

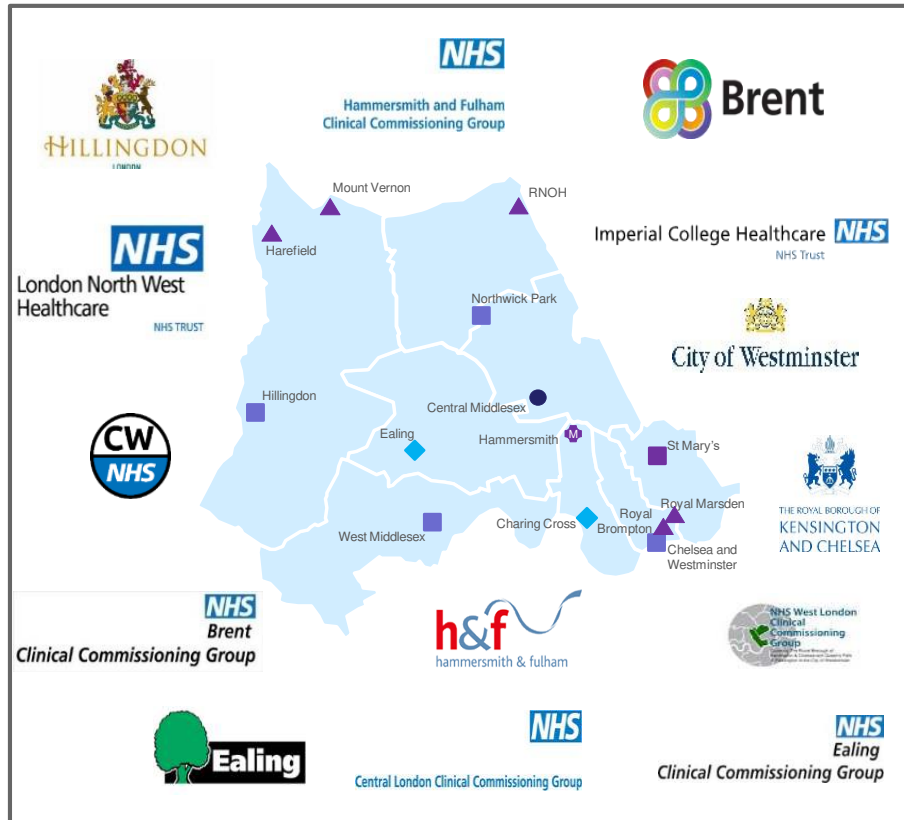
in partnership with:

West London Alliance - Integrated Hospital Discharge Programme



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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.

Introducing a WLA resident: Charlie

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.'

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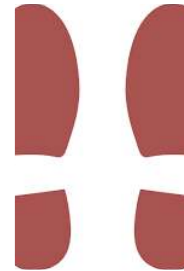
The programme's
approach to change
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The programme's
approach to stakeholder
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The impact on patient
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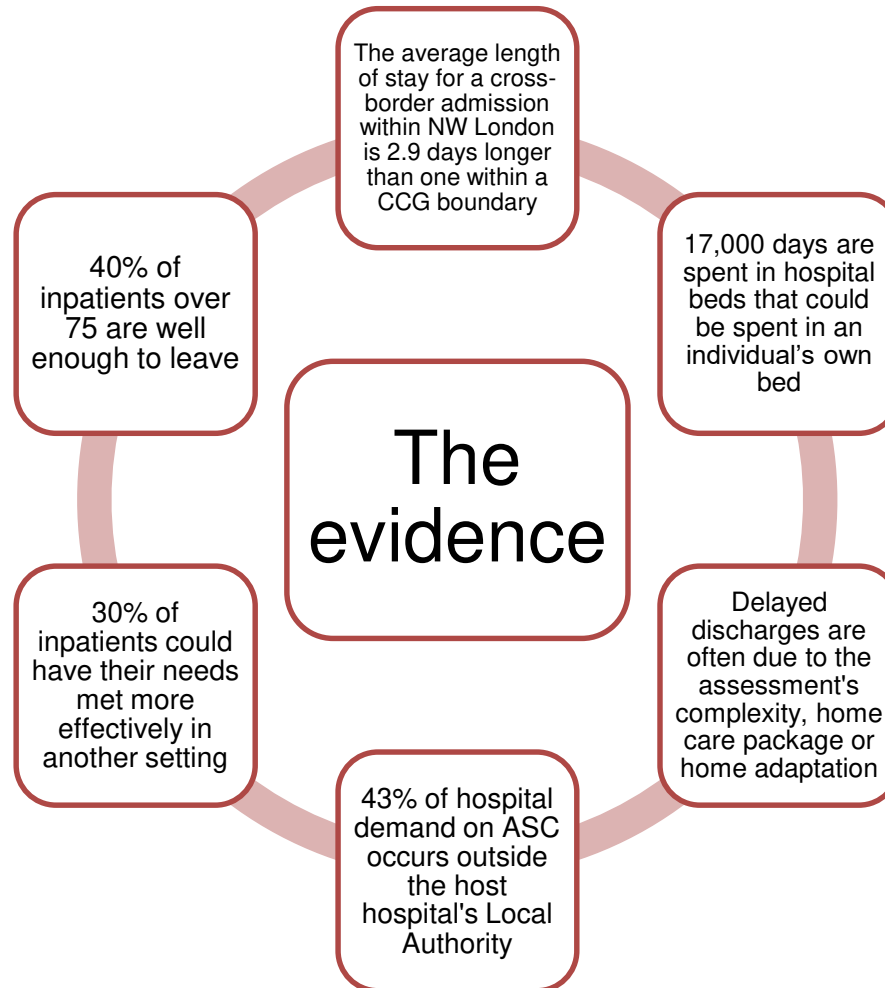
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The strategic context for integration

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.

What was happening in North West London before the programme?



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.

What did the programme focus on, to improve patient experience?

- **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

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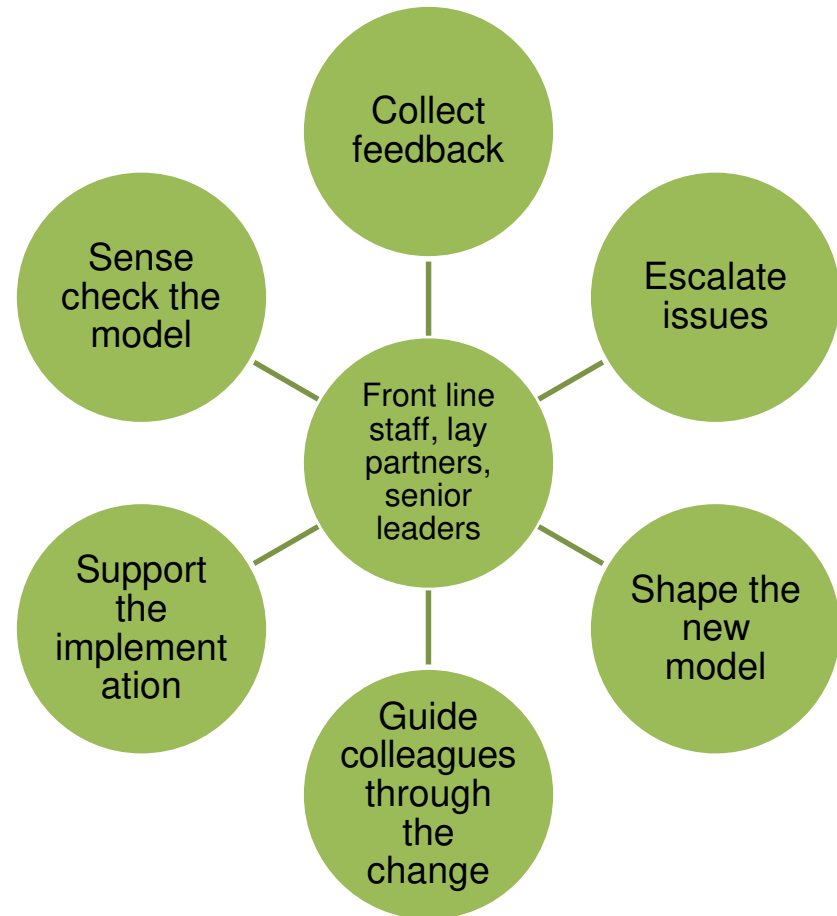
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How did the programme team design the new model of care?

Co-design

Co-
production



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

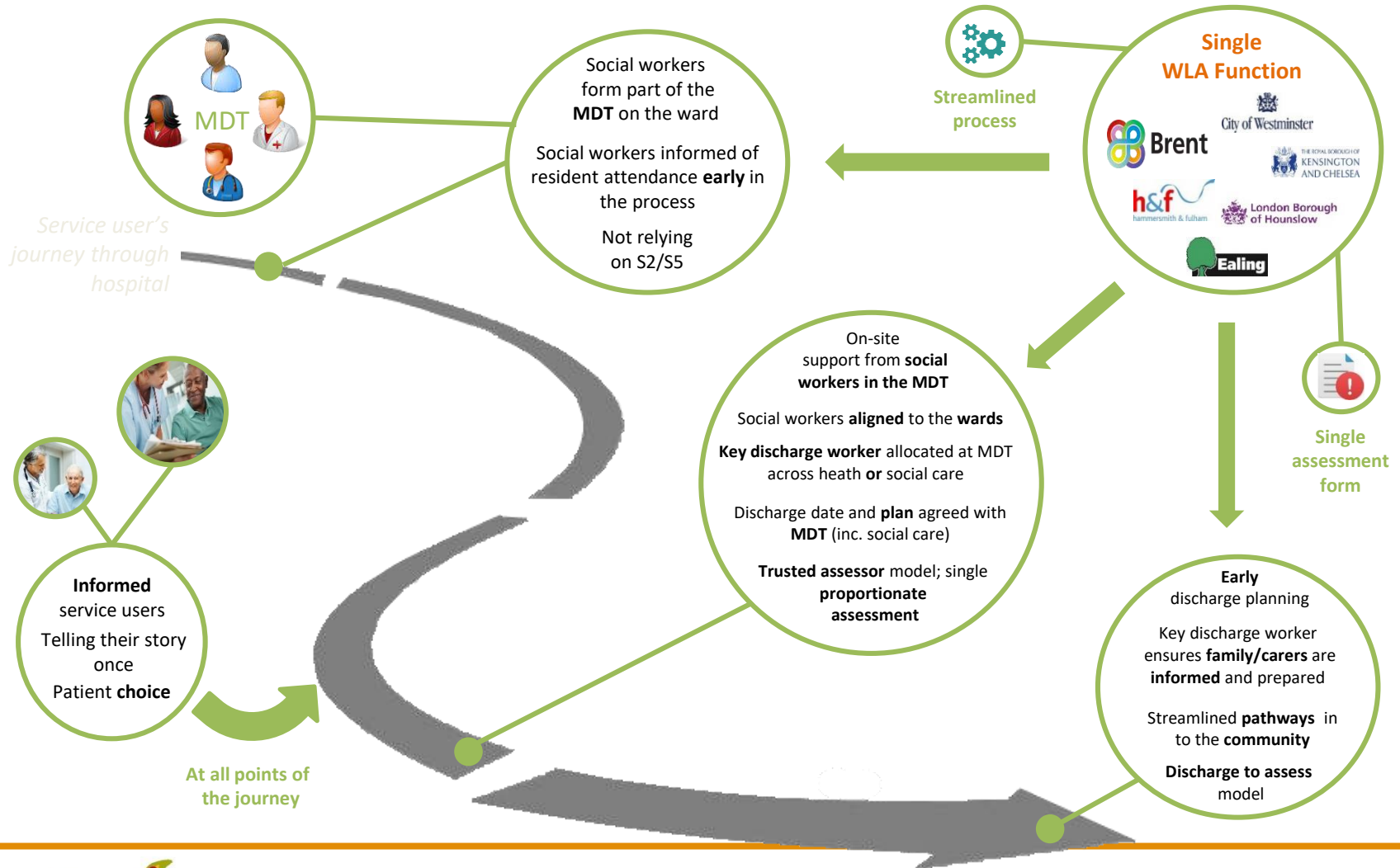
What is the aim of co-design?

The aims of the co-design process were to:

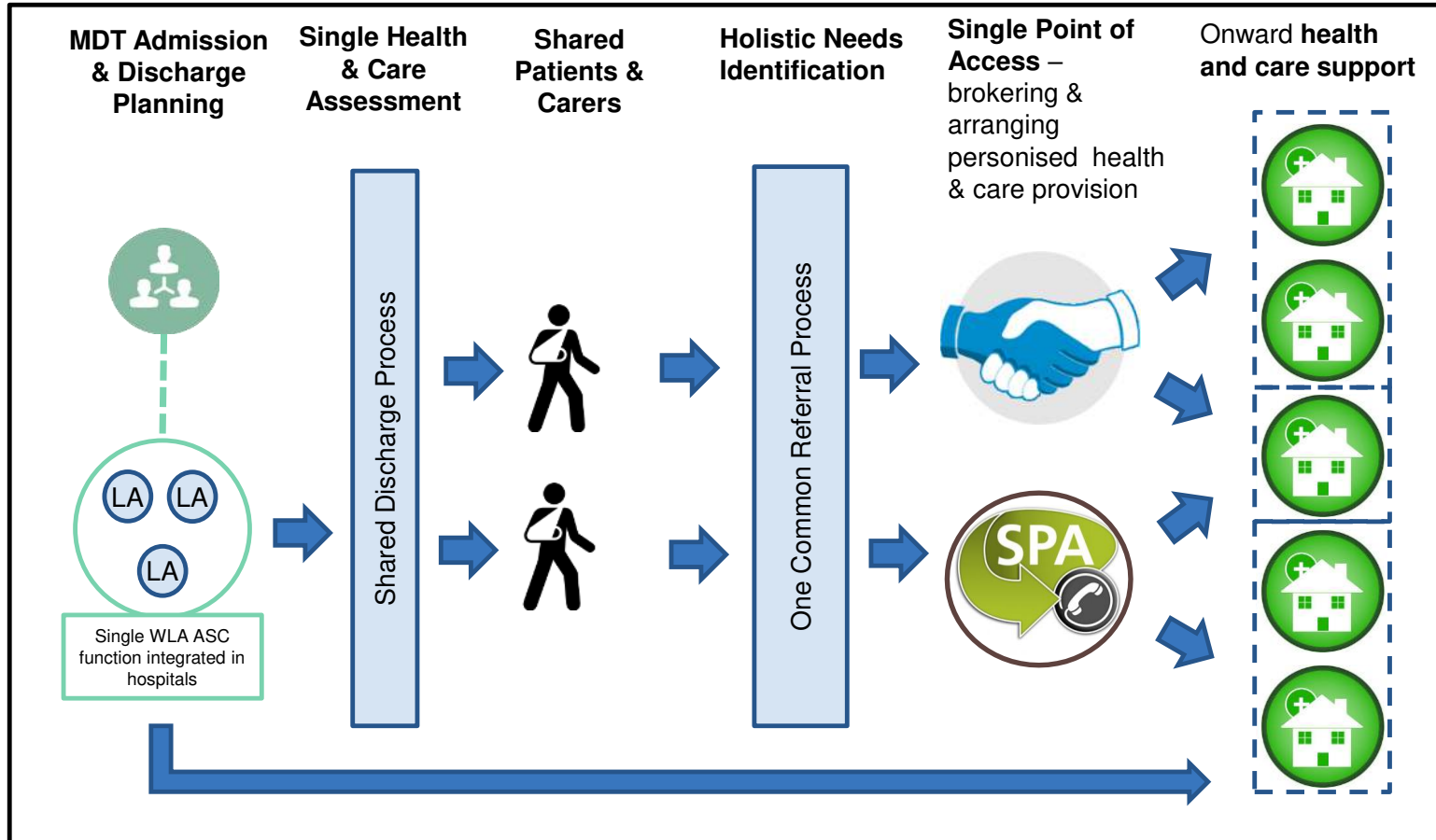
1. Align the approach to discharge across Three Boroughs, Ealing and Brent local authorities.
2. Align the approach to discharge across health and social care staff to enable joint working.
3. Define **simple and effective hand-ons** between the hospital teams and teams within the community.
4. Provide 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



The co-designed interdisciplinary model of care 2



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.



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How did the programme team engage with stakeholders?

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

What opportunity did Charlie have to have his voice heard?

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



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What does this mean for patients?

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

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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.

A positive experience for Charlie

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.



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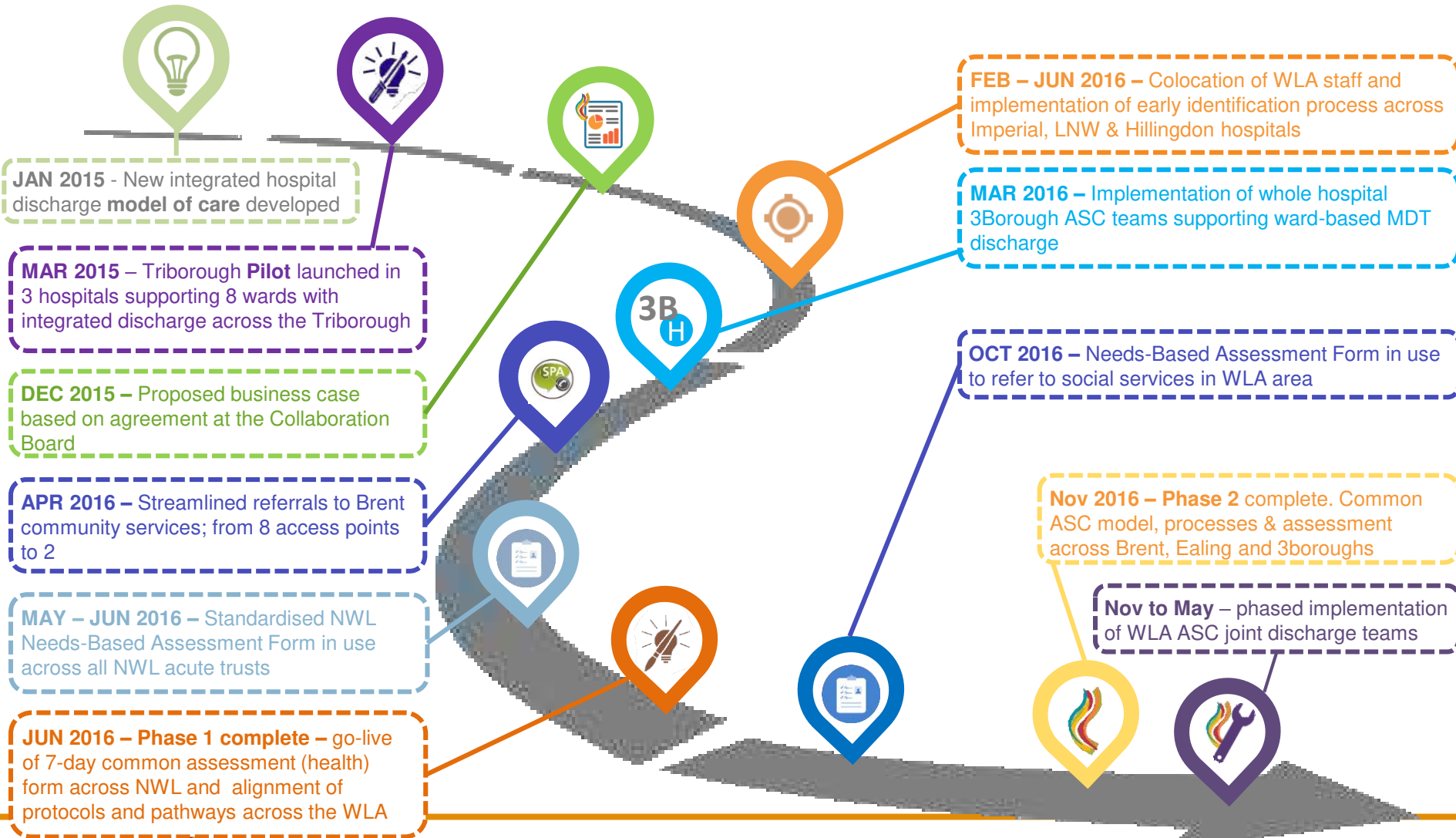
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The programme team is still working on extending the model and embedding the changes.

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



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.