High Impact Change Model York

A self-assessment of implementation of the High Impact Change Model for managing transfers of care and has been undertaken and is summarised below

Impact change	Where are we now?	Update on Implementation
Change 1: **Early discharge planning**	Established.	**What have we done so far?** We have systems in place around early discharge. This includes operation of trusted assessor, multi- agency discharge hub, and investment in additional step down beds, alongside BCF funded reablement and home from hospital services. There is significant investment in assistive technology as part of our approach to early discharge. **Next Steps** There is a remodelling of the intermediate care services to ensure improved early discharge pathway from hospital to integrated neighbourhood based service that makes best use the NHS, local authority.
Change 2: **Monitoring and responding to system demand and capacity**	Established	**What have we done so far?** The York system has undertaken a system analysis on capacity and demand Venn Consulting. Many aspects of the system in York work well to ensure that people are supported out of hospital, particularly early intervention and for those with long term care needs. Where capacity needs to be strengthened in intermediate care- work is underway to achieve this. Investment through BCF supports all pathways from low level universal services such as small tasks at home through to Nursing Home placements for those with complex needs We have brought in the provider assessment and market management solution PAMMS to enable the shaping of the market, improved capacity where it is required, better value and access to services **Next Steps** Alongside embedding PAMMS, the development of virtual ward, frailty hub and the remodelling of intermediate care services, there will be a recommissioning of home care services to improve capacity outcomes and value and further moves to secure sufficient commissioned beds over reliance on spot purchasing
Change 3: **Multi-disciplinary working**	Established	**What have we done so far?** Multi agency hubs are in place to enable transfer of care. Board rounds, trusted assessor, and daily calls to prevent delays are in place. Home From Hospital support from the voluntary sector is closely aligned with discharge planning. This transfer of care is supported by services including York Integrated Care Team (YICT) a multi-disciplinary team based in primary care, aimed at avoiding admission and enabling timely discharge.

		System leadership is in place with senior managers working together on system planning through Health Care Resilience Board and local out of hospital workstreams. **Next Steps** The next phase of our work is to move a single integrated neighbourhood based offer for community discharge, including technology and to further embed the home first model, implementing learning form both our demand and capacity modelling and through events such as our home first week.
Change 4: **Home first D2A**	Established	**What have we done so far?** Home first continues to be our strategy and our commissioning investment is focused on home-based services. Where we are using beds on discharge there are short term and focused on independent living as the first option before using residential or nursing bed options. We work to a trusted assessor model that uses D2A , Home First documentation to enables discharge from hospital into the community Further work is planned on home first – using perfect week methodology to understand how the strengths and gaps in our system enabling us to strengthen practice, pathways, and provision where necessary
Change 5: **Flexible working- 7 Day Discharge**	Established	**What have we done so far?** We have 7 day working to support discharge through the discharge hub and in crucial services such as the rapid assessment and treatment service, to facilitate earlier discharge and prevent admission. **Next Steps** As part of our work with the independent sector we will work to improve their ability to support weekend discharge
Change 6: **Trusted assessment**	Established	**What have we done so far?** Trusted assessor process are in place to enable hospital discharge. These are effective in reducing delays and preventing deconditioning. **Next Steps** Further work is needed to ensure we do not over- prescribe care, and we optimize strength based approaches, technology enabled support and best use of community and voluntary sector resources
Change 7: **Engagement and choice**	Established	**What have we done so far?** There is a system agreed choice policy and process in place that supports a right place, right care approach, so that those who no longer need treatment in hospital are enabled to access the right service for them. Early conversation are held to enable shared expectations and plans about discharge Options for discharge are increased through engagement with the voluntary sector who are well invested in through BCF, including Carers support, home from hospital, social prescribing and small task services,. This provides opportunities for greater choice , more pathway 0 discharges.

		Next Steps Further improvement in early discharge based on our capacity and demand analysis is intended reduce the needed for enacting the choice policy. Through ensuring access to community and voluntary sector, improved intermediate care and reduced reliance on bed based, the availability and engagement in these options will increasingly support the right place right care approach
Change 8: **Improved discharge to care homes**	Established	**What have we done so far?** We have a care home support team in place which enhances the ability of care homes to support people to prevent admission and timely discharge. There is a collaborative approach in place between partners to support quality and safety in homes. Commissioning activity means that there are now dedicated providers for stepdown provision and there is agreement for access to beds between North Yorkshire and York system **Next Steps** Further insight into the residential and nursing sector will follow as PAMMS is embedded, enabling us to shape provision and improve discharge
Change 9: **Housing and related services-equipment**	Established	**What have we done so far?** A homelessness pathway is in place through the bed ahead scheme. There is an integrated approach through housing to falls prevention, occupational therapy and equipment. **Next Steps** The next year will see a major focus on assistive technology, ensuring that the right technology is available to install in peoples homes and this is built into pathways