Managing transfers of care using the High Impact Change Model

Mary Sumner House, Westminster
28 September
Setting the Scene: The Better Care Fund, Delayed Transfers of Care and the High Impact Change Model

Rosie Seymour
Deputy Director
Better Care Support team

28 September 2017
### Setting the Scene: 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>Spring Budget Announcement</td>
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<tr>
<td>March</td>
<td>DH/DCLG BCF Policy Framework</td>
</tr>
<tr>
<td>July</td>
<td>DH/DCLG/NHSE BCF Planning Requirements</td>
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<td>July</td>
<td>DToC Trajectory Exercise</td>
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<td>Sept</td>
<td>Submission of BCF Plans</td>
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<td>Oct</td>
<td>BCF Plan Assurance</td>
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<tr>
<td>Future</td>
<td>An emerging picture…</td>
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</tbody>
</table>
Delays in transferring people who have been assessed as fit for discharge have increased over the last 2-3 years.

Evidence is clear that delays cause poorer outcomes for patients, particularly older people.

Demographic factors, including an ageing population and growing demand for support for working age people with disabilities contribute to this – as does pressure on budgets.

Although councils have protected social care budgets in relative terms, ASC budgets have fallen in real terms.
8 March: 2017 Spring Budget

The government provided additional money for social care over the last few years including:

- Better Care Fund – minimum contribution to social care from CCGs
- Additional precept raising powers
- IBCF grant announced in SR2015

Spring Budget 2017 announced an additional £2 billion for social care, as part of an expanded iBCF, to be paid to councils and pooled in the BCF.

Condition of grant that all areas implement the High Impact change Model.
Better Care Fund 2017-19

Policy Framework 2017-19

**Fewer national conditions** for 2017-19

- Jointly agreed plan
- **NHS contribution to adult social care to be maintained in line with inflation**
- **NHS commissioned out of hospital services**
- Managing transfers of care

- New grant to local authorities for social care; **Improved Better Care Fund**
- Introduction of the **High Impact Change model** as a National condition

- BCF plans are used to confirm local plans for implementing the HIC model.

- Funding for the model can come from IBCF, CCG minimum, additional contributions or wider budgets
DToc Trajectory Exercise

• All HWB areas must set metrics for reducing Delayed Transfers of Care

• Department of Health published a set of expectations for DToc reductions at HWB level that each area must adopt in their BCF metrics.

• Targets must be split locally between NHS, social care and joint delays and these must be consistent with the national figures

• The implementation of the High Impact Change Model nationally will support reductions in delays by ensuring that proven best practice is implemented across the country
The Future

• Understanding what works in integration and its impact

• First wave of BCF graduates

• Accountable Care Systems – links to health and social care integration and graduation

• Integration scorecard – Government model for integration of health and social care

• Green paper on future of social care
There is an extensive support offer available for implementing the High Impact Change Model, delivering BCF plans and embedding integration, including:

- Better care advisor / multi-disciplinary support
- National thematic workshops, regional learning events and webinars
- The Better Care Exchange online collaboration platform
- BCF learning and development Programme
- LGA HIC model workshops
- Post-CQC brokerage support programme
Examples of Emerging Practice

The support offer will include a resource to support the implementation of the High Impact Change Model

• Intended to share learning and support local systems to developing local practice

• The resource will include:
  • Examples of emerging and developing practice across each of the eight changes
  • Signposting links to national guidance and tools
  • Examples from today, as well as others from across country

• To be published later this month as a ‘work in progress’

• Welcome additions and edits in this field of emerging practice
The HICM model – what the tool is all about and key messages for using it

Sarah Mitchell, Adult Social Care Improvement Adviser
High impact change model
Managing transfers of care between hospital and home


A self-assessment tool for local health and care systems
1. Introduction

This model was developed by strategic system partners including the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), NHS England, the Department of Health (DH), the Emergency Care Improvement Programme (ECIP), Monitor and the Trust Development Authority (now NHSi) during 2015.

It builds on lessons learnt from practice and promotes a new approach to system resilience, moving away from a focus solely on winter pressures to a year-round approach to supporting timely hospital discharge.

Whilst acknowledging that there is no simple solution to creating an effective and efficient care and health system, this model signals a commitment to work together to identify what can be done to improve current ways of working. The model was endorsed in a joint meeting between local government leaders and secretaries of state for health and for communities and local government in October 2015.
2. Purpose of the model

This high impact change model aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters.

It offers a practical approach to supporting local health and care systems to manage patient flow and discharge and can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year.

The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

• early discharge planning
• systems to monitor patient flow
• multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
• home first/discharge to assess
• seven-day services
• trusted assessors
• focus on choice
• enhancing health in care homes.
3. Principles

This model is not designed to be a performance management tool. Instead, it takes as its starting point a recognition that even the best performing systems will be experiencing challenges in relation to hospital discharge.

The model is underpinned by a sector-led improvement approach which emphasises the importance of triangulating both hard and soft types of data to tease out local stories within a culture of openness and trust. This model supports genuine, honest reflection and discussion between trusted colleagues within local health and care systems and includes a suggested action plan so that decisions arising from conversations using the model can be implemented across the year.
Working with local systems, we identified a number of high impact changes that can support local health and care systems reduce delayed transfers of care...

| Change 1: Early Discharge Planning. | In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours. |
| Change 2: Systems to Monitor Patient Flow. | Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual. |
| Change 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. | Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients. |
| Change 4: Home First/Discharge to Assess. | Providing short-term care and reablement in people’s homes or using ‘step-down’ beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow. |
| Change 5: Seven-Day Service. | Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people’s needs. |
| Change 6: Trusted Assessors. | Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way. |
| Change 7: Focus on Choice. | Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care. |
| Change 8: Enhancing Health in Care Homes. | Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge. |
4. The model

Change 1

Early discharge planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

Change 2

Systems to monitor patient flow. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.

Change 3

Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients.

Change 4

Home first/discharge to assess. Providing short-term care and reablement in people’s homes or using ‘step-down’ beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5

Seven-day service. Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people’s needs.

Change 6

Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7

Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.

Change 8

Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.
4. The model

High impact changes that can reduce delayed transfers of care between hospital and home

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Early discharge planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

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<tr>
<th>Not yet established</th>
<th>Plans in place</th>
<th>Established</th>
<th>Mature</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early discharge planning in the community for elective admissions is not yet in place</td>
<td>Clinical commissioning group (CCG) and adult social care (ASC) commissioners are discussing how community and primary care coordinate early discharge planning</td>
<td>Joint pre-admission discharge planning is in place in primary care</td>
<td>GPs and District Nurses lead the discussions about early discharge planning for elective admissions</td>
<td>Early discharge planning occurs for all planned admissions by an integrated community health and social care team</td>
</tr>
<tr>
<td>Discharge planning does not start in A&amp;E</td>
<td>Plans are in place to develop discharge planning in A&amp;E for emergency admissions</td>
<td>Emergency admissions have a provisional discharge date set in within 48 hours</td>
<td>Emergency admissions have discharge dates set which whole hospital are committed to delivering</td>
<td>Evidence shows X percent patients go home on date agreed on admission</td>
</tr>
</tbody>
</table>
### 4. The model

#### Change 2

Systems to monitor patient flow. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

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<tr>
<td>No relationship between demand and capacity in care pathways</td>
<td>Analysis of demand underway to calculate capacity needed for each care pathway</td>
<td>Policy agreed and plan in place to match capacity to care pathway demand</td>
<td>Capacity usually matches demand along the care pathway</td>
<td>Capacity always matches demand along the whole care pathway</td>
</tr>
<tr>
<td>Capacity available not related to current demand</td>
<td>Analysis of demand variations underway to identify current variations</td>
<td>Analysis completed and practice change rolled out across trust and in community</td>
<td>Capacity usually matches demand 24/7 to match real variation</td>
<td>Capacity always matches demand 24/7 reflecting real variations</td>
</tr>
<tr>
<td>Bottlenecks occur regularly in the trust and in the community</td>
<td>Analysis of causes of bottlenecks underway and practice changes being designed</td>
<td>Analysis completed and practice changes being put in place and evaluated</td>
<td>Bottlenecks rarely occur and are quickly tackled when they do</td>
<td>There are no bottlenecks caused by process or supply failure</td>
</tr>
<tr>
<td>There is no ability to increase capacity when admissions increase – tipping point reached quickly</td>
<td>Analysis of admissions variation ongoing with capacity increase plans being developed</td>
<td>Staff understand the need to increase capacity when admissions increase</td>
<td>Capacity is usually automatically increased when admissions increase</td>
<td>Capacity is always automatically increased when admissions increase</td>
</tr>
<tr>
<td>Staff do not understand the relationship between poor patient flow and senior clinical decision making and support</td>
<td>Staff training in place to ensure understanding of the need to increase senior clinical capacity</td>
<td>Staff understand the need to increase senior clinical support when necessary</td>
<td>Senior clinical decision making support is usually available and increased when necessary</td>
<td>Senior clinical decision making support available and increased automatically when necessary to carry out assessment and reviews 24/7</td>
</tr>
</tbody>
</table>
4. The model

Change 3
Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Coordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients.

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<tbody>
<tr>
<td>Separate discharge planning processes in place</td>
<td>Discussion ongoing to create integrated health and ASC discharge teams</td>
<td>Joint NHS and ASC discharge team in place</td>
<td>Joint teams trust each other’s assessments and discharge plans</td>
<td>Integrated teams using single assessment and discharge process</td>
</tr>
<tr>
<td>No daily multidisciplinary team meeting in place</td>
<td>Discussion to introduce MDTs on all wards with trust and community health and ASC</td>
<td>Daily MDT attended by ASC, voluntary sector and community health</td>
<td>Integrated teams cover all MDTs including community health provision to pull patients out</td>
<td>Integrated service supports MDTs using joint assessment and discharge processes</td>
</tr>
<tr>
<td>Continuing Health Care assessments carried out in hospital and taking “too” long</td>
<td>Discussion between CCG and trust to establish discharge to assess arrangements</td>
<td>Discharge to assess arrangements in place with care sector and community health providers</td>
<td>CHC and complex assessments done outside hospital in people’s homes/extra care or reablement beds</td>
<td>Fully integrated discharge to assess arrangements in place for all complex discharges</td>
</tr>
</tbody>
</table>
4. The model

Change 4
Home first/discharge to assess. Providing short-term care and reablement in people's homes or using ‘step-down’ beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

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<tr>
<td>People are still assessed for care on an acute hospital ward</td>
<td>Nursing capacity in community being created to do complex assessments in the community</td>
<td>People usually return home with reablement support for assessment</td>
<td>People return home with reablement support from integrated team</td>
<td>All patients return home for assessment and reablement after being declared fit for discharge</td>
</tr>
<tr>
<td>People enter residential /nursing care too early in their care career</td>
<td>Systems analysing which people can go home instead of into care – plans for self funder advice</td>
<td>People usually only enter a care/nursing home when their needs cannot be met through care at home</td>
<td>Most people return home for assessment before making a decision about future care</td>
<td>People always return home whenever possible supported by integrated health and social care support</td>
</tr>
<tr>
<td>People wait in hospital to be assessed by care home staff</td>
<td>Work being done to identify homes less responsive to assess people quickly</td>
<td>Care homes assess people usually within 48 hours</td>
<td>Care homes usually assess people in hospital within 24 hours</td>
<td>Care homes accept previous residents trusting trust /ASC staff assessment and always carry out new assessments within 24 hours</td>
</tr>
</tbody>
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4. The model

Change 5

Seven-day service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people’s needs.

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<tbody>
<tr>
<td>Discharge and social care teams assess and organise care during office hours five days a week</td>
<td>Plan to move to seven day working being drawn up</td>
<td>Health and social care teams working to new seven day working patterns</td>
<td>Health and social care teams providing seven day working</td>
<td>Seamless provision of care regardless of time of day or week</td>
</tr>
<tr>
<td>OOHs emergency teams provide non office hours and weekend support</td>
<td>New contracts and rota for health and social care staff being drawn up and negotiated</td>
<td>New contracts agreed and in place</td>
<td>New staffing rota and contracts in place across all disciplines</td>
<td>New staffing rotas and contracts in place and working seamlessly</td>
</tr>
<tr>
<td>Care services only assess and start new care Monday to Friday</td>
<td>Negotiations with care providers to assess and restart care at weekends</td>
<td>Staff ask and expect care providers to assess at weekends</td>
<td>Most care providers assess and restart care at weekends</td>
<td>All care providers assess and restart care 24/7</td>
</tr>
<tr>
<td>Diagnostics, pharmacy and patient transport only available Monday to Friday</td>
<td>Hospital departments have plans in place to open in the evenings and at weekends</td>
<td>Hospital departments open 24/7 whenever possible</td>
<td>Whole system commitment usually enabling care to restart within 24 hours, seven days a week</td>
<td>Whole system commitment enabling care always to restart within 24 hours, seven days a week</td>
</tr>
</tbody>
</table>
4. The model

Change 6

Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

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<tr>
<td>Assessments done separately by health and social care</td>
<td>Plan for training of health and social care staff</td>
<td>Assessments done by different organisations accepted and resources committed</td>
<td>Discharge and social care teams assessing on behalf of health and social care</td>
<td>Integrated assessment teams committing joint pooled resources</td>
</tr>
<tr>
<td>Multiple assessments requested from different professionals</td>
<td>One assessment form/system being discussed</td>
<td>One assessment format agreed between organisations/professions</td>
<td>Single assessment in place</td>
<td>Resources from pooled budget accessed by single assessment without separate organisational sign off</td>
</tr>
<tr>
<td>Care providers insist on assessing for the service or home</td>
<td>Care providers discussing joint approach of assessing on each other’s behalf</td>
<td>Care providers share responsibility of assessment</td>
<td>Some care providers assess on each other’s behalf and commit to care provision</td>
<td>Single assessment for care accepted and done by all care providers in system</td>
</tr>
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4. The model

Change 7

Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

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<tr>
<td>No advice or information available at admission</td>
<td>Draft pre-admission leaflet and information being prepared</td>
<td>Admission advice and information leaflets in place and being used</td>
<td>Patients and relatives aware that they need to decide about discharge quickly</td>
<td>Patients and relatives planning for discharge from point of admission</td>
</tr>
<tr>
<td>No choice protocol in place</td>
<td>Choice protocol being written or updated to reduce seven days</td>
<td>New choice protocol implemented and understood by staff</td>
<td>Choice protocol used proactively to challenge people</td>
<td>All staff understand choice and can discuss discharge proactively</td>
</tr>
<tr>
<td>No voluntary sector provision in place to support self-funders</td>
<td>Health and social care commissioners co-designing contracts with voluntary sectors</td>
<td>Voluntary sector provision in place in the trust proving advice and information</td>
<td>Voluntary sector provision integrated in discharge teams to support people home from hospital</td>
<td>Voluntary sector fully integrated as part of health and social care team both in the trust and the community</td>
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### 4. The model

#### Change 8

Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

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<tr>
<td>Care homes unsupported by local community and primary care</td>
<td>CCG and ASC commissioners working with care providers to identify need</td>
<td>Community and primary care support provided to care homes on request</td>
<td>Care homes manage the increased acuity in the care home</td>
<td>Care homes integrated into the whole health and social care community and primary care support</td>
</tr>
<tr>
<td>High numbers of referrals to A&amp;E from care homes especially in evenings and at weekends</td>
<td>Specific high referring care homes identified and plans in place to address</td>
<td>Dedicated intensive support to high referring homes in place</td>
<td>No unnecessary admissions from care homes at weekends</td>
<td>No variation in the flow of people from care homes into hospital during the week</td>
</tr>
<tr>
<td>Evidence of poor health indicators in Care Quality Commission (CQC) inspections</td>
<td>Analysis of poor care identifies homes where extra support and training needed</td>
<td>Quality and safeguarding plans in place to support care homes</td>
<td>Community health and social care teams working proactively to improve quality in care homes</td>
<td>Care home CQC ratings reflect high quality care</td>
</tr>
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</table>
## 4. The model

### Action planning template

<table>
<thead>
<tr>
<th>Impact change</th>
<th>Where are you now?</th>
<th>What do you need to do?</th>
<th>When will it be done by?</th>
<th>How will you know it has been successful?</th>
</tr>
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<td>Early discharge planning</td>
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<td>Systems to monitor patient flow</td>
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<td>Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)</td>
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Lincolnshire Delayed Discharge Journey June 2015 to present

Lynne Bucknell
LCC Adult Care and Community Wellbeing

Michele Seddon
Chief Executive Age UK Lincoln & Kesteven
Introduction to Lincolnshire
Significant Events June 2015 to Present

June 2015; LCC awarded 12 Prime provider Home care contracts covering the County

November 2015; LinCA CHTA commenced
Allied Healthcare commenced Reablement contract
Hospital avoidance response team (HART)

December 2015; Transitional Care Pathways agreed and imbedded in discharge hubs

August 2016; Home First Principles Launched

October 2016; Joint procurement of Transitional beds with LCHS goes live
Significant Events June 2015 to Present

**2017;** BCF Plan commences

**January 2017;** All acute hospital discharges with 4 specialist teams

**July 2017;** LCC acute hospital based staff commence 7 day working contracts

**September 2017;** BCF Narrative Plan completed

**October 2017;** Lincolnshire DTOC Summit
In June 2015, Lincolnshire County Council awarded 12 contracts to Home Care Providers across the county under a new "Prime Provider" approach

- County split into 12 geographical zones:
- Each zone has a sufficient level of guaranteed work to make it both commercially viable and attractive to providers;
- Zones align to the social work area teams making operational engagement easier;
- More efficient planning of rounds for providers to improve continuity of care and drive down inefficiencies;
- Reduced competition for staff as less organisations operating on the same patch thus leading to improved retention of key staff and improved resilience – one of the most pressing issues facing home care locally and nationally;
New standardised hourly rates
Award of one contract per zone:

• A 'Prime Provider' per zone to act as exclusive lead in delivering homecare services;

• Model designed to allow for organisations to put forward collaborative solutions;

• Requirement to sub contract a minimum of 10% to Small Medium Enterprise (SME) providers to support the diversity of choice within Lincolnshire;
Nationally the number of delayed days (per 100k) for social care has increased steadily since April 14, peaking in March 17, before falling slightly. Within Lincolnshire the numbers have fallen significantly since January 17 to 23.7 days per 100k in July 17.
Care home trusted assessor

Working together to improve transfers from hospital to care homes
THE STORY SO FAR

Sept 15
Pilot agreed - Assessor to be employed by Care Home Sector to work on behalf of Managers

Nov 15,
CHTA recruited to cover 27.5 hours at one hospital site

April 16
Coverage extended to all hospital sites in Lincolnshire and Peterborough

September 2016
7 day working commenced
STATS WITH ONE CHTA SEPT 15 – MAR 16

- 151 referrals made
- 90 Assessment completed
- 80 discharges agreed
- 61 of referrals CHTA played major role in discharge plan
- Total Savings: £193,000 Gross
  - £143,050 Net
- Total days saved: 351
FIRST FULL YEAR STATS

439 referrals
340 Assessments Completed
304 discharges
Total days saved 735
Total Savings £400K (Net)
BUILDING FOR THE FUTURE

Estimated savings
- 7 day coverage at 3 sites
- Net £750,000
Single County Wide Reablement contract awarded to Allied Healthcare

- Eligibility kept wide
- One County wide Provider
- Focused on delivering excellent reablement Outcomes
- 40% increase in capacity in year one
- 60% people reabled to no ongoing AC support
Michele Seddon
Chief Executive
As with most successful partnerships, timing is key.......
LILP

Partnership Agreement

• November 2013

‘Working in partnership with Commissioners & Providers to develop and improve local Services’.
Membership

• LACE Housing Association
• Age UK Lincoln & Kesteven
• Lincs Home Independence Agency
• St Barnabas Hospice
• Boston Mayflower Housing
Projects

- PACT – 2012/3
- Wellbeing Service 2014/18
- HART 2015/18
Offer

- Diverse
- Resources
- Accessible
- Flexible
- Responsive
- Experience, skills & knowledge
- Local
- Outcome focused
Wellbeing Service
What is it?

Lot 1, Countywide Monitoring Service
• TeleCare monitoring, response triggering, proactive wellbeing phone calls – NRS Health Care

Lot 2, Wellbeing Support and Response Service
• Trusted Assessment (7 days from referral)
  Generic Support (10 days from assessment)
  Minor Adaptations (7 days from assessment)
  Equipment (5 days from assessment)
  TeleCare (7 days from assessment)
  Wellbeing Response – Stay Safe & Home Safe (365)
• Delivered by four LILP members in Boston Borough, City of Lincoln, South Holland, South Kesteven and West Lindsey
• Delivered by East Lindsey and North Kesteven District Councils in their districts…but Home Safe delivered by LILP
HART Service
– What does it offer?

*Reduction in delayed discharges and support admission avoidance by:*

- Facilitating a supported discharge and providing up to 72 hours of care and support to resettle a person at home
- Offer a ‘bridging the gap service’ for a 72 hr period to give other domiciliary providers or the reablement service the opportunity to commence later in the pathway
- Support the C.A.S. Team to avoid hospital admission and/or attendance at A&E
- Offer a telecare unit as part of the service, enabling person to have access to the responders 24/7 – assurance of support through the night should it be required
- offers the person a Wellbeing Service assessment and will refer them on appropriately if accepted
HART Service – Activity

The Story So Far
(Dec 2015—August 2017)

- 1,553 People Supported
- 464 Support to non-injury Falls Call outs
- 4761 Responsive & Planned Call outs
- 346 Referrals onto Wellbeing Service
- 281 Self Care or Independent Pathways
- 1,250 Hospital Discharges (80%)
- 303 Admission Avoidances (20%)
- 539 Ambulances stood down

*Savings to local NHS
£400 per bed day
£2000 AA

£1.3mill
• HART provided Admission Avoidance support at home to 303 patients from December 2015 to August 2017.

• Assuming a saving of £2000 per admission, this equates to a saving of £606,000.
HART provide a ‘Bridging the Gap’ service, whereby they provide interim support at home until other services are available.

Approximately 1220 bed days were saved from December 2015 to August 2017, which equates to a saving of £488,000 (assuming a cost per bed day of £400).
HART Service
– Key outcomes

• 1553 people supported between 15th December 2015 and 31st August 2017
• Currently accepting up to 106 referrals per month
• Service offers agility and flexibility
• A proven 1,220 bed days saved equating to a cost saving of £488,000
• 670 further days potentially saved equating to a saving of £268,000 (in addition to the £488,000)
• 303 Admission avoidances equating to a saving of £606,000

• Total Savings - £1,094,000
Resources/Criteria

- Service charge until end of August 2017 - £386,156
- Delivered by LILP members Age UK Lincoln & Kesteven and Boston Mayflower (Sub-contract to Walnut Home Care)
- Live in Lincolnshire – over 18’s – would stop an avoidable A&E attendance/admission into secondary care – plus speed up discharge out of secondary care.
- Training: Staff complete mandatory training – plus Care Certificate/First Responder.
- Shift Pattern – covering 24hours / 7 days / week – Co located at the Lincolnshire Community Health Services Centre.
The functions of Transitional Care

- Neighbourhood Care Teams
- Long Term conditions
- Self Care
- End of Life
- Single or Short Term Interventions

Transitional Care

- Patient Flow Management
- Transitional Care HOME FIRST
- HART
- Lincolnshire Reablement Service (LRS)

Short Term Interventions
Recovery
Rehabilitation
Reassessment
Reablement

Transitional Care Placements
Community Hospitals (Inpatient)
Care Homes
Step Down Flats

Responsive

End of Life
Long Term conditions
Transitional Care
Self Care
Single or Short Term Interventions
Neighbourhood Care Teams

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Transitional Care – Home First Principles

Home
We will support people to remain in their own homes wherever possible and if they are not at home we will strive to ensure they return home as swiftly as possible

Outcomes
We will work with people to understand what is important to them and support them to achieve the outcomes they identify

Empower
We will recognise that people are individuals, not patients or conditions. Our role is to support people to be stronger, more confident and in control of their own lives

Innovative
We will not match people to services, but will build on the permission we have to develop and utilise new ways of supporting people to meet their goals

Risk
We will be positive in our identification of risks and support people to make their own choices about how and where they wish to live their lives

Strengths
We will recognise that everyone we work with has strengths and assets. We will support people to identify these assets and work with them to utilise them in the best possible way
Empowering the local population to take an active role in their health and wellbeing— with greater choice and control.

Local Population (Fit / Low)

Neighbourhood Care Team (Moderate / Severe)
Primary Care, Statutory, Independent Voluntary organisations

Neighbourhood Network (Low / Moderate)
Self Care, social prescribing, voluntary, preventative, Public Health, community groups
July 2017 Summary

- Both Nationally and within Lincolnshire the majority of delayed days are attributable to the NHS, 56% nationally and 76% in Lincolnshire.
- In July only 8% of delayed days within Lincolnshire were attributable to Social Care, compared to 37% nationally.
Moving Forward

- Joint commissioning across Health & Care
- Community pull from the hub model
- Work with all partners on early discharge planning

The Journey continues
Discharge to Assess in Tower Hamlets

Breaking paradigms, creating ambition, raising the bar

Patricia Oguta – Adult Social Care Lead
Fiona Davies – Clinical & Project Lead, Admission Avoidance & Discharge Service
To implement an integrated ‘discharge to assess model (D2A)’ for Tower Hamlets residents so that they are discharged from hospital as soon as they are medically optimised, rather than staying on the ward waiting for further social and functional assessments to take place.
AADS and Discharge to assess – history and where we are now

- **CCG funded a D2A pilot in 2015-16**
- **Started small – 15 patients**
- **Other winter resilience schemes running in parallel – AAT, H@H, out of hours hospital social work**
- **Merged to re-launch as AADS in September 2017**
- **No step-down beds since original pilot**
- **D2A CHC pathway being piloted**
- **Supported by Age UK “Take Home & Settle” Service**
AADS and Discharge to assess – history and where we are now

- **Tower Hamlets D2A - success has been down to partnership working and a whole systems approach, with a big emphasis on supporting people in their home**

- **Trusted Assessor model: we are implementing this to screen patients in hospital before discharge**

- **We are currently reviewing and refining the process to make the best use of our staffing resource**
AADS and Discharge to assess – what is AADS?

**AADS = Admission Avoidance & Discharge Service**

- **Rapid Response in the community**
- **Admission Avoidance Team in the RLH Emergency Department** (works in partnership with social workers)
- **In-reach nurses and AADS screeners based at RLH**
- **Intermediate Care Team** – uses D2A model and offers up to 6 weeks intensive rehabilitation in the community

**Eligibility criteria: 18yrs+, Tower Hamlets resident, further assessment needed in the community**

**Exclusions: Fast Track completed, palliative care and no therapy needs**
AADS and Discharge to assess – referral and discharge process

- **Referral received by screeners on dedicated phone**
- **Screener goes to ward (ideally with social worker if care package required)**
- **Establish if medically optimised or date this is expected**
- **Meets patient and family if present, liaises with ward therapists/nurses re immediate needs at home (e.g. equipment)**
- **Shares screening paperwork and recommendation re package required with social worker if not present at initial meeting**
- **Social worker completes Reablement request on Framework-I**
- **Discharged same day if possible; care starts same day**
- **Same day therapy or nursing visit allocated if additional risks identified/immediate assessment needed**
- **Community therapist and/or nurse visit allocated at AADS meeting next morning and visit takes place within 24hrs of discharge (or allocated to CHC D2A pathway)**
AADS and Discharge to assess – referral and discharge process

**Referral received**

**Screener goes to ward**

Within 2 hours

**Meets patient & liaises with MDT re immediate needs**

Same day

**Medically optimised**

Care package arranged if required

Discharged home

AADS team visit within 24 hrs
AADS and Discharge to assess – history and where we are now

• Currently D2A is a pathway within AADS and has:
  ➢ 3 Social Workers, 4 OTs, 3 physios, 4 nurses, 3 RSWs
  ➢ 2 case finders/screeners (one nurse, one therapist)
• 7 day service 8-6pm, up to 6 weeks community input
• The full social care assessment starts in the community, depending on individual needs
• Most packages provided by the Reablement Team and support the goals set by the Therapists
• Short-term night care possible
Success with more complex patients (e.g. CHC checklist in hospital - no longer required post AADS)

KPI's include readmission rates (30 & 90 days post discharge)

Improved recovery as patient assessed in own home, familiar environment

Recent data for 45 people: 30 required reduced or no care package on discharge from the pathway = 66%

Average readmissions for D2A patients within 30 days June-August 2017 = 11.4%

Overall cash benefits/savings for the LA, CHC, CCG

At the end of pathway, fewer people require on-going commissioned care packages/long term social care support

Where we are now and where we want to be
Outcomes of D2A

- TH D2A model continues to impact on Delayed Transfer of Care (DTOCs)
- Improves patient flow and reduces length of stay
- Reduced LOS if admitted (AADS follows up patients who attend ED/are admitted to hospital and facilitates discharge)
- Closure of inpatient rehabilitation ward and 2nd ward closing in next few weeks (2 x 24 bedded wards)
- Reduction in CHC assessments and admissions to residential and nursing care homes (3 patients of 350+ since November 2016)
- **Challenges** – funding/new culture/way of working
• 77 year old man, lives alone, no family, friends or next of kin
• Admitted to RLH after being found on the street by the police wandering and appeared confused
• Previous diagnosis of dementia, additional confusion thought to be due to a UTI. RAID involved on ward
• Prior to admission, care package of two visits daily from a care agency, known to care navigator
• MDT had a meeting and made the decision that he required 24 hour support (placement recommended), checklist was undertaken on the ward
• Referred to AADS, clear that he wished to be discharged home
• Blitz cleaning of his property was undertaken in his best interest in consultation with IMCA
Patient story -

• Believes he is still living with his mother and reported spending his day in St. James’s Park
• Discharged home with 24 hour carer support to accompany/escort him on all outings, observe how he manages outdoor activities, ensure his safe return, identify risks and safety issues
• Therapy intervention (OT), given opportunity to take the lead with his support services, given a mobile phone
• After a week, care changed to two block hours (7 hrs and 2 hrs), overnight service was stopped
• Outcome of AADS input is that he has demonstrated good orientation to his environment and variable safety awareness
• Tends to go out of his property on a regular basis but always manages to find his way back home
• Local authority arranged appointeeship for finances
Patient story

- 77 yr old male, residing in residential home admitted to RLH with sepsis, history of heart failure, falls and above knee amputation

- Assessed by AADS – initially home manager refused for him to return without additional services being arranged or a move to a nursing bed

- Requested low profiling bed, 24 hour one-to-one carer, DN to administer insulin, physiotherapist

- Discharged back to care home with all service/equipment in place, 24 hr care (waking nights), to monitor current level of need as not engaging on the ward

- POC reviewed after two weeks - no longer needed 24 hour care as sleeping during the night, care package reduced to 12 hours
• Care agency noted improvement in physical health, eating and drinking but still needed encouragement
• Started using the garden with the support of the carers
• Still needed carers to support with above and personal care, toileting and changing his pad so care agency were to continue with 12 hrs day-time care package
• Another review took place after a week and further improvements noted - care package reduced to four visits daily
• Reviewed again later that week - extra agency care package stopped and care home took over
• Initial concerns from care home manager, but negotiated and agreed to continue
Patient story

- 68 yr old woman, spinal brace, dementia, 1:1 on ward to prevent her removing it as felt to be confused
- Bengali speaking, living in extra care sheltered housing that specialises in care for Asian elders
- Needed 4 people to log-roll twice daily to put on and take off brace, 24 hr carer to ensure she kept it on
- No nursing home would accept her
- AADS assessed and arranged 24 hour Bengali speaking carer and OT, additional visit from Reablement
- Found to be less confused than ward had indicated once she understood why she needed to wear the brace
- Care reduced to sleeping night carer
• 100% patient satisfaction achieved most months

Patient feedback: “...It’s reassuring and gives you that confidence, definitely. Because like for me, I’m not moving in hospital like I do at home, because you haven’t got rails and things for me to pull myself around on...Literally I was having 3 or 4 nurses to help me just get off the bed, ...they said to me, “How many carers do you have at home?” I said, “One.” ...because I’ve got furniture, I’ve been doing it years, I’ve lived in my house since 1980, so my body is used to going a certain way... I’ve got things around to hold on and lean on. And I came back home and, yeah, I struggled for a little while because I didn’t want to push myself. I didn’t want to go too fast too quickly, yeah, but I didn’t want to not do it either. So it was great, because now I’m back to where I was before I ever went in hospital and that’s how I like it.”
Developing a Home First Approach

A Journey to Improving Discharge and Avoiding Admissions

Ruth Lake, Leicester City Council
Overview

Developing a collective concern
Understanding the reality
Working together
Monitoring Impact
Sharing success and aiming higher
Leicester: 5000-1 City…but a challenged system

Highly deprived city with poor health & life outcomes

- Highly diverse (52.6% BME) with ill health at an early age
- Health literacy of c.7 years of age
- High acute use compared to peers
- Poor perceptions of primary care access

Particularly poor winter 13/14

- Failing A&E standards
- Failing DTOC standards
- Failing ambulance standards
- Poor patient feedback
- Poor external reviews

...but we are a City genuinely open to innovation. We can deliver the most unexpected results in the most challenging of circumstances.
Developing a Collective Concern

• Senior Recognition that we were letting people down
• Agreeing a simple objective
• Open book approach to the current position
• BCF as a catalyst
Understanding the Reality

DATA, DATA, DATA

- Collect and challenge
- Find the common truth
- Questions are as helpful as answers
- Use performance data to evaluate service effectiveness – open and transparent
Working together
Leading change from the frontline

**disruption** is the new normal!

“By questioning existing ideas, by opening new fields for action, change agents actually help organisations survive and adapt to the 21st Century.”

Céline Schillinger

1. Activate disruptors, heretics, radicals and mavericks
2. Lead transformation from ‘the edge’
3. Change your story
4. Curate rather than create knowledge
5. Build bridges to connect the disconnected

Old power vs. new power:
- Currency vs. Current
- Held by a few vs. Made by many
- Pushed down vs. Pulled in
- Commanded vs. Shared
- Closed vs. Open
- Transaction vs. Relationship

Jeremy Simmons TED talk: “What new power looks like”
https://www.youtube.com/watch?v=50tSgY7E4A
The Leicester City BCF-enabled pathway of care

- **Integrated Lifestyle Hub** tackling wider determinants of ill health
- **GP-led care planning** for patients identified via Risk Stratification system
- **Clinical Response Team (CRT)** – Emergency Care Practitioner-led teams roving the City & taking admissions avoidance calls from 999/111, GP urgent referrals & care homes (Ad Av / HICM 5)
- Supported via **integrated crisis response service (ICRS)** and community health services on a 2 hour response basis (Ad Av / HICM 4 / 5)
- Wrap around rapid access to services such as AT, falls assessment, equipment, handyperson Ad Av
- **Daily patient tracking** meetings in partnership with the acute site with dedicated hospital Social Work team (HICM 2)
- **Enhanced community ‘beds at home’** – Intensive Community Support (ICS)
- **Integrated pathways for non-weight bearing patients plus Discharge to Assess services** (HICM 4)
- **Proactive discharge follow up** for at risk groups (HICM 8)
Integrated Crisis Response Service

- Over 5500 urgent referrals per annum
- 25% = falls management
- 25% = pre-admission discharge avoidance
- In 2015 of 1010 falls cases, only 11 conveyances to hospital
- 1565 cases shared with health services
- 75% require no further services after intervention
- Exceptional patient satisfaction rates
- [https://vimeo.com/album/2414935](https://vimeo.com/album/2414935) (password = lcc001)
- A ‘can do’ culture
Health Transfers Service

- Dedicated hospital SW plus reablement function
- Redesign of existing resources: Ward linked staff
- Proactive – find our clients before notification
- HomeFirst – why not home; why not today
- Reduced acute delays to minimum
- 70% discharges without statutory notification
- April 2017 – Integrated Discharge Team across Leicester / Leicestershire (HICM 3 / 6)
- Changing what you control vs changing in collaboration
Emergency Admissions

• Coding is a constant challenge to understanding impact
• 5.8% growth noted in emergency admissions for Leicester City patients when comparing year on year activity but…
• Large growth in 0-6 hour emergency admissions overall for all age groups (+41% compared to same time last year).
• Children - due to a pathway change in our new ED floor after contract completion for 17/18

• Net position approximately -1%
Leicester City - NHS Delays

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>9.6</td>
<td>7.5</td>
<td>7.6</td>
<td>8.5</td>
</tr>
<tr>
<td>Q2</td>
<td>7.5</td>
<td>7.3</td>
<td>2.8</td>
<td>6.7</td>
</tr>
<tr>
<td>Q3</td>
<td>7.6</td>
<td>2.8</td>
<td>3.5</td>
<td>4.9</td>
</tr>
<tr>
<td>Q4</td>
<td>7.3</td>
<td>2.9</td>
<td>6.4</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Actual: Leicester City

Target: 6.4
Move towards ‘Integrated Locality Teams’ across the City

- Applying our BCF model of Integrated Care to a bigger cohort of patients across the system
- Expanding what already works at a more local level (c30k pts) rather than pan-city
- Adding in joint case management functions across all disciplines
- Redesigning the full ASC and community health services offer around localities
Key Messages

• Start with the truth
• Commit to changing yourself
• Frontline staff design: Senior people facilitate
• Have a clear goal – allow your plan to develop
• Use data to evidence your impact
• Stick with it – it takes time and it’s unlikely to be plain sailing
Thank you for your time
Delayed Transfers Of Care
High Impact Changes
Kent County Council

Anne Tidmarsh
Director Older People and Physical Disability

28 September 2017
**Eight high impact changes**

<table>
<thead>
<tr>
<th>Change 1</th>
<th>Early Discharge Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change 2</td>
<td>Systems to Monitor Patient Flow</td>
</tr>
<tr>
<td>Change 3</td>
<td>Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector</td>
</tr>
<tr>
<td>Change 4</td>
<td>Home First/Discharge to Access</td>
</tr>
<tr>
<td>Change 5</td>
<td>Seven-Day Service</td>
</tr>
<tr>
<td>Change 6</td>
<td>Trusted Assessors</td>
</tr>
<tr>
<td>Change 7</td>
<td>Focus on Choice</td>
</tr>
<tr>
<td>Change 8</td>
<td>Enhancing Health in Care Homes</td>
</tr>
</tbody>
</table>
South East ADASS Branch:

• South East ADASS focus on managing transfers of care continues at South East ADASS branch meetings.
  - DASS2DASS peer discussions
  - analysis by central team
  - self assessment repeated 2017
  - bespoke work commissioned by CHIA

• Regional SE Network agreed to:
  – share effective practice
  – establish how to take forward a more informed social care perspective
Kent

4 Acute Trusts spread over 7 sites
7 CCGs
2 Community Health Providers and 1 MH
12 District Councils and 1 County Council
Wide range of Private and Voluntary Sector Care Providers
Eight high impact changes

Change 1: **Early Discharge Planning**: Social Care presence at Front Door

Change 2: **Systems to Monitor Patient Flow**: use of SHREWD and new Dashboard

Change 3: **Multi-Disciplinary/Multi-Agency Discharge Teams**, including the voluntary and community sector in place on all sites

Change 4: **Home First/Discharge to Access**, well established in East Kent, in development in West and North Kent

Change 5: **Seven-Day Service**, well embedded in social care not in the Trust

Change 6: **Trusted Assessors**, part of the IDTs but could be developed further

Change 7: **Focus on Choice**, implemented on all sites

Change 8: **Enhancing Health in Care Homes**, models being developed on a CCG footprint
Our Journey to date

• Phase 1 Transformation started in May 2013
• Working with Efficiency Partner - Newton Europe
• 3 programmes – Care Pathways, Optimisation and Commissioning
• Work focused on making better use of systems and embedding the culture of promoting service user independence, whilst establishing the foundations for future transformation
• Phase 2 started 2014, 2 programmes – Acute Hospitals Optimisation and Access to Independence.
• Phase 3-pathway redesign, started April 2017
The Vision For Adults

Supporting KCC’s strategic outcome: older and vulnerable residents are safe and supported with choices to live independently.
Acute Hospital Optimisation

In 11% of cases residential was deemed appropriate.
What is our Service aiming to achieve?

1. Identify and select the best outcome for each person.
2. Understand and address the biggest issues preventing the most appropriate outcome.
3. Escalate issues for Area- and County-wide action.
4. Training, tools, processes and governance in place to support staff in the delivery of an effective service.
Wash-up Board

Acute Hospital Optimisation
‘Selecting pathways that promote independence following hospital stays’

Triage
Assessment
Decision
Discharge
What is required to get this person back home safely?

Can this be managed by someone other than KCC staff?

Are there any blockers to accessing what we need to get this person home?

Can we challenge the obstacles?

What is the alternative if the ideal service is not available?

Concern from family / friends?

Capacity?

No suitable accommodation?

Care Navigators

Concern from wards?

Availability?

Delay in accessing equipment?

Is a risk assessment required to support decision making?

Can we take this to the weekly improvement cycle - shall we make that an action?
<table>
<thead>
<tr>
<th>Patient’s name</th>
<th>Ideal outcome</th>
<th>Expected outcome</th>
<th>Blocker reason</th>
<th>Action, action owner and deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Smith</td>
<td>Home</td>
<td>Long term residential care</td>
<td>Night sitting service not available</td>
<td>Escalate issue at weekly improvement cycle meetings, and AMT.</td>
</tr>
</tbody>
</table>

All complex cases (those at risk of leading to placement) are added to the wash up board.

All new referrals will be put on the board prior to the next meeting.

Once the discharge date is confirmed, the Business Support Officer should input the following information onto SWIFT; patient ID, ideal outcome, actual outcome, blocker reason and date of discharge.

Research alternatives

Review: 26th April
Weekly improvement cycle

Acute Hospital Optimisation

Discussions at wash-up

Blockers identified

SWIFT report showing blocker pareto

Action taken to resolve blocker issue during weekly improvement cycle or escalated to area management team

To achieve the best outcome for the service user
# Sustainability Matrix

## Acute Hospital Optimisation

### Identifying and Selecting the best outcome for the service user

**1 Shared Principles**
A vision and set of principles that justify and drive actions and behaviours in a consistent manner. Vision to promote independence for those leaving an acute setting by ensuring they end up on the best pathway for their needs.
- What is the most appropriate setting for this person?
- How can we understand and address the biggest issues preventing the most appropriate outcome?
- What issues require Area and County-wide action?

<table>
<thead>
<tr>
<th>County Owner (Director)</th>
<th>Anne Tidmarsh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area Owner (AD)</td>
<td>TBC</td>
</tr>
<tr>
<td>Owner (SCDC)</td>
<td>TBC</td>
</tr>
</tbody>
</table>

**2 Senior Support**
Senior resource with the right skills and mindset allocated to drive the right behaviours and support the team in setting goals for Service Users’ ideal outcomes.

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</tr>
</tbody>
</table>
### Acute Hospital Optimisation

#### Ward Staff Team Leader:
“I don’t know half of what’s on there, the girls on the ward don’t stand a chance”

#### Matron:
“We’re all talking different languages and patients are totally confused”

#### Pathway Team Manager:
“Social care can often only share previous care package details verbally and not in print, thus picking the most appropriate care is made far harder.”

---

**It is not expected that every professional would know every service, but it is clear that the ward staff are not the best people to discuss post-acute services with the citizen and their family**

**System needs to be designed so that the correct option is the easiest option**
"Everyone feels more supported in getting someone home."

"The daily wash-up process provides us with a mechanism to ensure we are applying an evidence-based method of approaching cases and achieve the best outcome for service users."

59% Reduction in Long-Term Resi

54% Reduction in Short-Term Beds

350 Extra People Going to Live Back at Home Each Year

LTB

STB

“Own Bed is Best Bed”

Reduction in Short-Term Beds
Area Results

**East:**
- LTB: ↓60%
- STB: ↓65%

**North:**
- LTB: ↓46%
- STB: ↓22%

**West:**
- LTB: ↓45%
- STB: ↓76%

Extra People Going to Live Back at Home Each Year

- **East:** 250 x10
- **North:** 50 x10
- **West:** 50 x10

Own Bed is Best Bed
The benefit delivered through transformation has resulted in KCC performing well across a number of national benchmarks, including OP Residential and Nursing Placements.
Measuring Performance

This box would show inappropriate discharges in the last two weeks, however there have not be any for this reporting period.
Reduced delays through better flow.
Improvement Cycle

Data Capture
Discussions at Washup
Supported Daily decision making and accurately recording information

Data Analysis
Then what? Your opinions are heard. Highlighting the biggest blocker to the best outcomes

Problem Solving
Getting the BEST outcome for the Service User

Resource Allocation
Actions Identifying who can solve the problem at the Weekly Improvement Cycle Meeting
### Sustainability Matrix

**Acute Hospital Optimisation**

<table>
<thead>
<tr>
<th>Identified Issue</th>
<th>QEQM</th>
<th>WHH</th>
<th>KCH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bronze</strong>: Teams are running the changed service with support from the project team</td>
<td>Bronze</td>
<td>Gold</td>
<td>Gold</td>
</tr>
<tr>
<td><strong>Silver</strong>: Bronze is achieved, changes are owned by KCC and maintained with Senior Management support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Gold</strong>: Silver is achieved independently within teams, and there is a drive to continually improve processes. For hospital teams, an integrated service is run with the Health colleagues.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Feedback from staff

“Big positive being able to discuss a case, having colleagues’ input.”

“Initially hard to challenge each other.”

“Makes us work more similarly and more consistent in the way we work.”

“It’s changed the way that we think”

“Provides more support for us”

“Useful seeing things from other people’s perspective.”

“Didn’t feel comfortable at first... our way of thinking has changed through the process.”

“There was a fear of the unknown before we started.”

“It’s like a group supervision... gives you more confidence in your decision making.”
“Everyone feels more supported in getting someone home.”

Mrs H’s Story
- Admitted following a severe stroke
- Previously lived with her husband and had been entirely independent
- Referred into long term bed by health as she was on a peg feed
- Speech and Language Therapist reviewed Mrs H and upgraded her to a soft diet
- Mrs H wanted to go home but her family were scared about her ability to cope
- The social worker offered additional support to help Mrs H go home:
  - Dietician created a list of suitable meals
  - Apetito providing meals on wheel for 3 weeks to help give Mr H ideas for what he could cook
  - Enablement and Telecare (falls sensor and carer’s assist)
  - 24-hr care from Crossroads to help with the first 3 days of discharge

“The daily wash-up process provides us with a mechanism to ensure we are applying an evidence-based method of approaching cases and achieve the best outcome for service users”
Kent Transformation Programme

**Phase One**

- Additional **3,500** older people per year accessing enablement
- Additional **2,000** older people per year accessing telecare
- Additional **3,600** older people per year receiving Promoting Independence Reviews
- **£21m cashable savings**

**Phase Two**

- Reduction of **55 minutes** in the average package size for older people receiving care after enablement
- Additional **350** older people per year going home when discharged from hospital
- Reduced hospital delays
- **£15 m cashable savings**

**Phase Three**

- Finalising the new operating model: acknowledging professional competencies (OT, Social Work, Nursing) and improving quality of service response (including Safeguarding).
- Demand management: Voluntary Sector response to reduce statutory, more expensive services
- Improved recruitment

Outcomes have been improved for service users and staff, with an operating model fit for the future to be embedded and sustained as BAU.
The Vision for the next five years is:
“To help people improve or maintain their wellbeing and to live as independently as possible”.

Good Practice and the delivery of quality services remains a priority.

DTOC key national target and HICs good framework.

Operating model changes, professional qualifications linked to role.