CARE QUALITY COMMISSION SYSTEM REVIEW OF DELAYED TRANSFERS OF CARE 2017

TRAFFORD SYSTEM ACTION PLAN

OCTOBER 2017- OCTOBER 2018

Action Plans Only

Updated 16/06/2018

Background

Following the publication of the Care Quality Commission (CQC) Local Review of Health & Social Care Services in Trafford report on 18th December, 2017 (link:), this Action Plan has been developed in response to the issues highlighted in order to enable all partners to play their part in driving forward improvement in outcomes for the Trafford population of older people.

The joint action plan will be the mechanism by which partners are held to account, through the new governance structure, by the Health and Wellbeing Board for improving performance and ensuring effective monitoring and evaluation.

This joint action plan takes account of and cross-references the following plans that have been developed by partners:

Transfers of care plan 2017
Winter Plan 2017
Better Care Fund Plan 2017-18
Trafford Locality Plan 2016
Trafford Transformation bid 2017
All Age Health and Social Care Business Plan 2017-18

Partners are committed to system wide reform as expressed in the Trafford Locality Plan and work is well underway to implement the big ideas detailed in the Trafford Transformation Funding Bid. These include the Urgent Care project, the integration of the Council and the CCG into one new organisation, and the Trafford Local Care Organisation, the delivery model that we see as the future way of working in Trafford.

Trafford's plan for reform is ambitious as is its desire to improve performance around transfers of care. This plan tries to describe all relevant work required to improve that performance and as such cross-references areas of work that are already underway and subject to close monitoring.

Post-CQC the Trafford system has continued to make significant improvement in reducing delayed transfers of care.
The system delivered significant improvement in November and December, and the 'Home for Christmas' campaign engaged the workforce and partners in achieving great performance in the run up to Christmas.

The issues highlighted within the report have been reviewed and themed under the following headings:-

- Maintaining well-being in usual place of residence
- Crisis management: Preparation for winter & urgent care
- Step down, return to usual place of residence and/or admission to a new place of residence
- Challenge and scrutiny
- Market management/commissioning
- Intelligence and evaluation

This Action Plan has been developed by the system as follows:

Trafford Council
Trafford Clinical Commissioning Group
Manchester University NHS Foundation Trust
Pennine Care Community NHS FT
Salford Royal NHS Foundation Trust
Healthwatch Trafford
Trafford Health and Wellbeing Board

Those actions highlighted in grey are assumed to have been completed based on current feedback. This needs to be agreed within the virtual review by the responsible officers

1. Maintaining the wellbeing of a person in usual place of residence

Action No.	Action Required	Responsible Officer	Mgmt Lead	By When		Progress Made to Date
				Start	Finish	
1.1	Implement transfers of care plan and develop evaluation and performance metrics. (This includes compliance with the High Impact Changes model). See APPENDIX 1	JC CW	KA DE JG/TC	October 2017	November 2018	Noted in full in the plan in Appendix 1 – to be updated monthly. A performance dashboard will be developed as part of the commissioning programme for the LCA.
1.2	Implement Primary Care/Care Home MDT project	CW	TL/JBS	January 2018		Project goes live from 19.1.18 with 6 care homes and will continue to be rolled out cross Trafford over the next 3 months as new staff come on stream. Model has been developed as an integrated service offer between existing providers including Pennine Care, NMOPC and Mastercall with opportunities for further support through the voluntary sector. NO UPDATE AVAILABLE ON PROVISIONAL OUTCOMES AT THIS DATE
1.3	Clarify investment via GM H&SC Partnership Transformation Programme into primary care	JC CW	RD IT HZ	January 2018	January 2018 CLOSED ACTION	No update available – therefore action closed down.
1.4	Engage VCS/Third Sector in discharge and planning processes at an earlier stage	KA & KP	Jo Gibson Angela Brown	November 2017	ongoing	Initial discussions have taken place between the CCG and Thrive and a care navigator's pilot have been commissioned.

						Thrive are part of the LCA and further discussions will take place as part of the workplan which is currently being established.
1.5	Refresh Seven Day Services Plan	DE RS MB	Diane Eaton	February 2018	April 2018	We have discussed 7 day working already in place with Wythenshawe site. This remains in place until wider internal work is complete. Trafford testing opening the UCCR at Easter BH's. The good Friday BH was very successful, but Bank Holiday Monday didn't help with any discharges. Therefore will only open on a Friday BH until the wider internal pathway redesign is completed.
1.6	Develop a transformation model for support at home underpinned by a new contractual framework	KA	JG	April 2018	CONCLUDED TO BE REVIEWED AS PER MILESTONE	- GM care at home work concluded and reported to GM H&SC partnership. - Pilots underway in Partington and Sale to be evaluated retrospectively in July/August.
1.7	Review impact of support at home prototypes	KA	JGt	August 2018		- In keeping with timescales above. Post recruited to and start date agreed for August 2018.
1.8	Develop improvement programme for nursing and residential care	KA/MM	Merry Leslee	February 2018	Sept 2018	- Adult Safeguarding Board briefed and supportive. - Providers engaged and registered managers network set up agreed with support from Skills for Care. - Current quality assurance tools and approach being externally evaluated by MHSCP. - Cost, quality and sustainability group set up. - Work underway on improving the flow of notifications of quality concerns. - Band 11 post being reconfigured to

						provide a strategic lead. - TECHHT programmes being piloted in 8 care homes. - Trafford part of the Teaching Care homes GM work. - Trafford part of the GM work on improving care home quality workstream.
1.9	Develop comprehensive stakeholder & public engagement programme and strategy.	TG	RD AB Jo Gibson	December 2017		- Engagement workshops underway. - Existing work with Thrive to agree future model. - Engagement structure under development as part of Trafford Together.
2.0	Ensure new model of primary care addresses improvement required.	Dr NG	Stephen Spencer			- Implementation of the MDT commences 19.1.18 and the Primary Care Organisation has a formalised Advisory Board in place though a MoU. Clinical pharmacist recruitment has been successful with commencement on 1.2.18. **Update 19.06.2018** - MDT commenced Feb 2018. - Initial phase focussed on urgent admission avoidance. - May/June proactive care model developed. - July Recruitment to full model. - Sept Full model in place. - Dec Service to include housebound.

2. Crisis management & urgent care

Action No.	Action Required	Responsible Officer	Mgmt Lead	By When		Progress Made to Date
				Start	Finish	
2.1	Implement Winter Plan – see APPENDIX 2.	TG JC RS MB	?	October 2017	March 2018	Winter plan implemented, Cold Debrief to be undertaken early February 2018. Winter plan 2018/19 to be developed by August 2018. Debrief undertaken and lessons to be included in the 18/19 plan.
2.2	Prepare and agree Easter plan.	As above	DE Who is CCG lead?	March 2018	April 2018	IWTA Escalation Plan finalised March 18 and implemented. Completed and delivered as above.
2.3	Primary Care prevention schemes for UTI and respiratory conditions (preventable admissions) to be considered.	ER Dr NG	?	February 2018		Respiratory T&F group established looking at 'quick wins' to support admission avoidance, in partnership with PCO and community services provider. MDT incorporates an acute visiting element to manage exacerbations of LTC symptoms, acute infections and falls. Clinical review of respiratory pathway with MFT scheduled for Jan 18 to inform admission avoidance pathway in primary care. Respiratory being picked up through respiratory programme as part of commissioning UTI to be established as a work stream.
2.4	Primary Care access and availability to be reviewed.	Dr MJ	JBS	February 2018	July 2018	Additional primary care access supported through winter resilience monies has been secured with go live date of 1.2.18. Full extended access model has been developed through the GP Fed with go live date 3.4.18 with provision through 4 neighbourhood hubs including Sat and Sun opening.

						This is being undertaken under new models of care The full Extended Access programme will be delivered from 1st July 2018. This will see additional clinical capacity available at hub site, with one hub in each of the four Trafford neighbourhoods. This will create an additional 30 minutes per 1000 patients per week. Each hub will provide additional appointments for all registered patients across Trafford during extended weekday hours (6.30pm – 8pm Monday to Friday) and 9am-1pm Saturday and Sunday.
2.5	Engage VCS/Third Sector in Winter Plan.	KA	AB	October 2017	August 2018	As per actions in section 1.
2.6	Ensure all acute providers have accurate and timely information relating to local services – TCC to be considered as the delivery vehicle.	DE SR JG	DE SR JG	February 2018		- Issued through the winter plan and regularly updated. - TCC future role currently in consideration.
2.7	Reablement/Care at Home capacity to be reviewed and developed.	KA SB	Vacant post	May 2018	Ongoing	This is the re-tender of the SAMS and homecare service taking place in 18/19.
2.8	Rapid implementation of single hospital discharge team at MFT Wythenshawe site with MCC.	DE		Jan 2018	January 2019	In place – ACTION COMPLETE.
2.9	Early discharge planning to be improved.	MB		February 2018		Underway through Integrated Discharge Team. This is being picked up through the IDT. Community support in ED.
3.0	Escalation channels and reporting to be made clear to all staff.	MI		February 2018		This will be part of all escalation plans for clarity on roles and responsibilities. It will remain all system leaders role to ensure that each aspect of the system is contributing. This will be escalated to GM if there remain outstanding issues. Opel with the four levels of reporting.

3. Step Down and return to normal place of residence

Action No.	Action Required	Responsible Officer	Mgmt Lead	By When		Progress Made to Date
				Start	Finish	
3.1	Discharge summaries and information sharing with community providers to be improved.	MB DE	MB Integrated Discharge team (Wyth)	March 2018	April 2018	- Control hub established and up and running since November 2017. - Information sharing flowing more easily across providers as part of the D2A process.
3.2	Learning from critical incidents to be routinely shared with clear feedback to all professionals.	TBC	TBC	January 2018		Discussed with Trafford Safeguarding Adults Board, processes and protocols to be considered by the Board and the relevant sub-group. New Strategic Safeguarding Board set up with new structure already in place. The Learning Review group will lead on this.
3.3	Personalisation and personal health budgets to be more routinely considered.	MM	ML	January 2018	Ongoing	A strategy for the improvement in PHB and direct payments is underway.
3.4	1.1 Roll out of positive outcome for preventing admissions and reducing LOS for frail older people from Wythenshawe Hospital into Trafford General Hospital.	Sally Briggs, Divisional Medical Director, Unscheduled Care	Lauren Wentworth Clinical Director	December 2017	November 2018	Over the last 3 years the Complex Care team based at Wythenshawe hospital have developed a well-recognised frailty service. This now operates seven days a week on AMU, as well as five days a week in the Emergency Department. There is also a robust orthogeriatric and surgical liaison service five days a week and discharge to assess beds. The service benefits from a continuous improvement approach and there is currently a plan to develop a separate frailty unit so that both the current AMU and ED services would merge to provide robust 7 day cover. Following the merger and creation of MFT there is now a

						desire to improve all sites to this standard, providing identification of frailty and access to timely comprehensive geriatric assessment. The Wythenshawe, Trafford and MRI teams have already met to discuss the setting of standards for their services and a further workshop is planned for February 2018. A key aim of the workshop is to identify which areas of frailty to prioritise as each site will have different cohorts of patients e.g. orthogeriatrics may be key for Trafford, whilst frailty support for surgical patients at MRI might be the more urgent need. Further aims of the workshop will include identification and sharing of resources and expertise and methodology for continuous development over the longer term. ECIP update visit and OPAL house rehab pathway. Non weight bearing social admissions. Workshop occurred at MRI and plan being developed but will require a Business Case.
3.5	Operational policies in place at Opal House should be reviewed to ensure they are not placing additional burdens on the wider system.	Lauren Wentworth, Clinical Director	Lauren Wentworth Clinical Director	December 2017	April 2018	An audit is taking place to review appropriateness of patients transferred from OPAL House to the Emergency Department. The SOP will be reviewed to consider options for management of acutely unwell patients at OPAL House. The areas for consideration will be: 1. The admission criteria – depending on the outcome of the audit, it might be that patients with any outstanding medical should no longer be transferred to OPAL House. However this will be assessed against the risk of the benefits

						of early transfer for patients. 2. Medical staffing model – This is currently a therapy/nursing led unit with Clinical Fellow input 9-5 Monday to Friday. Out of hours medical cover is via GoToDoc and not by the hospital on call teams. SOP Reviewed and action closed.
3.6	Review of Ascot House Intermediate Care facility.	RS	TC DE	February 2018	TBC	Routine review of capacity and flow is in place on a daily basis through the control hub and the daily monitoring report – therefore ongoing.

4. Challenge and scrutiny

Action No.	Action Required	Responsible Officer	Mgmt Lead	By When		Progress Made to Date
				Start	Finish	
4.1	Aging well strategy, Dementia strategy, frailty strategy and falls strategy to be concluded and implemented.	ER Cllr Judith Lloyd		February 2018	July 2018	All strategies have been in development for some time and are progressing well. GM dementia work underway in Trafford. How does this fit in with our other schemes.
4.2	H&WB Aging Well group to be established.	ER		February 2018		Established.
4.3	BCF reporting to include detailed analysis of urgent care performance system wide.	JG TC	Andrea Gallant	March 2018	September 2018	The H&WB actions will also take account of this. System wide urgent care resilience for both Manchester & Trafford is reported and monitored through MHCC.
4.4	Health Scrutiny Committee challenge function to be strengthened.	JC Cllr Rob Chilton	Democratic Service TMBC	January 2018	February 2018	Meeting planned in the diary accordingly. There is a new administration and the composition of the Health Scrutiny Committee has changed. This will be an on-going piece of work.

4.5	Ensure Trafford has a clear role in the GM partnership and can draw on appropriate support where required.	TG	All		Ongoing	- Part of the Urgent Care network and support received via the GM urgent care approach. - Trafford input into the GM Transformation Board to share learning from others across GM. - CCG CO part of the GM wide CCG CO group and CCG Association to ensure shared learning is received.
4.6	Review role of the VCS/Third Sector in the H&WB Board sub-groups with a view to strengthening engagement.	ER Cllr JL	ER	Ongoing		- Progress underway to confirm vision/statement of intent of working with VCSE as an equal partner in the engagement of commissioning plans across Trafford. CCG (Rebecca Demaine), TC (Adrian Bates) and Thrive Trafford (Chris Hart on behalf of all VCSE in Trafford) to put in place additional infrastructure so that there is an effective two-way engagement between the public sector and VCSE on commissioning and delivery.
4.7	Ensure LCA development takes account of all relevant contracting and business continuity issues.	TG JC	RD IT		April 2018	- Broad outcomes and design principles agreed for the LCA. Originating partners established a working group to determine operating model, service content and support to put in place shadow form Trafford LCO from 1 April 2018. Likely to commence with MDT services and build in phases over the next three years. - All services (bar specialised) included, all age and all providers including VCSE, community, social care, primary care, mental health and acute.

5. Market management/commissioning

Action No.	Action Required	Responsible Officer	Mgmt Lead	By When		Progress Made to Date
				Start	Finish	
5.1	System wide response to social care market and domiciliary care capacity to be developed and agreed.	KA RD AB	Vacant Post	March 2018	June 2018	- GM Care at Home workstream which Jill Colbert has led on in 2017 has provided framework to move forward. - This is being co-ordinated through the HOC. - Underway.
5.2	Construct a procurement model that engages service users in the process of selecting service providers/new service design.	KA AB	Jo Gibson Vacant Post	May 2018	July 2018	- Strong dynamic procurement framework in place.
5.3	Agree routine reporting to Joint Commissioning Board on provider performance.	RD KA		February 2018		- The governance structure has changed with integration. Provider performance will be reported to the Commissioning Board for Council commissioned services in the meantime until an integrated process is established.
5.4	Ensure all providers are making accessible information available to carers and residents to enable easy navigation through services.	DE				- The leaflet for patients upon admission has been updated and simplified .It is proposed to use this across all MFT sires. The leaflet on SAMS and D2A has been updated and simplified.

6. Intelligence and evaluation (including Quality Assurance)

Action No.	Action Required	Responsible Officer	Mgmt Lead	By When		Progress Made to Date
				Start	Finish	
6.1	Develop a clear performance dashboard to report to H&WB the Joint Commissioning Board and Scrutiny Committee.	IT PF MI	Abdus Waddee Darren Wagstaff			This will be a key role for the new CCG and Council integrated organisation. The new Joint Committee will need to ensure there is oversight on progress to adequately support the HWB.
6.2	CEC referral and activity data to be improved	RS	DE	March 2018		Provided through the urgent care control room capacity management.
6.3	Accelerated work on single case records/case summaries for all providers to view on an individual basis.	Integrated IT lead (to be announced)	Ridhwaan Hafezji ?			Optimisation of the TCC to be considered here.

Leads Key			
TG	Teresa Grant	TL	Tracie Lee
JC	Jill Colbert	JBS	Jason Bamford-Swift
KA	Karen Ahmed	IT	Ian Tomlinson
DE	Diane Eaton	HZ	Helen Zammitt
RD	Rebecca Demaine	KP	Kate Provan
TC	Tracy Cartmell	RS	Richard Spearing
JG	James Gray	MB	Mandy Bailey
MM	Mary Moore	SB	Sally Briggs
Dr NG	Dr Nigel Guest	MI	Michelle Irvine
AB	Angela Brown	ML	Merry Leslee
ER	Eleanor Roaf	PF	Peter Fink
Dr MJ	Dr Mark Jarvis	SR	Sharon Richardson

Trafford Transfers of Care Plan

Action Plan Only

Version 11.0

The table below cross references each of the Programme Objectives against each of the reportable reasons for DTOC.

DTOC Key										
	A	A) Completion of assessment	**C**	C) Further non acute NHS care (including intermediate care, rehabilitation etc)	**Dii**	D) Care Home placement - ii) Nursing Home	**F**	F) Community Equipment/adaptions	**H**	H) Disputes
	B	B) Public Funding	**Di**	D) Care Home placement - i) Residential Home	**E**	E) Care package in own home	**G**	G) Patient or family choice	**I**	I) Housing - patients not covered by NHS and Community Care Act

Programme Objectives	**Projects and Progress**	**Time scale**	**Exec Lead**	**Mgmt Lead**	**Impact of DTOC (See Key above)**	**RAG (As of Jun,18)**
1. Early Discharge Planning						
An integrated community health and social care team plan early discharges for all elective patient admissions.	1a. Elective discharge planning for hip and knees at UHSM. New IDT manager commences at UHSM on 8th Jan. Social Worker to be involved in Pre-Ops.	Sept 18	D Eaton	D Walsh / D McNicoll / Joe Kelly	B, F	
Robust systems support the development of plans for the management and discharge of all emergency and unscheduled patient admissions, with EDD set within 48 hours.	1b. Integrated discharge team at UHSM, Salford and TGH – Full plan for patient track being developed for UHSM. Length of stay group underway at Trafford general (reduced to below 70 days).	Jan 18	D Eaton	D Walsh / L Lyons	A	

	District nurse liaison approach agreed for Salford and Trafford general. **06.02.2018** D2A team base agreed and cabling / Wi-Fi has been reviewed – to be fitted asap. Separate D2A team to be established using ;- 1 Senior Practitioner 2 Social Workers 2 SCA Deputy Community flow manager 1 admin OT. Supervision of Ascot and Hospital Senior practitioners to move to the control room.					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun,18)
2. Systems To Monitor Patient Flow						
Robust patient flow systems and models are in place to support integrated teams and clinical decision makers to identify and manage problems and prevent bottlenecks 24/7.	2a. Community flow manager recruitment. **09/01/2017**; Started in post 21/11/2017.	Oct 17	D Eaton	D Walsh/M Albiston	Maximise capacity throughout the system.	
Transfers of care are planned around the individual and patient flow systems allow capacity to be automatically increased where demand (admissions) increases.	2b. GM Discharge pathway mapping project (complete mapping against process and identify gaps). **09/01/2017;** Mapping workshop took place on 16.11.2017. Revised Discharge Pathway documentation circulated and in test throughout the system and all four acute sites. 2c. Identify resources to meet increased demand (GM-Transformation Fund Bid). **09/01/2017;** Additional out of hospital capacity commissioned for D2A beds from 27/11/17. Urgent Care Control Room established	Nov 17	T Cartmell	D Walsh J Gray	Maximise capacity throughout the system.	

	in November 2017, is monitoring capacity and demand throughout the system and informing commissioning intentions. **06.02.2018** The numbers of beds is presenting a significant strain on community teams and delays in discharges. Commencing a review of data re admissions, referrals to social care and package of care requirements The patterns to referrals to support the ability to flex resources.					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun,18)
3. Multidisciplinary/agency Discharge Teams						
All discharge planning promotes a coordinated discharge to assess approach, through integrated MDTs, that is based upon joint assessment and discharge pathways, processes and protocols.	a. Discharge to assess project. (To develop an agreed model and identify additional necessary capacity). 09/01/2017; D2A beds commissioned from 27/11/2017. Admission criteria/spec letters etc.in use –review booked with homes this week. Rehab /intermediate care process developed. b. Procure discharge to assess nursing/ EMI bed(s). 09/01/2017; 13 Nursing home beds commissioned including 2 EMI beds.	Nov 17	K Ahmed	J Gray M Leslee J O'Donoghue J Gray M Leslee J O'Donoghue	Di, Dii, G	
	c. To identify agreed SW/DNL capacity required (GM – Transformation Fund Bid). 09/01/2017; Interim community social work allocation process being monitored pending agency	Nov 17	K Ahmed	M Albiston		

	recruitment to track use of D2A beds and completion of social work assessments. d. Training and development requirement for GPs in MDT. 09/01/2017; MDT due for initial rollout in late January.	Jan 2018	M Jarvis	R Demaine		

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun,18)
Integrated discharge MDTs have shared and agreed responsibilities, they include the third sector in discharge planning and they provide special arrangements for complex discharges.	e. Integrated discharge team at UHSM, SRFT, TGH (as per table section 1). 09/01/2017; Integrated discharge team at; UHSM SALFORD TGH Integrated manager started at UHSM on 8th Jan 18. Discussions commenced with Salford and Trafford general re Integrated on site management arrangements.	Jan 18	D Eaton	D Walsh/Joe Kelly	A,G	
	f. Role of Trusted Assessors agreed and implemented for specific tasks e.g. funding decisions social care/CHC (As per table section 7). **09/01/2017;** Trusted assessors in place at UHSM AMU /IMC However we Review the Trusted Assessor role –due to D2A process.	Jan 18	D Eaton	D Walsh/D McNicol	A,G	
	g. Co-design of new model for Voluntary Sector home from hospital (As per table section 7).	March 18	K Ahmed	A Brown	E,I,G	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun,18)
4. Home First Discharge to assess						
Patients always return home for assessment and reablement, where possible, after being deemed medically ready for discharge and are supported fully by integrated care and support teams.	a. Discharge to Assess Project (As per section 3). b. Increase in SAMS capacity procured – ongoing. **09/01/2017;** Streamlined assessment introduced and tracking in place. Daily availability included in the daily tracking sheet through the urgent care control room. Clear line of sight on numbers per day and expected availability and those waiting has supported commissioning to prepare for extension of SAMS with anew provider. Discussions re expanding SAMS with one provider with potential start date in January. c. Develop capacity in Homecare market.	Jan 17 Jan 17 Ongoing	K Ahmed K Ahmed K Ahmed	J Gray M Leslee J O'Donoghue D Gent D Gent	Di, Dii, G E E	

	09/01/2017; On-going- New homecare provider sourced. d. Develop single-handed care to provide more market capacity. **09/01/2017;** Potential models being worked up. Business Case will be needed.	Jan 17	D Eaton	D Walsh	E	
Where discharge home is not possible, step down beds will be utilised for assessment and additional care and support, where this is required.	e. Ascot House Step down beds. **09/01/2017;** All beds know as discharge to assess. Patients requiring an interim 24 hour care placement will be processed through the D2A beds.	Nov 17	K Ahmed	D Gent Sue Burrell	E	
Care homes accept previous residents trusting Trust /ASC staff assessment and always carry out new assessments within 24 hours	f. New framework for nursing and residential homes. **09/01/2017*;*** Contract currently with solicitor. Meeting to be arranged with K Ahmed and Merry-Fair Price for Care.	April 18	K Ahmed	D Gent J O'Donoghue	Di, Dii	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun,18)
5. Seven Day Services						
Patients receive seamless care provision that includes assessment and restart of care (within 24 hours) regardless of the time of day or week.	a. 7 day social worker and DN liaison provision for assessments at UHSM. **09/01/2017;** 7 day SW/ DNL in place at UHSM/TGH and Salford.	In Place	D Eaton	D Walsh	A, E	
Sustainable staffing rotas and new contracts are in place to deliver person centred seven day discharge to assess services.	b. 7 day social worker and DN liaison provision for assessments at UHSM. (As above).	In Place	D Eaton	D Walsh	A, E	
6. Trusted assessors						
Single integrated assessments, carried out across the system, can directly access jointly pooled resources and funding (without separate organisational sign off) and are 'trusted' and accepted by all care providers within the system. In Trafford we expect this to include acceptance by core agencies eg CCG and TMBC.	a. Implementation of Trusted Assessor policy within Trusts 24/7. See section 3f. b. Trusted Assessor trial project with Salford for CHC cases. **14.11.2017** Monthly meetings in place. Monitor impact. Evaluation due January 2018. **06.02.2018** Trusted assessors in place at UHSM AMU /IMC. However we Review the Trusted Assessor role –due to D2A process – to be looked within the workshop.	Sept'17 Nov'17	D Eaton M Moore	M Albiston S Kass	A, E A, Dii	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun,18)
7. Focus on Choice						
Staff understand choice and can discuss discharge proactively, including the active involvement of patients and relatives at the point of admission.	a. Full Implementation of the choice policy including senior ownership of eviction process at each Trust. **09/01/2017***;* Leaflets in redesign MCA processes been reiterated across all sites to ensure D2A options are used.	Sept'17.	K Ahmed D Eaton J Gray C Watts CMFT lead	Acute Trust leads	G	
8. Enhancing Health in Care Homes						
Care homes integrated into the whole health and social care community and primary care support.	a. MDT for Care Homes; NMOC work, reliant on GM Transformation Fund bid **09/01/2017**; Pennine care, OOH Mastercall and CCG preparing implementation plans. First phase roll out planned by end January. Meadway office being prepared to accommodate care homes team initially.	Jan 18.	R Demaine	T Cartmell.	Admission Avoidance	
	b. Scope Red Bag transfer System.	Nov 17.	M Leslee	New Commissioning Manager.	Admission Avoidance.	
There is no variation in the flow of people from care homes into hospital during the week.	c. C. ATT Plus project. **09/01/2017;** Service under review	Oct'17.	T Cartmell	J Gray.	Admission Avoidance.	

	within OOH contract.					
Care home CQC ratings reflect high quality care.	d. Implement Enhanced Health in Care Homes quality framework. **14.11.2017** – NHSE Vanguard work to build into MDT standards. Further review Jan 2018.	Jan 18	M Moore	M Leslee	Di, Dii, G	
	e. Project to increase registered management capacity.	April 18	K Ahmed/M Moore	J O'Donoghue	Di, Dii, G	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun,18)
9 Development of home care market						
There is a high quality home care market in place with sufficient, flexible capacity to meet local need.	a. GM transformational work stream for Support at Home Project. b. Partington Pilot active. **09/01/2018**; pilot live in Partington and Sale.	Sept 18 Nov 17	J Colbert K Ahmed	K Ahmed D Gent	E E	
10. Development of the TCC						
The TCC reviews and supports those at greatest need and prevents unnecessary hospital admissions by supporting primary care and linking to appropriate services.	a. Deliver a Care Coordination service to 2,000 patients by April 2018, identified through a risk stratification tool. b. Discharge coordination service to prevent readmission. 09/01/18; pilot underway with Wythenshawe site. c. Agree referral protocols with Community Enhance Care (CEC) service. d. Link TCC to Urgent Care control centre (the central point for the utilisation of commissioned services).	Jul 17 -Apr 18 Dec'17 Jan 18 Mar 18	T Cartmell M Jarvis	T Weedall	Admission Avoidance	

	06/02/2018 The TCC reviews and supports those at greatest need and prevents unnecessary admissions by supporting primary care and linking to appropriate services. TCC development Facilitate discharge / prevent admission—increase service users based on risk stratification tool to facilitate advanced planning with CEC- initial discussions held re how we can develop the model. Referrals to CEC from risk stratification tool being tested.					

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun 2018)
11. Development of Intermediate Care Services						
Increasing the utilisation of Intermediate Care (Ascot House) services in Trafford and reducing delays within the unit to ensure effective and timely response and efficient flow.	a. Clinical model and pathway developed reviewed and confirmed. b. The business model arrangements to reflect service model. **09/01/2018;** Care at home taking dedicated step down from Ascot, CEC and MRI –working well and supporting flow. New manager appointed in Care at home. Electronic rota system being explored Pathway being reviewed further to develop trusted assessor /and three conversations as new senior prac started at Ascot house. Pathway from CEC revised and working well with capacity available on a Monday to take step downs Available resource in community showing successful improvements in community flow.	Dec 17	R Demaine	J Gray D Eaton	C	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun 2018)
12. Public Funding decision making						
To ensure decisions for public funding are made appropriately and timely to avoid DTOC	a. CHC funding decisions b. Social Care funding decisions **09/01/2018;** All decisions up to £850 delegated to senior pracs on site in hospital teams being extended to include new IDT manager. New funding operating procedures written. System changes completed. Fast track decisions making in place for decisions above £850. Out of panel MH cases activated. **06/02/2018** Mtg MH RAID service held –need a further session with GMMH to discuss completion of assessment process and out of panel decisions making and distribution to all acute sites. Access to HOST out of hours added to Easter plan. Trafford housing trust out of hours process added to Easter plan.	Nov 17 Nov 17	M Moore D Eaton	Sally Kass TBC	B B	

Programme Objectives	Projects and Progress	Time scale	Exec Lead	Mgmt Lead	Impact of DTOC (See Key above)	RAG (As of Jun 2018)
13. CQC action plan						
To identify any actions from the CQC review of the health and social care system which are relevant to the Urgent Care Board.	a. Action Plan to be developed. **09/01/2018;** plan in development to be integrated on completion.	Jan 2018	J Colbert	K Ahmed T Cartmell	A, Di, Dii, E, G	