10 High Impact Changes

For Complex Care

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Continuing NHS Healthcare
National Programme**

Document Information

Title	**10 High Impact Changes for Complex Care**
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Purpose	This document is a product of the Continuing NHS Healthcare National Programme, outlining the principal areas of service development and improvement identified. The document is intended as a communication tool to raise awareness of Complex Care, engage and support health and social care Practitioners and stimulate debate and action within Local Health Boards and local government.
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Attention	Local Health Boards within NHS Wales and Partner Organisations: • Executive Directors responsible for Continuing Care • Managers and Practitioners in Complex Care
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Foreword

The effective management of complex care needs has never been more relevant to the NHS and local government than it is today. The predicted growth in the older people's population of 33% by 2020 and the increasing numbers of children and young people with complex needs following serious illness or injury, coupled with the current challenging resource environment faced by statutory organisations, makes the need to ensure resources are used appropriately and effectively even more essential.

Utilising the principles from the 1000 Lives campaign of identifying, and minimising waste, harm and variation can play a key role in ensuring we continue to deliver high quality services for those in need.

Welsh Assembly Government policy reflects these challenges, and describes how the NHS local government, the independent and the third sector will need to work in partnership to deliver services that meet need in the most appropriate location. *Setting the Direction* and *Fulfilled lives, Supportive communities* recognise the need to further develop community based responses wherever appropriate, maintaining and supporting people within their usual residence/care setting. Evidence tells us that disrupting usual living arrangements for frail older people, such as, for example, by admission to hospital, or early admission to a care home is likely to mean reliance upon higher levels of care and more restrictive lifestyle for life.

The *10 High Impact Changes* identified in this guidance have been developed as the first product of the Continuing NHS Health Care National Programme. They are the result of health and social care practitioners working together to identify the main levers that help to support and maintain independent living, and manage those people with complex care needs in the most appropriate setting, responding to changing need promptly, and avoiding unnecessary and unplanned admissions to hospital or care home. They are person centred and evidence based, and reflect the main challenges that health and social care operational staff face on a regular basis. Some may sound obvious, but if these changes are implemented they will provide a solid foundation from which further actions to improve the management of complex care needs can be developed and delivered.

The changes are deliberately not linked to the location of care or to the organisation providing the care – they are actions that can be implemented in a range of locations and by a range of staff. The one exception to this is for Change 5 which refers to ensuring effective and responsive Hospital Discharge Planning arrangements. The underpinning aim of all the suggested changes is to promote independence, ensure people retain control of the service they receive, support community based responses to need wherever possible and appropriate, reduce inappropriate reliance on high levels of care need, and improve the service for those people who do have complex care needs. Collectively, these actions will help to maintain and maximise opportunities for independence for those most at risk of losing their independence.

Although developed as part of the Continuing NHS Health Care National Programme, the changes are proposed to improve the management of those with complex care needs, not just those whose needs indicate they require Continuing NHS Health Care. Improved management of those requiring complex care, along with the development of community based health and social care service models, will contribute to maintaining independent living arrangements and help to prevent the need for higher level services.

The guide provides generic advice on the management of those with complex care needs. It does not reflect the best practice requirements for those with mental health needs - the Mental Health National Programme will address the specific requirements of people with mental illness, including those with dementia. Similarly, there is generic advice on longer term care management - specific guidance on Chronic Conditions Management will be issued via the National Programme.

The format used to set out the Changes within this guide has been adapted from that used by the *10 High Impact Changes for Service Improvement and Delivery* guide produced by the Modernisation Agency in 2004, but has been revised to complement the methodology and approach used for the *1000 Lives Plus* campaign. It supports consideration of complex care delivery from a person centred perspective, identifies the partnership approaches that are necessary in order to deliver effective care, and ensure positive outcomes for those people with complex needs that require multi agency care planning and service responses.

Our thanks go to those health and social care staff that provided comments, advice and guidance to the Programme Director during the development of this Guide.

Further products from the National Programme will provide the NHS and local government with tools to support increased efficiency, using opportunities to learn from each other and develop shared partnership approaches wherever possible. These further actions will build upon the changes set out within this guide – we recommend therefore that you consider how local services are positioned against the changes proposed, and develop approaches to address any gaps you may identify.

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10 High Impact Changes for Complex Care

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High Impact Change 1:

Avoid disruption to the usual care setting

We must utilise all opportunities to maintain independent living by promoting independence and maintaining people within their usual place of residence or care setting wherever possible.

Any disruption to the usual living and support arrangements can have a major impact on the need for care and support on a longer term basis. In those circumstances where admission to hospital is unavoidable, the default position when goal setting for discharge should always be to ensure people are able to return to their usual place of residence as soon as possible.

Key Principles

- The overall aim must be to promote and maximise independence, and utilise all opportunities for promoting independent living. Evidence tells us that any disruption to usual living arrangements can have major impacts on an individual's need for care and support on a longer term basis.

- Informal carers and family often have a pivotal role in maintaining people within their usual residence. It is essential that there is consideration of their willingness and ability to undertake this support role, and, if so, the help they may need to do so.

- Access to high quality and timely information and advice is vital in enabling people to make informed choices and decisions about their future lifestyle and wellbeing.

- All options need to be considered that help to maintain a person within a community setting. In addition to social services, telecare and housing options, broader local authority responsibilities such as, for example, life long learning, community safety, and environmental health may have a role to play in supporting a person within the community and should be considered as part of the care planning process.

- Third sector support can be pivotal in supporting people within their own homes, both by providing direct support and also through providing advice and guidance, for example on accessing benefits.

- Admission to hospital can be a life changing event and, for vulnerable groups, can lead to a loss of independence and greater reliance on support from a range of services. In those circumstances where admission is unavoidable, then discharge planning processes that identify potentially complex discharge requirements early, actively involve relatives, carers and community and social care staff involved in the usual care arrangements <u>must</u> be put in place as soon as possible. Wherever possible community based resources e.g. Intermediate

Care should be used to deliver care close to home and prevent unavoidable admission to hospital.

- The discharge process must be actively managed to ensure there are no delays during a stay in hospital. Do not prejudge or assume outcomes – many people if assessed when acutely unwell will have high levels of need identified.

- Effective arrangements are in place between and within organisations to ensure that all necessary members of the multi disciplinary team are accessible irrespective of care setting.

- Escalation should not mean inappropriate admission to secondary care – community based escalation processes based upon timely responses to change in need, can maintain people within their usual place of residence.

The Benefits

Reducing Waste:	**User Experience:**
- Avoids inappropriate admissions to hospital or care homes. - Provides services in the least invasive setting. - Maintains people within their usual place of residence. - Reduced demand for beds, improved efficiency. - Fewer delayed transfers of care.	- Avoids disruption to usual living arrangements. - Maintains relationship with primary and community team. - Promotes continuity of care and relationships with health and social care staff within usual care setting. - Reduces fear of losing independence.
Reducing Harm:	**Reducing Variation:**
- Avoiding unnecessary admissions reduces potential for threats to independence. - Removes risks associated with in patient stay. - Supports ability to shift resources towards community care. - Staff providing care have long term view of the person, as opposed to acute episode of care in hospital.	- More consistent approach to service delivery. - Fewer complex discharge issues to resolve. - Reduced demand for beds – better able to manage flow. - Supports shift in service provision into primary and community care settings – able to receive care in usual care setting wherever possible.

Key Actions

In line with *Setting the Direction*:

- Map current health and social care services that maintain independence and support people in their own homes, linked to the National Service Framework for Older People.

- Identify gaps in services or service cover that are preventing increased community based support.
- Develop triggers to identify those at risk of losing independence.
- Focus preventative action on those areas of the population at most risk e.g. the most frail.
- Always consider and use opportunities for rehabilitation and reablement, and do not assess for longer term care whilst still in an acute setting – especially consideration of the need for residential care.
- On a partnership basis plan how to manage and address service gaps.
- If admitted, ensure community in reach approach is in place to discharge people back to community setting as soon as appropriate.
- Develop community escalation processes that can respond to and accommodate changes in need without defaulting to secondary care/residential care admission.

Potential Impact

If this High Impact Change were implemented it is estimated that:

- There would be fewer admissions to hospital
- Significant in patient bed capacity could be released
- Outcomes would be better, with less people requiring residential care services.

Outcome Indicators

The suggested outcome indicators for this change are:

- % of people admitted from their own home/usual place of residence who are discharged back to the same location.

- Number of people receiving community health services and social care services in their own home.

High Impact Change 2

Identify complex needs as early as possible

Irrespective of location, we must identify those people who are likely to have complex longer term care needs and ensure that an initial care plan is in place within 48 hours that sets goals related to next stage of care. The care plan must not be limited to clinical needs, but should develop into a comprehensive reflection of the person's current and longer term needs.

Key Principles

- Tools and techniques are available within *Passing the Baton* that support the early identification of likely complex care requirements. Using these tools will support a more proactive approach to the management of ongoing complex care needs. The *Simplicity Matrix* will support early identification of complexity, and repeating the process at intervals will help to provide a consistent assessment of complexity, and any changes to that status.

- Early identification of complex needs supports more effective care planning, reducing the risk of delays in putting services that will meet need in place. The earlier complexity is identified, the greater the opportunities to manage and plan for better outcomes.

- All those who are involved in a person's care on a long term basis, including family carers, should be included in the care planning process. If complexity is identified as part of a hospital stay, it is essential that community based staff that have been engaged with the person on a longer term basis are identified as key stakeholders and included in the care planning process at the earliest opportunity. This should include independent sector domiciliary care providers as appropriate.

- A care plan engaging all partners should be put in place without delay. This will require full access to, and a prompt response from, appropriate members of the multidisciplinary team, irrespective of location, and a positive approach to risk management.

- Senior level awareness of the level of complexity will provide Board level assurance that organisations focus on appropriate and timely assessment and thus prevent delays. Effective and responsive escalation processes need to be in place across community and hospital settings to ensure appropriate response to address "sticking points", and to flag potential risks to independence.

The Benefits

Reducing Waste:	User Experience:
- Early identification of complex need will avoid delays and ensure more effective use of resources. - Reduced costs. - Earlier management of complexity ensures prompt responses to changes in need.	- Care needs will be identified and met without delay. - Supports targeted interventions. - Allows for a focused response that treats people as individuals rather than delivering fragmented care.
Reducing Harm:	Reducing Variation:
- Reduced delays in delivering appropriate services and models of care, less risk of inappropriate care. - Improved outcomes based upon focused interventions. - Raises awareness of levels of complexity.	- Early identification of complex needs will improve management of the care pathway. - Ensures complex care is identified and managed in a consistent way. - Consistent and planned responses to assessed need.

Key Actions

- Using tools within *Passing the Baton* identify likely complexity as soon as possible.
- Ensure effective communication so that service models support prompt and effective responses to the identification of complexity.
- Develop outcome focused and timely care plans that reflect long term needs and care planning in addition to presenting needs.
- Focus expertise of complex care practitioners on those identified as having complex care needs.
- Work with partner organisations to maintain within usual care setting wherever possible, and provide information and support to family and carers.
- Ensure escalation processes are in place to highlight any problems that challenge independence.

Potential Impacts

Implementing early identification of complexity could:

- Reduce delays in providing appropriate responses.
- Enhance the approach to complex care assessment.
- Support clear pathways that allow for early access to appropriate expertise.

Outcome Indicator

The suggested outcome indicator for this change is:

- Proportion of assessments carried out within timeframe.

High Impact Change 3:

Agreed triggers and timely assessment

We must get the timing right and not assess for longer term care needs when the person is at their lowest ebb or acutely unwell. Assessments at this point are likely to evidence high levels of care need that are reflective of the person's needs at this point in time, rather than a holistic assessment of need that supports future care planning.

We must agree and implement triggers that will identify changing needs and prompt a timely assessment and review. Accurate assessment requires expertise which is developed over time, based upon knowledge, skills, experience and training. Multiagency assessment requires an understanding of, and respect for, the different approaches and perspectives between disciplines and organisations.

Key Principles

- A properly co-ordinated assessment process captures current active needs, and longer term, well managed needs. Together, these provide a well rounded and robust assessment of an individuals overall needs that will support health and social care agencies to decide how best those needs can be met, through a care planning process.

- Unified assessment (UA) is the fundamental process that will support the provision of an effective assessment process that draws on the contributions of all relevant parties and supports the creation of effective solutions and positive user outcomes. This should include the individual concerned, and their relatives and/or carers where appropriate. Ensure the individual is fully informed of the purpose of the assessment and how the process will be conducted. Any concerns regarding capacity and consent should be managed through each organisations policy and procedures.

- Within the principles of UA, ensure a person centred approach to managing care, ensuring the service user is at the centre of the whole process. Completion of the "carer domain" is important in establishing what role the carer plays in supporting the individual, and if they are willing to continue to do so.

- Assessment should be proportionate to a person's needs, and be delivered by statutory agencies working together to reduce duplication and combine skills.

- Assessment is conducted based upon need and not availability of services.

- Understanding when to assess a person's longer term care needs requires expert judgement. Conducting an assessment too soon may mean that care planning is based upon an inaccurate assessment of need over time, and may result in inappropriately high levels of identified need.

- Triggers can be developed that will identify likely complexity and support early and active intervention.

- Decisions on longer term care needs should not be made whilst a person is acutely ill. Decisions made at this point are more likely to identify high levels of care need that may form the basis for inappropriate and risk averse decisions on longer term care requirements.

- Only in exceptional circumstances should a person be assessed as requiring ongoing care within a care home whilst still receiving acute in-patient care. All opportunities for recovery and rehabilitation, including reablement in their own home, should be considered prior to such decisions being made.

- Having a range of community based care models will reduce the likelihood of residential care options.

The Benefits

Reducing Waste:	User Experience:
- Reduction in inappropriate demand for high level services. - Focused access to expertise, based upon clear triggers, applied at the right time. - Reduction in admission to residential care following an episode of acute illness. - Reductions in inappropriate referrals. - Reduction in acute bed days.	- Appropriate services delivered without delay. - Increased access to community based models of service delivery. - Access to focused expertise to meet assessed need. - Ensures holistic assessment of need.
Reducing Harm:	Reducing Variation:
- Provides clarity of purpose and structure for complex care delivery. - Development of community based service options. - If in hospital reduces length of stay. - If in community reduces risk of increased dependency through inappropriate response.	- Provides clarity on service models and approach to complex care assessment. - Supports clear and explicit service models and responses. - Encourages better and more focused use of expertise, reduced levels of inappropriate referral. - More timely access to services for those whose level of assessed need indicates is required.

Key Actions

- Ensure interventions are available in least invasive setting.
- Develop systems and processes across organisations to ensure assessments are undertaken at the right stage of recovery, in order to properly identify longer term care requirements.
- Ensure opportunities for reablement and rehabilitation are considered and available across a range of settings.
- Ensure triggers that identify likely complexity, and changes in need, are in place and utilised, with timely access to expertise appropriate to need.
- Develop service models that can respond to and meet assessed need. Wherever possible, such models should be community based.

Potential Impacts

Implementing timely assessment based upon triggers will help to:

- Ensure expertise is available appropriate to need.
- Support timely responses and reduce delays and the risk of people "sticking" within the whole system, impacting upon outcomes.
- Reduce inappropriate referrals and demands for services.
- Support community based models of care.

Outcome Indicators

The suggested outcome indicators for this change are:

- Triggers are developed and implemented within care plans that identify changes in need.
- Proportion of people with a care plan in place that defines outcomes and goals.
- Proportion of people in hospital with complex care needs with a length of stay in excess of 20 days.

High Impact Change 4

Effective multidisciplinary team working

Multidisciplinary working is the foundation of effective complex care and must be supported and developed. It is not just the reserve of formal team meetings, it is fundamental to the day to day planning and delivery of services at the frontline.

We must ensure that multidisciplinary teams, across every care setting are able to operate and communicate effectively and efficiently and there is a clear and shared understanding of the roles and responsibilities of everyone involved.

Key Principles

- The multidisciplinary team (MDT) is fundamental to the effective management of complex care. The MDT approach provides a co-ordinated and comprehensive approach that will identify and respond to need.

- There is no set composition for an MDT - the membership will vary, depending on individual circumstances, and should include the necessary expertise to manage a persons needs, but as a minimum the MDT should comprise a social worker and a health professional. Knowing who to include within the MDT and what skills they will bring are key to effective MDT working.

- Effective MDT working requires an investment of time and effort in order to understand and respect the different approaches and methods in place between professional groups and across organisational barriers. Time invested in clarifying roles, responsibilities and accountabilities within the team will ensure effective and robust assessments that will support consideration of future care requirements.

- Ensure there is an effective and robust process in place to capture and share the information considered, the conclusions reached, and the basis upon which decisions on future care needs and goals are set. It is important to ensure that evidence of the process is captured and maintained.

- Specific skills are required to effectively manage a MDT meeting or a case conference. Again, time spent in ensuring that professionals and clinicians understand their responsibilities and have a process in place to capture decision making is essential.

- Ensure those people involved in meeting need within the usual care setting/place of residence, including family/carers, are included as key members of the MDT. If a person is undergoing MDT assessment in a hospital, the team should always seek to include any health or social care staff involved with providing care in usual care setting. This will help to ensure the potential for the person to return to their usual care setting is fully explored, and risks

are properly identified and managed. Care co-ordination should be in place to support users and informal carers throughout the process.

The Benefits

Reducing Waste: • Active management reduces length of stay. • Improves efficiency. • Reduction in acute bed days. • Improved flow through hospitals. • More effective use of multidisciplinary expertise.	**User Experience:** • Ensures expertise is available to identify need and plan how best to meet need in a range of settings. • Staff involved with usual care and support arrangements are included to ensure continuity and that the potential to return to usual care setting/place of residence is fully considered.
Reducing Harm: • Provides a comprehensive multi agency approach to support improved outcomes. • Ensures care planning is based upon comprehensive and expert advice and input. • Enhances clinical care. • Ensures focused response to those most at risk of losing independence.	**Reducing Variation:** • Ensures a consistent response to the identification of complex needs. • Provides a co-ordinated process within which to manage complex care needs. • Provides access to a range of expertise and advice as necessary to meet individual need. • Improved opportunities for care planning and reduced risk of challenge to decision making.

Key Actions

- Ensure that partner organisations have a joint approach to the training, development and monitoring of multidisciplinary working within service delivery teams.
- Using tools within *Passing the Baton* to identify likely complexity as soon as possible.
- Ensure service models support prompt and effective responses to the identification of complexity.
- Develop service models that support access to MDT advice and input in community settings as well as secondary care.
- Develop a care plan that reflects long term needs and care planning in addition to presenting needs, supported by engaging with those providing care and support on a longer term basis.
- Focus expertise of complex care practitioners on those identified as having complex care needs.
- Work with partner organisations to maintain the individual within their usual care setting wherever possible.

- Develop explicit guidance on the management of MDT meetings, including expectations and requirements on communication and record keeping.

Potential Impacts

Implementing early identification of complexity could:

- Reduce delays in providing appropriate responses.
- Enhance the approach to complex care assessment.
- Support clear pathways that allow for early access to appropriate expertise.

Outcome Indicator

The suggested outcome indicator for this change is:

- % of health and social care staff who have received training on their role as part of the multidisciplinary team.

High Impact Change 5:

Proactive discharge planning

We must actively manage the discharge and transfer of care process. Organisation have to recognise that discharge planning is a fundamental element of care planning and put mechanisms in place to support frontline staff and ensure that the discharge process is efficient, effective and timely.

Key Principles:

- The over-riding aim must be to maintain and promote independence, and to ensure that treatment in hospital does not in itself compromise a person's ability to return to their usual life pattern. Poor planning for discharge and risk averse behaviour can lead to an increased dependence on services and result in poorer outcomes for people. Ensure that the individual is fully informed and engaged with the discharge planning process and their views are central to the discharge planning process. Any issues regarding capacity and consent should be managed via each organisation's protocol and procedures.

- Central to the hospital discharge planning process is consideration of the wishes of each individual, especially when considering future care options. The assessment and discharge process must be person centred and involve regular consultation with the patient and their family, carers or advocates and where appropriate paid care staff or providers of services. Written information for service users describing the discharge process will support this.

- Effective hospital discharge arrangements require planning and active management across all partners. This planning needs to be operating concurrent with clinical care to ensure that, if at all possible, a person can be discharged back to their usual place of residence without delay in order to avoid compromising their usual living arrangements.

- Planning for hospital discharge must begin at, or in the case of a planned admission, before admission to hospital. It is a process not an event, and is not the responsibility of one person or one agency; it requires the input and engagement of all appropriate members of the multidisciplinary team, including voluntary sector and statutory partners as appropriate. Where transport arrangements are likely to be included within the discharge planning process, then the transport options available should be considered.

- The planning for discharge process must include goal setting, working towards a planned discharge date that is agreed between partners, actively managed and reviewed and updated as necessary. The provision of an explicit discharge date allows families and carers the opportunity to become actively involved in the plans for discharge, and supports health and social care agencies to plan demand more effectively.

- The hospital discharge process should be coordinated by a named person who has responsibility for managing the patient's journey. Some patients will require complex treatment and care that will need to be provided in a number of specialists, resulting in multiple transfers. This has the potential for the care to become episodic and for clinical teams to lose sight of the overall pathway and the potential for reablement. The named coordinator should ensure that carers and community staff involved in supporting a person in their usual place of residence are fully engaged.

- Hospital discharge planning is a continuous process that takes place seven days a week. Whilst not all members of the multi-agency team may be available on this basis, communication, co-ordination and planning must continue. This will be particularly significant in planning simple/non complex discharges which comprise the majority of hospital discharge arrangements.

- The discharge policy is implemented within the framework, context and principles of Unified Assessment or the Care Programme Approach. In the event of patient transfer the assessment information collated to inform care planning must be shared with the receiving area to avoid duplication of assessment and/or loss of key information, leading potentially to extended lengths of stay.

- An assessment of likely simple or complex discharge planning requirements should be undertaken within 48 hours of admission, and repeated at appropriate intervals, to determine the most effective approach to planning discharge. Tools available in *Passing the Baton* and the discharge pathway available on *Map of Medicine* should be utilised to support the assessment.

The Benefits

Reducing Waste:	User Experience:
- Reduction in delays. - Shorter lengths of stay. - Ability to manage demand more effectively. - More effective use of resources and workforce, allows focused access to expertise.	- Care and planning is better co-ordinated. - Reduces uncertainty – patient is kept fully informed of, and engaged with, discharge planning process. - Feels more in control. - Understand and can contribute to longer term care planning.
Reducing Harm:	**Reducing Variation:**
- Supports early and appropriate transfer back to community based service models. - Relatives and individual fully informed and working with staff to meet goals. - Removes unnecessarily prolonged stays in hospital that may threaten independence.	- Effective discharge processes reduce variation. - Staff are more in control of the discharge process – can plan to meet demand more effectively. - Reduced risks of inappropriate dependency, and prolonged lengths of stay.

Key Actions

- Identify complexity early and use tools available to determine those people likely to have complex needs and manage them via complex discharge pathway.
- Ensure community based support staff involved in usual care arrangements are included as key members of the MDT.
- Ensure goal planning approach in place, working towards a safe and planned discharge date.
- Ensure opportunities for rehabilitation and reablement are available and considered prior to making any decisions on longer term care needs.
- To support frontline staff, Health Boards must ensure that there are effective escalation processes for staff to raise problems and concerns which directly affect the ability of the staff to discharge or transfer the care of patients in a timely way.

Potential Impact

If this High Impact Change were implemented it is estimated that:

- Length of stay would reduce.
- There would be a reduction in readmission rates.
- Discharges could be predicted and planned for more effectively.

Outcome Indicators

The suggested outcome indicators for this change are:

- % of people discharged to usual place of residence.
- % of people discharged with the support of a Community Reablement Service or Community Resource Team.
- Hospital readmission rates within 28 days of discharge.

High Impact Change 6:

Rapid systems of escalation

When a person's needs are complex, frontline staff can often identify and predict problems early in the journey through care. We must ensure that staff are able to effectively escalate these concerns and quickly access additional support to prevent problems and avoid delays. We need effective systems in place that set out the processes to be followed when an issue needs to be escalated, to whom, and how. Escalation processes should be in place across all care settings and in each organisation, to manage the risks to both individuals and services. These should set out clearly what actions will be taken and the support available to manage the issue of concern.

Key Principles

- Effective escalation processes will ensure that the MDT is able to access additional expertise and advice when necessary. This will assist in a timely response to challenging or difficult issues that require an enhanced MDT input, and prevent delays that may threaten positive outcomes.

- All organisations should ensure their staff have access to expert advice, including legal advice to support the management of complex issues. Explicit protocols should set out how this advice is accessed, the circumstances when senior managers/executive directors need to be informed, and set out an expectation of an appropriate response.

- Escalation processes in community settings should set out clearly the processes and systems in place to manage escalation within that setting – community escalation should not mean inappropriate admission to a hospital or residential care settings

- For those people in hospital, delays within the in-patient pathway should be identified and managed as soon as possible, to avoid inappropriately prolonged hospital stay that may threaten opportunities to return to usual place of residence.

- Proactive profiling of those people with complex needs will help to ensure complexity is identified early and delays avoided. For those people in hospital identified as a delayed transfer of care, escalation processes should be in place to ensure that delays are reported to senior managers, and actions put in place to address the delay as soon as possible.

- From a corporate perspective, risk management is an essential feature of any organisation and must be an integral part of all practices, processes, activities and business plans. Organisations should ensure they have risk management processes and mechanisms in place that ensure corporate risk can be properly identified and managed.

The Benefits

Reducing Waste:	User Experience:
• Prevents delays – more effective care pathway. • Timely access to expertise and to those able to manage the area of risk.	• Access to expertise as required. • Problems and issues are managed promptly, avoiding inappropriate care or delays.
Reducing Harm:	**Reducing Variation:**
• Reduced likelihood of extended stay in inappropriate care setting. • Assurance that appropriate care is provided, with robust mechanisms to identify and manage risk.	• Improved and consistent approach to risk management. • Improved and proactive approach to risk. • Additional capacity to manage demand.

Key Actions

- Ensure escalation processes are in place that are appropriate to care settings and set out clearly the escalation triggers that apply.
- Ensure front line staff have a clear understanding of how to identify and manage risk, when and how to escalate complex care issues and that there is a prompt response.
- Ensure escalation processes provide a route to senior managers/Board members, so that any issues that may present a corporate risk to the organisation are identified and managed without delay.

Potential Impacts

If this High Impact Change were implemented it is estimated that:

- Operational teams would have access to the necessary advice and expertise to manage challenging or complex issues.
- Senior managers/Boards would be aware of issues that may present a corporate risk.
- There would be less delay in addressing complex care issues.
- Those who need to know and have responsibility for services would be involved and able to take appropriate action.

Outcome indicators

The suggested outcome indicators for this change are

- Proportion of escalated issues that resulted in an appropriate response.
- If in hospital, proportion of delayed transfers of care prevented via profiling and proactive management.
- Proportion of delayed transfers of care escalated to next level in the organisation for further action.

High Impact Change 7

Responsive long term care

All forms of long term care must be based on the principle of responsiveness, to actively plan to stay well and respond quickly and effectively when a person's needs change. We must ensure that those people with longer term care needs are able to access the services they need without delay to maximise the opportunities to remain within their usual setting and avoid unnecessary and potentially life changing emergency responses such as unplanned admissions to hospital.

Key Principles

- Early identification of illness and appropriate intervention and support across health and social care organisations will help to ensure individuals are able to maintain healthy, active lives.

- Effective communication and information form the basis of effective community service delivery between partners.

- Working in partnership will help to ensure that the right care and support is identified and delivered in the right way, and by the right people. Actively assessing need, managing risks, planning and managing care and co-ordinating services across partners is fundamental to delivering this principle.

- For those people with chronic conditions, use population level information available to provide a solid basis for health and social care to plan, co-ordinate and commission services and support. This support should ensure effective active self care and management at home or in the usual care setting.

- Local authority services, such as enhanced supported housing options and telecare opportunities will help to enable people to remain within non residential settings.

- Effective support will need to be planned and co-ordinated across the NHS, local government, voluntary and independent sectors. Joint packages of care, joint roles, and services will play an important part in meeting the changing needs of individuals and carers in an integrated and seamless way.

- Supporting people and delivering care within their usual place of residence/care setting improves the quality of care, reduces fear and anxiety, and enables people to lead fuller lives with their families and communities.

- Consider the use of community based Intermediate care services to provide extra support to people promptly and effectively at time of crisis.

- The Primary Care and Chronic Conditions Management Programme is currently developing detailed advice on Chronic Conditions Management, and will provide guidance via specific High Impact Changes aimed specifically at this key area.

The Benefits

Reducing Waste:	User Experience:
- Better integrated and managed care within community settings. - Reduced unnecessary admissions to hospital and care homes. - Reduced reliance on higher level care services. - Reduced demand on unscheduled services reduced emergency admissions. - Reduced length of stay.	- Care becomes earlier on and closer to home. - Reduced disruption to usual living arrangements. - More in control of own health and management of illnesses.
Reducing harm:	**Reducing variation:**
- Improved service responses. - Reduction in acute exacerbations. - Care is more proactive and reduces potential complications/deterioration. - Greater empowerment and improved self management.	- Clarity on long term community arrangements to support discharge planning. - Frameworks in place to improve the management of chronic conditions provide a consistent approach to care planning and service delivery.

Key Actions

- Ensure people with long term care needs have access to advice, guidance and education to support improved self management.
- Ensure community based responses are in place that can respond appropriately to those with long term care needs.
- Ensure systems are in place to respond to, and manage, escalating need within community setting/usual place of residence wherever possible.
- Close partnership working will ensure a comprehensive and robust response. Ensure local management processes reflect the fundamental requirement for partnership working to deliver sustainable community based responses.

Potential Impact

If this High Impact Change were implemented it is estimated that:

- Inappropriate admissions to hospital/residential care could be avoided.
- Shared care arrangements would maximise opportunities to make the best use of workforce.

- Opportunities for community based care management are exploited.
- People are able to remain independent for longer.

Outcome Indicators

Capturing information on outcomes for those with long term care needs will be achieved by using the outcome indicators proposed for High Impact Changes 1 to 6.

Outcome indicators specific to Chronic Conditions will be available within the guidance to be issued by the Primary Care Assurance and Chronic Conditions Management National Programme.

High Impact Change 8

Focus on the data for complex care

We must actively use existing data sources and information systems to identify and intelligently manage complex care needs. A considerable amount of data is already available to measure and monitor the dependency of care and the movement of people from simple needs to complex care packages. We must work together to determine the most useful information, have clarity over its purpose and function, and agree the best method of articulating that knowledge to the appropriate audiences thus informing service development.

Key Principles

- This High Impact Change is an enabling change, rather than a change in its own right. Effective use of data and recognising its value as management information will enable delivery of the other changes identified within this guide.

- Information collected and collated should have a clear purpose and value to both those who use it and collect the data. Taking time to consider information requirements will support effective and robust service planning and support identification of areas where change is required.

- Using the right information intelligently will support an approach based upon service improvement, rather than systems developed to prevent performance failure.

- Understand and manage the different approaches to collecting and analysing data between organisations. Different does not mean wrong. Recognise and work with the different perspectives that may exist between the NHS and local government to develop a broader consideration of both population level and person level data.

- A range of data is available to support improved management of complex care, but this data is rarely considered together, or used to measure the impacts of services or the outcomes for people. Ensure all data relevant to complex care is considered collectively, and is used to measure and capture outcomes.

- Ensure information is reaching the right people in a timely way, and is used as the basis of service planning and review. This includes health and social care professionals, service planners, senior managers and executive teams.

- Information does not need to be complex to be of value – some very simple pieces of data can alter the perspective and release additional benefits. For example: for those people admitted to hospital, identify the source of admission and the location on discharge. Simple comparisons of data such as this can help

to identify the impacts of a hospital admission on usual living arrangements, and the potential bearing on future need for care services.

The Benefits

Reducing Waste:	User Experience:
• Supports process analysis and redesign of long term systems of care. • Services more focused on responding to changes in need. • Makes best use of resources.	• Supports more effective and targeted care planning and service delivery. • Effective use of data by profiling and identifying complexity can help to avoid delays and reduce risks to independence and disrupting a person's usual lifestyle.
Reducing Harm:	Reducing Variation:
• Supports effective clinical interventions and service improvement. • Robust data support more effective risk management. • Supports measuring for improvement.	• Ability to flag where best to focus expertise where it's needed most. • Data currently available can be considered in alternative ways to provide a basis for capturing impacts on independence.

Key Actions

- Establish key measures to monitor and capture the transition into complex care, and better plan and predict future services needs. For example, actively monitoring and reporting on changes in the place of residence and extent of care packages for individual service users.
- Use the outcome indicators developed for all the High Impact Changes to produce an independence-based dataset that will support early identification of complexity and focused response.
- Understand and utilise information collected by partners – a shared approach is likely to provide a richer context that pure health or social care data analysis.
- Consider the value of data available to different aspects of the organisation – for example delayed transfers of care data is required for performance management purposes but is also of value from a risk/governance perspective in identifying those people who have complex needs who "stick" within the system that is of value to service planners and Board members.

Potential Impacts

Using data more effectively could:

- Support the early identification of complex care needs.

- Inform service planning from a patient/service user perspective.
- Manage corporate risk.
- Improve and enhance clinical management.

Outcome indicator

Implementing this change will be vital to the successful implementation of the other nine changes proposed, and will, in itself, provide evidence of improvement that can be described as:

- An accurate measure over time, of the level of dependency of the people being served with a national performance management system for complex care.

High Impact Change 9

Integrated services and effective partnerships

We must utilise all opportunities for genuine partnership working. Effective partnership arrangements provide a shared approach that ensures services are organised around individuals and encourages appropriate responses from services irrespective of organisational boundaries. Partner organisations must recognise the interdependency of public services and improve the quality of the services being delivered from the perspective of the user.

Key Principles

- People very rarely become a dependant overnight unless they have experienced a sudden catastrophic trauma or illness. Most people have a history of engagement with both health and social services over time. Appropriate models of service in place between the NHS and local government will support improved outcomes for service users and make better use of resources.

- The NHS and local government should have effective joint arrangements in place for assessment and care planning, and for funding, securing and monitoring services.

- Even for those with high levels of assessed care need, there are still opportunities for the NHS and social services to engage in effective partnerships to improve outcomes for service users and make better use of resources.

- The NHS and local government share common customers – people do not live their lives within the administrative or organisational boundaries we create. Services should be organised around the service user.

- Services are usually inter-dependent – decisions taken by one agency will often have a significant impact on its partner. When working in partnership it needs to be recognised that costs and risks need to be shared, in addition to the rewards.

- Quality and cost effectiveness of services can be significantly improved when organisations work well together. Governance issues are more clearly addressed in formal partnership arrangements.

- A unified approach to assessment and care/support planning is essential towards collecting the relevant information and developing a coherent care plan. This improves outcomes for service users and carers, provides for a more effective management of risk and makes better use of resources than would be the case with serial assessments.

- A coherent joined up approach to securing services can help to contribute towards more effective shaping of services and may also be helpful to

providers. The effective transfer of care between sectors or agencies requires all professionals to have a good understanding of the service options available and above all have confidence in them. This requires effective partnership working.

- Formal partnerships offer opportunities to realise benefits as outlined above. They provide greater transparency of resources and the governance arrangements are stronger.

The Benefits

Reducing Waste:	User Experience:
- Single systems will significantly reduce transaction time and costs and support more flexible use of resources. - Avoids duplication of effort. - Reduced decision making processes empower staff and improve morale. - Increased speed of response to prevents delays. - Responds better to escalating demand.	- Single service for user – less need to have multiple contacts based on multiple organisational services. - Service is seamless. - Less risk of repetition of information or loss of continuity of care.
Reducing Harm:	Reducing Variation:
- Improved management information. - Improved assessment and information sharing across organisations. - Stronger governance arrangements. - Improved communication systems.	- Increased potential for joined up planning, reduction in blame type culture. - Improved clarity and transparency over use of resources. - Improved commissioning processes.

Key Actions

Factors critical to success of partnerships include:

- Identify objectives at the outset – ensure there is clarity on aims, objectives, values, principles, accountabilities and timescales
- Ensure user focused outcomes measures are identified and implemented
- Ensure time is identified to invest in communication with service users and staff
- Clear lines of accountability for the performance of the partnership
- Ensure appropriate level of financial expertise and input is available at an early stage.
- Map processes both in the community and in hospital to ensure they are fit for purpose and focus on the individual.

- Review practice on a regular basis to learn from positive and negative experiences.

Potential Impacts

Implementing improved partnership working could:

- Reduce duplication of services, and exploit opportunities for shared service models.
- Ensure a seamless approach to service delivery, with the person at the centre of service planning.
- Make best use of health and social care resources.

Outcome Indicator

There is no outcome indicator for this High Impact Change – it is an enabling change that will support more effective and responsive service delivery across the whole system.

Where partnership arrangements are in place – either formal or informal – these should consider and set specific outcome indicators to support the management of complex care as identified in the key principles section.

High Impact Change 10:

A workforce designed to serve complex needs

Complex care is emerging as field of service in its own right, yet few practitioners across public services are trained to specifically support people with complex or multifactorial needs.

Workforce strategies recognise the need to re-balance the workforce to support whole systems change through a shift from hospital to community to primary care, supported by an increased proportion of the workforce who deliver care out of hospital. In meeting the needs of people who require complex care, we must consider opportunities to provide safe and effective services, close to home, 24 hours a day, 7 days a week to sustain and streamline their journey through care.

Key Principles

- The overall aim is to have the right staff in the right place at the right time, providing the right service. There are a wide range of staff across the partner agencies that have developed a unique set skills and experience in managing people with complex needs. The people with this expertise must identify and actively manage their workforce to ensure that every service has an established knowledge base from which to plan and deliver complex care.

- To support the shift to community settings and cross sector working, identification of education and training requirements should be made including support for communication hubs and a focus on the interface workforce between health and social care

- NHS services must consider the delivering of changes to skill mix which maximise the opportunities of Agenda for Change and other pay modernisation initiatives ensuring the appropriate distribution of staff across the grades and between differently contracted staff groups.

- All NHS organisations are expected to work towards achievement of a 10% increase in the proportion of staff providing services in a community setting, to be achieved between 2010 to 2013. All organisations must demonstrate changes to skill mix across ALL grades and bands which maximise the use of flexibilities available under the provisions of A4C and medical contracts. This skill mix change must ensure that staff are only deployed in roles and in a band which require their level of skill, knowledge and experience. This skill mix change must reflect growth in staff in Bands 1-4 of 3%, per annum, between 2010-2013.

- Specifically for complex care, options should be considered to developing assistant practitioner, advanced practitioner, case manager, care coordinator and joint Health and Social Care roles.

- For social work and social care staff, the Workforce Task Group will consider ensuring coherent professional development, supporting evidence based practice, and regulation. The need to ensure collaborative and cross agency working will continue to be a relevant and necessary consideration. The outcomes from the Workforce Task Group are expected later in 2010.

The Benefits

Reducing Waste:	Patient Experience:
• Efficiencies in care delivery, due to less duplication of activity. • More care can be provided out of hospital. • Full utilisation of staff and resources 24/7. • Maximises the contribution of each member of staff, ensuring utilisation of specialist skills appropriately.	• Care co-ordinated at centre. • Reduction in the number of staff visiting at home. • Continuity of carer. • Less duplication of care.
Reducing Harm:	Reducing Variation:
• Specialist skills of staff used more appropriately to provide expert input to more patients. • Focus on holistic care including prevention and health promotion. • Increased likelihood of rapid response and prevention of complications. • Continuity of care increases ability to diagnose deterioration in condition more quickly.	• Greater continuity of care. • Experience of work in primary and community care settings – more consistency of approach regarding risk management. • Access to education and training to support personal and professional development. • Full utilisation of expertise as appropriate. • Increased job satisfaction.

Key Actions:

- Establish a workforce strategy to actively identify and manage those staff that have specific training or experience in planning and providing services for people with complex needs. The strategy should include a system for developing and enhancing the future workforce with the knowledge and skills necessary to work effectively within a multidisciplinary and complex environment.
- Partner organisations should establish structures, systems and processes to jointly manage and maximise the effectiveness of staff with specific roles that support complex care, for example specialist practitioners in assessment and care planning.
- Implement effective and integrated workforce planning processes to support ongoing service and workforce modernisation including proposals to repatriate services locally with Wales.

- Provide appropriate and targeted training and development interventions which support continuous improvement and new models of service delivery to support continuing care.
- Target investment which directly contributes to the development of skills and competencies supporting service re-design, ensuring appropriate training programmes for Assistant Practitioners (NHS Band 3/4) and Advanced Practitioners (NHS Band 6/7).
- Contribute to the overall programme to achieve cultural change through the establishment of visible and inspirational leadership, innovations and empowerment of frontline staff.
- Review opportunities around broader public service staff integration, recognising the closer relationships emerging for social services, public service shared services and voluntary sector opportunities (including social enterprise), which will require a clear framework and local implementation.

Potential Impact

If this High Impact Change were implemented it is estimated that:

- Skill mix changes would bring about efficiencies in utilisation of resources.
- Roles would fully maximise the competencies within bandings.
- There would be an increase in staff satisfaction.
- It would create increased opportunities for continuing care repatriation.

Outcome Indicator

Workforce modernisation is an enabling change that will support delivery of improved whole systems working, therefore a range of specific complex care outcome indicators will develop over time. The over arching outcome can be described as:

- Health Boards and partner organisations are able to provide assurance and report on, the extent and range of the workforce that manages and provides services for people with complex needs.