ANNEX 1

						Narrative			
		Q1 18/19	Q2 18/19	Q3 18/19 (Current)	Q4 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	Established		Significant cultural change needed across a range of disciplines to pull discharge planning earlier in patient journey, this is incorporated as part of overall SAFER implementation rather than addressing piecemeal. Limited work to date from commissioners for pre-operative discharge planning in primary care - this has been highlighted as an issue through local 'Home First' engagement exercises.	SAFER refresh at York FT includes focus on earlier discharge planning, local delivery plans in place for each clinical area with ongoing review process with senior leadership team. Intensive roll out for targeted taken place, this is developing criteria led discharge approach in a number of wards. Integrated discharge hub have developed electronic internal referral and initial fact finding process to support earlier intervention in complex discharge planning - initial pilot developed with Elderly wards and rolled out across all wards through July 2018. Additional funding for weekend discharge liaison and weekend social work is allowing earlier input for patients identified at weekend and earlier access to families. Pilot of discharge planning with OT in vascular pre-op assessment commenced in Q3.	Evaluation from elsewhere to support commissioning of pre-operative discharge planning in primary care
Chg 2	**Systems to monitor patient flow**	Plans in place	Plans in place	Plans in place	Established		Availability of analytical capacity across the system to undertake detailed capacity and demand required.	Weekly multi-agency discharge events set up through winter months with additional daily system escalation as required. Winter plan successfully deployed additional capacity through intermediate care based on OPEL level and activity surges. Winter plan included increase in domiciliary and step down bed capacity to proactively address expected increase in demand over winter period. Better Care Fund has agreed to prioritise capacity and demand exercise for system (most recent plan is that this will be for the CYC footprint to allow the work to progress).	Already flagged as an area of required support, BCF Manager continues to work with local system to take forward.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Established		Capacity of discharge hub to attend all daily ward based MDTs (Board Rounds). Capacity of CHC teams to continue to support Integrated Hub - ability of CHC to provide D2A service	Integrated Discharge Hub bringing together discharge liaison and hospital social work teams commenced in December 2017. Hub leading multi-agency redesign of complex discharge pathway and working through ward based discharge liaison officers to strengthen links between hub and ward based teams. Hub are testing ward based social workers for high referring areas and exploring opportunities for social workers to join weekly MDTs. Discharge to assess beds commissioned on pilot basis for CHC patients from December 2017 and new pathways developed to be introduced from January 2018. Following review of pilot, CCG have confirmed ongoing funding for 1 discharge to assess CHC bed and exploring options to utilise community beds to extend this further. End of life specialist nurse and social worker to work alongside discharge hub for 12 months to improve fast track referral process.	N/A
Chg 4	**Home first/discharge to assess**	Established	Established	Established	Established		Capacity within system to implement transformational change in so many areas simultaneously. Constraints on short term discharge support due to lack of capacity in long term domicilliary care.	Ongoing development of the 'One Team' to improve access to short term intermediate care and reablement to support discharge to assess approach. One Team are piloting a discharge to assess model that prevents the need for social care assessment in hospital for people who require reablement. Vision for service being refreshed through new commissioning intentions to be agreed in Q4. Additional funding secured by CYC to increase capacity in reablement again in 2018-19 and increase home care capacity. Capacity and demand exercise recommended by BCF group to enable accurate capacity planning to deliver a D2A approach.	Evaluation from elsewhere on long term savings associated with increased short term capacity to deliver discharge to assess model

Chg 5	**Seven-day service**	Plans in place	Plans in place	Plans in place	Established		Care homes and domiciliary care agencies remain unwilling to accept new referrals at the weekend. Need for HR process to change terms and conditions of social care staff to move to seven day working	Trial of 7 day social work presence in hospital commenced in December 2017, funding received to commence 7 day discharge liaison nurse presence in hospital and weekend reablement co-ordinator from March 2018. BCF funding secured to maintain 7 day social work and discharge liaison presence - currently being delivered through staff goodwill so not meeting required for T&C change but recruitment underway to permament posts in discharge liaison and CYC plan to address through future focus programme over next six months.	N/A
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Plans in place	Plans in place		Independent care group have tested enthusiasm amonst care home managers for trusted assessment model with mixed response - workshop session to be held in January 2019 to better understand the discharge processes, identity areas where system changes can be made [from the point a care home is contacted] to reduce delays and improve the patient experience and to discuss trusted assessor as one potential option for improvement. Aiming to identify willing care providers to scope / test out any recommended options.	Some areas of good practice (trusted assessment well established for intermediate care and being trialled for reablement service) and discussions on single assessment process and documentation started through Integrated Discharge Hub and One Team projects. Trusted assessment for patients moving to discharge to assess CHC beds agreed and piloted in Q4 - ended in March 18 following conclusion of winter pilot but ongoing conversations regarding trusted assessment work with care home involved. The Independent Care Group is supporting the wider system in considering a trusted assessment approach.	Financial support to bring forward a dedicated role to pilot trusted assessment with care homes and / or home care.
Chg 7	**Focus on choice**	Plans in place	Plans in place	Plans in place	Established		Choice remains a significant factor in DTOC performance. Voluntary sector not currently involved in discussions about self-funders. Cultural challenge to embed choice protocol at ward level	Transfer of Care Protocol includes Choice. Pathway Development Manager and Hospital social work team addressing consistent practice at referral stage. Multi-agency workshop to review and re-write Transfer of Care Protocol took place in July 2018 and agreed 'Why not home?, Why not today?' project will lead re-writing of protocol with a planned implementation date of April 2019 to allow time for engagement, communication and training of staff - counting and coding workshop scheduled for October 2018. Public health undertaking topic specific needs analysis for self-funders to inform work required - discussed by multi-agency steering group in December 2018 and presentation from 'Care Home Selection' independent provider that can support patients and their families in choosing a home scheduled for 1 February. Discharge hub are taking a case management approach with self-funders to improve the co-ordination and consistency of support to this patient group.	N/A
Chg 8	**Enhancing health in care homes**	Established	Established	Established	Established		Capacity in the system and workforce in independent sector. Engagement of CCG care home project leads into wider work on supporting discharge - discussions ongoing to address and make links more evident	Care homes pilot to reduce admissions to hospital from care homes (through Priory Medical Group), Quality initiatives established in CCG, Quality Manager appointed and in post.	N/A