed as they arise.

Since the establishment of the alliance, stronger system-wide relationships have been observed with a reduction in the 'blame culture' between services and organisations and a more flexible approach to addressing challenges among care providers. Alongside the other initiatives run by the trust, these relationships helped Epsom and St Helier University Hospitals NHS Trust achieve the A&E four-hour target in 2016/17.

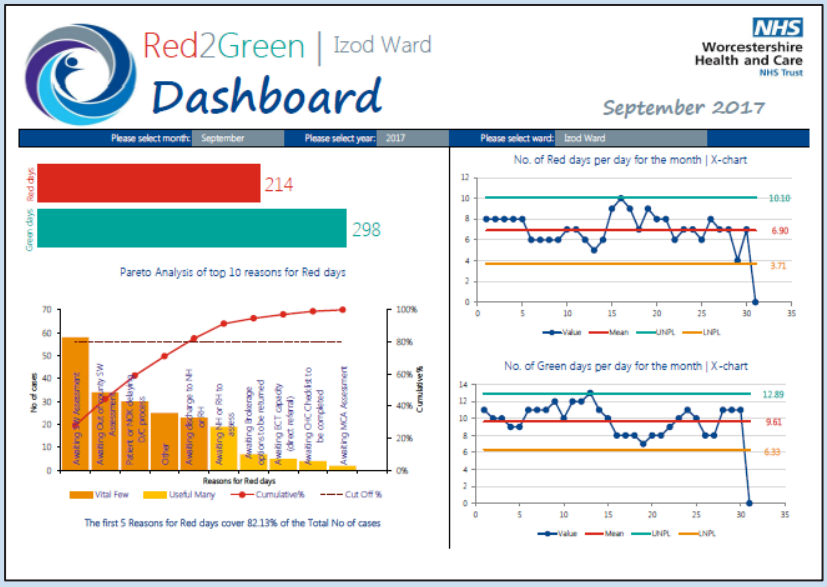
Boosting operational focus in providers of community health services

The barrier: There is significant variation between community providers in the attention given to operational processes. This can diminish a trust's understanding of patient flow, and how to manage associated problems (for example effective roll-out of initiatives). Developing this capacity requires investment and resource.

Over this winter (within six months), we expect providers of community health services to:

6. Collect and share data for Red2Green days, creating a feedback loop between senior operational staff and the clinical workforce

- All providers should implement the Red2Green (R2G) approach on bed stock in their wards, to identify whether each patient's bed day is red (not adding value) or green (adding value). Full details are on our website. Providers should implement this in conjunction with the SAFER bundle, with details also on our website.
- Providers should then use the data collected to create a dashboard that identifies the bottlenecks for flow in real time. Clinical staff and senior operational staff should then regularly discuss the data to drive performance improvement. An example dashboard is presented below:



To support trusts in implementing this, we have developed a digital tool that uses provider data to auto-populate a R2G dashboard.

Case study: Worcestershire Health and Care NHS Trust

The trust has successfully implemented the R2G approach with data-sharing and regular feedback to staff, across both physical and mental health services. It has achieved this by focusing on its operations and the data needed to understand flow.

Each ward makes its R2G assessments over the course of each day, and adds these details to a Microsoft Access database using a PC. The trust uses this data to prepare and review performance dashboards fortnightly at its capacity and flow steering group. It creates a feedback loop by sharing these dashboards back with each ward every week. For each ward, the dashboard includes the number of red and green days, trends for red and green days over the month, and key causes of red days. Ward- and site-level discussions also happen naturally and regularly as a result of applying this process.

The inpatient health nurses, capacity team, urgent care lead and clinical nurse lead for community care together led on implementing R2G in community hospitals, while the trust's quality governance information team led on devising and administrating the database and dashboards.

R2G was implemented in the trust between summer and autumn 2016. The development of the data collection and reporting system took place between winter 2016 and spring 2017. The trust needed to persist with the system so that staff became familiar with inputting data, bought into the system, and used it accurately.

As one of the first applications of R2G for mental health services, this work ought also to contribute to reducing DToC in mental health inpatient settings.

Further good practice for providers of community health services to consider

Moving towards collaborative, integrated services to remove organisational barriers

Further good practice 1: Enabling staff to work in different settings

Providers should consider the potential benefits of offering staff secondments and joint posts (see also good practice below on rotations). These can enable staff to broaden their knowledge of and experience in the wider system, help to build networks across organisations and contribute to a clearer view of how to improve patient flow.

Case study: Norfolk Community Health and Care NHS Trust

A ward nurse from the trust went on secondment to the regional commissioning support unit's continuing healthcare (CHC) assessment team. Although it was planned as a typical secondment, rather than as part of wider strategy to share skills and knowledge across organisations, the trust has operated its CHC assessments more effectively as a result of the exchange. The ward nurse has used the experience gained from the secondment to conduct CHC assessments on the ward, where necessary, which has kept the waiting time for assessments at an appropriate level.

Addressing challenges in resolving patient choice

Further good practice 2: Assisting patients to identify the best care packages for them

Providers should consider offering focused resources to help patients find suitable care packages. Support can range from providing information packs, to allocating discharge co-ordination staff, to arranging an independent support service. For instance, providers may want to consider the use of a social care brokerage system for self-funding patients.

Experienced brokerage staff have a broad understanding of available care packages and can therefore support patients in identifying the most suitable packages and negotiate better prices for what can be costly lifelong care. As well as helping patients through this process, brokerage schemes may also support staff in resolving cases that typically leave them feeling vulnerable to complaints.

Recruiting and developing an effective workforce

The barrier: The need in providers of community services for highly autonomous working and the perception of a slower paced environment compared to acute settings can make working in the community sector appear less attractive for junior nurses, exacerbating the wider challenges the nursing workforce is facing. Providers can experience similar problems in recruiting therapists.

Further good practice 3: Taking steps to make nursing and therapy roles more attractive

Creating a workforce plan that is exciting and attractive for staff should become a part of providers' recruitment exercises. To attract nursing and therapy stuff to community services work, providers should identify the workforce and development needs of these staff. Offering rotational posts is one such way of improving the attractiveness of their roles.

Case study: Cambridgeshire Community Services NHS Trust

The trust is implementing rotational posts, and plans to give band 5 nurses experience in both acute and community care from working for three to six months in each setting. This action is being taken to overcome the lack of nurses with knowledge of, or experience in, the community. The trust has used many enablers to facilitate the posts. They have built good collaborative relationships with the neighbouring acute provider, and have carefully listened to feedback from medical and nursing students. The trust has spent time working through the rotations by talking to secondary care leads, recruitment leads and its contracting team. The trust believes the posts will enhance patient care on the ward as nurses will understand how it feels to support patients in their own homes and will better prepare them for discharge.

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