Appendix C – High Impact Change Model for Managing Transfers of Care

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***

A fully integrated LLR-wide action plan is in place for the delivery of the HICM, led by the multiagency LLR Discharge Working Group (DWG). The Leicestershire BCF plan provides 0.5wte project management resource into the DWG to support the coordination, delivery and reporting/assurance process associated with the HICM.

The HICM drives the prioritisation of hospital discharge investments within the Leicestershire BCF/IBCF and is delivered through the action plan led by the DWG. The Leicestershire BCF/ IBCF expenditure plan also includes mapping of specific investments to the categories of the HICM for ease of reference.

The following priority areas for 2019/20 have been identified via the Q1 review of the DWG action plan, and are targeted activities to remaining areas of DTOC concern/HICM delivery.

- Awaiting assessments in mental health – MHSOP and AMH
- Roll-out use of D2A beds for MHSOP
- Care homes bed capacity tracker
- IAG for Self-Funders
- Trusted Assessor for Care Homes – EMCARE worker
- Social Care Assessment beds
- Expansion of the HET service
- Learning from developments of Integrated locality commissioning pilot site at Hinckley and Bosworth focusing on unsupported discharges

At the end of the 2018/19 financial year, 'seven-day services' was assessed as 'Plans in Place' against the HICM framework. In Q1 of 2019/20 this progressed to established due to recent MADE events and improved discharge planning and further investment in provider pick-up times for domiciliary care.

All eight high impact changes are therefore now assessed as Established, with the exception of Focus on Choice, which is assessed as 'mature'.

Additional Adult Social Care funding has been recognised as making a positive contribution to the progression of delivery of the HICM with all eight areas scheduled to reach maturity by the end of the 2019/20 financial year. For 2019/20, this has been concentrated in areas that require improvement and are detailed below:

- Multi-disciplinary teams: 100k to support additional social care link-workers in community hospitals and out of county hospitals. This work has contributed to this change reaching the 'mature' assessment within Q1, 2019/20.
- Trusted assessors: £70k to procure Trusted Assessors, in conjunction with EMCARE, to provide support to care home providers. This will reach 'mature' within Q2 2019/20

- Focus on Choice: £30k to support the development of the information and guidance offer for self-funders.
- Enhancing health in care homes: £50k to support a Project Implementation lead; working with the care home provider market to determine needs across LLR. This includes supporting homes to manage complex dementia patients and investigating electronic solutions to care. This will contribute to this high impact change reaching 'mature' status in Q2, 2019/20

Further to the above, there has been significant progress made to further embed the Enhanced Health in Care Homes programme. The Care Home Sub Group (CHSG) has been refocusing and strengthening LLR's programme of work under the national Enhanced Health in Care Homes (EHCH) agenda.

Improvements have been made in the following areas:

- Increasing the take-up of digital communications tools by care homes, enabling improved care by increasing their direct access to health information about their residents.
- The red bag project is ensuring improved information travels residents admitted to hospital, reducing the need for clinicians to chase for supplementary information and ensuring that individuals' preferences are factored into care decisions more systematically.
- The care home bed tracker has been introduced in well over half of LLR's homes, making it easier to for commissioners to support prompt hospital discharge where a care home bed is required. This will also support members of the public looking to identify care homes with vacancies.
- We have been linking different care home datasets to provide a richer picture of the crisis care needs of homes
- Successful pilot projects have been run in a range of areas increasing the learning about what makes a difference, for example to prevent falls or reduce the use of food supplements

Changes that will be embedded in the coming months include:

- The UHL Medicines Optimisation in Care Homes project implementation will support step down from hospital.
- A second national digital funding bid, supplemented by social care winter pressures funding, is looking to enable wider rollout of the DSP Toolkit, NHSmail and the EPR system (also opening up synergies with Medicines Optimisation). The tools would bring efficiencies to up to half of LLR's 300 homes, to health and care colleagues and support improved care.
- We are collating a consolidated view of the training available from various sources across LLR and looking to evolve the offer
- The care homes element of the falls prevention demonstrator project will be implemented
- We are investigating communications platforms to ensure that homes can access the information they need, better supporting self-help approaches.

Adult Social Care are reviewing and improving the reablement offer within Leicestershire as part of the target operating model and redesign of the work of the department.
Six 'Try Its' for the reablement workstream were put into place and tested in Hinckley. The detail below provides an update on how the reablement KPI has changed over this period.

The aim of the workstream is to increase the numbers of people able to benefit from an improved HART (LCC reablement) service. This involves moving HTLAH (independent sector) reablement packages into HART and maximising the independence of those accessing the service.

In order to take on the target increase in HART service users (929) across the county, we need to release 31% of capacity. The average duration of reablement in Hinckley during the try it phase has reduced from c23 days to c15 days, representing a 34% reduction.

Further work will need to take place to establish the right balance of capacity and demand across the remaining nine ASC neighbourhood teams to ensure this benefit can be realised across the county. Key deliverables are listed below:

- OT and review Co-location with the HART Team.
- Update the Language in Service User Guide
- Transfer of Hinckley HTLAH Reablement Cases in to the HART Service
- Change Job Role Language of HART Workers
- Senior First Visit Checklist including Goal Setting
- Frequent Feedback on Goal Progression between HCAs and Senior HCAs

So far, the majority of the impact has been seen in reducing the duration of reablement episodes. Therefore, we will be looking to focus on how we can further improve the goal setting/progression activities and utilise the OT and Review resource to reduce the ongoing need of our service users in coming months.

Summary

The DWG will continue to work in the same manner as in 2018/19 and has already provided assurance that the current HICM framework will be fully implemented to Established level (or better) by the end of Q1 2019/20.

In addition, the action plan and focused areas of work listed above, which are supported by BCF/IBCF funding, will contribute to six of the eight high impact change areas being assessed as mature by Q4 19/20 with the exception of seven-day services which will be assessed as Established and Focus on Choice which will be assessed as Exemplary.

The DWG will continue its innovation and improvement ethos throughout 2019/20, for example they will be closely involved in the next steps on MH and LD accommodation solutions and they will look ahead to the revised HICM requirements from 2020, in order to address these as soon as practicable.

Current position of maturity for each High Impact Change and planned level of implementation by March 2020.

		Please enter current position of maturity	**Please enter the maturity level planned to be reached by March 2020**
Chg 1	Early discharge planning	Established	Mature
Chg 2	System to monitor patient flow	Established	Mature
Chg 3	Multi-disciplinary/multi-agency discharge teams	Mature	Mature
Chg 4	Home first/discharge to assess	Established	Mature
Chg 5	Seven-day service	Established	Established
Chg 6	Trusted assessors	Established	Mature
Chg 7	Focus on choice	Mature	Exemplary
Chg 8	Enhancing health in care homes	Established	Mature