Better Care Fund Template Q4 2017/18

4. High Impact Change Model

Selected Health and Well Being Board:	Wirral

		Maturity assessment					
		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
Chg 1	**Early discharge planning**	Plans in place	Established	Plans in place	Established	Mature	
Chg 2	**Systems to monitor patient flow**	Plans in place	Established	Established	Established	Mature	
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Established	Mature	
Chg 4	**Home first/discharge to assess**	Established	Established	Established	Established	Mature	
Chg 5	**Seven-day service**	Established	Established	Established	Established	Mature	
Chg 6	**Trusted assessors**	Plans in place	Established	Established	Established	Mature	
Chg 7	**Focus on choice**	Established	Established	Established	Established	Mature	
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Established	Mature	

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 re

		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.
UEC	**Red Bag scheme**	Plans in place	Plans in place	Established	Established	Established	

Narrative		
Challenges	**Milestones met during the quarter / Observed impact**	**Support needs**
implementing safer consistently.culture and behaviours. workforce recruitment and retention.	grip on stranded patients-focussed group and transparent data. Review of IDT toimprove progress to next level.	N/A
full implementation of safer. Increasing focus on MO and stranded. Flexing to winter workforce.	improved performance monitoring. SDIP now contractual. Capacity and demand modelling to inform pathways and flow. Electronic screens in wards.	N/A
refinement of approach following IDT review.	nursing home trusted assessor in place and being embedded. T2A model rolled out Oct '17 Transfer of Care form signed off across healthcare economy	N/A
scaling up to deliver sustainable home first model.	t2A model in place. Home first pilot evaluated.	N/A
adapting workforce across 7 days as required. Whole system challenge within cost envelope.	PTWR, planned weekend ward rounds well established. 'Discharging consultant' ward rounds for potential discharges in place for wards without job planned weekend ward rounds. review of 7 day services and gaps.	N/A
fully embedding across sectors. Culture and behaviours.	TA for Care Homes Nurse started 3rd Nov 17 and currently shadowing providers and supporting speedier discharges. MOU/Business process being finalised for full assessment to be undertaken by TA and single	N/A
consistent application to evidence mature in self assessment	New Early Intervention and Prevention commission started 1st Oct, Age UK Home of Choice (Right Time Right Place coordinators) and Home from Hospital (Home & Communities) support in place and integrated	N/A
evidence consistent application and fully embedd to achieve mature self assessment	24/7 Teletriage Nurse/GPOOH Service in 30 homes and rolled out to another 34 homes by end of Feb 18. High usage over weekends admissions being avoided (85% of calls deflecting an admission) and AVS Doctor	N/A

sidents move between care settings and hospital.		
Challenges	**Achievements / Impact**	**Support needs**
consistent application	progress made to scale up	N/A