High Impact Change Model Tab

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 commitments to reablement and Enhanced Health in Care Homes in the NHS Long-term Plan;
- Anticipated improvements from this work.

Current performance issues

The performance issues to be addressed include:

- GPs and District Nurses consistently leading discussions on early discharge planning for elective admissions across neighbourhoods;
- Health and Social Care system is yet to agree service specification for the integrated discharge service;
- Resources are not focused in the right places;
- Ensuring consistent clinical decision making 24/7 across all THH wards;
- Increasing step-down throughput;
- Care homes consistently being able to assess within 24 hours of referral;
- The clinical and reablement exclusion criteria needs to be reviewed to support more patients with complex needs on pathway 2 to be discharged to their preferred place of residence;
- Standards for triaging are not yet developed;
- Standard Operating procedures for the service need to be formally signed off;
- There are multiple assessments being undertaken for each handoff;
- Refusal of care homes to accept Hospital/ASC assessments;
- Reluctance of care homes to accept people with more complex needs.

The changes that you are looking to embed further

The changes to be delivered and embedded include:

- Realigning the eight Neighbourhood Teams to six PCNs across the borough;
- Rolling out criteria-led discharge to all wards within THH;
- Establish a single point of coordination within Hillingdon Hospital for hospital discharges, managed under a single, integrated management function;
- Establishing a single point of coordination for access to community resources to build up suitable packages of care and support;
- Developing a service specification for the integrated discharge service;
- Developing and implementing pathways with inclusion criteria that support the discharge of patients on pathway 2;
- Developing and implementing the standards for the triaging process including the automation of data reporting;
- Reviewing all assessments and agreeing a simplified joint assessment for patients on all pathways;
- Review all specialist pathways to include Frailty, End of Life and Palliative Care to ensure these are aligned to the integrated discharge model;
- Develop an education programme for all staff including induction;
- Develop and implement a communication plan for all patients and staff;
- Review current triage arrangements for accessing community resources;
- Exploring the feasibility of rapid access care provision to secure care home placements, particularly for people with more complex needs;

- Continuing the involvement of Reablement as a key component of the out of hospital services;
- Fully implementing the Enhanced Support for Care Homes and Extra Care Sheltered Housing Service;
- Promoting a training programme for care home staff, including leadership, recognising the signs of deterioration and medication administration.

Anticipated improvements

The work being undertaken in 2020/21 will contribute to the following:

- Delivery of a 2-hour response time for urgent community referrals;
- Delivery of a 2-day response time for intermediate care, case management and packages of care;
- A reduction in acute DTOCs;
- A reduction in long length of stay, i.e. $\leq$ 21 days;
- A reduction in the number of CHC assessments undertaken in an acute setting;
- A reduction in the number of patients on the End of Life/Palliative Care pathway dying in hospital (if this is not their preferred place of death).