Appendix 2: High Impact Change Model Milestone Plan

		Norfok wide	Key dates
Change descriptor			
Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.	**Current Position**	All 3 acutes have a planned approach in place, but have identifed areas for improvement. Some will be at a local system level, others at County / whole system level	April 2017
	Planned Activity	Increased focus on supporting the red to green approach and board and ward round attendance. (Local) Increased focus use of ICCs & MDTMs in GP surgeries.(Local) Plan to be developed to improve discharge date planning across the system including community hospitals.(System wide) Appointment of a Capacity Manager post to understand, monitor and facilitate capacity across the system (System wide)	Work commenced July 17 Systemwide plan to be approved October 17 By October 17
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.	**Current Position**	Silver systems in place at two acutes NNUH & QEH, with dashbords and information monitored daily. JPH takes Red & Green bed day approach.	April 2017
	Planned Activity	JPH A&E delivery board to review plans linking with NNUH and QEH. (Systemwide) Consider introduction of electronic patient flow systems (Local / Systemwide)	A&E Joint Delivery Board to have approved plan by Oct 17
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	**Current Position**	Across the system plans are established to mature, with daily MTD meetings taking place. Involvemnt of voluntary sector and housing varies across the system. In NNUH; D2A in place with care providers, ASC and community health provider. CHC assessments increasingly undertaken outside hospital (D2A).	April 2017
	Planned Activity	Review involvement of voluntary sector and housing. (Local) Expand Social prescribing wider than GPs (Systemwide)	Plans shared with stakeholders Sept 17
Home First/Discharge to Assess. Providing short-term care and reablement in people's homes or using 'stepdown' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.	**Current Position**	Due to the varience in DTOC figures acrsoss the whole system each acute has a slightly different current model and future plan. Development of Intermediate Care Strategy Discharge to asses review undertaken with Emergency Care Improvement Programme (ECIP)	April 2017 June 2017 July 17
	Planned Activity	**Discharge to assess** Proposals to joint A & E Board for a programme of work to support Pathway 1 (System wide). Existing Pathway 3 work in East & Central being evaluated with support from Healthwatch to inform future investemnt in posts to support D2A (System wide) **Home First** Commissioning to support increased capacity and improve sustainability in the Home Care Sector (system wide) Crisis Homecare – To include; Home support wrap around service, Enhanced flexible dementia offer. (systemwide) Micro Commissioning to support Homecare (local) Bed Based Reablement – Delivery models being developed (system wide)	August 2017 September 2017 October 2017
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, and means that services are more responsive to people's needs	**Current Position**	Plans are in place system wide for social care services, including availability of Care Arranging Services at weekends. Local schemes are in place such as Healthy Homes Project and Hospital Care at Home	April 2017
	Planned Activity	Further work is required at both system wide and local level to: Define the core level of services that are required at weekends. Clarify 7 day service not 7 day working. What this means for health services?	Ongoing

Trusted Assessor. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way	**Current Position**	No consistent system wide approach in place, some local examples of Trusted Assesor models at QEH	
	Planned Activity	**Systemwide model** Research of Trusted Assessor Models undertaken. Planning commenced at Health & Social Care Consultative Forum. Data analysis to inform demand. Meetings with all 3 Acutes. Meetings with representatives of the provider market to support co production. Link with Enhanced Health in Care Homes Project.	July 2017 August 2017 September 2017
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, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.	**Current Position**	Local arrangemnts in place including contracts with CHS Healthcare working within a Trust to expedite a range of patients – predominantly family choice / self-funders.	
	Planned Activity	Each acute is looking at their current system with a focus on how Discharge Coordinators link with Integrated Care Coordinators /GP surgeries / Local voluntary organisations. (Local)	Ongoing
Enhancing Health in Care Homes. Offering people joined-up, co-ordinated 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 improve hospital discharge.	**Current Position**	Well established project with a clear forward looking plan.	April 2017
	Planned Activity	Development of a robust care homes dashboard. Workforce development. Develop and introduce a falls prevention tool for care homes. Improve the pathway between hospital and care homes. Introduce a communication tool to support decision to support decision making by care home staff. Target support at care homes making most use of 999.	30th June 2017 30th Sept 2017 30th November 2017 31st December 2017 31st March 2018