

High impact change model

Managing transfers of care between hospital and home

**Updated for 2019/20**

A self-assessment tool for local health and care systems

**HIGH IMPACT CHANGE MODEL** MANAGING TRANSFERS OF CARE BETWEEN HOSPITAL AND HOME

# Contents

1. Introduction 3
2. Purpose of the model 4
3. Principles 5
4. ‘Making it Real’ Framework 6
5. How to use the HICM 7
6. The model 9

Change 1 – Early discharge planning 10

Change 2 – Monitoring and responding to system demand and capacity 12

Change 3 – Multi-disciplinary working 14

Change 4 – Home first 16

Change 5 – Flexible working patterns 18

Change 6 – Trusted assessment 20

Change 7 – Engagement and choice 22

Change 8 – Improved discharge to care homes 24

Change 9- Housing and related services 26

1. Action planning template 28

This model was developed in 2015 by strategic system partners, and has been refreshed in 2019 with input from a range of partners including the Local Government Association, the Association of Directors of Adult Social Services, NHS England and Improvement, the Department of Health and Social Care, the Ministry of Housing, Communities and Local Government and Think Local Act Personal Partnership.

As the model has been in use for several years, it was felt a refresh of its effectiveness was appropriate. This included a review of a wide range of materials, as well as consultation events to invite views from those using the tool. The evidence gathered included:

* Feedback from nine consultation events in each local government region, gathering reflections of over 550 colleagues from across health and local government.
* Online questionnaire asking for reflections on the model, completed by 44 respondents.
* Performance and reporting data, such as on implementation of the tool from BCF quarterly reports.
* Work of partner organisations and various regional projects underway to develop HICM support and collate good practice at a more local level.
* New sector research, quick guides and guidance (links to some of these materials are at the end of the introduction).

Review of the HICM

It builds on lessons learnt from best practice and promotes a new approach to system resilience, moving away from a focus solely on winter pressures to a year-round approach to support timely hospital discharge resulting in quality outcomes for people. While 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. Throughout implementation of the model, people need to be kept at the centre, with information and advice to support them to make decisions about their care. The model is endorsed by government through its inclusion in the Integration and Better Care Fund (BCF) policy guidance.

The refreshed model

The review broadly endorsed the High Impact Change Model (HICM) as a positive tool to support the continued reduction of delayed transfers of care. Respondents asked for more clarity, a strengthening of focus on the person, and greater emphasis on the key Home First policy. The resulting refresh therefore consists of a number of additional components including:

1. I and We statements: these expand on the impact of the changes from the perspective of the person or worker supporting them; these were chosen from Think Local Act Personal’s Making it Real framework, and their usage is supported by the National Coproduction Advisory Group.
2. Tips for success: these are in addition to the outcomes in the performance matrix and are often key principles.
3. The maturity levels are more focused on outcomes for both the system and people: these will not all match every system, but are intended to reflect what the changes should feel like.
4. Expanded links to supporting materials, including up-to-date case studies and fuller papers on certain changes.
5. Advice on measuring and monitoring success: a linked document [link to come] provides suggestions on how to measure progress, based on the principle of continuous improvement and using live data proactively and responsively, rather than conducting time-intensive analysis and evaluation projects.

This HICM aims to focus support on helping local system partners to improve health and wellbeing, minimise unnecessary hospital stays and encourage them to consider new interventions.

It offers a practical approach to supporting local health and care systems to manage the individual’s journey and discharge. It 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 original model identified eight changes which will have a significant impact on reducing delayed discharge; we have added an additional change in the refresh; these are:

• early discharge planning

• monitoring and responding to system demand and capacity

• multi-disciplinary working

• home first

• flexible working patterns

• trusted assessment

• engagement and choice

• improved discharge to care homes

• housing and related services (the new change).

The new change was created in response to feedback about the importance of home-based support in facilitating discharge, and includes the use of effective housing, home adaptations and assistive technology services. The change is focused on what is needed in terms of the ‘living environment’ in order to enable a safe and effective discharge. Respondents to the review also asked for the model to extend to cover admissions avoidance and other preventative actions. National partners concluded this area of focus was too important and expansive to include as one change in this refresh and instead are now developing a separate good practice tool. This new tool will seek to identify actions which delay, divert or prevent the need for acute hospital and statutory care, and instead increase focus on maximising people’s independence and helping to keep them well in their usual place of residence.

**HIGH IMPACT CHANGE MODEL** MANAGING TRANSFERS OF CARE BETWEEN HOSPITAL AND HOME

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 can experience challenges in relation to hospital discharge. Its inclusion as a national condition in the BCF is intended to support implementation of good practice, rather than to performance manage local systems.

The model is underpinned by a sector-led improvement approach which emphasises the importance of triangulating both hard and soft types of data and insight 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.

There are a number of overarching principles that underpin the model:

* Home First is a mindset that everyone involved in a system needs to understand and implement.
* A hospital is a very poor place to give information and advice to support people to make long-term decisions about their care with families, carers or advocates.
* An asset or strength-based approach, as espoused in the Care Act as part of a personalised approach, is essential.
* A whole-system response is necessary, and changes need to start to be implemented as early as possible.
* Systems should be supported to share good practice and challenges.
* The changes apply to all delayed discharges, although systems may want to focus on specific populations, particularly around their duties in reducing health inequalities.
* The changes are inter-linked and interdependent; they are also solutions to problems and, not necessarily needed in their own right if that problem does not present in the local system. So, set out to improve outcomes for people not tick a performance tool.
* Although there is no specific reference to overarching enablers of the good practice highlighted in the tool, these – including workforce, communication, culture, governance among others – are crucial and should be considered in any local conversation.

**HIGH IMPACT CHANGE MODEL** MANAGING TRANSFERS OF CARE BETWEEN HOSPITAL AND HOME

4. ‘Making it Real’ Framework

Providing personalised care and support is central to improving better outcomes for people transferring from hospital to an appropriate setting. Consequently in this updated HICM there is a greater prominence to this, linking the High-Impact changes to a person-centred approach. This model borrows from Think Local Act Personal’s ‘Making it Real’ framework, which is a set of “I and We” statements that describes what good care and support looks like from a person’s perspective and encourages organisations to work together to achieve good outcomes for people. TLAP’s National Co-Production Advisory Group, made up of people with lived experience of accessing care and health, including family carers, were engaged to help decide how best to incorporate a more person-centred approach through inclusion of the Making it Real framework.

The framework is based on the following principles and values of personalisation and community-based support:

* People are citizens first and foremost.
* A sense of belonging, positive relationships and contributing to community life are important to people’s health and wellbeing.
* Conversations with people are based on what matters most to them. Support is built up around people’s strengths, their own networks of support, and resources (assets) that can be mobilised from the local community.
* People are at the centre. Support is available to enable people to have as much choice and control over their care and support as they wish.
* Co-production is key. People are involved as equal partners in designing their own care and support.
* People are treated equally and fairly and the diversity of individuals and their communities should be recognised and viewed as a strength.
* Feedback from people on their experience and outcomes is routinely sought and used to bring about improvement.

Through engagement with TLAP’s National Co-Production Advisory Group and the Making It Real framework, the refreshed HICM ensures that the tool reflects the voices of people and enables a focus on what matters to people when transferring in, out and through hospital. For more information, visit <https://www.thinklocalactpersonal.org.uk/_assets/MakingItReal/TLAP-Making-it-Real-report.pdf>

The self-assessment matrix forms part of the model, and the intention is for the matrix levels to describe the journey to what good looks like. This should enable a system to see where they might benchmark their current performance and thus inform their development plans. The wording of the matrix has been purposely chosen to provide systems with the flexibility to make a judgement call on where they would self-assess to be against a particular level. For example, instead of specifying exact timings or figures, the matrix uses words like ‘many’, ‘often’, and ‘early’. While it is important to make an accurate assessment of your system, it is also important to ensure there is consensus across partners.

**HIGH IMPACT CHANGE MODEL** MANAGING TRANSFERS OF CARE BETWEEN HOSPITAL AND HOME

5. How to use the HICM

This tool is about supporting improvement, so once a level is agreed upon, the crucial point is that partners come together to create an improvement plan. The outcomes in the matrix are not set in stone. As a result, a system may feel it is performing well in any particular area but not always delivering as the matrix suggests. Given the flexibility of the model this is entirely possible. Systems should be able to go back to the problem the change is designed to address and show how they have achieved the change in their part of the world.

**Self-assessment matrix levels:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| Processes are typically undocumented and driven in an ad hoc reactive manner. | Developed a strategy and starting to implement, however processes are inconsistent. | Defined and standard processes in place, repeatedly used, subject to improvement over time. | Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show. | Fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes. |

Emerging and Developing Practice

The Emerging and Developing Practice [link] resource supplements the HICM by bringing together examples of work being undertaken across the country for each of the nine system changes. It references a range of initiatives where there is already evidence of impact, and points to examples of emerging practice that are starting to make a difference. This resource is designed to be used alongside the HICM to provide a sense of what ‘good’ looks like when self-assessing, but also provide inspiration to support the development of joint improvement plans.

Measuring and Monitoring Success

As part of the refreshed model, one of the key challenges identified by many systems was how hard it could be to monitor and measure progress against each change. While systems implement the changes and make improvements to patient flow, it can be hard to show the impact or to maximise how well a particular change is working. The Measuring and Monitoring Success [link] document is designed to take learning from what systems are already doing and offer suggestions on how to best measure and monitor success, with a focus on continuous improvement.

In addition, there are a number of support options available to systems if they require further help in implementing a particular change. For more information, speak to your Better Care Manager or LGA Care and Health Improvement Adviser, or visit [web link to come].

Supporting Materials

Throughout the tool, there are links to further information, case studies and guidance. There are a range of materials which apply across more than one change [links to come]:

* NHS good practice guides: [focus on improving patient flow](https://improvement.nhs.uk/documents/1426/Patient_Flow_Guidance_2017___13_July_2017.pdf); [reducing long length of stay](https://improvement.nhs.uk/documents/2898/Guide_to_reducing_long_hospital_stays_FINAL_v2.pdf)
* [Why not home? Why not today?](https://www.local.gov.uk/sites/default/files/documents/NEW0164_DTOC_Brochure_Online_Spreads_1.0.pdf) — (Newton, 2017)
* [People first, manage what matters](https://reducingdtoc.com/People-first-manage-what-matters.pdf) — (Newton, 2019)
* [Reducing delays in hospital transfers of care for older people](https://ipc.brookes.ac.uk/publications/pdf/Some_key_messages_around_hospital_transfers_of_care.pdf) — (Institute of Public Care)
* [London’s mental health discharge top tips](http://londonadass.org.uk/wp-content/uploads/2017/12/MH-top-tips.pdf) ­— (ADASS, 2017)
* [Factsheet: hospital discharge](https://www.ageuk.org.uk/globalassets/age-uk/documents/factsheets/fs37_hospital_discharge_fcs.pdf) — (Age UK, 2019)
* [NICE guideline – NG 27](https://www.nice.org.uk/guidance/ng27/evidence/full-guideline-pdf-2185185565)
* [NHSE/I hospital to home activities](https://www.england.nhs.uk/urgent-emergency-care/hospital-to-home/)
* [Rapid improvement guide to: red and green bed days](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-red-green-bed-days.pdf) — (NHS)
* [NHS benchmarking report – (NHS)](https://s3.eu-west-2.amazonaws.com/nhsbn-static/NAIC%20%28Providers%29/2018/Positive%20deviance%20inintermediate%20care%20services%20FINAL.pdf)

##  Change 1

**Early discharge planning** In elective care, planning for discharge 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

**Monitoring and responding to system demand and capacity** Develop systems across health and social care to provide real-time information about demand and capacity. All partners should work together to match capacity and demand by responding to emerging system needs, making effective strategic decisions, and planning services around the individual. Data should also be used to identify and respond to system blockages.

## Change 3

**Multi-disciplinary working** Multi-disciplinary teams (MDTs), including the voluntary, community and social enterprise sector (VCSE), work together to coordinate discharge around the person. Effective discharge and positive outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, shared and agreed responsibilities, and above all, good conversations with people and families.

## Change 4

**Home first** Home first is as much a system mindset as a service. It means always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best.

## Change 5

**Flexible working patterns** Where it will help to deliver the “right care, right time, right place”, consider how seven-day working, weekend working and extended hours for services across health and social care can be utilised. This will help to deliver care throughout the week, reduce delays moving through the system and improve individuals’ experiences.

## Change 6

**Trusted assessment** Using trusted assessment to carry out a holistic strengths-based assessment avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

## Change 7

**Engagement and choice** Early engagement with people who are using services, their families and carers is vital so they are empowered to make informed decisions about their future care and take ownership of their choice. The VCSE carers and advocates can be a real help with this. A robust choice protocol, underpinned by a fair and transparent escalation process, is essential so that when people have capacity they can understand and consider their options.

## Change 8

**Improved discharge to care homes** The NHS Enhanced Health in Care Homes framework supports ways to join up and coordinate health and care services to support care home residents. In considering how to achieve timely and safe transfers of care, the initiatives in this high impact change focus on how to improve outcomes for care home residents by reducing unnecessary admissions to hospital and facilitating smoother hospital discharge into care homes.

## Change 9

**Housing and related services** Effective referral processes and good services which maximise independence are in place to support people to go home. The need for housing and homelessness services, home adaptations and equipment are addressed early in discharge planning and readily available when needed.

## Change 1: Early discharge planning

In elective care, planning for discharge 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.

**‘Making it Real’- I/We statement**

When **I** move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place before change happens.

**We** support people to plan for important life changes, so they can have enough time to make informed decisions about their future.

**Tips for success:**

Supporting Materials

* [NHS guidance on hospital discharge planning](https://improvement.nhs.uk/documents/2100/discharge-planning.pdf)
* [NHS explainer for health and social care staff on early discharge planning](https://www.england.nhs.uk/wp-content/uploads/2018/12/2-grab-guide-plan-for-discharge-early-v2.pdf):
* [A review of discharge planning from the Nursing Times](https://www.nursingtimes.net/Journals/2013/01/17/x/l/m/130122-Effective-discharge-planning.pdf%3A)
* [British Red Cross research and recommendations for getting discharge right](https://www.redcross.org.uk/hospital-discharge)
* [NHS quick guide explaining how the red bag scheme works and how it supports discharge planning](https://www.england.nhs.uk/publication/redbag/)
* Ensure the MDT sets a proposed date of discharge prior to admission for elective admissions and within two days of an emergency admission.
* Ensure the individual and their family and carers are involved and central in discussions about discharge and that this occurs as early as possible. Encourage and support them to take responsibility in discharge planning.
* Draw up a simple but practical discharge plan and ensure practical considerations are accounted for (e.g. keys, clothes, heating). Identify potential barriers to discharge and review these on a daily basis (e.g. the individual is homeless or their home will be unsuitable to return to meaning they need a move to more suitable short-stay or permanent accommodation, or aids and adaptations to their home).
* Ensure there is clear ownership of actions and all agencies required for resolution are involved. Staff should have a strong understanding of procedures and escalation processes.
* Ensure all staff are aware they all have a role in discharge planning.

Examples of emerging and developing practice:

* **Newcastle Gateshead: Bringing care homes from the periphery** [link]- introduction of a ‘transfer of care bag’, helping to improve communication between hospital and care home teams when residents moved between both settings, and raising the profile of older people living with frailty and very complex needs in care homes.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **Planned** | Discharge is not discussed when planning an admission or at the referral stage in the community. | There is an active plan led by senior staff to instigate early discharge planning for all planned admissions. | Joint pre-admission discharge planning is in place in primary care. A discharge plan, including an estimated discharge date (EDD), is started for all planned admissions. | GPs and district nurses lead the discussions about early discharge planning for elective admissions. Discharge planning is business as usual for all staff involved in referrals including community staff such as GPs and district nurses. People know what is going to happen to them and when they will be going home. | Early discharge planning occurs for all planned admissions by an integrated community health and social care team along with the person and their carers as well as other relevant agencies e.g. housing. People have a clear understanding of when their treatment is going to happen, what it will achieve and when they will go home. |
| **Emergency** | Discharge planning does not start in A&E (if an admission has been agreed). | There is an active plan led by senior staff to instigate early discharge planning for all emergency admissions. | Emergency admissions have a provisional discharge date set within 48 hours and planning to support discharge begins as early as possible. | Health and social care work with individuals and their families and carers to plan for and deliver EDDs. People at a high risk of admission already have plans in place. People know what is going to happen to them and when they will be going home. | Evidence shows all individuals go home on date agreed on or near admission or there is recorded reason why this didn’t happen, and a new date was set. |
| **Red Bag Scheme** | The red bag scheme (or appropriate substitute) is not being used. | There is agreement across partners to implement the red bag scheme and a project plan in place. | The red bag scheme is being piloted on at least one ward. | The red bag is business as usual across the system. | Staff understand the red bag scheme well and use it confidently, leading to smoother discharges. |

## Change 2: Monitoring and responding to system demand and capacity

Develop systems across health and social care to provide real-time information about demand and capacity. All partners should work together to match capacity and demand by responding to emerging system needs, making effective strategic decisions, and planning services around the individual. Data should also be used to identify and respond to system blockages.

**‘Making it Real’- I/We statement**

**I** have care and support that is coordinated and everyone works well together and with me.

**We** work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services.

Supporting Materials

* [NHS guide to demand and capacity management](https://improvement.nhs.uk/documents/2099/demand-capacity-comprehensive-guide.pdf)
* [NHS resources for demand and capacity management](https://www.england.nhs.uk/ourwork/demand-and-capacity/resources/)
* [NHS Digital guidance on data sharing](https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga/information-governance-resources/information-sharing-resources)
* [Nuffield Trust guide on understanding flow in hospitals](http://www.nuffieldtrust.org.uk/files/2017-01/understandingpatient-flow-in-hospitals-web-final.pdf)
* [Safer, faster, better: good practice in delivering urgent and emergency care](http://www.england.nhs.uk/wp-content/uploads/2015/06/trans-uec.pdf)
* [Health Foundation/AQA guide on understanding whole system flow](https://www.health.org.uk/sites/default/files/ChallengeAndPotentialOfWholeSystemFlow.pdf)
* [NHS presentation on modelling to identify system bottlenecks](https://www.england.nhs.uk/expo/wp-content/uploads/sites/18/2018/09/13.00-Hospital-bed-modelling.-where-are-the-bottlenecks-P6C.pdf)
* [NHS ‘Guide to reducing long hospital stays’](https://improvement.nhs.uk/resources/guide-reducing-long-hospital-stays/)
* [NHS ‘Rapid improvement guide to: red and green bed days’](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2016/12/rig-red-green-bed-days.pdf)

**Tips for success:**

* Establish a digital platform to provide real-time information about people and capacity across the system. You might develop a bespoke platform for your area or adopt an existing system.
* Use data analysis to understand system trends, to lead medium and long-term strategy, and to anticipate service demand.
* Create plans to manage variance in system demand on a seasonal, weekly and daily basis, and to respond to unanticipated demand. This may not mean increasing capacity, but instead arranging staff rotas etc. to put resources in the best place/time.
* Identify key system blockages and take action to resolve them. This may involve other high impact changes, such as discharge to assess or seven-day services, depending on your system’s needs.
* Utilise ‘Red and Green Bed Days’ system help understand flow through the hospital by identifying wasted time in a person’s journey in both acute and community ward settings.
* Give frontline staff the information they need to understand service capacity and to make the best decisions for individuals.
* Make plans for sharing relevant information easily and in a timely manner among partners. This will require an understanding of what information is useful to which system partners, and consideration of data governance.

Examples of emerging and developing practice:

* **Kent: Use of SHREWD** [link]- use of a daily reporting system to view capacity and flow within Home First/ Discharge to Assess pathway.
* **Central Bedfordshire: Hospital Discharge Service- Person Tracker** [link]- To support the working of the co-located discharge teams, a ‘person tracker’ was developed, which has enabled the council to provide a single point of monitoring for its residents’ admission, hospital stay and discharge data.
* **Southampton: Hospital flow and bed management** [link]- implemented an electronic system as a more effective way of managing complex discharges, which includes a user dashboard designed to provide “at a glance” status reports.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **Responsive capacity** | There is no understanding of system demand or its variations.  | Analysis is underway to develop understanding of system demand and its variations. | Analysis has created an understanding of system demand and its variations, and practice changes are being implemented to better match demand and capacity.  | Capacity usually matches demand and responds to variations. Understanding of system demand informs decision making.  | Capacity matches demand and responds in real-time to variations. A sophisticated understanding of system demand informs decision making at all levels. |
| **Improving how the system flows** | There is no understanding of how the system flows or its blockages. | Analysis is underway to develop understanding of how the system flows and its blockages. | Analysis has created an understanding of how the system flows and its blockages, and practice changes are being implemented to improve performance. | There are no major blockages and ongoing action is taken to monitor and respond to issues with how the system flows.  | Flow across the system is smooth, timely, safe and effective.  |
| **Effective information sharing** | Information about how the system flows and demand is not shared with partners.  | Conversations are taking place to develop information sharing infrastructure between system partners. | System partners share data about how the system flows and demand effectively and quickly. | Partners share an understanding of how the system flows. | Partners use a shared understanding of how the system flows to coordinate service delivery. |

## Change 3: Multi-disciplinary working

Multi-disciplinary teams (MDTs), including the voluntary community and social enterprise (VCSE) sector, work together to coordinate discharge around the person. Effective discharge and good outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, and shared and agreed responsibilities.

 **‘Making it Real’- I/We statement**

**I** have care and support that is coordinated and everyone works well together and with me.

**We** work with people as equal partners and combine our respective knowledge and experience to support joint decision-making.

**Tips for success:**

* Work out who to involve in your MDT. Independent and VCSE organisations are important, particularly for supporting people who are funding their own care. Members of your MDT could include doctors, nurses, therapists, mental health practitioners, pharmacists, carers, dietitians, social workers, housing representatives (such as housing or homelessness officers or home improvement agency staff), and any other specialists who may bring useful expertise and coordination.

Supporting Materials

* [NHS guide for MDT development](https://www.england.nhs.uk/wp-content/uploads/2015/01/mdt-dev-guid-flat-fin.pdf)
* [Social Care Institute for Excellent resource for MDT working](https://www.scie.org.uk/integrated-care/research-practice/activities/multidisciplinary-teams)
* [National Institute for Health and Care Excellence guidelines on transfers of care, including how the multi-disciplinary team should work](https://www.nice.org.uk/guidance/ng27/chapter/recommendations)
* [Health Education England framework for care navigation](https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf)
* Foster a collaborative and integrated working culture in the MDT, for example through joint training and co-location.
* Ensure social care and representatives of other discharge support services are involved in board rounds.
* Train your MDT to take a strengths-based, person-centric approach to coordinate care and support around the individual. Use continuous feedback and evaluation to improve the experience for staff and people accessing care.
* Make sure people have a named point of contact within the team and know who to talk to about planning their discharge.
* Tackle barriers to smooth and effective MDT working: ensure processes are clear and well-understood, and take measures to reduce funding disputes or confusion about responsibilities.
* Communicate clearly with staff so they understand who should be referred to the MDT. Overcome potential bottlenecks by not sending simple discharges to the MDT.
* Ensure the individual is treated as an equal partner in the co-planning of care.
* Work towards taking a multi-disciplinary approach more widely across your system, and embed multi-disciplinary working at the heart of your approach to other high impact changes.

Examples of emerging and developing practice:

* **Durham: Multi-disciplinary discharge teams** [link]- Teams Around Patients (TAPs) is a virtual model of integrated care delivery, which uses a multi-disciplinary working platform involving social workers, nursing and allied health professionals.
* **Lincolnshire: Hospital avoidance response team** [link]- a service delivered by members of the Lincolnshire Independent Living Partnership, which takes referrals from secondary care discharge hubs, A&E in-reach teams, the ambulance service, primary care and community health providers, to help either prevent an avoidable A&E attendance or admission, or speed up discharge from secondary care.
* **Luton and Dunstable: Integrated discharge hub** [link]- co-location of the team which has regular multi-disciplinary sessions to track and discuss complex patients and their length of stay.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **MDT working** | No daily multi-disciplinary team meeting in place. Health and adult social care work in silos.  | Plans developed to introduce MDTs on all wards, involving adult social care, community health and VCSE. | MDTs established on all wards, and work underway to foster collaborative working. Daily MDT meetings attended by adult social care, community health and VCSE. | MDT members work together well, leading to more effective discharge and better outcomes for people.  | Strongly embedded MDT culture means discharge is smooth and coordinated around the person. |
| **Discharge planning and assessment** | Separate discharge planning processes in place.  | Discussion underway to integrate health and social care assessment and discharge processes.  | Practice changes to integrate health and social care assessment and discharge processes, through the MDT. | MDT staff trust each others’ assessments and discharge plans. | MDTs use trusted assessment and discharge processes. |

## Change 4: Home first

Home first is as much a system mindset as a service. It means always prioritising and, if at all possible, supporting someone to return home before considering other options, because home is best. Home first requires staff across the health and social care system (including VCSE organisations) to understand that a hospital is not a suitable environment to carry out an assessment of someone’s long term need, and to work together with the individual, family, carer or advocate to discharge people from hospital as soon as they are medically optimised and it is safe to do so.

**‘Making it Real’- I/We statement**

**I** can live the life I want and do the things that are important to me as independently as possible.

**We** talk with people to find out what matters most to them, their strengths and what they want to achieve and build these into their personalised care and support plans.

**Tips for success:**

* Establish system-wide principles between partners and develop a single narrative across the system about supporting people home as a default option. Concentrate on costs to the system, not provider versus commissioner or health versus social care costs.
* Simplify pathways for hospital discharge, and ensure discharge pathways are set up so home first is the favoured option.

Discharge to assess

Discharge to assess (D2A) is a model that can achieve the home first aim. Providing short-term care and reablement in people’s homes or using ‘step-down’ beds which work with therapies or reablement staff to bridge the gap between hospital and home means that people no longer need to wait unnecessarily for assessments in hospital. In turn, this improves how the system flows and the quality of the assessments made. A strong system-wide emphasis on reablement and recovery improves long-term outcomes for people.

* A home first approach and understanding that home is best also involves system-wide work to support people to remain at home: consider how multi-disciplinary teams and community/home care services can be developed to prevent escalation of need and avoid unnecessary hospital admissions or readmissions.
* Start with domiciliary support (rather than bed-based options) both in terms of service development and choice. The quality of providers needs to be ensured and that they can deliver the care which is needed.
* Remember there is strong evidence that therapy-led services achieve the best results. Consider merging reablement and rehabilitation services with voluntary sector support.
* Regularly review and evaluate intermediary care to ensure ‘temporary’ beds are not becoming permanent. Take measures to ensure the focus here is on reablement and recovery, not on getting people out of acute hospital beds.
* Ensure Continuing Health Care (CHC) and other assessments of long-term need are made after a period of reablement and recovery, during which a person’s support requirements may change.
* Consider using trusted assessment to provide speedy access for discharge to assess pathways or other discharge support services.
* To have a good home first support service you need it to be fully integrated i.e. NHS, the local authority, and VCSE and independent sector as well as having support structures of families, carers or advocates.
* Make sure these services will work for everyone: consider a single point of access, including for people who fund their own care, people who need only low-level support, people who appear to meet the Care Act eligibility threshold and people who don’t, and people with ongoing care needs.

Supporting Materials

* [ADASS partnership quick guide on discharge to assess](https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf)
* [NHS guide on home first for health and social care staff](https://www.england.nhs.uk/wp-content/uploads/2018/12/3-grab-guide-getting-people-home-first-v2.pdf)
* [Blog post about the importance of a home first mindset, and how to develop it](https://fabnhsstuff.net/fab-stuff/developing-home-first-mindset-liz-sargeant)
* [ECIP presentation explaining discharge to assess, with practical tips for implementation](https://londonadass.org.uk/wp-content/uploads/2017/10/Discharge-2-Assess-Medway-approach.pdf)
* [Sample discharge to assess model, used in Staffordshire and Stoke on Trent partnership NHS trust](http://www.wmqrs.nhs.uk/download/601/Discharge-to-Assess-3-%28revised%29_1445506859.pdf)
* [Sample public-facing page providing information about home first, developed by Suffolk County Council](https://www.suffolk.gov.uk/adult-social-care-and-health/help-at-home-care-home-information-and-mental-health/home-first/)
* [Royal College of Occupational Therapists guide on embracing risk and enabling choice](https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/embracing-risk)
* Track people to see where they are six months after discharge to monitor progress and impact of home first initiatives. You should expect to see a reduction in support for those with ongoing support needs. Monitor services as to their quality and effectiveness in terms of reablement and do not use services that will not provide that information or whose results are poor.
* Consider joint commissioning and strong market management interventions where they are needed. i.e. it is not helpful to have an excellent intermediate service if there is a lack of capacity to provide ongoing support.
* Work with consultants and therapists to build confidence and overcome risk aversion to discharge, using positive stories to achieve a hearts-and-minds culture change.

Examples of emerging and developing practice:

* **North Staffordshire: Track and triage** [link]- 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.
* **Bath: Home first/D2A** [link]- a step down service (which uses apartments), and can be commissioned by any hospital clinician or health care professional involved in the discharge process.
* **Tower Hamlets: Admission avoidance and discharge service** [link]- consists of: rapid response in the community; an admission avoidance team; in-reach nurses and admission avoidance and discharge service (AADS) screeners; and an intermediate care team using a D2A model and offering up to six weeks intensive rehabilitation in the community.
* **Medway: Home First** [link]- an approach and ethos which has sought to achieve Medway Health and Social Care Partners’ pledge to: minimise patients’ acute hospital length of stay; maximise independence through enablement; support care at home or closer to home; and make no decision about long term care in an acute setting.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **Discharge to assess** | People are usually assessed for care on an acute hospital ward. | Plans have been drawn up for a discharge to assess pathway, and nursing capacity in the community is being created to do complex assessments outside of acute hospital wards. | Discharge to assess pathway implemented, and practice changes in place to increase the number of complex assessments in the community. | Whenever possible, people are supported to be assessed in their usual place of residence.  | Assessments in usual place of residence lead to improved outcomes for people. There is a reduction in care needs and more timely discharges from hospital. |
| **Reablement and pathways** | Long-term care decisions are routinely made in an acute hospital ward. People are entering residential/nursing care too early.  | Existing pathways have been evaluated and solutions developed for shifting the focus to reablement and recovery. Capacity is being created for reablement and intermediate care. | Practice changes in place to make reablement and recovery the norm.  | Decisions about long-term care are not made in acute hospital wards, but instead after people have accessed reablement/intermediary care services. Whenever possible, people return home with reablement/intermediate support. | A system-wide approach of reablement and home first leads to improved long-term outcomes for people. |
| **Embedding and home first mentality** | Home first D2A is not well understood. | Home first is being debated as an overarching principle to inform other developments.It is raised in business as usual meetings. | Training material and workshops provide home first evidence and guidance. Staff know what home first means as concept as well as a service and own this way of working. | Staff expect to steer people into a home first pathway; it is their default position. | Staff have a strong understanding of home first principles which they use proactively. People accessing care and their families and carers understand and are on-board with home first. |

## Change 5: Flexible working patterns

Where it will help to deliver the “right care, right time, right place”, consider how seven-day working, weekend working and extended hours for services across health and social care can be utilised. This will help to deliver care throughout the week, reduce delays moving through the system and improve individuals’ experiences.

**‘Making it Real’- I/We statement**

**I** can choose who supports me, and how, when and where my care and support is provided.

**We** make sure that people can rely on and build relationships with the people who work with them and get consistent support at times that make sense for them.

**Tips for success:**

* Consider your system’s demand, capacity and bottlenecks (see change 2) and identify where extended hours or weekend working could have the biggest impact. Local systems tell us that seven-day working does not need to be in place across the whole system for benefits to be seen. Be prepared to start somewhere even if corresponding services are not in place.

Supporting Materials

* [NHS resources on achieving seven-day working, including clinical standards and case studies](https://improvement.nhs.uk/resources/seven-day-services/)
* [NHS resources for seven-day working](https://www.england.nhs.uk/seven-day-hospital-services/)
* [NHS Digital data and indicators on seven-day working](https://digital.nhs.uk/data-and-information/publications/ci-hub/seven-day-services)
* [NHS resource on costing seven-day services](https://www.england.nhs.uk/wp-content/uploads/2013/12/costing-7-day.pdf)
* [King’s Fund vision for seven-day working](https://www.kingsfund.org.uk/reports/thenhsif/what-if-community-services-older-people/)
* Take a pragmatic approach to responding to your system’s need: this does not need to be 24/7 working across all services; instead it is about placing staff well to ensure consistent flow throughout the week. Practical alternatives to seven-day services may work better for parts of your system, for example having a bigger volume of staff on Mondays to handle a weekend backlog.
* Think broadly about your whole system: identify where seven-day working could be helpful across health and social care, including pharmacy, transport and housing services. Talk to all partners, including care providers and work out cost implications.
* Developing trusted assessment (change 6) can help to enable individuals to be assessed throughout the week or at the weekend.
* Engage with practitioners to understand how increased seven-day working would affect them personally and what you can do to help. Don’t assume staff won’t work weekends – talk to them about how it could work.
* This change is undoubtedly challenging, so work gradually and draw on shared best practice and resources.

Examples of emerging and developing practice:

* **Hertfordshire: Seven-day working** [link]- Seven-day working strategy with the aim of improving the flow from acute to community settings, ensuring discharges were not delayed over the weekend while people waited for a package of care due to processes outside of the Monday to Friday norm.
* **Hackney: “A continuous cycle of improvement in patient flow”** [link]- development of weekend working in strategically important service areas to help improve patient flow.
* **Milton Keynes: Getting people home** [link]- Seven-day working through home first reablement supporting discharges every day of the week as part of wider strategy to “get people home”.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| Assessment and decision making | Discharges are delayed by limited timings of assessment and decision making.  | Plan being drawn up to move to seven-day assessment and decision making.  | Practice changes in place in some areas of system to move towards seven-day assessment and decision making. | Increased seven-day working means less delays due to assessment and decision making. Work underway to further extend seven-day working according to system need. | Assessments and decisions about care take place without delay when the individual is ready, regardless of the time or day of the week.  |
| Discharge services | Services to support discharge (e.g. transport, pharmacy, housing) only available Monday to Friday, causing delays. | Service areas which could benefit from extended hours/weekend working identified and plans being drawn up for change. | Practice changes in place to extend service provision to facilitate timely discharges. | Increased seven-day service provision creates improved system flow. Work underway to further extend services according to system need. | Services are in place (e.g. transport, pharmacy, housing) to support smooth discharges when the individual is ready, regardless of the time or day of the week. |
| Care packages | Care providers only accept new referrals and restart packages of care Monday to Friday, leading to delays.  | Discussions underway about how care providers can move to seven-day working. | Some care providers have moved towards seven-day working. | Most care providers accept new referrals and restart packages of care when the individual is ready, regardless of the time or the day of the week. | Whole-system commitment enabling care always to restart within 24 hours, seven days a week. |

## Change 6: Trusted assessment

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

 **‘Making it Real’- I/We statement**

**I** am supported by people who listen carefully so they know what matters to me and how to support me to live the life I want.

**We** know how to have conversations with people that explore what matters most to them – how they can achieve their goals, where and how they live, how they can manage their health, keep safe and be part of the local community.

**Tips for success:**

* Start by agreeing what the problem you are trying to solve is.

Supporting Materials

* [A guide to trusted assessors and trusted assessments](https://improvement.nhs.uk/resources/developing-trusted-assessment-schemes-essential-elements/), co-authored by The Care Provider Alliance, NHS England and Improvement, Local Government Association and Association of Directors of Adult Social Services
* [An example of a successful trusted assessor scheme in Lincolnshire](https://improvement.nhs.uk/resources/lincolnshire-care-home-trusted-assessor-project/)
* [Better Care Exchange section on trusted assessment, including shared resources](https://future.nhs.uk/connect.ti/bettercareexchange/view?objectId=10733776#10733776)
* [NHS FAQ page developed from a series of trusted assessment webinars](https://improvement.nhs.uk/documents/2651/Trusted_assessment__FAQs_v5_44JW_4_FINAL.pdf)
* [CQC guidance on trusted assessment](https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf)
* [Rapid improvement guide: trusted assessors](https://improvement.nhs.uk/resources/rapid-improvement-guide-trusted-assessors/)
* Remember a trusted assessment can be either:
	+ An assessment completed earlier in the persons’ pathway being used, with agreement, for a second purpose and thus avoiding a delay
	+ An assessment carried out by a third party on behalf of another organisation
* Think about using trusted assessment at any time where there is a delay in the pathway caused by an assessor not being able to do their assessment when needed – this includes access to home care.
* Remember trusted assessment can be used in a variety of settings, such as:
	+ to agree restarts and ensure the person gets home more quickly
	+ to support hospital discharge to a residential or a community service, in place of the provider carrying out their own assessment
	+ to move between services
	+ to make a local authority eligibility determination.
* Consider how trusted assessment interlinks with home first and discharge to assess pathways – think holistically about your approach to the changes.
* Without trust between partners, trusted assessment will not work. Think about how to achieve and build trust to avoid poor outcomes for people. Trusted assessments can only be used with the agreement of all parties, so a co-design approach is essential. This involves engagement with care providers too.
* People should be informed that it is not necessary to make decisions about a permanent move when they are in hospital.

Examples of emerging and developing practice:

* **Newcastle Gateshead: Trusted assessment** [link]-
* **North Yorkshire: Trusted assessment** [link]- implementation of integrated discharge pathways and to use trusted assessment to facilitate discharge to assess.
* **Lincolnshire: Care home trusted assessor** [link]- creation of a trusted assessor role to improve the trust between acute sector assessment team and care home managers.
* **Blackburn and Darwen: Home first with trusted assessment** [link]- focus on people waiting for packages of care. Led by a home first approach in which ward staff undertake a partial assessment before the person is discharged to their home, with wraparound care offered until a full assessment is completed.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **Independent care sector assessments** | Care providers insist on assessing for the service or home regardless of their capacity to do so in a timely manner. | Care providers engaged in discussions about whether existing assessments completed in the hospital can be made to meet their needs / agreement to appoint a trusted assessor. | An existing assessment has been adapted to serve the needs of a pre-admission assessment or a worker has begun to carry out assessments on behalf of at least one provider. | An existing assessment has been adapted to serve the needs of a pre-admission assessment and is being used with several providers or a worker(s) is carrying out assessments on behalf of several providers. | People do not experience delays due to lack of timely assessment. |
| **Within hospital (acute or community)** | Each profession insists on doing its own assessment and this causes delays in the person’s pathway. | Professionals are engaged in discussions as to when a shared or joint assessment might be possible. | Existing assessments are used for more than one purpose for at least one pathway. | Existing assessments are used for more than one purpose for several pathways. | People do not experience delays due to lack of timely assessment. |
| **Adult social care (hospital and community)** | People have to wait a long time to have an eligibility determination. | Exploration is under way to determine why this is and to address it. | A third party has been trained and authorised to carry out eligibility determinations. | Eligibility determinations are routinely carried out by a third party when the local authority is unable to do so on time. | People do not experience delays due to lack of timely assessment. |

## Change 7: Engagement and choice

Early engagement with people and their families and carers is vital so they are empowered to make informed decisions about their future care and take ownership of their choice. The VCSE sector and advocates can be a real help with this. A robust choice protocol, underpinned by a fair and transparent escalation process, is essential so that when people have capacity they can understand and consider their options.

 **‘Making it Real’- I/We statement**

**I** can get information and advice that helps me think about and plan my life.

**We** provide information to make sure people know how to navigate the local health, care and housing system, including how to get more information or advice if needed.

**Tips for success:**

* Talk to people (including family and friends) on or, where possible, before admission about their likely discharge route (see change 1).
* Provide information in community settings and on wards about discharge routes
* Be creative to deliver the message in the best way for people e.g. use videos in waiting rooms, or leaflets in mailings. Take a co-design approach and involve patient groups and other organisations in developing the message.

Supporting Materials

* [NHS quick guide, describing the choice protocol and providing sample template policy and template patient letters](https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf)
* [The Care Act](http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf): see 30, cases where adult expresses preference for particular accommodation and Annex A of [2014 Statutory Guidance](https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#contents%20Care%20Navigation:%20A%20Competency%20Framework:%20https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdfhttps://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-)
* [Care Navigation: A Competency Framework](https://www.hee.nhs.uk/sites/default/files/documents/Care%20Navigation%20Competency%20Framework_Final.pdf)
* Get the whole team involved, it’s everyone’s business.
* Don’t be afraid to be clear – waiting in hospital is not an option, but people must know what their options are.
* Utilise key messages and communications support issued as part of initiatives to reduce length of stay in hospital – these should focus on information around harm and deconditioning as the key drivers to people and their families and carers to seek earlier discharge.
* Work with colleagues across the health and social care system to manage people’s expectations of the care they will require after discharge, and to avoid unrealistic claims about the support people will receive. Managing expectations requires giving people the right information and advice throughout so they are fully informed.
* Remember long-term decisions should rarely be made in acute hospital. D2A and other intermediate care are not subject to a choice protocol but should be seen as the next stage in the treatment programme.
* Remember the Care Act 2014 guidance on choice of accommodation is that while any choice should be real they should also be within the personal budget and practicable.
* Do involve the voluntary sector to support discharge.
* People who fund their own support are often forgotten, it is important to engage with everyone to provide appropriate information and support so that everyone can make informed decisions.
* Do carry out a demand, capacity and quality audit of your independent care market, as a system.
* Try to avoid the need for choice letters, but when necessary don’t be afraid to issue them, as they are in the person’s best interest.
* Ensure the choice protocol is part of team induction training.

Examples of emerging and developing practice:

* **Isle of Wight: Care navigators** [link]- the service was developed as a different way of working with and utilising the VCSE sectors, to build capacity in stretched services and support the island’s new model of care and system redesign.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **Information and support to decide care** | No advice or information about discharge options available at admission. | Co-designed information packs are being prepared with patients and their families to ensure that they are helpful resources. | Admission advice and information leaflets in place and being used in different formats to engage with people, regardless of how they fund their care. | People and their family and carers are aware of the value of making timely decisions about discharge. | People and their family and carers, regardless of how they fund their care, are engaged and involved in discharge planning from or before admission. |
| **Choice protocol** | No choice protocol in place. The choice DTOC code is regularly among the top reasons for delays. | Choice protocol being written or updated to reduce long length of stay. | New choice protocol implemented and understood by staff. | Choice protocol used proactively to challenge people as necessary. | All staff understand choice and can discuss discharge proactively. There is a reduction in choice delays and people feel empowered to manage their discharge. |
| **VCSE provision** | No provision in place to support people to make decisions about their care, regardless of how they fund it. | Health and social care commissioners co-designing contracts with VCSE or other support. | VCSE support in place, providing advice and information. | VCSE or other provision integrated in discharge teams to support people, regardless of how they fund their care, home from hospital. | Everyone is supported through the discharge process, from admission. People are provided with good information in good time to make decisions about their future care. |

Change 8: Improved discharge to care homes

The NHS Enhanced Health in Care Homes framework supports ways to join up and coordinate health and care services to support care home residents. In considering how to achieve timely and safe transfers of care, the initiatives in this high impact change focus on how to improve outcomes for care home residents by reducing unnecessary admissions to hospital and facilitating smoother hospital discharge into care homes.

 **‘Making it Real’- I/We statement**

**I** have a place I can call home, not just a ‘bed’ or somewhere that provides me with care

**We** have a ‘can do’ approach which focuses on what matters to people and we think and act creatively to make things happen for them.

**Tips for success:**

* A person should not be making long-term decisions about their care from a hospital setting. See change 4, for further support and guidance on how people can be supported to move to a suitable environment from where they can make decisions.
* Join your local care forum and hear what care providers find unhelpful when admitting people from hospital.
* Refer to best practice in discharge planning as can be found in other high impact changes, particularly change 1 and the supporting material. Involve care homes in the discharge planning process, and provide them with the information they need in good time.
* Find out the top reason causing care homes to delay or refuse to take a discharge and fix it such as ensuring all medication sent home with people comes with clear guidance.

Supporting Materials

* [NHS overview of the enhancing health in care homes project](https://www.england.nhs.uk/new-care-models/about/care-homes-sites/)
* [NHS enhancing health in care home framework](https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf)
* [Health Foundation article about the importance of good relationships](https://www.health.org.uk/blogs/enhanced-health-in-care-homes-%E2%80%93-good-relationships-are-key)
* [King’s Fund review of learning about enhancing health in care homes](https://www.kingsfund.org.uk/publications/enhanced-health-care-homes-experiences?gclid=CjwKCAjwycfkBRAFEiwAnLX5IZdIx05tDvnAmzddQMeG3nD_p1Jo-aOAKxW2iu3OcD-rvC4ocAC-wRoCJpkQAvD_BwE)
* [NHS quick guides for supporting care homes](https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-clinical-input-to-care-homes.pdf%3B%20https%3A/www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Technology-in-care-homes.pdf)
* [NHS quick guide: Improving Hospital Discharge into the Care Sector](https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf)
* Ensure each care home is linked to a consistent, named GP and wider primary care service.
* Provide access to out-of-hours/urgent care to prevent unnecessary hospital admissions and to support care home staff. Areas have taken an innovative approach to this – for instance Airedale’s telehealth hub connects local care homes directly with the MDT.
* Develop channels for sharing information with care homes – NHSmail accounts for care homes can make it simpler to share personal details.
* Involve your ambulance service in planning. It will have valuable information on care homes in need of support, and can help develop solutions.
* Include care homes in system conversations. Talk and listen to them to understand the pressures they face and their support needs; work together to develop the market and workforce.
* Link work on Enhancing Health in Care Homes with other high impact changes: a MDT approach helps to coordinate care; early discharge planning should involve care homes (including using the red bag scheme); and information sharing is crucial.
* Consider how your system can provide enhanced services to better support vulnerable people in community settings, such as through rapid response.
* Build on the existing learning and training opportunities to ensure that staff who are employed by social care providers receive a wide range of training and development opportunities.
* See the NHS guidance on Enhanced Health in Care Homes for additional components of this work which can support your system. Evidence shows certain relatively small investments can yield significant results both for people and the system.

Examples of emerging and developing practice:

* **Herts Valley: Clinical commissioning group quality improvement team** [link]-
* **Wirral: Care home teletriage service** [link]- care homes have been provided with HD iPads and secure nhs.net email addresses to access a triage service, and staff have been trained to take basic observations and equipped with blood pressure monitors, thermometers, urine dip sticks and pulse oximeters.
* **Surrey: East Surrey care home multi-disciplinary project** [link]- aim of the project was to enhance the level of care to all residents of care homes by increasing GP time to support care homes; care coordinated approach; and improved medicine management support and training.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **Discharge support** | Best practice in discharge planning is not established and there is little trust between care homes and hospitals. | Systems are reaching out to care homes to find out where the systems need to change. | Systems have a regular dialogue with care homes (ideally through the care forum) and discharge is a regular agenda item. | Care homes and systems work in tandem to facilitate discharges seven days a week including evenings. | Care homes report little or no failed discharges as a result of system failure. Systems have reduced delayed discharges.  |
| **Enhanced primary care** | Care homes are not linked with local community and primary care. | Scoping is underway to understand care home need. Plans have been made to establish clear links with primary and community care.  | Community and primary care support provided to care homes on request. All care homes have access to a consistent, named GP. | People with increased acuity are well-managed in care homes due to a strong support network with primary and community care. | Care homes are firmly integrated into the whole health and social care community and there is mutual trust. |
| **Access to out-of-hours/urgent care** | High numbers of referrals to A&E from care homes, especially in the evenings and at weekends. | Specific high-referring care homes identified, and plans developed to provide better support.  | Dedicated intensive support provided to high-referring care homes. | Improvement seen in unnecessary admissions from care homes, particularly on evenings and at weekends.  | Across the system, care homes are well-supported by access to out-of-hours/urgent care. There is no variation in flow of people from care homes into hospital throughout the week. |

Change 9: Housing and related services

## Effective referral processes and good services which maximise independence are in place to support people to go home with alternative pathways for people who have no home, or cannot go straight home. The need for safe and accessible housing, housing and related support services, home adaptations and equipment are addressed early in discharge planning and readily available when needed.

##  **‘Making it Real’- I/We statement**

## **I** live in a home which is safe, accessible and suitable so that I can be as independent as possible.

## **We** have conversations with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments.

Supporting Materials

* [NHS quick guide to health and housing](https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-health-and-housing.pdf)
* [NHS quick guide to better use of care at home](https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-better-use-of-care-at-home.pdf)
* [NICE guidelines on home care](https://www.nice.org.uk/guidance/ng21/chapter/recommendations)
* [National Housing Federation resources on housing, care and health](https://www.housing.org.uk/topics/health-care-and-housing/)
* [Skills for Care the role of housing in effective hospital discharge](https://www.skillsforcare.org.uk/Documents/Leadership-and-management/Workforce-integration/housing/The-role-of-housing-in-effective-discharge-from-hospital.pdf)
* [Care and Repair England/Centre for Ageing Better: Adapting for ageing: Good practice and innovation in home adaptations](https://www.ageing-better.org.uk/sites/default/files/2018-10/Adapting-for-ageing-report.pdf)
* [Housing LIN health and housing resources](https://www.housinglin.org.uk/Topics/browse/HealthandHousing/)
* [Foundations/Housing LIN best practice map](https://www.housinglin.org.uk/Topics/browse/HealthandHousing/)
* [Royal College of Occupational Therapists Adaptations without delay](https://www.rcot.co.uk/adaptations-without-delay)
* [The Regulatory Reform Order](https://www.foundations.uk.com/dfg-adaptations/dfg-regulations/the-regulatory-reform-order/)
* [Online directory of home improvement agencies](https://www.findmyhia.org.uk/)
* [SCIE Moving between hospital and home, including care homes](https://www.nice.org.uk/Media/Default/About/NICE-Communities/Social-care/quick-guides/Moving-between-hospital-and-home-quick-guide.pdf)

Tips for success:

* As part of early discharge planning talk to the person and their family or carers about their current housing/home situation to understand if a person’s home is going to be safe and suitable for them to return to if there may be any issues that could affect discharge.
	+ Take action as early as possible – a person’s housing status should be known as soon as possible after admission.
	+ Are there specific issues with their home which may affect its suitability, for example, is it accessible to the person given any changed mobility or health needs; or is there a problem with heating or damp?
	+ Don’t wait until the individual is medically optimised to refer. Talk to any relatives, particularly if the person does not have a normal place of residence, as this may mean they don’t have somewhere they can be discharged to.
* Include housing/housing service provider(s) as real or virtual member(s) of your discharge planning team.
* Take a holistic, person-centred approach to understand what matters to the people in your care, taking a positive attitude to risk and how you can best help them to be as independent as possible in their home.
* Consider how your VCSE sectors can help people to get home and access community support.
* Ensure staff know what housing options and support services are available and understand how to make referrals to them. There should be well-developed links between the discharge planning team and these services. Consider creating a single-point of contact to help guide staff through the various housing options available. Staff should understand their statutory duties with regard to housing, as well as how to access specialist housing (such as extra care or supported housing). For example, there is a new statutory duty to refer people who are homeless or at risk of homelessness to the housing authority.
* Educate staff about the housing support needs of different groups. These go beyond aids or adaptations for older people, and include, for example, support for people who are homeless or who may have mental ill-health, substance misuse needs, a learning disability or dementia.
* Minor repairs and small home adaptations can make a real difference to the speed and ease of discharge when they are readily available, and delivered quickly. Identify needs as early as possible, not just what will help people get home without delay, but what will aid independence and help avoid hospital readmission or future health or care needs.
* Housing-based short-term accommodation such as step-down or intermediate care can be appropriate for people who are medically optimised but waiting for a new home or adaptations. This is not a substitute, however, for late assessment of need or a lack of capacity for a more appropriate service.
* Understand the demand for, and capacity of housing and related support services across your system, and ensure this analysis informs commissioning intentions. Work with partners to identify and prioritise addressing the most challenging areas for your system. Approaches to this change will vary greatly in different systems, and may involve developing better processes, improving services or investing in extra capacity whether to meet any planned care needs or help facilitate self-care.
* Be creative in considering how technology and innovation can improve the way you support people to live at home; for instance telecare and assistive technologies can be very useful. Everyone involved in discharge should know what is on offer and how to access it locally.
* Homelessness should not be a reason for delaying discharge –
	+ NHS trusts have a statutory duty under the [Homelessness Reduction Act](http://www.legislation.gov.uk/ukpga/2017/13/contents) (2017) to refer people who are homeless or at risk of homelessness to a local housing authority.
	+ Referrals should be made at the earliest opportunity as soon as it has been identified that a person may be homeless on discharge as this provides more time for the housing authority and other support services to respond. The person must give consent, and can choose which authority to be referred to.
	+ Persons who have no recourse to public funds are not eligible for homelessness assistance, but are entitled to receive housing advice. It is not the responsibility of NHS trust staff to assess whether a person is eligible for such support; this is determined by the housing authority.
	+ The Local Housing Authority should incorporate the duty to refer into their homelessness strategy and establish effective partnerships and working arrangements with agencies to facilitate appropriate referrals.

Examples of emerging and developing practice:

* **West of England - Reducing DTOC through housing interventions** [hyperlink: <http://careandrepair-england.org.uk/wp-content/uploads/2014/12/WE-C-R-Case-Study-Final.pdf>
* **Leicester: Lightbulb** [link]- the scheme involves housing enabler posts, their role involves aiming to assess patients as early as possible, and offer patients options to resolve housing issues.
* **Cambridgeshire: Technology Enabled Discharge (TED)** [link]- to help people overcome the complications of referral and installation, Cambridgeshire Technology Enabled Care offers a custom telecare discharge package, which includes installation and rental of the lifeline, alongside other pieces of appropriate equipment such as smoke alarms, temperature sensors and fall detectors.
* **Kirklees Council: Home from Home initiative** [link]- the service provides seven accessible flats as temporary accommodation for people awaiting adaptations in their own home or changes in accommodation.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not yet established** | **Plans in place** | **Established** | **Mature** | **Exemplary** |
| **Systematic response, and demand/capacity** | Housing and homelessness issues are not considered as part of a discharge support strategy. | Responses to housing issues and homelessness are usually discussed during ward rounds. | Staff have clear guidance which they routinely use to inform referrals and advise people and their families.  | The impact of housing and homelessness issues on discharge and people’s outcomes is understood and used to improve them. | System planners use demand, capacity and impact data to improve support, so as to avoid delays because of housing needs or homelessness. |
| **Early needs assessment and response** | Housing status and support needs are not part of the admission checklist. | Amendments to the checklist are proposed/being considered. | A person’s housing status and support needs are routinely noted on admission and where needed acted on during their hospital stay.  | A person’s housing status and support needs are part of a wider housing needs assessment on admission, with support put in place, including temporary accommodation if necessary, by expected discharge date. | There are no delays caused by not knowing a person’s housing status or acting on their support needs. |
| **Integration/joint working** | Service response is slow, disjointed or unavailable, causing delays. | Links between housing and discharge teams are being planned. | Discharge services have a named housing link, and there is regular contact between services/staff. | Housing staff are part of discharge support services, and good working relationships across the system are reducing delays or problems.  | Joined-up services deliver timely, person-centred support which maximises recovery and independence.  |
| **Home adaptations, equipment, telecare and health**  | Staff are not aware of available services. | A stock take of available support is being undertaken. | Discharge services know what is available and routinely access in good time. | Support is quick and easy to access, and is delivered promptly, avoiding discharge delays. | Support is integrated with related services, delivered 24/7, and using streamlined practices such as trusted assessment by discharge teams, resulting in no delays.  |

##  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?** |
| Change 1: Early discharge planning |  |  |  |  |
| Change 2: Monitoring and responding to system demand and capacity  |  |  |  |  |
| Change 3: Multi-disciplinary working |  |  |  |  |
| Change 4: Home first  |  |  |  |  |
| Change 5: Flexible working patterns |  |  |  |  |
| Change 6: Trusted assessment |  |  |  |  |
| Change 7: Engagement and choice |  |  |  |  |
| Change 8: Improved discharge to care homes |  |  |  |  |
| Change 9: Housing and related services |  |  |  |  |



**Local Government Association**

Local Government House Smith Square

London SW1P 3HZ

Telephone 020 7664 3000

Fax 020 7664 3030

Email info@local.gov.uk [www.local.gov.uk](http://www.local.gov.uk/)

© Local Government Association, October 2019

### For a copy in Braille, larger print or audio, please contact us on 020 7664 3000.

We consider requests on an individual basis.

REF 25.1