Managing Transfers of Care (DTOC reduction delivery plan) 2017/18										
Ref	Task Description (8 High Impact Changes)	Organisational Owner	Lead	Intended Outcome	Estimated impact on reducing DTOC	Completion Date	Progress			
							Q1	Q2	Q3	Q4
1	**Early Discharge Planning**									
1.1	Expand the joint discharge policy and procedure to reflect the specific service options available to support discharge in each borough.. **(Include MH colleagues)**	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.2	Develop information for patients.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.3	Establish a consistent approach to the use of an MDT process in advanced discharge planning on all wards.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.4	Develop elective discharge planning across the whole systems pathway with integration with existing pathways e.g. primary care.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.5	Improve understanding and utilisation of the CIS (particularly CIS Liaison role to ensure effective use of resource.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.6	Improve understanding and the impact of the Trusted assessor model on early discharge	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	reduce internal delays and facilitate discharges		31.12.17				
1.7	**Mental Health focussed actions:** Scope 72 Hour Formulation Meetings, early stage addressing of barriers to discharge. Senior Managers from inpatient and community enagaged; ongoing input of community teams during admission Consider Discharge Intervention Team – moving community discharge workers to work closer into wards Development of Accommodation Pathway Guidance Explore training for ward managers on Care Act, Ordinary Residence, s117 Scope an “Adult Pathway” review	LBHF & H&F CCG	Shazia Khan	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		31.10.17				

1.8	**Improving access to MH input** - specific MH Practitioner to support assessment and planning discharge for each hospital site (Chelwest/Charing Cross/Imperial) x 3 MHP (band 7)	LBHF & H&F CCG	Ray Boateng	Reduce length of DTOC for people with Challenging behaviour needs. Effective working with Psychiatric Liaison teams..		31.12.17				
1.9	Check the capacity and functionality for timely Continuing Healthcare screening and assessment within the discharge planning process to meet national standards.. Allocate additional CHC Case Managers/Coordinators capacity (per hospital site)to facilitate CHC assessment and decision making where needed. X 3 CHC Case Coordinators (Band 7)	Hammersmith & Fulham CCG	Ray Boateng	Reduce internal delays associated with CHC process. Identify care pathway for interim care or discharge to assess		31.12.17				
1.9	Explore options for an integrated model of Continuing Healthcare Assessment.and brokerage **(incl MH)**	Hammersmith & Fulham CCG	Ray Boateng	speed up access to care provision		31.12.17				
1.11	Check the timely ordering of community equipment so that it is in place by the date of discharge.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	speed up access to care provision		ongoing				
1.12	Address any contract-related process issues. Eg Deep Cleans.	LBHF	Frank Hamilton	speed up access to care provision		*30.09.17*				
1.13	Check and embed earlier referrals to Hospital Transport.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	speed up access to care provision		31.10.17				
2	**Systems to monitor patient flow**									
2.1	Establish robust process for agreeing SiTReps to ensure full sign off by all partners before submission. To include in guidance (see action 1). Process in place for MH chaired by the DAS in H&F.	ICHT/Chelwest	Rebecca Campbell/Richard Turton	Develop better systems and information for managing DTOC		31.10.17				
2.2	Consider creating a Patient flow coordinator role to establish robust process, accurate information and systems for effective management and progress chasing DTOC	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	Develop better systems and information for managing DTOC		31.12.17				

2.3	Development of Discharge Teams is in progress, EDD tracking, support to ward staff responsible for discharges.SAFER bundle implementation through Summer to ensure readiness and efficiency of timely discharges with care plans	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	Develop better systems and information for managing DTOC		31.10.17				
2.4	Discharge2Assess Home pilot. Support ward/ social services staff to implement and embed D2AH and Process changes to support effective implementation and 'ramp up' the number if D2A home patients	LBHF	Senel Arkhut	Help plan and faciltitate timely discharge		31.12.17				
2.5	Establish system for daily updates on availability of intermediate care beds (similar to bed state reports)	Hammersmith & Fulham CCG	Lisa Cavanagh	Help plan and faciltitate timely discharge		31.09.17				
3	**Multi-Disciplinary /Multi agency discharge teams including the voluntary and community sector.**									
3.1	Issue Joint statement of Commitment to staff on partnership working, professional behaviour, no blame culture.	Health and Social Care	Joint Executive Team	common process and approach		31.10.17				
3.2	Develop a Standard Operating Process for Joint/Multi-agency discharge teams – standard assessment tool, single approach to managing discharge, and joint budget	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		31.12.17				
3.3	Develop an integrated model that clarifies and incorporates the third sector input into the 'system' to support patients.	LBHF/ICHT/Chelwest	Senel Arkhut/Rebecca Campbell/ Richard Turton	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		31.12.17				
3.4	Geriatrician involvement in the community and hosptial based MD team	LBHF/ICHT/Chelwest	Senel Arkhut/Rebecca Campbell/ Richard Turton	Joined up approach towards an integrated discharge function.		31.12.17				
3.5	SW use health data base on wards to state care on discharge, reduce ward staff and discharge planning need to contact SW.	LBHF	Senel Arkhut	Joined up approach towards an integrated		31.12.17				

3.6	Discharge planners able to access to SW office and enable co-location for SW, therapy, and discharge planning..	LBHF	Senel Arkhut	Joined up approach towards an integrated		31.12.17				
4	**Home First Discharge to Assess**									
4.1	Implement lessons from the Home to Assess Pilot (H2A) and roll out across NWL	LBHF	Senel Arkhut	reduce delays associated with assessment and management		31.12.17				
4.2	Discharge home with short term reablement - increase capacity	LBHF	Senel Arkhut	Ensure bridging home care arrangements for people with complex needs as a contingency for winter demand surge period.		31.12.17				
4.3	Include community based programmes in supported discharge:SHSOP,CIS,fals prevention,cognitive impairment/MH.	LBHF & H&F CCG	Senel Arkhut	Check alignment with other actions						
4.4	Pharmacy- patient access to meds before discharge	Acute providers	t.b.c	Check alignment with other actions						
4.5	Explore a bridging short term night care service for people with complex needs	LBHF & H&F CCG	Ray Boateng/ Shazia Khan	Reduce delays associated with lack of support at night		31.10.17				
5	**Seven Day Services**									
5.1	Joint 24/7 services available to support discharge, includes health and front line services and commissioned support services both voluntary and community sector.	West london, Central London & Hammersmith and Fulham CCGs	t.b.c	Joined up approach towards an integrated discharge function. Reduce delays for both health and social care		30.11.17				
5.2	Review current social work input at weekends and target it in the most effective areas of the hospitals such as admission avoidance BCF A4	LBHF	Senel Arkhut	Joined up approach towards an integrated discharge function. Reduce delays for		31.12.17				
5.3	Work with care homes to improve access at weekends and out of hours.	West london, Central London & Hammersmith and	Meeta Kathoria	Reduce delays for both health and social care		31.12.17				

5.4	WL Care home project staff to improve liaison with CIS, MCMW and LAS	West london, Central London & Hammersmith and	Meeta Kathoria	Reduce delays for both health and social care		31.12.17				
5.5	Improved involvement and working with third sector (inc. self-care programmes) and primary care to support 7 day working.	West london, Central London & Hammersmith and Fulham CCGs	Primary Care Leads	Reduce delays for both health and social care		ongoing				
6	**Trusted Assessors**									
6.1	Implement plans required to ensure training and competency of Trusted Assessor	CLCH	Ian Jones	Joined up approach towards an integrated discharge function. Reduce delays for		31.10.17				
6.2	Ring-fenced resource for 2 wte dedicated Care Home Nurse Assessors for our Care home providers (especially Care UK and Sanctuary) to enable them to undertake assessments within 24hrs and share assessments with other care providers if unable to accept	Care UK / Santuary Care	Michelle Sampang/ Jane Darani	Reduce delays as a result of nursing homes assessment		30.11.17				
7	**Focus of Choice**									
7.1	Co-produce 'Choice Policy' including standard practice 1-2 residential and nursing home placements, not 3 as currently stands.	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	develop common appraoch and process		30.11.17				
7.2	Update/Create one document/ leaflet outlining the offer in line with the Choice Policy produced above	ICHT/Chelwest	Rebecca Campbell/ Richard Turton	develop common appraoch and process		30.11.17				
8	**Enhancing health care in homes (Incl a sustainable market)**									
8.1	N. B work completed in STP work stream on care homes- completed a Baseline Needs Assessment against the national template across NWL.			Ensure that this information is available to leads.						
8.2	Work with the West London Proactive Care Home Project and the H&F Caring for Care homes project to enhance care in care homes	CWHHE CCGs	Meeta Kathoria	reduce avoidable admissions from care homes		ongoing				

8.3	**Improve Accessing of specialist services input into care homes to reduce avoidable admissions**	Hammersmith & Fulham CCG	Louise Maile	reduce avoidable admissions from care homes		31.12.17				
8.4	Aligning Commissioning and Quality Assurance and Contracting for Care Homes across health and social care.	LBHF & H&F CCG	Frank Hamilton							
8.5	Commissioning of 4 dedicated Care Home and Extra Care Advanced Primary Care Nurse Leads - affiliated to Primary Care and GP Federations to provide clinical leadership, service access, quality improvement,workforce devlopment and support service integration. for the care homes community (903 beds) across the three borough CCG areas.	West london, Central London & Hammersmith and Fulham CCGs	Caroline Durrack	Improve quality of care and productivity and reduce avoidable admissions from care homes		31.12.17				
8.6	Explore options for a single team to deliver brokerage, client and service review, contracting and quality assurance function across health and social care	LBHF & H&F CCG	Ben Gladstone & Ray Boateng	Improve quality and productivity in care homes		31.12.17				
8.7	Consider the provision of interim step down/Transitional care beds to enable step down from hospital for people who: • cannot be discharged home immediately and require assessment and planning • This includes interim bed options to carry out Continuing HealthCare Assessments (CHC) outside hospital • Support people with care needs who have temporary accommodation needs Consider case for funding to bolster support current interim step down beds to admit more complex people who are delayed	Hammersmith & Fulham CCG	Ray Boateng	Help plan and faciltitate timely discharge and reduce delays associated with assessment and care provision process		31.12.17				
8.8	Develop care home provision for older people with challenging behaviours, including people with dementia.	CWHHE CCGs	Meeta Kathoria / Ray Boateng	ensure right care in right unit to facilitate discharge and reduce readmission		31.12.17 and ongoing				
8.9	Develop appropriate care setting provision for people of working age with challenging behaviour needs.	CWHHE CCGs	Meeta Kathoria/ Ray Boateng			31.12.17				

8.1	Admission avoidance Hospital SW aligned to A&E and able to switch on short term services within 2-4 hours.	LBHF	Senel Arkhut	Reduce hospital admissions		31.10.17				
8.11	Support for care homes for people with severe mental illness, including dementia.	See Care Homes project	Meeta Kathoria	Improve quality and reduce hospital		ongoing				
8.12	Development of Tele medicine initiative in care homes	West london, Central London & Hammersmith and Fulham CCGs	Toby Hyde	Improve quality and reduce hospital admissions in care homes		ongoing				
8.13	On-going Workforce Development and training to care home staff	CWHHE CCGs	Meeta Kathoria	Improve quality and reduce hospital admissions in care homes		ongoing				