High impact change model – managing transfers of care between hospital and home Appendix 1e

Background	The Government's mandate to NHS England for 2017/18 set a target to reduce the national delayed transfers rate to 3.5% by September 2017. A delayed transfer of care is where a patient is ready and safe to leave hospital care, but is unable to do so, and remains occupying a hospital bed. This is detrimental to the patient and impacts adversely on the health and care system flow and efficiency. The high impact change model includes eight system interventions with the greatest impact on reducing delayed discharges. Central Bedfordshire population has a broad patient footprint using up to seven hospitals in surrounding local authority areas, none of which are situated in the Central Bedfordshire boundary. This makes the transfer of care from hospital to the community complex and involves liaison with a number of different systems and A&E delivery boards. In 2016/17 Central Bedfordshire saw an overall increase in DTOCs, a deep dive analysis was undertaken and highlighted that the two most significant reasons for delay were waiting for further NHS non acute care and patient choice. Two discharge workshops have taken place with stakeholders and a self assessment against the eight high impact interventions has been completed. This work has identified areas for improvement in the transfer of care process, including redesign and integration of services and the need for investment to provide additional capacity and support new ways of working.			
Objectives	To develop process, systems and models to deliver the 8 high impact interventions and reduce delays in transfers of care between hospital and home. To improve patient experience, maximise patient outcomes and support people to remain independent in their own homes by ensuring people do not experience delays in discharge from hospital. To provide a consistent and equitable discharge service to all Central Bedfordshire residents whichever acute trust they use. To reduce avoidable re-admissions by providing integrated health and social care services on discharge and community multidisciplinary team working.			
Scope	Within Scope	Discharge pathways from all acute and community trusts treating Central Bedfordshire patients.		
	Outside Scope			
Constraints	Co-dependencies with partner organisations across the system required to support implementation The STP is responsible for the development of integrated care records and sharing agreements across the health economy Approval of funding			
Assumptions	Partner organisations and stakeholders will engage and commit to delivery of the 8 high impact change model.			
Risks	• Securing funding for primary care home model • Availability and capacity of workforce resource across health and social care • Stakeholder buy in.		Mitigation	• Application for funding made to CCG • Stakeholder engagement

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Deliverables	• Early discharge planning – additional social workers in post to facilitate an improved discharge process from all acute trusts used by Central Bedfordshire patients. • Systems to monitor patient flow – implementation of local tracking system to monitor DTOC and ensure early escalation of patients experiencing delays. • Multi-disciplinary/multi agency discharge teams, including the voluntary and community sector – Integrated health and social care discharge service established providing a single assessment process. Rehabilitation and reablement teams provide an offer of integrated intermediate care. • Home First/Discharge to Assess – agreement of a model to ensure assessments take place in the community rather than in the acute trust. An increase in community capacity is in place to support the model. • Seven Day service – trusted assessor model agreed and Implemented to support seven day discharge. • Trusted Assessor – Trusted assessor roles established for care homes and for intermediate care. • Focus on Choice – Further analysis on the reasons for delays associated with choice and an action plan to address these. • Enhancing health in care homes – an action plan agreed to deliver enhanced care to care homes to reduce avoidable hospital admissions and improve patient outcomes, including: complex care support, trusted assessor, medication reviews, Geriatrician support to GPs, implement red bag initiative, involvement in STP digitisation in Care homes, improved training offer to care homes, well being programmes in care homes.	
National Conditions	Protection of social services Out of Hospital Services High Impact Change Model to reduce transfers of Care	National Metrics Non elective admissions Delayed Transfers of Care Rehabilitation and reablement Reducing permanent admission into residential care