ITEM **8(e) (ii)**

HEALTH AND WELLBEING BOARD

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HIGH IMPACT CHANGE MODEL – DELAYED TRANSFERS OF CARE

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Purpose of Report:

This report summarises the findings of the Peer Review undertaken using the High Impact Change Model into Milton Keynes Social Care Delayed Transfers of Care. It provides the Health and Wellbeing Board with the initial findings of the review and next steps.

1. Background

Across the whole system, our common aims are to:

- Improve services for patients by avoiding situations where, particularly older people are put at risk by remaining in the acute sector when they no longer need acute care.

- Encourage systems to invest together in an extended range of services to prevent delays occurring in the first place.

- Reinforce partnership working between acute trusts and local authority social care departments.

- Drive a better system of discharge planning encouraging the development of proactive planning for discharge rather than the reactive last minute planning for discharge that still exists in many trusts.

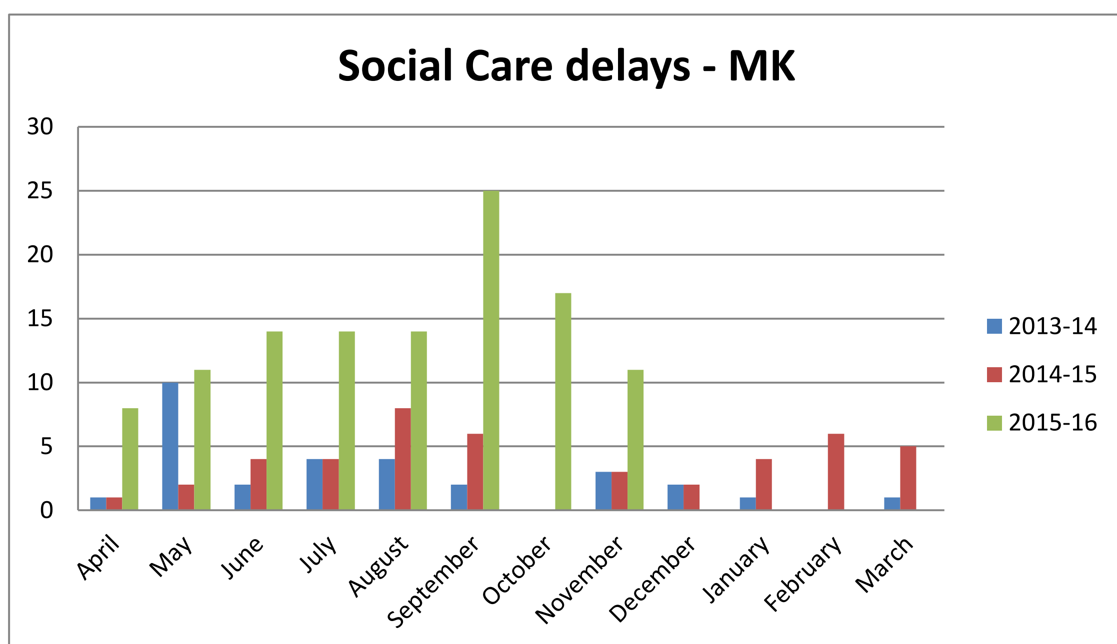
Milton Keynes was in the lowest quartile of performance for social care delays in August and September 2015. In September 2015 the rate of delays per 100,000 population was 180.4 and Milton Keynes was 131/151 Local Authorities in that month.

In November the Local Government Association (LGA) Care and Health Improvement Advisor (East Midlands & East of England) contacted all Directors of Adult Social Services in the lower quartile performance band on DTOCs to offer support to improve performance. A Peer Review team was identified from Leicester City Council and NHSE. They visited MKC on 22nd January 2016 and interviewed staff from the Hospital Discharge and Reablement Service and Milton Keynes University Hospital Foundation Trust Discharge Team. The Team used the eight areas of the model to assess current performance and areas for improvement.

The High Impact Change Model is a tool developed as part of the winter resilience sector led improvement programme. The model was developed through the Helping People Home Team's work (a joint Department of Health, Department of Communities and Local Government, NHS England, ADASS and

LGA programme) with some co-design to help local systems over the 2015/16 winter. It was designed to encourage areas to consider new interventions and to assess how effectively current systems are working. A number of high impact changes have been identified that can support local health and care systems, and reduce delayed transfers of care.

Given the pressures on local health and care systems, especially around patient flow and discharge, the High Impact Change Model can be used to support local systems with practical assistance. Support on how to implement any of these changes is offered from the Emergency Care Intensive Support Team (ECIST) and the LGA Care and Health improvement advisors working with local systems.



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 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 Access. 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.

2. Recommendations

1. That the report be noted.
2. That an updated report be provided in 6 months' time to the Board in respect of the performance compared against the developed action.

3. Key Issues

The review found there was some good work underway and innovative pilots across the system to support transfers of care. They focussed on areas for improvement, given the DTOC position.

The review found the challenges are varied but key issues appeared to be:

- Pathways – not always clear, coordinated or streamlined.
- Information – early information is available but not getting to Adult Social Care (ASC) to aid discharge planning / capacity planning.
- Capacity – lack of bed and home care capacity in some areas.
- Flow – the right people are not in the right services for the right length of time.
- Internal resources – these are available and could be better focussed on supporting discharge and flow.

- Joint working – ASC delays were high but in the context of high system delays – unlikely to make real inroads in isolation unless market capacity changes fundamentally.

- Progress review of Intermediate Care and consider role of internal home care services.

- Within this, consider screening for eligibility prior to offer of reablement / social care intermediate care.

- Introduce clear policy of charging after reablement period in line with residential or community charging policies.

- Look at domiciliary care contracts referral action timeframes.

- Align a higher number of social work staff to acute wards.

- Consider the use of these ward-linked staff in reviewing the existing 'amber' list of medically well patients.

- Consider extension of the care home passport to a trusted assessment tool, which allows for ASC to screen for likely eligibility as well as providers accept a transfer of care.

- Work with joint commissioning team about contracting / incentive models for step down / step up – currently seem to be too weighted towards the provider 'keeping' patients for financial benefit long term

- Agree a non-weight bearing pathway that enables people to be cared for outside of hospital and then access reablement / intermediate care – to prevent decompensation and higher support needs longer term.

Long term issues

- Market capacity -a commissioning approach is required to secure sufficient capacity / staffing across the Health & Social Care system.

- System wide commitments – System Resilience Group needs to address the issue of health DTOC.

- Cross-border issues – work with adjoining councils and CCGs on market issues in particular as well as operational agreements on the discharge pathway.

Next Steps

Develop an action plan to address key areas identified by Peer Review.