# Better Care Fund Template Q4 2017/18

**4. High Impact Change Model**

Selected Health and Well Being Board: Central Bedfordshire

| | | Maturity assessment | | | | | Narrative | | | |
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| | | Q2 17/18 | Q3 17/18 | Q4 17/18 (Current) | Q1 18/19 (Planned) | Q2 18/19 (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** | Established | Established | Established | Mature | Mature | | The challenge is coordinating early discharge planning across 7 hospitals used by Central Bedfordshire residents.<br><br>With the implementation of an Integrated Hospital Discharge service for Central Bedfordshire residents, the aim remains to bring the service to a mature standard, recognising that there are different processes in place across the different acute trusts.<br><br>To overcome this challenge a Data & Intelligence Officer is in post to manage this and maintain a flexible and resilient approach to surge and escalation. | Established partnership working with Emergency Departments and Clinical Navigation teams to mitigate against hospital admission across acute trusts.<br><br>A duty/triage function to complement the approach taken in Accident & Emergency has been established.<br><br>Complex discharge arrangements are supported by social workers attending ward based MDT board rounds and identifying appropriate persons to support safe and timely hospital discharge.<br><br>A sub-acute pathway which supports the early discharge planning arrangements and transfer to in patient rehab units and/or Reablement/Intermediate Care at home has been established. | None |
| Chg 2 | **Systems to monitor patient flow** | Plans in place | Established | Established | Established | Mature | | Current OPAL patient flows only covers a proportion of Central Bedfordshire residents - those attending the Luton and Dunstable and Bedford Hospitals.<br><br>Links need to be made to monitor patient flows to remaining hospitals. | A person tracker has been developed to monitor the customer journey from admission to discharge within the Hospital Discharge Service across multiple acute and non-acute NHS trust settings.<br><br>Work is underway with primary care colleagues to establish the sharing of the person tracker with wider system partners, with a view to providing a seamless process of information sharing across agencies involved in the joined-up care and support of customers.<br><br>Daily briefing within the Hospital Discharge Service, to review caseloads and identify complexity associated with discharge has commenced.<br><br>The DToC tracker now provides a central point of data recording across multiple acute NHS trusts and non-acute settings to monitor and report performance associated to delayed transfers of care. | None |
| Chg 3 | **Multi-disciplinary/multi-agency discharge teams** | Established | Established | Established | Mature | Mature | | Information sharing and shared case management systems across health and social care remains a challenge. | The Hospital Discharge Service is structured with social care staff managing both social care and NHS Intermediate Care customers.<br><br>The service operates within a range of acute and non-acute NHS trust settings managing the flow of persons across a system and engaging in the multi-disciplinary discharge planning of both health and social care customers. | None |
| Chg 4 | **Home first/discharge to assess** | Plans in place | Plans in place | Plans in place | Plans in place | Plans in place | | Difficultly integrating access.<br><br>Workforce capacity within current providers is limited.<br><br>Decisions regarding ongoing care being made in acute settings as a result of limited integrated approach. | An established Integrated Triage Service aligns the Council's Reablement and Community Health Service Provider's Intermediate Care Services, providing a single point of contact for referrals and triage in an integrated context.<br><br>The joining up of Intermediate Care Services enables customers to leave acute settings earlier as referrals are triaged in parallel by assessing the customer outside of the acute setting, whilst ensuring their needs are met. | None |
| Chg 5 | **Seven-day service** | Established | Established | Established | Established | Established | | Full range of support services are not always available 24/7.<br><br>Difficulties extending a seven-day service across private community services. | An integrated hospital discharge service has provided a seven-day approach for two years.<br><br>As part of the service's surge and escalation plans, there is scope to increase staffing levels at weekends and Bank Holidays, as and when periods of surge are experienced.<br><br>Work is ongoing to implement and improve the seven-day service in relation to the access to community providers. | None |
| Chg 6 | **Trusted assessors** | Plans in place | Plans in place | Established | Established | Mature | | Expanding the Trusted Assessor role across acute hospitals used by Central Bedfordshire residents.<br><br>Implementation of a seven-day service | The Hospital Discharge Service hosts a Care Home's Trusted Assessor employed via Bedfordshire Care Group in place at Luton & Dunstable and Bedfordshire Hospitals.<br><br>Trusted Assessor supports both new care admissions and transfer arrangements of residents returning from both the Emergency Department and wider Hospital wards to usual place of care home residence, regardless of the funding stream of the person.<br><br>The Trusted Assessor joins the Service's daily briefing and supports the previously mentioned board round process for wards/departments with higher concentration of care home admissions. | None |
| Chg 7 | **Focus on choice** | Established | Established | Established | Established | Established | | Patient choice for self-funders.<br><br>Fragile market. | Implementation of the Community Catalyst to help create a diverse care market and build capacity particularly in rural areas.<br><br>The Hospital Discharge service supports a range of acute trust policies associated to person choice.<br><br>A partnership approach is adopted with acute trust discharge teams supporting people to make appropriate and timely choices regarding their ongoing care arrangements, regardless of the funding stream of the ongoing service.<br><br>The Service will support discharge to assess arrangements of all persons it supports, with a view to making more longer term and significant decisions with customers outside of the acute trust setting. | None |
| Chg 8 | **Enhancing health in care homes** | Established | Established | Established | Established | Established | | There is a risk that Care Homes will be overwhelmed by the number of initiatives being introduced.<br><br>Whilst there is engagement and enthusiasm to support the delivery of the enhanced care framework, there is some anxiety about the capacity to adopt the change.<br><br>Staff turnover in the residential and nursing care market is likely to impact on projects.<br><br>Leadership and project management capacity is required to provide support and mentoring to Care Providers to ensure the success of the projects and modernisation agenda. | The aforementioned Trusted Assessor is in place and engaged with all the care homes.<br><br>The Red Bag scheme has been implemented and there is good engagement with Care Providers<br><br>Partnership work with Bedfordshire Care Group continues to progress initiatives.<br><br>Hydration Project rolled out to all care homes and response is positive.<br><br>Medication Reviews are ongoing.<br><br>GP alignment in place in two of four localities.<br><br>Digitisation - technological capabilities have been established and homes within the LGA pilot have completed their training.<br><br>Care Home Data analysis has taken place and data has informed winter initiatives. | None |

**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 | Q3 17/18 | Q4 17/18 (Planned) | Q1 18/19 (Planned) | Q2 18/19 (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 residents. | Challenges | Achievements / Impact | Support needs |
|---|---|---|---|---|---|---|---|---|---|---|
| UEC | **Red Bag scheme** | Plans in place | Plans in place | Plans in place | Established | Established | | None | Scheme has been implemented<br>Good engagement with care providers. Use of Red Bags will be closely monitored and any emerging issues addressed.<br>Trusted Assessors will play an active role in the use of the Red Bags. | None |