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Framework for NHS provider and commissioner involvement in:

- Maximising the appropriate use of care homes

- Cohort caring in Therapy-Led Units for inpatients ready/safe to be discharged/transferred

December 2017

Executive Summary

NHS England and NHS Improvement have produced a **Best Practice Framework** to support sustainability and transformation partnerships (STPs) and their Provider Organisations. This is in recognition of the pressure that can build in the system, with ensuing threats to patient safety, during the winter months.

The framework aims to address two models and the implementation approach that needs to be taken by STPs and their Provider Organisations. These models aim to:

1. maximise the appropriate use of care homes by identifying and supporting care homes at risk of closure, and using surveillance to monitor capacity and patient flow across the care sector

2. identify and care for the cohort of patients, in Therapy-Led Units who are medically fit for discharge, and therefore contributing to the stranded patient and Delayed Transfers Of Care (DTOC) metrics in hospitals, with the right therapeutic conditions and appropriate staffing models.

This framework is for all organisations to re-examine local escalation plans in accordance with initiatives known to reduce the number of people with a delayed transfer of care, outlined in Appendix 2.

In using this framework it is vital that NHS organisations engage with their local authority partners and adult social care providers in local systems, especially for the first objective. Use of care home beds is core business for local authorities and having a sustainable care home market is part of their duties under the Care Act 2014.

Best Practice Framework

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The purpose of this framework is to supplement local escalation plans by describing standards of care and ways of working, which are in use and making a difference to discharging patients and maximising use of beds outside the hospital setting.

When using this framework consideration must be given to ensuring that individuals are treated equally and with parity, reflecting their personal needs.

The aims of the framework are to:

- Describe ways of working to maximise the appropriate use of care homes
- Describe an operating model for optimising care of cohorted patients in Therapy-Led Units, who are Medically Fit For Discharge
- Set out the next steps and implementation approach
- Ensure governance and accountability.

For further information about the use of the framework, see:

- Appendix 1: System evidence of best practice
- Appendix 2: Initiatives to decrease DTOC lists
- Appendix 3: High level implementation plan.

1. Maximising the appropriate use of care homes

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This section describes ways in which to maximise the appropriate use of care homes by identifying and supporting care homes at risk of closure. Using real-time surveillance to monitor capacity in the care home sector can accelerate patient flow from acute care settings.

The actions to be taken are outlined within the following sections:

1.1. Identify care homes at risk of closure and/or admission restrictions and explore intervention approaches through local collaboration and monitoring, using mechanisms such as Quality Surveillance Groups and formal notices of unsafe care home services from CQC, safeguarding alerts about care homes, and soft intelligence from professionals', carers' and residents' concerns.

1.2 Ensure collaboration between care homes and NHS bodies to prevent and/or mitigate closure or restrictions to admissions.

1.3 Implement a real-time system-monitoring Information Technology solution to access care home bed availability in order to determine bed capacity and accelerate patient flows.

1.4 Monitor impact through key metrics.

For evidence underpinning the need to maximise the appropriate use of care homes, see Appendix 1.

1.1 Local monitoring to identify care homes at risk of closure

Use of monitoring will enable economies to understand and work with care homes that are at risk of closure or subject to restrictions. This information is already available to Local Authorities (LAs). We therefore ask STP partners to work with all CCGs to ensure they are:

- Working together with their Local Authorities to review this information routinely, and that they use the Quality Surveillance Group (QSG) to escalate and explore appropriate potential solutions that support the continuity of quality services

- Working closely with the CQC, and using QSGs, Local Authorities and other providers, to consider a range of options as outlined in 1.2, *slide 6.*

Case Studies:

Birmingham Cross City CCG (elements of the system)
https://www.england.nhs.uk/leadingchange/staff-leadership/framework-to-support-winter-pressures-2017-18/

Newcastle and Gateshead CCG
https://www.enhancedcare.org/what-the-poc/?rq=pathway%20of%20care

1.2 Collaboration between NHS bodies, care homes and local authorities

There are many examples of good system working with care homes that result in an improvement in care home quality, reduction in hospital admissions (and pressure on EDs) and earlier discharge. Work has shown that a more effective relationship with care homes and support leads to significant system benefits for all those involved, including the residents. *Case Studies: Community Link Nurses and Hospital Transfer Pathway (the 'Red Bag' Scheme)*

Where homes are identified as at risk of closure and/or admission restriction, local commissioners can work *with* providers to explore a range of options that support provision of quality services.

In-reach support

There are a number of essential principles that should apply in care home closure situations. This guide sets out key issues that need to be addressed, underpinned by a detailed checklist of actions to ensure people are at the heart of the process.

Joint venture

NHS organisations, local authorities or other social care providers can pursue a joint venture with providers in the care home sector. Collaborations may include the estate/physical environment of care homes, sourcing nursing and other care or professional staff, and operational management.

- **Case Study:**
  https://www.england.nhs.uk/leadingchange/staff-leadership/framework-to-support-winter-pressures-2017-18/

Full ownership

The CQC has a defined process and will work with the regions to understand and achieve registration where required in the shortest time possible. See Fig.1 below.

Effective ways to ensure care staff and residents receive flu vaccinations

Influenza vaccines should be offered in the autumn. The best time to have a flu vaccine is from the beginning of October to just before the festive break.

All residents should be offered their influenza vaccine in the care home by their General Practice. Under local agreements this may be delegated to an appropriately trained Community Nurse or care home nurses. Pharmacies registered to deliver the Community Pharmacy Seasonal Flu Advanced Service can also be asked to vaccinate residents in care homes.

NHS England has announced that social care staff employed by a registered residential care/nursing home or registered domiciliary care provider are eligible for their own free influenza vaccine, using their ID badge.

Figure 1: CQC defined process of full ownership

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Where all attempts have been exhausted and a change of owner / registered provider of the Care Home is necessary, close collaboration with the local authority, given its duties under the Care Act 2014 about Continuity of Care, will be important.

To help comply with this process, please see the following steps.

1. **Contact your Head of Registration (HOR):**
   - If the legal entity (the provider) of a service changes or the service intends to change its regulatory activity or conditions of registration (e.g. number of beds)
   - Where a registration change is predicted, this should be well planned and done in advance. The CQC registration standard can take up to 10 weeks. However CQC HORs will work with each region to secure the most effective route to registration, where required.

2. **Establish case for prioritisation:**
   - In the event of a case for prioritisation, the HOR should be contacted to understand what service will be provided and who will be the provider of that service
   - A registration change may not always need to happen as some of the models that need to be addressed are about how acute services can provide support to care homes or DCAs.
   - Even understanding that this is a prioritisation, the HOR should be contacted as early as possible.

3. **Complete application form accurately**:
   - An application form for registration will still need to be submitted as this is a legal process
   - If the service is a new provider, this will be a new application process
   - If the service needs to change (e.g. increase number of beds or change regulated activity), this will be a variation to the registration.

4. **Liaise closely with Head of Registration:**
   - There should be liaison with the relevant HOR on progress and to ensure you are never in a position of providing care in an unregistered service.

HEADS OF REGISTRATION (HORs)

Deborah Cotton
Head of Registration (London)
Email: Deborah.cotton-soares@cqc.org.uk

Patrick Wright
Head of Registration (Central Region)
Email: patrick.wright@cqc.org.uk

Janet Shipman
Head of Registration (South)
Janet.shipman@cqc.org.uk

Emily White
Head of Registration (North)
Email: emily.white@cqc.org.uk

1.3 Engage in nationwide roll-out of real time system surveillance enabled through Information Technology

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Local Authorities may already have established processes for monitoring and sourcing care home capacity that can be made more visible and accessible to the NHS. Therefore NHS commissioners are required to discuss with Local Authority colleagues if these exist and can be extended so all relevant people can make planning decisions based on real time and accessible information.

NHS England are enabling providers and commissioners to access to Information Technology solutions that will give visibility of available care home placements across a whole area on a daily basis. These will help optimise care home placements. There are a small number of validated, IT platforms that provide this and effective implementation requires primary, community and in patient services to work in partnership with commissioners and social care.

We will support local areas to roll out appropriate solutions via this framework . We will work through our regional networks to target direct support and this will be complemented with a series of learning events.

Real Time System Surveillance Enabling Technology

Real Time System Surveillance tools should furnish commissioners and providers with real-time care home bed availability. This should mean that family members, discharge teams and CCG commissioners can make decisions quickly and safely about discharge. It would therefore help to:

- support patient choice

- create better patient flow

- provide better outcomes for partners and patients

- support the reduction of length of stay and delayed transfers of care in acute and community hospitals

- support timely discharge and better bed utilisation in residential and care homes.

1.4 Metrics for monitoring impact: Care Homes

The following are suggested metrics in order to monitor impact:

Bed state for the system

- daily update of Bed State portal by care home

- more than 85% care home bed occupancy

- triangulation of care home bed space with DTOC patients needing care home beds

Stranded Patient Metric – those with a length of stay >7 days

- definition: the number of beds occupied by patients who have been in hospital for 7 days or more

- metric: weekly decrease post-implementation of Care Home Bed State portal.

2. An Operating Model for Therapy-Led Units (TLUs) optimising care of patients who are Medically Fit For Discharge (MFFD)

Context

Unnecessary delay in discharging older patients (those aged 65 and over) from hospital is a long-standing issue. There are two distinct groups of patients who fall into the delay category, although there will be an overlap between the categories – Medically Fit for Discharge (MFFD) and Delays in the Transfer of Care (DTOCs).

Cohorting patients based upon need, aligned to a focus on functional re-enablement, can provide and effect a solution to this issue. Evidence shows that longer hospital stays for older patients can lead to worse health outcomes and an increase in their care needs on discharge. For example:

- Older people can lose mobility, and experience reduction in muscle strength, by as much as 5% per day very quickly if they do not keep active

- Healthy older adults with 10 days of bed rest led to a 14% reduction in leg and hip muscle strength and a 12% reduction in aerobic capacity: the equivalent of 10 years of life

- Older people are more likely to acquire hospital infections. Between 2008 and 2012, the Methicillin-resistant Staphylococcus aureus (MRSA) infection rate for men aged 85 years and over was 574 times greater than the rate for those aged under 45 years.

2.1 Key Facts - Medically Fit for Discharge (MFFD)

- **Definition of MFFD:** A patient who has completed their episode of acute care and who is now medically fit for discharge. All relevant investigations have been completed and none further are anticipated. The patient, however, may require further therapy or social input.

- The patient may not have had a MDT decision at this point, and may require further therapy or social care input prior to an MDT agreement; the patient is therefore not a reportable DTOC delay at this point.

- In general there will be more patients in an acute Trust that are MFFD than DTOCs. The National Audit Office estimates that 2.7 million hospital bed days are occupied by older patients who are no longer in need of acute treatment (MFFD).

Reablement and rehabilitation are vital to returning people home from hospital in a timely manner. Caring for a cohorted group of people TLUs who are MFFD but require further physical, psychological or social support to regain or maintain skills, confidence and independence, will support more timely discharges home, and may lessen the requirement for ongoing care once they are back at home.

- **Reablement** is the active process of an individual regaining the skills, confidence and independence to enable them to do things for themselves, rather than having things done for them.
- **Rehabilitation** is a personalised, interactive and collaborative process, reflecting the whole person. It enables an individual to maximise their potential to live a full and active life within their family, social networks, education/training and the workplace, where appropriate. (NHS England, 2016)

2.2 TLU Aims and Objectives

To improve and reduce stranded patients and DTOC in acute hospital settings by creating an environment for patients who are MFFD which promotes a philosophy of self-care and self-management.

This supports organisational flow and ED pressure, promotes well-being, and maintains functional capacity in alignment with existing initiatives such as Red2Green, Mobility Bundle, Safer Patient Flow Bundle, End Pyjama (PJ) paralysis, last 1000 days, Criteria Led Discharge, and Eat, Drink, Move. It also:

- expedites discharges safely through MDT Board Rounds with enhanced links with the community and social care, including independent organisations, to maximise on social capital

- provides on-going care with a reablement and rehabilitation focus, to prevent deconditioning, and to strive towards the stepping down of care needs on discharge by improving function

- enhances patient confidence and competence in their daily activities

- promotes on-going independence, social inclusion, and safe discharge.

2.3 TLU – Standard Operating Procedure 1

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Therapeutic Environment

The environment adopted will be focused on a therapeutic/enabling approach. The benefits of this model of care are:

- Therapeutic interventions will be available through interventions to promote meaningful activity and time use.

- Therapeutic interventions will become more individualised, as they take into account personal routines and will be goal focused. Habits and routines will be embedded in a way which is more consistent with individuals' routines post discharge.

- An increase in professional skills and perspectives (MDT working develops a greater appreciation of each other's core skills and professional perspectives) to provide the greatest opportunity for reablement, rehabilitation and recovery.

- Therapeutic skills and perspectives will contribute to more elements of the ward routine, further supporting the philosophy of care.

2.3 TLU – Standard Operating Procedure 2

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Workforce Principles

An integrated multi-professional approach to supporting people to return home is vital. Evidence from the National Audit of Intermediate Care (NAIC) identifies a strong positive link between outcomes and the number of different staff disciplines the service user came into contact with, in both bed and home based intermediate care services.

Units should therefore adhere to the following:

- The workforce should reflect the demands and care needs of the people accessing the service. Medical care will have been completed, and therefore the skill mix may be very different to that of an acute hospital. However, the person may still have significant care needs on admission, for example, needing two people to mobilise.

- These wards should be led by a therapist or ward manager with a complement of staff aligned to therapy, nursing and pharmacy disciplines, from a range of sectors such as health, care and voluntary.

- Working in partnership and close collaboration with community services, social services and the independent sector, both in-reach and outreach, is vital to supporting a safe return home.

- The principles contained in the National Quality Board (NQB, 2016) 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe, sustainable and productive staffing' need to apply in this care setting to optimise productivity and efficiency while maintaining the focus on improving quality.

2.3 TLU – Standard Operating Procedure 3

Admission Criteria

- Medically Fit for Discharge (MFFD), the episode of medical care is completed, all relevant investigations have been completed and none further are anticipated.

- Further therapy or social input is required to regain or maintain the skills, confidence and independence to support safe return home and lessen the requirement for ongoing care once back at home.

Discharge Criteria

- Attainment of their goals
- Criteria-led discharge

Admission Assessment

- Current care plan and discharge plan.

2.3 TLU – Standard Operating Procedure 4

Medicines Management

- Multicompartment Compliance Aid (MCA) / Monitored Dosage Systems (MDS)
- Workplace assessment, supervision and coaching.

Skills Training

Provide a comprehensive programme which considers building competencies from fundamentals of care to those that capture more complex needs and are broad enough to address the diversity of reablement and rehabilitation practice. Training needs to be designed and delivered within an integrated partnership approach.

KPIs

Pre and post discharge:
- Goal Attainment Scale (GAS)
- Level of mobilisation
- Care Hours required
- Planned place of discharge – place of discharge

Other

- Length of stay
- Readmission

2.4 Learning from others - examples of best practice in the cohort of MFFD patients

- **Evergreen Ward (Worcestershire)**

- **B49 Community Ward (Nottingham)**

- **Developing occupation-focused in-patient mental health services through integration. (Cambridge and Peterborough)**

https://www.england.nhs.uk/leadingchange/staff-leadership/framework-to-support-winter-pressures-2017-18/

3. Next Steps and Implementation

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NHSE and NHSI will publish frameworks as clear guidance through the single operating model in **early December 2017.**

Systems should support their commissioners and providers to make sure they work together to do the following:

- Include the framework in their local escalation plans.

- Discuss with local authorities in their systems how to implement the framework appropriately in shared local escalation plans, and how the framework should be used operationally.

- If there are discrepancies between current local escalation plans and the standards outlined in this framework, please develop a plan, as required, for achieving the standards of care and ways of working described in this document.

Exploring technological advances to support the framework and associated funding subject to approval from **December 2017**. **Slide 22** of this framework includes a high level implementation plan.

4. Governance and Accountability

- National Winter Team must be assured that all organisations have robust plans and evaluation of impact.

- All plans must be sent to local UEC Delivery Boards.

- Regional teams should monitor local escalation plans and escalate as required.

- All plans must be signed off internally by boards / governing bodies.

Appendix 1: Evidence

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Care home closures

From January to August 2017 there were over 931 care home de-activations. Of these, 70 were forcibly de-registered via the CQC.

- This is a very well-reported risk to the disruption of people's daily lives, and system safety.

- Currently there are very few surveillance systems, and only two value-for-money systems are working.

DTOC range

- Trust level rate calculated using bed occupancy, availability and delayed transfers of care.

- As of September 2017, the range nationally is between 59.6% for Lincolnshire Partnership NHS FT and 0% for Moorfilds Eye Hospital NHS FT, Surrey and Borders Partnership NHS FT, Papworth Hospital NHS FT, The Royal Marsden NHS FT, Queen Victoria Hospital NHS FT and Leeds Community Healthcare NHS Trust.

- There are a number of organisations that have deployed DTOC-reducing initiatives. Please see Appendix 2.

Appendix 2: Initiatives to decrease DTOC

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Discharging Patients Sooner	✓
Supporting housing placement and step downs	
Information-driven decision making	
Information and advice to patients	
Dementia focus	
Supporting outside the hospital	
Changing hospital pathways or tariffs	
Leveraging the specialists	

Avoiding Admissions	✓
Specialist assessments in the ED	
Falls rapid response team	
Streaming non-acute patients to better settings	

Initiatives to Improve Hospital Flow	✓
Correct allied health professional rehab model	
Comprehensive geriatric assessments	
Daily senior clinical reviews and discharge planning	

New Models of Care Vanguards	✓
New models of care vanguards	

This checklist is derived from the Horizon Scanning document and enables you to assess which measures your Trust already has in place. **Please click on link for description.**

If your Trust scores:

0 – 3: you must incorporate the best practice framework

4 – 7: you must engage in real-time surveillance roll-out

≥ 8: you must demonstrate that both elements of the framework have been considered and incorporated in the winter plans.

Appendix 3: High-level Implementation Plan

December	Week 1	Week 2	Week 3	Week 4	January onwards

1 **Preparing Implementation of Care Home Digital tools** — Engage with the Regions linking with existing local initiatives — Complete Situational Analysis on existing digital tools and support

2 **Sharing Best practice for the Whole Winter Framework** — Series of Webinars to share best practice winter framework (further details to follow)

3 **Implementation Planning of Care Home Digital tools** — Develop tailored regional Implementation plans including additional support or tools required

4 **Mobilisation Care Home Digital tools** — Implement regional plans — Formal reporting to local UEC Delivery Boards

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