Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board:	Rotherham

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including:

- Current performance issues to be addressed
- The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan
- Anticipated improvements from this work

The project to integrate the health and social care discharge team has been completed. 27 discharge destinations have been streamlined into 3 pathways, discharges home for over 65s have increased by 4.04% and DTOCs have been consistently reduced to below the national average. It is estimated that c £0.5M of acute bed days have been saved and that the introduction of a new single electronic referral process saves c 30 minutes per patient, which can now be spent on care. DSTs are now all carried out outside of the acute setting. A weekly hospital wide review of stranded patients has been introduced, based on the Emergency Care Intensive Support Team (ECIST) model. The integrated team won a national Health Service Journal award for value for money. There remains some performance variation and seasonal spikes through the year. In order to embed the change and continue to reduce DTOCS, we are reviewing the Integrated Discharge Team, with the aim of implementing a fully funded 7 day service in 2019/20. As part of the Rotherham Place Plan, intermediate care pathways will be streamlined from 7 to 3, with home based care as the default pathway. The new model will have an integrated leadership structure, enabling end to end management of patient flow starting with early discharge planning and management of patient transfers from acute discharge, through community beds (where appropriate) and back home. This will ensure that patients receive the right level of care for them and that processes are streamlined to speed up transfers and reduce duplication and gaps resulting from previous siloed working. A new therapy led community unit with nursing offer, within the independent sector, will bridge the gap for patients who do not require consultant led care, but still require some medical intervention which cannot be met at home.

Achievements within the Enhanced Health Care in Care Homes domains over the last 12 months include working to embed pharmacy teams into the health and social care system to support care homes and their residents with medicines optimisation, relaunch of red bag system to improve communication between care home and hospital, development of an integrated health and social care training offer to support workforce development, in particular on areas such as hydration, nutrition, diabetes, respiratory, dementia, pressure areas and oral health. Apprenticeships for trainee nurse associate are also being offered by South Yorkshire Region Excellent Centre (SYREC) to improve recruitment and retention of staff and development of career pathways. A community physician working with care homes will support delivery of enhanced case management for those identified as at risk of attending/admission to A&E. All care homes are now registered on the NHS Capacity tracker system which provides regular ‘live’ updates on information, including current bed vacancies, placement costs, location, contact details and CQC ratings. The portal assists practitioners to identify where available placements are and provides coordinated data in one place and supports hospital discharge planning. All care homes are now registered on the Data Security and Protection Toolkit and NHS mail system to ensure secure and efficient communication between organisations e.g. hospitals, GP practices, pharmacies and care homes so that patient data is shared safely. Hospice at Home Care Home Pilot has now been extended until 31.3.20, which addresses both immediate advice and rapid response in emergency situations and the provision of education and supervision of front line care and residential home staff. Rotherham Health App has been developed which enables patients to make on-line GP appointments, view their records and order repeat medication. Carers can be given "proxy" access for the people they care for, to enable them to make appointments and request medication on their behalf. There is the potential to give care homes a dedicated portal to manage their residents and this would allow them to see discharge letters. CCG/BCF funding is continually provided to support the GP Local Enhanced Service (LES), Care Home Support, Advanced Nurse Practitioner, Mental Health Liaison Team and Clinical Quality Advisor to reduce emergency hospital admissions and improve quality standards. Rotherham CCG are currently considering the implementation of Extension to Community Healthcare Outcomes (ECHO) project in 2019/20 which aims to make specialised medical knowledge accessible wherever it is needed, placing local clinicians together with specialist teams at academic medical centres in weekly virtual clinics or tele-ECHO clinics. It also has the ability to release staff to attend training courses by remotely educating staff, reduces variation in training and supports the education of care home staff through distance learning.

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	**Early discharge planning**	Established	Established	
Chg 2	**Systems to monitor patient flow**	Mature	Mature	
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Exemplary	Exemplary	
Chg 4	**Home first / discharge to assess**	Mature	Mature	
Chg 5	**Seven-day service**	Established	Mature	
Chg 6	**Trusted assessors**	Mature	Mature	
Chg 7	**Focus on choice**	Established	Mature	
Chg 8	**Enhancing health in care homes**	Mature	Mature	