APPENDIX 1- DTOC Action Plan linked to High Impact Change Model Self-Assessment (NHSE)

Key Milestone	Actions	Start Date	End Date	Lead Organisation	Progress/ Comments	Rag Rate
1. Full integration of discharge planning	Map out current teams/function of Transfer of Care Team, Hospital Social Work and MDTs	**July 2017**	**August 2017**	RFT/RMBC	Exercise undertaken through 2x workshops with staff to understand current position including FTEs across each service and main function.	
	Discussion with Doncaster re; their model including possible secondment of Doncaster colleague (6 month).		**August 2017**	RFT/CCG/ RMBC	Doncaster visit by all partners in late July to understand model and bring back learning. Secondment not available – however Rotherham staff experience of model is being utilised	
	Agree shared model for integration of discharge function		**September 2017**	All	Project Initiation Document completed on phased approach to implementation – to go through ACS governance in September	
	Integration of Hospital Social Work into new model for discharge. Formalise links with Mental Health and Community Teams		**December 2017**	RFT/CCG/ RMBC	Standard operating procedures in development. Identification of appropriate office space underway.	
					Overall Rag Rating	
Agree Joint Reporting and Data Set	Agree revised joint reporting structure and governance for reporting (acute, social care and non acute).	**July 2017**	**September 2017**	CCG/TRFT/ RMBC	**Change 2** Leads for performance (CCG/RMBC/TRFT) met and agreed process for sharing data set.	

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	Agree process for signing off delays (acute, social care and non acute)	**July 2017**	**September 2017**	CCG/TRFT/ RMBC	Standard Operating Procedures are being developed to support appropriate and consistent identification of DTOC across the system. To be agreed shortly.	
Awareness training to include full understanding of Care act 2014	Awareness training required to ensure principles of Care Act implemented – Prevent, Reduce, Delay (Home First) All appropriate Health colleagues complete the E-Learning training commissioned by RMBC	**August 2017**	**March 2018**	TRFT Support from Nigel Mitchell RMBC	**Change 3** E-Learning packages available through RMBC – TRFT lead to be identified to ensure work is progressed	
Ensure a Universal Home First Approach is offered	Expanded Integrated Rapid Response – incorporate enabling/reablement into the provision to provide a universal offer of discharge home as pilot provision **NB** requires investment possible IBCF.	**July 2017**	**October 2017**	CCG/RMBC Jacqui Clark	**Change 4** Business Case for additional resource has been agreed and will be funded through IBCF. RMBC are currently in negotiation with provider for a proposed start date in October 2017	
	Map current DST activity in acute setting. Revise and implement new pathway to D2A provision at Waterside Grange Longer term solutions – • Review of Discharge to Assess beds (potential to shift financial resource to home model) • Review of enabling service provided by RMBC	**July 2017**	**October 2017** **March 2018**	CCG CCG/RMBC Support from partners	Pathway process has been developed for 3 of the 6 beds at Waterside Grange. New process to be phased in throughout September	
Agree escalation process and response	All partners on EMS	**July 2017**	**August 2017**	All partner leads	**All changes** All partners have triggers and actions agreed	

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	TRFT revise triggers for acute and community		**September 2017**	TRFT	Report taken to TRFT transformation board to revise triggers – work is ongoing	
Social Care offer in new Emergency Centre	Consider how social care will support the new EC model of front end streaming (admission avoidance)	**July 2017**	**March 2018**	RMBC Jo Martin CCG/TRFT	**Change 4** RDASH integration progressing well. Social Care involved in the frailty team. Further work to embed model and understand role of social care as team becomes integrated	
Review 7 Day Offer	Review 7 Day services offer across acute/community – opportunities to expand or reconfigure provision to better meet need	**July 2017**	**September 2017**	RMBC	**Change 5** Helen Brown change lead working on therapy pathway and options for flexibility in provision (expansion of OT offer to meet need of service). Potential to take longer to implement service redesign.	
	Provision of robust 7 day week offer from social care providers (Dom Care/Residential Care)		**March 2018**	Jacqui Clark RMBC / CCG		
Develop trusted assessor model with social care providers	Pilot and look to roll out trusted assessor model in social care – Residential Care	**September 2017**	**March 2018**	Jacqui Clark RMBC / CCG	**Change 6** Work underway to integrate discharge team. Workshop took place July 2017 with partners and patients re; integrated assessment.	
Patient and Family Choice	Improve early identification of patient likely to need care home	**September**	**March 2018**	TRFT	**Change 7**	

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(19% of DTOCs in 2015-16)	admission. Re-design of discharge leaflet.	**2017**			Reviewing this for IRR/CCC	
Review MoU Agreement	Review of MoU Agreement already in place, to reflect changes in the discharge teams (as above). All partners to implement MoU which includes Trusted Assessor	**December 2017**	**January 2018**	CCG/RMBC support from Partners	**Change 1 & 3**	
Review and streamline discharge pathways **NB** links to wider place plan priority re; reablemet review.	Map current position across the discharge pathways (currently 3 in place – discharge home, discharge to intermediate care beds, and discharge to nursing/assessment beds).	**July 2017**	**October 2017**	CCG/RMBC	**Change 1 & 3**	
	Streamline processes and ensure all relevant partners are aware of the pathways.		**March 2018**	Support from partners		