**BCF Action Plan for Managing Transfers of Care**
**(8 High Impact Change Model)**

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| **Local Authority** | Cambridgeshire |
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| **Date** | 03/08/2017 System Wide HIC workshop - G Bennett (CUH), S Pitts (CCG), M Smith (CCG), R O'Driscoll (CCC), D McQuade ( PCC), N Sheperd (PCC), C Townsend (CT), L Chibuzor (CCG), L Hurren ( Care Network), A Howard (CCC), M Donaldson (NWAFT), J Fallon (CCG), C Mitchell (CCG)<br>24th July workshop - completed by Gill Kelly(CCG), J Fallon(CCG), C Townsend (PCC), Alison Edwards (CPFT), Phil Vinning (CUH), Gill Bennett (CUH), Richard O'Driscoll (CCC), Lynette Hurren (Care Network), Sandra Myers (CUH), Sara Rodriguez-Jimenez (C&P CCG) |

| Impact Change | | Current Position | Where are you? | What do you need to do? | When will it be done by? | By Who? (one lead) | How will you know it is successful? | Key milestones | Reference to existing plan | Cost | Funding source |
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| 1a | **Early Discharge Planning**. **In elective care**, planning should begin before admission. | Established | 1. Joint pre admission discharge plannin place in primary care . Early discharge planning project in place - as part of the PRIME process in CUH but not joined up across the system.<br>2. Joint pre admission discharge planning is in place in primary care | Expand early d/c planning project to include whole system including community services, primary care and VCS. | Self assessment of individual organisations by Dec 2017.Joint planning for cross organisational planning by Mar 2018 | Sandra Myers | Patients seen in the PRIME clinic will have a joint assessment that follows them to the clinic and back to the community post hospital admission.Patient better prepared for discharge and less likely to have related re admission. Reduction in elective DTOC | Joint task and fininsh group CUH/CPFT | Link to CUH Improvement project | Nil | |
| 1b | **Early Discharge Planning. In emergency/ unscheduled care**, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours. | Mature | 1. Emergency admissions have discharge dates set within 48 hrs - and which whole hospital is committed to delivering | 1. CCG/Acute Hospital need to do further work to improve systems in respect of Health D2A including Continuing Health Care .<br>2. Need to develop one D2A model inline with the guidance. 3.Define a the role the 3rd sector cwill play | 1. October 2017.<br>2. March 2018 | Katie Wilson/SaraRJ | 1.4Qs process agreed.2.Business case agreed. 3.VCS able to fully contribute to discharge pathway. All partners using same system and pathway | work with VCS to develop pathway/ | Review current contracts withh CCG/partners with the VCS | Nil | |
| 2 | **Systems to Monitor Patient Flow**. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual. | Plans in place | 1. Good systems in place with individual organisations - but NOT shared across the system. Cant flex capacity across the system.<br>2. Some relationships between demand and capacity in care pathways<br>3. Staff understand the relationship between poor patient flow and senior clinical decision making and support 4. Bottlenecks occur 5. No ability to increase capacity when capacity increases. 7. Staff training in place to ensure understanding of senior clinical capacity. | 1.Join up information systems for demand and capacity into one system.<br>2. Improve involement with voluntary sector earlier<br>3. Agreed escalation process<br>4. Senior leaders summitin 18 August 2017 to agree set priniciples in information sharing across organisations for North / South SPOC<br>5. Detailed project plan for schemes in place/pipeline including:Homecare contract, shared brokerage( residential/nursing homes, domicilllary care, and CHC), Intermediate care STD business case. 6. Develop OD Programme | Timeline to be agreed by system partners at the Intermediate Care Tier Operational Group with focus on D2A on 18/08/17. This will inform on development of a detailed project plan with milestones and deliverables which are designed to monitor and deliver patient flow. | Julie Frake-Harris | Project plan in place and milestones achieved. Shared information system in place and demonstrating reduction in delays due to information flow | as per project plan | BCF Business Plan | | |
| 3 | **Multi-disciplinary/Multi-Agency Discharge Teams,** including the Voluntary and Community Sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients | Plans in place | 1. separate planning processes in place. 2. CHC assessments carried out in hospital and taking too long. 3. discussions re creation of integrated ASC and health d/c teams. 4. Discussions on introduction of MDTs on all wards 5. Discussions in place to establish D2A arrangements. 6. There are plans in place to create a single mulit disciplinary hub for services to work together formally ( part of Intermediate Care business case SDU) | 1. Implement the plans that are in place with clear timescales and leads. 2. Engage voluntary sector earlier<br>3. Ensure organisations are aware of voluntary sector opportunities<br>4. Plans to address CHC assesemnts carried out in hospital earlier<br>5. Implement plans to establish the disciplinary hub | SPOC as part of the D2A process will have an MDT approach.<br><br>Discussion at DToC Operational Group Meeting on 16/08/17 regarding establishment of MDT for CUH area to focus on reducing DToCs to 3.5 with traction. Team to comprise of CUH, Social Care, CPFT, CHC etc. This would entail redeployment of staff to CUH for 6/52. BD MDTs | Julie Frake-Harris | CHC pathway in place and implemented | Workshop on 06/09/17 to agree ICT process with inclusion of CHC. | CHC Task and Finish Project | | |
| 4 | **Home First/Discharge to Assess**. Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow. | Plans in place | 1. Strong reablement service - people return home with re-ablement in place<br>2. CC care homes assess people within 24 hours ( not all care homes contracted by CC)<br>3. People only enter care home when needs cannot be met at home. | 1. Linked to the ICT business case and Action On Care Homes and implementation of the same 2. Ensure Multi disciplinary response for people when they go home<br>3. Strengthen relationships with care homes<br>3.. Review community capacity for interim beds, residential and nursing homes by end August 17. | Timeline to be agreed by the Intermediate Care Tier Operational Group. First meeting 18/08/17. This will inform on development of a detailed project plan with milestones and deliverables. | Julie Frake-Harris | Reduction in DTOC and incremental increases in numbers of assessments in the community | Staff recruited, reviised discharge policies and SOP implemented, CHC model reviewed and implemented. | BCF Business Plan | | |
| 5 | **Seven-Day Service**. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs | Plans in place | 1. Discharges are planned 5 days a week<br>2. Support and help not readily availble at weekends<br>3. Brokerage service not avaialble at wekends for SC to access<br>4. VCS Support is available at weekends if planned | 1. Get HIC change systems in place for Monday - Fridays in first instance - then build on this.<br>2. Review in 18/19 for opportunities in 7 day working with each element | Mar-19 | SM/JF-H/RO'D L H | 1. Weekend discharges are the same as weekdays.<br>2. Number of new dtocs doesn't increase after weekends.<br>3. 7 day consultant led ward rounds on all wards | This work will follow on from the implementation of the key changes to our D2A pathways and and changes to workforce . | This work will follow on from the implementation of the key changes to our D2A pathways and and changes to workforce . | ? | ? |
| 6 | **Trusted Assessor**. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way | Not yet established | 1. Plans are in place for training of health and social care staff<br>2. Joint assessment form shared with care home providers<br>3. Care Homes not yet discussing joint approach of assessing on each others behalf. | 1. CHC: test form in August & agree principles with vol sector. One document (SPOC) between professionals<br>2. Care Homes - a longet term piece of work look at Herts model of independent provider organisation / Lincs model | Sara RJ to complete | R Derrett/ R O'Driscoll/ Jill Houghton | 1. Trusted assessors in place.<br>2. Number of assessments undertaken by trusted assessors with incremental increases | Reduction in DTOC | Sara RJ to complete | Sara RJ to complete | Sara RJ to complete |
| 7 | **Focus on Choice**. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care. | Plans in place | 1. Pre admision leaflet and information available<br>2. Choice protocol in place | 1. work with voluntary sector to co-design contracts. 2. Agree updated polic - end July.<br>3.Training / support staff to implement choice policy - August 17<br>4. Leadership Review group for exception reporting and oversee cultural changes. | Policy agreed by 31/07/2017, training 30/08/2017, September implementation, December - aim for 'mature' | SM | Policy implemeneted, staff familiar with the policy and using it effectively.patients and carers understand what is their responsibility. | Policy signed off by end July 17.In use from August and review by Oct/Nov | All other choice policies are de commissioned | Design and print cost | |
| 8 | **Enhancing Health in Care Homes.** Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge. | Established | 1. Care home educator project - fully resourced across the system working with care homes to reduce admissions .2. community & primary care support to care hoes. 3 Dedicated intensive support to high referring hokes in place. 4. quality & safeguarding plans in plce to support care homes. | 1. Continue with Care Home Educators project - linked with JET and neighburhood teams. 2.Develop implementation plan and deliverables. | Sara RJ to complete | Care team recruited | Number of care home attendances and emergency admissions from care home reduced | Sara RJ to complete | Care Home business case | Sara RJ to complete | Sara RJ to complete |