Refreshing the High Impact Change Model for Managing Transfers for Care

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Refreshed high impact change model for supporting discharges

- The model is a good practice guide, identifying changes that the evidence shows can help systems to improve discharges from hospital
- It can be completed as a self-assessment by any size of system
- Widespread consultation last year found the model generally positively received by systems as a useful tool to support improvement
- Changes requested include greater clarity and guidance on what each change means, a strengthening of focus on the person, and greater emphasis on the key Home First policy
- Also… to extend scope to housing issues, and admission avoidance
- Input from Think Local Act Personal’s national coproduction advisory group, including helping to develop a public-facing version
The nine High Impact Changes

- Early discharge planning
- Monitor and respond to system flow
- Multi-disciplinary working
- Home First
- Flexible working patterns
- Trusted assessment
- Engagement and choice
- Improved discharge to care homes
- Housing and related services

Effective referral processes and good services which maximise independence are in place to support people who have no home, or cannot go straight home. The need for safe and accessible housing, housing and related support services, home adaptations and equipment are recognised early in discharge planning and readily available when needed.

Making it Real…

I live in a home which is accessible and designed so that I can be as independent as possible.

We have conversations with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments.
<table>
<thead>
<tr>
<th>Systematic response, and demand/capacity</th>
<th>Not yet established</th>
<th>Plans in place</th>
<th>Established</th>
<th>Mature</th>
<th>Exemplary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing and homelessness issues are not considered as part of a discharge support strategy.</td>
<td>Responses to housing issues and homelessness are usually discussed during ward rounds.</td>
<td>Staff have clear guidance which they routinely use to inform referrals and advise people and their families.</td>
<td>The impact of housing and homelessness issues on discharge and people’s outcomes is understood and used to improve them.</td>
<td>System planners use demand, capacity and impact data to improve support, so as to avoid delays because of housing needs or homelessness.</td>
<td></td>
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<tr>
<td>Early needs assessment and response</td>
<td>Housing status and support needs are not part of the admission checklist.</td>
<td>Amendments to the checklist are proposed/being considered.</td>
<td>A person’s housing status and support needs are routinely noted on admission and where needed acted on during their hospital stay.</td>
<td>A person’s housing status and support needs are part of a wider housing needs assessment on admission, with support put in place, including temporary accommodation if necessary, by expected discharge date.</td>
<td>There are no delays caused by not knowing a person’s housing status or acting on their support needs.</td>
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<tr>
<td>Integration/joint working</td>
<td>Service response is slow, disjointed or unavailable, causing delays.</td>
<td>Links between housing and discharge teams are being planned.</td>
<td>Discharge services have a named housing link, and there is regular contact between services/staff.</td>
<td>Housing staff are part of discharge support services, and good working relationships across the system are reducing delays or problems.</td>
<td>Joined-up services deliver timely, person-centred support which maximises recovery and independence.</td>
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<tr>
<td>Home adaptations, equipment, telecare and health</td>
<td>Staff are not aware of available services.</td>
<td>A stock take of available support is being undertaken.</td>
<td>Discharge services know what is available and routinely access in good time.</td>
<td>Support is quick and easy to access, and is delivered promptly, avoiding discharge delays.</td>
<td>Support is integrated with related services, delivered 24/7, and using streamlined practices such as trusted assessment by discharge teams, resulting in no delays.</td>
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Change 9: Housing and related services

Key points

• Early discharge planning includes a person’s housing situation or needs
• Include housing/housing service provider(s) as real or virtual member(s) of your discharge planning team
• Communications and collaboration – working together
• Fix it now
• Inform your workforce – educate them about options, beyond aids and adaptations
• Consider the role of the voluntary, community and social enterprise sector in support people to get home, and access support in their community
• Short-term accommodation, such as step-down, can be appropriate where a person is ready to go home but their home is not ready
• Use data to understand demand for, and capacity of housing services
Some good ideas…

- Knowsley Centre for Independent Living
- Leicestershire’s Lightbulb service
- Wirral’s care home tele-triage service
- Nottingham Housing to Health
What support is on offer?

• Support to develop the HICM as a whole model, or to assess, progress or implement individual changes

• Peer reviews:
  – Collaborative, peer-led reviews to assess strengths, challenges and progress, and identify next steps

• Bespoke support:
  – On-site support challenges around the interface with hospitals including delayed transfers of care
  – Facilitated sessions to progress integration ambitions

• National resources:
  – Events, masterclasses, guidance, case studies and good practice tools
A new tool on reducing preventable admissions to health or care settings
Why develop a tool?

1.5m people could have avoided an admission...

26%... 24-40%... opportunities missed to avoid admission

87% increase in number of older people with social care

Strong interest from colleagues

Issac’s story
What tool do we want to develop?

• It will be a good practice tool:
  • Practical examples that will help systems reduce preventable admissions to health or care settings
  • Focused on supporting systems to provide the right care in the right place at the right time
  • Equally covering health and care interventions – including housing and wider public services – and applicable on any footprint
  • A self-assessment for improvement, not performance management

• The chosen interventions will be:
  • Whole-system
  • Evidence-based
  • Person-centred
  • Strengths-based

• Jointly being developed by the LGA, and NHS England and Improvement, with input from wide range of partners
What will the tool cover?

• Centred around points where appropriate support and interventions could avoid a preventable admission:

  Maintaining health and wellbeing  At risk or entering a crisis  At or close to the point of admission

• We have divided the possible themes into five areas:
  1. Know your populations and data
  2. Empowering the individual
  3. Collaborative problem-solving
  4. Community crisis and short-term responses
  5. Technology and medicines
Today’s discussion

- Across the five themes and three points of intervention:
  - What does “good” look like?
  - What are the critical success factors?
  - What examples of good practice could we include?
  - What tips for success should we include?
  - Are there any resources or guidance we can include or signpost to?