Appendix 1

High Impact Change Model – Managing Transfer of Care – Current LLR Position – April 2016

Impact Change	Status	Current Activity	Gaps	Next Steps	Timelines	Success Criteria
Change 1: Early Discharge Planning. *In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.*						
• Elective Care	Plans In Place	Early Discharge in place for both community hospital beds and elective admissions. There are Pre assessments for some surgical elements				
• Discharge planning does not start in A&E	Exemplary	Understanding discharge dates set are achieved				
• CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning.	Established	Primary care is currently not in place and system is to be developed, however joint management of preadmissions is widely undertaken			.	
• Plans are in place to develop discharge planning in A+E for emergency admissions	Plans in place	LLR have a system wide discharge group that meets monthly Perform complex case management via out DTOC lists Daily Conference Calls are undertaken with actions put in place				
• Joint pre admission discharge planning is in place in primary care .	Plans in place	Primary Care Coordinators are in place				
• Emergency admissions have a provisional discharge date set in within 48hrs	established	Emergency call have discharge date set within 48 hours				
• GPs and DNs lead the discussions about early discharge planning for elective admissions	Not yet Established	GP Elective does not occur				
• Emergency admissions have discharge dates set which whole hospital are committed to delivering	Plans In place	The aim is for all patients to have a discharge date which is set in the ED, with a commitment to deliver.		we are looking what percentage EDD are met and reason why this slips		
• Early discharge planning occurs for all planned admissions by an integrated community health and social care team.	Exemplary	This is undertaken				
• Evidence shows X% patients go home on date agreed on admission	Plans in place	Routinely do not have planning integrated team for emergency planned admissions. Not routinely completed.				
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.*						
• No relationship between demand	Plans in place	Policy in place through new				

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and capacity in care pathways		discharge pathway (Pathway 3)				
• Capacity available not related to current demand	Not yet established	Analysis to determine new discharge pathway with further work to be undertaken which includes what this will mean in terms on capacity, demand and flow into A&E				
• Bottlenecks occur regularly in the Trust (UHL) and in the community	Plans in place	Bottlenecks have been analysed in relation to complex discharges. A discharge summit to improve performance, recognise core work around less complex cases has been arranged for 5th May 2016.				
• There is no ability to increase capacity when admissions increase – tipping point reached quickly	Plans in place	We have an escalation process which is utilised on a regular basis				
• Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	Established	Staff and providers understand the requirement to increase clinical support however this is not consistently applied in time				
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*						
• Separate discharge planning processes in place	Mature/established?	Joint discharge working is in place – i.e. Programme in place with a single assessment process. Developing plans through Minimum Data Set				
• No daily MDT meeting in place	Mature / exemplary	MDT meeting are in place within community wards and adult and social care; however this doesn't have voluntary sector involvement		The system has initiated a pilot integrated process to support the MDT		
• CHC assessments carried out in hospital and taking "too" long	Established / mature	The system has discharge process in place with CHC complex extra care in acute services. Link to pathway 3.		Looking to extend within the community an improved service to deliver a bed based plan i.e. pathway 3.		
• Discussion ongoing to create Integrated health and ASC discharge teams	Mature			Developing new discharge pathway which encompasses a fully integrated discharge service.	Winter 2016	
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.*						
• People are still assessed for care on an acute hospital ward	Mature	currently there are some patients who return home with reablement support from an integrated team		Integrated team is in place with further role out to be undertaken	Winter 16	
• People enter residential /nursing	Mature	Most have assessment for the		Need to prioritise final decisions being		

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care too early in their care career		longer term home care.		made for out of hospital transfers before permanent decision are made for suitable placements		
• People wait in hospital to be assessed by care home staff	Plans in place	There are currently still to many patients waiting for transfers to care homes with UHL.		Further work is being carried out to identify care homes and work with relative to resolve issues		
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.*						
• Discharge and social care teams assess and organise care during office hours 5 days a week	Plans In place	Within some areas we have 7 day working patterns Access to 7 day services is arranged in some areas with established access to a range of services. Not all discharge service are offered on a 7 days basis		Other areas require further work		
• OOHs emergency teams provide non office hours and weekend support	Plans in place	CNCS cover for patients at weekends/bank holidays. CCGs have their respective Weekend services such as Weekend Access Service and CRT, Hubs?		Further work to be undertaken such as Dietetics		
• Care services only assess and start new care Monday – Friday						
• Diagnostics ,pharmacy • and patient transport only available Mon-Fri		Diagnostic for pharmacies and transport is in place				
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.*						
• Assessments done separately by health and social care	Established	Jointly we do assess on each other's behalf in some areas such as OT.				
• Multiple assessments requested from different professionals	Established	Single assessment is performed with a mechanism of professional boundaries sharing information at the best interest of the patient.				
• Care providers insist on assessing for the service or home	Not yet established	Care home assessments are performed in early stages on complex packages of care for CHC.		Care homes dialogue has started this is to ensure assessment is performed at an early stage.		
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.*						
• No advice or information available at admission	Plans in place	At present individual advice and information available includes community and acute sectors.		We acknowledge the need to review and determine what information, advice and guidance is available for patient and families and are currently in the process of revising this as this needs to be robust		
• No choice protocol in place	Plans in place	Ensuring we are being proactive				

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• No voluntary sector provision in place to support self-funders	Not yet established					
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.*						
• Care homes unsupported by local community and primary care	Established	This is subject to intensive support in hiring homes. There is case management across acute and primary care teams using a "one home on practice model"				
• High numbers of referrals to A+E from care homes especially in evenings and at weekends	Plans in place	There are a number of schemes that are designed to support improving health and wellbeing of resident of care homes and reduce unnecessary admission to acute hospitals; this include good case management, acute visiting service, dedicated pharmacy and dietician services in some areas. include good case management, acute visiting services, dedicated pharmacy and dietician service in some		Further work to be carried out with small a number of care homes to understand processes and establish relationships to promote integration, data analysis for admission, quality improvements and compliance issues		
• Evidence of poor health indicators in CQC inspections	Established	Robust process in place for when CCGs are informed of CQC outcome for providers. Plans to address issues Appropriately and in a timely manner.				