Appendix 2

B&NES Council and BaNES CCG Better Care Fund Delayed Transfers of Care Action Plan
"Everyone's Issue"
2016-2017

Introduction:

This plan has been developed using feedback from the Home for Christmas Review (29 January 2016) and also from the High Impact Change Model feedback from the RUH and Sirona in December 2015. The High Impact Change Model was developed by the LGA, TDA, ADASS, Monitor, NHSE and Department of Health and sets out a number of high impact changes that can reduce the likelihood of Delayed Transfers of Care (eg 7 days a week services, capacity modelling for example) . B&NES Council was asked to submit an assessment of status against each category in December. This took place with feedback from Sirona and the RUH.

The plan carries the title "Everyone's Issue" which reflects the view of colleagues across health, social care, providers and voluntary sector colleagues who attended the Home for Christmas Review event in

Reference	High Impact Change/Local Target	Issue Reported	Actions to take	By when	Lead organisation	Outcomes expected - how will we know it has been successful?	RAG status	Comments
	Ensure governance and monitoring in place for DTOC plan	BCF requires trajectory and governance in place	Set out governance arrangements and sign off with key partners.	Mar-16	BaNES CCG and B&NES Council	Clear governance in place		
			Set and sign off formal trajectory reported within BCF, plus local trajectories at acute and community level	Apr-16	BaNES CCG and B&NES Council	Visible trajectory with clear monitoring and reporting in place		
			Agree local forum which will lead delivery and monitoring of operational changes. Proposed to be System Flow subgroup of SRG.	Mar-16	BaNES CCG and B&NES Council	Clear monitoring of operational changes taking place		
	Recording and baseline data	Are DTOCS being fully recorded? Domiciliary care delays can be outside hospital settings	Ensure formal DTOC definitions are used across both RUH and Sirona with consistency.	Mar-16	RUH, Sirona and AWP	The health and social care economy will be clear on the numbers of DTOCs each week and where to focus efforts		
			Ensure NHSE 3 step ready for transfer used	Mar-16	RUH, Sirona and AWP	One definition of patients ready for discharge will be used across the system.		
			Develop sub-set of reports focusing on domiciliary care delays and care home delays (the 2 most common delays)	Mar-16	BaNES CCG	Better visibility each week of the scale of domiciliary care capacity available.		
			Confirm SRG support to collect and monitor data on patients who are "Ready for Transfer" for whom immediate transfer is not possible and where they have not yet been formally coded as a Delayed Transfer of Care	Mar-16	SRG			
	Capacity - modelling capacity required	Bottlenecks regularly occur and capacity is not always flexible - ie there is not always opportunity to increase capacity at peak times at short notice.	Undertake review of demand and capacity for key pathways and develop analysis of demand. To include audit of from when patients become ready for transfer to when they are discharged	May-16	BaNES CCG and B&NES Council, RUH, Sirona and AWP	There is better understanding across the system of the capacity required and how to address this as demand increases.		
	Domiciliary Care Capacity	Lack of domiciliary care capacity - up to 75-85 requests at any one time	Uplift fees for 4 strategic providers to ensure funding for National Living Wage	Jan-16	B&NES Council	Increased numbers of carers employed and capacity grows		Uplift implemented Jan 2015
			Hold joint B&NES/Somerset/CCG/NHSE domiciliary care summit	21-Apr-16	BaNES CCG	A set of tangible outcomes and actions will be in place to address the development of domiciliary care capacity and services provided.		Event in diary for 21 April 2016
			Develop rapid out of hospital domiciliary care offer to bridge capacity gaps and facilitate rapid discharge.	*Jun-16*	B&NES Council	Extra block capacity will be in place to facilitate hospital discharges and carry out assessments within the patients' own homes with an expected stabilisation and recovery taking place in the first 4 weeks before assessment of ongoing need is compled.		
			Agree plan to address "over prescribing" of care in hospital and community and capacity to reassess promptly to release care back into the system.	Sep-16	B&NES Council and Sirona	Risks will be managed appropriately and care will be in proportion to assessed risks. Care will then be reassessed promptly to ensure that it is made available again as soon as possible.		
			Plan and agree minimum levels of dom care capacity availability at times of high pressure	Jul-16	B&NES Council	A capacity model for domiciliary care during winter pressures is agreed and plans in place with providers to deliver this care.		
			Review opportunities for Extra Care Sheltered Housing to become hubs and outreach with care/response options	Oct-16	B&NES Council	All options for maximising care are explored.		
			Agree workforce development plan with domiciliary care providers	Sep-16	B&NES Council			
	Reablement Capacity	Reablement beds in place but strategic direction and impact unclear. Community reablement service under pressure and reviewed as part of the Adult Services Review and recommendations due end of March 2016	Implement recommendations within Adult Services Review	Dec-16	B&NES Council and Sirona	The pathway and offer will be clear. The definition of reablement will be clear, with the expected outcome that capacity will be directed at those most able to benefit from the reablement offer.		
			Consider option of including telecare as an assessment tool during reablement and discharge to assess pathway	Apr-16	B&NES Council	Technology will become a common feature of assessment, tested during this pathway so that ongoing needs can be accurately assessed and met.		
			Review the availability and nature of reablement care bed base to ensure the system can flex to meet the right type and level of demand and ensure open to all parts of the system including ambulance service	Sep-16	B&NES Council, BaNES CCG and Sirona	Expectations around the nature and type of bed availability are set out and beds commissioned as appropriate.		
	Offering multi disciplinary and multi-agency assessment within a hospital setting and facilitating discharge outside the hospital setting	The IDS service is becoming established within the RUH. There are several options, including Discharge to Assess, Facilitating Hospital Discharge (domiciliary care) and Home from Hospital (Age Uk). Despite these services, access to urgent domiciliary care upon discharge is still a gap.	Other service options for discharge pathways need to be explored alongside discharge to assess to ensure we maximise all opportunities. See also Facilitating Hospital Discharge scheme above.	Sep-16				
			Further develop metrics to show benefits of Discharge to Assess, Facilitating Hospital Discharge (eg set timeframe for patient discharge from referrral)	Jul-16				
		Further development of Integrated Discharge Service (IDS)	Co-location taking place in March. Operational processes to be developed from April 2016 IDS Project Group re-established	May-16	RUH and Sirona			

	7 days a week services	Care homes do not accept admissions at weekends and can take several days to assess patients.	Work in partnership with care homes to identify those willing to admit at weekends, identify issues from their perspective and develop a plan in response to these issues	Jul-16	B&NES Council	A list of care homes willing to admit at weekends is available and the views of care homes are understood with plans in place to meet their concerns		
			Work with care homes to establish reasonable time frames for assessment (eg within 48 hours)	Jul-16	B&NES Council	Care homes understand the need to assess promptly and this has been expressed formally by commissioners.		
		The CRC reablement beds do not accept admissions at weekends	Work with Sirona to identify how DLNs could support admissions to CRCs	Jun-16	Sirona	Weekend admissions from the RUH to the CRC reablement beds are possible.		
		Domiciliary care providers and reablement do not accept new cases at weekends	Clarify expectations with providers	Apr-16	B&NES Council	Weekend discharges to domiciliary care providers and reablement takes place.		
		There is a reluctance to take admissions by care providers due to concerns about key support at the weekend (eg meds, equipment delivery, medical cover etc)	Understand concerns from care providers about taking admissions at weekends and develop a plan to respond to these (eg medication, equipment delivery)	Jun-16	B&NES Council	Concerns are understood, a plan is in place and weekend discharges become more common.		
		The Trusted Assessor role is under development but could be used more effectively to support assessments and discharge planning	Single referral form now designed for RUH. Continue to develop Trusted Assessor role, identification of best pathway for patient and who should assess. To include social care assessments.	Sep-16	RUH and Sirona	A core assessment can be undertaken by a number of different professionals and colleagues accept and trust each other's assessment. Capacity over a 7 day period is maximised and flow continues.		
		The Trusted Assessor role is not accepted currently by external providers due to concerns about CQC requirements to ensure homes can fully meet needs.	Open dialogue with care providers about the trusted assessor role and whether this could be explored further with care home providers	Aug-16	B&NES Council			
	Escalation of Delays and use of Choice Protocol	Lack of clarity about where to escalate problems with discharge that cannot be solved at operational levels.	Amendment to Standard Operating Procedure for IDS so that issues are escalated to a Director in the first instance for pts at the RUH. Similar procedure required for both Community Hospital and community patients. Time frame for escalation needs to be agreed.	Mar-16	RUH, Sirona and AWP			
			Introduce NHSE recommended 7 day Stranded Patient Metric within RUH, Community Hospitals and community services	Aug-16	RUH Sirona and AWP	Stranded patients identified and escalation plans put in place to minimise further delays and ensure patients are supported to be discharged as soon as possible.		
			Agree trigger metrics for stranded patients	Aug-16	RUH,Sirona and AWP	all partners are clear when a patient is considered to be stranded and a clear escalation process is used.		
			Develop proposals to support self-funders with timely information and advice.	Jul-16	B& NES Council	There is clarity about the offer for self funders and who will manage this process.		
			Ensure cross CCG agreeements are in place to deal with complex over border discharges	Jul-16	BaNES CCG	A clear process is in place for complex over the border discharges so that the process for agreeing arrangements is smooth.		
		Consistency in usage of Choice directive - is implementation of the policy clearly in place and is it robustly followed?	Develop supporting difficult conversation with families pack and training for staff	Jun-16	System Flow SRG Sub-group?	Use of the policy is standard and staff feel supported to manage difficult conversations		
			Take up training offered by Wilts on Choice policy	May-16	RUH, Sirona and AWP	Training and implementation of Choice policy continues, even whilst waiting for national guidance.		
			Complete revision of Choice policies following publication of national guidance	TBC	RUH , Sirona and AWP	Policy is updated with national guidelines and good practice.		
	Enhancing Health in Care Homes	Develop plans for a falls response service	See left	May-16	Falls Strategy Group	A response service is in place which enables older people in care homes to have their fall assessed and treated where appropriate in their care home setting.		