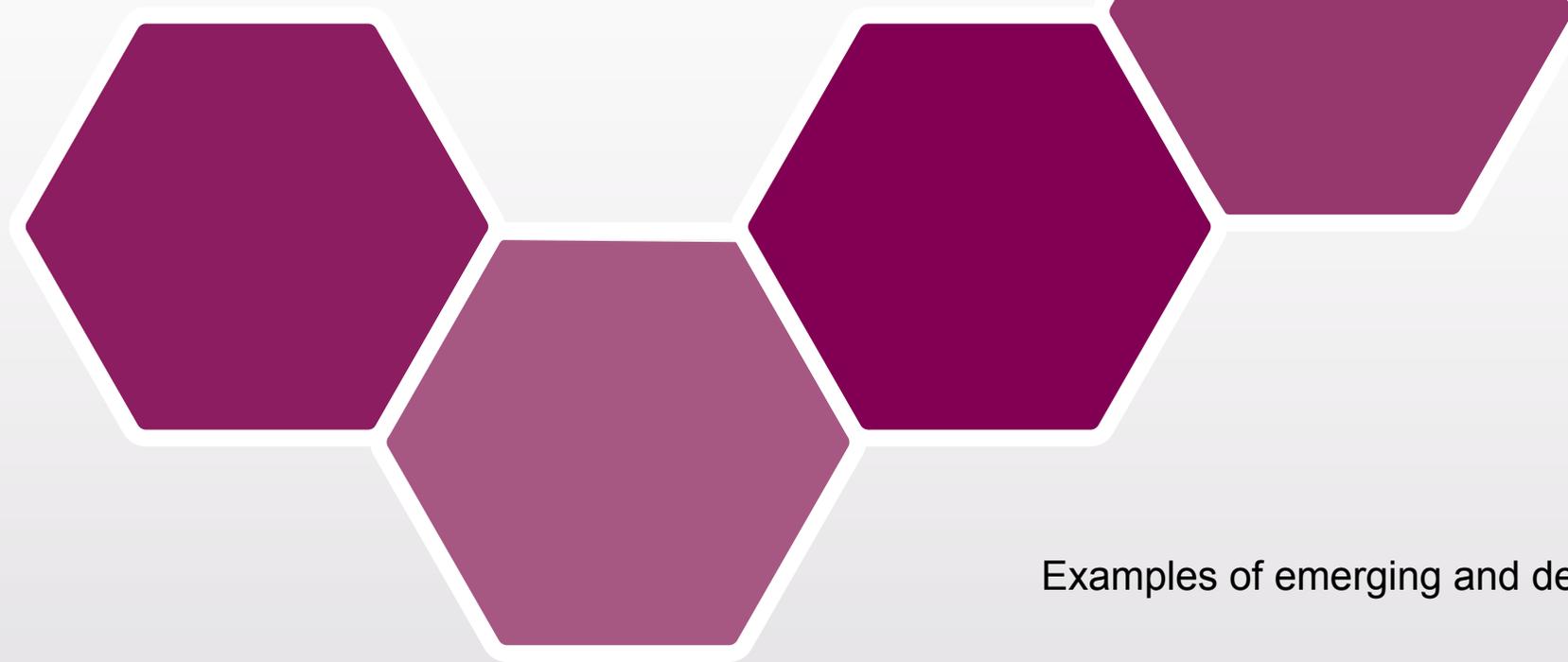


# High impact change model

Managing transfers of care



Examples of emerging and developing practice

# Contents

About this resource	3
Managing transfers of care using the high impact change model examples of emerging and developing practice	4
The high impact change model – an overall approach	5
Examples of how local areas are working to implement overall system change	6
Change 1. Early discharge planning	11
Examples of local initiatives	12
Change 2. Systems to monitor patient flow	17
Examples of local initiatives	18
Change 3. Multi-disciplinary/multi-agency discharge teams	20
Examples of local initiatives	21
Change 4. Home first/discharge to assess	24
Examples of local initiatives	25
Change 5. Seven-day services	30
Examples of local initiatives	31
Change 6. Trusted assessors	32
Examples of local initiatives	33
Change 7. Focus on choice	34
Examples of local initiatives	35
Change 8. Enhancing health in care homes	38
Examples of local initiatives	39

# About this resource

The High impact change model for managing transfers of care, which was developed by the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS), national partners and the sector in 2015, offers a practical approach to managing patient flow and hospital discharge. The model identifies eight system changes that will have the greatest impact on reducing delayed discharge.

This resource supplements the model by bringing together examples of work being undertaken across the country, for each of the eight system changes. It references a range of initiatives where there is already evidence of impact, points to examples of emerging practice that are starting to make a difference and includes links to published guidance, and further information.

## Emerging practice and shared learning

Local health and care systems face a range of challenges, and managing transfers is a complex task, for which there is no single answer or quick fix. This resource is not a checklist of actions, and not all of the examples will be the right solution for your context, but we have included a range of ideas and initiatives that you may want to explore and develop further. Many of these are new or recently implemented, and we are enormously grateful to the people who have been willing to offer up information about their work and their experiences, with a real spirit of shared learning.

Our aim is for this resource to grow and develop as the evidence base expands, and we intend to regularly review and update it. For that to happen, we will continue to be reliant on your contributions. If you would like to share learning from your own practice, whatever its stage of development, or have additional or updated information about any of the current examples, please contact [chip@local.gov.uk](mailto:chip@local.gov.uk)

We'd also welcome your views on what's included, and what you'd like to see more of.

## Version control

Version 1.0 – Published 2017, Next review date March 2018

# Managing transfers of care using the high impact change model

## examples of emerging and developing practice

### Initiatives that cross a number of change elements

<b>Sheffield</b> Reducing delayed transfers of care	<b>Leicester</b> A journey to improving discharge and avoiding admissions	<b>Newcastle Gateshead</b> Testing new models to improve transfers of care	<b>Lincolnshire</b> Improving the delayed discharge journey	<b>Mansfield</b> Implementing the ASSIST hospital discharge scheme
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### Initiatives addressing specific change elements

1. Early discharge planning	2. Systems to monitor patient flow	3. Multi-disciplinary/ multi-agency discharge teams	4. Home First/ Discharge to Assess	5. Seven day services	6. Trusted Assessors	7. Focus on choice	8. Enhancing health in care homes
<b>Sutton</b> The 'red bag' approach	<b>Kent</b> Acute hospitals optimisation	<b>Lincolnshire</b> Hospital avoidance response team	<b>North Staffordshire</b> Track and triage	<b>Surrey</b> Seven day, eight to eight	<b>Newcastle Gateshead</b> Trusted assessment	<b>Gloucestershire</b> Care navigators	<b>Wakefield</b> Enhanced health in care homes vanguard
<b>Newcastle Gateshead</b> The 'transfer of care' bag	<b>Kent</b> Use of SHREWD	<b>Durham</b> Multi-disciplinary discharge teams	<b>Medway</b> Home First		<b>Lincolnshire</b> Care Home Trusted Assessor		<b>Surrey</b> Enhancing health in care homes
<b>Oxfordshire</b> Multi-disciplinary approach		<b>Kent</b> Integrated discharge teams	<b>Surrey</b> Discharge to assess		<b>Blackburn with Darwen</b> Trusted Assessment		
<b>Leicester</b> Integrated crisis response service			<b>Tower Hamlets</b> Admission Avoidance and discharge service				
<b>Gloucestershire</b> Integrated commissioning function			<b>Hull</b> Transfer to assess				

# The high impact change model – an overall approach

The high impact change 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. The model supports genuine, honest reflection and discussion between trusted colleagues within local health and care systems.

## **Some things that people have told us – about what works and how to overcome the challenges:**

- cross-system leadership that champions the necessary culture change, supports risk-taking and empowers staff to make changes happen
- involving partners as equals from the outset so that changes are co-produced, with shared funding and shared risks
- developing a shared narrative or vision across the system that is person, not process, centred
- establishing a no-blame culture and encouraging a learning and enabling environment that fosters innovation.

## National guidance and tools

LGA, Hospital to home transfers: resources and emerging good practice

[www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/resources/emerging-practice](http://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/resources/emerging-practice)

NHS England, quick guides on urgent and emergency care

[www.nhs.uk/quickguides](http://www.nhs.uk/quickguides)

National Institute for Health and Care Excellence (NICE), Transition between inpatient hospital settings and community or care home settings for adults with social care needs

[www.nice.org.uk/Guidance/NG27](http://www.nice.org.uk/Guidance/NG27)

# Examples of how local areas are working to implement overall system change

## Sheffield

### Reducing delayed transfers of care

Sheffield, like other areas across the country, has found itself under a lot of scrutiny both regionally and nationally because of its delayed transfers of care (DTOC) performance. In the winter of 2016/17 this reached a point where challenging performance in accident and emergency, and very little flexibility or capacity in the system, meant working relationships were becoming strained and responsibilities unclear.

Support from consultancy Newton Europe, as part of a regional Better Care Support Team approach to improving delayed transfers, helped the area to diagnose system issues and identify changes that could be embedded and sustained, as well as generic lessons that could be shared more widely.

At the outset, the system recognised the importance of celebrating what was already in place, including a single shared vision; a common purpose to always put the patient first; some really strong practice and a shared high desire to improve. System leaders also understood the importance of effective relationships across health and social care, seeing this as the essential foundation for improvement.

The findings of the diagnostic work fed into a system-wide summit, led by the chief executive officers from the council, Sheffield teaching hospitals and the clinical commissioning group (CCG), and from this a clear set of outcomes were agreed, with 10 areas of focus and a clear process for overseeing progress:

#### **Get people home:**

- celebrate success on every ward
- establish three routes for hospital discharge
- understand perceived barriers to discharge
- increase support to therapists.

#### **Rapid community care**

- integrated activity recovery service
- provide a seamless service to patients to improve outcomes and increase productivity
- increase resilience of homecare
- intermediate care beds: improve outcomes and productivity.

#### **Assessment at home**

- increase complex discharges via discharge to assess
- restructure assessment capacity to deliver more home-based assessments.

Partners now recognise that they have the resources locally to enable them to deliver the changes, but they also know that it takes a real ongoing commitment to make it happen – with twice weekly face to face meetings now established.

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# Examples of how local areas are working to implement overall system change

## Leicester

### A journey to improving discharge and avoiding admissions

Partners in Leicester have taken a five-stage approach to improving discharge and avoiding unnecessary admissions. This has involved:

- developing a collective concern
- understanding the reality
- working together
- monitoring impact
- sharing success and aiming higher.

Using the Better Care Fund (BCF) as a catalyst, partners have created a pathway of care, which includes:

- an Integrated Lifestyle Hub tackling the wider determinants of ill health
- GP-led care planning for patients identified via a risk stratification system
- clinical response team – emergency care practitioner-led teams roving the city and taking admission avoidance calls from 999/111, GP urgent referrals and care homes, supported via an integrated crisis response service and community health services on a two hour response basis
- wraparound rapid access to services such as assistive technology, falls assessment, equipment and handyperson
- daily patient tracking meetings in partnership with the acute site, with a dedicated hospital social work team
- enhanced community 'beds at home' via an intensive community support service
- integrated pathways for non-weight bearing patients plus discharge to assess services
- proactive discharge follow-up for at-risk groups.

As a result, in comparison to Q1 16/17, attendances at A&E in Q1 17/18 were down by 2.9 per cent. These figures include all age cohorts, including those age cohorts where there is traditionally a rise in attendance year on year. Although coding continues to be a challenge in terms of understanding the impact on admissions, figures indicate a net position of -0.1 per cent.

See also – Change 1. Early discharge planning.

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# Examples of how local areas are working to implement overall system change

## Newcastle Gateshead Testing new models to improve transfers of care

For Newcastle Gateshead CCG, one of the very best things occurring as a result of being part of the NHS England New Care Models programme has been the opportunity to test and evaluate new models. The confidence to test and be open to failing as well as succeeding comes from a now well-established clinical engagement forum. Frontline staff need support to explore and evaluate new ways of doing things and a cross-agency, multidisciplinary forum that includes statutory, independent and charitable organisations is stronger both in terms of planning and evaluation.

As a care home vanguard, the main focus for transfer of care has been in relation to transferring care home residents between care homes and hospitals and vice versa. This has included developing a robust plan to introduce a 'transfer of care' bag which will be launched before the end of 2017, and the introduction of a trusted assessment model for when patients are moving between hospital and residential intermediate care.

In terms of the 'transfer of care' bag, through clinical engagement the CCG has been absolutely clear that this is not about the introduction of a bag but is about raising the profile of older people living with frailty and very complex needs in care homes. The introduction of a 'transfer of care' bag takes time to ensure all stakeholders hold a common vision and purpose – which are known contributors to implementing change successfully.

The approach to introducing trusted assessment included holding a workshop with key personnel to consider Care Quality Commission (CQC) guidance and the perspective of all stakeholders, paying attention to the direction set by national standards as well as to the clinical evidence base and anecdotal experience. Most importantly the local system considered the needs of care home residents and the impact of introducing trusted assessment in terms of the quality of care delivery, and their safety and experience.

Trusted assessment is expected to result in earlier discharge planning and improved patient flow. To measure these, however, partners have learned that a baseline for comparison is needed and time needs to be spent working out how best to collate this. There is also an opportunity to think about broader learning and metrics such as decision making, time frames and any links with readmission rates.

More widely than this, learning can be shared with strategists and policy writers, for example in terms of local hospital discharge policies and with BCF initiatives.

Underpinning the work is an agreed set of best practice standards relating to transfers from one care setting to another. Their aim is to ensure that timely communication (verbal and written) occurs whenever a person moves from one care setting to another.

See also –

Change 1. Early discharge planning

Change 6. Trusted assessment.

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# Examples of how local areas are working to implement overall system change

## Lincolnshire

### Improving the delayed discharge journey

Since June 2015, partners in Lincolnshire have implemented or improved a number of programmes and initiatives which together have had a positive impact on reducing delayed transfers of care. These include:

- **prime provider homecare contracts across the county**  
The county is split into 12 geographical zones, aligned to social work area teams to support operational engagement. A prime provider for each zone acts as the lead in delivering homecare services, but is also required to sub-contract a minimum of 10 per cent to small and medium-sized enterprises to support diversity of choice. Each zone has sufficient levels of guaranteed work to make it both commercially viable and attractive to providers. Fewer organisations operating in each zone has led to improved retention of staff and improved resilience for organisations.
- **care home trusted assessor**  
Starting with a pilot approach in September 2015, coverage was extended to all hospital sites in Lincolnshire by April 2016, with seven day working from July 2017 (see also Change 6).
- **countywide reablement contract**  
A contract awarded to one countywide provider has seen a 40 per cent increase in capacity in year one, with 60 per cent of people requiring no ongoing social care support.
- **Lincolnshire independent living partnership**  
This is a partnership between LACE Housing Association, Age UK Lincoln and Kesteven, Lincs Home Independence Agency, St Barnabas Hospice and Boston Mayflower Housing, working to deliver a flexible and responsive support offer. This includes a countywide monitoring service, a wellbeing support and response service, and a hospital avoidance response team (see also Change 4).
- **transitional care pathways**  
Four pathways were introduced in December 2015 (there were previously more than 12). They are based on home first principles, and support patient flow management via short term interventions, transitional care placements, reablement and hospital avoidance.
- **integrated neighbourhood working**  
Operating at three levels:
  - 1) local population – empowering the local population to take an active role in their health and wellbeing, with greater choice and control
  - 2) neighbourhood network – including self-care, social prescribing, preventative activity, community groups and public health
  - 3) neighbourhood care team – primary care, statutory services, independent services and voluntary organisations.

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## Examples of how local areas are working to implement overall system change

### Mansfield

#### Implementing the ASSIST hospital discharge scheme

The ASSIST– advocacy, sustainment, supporting independence and safeguarding team – scheme brings together teams from the district council, Nottinghamshire County Council, Sherwood Forest Hospitals NHS Foundation Trust, Mansfield and Ashfield Clinical Commissioning Group, and Nottingham Trent University.

Referrals to the ASSIST team are made by health and social care colleagues at King’s Mill Hospital in Sutton-in-Ashfield who identify patients with a housing or social care need. The team works with Mansfield District Council housing department to find solutions that enable these patients to leave hospital safely.

The scheme, which won this year’s Shared Learning Awards organised by NICE, is helping to reduce discharge delays by making sure that patients have the necessary housing support when they are discharged, which may be in the form of home adaptations or a change of accommodation that better meets their needs when they leave hospital.

Specifically, the scheme works to:

- speed up hospital discharge and prevent hospital readmissions; providing access to a 24/7 service
- source alternatives to residential care; using housing stock to meet local need, and prioritising the letting of existing adapted accommodation; fast-tracking repairs to properties, providing key safe installation and minor adaptations, and installing lifeline and telecare systems
- use temporary accommodation and respite units (funded by Nottinghamshire County Council) to facilitate discharge
- access food banks and furniture projects as needed
- support the hospital’s emergency department ‘front door’ by engaging with people who have a social need and freeing up hospital staff to deal with emergencies
- support discharged patients in the community.

A study by Nottingham Trent University and Mansfield and Ashfield CCG found clear evidence that the scheme saves the NHS £1.371 million annually by freeing up beds.

The scheme saved an average of 4.5 bed days per patient helped and this represented a saving of £936 per patient.

Since its inception in October 2014 up to January 2017, it has helped well over 2,000 patients.

A video which explains the partnership aspects of the ASSIST scheme and highlights its benefits can be found at [www.facebook.com/mymansfielduk](http://www.facebook.com/mymansfielduk)

For further information:

[www.nice.org.uk/sharedlearning/better-together-assist-hospital-discharge-scheme-ahds](http://www.nice.org.uk/sharedlearning/better-together-assist-hospital-discharge-scheme-ahds)

[www.scie.org.uk/news/opinions/early-discharge-scheme](http://www.scie.org.uk/news/opinions/early-discharge-scheme)

[www.housingforhealth.net/assist-hospital-discharge-scheme-in-mansfield/](http://www.housingforhealth.net/assist-hospital-discharge-scheme-in-mansfield/)

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# Change 1. Early discharge planning

In elective care, planning should begin before admission. In emergency or 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.

## **Some things that people have told us – about what works and how to overcome the challenges**

- ensuring A&E has the right information
- setting the tone about discharge as soon as possible; engaging the family in thinking about discharge, and supporting conversations about ‘when am I going home?’ and ‘what do I need to do to get home’
- involving all the right people in strategic discussions at the local A&E delivery board, including primary care and the voluntary and community sector; so that all partners see the whole system, broadening out the focus from the acute sector
- joining up fragmented patient record systems and sequential assessment processes used by different professional groups
- achieving a shared understanding and use of expected date of discharge.

## National guidance and tools

NICE, Hospital Transfer Pathway

[www.nice.org.uk/sharedlearning/hospital-transfer-pathway-red-bag-pathway](http://www.nice.org.uk/sharedlearning/hospital-transfer-pathway-red-bag-pathway)

# Examples of local initiatives

## Sutton

### The 'red bag' approach

The red bag contains standardised paperwork, medication and personal belongings, and it stays with a care home resident from the time they leave the residential home to go to hospital until the time they return to their care home at the end of their stay in hospital.

The initiative:

- ensures that everyone involved in the care for the individual will have vital information to hand, including about the resident's general health, the current concern, and any medication he/she is taking
- saves time at the transfer from care home to ambulance and at the transfer from ambulance to A&E
- allows A&E staff to make more informed decisions about the patient
- enables speedier discharge, as hospital staff will know that the patient is going back to the care provided by expert staff in the care home
- enhances the experience and continuity of care for care home residents and helps staff to treat them with dignity and respect.

Over a period of nine months, 179 residents of care homes were tracked through the local hospital. For these, the average length of stay with a bag was 13.4 days, compared to 17.4 days without a bag, meaning that residents with a bag spent 4 days less in hospital than those without a red bag.

A fuller description of the scheme is available here:

[www.suttonccg.nhs.uk/Aboutus/Our-board/Documents/Hospital%20Transfer%20Pathway%20-%20Red%20Bag%20Brief\\_Final.pdf](http://www.suttonccg.nhs.uk/Aboutus/Our-board/Documents/Hospital%20Transfer%20Pathway%20-%20Red%20Bag%20Brief_Final.pdf)

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# Examples of local initiatives

## Newcastle Gateshead

### The 'transfer of care' bag

This initiative focuses on older people living with frailty and very complex needs in care homes. Partners have worked to define a common vision and purpose for the approach, and are clear it is not just about introducing a bag. It is about:

- raising the profile of care home residents
- developing the workforce to better understand their needs through the sharing of information
- improving health and wellbeing and facilitating peaceful deaths in familiar environments through earlier and improved comprehensive assessment and care planning
- recognising hospital as the smallest part of the patient's journey
- developing respectful relationships with care home teams
- improving safety through reducing avoidable hospital re-admission and too long a stay
- bringing care homes from the periphery into the system.

See also: Examples of overall approach.

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# Examples of local initiatives

## Oxfordshire Integrated liaison hub

In 2015, a whole-system review looked at the interface between social care and health. This improved working relationships, and enabled open and honest system challenges. Daily 'board rounds', 'breaking the cycle' weeks and new local policies for delayed transfers of care (DTC) counting were introduced, and an integrated liaison hub was established.

The hub acts as a liaison point supporting service users and ensuring good multidisciplinary team (MDT) planning and care, including:

- administering arrangements with nursing homes, with GPs and clinicians
- managing the logistics of communication with patients and families and escalating any concerns and issues as appropriate
- maintaining a tracking system on all patients who have moved and their onward destination
- making a daily check with nursing homes to proactively support patient management.

The liaison hub is staffed by a MDT including qualified nurses and therapists with expertise in discharge planning, discharge planners, administrators and staff from adult social care (in-reaching). Each nursing home has an assigned MDT attached to it, with a named nurse who makes daily contact. A communication log is kept in the hub to ensure responses are systematic and timely, and there is a dedicated phone line and email address with a separate phone line for GPs to have direct contact with the duty senior interface physician.

The liaison hub has brought together health and social care professionals in a positive way and delivered a fully integrated service, which has resulted in a reduction in delays and the release of acute beds. Service users are cared for in a more appropriate environment and for some patients rehabilitation occurs earlier in their pathway.

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## Examples of local initiatives

### Leicester Integrated crisis response service

Leicester is a city with high risk factors for emergency care; for people over 85 and frail people under 65. With a range of communities and cultures, there are elements of socio-economic deprivation and chronic illness, with low health literacy.

A system review highlighted a lack of clinical confidence to not admit, and a range of services that were not coordinated or timely enough.

The crisis response service was established as a 24/7, 365 day solution for all client groups. Funded via the BCF, daily multi-disciplinary meetings take place in a co-located hub, which is operationally integrated with community health services, mental health services for older people and therapy services.

The model offers up to 72 hours of support, which includes care, assessment, risk management and wraparound services such as equipment, assistive technologies and handyperson.

In 2016/17 there were 6,343 client episodes. Of these:

- 100 per cent received a response within two hours
- 1,402 were related to falls – with 93 per cent remaining supported at home
- 50 per cent of cases received a joint intervention with community health services
- 1,413 supported exits from hospital – both pre-admission and post-admission
- 80 per cent remain at home long term (55 per cent with no ongoing support).

As well as achieving exceptional patient satisfaction rates, the service has had a positive impact on attendances at A&E and delayed transfers of care.

Mark Pierce, Senior Strategy and Implementation Manager at Leicester City CCG, concludes: “The integrated crisis response service has been a critical partner for Leicester City CCG over the past three years in our drive to contain and then reduce the level of unscheduled admissions and attendances to hospital. I have no hesitation in saying that this service has been a game-changer for the local health and care system in helping us deliver more of the right care in the right place at the right time. It has been a model for other partners in understanding the power of ‘can-do’ and working together at pace.”

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# Examples of local initiatives

## Gloucestershire

### Integrated commissioning function

Joint contracting arrangements – for care homes, community based and voluntary sector provision – are headed up by the director of integrated commissioning, with lead commissioners incorporating children and maternity, disabilities and older people.

Brokerage teams source all care post assessment, including the hospital to home service, discharge to assess pathways, continuing healthcare and end of life provision. The approach also offers enhanced brokerage and care navigators to support self-funders to reduce delays.

Multidisciplinary team (MDT) case management and frailty pilots are showing significant cost and quality benefits and there has been a direct impact on A&E delivery, four-hour improvement plans and preparation for winter pressures.

In addition:

- Gloucestershire is an integrated personalised commissioning pilot site, which includes personalised wheelchair budgets
- a housing action plan, linked to the Better Care Fund (BCF), includes pooled arrangements with districts for innovation and improved processes
- an extension to Warm and Well – Gloucestershire's energy efficiency grant – is also helping to bring citizens out of fuel poverty.

See also – change 7. Focus on choice.

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## 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.

### **Some things that people have told us – about what works and how to overcome the challenges:**

- developing a whole-system demand and capacity plan, showing trends across the system, and all possible impacts, including safeguarding concerns or potential care home collapse
- exploring differences between discharges from medical or surgical wards
- sharing real-time information – using data as an objective record to help dispel lack of trust
- developing alternative ways of thinking about options, such as live-in care.

### National guidance and tools

NHS Improvement, Transforming urgent and emergency care services in England

Safer, faster, better: good practice in delivering urgent and emergency care; a guide for local health and social care communities

[www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf](http://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf)

NHS Improvement, Emergency Care Improvement Programme

Rapid Improvement Guide: the SAFER Patient Flow Bundle

<https://improvement.nhs.uk/uploads/documents/the-safer-patient-flow-bundle.pdf>

NHS Improvement, Emergency Care Improvement Programme

Rapid Improvement Guide to red and green bed days

<https://improvement.nhs.uk/uploads/documents/red-and-green-bed-days-RIG.pdf>

NHS England, quick guide to supporting patients' choices to avoid long hospital stays

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf)

NICE and Social Care Institute for Excellence, quick guide to moving between hospital and home, including care homes

[www.scie.org.uk/publications/ataglance/moving-hospital-home.pdf](http://www.scie.org.uk/publications/ataglance/moving-hospital-home.pdf)

NHS Improvement, Good practice guide: focus on improving patient flow

[https://improvement.nhs.uk/uploads/documents/Patient\\_Flow\\_Guidance\\_2017\\_\\_13\\_July\\_2017.pdf](https://improvement.nhs.uk/uploads/documents/Patient_Flow_Guidance_2017__13_July_2017.pdf)

[https://improvement.nhs.uk/uploads/documents/Patient\\_Flow\\_Guidance\\_Case\\_studies\\_13\\_July.pdf](https://improvement.nhs.uk/uploads/documents/Patient_Flow_Guidance_Case_studies_13_July.pdf)

Nuffield Trust, Understanding patient flow in hospitals

[www.nuffieldtrust.org.uk/files/2017-01/understanding-patient-flow-in-hospitals-web-final.pdf](http://www.nuffieldtrust.org.uk/files/2017-01/understanding-patient-flow-in-hospitals-web-final.pdf)

NHS England: Transforming urgent and emergency care services in England

Urgent and emergency care consolidated channel shift model user guide

[www.england.nhs.uk/wp-content/uploads/2017/03/uec-channel-shift-model-user-guide.pdf](http://www.england.nhs.uk/wp-content/uploads/2017/03/uec-channel-shift-model-user-guide.pdf)

# Examples of local initiatives

## Kent

### Acute hospitals optimisation

Kent's transformation journey began in 2013 with the establishment of three programmes on care pathways, optimisation, and commissioning. Work focused on making better use of systems and embedding the culture of promoting service user independence, while establishing the foundations for further transformation.

Phase 2 started in 2014 with two programmes, access to independence, and acute hospitals optimisation.

Data analysis had shown that pathways from hospital to residential care placement were deemed appropriate only in about 11 per cent of cases. The aims for the acute hospital optimisation programme were therefore to:

- enable a greater number of service users to access the right service to help them achieve a more independent outcome
- give families confidence that an alternative to short or long-term beds would promote a better outcome
- provide case managers in the hospital team with additional knowledge and capability to make more appropriate placements promoting independence
- better evidence improved outcomes resulting from an improved process.

To achieve these aims the programme focused on:

- improving decision-making at the point of selecting a short-term pathway
- identifying and selecting the best outcome for each person
- understanding and addressing the biggest issues preventing the most appropriate outcome
- escalating issues for area and county-wide action
- improving accessibility and availability of services that might be required
- tracking and feedback of the effectiveness of short-term pathway options to supplement decision-making processes
- achieving financial benefits through reduced spend on short and long-term beds.

Daily wash-up sessions help staff to identify and resolve blockages and issues, and also act as a mechanism for applying an evidence-based method of approaching cases to achieve the best outcome for patients or service users.

Staff work to an improvement cycle of:

- discussions and data capture at wash-up meetings – supporting daily decision-making and accurate recording of information
- data analysis – identifying the best outcomes and biggest blockages
- actions – identifying who can solve the problem at a weekly improvement cycle meeting
- problem solving – getting the best outcomes.

Across the county, the transformation programme has seen a 59 per cent reduction in long-term residential placements and a 54 per cent reduction in short-term beds. Further information about the genesis of the programme can be found in the LGA publication Efficiency opportunities through integration.

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## Examples of local initiatives

### Kent

#### Single health resilience early warning database (SHREWD)

Over the past five years, the use of the single health resilience early warning database (SHREWD) has enabled Kent County Council to supply real-time data to support internal management and also operational partners. Not only has this facilitated more meaningful day-to-day operational decision-making, it has also enabled an operational evidence base to inform management decisions and planning.

The council's SHREWD indicators are identified in the system resilience plan and form a vital role in identifying areas of pressure as they arise across each of the county's individual acute hospital teams. They are also an integral part of the action plan, which forms part of the resilience plan; giving directives and actions to staff across all internal teams that are linked to short-term pathways.

The council has been approached by other local authorities and have shared its use of SHREWD, explaining how its dual use as an internal management tool and as part of system resilience planning can bring greatest benefit.

#### Contact

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## Change 3. Multi-disciplinary/multi-agency discharge teams

Coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients.

### **Some things that people have told us – about what works and how to overcome the challenges:**

- focus on decision-making in the right place – making it a principle that assessment for long-term care should not take place in hospital
- overcoming possible bottlenecks by not sending simple discharges to the integrated team
- involving voluntary and community sector organisations with self-funders who may not want to talk to adult social care.

### **National guidance and tools**

NHS England, quick guide to identifying local care home placements

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Identifying-local-care-home-placements.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Identifying-local-care-home-placements.pdf)

NHS England, quick guide to sharing patient information

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-sharing-patient-information.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-sharing-patient-information.pdf)

NHS England, quick guide to health and housing

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-health-and-housing.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-health-and-housing.pdf)

NHS England, MDT development – working toward an effective multidisciplinary/multiagency team

[www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf](http://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf)

# Examples of local initiatives

## Lincolnshire

### Hospital avoidance response team

The hospital avoidance response team – HART – service is delivered by members of the Lincolnshire Independent Living Partnership and takes referrals from secondary care discharge hubs, A&E in-reach teams, the ambulance service, primary care and community health providers.

Eligibility extends to people over the age of 18 who live in Lincolnshire and for whom support would either prevent an avoidable A&E attendance or admission, or speed up discharge from secondary care. This is achieved through:

- facilitating a supported discharge and providing up to 72 hours of care and support to resettle a person at home
- offering a 'bridging the gap service' for a 72-hour period to give other domiciliary or reablement services the opportunity to commence later in the pathway
- supporting the clinical assessment service to avoid hospital admission and/or attendance at A&E
- offering a telecare unit, enabling access to the responders 24/7 – with the assurance of support through the night if required

- offering a wellbeing service assessment with onward referral as appropriate.

The service is currently accepting a little over 100 referrals per month, with 1,553 people supported between December 2015 and August 2017.

During this period, 303 admissions were avoided, a proven 1,220 bed days were saved, and a further 670 days were potentially saved.

Assuming an admission cost of £2,000 per admission, and £400 per bed per day, the service has achieved an indicative saving of between £1,094,000 and £1,362,000.

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## Examples of local initiatives

### Durham

#### Multi-disciplinary/multi-agency discharge teams

Following a review by the Emergency Care Improvement Programme (ECIP) in October 2016, County Durham and Darlington Local Area Delivery Board has implemented a system-wide set of changes to improve performance.

Wherever possible, people are enabled to access primary prevention through universal services, facilities or resources which promote wellbeing and help avoid the development of needs for health and/or social care services.

For those who need support, proactive case management focuses on standardisation of care planning, risk stratification and risk management, and the development of emergency or anticipatory health care plans.

MDT meetings involve GP practice teams, district nurses, case managers, social workers, therapists and mental health services for older people, with support from specialist nurses, mental health, podiatry, pharmacy, diagnostic services and the voluntary sector where necessary.

Where there is a change or deterioration in condition, specialist assessment and support is offered through rapid access clinics and 'front of house' frail elderly teams, which aim to prevent avoidable admissions and either maintain the patient in the community or arrange a planned admission; linking in with intermediate care, domiciliary care and reablement as necessary.

If a patient is admitted to hospital, the integrated discharge management team focuses on home first principles, and liaison services link with medical, surgical, orthopaedic and mental health staff as required.

Elements of the system-wide approach, which have seen an impact on reducing delayed discharges include:

- investment in reablement – this has made a significant difference and is the default offer wherever possible to facilitate discharge and avoid unnecessary homecare packages
- discharge to assessment arrangements are in place with the care sector and community health providers; with assessments undertaken outside hospital in people's homes, extra care, or reablement beds
- work undertaken with care homes, including matrons from care homes carrying out in-hospital assessments
- acceptance of assessment by 'other' professionals.

Plans are in place to develop a brokerage service to facilitate hospital discharge for people who have no one to assist them – whether privately or state funded.

#### Contact:

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# Examples of local initiatives

## Kent

### Integrated discharge team

Since October 2013, an integrated discharge team (IDT) has been up and running in North Kent. The team aims to reduce admissions, ensure patients' needs are proactively managed to reduce their length of stay and to enable patients whose

medical conditions are stable to leave hospital in a timely manner.

The IDT is multidisciplinary and consists of:

- Operational clinical lead – this post leads the operational team, supports the planning process, improves integrated care and monitors results informing future strategy and operational activity.
- Integrated therapists and falls service – physiotherapists and occupational therapists working together
- Specialist nursing services – proactively supporting patient reviews and joint assessments with the specialist teams in Darent Valley Hospital, both on the wards and within A&E.
- Discharge coordinators (nurses) – the nursing team work within A&E assessing and treating patients, and enabling same-day discharge where possible, in addition to supporting timely discharge from the wards.

- Pharmacists – all patients who need medical admission are seen by a team of doctors on the post-take ward round. The presence of a pharmacist on this round means that pharmacist interventions can occur at the time of prescribing. This also informs the pharmacist of patients' care plans and predicted discharge dates, facilitating prompt supply of medication at the point of discharge. This part of the service has been shown to be effective in supporting discharge and it has been agreed that the pharmacist will also work at the front-end of the A&E, five days per week, supporting admission avoidance and timely discharge.
- Acute/community geriatrician – the aim of this post is to work across acute and community settings, working in A&E with the IDT, focusing on geriatric admission avoidance by carrying out a comprehensive geriatric assessment, providing prompt intervention and tailored support and discharge the same day.
- GPs – working at the front end of the A&E, they identify those patients who can be seen by primary care and discharged safely to primary care.
- Case management – additional social care practitioners have been recruited to work in the integrated discharge team.
- Additional psychiatric liaison – a specialist mental health assessment service out of hours and at weekends, based at Darent Valley

Hospital, to reduce delays in treatment for people with mental health conditions.

Achievements within the team to date:

- multi-organisational work and multi-disciplinary work are much improved with a combined sense of purpose, better communications, sharing of information and data and a greater 'can do' attitude
- anticipatory care plans are being developed for patients with long-term conditions, dementia and repeat presentations at A&E
- dementia management support is much improved. The IDT now works with Alzheimer's and Dementia Support Services (ADSS), as well as other agencies, to provide integrated support for these patients, thus avoiding admission. ADSS provide support up to a month after discharge.

For further information

<https://local.gov.uk/sites/default/files/documents/case-study-kent-operating-cd5.pdf>

#### Contact:

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## 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 mean that people no longer need to wait unnecessarily for assessments in hospital. In turn this reduces delayed discharges and improves patient flow.

### **Some things that people have told us – about what works and how to overcome the challenges:**

- investing in the first 24, 48, or 72 hours with a strong focus on not wasting those hours
- concentrating on costs to the system, not provider versus commissioner or health versus social care costs
- establishing system-wide principles between partners and having a single narrative across the system about getting people home as a default option
- ensuring continuity of care coordination from admission through to discharge
- linking equipment planning to discharge planning, so that equipment is available at home on the day of discharge
- setting an ambition for percentage of continuing health care assessments to be completed outside the hospital
- working with consultants and therapists to build confidence and overcome risk aversion to discharge, using positive stories to achieve a hearts and minds culture change.

### National guidance and tools

NHS England, quick guide to Discharging to Assess

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf)

NHS England, quick guide to better use of care at home

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-better-use-of-care-at-home.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-better-use-of-care-at-home.pdf)

Liz Sargeant, ECIP, Developing a Home First mindset

<https://fabnhsstuff.net/2016/02/17/developing-home-first-mindset-liz-sargeant/>

Health Education England, Care navigation: a competency framework

[www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework\\_Final.pdf](http://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf)

Housing LIN, Hospital to home resource pack

[www.housinglin.org.uk/hospital2home\\_pack/](http://www.housinglin.org.uk/hospital2home_pack/)

# Examples of local initiatives

## North Staffordshire

### Track and triage

The system in North Staffordshire faced a number of issues, including risk-averse practice and fragmented services in the community. Hospital pressures were increasing, but assessments were still happening in hospital and there were too many people stranded in hospital when medically fit for discharge, with gaps in seven-day services and areas of duplication and inefficiency contributing to delays.

This meant that too many patients were losing independence, going into beds and not to their own home.

System-wide health and social care demand and capacity planning was undertaken and a 'Track and triage' discharge to assess (D2A) system has now been implemented. Replacing the assessment functions on the acute site, it tracks patients from entry to end of D2A, with a 'pull' function once the patient is judged medically fit for discharge.

Clinical triage ensures that patients move to the right service based on health and social care needs with moves to beds as exceptions. Home first is now viewed as the first option at all times.

Track and triage has been set up to be a seven-day function which will cover the whole footprint for University Hospitals of North Midlands, working with discharge facilitators and patient flow staff to ensure that patients move to the right place first time.

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## Examples of local initiatives

### Medway

#### Home First

Home First is an initiative developed through the partnership of Medway Foundation Trust Hospital, Medway CCG, Medway Council and Medway Community Healthcare. It provides support for patients medically fit to be discharged, but who still require additional home support.

Patients receive a full assessment in their own home, within two hours of leaving the hospital. An occupational therapist will discuss with the patient what social and/or health care is needed to help their recovery. A care plan is then jointly agreed, which might include equipment to restore patients back to their daily routine of getting around the home, support with preparing meals or regular home visits from a healthcare professional.

In less than a year Home First helped over 1,000 patients to get back home quickly. The approach has been a success because it brings together health and social care services to deliver more joined-up personal services with staff providing care and working as part of the same team.

For more information:

<https://fabnhsstuff.net/2016/10/25/getting-patients-home-first-medway/>

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/3-medway-D2A-model.docx](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/background-docs/3-medway-D2A-model.docx)

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# Examples of local initiatives

## Surrey

### Discharge to Assess

In East Surrey, adult social care and the CCG are working together to pilot the use of discharge to assess for all continuing healthcare (CHC) assessments. Via social care, the partnership has commissioned beds in a specialist dementia care home, and a nursing home specialising in end of life support.

Patients are identified at multi-disciplinary discussions with adult social care and a CHC liaison nurse based within the integrated discharge team. Admission into care homes is co-ordinated through a trusted assessor model, directly from adult social care or the CHC liaison nurse, thus eliminating the need for the care home to assess the patient prior to admission.

Nurse-to-nurse discussions (CHC liaison nurse and nursing providers) support the development of professional working relationships and improve willingness to talk through issues and challenges.

Patients who have a dementia need such as wandering, or challenging behaviour, are placed in a specialist dementia care home, where they can be best supported or stabilised in order to complete the CHC decision support tool and give an accurate depiction of their needs.

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# Examples of local initiatives

## Tower Hamlets

### Admission avoidance and discharge service (AADS) and Discharge to Assess

A CCG-funded pilot was initiated in 2015, starting with 15 patients and running in parallel to other winter resilience schemes, including an admission avoidance team, hospital at home service and out of hours social work. In September 2016 these separate schemes were merged to form the admission avoidance and discharge service (AADS).

AADS consists of:

- rapid response in the community
- an admission avoidance team in the Royal London Hospital (RLH) A+E department
- in-reach nurses and AADS screeners based at RLH
- an intermediate care team using a discharge to assess model and offering up to six weeks intensive rehabilitation in the community.

In addition, there is an out-of-borough social worker, and social workers who work out of hours, to respond to referrals from the admission avoidance team and the acute admissions unit.

The Discharge to Assess pathway sitting within AADS includes social workers, occupational therapists, physiotherapists, nurses, reablement support workers and case finders/screeners. It is offered as a seven-day service from 8am to 6pm, with up to six weeks community input following discharge.

The minimum information to ascertain what support is required on the day of discharge is gathered by the screeners and follow-up takes place in the community within 24 hours. Where possible, full social care assessment then starts in the community, with most packages provided by the reablement team to support the goals set by therapists. The approach has shown improved recovery for patients assessed in the familiar environment of their own home, with recent data showing 66 per cent of people requiring either reduced or no care packages on discharge from the pathway.

Despite the challenges of developing new cultures and new ways of working, the model continues to impact on delayed transfers of care, improving patient flow and reducing length of stay – with AADS following up patients who have been assessed by the admission avoidance team in the A+E department and were admitted to hospital. It has also enabled the closure of two 24-bed wards and reductions in continuing healthcare assessments and admissions to residential and nursing care homes.

Success has been down to partnership working and a whole-systems approach, with a strong shared emphasis on supporting people in their home.

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# Examples of local initiatives

## Hull

### Transfer to assess

The model in Hull, which forms part of a system-wide approach to reducing delayed transfers of care, is based on the principle of 'active recovery' with the aim of:

- supporting timely discharge from hospital
- maintaining independence where possible
- reducing the level of long-term care packages
- achieving a net neutral impact on social care spend.

Active recovery builds on the idea of reablement, underlining the importance of recovering as much independence as possible, with active input from service users and staff. It is something that happens throughout – from assessment, through short-term intensive input and into longer-term support. Clear goals give the person and the practitioner something to aim for and provide a focus for tasks and future work. They provide an objective measure of achievement and help build confidence through reflection.

The transfer to assess pilot commenced in July 2016, supporting people who were being discharged from the acute trust and intermediate care facilities to their home address.

Staff work with a solution-focused approach and a commitment that supporting people to regain their independence is one of the most important things they do.

When a person is deemed medically fit, a health or care practitioner will see the person on the ward or intermediate care facility. If support is required to facilitate discharge they will create a basic support plan agreeing achievable goals for active recovery, and discharge will take place. A practitioner will then undertake the assessment within the person's home.

Between July 2016 and August 2017, of 364 people discharged through transfer to assess:

- 51 per cent have become fully independent
- 13 per cent have decreased levels of support following active recovery
- 36 per cent have been moved on to long-term support but had a reduced hospital stay.

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## Change 5. Seven-day services

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.

### **Some things that people have told us – about what works and how to overcome the challenges:**

- social workers in hospitals on Saturdays and Sundays – a good time to meet with self-funders, carers and family, and to get people ready for discharge on Monday
- ensuring the rest of the system also offers seven-day working – including transport and pharmacy
- engaging care providers
- adopting flexible working practices
- overcoming concerns and sensibilities – for example that people won't be discharged on Christmas day.

### **National guidance and tools**

NHS Improvement, Seven Day Services in the NHS

<https://improvement.nhs.uk/resources/seven-day-services/>

# Examples of local initiatives

## Surrey

### Seven day, eight to eight social care at Surrey's five acute hospitals

In 2011 there was growing pressure for change across the whole system of health and social care. Feedback from residents and the Surrey LINK suggested there was significant demand for weekend and weekday evening services. At the same time, there was national concern about the quality of out-of-hours care in hospitals, and Surrey's hospitals were experiencing growing pressure on their bed capacity.

Between January and October 2012, Surrey County Council worked closely with health partners to introduce reliable seven days per week social care services, including earlier weekday mornings and later evenings.

Key underpinning principles between Surrey County Council and the five hospital trusts included:

- joint commitment to improving outcomes
- senior leadership and sponsorship from all partners
- shared investment of resources
- flexible local arrangements within a countywide framework

- co-design with staff doing the work
- practical, integrated working arrangements
- creative new ways of working together.

The increased accessibility of adult social care staff has reduced patient length of stay, freeing up much-needed hospital beds sooner. This has supported the hospital trusts to achieve their nationally defined Commissioning for Quality and Innovation (CQUIN) targets. Locating adult social care staff in A&E and medical assessment units at weekends and weekday evenings has helped to reduce the number of avoidable admissions into hospital. Patients, families, carers and health professionals can access social care information and advice seven days a week, supporting effective decision-making.

In 2017, Surrey social care teams still operate out of the five acute hospitals, and still work seven days a week, from 8am to 8pm. The positive change delivered during 2012 is bringing the Surrey health and care system long-term benefits, as this approach is now established as business as usual.

Since seven day, eight to eight working began, hospital team managers have been meeting regularly to ensure consistent approaches and best practice across all sites providing a hospital social work service.

They have used these sessions to:

- understand and follow national guidance and drivers
- undertake comparative learning and sharing of Surrey approaches to collaborative working and integration in relation to hospital discharge (and wider).

There has been benefit to the workforce in that they have been able to develop consistent practice across all of the acute hospital sites. Additionally hospital team managers have been able to use peer manager relationships to achieve solutions to practice challenges.

Looking at DTOC (total attributable) by Surrey hospitals over the past seven years, DTOC days have increased by 62 per cent in total across England but have reduced by 17 per cent in Surrey.

Between 2010/11 and 2011/12, Surrey's performance was behind the England average. With action taken across the system since then, including the implementation of 8am to 8pm working seven days a week, has enabled Surrey to outperform the England average.

#### Contact:

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## 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.

### **Some things that people have told us – about what works and how to overcome the challenges:**

- adopting as a key principle that long-term assessments are not carried out in hospital
- placing an emphasis on trust – working through the MDT, so staff read each other's assessments rather than do their own
- co-designing and delivering approaches with care providers and residential homes.

## National guidance and tools

NHS Improvement, Developing trusted assessment schemes – essential elements

<https://improvement.nhs.uk/resources/developing-trusted-assessment-schemes-essential-elements/>

NHS England, quick guide to improving hospital discharge to the care sector

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf)

NHS England, quick guide to Discharging to Assess

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf)

# Examples of local initiatives

## Newcastle Gateshead CCG

### Trusted assessment

The approach to implementing trusted assessment involved:

- identifying the best team to develop trusted assessment – using an interface team of nurse, physiotherapist, occupational therapist and social worker
- developing a trusted assessment tool with care partners – undertaking an interagency review of existing tools and stakeholder consultation to develop a trusted assessment tool
- testing the process within a safe environment – with patients transferring from hospital to step-down beds
- evaluating the impact – which showed that 66 per cent of patients were transferred the same day, 28 per cent the next day and 3 per cent at a later date. Issues identified related to mobility, communication and discharge planning.

#### Contact

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# Examples of local initiatives

## Lincolnshire

### Care home trusted assessor

In Lincolnshire, a number of delays were occurring while waiting for care homes to visit the acute hospital to carry out assessments. Lincolnshire chose to address this through the introduction of a care home trusted assessor role, which would not only enable assessments to be carried out more quickly, but would also help to develop relationships and trust across the system.

In September 2015 a pilot project was agreed for an assessor to be employed by the care home sector and located within the discharge hub at Lincoln County Hospital. Working in partnership with care homes and the hospital to find solutions to current challenges, the role was established to:

- support and facilitate timely and safe discharges from hospital to care homes
- undertake assessments and re-assessments on behalf of the care homes
- ensure the discharge documentation was complete to accompany the resident on discharge
- liaise with the care homes about the discharge arrangements to streamline processes
- act as a point of contact when residents were admitted to hospital to monitor progress.

The people identified to undertake the role were fully independent, employed by the Lincolnshire Care Association. They have been given access to the bed management system and to the trust's IT systems, and there is a strong focus on regular communications with care homes.

In April 2016, coverage was extended to all hospital sites in Lincolnshire and Peterborough and seven day working began in late 2017. Over the first full year, 439 referrals were made, 340 assessments completed and 304 discharges supported, leading to an estimated saving of 735 bed days.

For further information:

<https://improvement.nhs.uk/uploads/documents/lincolnshire-care-home-trusted-assessor-project-case-study-ECIR.pdf>

#### Contact:

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## Examples of local initiatives

### Blackburn with Darwen Home First with trusted assessment

Success for partners in Blackburn with Darwen has been achieved through shared recognition of a problem, and a commitment to developing a solution, and testing, revising and taking it further.

Having acknowledged that some patients were waiting up to five or six days for discharge processes to be completed, health and care partners decided to develop new ways of working, setting themselves the ambition that people could be discharged on the same day as they were deemed medically optimised.

The initial focus was on people with lower-level needs. Senior managers and frontline staff co-designed a trusted assessment document, which would capture background information and move with the person, so that everyone involved in discharge planning could update it. An integrated step-down team was established to receive the trusted assessments and coordinate discharge to reablement, sub-acute support or residential rehabilitation.

The approach was implemented in October 2016 and worked successfully over the winter months; it has now been in operation for over 12 months.

Building on this success, the next steps have been to extend this approach to patients waiting for packages of care, with a real focus on 'home first'. Ward staff undertake a partial assessment on the ward, and the person is then discharged to their home, with a full assessment taking place on day three. Wraparound care is offered for up to five days, during which time multi-disciplinary care staff help to enable the individual as much as possible, working with the family and introducing universal services.

By starting with just one or two patients a week, they have been able to test and adjust the pathway and recruit additional staff, and the approach is now being rolled out across a broader area, in partnership with Lancashire County Council, East Lancashire Hospitals NHS Trust and Lancashire Care NHS Foundation Trust, to achieve a more consistent discharge route for people, wherever they live.

Key to success has been the relationships built between professionals, based on a shared belief that nobody should be in hospital for longer than necessary, and the time taken to co-design the trusted assessment document. Training and communication have helped to embed the approach, with co-located teams making it easier to talk through and resolve issues as they arise. Throughout the development and implementation of the approach there has been a real focus on the person at the centre.

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## 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.

### **Some things that people have told us – about what works and how to overcome the challenges:**

- adopting early engagement as a key principle
- understanding patient dynamics – using the ‘four questions’ approach to empower them – What’s wrong with me? What will happen today? What do I need to do to help me get home? When am I going home?
- skilling up staff to have difficult conversations
- helping doctors to understand their local care market.

### **National guidance and tools**

NHS England, quick guide to supporting patients’ choices to avoid long hospital stays  
[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf)

Think Local Act Persona, A narrative for person-centred coordinated care  
[www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf)

Health Education England, Care navigation: a competency framework  
[www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework\\_Final.pdf](http://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf)

# Examples of local initiatives

## Gloucestershire Care navigators

Care navigators use their local knowledge of community services and care options available to help individuals and their families make decisions about the best ways to stay independent and safe.

They help people by simplifying the process of finding affordable services to meet their needs at a time of crisis, taking a broad approach, which includes housing options, signposting for financial advice and maximising income or benefit entitlement.

They are able to make appropriate links and referrals with direct access into adult social care brokerage, locality teams and voluntary and community sector services such as Age UK and a British Red Cross resettlement service.

As a result, care navigators are helping to reduce unnecessary referrals into adult social care teams from acute hospitals – a mapping exercise identified that nearly 70 per cent of referrals did not require social worker input, or result in ongoing adult care-funded services.

The team includes two navigators redeployed from reablement services, which has helped to increase the numbers of people going straight home. Other navigators have been recruited from voluntary and community sector organisations and there is also a joint post with Gloucestershire Fire and Rescue Service which has been set up as a pilot to support 'safe and well' visits, an existing responder service and proactive discharge follow-up.

The model includes capacity for evening and weekend visiting times.

See also – change element 3. Multi-disciplinary / multi-agency discharge teams

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## 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.

### **Some things that people have told us – about what works and how to overcome the challenges:**

- training for care staff to deal with greater frailty and complexity
- incentivising the market to have the right kinds of placements available.

### **National guidance and tools**

NHS England, New Care Models – The Framework for Enhanced Care in Care Homes

[www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf](http://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf)

NHS England, quick guide to clinical input into care homes

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-clinical-input-to-care-homes.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-clinical-input-to-care-homes.pdf)

NHS England, quick guide to technology in care homes

[www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Technology-in-care-homes.pdf](http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Technology-in-care-homes.pdf)

NICE and Social Care Institute for Excellence, quick guide to moving between hospital and home, including care homes

[www.scie.org.uk/publications/atagance/moving-hospital-home.pdf](http://www.scie.org.uk/publications/atagance/moving-hospital-home.pdf)

Further NHS England quick guide due for publication in late 2017: Upskilling for care home staff.

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## Wakefield District Enhanced health in care homes vanguard

The programme aims to tackle loneliness and fragmented care by joining up services for older people in supported living schemes and care homes, to help people live longer, healthier lives at home and within their communities. The approach is currently implemented in 15 care homes and two extra care facilities within the vanguard and in 2017/18 will be expanded to take in 12 more homes.

The programme is a collaboration between health, social care, housing and the voluntary sector with a focus on the wider determinants of wellbeing – ‘somewhere to live, someone to love, something to do’. It includes reablement and rehabilitation services and the development of community assets to support resilience and independence, and enable people to live in the most independent setting for as long as possible.

Assessment and care planning is proactive and multi-disciplinary, involving GPs, community nurses, therapists, pharmacists, voluntary workers and care home staff. Enhanced primary care support (working with 25 out of 40 GP practices in Wakefield) allows access to a consistent, named GP and wider primary care services, and a coordinated support package helps to keep people socially connected to activities in the wider community (via Carers Wakefield, Age UK).

This holistic approach helps to reduce the risk of deterioration and dependence. It also helps build the confidence, capability and continuity of staff working in care homes through continued training, overall reducing the frequency of emergency call-outs.

For residents and their families it means they stay in control of their care while maintaining optimum health. Every resident has an end of life plan, enabling people to die in their place of choice instead of experiencing the distress of being transferred to hospital in their last hours.

Additionally, the approach is:

- reducing accidents and health deterioration which result in urgent GP calls and hospital attendance or admission
- reducing the number of people choosing to go from independent living into care settings to escape loneliness
- enabling couples to be supported to stay together in independent living schemes.

For further information

<https://connectingcarewakefield.org/wp-content/uploads/2016/01/care-homes-case-study.pdf>

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# Examples of local initiatives

## Surrey

### Enhancing health in care homes

In 2014 East Surrey CCG embarked on a project to improve the medical care of residents of nursing and residential homes. Within care homes, out-of-hours support would routinely send individuals to hospital, often with a lack of available information with regards to a plan of care. The key aim was enhancing the level of care to all residents of care homes based on a proactive and preventative approach to care, using personal planning and reducing the variation in care experienced across care homes.

#### Phase 1:

- nurse advisors for care homes – First Community Health and Care (Community Provider)
- redesign of the locally commissioned service to facilitate work of GPs in care homes
- improving links with pharmacy
- developing a new ambulance pathway.

#### Phase 2 (current) aims to:

- introducing anticipatory care records secondary care, ambulatory care, frailty unit, integrated reablement unit and emergency department.
- increasing pharmacy support to regularly review more care home patients – 1,800 patients – with average length of stay of approximately 20 months
- promoting access to community services, ambulatory care and frailty unit
- appointing a dietician to complement the provision of medicine management.

## Evaluation

#### Quality of care:

- patient centeredness – one GP seeing all patients in one home was viewed by care home staff as providing good patient care
- polypharmacy – 592 residents were reviewed leading to 861 medicines stopped, contributing to a reduction in waste.

## Acute activity

The project has led to a fall in acute activity:

- latest data shows average reduction of 51 per cent for both A&E admissions and A&E attendances equating to £253,417 saving compared with 2016/17
- emergency admissions to hospital of patients from all care homes fell by 7.3 per cent in 2016/17 (949) compared to 2015/16 (1,024)
- by having care plans in place, ambulance crews have reduced the number of patients being transferred to A&E as an emergency; they now 'see and treat'.

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