Annex 2: Detailed Scheme Descriptors

1. Scheme name
1 - Front Door

2. What is the strategic objective of this scheme?
To create a hub of IAG that enables citizens to access the right support at the right time. • Implementation of a new sustainable model that includes a professional support team. • To reduce the number of citizens being referred to formal or statutory assessment. • To create a first point resolution service with a timely response to customer queries. • Encourage self-help & support utilising and developing the tools and services available to provide robust preventative interventions

3. Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted
The scheme uses good quality Information and advice (Telephony and web based) and targeted professional support alongside a range of self-help and digital support tools. This is then supported by process improvements to simplify and improve user experience, streamline customer journeys and support frontline practitioners to utilise the available resources and in turn ensure consistency of approach and good practice. The delivery of this scheme focusses on two core projects: **1. Professionalised Front Door** Following implementation of the Care Act 2014 and the creation of the SSOTP Transformation Programme it was agreed that the Front Door Pathway should be re-designed, to enhance the Staffordshire Cares offer through the introduction professional support within the contact centre environment. SSOTP and SCC accountable leads coproduced the model to facilitate better outcomes for the customer, ensuring the needs of service users are met but also supporting self-funders, carers and frontline workers to make informed decisions about their health, care and support needs/ options through an easily accessible, robust and professional front door service for Staffordshire. The patient cohorts in scope for the Project was any citizen over the age of 18 who presents with an indication need at Staffordshire Cares who may benefit from the new ways of working. **2. Primary and Secondary Care Self-help and independence Pilots.** We have developed a pilot with a GP surgery to provide Information and advice and low level assistive technology (AT) to patients as part of consultations, home visits and Healthcare assistant appointments to encourage use of the tools available in Staffordshire (Staffordshire cares, Staffordshire Marketplace, supported self-assessment, ask sara) and have developed a “Box of Trix” which includes top 10 most useful/ used pieces of assistive technology to support self-care and independence funded by the local CCG which are to be distributed to every practice in the CCG area alongside training and support from SCC and demonstration video’s showing how to use the equipment. The surgery has added “quick picks” to their EMIS system which allows GP’s to identify when Early/ self-help Information, Advice & Guidance

(IAG) has been given to the patient or AT has been discussed and demonstrated. This pilot is now being rolled out to 2 other surgeries in the locality with the aim of having it in all 20 practices by December 2016.

In secondary care we are taking a similar approach but working closely with discharge facilitators/ liaison teams in hospitals to dispense relevant IAG and low level assistive technology to enable people to return home in a timely and appropriate manner, ensuring they have the necessary low level help to support ongoing independence. For this group a different "box of Trix" has been developed on advice from the teams themselves with regards to their knowledge of what patients struggle with on leaving hospital and common causes for re-admission e.g. incorrect use of medication, dehydration, falls etc.

3.Primary & Community Care Practitioner Information & Advice line

Staffordshire Cares is an easier way to find trusted sources of information and advice for people of all ages in one place through a single telephone number, interactive website and local Access Points

This project extends the use of the Staffordshire Cares telephony based information and advice service offered by the contact centre by targeting practitioners within Primary care and community settings across the County through training and tailored communications campaigns. Supporting the use of one number which in turn ensures consistency of approach and the quality of information advice and guidance offered.

The aim of this project is to give practitioners a "go to" place for non-clinical advice. This is an enhanced offer for healthcare practitioners as a range of digital self-help and advice tools are now available, as part of the Staffordshire Cares "Family", to help identify and provide support with "non-medical" issues which impact on people's health and ability to remain independent. These tools can be used by Staffordshire Cares advisors with practitioners or patients over the telephone (supported Digital) where they are not confident with online resources or if I.T. Literate and keen on self-service, they can advise of the availability of such tools on the Staffordshire Cares website, those most suited to their enquiry and provide advice on how to access them. A follow up call can also be offered to identify where resources have been helpful and identify where additional information and advice may be required. Key resources offered through the Staffordshire Cares Family are:

- **The Staffordshire marketplace -** An online directory of over 1400 local care, support and wellbeing services, activities and events across Staffordshire aimed at the whole family.
- **Ask Sara** – Ask SARA is a guided advice tool giving expert information and advice on daily living equipment for older and disabled people*.*
- **Me, Myself & I -** A fun and interactive game to help people say what is important to you and help you find the information, advice and services you need.
- **Social Care Self-assessment** - Social Care self-assessment/ Eligibility checker to help people understand support needs, information and services available to support with this, potential eligibility for social care support and how to make a referral.
- **Staffordshire's Healthy Hub –** Help to find information, advice and services on improving your lifestyle and create a personalised brochure that people can download, print or email.
- **Equipment & Living Aids Catalogue** – A product showroom which lists equipment and products to meet a wide variety of mobility and daily living needs. People can browse and search for products with an added option to buy direct from the retailers.

These resources can also be utilised by staff on hospital wards as part of discharge planning or in residential and nursing care settings as part of risk assessment/ care planning process to support people to return home from hospital quicker and reduce admissions for example by using ask Sara to identify what people are struggling with then go on equipment catalogue/ marketplace directory to show people

where and how to source items or use daily living fact sheet on Staffordshire Cares to get advice on buying equipment and find local suppliers.

4. As part of the BCF we will be evaluating the impact of these projects and how they could potentially be rolled out across Staffordshire.

3. The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Project Group reports into Programme Board which is a Partnership Board consisting of SCC and SSOTP representatives. The Project Group consists of -

County Commissioner – SCC, Area Manager – SSOTP, Accountable Leads Head of Customer Services, SCC, Operations Manager, SCC, Team Manager, SCC, OT, SSOTP, SW, SSOTP.

Key partners in the delivery projects are:

East staffs CCG – Senior Commissioning Manager, UHNM Trust (Discharge facilitators, Sustainability lead, commercial developments), Burton Hospitals NHS Foundation Trust (Lead Discharge Nurse), Staffordshire University (Research), VAST, Peel Croft Surgery.
Staffordshire Cares/ SCC Customer services

4. The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Learning approach adopted was action orientated and iterative. We agreed to test and learn as we go, with a view to roll/out where success was realised. The approach mitigated a “learning lag” as time was critical to realising performance and financial objectives.

The individual primary and secondary care pilots where developed collaboratively with the participating partners and used as “proof concept” and are being monitored and assessed in terms of both outputs and potential benefits and outcomes by Staffordshire University with the aim of rolling them out to additional primary and secondary care settings across the county.

Staffordshire Cares collects a wide variety of data will regards to call numbers, reasons for call, average length of calls and resulting actions (see attached) which will be used as a baseline for demand analysis on the service post implementation of the targeted communications and training/ briefing sessions with practitioners. Customer feedback and case studies are sought on an ongoing basis to understand user experiences, needs and identify potential gaps in provision. Business design work will be undertaken to understand peak times for enquiries, service capacity issues using call abandonment rates and training needs for advisors based feedback from users and practitioners. Regular Reflection Session were organised to capture, learn from and apply best practice to enhance the outcomes. We adopted a task and finish activity approach for removing barriers to the process.

Before implementing the Pilot analysis was undertaken to review the volume and type of calls in Staffordshire Cares to understand potential impact any proposed model could be.

5. Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
This scheme has an existing budget that is not currently included within the BCF pool.
6. Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Depending on what option is decided moving forward (in addition to the CSF and Measures below) they should reduce the dependency of service users on statutory services, manage demand at an earlier stage and release operational capacity within SSoTP, primary and secondary care by increasing the number of people accessing universal and community services and assistive technology in order to meet their needs and desired outcomes.
7. Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Robust measures were agreed and reporting mechanism in place to track and report against the critical success factors below. Regular “Reflection Sessions” were scheduled with the working group and practitioners within the work area to feedback and collate lessons learnt from the pilot. This was used to evolve and further develop the pilot over the 6 month period.
8. What are the key success factors for implementation of this scheme?

Critical Success Factors for the Project were:

- Reductions in SSOTP of statutory assessments.
- Reduction in hospital admissions
- Reduced length of stay in hospital attributed to IAG/ AT measures in place
- Citizens to remain as independent for as long as possible.
- Reduction in the number of repeat contact.
- Ensuring there is an appropriate response to Safeguarding.
- Citizens have access to AT, Prevention and Reablement without going through a lengthy process.
- Increased use of social capital.
- Ability to identify and feedback unmet need.
- Staff having confidence and clear understanding of what constitutes an appearance of need and preventative approaches

As a result the Project Team was tasked with baselining and tracking several performance measures throughout the Project Lifecycle. The measures agreed at Programme Board were:-

- Number of contacts referred for assessment by financial year end (<6541)
- % of initial contacts deflected to primary and secondary prevention (>66%)
- % of Referrals to SSOTP that end in No Further Action (<25%)

Front door

Milestone	Start Date	End Date
Introduction of Call Back Service within SC	May-15	Jul-15
Scripts strengthened at Front Door	May-15	Jul-15
"Ask Sara" Self-Assessment Tool Live	May-15	Ongoing
E-Marketplace Developed	May-15	Ongoing
OT In Contact Centre	Jun-15	Aug-15
Mechanisms in place to capture active learning via Pilot	Jun-15	Aug-15
Bespoke IAG CRM System Developed	Jun-15	Ongoing
IFA Helpline in place	Jun-15	June 16
Solla Care advice standard achieved (Staffordshire Cares Advisors)	Jun-16	Ongoing accreditation scheme
Professional support embedded in Staffordshire Cares	Jul-15	Sep-15
Pilot underway and impact analysis undertaken	Jun-15	Mar-16
Options paper	Mar-16	May-16
Implementation	Apr-16	Jun-16

Primary and Secondary Care Self-help and independence Pilots

Milestone	Start Date	End Date
GP Pilot	Nov-15	Sept -16
UHNM Long term Care Project (Discharge Lounge Pilot)	Feb - 16	Feb - 17
Burton Hospital – Discharge Liaison Pilot	Feb -16	Feb -17
Pilot Evaluation	Oct - 16	Nov - 16

Roll out of GP pilots to identified Localities	Sept-16	Ongoing
Roll out secondary Care Pilot to remaining settings	Sept 16	Ongoing
Bespoke IAG CRM System Developed	June-15	Ongoing
IFA Helpline in place	June-15	June 2016

Primary & Community Care Practitioner Information & Advice line

Milestone	**Start Date**	**End Date**
Baseline data	Mar 2016	May 2016
Scheme KPI's and Outcome measurements agreed	May 2016	June 2016
Revised SLA in place with Contact centre	June 2016	April 2017
Staffs Cares Advisors briefed and trained	June 2016	ongoing
Pathways created within CRM to track usage	June 2016	July 2016
Targeted promotion/ GP adoption strategy rolled out across all CCG areas	June 2016	March 2017
Targeted Communications campaign	June 2016	March 2017
Business Design/ service capacity work	Oct 2016	Feb 2017
Final evaluation and Recommendations	Feb 2017	March 2017

1. Scheme name

2 – Enhanced community care model

2. What is the strategic objective of this scheme?

Increase independent living & self-management and reduce and shorten hospital admissions by strengthening community based prevention, support, health and care networks. This is complementary in nature to a person-centred model for integrated care and support, based around registered populations and natural communities, which promotes the health, well-being and resilience of local people. The essence of this approach will:

- Improve identification of local populations and their associated profiles allied to health and wellbeing risks.

- Creating efficient and effective interventions and pathways that reduce dependency upon secondary services and keep people's care as close as possible to home. This will include maximising opportunities for Technology Enabled Care Services, utilisation of integrated community equipment services, set within efficient and effective care coordination that promotes choice and control within local community settings.

- Delivering interventions at the right time in the right place by the right skill set, maintaining people at their highest level of independence. Integrated Intermediate Care and Reablement is a cornerstone of care and support that is asset based focused upon realising people's potential for continued independence, either with no support or just enough support to promote continued independence.

- Where people require on-going support due to the long term nature and complexity of their needs, we will seek to further enhance effective care coordination and delivery of provisions. Improve the experience of local citizens and their carers. Improved outcomes for carers will have a positive impact on reduced non elective admissions, delayed transfers of care and admissions to residential and nursing homes.

3. Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Establish new ways of working, united by our strategic objectives, but building on a range of enhanced community care initiatives already in place across Staffordshire. Embracing diverse approaches to different population groups and supporting autonomous working and development of teams, but embedding continuous learning and evaluation within each team, together with robust methods to share learning, understand impact and thereby rapidly evolve enhanced community care across the whole of Staffordshire.

Natural 'communities of care', based on populations of 30-50,000, will be identified across the county around which place based enhanced community care can be developed and delivered. Each team will be tasked to identify the first 200 people with whom they will work to achieve the strategic objectives outlined above. The cohorts may vary from team to team, but each will need to explain their choice and provide a

rationale for their chosen skill and team mix and interventions they then apply to achieve maximum 'added value' and impact on their cohort of people.

System leadership, co-ordination and expertise in learning, evaluation and workforce development will be continuously provided by a central Programme Management Office. A robust business plan and governance process will accommodate a diverse range of activities but effectively hold teams and the system to account for achieving the required pace of evolution and level of impact.

The overall aim of embedding continuous Plan – Do – Study – Act cycles at the heart of team development is to move away from the management of a complex adaptive system in a largely reactive way in which cause and effect, intended and unintended consequences are impossible to determine, towards a complex evolving system where proactive and more predictable change predominates.

In summary our approach will build a holistic local integrated service which is capable of flexing to fully meet the health and social care needs of a local population. The key elements to the proposed approach/model are:

- An integrated core team of health and social care professionals co-located.
- Specialist services available to support the core team to meet individual's needs in community wherever possible.
- Direct partnership work with primary care.
- Closer partnership working with voluntary sector and the local community.
- An emphasis upon the strengths that people have and reinforcing their assets, and critical to supporting self-management with be technology enabled care solutions, integrated community equipment services, access to robust information and advice and services that promote enablement, Reablement and intermediate care to realise and maximise potential for independent living.
- Accurate and up to date information and advice available in a timely manner to aid self-management. This will in turn reduce, prevent and delay the need for high intensity services.
- As indicated above frontline practitioners are charged with fully developing the model by learning what is required to fully meet local need.

Our approach will reinforce a coordinated, complementary and comprehensive model that will afford the following:

- Prevention and self-care – helping people to self-manage their own health and care needs, empower them to make choices about their care and ensure the right services are available to all our communities. This will include making best use of technology enabled care services (TECS) and assistive technologies. This will involve a collaborative partnership approach to making the best use of TECS to support people and their carers recognising the benefits of an integrated approach to implementation at scale and pace. TECS supports our goals to reduce admissions and readmissions to hospital and long term care among older people as well as support to people of all ages to take greater responsibility for their own health and wellbeing and that of their families. We can build TECS into the increased adoption of personal health and care budgets to improve person centred outcomes and support self-care. Assistive technology funding will also continue to support the 'Live at Home' facilities, which allow people to try out assistive technologies through demonstration sites, working with the community groups and provider agencies. In many cases these are jointly delivered with partner agencies, such as local telecare providers, carer support groups and Staffordshire Fire and rescue service.
- Integrated teams of specialist health and social care professionals – teams comprising community

nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, lead psychiatrist, pharmacy, geriatricians, GPs, the voluntary sector and specialists in palliative care and domiciliary care. They will ensure joined up care for service users and patients, especially those who are vulnerable or have complex needs. An example of the joined up nature of services is the integrated commission to provide community equipment services(ICES), which enables health and social care prescribers across all acute and community providers to have access to a catalogue of aids and equipment. They can draw down items suited to support the needs of people who are either finding it difficult to remain living independently at home or who are about to be discharged from hospital. Items may be provided on a permanent basis or for a time limited period to support rehabilitation. The service also offers the potential to support self-assessment by individuals and the deployment of aids and equipment directly rather than as part of a formal assessment of health and social care needs again promoting greater self-management.

- Enhanced community services – for people in their own homes, in GP surgeries and local, community hospitals. The Carers Scheme is part of a range of complementary enhanced community services. At the core of this service is the Carers Hub, which is a one stop shop for carers seeking information, advice and guidance or looking for help and support. The hub is run by People Plus who have a contract with the aim of significantly increasing the numbers of carers receiving support to a minimum of 8000 in the first year. They are able to offer all carers who contact them a universal assessment in line with the requirements of the Care Act. The service is now also able to offer a Personal Wellbeing Budget and this allows carers to access a direct payment to meet their eligible needs when they cannot be met by services already provided. Hub staff have also received training on the benefits of assistive technology and the budget can be used to purchase such equipment. Other commissioned services exist to support carers, this includes crossroads and respite and emergency respite.

- Access into and out of specialist inpatient care – this will see an enhanced approach to step up and step down care and a coordinated Intermediate Care and Reablement tier of support for health and social care needs. There are four elements within the intermediate tier of support for health and social care – Crisis response (health), Home based intermediate care (health), Bed based care (community hospitals/care homes 0 health and social care) and Reablement service (care). Health and social care will work together to ensure that individuals receive a coordinated personalised care tailored to their needs and aspirations to maximise their independence and wellbeing by:

    - Up-skilling frontline staff through training and professional development to take an appropriate and proportionate approach to assessing individual's needs.
    - Enabling staff to help individuals to understand their strengths and capabilities and the support available to them in the community and through other networks and services.
    - Enabling staff to take a positive approach to risk management enabling individuals to take informed risks about how their care is delivered supporting choice and control.
    - Gateway criteria will prioritise intermediate care provision for people based on need rather than diagnostic condition who – are at risk of admission to hospital, which could be avoided through this provision; are at risk od a delay in their discharge from hospital which could be facilitated through this provision; are at risk of admission to a residential/nursing care home; have a health related need and meet the DH intermediate care definition; require a level of intervention that cannot be met by core services; minimises the time that support is offered and will be reviewed in a timely manner.

4. The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Enhanced Community Care programme will be accountable to the Transformation Board, comprised of Commissioner Accountable Officers and Provider Chief Executives. A central Enhanced Community Care PMO will form part of the transformation team and will provide co-ordination, expertise and support

to teams working across the county. The programme will be clinically led by the Medical Director of the Transformation Programme and be clinically assured through the Clinical Leaders group, a formal subcommittee of the Transformation Board. Senior practitioner / manager partnerships from every CCG and Provider organisation involved in the programme will be identified and enabled to work in collaboration and in partnership across organisational boundaries to deliver the strategic objectives employing the new ways of working described above. Commissioners and Providers will be co-responsible for delivery and to ensure an equal working partnership with local authorities, and the voluntary and charitable sectors.

In addition we will develop a high level performance/outcomes framework that will distil key indicators and measures to provide assurance that we are impacting from a whole systems perspective.

A bespoke performance monitoring framework will also be developed for this scheme, data collection methods will be refined in tandem with the roll-out of our data sharing arrangements (overtime our approach will include measurement and comparison of GP attendance, A&E attendances and non-elective admissions, admissions to residential and nursing home care, complementary indicators allied to technology enabled services, assistive technologies, enablement, reablement and intermediate care and carers related support services. In addition we will continue to develop and apply an approach which logs whether/how people's personal outcomes are met, and records user feedback at the end of interventions.

5. The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Right Care Programme

House of Care

5yr Forward View

NHSE quick guide to better use of care at home

Future hospital commission 2013

Monitor 2015. Moving healthcare closer to home: a literature review of clinical impacts

Monitor 2015. Moving healthcare closer to home: implementation considerations.

As part of our vision and approach we are championing new models of care which see services move away from hospitals and provide care closer to home or sustain people independence within their own home. The approach reinforces the following evidence base and are described as follows

- Fully integrated provider of out of hospital care with a clear and robust governance structure and its own organisational capacity.
- Built around the registered list, focused upon population health and self-care, to enable greater scale and scope of service that dissolve traditional boundaries between primary and secondary care.
- Making the most of digital technologies, with joined up electronic health records for its registered populations, risk stratification and patient population's segmentation, and targeted services for different groups of users/patients.
- New skills and roles for multi-disciplinary community teams.
- Based on population sizes of at least 30 to 50,000.
- Carers UK National Carers Survey: The state of caring and Personal social services National Survey of Adult Carers in England. Locally the Carers Conversation led by Health Watch.

6. Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The enhanced Community Offer will involve a stock take of current service operations, understanding and developing improved care pathways that will refocus and redesign community services, as described, but the re-engineering of services will seek implementation of the enhanced community Offer within existing resources, recognising the current financial context. Discussions are in train to understand the financial position going forward.

7. Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The model of enhanced community care will aim to achieve the following outcomes for individuals:
Maximise independence after illness or disability through working within a rehabilitation, Reablement and enablement philosophy to return people to optimal levels of functioning, supporting them to remain at home for as long as possible.

- Enhanced quality of life, supporting individuals to make the most of their capacity and potential.
- Empowering people and their carers to take personal responsibility and agree goals for their period of Reablement/intermediate care.
- Increased self-management/management of conditions with an increased focus on service users strengths and support networks already available.
- Delayed and reduced need for care and support, ensuring people receive tailored support/access to appropriate technologies, in the most appropriate setting enabling them to manage their conditions independently.
- Increased confidence, people using the service given the opportunity to shape their individual support and how it is delivered.
- Increased assurance to carers and families, by a trusted environment for individual enabling them to make informed choices about the care they receive.
- Faster recovery from illness.
- Improved/maintained health and emotional wellbeing through increased independence, choice, control, dignity and quality of life.
- More effective use of resources, ensuring limited resources are targeted at those who need them.

8. Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Continuous feedback and learning will be embedded as described in section 3. Cause and effect in regard to whole system metrics such as admission rates, length of stay, delayed transfers of care and other delays are notoriously difficult to establish, so in addition to monitoring these, part of the learning and evaluation process will involve the development of more meaningful metrics which accurately capture effective admission avoidance activities and improved self-care and self-management.

9. What are the key success factors for implementation of this scheme?

Adequate resourcing of teams and PMO
Effective system leadership to enable strong partnerships and collaboration across the whole system
Effective working across organisational boundaries
Clear leadership and accountability within teams drawn from multiple different employing organisations
Robust work-planning to build in the required time for continuous learning and feedback.
A step change in clinical and care decision making to improve risk management in community settings.

Enhanced community care model

Milestone	Start Date	End Date
Property rationalisation considered across NEB locality for co-location of teams	Feb-16	Mar-16
Task and finish groups identified to enable practitioners to improve integrated working.	Jan-16	Jun-16
Operational delivery groups formed to develop relationships across sectors and start shaping local delivery.	Jan-16	Apr-16
Governance across Staffordshire under the together we're better transformation programme to be confirmed.	Jan-16	Mar-16
Dedicated operational resource secured and in place to provide leadership to social care teams.	Feb-16	Mar-16
Data sharing agreement and memorandum of agreement developed and agreed by partners.	Feb-16	Apr-16
Mapping exercises undertaken to identify baseline information for the locality teams.	Feb-16	Feb-16
Evaluation of Community Wellbeing model and Vanguard sites visited to understand key learning points and consider for the local model and its implementation.	Jan-16	Apr-16
Interdependencies and other key work streams across the local health economy to be understood to enable the models implementation.	Feb-16	Mar-16
Integrated systems, processes and pathways to be developed by practitioners with localities.	Feb-16	Jun-16
Communication and engagement plan considered to ensure key stakeholders are aware of the early implementer sites and the intended outcomes.	Feb-16	Apr-16
Implement new ways of working across the NEB locality.	Apr-16	May-16
Evaluate the learning from the locality prior to considering future commissioning intentions and potential roll out.	Apr-16	Sep-16

1. Scheme name:

3 – Reablement/ intermediate care

2. What is the strategic objective of this scheme?

Effective alignment of intermediate care and reablement across health and social care. This needs to challenge all existing models and consider new delivery vehicles and options.

There will be a model of Intermediate care which will maximise independence, support the recovery from illness and actively enable people to return to optimal levels of functioning. This includes, but is not limited to the treatment and support of people in times of health or social care crisis to avoid hospital admission and to support people following an inpatient episode.

3. Overview of the scheme:

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?
- In the template could you reference where possible how the scheme will help support/align to the enhanced community offer

There are currently four key elements within the intermediate tier of support for health and care needs:

- Crisis response (health)
- Home based intermediate care (health)
- Bed based care (community hospitals or care homes – health and care)
- Reablement services (care)

Staffordshire and Stoke currently have a range of commissioned services that fit within this tier ranging across:

- Step up
- Step down
- Community intervention service
- Living independent services

The current user group is mainly older people with multiple long term conditions, frailty and complex life predicaments who are at a crisis in their health and /or care needs.

After an escalation in health and/or care needs individuals are supported to return to a level of stability achieving maximum possible independence and their wellbeing objectives.

Health and Social Care will work together to ensure that individuals receive a co-ordinated personalised care tailored to their needs and aspirations to maximise their independence and wellbeing by:

- Upskilling front line staff through training and professional development to take an appropriate and proportionate approach to assessing individual's needs.

- Enabling staff to help individuals to understand their strengths and capabilities, and the support

available to them in the community and through other networks and services.

- Enabling staff to take a positive approach to risk management enabling individuals to take informed risks about how their care is delivered supporting choice and control.

- Supporting staff through peer support and having a clear escalation process and access to senior professionals to seek advice to aid their decision making and provide quality assurance.

- Changing the protection culture from one of potential over prescribing which drives long term dependency on services to that of a reablement culture to maximise independence and wellbeing.

Current Financial Recovery Plans and Medium Term Financial Savings plans set out a vision for health and social care to achieve increased efficiency and cost reduction. However, through the delivery of the schemes described within the better care fund, health and social care will deliver integrated pathways of care which will enhance current plans and articulate a shared vision across the local health economy.

If we strip away the segregation of having a health or a care need, we get to an "offer" which requires:

- The rationale of providing a direct alternative to hospital/nursing/residential care by:

    - preventing admission
    - expediting discharge
    - and offering the opportunity for rehabilitation following an exacerbation or crisis.

  Every case should meet this test.

- An immediate response to someone in crisis (which is a health crisis, or an eligible social care crisis) – this needs to be less than 2 hours. Only 10% of people who get this response ever need a hospital admission.

- This response needs to be 7 days a week and offered for extended hours dependant on need.

- Stop providing for people who would otherwise get better on their own; and for people whom the current teams support who do not have rehabilitative potential e.g. long term complex care; maintenance packages of care. The service specification currently under development for this service has been amended to state that this provision can only be used for maintenance packages as a provider of last resort where the provision cannot be sourced from the independent market. There is a domiciliary care project team working up the options for recommissioning of domically care which will take this issue into account in order to free up this capacity for reablement/intermediate care.

- The targeting of people - not an open door. The gateway criteria will prioritise Reablement Care provision for people who:

❖ Are at risk of admission to hospital which could be avoided through this provision.
❖ Are at risk of a delay in their discharge from hospital which could be facilitated through this provision.
❖ Are at risk of admission to a Residential Care Home which could be avoided through this provision.
❖ Have requested an assessment for a Social Care provision, the intensity of which could be reduced through the provision of this service, or no longer required because they are likely to recover during this intensive period of support.
❖ Are already in receipt of Social care eligible domiciliary care, the intensity of which could be reduced through the provision of this service, potential reducing high cost care packages.
❖ Are currently living in a Residential Care Home and who have the potential to return to independent living in the Community following a period of Reablement/ Intermediate Care.
❖ Have a health-related need and meet the DH intermediate care definition :

- "a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admission to long-term residential care, support timely discharge from hospital and maximise independent living".

❖ Are identified as 'end of life' and have an urgent need for short term health or social care. E.g. Intravenous antibiotics for a chest or urinary tract infection to avoid hospital admission or carer breakdown
❖ Require a level of intervention (either in terms of frequency, intensity or complexity) that cannot be met by core services with the overall goal being to prevent admission (to hospital or long term care) or facilitate safe discharge
❖ Minimising the time that support is offered rather than maximising the 6/12 week time limit. Intermediate care offers 13 contacts on average, versus 36 hours of enablement.
❖ Individuals will receive a timely review of their needs to ensure that they are reabled to reach maximum independence, this may result in a reduction of support as independence increases or a level of maintenance support is established.

Although the focus of the Staffordshire BCF submission is the frail elderly population, this scheme will benefit the adult population of Staffordshire.

4. The delivery chain:

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved:

Whilst existing arrangements operate in parallel currently, commissioners will work with providers to ensure the integrated model of care is embedded within practice across all parts of the county. The commissioning organisations will be:

- Staffordshire County Council
- Stafford and Surrounds and Cannock Chase CCGs
- Cannock Chase CCG
- North Staffordshire CCG
- East Staffordshire CCG
- South East Staffordshire and Seisdon Peninsula CCG

Key providers include:

- Staffordshire and Stoke on Trent NHS Partnership Trust
- Primary Care
- GP First
- Voluntary Sector
- University Hospital of North Midlands
- Burton Hospitals Foundation Trusts
- Royal Wolverhampton Hospital Trust
- North Staffordshire Combined Healthcare Trust
- South Staffordshire and Shropshire Foundation Trust

The work would also recognise what's happening with reference to the SSOTP transformation programme – year 2 plan:

- This links to the 'Best value review of social care reablement service' with some already identified expected savings. These two projects have been aligned and will be project managed under one work-stream.
- This work also links to the front door work stream taking place under SSOTP one of the aims is as

follows; Citizens to have access to AT, prevention and reablement without going through a lengthy project. So it would be necessary to ensure that appropriate link exist between services and projects.

- It is also imperative that close links are made to the SSOTP workforce programme in order to ensure the services have the correct staff in place, fully trained to deliver these services.

Delivery of this scheme will be project managed via the SCC Transformation project manager and will incorporate continuous learning.

5. The evidence base:

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Staffordshire currently has an 'integrated' health and social care provider, in the form of SSoTP. However, work by this provider is commissioned separately by health and social care commissioners. There is national acknowledgement that deeper integration of health and social care is required to deliver better outcomes for individuals and deliver the required financial savings for health economies.

The National Audit of Intermediate Care categorises reablement as services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals. Reablement workers support and enable independence with individuals with personal care, with daily living activities and other practical tasks and encourage service users to develop the confidence and skills to carry out these activities themselves and continue to live at home.

A quality, outcome focused reablement service can reduce dependency on social care services. By ensuring more people are enabled rather than being put into long term care services unnecessarily, this will improve outcomes for individuals enabling them to remain/become more independent rather than the current model of dependency on services.

Integration:

- Intermediate care is at the forefront of the integration agenda with the NHS and Local Authorities having worked together to commission and provide intermediate care services for many years.

Patient experience:

- The results showed a very high level of satisfaction with services, and in particular, the proportion of service users who felt they were treated with dignity and respect was more than 89%. 75% of patients reported feeling less anxious as a result of their experiences.

Demand and Capacity:

- There is no evidence in the 2014 audit of a national trend towards materially higher investment levels in intermediate care, although two areas have invested significantly more than average in home based services. Around one-third of home based capacity and two-thirds of bed based capacity is being used for step-down care. In this year's sample, reablement services reported a shift towards step-down care with 44% of referrals coming from acute trusts compared to 35% in 2013.

Use of resources:

- Reablement length of stay remains consistent with NAIC 2013 findings at 32.7 days.

Dependency and outcomes:

- The average dependency level of service users on admission to bed based services has increased. However, the vast majority of service users experience a positive outcome with 92% of service users in home based care and 94% in bed based care maintaining or improving their level of functioning across a range of everyday activities.

The Care Act 2014 requires integration, cooperation and partnerships. For people to receive high quality health and care and support, local organisations need to work in a more joined-up way, to eliminate the disjointed care that is a source of frustration to people and staff, and which often results in poor care, with a negative impact on health and wellbeing. The vision is for integrated care and support that is person-centred, tailored to the needs and preferences of those needing care and support, carers and families. Sections 3, 6 and 7 of the Act require that:

- Local Authorities must carry out their care and support responsibilities with the aim of promoting greater integration with NHS and other health-related services.
- Local Authorities and their relevant partners must cooperate generally in performing their functions related to care and support.
- Local Authorities and their partners must cooperate in performing their respective functions relating to care and support and carers wherever they can.

The Care Act states that "Intermediate care" services should be provided to people, usually older people, after they have left hospital or when they are at risk of being sent to hospital. These individuals do not have to have eligible needs for care and support. Intermediate care should be provided for a limited period to assist a person to maintain or regain the ability to live independently.

Early or targeted interventions such as a period of reablement and providing equipment or minor household adaptions can delay an adult's needs from progressing. The Local Authority (LA) may 'pause' the assessment process to allow time for the benefits of such activities (prevention) to be realised, so that the final determination of need is based on the remaining needs. If the LA believes that a person may benefit from short term reablement services, it may put that in place and complete the assessment following the provision of that service.

Where a person is provided with any type of service, or supported to access any facility or resource as a preventative measure, the LA should also provide the person with information in relation to the measure undertaken. The LA is not required to provide a care and support plan or a carer's support plan ('as per requirements associated with an assessment of need') where it only take steps under section 2 of the Care Act; however, it should consider which aspects of a plan should be provided in these circumstances, and should provide such information as is necessary to enable the person to understand:

  - what needs the person has or may develop, and why the intervention or other action is proposed in their regard;
  - the expected outcomes for the action proposed, and any relevant timescale in which those outcomes are expected; and
  - What is proposed to take place at the end of the measure (for instance, whether an assessment of need or a carer's assessment will be carried out at that point

- The National Service Framework for Older People - DH, (2001)
- High Quality Care for All NHS Next Stage Review Final Report - DH, (2008)
- Focus on: Frail Older People - NHS Institute for Innovation and Improvement (2009)
- NHS & Social Care Outcomes Frameworks

- NICE Guidance and recommended pathways http://guidance.nice.org.uk/
- Map of Medicine pathways provided by the NHS Institute for Innovation and Improvement http://eng.mapofmedicine.com/evidence/map/index.html
- Applicable National Service Frameworks http://www.nhs.uk/NHSengland/NSF/pages/nationalserviceframeworks.aspx
- Applicable recommendations made by Sir Robert Francis QC Report 6th February 2013 http://www.midstaffspublicinquiry.com/
- Intermediate Care – Halfway home - DH, (2009)
- Care Closer to Home/Our Health Our Future review -Lord Darzi report, DH (2007)

6. Investment requirements:

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The intermediate care/reablement scheme will involve a stock take of current service operations, understanding and developing improved care pathways that will refocus and redesign community services, as described, but the re-engineering of services will seek implementation of the enhanced community offer as a key component, within existing resources, recognising the current financial context. Discussions are in train to understand the financial position going forward.

7. Impact of scheme:

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The service aims to achieve the following outcomes for individuals:

- Maximise independence after illness or disability through working within a rehabilitation, re-ablement and enablement philosophy to return people to optimal levels of functioning, supporting them to remain at home for as long as possible.
- Enhanced quality of life, supporting individuals to make the most of their capacity and potential.
- Empowering people and their carers to take personal responsibility and agree goals for their period of reablement/ Intermediate care.
- Increased self-care/management of conditions with an increased focus on service users' strengths and support networks already available.
- Delayed and reduced need for care and support- ensuring people receive tailored support/ access to appropriate technologies, in the most appropriate setting enabling them to manage their conditions independently.
- Increased confidence; people using the service can regain skills they may have lost.
- Increased Choice and Control; people are given the opportunity to shape their individual support and how it is delivered.
- Increased reassurance to carers and families, by providing a trusted environment for individuals enabling them to make informed choices about the care they receive.
- Faster recovery from illness.
- Improved /maintained health and emotional well-being through increased independence, choice, control, dignity and quality of life.

Commissioner outcomes:

- More effective use of resources; ensuring limited resources targeted at those who need them.
- Reduction in long term demand for domiciliary care; fewer inappropriate referrals into maintenance packages.
- Increase in preventative solutions thus reducing the long term cost of health and social care e.g. increased use of Assistive Technologies (AT); improved evidence of AT within support plans.
- Raising awareness and understanding of the benefits of AT to help people self-care.
- Hospital admission avoidance through provision of Step-up care, and assisting hospital discharge through Step-down care.
- Reablement philosophy embedded in care pathways to increase independence and reduce dependency on services and 'delay' the need for care.
- Increased levels of Service User satisfaction, ensuring that people are at the heart of any decision that affects their life.
- Improved performance in relation to:
- Effectiveness of reablement ; outcomes based on evidence of effectiveness
- Prevent unnecessary Emergency admissions
- Enable timely discharge for social care related delayed hospital discharges
- Prevent/ reduce premature admissions to residential and nursing care Shorter lengths of stay within the acute and community trust setting
- Reduced numbers of re-admissions within 30 days for patients

Savings from this scheme would be generated by:

- Increasing effectiveness of services so making sure the services work with the right people at right time and to increase responsiveness to crisis.
- Making sure that the unit cost of the various services is a low as possible making use of integration possibilities and opportunities to outsource provision to independent sector.
- Managing/rationing the demand into the service so it only does what it should be doing –i.e. targeting the right cohort of people at the right time.
- Increasing income from charging users of the service where appropriate; charging for maintenance, and considering social eligibility charging for reablement.
- Reduction in secondary care admissions particularly for ACS conditions

8. Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly monitoring of Key Performance Metrics against agreed targets:

Metrics

• **Decrease in Admissions to residential and care homes**

The rationale of providing a direct alternative to hospital/nursing/residential care by preventing admission, expediting discharge and offering the opportunity for rehabilitation following an exacerbation or crisis.

LGA Adult Social Care Efficiency Programme - Developing more integrated services. Northumberland have saved £5 million through their integrated model of care with Northumbria Health Care Foundation Trust. The approach has seen a 12 per cent reduction in residential care while demand for domiciliary care has been maintained at a constant level despite demographic pressures. Richmond's integrated reablement service has saved £2.1 million over the three years, reducing demand for council services, avoiding admissions to hospital and reducing the length of time people stay in hospital.

• **Effectiveness of reablement - Increase in number of individuals successfully reabled (14/15 outturn – 3,081)**

This tier of response is half the size it needs to be based on national averages and assumptions that 30% of (older) people can be supported other than at A&E, and that 25% of older people admitted could be discharged earlier. This isn't about costing more – it is stopping a higher cost elsewhere in the system, and not providing a response to everyone – especially where the evidence suggests there is no benefit.

The targeting of people - not an open door : who would otherwise need a hospital bed, a community hospital bed, a care/nursing home bed, a high cost care package, and those who meet eligibility criteria (for social care).

- **Decrease in Delayed transfers of care**

An integrated and effective intermediate care and reablement service would add additional service capacity to the community offering the opportunity to expedite more hospital discharges. Agreement on local action plan required to reduce delayed transfers of care.

- **Patient / service user experience - Individuals reporting a positive experience of care**

A new measure of the effectiveness of the service in supporting people to maintain their independence has been added to Domain 2. This measure will provide evidence of a good outcome in delaying dependency or supporting recovery – short-term support that results in no further need for care.

Placeholder measure 2E remains, to support the interpretation of the new measure of the effectiveness of reablement services. This is intended to support a more rounded view of the success of short-term support in supporting people to recover their independence. It has been agreed that it would be most desirable to include a measure which asks those in receipt of short term services about their outcomes, and/or the quality of services they received.

- **Reduced readmissions within 90 days**
  Percentage of Older people still at home 91 days after discharge from hospital into reablement (ASCOF 2B (1) – (14/15 outturn 87.9%)
- **More patients supported to remain at home following a rehabilitation/reablement intervention**
  Older people still at home and needing no ongoing social care services 91 days following receipt of the service. (14/15 outturn 54.8%).
- **Reduced number of individuals receiving intensive care packages**
  Percentage of people receiving reablement where the immediate outcome was no support or low level support (ASCOF 2D) (14/15 outturn 69.1%)
- **Reduced length of stay in both acute and community hospitals**
- **Reduced number of readmissions to hospital within 30 days**
- **Reduced number of secondary care admissions for ASC conditions**

9. What are the key success factors for implementation of this scheme?

<u>What Needs to Change:</u>

There needs to be a whole system culture shift so that asset based assessment, Assistive Technology and reablement/intermediate care are an integral part of the assessment process embedded throughout. This asset based approach, including Assistive Technology will enable people to self-care, without the need for

on-going support. These changes will impact on Social Care staff undertaking assessments and sourcing care packages, therefore staff will need to have the correct process to follow and to feel confident that they can challenge and escalate decisions they think are incorrect.

The main proposal for this tier is that changes are enacted which:

- Target the right people who can recover in the best possible way (outlined in section 3).
- Create a new care pathway for all older people, where support at the least intrusive intervention is a default.
- Within that pathway, implement a Discharge to Assess approach with going home as the default practice. Promoting a "home first" philosophy.
- Introduce "eligibility" for social care support (rather than the current open door approach).
- Stop providing support within this tier for people who will get better, who need long term care or whom do not have current rehab potential anyway; introduce gateway criteria as outlined in section 3.
- Address the misinforming of expectations about what an "entitlement" is and what is "free" across the whole workforce.
- Introduce the appropriate mechanisms to charge for chargeable services and collect the income due.
- Work towards every area offering effective crisis response within 2 hours, across an extended day for 7 days per week which GP's, social care, and ambulance services.
- Structure the intermediate tier as an integral part of new and emerging integrated local teams of multiple practitioners.
- Remove maintenance support from the existing Reablement service; understanding where else this support can be provided for e.g. frameworks, block purchase support, develop care in hard to reach areas.
- Change the length of support from an entitlement culture of 6/12 weeks to a needs led bespoke response per patient/person.
- Quantification of need/demand for specific interventions, as well as sufficient community capacity to accommodate demand.

Reablement/ Intermediate care

Milestone	Start Date	End Date
Financial modelling	Mar-16	May-16
Productivity benchmarking & comparison (KPMG)	Mar-16	May-16
Approval (Programme Board)	Apr-16	Jun-16
Implementation Plan	Apr-16	Jun-16
Mapping As Is - LIS/Cis	Apr-16	Jun-16
Confirm funding streams	Apr-16	Jun-16
SCC advice re period of reablement (6 weeks or 12 weeks)	Mar-16	May-16
Look at best practice	Mar-16	May-16
Remodel reflecting approach to maintenance care	Mar-16	May-16
Option appraisal	May-16	Jul-16

	Approval (Programme Board)	May-16	Jul-16	
	Implementation Plan	Jun-16	Aug-16	
	Procurement Process	Jun-16	Aug-16	

1.Scheme name

4 - Discharge /delayed transfer of care

2. What is the strategic objective of this scheme?

There is an increasing cohort of frail elderly and older people with Long Term Conditions (LTC) including dementia, being admitted to acute facilities. These patients are placing an increased demand and stretch on health and social care services both in the acute and community settings. The complexity of this cohort of people has an impact on timely and seamless discharges across the Staffordshire Health Economy. There is a significant increase in health and social care assessments, delayed transfers of care (DTOC), packages of care (POC) and demand enablement beds both health and social.

The complexity of discharges and longer Length of Stay (LoS) has had a major impact on our healthcare system particularly since January 2016 and a subsequent negative impact on the A & E Constitutional standards. However this picture is reflected across the West Midlands.

There is National evidence to say that older people decompensate on admission and in particular with a longer length of stay. The result of which can lead to the person not regaining their pre-hospitalisation mobility and status resulting in the need a higher domiciliary care package or for a permanent change of residence such as Nursing Home. A good example of this is the case highlighted Nationally of Mrs Andrews story.

The strategic objective of this scheme is to apply the Home First principle which includes:

- Reduction in the number of DTOCS to below the national target of 3.5% where applicable and maintain position in context of unmet need performance. (Current performance for DTOCS in Northern/Stafford is 2.9% Dec 2015 and East 6.0% Jan 2016)
- Develop Discharge to Assess (D2A) pathways
- Improve the Fast Track pathway (patients requiring palliative care)
- Improve discharge process across organisational boundaries with a designated lead for discharge

3. Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The themes of discharge are consistent throughout Staffordshire and in acute trusts over the borders, including delays as a result of patient choice, long waits for assessments (health or social), limited capacity to provide care packages, nursing/residential home placement, housing issues and capacity/availability of community teams.

For Northern Staffordshire/Stafford the delivery of whole system urgent care presents a significant challenge to all stakeholder organisations. The urgent care system has consistently failed to achieve the national target of seeing 95% of patients within 4 hours, with a significant number of 12 hour trolley breaches.

There have been a number of diagnostics undertaken within the health economy to understand the reasons for the challenges within the urgent and emergency care system.

As the A&E trajectory had not been achieved further diagnostics on the system have been undertaken by Dr Ian Sturgess. This resulted in the development of high impact interventions designed to resolve the issues identified in the economy. More recently a system diagnostic by the Emergency Care Improvement Programme (ECIP) has resulted in the following six key priorities being identified:

- Leadership
- MADE
- Ambulatory care
- SAFER
- Therapies
- Frailty and D2A

Working with ECIP all existing plans have therefore been rationalised and a framework developed to deliver improvement across the urgent and emergency care system. The framework for delivery includes assess before admission, todays work today and D2A. This supports DTOCS as part of the unmet demand. A range of schemes have been developed to support with the delivery of the framework with leads and is monitored by the SRG.

For East Staffordshire in September 2015 DTOC performance declined to 10.9% with most of the delays due to social care (77%) and 15% due to health and 8% due to both. A recent West Midlands Quality Review reinforced the view that there is an increasing cohort of frail older people, with comorbidities, including dementia, being admitted to Burton Hospital Foundation Trust. These patients are placing an increased demand on health and social care services in terms of undertaking timely assessments and ensuring that there is sufficient capacity commissioned in the community and independent sector to meet both their simple and complex discharge needs.

As part of a wider Staffordshire system plan to maintain flow an action plan specifically to address DTOC issues was produced following a cross economy workshop at the beginning of November. It articulates how Eastern Staffordshire SRG plan to achieve the 3.5% target by April 2016 which equates to 15 people medically fit for discharges, who are taking up a hospital bed due to delays elsewhere in the system.

The general cohort of the patients this impacts on are the frail elderly and patients with long term conditions who will be the main focus of this scheme.

The objectives are:

- Patients are able to return to their usual residence with or without support
- Improved clinical patient outcomes to include reduction in induced immobility, hospital acquired infections
- Rapid access to rehabilitation (health) beds for intensive therapy input
- Improved patient and family experience – patients are only moved once
- Optimal care to meet the current needs of the patient in a seamless and coordinated manner
- Fewer people accessing long term care
- Improved discharge flow and processes to include integration of teams and a designated lead each patients discharge
- Patients who are at ‘End of life’ can exercise choice and are able to die at home

The Outcomes are:

- Reduction in numbers of DTOC
- Reduction in LoS
- Reduced Excess bed days

- Improved bed utilisation hospital and community
- Reduction in hospital acquired infections
- Improved rehabilitation potential and reduction in decompensation
- Increased number of palliative patients are able to die at home or place of choice

The model of care will be that of 'Home First' and will include the following areas:

- Discharge to assess pathway (D2A) including a Dementia pathway
- Community Rehabilitation – increased capacity and capability
- Redesign of Fast Track discharge pathway/processes
- Redesign of the discharge team model with integration across organisational boundaries
- Improved pathway for patients admitted from Nursing /residential care home to include the 'Trusted Assessor ' model
- Step up/step down – pathway

4. The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Northern (includes South West) Systems Resilience Group (SRG) meets on a fortnightly basis and has members from all key stakeholders from Health & Social Care who oversee the local health economy (LHE) ECIP plan.

Governance Structure

Delivery of their actions is supported through a PMO with a number of specific working groups responsible for the delivery of this scheme across UHNM including both County and Stoke hospital sites. The strategic oversight of the plan is undertaken by the Northern Delivery Group/SRG, the tactical by the Integrated Operational Group and operational by the Delivery Groups. The delivery groups are responsible for work associated with delivering the key priority areas of assess before admission, todays work today and D2A.

Critical Success Factors

For the three priority areas (listed above), 35 critical success factors have been developed. Each action has in place a:

- Accountable Lead;
- Operational Lead;
- Time for completion;
- Metrics to determine impact.

This scheme seeks to reduce the disparity between hospital sites and have an overall model which may have slight differences due to service provision.

Within Eastern Staffordshire a similar structure is in place with the System Resilience Group (SRG) being chaired by the Accountable Officer from East Staffordshire CCG overseeing the delivery of the DTOC plan. A System Resilience Operational Group (SROG) is in place to provide a forum for open discussion and to facilitate collaborative working across the health and social care economy. The SROG reports directly to the SRG and the Chair of the SROG is a member of the SRG.

The SROG has instigated Task and Finish Groups to focus on key pieces of work that would support better flow, address currently issues in the system and provide support to the system. The Task and

Finish Group leads are accountable to SROG.

Key stakeholders include:

- UHNM
- Burton Hospital Foundation Trust
- RWHT
- Staffordshire County Council
- SSoTP
- Virgin Care
- Health care professionals across the pathway
- CCG Directors and Unplanned care leads
- Quality lead

Levels of Discharge and DTOC has a direct dependency on Intermediate Care services (where there is a health need) and/or community social support services (where there is a social care need) therefore this scheme is dependent on/part of Intermediate Care/Reablement Scheme (scheme no. 3).

5. The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

DTOC Roadshows - A total of 8 interventions were outlined to have been developed through last year's Helping People Home team's work, of which "Change 4: Home First/ Discharge to Assess" is a recommendation.

The NHS Outcomes Framework 2014/15

NICE Commissioning guide
Older People in Acute Settings, NHS Benchmarking, April 2015.

Improving Patient Flow, Health Foundation, April 2013.
NHS England (2015) Transforming urgent and emergency care services in England.

Evidence suggests that there is a significant relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity. Gill et al (2008) observed that 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over the age of 80.

Professor Ian Philp has put forward 4 key principles to improve care for older people as follows:

- 'choose to admit' only those frail older people who have evidence of underlying life-threatening illness or need for surgery – they should be admitted, as an emergency, to an acute bed.
- provide early access to assessment, ideally within the first 24 hours, to set up the right clinical management plan.
- 'discharge to assess' as soon as the acute episode is complete, in order to plan post-acute care in the person's own home.
- provide comprehensive assessment and re-ablement during post-acute care to determine and reduce long term care needs.

6. Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The discharge scheme will involve a stock take of current service operations to support discharge, understanding and developing improved care pathways within existing resources, recognising the current financial context. Discussions are in train to understand the financial position going forward.

7. Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Improved patient and family experience
- 'Home First' principle
- Increased number of palliative patients are able to die at home or place of choice
- Reduction in numbers of DTOC
- Reduction in LoS
- Reduced Excess bed days
- Improved bed utilisation
- Reduction in hospital acquired infections
- Improved patient flow across the health and social care system
- Improved patient outcomes as people will be support to access the right care at the right time.
- There will be fewer assessments and removal of duplication within the system
- A reduction in readmissions
- Increased emphasis on re-ablement and rehabilitation
- Improved patient experience and outcomes
- A reduction in need for social care funded long term residential and nursing care
- A reduction in high level of social care packages
- Reduced need / expenditure at Continuing Health Care (CHC) levels.

8. Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

All progress and outcomes of the scheme will be monitored at a project and programme level and reported up to the SRGs until the new model becomes business as usual. The NHS service improvement methodology will be applied and all redesign areas will be tried and tested using the 'Plan, Do, Study and Act' (PDSA) cycle. Where an action or step in the pathway is not working then it will be tweaked as per the evidence gained from the review (PDSA cycle).

Once business as usual activity and outcome measures will be formulated and fed back to commissioners via contract monitoring mechanisms and outcomes reporting.

9. What are the key success factors for implementation of this scheme?

- Improved patient and family experience
- Reduced number of DTOC (to maintain or reduce to the national target of 3.5%)

- Improved Patient Outcomes
- Reduction in LoS
- Increased number of patients discharged to usual residence

Discharge/ Delayed transfer of care

Milestone	Start Date	End Date
Roll out exemplar ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in acute hospitals	Nov - 15	Jan-16
Roll out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in community hospitals	Nov - 15	Jan-16
Roll out Exemplar Ward (safer bundle) principles, where appropriate, in the mental health trust	Dec - 15	Feb-16
Align and improve discharge processes for South Staffordshire patients treated at Royal Stoke	Jan - 16	Mar-16
Plan for discharge within 48 hours for emergency admissions	Jan - 16	Mar-16
To have accurate and timely information related to discharge of patients with complex needs and use it to forward plan	Dec - 15	Feb-16
Establish a multi-agency accelerated discharge team	Dec - 5	Feb-16
Medical ownership of speciality outlier	Sep - 15	Nov-15
Develop 'without prejudice' agreements between health and social care to enable patients to move into a care home placement for assessment	Jan - 16	Mar-16
Work with Care Homes to assess previous residents within 24 hours	Feb - 16	Apr-16
Roll out of trusted assessor model across the health and social care economy	Feb - 16	Apr-16
Develop a single health and social care direction of choice policy	Jan - 16	Mar-16
UHNM will operate 3 community hospitals for step down and the management of patients from admission to final destination	Jan - 16	Mar-16
Reduce the number of care packages held open when people are admitted to hospital	Feb - 16	Apr-16
Increased supply of domiciliary care within North staffs	Dec - 15	Feb-16
Reduce the amount of time taken for residential and nursing care	Dec - 15	Mar-16
Increase capacity in Domiciliary care	Nov - 15	Jan-16

7 Day Services

Assess before Admission

Exemplar Front Door

Aims: To develop a model of care for adults patients who require urgent assessment and possible intervention, which facilitates rapid assessment and decision making at the appropriate stage in the patients journey, rather than defaulting to an emergency admission. Provide immediate assessment intervention from expert team for frailty. Embed and Expand emergency ambulatory pathways designed to avoid admission. Right Care, right time by right person with right skills in right place.

Outcomes: Enhanced patient experience. Seamless pathways which avoid hospital admission. Improved care coordination across all settings supporting right care, right place, right person. Development and enhancement of existing FoH initiatives. Improved patient flow. Improved discharges. Increased transfer to ambulatory pathways. Hot Clinic Provision

Benefits: Contribute to the delivery of A&E 4 hour target. Increased patient satisfaction. Less outliers. Decreased admission rates by age by head of population. Increases number of patient on ambulatory pathways. Reduced conversion to in-patients. Avoid decompensation of patients from hospital admission.

Frailty

Step Up

Ambulatory Pathway

Today's Work Today

Review of cross economy bed based Services

SAFER

Aims: All patient to have a Consultant Review before midday. All patient will have an EDD based on medically suitable for discharge status agreed by clinical teams.
To increase the flow of patients at the earlier opportunity. 33% of patients will be discharged from base inpatient wards before midday. Weekly systematic review of patients with extended lengths of stay.
Outcomes: Structure to the days to day running of the ward. Consistent organised and disciplined approach. Efficient use of time and resources. Care coordinated appropriately. Required capacity created for incoming patients.
Benefits: Improved care coordination and standardisation of approach. Well planned, informed and timely discharge. Less Outliers. Patients will be less likely to be cared for in crowded wards and departments.

Therapies

Aims: Realigning service models. Appropriate therapy resource in the right environment. Reduce the level of decompensation in a bed based service.
Outcomes: Improved patient Flow. Improved discharges. Improve the services provided as part of Assess before admission. Active intervention and reablement reduce decompensation and maximise independence
Benefits: Reduction in NH/RH home placements needed. Reduction in the hours of Dom Care needed. Reduce reliance on bed based services. Increased patient satisfaction. Redirection to lower level of care. Contribute to A&E 4 hour target.

Discharge to Assess

Home First

Aims: Discharge to assess with Home First principles. Reduced impact on independence and future quality of life. Decreased risk of harm.
Outcomes: Enhanced patient experience. Decrease in the number of patients admitted to long term care. Active intervention and reablement reduce decompensation and maximise independence. Improved patient flow.
Benefits: Contribute to A&E 4 hour target. Increased patient satisfaction. Less outliers. Redirection to lower level of care. Reduced LoS. Reduction in NH/RH home placements needed. Reduction in the hours of Dom Care needed. Reduce reliance on bed based services

Step Down

Aims: Address Staff capacity, capability and engagement shortfalls. Create appropriate infrastructure and estate. Embed effective governance and achieve compliance. Achieve quality and safety standards. Meet national performance standards. Achieve financially stability
Outcomes: develop Collaborative working and partnerships. Develop existing community services, Develop seamless integrated services, improve patient experience. Appropriate utilisation of resources.
Benefits: Contribute to A&E 4 hour target. Increased patient satisfaction. Less outliers. Redirection to lower level of care. Reduced LoS

Escalation Planning

Workforce Development and OD

ICT Enabling schemes

Capacity and Demand Modelling

Communications and Engagement

These projects will help with admission avoidance

These projects will help with bed based services sustainability

These projects will help with hospital flow

Assess before Admission

Actions highlighted in pink are actions contributing to the MFFD & DTOC plan

On Track
Off track but recoverable/impact expected but not fully achieved or demonstrated
Off track/impact not realised or not demonstarted

Scheme	Relates to UCRP Action Number:	Critical Success Factors	Accountable Lead	Operational Lead	Short / Medium / Long Term	The Metrics	RAG Time	RAG (Impact)	RAG (Risk)
Exemplar Front Door	**22**	Extend the SPEED Team	Helen Lingham	Gill Adamson	Short Term - 31.03.16	• Reduction of 7 avoided admissions per day from 01.12.15 • Reduction of 10 avoided admissions per day from 31.03.16			
	35	Increase the number of patients conveyed by WMAS to FOH	Paul Jolley	Natalie Cotton	Short Term - 01.03.16	• Delivery of 40 net divert to FOH/UCC per day. Attainment of ED SLA, on a monthly basis		Avg. 42 diversions per week (Q3 Avg)	Capacity for clinical handover
	36	Direct booking in to UCC from the NHS 111 service	Paul Jolley	Tim Jones	Short Term - 01.03.16	• Delivery of 40 net divert to FOH/UCC per day. Attainment of ED SLA, on a monthly basis		Avg. 42 diversions per week (Q3 Avg)	Obtaining formal agreement for implementation
	38	Development of Liaison Psychiatry to 24/7 at RSUH	Sandra Chadwick	Jane Barnes / Ron Daley	Short Term - 30.01.16	• 24 hour access to specialist MH assessment in ED and Acute wards • Effective MH interventions in ED and Acute			
Frailty	**27**	Improve patient experience by changing the pathway for care of the Frail Elderly patients presenting at UHNM	Helen Lingham	Gill Adamson	Short Term - 01.12.15	• AMU transitions direct to Elderly Care Wards • Increased capacity in the ED by 0.5% • 2% reduction in AMU occupancy			
	28	Re-specify the FEAS to provide in-reach to portals	Sandra Chadwick	Dave Sanzeri	Short Term - 11.01.16	• 10% reduction in NEL admission for over 75's Pan Staffordshire (5% for Northern Staffordshire - already delivering some impact) Pan Staffordshire this equates to 5976 NEL reduction (Northern Staffordshire impact 794 and contribute to the avoidance of 4771 NEL) TBC reference to ECIP			
	29	Re-specify the FEAS to provide GPs with a same day / next day service	Helen Lingham	Ian Donnelly	Short Term - 05.10.15				
	30	Re-specify the FEAS to provide GP support for anticipatory planning including Comprehensive Geriatric Assessment (CGA)	Helen Lingham	Ian Donnelly	Short Term - 30.01.16				
	18/20	Expand the Nursing Home project	Sandra Chadwick	Dave Sanzeri	Short Term - 30.12.15	• Reduction in NEL by 520 per year FYE over 38 Nursing Homes			
Step up	**37**	Further increase the clinical portfolio of the FOH/UCC	Paul Jolley	Natalie Cotton	Long Term - 01.02.16	• Increased capacity of the FOH/UCC (quantitative KPIs to be determined)			Procurement timescales and agreeing the agreed option
	19	Implement the specialist Integrated Long-Term Condition Pilot, to establish UHNM as the lead for the community-based integrated Long-Term Conditions service delivered by Specialist nurses under clinical governance of the UHNM consultants	Helen Lingham	Dave Sanzeri	Medium / Long Term - 24.12.15	• Reduction of 1300 NEL admission in 2015/16			
	21	Increase capacity for Step up Intermediate Care	Becky Scullion	Christine Wheeler	Short Term - 30.12.15	• 3009 step up Intermediate Care Packages available FYE in 16/17. Overall step-up/stepdown case load increased to 113 by December 2015 continual review and promotion of service to GPs and Nursing Homes			
	31	Reduce the number of High Volume Users (Frequent Attenders)	Paul Jolley / John Ox	Leanne Sheppard	Medium Term - 31.03.16	• Reduction in 1 NEL admission/ per month / per practice			
	32	Implement a clinical reappraisal mechanism for green ambulance and ED disposition, from the NHS 111 Service	Paul Jolley	Tim Jones	Medium Term - 01.09.14	• Delivery of 84 diversions per week (as reported via the NHS 111 Sitrep) • ED and ambulance dispositions to be maintained at or below the national average on a monthly basis			
	33	Maximise Utilisation of the Walk in Centres	Mandy Donald	Cath Skerratt	Short Term - 31.12.15	• Divert 2-3 patients each day to walk in centres			
	34	Maximise utilisation of step up beds	Kieron Murphy	Lisa Hulme	Short Term - 31.12.15	• Increase referral to step up			
Ambulatory Pathway		AEC Model & Short Stay	Ian Donnelly	Amanda Wilding	Short Term - 19.02.16	• Paper to SRG on 11/02/16			

Today's Work Today

On Track
Off track but recoverable/impact expected but not fully achieved or demonstrated
Off track/impact not realised or not demonstarted

Actions highlighted in pink are actions contributing to the MFFD & DTOC plan

Scheme		Relates to UCRP Action Number:	Critical Success Factors	Accountable Lead	Operational Lead	Short / Medium / Long Term	The Metrics	RAG Time	RAG (Impact)	RAG (Risk)
Cross Economy bed based services	SAFER	**9**	Roll out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in Acute Hospitals	Helen Lingham	Judith Earl	Short Term - 30.11.15	• 50% improvement productive patient days caused by internal delays • Reduction in the number of stranded patients over 70 years 10+ days • Increase in the number of discharges to pre admission place of residence • Achieve 30% of patients discharged before 12:00. Achieve 35% of patients discharged before 13:00			
		10	Roll out Exemplar Ward (safer bundle) principles to identify blocks to effective patient flow for patient with complex discharge needs in Community Hospital	Mandy Donald	Lisa Hulme	Short Term - 30.11.15	• 50% improvement productive patient days caused by internal delays • Reduction in the number of stranded patients over 70 years 10+ days • Increase in the number of discharges to pre admission place of residence • Achieve 10% of patients discharged before 13:00 from identified benchmark			
		11	Roll out Exemplar Ward (Safer Bundle) principles, where appropriate, in the Mental Health Trust	Andy Rogers	Jane Munton-Davies	Short Term -20.12.15	• To reduce the number of stranded patients over 70 years 10+ days • To increase the number of discharges to pre-admission place of residence • To increase the number of earlier in the day discharges			
	Therapies		Review of Therapy service to be undertaken Plan for improvement to Therapy Service's to be developed	Liz Rix	TBC	Short Term - 31.03.16 Medium Term -	TBC			

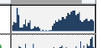
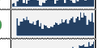
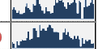
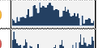
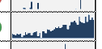
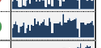
Discharge 2 Assess

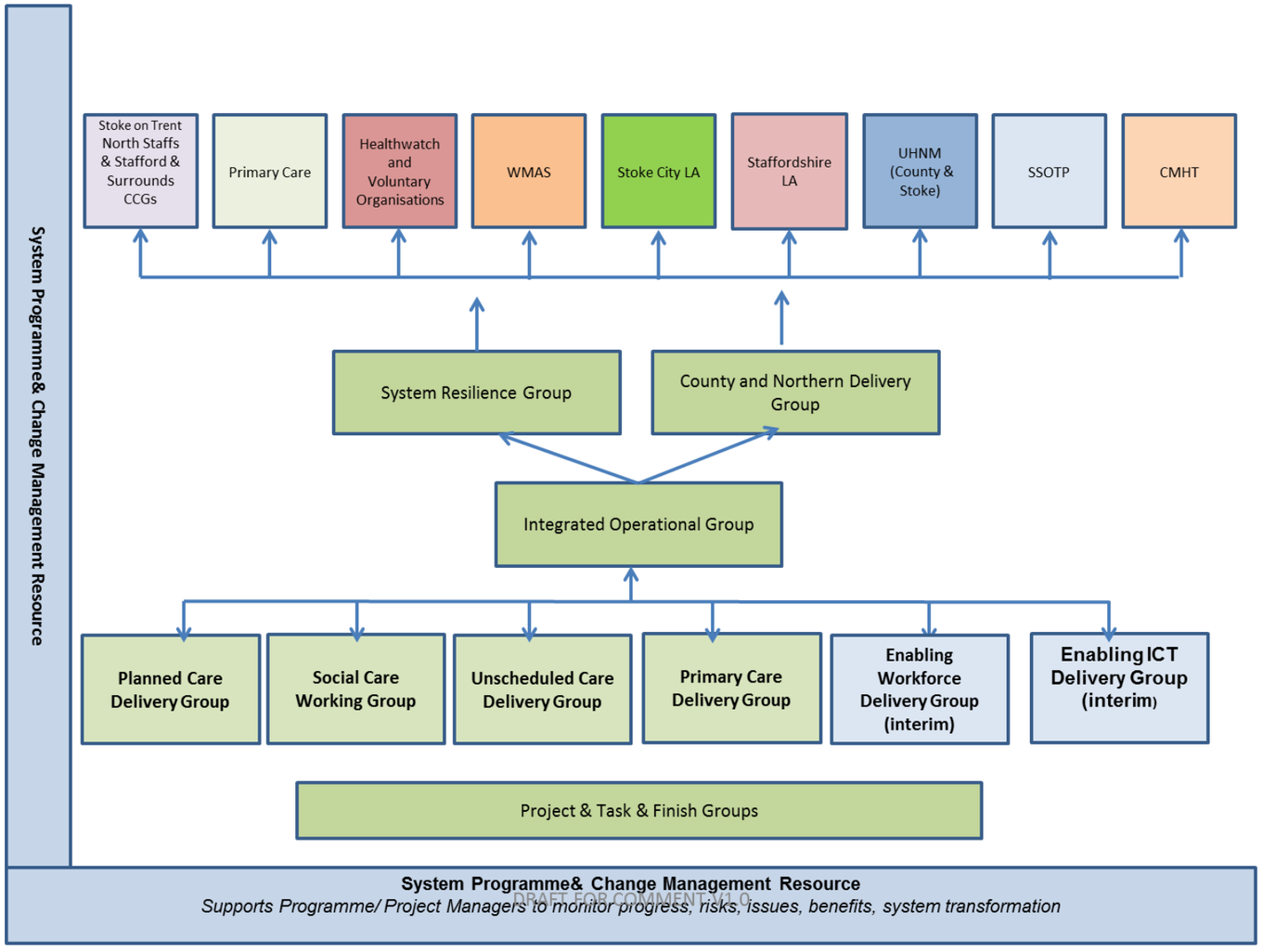
Actions highlighted in pink are actions contributing to the MFFD & DTOC plan

On Track
Off track but recoverable/impact expected but not fully achieved or demonstrated
Off track/impact not realised or not demonstarted

Scheme	Relates to UCRP Action Number:	Critical Success Factors	Accountable Lead	Operational Lead	Short / Medium / Long Term	The Metrics	RAG Time	RAG (Impact)	RAG (Risk)
Home First	**3**	Align and Improve discharge processes for South Staffordshire patients treated at Royal Stoke	Rob Lusuardi / Claire MacKirdy	Alex Bennett / Nicky Cooke	Short Term - 30.01.16	• Monitor Progress and Delivery through DOG and SRG • Pathway Implemented • CIS support in place • Reduction in MFFD and DTOC			
	2	Plan for Discharge within 48 hours for emergency admissions	Helen Lingham	Gill Adamson	Short Term - 18.01.16	• Increase in the number of patients discharged against initial EDD • Discharge plans in notes • Reduction in MFFD and DTOC			
	4	To have accurate and timely information related to discharge of patients with complex needs and use it to forward plan	Gill Adamson	Carla Bickley	Short Term - 21.12.15	• Reduction in MFFD and DTOC			
Step Down	**7**	Establish a multi agency accelerated discharge Team	Gill Adamson	Carla Bickley	Short Term - 01.12.15	• To contribute to the benefits and productivity assumptions detailed in the step down business case • Reduction in MFFD and DTOC			
		Medical Ownership of Speviality Outlier	John Oxtoby	Ian Donnelly	Short Term - 30.09.15	• Reduction in MFFD and DTOC			
	8	Develop 'without prejudice' agreements between health and social care to enable patients to move in to a care home placement for assessment	Dave Sanzeri	Bev Jocelyn	Medium Term - 30.01.16	• Reduction in number of patients having assessment carried out in acute setting by incremental change to be agreed from Jan to March 2015 • Increase in the number of patients having assessments carried out in own home, care home or step up bed to be agreed from Jan to March 2015 • Reduction in MFFD and DTOC			
	12	Work with Care Homes to assess previous residents within 24 hours	Helen Trousdale	Becky Bowley / Bev Jocelyn	Short / Medium Term	• Reduction in LOS in hospital setting • Reduction in MFFD and DTOC			
	16	Roll out of Trusted Assessor model across the health and social care economy	Helen Lingham	Gill Adamson	Short / Medium Term - 27.02.16	• Reduction in MFFD and DTOC			
	17	Develop a Single Health and Social Care Direction of Choice Policy	Sandra Chadwick	Sharon Maguire	Short / Medium Term - 31.01.16	• Reduction in MFFD and DTOC			
	23	UHNM will operate 3 community hospitals for step down and the management of patients from Admission to final destination	Helen Lingham	Gill Adamson	Short / Medium Term - 31.03.16	• 146 Community Hospital beds available from 31 march 2016 • 1405 Step Down Intermediate Care packages available from 31 March 2016 • Reduction in MFFD and DTOC			
	13	Reduce the number of care packages held open when people are admitted to hospital	Simon Robson / Helen Trousdale	Becky Bowley	Short / Medium Term	• Release of Domicillary Care capacity • Number of patients taken out of hospital with enablement packages • Reduction in MFFD and DTOC			
	24	Increase supply of domiciliary care within North Staffs through the	Helen Trousdale	Bev Jocelyn / Rosanne Corran	Short Term - 14.12.15	• Each rota to provide 112 hours of care (inc travel) per week • Maximum number of people in each rota will be 5 at any one time			
	25	Reduce the amount of time taken for residential and nursing care	Helen Trousdale	Bev Jocelyn / Rosanne Corran	Short Term - 14.12.15	• Assessments completed within 24 hours • Estimated could support up to 200 patients to be discharged			
	26	Increase capacity in Domiciliary Care	Simon Robson	Becky Bowley	Short / Medium / Long Term - 01.11.15	• Increase capacity to 1600 hours a week • Support reduction in MFFD and DTOC • Additions 175 hours in CWS per week provided			

SYSTEM DASHBOARD AS AT 06/03/16

Area	Indicator	Target	4 Week Average	13 Week Average	TREND 52 Weeks
ABA - Pre Hospital	NHS 111 calls	tbc	5,610	5,926	
ABA - Pre Hospital	Step-Up Community hospital admissions	19	29	24	
ABA - Pre Hospital	Step Up Schemes to Intermediate Care Activity	38	40	42	
ABA - Pre Hospital	WMAS - Diversions	tbc	359	315	
ABA - Pre Hospital	WMAS - Comveyances	tbc	1,239	1,259	
ABA - Pre Hospital	Care Home Scheme	tbc	4	7	
ABA - ED / Portals	A&E Attendances RS ED Type 1	2275	2,575	2,533	
ABA - ED / Portals	4 Hour % Performance RS ED Type 1 only	95%	65.1%	67.0%	
ABA - ED / Portals	4 Hour % Performance County	95%	83.8%	85.9%	
ABA - ED / Portals	4 Hour % Performance - UHNM ALL Types	95%	77.7%	78.8%	
ABA - ED / Portals	A&E time to initial assessment (95th %ile - minutes)	<=15 mins	39	37	
ABA - ED / Portals	A&E median time to treatment (minutes)	<=60 mins	262	248	
ABA - ED / Portals	Admission Conversion %	30%	35.2%	37.0%	
ABA - ED / Portals	12 Hour Trolley Waits - zero tolerance	0	-	4	
ABA - ED / Portals	Front of House Activity	210	395	360	
ABA - ED / Portals	RAID - A&E Emergency Portal referrals seen within 1 hour		91.0%	92.3%	
ABA - ED / Portals	RAID - Referrals in FEAU, other portals & urgent wards seen within 4 hours		100.0%	100.0%	
ABA - ED / Portals	RAID - All other referrals seen on same day or within 24 hours		95.0%	91.0%	
Todays Work Today - Flow	Number of Emergency Admissions		1,509	1,536	
Todays Work Today - Flow	LoS <24 hours for % of Emergency Admitted patients	30%	41.2%	41.1%	
Todays Work Today - Flow	LoS <2 days for % of Emergency Admitted patients	60%	59.4%	59.0%	
Todays Work Today - Flow	LOS <7 days for 80% of Emergency Admitted patients	80%	82.6%	82.6%	
Todays Work Today - Flow	LOS <10 days for 90% of Emergency Admitted patients	90%	88.1%	88.3%	
Todays Work Today - Flow	Stranded Patients - Non Elective, LOS >=10 days, Age >70	150	237	220	
Todays Work Today - Flow	Occupancy - *Total 3 Bed Pools*	92%	97.2%	95.0%	
Todays Work Today - Flow	Medically Fit (MFFD) Average Daily - Royal Stoke	67	131	119	
Todays Work Today - Flow	Average Days in Hospital (Elective & Non-Elective)	tbc	13.6	13.0	
Todays Work Today - Flow	Community Beds: Number of patients in Beds	258	244	253	
Todays Work Today - Flow	Community Beds: Average Length of Stay	tbc	27	32	
Discharge - Acute	Discharges - PRE NOON	35%	21.6%	21.4%	
Discharge - Acute	Discharges - PRE 4pm	70%	56.7%	57.7%	
Discharge - Acute	Discharges - Home First (back to usual residence) AGE >70	90%	84.9%	85.2%	
Discharge - Acute	Discharges - Complex	215	176	175	
Discharge - Acute	Discharges - Simple & Timely	740	830	817	
Discharge - Acute	Discharges - Emergency Portals		541	546	
Discharge - Community	Discharges - Step Down Intermediate Care Referrals	16	18		



Eastern Staffordshire Resilience Group (SRG)
Delayed Transfers of Care Recovery Plan
March 2016

1. Introduction

A recent West Midlands Quality Review reinforced the view that there is an increasing cohort of frail older people, with comorbidities, including dementia, being admitted to Burton Hospital Foundation Trust. These patients are placing an increased demand on health and social care services in terms of undertaking timely assessments and ensuring that there is sufficient capacity commissioned in the community and independent sector to meet both their simple and complex discharge needs.

The national benchmark for DToCs is 3.5% with a stretch of 2.5%. This plan is part of a wider Staffordshire system plan to maintain flow and has been aligned with the plans of North Staffs SRG. It articulates how Eastern Staffordshire SRG plan to achieve the 3.5% target by April 2016 which equates to 15 people medically fit for discharge, who are taking up a hospital bed due to delays elsewhere in the system.

2. Current Performance and Progress

In September 2015 our DTOC performance declined to 10.9% with most of the delays due to social care (77%) and 15% due to health and 8% due to both. Since September performance has gradually improved. We launched an Action Plan following a cross economy workshop at the beginning of November. All schemes agreed have now been mobilised and the combined impact of these has had a positive impact on our performance.

DToC Performance

Sept 2105	Oct 2015	Nov 2015	Dec 2015	Jan 2016
10.9	8.9	9.0	6.9	6.0

Delayed transfers of care (DToC) have over the last year had a major impact on our healthcare system and BHFT continue to report this has subsequent negative impact on the Urgent Care performance targets, although this is not immediately recognised by patterns in performance.

A&E 4 Hour Wait Performance

Sept 2105	Oct 2015	Nov 2015	Dec 2015	Jan 2016
98.05	95.09	95.16	92.02	89.89

Anecdotal feedback from staff at Queens is that the high volumes of people combined with high levels of acuity may have inadvertently led to improvements in DToC performance due to people not being well enough to be discharged from hospital and requiring a longer length of stay. We continue to monitor this.

Eastern Staffs SRG continue to give DToCs a targeted focus, as we are acutely aware this is subjecting our patients to a sub optimal system.

3. Gaps / Issues

- **Inadequate Social Care Assessment Capacity / Lack of Integrated Working between Community and Acute Teams**

Our assessment capacity is unable to keep up with the number of patients requiring social care assessment. Referrals to the hospital discharge team have grown by 30% in the last 3 years. SSOTP have significantly redesigned how they work and in Partnership with Queens Hospital have reduced the number of referrals requiring higher level of domiciliary care support.

Social Worker representation on Ward Board meetings was not standard on all wards. This leads to further delays in social care assessment, leading to decompensation in some elderly patients who then require higher levels of post referral social care support. Faster discharge planning will reduce length of stay and subsequent high level of domiciliary care support needed upon discharge.

- **Increase in Demand**

The Care Act has potentially increased the numbers of people seeking assessment and the parameters by which assessments take place has changed (Wellbeing now being the primary criteria rather than previous 'substantial/critical criteria') making it more difficult to 'screen out' cases prior to a full assessment. Carers assessments are now mandated post Care Act where previously were good practice only. The Care Act means that weekends are in scope for DTOC reporting.

Changes SSOTP have put in place with partnership with Queens have put further demands on social workers time, e.g. to attend ward boards. This is the right thing to do but takes more time out of the working day.

Not only has demand grown but complexity has also increased including

- Patients with safeguarding concerns
- Patients who are homeless
- Patients who do not have capacity to make their own decisions

- Patients who have not been in receipt of any care prior to admission/not known to services presenting with complex needs
- Patients in need of a full statutory assessment for long term residential/nursing places

- **Insufficient Brokerage**

Sourcing care packages in a timely fashion is a challenge. The Social Care broker only brokers domiciliary care for clients eligible for social care funding of care. Currently Care Home Select has been providing brokerage support for self-funders and for supporting family choice of residential/nursing settings. Brokerage is largely a 5 day week function.

- **Inadequate Domiciliary Care Provision, particularly in Certain Areas**

The available of Staffordshire County council have reviewed our social care provision and provided an 8% increase in provision with 10 additional providers on their newly launched framework. This additionality has however not resolved the issues around sourcing domiciliary care in certain "hard to place areas". The community provider report that this is due to the opening of major supermarkets which has had an impact on availability of domiciliary care workers in these areas.

Our community provider report that their re-ablement teams are blocked by people being supported at home while awaiting longer term packages of care.

- **Inefficient Assessment/discharge pathways**

There has been no discharge to assess pathway implemented in this economy. Members of the SRG are in agreement that we need to move towards a discharge to assess model..

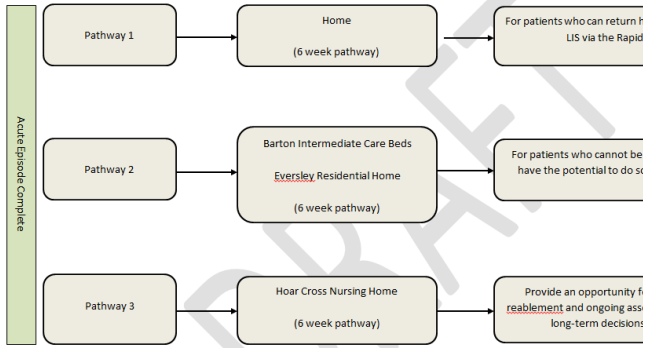
4. <u>Updated Action Plan March 2016</u>

The schemes implemented from the November cross economy workshop have been mobilised and have had significant impact, however, to maintain continued improvement we have identified, agreed and commenced to mobilise new work streams.

Ref	Scheme	Anticipated Impact (1-5)	Implementation Date
1	**Planned Discharge from Admission with Clear Clinical Plans** Over Christmas we commissioned an independent review of discharge processes	**4**	**Commenced 20th Feb – Planned completion 30 April 2016**

	and pathways which has led to further work on refining discharge pathways. Allocated Social Worker on all Ward Board meetings is now becoming standard in addition to the therapy input. This is constrained by capacity challenges described above. This is facilitating more proactive discharge planning as standard practice on wards where this has been implemented. We are focussed on developing proactive management of ward board rounds with full engagement by all partners, agreeing who is responsible for specific actions and making decision on the process and timing of discharges and transfers. The implementation of CRU software on all boards at SSoTP will further support the transformation of ward boards. This has been further supported with the implementation of the discharge coordinator role. We are ensuring patients and carers are involved at all stages of discharge planning and that they are provided with information to enable care planning decisions and choices to be made. We are also developing community discharge pathway on a page to include out of areas patients. Further supporting this is “Home First” training which is being led by our Community Provider. Uptake of this training has been low to begin with due to increased demand and capacity of ward staff, however, we aim to improve this.		

	This model is implemented in some wards and is being replicated across the whole of the Trust.		
2	**Early Senior Review** BHFT have been using SAFER working however over Christmas the independent review of processes and pathways found that this best practice was not standard on all wards. We identified 1 ward who had senior clinician leading ward board meetings, and their meetings always had social care and therapy representation. We are now using this as best practice model for the rest of the trust (this is part of the work described in 1 above).	**4**	**Commenced in January, Roll out will continue into April and May 2016**
3	**Move out When Medically Optimised** We have mobilised pilot Discharge to Assessment pathways. This work has been shared with Virgin and the wider Staffordshire economy to ensure alignment with longer term and larger scale plans. The 'enhanced discharge pathway' will focus on Ward 20, Queens Hospital site. The 8am ward 'board round' will be supported by a Rapid Discharge Assessor and social worker who will, with the agreement of the nursing and therapy team, identify those patients who are not yet ready to be discharged directly home but who have the potential to do so if given additional rehabilitation and support by the LIS Team. The prominence being on identifying these patients 'up stream', proactively manage the	**5**	**Planned mobilisation by 21st March 2016.**

	patient pathway to facilitate a more timely discharge and reduce inter-ward transfers. This in turn would improve patient flow, patient experience and support the ward staff in their decision making about availability of services in the community.  This work is aligned to Virgin Care plans who are working with us to mobilise this as a pilot in the short term, which is in line with their longer term plans.		
4	**Coordination and Improved Flow** a. SSoTP have a single point of access which currently - Takes all referrals from Queens for patients who need a District Nurse on discharge to try and reduce the number of cases where receipt of referrals were delayed or omitted on discharge - Providing rapid assessment for social	**4**	**SSoTP SPA mobilised November 2015.** **Virgin SPA planned mobilisation May 2016**

	care needs for people in the community – with a view to preventing crises and maximising independence. Virgin Care's clinical design centres on care coordination for high risk patients which include co-morbid, frail and frequent admissions. Work is on-going with SSoTP and Virgin Care around how integrated points of access may work in the future. Care coordination is an assessment-based approach to integrated health care in which an individual's needs are assessed, a comprehensive care plan is developed with the patient defining their own outcomes, and services are coordinated and managed by skilled case managers. Particular emphasis placed on reducing unnecessary hospital attendance and admission, and on accelerating discharge. The care coordination 'hub' also acts as a single point of access for clinicians and patients requiring help. Services provided by care co-ordination are:		

	• Service “orchestration” with single point of contact for patient and clinicians • Patient-centred care plan coordination post ALL care encounters for high risk patients – to ensure timely scheduling and order completion for tests, procedures, and medications, including arrangement of transportation and health coaching • Admission and discharge notification and transition planning with GP and community-based providers to ensure care plan continuity • Redirection to urgent care where appropriate • Access to rapid assessment and services in the community • Community-based diagnostics and testing (improved experience & adherence) • Remote monitoring of activity, vital signs, symptom tracking and social and environmental factors in the home • Outcome measurement • Centralised scheduling and registration (long term goal) b. We are improving communications with and referral to patient's identified community pharmacy to access services		

	such as Medicines Use Review or New Medicine Service to both support immediate medication needs and ongoing Medicines Optimisation. c. We are currently promoting the use of assistive technology with discharge teams. To further support this our patient transport provider are engaging handyman ACA's and stocking some standard daily living aids such as grab rails, coded lock entry etc. This means that people who require patient transport and who would benefit from aids and adaptations will receive these sooner. Discharge teams will engage with the patient transport provider to advise which patients will be going home that require additional assistance ie changes to their home or extra care. The transport provider will then ensure ACA Handymen is on board with the required aids when the patient is collected from hospital. The ACA handyman is then dropped off with the patient and remains in their home for that first vulnerable hour (Or SO) during which time they fit the various living aids and ensure the heating is on the patient had a warm drink and food and is settled in and understands how to use their new equipment and is comfortable with it. Once clear they radio back in to base and make themselves available for their next job.		

5. High Level Performance Trajectory

We have kept our trajectory which was agreed in November 2015 as we have maintained this in December and January.

DToC Target	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April
3.5%	7.5%	7.0%	6.5%	5.0%	3.5%