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Integration and Better Care Fund

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Local Government Association

NHS England

directors of adass adult social services eastern region connecting innovating improving

HIGH IMPACT CHANGE MODEL

DEVELOPING GOOD PRACTICE

IN THE EAST OF ENGLAND

AnalyticsCambridge

Prepared for Association of Directors of Adult Social Services, East of England and NHS England

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Summary

1. This report looks at examples of the implementation of the High Impact Change Model (HICM) in the East of England. Information has been given through 20 interviews, examples provided and additional contact through regional meetings.

2. Appendix 2 lists those who gave their time to be interviewed and to provide examples[1]. The examples used have come in a number of different formats - such as reports, presentations and links to web pages. The text used has been checked back with those who sent it but, given the pace of change and adaptation, they are best considered as illustrative examples of practice which are there to be followed up.

3. There are eleven Local Authorities in the region with responsibility for social care. Five are County Councils and six are Unitary Authorities. Within the County Council areas there are 41 District Local Authorities[2]. The region has 19 Clinical Commissioning Groups and 18 Acute Hospitals. To show the variation in relationships, there are four Acute Hospitals in the area of Essex County Council while there are none within either Central Bedfordshire or Thurrock.

4. As in other regions, the East of England has diversity and varied social and organisational geographies:

    - Five Local Authorities are urban parts of major conurbations while eight are largely rural
    - The average house price in Great Yarmouth is £171,500 while in Three Rivers Local Authority (west of Watford) it is £509,100.
    - The differing positions of the Local Authorities within a national measure of health deprivation and disability also shows the variation in the East of England
    - In two Local Authorities more than one in eight residents is aged 75 or older. While in 18 Local Authorities the proportion 75 and above is less than the England average.

[1] The roles given in Appendix 2 and as sources for some of the examples are those held at the time, some will have changed since.

[2] Refers to before 1st April 2019, which is the date when Suffolk Coastal District Council and Waveney District Councils merged to become East Suffolk (District) Council and Forest Heath and St Edmundsbury District Councils merged to become West Suffolk (District) Council. This reduces the number of District Local Authorities to 39.

5. For this report 22 examples are shown of ways in which the HICM is being implemented. These are for each of the eleven Local Authorities with social services responsibilities and are shown for seven of the eight Changes in HICM. They give the wide range of approaches different places are adopting to move from existing relationships to new ways of working.

6. The information shown in the examples is there to give a picture of what has been done and is being tried. They are summaries from reports, presentations, and some give the experience of those affected by them.

7. From the interviews progress comes from "trying things out". The importance of learning from others is a key to making progress. There are elements to "take" from other people, but keep the need to improve.

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Glossary

Abbreviation	Meaning
A&E	Accident and Emergency
AAU	Acute Admissions Unit
ADASS	Association of Directors of Adult Social Services (in England)
ACS	Adult Care Services
BTUH	Basildon and Thurrock University Hospital NHS Foundation Trust
BCF	Better Care Fund
BCHS	Bedfordshire Community Health Services
CCG	Clinical Commissioning Groups
CCP	Complex Care Premium Homes Programme
CHIT	Care Home Intervention Team
CHTA	Care Home Trusted Assessor
CQC	Care Quality Commission
CUH	Cambridge University Hospital
D2A	Discharge to Assess
DTOC	Delayed Transfer of Care
ECP	Emergency Care Practitioners
EIT	Early Intervention Team
EPUT	Essex Partnership University NHS Foundation Trust
ERS	Enhanced Response Service
FT	Foundation Trust
GP	General Practitioner
HH	Hinchingbrooke Hospital
HICM	High Impact Care Model
HUC	Herts Urgent Care
IDT	Integrated Discharge Team
IPC	Infection Prevention and Control
IHT	Ipswich Hospital NHS Trust
IT	Information technology
LA	Local Authority
LinCA	Lincolnshire Care Association
LOS	Length of Stay
MDT	Multi-Disciplinary Team

Abbreviation	Meaning
MSB	Basildon and Thurrock University Hospital NHS Foundation Trust, Mid Essex Hospital NHS Trust and Southend University Hospital NHS FT (the msb Group)
NELFT	North East London NHS Foundation Trust
NHS	National Health Service
PCH	Peterborough City Hospital
QIPP	Quality, innovation, productivity and prevention
RIV	Rapid Intervention Vehicle
SPoA	Single Point of Access
STARR	Short Term Assessment, Reablement and Rehabilitation
STP	Sustainability and Transformation Partnerships
SUHFT	Southend University Hospital Foundation Trust
VCS	Voluntary and Community Sector
WHHT	West Hertfordshire Hospitals NHS Trust

1 Introduction

1.1.1 The report aims to give the experience of developing good practice in the High Impact Change Model (HICM) in the East of England. It has been commissioned by the Association of Directors of Adult Social Services in the East of England together with NHS England. It is there to be shared both across the region and more widely as a contribution to support the HICM in minimising unnecessary hospital stays.

1.1.2 The work has been carried out through interviews with Local Authorities in the East of England and also national organisations who interact with the region[3]. The report gives examples to show ways in which the HICM is being implemented. It also captures the lessons from implementation: describing factors which have helped and built foundations for others. The report starts from the perspective of Local Authorities, but this only seen as a way into the partnership work in practice. A number of those interviewed work in multi-disciplinary teams and are based in hospitals (Appendix 2 shows those interviewed or who have contributed examples).

1.1.3 The report gives examples of what has been implemented or tried around the eight Changes set out in the model (see Figure 1). They show how the Changes are interlinked and many examples impact on more than one Change. The report then draws together underlying themes that have been considered important for the development of the new ways of working.

1.2 The High Impact Change Model

1.2.1 The High Impact Change Model was developed in 2015 by the Local Government Association (LGA), the NHS and other key partners[4]. It is a framework for a practical approach to supporting local health and care systems to manage patient flow and discharge. It can be used to self-assess how local care and health systems are both working and planning for action to reduce delays throughout the year.

1.2.2 The model identifies eight system Changes which may impact on reducing delayed discharge (Figure 1). They start with early discharge planning and the role of systems to allow an expected date of discharge to be set within 48 hrs, working with emergency or unscheduled care. Other Changes include systems to model patient

[3] 20 interviews were carried out, with additional information through attending regional Delayed Transfer of Care (DTOC) meetings and correspondence with organisations

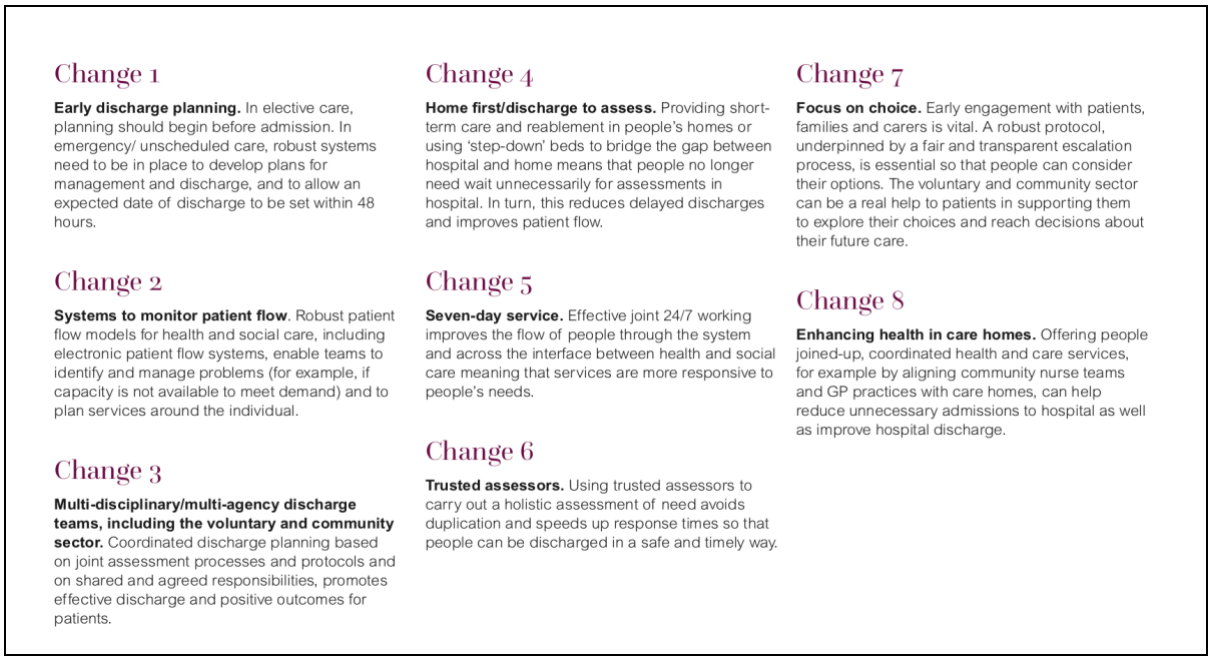
[4] "This model was developed by strategic system partners including the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), NHS England, the Department of Health (DH), the Emergency Care Improvement Programme (ECIP), Monitor and the Trust Development Authority (now NHSi) during 2015". Local Government Association (2017) High impact change model: Managing transfers of care between hospital and home https://www.local.gov.uk/sites/default/files/documents/25.40%20High%20Impact%20Change%20model%20CHIP_03.pdf

flow, multi-disciplinary / multi agency discharge teams, the provision of short term care and reablement in people's homes, how services can be available over seven days and 24/7, how assessment of need allows options to be considered and how health in care homes can be enhanced.

1.2.3 The model is not designed to be a performance management tool where activity is measured *only* by data and indicators. Its approach emphasises the importance of triangulating both hard and soft data to tease out local stories within a culture of openness and trust.

1.2.4 The Changes show their purpose and benefits. For any area the focus on change can be varied depending on existing arrangements, strengths and possibilities. The examples in this report show a range of ways in which the Changes are being implemented.

Figure 1 Description of Changes in the High Impact Change Model



Source: Local Government Association (2017) High impact change model: Managing transfers of care between hospital and home, page 6

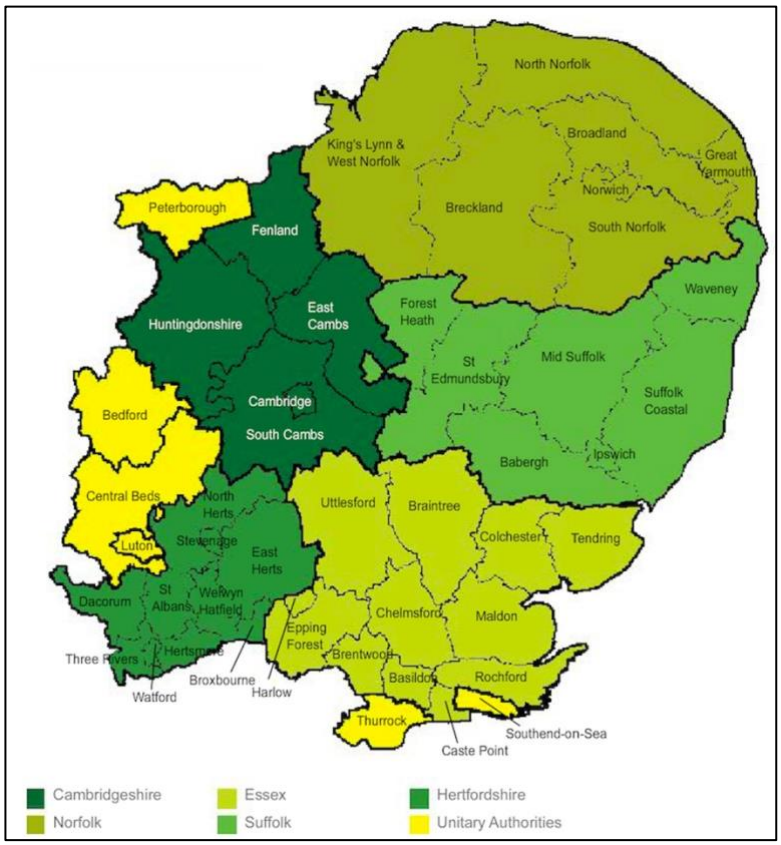
1.2.5 The differing ways Changes are being made can reflect the differing areas and people who live in them. The next section shows some of the characteristics of Local Authorities in the East of England which provide part of the background for change. One aspect comes from their boundaries with those of Clinical Commissioning Groups (CCGs) and the location of Acute Hospitals. The rurality of places varies across the region as does the health and deprivation of older people. Similarly the proportion of older people living in areas changes from place to place. These give context which can impact on the implementation of the model. It may also help others look at Local Authorities or areas similar to theirs.

1.2.6 After introducing the variation in the region the report then gives examples of Changes in the context of the HICM, showing different approaches used. It then summarises themes and characteristics which have helped Local Authorities, CCGs, Acute Hospitals and others generate and implement proposals for Changes.

1.3 Geographical relationship between Local Authorities and CCGs

1.3.1 The East of England has 11 Local Authorities with responsibility for social services: six Unitary Authorities and five County Councils. Figure 2 shows their location. Unitary Councils have a responsibility for all local government functions. Within the boundaries of County Councils there are District Councils[5] who are accountable for a number of services which interact closely with social care. One of these is housing and the importance was mentioned by a number of the LAs interviewed[6]. Figure 2 shows the District Councils in each County which ranges from five in Cambridgeshire to 12 in Essex.

Figure 2 Map of Local Authorities



Source: East of England Local Government Association
https://www.eelga.gov.uk/about/local-government-in-the-east-of-england.aspx

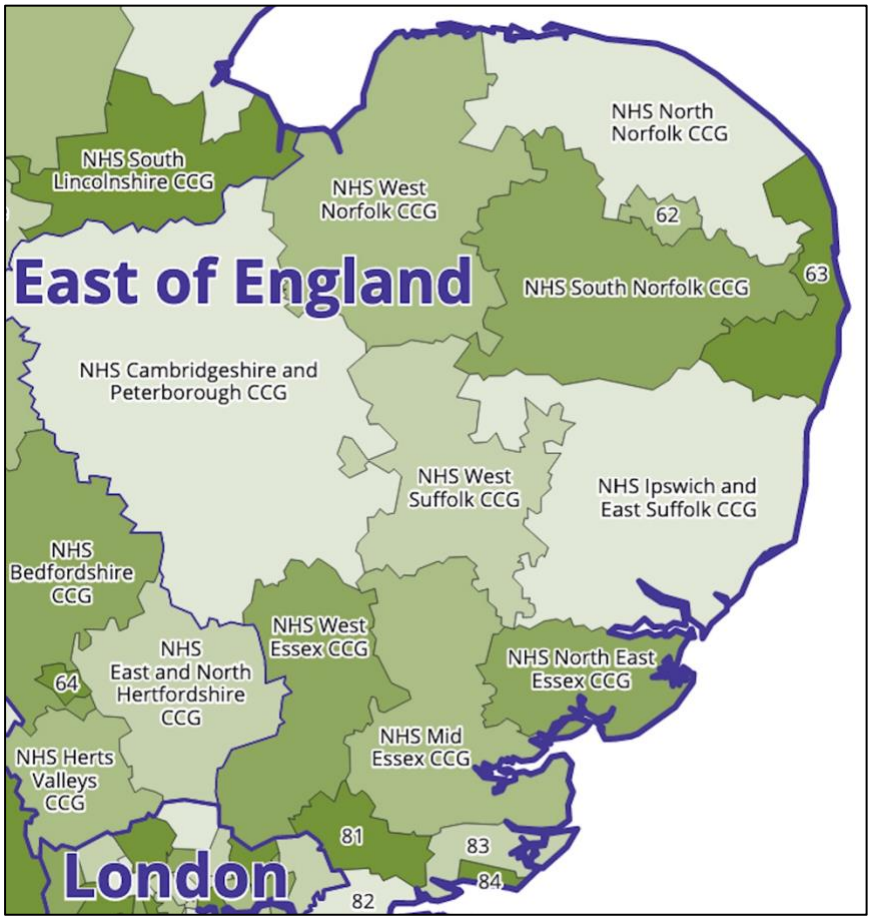
Notes: this map shows the District Authorities before the merger On 1st April 2019 of Suffolk Coastal District Council and Waveney District Councils to become East Suffolk (District) Council and the merger of Forest Heath and St Edmundsbury District Councils to become West Suffolk (District) Council.

[5] 1st April 2019 two Districts - West Suffolk and East Suffolk - were created from four District Local Authorities
[6] For example in Change 4, home first / discharge to assess.

1.3.2 For the HICM to be implemented relationships between Local Authorities[7] and Acute Hospitals are key. The geographical relationships vary across the East of England. Central Bedfordshire and Thurrock do not have Acute Hospitals within their boundaries: while five LAs have more than one: Essex (4), Cambridgeshire (2), Hertfordshire (3), Norfolk (3) and Suffolk (2). Appendix 1 gives the geographical relationships between LAs, Acute Hospitals and also Clinical Commissioning Groups (CCGs).

1.3.3 The CCG boundaries are shown in Figure 3. Some larger Local Authorities (e.g. Essex or Norfolk) contain more than on CCG. Some CCGs (e.g. Bedfordshire) are made of more than one Local Authority.

Figure 3 Map of Clinical Commissioning Groups



Notes:

62 NHS Norwich CCG
63 NHS Great Yarmouth and Waveney CCG
64 NHS Luton CCG
81 NHS Basildon and Brentwood CCG
82 NHS Thurrock CCG
83 NHS Castle Point and Rochford CCG
84 NHS Southend CCG

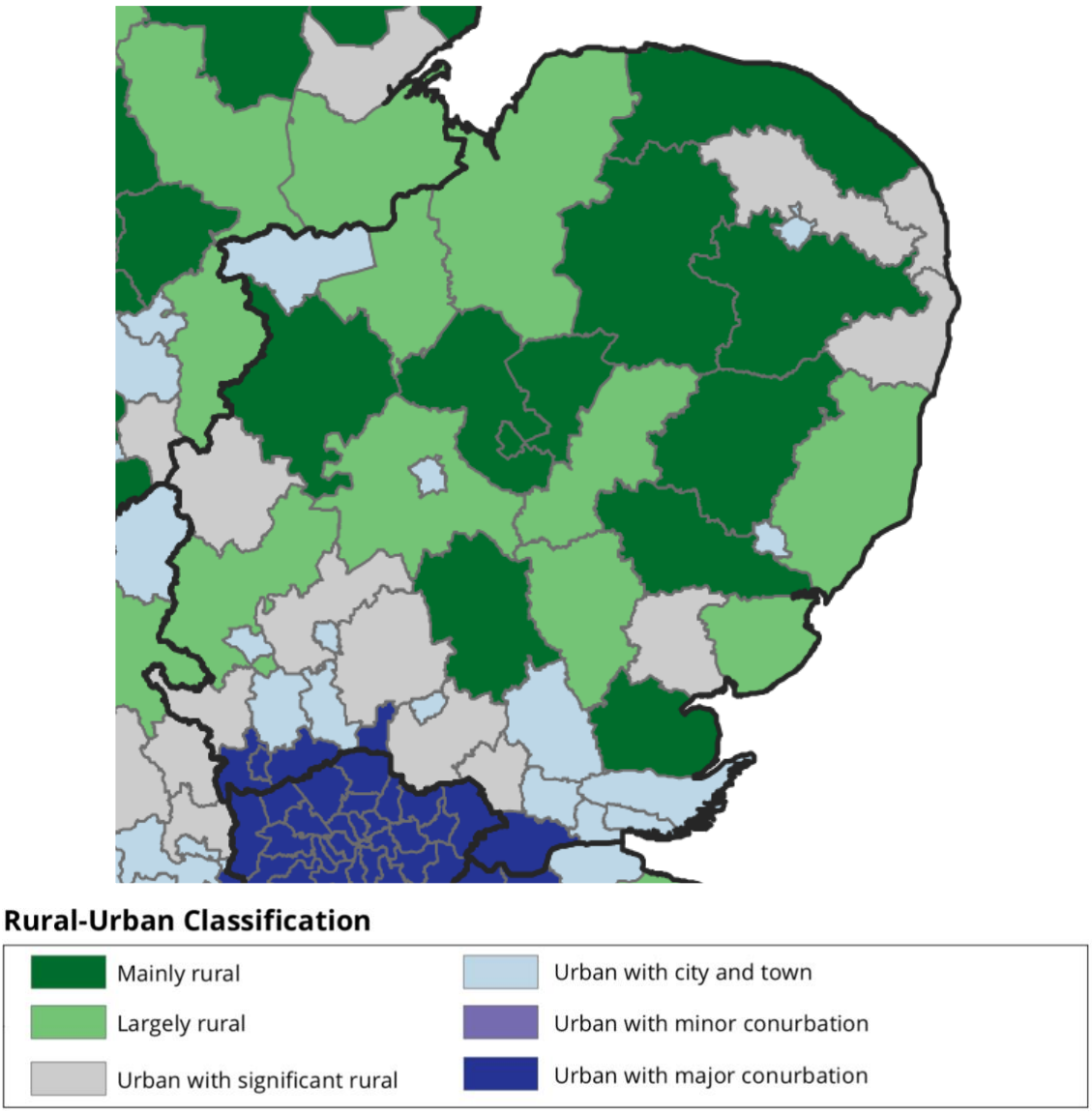
Source: NHS Data Catalogue, https://data.england.nhs.uk/dataset/ccg-map/resource/923fdfe0-7806-4c92-8494-ba8251bcd57a?inner_span=True

[7] For simplification this report uses the term Local Authority to generally to apply to County Council or Unitary.

1.4 Urban and rural areas in the Eastern of England

1.4.1 The Changes in the HICM may requires different approaches in rural areas compared to those which are urban. Figure 4 maps Local Authorities and how urban or rural they can be considered[8]. The variation across the region can be seen through these classifications of the 47 District or Unitary Authorities. Five in the south of the region are close enough to London to be considered urban with major conurbations; 14 are urban with a city or town. In contrast, 10 Local Authorities are *mainly* rural and eight are *largely* rural.

Figure 4 Urban and Rural Local Authorities



Source: England: Rural-Urban Classification for Local Authority Districts (LADs), 2011
http://geoportal.statistics.gov.uk/datasets?q=Rural%20Urban%20Classification%20Maps%20Local%20Authority%20Districts&sort=name

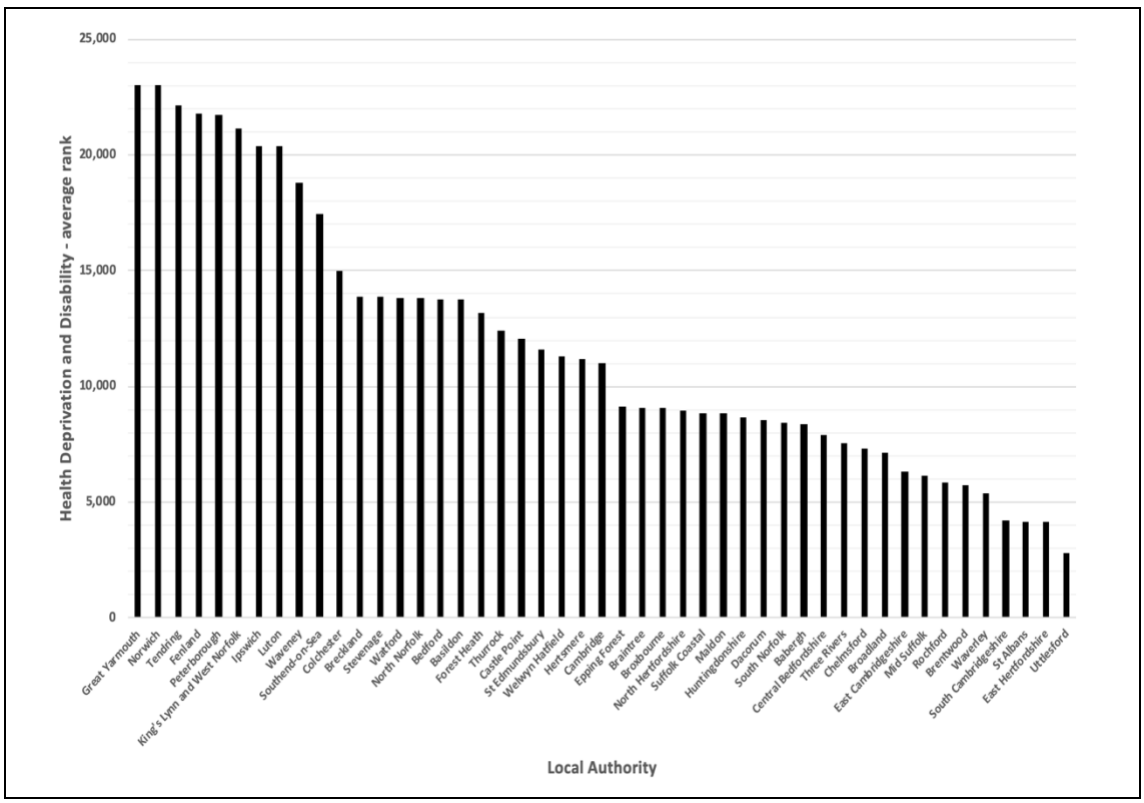
[8] The definition through the Office for National Statistics

1.5 Indicators of health and deprivation

1.5.1 Measures of deprivation and health can influence Changes for the HICM. A complementary indicator, which can also impact on social care for the elderly, is given through average house prices. Figure 5 and Figure 6 show the patterns for Local Authorities in the East of England[9]. Great Yarmouth has the highest health deprivation and disability score and also the lowest house prices. St Albans has the highest house prices and the third lowest health deprivation and disability score.

1.5.2 Even within a County Council there can be wide ranges of both health deprivation and house prices. In Essex, Brentwood District has the sixth lowest regional health deprivation score while Tendring Council has the third highest.

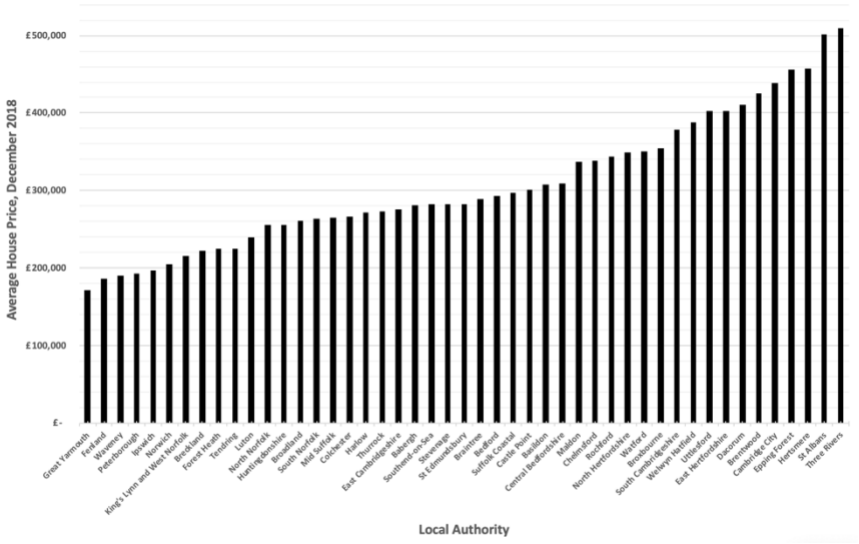
Figure 5 Measure of Health Deprivation and Disability for Local Authorities, 2015



Source: Department for Communities and Local Government, 2015, English Indices of Deprivation, Local Authority District Summaries https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015

[9] 47 Unitary or District Councils, as defined before 1st April 2019 when two Districts - West Suffolk and East Suffolk - were created from four District Local Authorities.

Figure 6 Average House Price, December 2018, by Local Authority

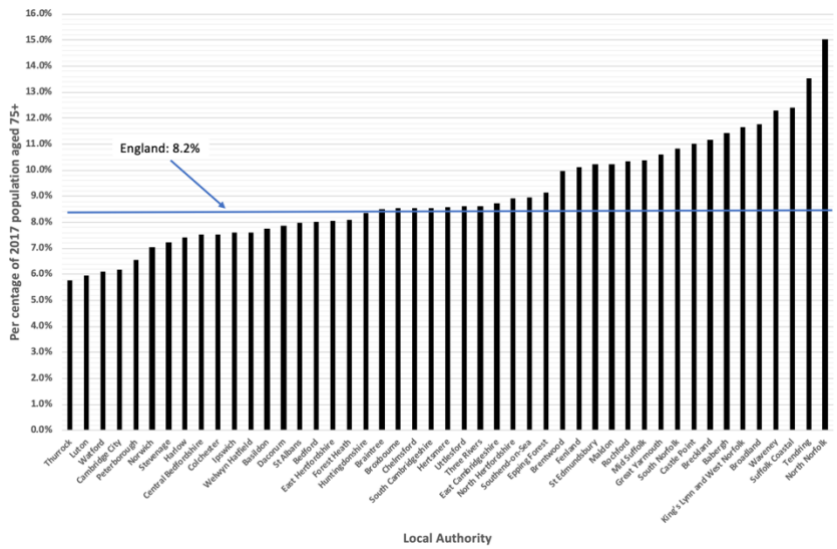


Source: HM Land Registry, UK House Price Index Summary: December 2018
https://www.gov.uk/government/statistics/uk-house-price-index-summary-december-2018
Notes: Average price of houses sold in December 2018. At the time this data was extracted they are provisional and may be revised

1.6 Age of the population

1.6.1 The age of the population is another factor with impact implementing the HICM. There is a wide range between Local Authorities. In 18 of the 47 District or Unitary Local Authorities the proportion of their population aged younger than 75 is *less* than the average for England (8.2%): these are urban areas such as Peterborough and Thurrock. A greater number (29) of the Local Authorities, particularly in rural areas, have proportions of the elderly *higher* than the England average. In both Tendring and North Norfolk more than one in eight of the people living there are aged 75 or over.

Figure 7 Per centage of population aged 75 and over



Source: Office for National Statistics 2017 mid-year population estimates
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland

2 Examples of work in the High Impact Change Model

2.1 Introduction

2.1.1 This chapter gives examples of good practice in the East of England. As examples they show what has been implemented and what is being tried.

2.1.2 The examples are structured into the stages indicated for the HICM (which were shown in Figure 1). Many are of work which impacts or relates across more than one Change. To show this Example 2 is from a paper to the Southend CCG Governing Body in January 2019[10]. It starts with work on early discharge planning (Change 1): "A&E Social Worker is now being trialled to identify patients within the Emergency Department to prevent unnecessary admission and also identify early patients requiring discharge planning earlier in the patient pathway". It also includes "carers support worker and dementia navigator currently in place to support with navigation", which can be considered as Change 3. That the Increased Discharge Team "has presence on SUHFT[11] site at weekends" shows the move towards a seven days service (Change 5). The report also states that the Trusted Assessors workstream is underway (Change 6).

2.1.3 Considering partnership across geographical boundaries and organisational responsibilities, the paper to the governing body gives information for both Castleford and Rochford CCG as well as Southend CCG. It notes the support for the integration of the Southend University Hospital Foundation Trust (SUHFT) Discharge Team, the Southend Borough Council social work team and the Essex County Council social work team.

2.2 Change 1: Early Discharge Planning

2.2.1 In the outline of the High Impact Change Model Change 1 is introduced as: "*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*."

2.2.2 Hertfordshire County Council see the importance of links between assessments and wards in forming a key part of planning for early discharge. **Example 1** shows the work underway with West Hertfordshire Hospitals NHS Trust (WHHT) through a jointly managed multi-disciplinary integrated discharge team (IDT). It's one of a number of teams supported by Adult Care Services (ACS) focussing on hospital discharge and post hospital discharge review.

[10] https://southendccg.nhs.uk/news-events/governing-body-papers/january-2019/ Item 09 Appendix 7 IAF Summary 300119

[11] Southend University Hospital Foundation Trust

Example 1 Watford General Hospital Integrated Discharge Team

The Integrated Discharge Team (IDT) is a multi-disciplinary team and is jointly managed by Hertfordshire County Council and West Herts Hospital Trust (WHHT). It is one of a number of teams supported by Adult Care Services (ACS) focussing on hospital discharge and post hospital discharge review.

IDT recognise the importance of early discharge planning and are committed to the ambition of establishing a process with WHHT … to support pre admission planning for planned admission. Currently the focus is more around working with WHHT to establish mechanisms by which IDT can be notified earlier about patients that are likely to require complex discharge planning and achieving receipt of referral notification with 48 hours of admission to hospital.

Source: Herts Valleys Integrated Hospital Discharge Service Watford General Hospital Integrated Discharge Team, Scrutiny Report https://democracy.hertfordshire.gov.uk/Data/Hospital%20Patient%20Flow%20Topic%20Group/201805181000/Agenda/Km2f6ftPRF6HhEZCidKULHdVNFXNB.pdf

2.2.3 As noted in the introduction to this chapter, a report to the Southend CCG Governing Body gives progress across the High Impact Change Model, including placing a social worker in Accident and Emergency as part of the larger effort on delayed transfers of care (**Example 2**).

Example 2 Southend – preventing unnecessary admissions

• A&E Social Worker is now being trialled to identify patients within the Emergency Department to prevent unnecessary admission and also identify early patients requiring discharge planning earlier in the patient pathway
• As part of Winter Room system support, daily 09:30 complex discharge huddle to identify any challenges around capacity and resilience early
• Integrated Discharge Manager appointed September 2018, supporting with integration of [Southend University Hospital Foundation Trust] SUHFT Discharge Team, Southend Borough Council social work team and Essex County Council social work team
• Carers support worker and dementia navigator currently in place to support with navigation
• Home first / Discharge to Assess - Under consideration by CCG
• Increased Discharge Team presence on SUHFT site at weekends
• Trusted assessors - workstream underway. Choice policy being reviewed, across MSB group
• Enhancing health - Highly successful joint demand management QIPP has been in place during 2017/18 and 2018/19 to support with training. GP practices aligned to care homes

Source: Public Part I Meeting of the NHS Southend Clinical Commissioning Group Governing Body Wednesday 30thJanuary 2019, Integrated Performance/Governance Report https://southendccg.nhs.uk/news-events/governing-body-papers/january-2019/2631-item-09-appendix-7-iaf-summary-300119/file

2.2.4 **Example 3** is the Front Door Team in Peterborough. The story, given through that of Mrs B, is planning beginning before admission and helping Mrs B safely return home three hours after arrival at the hospital. The interventions provided allowed Mrs B to safely return home only three hours after she arrived at hospital. The work also engages with social care and voluntary organisations: this is an aspect for many other examples of model Changes.

Example 3 Peterborough – Front Door Team

Mrs B lives alone and usually manages with occasional help from neighbours. Today she fell over outside and couldn't get up. Mrs B was found by her neighbour who called an ambulance, which transported her to hospital. Mrs B was seen by a Dr in the Emergency Department. Although Mrs B was not seriously injured there were concerns about how she would manage at home.

To prevent admission Mrs B was assessed by the Front Door Team:
- Lifeline information provided
- Equipment provided to enable independence
- Social Care assessment for home support
- British Red Cross referral to help with shopping
- Physical assessment to see if Mrs B can complete the activities she needs to do safely
- Falls referral coplotted to prevent further falls

The interventions provided allowed Mrs B to safely return home only 3 hours after she arrived at hospital, helping towards achieving the four hour target.

Source: from Better Care Support Team Regional Workshop: East Midlands, presentation by Catherine Paterson and Tracy Williamson, Peterborough City Council

2.3 Change 2: Systems to monitor patient flow

2.3.1 In the outline of the High Impact Change Model Change 2 is introduced through: "*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*".

2.3.2 Luton and Dunstable Hospital has an App that discharge officers complete on the ward every morning (**Example 4**). The provider for the App is (now) a company call 'PHEW'. The App shows the length of stay from going to ward. Its introduction was with the support of the Chief Executive, Deputy Chief Executive and Director of IT.

Example 4 Discharge App in Luton and Dunstable Hospital

The Luton and Dunstable University Hospital Discharge Planning Team, working in close collaboration with Phew, launched their new online Patient Discharge Management system in December 2018. With a deadline of only six weeks to develop and deliver this project Phew achieved their goal to launch on-time and to budget.

The App tracks every patient and organisation responsible. It is updated throughout the day by the Discharge Officers on the wards and feeds live information directly to Discharge Team and executives.

One advantage is that this prevents duplication. It releases staff to actively discharge and provides up to date information and escalation. Executives know what is happening without having to ask – there is immediate availability of reports. External organisations can now have immediate information on their own patient group and it reduces pressure across the whole system.

Source: from presentation by Marilyn George, Integrated Operations Manager, Luton Borough Council and the Luton and Dunstable Hospital. Photo is from Luton and Dunstable Hospital website. Photo and first para from: https://www.phew.org.uk/2019/02/phew-to-showcase-pioneering-new-patient-discharge-management-system-at-reducing-long-hospital-stays-conference-in-london-on-4-march-2019/

2.3.3 One issue for Central Bedfordshire is that majority of discharges for residents are from seven feeder hospitals. A bespoke Hospital Discharge Service, was established in October 2017 and to support this a "person tracker" was developed. This has enabled the council to provide a single point of monitoring, for its own residents, admission, flow and discharge data (see **Example 5**). The tracker was also required to act as an early warning system when people were at risk of becoming delayed. It has supported the council managing the fluctuating levels of surge/demand outside of the traditional periods of 'seasonal pressures'.

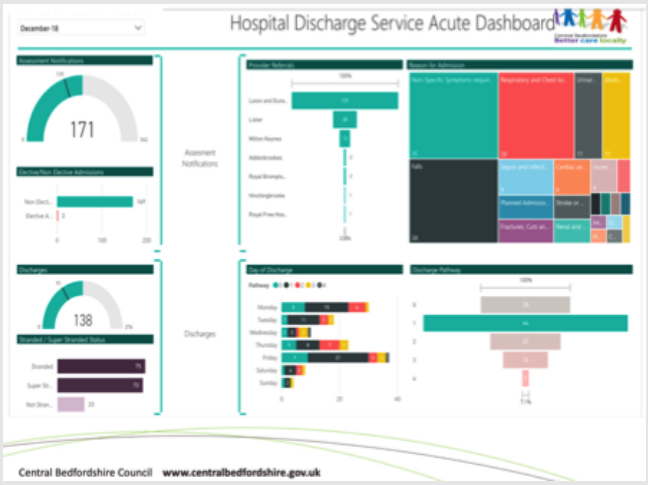
2.3.4 To support the implementation and function of the tracker the role of a Data & Intelligence Officer was created. This ensured that both the skills and experience associated to hospital discharge from an operational and delayed transfers perspective were matched with those of an advanced information technology user. The role also ensured that the important relationship between customer data and associated delayed transfers across the various acute hospital trusts was strengthened.

2.3.5 The outcomes of the project are reflected by the significant improvement relating to delayed transfers performance. The council consistently remains within its agreed BCF trajectory. Next steps include planning to take the learning and widen the use of the tracker and provide an overview of interplay between acute and community-based services. This will facilitate enhanced integrated responses to discharge planning through multi-disciplinary working.

Example 5 Central Bedfordshire Hospital Discharge Service: Person Tracker

Central Bedfordshire have developed a system for helping track people home from hospital – to monitor patient flow across health and social care. The Hospital Discharge Service Tracker functions for:

- Case management reporting & notification
- Monitoring length of stay, and highlighting those with longer periods of stay
- Showing data on readmissions
- Allowing information sharing & engagement with Primary Care



Source: via Anthony Prior, Operational Manager Hospitals & Community Pathways, Central Bedfordshire Council

2.4 Change 3: Multi-Disciplinary / Multi-Agency Discharge Teams

2.4.1 In the outline of the High Impact Change Model Change 3 is introduced through: "*coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients*".

2.4.2 The co-ordination of discharge planning is in the examples already given and is important for this Change. As with Watford General Hospital Integrated Discharge Team there is an integrated discharge team at Luton and Dunstable University Hospital. **Example 6** shows how team members have a range of roles and skills – including bringing together social work and nursing. The working together is carried out through multi-disciplinary sessions as well as the discharge APP (**Example 4**).

Example 6 Luton and Dunstable University Hospital integrated discharge team

The team has the responsibility in discharging in a timely way.

The integrated team has worked in the hospital for many years and the last 5 years have developed the service to reflect the needs of the community.

The team have regular, multi-disciplinary sessions to track and look at complex patients and their length of stay. The front door (A&E) and the back door (Discharge Planning) work together and with the discharge APP.

Integrated Discharge Team is:
- Integrated Operational Manager Head of Discharge Planning
- Discharge Managers
- Discharge Officers (27)
- Senior Officers (4)
- Social Workers
- Community Sisters
- Ward Clerks (25)
- Administrators

Source: through Marilyn George – Head of Discharge Planning, Luton and Dunstable Hospital

2.4.3 Discharges from Bedford Hospital into community and winter beds have shown significant improvements (see **Example 7**). This is strongly influenced by the discharge pathway re-modelled by health and social care professionals and which is now well established. Its clarity across the board has attributed to the success of flow. The pathway includes hospital discharge teams, therapy teams, social care staff, community providers, trusted assessors[12], care home staff and more. As a result, patients have been receiving therapy and returning home in a timely way and there has been a constant flow in, and then out, of beds.

2.4.4 In making the changes the learning from previous years was taken into consideration from all health, social care and voluntary agencies who had a role to play. As a result systems and processes were established so improved pathways were in place to support the system flow and care quality for patients using the services.

2.4.5 One key factor was the commissioning of a new "company" to deliver discharge assessments and training for care providers. It was set up by the care providers with support and funding from the Council. It now employs the Trusted Assessors based in the acute trusts. They work across the Borough and neighbouring authorities. There is a project manager to co-ordinate and deliver training across the care sector.

[12] As another example of impact across more than one Change, Change 6 is labelled as "Trusted Assessors".

2.4.6 Outputs from this work include 100% of assessments being completed within 24 hours of notification, significant improvement in matching patient needs with appropriate vacancies and improved communication across all the teams involved.

2.4.7 Another output has been more training across care homes and with better focus and engagement. This was established to develop an offer supporting enhanced health in care homes and to provide a single point of reference for care home training. The training itself is delivered by both in-house and external providers.

2.4.8 Bedford give an example of the impact of the multi-disciplinary team on a person who is a high user of GP services, telephone calls and out of hours services (**Example 7**). The effect is to help Mrs V be more independent and reduce the need for home visits. It shows the potential impact of a multi-disciplinary team outside a hospital.

Example 7 Impact of the Multi-disciplinary team (MDT) in Bedford

Mrs V is a 78-year-old and was a high user of GP services for home visits and telephone calls as well as out of hours services. She lived in an assisted living complex but was often lonely and experienced high levels of anxiety. She was also suffering with chronic back pain & constipation. In referring her to the MDT, the aim was to reduce unnecessary contact with primary & secondary care services and improve her general quality of life. Mrs V herself wanted to be in less pain. At the MDT meetings it emerged that having the GP actively managing the patient's home visits prevented her from calling the surgery so often & meant the visits could be reduced to once a week.

Re-enablement was organised and the patient received regular visits from a care agency. After 2 months the care package was reduced and monthly GP reviews seemed to be working in helping Mrs V to be more independent. Eventually she no longer needed home visits as she started attending the surgery. Her pain was able to be managed and the MDT group agreed to discharge.

Source: through Simon White Chief Officer, Health Integration, Bedford Borough Council

2.4.9 These examples of Change 3 have been from Unitary Authorities whose responsibilities include housing. For County Councils the housing responsibility is with District Councils. The example (**Example 8**) led by South Norfolk District Council shows the partnership working between a County Council and a District, and the advantages this can bring.

Example 8 South Norfolk: Getting home with District Direct

Objectives: To identify and overcome barriers to discharge via a dedicated district council resource within the integrated hospital discharge hub. The aim is to support residents to return home in a timely manner from hospital to an environment that meets their needs with the necessary support in place

Timescale: Pilot ran September 2017 - March 2018, with a year's funding secured until March 2019

Cost to authority: In-house resources used during pilot and extended via winter pressure money. Extra year's funding secured via adult social care, CCGs and district council contributions

Number of staff working on project: 1 full-time employee during pilot, with 2.5 full-time employees ongoing

Outcomes: Between Sept. 17 – March 18 The pilot supported 184 patients, has undertaken 290 interventions and provided wider information and advice to patients and Norfolk and Norwich University Hospitals staff. The age of patients has ranged from 31 to 96, with an average age of 71 years

Source: from https://www.lgcplus.com/idea-exchange/south-norfolk-how-district-direct-helps-patients-get-home/7025385.article

2.5 Change 4: Home First / Discharge to Assess

2.5.1 In the outline of the High Impact Change Model Change 4 is introduced through: "*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*".

2.5.2 The roll out of the Discharge to Assess Pathway 2[13] in East Suffolk engaged with Community Hospitals as well as the Acute Hospital and the voluntary sector (see **Example 9**). Communication was put in place to increase awareness of the option.

2.5.3 **Example 10** is the interim beds and reablement beds established at the Care Home Collins House in Thurrock - run by the Council. One of the criteria is that these can be used while homes are adapted so people can return to them. The initiative offers interim beds and reablement beds: schemes with more than one type of bed may have a greater scope. Interim flats are also available in extra care housing.

[13] A short guide to Discharge to Assess Pathways is given here https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

Example 9 Roll out of Discharge to Assess Pathway 2 to Felixstowe and Aldeburgh: Community In-Patient Beds Hospital Sites

In July 2018, the local East Suffolk health and care system agreed to commence the roll out of Discharge to Assess (D2A) Pathway 2 at the other community hospital in-patient beds sites - Felixstowe and Aldeburgh. The focus to date has been establishing the short term intensive assessment reablement and rehabilitation service (STARR Centre) based in Ipswich. The STARR Centre monthly figures had been hitting very high numbers, with the STARR team seeing on average 60 patients admitted and discharged per month, and with an average length of stay of 10.6 days.

The change management work happening at the Felixstowe and Aldeburgh community bed sites involved using the learning and best practice from the STARR Centre. The teams engaged positively with targets and changes in processes By August 2018 the teams had already met the 4 week Length of Stay target and had increased their flow.

The following priorities were agreed with the Felixstowe and Aldeburgh teams to ensure that the good work and system flow was sustained going into winter 2019/19:

- Matrons from Felixstowe and Aldeburgh Community hospitals attending their ward rounds with up to date bed state information and daily contact with both the acute trust discharge team and the key referring acute wards to ensure full community bed occupancy to support system flow
- Development of a communication tool by an acute based hospital based therapist that highlighted case studies, for which patients can go to a community hospital bed. This helps educate acute ward staff on appropriate referrals
- A roadshow where educational sessions would be taken to the acute wards to further embed D2A Pathway 2
- Shared paperwork processes for all sites
- Red Cross D2A Reablement Team working closely as part of Pathway 2 to facilitate discharges

Source: Jo Cowley, Head of Service Redesign and Contract Management, Adult & Community Services, Suffolk County Council
Note: the map Contains OS data © Crown copyright and database right (2019)

Example 10 Interim care beds and reablement beds, Collins House, Thurrock


Thurrock Borough Council

Collins House

Inspection report

Springhouse Road
Corringham
Essex
SS17 7LE

Tel: 01375652987
Website: www.thurrock.gov.uk

Date of inspection visit:
05 February 2019

Date of publication:
19 February 2019

Thurrock Council have established interim care beds and reablement beds at Collins House. These provide 12 short stay beds for adults who are medically fit for discharge from hospital and require a short term transfer whilst waiting for a care package. It also is available for adults matching other criteria.

The aims are to:
- Facilitate timely discharge from an Acute or Community Hospital to prevent unnecessarily prolonged stays when hospital care is no longer needed but where a return to an individual's own home would be premature
- Prevent unnecessary admission to an inappropriate long term care setting by allowing time for a full assessment of the person's long term care needs
- To provide support to return home or allow choices for appropriate placement that require full consideration
- To allow an individual an opportunity to regain their strength and abilities following a hospital stay
- To support confidence building following an admission to hospital

For people whose family/carer situation requires stabilisation that would otherwise prevent a return home
For people who need their housing reassessed or need new housing arrangements

Source: Kay Kimmings, Registered Manager, Collins House, Carers Centre and Day Services, Adults Housing and Health, Thurrock Council. Tania Sitch, Partnership Director, NELFT and Thurrock Council

2.6 Change 5: Seven-Day Services

2.6.1 In the outline of the High Impact Change Model Change 5 is introduced through: "*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*".

2.6.2 In the Bedfordshire Primary Care Home model a Single Point of Access (SPoA) (**Example 11**) is considered central to the Better Care Fund plan. It was co-designed across health, social care, voluntary agencies and patient representatives[14]. From the re-design the front door to community services were established and delivered by the community services contract (jointly contracted across health and social care), as the gateway to all community services. The contact number is available 24 hours a day, seven days a week. The SPoA received 80,000 calls in a year and is accessed by a huge array of professionals and patients/carers alike. The significant re-design involved recruitment of additional staff, new IT software and hardware, intense training and significant processes and engagement.

Example 11 Single Point of Access Service: Bedfordshire[15]

Single Point of Access Service (SPoA) - Bedfordshire

What is the SPoA?
It is a new coordination centre for adult services within Bedfordshire Community Health Services. This centre is accessed via a single number, which is where the name SPoA comes from; it stands for 'Single Point of Access'.
The SPoA provides customer service and information for service users, family, carers and healthcare professionals.

What is the SPoA contact number?
The contact number is **(0345) 602 4064** and the centre is available 24hours a day/7 days a week

A new coordination centre for adult services within Bedfordshire Community Health Services, accessed via a single number. Single Point of Access (SPoA) is able to handle calls for all the following adult services:

- Community Nurses – housebound patients, wounds, pressure sores, pressure-relieving equipment, catheters (adults)
- Occupational Therapists (OTs) - equipment around the house e.g. grab rails, shower assessments, transfers
- Intermediate Care (IMC) - meal preparation, washing/dressing, rehabilitation and enablement
- Rapid Intervention (RIT) - emergency care needed for no longer than 72 hours in the community (out of hours service)
- Matrons - long-term chronic illnesses (adults)
- Community Beds - inpatient rehabilitation beds
- Neuro-Stroke - neurological disease, early supported discharge
- Special Palliative Care - emotional and physical support and care for those with life limiting illnesses
- Physiotherapy – functional rehabilitation, walkers & walking sticks, mobility help
- Phlebotomy
- Continence
- Tissue Viability (Wound Care)

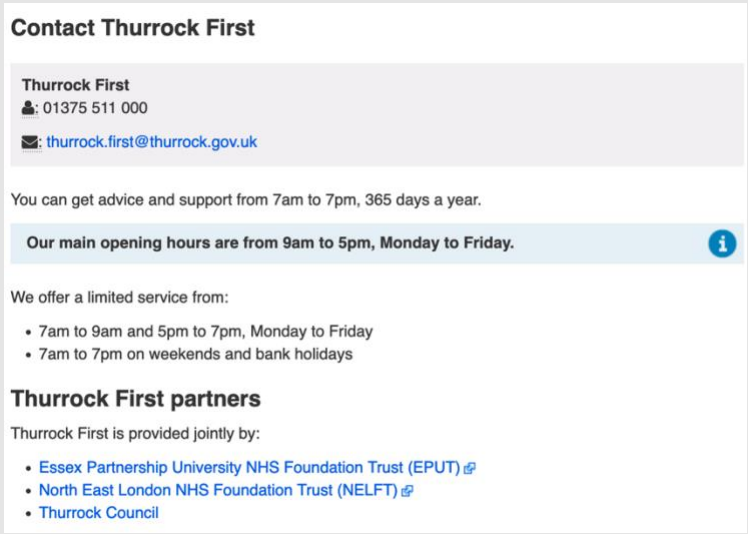
Source: https://www.elft.nhs.uk/service/433/Single-Point-of-Access-Service-SPoA---Bedfordshire

[14] On 26th June 2018 a round table event was attended by Bedfordshire Clinical Commissioning Group, Healthwatch Bedford Borough, Bedford Hospital, St John's Hospice Sue Ryder, Central Bedfordshire Council and Bedford Borough Council https://www.elft.nhs.uk/News/New-Look-Contact-Centre---Bedfordshire

[15] Bedfordshire would be two Local Authorities: Bedford Borough and Central Bedfordshire

2.6.3 In Thurrock a point of contact (Thurrock First, **Example 12**) has been set up in partnership between Thurrock Council, Essex Partnership University NHS Foundation Trust (EPUT) and North East London NHS Foundation Trust (NELFT)[16]. This point of contact for adults is offered for extended day time hours for every day (including weekends and bank holidays).

Example 12 Point of contact: Thurrock First



Contact Thurrock First

Thurrock First
: 01375 511 000
: thurrock.first@thurrock.gov.uk

You can get advice and support from 7am to 7pm, 365 days a year.

Our main opening hours are from 9am to 5pm, Monday to Friday.

We offer a limited service from:

- 7am to 9am and 5pm to 7pm, Monday to Friday
- 7am to 7pm on weekends and bank holidays

Thurrock First partners

Thurrock First is provided jointly by:

- Essex Partnership University NHS Foundation Trust (EPUT)
- North East London NHS Foundation Trust (NELFT)
- Thurrock Council

Thurrock First is our first point of telephone contact for adults living in Thurrock who want to talk to someone about:

- any issues relating to their health or care including:
  - mental health
  - care and support available in the community
  - where to get help with health problems and how to access services

We will have a conversation with you and support you to find the right service or solution needed.

Source: https://www.elft.nhs.uk/service/433/Single-Point-of-Access-Service-SPoA---Bedfordshire and Tania Sitch, Partnership Director, NELFT and Thurrock Council

2.6.4 The Great Yarmouth and Waveney CCG covers areas in both Norfolk and Suffolk Counties. Their Winter Plan for 2018/19 gives services to support admission avoidance and discharge planning. Waveney Night Response (**Example 13**) is part of this. The service is available from 19:00 to 07:00, seven days per week. It provides a crisis response: to attend to people who require emergency care and support in their own homes. This reduces Ambulance attendance and prevents crisis escalation and admission.

[16] To show the complexity of geography, North East London Foundation Trust provides services in nine Local Authorities: as well as Thurrock there are Basildon and Brentwood in Essex as well as five in London and one in Kent https://www.nelft.nhs.uk/our-services

Example 13 Great Yarmouth and Waveney Health and Social Care System, Winter Plan2018/19, including Waveney Night Response

Suffolk

British Red Cross	To support patients being discharged from acute care
Trusted Assessors	Support for self-funders and working closely with care homes to facilitate discharge
Bed Based reablement	6 beds community beds
Waveney Support to go home	Additional reablement team supporting discharge from acute care
Social Prescribing	Working with Waveney practices to enhance existing social prescribing models and supporting patients in the community
Healthy Homes	Providing rapid early access to Disabled Facilities Grants for home adaptations through an integrated single point of access on behalf of Norfolk and Suffolk County Councils, Waveney District Council and Great Yarmouth Borough Council, to enable earlier discharge and admission avoidance.
Waveney Night Response	The service is available 19:00-07:00 7 days per week providing a crisis response, to attend to people who require emergency care and support in their own homes within the Waveney area, thereby reducing Ambulance attendance and preventing crisis escalation and admission
Social Work provision for 7 day working at JPUH and Out of Hospital Teams	Supporting discharge planning 7 days a week

Source: Great Yarmouth and Waveney Health and Social Care System, Winter Plan2018/19
http://www.greatyarmouthandwaveneyccg.nhs.uk/_store/documents/agenda-item-7b-integrated-seasonal-resilience-plan.pdf

2.7 Change 6: Trusted Assessors

2.7.1 In the outline of the High Impact Change Model Change 6 is introduced through: "*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*".

2.7.2 A number of Local Authorities have discussed the work they have put into establishing trusted assessors and the benefits from this. These can start with the simple knowledge of which Home a person has come from so the Home can be contacted. With the building of relationships the Home might be prepared to take assessments by phone.

2.7.3 In Cambridgeshire and Peterborough there are Trusted Care Assessors to support and facilitate discharges into care homes from the three acute hospitals within their Local Authority boundaries: Cambridge University Hospital (CUH), Peterborough City Hospital (PCH) and, more recently, Hinchingbrooke Hospital (HH) (**Example 14**).

Example 14 Cambridgeshire and Peterborough: Trusted Care Assessors

Model

• Care Home Trusted Assessor, located in the Discharge Hub, to support and facilitate discharges from Peterborough City Hospital (PCH) and Cambridge University Hospital (CUH) and more recently Hinchingbrooke Hospital (HH) into Care Homes and to undertake assessments/re-assessments on behalf of Residential and Care Homes with Nursing to support safe and timely discharges. This may involve a patient/resident returning to a Care Home or going for a short period of recovery/rehab and/or respite stay, at a Care Home

• The Care Home Trusted Assessor/s are senior members of staff from Lincolnshire Care Association (LinCA) who are an independent organisation: either a Manager or Deputy with appropriate qualifications, knowledge and skills in health and social care services

• It is recognised that the success is in part due to the contract being with LinCA who are completely independent from the hospitals and the Councils. Care Home providers are assured that the person has the knowledge and expertise required to complete the assessments and ensure all necessary arrangements are in place for a safe discharge to the Care Home

• The model reduces the time people spend in hospital waiting for assessment or reassessment at risk of further deterioration and importantly it will save Care Home Managers (other staff) precious time and resource

Benefits

The following mutual benefits have resulted from this initiative:

• Patients and residents receive a more timely and effective service to ensure discharge from hospital once medically fit

• It is more effective and efficient for Care Homes as it reduces the discharge assessment visits to hospitals and the completion of associated paperwork

• It is a more effective and efficient use of hospital beds as it reduces discharge delays

Source: via Debbie McQuade, Assistant Director Adults and Safeguarding, Adult Social Care, Peterborough City Council

2.7.4 An additional way of improving the movement of people between Care Homes and Hospital, both ways, is offered by "the Red Bag Scheme". **Example 15** shows its operation in south east Essex and Southend. A key part is "a dedicated Red Bag that contains standardised information about the resident's general health, any existing medical conditions they have, medication they are taking, as well as highlighting the current health concern".[17]

[17] Department of Health and Social Care, NHS England and NHS Improvement, 2018, Quick Guide: Hospital Transfer Pathway - 'Red Bag' https://www.england.nhs.uk/publication/redbag/

Example 15 Red Bag scheme in South East Essex and Southend

James Currell, General Manager for Medical Specialities at Southend University Hospitals NHS Foundation Trust, said:

"This is a great example of how local health and social care services can work together in partnership to improve patient care. We know that it can be confusing and very stressful for care home residents when they need to be transferred to hospital, particularly in an emergency, but this simple patient centred initiative will enhance patients' experiences by ensuring a smoother transfer in and out of hospital. We also welcome the positive impact it will have for patient safety by allowing health care professionals to immediately identify the patient as a care home resident. It provides us with the information we need to provide individualised care, which is particularly important for patients with memory problems or longer term dementia. The Red Bag also makes it simpler to keep track of the patients' essential belongings and other items including personal information."

Source: https://southendccg.nhs.uk/news-events/421-red-bag

2.8 Change 7: Focus on Choice

2.8.1 In the outline of the High Impact Change Model Change 7 is introduced through: "*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*".

2.8.2 The Local Authorities spoken to recognise this issue but also its complexity. One mentioned that when considering the preferences and requirements of a patient the nearest home suitable might be 20 miles away. For this Local Authority there are seven other Local Authorities within 20 miles[18] and the distance to the home was not considered suitable by the patient's family.

2.8.3 A County Council spoke of the added complexity from the range of house prices within its boundaries: in one District the average house price was 40% above that with the lowest average house price.

[18] This is the number of County or Unitary Authorities with social care responsibilities. If District Councils were included the number would be larger.

2.8.4 Hertfordshire County Council, together with East and North Hertfordshire CCG and Herts Valleys CCG, have a Market Position Statement older people[19]. This is designed to summarise their commissioning intentions to help support current and potential providers to develop the right services for residents: "*We see personalisation of services as key to achieving this. We recognise that individuals often know what is best for their own care and wellbeing. We want to commission services that work proactively with individuals to understand their needs, wants, interests, and ambitions, and that build on individuals' strengths and assets in providing care and support for them*".

2.8.5 Hertfordshire have also produced a Ten Year Supported Accommodation Strategy (see **Example 16**). The strategy is supported by a governance structure and there are profiles for each of the 10 District Local Authorities in Hertfordshire. These include the projected supported accommodation demand for older adults (over 65) by 2025.

Example 16 Hertfordshire Ten Year Supported Accommodation Strategy

People aged 65+	HCC's Future intentions
Residential care homes	Slowing growth in residential care home beds and actively reducing long stay placements in residential care. Place a greater focus on supporting older people with dementia in the remaining places.
	Greater investment in short stay, rehabilitation, 'step down' and assessment bedded services to enable people to return home from hospital
	Reduction in overall commissions from HCC.
Nursing care homes	Growth and increased investment across all services within nursing sector.
	Accelerated growth in nursing dementia care
	Integrated nursing services across the NHS, social care, continuing health care and high needs dementia.
Flexicare Housing	Growth in local communities with greater flexibility of care to support a wide range of care needs
	More Flexicare accommodation for people and couples living with dementia

Source: https://www.hertfordshire.gov.uk/media-library/documents/about-the-council/084022-accommodation-strategy-2017-27-nov-2018-final-for-publication.pdf

[19] There are five market position statements, in addition to that for older people: autism, carers, learning disability, mental health and physical disabilities
See https://www.hertfordshire.gov.uk/about-the-council/freedom-of-information-and-council-data/open-data-statistics-about-hertfordshire/our-policies-and-procedures/market-position-statements/market-position-statements.aspx

2.9 Change 8: Enhancing Health in Care Homes

2.9.1 In the outline of the High Impact Change Model Change 8 is introduced through: "*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*".

2.9.2 The Herts Valleys Clinical Commissioning Group Quality Improvement Team has an objective to reduce non elective admissions and attendances to acute care (**Example 17**). The aim is to ensure that the care provided in care homes, and by home care providers, is of a high standard and meets quality and compliance standards.

2.9.3 The context is that within the locality there are 173 care homes with a total of 4,916 beds. Some will be occupied by privately funded residence, some will be funded entirely by the CCG and others may be receiving CCG contribution to their funding through Funded Nursing Care. The number of providers of home care fluctuates as demand increases.

Example 17 Herts Valleys Clinical Commissioning Group Quality Improvement Team: the objective to reduce non elective admissions and attendances to acute care

Quality visits to care homes are prioritised to those where significant issues have been identified e.g. an increase in the number of safeguarding alerts. In a year the CCG quality lead made 69 care home visits and 3 home care provider visits due to concerns. The visits are supported the Care Home Improvement Team.

Support for quality visits to acute providers. The Quality Improvement Team support quality visits to acute providers and remain the lead for Herts Urgent Care (HUC) out of hours visits.

Understanding the problem can help work on solutions. As an example a full audit of A&E was undertaken. This helped identify that the assumption that many admissions were from care homes due to care home staff calling an ambulance was not correct. Looking at 310 attendances/admissions 24 came from care homes while over 75% were admitted following GPs' and other professionals' visits.

Collaborative working: the team offers support to any care home who notify Public Health about any type of infectious outbreak. All homes who have multiple outbreaks are offered additional training.

Work on pathways and training is being developed and once the new process is agreed then work will start on rolling out the guidance and training for the care home staff in preparation for winter 2018.

Safeguarding alerts in care homes: the team have worked closely with the Head of Adult Safeguarding to address any serious safeguarding issues in care homes. The aim is to provide clinical support to the homes to help minimise the impact on system resilience and avoid embargoes from the CQC on admissions.

Source: for example see Care Home Improvement Team (CHIT), Q2 2018-19 report, Analysis and Narrative, from Joan Plant, Head of Quality Improvement, Nursing and Quality, Herts Valleys Clinical Commissioning Group
Note: photo is of Forest Care Village care homes in Borehamwood, Hertfordshire

2.9.4 Cambridgeshire has introduced an Enhanced Response Service (ERS) where one aim is to provide an alternative response service to an Ambulance and which could meet an urgent need (**Example 18**). This service should reduce demand on the Ambulance Service. This should then avoid inappropriate admissions to acute hospitals when the Ambulance Service has no alternative suitable service.

Example 18 Cambridgeshire Enhanced Response Service

Cambridgeshire County Council

Care and Health Integration/Admission Avoidance

Enhanced Response Service (ERS)

Challenge

The main challenge was that the Telecare Call Centres in the 5 Districts would call out an Ambulance if no informal carer could be contacted. The Ambulance service received a high number of calls that were not a medical emergency, but were given an appropriate low priority following the Ambulance triage and unnecessary admissions to hospital.

Aims

- To provide a timely response for ad hoc social care needs that enables people to maintain their independence and well-being, to continue living in their homes as long as possible but have a sense of security and safety that help is available when they need it.
- To provide an alternative response service to an Ambulance but one that could meet an urgent need and thus reduce demand on the Ambulance Service.
- To avoid inappropriate admissions to acute hospitals, when Ambulance have no alternative suitable service.
- To increase support for informal carers, especially frail carers who may not be able to manage moving and handling after a fall or who need support overnight to enable them to continue their caring role during the day.

Outcomes

Numbers of ERS calls per month is increasing and recently has been between 350 and 400. The calls are distributed fairly evenly over the three shifts: morning 7-14, afternoon 14-22 and night 22-7. Since the start of ERS they have responded to 4,539 calls which translate into an avoidance of Ambulance calls of 4,287 at £249. This has released capacity for Ambulance response times and medical emergencies.

Source: via Debbie McQuade, Assistant Director Adults and Safeguarding, Adult Social Care, Peterborough City Council

2.9.5 Norfolk Council engaged with the Enhanced Health Care in care homes framework to reduce admissions from care homes to hospital (**Example 19**). A care homes dashboard was developed to show admissions to hospital, the use of 111 and quality ratings by care homes.

Example 19 Norfolk – Care Homes dashboard

Norfolk County Council

The Norfolk system is engaged with the Enhanced Health Care in Care Homes framework as a basis for reducing admissions from care homes to hospital and is collaborating to support improvement in the quality of care offered. This is also a HICM priority.

This work has progressed well and all milestones have been achieved. Further investment has been agreed for the coming year to ensure the pace and impact of this work can be maintained.

Norfolk has developed the care homes dashboard to show admissions to hospital, use of 111 and quality ratings by care homes. It has been adopted by NHS England and is being presented and promoted as a model of good practice. It highlights a reduction in avoidable hospital admissions to hospital from care homes for 2017/18 compared to 2016/17 (based on data from the first half of each year).

- North Norfolk: 8.3%; Norwich: 35.3%; South Norfolk: 14.6%, West: 15.8%

Source: Health & Wellbeing Board, Wednesday 2 May 2018, "Integration – a vision for Norfolk Adult Social Services and review of the Better Care Fund 2017/18" para 2.4

2.10 Examples of additional and relevant good practice

2.10.1 The High Impact Change Model provides a framework to support the modelling of patient flow and discharge (as set out in Figure 1). Some Local Authorities have sent examples of relevance with clear impact on patient flow but which sit outside a narrow definition of change. An example is provided through the west Suffolk multi-agency Early Intervention Team (EIT) and the East of England Ambulance Service (**Example 20**). This has led to better outcomes for people in west Suffolk and fewer admissions to hospital. The service has a Rapid Intervention Vehicle (RIV) staffed by a paramedic and a therapist from the EIT. It was launched in Bury St Edmunds and Sudbury in October 2018 to support winter pressures. This has now been expanded to cover all localities in west Suffolk.

2.10.2 The service provides rapid, holistic assessment and treatment for people in a crisis. The most effective use of the RIV has been when someone has fallen, where the combined skill set of the team has provided increased confidence and access to services in order to keep people at home.

Example 20 West Suffolk Rapid Intervention Vehicle

Mrs X had been prescribed antibiotics by her GP for a urinary tract infection. After taking the first tablet she was unwell and became unable to speak and very confused.

The GP called the Rapid Intervention Vehicle (RIV) team and the specialist paramedic changed the medication as the episode was likely to have been a reaction. The patient remained very anxious being home alone as she worried that she would have another episode. Because of this the therapist on the RIV arranged for an overnight carer to support her overnight and to monitor the effects of the new mediation.

Without this help it is likely that Mrs X would have made repeat calls to the 111 and 999 services, and there is a possibility that she could have been admitted to her local hospital.

The team consists of community nurses, social workers, occupational therapists, physiotherapists, rehabilitation assistant practitioners, re-ablement support workers, as well as support workers from British Red Cross and a carer link worker from Suffolk Family Carers.

Source: Jo Cowley, when Head of Service Redesign and Contract Management, Suffolk County Council. Picture from https://twitter.com/WSH_EIT/status/1061016390700802048

2.10.3 The aim of preventing older people needing to go to hospital is also supported in South East Essex, and Castle Point and Rochford and Southend CCGs. A community team (SWIFT) has been established with the aim of helping patients stay at home when they are feeling unwell, rather than be transferred to hospital (see **Example 21**). The service is designed with a "home first" ethos and will provide specialist, nurse-led care in people's own homes. They will visit within two hours of receiving a

referral from their GP practice to stabilise the immediate health need. If at any point the patient deteriorates and can no longer be safely managed at home the SWIFT team will co-ordinate safe transfer to the hospital for an inpatient admission.

Example 21 South East Essex and Southend SWIFT community team

Sources: https://eput.nhs.uk/our-services/essex/south-east-essex-community-health-services/adults/swift/ and sent by Ashley Mitson, Team Manager Hospital Social Work Team, Southend-on-Sea Borough Council
Note: The website states "South East Essex refers to South East Essex, Castle Point and Rochford and Southend CCGs".

2.10.4 In the Hertfordshire Herts Care Providers Association[20], Hertfordshire County Council and East and North Hertfordshire CCG have focused on upskilling Care staffing in a range of subject areas (see **Example 22**). This is through the Complex Care Premium Homes Programme (CCP). Delegates not only gain confidence from the Pathways they take to become a Champion, they also are taught how to teach their peers what they have learnt: therefore cascading their knowledge and strengthening the team. Over the last 3 years there has been a reduction in A&E attendance, with CCP homes reporting an 11% *decrease* while non CCP homes have seen a 24% *increase*.

Example 22 Complex Care Premium Homes Programme: Hertfordshire

The aim is to keep frail, elderly residents healthy, independent and, importantly, out of A&E and hospital beds.

The aim is to have in each home a trained champion in each of: Dementia; Falls; Nutrition; Wound Management; Respiratory & Continence Care; End of Life Care; Engagement

The Champions would form a multidisciplinary team (MDT). These MDT teams work together and with outside professionals to tackle deterioration in residents, change practice within the organisation and create an active environment of prevention.

Source: from Kulbir Lalli, Head of Integrated Accommodation Commissioning, Adult Care Services; Hertfordshire County Council

[20] https://www.hcpa.info/

2.11 Conclusions

2.11.1 This chapter has given twenty two examples of projects and work carried out to implement the High Impact Change Model. These have been provided or sign-posted initially through the eight Changes highlighted in the model as starting points. They are introductions and provide a flavour to the work carried out. Some of the examples come from plans on the work, some give measured understanding of the impact and some give the experience of people affected.

2.11.2 The work is carried out across the wide range of different areas in the East of England, for example some rural: some urban. The examples also show the wide range of different organisations involved from health, local government and the voluntary sector. Many different roles are shown engaged in differing examples – social work and nursing are there, but some of the others included are: administrative staff, a dementia navigator, discharge officers, occupational therapists and ward clerks.

2.11.3 In addition to the variation in how the work is being done the examples also show that the eight Changes given in the High Impact Model can be brought together: systems to monitor patient flow (Change 2) may be used by multidisciplinary discharge teams (Change 3) to help early discharge planning (Change 1).

2.11.4 They give the opportunity to be considered as possibilities and ways of working that can be tried in other places. Some examples may stretch outside the strict boundaries of the model, for example by looking beyond improving relationships with care homes to help reduce unnecessary admissions into helping people living at home and reducing admissions.

2.11.5 There are a number of factors which help projects such as these be set up and become active. The next chapter looks at these.

3 Factors behind change

3.1 Introduction

3.1.1 This report comes from information given through 20 interviews, the examples suggested and also additional contact through regional meetings. The examples given in the previous chapter show what is being done which interacts with HICM.

3.1.2 The HICM provides a structure and tools which can be used. When considering how to engage with new or different ways of working there is no uniform approach to be adopted. This can be seen as a strength that allows local circumstances to be built on.

3.1.3 Running through the examples that have been given are approaches and factors which have helped and led to their adoption.

3.2 Where to start?

3.2.1 The High Impact Change Model gives eight Changes for managing transfers of care between hospital and home. Those interviewed did not consider that there was a single Change which had to be implemented first. In part this relates to the different structures and relationships existing. One Local Authority felt that a number of the Changes were already in place.

3.2.2 The knowledge of local circumstances and relationships can provide a foundation. Change can be introduced which builds on these, a bottom-up approach. This comes from those willing to address changes.

3.2.3 Another way can be through the measurement of costs and benefits used to present a clearer picture. A top-down approach can use these and implement the formality of structural changes.

3.2.4 One Local Authority found a peer review helped to provide a way forward to address system wide problems.

3.3 Ways of progressing

3.3.1 A key aspect to all the examples given is the need to work in partnership. This can be seen as bringing different organisations together and the examples all show organisations working together. The complexity varies: there are considerable differences in the sizes of the Local Authorities and relative location of hospitals in the East of England. There are also differences in the number of organisations within any one set of boundaries.

3.3.2 The nature of partnership working is varied, the Model makes no legal definition of what is required. There are great benefits from the sharing of information, but there are different ways this can happen. A number of examples were of information systems which brought together information in one place so all could work from it. There are also "softer", real advantages from partnership working that can come in a number of different ways:

- One person interviewed mentioned the simple advantage of working together in understanding the language and words used by others
- For another, having a place to bring together different people into the same room to share information simplified and enhanced the exchanges
- One Local Authority mentioned that recruitment to new posts was undertaken through the Hospital as the recruitment process was easier
- The pilot between health and social care in north Essex (through the Integrated Discharge Hub at Colchester Hospital) looked at closer links with housing. A self review noted that the importance was through relationships and partners feeling valued by each other and understanding the role each play in meeting someone's care needs

3.3.3 A culture of understanding the need for change is seen as important. With this can come how change is delivered. One person interviewed said that what helped was that there was a hierarchy within the organisation but people were accessible and approachable. The executive team could be called on but they "let you get on with what you were doing".

3.3.4 With the culture of understanding comes trust. The Change 6 – Trusted Assessors indicates the need for this. How it can be built varies: one Local Authority mentioned the benefit of recruiting people who had been Care Home managers to these roles. When these new roles have been developed there can be acceptance of information made in phone calls rather than visits.

3.4 Continuing progress

3.4.1 The variety of examples given show that there are many different solutions to implementing HICM. A number of papers to Committees show how the measurement of hard data can be part of reporting progress. It could build on any formal analysis of benefits and change made at the start. But it is only part of reporting progress.

3.4.2 Progress is driven by “trying things out”. Some of the examples indicate areas for improvement that will be considered. One Local Authority mentioned a change that had been introduced, it was then seen as not working and now a different approach is being tried.

3.4.3 The importance of learning from others was given by one Local Authority as a key to making progress – there are elements they “take” from other people, but they don’t say they have “got it right” and still feel the need to improve.

4 Appendix 1: Geographical relationships between CCGs, LAs and Acute Hospitals

Clinical Commissioning Group	Local Authority with responsibility for social care	Acute Hospital	Location of Acute Hospital
Bedfordshire	Bedford Borough	Bedford Hospital	Bedford
Cambridgeshire and Peterborough	Cambridgeshire County	Hinchingbrooke Hospital	Huntingdon
Cambridgeshire and Peterborough	Cambridgeshire County	Addenbrooke's (and the Rosie) Hospital	Cambridge
Bedfordshire	Central Bedfordshire		
Basildon and Brentwood	Essex County	Basildon University Hospital	Basildon
Castle Point and Rochford	Essex County		
Mid Essex	Essex County	Broomfield Hospital	Chelmsford
North East Essex	Essex County	Colchester General Hospital	Colchester
North West Essex	Essex County	The Princess Alexandra Hospital	Harlow
East and North Hertfordshire	Hertfordshire County	Lister Hospital	Stevenage
East and North Hertfordshire	Hertfordshire County	Queen Elizabeth II Hospital	Welwyn Garden City
Herts Valleys	Hertfordshire County	Watford General Hospital	Watford
Luton	Luton Borough	Luton and Dunstable Hospital	Luton
North Norfolk	Norfolk County		
Norwich	Norfolk County	Norfolk and Norwich University Hospital	Norwich
South Norfolk	Norfolk County		
West Norfolk	Norfolk County	The Queen Elizabeth Hospital	Kings Lynn
Great Yarmouth and Waveney	Norfolk County and Suffolk County	James Paget Hospital	Great Yarmouth, Norfolk

Clinical Commissioning Group	Local Authority with responsibility for social care	Acute Hospital	Location of Acute Hospital
Cambridgeshire and Peterborough	Peterborough City	Peterborough City Hospital	Peterborough
Southend	Southend-on-Sea Borough Council	Southend University Hospital	Southend
Ipswich and East Suffolk	Suffolk County	Ipswich Hospital	Ipswich
West Suffolk	Suffolk County	West Suffolk Hospital	Bury St Edmunds
Thurrock	Thurrock		

Sources: the relationship between Councils and CCGs is from the two maps, the source for Acute Hospitals is CQC service ratings across England. https://www.cqc.org.uk/help-advice/help-choosing-care-services/map-service-ratings-across-england
Note: Great Yarmouth District is in Norfolk and Waveney is in Suffolk.

5 Appendix 2: Those interviewed or have contributed their experience

The positions given are those that were held at the time of interview or when the example was sent.

First Name	Surname	Post	Organisation
Natasha	Burberry	Sector Led Improvement Programme Manager	ADASS East
Chris	Rowland	Improvement Programme Director	ADASS East
Jodi	Simpson	Manager for Older People and Physical Disabilities	Bedford Borough Council
Simon	White	Chief Officer, Health Integration	Bedford Borough Council
Debbie	McQuade	Assistant Director Adult Operations	Cambridgeshire and Peterborough Combined Authority
Anthony	Prior	Operations Manager Hospitals	Central Bedfordshire Council
Ann	Ford		Care Quality Commission
Charles	Rendell	Strategy Manager	Care Quality Commission
Emma	Richardson née Manley	Head of Integration and Partnerships	Essex County Council
Chris	Badger	Operations Director, Older People	Hertfordshire County Council
Ed	Knowles	Assistant Director	Hertfordshire County Council
Kulbir	Lalli	Head of Integrated Accommodation Commissioning	Hertfordshire County Council
Andrew	Mallabone	Head of Integrated Discharge Services (Social Care)	Hertfordshire County Council, Watford General Hospital
Joan	Plant	Head of Quality Improvement	Herts Valleys Clinical Commissioning Group
Claire	Bruin	Care and health improvement adviser	Local Government Association
Anna	Jennings		Local Government Association
Marilyn	George	Head of Integrated Discharge	Luton Borough Council and the Luton and Dunstable Hospital
Chilala	Chitava	Better Care Fund Implementation Manager	NHS England

First Name	Surname	Post	Organisation
Toni	Jeary	Head of Integrated Commissioning (Central)	Norfolk County Council
Ashley	Mitson	Team Manager Hospital Social Work Team	Southend-on-Sea Borough Council
Jo	Cowley	Head of Service Redesign and Contract Management	Suffolk County Council
Rachel	Bottomley	Senior Transformation Lead	NHS Ipswich and East Suffolk CCG
Katy	Snelgrove	Discharge to Assess Programme Manager	Suffolk County Council / NHS Ipswich and East Suffolk CCG
Linda	King	Team Manger	Thurrock Council
Tania	Sitch	Partnership Director	NELFT and Thurrock Council
Kay	Kimmings	Registered Manager	Collins House

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