## 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***

In the continued absence of the Policy Framework and Technical Guidance for 2020-21, the working assumption is that 2020/21 will effectively be a roll-over year. The Strategic Narrative is therefore largely unchanged from that submitted in 2019/20.

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.

Additional Adult Social Care funding continues to make a positive contribution to the progression of delivery of the HICM.

The Care Home Sub Group (CHSG) Continues to focus and strengthen LLR's programme of work under the national Enhanced Health in Care Homes (EHCH) agenda.

Improvements made in the following areas have been established;

- 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 ensures 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 makes it easier 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.
- Linking different care home datasets provides 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.

Planned changes previously reported are in the process of being recovered and/or impact assessed in light of Covid-19:

- 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.
- Collation of a consolidated view of the training available from various sources across LLR and looking to evolve the offer

- Implementation of the care homes element of the Falls prevention demonstrator.
- Communications platforms to ensure that homes can access the information they need, better supporting self-help approaches.

Work continues to improve the reablement offer within Leicestershire following the target operating model and redesign work within Adult Social Care. This also takes into account changes in working practices as a result of Covid-19.

Plans to move HTLAH (independent sector) reablement packages into HART and maximising the independence of those accessing the service, continue despite the replacement for HTLAH being delayed due to Covid-19.

Work continues 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

Summary

Much of work previously planned has either been directly impacted by Covid-19 and in the process of being recovered or requires further analysis/assessment as a result of changes in working practices brought about by the pandemic. The outcome of this work will be key to establishing the pans for 2020/21.

**Current position (subject to Covid recovery assessment) 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 |

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