skillsforcare

Building trust between social care and health organisations

Working together to improve people's experience of hospital admission and discharge back into the community

The extent to which organisations work together, affects people's experiences of being admitted and/or discharged from hospital.

We spoke to a range of adult social care and health employers to find out how they work with each other and other sectors, particularly around hospital admissions and discharges.

We've developed these top tips based on the findings, to help you build effective relationships and refine current ways of working with different organisations in your integrated care system.

Top Tips

1 Build a shared statement of purpose

"Effective working can be facilitated by shared agendas"

What does this mean in practice?

It's vital to have good leadership and a statement of purpose or vision which focuses on improving integration, working collaboratively and planning together. This should be communicated clearly through integrated care systems along with shared performance indicators.

Partners should embrace and adopt person centred care as the principle for working together and this should be the focus for all policy and practice solutions. Making sure people who access care and support are at the centre of what you do and enabling choice and control.

"Collaboration within and across systems plays a vital role in the delivery of services. Effective leaders work in partnership with people who use services, their carers and representatives and colleagues to deliver and improve services."
Page 21 https://www.skillsforcare.org.uk/Documents/Leadership-and-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.pdf

Start by ensuring there is an understanding of both social care and health:

- Do health colleagues understand how many care providers there are in their local area, what they do and how they are commissioned?
- Do social care colleagues understand how the health system works across both acute and primary health care, and what roles and responsibilities different health organisations have?

Make use of existing networks and promote other opportunities for joint discussions by ensuring you have the right people including social care providers at all meetings. This will help to build deeper understanding of what is already happening locally, how initiatives can contribute to shared goals and generate ideas that may not otherwise have been indentified.

This can be supported by new roles or new ways of working for existing staff, such as a spokesperson for health and the local area or specific care co-ordinator or care navigator roles that work across the care and health system.

Find out more in our Guide to coordinating care.

2 Develop clear plans and pathways

"Joint working can be improved through clear plans and pathways"

What does this mean in practice?

We know that when it works well there are processes in place for admission and discharge that everyone including the person themselves understands and works to. This includes a joint assessment process, transport plans, arrangements for medication, follow up care and reviews and other practical factors that impact on the efficiency of admissions and discharges.

Facilitating transformation means contributing to change processes that lead to improved social care and health.
Page 34 https://www.skillsforcare.org.uk/Documents/Leadership-and-management/Leadership-Qualities-Framework/Leadership-Qualities-Framework.pdf

Person centred care needs to inform the pathways that are developed and should reflect the most appropriate options of care and support that individuals require.

Solutions should include involving social care representation in multidisciplinary meetings and involving primary care including GP's in developing pathways to ensure commitment and understanding from all parts of the system.

Independent trusted assessors who work across all services can help bring consistency to local approaches.
Page 33 and 35 Beyond Barriers how older people move between health and social care in England CQC

The involvement of the person themselves, their families and social care staff from the outset is crucial; they are all critical in designing and reviewing processes.

Consider implementing a process which allows for review and follow up when people are back home in their community, recognising that their needs will change so support will need to be flexible and adaptable.

New roles or new ways of working for current staff (see tip 1) have a part to play in identifying local solutions that work for everyone.

3 Review current responsibilities

"Things work well when there are better links between teams."

What does this mean in practice?

Examine your current practice and processes, identify who is responsible for what and what communication there is around this; and then review. Learn from best practice elsewhere and consider if there is a need for specialist roles or improved awareness of who is responsible for what.

Many examples of good practice include having specialist roles within the system giving both clarity and accountability and a central point of communication and contact for all. They would typically lead on assessment, admission, discharge avoiding confusion, multiple assessments and inappropriate care and support decisions.

Examples of good practice include a trusted assessor model where there are independent assessors trusted by both health and care. They are employed on behalf of the integrated care system employer organisations and hosted in one of these organisations or hosted by an independent organisation for both care and health. There are other options such as social care assessors, discharge roles in hospitals, named link people for example that could also be considered.

To find out more NHS England has a series of quick guides covering a range of key topics.

4 Establish clear lines of responsibility and accountability

‘’It is important to have clear lines of accountability and understanding of responsibilities in the process”

What does this mean in practice?

Blurred lines of responsibility can interfere with building good relationships between the health and care sectors but planning in partnership and establishing good governance will really help, along with clear procedures and processes.
It is crucial to establish a culture of openness, transparency, honesty and desire to work in a person-centred way to achieve the best outcomes.

Consider identifying a key worker or specialist role who can lead the process, this could be a care navigator or care co-ordinator. Use any existing quality frameworks that could be used jointly for consistency. Joint learning and development could be used to ensure staff fully understand processes and their role within the system.

Regular communications and ongoing meetings/working groups will help to complete the picture locally and understand any snags and make ongoing improvements in the process.

For best practice look at NICE Quality standard [QS136], Transition between inpatient hospital settings and community or care home settings for adults with social care needs.

5 Establish mutual professional respect

"45% of social care respondents to an online survey said they were not treated with the same respect as other colleagues - and this happened on a weekly basis."

What does this mean in practice?

Spend time increasing understanding of each other's roles and responsibilities in both health and care to build awareness of each other's pressures, constraints and priorities. Make the most of opportunities for joint working and encouraging greater involvement at all levels to encourage collaboration and build effective professional relationships.

"Good relationships are the heart of good local systems." page 41 and 42 Beyond Barriers how older people move between health and social care in England CQC

Identify opportunities for joint training from leadership programmes; integrated or rotational apprenticeships; opportunities to shadow across care and health though job shadowing schemes, as these have all proved effective. Establish themed multi-agency networks (e.g. Dementia/End of Life Care) to discuss together new models of practice / good practice.

Other valuable approaches include; attendance at local social care provider forums, Registered Manager's Network meetings; setting up joint health and care locality forums and ensuring that Care Providers are involved with STP Workforce groups.

NHS staff involved with admission and discharge could spend time in different care settings to increase understanding of what each has to offer and the possible challenges and opportunities. Rotational posts could be developed to increase shared understanding.

"There are different reasons why your organisation, and therefore your workplace culture, might need to evolve. Person-centred care and support should be flexible and tailored to an individual's wants and needs, and therefore your organisation also needs to be flexible." Creating a positive workplace culture, Skills for Care.

6 Review current communication methods

"Joint working can be supported by good communication"

What does this mean in practice?

Effective communication is essential across all those involved with admissions and discharge if we are to trust each other, this includes the person themselves. Jointly review your communication methods regularly to identify where the sticking points are and make any improvements.

Active inclusion of social care providers in ongoing discussions is paramount, there needs to be structured processes for clear communication that everyone understands and can participate in. Shared activities and routine meetings will help to build a communication bridge between individuals and different teams.

For example, engage with local social care provider forums, registered manager's network meetings, joint health and care locality forums, or other similar meetings and events, to build the communication channels.

Share ideas and jointly develop paperwork and systems that everyone involved can agree on. Listen to people's concerns, act on these and communicate with each other about how and when these will be addressed. Informal communication methods work too.

Stockton and Hartlepool Integrated Discharge Team was created to reduce unnecessary delays in discharging patients from hospital and provide a patient centred approach to discharge for the benefit of patients and to give them more choice and control. The team consists of representatives from discharge liaison, emergency care therapy team, LA reablement teams, social workers from locality teams, Citizens Advice Bureau, hospital volunteers and acute therapies. A new integrated approach was developed which all key partners agreed to and they put their success down to the commitment and support of all partners.
https://www.hartlepoolandstocktonccg.nhs.uk/wp-content/uploads/2017/09/AE-Delivery-Board-7th-June-2017-2-.pdf

7 Improve information sharing

"Around a third of employers who responded to our online survey reported poor information sharing"

What does this mean in practice?

Access to information and good information sharing processes can be a challenge due to practical barriers like technology and data protection concerns. There is a need to improve the way this takes place though, and to find practical workable solutions to meet the individual's personal needs and preferences.

One example is the well documented 'redbag scheme'.

Work towards having in place electronic notes and care plans that can be updated in real time and accessed by those who need them. NHS England has developed a series of quick guides to support effective admission and discharge. The information shared should be sufficient and able to meet personal needs and preferences. GDPR is not a barrier to sharing information but needs to be taken into account and GDPR regulations followed.

Staff in all services across health and care need support and training (ideally joint) to ensure they understand the processes and the information being shared. They need to be competent and understand how to deliver the care and support plan and provide care that meets individual's personal needs and preferences.

"Good communication and information sharing underpins safe and effective transfers of care. The timeliness and accuracy of the information provided is important for ensuring that the person being discharged understands what will happen next – and also for anyone providing ongoing care to know how to support them."
Page 36 Beyond Barriers how older people move between health and social care in England
CQC

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