STAFFORDSHIRE
HEALTH AND WELLBEING BOARD

Appendix C – High Impact Change Progress
HWBB BCF Update 06.09.18

Change	Maturity	Challenges	Milestones met during the quarter / Observed impact	Support needs
Early discharge planning	Established	To continue on the downwards trend delivered to date against plan	Continue to promote and challenge simple & timely (S&T) discharges from the Acute. Agreement between UHNM and MPFT re role of Track & Triage in challenging referrals to complex that should be S&T and to maximise services available alongside family support e.g. revival. T&T will continue to oversee coordination and tracking of discharge planning. Both S&T and complex discharges are monitored through MADE meetings/ calls - 3x times daily.	n/a
Systems to monitor patient flow	Established	Consistency and accuracy of reporting. Improving with the 3x times daily MADE information.	T&T continue to provide daily information to the system. Commissioners to continue to work with Burton to develop a T&T model which is expected to be operational during Q2.	Ongoing support will provide implementation support for identified opportunities to improve outcomes, reduce delays and improve flow at the point of discharge from hospital
Multi-disciplinary/multi-agency discharge teams	Established	To ensure a co-ordinated approach and to deliver 7 day cover with Exemplar Front Door	Continue to maximise the Exemplar Front door Model at Royal Stoke University Hospital .	Further develop multidisciplinary decision making in hospital to achieve more independent outcomes for people at the point of discharge.
Home first/discharge to assess	Established	To ensure capacity in in place in line with commissioned levels To ensure flow is in line with the modelled assumptions To ensure local agreements in relation to assessment timeframes are implemented	Home First service and beds are now commissioned in full by the CCGs in line with modelling.. D2A in the South is now operational, however there are some challenges regarding Home First and D2A to spot purchase bed capacity. The implementation of D2A in Burton is progressing and expected to be operational during Q2.	Methodological support to understand patient flow and if necessary remodel D2A capacity Implementation support for large scale DTOC counting methodology Resolve residual issues with DTOC counting
Seven-day service	Established	Management of change requirements for services that are	Range of services currently available 7 days per week: hospital social work team, enablement services, Intermediate care referral line,	n/a

		not 7 days per week. Any required investment.	Intermediate care and home-based community services such as district nursing Domiciliary Care is available 7 days per week. • Fast track end of life home care services recently commissioned, based on 7 day service. Plans being developed to move towards a fully functioning CHC/ ADAM services 7 days per week to support discharges over the weekend	
Trusted assessors	Plans in place	To ensure care homes have sufficient confidence and support to facilitate an effective trusted assessor scheme. Staffing resource to deliver assessments across the geographical footprint in a timely manner to support flow.	Trusted Assessor is utilised across the directly commissioned care home beds under the D2A model. There has been positive feedback from a number of homes, however there is concern that it is not always possible for the assessment to be completed by a clinical member of of staff which is an issue in terms of homes accepting patients against their CQC registration. Monthly reports are now established and circulated to monitor performance and impact the scheme.	n/a
Focus on choice	Established	Consistency and willingness of partners to fully embed the principles of the Choice Policy at all stages including point of admission.	Choice policy launched and operational. An audit in terms of use and impact would be required and expected to commence during Q2.	n/a
Enhancing health in care homes	Established	Number of homes rated as inadequate or requiring improvement. Change of culture regarding the management of frailty in care homes. Care Homes are not established to provide a 7 day service resulting in patients waiting in acute beds over weekends.	CCGs commissioned a wraparound support for the most challenged 28 nursing and residential homes with rapid response to prevent non elective admissions and A&E attendances.	n/a