Submissions to the Right place, right time commission

To request further information about any of these case studies, please contact Martha Everett

Organisation	Focus	Summary
Aintree University Hospital NHS Foundation Trust	Discharge to assess	Aintree at Home - Discharge to Assess facilitates early and safe discharge through functional and social care assessment in the service user's home. The service has been developing since 2012 and began working in partnership with the local authority in February 2015. This change has led to undertaking social care assessments in the community rather than during hospital admission. Between February and July 2015 the service treated 40 patients and saved 327 bed days, with eight bed days saved on average per patient.
Airedale NHS Foundation Trust	Intermediate care hub	Airedale NHS Foundation Trust launched an Intermediate Care Hub in November 2014 to route referrals into intermediate care services through a single point of access, in which health and social care staff triage information and look to direct the patient to the correct service at the correct time. Airedale submitted two case studies, which highlight that long term or inpatient rehabilitation is not always required when engaging early with health and social care teams through the Intermediate Care Hub.
Arden and Greater East Midlands CSU (submitted by the Department of Health)	Discharge to assess	Working together, South Warwickshire CCG and Arden and GEM Commissioning Support Unit established a new integrated model of care, Discharge to Assess, where patients are treated and assessed in a care home setting instead of an acute hospital. The CCG and CSU worked collaboratively with the local authority, local hospital, Age UK and care home providers to design the model and offer a fully integrated and streamlined service. By accessing care home beds, patients could be discharged from hospital into a more appropriate care setting.
Birmingham City Council and CCG (submitted by the Department of Health)	Discharge to assess	Birmingham City Council and Birmingham Cross City CCG are working with care home providers in Birmingham using a discharge to assess pathway that enables them to provide rehabilitation to elderly patients who are not yet able to go home, but do not need further medical attention. Piloted since December 2014 and now being rolled out more widely, the scheme has already seen significant improvements in care as well as cost reductions

Birmingham Mind (submitted by the Mental Health Providers Forum)	Mental health rehabilitation	Pershore Road is a registered ten bed care home. Since 2007 it has been contracted to deliver a limited rehabilitation service for adults recovering from mental health problems. Most users have been in hospital or medium secure units, for whom they provide a step down service for them to work towards independent living. They follow a rehabilitative ethos through a service user-led approach.
Birmingham and Solihull Mental Health NHS Foundation Trust	Psychiatric decision unit and mental health street triage.	Birmingham and Solihull Mental Health NHS Foundation Trust has established a Psychiatric Decision Unit (PDU) to provide extended assessment and short term support to people in mental health crisis who access Accident and Emergency within acute hospitals and offers a Mental Health Street Triage service which diverts people away from presenting at A&E. It provides an alternative setting where prolonged assessment can take place in a more appropriate, supportive environment with skilled mental health nurses and psychiatrists. Funding for the unit was agreed through the local System Resilience Group. The unit has been running since November 2014. After a slow start with some difficulties for patients transferring from A&Es across the city to access the PDU, numbers have steadily increased to around 80 users accessing per month.
Bromford (housing support) and St Giles Hospice	My Home Support service	My Home Support is a joint project between St Giles Hospice and Bromford. The aim is to support independence and resilience for patients who are referred to St Giles who either do not need specialist clinical intervention, or whose hospice care would be enhanced by the supportive care skills that Bromford offers. The impact is evaluated on the following outcomes: • Support people who wish to be at home as long as possible at the end of life. • Reduction in inappropriate use of clinical time • Reduction in accidental falls/injuries and social isolation • Improved quality of life • Reduction in unplanned admissions/readmissions to hospital The Bromford Support Worker has an honorary contract with St Giles and can record in the patient's electronic clinical record. A holistic assessment is conducted utilising a framework used to supporting people within the housing sector. The assessment reports on six key indicators.

The Christie NHS Foundation Trust	Enhanced supportive care	Enhanced supportive care (ESC) is a new initiative at The Christie NHS Foundation Trust, aimed at addressing more fully the needs of patients throughout their 'cancer journey' from diagnosis, through treatment, into survivorship, progressive disease and end of life. This approach aims to improve care in the lasts weeks and days of life and integrate palliative care in identified cancer-specific disease groups. These demonstrated improved patient and staff experience through: • Recognition of advanced progressing disease and support in the transition to best supportive care • Improved staff confidence in supporting advance care planning • Patient involvement in decisions and discussions around their care • Offer of referral to palliative care/symptom control at an appropriate time • Improved communication between The Christie and community teams, improving discharge arrangements and better co-ordination with community services, allowing rapid discharge and transfer of care in the last days of life so that patients can die at home if this is their preferred choice. A Priority Discharge document and flow chart for 'Rapid discharge for patients at end of life' have been developed and provide a framework for the management of a safe and effective discharge.
Care Quality Commission	Transfers of care and hospital discharge	Through its inspections over 2014-15 the CQC has identified three key factors that are important in supporting good practice in the management of transfers of care and hospital discharge. These include: • visible, positive and engaged leadership, where providers work with people using services and other local groups and agencies to understand the needs of their local population; • effective communication, where support is given to people using services to help them to navigate the health and care system; and • collecting and using data to ensure services meet the needs of local people. CQC included some recommendations following three reviews which looked at the quality of care across a pathway, including transfers of care between services, as well as four examples of good practice.

Department of Health	Discharge to assess	The Department of Health provided three case studies of how social care providers are playing a proactive role in integration and in working with primary and acute health services. The first two case studies are around reducing delayed discharges and involved Langton Care and Coverage Care. The third was around preventing admissions and involved Marches Care.
Derbyshire Community Health Services NHS Foundation Trust	Discharge to assess	Derbyshire Community Health Services NHS Foundation Trust has developed a new Discharge to Assess and Manage (D2AM) model which aims to reduce unnecessary lengths of stay in the hospital environment by ensuring that discharge is considered from the date of admission and that essential assessments are completed in a patient's own home. Patients discharged via D2AM will have basic therapy assessments completed as soon as they are well enough to participate. These assessments ensure that the patient is safe to return home and that essential equipment is provided. The patient is then discharged home with D2AM into the Integrated Care Team (ICT), which is a team of social care, therapy and nurses working together within the patient's local community. The ICT will assess the patient within two hours of being discharged and complete any health and social care assessment in the patient's home, rather than an unfamiliar hospital setting. The ICT then tailors a health and social care package to meet the patient's needs.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Integrated discharge service	Doncaster and Bassetlaw Hospitals NHS Foundation Trust has operated a fully integrated discharge service since 2012. The service focuses on the safe discharge of patients from hospital to the most appropriate setting at the earliest opportunity, ensuring that care continues in the community or wherever is clinically appropriate. Elements of the service include: • A fully integrated discharge service • Improved discharge planning and referral process in partnership with other agencies • Enhanced discharge documentation and a 'discharge passport' • Improved communication between patient carers and multi professional groups • Better working relationships between health and social care • An award winning patient pathway tracking tool, called 'itracker' - an innovative IT system that monitors length of stay, flags expected date of discharge and detects delays in the system The new ways of working have resulted in better planning and coordination of existing resources, and a small investment in order to move to seven day provision of the service. There have been real benefits for partnership working across professional boundaries and an example of integration for the benefit of patients and the organisation.

East Lancashire Hospitals NHS trust	Medicines management	East Lancashire Hospitals NHS Trust provided a summary of its transfer of care initiaitives in medicines management. These include: • Electronic Patient Tracking System to identify patients in need of new medicines reconciliation on admission to hospital. • Transfer of care 'friendly' prescription chart • Core training for junior doctors (including OSCE) on using the transfer of care 'friendly' prescription chart • Transfer of care 'friendly' e-discharge letter • Mandatory authorisation by pharmacist of e-discharge letter • E-discharge letter tracking report to identify patients discharged without a discharge letter being sent to GP • Medicines Reconciliation Checklist • Medical Assessment Unit (MAU) pharmacy model • Medicines reconciliation training and competency assessment for pharmacy staff • Refer-to-Pharmacy – e-referral from hospital to community pharmacy • Care Homes hospital admissions checklist • Ambulance POD bags (patient's own drugs) • Ward round checklist and/or dedicated ward pharmacist to participate in multi-disciplinary consultant-led ward rounds • Direct access to local GP records in and out of hours
Foundations	Home support for discharge	Five short case studies of how home support agencies have supported hospital discharge schemes. The case studies cover Swale (preventing falls), North Essex (older people A&E discharge), Manchester (older people discharge), Somerset (discharge generally) and Croydon (older people discharge).

FTN benchmarking	Elderly care	A summary of the FTN Benchmarking workshop on elderly care services in November 2011. Some of the main emerging themes from the breakouts and panel discussion were: • The support available to patients outside the trust in terms of step down beds and domiciliary services, as well as bed flow and staff skill mix, was found to impact the acute elderly care model of service delivery. • Early specialist geriatric input into the elderly care acute pathway was associated with greater admission avoidance, more effective streaming of patients to specialist wards and a lower length of stay. Effective involvement of specialist nursing and therapists facilitated assessment and delivery of patient needs. • Trusts with lower lengths of stay also demonstrated effective discharge planning and proactive management of the interface between acute and community care, including early involvement of social services and palliative care staff. • Outreach initiatives from acute-based geriatric staff such as domiciliary visits and nursing home rounds had successfully prevented admissions and re-admissions for elderly patients.

FTN benchmarking (the former name for NHS Providers)	Older people's services	A summary of the FTN Benchmarking workshop on older people's services in February 2014. The key areas addressed in the workshop were: • Service delivery models including how to develop older people services skills as a trust; structuring, managing and resourcing pathways effectively to deliver effective care to the patient population and adopting standard nomenclature for service initiatives to facilitate comparison and knowledge sharing. • Strategic collaboration across providers to develop services and patient pathways, progress made so far and practical tips other trusts could consider adopting. Includes an example of good practice from Mid Yorkshire NHS Trust. • The issues surrounding the transfer of care between providers and initiatives that have helped participating trusts to deliver a good patient experience. Includes examples from Doncaster and Bassetlaw Hospitals NHS FT, North Tees and Hartlepool NHS FT, Sheffield University HospitalNHS FT, University Hospitals Bristol NHS FT and Royal Liverpool and Broadgreen NHS Trust. • How to avoid admissions: the initiatives used to tackle rising demand for non-elective admissions for older adults and ensuring that patients are accessing the right services at the right time. Includes examples from University Hospitals Bristol NHS FT, County Durham and Darlington NHS FT, Doncaster and Bassetlaw Hospitals NHS FT and North Tees and Hartlepool NHS FT. • How the FTN could support the group going forward, including: facilitate the sharing of documents and templates across trusts, sharing information on workforce capacity and skills mix in the context of the service that is being delivered, as well as supporting networking and the discussion of pertinent issues in detail.

Guy's and St Thomas' NHS FT	Hospital to care home transfer bundle and staff training course	Outlines three good practice initiatives to address the transition between care settings: • An older people's directory - an online directory of clinical, social and voluntary sector support services for older people to prevent social isolation and reduce the impact of crises which could result in hospital admissions and residential care. The directory also helps health and social care professionals to access information about services not previously on their radar, understand how they operate and consider alternatives to traditional services. • The transfer of care bundle sets out the best practice steps for discharge within a checklist alongside the transfer forms required for people moving from hospital to a care home, and vice versa. The best practice was intended to support improved communication, collaborative working and early issue resolution. Testing was successful and it has had a particularly positive impact on the quality of the discharge process and patient experience. It was officially adopted at King's in April 2015 and will be rolled out to GSTT soon. • "Good to go", a multi-professional training course to support transfers of care, is part of the simplified discharge work stream and has been designed for staff from health and social care, working in both the hospital and the community. The course aims to help staff to support older people, their families and carers to prepare for leaving hospital. They worked with London Southbank University and the Simulation and Interactive Learning Centre (SalL) at Guy's and St Thomas' Hospital to develop the course.

Guy's and St Thomas' NHS FT	Neuro-rehabilitation Enhanced Transition Team and @home service	Outlines two good practice initiatives to address the transition of patients between care settings: • @home - a multidisciplinary team delivering care at home for patients who would otherwise be admitted to hospital or who are not quite medically stable for routine discharge but who, with support, are discharged from hospital early and stabilised in their own home. Since November 2014 they have been working with London Ambulance Service on an admission avoidance pathway. • Neuro-rehabilitation Enhanced Transition Team (NETT) – from November 2014 they offer neuro navigation and/or intensive and responsive community-based rehabilitation. The team aims to improve patient experience and provide cost efficiencies through a reduction in length of stay in acute inpatient care and specialist rehabilitation units as well as reducing avoidable admissions to bed-based care in acute/specialist neuro-rehabilitation settings/care homes.
Hackney Council via Homerton University Hospital NHS FT	Patient and carer engagement	Hackney Council carried out an engagement exercise with local residents to gather views via email survey on the effectiveness of discharge processes from local hospitals.

Health Foundation	Improved transfers of care/discharge for older people	Outlines three case studies: • Sheffield (improving discharge of frail older patients): As part of the Health Foundation's Flow Cost Quality programme, Sheffield Teaching Hospital NHS FT tested a discharge to assess process. The first ward to fully implement the model in 2013 achieved a reduction in the mean patient length of stay of seven days. The project has also reduced falls from a mean of almost 14 to just under 10. • London (improving the discharge process for patients with dementia): The Health Foundation funded a project led by the Royal Free London NHS FT that aimed to give every patient with dementia a safe, dignified, timely and sustainable discharge. It involved a specialist dementia occupational therapist providing a single point of contact for the patient, family and staff throughout the admission and discharge process. As a result the average length of hospital stay decreased by 1.9 days, re-attendances via A&E decreased by 26% and the trust made an estimated cost saving of £48,708 in 9 months. • East Kent (improving communication during transfer of care for frail older patients): At East Kent Hospitals University NHS FT inadequate communication between the acute and community sectors led to 'revolving door' admissions, with patients being admitted and discharged without adequate information being shared. Through a number of measures, the trust reduced re-admissions from care homes to the hospital from 25% to 15% at 30 days, without a rise in length of stay. Ashford CCCG also reported a reduction in total admissions of older people, leading to an estimated saving of £500k in the first year of the project.

Heart of England NHS Foundation Trust	Patient flow, pathways and partnerships	A summary of initiatives undertaken by Heart of England NHS FT. Progress is largely defined within three key areas: patient flow, development of new pathways and partnership working. The plans reflect the triumvirate approach within the organisation (medical, nursing/therapy and operations) with lead clinicians taking responsibility for actions and delivery. • Patient flow has been redesigned to enable discharge planning on all wards. Each ward has a daily board round with outcomes and decisions recorded on the electronic JONAH visual display board. Roles and actions are defined within Bronze, Silver and Gold levels of escalation with all teams having oversight at different levels. • New pathways: HEFT has designed the Supported Integrated Discharge Service (SID) in collaboration with Birmingham City Council and Solihull Metropolitan Borough Council. In addition to D2A pathways to support patients home there is whole system planning to consider patients with more complex needs, provided through a collaborative approach involving five local agencies (CCG, LA, Primary Care, HEFT, Birmingham and Solihull MH Trust and local provider). • Partnership working: various multi-agency forums exist to support specific programmes of work around integrated models of care and services. This is evidenced through the Solihull ICASS programme (Integrated Care and Support Solihull) and the local SRGs for each area.
Kent County Council (submitted by the Department of Health)	Integrated discharge service	A summary of Kent's integrated discharge team work to date. The submission outlines the following: • The team composition • Achievements date including improved multi-organisational and multi-disciplinary work; anticipatory care plans for patients with long-term conditions and repeat presentations at A&E; improved dementia management support; indications that length of stay for people over 65 and admissions following a fall are reducing; early indications that referral for long term placement is reducing; improved goal setting with estimated dates of discharge for 95% of inpatients. • A number of patient stories outlining the impact of the team

King's College Hospital NHS Foundation Trust	Community peace documents	A summary of the implementation of care management plans (peace documents) for nursing home residents with severe frailty and/or advanced dementia who were thought to be in their last year of life. The model has effectively reduced readmissions and resulted in more patients dying in their place of preference (the care home) than in hospital. This project was carried out by Julie Whitney working in the care home interface practitioner post funded by King's College Hospital to reduce avoidable admissions. Following the use of the peace document, patients had a 50% lower risk of hospital admission compared to the previous year.
King's College Hospital NHS Foundation Trust	Discharge bundle	A series of documents which are used to support the discharge process at King's College Hospital, namely: • A PowerPoint presentation on why, when and how to use the transfer bundle documentation • A checklist for transfers of care • A discharge checklist from hospital to care homes • An example form for care home to hospital transfers • The peace documents outlined above
Leeds and York Partnership NHS Foundation Trust	Gateway accommodation pathway for mental health	A summary of the accommodation gateway project undertaken by the Leeds and York Partnership NHS FT. The document outlines the establishment of the gateway co-ordinator role to support patients to secure appropriate accommodation after being discharged from mental health services. The gateway team were able to support patients to understand the options available to them, improve the knowledge base of NHS staff in regards to housing and secure improvements in how information was shared between the council, NHS and housing providers.
Lincolnshire Community Health Services NHS Trust	Community in-reach and out of hours services	A summary of what the Lincolnshire Community Health Services community in-reach team do and how they have impacted on the patient journey. The in-reach team focuses on preventing hospital admissions and is based at the front door of the trust to review potential admissions and educate patients to prevent A&E attendance where appropriate, as well as providing advice to medical practitioners who feel a patient may require hospital admission.

Public Health Observatories / Centre For Public Mental Health, Durham University	Mental illness needs index	A study to develop a mental health needs index to predict admissions for specific geographical areas, for use by commissioners and providers to consider the predicted bed admissions for their populations. In different types of area, people are more or less likely to suffer with mental illnesses. To some extent this can be predicted from characteristics of the population measured by the census or other types of survey. Mental health needs indices estimate by how much. A needs index of 0.8 suggests that there will be 20% less illness in an area than in the country as a whole, an index of 1.2 suggests 20% more. The NE Thames area was chosen as a pilot study. predicting admissions for specific geographical areas. More information is available at www.apho.org.uk/resource/item.aspx?RID=48886
National Housing Federation	Reablement services	A registered care home located in Middlesborough, offering a limited number of long term placements to children and adults, and offering specialist nursing care, rehabilitation, a wellbeing hub, health club and transitional housing complete with leisure facilities. Clients have long term cognitive and behavioural difficulties and nursing needs.
Local Government Association	Efficiency opportunities through integration	LGA commissioned Newton Europe to explore 'efficiency opportunities through health and social care integration' particularly looking at pathways and moving care to the community. The study aimed to quantify how many service users ending up in A&E would have benefitted from a preventative service, how many could benefit from step down services etc. and provides useful figures.
NHS Alliance	Housing for health	Useful case studies about supported housing offers. The ASSIST discharge scheme in Mansfield helps support people leaving hospital to find alternative accommodation where they need it, helps adapt a person's own home so they can return in a timely manner and provides discharged patients with support services including advice on money and welfare at home. A recent evaluation showed £379,800 monthly savings from the current model with potential to increase these significantly if it could be rolled out at greater scale.
NHS Providers	Fines to local authorities for DTOC	NHS Providers' information on the levels of fines levied on local authorities and the possible causes of increases in DTOC.

NHS Providers	Response to Lord Crisp interim report	NHS Providers' response to Lord Crisp's interim report focussing on a whole system response and ensuring parity for mental health services in terms of funding, systems and processes. Focuses on the need to address the currently fractured approach to commissioning, which results in disjointed and uncoordinated care and means, for example, that specialist inpatient services rely on CCGs to commission appropriate step-down services and local provision of support but this is not always done, leading to delayed discharges.
Norfolk Community Health and Care NHS Trust	CQUIN scheme for system flow	CQUIN scheme which has contributed to better patient flow by improving information sharing, including a joint validation report with social care. This is the result of an investment of time and energy in partnership working in the locality.
Norfolk and Norwich University Hospitals NHS Foundation Trust	Inpatient reablement model	The Henderson Unit offers an inpatient reablement model for those patients not ready to go home or to be supported elsewhere. The focus is on empowering the patient and on reablement to support safe discharge to their usual place of residence. The unit opened in January 2015 and is a partnership between the trust, the county council, therapy and nursing staff. The team also has access to pharmacy, medical cover, speech and language therapies etc. Average length of stay has stabilised at ten days, with approximately 80% of residents being discharged to their usual place of residence.
North East Public Health Observatory	Mental health and mental health service us in England.	Analysis of mental health and mental health service use in the North East. A good practice model with a wealth of information for providers, commissioners and policy makers. Includes a user survey and aims to improve detailed intelligence about mental health needs and available services.
Northumberland Tyne and Wear NHS Foundation Trust	Mental health bed management, transfers between primary and community care and initial response service.	Three case studies: • Bed management system in mental health including out of area packages, delayed transfers of care, practicalities of new admissions, transfers, step ups and step downs, which has reduced out of area admissions. • Developing focus on transfer between primary and community care in mental health services to improve handover between IAPTs and community mental health teams through a shared framework to create informal, integrated working with partners. • Initial response service, with a rapid response and triage for people defining themselves as requiring urgent help with their mental health. this service is often mentioned by Geraldine and has fantastic feedback from service users.

Northumbria Healthcare NHS Foundation Trust	Hospital2Home	Joint programme between the trust and the county council to help people regain and maintain independence following a health crisis or accident. Multi-disciplinary approach involving primary, community, secondary and social care. Since 2014 referrals to the team have increased, and length of stay in hospital has reduced (despite a tough winter). 11% reduction in avoidable admissions in the pilot area.
Nottingham University Hospitals NHS Trust	Emergency pathway quality report	The Emergency Pathway Taskforce has three workstreams focusing on admission avoidance, rehabilitation and discharge and in-hospital flow and provided a summary of a range of initiatives within these three workstreams. For example, in workstream 1, the trust is also a vanguard and uses a 'primary care sorter nurse' to help triage in A&E, in workstream 2, they describe co-location of services with social care, and in workstream 3, they are focusing among other things on internal process improvement. They are measuring a range of success indicators.
Nottinghamshire Healthcare NHS Foundation Trust	Transfer action group	Daily meetings involving community clinicians within a secondary care setting to facilitate timely and supported discharge home for the patient. Any patients with length of stay of seven days or more are discussed. Length of stay for those requiring supported discharge has dropped from 23.9 days (October 2014) to 16.8 days (January 2015). This also supports partnership working, including with the voluntary sector. Overall length of stay has reduced from nine days (October 2014) to 5.3 days (January 2015).
Oak Group	Benchmark and audit data	A range of information including a study of DTOC at a particular facility, a report for Kent Community Health FT on areas for improvement in services for the elderly and people with chronic or complex conditions, a report for the Nuffield Trust on length of stay and an audit of bed occupancy at a particular unit. Includes some helpful international comparisons and underlines the need to invest in step down care and community-based services.

One Housing Group and Camden and Islington NHS Foundation Trust	Care Support Plus housing for people with mental health needs	Care Support Plus is a fully integrated service model, launched in 2012 in London between Camden and Islington NHS Foundation Trust and One Housing Group, offering 15 units of self-contained supported accommodation for mental health serivce users. It delivers a unique approach to supported housing and recovery for people with complex mental health needs, providing onsite clinical input to offer a genuine alternative to hospital and expedite discharge for patients. The primary aims of the service are to: • reduce reliance on expensive out of borough care and forensic placements • reduce hospital admissions frequency and length of stay • improve quality of life and outcomes for patients • provide a high quality independent living environment At the same time the model offers considerable value for money through both short term savings in reduced placement fees, and longer term savings through improved and sustained outcomes.
Oxleas NHS Foundation Trust	Bed management policy and Care Support Plus transfer policy	The bed management policy for Oxleas NHS FT's acute mental health inpatient services for working age adults. Managing demand is not the sole responsibility of crisis and inpatient teams but "everybody's business". Community teams should support patients and increase support when they are in crisis, including crisis and home treatment teams so as to avoid admission where possible. Throughput should be maintained through close working and collaboration with rehabilitation units, low secure units and the local authority and third sector as appropriate. The Care Support Plus transfer policy details transferring care of clients within Oxleas and externally. Its aim is to ensure a high and consistent standard of care for all people using Oxleas' services. The procedures are designed to be flexible and responsive to individual circumstances to ensure that the transfer of care is seamless, ensuring continuity of care for service users and their carers. This is done through the use of a care co-ordinator, care plan and weekly caseload zoning MDT meetings.

Oxford Health NHS Foundation Trust	Oxfordshire Mental Health Partnership	A new collaborative between the mental health provider trust and five voluntary sector organisations working together to achieve positive and meaningful health outcomes for people experiencing mental health problems. The partnership formally will provide health and social care, employment, housing and wellbeing services, delivering a more flexible and accessible needs-led approach and personalised recovery-focused service with an emphasis on reducing the transfers of care between services and organisations and ensuring better access for patients into services. They will implement a single measure of recovery and ensure carers are supported and meaningfully involved in the delivery of care. A Recovery College, co-produced and co-run by people with lived and professional experience of mental illness, will take an educational rather than therapeutic approach to empower people to manage their own mental health recovery. Pilot courses started in September 2015. The partnership will use an innovative outcomes-based contract.
Queensland University (via Heart of England NHS FT)	Analysing sub-acute and primary health care interfaces – research in the elderly (study)	A study is examining the diverse care transitions of older people who transfer from the community across different locations and levels of care incorporating sub-acute care. It aims to provide a better understanding of the complexity of factors that influence these experiences and assist in deriving a whole-of-system approach to optimal patient care. The study is timely and critical for building the evidence base about the delivery end of policy initiatives aimed at enhanced integration of sub-acute and primary health care services for older people.
Royal College of Emergency Medicine	Exit block	RCEM analysis of the impact of "exit block" on transfers, including crowding and the impact on staff retention. The evidence from RCEM's research shows that exit block: • Increases patient mortality by about 13 deaths a year per Department seeing 50,000 patients • Increases the length of stay of admitted patients • Delays time critical interventions • Is associated with increased risk of adverse events • Decreases patient satisfaction • Increases staff stress and burnout • Increases the number of patients whose operations are cancelled

Royal Marsden NHS Foundation Trust	Best use for best outcome access policy	In November 2014, The Royal Marsden launched a new access policy, Best Use for Best Outcome, which focuses on working with patients and the health economy to better manage pathways and ensure patients are treated in the right place at the right time. The following key changes were made: • Non-elective admissions: structured 24 hour triage of non-elective admissions based on clinical criteria to determine whether a patient should be admitted to The Royal Marsden or to their local hospital, or be seen by their GP. • Elective referrals: the trust reviewed its access policy to clarify that it focuses its resources on areas where The Royal Marsden can make a difference to patients. • Second opinions: Due to high numbers of second opinion requests, a robust process for accepting and monitoring these referrals was developed. • Review of non-cancer treatments offered at The Royal Marsden: the trust reviewed treatments currently offered and altered its policy to focus capacity on offering delayed reconstruction for patients who received their original surgery at The Royal Marsden which is anticipated to result in shorter waiting times.
Sheffield Teaching Hospitals NHS Foundation Trust	Frailty unit, active recovery service, single transfer of care team and discharge to assess	The trust identified the potential to reduce the time for people with frailty to be seen by a consultant geriatrician and have a care plan established. An analysis of long stays found opportunities were missed to discharge patients after rapid assessment and consultant review, because the services involved in discharge were unable to respond quickly enough. A frailty unit was established to improve the flow for emergency frail general medical patients, and leading on from this, a discharge to assess model. Progress was tracked using daily bed occupancy. A review of all push/pull services was undertaken and community teams and hospital teams were subsequently combined. A single transfer of care team now facilitates front door turnaround of patients using appropriate community pathways, including active recovery, a jointly provided service between health and social care that puts in place interventions and treatments to support patients in their own homes. The service receives referrals from GPs and other community teams. Active recovery can respond within 2 hoursto assess the patient in their own home. The service also facilitates timely discharge of more complex patients from hospital to continue their assessment, rehabilitation and recovery at home.

Sheffield Teaching Hospitals NHS Foundation Trust	System flow governance arrangements	Terms of reference, ways of working and commitments for the trust's system flow governance arrangements. The flow group meets weekly, bringing together health and social care senior managers/directors to facilitate a coordinated, operational overview of the development of systems across the city to facilitate admission avoidance and maintain flow through all pathways. This facilitates timely discharge from hospitals, intermediate care beds and other community services. The group uses intelligence from the system dashboard and is informed of current pressures through escalation from length of stay and DToC meetings. The length of stay and DToC groups meet on a weekly basis (every Tuesday) to analyse patient level detail and facilitate the flow of service users through the health and social care systems. They analyse delayed cases and ensure actions are taken to 'unblock' flow as appropriate.
Southern Health NHS Foundation Trust	Enhanced recovery and support at home	The Enhanced Recovery and Support at Home (ERS@Home) scheme helps frail older people with complex health and social care needs to regain and maintain their independence, offering intensive support tailored to the individual.The scheme facilitates earlier discharge from hospital or prevents admission to hospital in the first place, and has provided enhanced out-of-hospital care to more than 1,250 patients in Hampshire. In-reach coordinators work with the local acute hospitals to identify patients suitable for referral to the scheme, speeding up their discharge where appropriate while ensuring an appropriate, tailored package of care is in place. The teams have been able to facilitate the discharge of some patients while their package of social care is being put together, helping to reduce delays. In some cases, this has resulted in a reduced need for social care, due to the intensive support the patient has received from the ERS@Home team. Patients receive a tailor made programme of rehabilitation starting with up to four visits a day if required.

St Giles Hospice and Heart of England NHS Foundation Trust	Accelerated discharge service	In September 2013 St Giles Care Agency commenced an accelerated discharge service at Good Hope Hospital. There is often a delay between patients being confirmed medically fit for discharge and a social care package being available. The accelerated discharge service is able to deliver the package of care required to allow those patients to return home. Typically Sty Giles provides the service for 5.5 to 7 days per patient, until statutory services are able to respond and take over. A package of care per patient costs on average £72 per day, compared with around £300 per day in an acute ward - a £228 net saving per patient per day. As at 18 months the service had saved well over 4,500 bed nights reducing the pressure of flow on A&E and protecting elective admissions.
Surrey and Sussex Healthcare NHS Trust	Daily integrated discharge sitrep	A range of graphics showing data from the daily integrated discharge dashboard, including waits for continuing healthcare.
University Hospital Southampton NHS Foundation Trust	Therapy-led discharge to assess and 'CHC in 5 days' redesign.	Therapy-led discharge to assess enables patients to be immediately discharged to their usual residence when medically well, with a UHS funded temporary package of care. This is followed by a therapist visit to perform assessments and, via a trusted assessor scheme, to commence the appropriate package of care according to needs. Therapy-led discharge to assess had been running for three weeks and had been well received by patients, relatives, health and social care teams. 12 patients had been discharged on the scheme with the therapy capacity for up to three home visits per day. Initial estimates suggest 27 acute hospital bed days had been saved and a reduction in the level of care needed at home. 'CHC in 5 days': a drive to undertake fewer unnecessary CHC checklists and to move from CHC checklist positive to full outcome within five days. This is achieved by strict case management by the CHC coordination team, full cooperation from the social work team and 'CHC trusted assessor status' for the CHC team. CHC trusted assessor status enables UHS employees to ratify CHC applications on behalf of the CCGs without the need to go to panel.

South Worcestershire CCG (submitted by the Department of Health)	Discharge to assess	The discharge to assess pilot project at Worcestershire Royal Hospital aims to speed up hospital discharge and improve outcomes for older people by arranging a care support package at home for those who need support in order to leave hospital earlier. Ward-based discharge assessments can be time-intensive and once the patient is medically fit to leave hospital, it can take significant time to get their home support in place. The pilot ran for six to eight weeks with the aim of delivering care in a more appropriate setting and improving the experience of patients who no longer need the care of an acute hospital but are able to manage at home with support or in a residential home. This is a multi-agency project led by South Worcestershire CCG working with Worcestershire County Council, Worcestershire Acute Hospitals NHS Trust and Worcestershire Health and Care NHS Trust.
NaviCare at Home	Patient safety system for use in patients' homes	NaviCare at Home is an innovative patient safety system to support people at home using a unique medicine administration and risk reduction system. It directly cuts mistakes at the point of care and regularly monitors patient health. NaviCare transfer of therapies and medication to patients' homes helps early discharge of patients from hospitals and reduces pressure on hospital beds.This is made possible by software which reduces mistakes at the point of care and triggers alerts for any adverse drug reaction symptoms or vital signs by prompting text messages. This leads to early action, thus reducing harm and saving money and lives. A secure role-based system allows various trust departments, GP, Social services etc. to log into the patient information portal, enabling better communication and decision making.