Healthy London Partnership

# Urgent and Emergency Care Improvement Collaborative

## Acute discharge

Supported by and delivering for:

Public Health England

NHS

directors of adass adult social services

SUPPORTED BY MAYOR OF LONDON

**London's NHS organisations include all of London's CCGs, NHS England and Health Education England**

# Agenda

| Time | Item |
|---|---|
| **10:20 – 10:30** | Welcome and overview |
| **10:30 – 10:50** | Promising practice |
| **10:50 – 11:00** | Focus on 8 HIC |
| **11:00 – 11:30** | Action planning |
| **11:30 – 11:35** | Final points about actions |

# 8 High Impact Changes Hospital to Home

## Change 1

**Early discharge planning.** In elective care, planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

## Change 2

**Systems to monitor patient flow**. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.

## Change 3

**Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector.** Coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients.

## Change 4

**Home first/discharge to access.** Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

## Change 5

**Seven-day service.** Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people's needs.

## Change 6

**Trusted assessors.** Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

## Change 7

**Focus on choice.** Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.

## Change 8

**Enhancing health in care homes.** Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

# Action plan

| Change ambition | Specific short term actions | Next steps | Owner | Timescale |
|---|---|---|---|---|
| | | 1 | | |
| | | 2 | | |
| | | 3 | | |
| | | 4 | | |

# Home First

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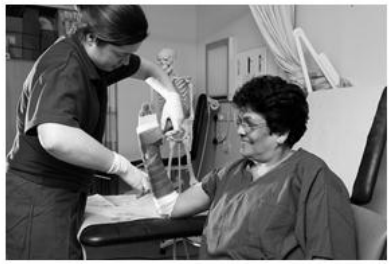
**Emergency Care Improvement Programme – Clinical Lead Health and Social Care**
**Transformation Director Health and Social Care Barking, Havering and Redbridge System**

**20th September 2017**


# What needs to change

- Attitudes
- Behaviours
- Culture

# Lessons learnt

Keep it Simple – centred on the person – feedback from patients is vital

Clear and agreed vision – no decisions about long term care made in hospital (minimal exceptions)

This is not necessarily about new services – it is about using existing services together differently

- Create a single intermediate tier of services, single point of access – always says ‘Yes’ (can be virtual)
- Flexibility of existing contract specifications
- Blurred boundaries and networks of care
- Leadership at all levels

Reduce handoffs and duplication

Reduce paperwork

Speaking to each other is vital – build trust

Learning and supportive environment

6968

Sunday

Acute Medicine/Care Consolidation

102

S/Scenarios

S2 + S3 - NEW

Shortcut #

MRU — 1

ERU — 2

BBA — 7

BBB — 7

ClemA — 3

Clem B — 7

Man A — 2

Man B — 4

CF B — 5

Har A — 3

Har B —

Sun A — 1

Sun B —

Ocean A — 7

Ocean B — 9

Amb A — 7

Amb B — 4

San A + HASU — 4

San B —

TOTAL QH - 73

TOTAL QH 74

147

## Challenges of the week

① 100 patients in Clothes across Trust By 12midday

② 'Pull' at least 1 patient to every ward before 10am

End use of 'full Capacity protocol daily'

③ 'Gold' Discharge for each day - for 8am Discharge for each Ward

TWEET YOUR SUCCESS

#ENDPJPARALYSIS

# RED2GREEN

# SAFER

Link QBHR HOSPITALS in your TWEET

#WECANDOTHIS.


Making the simple
complicated is
commonplace;
making the
complicated simple,
awesomely simple,
that's creativity.
Charles Mingus

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