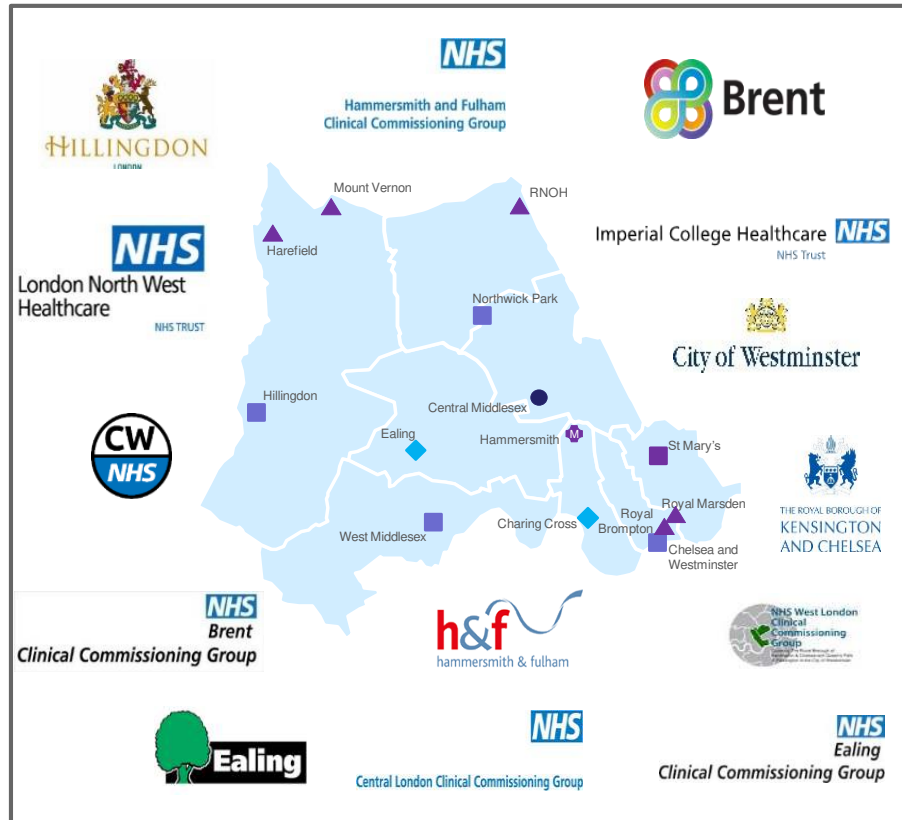in partnership with:

West London Alliance - Integrated Hospital Discharge Programme

Stephen Day and
Cheryl Barsdell

What is the WLA Integrated Hospital Discharge Programme?

The WLA IHDP is a programme of integration of health and social care teams, at the crucial transition of hospital discharge.

- Social Workers are allocated to the wards and join the Multi-Disciplinary Team meetings.

- Local authority teams are co-located key hospital sites, thus allowing early identifications of patients with social care needs.

- The discharge pathways are streamlined across the region.

Who is Charlie?

Charlie lives alone in a 3rd story flat in Wembley. He has no close family or friends to support him. Charlie has arthritis that can occasionally cause him pain when walking upstairs or getting out of bed. Charlie has a dog who lives in the flat with him.

Charlie has a fall while out shopping.

Passers by phone an ambulance and Charlie is taken to Ealing hospital. Charlie has fallen on his arm with some heavy bruising starting to show and so is **admitted to a ward for tests** to take place. Charlie's dog is taken to a kennel on Charlie's admission as there is no one to care of him.

How Charlie feels

'**I want to go home as soon as possible** and be at home to look after my dog. I have lived on my own for several years and have never needed any help. **I want to get back to my normal routine around the house** and walk the dog to the shops each day to pick up my shopping.'

Table of contents

Objectives
The strategic context of change
Co-design and co-production
Stakeholder engagement
Results and impact
Conclusion
Next steps

The programme's approach to change management

The programme's approach to stakeholder management

The impact on patient experience

Overview of next steps

Objectives
The strategic context of change
Co-design and co-production
Stakeholder engagement
Results and impact
Conclusion
Next steps

1. **Prevention & Demand Management** – ability to intervene early to improve outcomes

2. **Integration & Whole systems working** – integration between LAs, sub-regional and sector-wide with sector STP plans

3. **Personalisation** – putting the person at the heart of the offer and process

4. **Systematisation** – scale at different spatial levels

5. **System Resilience** – linking into Urgent Care networks and enabling trust-building across health and social care

6. **Workforce** – an increase in demand vs decrease in supply and London has a significant shortage of social care, nursing and therapist practitioners.

The evidence

- The average length of stay for a cross-border admission within NW London is 2.9 days longer than one within a CCG boundary
- 17,000 days are spent in hospital beds that could be spent in an individual's own bed
- Delayed discharges are often due to the assessment's complexity, home care package or home adaptation
- 43% of hospital demand on ASC occurs outside the host hospital's Local Authority
- 30% of inpatients could have their needs met more effectively in another setting
- 40% of inpatients over 75 are well enough to leave

What experience of care did Charlie have?

Charlie is identified as requiring social care by the ward staff, however no Brent social worker is located at the hospital. Although Charlie appears to be medically fit, it is clear that he has social care needs and will require an assessment from the therapists.

It is unclear what care Charlie previously received before being admitted.

Charlie is assessed by the doctors and nurses and confirmed as medically fit. No one has time to complete the Section 2 immediately.

The assessment notification is received by ASC followed shortly by the Section 5. The Brent worker requires additional information to what has been recorded on the Section 5 and will need to visit Charlie in Ealing hospital to further assess him.

Although Charlie was confirmed as medically fit several days ago, **his discharge has been delayed**. The hospital place Charlie in a community bed to prevent his discharge being further delayed. The social worker's assessment identifies that Charlie would have been better cared for at home with Reablement care to help him achieve his goals however Charlie has now become dependant on the higher level of care provided.

West London Alliance
IMPROVING OUTCOMES FOR WEST LONDON

- **Focus on residents & customers** – design one way of discharging patients from all hospitals in the region

- **Create standard and clear offer to residents and patients across WLA –**align systems to evidence base – i.e. NICE guidelines and national best practice

- **Drive better outcomes and through better use of resources** – remove duplication and variations in quality of care

- **Invest in people and capability** – significant culture change, system leadership required to achieve sub-regional working

- **Maximise current levers & mechanisms** e.g. BCF timelines to be moved forward to allow adequate system planning

- **Overcome system hurdles, policies, legislation –** highlighted through sub-regional which needs to be addressed by NHS England and public sector leaders

Objectives
The strategic context of change
Co-design and co-production
Stakeholder engagement
Results and impact
Conclusion
Next steps

Co-design

Co-production

Collect feedback

Escalate issues

Sense check the model

Front line staff, lay partners, senior leaders

Support the implementation

Shape the new model

Guide colleagues through the change
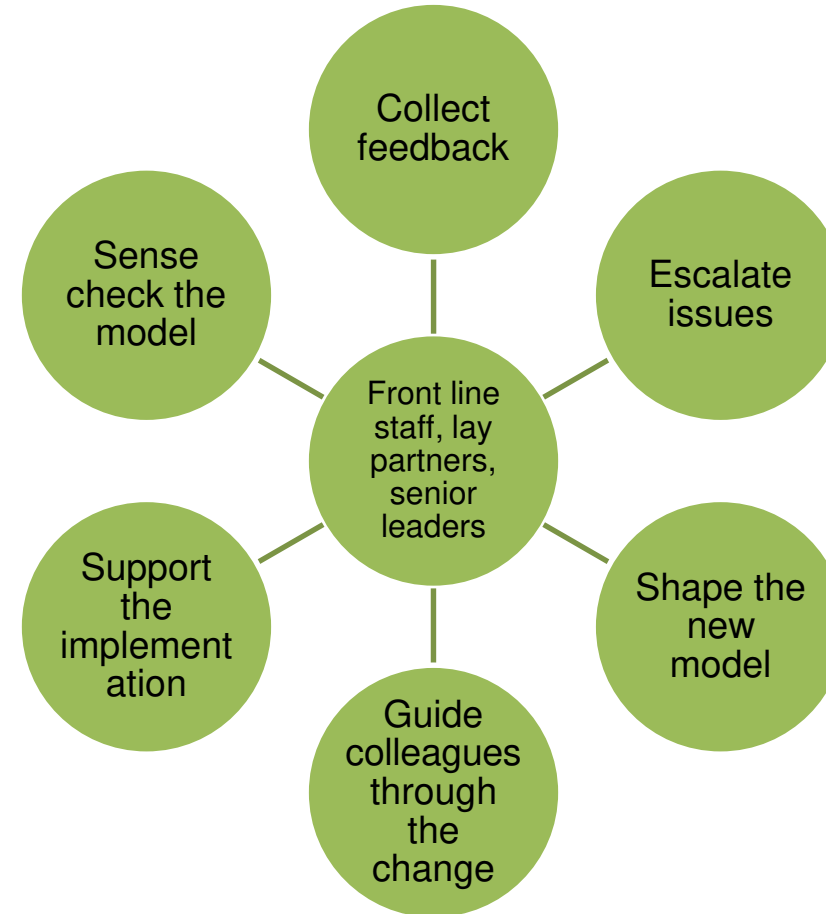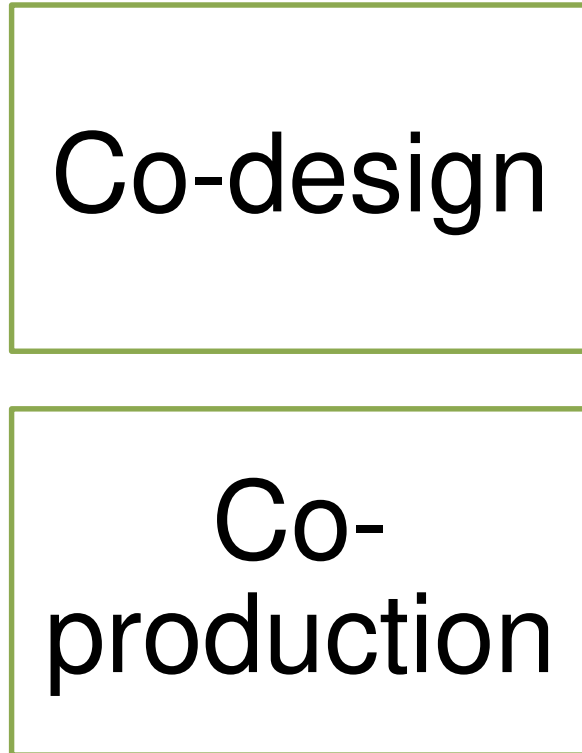
Co-design and co-production mean involving key stakeholders throughout the change

The aims of the co-design process were to:

1. Align the approach to discharge across Three Boroughs, Ealing and Brent local authorities.

2. Align the approach to discharge across health and social care staff to enable joint working.

3. Define **simple and effective hand-ons** between the hospital teams and teams within the community.

4. Provide a 'streamlined approach' to hospital discharge which meets best practice and a **co-designed set of design principles**.

5. Ensure the process can be flexibly implemented at each hospital site to **take into account real local differences**.

6. Ensure **lay partners and patients** have the opportunity to give their feedback and express their views, to actively shape the design process.

Co-design and co-production ensure the solution is tailored to the local needs

The co-designed interdisciplinary model of care 1

MDT

Service user's journey through hospital

Single WLA Function

Brent
City of Westminster
KENSINGTON AND CHELSEA
h&f hammersmith & fulham
London Borough of Hounslow
Ealing

Streamlined process

Social workers form part of the **MDT** on the ward

Social workers informed of resident attendance **early** in the process

Not relying on S2/S5

Single assessment form

On-site support from **social workers in the MDT**

Social workers **aligned** to the **wards**

Key discharge worker allocated at MDT across heath **or** social care

Discharge date and **plan** agreed with **MDT** (inc. social care)

Trusted assessor model; single **proportionate assessment**

Informed service users

Telling their story once

Patient **choice**

Early discharge planning

Key discharge worker ensures **family/carers** are **informed** and prepared

Streamlined **pathways** in to the **community**

Discharge to assess model

At all points of the journey

West London Alliance
IMPROVING OUTCOMES FOR WEST LONDON

The co-designed interdisciplinary model of care 2

MDT Admission & Discharge Planning

Single WLA ASC function integrated in hospitals

Single Health & Care Assessment

Shared Discharge Process

Shared Patients & Carers

Holistic Needs Identification

One Common Referral Process

Single Point of Access – brokering & arranging personised health & care provision

Onward **health and care support**

SPA

What are the core principles of the new model of care?

Customer centred care – Service users and their carers input in to their care and are fully informed throughout the journey. Service users only have to tell their story once.

Clear Segmented Pathways – Ensure that patients are directed towards the most appropriate level of care.

An integrated hospital discharge pathway across ASC and health.

Tailored design per hospital – Ensure that the designs fit with the way each hospital works now.

Single discharging function – Think about discharge in a truly holistic sense.

Early assessment – Reduce delays, ensure that the most appropriate care for patients is identified early.

Inter-disciplinary working – Coordination across professions supports discharge.

Consistent approach for all WLA residents, irrespective of their hospital.

Single and streamlined assessment approach – Reduce the amount of duplication and make it easier to share information.

Simple hand-ons between WLA ASC hospital teams – Simple hand-ons to home borough team shortly after discharge to manage the specific local processes involved in onward care and reviews.

What difference does this make to Charlie's care?

A social worker attends the MDT and obtains all relevant information from all health professionals involved.

The social worker and therapists assess Charlie for his immediate health and social care needs.

The social worker quickly arranges the care needed to get Charlie home.

Charlie gets to return home and the community teams will work with him to achieve his goals.

Objectives

The strategic context of change

Co-design and co-production

Stakeholder engagement

Results and impact

Conclusion

Next steps

The programme team involved all the relevant stakeholders, throughout all phases of change.

The engagement strategy focused on allowing staff to own parts of the programme, giving them control over the content and approach to the changes.

This meant involving staff in focus groups and design groups, to facilitate the process of coming up with ideas and sharing them.

The programme also ensured that the governance, decision-making processes and accountability lines were clear to all involved.
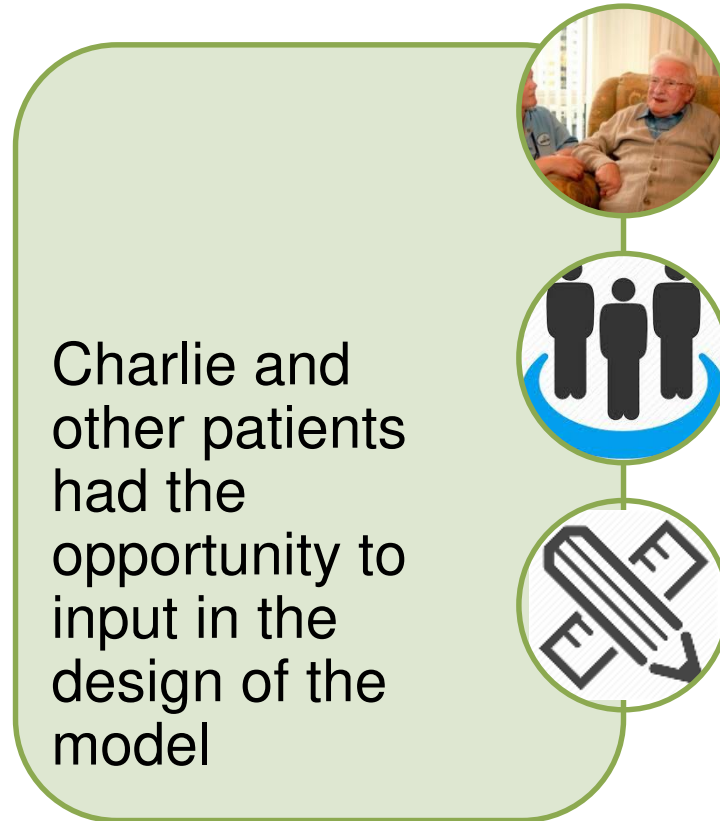
The programme team managed relationships with over 200 people across:
- 3 CCGs
- 3 NHS Trusts
- 8 Local Authorities

Effective stakeholder engagement is essential to the success of the programme

The programme team run a lay partner session and worked closely with a patient reference group.

Charlie and other patients had the opportunity to input in the design of the model

Objectives
The strategic context of change
Co-design and co-production
Stakeholder engagement
Results and impact
Conclusion
Next steps

The new service improves patients' experience, and creates a standard and clear pathway to residents and patients across WLA, aligned to the National Institute for Health and Care Excellence guidelines (NICE) and national best practice. The new service achieves the following patient outcomes:

- Patients return home from hospital sooner.
- Patients have a bigger input on the care they receive after leaving hospital (**personalisation**).
- Patients have clear information about the care they will receive, as soon as possible.
- Patients tell their story once and professionals share this information amongst themselves (**inter-disciplinary working** and **trusted assessor**).
- Patients understand who is responsible for their care and can contact them easily (**key discharge worker**).
- Patients feel that the people caring for them are working together as a single team (**system resilience**).

What does the evidence say?

Patients' experience of hospital discharge has improved as a result of the new model implementation. In comparison between the 2014 and 2015 Care Quality Commission Adult Inpatient Survey at Chelsea and Westminster Hospital, in 2015:

• More patients felt involved in their discharge decisions.

• More patients were given enough notice of their upcoming discharge.

• More patients had their home situation taken into account during discharge planning.

Patient experience has improved

Objectives
The strategic context of change
Co-design and co-production
Stakeholder engagement
Results and impact
Conclusion
Next steps

The WLA programme has delivered…

1. A new integrated model of hospital discharge.

2. Better outcomes for patients.

3. Improved patient experience.

…Through

1. Co-design and co-production of the new models of care.

2. Effective stakeholder engagement.

Charlie's experience of hospital admission and discharge:

- Early identification of Charlie's needs.

- Continuity of care between hospital and the community.

- A holistic approach to Charlie's needs and care preferences.

Objectives
The strategic context of change
Co-design and co-production
Stakeholder engagement
Results and impact
Conclusion
Next steps

Next steps

The programme team is still working on extending the model and embedding the changes.

Over the next year, the plan is to:

- Put in place **hosted-provision arrangements**, allowing social workers to assess patients on behalf of other boroughs, regardless of the patient residency.

- Support the **IT integration** process, allowing social workers to access other boroughs' IT systems.

- Create a **single discharge function** on the wards.

- Implementation of **'Home First'** models, to get patients home, where assessments for long-term care can be completed in a setting that is more familiar to patients.

Programme timeline

JAN 2015 - New integrated hospital discharge **model of care** developed

MAR 2015 – Triborough **Pilot** launched in 3 hospitals supporting 8 wards with integrated discharge across the Triborough

DEC 2015 – Proposed business case based on agreement at the Collaboration Board

APR 2016 – Streamlined referrals to Brent community services; from 8 access points to 2

MAY – JUN 2016 – Standardised NWL Needs-Based Assessment Form in use across all NWL acute trusts

JUN 2016 – Phase 1 complete – go-live of 7-day common assessment (health) form across NWL and alignment of protocols and pathways across the WLA

FEB – JUN 2016 – Colocation of WLA staff and implementation of early identification process across Imperial, LNW & Hillingdon hospitals

MAR 2016 – Implementation of whole hospital 3Borough ASC teams supporting ward-based MDT discharge

OCT 2016 – Needs-Based Assessment Form in use to refer to social services in WLA area

Nov 2016 – Phase 2 complete. Common ASC model, processes & assessment across Brent, Ealing and 3boroughs

Nov to May – phased implementation of WLA ASC joint discharge teams

3B
H

West
London
Alliance
IMPROVING OUTCOMES FOR WEST LONDON

Phase 3 & 4

Overview of future plans

Earlier: 2015-2016

- Develop a business case and three pilot projects for managing people out of hospital, and a shared approach to admissions avoidance & hospital discharge across west London boroughs, aligned to hospitals across NW London.

Soon: 2017-2018

- Work with NHS NWL to develop a plan for providing better strategic alignment and system leadership
- Linking in public health to develop a focus on upstream prevention and demand management.
- Scope and roll out a collaborative approach to market management of health and social care services.
- Develop collaborative approaches to hospital discharge, avoidance and access to health and care services.
- Work with NHS England to establish a funding mechanism that allows for greater pooling of budgets.
- Developing new delivery models e.g. accountable care organisations, multiple specialist provider networks.

Later: 2019-2020

- Implement new health and social care commissioning models across North West London to keep patients and services users out of acute care and supported by community provision and affecting a shift from treatment to prevention.

West London Alliance
IMPROVING OUTCOMES FOR WEST LONDON