Better Care Fund Template Q2 2017/18

4. High Impact Change Model

Selected Health and Well Being Board: Bury

		Maturity assessment			Narrative			
		Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	Early discharge planning	Plans in place				• In hospital proactivity varies from ward to ward • Currently unclear if GPs or District Nurses etc. are consistently involved in discharge planning and at what stage	• The Bury Locality Plan includes plans for the development of Integrated Neighbourhood Teams. These Teams will support early discharge planning for elective admissions with primary and community health and social care involvement • Reablement Team is involved in discharge planning for their clients – case remains open where admission is short term • 'Bridging the gap' service planned as part of Home First model to provide domiciliary support prior to package of care commencing to reduce discharge delays due to wait for package of care to commence	• Consider potential value of social work input in A&E and Medical Assessment Unit as part of wider Home First developments
Chg 2	Systems to monitor patient flow	Established				• System wide analysis has not been undertaken • Further gap analysis is being planned in relation to EMI / EMD beds and patient flow • Opportunities for greater flexibility [e.g. in workforce deployment] to form part of Home First design • Implement electronic patient flow tool to provide real time updates on patients who are medically optimised and awaiting transfer [MOAT]	• Some 'informal' gap analysis has been done which has informed commissioning decisions e.g. to increase IMC bed capacity at Bealey Community Hospital and Reablement. • There is awareness of where current capacity limitations e.g. in relation to EMD / EMI beds and discharge to assess beds for CHC • Commission dedicated discharge to assess beds to support patient • BCF funding is being used to sustain increased capacity in IMC beds in Bealey Community Hospital and Reablement • Escalation beds available and deployed at FGH when required • Senior clinical decision makers and IDT staff routinely involved through daily 'board rounds' on each ward at FGH to support identification of patients who are fit for discharge and discharge planning	• Further work needed to assess current level of gap in capacity in EMI / EMD beds • Understanding of bottlenecks to inform design and development of Home First model as part of Bury Locality Plan • Point of Prevalence work underway on FGH wards to understand blocks and raise staff awareness
Chg 3	Multi-disciplinary/multi-agency discharge teams	Mature			• Co-located team but not fully integrated, however MDT across nursing and social work are working effectively.	• Cross boundary working needs to be established. • Implement new Discharge Policy • Align Bury and HMR policies for social work assessment • No current Voluntary Community Sector involvement	• Integrated [NHS and Adult Social Care] Discharge Teams in place at FGH & NMGH sites • New discharge policy for PAHT sites completed • Staff training on different area systems	• Different funding arrangements and criteria in different boroughs • Different IT systems • Staff training on different area systems
Chg 4	Home first/discharge to assess	Plans in place				• Responsiveness of care homes variable • Where provision is commissioned need to explore options for introducing maximum timeline standards for assessments • Although additional capacity has been put into in Reablement it is still a limiting factor	• Integrated discharge Teams are in place at the two main hospital sites, this includes single line management by Pennine Acute and includes Bury Social Workers. • Models for intermediate care and integrated discharge have been developed. • Commissioning arrangements in place to support additional community capacity as part of the implementation of Discharge to Assess, residents are to be offered transitional placements to enable patients and their families to contribute to a comprehensive assessment and avoid unnecessary stays in acute setting whilst waiting for a provider of choice. • Care at home retender and new model implemented. • Single point of access for bed based IMC.	• None required at This time
Chg 5	Seven-day service	Established				• This is a reduce service at weekends: 1 nurse and 1 SW each day at FGH, need to look at expanding to NMGH • Integration of IMC and domiciliary reablement teams with ability to take planned discharges 7 days a week	• Discharge Liaison Nurse input to IDT not currently in place at the weekends but support provided at weekends by Transfer of Care Nurses • Negotiations currently underway around new contracts and rotas for SW staff • If a patient in receipt of a package of care has been admitted to hospital for less than 24hrs the package of care will recommence if the patient is discharged at the weekend [no need for re-referral] • Planned discharges to IMC beds can happen 7 days a week	• None required at This time
Chg 6	Trusted assessors	Plans in place				• Cross-boundary working and mitigating through the union aspects of this. Training staff in multiple different systems. • Limiting factors: different funding arrangements and criteria in different boroughs and different IT systems	• Agreed common 'Passport' to support discharge to IMC in place	• Staff currently being trained in each others systems • Implement cross borough Trusted Assessor approach incorporating Oldham and Manchester with Oldham and Manchester SW staff part of FGH IDT
Chg 7	Focus on choice	Plans in place				• Implement new PAHT discharge policy including staff briefing • Ratification of GM policy by GM Health & Social care Partnership Board • Development of Trust / Site implementation plan • Development of new information for parents / families • Staff dissemination & training • Implementation of Integrated Neighbourhood Teams as part of Home First Model to support pre [planned] admission discharge planning & discharge following emergency admissions. VCS will form part of Integrated Neighbourhood Team model	• Advice and information leaflets in place and being used at FGH • Ward staff and Integrated Discharge Team liaise proactively with patients and relatives	• None required at This time
Chg 8	Enhancing health in care homes	Established				• CCG to consider supporting use of the Nursing and Residential Home Triage Tool (NaRT) in identified care homes as part of a NWAS pilot	• The CCG and adult social care commissioners working closely with care providers to monitor the quality of provision through a robust Quality Assurance process. • Well established Residential Care Provider Forum and initiatives in place providing enhanced health care in homes, NHS 'React to Red' toolkit to proactively reduce pressure ulcers. Falls and physical activity training. • Common approach to communicating bed availability to Integrated Discharge Teams and patients and their families. • The triage tool has been designed to support Nursing and Residential Home staff in making the most appropriate decision when seeking clinical assistance for their residents. The pilot of this project was initiated approximately twelve months ago, when the tool was introduced to the most high intensity users of NWAS. Following this introduction, call volume from each of the identified Nursing and Residential Homes was	• The lead for NHS England Nursing has been informed of the development of the triage tool and is keen that the Trust works collaboratively with care homes and residential homes to assist staff with decision making during acute episodes. As such, the tool is now being offered to as many care homes as possible across the North West. The overall aim of the development and implementation of the triage tool is to reduce the amount of inappropriate 999 calls and subsequent admissions to hospital.

Hospital Transfer Protocol (or the Red Bag Scheme)

Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q2 17/18 (Current)	Q3 17/18 (Planned)	Q4 17/18 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care	Challenges	Achievements / Impact	Support needs
UEC	Red Bag scheme	Plans in place				• There is already a Red Bag Scheme in place which refers to the dissolvable Red alginate bags for the washing of contaminated ben linen and clothing so the language used could be	• Working on a communication to be circulated to providers which will be refreshed at the next Residential Care Provider Forum • All LD service providers have adopted	• None required at This time