High Impact Changes Plan

Impact Change	Where are you now?	What do you need to do?	When will it be done by?	How will you know if it has been successful?	**Input of BCF investments**
Early discharge planning	Considerable work has gone into discharge planning between partners, with efforts made to ensure that all patients have an expected discharge date (EDD) set within 48 hours, or that patients are transferred to community provision early on in stay or straight from ED.	Setting of EDDs which help map out discharge plan has high compliance with 48 hour standard, but more work is planned at KCH to increase yet further. GSTT have 99% compliance, but both Trusts have work to do to ensure that Clinical Utilisation Review systems are fully in place so that EDD compliance can be monitored Further work also needs to be done across the system to ensure robust processes are in place for early discharge of elective patients.	Rollout of CUR is underway at KCH but full benefits will not be realised until end of March 2018. GSTT are currently reviewing options for similar system.	All patients have an EDD within 48 hours Monitoring of EDDs is systematically undertaken using the 'Red and Green Day' approach Elective patients who are likely to need social/community care support have provisional discharge plans in place prior to admission.	Although the focus of this work is on clinical systems in hospitals, the BCF indirectly supports the objectives of early discharge planning through extensive investments in hospital discharge related services (£5.456m) and enhanced community health care services (£3.9m). The iBCF is focussed on supporting provision of home and nursing care sufficiency which enables earlier discharge.
System to monitor patient flow	Organisations work flexibly to ensure that staff and capacity is flexed as far as possible during peaks in activity. Whilst individual services	Consideration needs to be given to having improved data flows between organisations to strengthen demand and capacity planning.	The SE London Surge Hub is currently reviewing options for improved data feeds and predictive tools – such as those	Data sharing arrangements in place which support development of whole system demand and capacity planning tool	This is not directly relevant to the BCF investment plan. However data sharing plans are a key enabler of integration and the council systems are being linked to the local care record.

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	undertake demand and capacity modelling, this is not yet done as a whole system.		used in East Kent – with a funding application likely to follow. Unlikely to be in place prior to 18/19 given complexity of the system.		
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Excellent joint working is in place, with hospital based social workers from each borough attending MDTs. Voluntary sector services are not systematically included within MDTs but attend where appropriate and are embedded within discharge planning pathways	Single Universal Assessment and Referral Form is shortly to be piloted with the aim of there being one form for hospital based staff to complete when referring to the majority of community/social care teams.	Form due to be piloted in Q1 with roll-out thereafter if successful.	Form is now used as default referral form, enabling all hospital, community and social care teams to be using same criteria and documentation.	The BCF provides extensive investments in hospital discharge related services (£5.5) and enhanced community health care services (£3.9m) and voluntary sector services (£0.9m). The overall Integration and BCF plan is predicated on enhanced MDT working around local care networks.
Home First Discharge to Assess	Whilst people are still often assessed for ongoing care whilst on acute wards, a number of Discharge to	A CHC Discharge to Assess Board for Lambeth and Southwark has been established with the ambition to move CHC and complex	Outputs of CHC group intended to impact by March 2018. Reablement teams moving to	Achievement of 90% of patients who are suitable to receive CHC assessments outside of hospital.	The BCF provides investment for the intermediate care, reablement and community health teams that will support the discharge to assess model.

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	Assess arrangements are operational across Lambeth and Southwark, including for example Enhanced Rapid Response teams (will support patients home from hospital with bridging care, and has social workers embedded within the team to complete SW assessments outside of the hospital) and local authority commissioned Discharge to Assess 'step down' flats	assessments out of the hospital and into a more appropriate setting closer to home. Work is ongoing to establish joint Reablement teams across health and social care in Lambeth and Southwark with the GSTT Community service team	new arrangements in Q1 2017/18	Implementation of new model of reablement services is in place.	Reconfiguration of these services within the BCF, including the development of more accommodation based step down provision.
Seven-day services	Core 7 day services in place, with social care presence on site at acute Trusts across the weekend, and community able to accept new	Adult Social Care have a 7 day presence in both acute hospitals, however not all hospital teams/community services operate 7 days which can limit discharge profiles at weekends.	Work to look at providers ability to start new packages of care and undertake weekend assessments will be reviewed as part of	Levels of weekend discharges increases.	The costs of the weekend discharge service are funded from the BCF (£400k) and specific funding for enhanced rapid response at weekends (£400k) is provided. The service funds care

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	patients 7 days	Also, there is variation between some care agencies and care homes as to whether they will undertake assessments or commence new packages of care at weekends.	contracts over the next 24 months.		packages that cover weekends aimed at supporting discharge. e.g. Nightowls service
Trusted Assessors	In place for @home team and reablement teams which are key discharge routes for local health and social care economy	Need to embed Trusted Assessors across the SE London system, noting that the most significant delays are from non-local boroughs.	Single Assessment and Referral Form being piloted in Q1 17/18. Trusted Assessor protocols for SE London aim to be piloted by October 2017.	Local professionals are able to assessments on behalf of other organisations.	The BCF funds services in which trusted assessor models are in place; @home community health services.
Focus on choice	Choice Protocol jointly developed by all local health and social care organisations and is in in place. Voluntary sector provision also integrated into discharge teams to support people home from hospital	Work is ongoing to review and refresh information packs provided to non-elective patients, including expectations regarding discharge planning	Review of discharge materials in Q1 and Q2 17/18. Choice protocol review in Summer 2017	Reduction in DTOCs and MFFDs attributable to patient or family choice.	This workstream is focussed on improving hospital procedures around operation of choice policy. However the BCF funds the hospital discharge teams. The availability of an adequate supply of nursing care has an impact on choice delays and the iBCF provides £2.15m additional funding for this provision.

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Enhancing health in care homes	Community service and primary care support is in place for all care homes in Lambeth and Southwark. As part of a winter initiative, Care Homes have also been visited and reminded of the value of 111 to support decision making	Working with the London team who are looking at 111 support to Care Homes to ensure that additionality augments existing GP support to care homes rather than causes confusion or destablisation	Q1 and Q2 17/18	Fewer ambulance call-outs to Care Homes and thus fewer admissions to hospitals for care home residents.	The BCF funds a community pharmacist to work in care homes to ensure safe management of mediations. Medicine reconciliation and medication review are core functions. The pharmacist also attends the monthly MDTs for each home. The BCF also funds end of life care co-ordinators working across care homes. The iBCF provides additional £2.15m funding to support the provision of Nursing Care.