High Impact Change model Action planning template – East Surrey

Impact change	Where are you now? - Plans in place - Established - Mature	What do you need to do?	When will it be done by?	How will you know it has been successful?
1. Early Discharge Planning	Established	Build on system resilience and planning with focus on integration. Frailty unit in place.	On-going	Development of dashboard measuring key objectives. Focusing on maximising potential referrals and outputs.
		Development of a discharge to assess patient pathway with Surrey County Council and Surrey Downs CHC teams involved to be developed, effectively communicated and implemented.	August -September 2017	Timely continuity of care throughout the pathway.
		Working towards the 24/7 community care model	Oct-17	Increase community capability to take more sub-acute patients to the community.
		Community teams in reach to highlight patients earlier in their stay and proactive manage their	Oct-17	A reduction in the Delay Transfer of Care (DToC).
		Implementation of the 'Let's get you home' programme to reflect community pathways and CCG capacity plans.	Within 12 months	The implementation of the programme will help patients avoid long stays in hospitals and normalise timely and effective discharge.
2. Systems to monitor patients flow	Plans in place: Updating systems and implementation plans	Standardise and complete implementation of system overview, resilience and escalation.	On-going	Working on the development of the automated update on SHREWED – currently manually operated.
		Access to information portal 'CUBE' regarding patient information.	On-going	This will contribute to setting up processes to improve patient flow.
		A robust process has already taken place to map out system wide patient flow with the intention to support discharge from hospital and better understand when bottlenecks still occur.	Complete	CCG will have automated process for assessing patient flow.
		Working closely with partners to ensure that information on Directory of Services (DOS) is accurate and that it best supports the flow of patients to alternative community pathways where appropriate.	On-going	Local access to the DoS and a process to increase the number of services profile on the DoS. View the shift of activity through changes on patients' mapping.
3. Multi-disciplinary multi-agency discharge teams (including voluntary and community sector)	Established/Mature: Joint NHS and ASC discharge team in place. Daily MDT attended by ASC, voluntary sector and community health. Discharge to assess arrangements are in place with care sector and community health providers An increasing number of CHC and complex assessments are done outside hospital in people's homes/extra care or reablement beds	Develop IT systems for inoperability. Embed Continuing Health Care in a local system of multi-disciplinary support. Embed CHC within local pooled budget arrangements.	Within 12 months	Complex assessments routinely take place out of the hospital vis trusted assessors and single shared care record; Discharge Co-ordinators will be fully integrated, improved use of the Integrated Reablement Unit and Frailty pathways.
		IDT in place	Complete	A reduction in (DToC).
		Implementation of early supported discharge for stroke.	Nov-17	Appropriate stroke patients are discharged into the early support team in the community with all
		Enhanced Community Neuro Rehabilitation Team (CNRT) will be in place from October 2017 with	Oct-17	To support patients with MND and other complex rare neurological conditions to receive care in the
4. Home First Discharge to Assess	Established: People usually return home with reablement support for assessment. People usually only enter a care/nursing home when their needs cannot be met through care at home. Care homes assess people usually within 48 hours	Continue the integration agenda for ASC reablement and community health rehabilitation and rapid response. Secure dedicated home based care support for East Surrey Hospital Social Work Team. There is a challenge in some parts of the area to achieve timely care home assessments. There is a Countywide project being initiated with providers to target this, as it is a challenge across Surrey area.	Within 12 months Within 3 months On-going	All individuals return home for assessment; senior decision makers available and flexible to meet demands; reduction in number of patients medically fit. Models of additional capacity provided by community hospitals or care homes for (step up/Down) in place.

5. Seven Day Services	Established/Mature: Health and social care teams providing seven day working. Social Care operate an 8am – 8pm service, 7 days a week. Staff ask and expect care providers to assess at weekends. Whole system commitment usually enabling care to restart within 24 hours, seven days a week	Engaged with 7 day services – development in acute services. Improved access to a local CHC pathway offering 7 day response. Reduce delays in DST process.	Within 12 months	Continue to develop the voluntary sector response to 7 day working.
		Investing in additional community capacity and capability to deliver 7 day services to patients.	On-going	A reduction in (DToC).
6. Trusted Assessors	Plans in place: Plan for training of health and social care staff. One assessment form/system being discussed	There are trusted assessments between partners, but not trusted assessors yet. Work is being undertaken to enable community providers to deliver assessments.	Within 12 months	Integrated assessment teams, working within pooled budget arrangements, including resources for CHC. No duplication of assessment processes, and timely responses. Community providers are equipped and authorised to act as Trusted Assessors.
		Working with mental health provider to develop trusted assessors on psychiatric liaison model.	Within 12 months	A single process will be in place for mental health assessment and it will be accepted by both
7. Focus on choice	Mature: Patients and relatives aware that they need to decide about discharge quickly Choice protocol used proactively to challenge people. Voluntary sector provision integrated in discharge teams to support people home from hospital	Continue to enhance good practice in this area.	On-going	Patients and Carers are informed and empowered. They know how systems work across health and social care. They can access and understand the information and advice available to them. Voluntary sector provision has expanded and grown – offering pre and post admission support, providing continuity of care along the patient pathway.
8. Enhancing health in care homes	Mature: Community and primary care support provided to care homes on request. Dedicated intensive support to high referring homes in place. Quality and safeguarding plans in place to support care homes	Admissions into hospital from care homes are managed well in East Surrey. Continue joint education and joint quality assurance approach with local care home market.	Within 12 months	No variation in admissions from care homes at weekends; CQC ratings for care homes reflect as good quality.

High Impact Change model Action planning template – Guildford and Waverley (Summary)

High Impact Change	Tasks	Completion Date
1 - Early Discharge Planning		
	Integrated multidisciplinary discharge team with a wide knowledge of resource available to assist with ensuring safe and appropriate discharges for patient from hospital to community.	Mar-18
	Discharge will be planned from the time of admission and patients will be given the expected date of discharge within 48hrs of admission. This can be done in conjunction with any community key worker.	Mar-18
	Non elective emergency admissions requires active discharge planning with an identified realistic date of discharge and includes first contact with discharge planning.	Mar-18
	Pre operative and elective admission assessment should identify all discharge risk factors prior to admission and robustly plan for discharge with patients prior to admission.	Mar-18
	Embed a consistent approach to discharge planning across the acute and community hospitals.	Jun-18
2 - Systems to Monitor Patient Flow		
	Robust patient flow models to optimise capacity and flow to ensure quality measure including emergency readmissions into hospital 28 days following discharge and proportion of older people who are still at home 91 days after discharge after hospital into reablement and rehabilitation services. The efficiency models include average LOS, DTOC, increase occupancy levels in community hospitals and reduction in excess bed days.	Mar-18
	Electronic patient flow information systems to allow robust whole system capacity and flow and surge monitoring and planning.	Mar-18
	Complex discharges to identify high risk delayed patients who require systematic discharge planning to0 include all aspects of legal social and medical assessment.	Mar-18
	Collaborative patient pathway to be developed to allow patients to flow from acute to community services.	Mar-18

3 - Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector		
	MDT to coordinate discharge planning with joint assessment processes and protocols.	Mar-18
	Improve utilisation of the third sector across the system.	Mar-18
	Identify Vulnerable Adults at point of admission to reduce readmissions and risk compliance	Mar-18
	CHC assessment models to be considered	Mar-18
	Agree Discharge models to be integrated across whole system to include documentation and access to records	Mar-18
	Nurse Led Discharge Models	Mar-18
4 - Home First/Discharge to Assess		
	Improve the efficiency and utilisation of the D2A models that currently exist.	Mar-18
	Scoping for the provision of non hospital bed stock for placing sub acute patients outside of the acute trust.	Mar-18
	Review of all current assessments and identify options for home based services.	Mar-18
5 - Seven Day Service		
	7DS across health and social care including community integrated teams and rapid response services.	Mar-18
	Improve communication between out of hours and crisis support.	Mar-18
	Procurement of private and independent providers	Mar-18
6 - Trusted Assessors		
	Trusted assessment from the acute hospital to care homes for early supported discharge and improve communication.	Mar-18
	Utilisation of assessment documentation across the whole system, to ensure safe communication and patient experience.	Mar-18
7 - Focus on choice		
	Early engagement with patients to ensure patient led discharge planning.	Mar-18
	Ensure Carers assessment during admission and pre assessment is optimised.	Mar-18
8 - Enhanced health in care homes		
	Enhancing services within care home to ensure the wellbeing of their residence and the reduction in unnecessary admissions.	Mar-18

High Impact Change model Action planning template – Guildford and Waverley (Detailed plan)

System Discharge Action Plan 17-18

Task & Sub-task	Task Description	Organisational Owner	Lead	Intended Outcome	Completion Date	Measures of success	Progress report to LAEDB by stream lead: Q1 June - 17	Q2 September - 17	Q3 December - 17	Q4 March - 17
High Impact Change 1: Early discharge Planning **- In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place for management and place for management and discharge and to allow an expected date of discharge to be set within 48 hours.**										
Lead: RSCH										
1.1	Integrated multidisciplinary discharge team with a wide knowledge of resource available to assist with ensuring safe and appropriate discharges for patient from hospital to community.	VCL/RSCH/ASC	Wendy Newnham/ Tina Hetherington	Review Community Matron and District Nurse involvement in MDTs at RSCH, Trial with ward TBC (Bramshott/Ewhurst/Eashing)	Mar-18	Sustained joint working as a single team by the various services				
			Wendy Hale/Brian Mayers	Increased Social Services input to Community Hospital ward MDTs including Hants and West Sussex Consider DST to navigate out of area ASC services	Mar-18	Evidence of increased social services presence to CH Ward MDTs				
1.2	Discharge will be planned from the time of admission and patients will be given the expected date of discharge within 48hrs of admission. This can be done in conjunction with any community key worker.	VCL/RSCH	Tina Hetherington / Wendy Newnham	Key worker with PCS and other community services needs to be alerted on admission of their patients	Mar-18	Increased percentage of key workers being notified of admission of their patient				
			Tina Hetherington / Helen Wilson / Nick Sands	Role out safer bundles and EDDs across the trust.	Mar-18	Weekend discharge numbers will increase Reduction in the stranded patient metric % of patients discharged before 12 midday will increase				
			Wendy Newnham/Verity Pearce	Community hospital to also implement SAFER bundles for their patients and to have an agreed EDD at point of admission to support patient flow.	Mar-18	Increased percentage of patients who have an agreed EDD set.				

	1.3	Non elective emergency admissions requires active discharge planning with an identified realistic date of discharge and includes first contact with discharge planning.	VCL/ASC	Brian Mayers/Wendy Newnham/Ben Hill	Refocus the IDT at front door In reach GP and ASC to start EDD planning and include the Involvement of PCS prior to admission	Mar-18	Increased percentage of patients who have an agreed EDD set within 48hrs				
	1.4	Pre operative and elective admission assessment should identify all discharge risk factors prior to admission and robustly plan for discharge with patients prior to admission.	RSCH	Clare Tickner/Helen Wilson/Julie Burgess	Contact Orthopaedic CNS to review pathway for pre op discharge planning for total hip replacements patients.	Mar-18	Increased % of total hip replacement patients identified pre-operatively				
				Helen Wilson/Julie Burgess	Include other Pre-operative assessments including discharge planning prior to admissions and alerting key workers in the community.	Mar-18	Increased % of patients identified and have their discharge planned for pre-operatively				
	1.5	Embed a consistent approach to discharge planning across the acute and community hospitals.	RSCH/VCL/ASC/CCG	Clare Tickner/Tina Hetherington	Advanced discharge planning from the point of admission.	Mar-18	Consistent approach to discharge planning across the acute and community hospitals.				
				Nick Sands/Alison Pirfo	Whole system complex discharge meetings (MADE)	Jun-17	MADE completed				
	High Impact Change 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.**										
	Lead: G&W CCG										
	2.1	Robust patient flow models to optimise capacity and flow to ensure quality measure including emergency readmissions into hospital 28 days following discharge and proportion of older people who are still at home 91 days after discharge after hospital into reablement and rehabilitation services. The efficiency models include average LOS, DTOC, increase occupancy levels in community hospitals and reduction in excess	RSCH/VCL/ASC/CCG	David Howell, Ben Hill, Bob Peet and Jon Cranfield.	Develop effective use of current electronic systems, common understandings of data to present an overview of the system.	Mar-18	Improved information reports in place and a consistent and presented to the LAEDB				
				Clare Tickner	Daily meetings to discuss patients need to be more focussed with clear escalation pathways Use to highlight gaps in services.	Mar-18	Daily meetings in place, evidence of using escalation DST.				
	2.2	Electronic patient flow information systems to allow robust whole system capacity and flow and surge monitoring and planning.	LAEDB	Ben Hill/ Bob Peet/LAEDB	Implementation of complete system overview e.g. SHREWD/ Alamac. In interim investigate providers presenting reports on their own services performance to LAEDB.	Mar-18	System in place to monitor whole system performance with up to date information received from all providers				
				Clare Tickner/Nick Sands/Wendy Newnham/Wendy Hale/Ben Hill	Ensure a system wide understanding of the functionality and information medworxx gives us.	Mar-18	System understanding that Medworxx gives us CUR criteria.				
	2.3	Complex discharges to identify high risk delayed patients who require systematic discharge planning to0 include all aspects of legal social and medical assessment.	RSCH/VCL/ASC/CCG	Nick Sands/Alison Pirfo	Look at completing a system Multi Agency Discharge Event (MADE)	Mar-18	MADE completed and evidence of reduction in delays week following event, issues identified	MADE Completed			
				Clare Tickner	Review purpose of Monday's Complex Discharge Meeting and focus on stranded patients.	Mar-18	Meeting will reduce length of stay and therefore stranded patients				

				Wendy Hale	Ensure plans are in place to increase demand in health and social care provision during periods of surge demand.	Mar-18	Robust plans in place				
	2.4	Collaborative patient pathway to be developed to allow patients to flow from acute to community services.	RSCH/VCL/CCG	Ben Hill/Sarah Taylor-Smith/Clare Alexander	Clear referral pathways for respiratory services to optimise access of all services.	Mar-18	Clear referral pathways for respiratory care in place				
				Wendy Newnham/Sarah Taylor-Smith	Link in with the In Reach GPs doing their work on care home patients	Mar-18	Collaborative working between community matrons and In reach GPs				
				Wendy Newnham/Nick Sands/Ben Hill/Jane Williams	To define, scope, plan, implement and deliver a community IV service for specific and establish clear clinical pathways.	Mar-18	Patients with certain conditions reviewed and actions taken to address their delayed discharges				
	High Impact Change 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.**										
	Lead: ASC										
	3.1	MDT to coordinate discharge planning with joint assessment processes and protocols.	RSCH/VCL	RSCH therapist/Wendy Newnham/ John Coleman	Review Community Matron and District Nurse involvement in MDTs at RSCH	Mar-18	Increased involvement of Community Matron/District Nursing input into RSCH's MDTs				
				Brian Mayers	Follow up letter that has been sent to Sussex and Hampshire with latest figures to West Sussex explaining impact of their delays	Mar-18	Improved engagement from Sussex and Hampshire social care teams				
	3.2	Improve utilisation of the third sector across the system.	CCG	Brian Mayers/Wendy Hale	Improve involvement of Vol Orgs in process.	Mar-18	Increased involvement of voluntary organisations				
				Tina Hetherington/Clare Tickner/Ben Hill	Develop trusted assessment within Trust and with providers		Trusted Assessment process in place and reduction in care home assessment delays				
	3.3	Identify Vulnerable Adults at point of admission to reduce readmissions and risk compliance	CCG	Brian Mayers/Wendy Hale/Kim Harriott/Kathryn Fisher/Vanessa Brunning	Utilise whole system to include Mental health and LD services within Discharge planning	Mar-18	Mental Health and LD services integrated into all provider's discharge planning processes				
	3.4	CHC assessment models to be considered	CCG	Jane Williams/Ben Hill/Sara Barrington/Clare Tickner/Tina Hetherington	Explore non acute based CHC assessment model to ensure 85% of assessments are outside the acute hospital	Mar-18	Non acute based CHC assessment model piloted and long term model scoped				
	3.5	Agree Discharge models to be integrated across whole system to include documentation and access to records	RSCH/VCL/ASC/CCG	Brian Mayers	Discharge Group to explore patient held records (red bags)	Mar-18	Patient held records in place and utilised by care providers including the use of red bags				
	3.6	Nurse Led Discharge Models	RSCH	Clare Tickner/Tina Hetherington/Julie Burgess/Vicki Mumford	RSCH to explore Nurse and AHP Led discharge	Mar-18	Nurse led discharge piloted and long term model in place				
	VCL/ASC: High Impact Change 4: Home First/Discharge to Assess - **Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home that mean people no longer need to wait unnecessarily for assessment in hospital. In turn, this reduces delayed discharges and improves patient flow.**										
	Lead: VCL/ASC										

	4.1	Improve the efficiency and utilisation of the D2A models that currently exist.	RSCH/VCL	RSCH therapy lead/Wendy Newnham	Establish a working group to review the current D2A pathway then define scope, plan and implement a true D2A model	Mar-18	Increased CM/DN involvement in D2A pathway from both RSCH and CH Increased % of daily discharges before 12 midday Increased number of patients with EDD Increased number of patients discharged home for assessment				
				Wendy Newnham, Wendy Hale	To plan a launch and education events across the system to ensure understanding of the redefined service and what it delivers and to change attitudes/culture across all professions.	Mar-18	D2A working group in place and anecdotal impact of changing attitudes/cultures				
	4.2	Scoping for the provision of non hospital bed stock for placing sub acute patients outside of the acute trust.	CCG	Jane Williams/Ben Hill/Wendy Newnham	Scoping of sub acute beds within either Community hospitals or Care Home to provide sub acute care outside of the acute trust.	Mar-18	Models of additional capacity provided by community hospitals or care homes for (step up/Down) in place				
	4.3	Review of all current assessments and identify options for home based services.	CCG/VCL	Jane Williams/Wendy Newnham	Working closer together project between RR therapy and CRT scoping underway in VC	Mar-18	Improved integrated working between RR/ therapies, CRT				
	***High Impact Change 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 means that services are more responsive to people's needs.**										
	Lead: G&W CCG										
	5.1	7DS across health and social care including community integrated teams and rapid response services.	RSCH/VCL/CCG/SECAMB	Bob Peet	To review gaps within the acute trust in 7DS To include Snr and Jnr Dr cover, Pharmacy and therapies.	Mar-18	Improved integration between services to deliver a 7ds				
				CCG	Ensure 7DS including 5YFV, 111 OOH implementation of Core 24 and access to urgent care as integrated across the system.	Mar-18	Improved integration between services to deliver a 7ds				
	5.1.1	Improve communication between out of hours and crisis support.	CCG	Dan Lorusso/Ben Hill	EMIS Access for out of hours.	Mar-18	EMIS access in place for the GP OOH service				
	5.2	Procurement of private and independent providers	ASC/CCG	Brian Mayers	Procurement and commissioning of homes based care providers to facilitate discharges across the seven days.	Mar-18	Procurement completed of home based care providers enabling 7 day discharges to these services				
	***High Impact Change 6: Trusted Assessors* - Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times to that people can be discharged in a safe and timely way.**										
	Lead: RSCH										

	6.1	Trusted assessment from the acute hospital to care homes for early supported discharge and improve communication.	CCG/RSCH/VCL	Clare Tickner/CCG/Wendy Newnham	Scope implementing named Community matron for Care homes to support trusted assessment with process for re-assessing patient post discharge and support Red bag development	Mar-18	Care home trusted assessors in place who reassess patient post discharge				
	6.2	Utilisation of assessment documentation across the whole system, to ensure safe communication and patient experience.	RSCH/VCL/CCG	All	Establish the sharing of patietn records across the system (This may be part of the STP Digital Roadmap)	Mar-18	Shared care record in place				
				Wendy Newnham/ Carole Saunders/Lucy Wright/RSCH Urologist TBC	Produce and launch a G&W Catheter passport to ensure robust catheter management across the system	Mar-18	Catheter passport in place and standardised across all providers. A reduction in stranded patients having to access the wrong service to get help such as urgent care. Improved Patient Experience and outcomes.				
				Wendy Newnham/ Clare Tickner/ Abigail Groves/Jayne Holland	EoL ensure recognition referral into palliative services(SPICT). Utilisation of PACE plans and ReSPECT. Scope potential for establishing palliative beds within a nursing home with outreach support from PTH.	Mar-18	PACe plans utilised and effective EoLC in place to enable rapid 72 hour discharge and admission avoidance. Introduction of ReSPECT and SPICT tools				
	High Impact Change 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.**										
	Lead: RSCH/VCL/ASC										
	7.1	Early engagement with patients to ensure patient led discharge planning.	RSCH	Clare Tickner/Wendy Newnham/CCG/Liz Patroe	Draft pre admission leaflet and information being prepared need to ensure it is not specific to RSCH and can be used at all providers	Mar-18	System wide pre-admission leaflet in place and utilised across all providers				
				Wendy Hale	Increased involvement of voluntary sector across the system	Mar-18	Increased involvement of voluntary sector across the system				
				Wendy hale, Wendy Newnham, Tina Hetherington	Optimisation of the protocol of choice.	Mar-18	Protocol of choice utilised and running effectively.				
	7.2	Ensure Carers assessment during admission and pre assessment is optimised.	RSCH	Clare Tickner/ Debbie Hustings	Utilisation of carers passport during discharge planning.	Mar-18	Increased utilisation of carers passport to reduce discharge delays				

	***High Impact Change 8 Enhancing Health in Care Homes* - Offering people joined-up, coordinated 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 improving hospital discharge.**										
	Lead: VCL										
	8.1	Enhancing services within care home to ensure the wellbeing of their residence and the reduction in unnecessary admissions.	CCG/VCL	Ben Hill/Wendy Newnham	Additional Named Care Home community matron.	Mar-18	Additional care home matron in place				
				Ben Hill	Roll out of the Hydrate project acorss all care homes.	Mar-18	Hydrate project implemented and reduction in care home admissions/attendances from those care homes				
				Ben Hill	Implementation of the Care home Line through 111 as part of the UECFYFV.	Mar-18	Care home line implemented and reduction of Care home attendances and admissions				
				CCG	Scope and explore increasing the In Reach gP service to include increasing medical support for care homes.	Mar-18	Medical input in place and reduction of care home admissions and attendances				
				CCG	Care Home forum for Peer support.	Mar-18	Sharing of best practice at care home forum and reduction in variation between admission and attendance rates between care homes				
				Tracey Rowland	Care Home Falls prevention.	Mar-18	Reduction in care home attendances and admissions as a result of falls				

High Impact Change model Action planning template – North West Surrey

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Early discharge planning	Established	Build on existing whole system working, strengthening the role of primary care to embed practice within the community – this will be done through SOG sub-groups (representatives from across health and social care system) and locality network boards	Developing across area – Mature for Woking within 6 months, 12 months for SASSE and Thames Medical	Evidence that discussions are underway and having an impact. GP and DN led in the community via an integrated hub health and social care team
Systems to monitor patient flow	Established	Continued use of the robust electronic systems in place across the whole system, which gives the ICB (Integrated Care Bureau) oversight of flow and system partners to proactively identify trends and surges and respond flexibly shifting capacity when required	Ongoing seeking to achieve sustainable success within 12 month	A&E performance improvement and confidence in Mature criteria including no process failings and capacity always managing demand across the whole care pathway
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Established	Embed CHC and Discharge Co-ordinators within ICB; improve flexible system capacity for all pathways, building on the voluntary sector already embedded within the hub and ICB. Accelerate the pace of change within our DACs service (integrated RR and Reablement); Hub teams more fully integrated and operating across whole area	Within 6 months (12 months for community)	Complex assessments routinely take place out of the hospital vis trusted assessors and single shared care record; Discharge Co-ordinators will be fully integrated, improved use of pathway 3 beds within the system; delivery of integrated community offer across the whole area
Home First Discharge to Assess	Established	Increase capacity within DACs to be able to respond quickly and flexibly to provide wrap around care as soon as required to ensure flow through acute (workforce planning); accelerate pace of change around traditional community hospital offer; implementation of improvement plan with independent sector providers	Within 12 months	All individuals return home for assessment; senior decision makers available and flexible to meet demands; reduction in number of patients medically fit
Seven-day services	Established	Improve trusted assessor including for CHC; implementation of improvement plan with independent sector providers; embedding integrated rapid response and reablement responses. Build on existing forums across health and social care system to strengthen relationships and enhance trust	Within 4 months	Consider movement towards Mature criteria – monitoring delivery against plans through SOG sub-groups. Shifted dialogue with independent sector providers and increased responsiveness. Credibility within the acute trust that discharges happen seven days a week.
Trusted assessors	Plans in place	Embedding consistent use of trusted assessment including with independent providers. Move from transition to transformation with new community services provider.	Within 3 months	Integrated assessment teams committing joint pooled resources including CHC; improved acceptance with care providers. No duplication and timely responses.
Focus on choice	Mature	Continued use of protocol of choice which is fair and transparent, including the use of the voluntary sector within ICB to support individuals to explore their options	Ongoing Within 6 months	Informed, empowered users and carers, working in partnership with the voluntary sector and statutory agencies. All staff including in the community are confident; voluntary service provider offer is embedded within system responses (community and acute)
Enhancing health in care homes	Mature	Care Home Support team in place with health and social care oversight and joint forums. Continue education and work with care homes; further development and transformation of hubs; extending offer to 7 day a week; enhance practice of proactive work with CQC and sharing information across the system	Within 6 months	No variation in admissions from care homes at weekends; CQC ratings for care homes reflect as good quality

High Impact Change model Action planning template – North East Hampshire & Farnham

High Impact Change model Action planning template – Surrey Downs

High Impact Change	Where are you now	What do you need to do?	When will it be done?	How will you know it has been successful?
1. Early Discharge Plan	Established – Hospital Discharge Coordinators in place and Continuing Healthcare Discharge practitioners to support complex discharge. SRG	Build on whole system resilience and planning with a focus key priorities of integration and placed based care.	Mature working expected in 12 months	Evidence in minutes that plans are in place. Evidence that Community Hubs have a process supporting in reach where necessary and
2. Systems to Monitor Patient Flow	Mature – there are times and locations where bottlenecks still occur, but this is the exception. The SRG group monitors system flow and a weekly System Call takes place that enables early problem solving.	Support for IT technology to improve flow – increased communication and evaluation of SRG schemes and alignment to A&E delivery boards	On going supported by contractual levers expecting change to have been delivered in 18 months	Evidence that IT solutions are planned for and change management has occurred.
3. Multi-Disciplinary/Multi-Agency Discharge Teams	This is not the same in each Acute system, so it was felt that three acute systems were Mature, and two were Established. Epsom Hospital holds daily bed meetings and a weekly 7 day length of stay meeting and a monthly MDT frequent attenders meeting. All relevant stakeholders are invited	All three systems are mature: Embed Continuing Healthcare into the community hubs supported by social prescribing. Support community hospital flow to enable capacity	Within 12 months	Assessments are timely and occur in the right place. Integrated community care
4. Home First/Discharge to Access	Established – there is a particular challenge on timely care home assessments across the system. There is a project being initiated with providers to target this. Continuing Healthcare practitioners as part of the discharge teams established. D2A systems such as trusted assessors are being scoped out	Discharge to assess schemes live and inflight.	Within 6 months	Identified and activated stakeholders with improved patient outcomes

5. Seven-Day Service	**Established** – though with very mature examples, like Epsom Health & Care Alliance. Key issues are seven day access to homecare, and access to the same level of decision making as during the week.	Develop maturity to all aligned acute hospitals and community hubs. work with primary care and LA and community care to support consistent communication and engagement of services	Within 12 months	Communication and engagement plan activated with positive feedback. Community hubs fully aligned and integrated with acute sectors where necessary
6. Trusted Assessors	**Plans in place** – there are trusted assessments between partners, but not trusted assessors yet. Work being undertaken to enable	Independent sector (specifically care homes with nursing) to be activated and part of the discharge 'trusted assessor pathway.	Within 6 months	Timely response to complex discharge Process being utilised and evaluation planned
7. Focus on Choice	Mature – it was felt that this is consistent across the system	On going alignment and review of choice policy recognising the patient and carer experience and cascading lessons learnt.	On going reviewed in 6 months	Patient stories are used at Boards meetings, and fed into lessons learnt. Review and alignment of choice policies aligned to A&E boards
8. Enhancing Health in Care Homes	Established – admissions into hospital from care homes isn't managed equally across the system, but some areas, like East Surrey for example, are very mature. Surrey Downs have commissioned a Quality in Care resource in 16./17 which support proactive working to prevent quality decline and risk of admission	Quality in care homes team fully embedded and performance managed. Primary care and independent sector are fully engaged and informed on progress and lessons learnt.	Within 6 months	Independent sector relationship management improved with feedback. Patient / carer experience improved, increase in lower level safeguarding alerts

High Impact Change model Action planning template – Surrey Heath

The local Frimley Health & Care STP implementation of the 8 High Impact Change model for managing transfers of care is governed and monitored by the A&E Delivery Board. Local oversight and governance to monitor implementation will be the responsibility of the Local Joint Commissioning Group.

The model is based on a person-centred discharge model where patients and staff experience is regularly sought and feeds into a collaborative and integrated continuous improvement cycle. An individual and collective ownership of safe, effective discharge and onward journey which reflects "Home First" principles in all aspects of operational delivery. Information available to commissioners to inform future commissioning intentions. All aspects of the model support the End of Life Care commitment that patients die in their place of choice

1. Early Discharge Planning

- Full implementation across all wards of the SAFER bundle
- Develop a patient-centred discharge model and delivery structure that embraces all partners involved be developed, effectively communicated and implemented
- Create a team approach across all partners for effective implementation of the model
- Asset based conversations" and approach across both health and social care and voluntary sector.

2. Systems to Monitor Patient Flow

- Timely access to appropriate shared data, for example through Connected Care (see implementation plan)
- Intelligent, timely decision making by all teams to minimise barriers and delays

3. Multi-disciplinary Discharge Teams

- Ensuring appropriate teams are brought together and jointly work to operationalise the agreed discharge model
- To monitor and review the model in order to continuously improve

4. Home First / Discharge to Assess

- Based on the agreed model, ensuring sufficient range, flexibility and capacity within services to manage the needs of our patients
- Discharge to assess is implemented as agreed for more complex cohort of patients
- Strengthened joint commissioning arrangements of more flexible health and social care packages
- No delays in discharge for those who may require NHS CHC assessment
- Increased use of a range of Assistive Technology to support independent living.

5. 7 day services

- A gap analysis of all current services supporting discharge from hospital with an evaluation of what is needed and its affordability and sustainability.
- Exploring opportunities in innovative workforce deployment.

6. Trusted Assessor

- Development of an agreed trusted assessment process for one person or team to perform trusted assessment on behalf of multiple teams
- A recognised cohort of trusted assessors with a mandated remit to undertake on behalf of whole system

7. Focus on Choice

- A Choice policy which is based on best practice and is agreed system wide (including cross-organisational enforcement processes).
- Roll out and embed new policy and pathways at local level, raising awareness with both staff, patients and families.
- Matching hospital to home services with patient preferences, support needs and wishes.

8. Enhancing health in Care Homes

- A mapping of current provision and outcomes against the framework for Enhanced Health in Care Home (Sept 2016). For example:
  - A framework to address consistent shortfalls in current service delivery
  - More streamlined access to clinician via access to NHS 111 for Care Homes out of hours

Strategic success indicators

This delivery plan contributes significantly to the delivery of the joint health and wellbeing strategic goals for each of the STP partners. Maximising the opportunity for residents to receive support in their own homes and remaining as independent as possible for as long as possible. Improved performance against delivery of NHSE "Quick Guide" recommendations

Quantitative measures

- 17 out of every 20 NHS CHC assessments take place out of hospital (85%)
- Increase in out of hospital assessment where appropriate (% TBA within local delivery plan)
- 33% appropriate discharges happen before noon
- A rapid, „can do" approach, minimising avoidable delays in discharge from hospital. Safe discharge, including transport to home, within an agreed minimum period of time (TBA within local delivery plan)
- Increased % (TBA within local delivery plan) of same day and next day discharges
- Reduction in medically stable patients remaining in hospital (% reduction TBA within local delivery plan)
- Reduction in the overall number of DTOC across the System to the NHSE target of 3.5%. Localised plans to reduce 3 main areas of delays.
- Reduced LOS by an agreed target across the System (% TBA within local delivery plan)
- Improved performance against the 4 hour target as a System measure demonstrating improved patient experience and flow. 90% by Sept 17 and 95% by March 18.
- Increased numbers of patients discharged at weekends (% TBA within local delivery plan)
- Reduction in non-action wait days ("red" days) within the first 7 days of inpatient stay (% TBA within local delivery plan).
- Reduction in avoidable readmissions for the same or associated conditions within 30 days (% TBA within local delivery plan).
- Reductions in frequent attenders (% TBA in local delivery plan).

Qualitative indicators

- Services demonstrate a joined up Person Centred approach. Systems are in place to seek feedback from the person and family (as appropriate) that show evidence of inclusion in decision making about future care delivery.
- Increase participation by patients in feedback mechanisms and evidence that their views are actively followed through.
- Carers report that they have been part of decision making (as appropriate) and feel supported.
- Every appropriate member of staff in the acute environment is able to describe the simplified "Home First" pathway for discharging patients , including who to contact and when.
- Increased patient understanding of, and confidence in, their choices and the options available to them.

Key success measures

- Reduction in permanent Care Home placements (% TBA within local delivery plans)
- Increased Home First transfers of care (% TBA within local delivery plans)
- Regular reviews and responsive plans to meet the ongoing / changing needs and maintain care and support at home (including Care Home environments).

This page is intentionally left blank