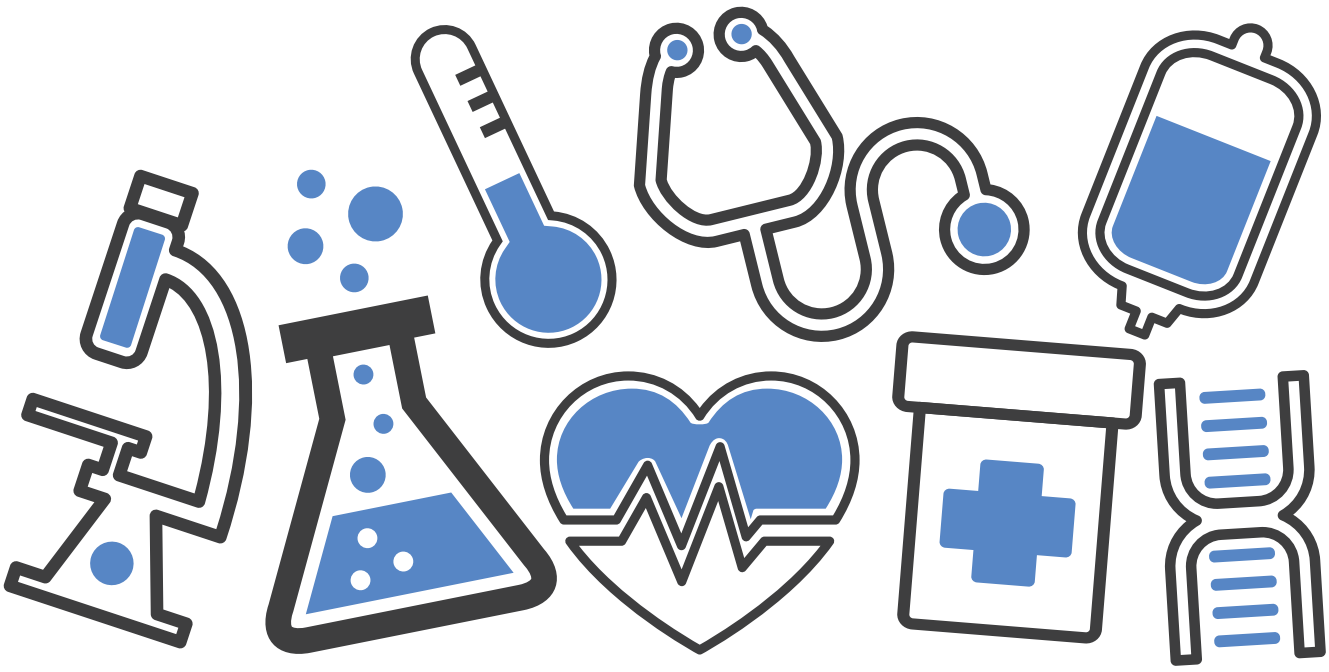
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Grant Thornton

Intermediate care:

How can private care operators provide pain relief for the NHS?



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Introduction

Over the winter of 2017/18 the average hospital had approximately 200 patients on its wards who had been deemed medically fit for discharge at a cost estimated to be between £300 and £360 a day. Many care providers have said there is sufficient availability in their sector to accommodate these patients, so why aren't the transfers taking place?

Tackling delayed transfers of care (DTOCs) has become a key focus for the Department of Health & Social Care over the last year after record delays were recorded in 2016/17. Figures published by NHS England revealed there were over 2.25 million delayed days across health and social care during the year – up 25% on 2015/16.

Since then, boosted by an additional £1bn through the Improved Better Care Fund and new targets set by NHS England, there has been a marked reduction in DTOCs.

Despite the difficult winter, figures published by NHS England in May show there were 154,600 DTOCs in March 2018 compared to 199,600 the same time last year. It is a dramatic improvement but still falls short of the NHS England target that no more than 3.5% of available NHS beds should be occupied by patients fit for discharge. According to a House of Commons Briefing Paper on NHS Key Statistics published in May, the latest data suggest that 4.4% of possible NHS bed days were lost to delayed transfers in September and that by March 2018, the rate had reduced to around 3.9%, with over 102,000 of DTOCs in acute care.

Trowers & Hamlins and Grant Thornton invited key stakeholders in the sector to take part in a roundtable discussion to help identify the problems and open a dialogue on how the public and private sectors can work collaboratively to find solutions.



Roundtable

List of participants

East Kent Hospitals University NHS Trust	Professor Stephen Smith - Chair
Saffron Steer Ltd	Michael Barker - Founder
National Association of Primary Care	Dr Nav Chana - GP and Chairman
Trowers & Hamlins	Alison Chivers - Partner
Optima Care	Eddie Coombes - Chief Executive
HFH Healthcare	Catherine Hellary - Chief Executive
Spring Ventures	John Hudson - Managing Director
Grant Thornton	Peter Jennings - Director Corporate Finance
Hilton Nursing Partners	Justin Jewitt - Non Exec Chair
Anchor Trust	Sarah Jones - Finance Director
Trowers & Hamlins	Tim Nye - Partner
SweetTree Homecare	Barry Sweetbaum - Chief Executive and owner
Grant Thornton	Rhiannon Williams - Healthcare Advisory Service







> “DTOCs are, rightly, high on the Government’s agenda but the feeling is that there is a lot more that could be done”

















“

The challenges are well known, but overcoming those challenges doesn’t seem to be so easy”









Identifying the problems

Chair Professor Stephen Smith, a clinician scientist and Chair of East Kent Hospitals University NHS Trust, kicked off the debate by asking the panel to consider the scale of the problem.

'To put this into context, in my hospital, which has 1,200 beds, as we speak there are 170 patients who have been deemed fit to leave the hospital. They are the 'super-stranded patients', who have been in the hospital for greater than 21 days. There are a further 150 who have been in the hospital for more than seven days, so close to a quarter of my 1,200 beds,' he said.

According to Stephen Smith, this is a problem that is replicated in hospitals across the country: where it has been decided that patients can go home without requiring nurse care, but where their transfer has been delayed.

> *'As you can see,' he added, 'this is a major issue for the NHS and the Secretary of State has made it clear that it is the most identifiable problem in the NHS.'*

Discharge process

The Panel felt that part of the problem lay in the discharge process, which can be fraught with complexities and frequently lacks coordination between health and social care professionals.

Justin Jewitt, Chair of Hilton Nursing Partners, said one of the key issues was that the discharge process could easily fall down due to the sheer number of people and processes involved in making it happen.

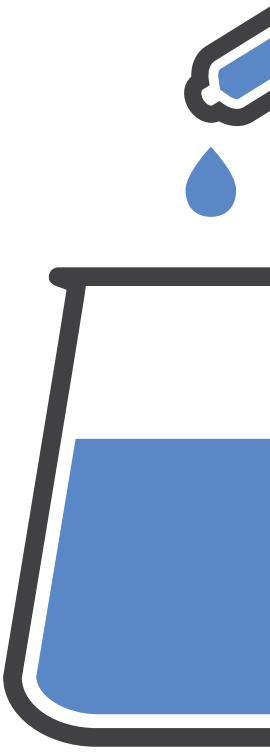
'It's very difficult to get a smooth process,' he said. 'There are so many aspects - are the pharmaceuticals ready, is the transport system ready and so on. Where is the individual who focuses on the patient? Who says right you're going home today and I'm going to get the drugs, the transport and take you home and then look after you in your own home for a while so you get over the post-acute shock of being in hospital? How does the complex gearing that's in a hospital slot into the minor gear of domiciliary care?'

Grant Thornton director of healthcare advisory Rhiannon Williams said the company's work with NHS trusts had revealed that many were unable to take this systematic approach because limited resources meant they were fire-fighting on a daily basis.

'We've done a lot of turnaround work, going into trusts who find themselves in financial difficulties and it's almost become this day-by-day model of 'we need a bed' or 'we can discharge today' as opposed to being systematic,' she said.

Catherine Hellary, who is CEO at HFH Healthcare, told the panel that her organisation frequently sees patients who have been deemed fit for discharge for some time but whose transfer has been slowed by poor channels of communication. 'By the time they get to that point,' she said, 'the CCG is overstretched and about to be fined so they actually over-commission to compensate.'

Stephen Smith agreed that CCGs can over-commission as a panic response at the end of the patient journey but, Barry Sweetbaum, managing director at SweetTree Home Care Services, thought the problems often began earlier in the admission process.



'I was a consultant advising hospitals and organisations on this and one of the things we did was track every patient from A&E through their patient journey to assess what actions would help them leave hospital more quickly and what inputs would assist with that. Interestingly, the key factor was what happened in the first 12 hours of care and it was the fact that the patient would come through A&E and go through an assessment ward but that that was treated as an admission ward and that started a process of what we called 'acquired debilitation'. What drove the outcome more than anything was which consultant did the ward round in the assessment unit. Some sent 90% of patients home some kept 90% in and they went through that process of acquired debilitation,' he said.

Inconsistency in the system

However, GP and chair of the National Association of Primary Care (NAPC) Nav Chana said the inconsistency in consultant behaviour often had more to do with whether carers and relatives were happy for the patient to go home. He told the panel 'One of the big contributors to delayed transfers of care is actually the views of carers and family members about when they are happy for their loved one to be discharged.'

Although the panel agreed that family had a significant role to play in the discharge process, it also heard how patients themselves sometimes fear discharge because they are unsure about how or where they will be cared for when they leave hospital.

Rhiannon Williams asked if that meant, controversially, that patients and their families were being given too much choice? 'Are we giving people the option to stay in hospital? Does it happen in other countries or is it more ruthless – do they say it's over to you and the family has to make those kinds of decisions and because so many people in the population are not eligible for free care, why do we allow people to carry on staying in hospital, why do hospitals not start charging?' she asked.

According to Eddie Coombs, Chief Executive at Optima Care, even a 2% decrease in bed usage could make a 'massive difference' in the NHS. 'We know there is a large population of older people that don't need to be in NHS beds and they could go into the community,' he said.



Funding

The panel thought that funding, and in particular, the split between free NHS care and means-tested social care was a key issue.

Grant Thornton director, Peter Jennings said this had to be a 'massive factor' for families who then faced the decision of making what could be a large financial commitment to look after relatives who are not eligible for free Local Authority care.

'That's when you get issues about people not wanting to get their loved one out of hospital,' said Nav Chana.

> *'We have a universal healthcare system and we have a means-tested social care system and that just is a barrier to integration.'*

Tim Nye, a partner at Trowers & Hamlins, said the two different funding systems were having a fundamental impact on continuity of care. 'At the moment you end up with a professional decision and a pathway based on what is best for the patient, but you get to the point where you have to say to the person who is receiving the care, 'now you are paying and it's coming out of your pocket',' he explained.

The consensus among the panel was that the challenges were acute but not insurmountable. Chair Stephen Smith asked: 'How can we begin to break this down. It can take hours to negotiate a person out of bed, so is this something an organisation should do? Should [providers] be in the hospital. Should GPs be doing ward rounds? Are there new ways we should be working and are there other solutions through electronic records and what not? We are trying to work within the system but are we all saying the system is bust? If so, how can we recreate it in a way which is effective?'

Exploring the solutions

ADASS, along with charities and organisations working in health and social care, have welcomed the recent decline in DTOCs. However, they have also urged the newly named Department of Health & Social Care (DHSC) not to rest on its laurels. In March, the NHS revised its mandate on DTOCs, replacing the 3.5% DTOC rate target with a target to reduce the average daily number of beds occupied by patients deemed fit for discharge to under 4,000 by September. Given this figure stood at a little under 5,000 in March, the NHS and social services have their work cut out over the coming months, making a collaborative approach and willingness to look at new models of care essential.

Health and social care funding - a values based approach

Once again, the panel thought the key starting point was funding.

Sarah Jones, finance director at Anchor Trust, said: 'The budgets are in separate places and they are ring-fenced so as to achieve a holistic outcome for someone, you need a holistic view of funding as well.' One of the answers, she added, was to be able to demonstrate to commissioners and payors, the value of the services on offer.

'If we can keep pushing that value message and how much money that can save, it's the idea of social capital. If you look at young offenders, you can demonstrate empirically that if you look after young offenders in a particular way they are specifically less likely to reoffend and therefore that saves X amount of pounds and, therefore, X amount can be reinvested in that service up front. If we can find the same way of demonstrating that for older people's services, sheltered accommodation, supported living, extra care, there's a myriad of terms around, that extra investment up front saves an absolute fortune on the other side of acute services,' she said.

Nav Chana agreed that a values-based approach was key. 'You could argue from a value perspective whether someone needs a neurosurgical procedure, they also need an adaptation at home to stop them from falling over and that can be allied, so I think we do need to get into value-based interventions. There is quite a lot of work going on at the moment, particularly in the NHS – GIRFT and that sort of stuff – but essentially the constructs are allocative value, how do we use every precious pound invested in health or care most wisely,' he said.

The panel concluded that as well as a more collaborative approach to health and social care funding, joined-up delivery of services on the ground could greatly assist in the reduction of DTOCs.

Collaborative working across provider

Catherine Hellary said that HFH had embarked on a project to get nurses and consultants working in the acute sector talking to community services. 'This was people they'd be speaking to on the phone but never meet so actually talking about some of the challenges in discharging patients it became clear that acute didn't understand how it works in community, what it takes to get a patient out. Commissioners don't understand but you've also got a nurse in ITU who has never discharged a patient back home, they are always just going downstairs, now they have to go home and that's a huge amount of responsibility for someone,' she said.

Justin Jewitt thought that this was where the system needed a 'lubricant' – an organisation or partnership focused on getting the patient out of hospital.

> *'I'm a great believer that you should have your staff working with the hospital, inside the hospital because that's where the patient is, and you have to focus on the patient, bring them out and give them stability,'*



'These are people who are ready for discharge so to actually have them stay an extra day in hospital is risking all sorts of things - falls, muscle atrophy etc. It's not what nurses want to happen to patients, it's not what the discharge team want to happen to patients and it's not what patients want to happen, so if you get those things aligned, you come back to the solution that you need a team of people to focus on the patient.'

Dedicated discharge teams

Tim Nye agreed that a dedicated team or professional focused on discharge could help provide a solution. 'From my perspective, and I'm not a practitioner, it seems to me that once someone is medically fit to be discharged, there doesn't seem to be one sole person responsible for getting that person out. It's all cross-professional working, different people coming in, but no one has sole responsibility, so if I was redesigning the system, someone has to be responsible,' he said.

Catherine Hellary said this kind of approach was working successfully in neuro-disability services. 'Neuro navigators are a good example where that really works, they navigate a patient that comes through neuro-services all the way back home,' she said.

Early discharge planning with patients and professionals

The panel thought this was where early engagement could become part of the solution, particularly if professionals can engage with patients early in the admittance process and start planning for discharge from Day One.

Catherine Hellary asked if part of the issue was that there is no single route for patients through hospital and out the other side: 'So, if somebody is in hospital and they don't have [ongoing care] already in place, they've been there for more than 20 days and have been identified as ready to leave, that process of going from identifying that patient as ready to leave to having everything in place takes time,' she said.

Improve population health management

Nav Chana said engagement could begin even earlier and pointed to work around population health management being conducted in primary care, which could help to identify those patients in most need before they are admitted to hospital.

'There are analytics now that we use so in my population, in Merton, where there are 30,000 people, we know who the 500 most likely to be sitting in hospital are so if we are able to organise ourselves proactively and say each person needs a case worker, each person needs access to the broad range of technology that we know can help their care, we've now got a good place to start,' he told the Panel.



The Primary Care Home Model, launched by the NAPC in 2015, brings together a range of health and social care professionals to work together to provide enhanced personalised and preventative care for their local community. According to Dr Chana, who is leading the programme, 12,000 GP practices – 15% of practices in England – covering 20% of the population are now using the approach.

'If we can identify cost and spend, so we now know that for these 500 people in Merton we've got £1m doing X, so we can think about how we can use that money in a different way… there are quite a few areas where that approach is beginning to have quite a lot of impact. It can't solve all the problems of an underfunded state system but things like patient satisfaction and staff satisfaction are improving and that's crucial because if we can't put the joy back for our staff, none of this will work,' he explained.

The Panel acknowledged the benefits of this approach, but asked how it would assist those patients who did require hospital admission.

'You can predict people who are about to fall over before they do, so there is a lot that can be done,'

replied Dr Chana. 'But I agree someone is always going to fall over or need an intervention and the question then is how do we create multi-professional teams that genuinely work across the population for that cohort of 500 people and how do those teams respond when that happens in a way that the discharge planning process starts the moment that person walks in the front door.'

Staff retention

Early evidence also suggests that the approach is aiding staff retention and recruitment.

Michael Barker, founder of Saffron Steer Ltd, said: 'If you have fun and creativity in your job then you're actually going to stay and happy staff equals happy patients at the end of the day.'

Dr Chana said that in Thanet, where they have adopted the Primary Care Home Model, creating integrated nursing teams which bring together community, palliative care and primary care nurses to provide integrated care across populations, it had actually averted a staffing crisis.

'Thanet had 23 district nurse vacancies a few years ago, now they have none now because the staff are working in integrated nursing teams. So, actually it's the sense of working for a team, it's fun, they are sorting stuff out, they are talking to each other and those very simple behavioural things do make a difference,' he said.

New models of care

According to Justin Jewitt, the approach is very similar to the Buurtzorg model developed in the Netherlands and increasingly being adopted by other health economies. Buurtzorg, which translates as neighbourhood care, is underpinned by four building blocks for independence based on universal values: people want as much control of their lives as possible; people strive to maintain and improve their quality of life; they seek social interaction; and they seek 'warm' relationships with others.

The nurses that work in Buurtzorg develop care models that encourage clients to self-manage and put support in place designed around individual needs, but the teams themselves have a high degree of professional freedom and decide how they organise the work, share responsibilities and make decisions.

Mr Jewitt said his organisation, Hilton Nursing, had begun adopting a similar approach. 'Recently, there have been over 14 patients taken out of East Kent hospitals who have actually been assessed as requiring a nursing home placement. They've been given a two-week intensive period of support from our nurses and our personal nursing home associates – and we have two of these, backed up by a nurse with every single patient - who make the decisions in Buurtzorgian fashion and we've yet to have one of those patients go on to a nursing home,' he said.

Peter Jennings said models being used in other countries had also achieved successful results by linking 'the big cogs of hospital care with the smaller cogs in the community'. He said

> *'If you look at Germany and France, where they've got much more rehabilitation, they've got centres set up for people who need rehabilitation to then return home. We are missing that link that could be more about assessing continuing need and putting people back into a care home or the community. I don't think we've got that provision at the moment,'*



Although the panel agreed that this and Buurtzorg were valuable models, they questioned whether they could work in the UK given the current funding and infrastructure.

Justin Jewitt said that although some aspects of the Buurtzorg model could be adopted in the UK, it could not be implemented system-wide because there is a single financial purchaser in the Netherlands, whereas in the UK funding remains split between health and social care.

Michael Barker added that another reason this approach works in Holland is 'because that nurse, super-qualified though they are will also do basic domiciliary care, they will clean the patient, they will dress the patient, but they will also administer drugs and they will also put in lines. There is one care provider who does everything for them.'

New technologies

As well as integrated service delivery, the Panel thought that enhanced technology also had a role to play in helping patients return home, in some cases reducing the need for intensive nursing care.

'At SweetTree, we've set up a branch of our activities which is around technology and using technology to monitor what's happening in people's homes, and I think that has to be one of the answers,' said Barry Sweetbaum. 'It's that window into whether somebody is well at home once they leave hospital - if they are struggling, where they might be struggling and then intervening at that point of need rather than keeping someone in hospital for all this time just in case. And we spend a lot of money in the care sector just in case something might happen, and we have the technology in the care sector to identify whether everything seems to be ok using the indictors of wellbeing and if they are not to intervene at that point.'

However, the panel felt that although new technology could be a genuine enabler for some patients, others would still require personal care.

'If you have been in hospital for a long time, your confidence is knocked, you haven't necessarily got someone at home with you, if you are then feeling quite vulnerable, irrespective of your understanding of technology, you are not going to want to go home and rely on technology, you are going to want someone to care for you,' said Catherine Hellary.

The panel also debated how far older people, in particular, were willing and able to adopt new technology.

However, Sarah Jones thought older people's ability to adapt was often underestimated. She said



'We look after 30,000-plus older people and you would be surprised in the uptake of technology. A lot of the technology we are looking at becomes part of a lifestyle and is not intrusive. It's built in, so if someone makes a cup of tea at 9am every morning, if their kettle doesn't get switched on at 9am we know there's a problem,'

The role of the independent sector

According to the latest figures from LaingBuisson, the independent sector operates around 94% of all care home capacity for older and physically disabled people and over 70% of non-residential care services in England, including homecare and supported living. Private and voluntary providers clearly have a significant contribution to make in reducing DTOCs, but are they currently being used effectively and could they play a greater role in finding a solution?

Some of the Panel thought that providers themselves should be more active in offering solutions to commissioners by finding out what is needed in their local area and devising tailored solutions.

Justin Jewitt said: 'The NHS is inundated with the day job. What the independent sector should be able to do is to actually work with individuals or groups in the NHS and say look we have these resources, these capabilities, these technologies and you have this demand. What is it that can be created? We need to talk with the local organisations, whether it's local GPs, local CCGs, local acutes and somehow work in a partnership.'

Rhiannon Williams felt the independent sector had a lot to offer but that the relationship between providers and the NHS remained 'very transactional', with the NHS entering into ad hoc partnerships when it had a specific need rather than looking for long-term, joined up solutions. She said

> *'If you look at countries like Australia, the public and private systems are intertwined in a way that they are not here and that's why it works,'*

Stephen Smith said one of the key difficulties with partnerships between the NHS and independent sector is that it is impossible to achieve on a national basis.

'I can see from the private sector, that it's extraordinarily difficult and next to impossible to do this nationally because the DHSC has no say in what happens in the NHS, which by the way is constitutionally how it's supposed to be, so [partnerships] are going to have to be local. Take, for example, the hyper-acute stroke units in London. If you're a private provider you'd want to discuss partnerships with the strategic health authority when it existed but now that's gone you have to go to the local organisation, which is the hyper-acute stroke unit, and because they are in a network it's very confusing and very slow.'

John Hudson, managing partner of Spring Ventures, said this reflected the experience at his organisation. 'Every trust has a different way of doing things, so as a private provider it's very, very hard to come up with a consistent approach that's going to be accepted by all the organisations you work with and when you have changes of policy either within individual trusts or from central government, then it's incredibly hard to plan an investment decision around what is the right way to treat these challenges. There have to be long-term solutions, ultimately, because these are long-term problems,' he said.



Tim Nye agreed. He said that although everyone refers to the NHS as a single entity, it is not one buyer or one partner, so providers have to think locally. He said

> *'Ultimately, you've got to think away from that term NHS and you've got to think trust, CCG whatever it is, and it is a multitude of bodies,'*

Catherine Hellary told the Panel that HFH had managed to establish very helpful partnerships with the NHS but on what she described as a 'hyper-local' basis.

However, Justin Jewitt thought that although providers should focus on local relationships, it is helpful to understand that the NHS has similar needs across the Board.

'I think you have to take the risk and you have to be open and you have to be creative with each individual trust,' he said. 'Trusts are different, but frankly they are all handling patients and all patients are human beings so you've just got to be flexible. You have to say to them 'I've got a capability, how would that best suit your needs? Do you have a short-term need, a medium-term need, a long-term need? Do you need that particular specialism?' That's what I think we've got to do as independent sector providers.'



Final word

The progress that has been made on tackling DTOCs over the last year should not be underestimated but the NHS and Local Authorities still have a long way to go if they are to get to the 4,000 daily DTOC rate and help avert another winter crisis.

There is not a single `magic bullet' that will improve the issue of delayed transfers, however, a combination of factors should help to address the issue, if they are employed.

One of the most important aspects is effective and comprehensive analytics - population health management. This ensures that high risk patients across the country are identified and their conditions managed before they become emergency admissions. The key to the success of such technology is comprehensive uptake. Currently there seems to be little sign of such technologies being implemented countrywide - rather they exist in pockets of care regionally.

Similarly the introduction of empowered discharge teams would have a real and significant impact on delayed transfer statistics and the level of holistic and timely care patients receive. However, just like the uptake of analytics there are areas of implementation around the country but not yet comprehensive uptake.

Whilst the funding challenges that affect delayed transfers are always going to be difficult - the feeling amongst the panel was that they are not insurmountable, indeed joining up health and social care budgets, as is currently happening, would be just one measure that can have a significant and immediate impact.

What is clear is that a defined national integrated care system is key. Whilst we are some way from achieving this, what is reassuring is that ICS at a regional level is happening in some parts of the country. As demonstrated by the panel, private operators have much to offer and are already supporting change through many of the initiatives discussed. The potential for private operators to support real and meaningful progress for regional care market development is considerable and more widespread activity by the private operators can only be hugely beneficial in improving DTOC in the long term.

Further information

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