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Trusted Assessor Pilot
Presentation for Care Providers
11th June 2020

Agenda

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- Welcome
  - Eddy McDowall, OACP Chief Executive
- National Picture
  - Fiona Florey, OACP Project Manager
- Trusted Assessor Service in Oxfordshire
  - Lynda Gardner and Alison Magnall, Trusted Assessors
  - Mary Rainford, Crossroads Care and Chantelle McCabe, My 1st Homecare
- Trusted Assessor Models and CQC
  - Chloe Hawkins, CQC Inspection Manager (Oxfordshire)
- Community Health Services
  - Katrina Baldry, Clinical Lead, Oxford Health NHS Foundation Trust
- Questions and further discussion

National Picture

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- Discharges high on the National Agenda

  - In 2017 **2.3 million bed days** lost because of delayed transfers of care (SCIE)
  - Age UK estimate an excess bed day in the NHS costs between **£2,089 and £2,532 a week**
  - Additional bed days can result in a reduction in condition of patient

  The *National audit of intermediate care* suggests that, for older patients, a delay of more than two days negates the additional benefit of intermediate care, and seven days is associated with a **10 per cent decline** in muscle strength due to long periods of immobility in a hospital bed.

  - **Why not home? Why not today?** (The Better Care Fund & Newton)

National Picture
NICE Guidelines

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- Huge array of published data showing that robust discharge planning significantly improves patient outcomes and reduces readmission

- NICE Guidelines for 'transition between inpatient hospital settings and community or care home settings for adults with social care needs', cite the need to ensure that
  - There is a smooth pathway
  - Accurate and appropriate information is shared between partners
  - Actions are efficient and timely
  - Key role of discharge coordinator

National Picture
NHS 5 Year Forward View

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- Published in October 2014 by NHS England, and set out a new shared vision for the future of the NHS based around new models of care

- In 2017 the 'NHS 5 Year Forward View - Next Steps' was published
  - Review the progress made since the launch of the NHS Five Year Forward View and sets out a series of practical steps
  - Key deliverable for 2017/18 and 2018/19, as a national condition of funding:

    'Health and Social Care partners to adopt practices to enable patient flow'

    implementation of trusted assessment schemes was noted as one of the key changes to improve discharge delays

National Picture
ADASS & CQC Guidance

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''Trusted Assessor' schemes are a national initiative designed to reduce delays when people are ready for discharge from hospital. It is based on providers adopting assessments carried out by suitably qualified 'Trusted Assessors' working under a formal, written agreement.'

CQC, Guidance: Trusted Assessors, 2018

- Key things to note from ADASS & CQC Guidance:
  - Optional
  - Permission from provider is required
  - Co-designed
  - Providers retain control
  - Mutually agreed JD & competencies framework
  - Formal written agreement – confirm details, escalation pathways, operating procedures

National Picture
National Network

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- Number of Trusted Assessor Schemes across the Country
- Primarily supporting with discharges in to Care Homes
- All commissioned and run differently
- National Network – meet regularly, share information and aim to achieve best practice
- Beginning to look at benchmarking, effectiveness, and gathering more information re: National Picture

National Picture COVID- 19

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- Additional challenges around discharge for care providers
  - Lack of access to hospital sites to assess
  - Challenges reaching wards via telephone
  - Increased pressure for quick discharge
  - Increased risk to care providers if information is missing

  Government guidance: 'COVID-19 Hospital Discharge Service Requirements', March 2020
    - Use of Trusted Assessment cited as essential to maintain flow and speed of discharge

National Picture
Useful Documents

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- NICE Guidelines 'Transition between inpatient hospital settings and community or care home settings for adults with social care needs'

https://www.nice.org.uk/guidance/ng27/chapter/Recommendations

- 5 year forward view – Next Steps

https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

- ADASS Guidelines – Developing Trusted Assessor Schemes: Essential Elements

https://www.adass.org.uk/media/6030/developing-trusted-assessment-schemes_essential-elements-280717.pdf

- CQC Guidelines – Trusted Assessor: Guidance

https://www.cqc.org.uk/sites/default/files/20180625_900805_Guidance_on_Trusted_Assessors_agreements_v2.pdf

- Government Guidance - COVID 19 Hospital Discharge Service Requirements

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/880288/COVID-19_hospital_discharge_service_requirements.pdf

Trusted Assessor Pilot
Key Facts

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IN ASSOCIATION WITH OUHT, OCC AND OCCG COMMENCED WITH ONE LEAD ASSESSOR 09.12.19, FURTHER ASSESSOR JOINED 05.03.20
ROBUST OPERATIONAL ENGAGEMENT WITH OUR ASSOCIATES

INITIALLY FOR EXISTING CLIENTS OF HTLAH PROVIDERS, BROADENED OUT TO ALL DOMICILARY CARE PROVIDERS + EXISITING CLIENTS OF OSJCT RESIDENTIAL/NURSING HOMES AND EXTRA HOUSING. MORE RECENT FLEXIBILITY TO PROVIDERS HAPPY TO ACCEPT OUR MOU

INITIAL FOCUS ON ROBUST & IMPARTIAL ASSESSMENT OF JR PATIENTS, INCLUSION OF OTHER SITES AND PROVIDERS DEPENDENT ON CAPACITY

Trusted Assessor Pilot
Who are we?

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- Lynda Gardner and Alison Magnall are Registered nurses, with substantial experience in the care industry including Live in care, domiciliary care and NHS Continuing care
- We have current knowledge of hospital and social work roles and activities, care pathways and the changing scene in pandemic times
- We use our knowledge and skills to assess and analyse patient needs working closely with internal and external multi-disciplinary teams
- We are acutely aware of the challenges and difficulties you can face when your client comes from the acute care setting !

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What do we do and our objectives

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- Support providers with robust assessments or fact finding to facilitate safe and effective discharge
- Complete a detailed review of the hospital and social services notes and discuss with all involved healthcare professionals and patients if possible
- Act as a single point of contact and aim for better use of your time and capacity to minimise need to visit the hospital to assess your clients
- Collaborate if changes to the package of care are required, e.g. extra visits, equipment and home adaptation
- Investigate situations where discharge is problematic/unsuccessful and respond to provider feedback

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What we need from you

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- Contact us when someone is admitted/or when you are approached about a new POC for an admitted client
- Complete our baseline assessment form (for existing client) for us to assess if clients are back/close to their baseline or are likely to need a change to their POC prior to discharge
- Provide us with an 'If not today then when' – what it is and why we need it ?
- Keep us informed regards your capacity to resume an existing POC/increase POC
- Return our 48 hour feedback form that we will send to you to help us improve our service and learn from any issues and challenges
- Any other feedback/ideas/involvement so we can continue to grow the service and make it what you need

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Next steps

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- Continue to build visibility and operational impact
- Develop relationships with additional providers and sites
- Liaise and provide mutual support to other relevant agencies eg. CHSS
- Give examples of best practice, success stories and areas for improvement

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How can you benefit?

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- Efficient use of resource – save time and money attending the hospital and chasing for updates. Use that time to invest in running your business.
- Access to additional information and assessments from MDT
- Information re: COVID status, test dates, symptoms = manage risk
- Less time spent resolving issues on discharge
- Improved patient flow and patient experience
- Access to a service that is imbedded in whole system – less transactional
- CQC best practice for managing transfers of care

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How can you benefit?

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Provider Testimonials

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Mr R - This gentlemen had a high risk of falls, he expressed his wishes to go home despite advice to the contrary but was deemed to have mental capacity. **A robust package of care gave him his choice**

Mrs G – This lady's choice was to go home to die, this was achieved with much multi disciplinary team liaison. Feedback from the agency was that ***'it was a pleasure working with you and we look forward to working with you again'***

Mrs S – This lady returned to her residence as planned, provider thanked us very much for our assessment '***it gave me all the information I needed to ensure a safe discharge'.***

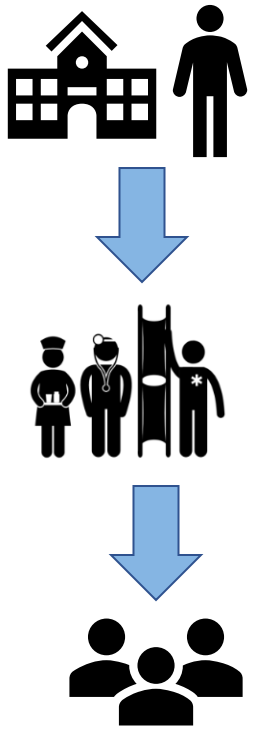
Trusted Assessor models and CQC

Chloe Hawkins,
11 June 2020

- *Beyond Barriers* report highlights organisations are focused on **individual drivers** for success, rather than thinking as a **system**

- To reduce delays and duplications of assessments, implementing a trusted assessment scheme is recommended as best practice for managing transfers of care.

- Fundamental to the success of the model is confidence in the assessment.



- While adult social care providers can enter into agreements in a variety of ways, they will always retain responsibility for meeting legal requirements in relation to assessments and care plans.
- This means that you will need to have complete confidence in the agreement and the ability of the other participants to properly fulfil the obligations involved.
- All agreements must be in writing
- Fiona and her team at OACP have ensured that your trusted assessor agreement meets all of our requirements

Trusted assessor discharge assessments

- Trusted Assessor discharge assessments and care plans must allow the accepting care provider to meet the requirements of Regulations 9, 10, 11 and 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (and all other relevant legal requirements).
  - Person-centred care
  - Dignity and respect
  - Consent
  - Safe care and treatment

Trusted assessor models and our Key Lines of enquiry

- S2 – Risk assessment and risk management
- E4 – working across organisations to deliver effective care
- E1 – Assessing people's needs in line with legislation and standards
- E2 – Do staff have the right skills, competence and qualifications
- E7 – Consent
- C3 – Data protection and the Equality Act
- R1 – Personalised care that is responsive to people's needs
- R3 – End of life care (where appropriate)
- W5 – Working in partnership with other agencies

Safe

Effective

Caring

Responsive

Well Led

Community Health Services

Katrina Baldry

Clinical Lead/ Senior OT

Main point of contact for any community service

- SPA: 01865 903750
- Open 08:00- 20:00 7 days per week

District Nursing

- House-bound patients only (NOT transport bound)
- 08:00- 18:30, 7 days per week
- Support with:
  - Wound dressing – pressure areas
  - Compression bandaging
  - Promotion of self care through education and teaching of carers
  - Health promotion, advice and support
  - Incontinence support
  - Palliative and end-of-life care
- Referrals from any HCP, patient, relative or carer
- Contact DN's via SPA

Community Therapy Service (CTS)

- Operate between the hours of 08:00- 18:00, 7 days per week
- OT's, Physio's, Mental Health practitioners, assistant practitioners and rehab assistants
- 18+ with any condition
- Rehab needs following an episode of illness, hospital admission or exacerbation of a long term condition
- Palliative and end-of-life care
- Duty system – respond within 48 hours to prevent hospital admission
- Routine referrals – routine rehab to reduce care packages, increase independence and function
- Accepts referrals from any HCP, patient, carer or relative
- Refer and contact via SPA

Adult Social Care

- OCC funded service
- OT's, social workers, sensory impairment and safeguarding teams
- Operates Monday - Friday 08:00- 16:00
- EDT for weekends
- Long-term needs and major adaptations
- Rental of equipment and aids
- Refer via the OCC website – request a needs assessment
- Telephone number: 01865 733299

Physical Disability Physiotherapy Service (PDPS)

- Provides physiotherapy for people with long-term neurological disability eg stroke, MS, Parkinsons Disease
- Emphasis is to enable patients and their carers to manage their disability in their own environment
- Hold PD exercise- based classes
- Monday – Friday 08:00- 16:00

Bladder & Bowel

- Assessment and treatment services
- See patients who attend clinics around the county or those with complex symptoms, best seen at home
- Housebound and care home patients are assessed by the DN's initially and then referred on to B&B if the DN requires support or the patient needs a bladder scan, teaching of intermittent self-catheterisations or rectal irrigation etc
- Monday – Friday
- 01865 904303 or oxfordhealth.bladderandbowelservice@nhs.net

Tissue Viability

- Provides specialist advice & support to healthcare professionals who are managing complex wounds
- Provide expert wound care advice, specialise healthcare equipment and education to prevent skin breakdown and support healing
- Only accept referrals from other health care professionals leading on the care of the patients – joint consultation are then completed
- Post – COVID, service is likely to change how it is delivered but unsure what this looks like currently

Diabetes

- Specialist Nurses provide support to primary care clinicians in managing adult patients with diabetes
- Patient education programme for people with Type 2 diabetes:
  - Diabetes2gether – single three-hour structured education session for newly diagnosed (<12 months)
  - Diabetes4ward- same three-hour programme but is designed as a refresher/ follow-on course
- Referrals made via GP or practise nurse

Learning Disability

- Support adults with a learning disability
- Clinical areas of practice teams are commissioned to support:
  - Epilepsy; Behaviour that challenges; Complex physical health; Forensic; Dementia; Mental Health and Autism
- MDT approach – Physio, OT, SALT, Nurses, Psychiatrists and Psychologists but work alongside wider health services to support needs
- Intensive Support Team – small complex case load of those with high level needs associated with mental health and/or behaviour that challenges. Only accept referrals from the Community LD Team.
- Community LD team accept refer from anyone – referral form needs to be completed
- North (Banbury and the west) – 01865 903500 LDnorth@oxfordhealth.nhs.uk
- South (Abingdon and the south) – 01865 903100 LDsouth@oxfordhealth.nhs.uk
- City (City and Bicester) – 01865 904555 LDCity@oxfordhealth.nhs.uk
- IST (countywide) – 01865 901419 or ISTeam@oxfordhealth.nhs.uk

Heart Failure

- Assess and treat patients with a confirmed diagnosis of left ventricular systolic dysfunction
- Education and support of the patient and their carer or family
- Monday – Friday 09:00- 17:00
- 01865 904006
- Refer via email address oxfordhealth.communityheartfailure@nhs.net

Respiratory

- Help to support patients with home oxygen and airways disease
- Initial referral is by a health care professional who can confirm diagnosis
- If a patient is already known to the service then they should have a self-management plan/ service leaflet or home oxygen – any concerns, patient/ carers/ relatives and contact the service directly
- Pulmonary rehab groups
- Monday – Friday 08:30 – 16:30
- 01865 904418

Chronic Fatigue Service/ Myalgic Encephalomyelitis

- Aged 14+ with an Oxfordshire GP
- Therapists and GP with a special interest
- Provide a recover-focussed approach with the aim of taking control of everyday life, increase function and engagement in local communities
- Can offer home visits if unable to visit a clinic setting
- Also a resource to other health, social, education and employment professionals working with people with CFS/ ME
- Contact the service for a referral form – oxfordhealth.CFS@nhs.net
- 01865 337540

Podiatry

- Diagnosis and treatment of foot health problems.
- **At-risk patients:** these are patients with pathologically impaired neurological and vascular supply to the foot eg patients with diabetes.
- **Musculoskeletal Podiatry:** these are generally active/mobile patients with a functional foot problem causing significant pain in the foot (or the knee) that is caused by gait.
- **Nail surgery:** these are patients needing surgical treatment of in-growing toenails.
- Referrals accepted from a healthcare professional
- Mainly clinic settings – Monday – Friday 08:30- 17:00
- 01865 902016

Care Home Support Service

- Support, signpost, educate and advise care homes and staff
- Aim to improve standards and promote a high standard of care
- Cover all care homes registered with an Oxfordshire GP
- Physical health nurses, mental health nurses, OT's and therapy staff
- Open referral system
- Monday – Friday
- 01865 903785

Other community services available:

- SALT, Dietetics, Community Mental Health Teams
- Specialist teams from OUH (Neurology, Stoma care etc)
- Age UK
- Generation Games
- Carers Oxfordshire
- Dementia Oxfordshire

End of Life Services

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- 24 hour EoL support line for clients, covering the whole county. - 0300 561 1970 The nurses can help clients by:
  - Talking through concerns about illness and dying
  - Listening to any worries about care or caring for a loved one
  - Giving advice on caring for someone at home
  - Giving advice on managing symptoms
  - Supporting you to ask for extra help if you are finding it difficult to cope at home

  - Lawrence Home Nursing Team are based in Chipping Norton provide End of Life care in patients' own homes. Refer via GP or DN. Care for patients registered with:
    - Chipping Norton Health Centre
    - Bloxham and Hook Norton Surgeries
    - Deddington Health Centre
    - Charlbury Medical Centre
    - Wychwood Surgery

  - Palliative Care Hub for South Oxfordshire and South Oxfordshire Hospice at Home (Sue Ryder). Advice, support, care and coordination for people in the last year of their life. 0330 053 6092.

  - Community Matrons via Oxford Health available across the whole county. Contact SPA.

Thank You!

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Thank you for joining us, we hope it was useful and really look forward to working with you in the future.

If you would like to receive our MOU and be contacted by the team please add your email address to the chat box.

How to contact us:

Alison Magnall and Lynda Gardner, Trusted Assessors: oacp.taoxon@nhs.net (please note, due to poor phone signal on the hospital sites email is always best in the first instance and the assessors will call back as soon as possible)

Fiona Florey, Project Manager: 07519 312513, fiona.florey1@nhs.net