8 High impact changes to support local health and care systems reduce transfers of care
Leicester, Leicestershire and Rutland response

Updated: May 17						
Impact change	**Where are you now**	**Status**	**Spread**	**Gaps**	**What needs to be done**	**When by**
Early discharge planning	Primary Care Coordinators and Therapists work together in ED to plan discharge for patients who are able to return home and 'push' into community services, or provide a summary of services received for those patients who are admitted	Established	UHL	Social Care staff are available but are not part of an MDT approach in ED. Regular/frequent attenders are not monitored or followed up	Creation of an Integrated Discharge Team for UHL that operates at the 'front door' and 'back door'. Primary care coordinator working with ED staff to review frequent attenders and support development of plan with primary care.	1st July 2017
	In-reach team identifies patients who are likely to require support on discharge and visits daily to 'pull' into community services. Available throughout all hospitals (UHL, PCH, LPT, RMH, ICS, Kettering, Melton etc)	Established	Rutland (UHL, PCH, LPT, RMH, ICS, Kettering, Melton)	Integrated and remote access to hospital patient electronic records to allow integrated team to access information outside of hospital building.	Link Rutland in-reach model to UHL IDT model for daily identification of Rutland patients at UHL	1st July 2017
	Acute Admission avoidance Nurses and Primary Care Coordinators work with therapists to plan discharge for patients on acute assessment units and 'push' into community services	Established	UHL	Social Care staff are available but are not part of an MDT approach on the assessment units	Creation of an Integrated Discharge Team for UHL that operates at the 'front door' and 'back door'	1st July 2017
	Daily boardrounds with MDT, estimated discharge date set and reviewed	Established	UHL and LPT community hospitals (Rutland team attends RMH boardrounds)	Discharge specialist not present on all boardrounds. Patients not always identified for right pathway first time. Duplicated referrals sent to multiple services	Creation of an Integrated Discharge Team for UHL that attends boardrounds daily on medical/high referring wards	1st July 2017
	Establishing boardrounds within ICS service	Plans in place	LPT	Progressing in some localities, direct contact and links have been made through locality meetings. Rutland receives daily patient list including patients within ICS	All ICS wards have daily boardround in place to review patients	
	SAFER care bundle rolled out across wards which sets an EDD and clinical criteria for discharge, includes a senior review daily through boardrounds	Established/Plans in place	UHL and LPT community hospitals	SAFER care bundle embedded across UHL medical wards Monday to Friday, and 2 LPT Community Hospital wards	Continued roll out across UHL specialty wards. Continued roll out across LPT community hospital wards. Clear and consistent data on performance of meeting SAFER criteria to be shared across LLR. All wards implemented afternoon boardrounds at LPT	Roll out to remaining 10 LPT wards to be completed by October 2017. Formal Launch to specialty wards at Glenfield to commence 5th June

	Red to Green process during boardrounds identifying delays in the patient's journey towards discharge. Daily MDT meeting/teleconference to review 'red' patients and seek resolution	Established	UHL and LPT community hospitals	UHL Medical wards and 2 LPT Community Hospital wards only	Continue to embed and sustain new ways of working for red to green wards at UHL. Roll out to LPT wards	Formal Launch planned for 13 wards at Glenfield Hospital week commencing 5th June
	Senior system wide escalation review of delayed/Red patients to resolve trends of delays, problem solve specific cases (includes UHL, LPT, Social Care, CHC, Out of area hospitals)	Established	UHL, LPT community hospitals, Rutland	Information is difficult to maintain as 'current'. Work progressing with Nervecentre to pull reports. LPT data pulled from daily patient census.	Progress with creating Nervecentre reports. LPT census data shared at weekly LLR meeting for trend review	Jun-17
	Creating 'Home First' philosophy for all discharge discussions between professionals and patients/family (including 'family first' transport requests). Some areas of good practice including reablement services for domiciliary care and bed based reablement trials but these are not yet a comprehensive offer.	Plans in place/Established	UHL, LPT	Not an established culture change yet across all health and social care professionals nor amongst patients and families. Reablement offer is not yet comprehensive to provide alternatives and support to return home.	IDT's role on boardrounds will be to spread this philosophy through discharge to assess schemes. Early conversation with patients and families to set expectations of discharge. Business cases for reablement services to follow the philosophy	1st July 2017 for IDT. June 2017 for business cases
	Home First philosophy for discharge in place in Rutland. Patients are discharged to home first unless this is not possible and either an interim discharge to assess/ NWB interim bed is used	Established	Rutland			
	Clear, consistent definition of 'medically fit for discharge' and 'ready for discharge' in use between partner agencies	Established	LLR			

	Discharge co-ordinators within Mental Health Services facilitate the discharge process to a new residence	Established	LLR		A 2017/18 ' Service Development and Improvement Plan (SDIP) is being finalised with LPT to complete actions from the 2016/17 Remedial Action Plan. LPT have also introduced a 'DTOC Strategic System Group' chaired by the LPT Medical Director with a multi-agency and senior officer focus on addressing system barriers that delay discharge, including the development of housing solutions.	
	Length of Stay CQUIN within Mental Health services to encourage early discharge planning and avoidance of delayed transfers of care In order to reduce length of stay)	Established				
	Liaison Psychiatry Team (Vanguard) assess patients at UHL's front door to ensure mental health issues do not delay discharges. Supports early discharge planning	Established	UHL			
	ICRS in-reach teams (City CC) have built positive working relationships with PCCs, wards and City ASC. Referrals into ICRS 24/7.	Established	UHL	Ensure PCCs remain fully aware of service and when to refer to ICRS	Ensure ICRS on new PCC induction to ensure sound understanding of remit	NA
Systems to monitor patient flow	LLR Discharge steering group meets monthly with multi-agency attendance and workplan to review DTOC, flow and other relevant issues	Established	LLR		To re-start in Summer 2017 after IDT/Tiger Team has finished and Home First Board/workstreams have established	Summer 2017
	Urgent and Emergency care performance data shared with AEDB (including flow)	Established	LLR	Requires narrative to support intelligent discussion (eg reasons for increased DTOC, trends for comparison). UHL DTOC dashboard available monthly, but similar information not available from LPT	DTOC and flow dashboard in creation/draft	Jun-17
	Daily senior system wide escalation call chaired by Director on Call reports today's operational pressures across LLR, including flow	Mature	LLR	Specific flow and discharge data is often subjective or disputed	IDT new process will support this call using actual data	1st July 2017

	Gold command meetings 8am, 1pm, 4,30pm, 6pm to review capacity and demand	Mature	UHL			
	Daily bed state and patient census is circulated to relevant partners across LLR to support flow discussions (including anonymised information to CCG support teams)	Established	LPT	Document is difficult to maintain current and accurate information	Bed state and daily census is monitored by LPT bed managers and issues escalated appropriately. Bed bureau has access to real time bedstate via systm1	
	Matron on call for the in-patient beds and named ICS lead available daily to support flow. Bed manager completes operational tasks to support flow	Established	LPT	Ward manager on community hospital site at weekends to support flow		
	Monthly review of performance data at Transfer of Care Meeting with partner organisations, recently refocused to include SAFER bundle information including discharge before 12pm	Mature	LPT and community partner organisations			
	Electronic whiteboards and twice daily bed state meeting using real time information (Mental health)	Established		Acute wards only		
	2 week review of initial care package built into new domicillary care package procurement, to support flow/capacity through the service	Established	County LA	Not all newly procured 'lots' are operational.	New procurement to cover vacant lots	
	Senior system wide escalation review of delayed/Red patients to resolve trends of delays, problem solve specific cases (includes UHL, LPT, Social Care, CHC, Out of area hospitals)	Established	UHL, LPT community hospitals, Rutland	Information is difficult to maintain as 'current'. Work progressing with Nervecentre to pull reports. LPT data pulled from daily patient census.	Progress with creating Nervecentre reports. LPT census data shared weekly with LLR meeting for trend review.	
	SAFER stranded patient review of patients with LOS over 6 days to resolve delays	Established	UHL	Dragons den weekly meeting established in ESM	Review process to undertake stranded patient review across CMGs	Jul-17

Multidisciplinary/multiagency discharge teams	Primary Care Co-ordinators, acute admission avoidance nurses, therapists and social care teams all based at UHL	Established	UHL	Teams do not operate as a 'single discharge team' and often have same patients on case list	Creation of an Integrated Discharge Team for UHL that operates at the 'front door' and 'back door'	1st July 2017
	Hospital Housing Team based at UHL and Bradgate Unit	Established	UHL, LPT community hospitals, Mental health	Not situated with other hospital discharge teams	Create strong working links with new IDT	1st July 2017
	Named social workers on in-patient wards with MDT and at boardrounds	Established	LPT	Not working as an integrated team	Phase 2 of IDT work to review approach at LPT	Once phase 1 is embedded
	In-reach team identifies patients who are likely to require support on discharge and visits daily to 'pull' into community services. Available throughout all hospitals (UHL, PCH, LPT, RMH, ICS, Kettering, Melton etc). Fully integrated discharge team includes social workers, therapists and community nurses.	Established	Rutland (UHL, PCH, LPT, RMH, ICS, Kettering, Melton)		Link Rutland in-reach model to UHL IDT model for daily identification of Rutland patients at UHL	1st July 2017
	System leadership Course attended by health and social care teams	Established	Rutland		completed in rutland of present cohort - second round of system leadership to support new staff planned - then join with existing staff to further embed integration and CPD	
	Case Managers to support patient journey in private and out of area rehab/specialist providers	Plans in place	Rutland			
	Health and Social Care case managers working together with MDT in domicilliary and bed based reablement services	Established	LLR	Reablement offer is limited	Business case for expanded bed based reablement services which includes case managers working as part of an MDT. Creation of an IDT at UHL.	1st July 2017
	Electronic Trusted Assessment tool in development to support MDT discharge teams	Plans in place	UHL and LPT community hospitals	Future funding needs to be secured to make this an integrated health and social care electronic solution	Business Case in draft. To be completed.	Jun-17
	Use of systmone within the in-reach team creates a trusted assessment tool and patient progress information for the team to act on behalf of each other	Established	Rutland	Doesn't currently link to Liquid Logic	Ongoing reviews and development	Ongoing piece of work
Home first/discharge to assess	Discharge to assess using interim beds if appropriate ensure that pathways 1/2/3 support the patient back to their home/community as soon as possible.	Established	Rutland			

	Discharge to assess model available in spot purchased care homes for patients needing further assessment	Established	UHL	Health case management resource is not adequate. Difficulty in sourcing timely community therapy input to progress patient's pathway	Complete business cases for comprehensive pathway 3 offer in order to switch off suboptimal D2A pathway	Summer 2017
	Help to Live At Home/Hart domicilliary care packages provides reablement for up to 6 weeks post discharge, including opportunity to assess for longer term needs at home	Established	County LA	Vacant lots and not all lots are operational leading to delays in start dates of packages	New procurement to cover vacant lots	Summer 2017
	Bed based reablement service with therapy input for up to 6 weeks in place as a trial (6 months of 14 block purchased beds) including opportunity to assess for longer term needs (eg CHC, permanent entry to care home)	Established	County patients	Small number of beds and unable to accept more complex patients during the trial. Doesn't include NWB patient group	Business case for Kingfisher Unit to provide 37 reablement and assessment beds for city and county patients, business case to continue Peaker Park 14 beds (plus procure more), review of NWB service	Summer 2017
	MDT hub for end of life care to provide discharge to assess opportunities	Plans in place	LLR		Business Case in draft. To be completed.	
	Integrated working across health and social care - community teams and in-reach services to support Rutland residents at EOL in the community	Established	Rutland			
	Discharge to assess pathway for patients with severe/complex dementia in discussion	Plans in place	LLR	Proposal created to gain support	Proposal to be shared across LLR	Summer 2017
	Pathways supported by principles of 'no eligibility assessments completed in the acute trust'	Plans in place		Not yet in place across health and social care		Plans in place
	Inreach nurses complete CHC checklist to establish funding of discharge to assess interim solution so that all DST are completed outside acute settings	Established	Rutland			

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	Use of systmone within the in-reach team creates a trusted assessment tool and patient progress information for the team to act on behalf of each other	Established	Rutland	Doesn't currently link to Liquid Logic	Ongoing reviews and development	Ongoing piece of work
	ICS service provides virtual bed service across LLR for step up and step down patients	Established	LPT			
	Continuing Health Care end to end process rolling out across LLR to support discharge to assess models	Plans in place/established	LLR	Rolling out across LPT, now planning for roll out to UHL	Mobilisation planning group monitors this	
Seven Day Services	Procurement of domicillary care packages requires services to be provided 7 days a week	Plans in place/establish	City LA (Plans in place) County LA and Rutland (established)	County lots not all operational. City procurement due to start in 2017	Complete procurements	Summer 2017
	Non emergency patient transport contract provides transport for hospital discharge (7 days for UHL, 6 days for LPT, 5 days for Mental health)	Established	LLR	New procurement of contract will include 7 days a week across all hospital discharge services and increase start/finish times.	Complete mobilisation of new contract	Summer 2017
	Adult social care reablement services is available to UHL 7 days per week	Established	County LA			
	Daily MDT ward review 7 days a week	Established	Mental Health	Adult acute wards only		
	Increased Consultant presence at weekends	Established	UHL			
	ICS available 7 days a week	Established	LPT	Therapy team and ANP within ICS work Mon-Fri		
	Community Hospitals available for admissions and discharges 7 days a week	Mature	LPT	Therapy team and ANP work Mon-Fri		
	Director on call and Heads of Nursing on site at the weekend	Established	UHL			
	Mental Health Crisis Team available 7 days a week	Established	Mental Health			
	REACH crisis response available 7 days per week.	Established	Rutland	Night nursing service being replaced with home visiting service and out of hours service		Jun-17
	In reach nurse available at PCH 7 days a week	Established	Rutland			
	Adult social care reablement services is available 7 days per week to discharge patients from hospital and also for admission avoidance.	Established	City LA			

	ICRS working 7 days a week to pull out patients over the weekend in UHL via established referral routes direct from wards or other trusted Assessor professionals.	Established	City LA			
Trusted assessors	Trusted assessors in place across UHL and LPT for specific community services (including a care home for reablement)	Established	LLR			
	Electronic Trusted Assessment tool in development to support MDT discharge teams	Plans in place	UHL and LPT community hospitals	Future funding needs to be secured to make this an integrated health and social care electronic solution	Business Case in draft. To be completed.	Jun-17
	Use of systmone within the in-reach team creates a trusted assessment tool and patient progress information for the team to act on behalf of each other	Established	Rutland	Doesn't currently link to Liquid Logic	Ongoing reviews and development	Ongoing piece of work
	IDT to work on behalf of each other and act as trusted assessors for each service	Plans in place	UHL and LPT community hospitals		IDT to commence at UHL	1st July 2017

Focus on choice	IDT to support ward MDTs in discussing and managing patient choice	Plans in Place	UHL and LPT community hospitals		IDT to commence at UHL	1st July 2017
	National patient choice protocol to be aligned to local protocols in Rutland	Established	Rutland			
	Increase awareness of personal health budgets and direct payments in Rutland	Not yet established	Rutland	PHB strategic lead for health no longer in post. Await replacement		
	Develop links with voluntary sector to support discharge in Rutland	Established	Rutland			
	In reach and advocacy services support care home choice	Established	Mental Health	Mixed success in reducing delays		
	Improve links between discharge and carers assessments in Rutland through carers assessment from in-reach team	Established	Rutland			
Enhancing health in care homes	Social Care Quality Improvement Team supports care homes to reduce the number of safeguarding incidents (County)	Established	County LA			
	Social Care Quality Improvement Team supports care homes to prevent avoidable admissions and reduce the number of emergency calls (County).	Established	County LA	Relies on care homes self referral to the team to ask for support		
	Social Care Quality Improvement Team supports care homes with Falls pilot work through use of assistive technology (County).	Established	County LA	Across 3 homes only		
	Braunstone Blues project supporting care home who had highest use of ambulances. Provided policy change and education (EMAS)	Established				
	Engagement with care homes to support improved experience of acute transfer of care	Established	UHL	Limited resource to continue. City care homes only	Review following implementation of IDT with possible creation of a regular forum	Aug-17
	Community Nursing Teams are aligned to Care Homes	Mature	LPT			