CASE STUDY

Reducing delayed transfers of care

Nottingham and Nottinghamshire

This is the story of how we worked across sectors in Nottingham and Nottinghamshire to reduce the number of delayed transfers of care from hospital, particularly amongst people aged over 75 with dementia.

The work was led by a steering group comprising of Nottingham Community Voluntary Services (NCVS), Nottingham University Hospitals, Adult Social Care, the Integrated Care System and Healthwatch Nottingham and Nottinghamshire (HWNN).

The challenge

In 2017, a review of 24 cases where patients had been discharged from hospital in Nottinghamshire found that 42% could have had an even more independent pathway if opportunities to support this were more available and known about. Doing this would have resulted in a 21% saving for health and social care budgets. Our aim was to address this issue, improving patient health and wellbeing, as well as creating a more effective and efficient health and care system that makes the most of all its assets.

TERMINOLOGY

CVS
Community and Voluntary Service

ICS
Integrated Care System – a new partnership and collaboration system between the NHS, local councils and others, that manages resources collectively to deliver NHS standards and improve the health of the population in their area.

NUH
Nottingham University Hospitals

VCSE
Voluntary, Community and Social Enterprise

Home first pathway
Patients needs can be safely met at home. The individual's needs can be safely met at home with further reablement to regain independence.

What we did

Drawing on national and local research, the ICS identified that better use of community resources and less risk-averse discharge planning could improve patients' independence and reduce costs to health and social care. Building on local research[1] around the 'home first' principle in 2018-19, we focused on raising awareness of and improving access to existing services available for people being discharged from hospital. The aim was not of redesigning discharge pathways or commissioning new services, rather to create a better picture of what it would take to reduce the number of patients who stay in hospital when other options (particularly going home) would be far better for their health and wellbeing.

We explored the role the VCSE sector could play as part of the health and social care system in supporting positive patient outcomes on and beyond discharge from hospital. We focused on the home first pathway[2] – 'Patient needs can safely be met at home', which looked at how to avoid hospital admission in the first place. Our aim was to reduce delayed transfers of care, particularly for those who are medically safe to be discharged from hospital and specifically for patients over 75 going home with dementia.

Through joint action research between the VCSE sector, HWNN and Nottinghamshire ICS, we identified better ways to support patients to leave hospital safely and live independently. The VCSE sector led the research and cross-sector researchers interviewed 14 VCSE organisations to understand:

- How VCSE organisations can support patients over 75 with dementia who are medically fit to leave hospital and move back home
- If and how we could scale up/expand existing services to support the over 75s with dementia and potentially others with long-term conditions to leave hospital earlier.

This initiative created a unique opportunity for VCSE organisations to share perspectives on the services and support that they provide to communities in Greater Nottingham. Learning from local experiences, also allowed us to understand how we could improve outcomes for patients leaving hospital and avoid admissions in the first place.

HWNN also carried out 9 interviews with family members of patients in NUH who were living with dementia to understand:

- Which VCSEs had been involved in planning discharge?
- Which VCSEs could provide support getting home?
- Which VCSEs could provide support once home?
- What additional information and support they would like from the VCSE to support themselves and their relatives

1 Internal research report *'Commissioning of hospital discharge packages'* based on a study by the Adult Social Care team conducted in July 2017.

2 Ibid

What we achieved

Listening to a diverse range of VCSE organisations' experiences of delivering services and support to help people leave hospital and live independently, and understanding what would be required to improve these in the future, was an important part of this enquiry. It was an opportunity to share learning on delayed transfers of care and build better relationships across the VCSE sector and health and social care to create a long-term partnership legacy. As a result, the group has been able to shape the development of a local action plan with potential for future investment (e.g. appropriate packages to support patients going home).

We found that more VCSE sector organisations than we had expected which helped improved knowledge of us as a group. These VCSE organisations had the necessary skills, experience and networks to jointly work with health and social care providers on delayed transfers of care. Our research process built connections between health and social care providers, including working with previously unknown organisations, indicating that cross-sector collaboration is key to developing appropriate pathways and support for patients leaving hospital.

Through the interviews with family members we found that there is need to ensure volunteers are adequately trained in dealing with people living with dementia and that consistent volunteers are provided and that there is a need for an information leaflet that describes the support the VCS can provide to people living with dementia and their carers.

What made it work?

- **Co-designing the approach:** Working together in this way made for a better and more informed action research exercise, drawing in learning and expertise from multiple system partners
- **Understanding that the process is as important as the result:** It was vital to allow the VCSE sector to take the lead (in this case, Nottingham CVS); they were best placed to identify the grassroots organisations to connect with
- **Knowing what is out there in the community and making the most of existing assets/ knowledge:** We found that there were more VCSE organisations in the community with the skills, experience and/or networks needed to work to support transfer of care than we had expected
- **Engaging cross-sector representatives from the whole healthcare system:** This kept the project on track and focused, and meant all priorities were heard
- **Ensuring the steering group was in regular communication:** This was essential to our success, even if it was often done remotely

What next?

The research resulted in a published report[3] and recommendations that will lead to a range of actions led by all partners, specifically Adult Social Care, including an information leaflet on the support that the VCS can provide to relatives of people living with dementia.

New partnerships between NUH and VCSE organisations will run joined-up activities, including an Excellence in Discharge Study Day in September 2019 and a hospital-hosted marketplace event for ward staff to meet voluntary sector organisations.

There is also a potential business case for building capacity in the community, shifting investment – and pressure – away from acute services.

Finally, new relationships have developed between the NUH Charity and the Hospital Volunteer Manager they are now planning joint activities with the local VCSE sector.

Contact

If you are interested in finding out more about this case study, please contact Alex Ball (alex.ball1@nhs.net).

Further information

This work was supported by the **Building Health Partnerships Programme**[4], delivered by the Institute for Voluntary Action Research and Social Enterprise UK and jointly funded by The National Lottery Community Fund and NHS England and NHS Improvement. For further information and resources, please visit **www.ivar.org.uk/transforming-together**

3 'Delayed Transfers of Care (DToC) & the Voluntary and Community Sector in Greater Nottingham - Findings and Recommendations', October 2019.

4 https://www.ivar.org.uk/our-research/building-health-partnerships/