Identifying and overcoming challenges at the Transitions of Care

Overview

Systems of care for older people[1], particularly people with frailty and complex needs, must have the ability to:

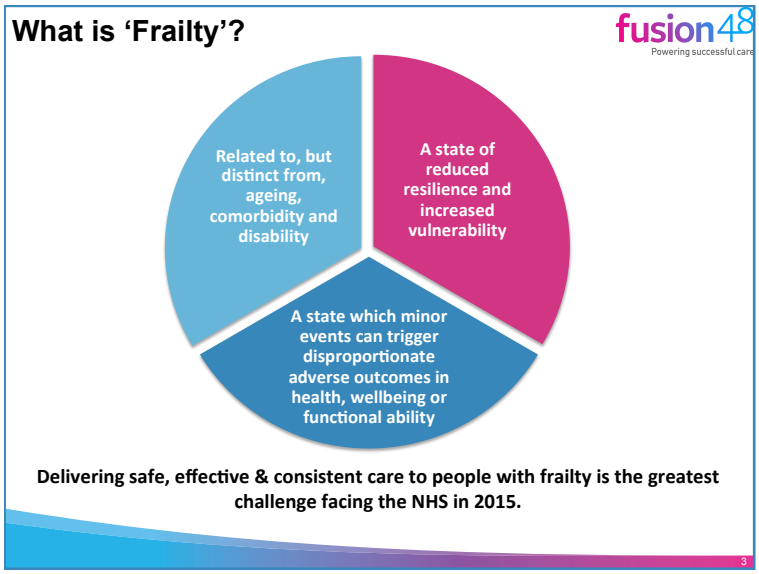
- Recognise the scope and complexity of these needs;
- Understand when these needs are changing and;
- Offer a timely response at the most appropriate place and level of care.

In particular, such systems of care should maximise continuity of care and minimise unplanned transitions of care.

Transitions of care are critical points in individual journeys of care. They are points at which people with frailty are at risk of suboptimal outcomes if care systems are poorly responsive or lack coordination, even if the individual services and components of care within these systems are effective and of good quality.

Fusion48 previously reviewed intermediate care and reablement (IC&R) services for a CCG in the North West and found that the majority of service users were experiencing successful transitions through these services, with consistent and measureable improvements in functional ability and positive patient-centred outcomes of care.

The same CCG also recognised that other people within their system were experiencing less successful care transitions. Fusion48 were therefore commissioned to carry out further work focusing upon a group of patients experiencing difficult transitions of care, specifically a cohort of people with Delayed Transfers of Care (DTOC) in the acute setting.



The objective of this review was to understand the similarities and differences between this cohort and those people with successful transitions through IC&R services, and thus aimed to identify early opportunities for intervention to positively influence patient journeys and avoid dysfunction at later care transitions.

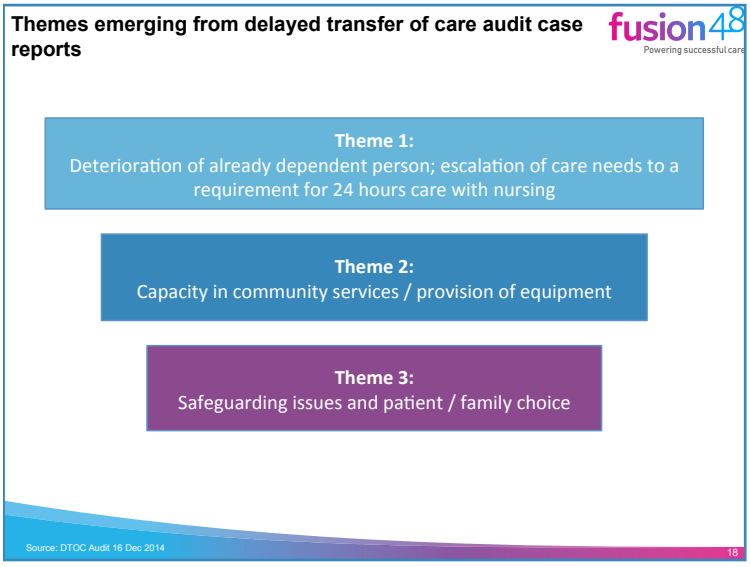
The methodological approach was similar to the IC&R review, with a combination of data analysis, clinical audit and detailed individual clinical case studies.

[1] British Geriatrics Society "Fit for Frailty", January 2015;
Kings Fund report "Making our health and care systems fit for an ageing population"

Key Findings

Many frailty themes found in the IC&R review were common to both groups and were articulated through three causative themes of delay within the DTOC group.

However, key differences also emerged.



- The DTOC cohort was younger but more dependent prior to admission than the IC&R cohort.
- Although the mean number of co-morbidities was similar in the two groups, there were important differences in profile. In particular, the prevalence of dementia in the DTOC group was considerably higher than expected for the age of the cohort and compared to the IC&R cohort. Diabetes, cardiovascular and cerebrovascular disease were also more common in the DTOC cohort.
- The majority of the patients transitioning through IC&R services were previously independent and had a clearly identifiable acute precipitating cause for the index episode. By contrast, many patients experiencing DTOC had trajectories of more general deterioration against a background of already advanced frailty and high dependency.

A significant opportunity was therefore identified for the potential to positively influence journeys and outcomes of care by offering more proactive support to a readily identifiable cohort of people with frailty and complex needs. This evidence is now being used to inform service redesign.

Case Example: Residential home to nursing home

This was a person in late 90s who lived in residential home (RH), who was generally deteriorating and fell and suffered fractured femur. **Medically fit** for discharge on **day 11**. RH assessed on **day 12**, said they could not accept patient back at current dependency and requested Intermediate Care (IC) referral.

Assessed by physiotherapist on **day 14** and declined for IC as not considered to have further rehabilitation potential. RH asked to reassess, which they did on **day 20**, still not able to accept patient back as consider they are now unable to meet needs (home was also suspended for new admissions at time of audit). Therefore assessment for Nursing Home placement initiated on **day 24,** audit completed **day 25**.

Fusion48 works with healthcare organisations to enable their planning and provision of high quality, cost effective services.

For further information please visit our website or contact us connect@fusion48.net