Local Government Association

High impact change model

Managing transfers of care between hospital and home

Draft updated for 2020/21

A self-assessment tool for local health and care systems

Contents

1. Introduction

This model was developed in 2015 by strategic system partners, and was then refreshed in 2019 with input from a range of partners including the Local Government Association, the Association of Directors of Adult Social Services, NHS England and Improvement, the Department of Health and Social Care, the Ministry of Housing, Communities and Local Government and Think Local Act Personal Partnership. It has now been updated in July 2020 to integrate emerging learning from responding to the COVID-19 pandemic.

It builds on lessons learnt from best practice and promotes a new approach to system resilience, moving away from a focus solely on winter pressures to a year-round approach to support timely hospital discharge resulting in quality outcomes for people. While acknowledging that there is no simple solution to creating an effective and efficient care and health system, this model signals a commitment to work together to identify what can be done to improve current ways of working. Throughout implementation of the model, achieving the right outcomes for people is key, enabling them, with the right information and advice to make the best decisions about their ongoing care. The model is endorsed by government through its inclusion in the Integration and Better Care Fund (BCF) policy guidance.

The refreshed model

The 2019 review broadly endorsed the High Impact Change Model (HICM) as a positive tool to support the continued reduction of delays in transferring people home from hospital. Respondents asked for more clarity, a strengthening of focus on the person, and greater emphasis on the key Home First and discharge to assess policies. The resulting refresh therefore consists of a number of additional components including:

1. I and We statements: these expand on the impact of the changes from the perspective of the person or worker supporting them; these were chosen from Think Local Act Personal's Making it Real framework, and their usage is supported by the National Coproduction Advisory Group.
2. Tips for success: in addition to the outcomes in the maturity matrix and are often key principles.
3. The maturity levels are more focused on outcomes for both the system and people: these will not all match every system, but are intended to reflect what the changes should feel like.
4. Expanded links to supporting materials, including up-to-date case studies and fuller papers on certain changes.
5. The whole-system response needs to support a hospital 'place-based approach', enabling local systems to develop creative solutions which meet local demand and capacity. A shared understanding of performance underpinned by an agreed set of metrics to create a single version of the truth will help to achieve this.

2019 REVIEW OF THE HICM

As the model has been in use for several years, it was felt a refresh of its effectiveness was appropriate. This included a review of a wide range of materials, as well as consultation events to invite views from those using the tool. The evidence gathered included:

- Feedback from nine consultation events in each local government region, gathering reflections of over 550 colleagues from across health and local government.
- Online questionnaire asking for reflections on the model, completed by 44 respondents.
- Performance and reporting data, such as on implementation of the tool from BCF quarterly reports.
- Work of partner organisations and various regional projects underway to develop HICM support and collate good practice at a more local level.
- New sector research, quick guides and guidance (links to some of these materials are at the end of the introduction).

2. Purpose of the model

This HICM aims to focus support on helping local system partners to improve health and wellbeing, minimise unnecessary hospital stays and encourage them to consider new interventions.

It offers a practical approach to supporting local health and care systems to manage the individual's journey and discharge. It can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to improve flow throughout the year.

The original model identified eight changes which will have a significant impact on effective transfers of care; we added an additional change in the refresh; these are:

- early discharge planning
- monitoring and responding to system demand and capacity
- multi-disciplinary working
- home first
- flexible working patterns
- trusted assessment
- engagement and choice
- improved discharge to care homes
- housing and related services (added in 2019)

The new change was created in response to feedback about the importance of home-based support in facilitating discharge, and includes the use of effective housing, home adaptations and assistive technology services. The change is focused on what is needed in terms of the 'living environment' in order to enable a safe and effective discharge.

Respondents to the review also asked for the model to extend to cover admissions avoidance and other preventative actions. This is being developed by national partners as a separate good practice tool. This new tool will seek to identify actions which delay, divert or prevent the need for acute hospital and statutory care, and instead increase focus on maximising people's independence and helping to keep them well in their usual place of residence.

3. Principles

This model is not designed to be a performance management tool. Instead, it takes as its starting point a recognition that even the best-performing systems can experience challenges in relation to hospital discharge. Its inclusion as a national condition in the BCF is intended to support implementation of good practice, rather than to performance manage local systems.

The model is underpinned by a sector-led improvement approach which emphasises the importance of triangulating both hard and soft types of data and insight to tease out local stories within a culture of openness and trust. It reinforces the values set out in The Ethical Framework for Adult Social Care, written in response to COVID-19. This model supports genuine, honest reflection and discussion between trusted colleagues within local health and care systems and includes a suggested action plan so that decisions arising from conversations using the model can be implemented.

There are a number of overarching principles that underpin the model:

- Home First is an approach which expects people to return home as the preferred option, rather than end up by default in bed-based care. Discharge to Assess (D2A) enables this approach through a single point of access building on the successful joint working developed during the COVID period.
- A hospital is not the right environment for people to make long-term decisions about their ongoing care and support needs. Home First and Discharge to Assess enable assessments to be completed at home with families, carers or advocates, after reablement or rehabilitation if required
- It is important for the system to follow best practice in safeguarding, giving due consideration to deprivation of liberty, Mental Capacity Act (2005), and any other concerns that have been identified.
- An asset or strength-based approach to assessment and planning, as set out in the Care Act as part of a personalised health and social care approach, is essential.
- The whole-system response needs to support a hospital 'place-based approach', enabling local systems to develop creative solutions which meet local demand and capacity.
- Systems are encouraged to share and learn from practice emerging from the COVID experience
- The changes apply to all discharges although systems may want to focus on specific groups, such as around health inequalities or risk groups needing targeted support post-COVID infection.
- The changes are inter-linked and interdependent, are also solutions to problems, and may not be needed in their own right. So, set out to improve outcomes for people not tick a performance tool.
- Although there is no specific reference to overarching enablers of the good practice highlighted in the tool, these – including workforce, communication, culture, governance among others – are crucial and should be considered in any local conversation.

4. 'Making it Real' Framework

Providing personalised care and support is central to improving better outcomes for people transferring from hospital to an appropriate setting. Consequently in this updated HICM there is a greater prominence to this, linking the High-Impact changes to a person-centred approach. This model borrows from Think Local Act Personal's 'Making it Real' framework, which is a set of "I" and "We" statements that describes what good care and support looks like from a person's perspective and encourages organisations to work together to achieve good outcomes for people. TLAP's National Coproduction Advisory Group, made up of people with lived experience of accessing care and health, including family carers, were engaged to help decide how best to incorporate a more person-centred approach through inclusion of the Making it Real framework. These principles support a Home First D2A approach which measures success by achieving the best outcome for people after treatment in hospital, avoiding their readmission and maximising independence through timely provision of reablement where needed with due consideration being given to any safeguarding concerns, for a safe and timely discharge.

The framework is based on the following principles and values of personalisation and community-based support:

- People are citizens first and foremost.
- A sense of belonging, positive relationships and contributing to community life are important to people's health and wellbeing.
- Conversations with people are based on what matters most to them. Support is built around people's strengths, their own networks of support, and resources (assets) that can be mobilised from the local community.
- People are at the centre. Support is available to enable people to have as much choice and control over their care and support as they wish.
- Co-production is key. People are involved as equal partners in designing their own care and support.
- People are treated equally and fairly, and the diversity of individuals and their communities should be recognised and viewed as a strength.
- Feedback from people on their experience and outcomes is routinely sought and used to bring

Through engagement with TLAP's National Co-Production Advisory Group and the Making It Real framework, the refreshed HICM ensures that the tool reflects the voices of people and enables a focus on what matters to people when transferring in, out and through hospital. For more information, visit https://www.thinklocalactpersonal.org.uk/_assets/MakingItReal/TLAP-Making-it-Real-report.pdf

5. How to use the HICM

The self-assessment matrix forms part of the model, and the intention is for the matrix levels to describe the journey to what good looks like. This should enable a system to see where they might benchmark their current performance and thus inform their development plans. The wording of the matrix has been purposely chosen to provide systems with the flexibility to make a judgement call on where they would self-assess to be against a level. For example, instead of specifying exact timings or figures, the matrix uses words like 'many', 'often', and 'early'. While it is important to make an accurate assessment of your system, it is also important to ensure there is consensus across partners.

This tool is about supporting improvement, so once a level is agreed, the crucial point is that partners come together to create an improvement plan. The outcomes in the matrix are not set in stone. As a result, a system may feel it is performing well in any area but not always delivering as the matrix suggests. Given the flexibility of the model this is entirely possible. Systems can go back to the problem the change is designed to address and show how they have achieved success.

Self-assessment matrix levels:

Not yet established	Plans in place	Established	Mature	Exemplary
Processes are typically undocumented and driven in an ad hoc reactive manner.	Developed a strategy and starting to implement, however processes are inconsistent.	Defined and standard processes in place, repeatedly used, subject to improvement over time.	Processes have been tested across variable conditions over a period of time, evidence of impact beginning to show.	Fully embedded within the system and outcomes for people reflect this, continual improvement driven by incremental and innovative changes.

Emerging and Developing Practice

This refresh has incorporated the Emerging and Developing Practice resource, providing examples of work being undertaken across the country for each of the nine system changes. These reference a range of initiatives where there is already evidence of impact, and point to examples of emerging practice that are starting to make a difference. The examples are designed to be used alongside the HICM to provide a sense of what 'good' looks like when self-assessing, but also provide inspiration to support the development of joint improvement plans. The LGA/ADASS summary of Care Home Support Plans describes recent COVID good practice examples.

Measuring and Monitoring Success

As part of the refreshed model, one of the key challenges identified by many systems was how hard it could be to monitor and measure progress against each change. While systems implement the changes and make improvements to patient flow, it can be hard to show the impact or to maximise how well a change is working.

There are a number of support options available to systems if they require further help in implementing a change or the overall model. For more information, speak to your Better Care Manager or LGA Care and Health Improvement Adviser, or visit our website

Supporting Materials

Throughout the tool, there are links to further information, case studies and guidance. There are a range of materials which apply across more than one change [links to come]:

- NHS good practice guides: focus on improving patient flow; reducing long length of stay
- Why not home? Why not today? — (Newton, 2017)
- People first, manage what matters — (Newton, 2019)
- Reducing delays in hospital transfers of care for older people — (Institute of Public Care)
- London's mental health discharge top tips — (ADASS, 2017)
- Factsheet: hospital discharge — (Age UK, 2019)
- NICE guideline – NG 27
- NHSE/I hospital to home activities
- Rapid improvement guide to: red and green bed days — (NHS)
- NHS benchmarking report – (NHS)
- LGA and ADASS National Overview of Care Home Support Plans

Change 1

Early discharge planning In elective care, planning for discharge should begin before admission. In emergency/unscheduled care, a joint crisis response for people living at home and in care settings can prevent unnecessary admission. However once admitted, an expected date of discharge should be set as soon as possible,

Change 2

Monitoring and responding to system demand and capacity Develop systems using real-time data about demand and capacity taking a joint approach to shaping the price, flow, quality and shape of the market. While councils remain the lead commissioners and retain their Care Act duties, a joint approach is key to developing step-down facilities, integrated health and social care support and work with the voluntary sector.

Change 3

Multi-disciplinary working (MDTs) COVID has underlined the importance of MDTs, including the voluntary, community and social enterprise sector (VCSE), working together to deliver a Home First D2A approach. Effective discharge and positive outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, shared and agreed responsibilities, and good conversations with, and information for, people and families. Working together with the individual at the centre results in a more timely, safer discharge to the right place for them.

Change 4

Home First D2A This means people going home as soon as possible after acute treatment. It means always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best. COVID has shown success of a single point of access operated by an MDT.

Change 5

Flexible working patterns COVID is showing that seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system. This is successful, however, only if it is applied to all services including clinical decision-making and practical support services, including innovative use of virtual delivery.

Change 6

Trusted assessment Using trusted assessment to carry out a holistic strengths-based assessment avoids duplication and speeds up response times so that people can be discharged in a safe and timely way. During COVID, it has worked well and should be sustained among professional groups and between care settings.

Change 7

Engagement and choice Early engagement with people, their families and carers is vital so they are empowered to make informed decisions about their future care. A robust choice protocol, underpinned by a fair and transparent escalation process, is essential so that when people have capacity they can understand and consider their options.

Change 8

Improved discharge to care homes The NHS Enhanced Health in Care Homes framework supports ways to join up and coordinate health and care services to support care home residents. COVID is strengthening these healthcare links, ensuring safe transfer from hospital to home, and making greater use of solutions including digital technology.

Change 9

Housing and related services Effective referral processes and good services which maximise independence are in place to support people to go home. The need for housing and homelessness services, home adaptations and equipment are addressed early in discharge planning and readily available when needed. COVID has highlighted that people who are homeless are at greater risk from the disease, and that support should now to focus on their increased vulnerability.

Change 1: Early discharge planning

I In elective care, planning for discharge should begin before admission. In emergency/unscheduled care, a joint crisis response for people living at home and in care settings can prevent unnecessary admission. However once admitted, an expected date of discharge should be set as soon as possible

'Making it Real'- I/We statement

When **I** move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place before change happens.

We support people to plan for important life changes, so they can have enough time to make informed decisions about their future.

Tips for success:

- Ensure the MDT sets a proposed date of discharge prior to admission for elective admissions and within two days of an emergency admission.
- Ensure the individual and their family and carers are involved and central in discussions about discharge and that this occurs as early as possible. Encourage and support them to take responsibility in discharge planning.
- Draw up a simple but practical discharge plan and ensure practical considerations are accounted for (e.g. keys, clothes, heating). Identify potential barriers to discharge and review these on a daily basis (e.g. the individual is homeless or their home will be unsuitable to return to meaning they need a move to more suitable short-stay or permanent accommodation, or aids and adaptations to their home).
- Ensure there is clear ownership of actions and all agencies required for resolution are involved. Staff should have a strong understanding of procedures and escalation processes.
- Ensure all staff are aware they all have a role in discharge planning.
- Early identification of people who will need support on discharge assists clinicians in enabling community health and social care staff to identify the appropriate pathway and achieve a same day discharge.
- This is important where there are concerns about mental capacity, safeguarding or other complexities where the right pathway needs to be chosen in a safe and timely way.

Supporting Materials

- NHS guidance on hospital discharge planning
- NHS explainer for health and social care staff on early discharge planning:
- A review of discharge planning from the Nursing Times
- British Red Cross research and recommendations for getting discharge right
- NHS quick guide explaining how the red bag scheme works and how it supports discharge planning

Examples of emerging and developing practice:

- **Newcastle Gateshead: Bringing care homes from the periphery** - Introduction of a 'transfer of care bag', helping to improve communication between hospital and care home teams when residents moved between both settings, and raising the profile of older people living with frailty and very complex needs in care homes.

	Not yet established	Plans in place	Established	Mature	Exemplary
Planned	Discharge is not discussed when planning an admission or at the referral stage in the community.	There is an active plan led by senior staff to instigate early discharge planning for all planned admissions.	Joint pre-admission discharge planning is in place in primary care. A discharge plan, including an estimated discharge date (EDD), is started for all planned admissions.	GPs and district nurses, often within a MDT, lead the discussions about early discharge planning for elective admissions. Discharge planning is business as usual for all staff involved in referrals including community staff such as GPs and district nurses. People know what is going to happen to them and when they will be going home.	Early discharge planning occurs for all planned admissions by a rapid response community MDT with the person and their carers as well as other relevant agencies e.g. housing. People have a clear understanding of when their treatment is going to happen, what it will achieve and when they will go home.
Emergency	Discharge planning does not start in A&E (if an admission has been agreed).	There is an active plan led by senior staff to instigate early discharge planning for all emergency admissions.	Emergency admissions have a provisional discharge date set within 48 hours and planning to support discharge begins as early as possible.	Health and social care work with individuals and their families and carers to plan for and deliver EDDs. People at a high risk of admission already have plans in place. People know what is going to happen to them and when they will be going home, and discharge is on the same day as the decision that the individual need no longer reside in hospital.	All patients go home on date agreed on or near admission, and discharge is on the same day as the decision that the individual need no longer reside in hospital.
Red Bag Scheme	The red bag scheme (or appropriate substitute) is not being used.	There is agreement across partners to implement the red bag scheme and a project plan in place.	The red bag scheme is being piloted on at least one ward.	The red bag is business as usual across the system.	Staff understand the red bag scheme well and use it confidently, leading to smoother discharges.

Change 2: Monitoring and responding to system demand and capacity

Develop systems using real-time data about demand and capacity taking a joint approach to shaping the price, flow, quality and shape of the market. While councils remain the lead commissioners and retain their Care Act duties, a joint approach is key to developing step-down facilities, integrated health and social care support and work with the voluntary sector.

'Making it Real'- I/We statement

I have care and support that is coordinated and everyone works well together and with me.

We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services.

Tips for success:

- Establish a digital platform to provide real-time information about people and capacity across the system. You might develop a bespoke platform for your area or adopt an existing system.
- Use data analysis to understand system trends, to lead medium and long-term strategy, and to anticipate service demand across health and social care.
- Create plans to manage variance in system demand on a seasonal, weekly and daily basis, and to respond to unanticipated demand. This may not mean increasing capacity, but instead arranging staff rotas etc. to put resources in the best place/time.
- While councils remain the lead commissioners and retain their Care Act duties in relation to assessment and care planning, safeguarding and market management, a joint approach is key to developing post-COVID step-down facilities, integrated community and primary health and social care support and work with the VCSE sector.
- Daily ward and board rounds – virtual or face to face are key to managing flow to ensure people are on track to go home in a safe and timely way.
- Identify key system blockages and take action to resolve them. This may involve other high impact changes, such as Home First D2A, depending on your system's needs.
- Utilise 'Red and Green Bed Days' system help understand flow through the hospital by identifying wasted time in a person's journey in both acute and community ward settings.
- Give frontline staff the information they need to understand service capacity and to make the best decisions for individuals.
- Make plans for sharing relevant information easily and in a timely manner among partners. This will require an understanding of what information is useful to which system partners, and consideration of data governance.

Supporting Materials

- NHS guide to demand and capacity management
- NHS resources for demand and capacity management
- NHS Digital guidance on data sharing
- Nuffield Trust guide on understanding flow in hospitals
- Safer, faster, better: good practice in delivering urgent and emergency care
- Health Foundation/AQA guide on understanding whole system flow
- NHS presentation on modelling to identify system bottlenecks
- NHS 'Guide to reducing long hospital stays'
- NHS 'Rapid improvement guide to: red and green bed days'

Examples of emerging and developing practice:

- **Kent: Use of SHREWD** - Use of a daily reporting system to view capacity and flow within Home First/ Discharge to Assess pathway.
- **Central Bedfordshire: Hospital Discharge Service- Person Tracker** - To support the working of the co-located discharge teams, a 'person tracker' was developed, which has enabled the council to provide a single point of monitoring for its residents' admission, hospital stay and discharge data.
- **Southampton: Hospital flow and bed management** - Implemented an electronic system as a more effective way of managing complex discharges, which includes a user dashboard designed to provide "at a glance" status reports.

	Not yet established	Plans in place	Established	Mature	Exemplary
Responsive capacity	There is no understanding of system demand or its variations.	Analysis is underway to develop understanding of system demand and its variations.	Analysis has created an understanding of system demand and its variations, and practice changes are being implemented to better match demand and capacity.	Capacity usually matches demand and responds to variations. Understanding of system demand informs decision making.	Capacity matches demand and responds in real-time to variations. A sophisticated understanding of system demand informs decision making at all levels.
Improving how the system flows	There is no understanding of how the system flows or its blockages.	Analysis is underway to develop understanding of how the system flows and its blockages.	Analysis has created an understanding of how the system flows and its blockages, and practice changes are being implemented to improve performance.	There are no major blockages and ongoing action is taken to monitor and respond to issues with how the system flows.	Flow across the system is smooth, timely, safe and effective. Outcome destinations reflect a Home First D2A approach.
Effective information sharing	Information about how the system flows and demand is not shared with partners.	Conversations are taking place to develop information sharing infrastructure between system partners.	System partners share data about how the system flows and demand effectively and quickly.	Partners share an understanding of how the system flows.	Partners use data to examine flow and have a shared understanding of the cause of poor outcomes of patients or reduced capacity in the system.

Change 3: Multi-disciplinary working (MDTs)

COVID has underlined the importance of MDTs, including the voluntary, community and social enterprise sector (VCSE), working together to deliver a Home First D2A approach according to the criteria to reside. Effective discharge and positive outcomes for people are achieved through discharge planning based on joint assessment processes and protocols, shared and agreed responsibilities, and good conversations with, and information for, people and families. Working together with the individual at the centre results in a more timely, safer discharge to the right place for them.

'Making it Real'- I/We statement

I have care and support that is coordinated and everyone works well together and with me.

We work with people as equal partners and combine our respective knowledge and experience to support joint decision-making.

Tips for success:

- Work out who to involve in your MDT. Independent and VCSE organisations are important, particularly for supporting people who are funding their own care. Members of your MDT could include doctors, nurses, therapists, mental health practitioners, pharmacists, carers, dietitians, social workers, housing representatives (such as housing or homelessness officers or home improvement agency staff), and any other specialists who may bring expertise and coordination.
- Foster a collaborative, integrated working culture in the MDT, for example through joint training and co-location. COVID has underlined the importance of MDTs and joint work with the VCSE
- Working together with the individual at the centre results in a more timely, safer discharge to the right place. Consideration of people's mental capacity, their rights to continuing healthcare and their ongoing Care Act support needs are all better discussed outside hospital in a setting which maximises their opportunity for independence and reablement.
- Ensure social care and representatives of other discharge support services are involved in board rounds.
- Ensure the individual is treated as an equal partner in the co-planning of care. Provide accurate information and advice to them and their families and carers about their options and the risks involved, dispelling fears and working together to achieve the right outcome.
- Train your MDT to take a strengths-based, person-centric approach to coordinate care and support around the individual. Use continuous feedback and evaluation to improve the experience for staff and people accessing care.
- Make sure people have a named point of contact within the team and know who to talk to about planning their discharge.

Supporting Materials

- NHS guide for MDT development
- Social Care Institute for Excellent resource for MDT working
- National Institute for Health and Care Excellence guidelines on transfers of care, including how the multi-disciplinary team should work
- Health Education England framework for care navigation

- Tackle barriers to smooth and effective MDT working; ensure processes are clear and well-understood, and take measures to reduce funding disputes or confusion about responsibilities.
- Communicate clearly with staff so they understand who should be referred to the MDT. Overcome potential bottlenecks by not sending simple discharges to the MDT. The Single Points of Access / Discharge Hubs have worked well in COVID as a way of pulling people out of hospital to home and ensuring that people are not assessed in an acute setting and not making long-term care decisions when they are at their most vulnerable.

Examples of emerging and developing practice:

- **Durham: Multi-disciplinary discharge teams** - Teams Around Patients (TAPs) is a virtual model of integrated care delivery, which uses a multi-disciplinary working platform involving social workers, nursing and allied health professionals.
- **Lincolnshire: Hospital avoidance response team** - A service delivered by members of the Lincolnshire Independent Living Partnership, which takes referrals from secondary care discharge hubs, A&E in-reach teams, the ambulance service, primary care and community health providers, to help either prevent an avoidable A&E attendance or admission, or speed up discharge from secondary care.
- **Luton and Dunstable: Integrated discharge hub** - Co-location of the team which has regular multi-disciplinary sessions to track and discuss complex patients and their length of stay.

	Not yet established	Plans in place	Established	Mature	Exemplary
MDT working	No daily multi-disciplinary team meeting in place. Health and adult social care work in silos.	Plans developed to introduce MDTs on all wards, involving adult social care, community health and VCSE.	MDTs established on all wards, and work underway to foster collaborative working. Daily MDT meetings attended by adult social care, community health and VCSE.	MDT members work together well, leading to more effective discharge and better outcomes for people.	Single points of access run by MDTs operating a Home First D2A approach to discharge are working in the community to pull individuals out of hospital and assess them at home or in a step-down facility.
Discharge planning and assessment	Separate discharge planning processes in place.	Discussion underway to integrate health and social care assessment and discharge processes.	Practice changes to integrate health and social care assessment and discharge processes, through the MDT.	MDT staff trust each others' assessments and discharge plans.	MDTs maximise people's independence enabling them to live at home using trusted assessment and a reablement approach working together with primary care.

Change 4: Home First Discharge to Assess

This means people going home as soon as possible after acute treatment. It means always prioritising and, if at all possible, supporting someone to return to their usual place of residence before considering other options, because home is best. COVID has shown success of a single point of access operated by an MDT.

'Making it Real'- I/We statement

I can live the life I want and do the things that are important to me as independently as possible.

We talk with people to find out what matters most to them, their strengths and what they want to achieve and build these into their personalised care and support plans.

Tips for success:

- Establish system-wide principles between partners and develop a single narrative across the system about supporting people home as a default option. Concentrate on costs to the system, not provider versus commissioner or health versus social care costs.
- Simplify pathways for hospital discharge, and ensure discharge pathways are set up so home first is the favoured option.
- A home first approach and understanding that home is best also involves system-wide work to support people to remain at home: consider how multi-disciplinary teams and community/home care services can be developed to prevent escalation of need and avoid unnecessary hospital admissions or readmissions.
- Start with domiciliary support (rather than bed-based options) both in terms of service development and choice. COVID has shown the real benefit of caring for people in their own homes with domiciliary care support or PAs arranged via a personal budget.
- Remember there is strong evidence that therapy-led services achieve the best results. Consider merging reablement and rehabilitation services with voluntary sector support.
- Regularly review and evaluate intermediary care to ensure 'temporary' beds are not becoming permanent. Take measures to ensure the focus here is on reablement and recovery, not on getting people out of acute hospital beds.
- Ensure Continuing Health Care (CHC) and other assessments of long-term need are made after a period of reablement and recovery, during which a person's support requirements may change.

Home First D2A

Return people home as soon as possible after their treatment and within one day of being no longer considered having a reason to reside in hospital (MFFD). A single point of access operated by an MDT has proved a successful model in Covid and ensures there are no gaps in the care pathways and specialist support is mobilised. Locally developed models based on good system relationships are key supported by united senior leadership, especially when demand begins to exceed capacity.

- Consider using trusted assessment to provide speedy access for discharge to assess pathways or other discharge support services.
- To have a good home first support service you need it to be fully integrated i.e. NHS, the local authority, and VCSE and independent sector as well as having support structures of families, carers or advocates.
- Make sure these services will work for everyone: have a single point of access, including for people who fund their own care, people who need only low-level support, people who appear to meet the Care Act eligibility threshold and people who don't, and people with ongoing care needs.
- Track people to see where they are six months after discharge to monitor progress and impact of home first initiatives. You should expect to see a reduction in support for those with ongoing support needs. Monitor services as to their quality and effectiveness in terms of reablement and do not use services that will not provide that information or whose results are poor.
- Consider joint commissioning and strong market management interventions where they are needed. i.e. it is not helpful to have an excellent intermediate service if there is a lack of capacity to provide ongoing support.
- Work with consultants and therapists to build confidence and overcome risk aversion to discharge, using positive stories to achieve a hearts-and-minds culture change.
- The decision about future care should not be made in an acute hospital in the persons own home after a period of reablement and be the persons own decision, wherever possible, not the decision of family, clinicians or other professionals – people need to be informed and empowered to choose, whatever their age, disability or circumstance.

Supporting Materials

- ADASS partnership quick guide on discharge to assess
- NHS guide on home first for health and social care staff
- Blog post about the importance of a home first mindset, and how to develop it
- ECIP presentation explaining discharge to assess, with practical tips for implementation
- Sample discharge to assess model, used in Staffordshire and Stoke on Trent partnership NHS trust
- Sample public-facing page providing information about home first, developed by Suffolk County Council
- Royal College of Occupational Therapists guide on embracing risk and enabling choice

Examples of emerging and developing practice:

- **North Staffordshire: Track and triage** - Replacing the assessment functions on the acute site, it tracks patients from entry-to-end of D2A, with a 'pull' function once the patient is judged medically fit for discharge.
- **Bath: Home first/D2A** - A step down service (which uses apartments), and can be commissioned by any hospital clinician or health care professional involved in the discharge process.
- **Tower Hamlets: Admission avoidance and discharge service** - Consists of: rapid response in the community; an admission avoidance team; in-reach nurses and admission avoidance and discharge service (AADS) screeners; and an intermediate care team using a D2A model and offering up to six weeks intensive rehabilitation in the community.
- **Medway: Home First** - An approach and ethos which has sought to achieve Medway Health and Social Care Partners' pledge to: minimise patients' acute hospital length of stay; maximise independence through enablement; support care at home or closer to home; and make no decision about long term care in an acute setting.

	Not yet established	Plans in place	Established	Mature	Exemplary
Discharge to assess	People are usually assessed for care on an acute hospital ward.	Plans have been drawn up for a discharge to assess pathway, and nursing capacity in the community is being created to do complex assessments outside of acute hospital wards.	Discharge to assess pathway implemented, and practice changes in place to increase the number of complex assessments in the community.	Whenever possible, people are supported to be assessed in their usual place of residence.	Assessments under the Care Act, continuing health care, and mental health capacity take place in people's own homes unless a short period of step down reablement is needed. Investment in joint community-based reablement delivers increased independence and increased flow through hospital.
Reablement and pathways	Long-term care decisions are routinely made in an acute hospital ward. People are entering residential/nursing care too early.	Existing pathways have been evaluated and solutions developed for shifting the focus to reablement and recovery. Capacity is being created for reablement and intermediate care.	Practice changes in place to make reablement and recovery the norm.	Decisions about long-term care are not made in acute hospital wards, but instead after people have accessed reablement/intermediary care services. Whenever possible, people return home with reablement/intermediate support.	Investment in joint community based reablement delivers increased independence and increased flow through hospital. Single points of access ensure clarity of pathways and equality of access.
Embedding and home first mentality	Home first D2A is not well understood.	Home first is being debated as an overarching principle to inform other developments. It is raised in business as usual meetings.	Training material and workshops provide home first evidence and guidance. Staff know what home first means as concept as well as a service and own this way of working.	Staff expect to steer people into a home first pathway; it is their default position.	Home First D2A is the destination of choice for all – individuals, families and carers, clinicians and other professionals involved in the person's care. It is seen to be a safe and timely alternative to bedded care.

Change 5: Flexible working patterns

COVID is showing that seven-day working, weekend working and extended hours for services across health and social care can deliver improved flow of people through the system. This is successful, however, only if it is applied to all services including clinical decision-making and practical support services, including innovative use of virtual delivery.

'Making it Real'- I/We statement

I can choose who supports me, and how, when and where my care and support is provided.

We make sure that people can rely on and build relationships with the people who work with them and get consistent support at times that make sense for them.

Tips for success:

- Consider your system's demand, capacity and bottlenecks (see change 2) and identify where extended hours or weekend working could have the biggest impact. Local systems tell us that seven-day working does not need to be in place across the whole system for benefits to be seen. Be prepared to start somewhere even if corresponding services are not in place.
- Take a pragmatic approach to responding to your system's need: this does not need to be 24/7 working across all services; instead it is about placing staff well to ensure consistent flow throughout the week. Practical alternatives to seven-day services may work better for parts of your system, such as having a bigger volume of staff on Mondays to handle a weekend backlog.
- Think broadly about your whole system: identify where seven-day working could be helpful across health and social care, including pharmacy, transport and housing services. Talk to all partners, including care providers and work out cost implications. COVID has highlighted how integrated community health and social care teams supported by virtual or digital solutions can reduce the pressure on local services to provide this cover.
- Developing trusted assessment (change 6) can help to enable individuals to be assessed throughout the week or at the weekend in the community setting.
- Engage with practitioners to understand how increased seven-day working would affect them personally and what you can do to help. Don't assume staff won't work weekends – talk to them about how it could work.
- This change is undoubtedly challenging, so work gradually and draw on shared best practice and resources.

Supporting Materials

- NHS resources on achieving seven-day working, including clinical standards and case studies
- NHS resources for seven-day working
- NHS Digital data and indicators on seven-day working
- NHS resource on costing seven-day services
- King's Fund vision for seven-day working

Examples of emerging and developing practice:

- **Hertfordshire: Seven-day working** - Seven-day working strategy with the aim of improving the flow from acute to community settings, ensuring discharges were not put back over the weekend while people waited for a package of care due to processes outside of the Monday to Friday norm.
- **Hackney: "A continuous cycle of improvement in patient flow"** - Development of weekend working in strategically important service areas to help improve patient flow.
- **Milton Keynes: Getting people home** - Seven-day working through home first reablement supporting discharges every day of the week as part of wider strategy to "get people home".

	Not yet established	Plans in place	Established	Mature	Exemplary
Assessment and decision making	Patient flow is poor as a result of limited timings of assessment and decision making.	Plan being drawn up to move to seven-day assessment and decision making.	Practice changes in place in some areas of system to move towards seven-day assessment and decision making.	Increased seven-day working improves outcomes due to timely assessment and decision making with better opportunity to involve carers. Work underway to further extend seven-day working.	Assessments and decisions about long-term care take when the individual is ready, regardless of the time or day of the week, and in an individual's own home or in a reablement step-down facility.
Discharge services	Services to support discharge (e.g. transport, pharmacy, housing) only available Monday to Friday.	Service areas which could benefit from extended hours/weekend working identified and plans being drawn up for change.	Practice changes in place to extend service provision to facilitate timely discharges.	Increased seven-day service provision creates improved system flow. Work underway to further extend services according to system need.	Services are in place (e.g. transport, pharmacy, housing) to support smooth discharges when the individual is ready, regardless of the time or day of the week.
Care packages	Care providers only accept new referrals and restart packages of care Monday to Friday.	Discussions underway about how care providers can move to seven-day working.	Some care providers have moved towards seven-day working.	Most care providers accept new referrals and restart packages of care when the individual is ready, regardless of the time or the day of the week.	Council-led joint system commissioning of the care provision supports providers to work 7 days a week, understanding the pressures of COVID and the impact on care provision if discharges are not properly managed.

Change 6: Trusted assessment

Using trusted assessment to carry out a holistic strengths-based assessment avoids duplication and speeds up response times so that people can be discharged in a safe and timely way. During COVID, it has worked well and should be sustained among professional groups and between care settings.

'Making it Real'- I/We statement

I am supported by people who listen carefully so they know what matters to me and how to support me to live the life I want.

We know how to have conversations with people that explore what matters most to them – how they can achieve their goals, where and how they live, how they can manage their health, keep safe and be part of the local community.

Tips for success:

- Start by agreeing what the problem you are trying to solve is.
- Remember a trusted assessment can be either:
  - An assessment completed earlier in the persons' pathway being used, with agreement, for a second purpose and thus avoiding a delay
  - An assessment carried out by a third party on behalf of another organisation
- Think about using trusted assessment wherever there is a delay caused by an assessor not being able to do their assessment when needed – this includes access to home care.
- Remember trusted assessment can be used in a variety of settings, such as:
  - to agree restarts and ensure the person gets home more quickly
  - to support hospital discharge to a residential or a community service, in place of the provider carrying out their own assessment
  - to move between services
  - to make a local authority eligibility determination.
- Consider how trusted assessment interlinks with home first and discharge to assess – think holistically about your approach to the changes.
- Without trust between partners, trusted assessment will not work. Think about how to achieve and build trust to avoid poor outcomes for people. Trusted assessments can only be used with the agreement of all parties, so a co-design approach is essential. This involves engagement with care providers too. Trusted assessment has worked well during the COVID pandemic, with trust built up across health and care. This needs to be sustained, but care providers remain concerned about the COVID risk they are asked to carry.
- People should be informed that it is not necessary to make decisions about a permanent move when they are in hospital.

Supporting Materials

- A guide to trusted assessors and trusted assessments, co-authored by The Care Provider Alliance, NHS England and Improvement, Local Government Association and Association of Directors of Adult Social Services
- An example of a successful trusted assessor scheme in Lincolnshire
- Better Care Exchange section on trusted assessment, including shared resources
- NHS FAQ page developed from a series of trusted assessment webinars
- CQC guidance on trusted assessment
- Rapid improvement guide: trusted assessors

Examples of emerging and developing practice:

- **Newcastle Gateshead: Trusted assessment**
- **North Yorkshire: Trusted assessment** - Implementation of integrated discharge pathways and to use trusted assessment to facilitate discharge to assess.
- **Lincolnshire: Care home trusted assessor** - Creation of a trusted assessor role to improve the trust between acute sector assessment team and care home managers.
- **Blackburn and Darwen: Home first with trusted assessment** - Focus on people waiting for packages of care. Led by a home first approach in which ward staff undertake a partial assessment before the person is discharged to their home, with wraparound care offered until a full assessment is completed.

	Not yet established	Plans in place	Established	Mature	Exemplary
Independent care sector assessments	Care providers insist on assessing for the service or home regardless of their capacity to do so in a timely manner.	Care providers engaged in discussions about whether existing assessments completed in the hospital can be made to meet their needs / agreement to appoint a trusted assessor.	An existing assessment has been adapted to serve the needs of a pre-admission assessment or a worker has begun to carry out assessments on behalf of at least one provider.	An existing assessment has been adapted to serve the needs of a pre-admission assessment and is being used with several providers or a worker(s) is carrying out assessments on behalf of several providers.	Systems have understood the challenges in accepting patients post-COVID and support care providers with clinical support and specialist equipment to care for people safely.
Within hospital (acute or community)	Each profession insists on doing its own assessment, taking longer to determine the person's pathway.	Professionals are engaged in discussions as to when a shared or joint assessment might be possible.	Existing assessments are used for more than one purpose for at least one pathway.	Existing assessments are used for more than one purpose for several pathways.	Assessments are carried out in people's own homes or in step-down facilities – initial screening ensures this is safe to do so drawing on expert advice as needed.
Adult social care (hospital and community)	People have to wait a long time to have an eligibility determination.	Exploration is under way to determine why this is and to address it.	A third party has been trained and authorised to carry out eligibility determinations.	Eligibility determinations are routinely carried out by a third party when the local authority is unable to do so on time.	People have safe and timely assessments in the right setting.

Change 7: Engagement and choice

Early engagement with people, their families and carers is vital so they are empowered to make informed decisions about their future care. A robust choice protocol, underpinned by a fair and transparent escalation process, is essential so that when people have capacity they can understand and consider their options.

'Making it Real'- I/We statement

I can get information and advice that helps me think about and plan my life.

We provide information to make sure people know how to navigate the local health, care and housing system, including how to get more information or advice if needed.

Tips for success:

- Talk to people (including family and friends) on or, where possible, before admission about their likely discharge route (see change 1).
- Provide information in community settings and on wards about discharge routes.
- Be creative to deliver the message in the best way for people e.g. use videos in waiting rooms, or leaflets in mailings. Take a co-design approach and involve patient groups and other organisations in developing the message.
- Get the whole team involved, it's everyone's business.
- Don't be afraid to be clear – waiting in hospital is not an option, but people must know what their options are.
- Utilise key messages and communications support issued as part of initiatives to reduce length of stay in hospital – these should focus on information around harm and deconditioning as the key drivers to people and their families and carers to seek earlier discharge.
- Work with colleagues across the health and social care system to manage people's expectations of the care they will require after discharge, and to avoid unrealistic claims about the support people will receive. Managing expectations requires giving people the right information and advice throughout so they are fully informed.
- Remember long-term decisions should not be made in acute hospital. D2A and other intermediate care are not subject to a choice protocol but should be seen as the next stage in the treatment programme.
- Remember the Care Act 2014 guidance on choice of accommodation is that while any choice should be real they should also be within the personal budget and practicable.
- Do involve the voluntary sector to support discharge.
- People who fund their own support are often forgotten, it is important to engage with everyone to provide appropriate information and support so that everyone can make informed decisions. This is particularly important given the desire many will have to arrange care at home post COVID.

Supporting Materials

- NHS quick guide, describing the choice protocol and providing sample template policy and template patient letters
- The Care Act: see 30, cases where adult expresses preference for particular accommodation and Annex A of 2014 Statutory Guidance
- Care Navigation: A Competency Framework

- Do carry out a demand, capacity and quality audit of your independent care market, as a system.
- Try to avoid the need for choice letters, but when necessary don't be afraid to issue them, as they are in the person's best interest.
- Ensure the choice protocol is part of team induction training.

Examples of emerging and developing practice:

- **Isle of Wight: Care navigators** - The service was developed as a different way of working with and utilising the VCSE sectors, to build capacity in stretched services and support the island's new model of care and system redesign.

	Not yet established	Plans in place	Established	Mature	Exemplary
Information and support to decide care	No advice or information about discharge options available at admission.	Co-designed information packs are being prepared with patients and their families to ensure that they are helpful resources.	Admission advice and information leaflets in place and being used in different formats to engage with people, regardless of how they fund their care.	People and their family and carers are aware of the value of making timely decisions about discharge.	People and their family and carers, regardless of how they fund their care, are engaged and supported to go home or to a step-down facility to enable them to make a considered choice about future care and support needs.
Choice protocol	No choice protocol in place.	Choice protocol being written or updated to reduce long length of stay.	New choice protocol implemented and understood by staff.	Choice protocol used proactively to challenge people as necessary.	All staff understand choice and can discuss discharge proactively, and there is good consideration of safeguarding concerns. People feel empowered to manage their own discharge.
VCSE provision	No provision in place to support people to make decisions about their care, regardless of how they fund it.	Health and social care commissioners co-designing contracts with VCSE or other support.	VCSE support in place, providing advice and information.	VCSE or other provision integrated in discharge teams to support people, regardless of how they fund their care, home from hospital.	Everyone is supported through the discharge process, from admission. People are provided with good information in good time to make decisions about their future care.

Change 8: Improved discharge to care homes

The NHS Enhanced Health in Care Homes framework supports ways to join up and coordinate health and care services to support care home residents. COVID is strengthening these healthcare links, ensuring safe transfer from hospital to home, and making greater use of solutions including digital technology.

'Making it Real'- I/We statement

I have a place I can call home, not just a 'bed' or somewhere that provides me with care

We have a 'can do' approach which focuses on what matters to people and we think and act creatively to make things happen for them.

Tips for success:

- A person should not be making long-term decisions about their care from a hospital setting. See change 4, for further support and guidance on how people can be supported to move to a suitable environment from where they can make decisions.
- Join your local care forum to hear what providers find unhelpful about admission from hospital.
- Refer to best practice in discharge planning as can be found in other high impact changes, particularly change 1 and the supporting material. Involve care homes in the discharge planning process, and provide them with the information they need in good time. This is particularly important when supporting individuals who are or may be COVID-positive.
- Ensure each care home is linked to a consistent, named GP and wider primary care service, particularly in relation to management of residents during the COVID pandemic.
- Provide access to out-of-hours/urgent care to prevent unnecessary hospital admissions and to support care home staff. Areas have taken an innovative approach to this – for instance Airedale's telehealth hub connects local care homes directly with the MDT.
- Develop channels for sharing information with care homes – such as NHSmail accounts.
- Ensure COVID care plans are provided, detailing test status, protective equipment and clinical support requirements. Step-down facilities must be available for those unable to return to their care setting because of infection in the care home. Digital solutions are vital to maintain support.
- Involve your ambulance service in planning. It will have valuable information on care homes in need of support and can help develop solutions. Include care homes in system conversations.
- Link work on Enhancing Health in Care Homes with other high impact changes.
- Consider how your system can provide enhanced services to better support vulnerable people in community settings, such as through rapid response.
- Build on the existing learning and training opportunities to ensure that staff who are employed by social care providers receive a wide range of training and development opportunities.

Supporting Materials

- NHS overview of the enhancing health in care homes project
- NHS enhancing health in care home framework
- Health Foundation article about the importance of good relationships
- King's Fund review of learning about enhancing health in care homes
- NHS quick guides for supporting care homes
- NHS quick guide: Improving Hospital Discharge into the Care Sector

- See the NHS guidance on Enhanced Health in Care Homes for additional components of this work which can support your system. Evidence shows certain relatively small investments can yield significant results both for people and the system.

Examples of emerging and developing practice:

- **Wirral: Care home teletriage service** - Care homes have been provided with HD iPads and secure nhs.net email addresses to access a triage service, and staff have been trained to take basic observations and equipped with blood pressure monitors, thermometers, urine dip sticks and pulse oximeters.
- **Surrey: East Surrey care home multi-disciplinary project** - Aim of the project was to enhance the level of care to all residents of care homes by increasing GP time to support care homes; care coordinated approach; and improved medicine management support and training.

	Not yet established	Plans in place	Established	Mature	Exemplary
Discharge support	Best practice in discharge planning is not established and there is little trust between care homes and hospitals.	Systems are reaching out to care homes to find out where the systems need to change.	Systems have a regular dialogue with care homes (ideally through the care forum) and discharge is a regular agenda item.	Care homes and systems work in tandem to facilitate discharges seven days a week including evenings.	Care homes report few poor discharges or failed discharges as a result of system failure.
Enhanced primary care	Care homes are not linked with local community and primary care.	Scoping is underway to understand care home need. Plans have been made to establish clear links with primary and community care.	Community and primary care support provided to care homes on request. All care homes have access to a consistent, named GP.	People with increased acuity are well-managed in care homes due to a strong support network with primary and community care.	Care homes are supported by their named clinical lead and have access to primary care support. They are able to access support and advice on managing COVID and supported to make the right decision for their provision.
Access to out-of-hours/urgent care	High numbers of referrals to A&E from care homes, especially in the evenings and at weekends.	Specific high-referring care homes identified, and plans developed to provide better support.	Dedicated intensive support provided to high-referring care homes.	Improvement seen in unnecessary admissions from care homes, particularly on evenings and at weekends.	Across the system, care homes are well supported by access to out-of-hours/urgent care with appropriate COVID support where needed.

Change 9: Housing and related services

Effective referral processes and good services which maximise independence are in place to support people to go home. The need for housing and homelessness services, home adaptations and equipment are addressed early in discharge planning and readily available when needed. COVID has highlighted that people who are homeless are at greater risk from the disease, and that support should now to focus on their increased vulnerability.

'Making it Real'- I/We statement

I live in a home which is safe, accessible and suitable so that I can be as independent as possible.

We have conversations with people to discover what they want from life and the care, support and housing that will enable this, without restricting solutions to formal services and conventional treatments.

Tips for success:

- As part of early discharge planning talk to the person and their family or carers about their current housing/home situation to understand if a person's home is going to be safe and suitable for them to return to if there may be any issues that could affect discharge.
    - Take action as early as possible – a person's housing status should be known as soon as possible after admission.
    - Are there specific issues with their home which may affect its suitability, for example, is it accessible to the person given any changed mobility or health needs; or is there a problem with heating or damp?
    - Don't wait until the individual is ready to leave hospital to refer. Talk to any relatives, particularly if the person does not have a normal place of residence, as this may mean they don't have somewhere they can be discharged to.
- Include housing/housing service provider(s) as real or virtual member(s) of your discharge planning team.
- Take a holistic, person-centred approach to understand what matters to the people in your care, taking a positive attitude to risk and how you can best help them to be as independent as possible in their home. People who are homeless are at greater risk from COVID and support needs now to focus on their increased vulnerability.
- Consider how your VCSE sectors can help people to get home and access community support.
- Ensure staff know what housing options and support services are available and understand how to make referrals to them. There should be well-developed links between the discharge planning team and these services. Consider creating a single-point of contact to help guide staff through the various housing options available. Staff should understand their statutory duties with regard to housing, as well as how to access specialist housing (such as extra care

Supporting Materials

- NHS quick guide to health and housing
- NHS quick guide to better use of care at home
- NICE guidelines on home care
- National Housing Federation resources on housing, care and health
- Skills for Care the role of housing in effective hospital discharge
- Care and Repair England/Centre for Ageing Better: Adapting for ageing: Good practice and innovation in home adaptations
- Housing LIN health and housing resources
- Foundations/Housing LIN best practice map
- Royal College of Occupational Therapists Adaptations without delay
- The Regulatory Reform Order
- Online directory of home improvement agencies
- SCIE Moving between hospital and home, including care homes

or supported housing). For example, there is a new statutory duty to refer people who are homeless or at risk of homelessness to the housing authority.

- Educate staff about the housing support needs of different groups. These go beyond aids or adaptations for older people, and include, for example, support for people who are homeless or who may have mental ill-health, substance misuse needs, a learning disability or dementia.
- Minor repairs and small home adaptations can make a real difference to the speed and ease of discharge when they are readily available and delivered quickly. Identify needs as early as possible, not just what will help people get home, but what will aid independence and help avoid hospital readmission or future health or care needs.
- Housing-based short-term accommodation such as step-down or intermediate care can be appropriate for people who are medically optimised but waiting for a new home or adaptations. This is not a substitute, however, for late assessment of need or a lack of capacity for a more appropriate service.
- Understand the demand for, and capacity of housing and related support services across your system, and ensure this analysis informs commissioning intentions. Work with partners to identify and prioritise addressing the most challenging areas for your system. Approaches to this change will vary greatly in different systems, and may involve developing better processes, improving services or investing in extra capacity whether to meet any planned care needs or help facilitate self-care.
- Be creative in considering how technology and innovation can improve the way you support people to live at home; for instance telecare and assistive technologies can be very useful. Everyone involved in discharge should know what is on offer and how to access it locally.
- Homelessness should not be a reason for staying in hospital –
    - NHS trusts have a statutory duty under the Homelessness Reduction Act (2017) to refer people who are homeless or at risk of homelessness to a local housing authority.
    - Referrals should be made at the earliest opportunity as soon as it has been identified that a person may be homeless on discharge as this provides more time for the housing authority and other support services to respond. The person must give consent, and can choose which authority to be referred to.
    - Persons who have no recourse to public funds are not eligible for homelessness assistance, but are entitled to receive housing advice. It is not the responsibility of NHS trust staff to assess whether a person is eligible for such support; this is determined by the housing authority.
    - The Local Housing Authority should incorporate the duty to refer into their homelessness strategy and establish effective partnerships and working arrangements with agencies to facilitate appropriate referrals.

Examples of emerging and developing practice:

- **West of England - Reducing DTOC through housing interventions**
- **Leicester: Lightbulb** - The scheme involves housing enabler posts, their role involves aiming to assess patients as early as possible, and offer patients options to resolve housing issues.
- **Cambridgeshire: Technology Enabled Discharge (TED)** - To help people overcome the complications of referral and installation, Cambridgeshire Technology Enabled Care offers a custom telecare discharge package, which includes installation and rental of the lifeline, alongside other pieces of appropriate equipment such as smoke alarms, temperature sensors and fall detectors.
- **Kirklees Council: Home from Home initiative - T**he service provides seven accessible flats as temporary accommodation for people awaiting adaptations in their own home or changes in accommodation.

	Not yet established	Plans in place	Established	Mature	Exemplary
Systematic response, and demand/capacity	Housing and homelessness issues are not considered as part of a discharge support strategy.	Responses to housing issues and homelessness are usually discussed during ward rounds.	Staff have clear guidance which they routinely use to inform referrals and advise people and their families.	The impact of housing and homelessness issues on discharge and people's outcomes is understood and used to improve them.	System planners use demand, capacity and impact data to improve support to people who have housing needs or are homeless.
Early needs assessment and response	Housing status and support needs are not part of the admission checklist.	Amendments to the checklist are proposed/being considered.	A person's housing status and support needs are routinely noted on admission and where needed acted on during their hospital stay.	A person's housing status and support needs are part of a wider housing needs assessment on admission, with support put in place, including temporary accommodation if necessary, by expected discharge date.	Discharge is timely because staff know a person's housing status and act on their support needs. Particular attention is given to their health needs in relation to vulnerability to COVID infection.
Integration/joint working	Service response is slow, disjointed or unavailable.	Links between housing and discharge teams are being planned.	Discharge services have a named housing link, and there is regular contact between services/staff.	Housing staff are part of discharge support services, and there are good working relationships across the system.	Joined-up services deliver timely, person-centred support which maximises recovery and independence.
Home adaptations, equipment, telecare and health	Staff are not aware of available services.	A stock take of available support is being undertaken.	Discharge services know what is available and routinely access in good time.	Support is quick and easy to access, and is delivered promptly.	Support is integrated with related services, delivered 24/7, and takes account of any COVID-related needs such as special equipment, rehabilitation etc.

Action planning template

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning				
Change 2: Monitoring and responding to system demand and capacity				
Change 3: Multi-disciplinary working				
Change 4: Home first				
Change 5: Flexible working patterns				
Change 6: Trusted assessment				
Change 7: Engagement and choice				
Change 8: Improved discharge to care homes				
Change 9: Housing and related services				

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