DRAFT

Managing Transfers of Care (DTOC reduction delivery plan) 2017/19

Local Authorities:

Hammersmith & Fulham Council (LBHF)

Royal Borough of Kensington & Chelsea (RBKC)

City of Westminster (WCC)

Clinical Commissioning Groups:

Hammersmith & Fulham Clinical Commissioning Group HFCCG)

Central London Clinical Commissioning Group (CLCCG)

West London Clinical Commissioning Group (WLCCG)

Content:

Action Plan

Intro and background

This draft document supplements the Integration and Better Fund Plan for the three boroughs for 2017-19. It is a plan in development in recognition of the recent challenges, changes, and opportunities to establish a clear and resourced plan to improve our citizens experience of a timely, appropriate, and person centred hospital discharge.

We recognise that a key part of our BCF is the interdependency of our schemes and commissioned services that reduce Delayed Transfers of Care (DToC) and support the principle that quality care is delivered in the right place.

We are committed to implementing the High Impact Change Model and have defined the areas that need input and the timeline of implementation by October 2017. A summary stocktake of our current position against each of the 8 High Impact Changes is attached as appendix 1. The stocktake has informed our action plan.

The High Impact Change Model remains challenging to implement and the three boroughs have therefore agreed to utilise approximately a third of the iBCF monies (£2.3m) to support improvement and change across the DToC pathway.

There is a strong base to build on from the 2016-17 plan which has enabled improvements both in the processes within hospitals and the capacity available to support people at home and in the community. They include:

- Developed integrated hospital discharge teams and pathways within several hospital wards to provide a common discharge approach across the three boroughs and working on extending this to include three additional boroughs to better manage hospital discharge
- Development of Home First (Discharge Home to Assess) model with enhanced care package, as well as access to Step Up Interim care beds should care breakdown at home
- Increased the provision of interim beds to enable step down from hospital and to allow for full assessments of people's needs to be undertaken in the community. This includes interim bed options to carry out Continuing HealthCare Assessments (CHC) outside hospital as well as support people with care needs who have temporary accommodation needs.
- Development of two Trusted Assessor Nurse posts for Care Homes to speed up assessment and discharge to care homes
- Utilised BCF resources to establish a 7-day hospital social work and therapy services which are due for review in 17-18 to evalaute their impact.
- Modelling and re-commissioning the established Community Independence service to enhance its focus on integrated working with GP's.
- Alignment of organisational Choice policies supported by information for patients, families, and carers on the local options available for community or home based care upon discharge

The draft Managing Transfers of Care Action Plan seeks to extend single Hospital Discharge function across health and social care and scale it up to support achievement of the DTOC targets which have been set for each borough.

Current context, performance, and targets

The stocktake to measure progress in delivering the high impact changes was recently undertaken to include the following;

- Early Discharge planning
- Systems to monitor patient flow
- Multi-disciplinary, multi-agency teams (including vol and community sector)
- Home First Discharge to Assess
- Seven day services
- Trusted Assessors
- Focus of choice
- Enhancing health in care homes

Clear that much good work is underway. For example, the single six borough hospital discharge model. However, it is also clear that there are a range of different project and governance arrangements in place (DA3, WLA, 2 * AE Delivery Boards, Three Borough Hospital Discharge Steering Group); and different challenges with borough hospital discharge performance. These are addressed within the action plan or progress included in this document (eg. Governance).

A copy of the stocktake is embedded here.

DTOC Impact Change 30-8-2017.d

The West London Alliance (WLA) is leading on a programme of change across North West London (NWL) to improve the service that residents receive when being discharged from hospital. To enable this change, the NWL boroughs are collaborating to provide a more consistent service and maximise the efficiency of existing resources by working more closely together.

Through the collaboration of a number of different local authorities in North West London the programme aims to improve outcomes for people being discharged from hospital, including the residents of the three Boroughs. The changes will provide a more consistent transfer of care service in NWL for the residents of all the boroughs, irrelevant of the hospital attended.

The WLA programme naturally progressed from the work undertaken in Hammersmith & Fulham, Royal Borough of Kensington & Chelsea (RBKC) and Westminster City Council (WCC) in 2015/16 to bring together the different hospital teams to act as one single adult social care hospital discharge function. This programme has shown a number of benefits for patients, for each local authority and for the system as a whole.

The benefits to be gained, as shown by the work already completed, can be divided into the following categories:

- Patient outcomes: a more consistent service supporting Hammersmith & Fulham residents
- Staff efficiencies: a more effective and efficient use of Hammersmith & Fulham staff to support service users
- Reduction in delayed transfer of care from hospital (DTOC)

For example, a collaborative service enabled the WCC and K&C social care teams to manage the H&F discharges at these sites, providing an onsite service. This has enabled a more consistent and more effective service for residents of the three boroughs at these sites, improving their outcomes during and after discharge. Not being located on site also caused communication issues with the hospital teams and limited the establishment of successful professional relationships with the trust staff.

The new approach was launched in March 2016 and in the 12 months following this (April 2016 – March 2017) delayed days due to ASC shared service assessments in hospital were 807. For the same period in the previous year (April 2015 – March 2016) the delayed days due to ASC shared services assessment in hospital were 738. Although this shows an increase of 9% this is significantly lower than the national average of 39% for this time period; the higher DTOC levels for 2016/17 can be attributed to the extreme pressure over the winter period compared to a much milder winter in 2015/16.

Furthermore, when focusing on the Imperial sites only (i.e. the sites impacted by this work) DTOC has dropped by 9% and 8 of the 12 months saw zero DTOC days for ASC assessments in this period, compared to 4 of the 12 months in the previous period. This provides clear evidence that the introduction of shared working has particularly reduced delays in Charing Cross and Hammersmith hospitals.

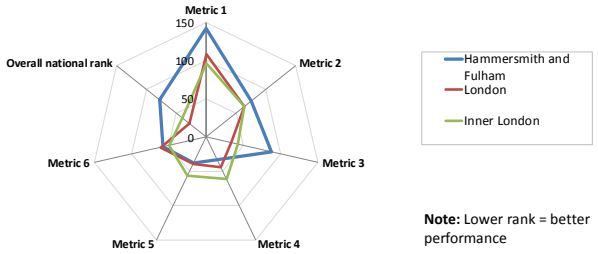
Based on the learning from this work and the evidenced benefits, the programme is looking to expand the arrangement to the London boroughs of Brent and Ealing, which will and provide an even wider level of support to the residents of three boroughs.

The performance dashboards for each borough are as follows

Hammersmith and Fulham

	Hammersmith and Fulham		London average		Inner London average	
	Score	Rank	Score	Rank	Score	Rank
1) Emergency Admissions (65+) per 100,000 65+ population	31,762	142	28,594	109	27,342	96
2) 90th percentile of length of stay for emergency admissions (65+)	21	75	21	64	21	64
3) TOTAL Delayed Days per day per 100,000 18+ population	13.0	88	6.8	34	8.1	42
4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement /rehabilitation services	89.2%	33	89.2%	44	86.2%	61
5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	4.0%	38	5.1%	39	4.1%	56
6) Proportion of discharges (following emergency admissions) which occur at the weekend	20.0%	58	20.0%	61	20.2%	50
National Rank (Dist from mean calculation)		**78**		**28**		**40**

Spidergram comparing ranks with regional & authority type averages



The Spidergram opposite shows performance of the chosen authority (measured as rank within all single and upper tier authorities) for the 6 metrics compared with the average for the authority type and the region relevant to the selected authority. Data is only partially available for the Isle of Scilly. Isle of Scilly and City of London are excluded from the overall national rank (as per the original dashboard published by DH).

Note: Lower rank = better performance

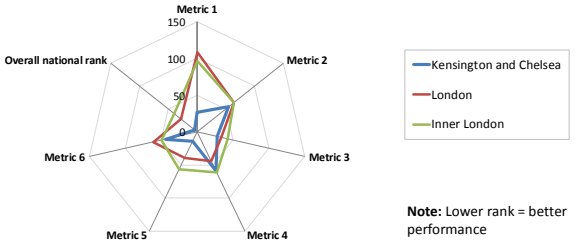
Hammersmith and Fulham vs different authority types - Metrics

	1) Emergency Admissions (65+) per 100,000 65+ population	2) 90th percentile of length of stay for emergency admissions (65+)	3) TOTAL Delayed Days per day per 100,000 18+ population	4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	6) Proportion of discharges (following emergency admissions) which occur at the weekend
Hammersmith and Fulham	**31,762**	**21**	**13.0**	**89.2%**	**4.0%**	**20.0%**
Outer London	26,591	21	8.8	84.4%	3.5%	20.3%
Inner London	28,594	21	6.8	89.2%	5.1%	20.0%
Metropolitan District	28,159	21	13.5	82.5%	3.3%	19.6%
Shire County	21,870	21	17.6	83.1%	2.5%	19.5%
Unitary Authority	24,511	21	14.2	83.0%	3.0%	19.5%

Kensington and Chelsea

	Kensington and Chelsea		London average		Inner London average	
	Score	Rank	Score	Rank	Score	Rank
1) Emergency Admissions (65+) per 100,000 65+ population	21,446	27	28,594	109	27,342	96
2) 90th percentile of length of stay for emergency admissions (65+)	20	55	21	64	21	64
3) TOTAL Delayed Days per day per 100,000 18+ population	6.6	28	6.8	34	8.1	42
4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	86.4%	59	89.2%	44	86.2%	61
5) Proportion of older people (65 and over) who are discharged from hospital who receive	5.4%	14	5.1%	39	4.1%	56
6) Proportion of discharges (following emergency admissions) which occur	20.2%	44	20.0%	61	20.2%	50
National Rank (Dist from mean calculation)		**4**		**28**		**40**

Spidergram comparing ranks with regional & authority type averages



The Spidergram opposite shows performance of the chosen authority (measured as rank within all single and upper tier authorities) for the 6 metrics compared with the average for the authority type and the region relevant to the selected authority. Data is only partially available for the Isle of Scilly. Isle of Scilly and City of London are excluded from the overall national rank (as per the original dashboard published by DH).

Note: Lower rank = better performance

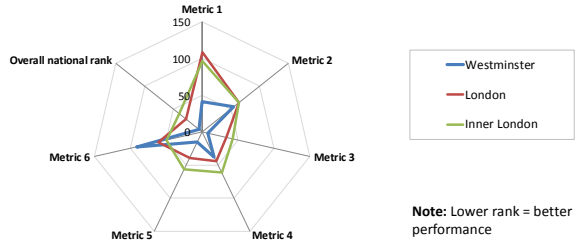
Kensington and Chelsea vs different authority types - Metrics

	1) Emergency Admissions (65+) per 100,000 65+ population	2) 90th percentile of length of stay for emergency admissions (65+)	3) TOTAL Delayed Days per day per 100,000 18+ population	4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	6) Proportion of discharges (following emergency admissions) which occur at the weekend
Kensington and Chelsea	**21,446**	**20**	**6.6**	**86.4%**	**5.4%**	**20.2%**
Outer London	26,591	21	8.8	84.4%	3.5%	20.3%
Inner London	28,594	21	6.8	89.2%	5.1%	20.0%
Metropolitan District	28,159	21	13.5	82.5%	3.3%	19.6%
Shire County	21,870	21	17.6	83.1%	2.5%	19.5%
Unitary Authority	24,511	21	14.2	83.0%	3.0%	19.5%

Westminster

	Westminster		London average		Inner London average	
	Score	Rank	Score	Rank	Score	Rank
1) Emergency Admissions (65+) per 100,000 65+ population	22,538	41	28,594	109	27,342	96
2) 90th percentile of length of stay for emergency admissions (65+)	20	55	21	64	21	64
3) TOTAL Delayed Days per day per 100,000 18+ population	3.9	8	6.8	34	8.1	42
4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	88.6%	38	89.2%	44	86.2%	61
5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	5.2%	15	5.1%	39	4.1%	56
6) Proportion of discharges (following emergency admissions) which occur at the weekend	19.5%	91	20.0%	61	20.2%	50
National Rank (Dist from mean calculation)		**5**		**28**		**40**

Spidergram comparing ranks with regional & authority type averages



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Note: Lower rank = better performance

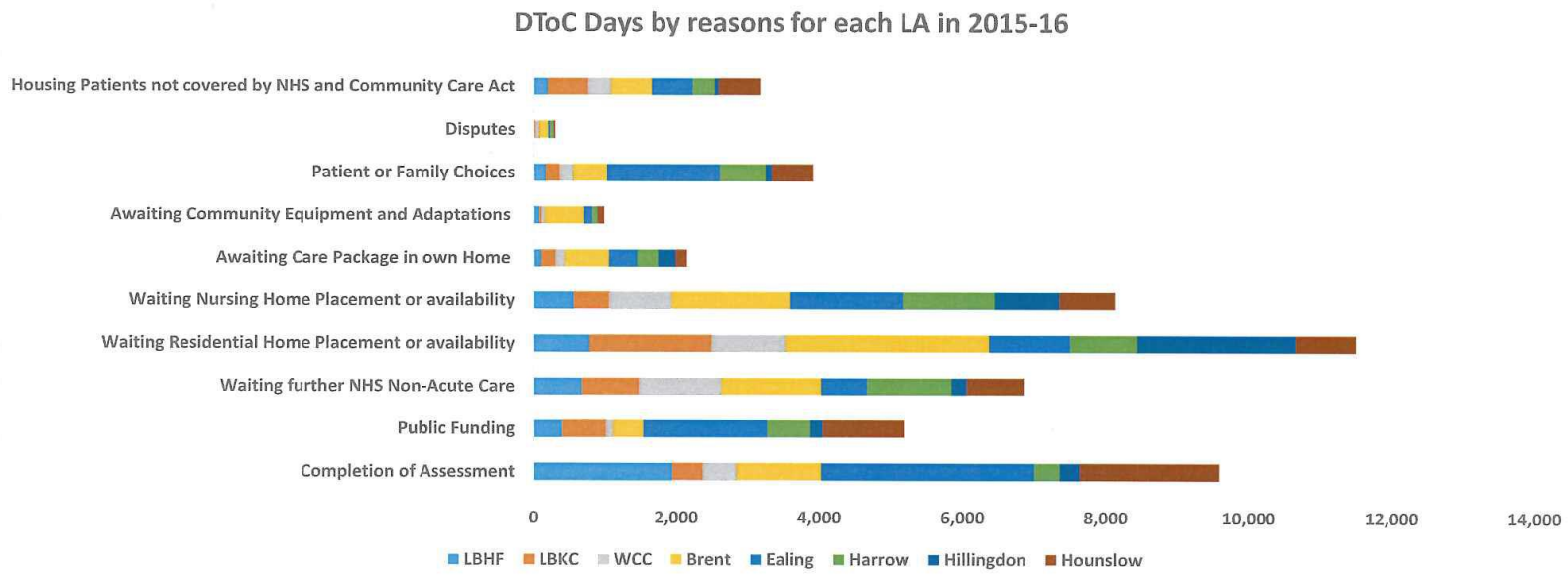
Westminster vs different authority types - Metrics

	1) Emergency Admissions (65+) per 100,000 65+ population	2) 90th percentile of length of stay for emergency admissions (65+)	3) TOTAL Delayed Days per day per 100,000 18+ population	4) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	5) Proportion of older people (65 and over) who are discharged from hospital who receive reablement/rehabilitation services	6) Proportion of discharges (following emergency admissions) which occur at the weekend
Westminster	**22,538**	**20**	**3.9**	**88.6%**	**5.2%**	**19.5%**
Outer London	26,591	21	8.8	84.4%	3.5%	20.3%
Inner London	28,594	21	6.8	89.2%	5.1%	20.0%
Metropolitan District	28,159	21	13.5	82.5%	3.3%	19.6%
Shire County	21,870	21	17.6	83.1%	2.5%	19.5%
Unitary Authority	24,511	21	14.2	83.0%	3.0%	19.5%

An analysis of the reason for delays for each WLA borough can be seen in the first two tables that follow, and a third table that forecasts the number of DtoC days for 17/18, 18/19, and 19/20.

Source: Adult Social Care Spend and Delayed Transfer of Care (DToC) days between the period from 2012-13 to 2014-15 and forecasts for 2016-17 to 2019-20. This report includes analysis and comparison of Adult Social Care spend by WLA Boroughs LBHF, LBKC, WCC, Brent, Ealing, Harrow, Hillingdon & Hounslow and DToC days by NHS Trust in their area. Information on Adult Social Care Spend for each WLA Borough was provided by Minesh Patel - Head of Finance, Brent Council while data for DToC days was downloaded from www.england.nhs.uk/statistics.

DToC days by reasons for each WLA Local Authority in 2015-16 - Contd..



The Graph above is linked to the Table on page above

Out of 51,831 total DToC days in FY 2015-16, 11,505 DToC days (22%) were due to waiting for Residential Home Placement or availability and Brent had the highest number of DToC days in this category - 2,842 DToC days (25%)

8,138 DToC Days (16%) were due to waiting for Nursing Home Placement or availability and again Brent had the highest number of DToC days in this category - 1,659 DToC days (20%)

3,176 DToC days or 6% were due to Housing Patients not covered by NHS and Community Care Act and Ealing had the highest number of DToC days - 578 days (18%) in this category.

DToC days by reasons for each WLA Local Authority in 2015-16

The Graph on the right and Table below are the analysis of DToC days by reasons for all WLA Local Authorities in year 2015-16

22% of DToC days in year 2015-16 were due to Waiting Residential Home Placements or availability

18% were due to Completion of Assessment and 16% were due to Waiting Nursing Home Placements or availability

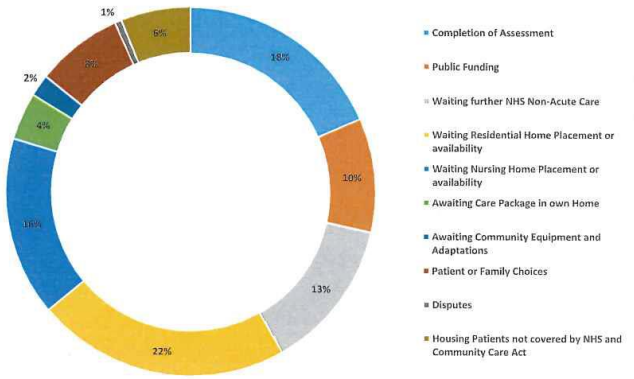
Under 22% category, Brent had the highest number of DToC days while Hammersmith had the lowest

Under 18% category, Ealing had the highest number of DToC days while Hillingdon had the lowest

Only 2% were due to Awaiting Community Equipment and Adaptations and 4% were due to Awaiting Care Packages in own Home

8% of DToC days in FY 2015-16 were due to Patient or Family Choices and only 1% were due to Disputes.

DToC Days by reasons in 2015-16



DToC days by reasons in FY 2015-16

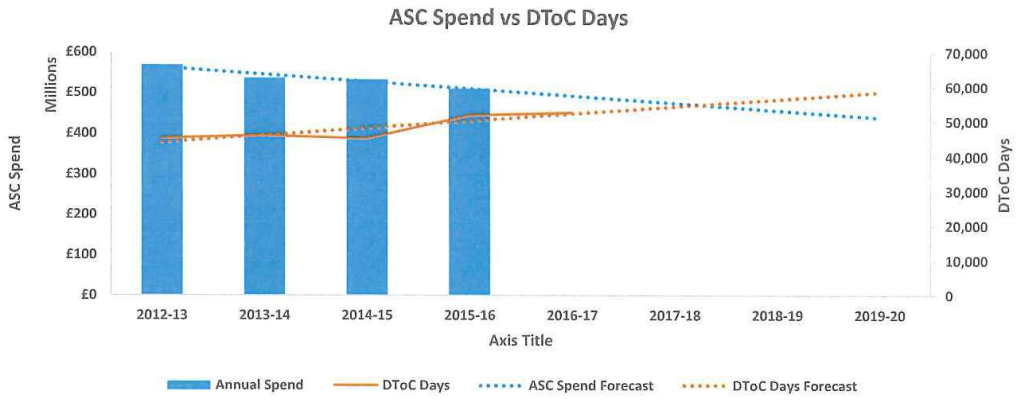
Local Authority	Completion of Assessment	Public Funding	Waiting further NHS Non-Acute Care	Waiting Residential Home Placement or availability	Waiting Nursing Home Placement or availability	Awaiting Care Package in own Home	Awaiting Community Equipment and Adaptations	Patient or Family Choices	Disputes	Housing Patients not covered by NHS and Community Care Act	Total
LBHF	1,950	411	684	789	571	105	80	185	13	217	4,992
LBKC	428	601	794	1,708	492	216	33	193	10	548	5,013
WCC	470	106	1,158	1,041	879	133	63	187	59	327	4,364
Brent	1,185	424	1,399	2,842	1,659	607	538	466	140	565	9,685
Ealing	2,979	1,731	637	1,133	1,570	399	112	1,589	21	578	10,728
Harrow	354	605	1,179	929	1,283	287	80	631	52	308	5,656
Hillingdon	281	173	212	2,226	909	250	3	86	0	56	4,196
Hounslow	1,944	1,133	797	837	775	154	83	584	18	577	6,884
Total	**9,591**	**5,184**	**6,860**	**11,505**	**8,138**	**2,151**	**992**	**3,921**	**313**	**3,176**	**51,831**
% DToC Days	**18%**	**10%**	**13%**	**22%**	**16%**	**4%**	**2%**	**8%**	**1%**	**6%**	

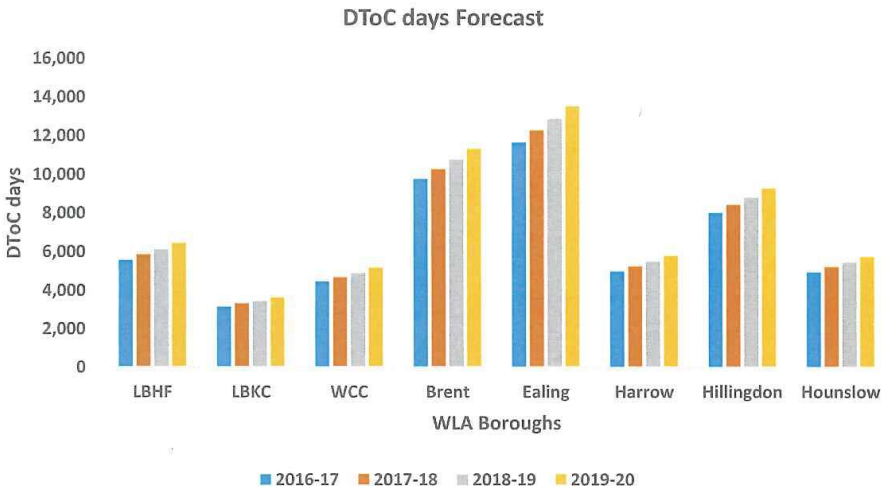
DToC days Forecast for 17/18, 18/19 and 19/20

The Graph on the right and below are the Forecasts of DToC days from FY 2017-18 to 2019-20

Based on past trends, DToC days have been increasing at a rate of 5% per annum and this value is used to forecasts for 2017-18, 2018-19 & 2019-20.

DToC days for FY 2016-17 are expected to increase by 1.5%





DToC days data for 2016-17 is available until Jan 2017 and Moving Averages were used to predict activity levels for the whole year.

Ealing will continue to have the highest number of DToC days based on past trends followed by Brent and Hillingdon.

DToC days Forecast

Local Authority	2016-17	2017-18	2018-19	2018-19
LBHF	5,543	5,820	6,111	6,417
LBKC	3,131	3,288	3,452	3,625
WCC	4,444	4,666	4,900	5,144
Brent	9,772	10,261	10,774	11,312
Ealing	11,677	12,261	12,874	13,518
Harrow	4,995	5,245	5,507	5,782
Hillingdon	8,020	8,421	8,842	9,284
Hounslow	4,965	5,213	5,474	5,748
Total	**52,547**	**55,174**	**57,933**	**60,830**

The table above is based on a past trend of DToC rates rising by 5% per annum. The actions required to achive a reduction in DToC must therefore arrest this trend and achieve the target reduction.

Our agreed trajectories for DToC for 2017/19 are as follows;

*Please note these trajectories may be subject to change

CCG Code	CCG Name	Type	Days (September)	NHS/Social Care Ratio	Baseline Total	Baseline Split	September Position	September Split	March Position	March Split	Phase 1 Step	Phase 2 Step
08C	NHS HAMMERSMITH AND FULHAM CCG	NHS	6.94	55.79%	16.6	9.26	12.45	6.95	8.3	4.63	0.39	0.39
08C	NHS HAMMERSMITH AND FULHAM CCG	Social Care	5.5	44.21%	16.6	7.34	12.45	5.50	8.3	3.67	0.31	0.31
09A	NHS CENTRAL LONDON (WESTMINSTER) CCG	NHS	5.49	70.29%	9.76	6.86	7.81	5.49	5.86	4.12	0.23	0.23
09A	NHS CENTRAL LONDON (WESTMINSTER) CCG	Social Care	2.32	29.71%	9.76	2.90	7.81	2.32	5.86	1.74	0.10	0.10
08Y	NHS WEST LONDON CCG	NHS	6.72	67.20%	12.5	8.40	10	6.72	7.5	5.04	0.28	0.28
08Y	NHS WEST LONDON CCG	Social Care	3.28	32.80%	12.5	4.10	10	3.28	7.5	2.46	0.14	0.14

Accountability and Governance

Progress on managing transfers of care and achieving the DTOC targets will be managed on a day to day basis by the two A&E/Urgent Care Delivery Boards. Progress will be overseen by the three borough Hospital Discharge Steering Group, which is chaired by a Director of Adult Social Care. Key decisions and current performance will be overseen by a Joint Executive Team meeting and by each Health and Wellbeing Board.

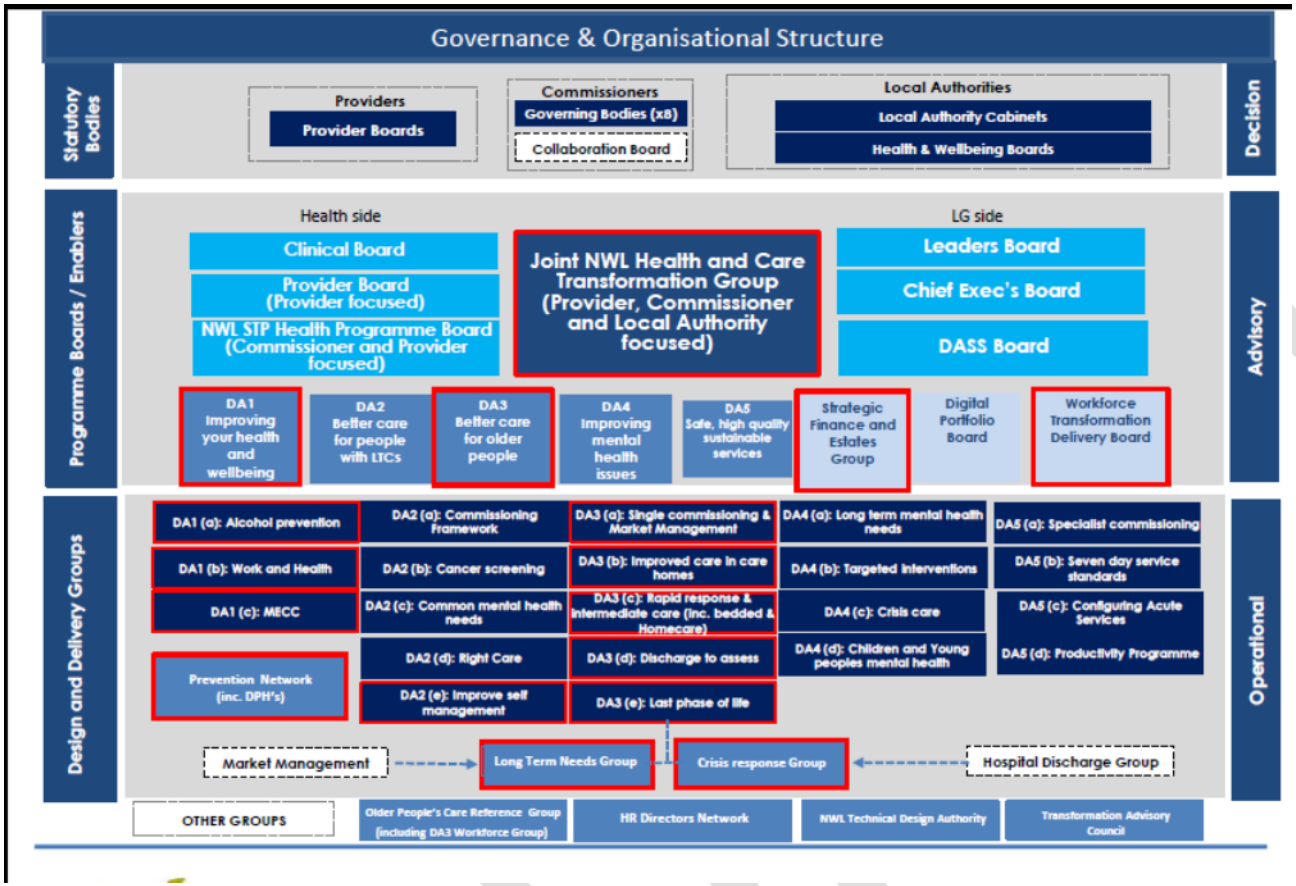
To continue work already underway and respond to the changing landscape a proposed co-ordination and governance structure is outlined below.

A DAS will be the SRO for the three boroughs for this work and will chair the coordination, progress and unblock barriers through the three boroughs Hospital Discharge Steering Group. In Hammersmith & Fulham the DAS chairs a weekly DToC monitoring group on MH delays as non-acute MH delays are a significant contributor to the overall DToC figures for this council and health.

Overall Coordination/Planning	Day to day coordination	3B Hospital Discharge Steering Group	Separate projects/schemes
NWL Health and Social Care Transformation Board DA3 Programme Board JET	2 * A&E Delivery Boards 3* A&E Operational Boards H&F DTOC Team	Early Discharge Planning MDTs Home First 7 Day Services Trusted Assessors Focus on Choice Step Down Beds	Hospital Flow (Acute Lead) Enhancing Care in Care Homes (3B Lead, WLA Support) Community Independence Service (CCG Lead, 3B Support)

An IBCF Transformation Fund has been created to support the delivery of the action plan and will be allocated to assist with improving performance where required. Project briefs, inc resources, costs and expected benefits/outcomes are being developed for new tasks in the action plan and those existing actions being extended further.

The West London Alliance (WLA) is leading on a programme of change across North West London (NWL) to improve the service that residents receive when being discharged from hospital. To enable this change, the NWL boroughs are collaborating to provide a more consistent service and maximise the efficiency of existing resources by working more closely together. The diagram below shows the governance arrangements for the WLA and how the actions in this plan will be designed and delivered, and monitored within this governance and organisational structure.


Governance & Organisational Structure
Statutory Bodies
Providers
Provider Boards
Commissioners
Governing Bodies (x8)
Collaboration Board
Local Authorities
Local Authority Cabinets
Health & Wellbeing Boards
Decision
Programme Boards / Enablers
Health side
Clinical Board
Provider Board (Provider focused)
NWL STP Health Programme Board (Commissioner and Provider focused)
Joint NWL Health and Care Transformation Group (Provider, Commissioner and Local Authority focused)
LG side
Leaders Board
Chief Exec's Board
DASS Board
DA1 Improving your health and wellbeing
DA2 Better care for people with LTCs
DA3 Better care for older people
DA4 Improving mental health issues
DA5 Safe, high quality sustainable services
Strategic Finance and Estates Group
Digital Portfolio Board
Workforce Transformation Delivery Board
Advisory
Design and Delivery Groups
DA1 (a): Alcohol prevention
DA1 (b): Work and Health
DA1 (c): MECC
Prevention Network (inc. DPH's)
DA2 (a): Commissioning Framework
DA2 (b): Cancer screening
DA2 (c): Common mental health needs
DA2 (d): Right Care
DA2 (e): Improve self management
DA3 (a): Single commissioning & Market Management
DA3 (b): Improved care in care homes
DA3 (c): Rapid response & intermediate care (inc. bedded & Homecare)
DA3 (d): Discharge to assess
DA3 (e): Last phase of life
DA4 (a): Long term mental health needs
DA4 (b): Targeted interventions
DA4 (c): Crisis care
DA4 (d): Children and Young peoples mental health
DA5 (a): Specialist commissioning
DA5 (b): Seven day service standards
DA5 (c): Configuring Acute Services
DA5 (d): Productivity Programme
Market Management
Long Term Needs Group
Crisis response Group
Hospital Discharge Group
Operational
OTHER GROUPS
Older People's Care Reference Group (including DA3 Workforce Group)
HR Directors Network
NWL Technical Design Authority
Transformation Advisory Council

Local Capacity

As part of our agreed use of iBCF monies the three boroughs have iIdenitfied the key areas for investment in sustaining the care market, expanding capacity, and using £2.3m to support initiatives to reduce Delayed Transfers of Care.

The full details of how this money will support our shared ambitions will be reported as part of the BCF quarterly submission.

The West London Alliance (WLA) is leading on a programme of change across North West London (NWL) to improve the service that residents receive when being discharged from hospital. To enable this change, the NWL boroughs are collaborating to provide a more consistent service and maximise the efficiency of existing resources by working more closely together.

Through the collaboration of local authorities in North West London the programme aims to improve outcomes for people being discharged from hospital. The changes will provide a more consistent transfer of care service in NWL for the residents of all boroughs, irrespectiveant of the hospital attended.

Action Plan

The attached spreadsheet of actions is a comprehensive list of areas for action under development. Once fully completed, the action plan will provide a clear leadership, accountability and expected outcomes for each action. Wherever possible, it will identifdy the estimated contribution of each action or scheme toward reducing DToC. This plan sits alongside and supports the individual DTOC reduction plans for each provider.

For example, Imperial College Healthcare NHS Trust have identified from health DTOCs by category that for H&F residents, the majority of days lost were due to waiting for non-acute NHS care e.g. a rehabilitation placement or continuing care home placement. The delays in this category are primarily for NHS Continuing Care assessment and access for Care at Home or Placements. This is followed by waits for assessment for interim nursing or permanent placement – particularly Dementia Nursing. It is anticipated that delays for these categories will be reduced through the implementation of Trusted Assessment (see below).

Delays experienced due to community equipment, such as beds, mattresses or hoists, will be improved through the implementation of Integrated Discharge Teams (see below).

37 per cent of delays for Adult Social Care relate to residential and nursing placements. It is anticipated that these delays will be reduced through a combination of Integrated Case Management and Integrated Discharge teams (see below). Capacity and access to assessment for care homes poses a risk to DTOC reduction plans. There are plans to recruit 2 Nursing Home Nurse Assessors as part of the better care plans to support hospital discharges, to facilitate access to nursing home assessment and placements.

The Trust has committed to reducing DTOCs by 50 per cent in H&F as part of an improvement plan to include the following:

- Early discharge planning – discharge planning commenced early in the pathway, with multidisciplinary board rounds, ward allocated Social Workers and assessment of need from admission or pre admission if possible.
- Multi-agency discharge teams – teams that are co-located where possible and include specialist discharge nurses/CHC assessors, British Red Cross, specialist homeless workers and therapy teams. The teams will work together, reducing duplicate assessments and referrals, streamlining processes and handovers of care needs.
- Home First – this is a pathway whereby people who are clinically optimised and do not require an acute hospital bed, but may still require care services are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.
- 7 day service – providing a service for patients and access to clinical review and senior decision making 7 days a week, resulting in access to care requirements and discharge from hospital when they are medically fit to leave. Services provided across the Trust 7 days a week include the specialist discharge team, social services and CIS.
- Trusted assessor roles – delays in patient discharge can be harmful to patients but most can be avoided, particularly if the delay is caused by waiting for a care provider to assess and accept a patient into their service. A trusted assessor carrying out the assessment − someone acting on behalf of and with permission of the provider − is an effective way of dealing with these delays.
- Focus on choice – partnership working to support where feasible choice of care provision and ensuring patients and families are given information on options available. Where first choice options and provision are not available ensuring a joint approach across health and social care to provide alternative care arrangements. Early discharge planning and information will aid the choice discussion and ensure all of the multidisciplinary team understand expectations and limitations.

This is being addressed through three interlinked strategies:

i. Home First (Discharge to Assess)

A Home First pilot commenced in July on four wards across the St Mary's and Charing Cross Hospital sites. This model has demonstrated significant benefit in reducing delays in other areas of North West London, although it has been more challenging than anticipated to identify suitable patients for discharge using this pathway in our hospitals. These challenges are being addressed through dedicated medical and nursing leadership and targeted communications to wards teams.

ii. Trusted Assessor

The Trust now has six trained trusted assessors in place to establish and the process for trusted assessment will be implemented by the newly established Integrated Care Management Team. The team is hosted by the Trust and works across the Imperial College Healthcare NHS Trust and Chelsea & Westminster NHS Foundation Trust sites. Since its establishment, and in the last two months, the team has supported increased occupancy and reduced length of stay at the Farm Lane bedded community rehabilitation unit thereby freeing up acute capacity.

iii. Integrated Discharge Team

The Integrated Discharge Team includes hospital-based specialist discharge nurses and co-ordinators working collaboratively with hospital-based social workers to address issues of complex social care. A pilot has been running on three wards across the Trust since June with positive feedback received from acute teams. Information technology and governance issues are delaying the reduction in duplicated health and social care assessments. The pilot was extended to include a further three wards from July.

In addition, the Trust is in the process of scoping the potential for establishing a winter ward in a local care home, potentially providing 10 beds for medically optimised patients awaiting placement in residential care. This would be focused on a cohort of patients for whom the Home First model would not be appropriate. The Integrated Care Management Team would be responsible for managing the flow of patients from acute beds to the winter ward. The scoping exercise will be completed and a decision on whether to proceed with this plan taken by the Trust by the end of September.

Appendix 1 Managing Transfers of Care (DTOC reduction delivery plan) 2017/19 for the three boroughs