Front Through To Back Door Model

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Sussex Community NHS Foundation Trust

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Brighton and Hove City Council
Agenda

• Prioritisation- following the Brighton and Hove journey

• Methodology

• Critical Success Factors

• Questions and Close
Step Change in Brighton and Hove- How did it start?

- SAFER event held within the Royal Sussex County hospital early 2016.
  - Challenges with navigating across health and social care
  - Variation in practice between wards with regards to discharge processes
  - Reliance on discharge teams to support most acute discharge
  - Ad Hoc use of additional support services e.g. British Red Cross
  - Unnecessary processes/ administration for dual reporting of discharges and ‘Discharge to Assess’ within SCFT (D2A under-performing).

- Lack of care capacity within the community, and lack of oversight of delays across all aspects of the health and social care system

- Service level reporting often reducing clinical capacity, and KPI’s aligned with services were inhibitive of change
Discharge environment April 2016

One patient may have 3-5 ‘organisational hand-offs’ before reaching their required destination

This is in addition to internal waits e.g. diagnostics, AHP assess

Ward teams are required to fill in different paperwork for different destinations

Need to ‘prescribe goals’ and determine destination before acceptance
How did we respond?

• Agreed to focus resolving quick wins on one Care of the Elderly ward as a pilot

• Primary focus and actions taken for pilot:

<table>
<thead>
<tr>
<th>Priority</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Duplication</td>
<td>Screening form completed by A&amp;E team follows the patient to the ward- details previous and current situation. Screening form used as part of community referral.</td>
</tr>
<tr>
<td>Reduce Administration</td>
<td>Replace all community health referral forms with A&amp;E screening form, and 2 page Ready to Transfer summary. Implement single Referral Management Team to prevent multiple referrals being sent.</td>
</tr>
<tr>
<td>Simplify Decision Making</td>
<td>Only decision to be made by acute wards= ‘Is the patient medically optimised for discharge?’ Functional Assessment and goal planning takes place in patients home.</td>
</tr>
<tr>
<td>Reduce Hand-Offs</td>
<td>Form a collaborative steering group with key partners to jointly problem solve and develop the model. Run Pilot as a PDSA cycle to empower CSG to make positive changes swiftly and maintain momentum.</td>
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</tbody>
</table>
Membership of Home First steering Group

- Sussex Community NHS Foundation Trust
- Possability People
- Brighton and Sussex University Hospitals NHS Trust
- British Red Cross
- Brighton & Hove City Council
- Victoria Nursing Homes
- Coastal Homecare
PDSA- setting the scene

– Agreed the following core principles

• To focus on the ‘simple’ discharges (80/20 rule), with ‘Discharge to Assess’ being viewed as business as usual

• To ask one question to trigger discharge- “Is the patient medically optimised to be discharged home?” – moving away from MDT fit and aiming for therapy at home

• Trust assessments completed by colleagues from other providers

• No individual will stop the project, it will only pause/ cease with agreement from the collaborative steering group

• Pace of rollout to be determined by the steering group, not the system

• A re-admission is NOT a failure
**Hospital Rapid Discharge Team / Frailty Team Initial Screening Tool**

**Frailsafe Criteria:**
- Reduced mobility
- Confused
- Lives in Care Home

**Consent to share information / contact NOK:**
- Yes [ ]
- No [ ]
- Unable [ ]

**Patient Name:**

**DOB:**

**NHS No / Hosp No:**

**Tel No:**

**Safeguarding concerns:**
- YES [ ]
- NO [ ]

**Reason for admission:**

**Next of kin / emergency contact / key holder / POA:**

**Relevant past medical history:**
- B&H [ ]
- East Sussex [ ]
- West Sussex [ ]
- Other [ ]

**GP Surgery:**

**Place of residence:**
- Home [ ]
- R. Home [ ]
- N. Home [ ]
- Comm. Rehab Bed [ ]
- Hostel [ ]
- Sheltered [ ]
- Assisted Living [ ]
- Extra care [ ]
- NFA [ ]

**Social Situation:**
- Type of property, layout of property, access, who else is at home, social support:

**Is patient a carer:**
- Yes [ ]
- No [ ]

**Are there children involved:**
- Yes [ ]
- No [ ]

**Are there pets involved:**
- Yes [ ]
- No [ ]

**Package of care:**
- YES [ ]
- NO [ ]

**Agency:**

**Telephone no:**

**Previous level of function:**
- Mobility: (indoor, outdoors, stairs, walking aids, wheelchair user, distance)

- Transfers: (chair, bed, toilet)

- Personal care: (Shower, bath, stripwash, dressing, toileting, night time)

- Domestic tasks: (meal preparation, shopping, housework, laundry)

- Equipment in place:
  - Lifeline / Carelink: Yes [ ]
  - Keysafe Yes [ ]
  - Keysafe no if appropriate:

- **Falls history:** (falls in last 6 months)

- **Medication Info** (tick as appro.)
  - Self-administer
  - Blister pack
  - Requires prompting
  - Administered by carers
  - Locked box

- **Cognition / AMT / Mood:**

- **Recommendation / Discharge Plan / Treatment Plan:** (Outcome of functional assessment, Social Work input)

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**Clinical Frailty Scale**

1. **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2. **Well** – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3. **Managing Well** – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4. **Vulnerable** – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being “slowed up”, and/or being tired during the day.

5. **Mildly Frail** – These people often have more evident slowing, and need help in high order (ADLs: finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6. **Moderately Frail** – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standing) with dressing.

7. **Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).

8. **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** – Approaching the end of life. This category applies to people with a life expectancy ~6 months, who are not otherwise evidently frail.

**Scoring frailty in people with dementia**

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal. In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help.
Patient Name:  DOB:  NHS No/Hosp No:

**Ready to transfer to Short Term Community Services**

Any additional Information on social history received since admission to hospital

Current needs regarding mobility/transfers (please include type of supervision and aids required e.g. transfers with 2, hoist, WZF)

Current care support needs (washing/dressing/eating/drinking/toileting assistance). Please include day and night needs and level of supervision for confusion/wandering required

Current needs regarding emotional/mental health support (Confusion, depression, CPN) Please include day and night needs

Current needs regarding medication support (Blister packs/assistance to self-medicate). Insulin or other injectable medication requirements

Any care or nursing issues noted (please include issues with continence/ wounds/pressure areas/pain)

Any equipment requirements (special mattress/bariatric equipment/commode)

**Additional Information**
Please include:
- Any relevant medical/nursing interventions and diagnosis since admission
- Changes to the person's pre admission history
- Any functional assessment outcomes
- Any pathology results

Referral advised for a Bed
Referral advised for assessment at home
Referral advised for short term support at home

If referral is for support or assessment at home what is the predicted home care needs required to support discharge (include additional needs if patient having a restart)

Original care package restarted if appropriate Y/N

Name:  Signature  Date:  Time:
Trusted Assessment - Social Care in Partnership

Brighton and Hove Adult Social Care
Grace Hanley- General Manager
Guy Jackson- Operations Manager
Holly Croydon- Social Worker

18 January 2016
**Trusted Assessments**

- Adult Social Care (ASC) working differently with an Independent Home care Provider
- Person- Centred approach- enabling support to ‘flex ‘ when needed
- ASC not completing formal assessments until person’s needs have stabilised - assessment taking place at the right time and right place
- Clear Parameters of Trusted Assessment:
  (i) No Mental Capacity concerns
  (ii) No safeguarding concerns
  (iii) No high-level care risks
  (iv) Service user (patient) in agreement with proposed change
Facilitating Reduced Length of Stay, and Better Outcomes

- The patient is discharged at the point of being medically optimised without formal social worker assessment - less ‘over prescription’ of care
- The social worker will assess within the patient's home when required - enabling higher risk discharge
- Named social worker for Patient, family and Provider
- Joint assessments will take place between Adult Social Care, and Coastal Homecare - less duplication/repetition
- The level of support continually reviewed by the Coastal Homecare staff with formal review of needs between 7-10 days from discharge
- Many packages are reduced following phone discussion (TA) between ASC and Coastal Homecare without the need for face to face ASC follow up.
Enhanced Risk Management

• In the acute setting the MDT are reassured that any concerns they have will be immediately followed-up in the community.

• The Home Care Provider and the independent/voluntary providers are reassured that if immediate amendments need to be made to the level of care provision, or other issues occur, health and social care will offer an immediate response.

• Service users and families are reassured that support is available when needed after discharge and level of support can be adjusted in response to the needs of the person

• Health and Social Care are reassured that high levels of ongoing communication and a collaborative approach ensures knowledge and resources are pooled and risks shared.
## Benefits for Care Provision

<table>
<thead>
<tr>
<th>For patients</th>
<th>For staff</th>
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<tbody>
<tr>
<td>Better continuity of care</td>
<td>Improved employment conditions</td>
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<tr>
<td>Increased opportunity to regain previous functional level</td>
<td>Single point of referral has improved communication</td>
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<tr>
<td>Better outcomes</td>
<td>Staff empowerment</td>
</tr>
<tr>
<td>Single assessment with initial joint assessment/trusted</td>
<td>Improved efficiency</td>
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<tr>
<td>assessment models</td>
<td></td>
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Current evidence of success

Home First and Social Care Referrals 01 April 2016 to 01 February 2017

<table>
<thead>
<tr>
<th>Home First and Social Care Referrals 01 April 2016 to 01 February 2017</th>
<th>Average age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home First patients</td>
<td>81.6</td>
</tr>
<tr>
<td>Other Community Social Care discharges</td>
<td>80.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. Patients</th>
<th>Mean LOS</th>
<th>Median LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home First patients</td>
<td>188</td>
<td>16.11</td>
</tr>
<tr>
<td>Other Community Social Care discharges</td>
<td>113</td>
<td>31.24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home First</th>
<th>Prev usage (hrs)</th>
<th>Saving with HF</th>
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<td>16.11</td>
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