Local Government Association

High impact change model

Managing transfers of care between hospital and home

A self-assessment tool for local health and care systems

Contents

1.Introduction

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

It builds on lessons learnt from practice and promotes a new approach to system resilience, moving away from a focus solely on winter pressures to a year-round approach to supporting timely hospital discharge. Whilst acknowledging that there is no simple solution to creating an effective and efficient care and health system, this model signals a commitment to work together to identify what can be done to improve current ways of working. The model was endorsed in a joint meeting between local government leaders and secretaries of state for health and for communities and local government in October 2015.

2. Purpose of the model

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

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

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

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

3. Principles

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

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

4. The model

Change 1

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

Change 2

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

Change 3

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

Change 4

Home first/discharge to 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. Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people's needs.

Change 6

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

Change 7

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

Change 8

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

4. The model

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

Change 1

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

Not yet established	Plans in place	Established	Mature	Exemplary
Early discharge planning in the community for elective admissions is not yet in place	Change to clinical commissioning group (CCG) and change to adult social care (ASC) commissioners are discussing how community and primary care coordinate early discharge planning	Joint pre-admission discharge planning is in place in primary care	GPs and District Nurses lead the discussions about early discharge planning for elective admissions	Early discharge planning occurs for all planned admissions by an integrated community health and social care team
Discharge planning does not start in A&E	Plans are in place to develop discharge planning in A&E for emergency admissions	Emergency admissions have a provisional discharge date set in within 48 hours	Emergency admissions have discharge dates set which whole hospital are committed to delivering	Evidence shows X per cent patients go home on date agreed on admission

4. The model

Change 2

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

Not yet established	Plans in place	Established	Mature	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

4. The model

Change 3

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

Not yet established	Plans in place	Established	Mature	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 other's assessments and discharge plans	Integrated teams using single assessment and discharge process
No daily multidisciplinary team 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
Continuing Health Care 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 people's homes/extra care or reablement beds	Fully integrated discharge to assess arrangements in place for all complex discharges

4. The model

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

Not yet established	Plans in place	Established	Mature	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

4. The model

Change 5

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

Not yet established	Plans in place	Established	Mature	Exemplary
Discharge and social care teams assess and organise care during office hours five days a week	Plan to move to seven day working being drawn up	Health and social care teams working to new seven day working patterns	Health and social care teams providing seven 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 to 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 Monday to Friday	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 24 hours, seven days a week	Whole system commitment enabling care always to restart within 24 hours, seven days a week

4. The model

Change 6

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

Not yet established	Plans in place	Established	Mature	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 other's behalf	Care providers share responsibility of assessment	Some care providers assess on each other's behalf and commit to care provision	Single assessment for care accepted and done by all care providers in system

4. The model

Change 7

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

Not yet established	Plans in place	Established	Mature	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 decide about 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 seven 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

4. The model

Change 8

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

Not yet established	Plans in place	Established	Mature	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 Care Quality Commission (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 home CQC ratings reflect high quality care

4. The model

Action planning template

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Early discharge planning				
Systems to monitor patient flow				
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)				
Home First Discharge to Assess				
Seven-day services				
Trusted assessors				
Focus on choice				
Enhancing health in care homes				

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