Community Living and Support Service

Thames Reach

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Our vision is of a society where street homelessness is ended and nobody need sleep rough on the streets.

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Community Living and Support Service:

Evaluation report for Thames Reach from SP Solutions 2022-25

by
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SP solutions
HOUSING SUPPORT AND
SOCIAL CARE CONSULTANCY SERVICES

Introduction

This report summarises the outcome of a review of the Community Living and Support Service (CLaSS), an initiative of the Lambeth Living Well Network Alliance (LWNA). The LWNA is an alliance of statutory and voluntary agencies which work together to deliver improved services for people with mental health problems in Lambeth. Formally established in 2018 (but existing in shadow form prior to that) it aims to remove barriers between hospital and community health and care services, including both statutory and non-statutory services.

CLaSS commenced in February 2020. The key aims of the service are:

1. to create and support improved discharge arrangements for people on Lambeth wards who are delayed or likely to be delayed in leaving hospital;
2. to work with community services to prevent admissions to hospital.

The team is led by Thames Reach and is made up of staff from mental health, social care, and voluntary sector services to ensure a holistic approach to support is available.

This review was commissioned by Thames Reach and conducted by SP Solutions. It focused on three broad areas:

1. Describing and analysing the design and implementation of the CLaSS team and the results it has achieved.
2. The underpinning factors behind these results.
3. The replicable learning from this service/approach for other Local authorities/Trust areas and how to communicate this.

The review was undertaken between October 2021 and January 2022. We reviewed documentation that was supplied, reviewed performance and financial data and engaged with fifteen stakeholders. Findings are outlined below. We have also included four case studies to illustrate the type and range of work that the team undertake.

Context

People with mental health problems are admitted to hospitals, usually at a point of medical crisis. However, it can often be the case that people remain on hospital wards long after they are medically fit for discharge (MFFD) because they are unable to return to the community. This is a significant problem because it can cause serious distress to patients. It is also expensive for the hospitals themselves: beds typically cost £500 per day (with private hospitals charging c£1000 per day) and a bed occupied by a patient who does not need it is a bed unavailable to someone who does need it. This is a particularly severe issue when people with mental health problems present at Accident & Emergency, given the acute pressure these services are under. Thus, managing patient flow out of hospital is important and hospitals employ discharge teams to facilitate this flow.

Typically, hospital discharge teams are staffed by clinicians or a mix of clinicians and social workers and are usually led by a clinician. However, the issues that prevent people who are MFFD from returning to the community are, by definition, not medical in nature, nor, usually, are they related to care needs. Typically, the issues preventing discharge relate to housing or the lack of community support: CLaSS was established in recognition of this.

How CLaSS works

The key aims of the service are to:

- Improve outcomes for people with mental health needs receiving acute care in Lambeth.
- Oversee all complex delays and ensure flow through the mental health system.
- Reduce length of hospital stays and the likelihood of re-admission to acute wards.
- Prevent hospital admission by advising and supporting Lambeth community teams.
- Establish close joint working arrangements with Lambeth hospital discharge support and other services, supporting improved communication between services,

and coordinating discharge support arrangements.
- Work with the Mental Health Placement Coordinator and placement providers.

The team is made up of staff from mental health, social care, and voluntary and community sector services. The team has a wide range of knowledge and skills which means they can offer advice in a number of areas which include housing and placements, social care packages, community connection and reducing isolation. Statutory care management responsibilities remain with social workers.

The service was established in February 2020, a challenging time to start a new service for obvious Covid-related reasons. Unfortunately, due to difficulties in recruiting staff members the team was not complete until September 2020, six months after the start of the service. It was further expanded in 2021/22.

The team consists of the following eight full time equivalent (FTE) staff.

Role	Organisation	FTE
Team Leader	Thames Reach	1
Senior Practitioner	Thames Reach	1
Social Workers	Local authority	2
Support Workers	Thames Reach	2
Administrator	SLaM	1
Patient flow clinician	SLaM	1

Table 1 below gives details of the current team costs:

Category	Cost (£)
Direct staff costs (exc.clinician)	359,000
Discharge enablement fund	50,000
Other direct running costs	17,000
Thames Reach overhead	34,000
Total	**460,000**

Thus the team costs c£460,000 per year, plus the cost of the seconded patient flow clinician. It is important to emphasise that these are not additional costs as there will always be a requirement to fund a hospital discharge team. We do not have data to compare costs but our sense is that the team is slightly larger than other teams (although it has a considerably broader remit), but that average salary costs are somewhat lower (voluntary and community sector workers are cheaper to employ than clinicians).

Referrals come mainly from LWNA partner organisation, with most referrals coming from bed management meetings, acute wards and consultants, ward multi-disciplinary team meetings and weekly MFFD teleconferences. Some referrals also come from acute trusts, police and probation services.

Referrals are typically people who are identified as having barriers potentially preventing their return to the community once they are MFFD. The reasons why people are unable to return to the community are varied but primarily relate to housing (e.g. property is unavailable, property is unsuitable, insufficient/inadequate support, hoarding or property requires intensive cleaning), benefit problems or, on occasion, complex ordinary residence or leave to remain issues. Complex delay issues are defined as:

- Currently on the MFFD list, or
- Not yet delayed but the plan for their discharge will take more than 28 days to enact, or
- Previously known to have significant delay issues.

The team works intensively to resolve these issues with a focus on facilitating discharge as quicky as can be done safely. The team also supports some patients once they have returned to the community, focusing on prevention of return to hospital.

Case study: L

History and context
20-year-old female care leaver with diagnoses of Emotionally Unstable Personality Disorder and Post Traumatic Stress Disorder. A history of severe self-harm and hospital admissions. From March 2019 L was in semi-independent 24-hour supported accommodation, placed there by local authority A (LAA). A dispute between LAA and local authority B (LAB) regarding ongoing responsibility for placement funding was a trigger for her mental health deterioration and she was readmitted. When MFFD interim alternative accommodation was arranged but L attempted suicide when she was told she would be moving from the ward.

What did CLaSS do?
Advocated to social care that she had been poorly treated by her previous CCG and due to her vulnerability, LAB should take on ongoing S117 responsibility. This was finally accepted. L's social worker was changed (her previous SW did not engage in a way that minimised risk regarding discussions around housing).

A gentler person-centred approach was taken, ensuring that Miss L was very involved in choosing her next placement – this disrupted the cycle of things being 'done to her'. Eventually a placement was found in Tottenham.

CLaSS and L's social worker advocated that it was essential that she remain on the community team caseload to ensure that she would not lose her place in the waiting list for Dialectical Behaviour Therapy (DBT) as she was next in line after waiting for one year. The community team were very unhappy about this as they felt that due to her chronic suicide ideation and numerous attempts at self-harm they would be unable to manage risk in the community if she was on the other side of London.

A professionals' meeting was arranged to discuss the need for continuing with the current community team and this was agreed. L was discharged to a placement while still on LAB's community team caseload, after 200+ days on the ward.

Outcomes
Six months on, L is thriving in her placement and is still accessing DBT on a weekly basis. For the first time in approximately three years, she has not attempted to harm herself on the anniversary of her sexual assault. She has now reached out to and is engaging with family members which she had not done for several years. Also, she has organised a trip abroad by herself, her first ever holiday.

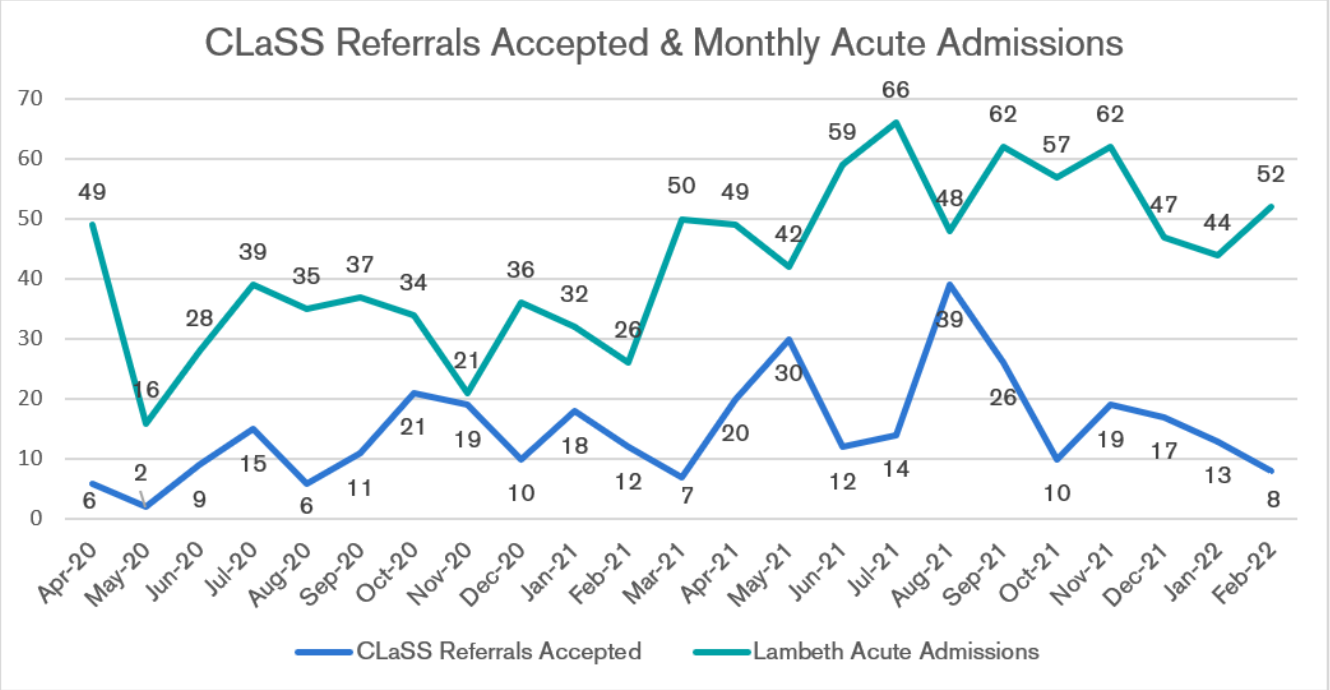

Diagram 1: CLaSS referrals accepted versus monthly acute admissions (April 2020 — February 2022)

Activity, performance, and outcomes

CLaSS only went live in spring 2020 and has only been fully operational since early 2021. Thus, performance data needs to be considered in the context that Covid had a big impact on system demand and performance during this period. However, even with this caveat, it is possible to ascertain certain factors about performance.

How many people does CLaSS work with?
In calendar year 2021 CLaSS accepted 224 referrals, c19 per month. All the referrals were people who, when MFFD, still faced significant barriers in returning to the community. From stakeholder feedback it seems likely that a high proportion of people who were in this category were referred to the team.

Diagram 1 gives month-by-month comparisons of referrals and admissions over a 23-month period. The two figures are not directly comparable on a month-by-month basis as referrals will lag admissions for obvious reasons, but in aggregate about 37% of all acute admissions are supported by CLaSS prior to discharge.

The proportion of discharges that were CLaSS clients was c27% during 2021 (see diagram 2 for month-by-month breakdown). This is a lower proportion than of referrals made, presumably reflecting the greater complexity of the situations of those patients referred to CLaSS.

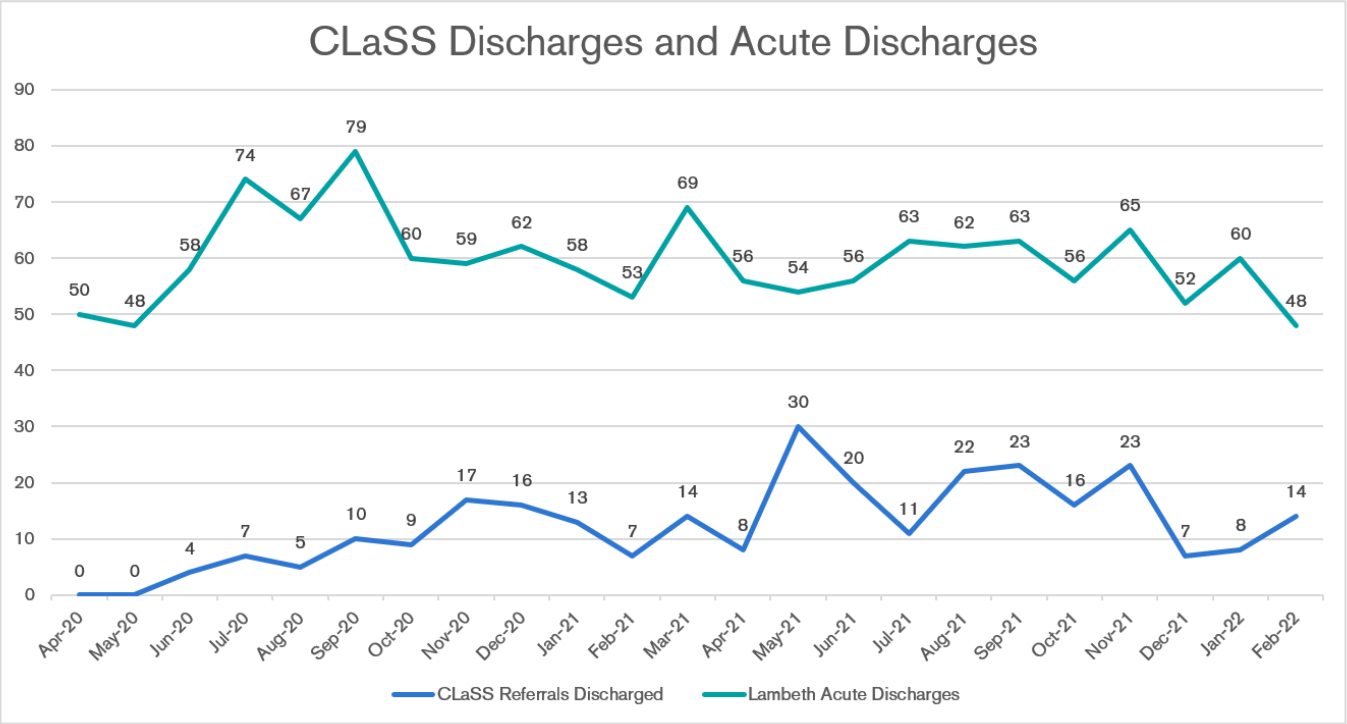

Diagram 2: CLaSS discharges versus acute discharges April 2020-February 2022

Thus, CLaSS worked with a substantial proportion of acute patients, including almost all of those who were MFFD. The team also supports an average of 20 people per month who have returned to the community, primarily people living in step down accommodation or bed and breakfast. The duration of the support is based on need.

How effective has CLaSS been?

The performance of CLaSS can be judged in a number of ways. The most obvious way is to compare the length of stay for those who are MFFD, before and after the establishment of the CLaSS team. The figures do not exist in this format but diagram 3 below shows that the average MFFD length of stay (LOS) was at a very low level in the early stages of the first Covid lockdown, increased substantially at the end of that lockdown but has decreased substantially since then, whereas the overall average ward LOS has remained constant. Given that the average ward LOS included people who are MFFD this implies that the ward LOS for people who are not MFFD has increased. It would be reasonable to assume that part of the reason for the reduction in average MFFD LOS has been the impact of the CLaSS team, although the fact that the period covered the Covid pandemic does qualify this.

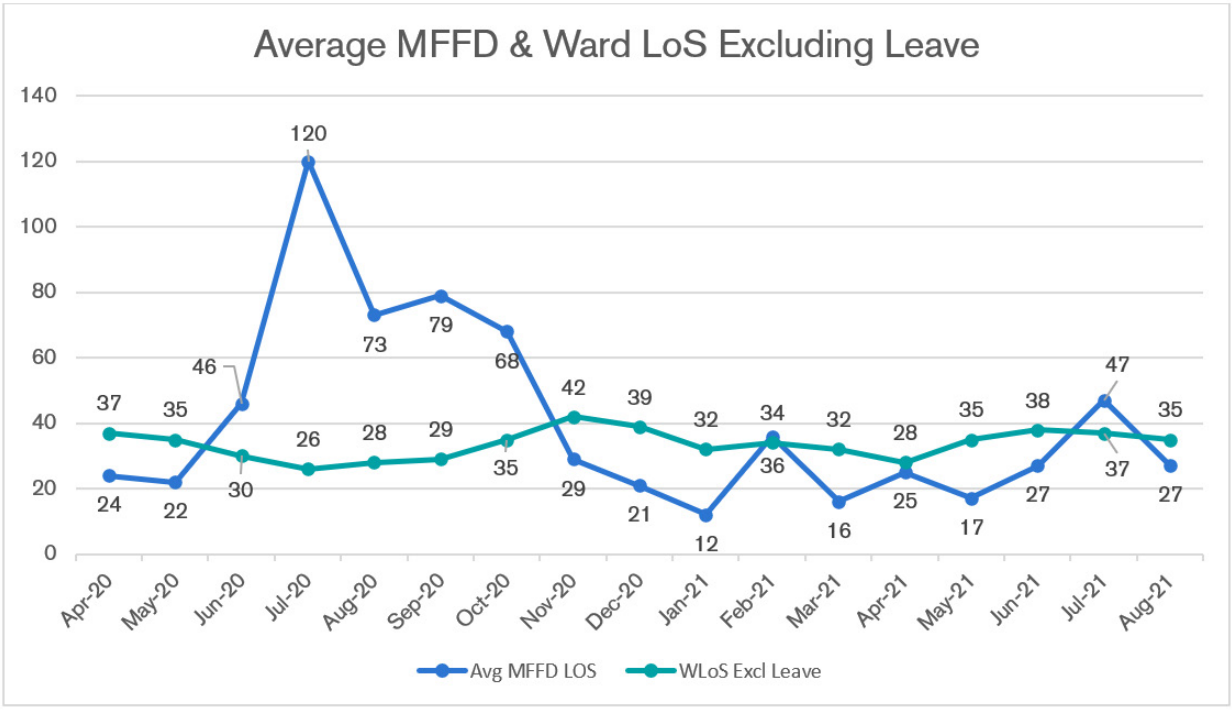

Diagram 3: average MFFD LOS and Ward LOS, excluding Leave Apr 2020 – Aug 2021

Other data comparing LOS over the summer periods from 2019 to 2021 shows a similar effect. Diagram 4 below shows substantial reductions in LOS from 2019 to 2020 and a steady position from 2020 to 2021; a pattern seen across all the four different metrics used. As this coincides with the establishment of CLaSS it seems reasonable to infer that this effect is, at least in part, due to the new service.

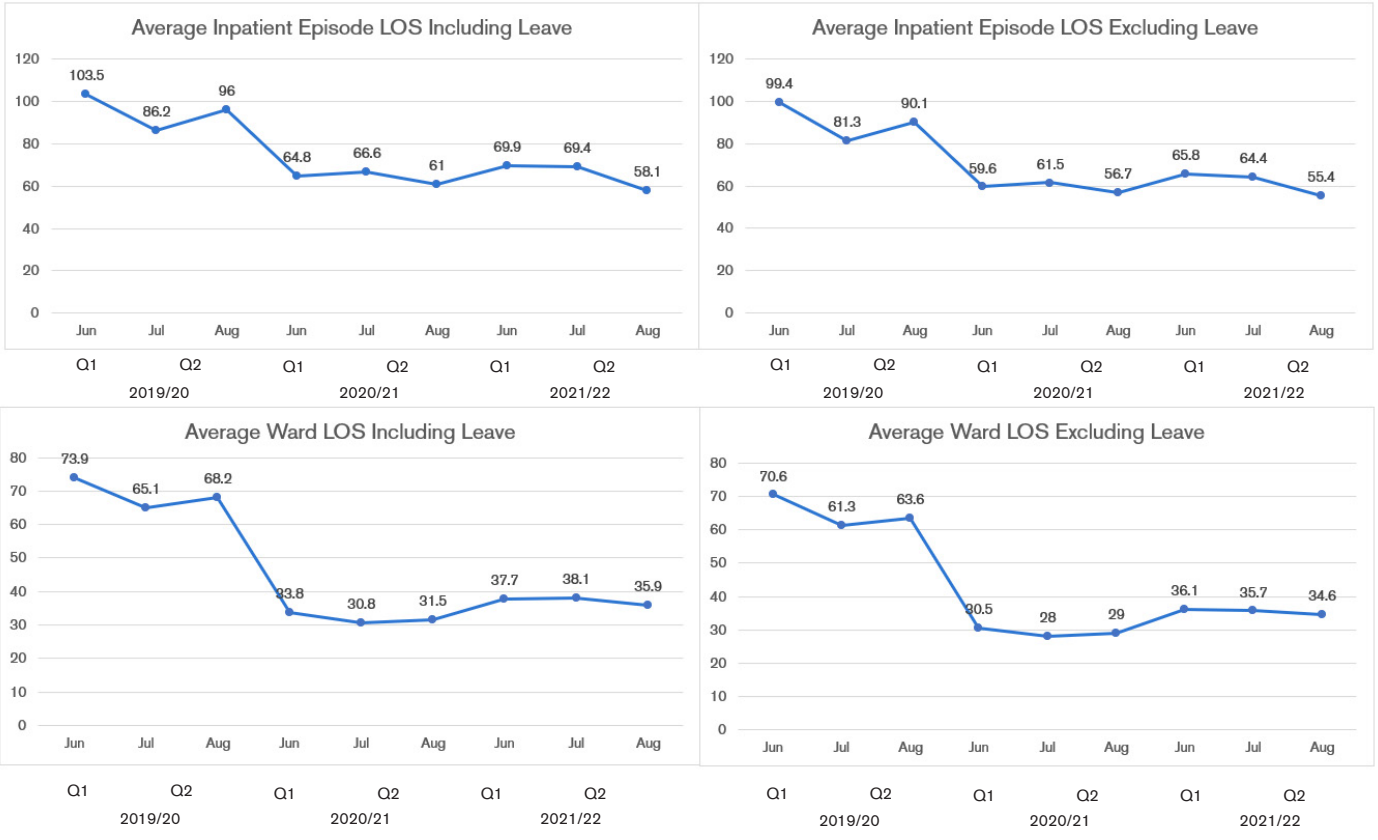

Diagram 4: inpatient activity summary

Another way in which this can be looked at is by looking at the number of successful discharges. Diagram 5 shows discharges by year from 2017/18 to 2020/21. There is a clear pattern of a slow increase in numbers which accelerates in 2020/21, the year that CLaSS was set-up: it would seem reasonable to attribute some of this at least to the new service.

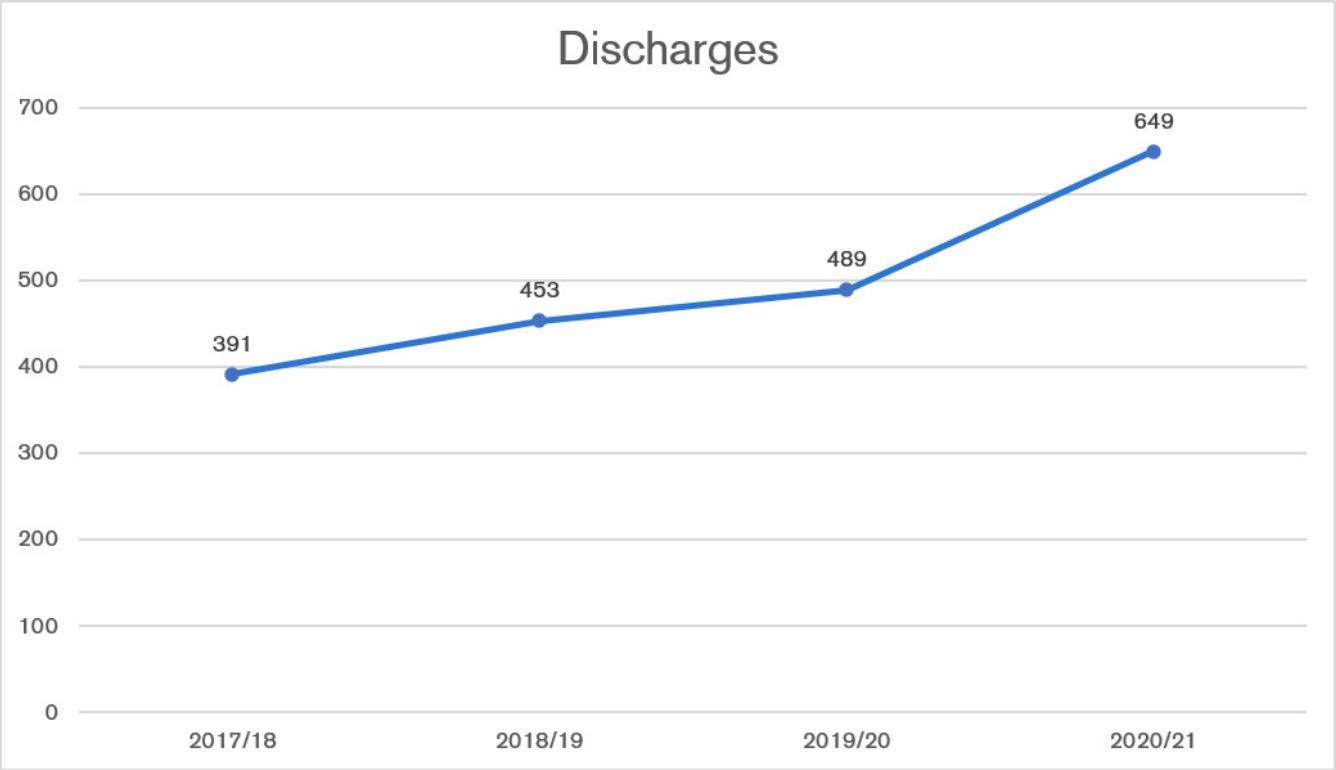

Diagram 5: discharges by year 2017-21

A further area where it would be reasonable to expect an impact from the CLASS service would be in re-admission rates of those people with whom the service has worked. However, the number of re-admissions within thirty days has moved around considerably since 2017/18 with no clear pattern (except for an increase during the lockdowns of 2020).

However, although the impact on re-admission rates is not clear, there is some evidence that the length of stay of those re-admitted has decreased (an effect one would expect if the intervention was effective). In a sample of eight patients in September 2021, each with an average of three previous stays, the prior average length of stay was 378 days, indicating the complexity of their circumstances. Following CLaSS's intervention this reduced to an average of 164 days.

Case study: CP

History and context
CP is a 31-year-old woman with a diagnosis of Bipolar Affective disorder and a history of opioid dependence with alcohol misuse. CP was initially seen at Lewisham A&E in the summer of 2020 after following an overdose of heroin and psychotropic meds. CP had been sexually assaulted three days prior to this and felt there was no reason to continue living. CP sex works to fund her drug habit. CP at the time was living in a flat with two males which she fled due to domestic violence and threats against her from people in the area.

CP had previously been to two rehab placements to help with her addiction issues. Unfortunately, these were not successful for CP.

CP could not return to her previous accommodation due to her partner returning there. She was a victim of domestic violence and was forced both to flee her flat and the borough. CP was therefore homeless and extremely vulnerable in terms of her drug addiction, and the sex work she does to fund this addiction.

CP was discharged to a Lambeth B&B in September 2020 by Lewisham hospital. CP made a homeless application to Lewisham council whilst she was on the ward. Unfortunately, CP then withdrew her application and was provided no further housing advice by the council. Due to her withdrawing her application, her case was not closed which meant Lewisham still had duty to house her. Lewisham then disputed this due to her being placed in a Lambeth B&B.

CP struggled with the B&B environment due to many residents misusing drugs. It was also difficult for her to keep to appointments due to her historical drug and alcohol misuse affecting her memory. During this time, CP was discharged from her community team due to non-engagement.

What did CLaSS do?
The CLaSS team checked in on CP's welfare on a weekly basis and supported her with her PIP application.

The CLaSS team liaised with Lewisham council to ascertain their duty, but this proved futile after much work chasing them.

CLaSS brought CP to the attention of Lambeth council, continually discussing her in meetings, and seeking guidance regarding next steps for her. Due to her having no links to the borough, Lambeth were also unable to house her suitably.

Fortunately, once she had been in the Lambeth B&B for over six months, CLaSS were able to complete a referral for CP to move to an all-female low-support supported housing scheme.

Outcomes
CP was accepted and is now living there and is doing well. She meets with her addictions worker regularly and has had one major drug relapse since being discharged from hospital. She has had no hospital re-admissions.

Qualitative feedback

Thus, there is considerable evidence that the service has proven highly effective. This is supported by stakeholder feedback from a variety of points of the system, all of whom were highly positive about the project. For example, the team was described as "well known and respected" (NHS manager) and as having "done a pretty good job" (LA Manager).

"CLaSS has been the best example of a discharge team that I have ever seen in the past 30 years" – consultant psychiatrist

We explored some of the reasons for this effectiveness with stakeholders, with the main points summarised below.

- **Team structure:** The multi-disciplinary mix of clinical staff, social worker and staff with community knowledge was felt to be critical to success, as each type of professional brought different expertise and technical knowledge to the task.
- **Team knowledge:** The knowledge of housing issues and the "wider system" amongst Thames Reach staff was particularly valued by clinicians whom we interviewed.
- **Advantages of voluntary and community sector (VCS) involvement — role of Thames Reach:** Although ensuring his type of knowledge is contained within a discharge team could be done in a number of ways – other discharge teams within SLaM directly employ housing workers, for example – it was felt by most interviewees that using VCS workers for this role made sense. This was partly because Thames Reach workers had the support of a wider organisation with an understanding of non-clinical issues that a statutory body would find difficult to emulate.
- **Advantage of VCS involvement – ethos of Thames Reach:** Probably more important however was that the ethos of the Thames Reach workers was felt by most interviewees to be quite different. Thames Reach staff were reported to be more approachable, "less judgmental," to "avoid restrictive thinking" and to have a different approach to risk-taking, in contrast to clinical and social work staff. This pragmatic, problem-solving approach was felt to be one of the key reasons for the team's success
- **Advantages/disadvantages of VCS team leadership of the team:** Having VCS leadership was felt to be an important reason for why this problem-solving approach

had been embedded throughout the team, and the consequent positive outcomes. One interviewee did qualify this point by observing that it came at a potential cost. In his view a team led by a clinician (as happens elsewhere in SLaM) has the capacity for more nuanced discussions with wards about when a person on the cusp of discharge was ready for discharge. This was not stated as a criticism of CLaSS and said in full recognition, both of the clinicians in the team and of how embedded CLaSS is in the day-to-day organisation of patient flow: the point was in relation to seniority and perceived professional-professional credibility.

- **Relationship between wards, CLaSS, and community services:** Several interviewees commented on this issue, with a variety of opinions being expressed. It was reported that communication between wards and community services was poor for a variety of reasons, including under-staffing, extensive use of bank staff and lack of clarity about respective roles. However, whilst CLaSS were acknowledged to have helped in dealing with much of this there was the view expressed by one interviewee that they were merely doing "what the wards should be doing." Others observed that there was an over-reliance on CLaSS to facilitate discharge and that the respective roles of wards, CLaSS and community teams needed to be reconsidered. Several interviewees commented on the need for knowledge of non-medical barriers to discharge to be spread better amongst the system, with wards taking (back) more responsibility for discharging MFFD patients.
- **Costs and benefits of using VCS staff (1):** There were a couple of points made about costs. Put simply, employing Thames Reach staff and managers was cheaper than employing clinical staff to perform the same roles (particularly when additional benefits are considered), as well as being more effective.

- **Costs and benefits of using VCS staff (2):** More subtly, throughout London, vacancy rates in clinical roles are high (c20-25% of nursing posts being reported to be unfilled): this reason alone indicates that it makes little sense to deploy such staff in roles which others can perform.
- **Potential for CLaSS to prevent admissions:** It was originally envisaged that the team would work with people in the community who were identified as being potentially at risk of being admitted. The (reasonable) hypothesis behind this was that non-medical factors (such as housing problems) could exacerbate medical problems, leading to admissions that could have been prevented if the non-medical factors had been addressed. For various reasons (mainly related to Covid but also about CLaSS taking on more responsibility than envisaged for the relationships between wards and community services) it has not been possible for the team to work in this way, until very recently. Thus the hypothesis remains largely untested, although some preventative work in the community is now taking place and interviewees were keen for this to be pursued.
- **Relationships between partners within LWNA:** This was felt to be an important element of the success of the service, particularly by Thames Reach interviewees. VCS agencies are often seen by NHS Trusts as peripheral to their work and often do not have access to decision-makers to challenge this perception. The structure of the LNWA, with Thames Reach having a strategic role in the Alliance, was felt by several interviewees to have been a critical enabler of the decision for the service to be designed in this way: Thames Reach had already built-up considerable trust with statutory stakeholders.
- **Senior management support:** Several interviewees commented on this element. Senior management were supportive of CLaSS and were publicly seen to be so: this enabled the service to develop relationships quickly and, from this, to build credibility and trust.

Case study: SSC

History and context:
SSC is a 35-year-old Black British woman known to SLaM with a diagnosis of Bipolar Affective disorder with psychotic features. She has had multiple admissions under the Mental Health Act (MHA), at times requiring Psychiatric Intensive Care Unit (PICU) admissions, including six inpatient admissions between 2015 and 2020, all under the MHA. She is a heavy cannabis user and drinks alcohol weekly, with some bingeing patterns when unwell.

She has a history of expressing both verbal and physical aggression and was recently detained for smashing up numerous cars with a baseball bat. She was found naked with a knife and also has a history of threatening to jump from her third-floor window.

What did CLaSS do?
SSC was provided with social care support from the CLaSS social worker. The community team felt that SSC's only option was locked inpatient rehab. CLaSS advocated against this restrictive setting as SSC had a daughter under 18 and this would mean that she would potentially have to go into care.

Discharging SSC home with an increased package of care was discussed. There was some unhappiness form the community team – this was finally agreed following advocacy from the CLaSS social worker.

CLaSS completed a referral for floating support on SSC's behalf. CLaSS liaised with SSC and her mother to gather the information needed to organise removals from her mother's home to SSC's new home. This was planned in such a way that it would align with SSC's discharge from hospital and with the removals - to avoid causing unnecessary stress to SSC, the removals service, or the ward.

CLaSS called SSC on a few occasions post-discharge to provide welfare checks, while waiting for floating support to commence. On the first welfare call, SSC had no hot water or heating. CLaSS contacted Lambeth Council right away, ensuring that they were aware that this requires a 24hr call out, as SSC is a vulnerable adult. CLaSS informed the Care Coordinator of this and kept SSC updated. The issue was resolved within 90 minutes of calling Lambeth Council.

CLaSS informed SSC of local support networks. SSC agreed to have a staff member from Mosaic Clubhouse call her for further information and a referral was made.

CLaSS chased the floating support service about the start date for support for SSC. The Care Coordinator was informed about the upcoming assessment date.

Outcomes
The removals issue was dealt with within three days, in time for SSC to be discharged. SSC was very receptive and grateful for the support. CLaSS continued to work with SSC post discharge, due to SSC's long history of non–engagement. Despite having six inpatient admissions in five years, since the most recent discharge and whilst actively working with CLaSS she has not had any further readmissions. She is now linked into Thames Reach and is now volunteering with them.

Conclusions

What results has CLaSS achieved?
The overall purpose of CLaSS is to improve outcomes for people with mental health needs receiving acute care in Lambeth. It seems clear that this purpose has been achieved:

- We interviewed a wide variety of stakeholders who were, universally, positive about the service.
- The quantitative data supports the view that CLaSS has had significant impact on reducing the Length of Stay (LOS) of those who patients who are Medically Fit for Discharge (MFFD).
- The case studies in this report illustrate three cases where CLaSS has helped to improve the lives of people with highly complex problems.

The service had a number of more specific objectives:

- **Oversee all complex delays and ensure flow through the mental health system:** CLaSS works with a significant proportion (35-40%) of all patients who are being discharged with highly positive feedback on the impact of patient flow. This objective has been achieved.
- **Reduce length of hospital stays and the likelihood of re-admission to acute wards:** Qualitative feedback was that the team has been effective in achieving both these objectives. This is supported by the data on LOS, which shows a clear overall reduction since the start of the service. The data for re-admissions is unclear, although there is strong anecdotal evidence of people with both far lower levels of re-admission and shorter lengths of stay if they are re-admitted.
- **Prevent hospital admission by advising and supporting Lambeth community teams:** CLaSS supports post-discharge an average of c20 people. This is a significant proportion of the case load; however, there is scope to define the post-discharge offer more clearly and to work more closely with community teams to prevent admission, a point acknowledged by the service itself and other stakeholders.
- **Establish close joint working arrangements with Lambeth hospital discharge support services, supporting improved communication between services, and coordinating discharge support arrangements. Work with the Mental Health Placement Coordinator and placement providers:** CLaSS moved rapidly to establish joint working arrangements and to co-ordinate discharge support arrangements. These were seen as key reasons for its success by stakeholders. Some stakeholders considered that the team took on too much responsibility and that there needed to be a greater focus on improved communication between services to complement the work of the service. The team's value is perhaps most clearly seen in relation to its ability to resolve complex local connection issues – all the case studies include issues of this type.

Thus, CLaSS has clearly achieved the outcomes it was intended to achieve, and the team is highly valued for the contribution it makes. There are four caveats to this statement:

- It is not possible to state with absolute confidence that the service has reduced the average LOS of people with MFFD as the data does not exist to make this assessment. However, the combination of the reduction in average LOS, the qualitative feedback, the case studies, and the anecdotal samples together present a compelling case that the service has been effective in its core goal.
- There is no clear quantitative data on impact on levels of re-admissions, although there is anecdotal and qualitative evidence supporting the view that the service has been effective in reducing these.
- There is scope for CLaSS to do more work on prevention of admissions, by working more closely with community teams. Linked to this there is a sense (although it was not expressed to us in these terms) that the existence of the service meant that there was reduced impetus for wards and community teams to begin to work together more closely.

What are the underpinning factors behind these outcomes?
There are a number of factors underpinning these positive outcomes:

- **Team structure:** The multi-disciplinary mix of clinical, social worker and staff with community/housing knowledge has been critical to success, as each type of professional has brought different expertise and technical knowledge to the task.
- **Technical/domain knowledge of Thames Reach:** Any discharge team needs community/housing knowledge to be effective. In theory this could be done in a variety of ways – other discharge teams within SLaM directly employ housing workers, for example. However, there is a clear rationale for using VCS workers, partly because Thames Reach workers had the support of a wider organisation with an understanding of non-clinical issues that a statutory body would find difficult to emulate.
- **Ethos of Thames Reach:** Probably more important however is the ethos of Thames Reach. Thames Reach staff were seen as pragmatic, solution focused and less restrictive in their thinking and it seems clear that this problem-solving focus is one of the key reasons for the team's success.
- **Thames Reach leadership of CLaSS (1):** in theory this ethos could be engendered within a team led by a clinician. However, there was a strong sense from the feedback that having non-clinical leadership from Thames Reach was an important element in ensuring that this problem-solving approach was embedded throughout the team, and the consequent positive outcomes. Thames Reach has a management structure that supports the team leader of CLaSS. This structure supports and engenders a solution-focused ethos, in a way that clinical supervision and management does not.
- **Thames Reach leadership of CLaSS (2):** There is a potential downside to this: a team led by a clinician may have the capacity for more nuanced discussions with wards about when a person on the cusp of discharge was ready for discharge, due to perceived professional-professional credibility. However, we would argue that the purpose behind CLaSS being set up in this way was as a challenge to this mind set.
- **Strategic relationships between partners:** VCS agencies can be seen by NHS Trusts as having little to contribute and often do not have access to decision-makers to challenge this perception. However, Thames Reach are in the unusual position, for a

VCS body, of having strong strategic relationships with the key statutory partners in Lambeth. The level of trust thus engendered was clearly a critical enabler of the decision for the service to be designed in the way it has been.

- **Senior management support:** Linked to this was the importance of visible senior management support to overcome any misperceptions of VCS bodies and to enable credibility and trust to be built quickly.
- **Costs and benefits of using VCS staff:** Employing Thames Reach staff was cheaper than employing clinical staff to perform the same role, as well as being more effective. More subtly, vacancy rates in clinical roles are high (c20-25% of nursing posts being reported to be unfilled): this reason alone indicates that it makes little sense to deploy such staff in roles which others can perform.

There are a number of areas for consideration in the future

- **Data collection:** The lack of clear data on re-admissions rates and duration is an important gap and makes judging the success of the service more difficult. It should be possible to generate data on re-admission rates and duration before and after intervention by CLaSS and to use this to monitor effectiveness.
- **Improving communication between different parts of the system:** This was one of the original aims of the service. There is a tension between this objective and improving discharge arrangements overall – our sense is that the team has been so effective that the role of other parts of the system is not always clear. The balance between the team "organising" discharge (i.e. doing all the work) and "facilitating" discharge (i.e. ensuring discharge is done properly by the right parts of the system) is a difficult one to strike, but probably needs further consideration.
- **Prevention of admissions from the community:** This has been a less-developed part of the service. There are questions about whether it is realistic to expect CLaSS to play a major role in this area (given their current capacity), the likelihood of effectiveness and how the impact of preventative work should be measured.

What is the replicable learning from this service?

The replicable learning from CLaSS is clear:

1. A hospital discharge service led by a VCS entity, with a problem-solving ethos and including a mixture of clinicians, social care and VCS staff can by highly successful in reducing LOS for patients who are MFFD.
2. It is, almost certainly, also true that such a service can reduce the number and duration of re-admissions of patients with whom it works.
3. The main reasons for this are that such a team will combine an appropriate focus on non-medical barriers to discharge, an understanding of how these non-medical barriers can be overcome and a pragmatic, solution-focused approach to facilitating discharge.
4. Systemic critical success factors for this are effective strategic relationships, allied to visible senior management support for the model to ensure credibility and trust and robust data collection arrangements to measure effectiveness.

There are a couple of issues to consider in how this should be communicated to Trusts:

1. The approach is one that is disruptive of standard NHS arrangements and, as such, is most likely to be of interest to those Trusts with substantial problems in relation to MFFD patients: identifying these would be an important first step.
2. Producing a summary of the model which includes the three systemic critical success factors is important: without these, in our view, the model is less likely to work.
3. On-the-record endorsement by senior leaders from SLaM and other parts of the NHS (e.g. Integrated Care System) will help to facilitate access to other Trusts.
4. It would be worth exploring a write-up of CLaSS in the health trade press e.g. the Health Service Journal.


Thames
Reach