

8 High Impact Change Model - Managing Transfers of Care Self-Assessment Introduction

<div> <div>SWINDON</div> <div>8 High Impact Change Model - Managing Transfers of Care</div> <div>Self-Assessment and action plan September 2017</div> </div>					
Impact Change	Link for definition and criteria	Where are you	What do you need to do and who is accountable	When will it be done by a	How will you know it is successful
Early Discharge Planning	Click here for self-assessment criteria and definition of IMPACT 1.	Plans In Place	Investigate current position of community planning via CCGs. Establish use of report detailing accuracy of EMFFD and discharges on this date (COO-GWH) . An increasing number of social workers involved in WhiteBoard rounds to identify pathway for discharge and plan discharge as soon as patient is admitted to hospital. Ensure effective assessment notifications to social care. Early identification of complex discharges through White Board rounds and daily IDS triage meetings (DASS - SBC). EMFFD and patients needs from partners needs to be transparent from ward level and quickly actionned from IDS team to minimise any delays. GWH to add discharge planning for elective admissions. Need to involve Distric Nurses and Gp's in discharge planning (COO - GWH). CHS - referrals to community services from Pre-op clinic will be improved by redesigned clinical hub. Working to give Community Matrons and Specialist teams access to MEDWAY to flag admissions of known patients so discharge can commence at earliest opportunity with secondary care and commuity teams 31.10.2017 (Director Community Services). Streamlining discharge pathways across Swindon and Wiltshire	30.9.2017	Report detailing accuracy of MFFD and discharges on this date will be regularly produced on a monthly basis (KPIs for IDS) for management within Division and via Integrated Discharge Service (IDS). Reduction in social care delays due to assessment and management of weekly KPIs by social care CHS Clinical Hub will report on source of referral and numbers of same day urgent referrals
Systems to Monitor Patient flow	Click here for self-assessment criteria and definition of IMPACT 2	Plans In Place	IDS from 3rd May has been designed to streamline d/c planning and support for changes in service delivery in community services Wilts and Swindon specifically. Evaluation through KPIs to take place Review of operational meeting to support efficient use of resources to target discharges and allow proactive response to blockages and small discharges numbers are being developed to actively manage patient flow so that an increasing number of simple discharges being managed and expedited should they fall short of expected average numbers by the acute in a proactive management. Early discussions with family and clinicians and reshaping of ward processes relating to discharge planning (COO - GWH). Implementation of findings from Meriden diagnostic CHS - Pilot utilising Liaison Nurse to support proactive identification of patients appropriate tot transfer to Swicc Commence Sept 2017 (Director Community Services)	Oct-17	Increased discharges, LOS reduction for MFFD patients and reduction in unnecessary DART referrals. Complinance against all OPEL actions and fully embedded and repsonded to. Compliance against Community Provider OPEL status (in development) by Oct 17
Multi-Disciplinary Multi-Agency Discharge Teams (including Vol & Commu sector)	Click here for self-assessment criteria and definition of IMPACT 3	Plans In Place	IDS commenced May 17 with single referral process. Joint assessments being discussed with social care in acute hospital. Plan to integrate IDS service with SwiCC and will progress when IT systems are aligned. Team will require boosting in terms of staffing to provide the comprehensive 7 day integrated service the model described. Review of roles and responsibilitis in IDS following work by Meridian (COO - GWH). Social work teams reshaped to increase social care discharges so that social workers attend MDT on main wards and this to be consolidated. Social care involvement in daily triage. Voluntary sector commissioning of carer support within GWH and circles of support to reduce isolation and loneliness to be enanced. Social work role in wards to be evaluated October 2017 (DASS - SBC) Trusted assessor model implementation to support timely transfer to community care (Executive Nurse CCG) CHS- re-design of local processes to improve discharge pathways to SwiCC and onwards to community services includes revised criteria for transfer, Common IT System and documentation, introduction of Board rounds and white boards Oct 2017 (Director Community Services)	Sep-17	Fully staffed integrated model will run over 7 days. KPIs for team met. Partner organisation will report appropriate number and quality of referrals. Wards will report support with discharge planning/reporting. Reduction in assessment notifications sent to social care on day patient is medically fit from 40% of current performance to 0% CHS will monitor community bed capacity in terms of numbers of patiетns waiting to transfer, 48 hour discharge forecast adn DTOCs
Home First Discharge to Assess	Click here for self-assessment criteria and definition of IMPACT 4	not yet established	BCF funds 1000 hours per week of discharge to assess domiciliary care capacity and 12 discharge to assess residential beds. Both services are being reviewed to ensure maximisation of reablement instead of bridging services. Further reduction of social care assessments taking place in hospital to be achieved through better use of Fessey beds and D2A nursing beds (DASS - SBC). Earlier identification of tele care necessaray to reduce delays. Trusted assessor to be implemented will reduce need for care homes to assess patients in hospital and reduce delay (Executive Nurse -CCG) CHS - Dedicated Therapy support having positive impact on reablement and so currently looking at opportunity to redesign therapy provsion to provide rapid and same day response as well as increase flow through reablement services (Director Community Services)	Oct-17	. Increase in number of patients accessing reablement from social work teams and reduction in use of residential care from hospital
Seven-Day Services	Click here for self-assessment criteria and definition of IMPACT 5	Plans In Place	IDS liaison work 7 days. Social care teams from Wiltshire currently provide one worker in the triage role on Saturday. Swindon Borough Council has completed 7 day working consultation for hospital social work, reablement and crisis support. Hospital social work team working 7 days a week as well as crisis support and reablement. Increased presence in hospital social work team to be implemented for winter (DASS - SBC) CHS - Clinical hub will provide 7 day /24 hour access to community health services Oct 2017 (Director Community Services)	Nov-17	Improved timely discharges with less medically fit patients within the Trust and improved Length of stay and improved ED 4hour wait time performance
Trusted Assessors	Click here for self-assessment criteria and definition of IMPACT 6	Plans in Place	A co-ordinated approach is helped with the evolving IDS delivery. Care Home Forums have been re-established to improve on our relationships with the move to more trusted assessments with increasin number of care homes. Trusted Nurse Assessor recruitment in place to avoid care homes assessing in hospital (Executive Nurse - CCG) CHS : Same day and urgent response teams will develop joint working arrangements with Social care colleagues. Training opportunities with community colleagues available for IDS. Reviw of discharge planning in SwiCC to improve interagency assessment and planning (Director Community Services)	Oct-17	Reduction in delays due to awaiting residential and nursing home placement CHS - 48 Hour discharge forecast and increase transfers to Swicc before 12pm
Focus on Choice	Click here for self-assessment criteria and definition of IMPACT 7	Plans in place	Choice policy in place with plans to replace with the Wiltshire version (once been ratified). The IDS teams are promoting earlier intervention regarding the discussions around discharge planning with the patient and families. Information leaflet need to be updated. Use of voluntary services is well established within the GWH and one service is based with the IDS team. Further training and understanding for ward based staff including development of discharge booklet and educational programme' (COO- GWH). CHS: Choice policy re-launched in SwiCC with improved monitoring (Director - Community Services)	Oct-17	A more informed IDS team who have contemporaneous training CHS - Reduction in DtoCs due to choice in SwiCC.
Enhancing Health in Care Homes	Click here for self-assessment criteria and definition of IMPACT 8	Plans in Place	CCG planning to establish care homes support services including community nursing and health service support to care homes. Also working to identify 2 or 3 care homes to pilot Red Bag Scheme; working up proposals for Trusted Assessor and LES for GP weekly ward round in identified care home (Executive Nurse CCG). CHS Reviewing input to care homes to identify any additional interventions to support enanced service including access to telehealth (myclinic) (Director Community Services)	Oct-17	Reduced attendances and admissions to hospital; reduced LoS for care home patients; reduction in delayed discharges/DToC for care home patients; increased weekend discharges; improved communication and relationships between hospital and care homes

CRITERIA for self assessment - 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.

MEASURE Not yet established	MEASURE Plans in place	MEASURE Established	MEASURE Mature	MEASURE Exemplary
Early discharge planning in the community for elective admissions is not yet in place. Discharge planning does not start in A+E	CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning. Plans are in place to develop discharge planning in A+E for emergency admissions	Joint pre admission discharge planning is in place in primary care . Emergency admissions have a provisional discharge date set in within 48hrs.	GPs and DNs lead the discussions about early discharge planning for elective admissions Emergency admissions have discharge dates set which whole hospital are committed to delivering	Early discharge planning occurs for all planned admissions by an integrated community health and social care team. Evidence shows X% patients go home on date agreed on admission

CRITERIA for self-assessment - 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.

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

CRITERIA for self-assessment - 3: Multi-Disciplinary/Multi-Agency Discharge Teams, including voluntary & 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

MEASURE Not yet established	MEASURE Plans in place	MEASURE Established	MEASURE Mature	MEASURE Exemplary
Separate discharge planning processes in place	Discussion ongoing to create Integrated health and ASC discharge teams	Joint NHS and ASC discharge team in place	Joint teams trust each others assessments and discharge plans	Integrated teams using single assessment and discharge process
No daily MDT meeting in place	Discussion to introduce MDTs on all wards with Trust and community health and ASC	Daily MDT attended by ASC, voluntary sector and community health	Integrated teams cover all MDTs including community health provision to pull patients out	Integrated service supports MDTs using joint assessment and discharge processes
CHC assessments carried out in hospital and taking “too” long	Discussion between CCG and Trust to establish discharge to assess arrangements	Discharge to assess arrangements in place with care sector and community health providers	CHC and complex assessments done outside hospital in peoples homes/extra care or reablement beds	Fully integrated discharge to assess arrangements in place for all complex discharges

CRITERIA for self-assessment - 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.

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

CRITERIA for self-assessment - 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.

MEASURE Not yet established	MEASURE Plans in place	MEASURE Established	MEASURE Mature	MEASURE Exemplary
Discharge and social care teams assess and organise care during office hours 5 days a week	Plan to move to 7 day working being drawn up	Health and social care teams working to new 7 day working patterns	Health and social care teams providing 7 day working	Seamless provision of care regardless of time of day or week
OOHs emergency teams provide non office hours and weekend support	New contracts and rotas for health and social care staff being drawn up and negotiated	New contracts agreed and in place	New staffing rotas and contracts in place across all disciplines	New staffing rotas and contracts in place and working seamlessly
Care services only assess and start new care Monday –Friday	Negotiations with care providers to assess and restart care at weekends	Staff ask and expect care providers to assess at weekends	Most care providers assess and restart care at weekends	All care providers assess and restart care 24/7
Diagnostics, pharmacy and patient transport only available Mon-Fri	Hospital departments have plans in place to open in the evenings and at weekends	Hospital departments open 24/7 whenever possible	Whole system commitment usually enabling care to restart within 24hrs 7 days a week	Whole system commitment enabling care always to restart within 24hrs 7 days a week

CRITERIA for self-assessment - 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.

MEASURE Not yet established	MEASURE Plans in place	MEASURE Established	MEASURE Mature	MEASURE Exemplary
Assessments done separately by health and social care	Plan for training of health and social care staff	Assessments done by different organisations accepted and resources committed	Discharge and social care teams assessing on behalf of health and social care	Integrated assessment teams committing joint pooled resources
Multiple assessments requested from different professionals	One assessment form /system being discussed	One assessment format agreed between organisations/professions	Single assessment in place	Resources from pooled budget accessed by single assessment without separate organisational sign off
Care providers insist on assessing for the service or home	Care providers discussing joint approach of assessing on each others behalf	Care providers share responsibility of assessment	Some care providers assess on each others behalf and commit to care provision	Single assessment for care accepted and done by all care providers in system

CRITERIA for self-assessment - 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.

MEASURE Not yet established	MEASURE Plans in place	MEASURE Established	MEASURE Mature	MEASURE Exemplary
No advice or information available at admission	Draft pre admission leaflet and information being prepared	Admission advice and information leaflets in place and being used	Patients and relatives aware that they need to make arrangements for discharge quickly	Patients and relatives planning for discharge from point of admission
No choice protocol in place	Choice protocol being written or updated to reduce < 7 days	New choice protocol implemented and understood by staff	Choice protocol used proactively to challenge people	All staff understand choice and can discuss discharge proactively
No voluntary sector provision in place to support self funders	Health and social care commissioners co designing contracts with voluntary sectors	Voluntary sector provision in place In the Trust proving advice and information	Voluntary sector provision integrated in discharge teams to support people home from hospital	Voluntary sector fully integrated as part of health and social care team both in the trust and the community

CRITERIA for self-assessment - 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.

MEASURE Not yet established	MEASURE Plans in place	MEASURE Established	MEASURE Mature	MEASURE Exemplary
Care homes unsupported by local community and primary care	CCG and ASC commissioners working with care providers to identify need	Community and primary care support provided to care homes on request	Care homes manage the increased acuity in the care home	Care homes integrated into the whole health and social care community and primary care support
High numbers of referrals to A+E from care homes especially in evenings and at weekends	Specific high referring care homes identified and plans in place to address	Dedicated intensive support to high referring homes in place	No unnecessary admissions from care homes at weekends	No variation in the flow of people from care homes into hospital during the week
Evidence of poor health indicators in CQC inspections	Analysis of poor care identifies homes where extra support and training needed	Quality and safeguarding plans in place to support care homes	Community health and social care teams working proactively to improve quality in care homes	Care homes CQC rates reflect high quality care