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 High Impact Change Model (HICM) project was established to develop integrated health working between health and social care, to reduce DTOC rates and bring in line within the national average. This was incorporated into the Rotherham Integrated Health and Social Care Place Plan to ensure strategic commitment and cross organisation governance. The project reported into the Urgent and Community Transformation Group on a monthly basis and Rotherham Place Board which are held every 6 weeks. The project report is also submitted to monthly Foundation Trust's transformation group and is now regularly monitored through the Foundation Trust's performance team and is built into the Meditech system which is received weekly. 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	The Foundation Trust is implementing the Safer Patient Flow Bundle and Red2Green principles across all ward areas. Rotherham has participated in the next cohort of the SAFER/Red2Green collaborative run by NHS Improvement (NHSI). A dashboard is being developed to support this with key metrics included. These focus on pre-noon discharges, % of patients with an expected discharge date (EDD) and length of stay.

Chg 2	**Systems to monitor patient flow**	Mature	Mature	All length of stays over 21 days are reviewed through a weekly cross system Multi-Disciplinary Team, based on Emergency Care Intensive Support Team (ECIST) model. Follow up escalation meetings are also held on a weekly basis and are chaired by the Deputy Chief Operating Officer. Delayed Transfers of Care are monitored through the Hospital Trust's performance meeting.
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Exemplary	Exemplary	Phase 1 is now completed which includes the establishment of an Integrated Discharge Team (IDT) which includes nurses, therapists and, social workers and the role of trusted assessor. End of project evaluation has been conducted by the CCG. Phase 2 is now underway. The intermediate care and reablement project will review how acute and community discharges are integrated into 3 integrated health and social care pathways where home is the default pathway. Where a community bed is unavoidable, IDT with in-reach from locality teams for people that are already known to the service will be responsible for timely discharges, thereby managing the whole of the end to end process for the first time.
Chg 4	**Home first / discharge to assess**	Mature	Mature	This is a Key Performance Indicator for the IDT which is based on the ethos of Why Not Home, Why Not Today? This is monitored by the Hospital Trust's performance team and a performance measure which is monitored by the Urgent and Community Transformation Group and Place Board. This will form part of the divisional quality performance management system and also contributes to the BCF metrics of % of older people discharged home from hospital who are still 91 days.
Chg 5	**Seven-day service**	Established	Mature	The IDT including therapy, nursing and social work staff who takes charge of discharge planning for those patients with complex needs who require co-ordinated care and support to return home. The team provide a 7 day service.
Chg 6	**Trusted assessors**	Mature	Mature	A trusted assessor model has now been embedded within the IDT, which will be further developed through the new Intermediare Care and Reablement project and will be monitored by the Urgent and Community Transformation Group.
Chg 7	**Focus on choice**	Established	Mature	A new Patient Choice policy has been drafted and will be circulated in October 2019. This procedure will be implemented once agreement has been reached by all key stakeholders.
Chg 8	**Enhancing health in care homes**	Mature	Mature	Achievements in Enhanced Health Care framework narrative is included in Tab 7 – HICM, Row 11.