Yorkshire and Humber High Impact Change Model (HICM) Event

20 September 2018, 09:30-13:00
The Met Hotel, Leeds
Purpose of the Event

• To discuss and share innovative practice in implementing the model
• To explore some of the opportunities and barriers to using various aspects of the model
• To contribute towards a refresh of the model for 19/20
Setting the Local Context

Richard Parry - DASS, Kirklees Council
“Supports local health and care systems to manage patient flow and discharge. Eight changes which have the greatest impact on reducing delayed discharge”

**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 assess.** 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.
## Progress on the High Impact Change Model across the 15 HWBs in Yorkshire and The Humber, 2018/19

<table>
<thead>
<tr>
<th>HICM – 8 changes</th>
<th>Q1 No of HWBs “established” or above</th>
<th>Q2 No of HWBs “established” or above</th>
<th>Q3 No of HWBs “established” or above</th>
<th>Q4 No of HWBs “established” or above</th>
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<tbody>
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<td>1. Early discharge planning</td>
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<td>3. Multi disciplinary/agency discharge teams</td>
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<td>4. Home first/discharge to assess</td>
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<td>5. Seven day service</td>
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<td>6. Trusted assessors</td>
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<td>7. Focus on choice</td>
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<td>8. Enhancing care in Care Homes</td>
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Data taken from the latest BCF quarterly returns
Implementation Challenges

Seven day service
- Developing the social care provider market for 7 day discharges
- Significant challenges remain regarding transport and the independent care sector
- Care homes and domiciliary care agencies remain unwilling to accept new referrals at the weekend
- Need for HR process to change terms and conditions of staff to move to seven day working

Trusted Assessors
- Building trust with care homes to accept the assessment and take patients back following hospital admission.
- Need a more 'joined up' approach to recording across the system to avoid unnecessary duplication/improve services.
- Culture change and the challenges around the trusted assessor approach
- Capacity in the discharge team to undertake the TA approach

Focus on choice
- Developing information, advice and guidance for people using services to manage expectations.
- Implementation of Choice Policies is still variable across systems
- Cultural challenge to embed choice protocol at ward level
Focus for Today

• ‘…………like a dog!”
• Keeping patients at the heart of everything we do
• Investing in relationships
• Consistency – how confident are we that everyone is consistently doing what needs to be done?
Managing Transfers of Care
A National Overview

Patrick Allen - LGA
Martha Dalton - DHSC
A ‘delayed transfer of care’ occurs when a patient is ready to leave a hospital or similar care provider but is still occupying a bed.

Behind every Delayed Transfer of Care, there is a person, in the wrong place at the wrong time.
DTOC – the story so far

DTOC has been a persistent problem over many years (national reports into DTOC since early 2000s)

More recently….

• **National Audit Office Report (2015)** - *Discharging older patients from hospital*
  – 5% muscle strength that older people can lose per day of treatment in a hospital bed
  – £820m gross cost to the NHS of older patients in hospital beds who are no longer in need of acute treatment.

• **National Strategy to address DTOC**
  – *Care Act (2014)*
    • Legislation outlining LAs duty in relation to assessing people’s needs and their eligibility for publicly funded care and support
  – *BCF National Conditions (New condition 4 (2017)*
    • Requirement for Social Care to work with NHS to implement **High Impact Change Model** to manage delays in transfer of care (expectations published)
    • iBCF monies
  – *NHS Five Year Forward View Next Steps*
    • Mandate for NHS to work with Social Care to reduce DTOC
  – *CQC Local System Reviews* (interface of Health and Care)
  – Increased collaboration centrally between national partners
    • Delayed Discharge Programme Board - Strategic (DHSC, NHSE/I, LGA, ADASS, MHCLG, CQC, BCST)
    • Discharge Steering Group - Operations (NHSE/I, DHSC, LGA ADASS, BCST, MHCLG)
DTOC – the story so far

- There has been significant improvement in DTOC over the past 18 months
  - in the face of persisting challenges (workforce, finances/austerity, commissioning complexity)
- By far, the most critical and important work has come from YOU (frontline colleagues)

Underpinning the data are numerous examples nation-wide, of health and care colleagues going above and beyond the call of duty, working together to ensure patients are not delayed unnecessarily in hospital – THANK YOU!
Despite the significant progress…
- **4500 patients** still in hospital every day (who don’t need to be there)
- We have to keep up the work nationally, locally and individually.

**Nationally** - a focus now beyond DTOC to reducing delays throughout the entire patient journey
- Ambition to reduce DTOC to 4000 beds by the latter part of 2018
- Ambition to reduce extended length of stay
- Provide support to local systems
National Support

Providing support to systems so that people get the right care, right place and right time and encouraging the development of home first principles

Programmes
1. Enhanced – 14 system reviews across 9 areas to really understand why transfers of care remain a challenge
2. Targeted – Tailored Peer Reviews to meet the needs of the system
3. Universal – HICM regional events, Learning from CQC events, Why not home, Hospital Discharge/Home First Practitioner Events

Tools
• Better Care Exchange / Bulletins
• LGA Guidance documents
• Webinars
• DTOC Improvement tool (NHS Improvement)
• Quick Guides (NHS Improvement)
• HICM (see next slide)
High Impact Change Model

• It was developed by national partners in 2015 to promote a new approach to system resilience and year around planning for timely discharge
• The model identifies eight system changes which will have the greatest impact of reducing delayed discharge

Why refresh the HICM
• To take account to new national guidance, address persistent implementation challenges and align guidance to reducing extended length of stay, improving patient flow and early intervention and prevention agenda.
Understanding what works

• We are keen to understand and collect an evidence base on what works and why some areas are challenged than others.
• We know that local leadership and collaborative working, investment in workforce and investment do have a role to play.
• We are also keen to explore whether a combination of national, local and regional support in this area works best.
Feedback from CQC Systems Review and the HICM Improvement journey

Elaine James - Interim Assistant Director, Bradford Council

Bev Maybury – Strategic Director, Health and Wellbeing, Bradford Council
Bradford District Local System Review

Happy Healthy at Home
Local System and People’s experiences

3 key points of focus

- Maintaining wellbeing (early help and prevention)
- Crisis management
- Discharge, step-down, reablement
Maintaining the wellbeing of a person in usual place of residence

1. Re-ablement

Crisis management

2. Admission to hospital via A&E Front door
3. Admission to alternative to hospital/rapid
4. Re-ablement

Step down

5. Return to usual place of residence
6. Admission to new place of residence
7. Re-ablement
8. I Statements

Communication

Person centred care
CQC Process

- Quality of relationships
- How well people move through the system
- Focus on the interfaces
- “The mum test” – what happens for people
- Test of the whole system – not just a focus on DToc
- CQC inspection outcomes for ASC services influence the key lines of inquiry before they arrive
A sense of Bradford and District the Place
System Strengths

- Shared ambition across the system for healthy, happy at home
- Innovation and continuous improvement grounded in a culture of research
- Partnerships on the ground that just work
- Winter Resilience and Responsiveness
- Healthy, constructive and challenging relationships
- Positivity and Passion for the Place
System Challenges

- Moving from alignment towards integration of our commissioning partnerships
- Strengthening resilience and the quality of our wider provider market
- Promoting what we do well and praising staff who do it (culture tends to be what could we do better rather than what have we achieved)
- Empowerment and autonomy in communities
Key Message:
Have a shared vision and narrative and make sure all partners at all levels own and know the story.
On an average Bradford & Airedale day: 65+

Key Message:
Be honest – well led systems are critically reflective and know their areas for improvement
Key Message:
Don’t just focus on DToC
Ask, do short term pressures drive long term outcomes?
Market and Commissioning

- Rapid expansion of self-care and self-directed support options including ISFs and PHBs
- Invest in the market using BCF tactically to address quality
  - Service Improvement approach towards coproduction
  - Funding following the person into hospital (retainer)
- Expansion of admission avoidance urgent home response
- Develop models of dementia care and end of life support at home
- Fair Cost of Care
  - CHC and Local Authority joint fee setting
  - Fair Cost of Care exercise using CIPFA national guidance
What do people want from their local system?

Key Message:
Focus story boards around evidence of people’s experiences of care support.
Implementing a successful Trusted Assessor Model

Paula Watson - Discharge Nurse Specialist, Newcastle Upon Tyne Hospitals
Implementing Trusted Assessment

Yorkshire and Humber
Sept 2018
Paula Watson Discharge Nurse specialist
Newcastle Upon Tyne NHS Foundation Trust
The daily challenge

2014 -15

677 pts delayed 11,555 days

214 pts delayed 4042 days
(11 bed days)

discharged to care homes

~ 19 days per pt
The awakening
Putting Trust into trusted assessment

- Inform care home if need to change care status as soon as agreed by MDT or if patient has died
- Inform care home of EDD within 48hrs of admission
  - Contact care home to rationalise discharge medications dispensed
- Complete complex transfer out of hospital care plan
- Provide adequate dressings / catheter care packs.
- Telephone care home to hand over patient care on day of transfer

- Advise criteria for transfer back to care home
- Complete telephone assessment if admission < 72 hrs
  - Manager assessment and patient return within 48hrs if required.
  - Manager to assess within 72hrs for new places
  - Care homes to identify deputy who has authority to accept patient in manager absence
Qualities for a Trusted Assessor

• Knowledge and experienced in primary and secondary care services
• Senior member of staff band 6 or above
• Patient assessment and documentation skills
• Flexible and adaptable
• Excellent communication skills
• Ability to develop care plans which meet all provider needs.
• Can be from any discipline, Nurse, physio, OT, social worker etc.
Developing Documentation

Documentation should be single assessment to include:

• Demographics
• Past medical history
• Base line care needs
• Current care needs
• Moving and handling assessment - equipment required
• Risks / considerations
• Goals
• Professionals involved
Step Down Beds Process

- Wards identified suitable patients.
- Patient triaged by discharge Nurses for suitability
- Care Coordination Team (CCT) assessment completed.
- CCT assessment faxed to care home/physio/ OT/Social worker.
- Care home accepted / patient transferred.
Testing the model

47 patients transferred to stepdown beds
44 pts transferred within 24hrs of referral
Challenges

• Communication – Fax / IT / security

• Patients condition changes between assessment and transfer.

• Getting the assessment right – priorities.

• MDT response capacity.

• CQC requirements. - regulation 12 Safe care and treatment
### Nursing home support team

<table>
<thead>
<tr>
<th>5 care homes stepdown to test process develop trust and relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stepdown beds with enhanced wrap around</strong> 10 care homes</td>
</tr>
<tr>
<td><strong>Time to think beds 10 care homes</strong></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Full procurement</th>
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<tbody>
<tr>
<td><strong>Step down beds</strong></td>
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<tr>
<td><strong>Time to think beds</strong></td>
</tr>
<tr>
<td><strong>Patients returning to existing homes</strong></td>
</tr>
<tr>
<td><strong>Transfer of care bag</strong></td>
</tr>
</tbody>
</table>

- **2015 - 16**
- **2016 - 17**
- **2017-18**
ENHANCED HEALTH IN CARE HOMES
TRANSFERRING CARE SAFELY
THE TRANSFER OF CARE BAG

It’s NOT about the bag, it IS about...

- raising the profile of care home residents
- developing the workforce to better understand their needs through the sharing of information
- improving health and wellbeing and facilitating peaceful deaths in familiar environments through earlier and improved comprehensive assessment and care planning
- recognising hospital as the smallest part of our patient’s journey
- developing respectful relationships with care home teams
- improving safety through reducing avoidable hospital re-admission and too long a stay
- bringing care homes from the periphery into the system
## Benefits

<table>
<thead>
<tr>
<th>Year</th>
<th>Returning to care home – all areas</th>
<th>Average days</th>
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<tr>
<td></td>
<td>Days</td>
<td>People</td>
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<td><strong>2014-15</strong></td>
<td>73</td>
<td>5</td>
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<td><strong>2015-16</strong></td>
<td>194</td>
<td>10</td>
</tr>
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<td><strong>2016-17</strong></td>
<td>45</td>
<td>5</td>
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<tr>
<td><strong>2017-18</strong></td>
<td>106</td>
<td>16</td>
</tr>
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</table>
## Benefits

<table>
<thead>
<tr>
<th>year</th>
<th>Returning to care home - Newcastle</th>
<th>Average days for Newcastle patients returning to care home</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Days</td>
<td>people</td>
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<tr>
<td>2014 - 15</td>
<td>38</td>
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<td>2015 - 16</td>
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<td>2016 - 17</td>
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<td>2</td>
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<tr>
<td>2017 - 18</td>
<td>49</td>
<td>9</td>
</tr>
<tr>
<td>Years</td>
<td>Days</td>
<td>people</td>
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<tr>
<td>2014 - 15</td>
<td>4042</td>
<td>214</td>
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<td>2015 - 16</td>
<td>2303</td>
<td>141</td>
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<td>2016 - 17</td>
<td>2708</td>
<td>187</td>
</tr>
<tr>
<td>2017 - 18</td>
<td>2952</td>
<td>221</td>
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</table>
The future

• Trusted assessment for all patients discharged to a care home in Newcastle

• Trusted assessment to neighbouring regions

• Improve access to care homes at weekends

• Change of choice directive to 7 days
Paula Watson Discharge Nurse Specialist
Newcastle Upon Tyne Hospitals
Tel 0191 2448900
paula.watson@nuth.nhs.uk
Calderdale: Improving Choice and shaping HICM improvements

Lorraine Andrew - Service Manager, Calderdale Metropolitan Borough Council
Graham Mozley - Commissioning Manager, Calderdale Metropolitan Borough Council
Implementing the High Impact Change Model

Thursday 20th September 2018

Lorraine Andrew and
Graham Mozley
## The Calderdale Journey

<table>
<thead>
<tr>
<th>Local Assessment of Current State</th>
<th>Discharge Planning</th>
<th>Patient Flow</th>
<th>MDT Working</th>
<th>Home first &amp; Discharge to Assess</th>
<th>7DS</th>
<th>Trusted Assessor</th>
<th>Choice</th>
<th>Care Homes</th>
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<tbody>
<tr>
<td>1 – not yet</td>
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<td></td>
<td>Apr 16</td>
<td>Apr 16</td>
<td>Apr 16</td>
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<td>2 - in place</td>
<td>Apr 16</td>
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<td>Apr 16</td>
<td>Apr 16</td>
<td>Apr 16</td>
<td>Apr 17/18</td>
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<tr>
<td>3 - established</td>
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<td>Apr 17</td>
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<td>Apr 17/18</td>
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<td>Apr 17/18</td>
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<td>4 - mature</td>
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<td>Apr 17/18</td>
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<td>Apr 17/18</td>
<td>Apr 17/18</td>
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<td>5 - exemplary</td>
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<td>Apr 18</td>
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Discharge planning

- Discharge planning starts at admission
- 80% compliance of EDD
- EPR across the system
- Screening tool for complex cases
- Alignment of systems and processes
- Co-location of staff.
- HAT working at front of hospital.
Patient Flow

- TOC
- MDT/Board rounds
- Notice of assessment (Section 2)
- SOP in place
- DTOC verification process in place including Mental Health
MDT Working

• Increased assessment capacity
• All MDT & ward rounds attended by Social Care
• Link Workers on each Ward across footprint.
• Focused assessment officers in re-ablement and intermediate care/transitional beds.
Discharge to assess

- Proportionate assessment
- Reviews
- Trusted assessor
- Transitional beds for ongoing assessment.
- Flexibility in bed base.
7 Day working

- Hospital team employed on contract of 5/7
- HAT team 5/7 8 to 8
- Consistent assessment presence Saturday and Sunday
Trusted assessor

- Discharge coordinators refer direct to re-ablement.
- Hospital Avoidance Team, have training in low level equipment.
- To expand for coordinators to have access to choice beds.
CHOICE

• TOC List highlights those awaiting home of choice
• Patient and family informed of availability
• Community bed capacity in line with demand
• POC demand aligned with demand and flexible to respond to flow.
Care home

- Worked with providers to build strong relationships. (e.g. Business Relationship Managers)
- Health Partners attend Providers Forum.
- Red bag roll out
- Bed state tool.
Recap of Calderdale Journey

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<tr>
<td>2 - in place</td>
<td>Apr 16</td>
<td>Apr 16</td>
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<td>Apr 16</td>
<td>Apr 17/18</td>
<td>Apr 17/18</td>
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<td>Apr 17/18</td>
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Calderdale Council
Calderdale BCF schemes 2017/19

The BCF plan is based around 7 scheme areas underpinned by 31 schemes

The BCF budget for 17/18 was approximately 16 million and the iBCF budget approximately 4.5 million

1. Information and Advice
2. Early Intervention and Prevention
3. Holistic Locality Assessment and Case Management
4. Reablement, Recovery and Rehabilitation
5. Admission Avoidance and Supported Discharge
6. Support at End of Life
7. Technology and digital solutions
Some of our key challenges in Calderdale

Demographic pressures:

• People are living longer. By 2024 it is forecast that there will be a 41.8% increase in people aged between 75 & 84 and a 28.5% increase in people aged over 85. There are also more people with complex and multiple conditions.
Social Care Market:

• The social care and health market face pressures around quality and supply- key areas include homecare and EMI nursing provision.
Delayed Transfer of Care from Hospital (DToC):

- Rising demand for health care, means that the NHS is treating more patients than ever before. As the national focus is on the NHS, this has placed increased pressure on Adult Services.

Substantial financial pressures across health and social care
## Population Pressures

<table>
<thead>
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<th>Age Band</th>
<th>2014</th>
<th>2024</th>
<th>Growth</th>
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<tbody>
<tr>
<td>65 to 74 years</td>
<td>20,500</td>
<td>22,700</td>
<td>+2,200 (+10.5%)</td>
</tr>
<tr>
<td>75 to 84 years</td>
<td>11,200</td>
<td>15,900</td>
<td>+4,700 (+41.8%)</td>
</tr>
<tr>
<td>85 years and over</td>
<td>4,600</td>
<td>6,000</td>
<td>+1,400 (+28.5%)</td>
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</tbody>
</table>
Measuring impact and monitoring performance

- Developed an initial dashboard
- Measure performance of each scheme through agreed set of Key Performance Indicators (KPIs)
- Impact of the schemes against the national metrics
- Provide management oversight of the BCF schemes performance (ie regular reporting to ICE Board)
Measuring success

DTOC - Actual days delayed by month compared to target

*The targets shown in the graph above are locally adopted targets from November 2014 to October 2017. From November 2017 to March 18 are the nationally agreed targets.
### Monitoring Impact

#### Number of Delayed Transfer of Care (DTOC) days

<table>
<thead>
<tr>
<th>Month</th>
<th>NHS</th>
<th>Social Care</th>
<th>Joint</th>
<th>Number of days delayed</th>
<th>Days delayed per 100,000</th>
<th>Target per 100,000</th>
<th>National average per 100,000</th>
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<tbody>
<tr>
<td>Nov-14</td>
<td>632</td>
<td>45</td>
<td>88</td>
<td>765 206</td>
<td>473.2 125</td>
<td>329.9</td>
<td></td>
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<tr>
<td>Dec-14</td>
<td>652</td>
<td>122</td>
<td>64</td>
<td>838 206</td>
<td>518.3 125</td>
<td>325.4</td>
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<tr>
<td>Jan-15</td>
<td>546</td>
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<td>51</td>
<td>742 206</td>
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<td>Feb-15</td>
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<td>598 206</td>
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<td>Mar-15</td>
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<td>19</td>
<td>594 206</td>
<td>350.4 125</td>
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*Figures shown under National average per 100,000 column of the above table are from NHS England and LSC Inform Plus

Note: Target figures in the above tables are in red. Revised NHS target of 303 days shown as the number of days delayed. However, still measuring against previous target set by NHS in 2013.
### Number of non-elective admissions

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### Supporting schemes and key performance indicators:

**Scheme Ref: S1P03**

**Scheme name:** Self-Care Assistive Technology for Independent Living

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<th>2016/17 Performance</th>
<th>2017/18 Performance</th>
<th>2018/19 Performance</th>
<th>Commentary</th>
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<td>Result</td>
<td>Target</td>
<td>Result</td>
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<td>Number of clients connected to Community Voice Careline</td>
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<td>High</td>
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<tr>
<td>2</td>
<td>Number of telecare devices installed (cumulative)</td>
<td>Monthly</td>
<td>High</td>
<td>553</td>
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<td>592</td>
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**Scheme Ref: S2P01**

**Scheme name:** Virtual Ward (Frailty)

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<th>2016/17 Performance</th>
<th>2017/18 Performance</th>
<th>2018/19 Performance</th>
<th>Commentary</th>
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<td>Target</td>
<td>Result</td>
<td>Target</td>
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<td>1</td>
<td>Number of medical non-elective 30 day readmissions as a % of all non-elective admissions at CHFT</td>
<td>Monthly</td>
<td>Low</td>
<td>15.6%</td>
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<td>6.5%</td>
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**Scheme Ref: S2P02**

**Scheme name:** Targeted Prevention for Dementia

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<th>Commentary</th>
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<td>Result</td>
<td>Target</td>
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<td>1</td>
<td>Number of active cases held by the Alzheimer's Society</td>
<td>Quarterly</td>
<td>High</td>
<td>496</td>
<td>-</td>
<td>319</td>
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<tr>
<td>2</td>
<td>Percentage of population predicted to have dementia accessing services</td>
<td>Quarterly</td>
<td>High</td>
<td>19%</td>
<td>-</td>
<td>13%</td>
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**Commentary:**

- A comprehensive review and audit of records held by the service provider compared to the LA was conducted in August and will improve the quality of performance information. This has caused a slight reduction compared to the previous year.

- 18/19 figure is yetd.

- Reduction in 2017/18 is a result of refocus by Alzheimer's Society on targeted delivery and reduced representation at dementia cafes.
Some scheme examples and reviews.

- Community Equipment Loan Store commenced January 2018
- Community Place
- Home Care Review
- Winter Resilience -
- First Point of Contact
Review of Calderdale’s equipment loan store:

- Equipment loan store is essential in giving patients the choice to remain at home and independent
- £2m budget
- 6 month review by adult commissioning
- Comprehensive review of loan store operations and processes including: systems, warehouse & stock management, finance and procurement.
- Looked at external models of good practice and compared to Calderdale’s equipment loan store operations
- Identified key areas of improvement to drive efficiencies and quality.
Introduction

• HICM was introduced in 2015 as a improvement toolkit to help health and social care systems consider a implementing a series of Changes in order to reduce DTOC and improve patient flow.

• This year, there is a ambition to refresh the model to better links with emerging national agendas on improved patient flow, community support and reducing length of stay.
HICM Refresh Questionnaire

- Below is a link for the HICM refresh questionnaire, This is a further opportunity for you to provide feedback as a means of informing the refresh of the HICM. It should take around 10 mins to complete.


- For reference the HICM can be found here
Purpose of the workshop

• To find out how you use the model and your views on how this could be improved?
• To find out what has been most useful / least useful when implementing the model and considering the impact it has had
• To find out what you think the gaps are in the current model and how you think it should be improved and why

The views from this workshop will directly feed into collecting the evidence base for revising the current HICM.
Stage 1

Spend 20 minutes considering the following questions

Q1. How do you use the HICM and what is missing?

Q2. What Change has had the most / least useful in improving patient flow and why?

Use prompt questions provided that are on the tables
Stage 2
Spend 20 minutes considering the following questions

Q3. How do you think the HICM could be improved?

Please make use of the prompt questions for this question provided on each table.
Next Steps

• Understanding the key themes from each of the nine HICM refresh workshop

• Set up of a National Reference Group of practitioners to act as a sounding board for the development of the refreshed HICM.

• Aim is to publish refreshed model by April 2019