High Impact Model – Action planning Template

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	**Established** • Information given as soon as possible after admission • System leaflet tracker in place	• Additional training so all staff understand their role to play in discharge planning • Electronic notifications for elective admission to social care with needs described • Increased MDT working for emergency admissions that involve families and carers further speeding up discharges	**May 2023**	• Quicker discharges – days waiting for discharge will decrease • Reduced waiting times when MOFD
Change 2: Monitoring and responding to system demand and capacity	**Established/Mature** • Data analysis to understand system trends for long and medium term strategies. • Key blockages identified, high impact change models such as Home First D2A being scoped for improvement. • Currently have a daily reporting system between partners to view capacity and flow	• A system-wide emphasis on impacting and reducing ambulance hand over times • Introducing virtual ward rounds to manage flow. • Increased integrated training to give all front-line staff the same message ensuring they understand service capacity, pathways enabling best decision making for individuals. • Increased working with VCSE sector to develop step down facilities	**Feb 2023**	• Increased patient feedback with increased positive outcomes • Less waiting days once MOFD • Improved ambulance hand over times • Better information sharing with less time spent trying to contact each organization. • Better engagement from VCSE services. Attending delivery groups more frequently.
Change 3: Multi-disciplinary working	**Mature** • We have established MDT working across the system, through the IDT hub and our co-located HomeFirst services • Support in place for Clinical Navigation Hub but yet to be recurrently funded	• Capturing continuous feedback and evaluation to improve the experience of staff and people accessing care. • Build on successful pilots started via Ageing Well and embed capacity needed to contribute to the Unscheduled Care Hub	**Dec 2022**	• Joint training across the system implemented • Improved experience for staff and people accessing care • Increased MDT working
Change 4: Home first	**Mature** • Established Home First Service	• Look at costs to system rather than each organisation for a truly integrated home first service. • Increase re-ablement and	**April 2023**	• Increased numbers of people going to their home after discharge • Decrease in social care services

		rehabilitation in the community to Increase capacity to address 85 / 95% discharge time targets • Better data reporting to track people 6 months after discharge to monitor progress of Home first services. • Streamlined pathways working towards a single point of access.		when more people are given re-ablement and rehabilitation after discharge • People are still at home 6 months after discharge • Better understanding of discharge pathways
Change 5: Flexible working patterns	**Mature** • ICRS and Reablement – 7 days per week, with 24 hours crisis cover and less than 2 hour response	• Consult with medical staff to provide more weekend cover • Consider brokerage needs if P1 is extended to take all discharges	**Jan 2023**	• UHL to look at 7 day staffing to further support discharges particularly consultant decision making and pharmacy
Change 6: Trusted assessment	**Established** • Trusted assessors in place across UHL and LPT for specific community services	• Looking to expand the role / realign it to the IDT in UHL and allow it to be more flexible with other roles within the IDT function	**March 2023**	• Quicker assessments resulting in quicker discharges
Change 7: Engagement and choice	**Established** • Many leaflets given out on admission	• Further engage with VCSE sector to be more involved in discharge planning and support • Update system wide leaflets on who funds care now D2A has reverted to 7 day funding • Clearer message to families on discharge routes and funding • Better streamlined choice protocol • Further involve group feedback i.e. patient groups when developing information leaflets • Be more creative when communicating this information i.e. talks on TV screens explaining in simple language	**Nov 2023**	• Families and people accessing care feel better informed on their choices • Better engagement with patient groups giving a voice to people accessing care • Regular representation with Healthwatch across the system • Housing Discharge enabler team linking to vol sector for earlier discharges
Change 8: Improved discharge to care homes	**Established** • NHS emails provided to care homes	• For out of hours care/urgent care, look at care homes having Ipads with GPs/professionals on the end of a video call which will reduce conveyances in the first place.	**March 2023**	• Reduced conveyances from carehomes who care for some of Leicestershire's most vulnerable people.

	• Trusted assessor role	• Attend local care home forums to establish what providers feel our challenges and working well on discharge process. • Better/faster communication between wards and care homes • Actively involve ambulance service when planning		• Decreased waiting days once MOFD • Use of TA's to reduce reliance on care home assessment requirements • Improved brokerage function
Change 9: Housing and related services	**Mature** • Established service/roles (housing enablers) to allow for early planning before discharge	• Use technology creatively within the home to enable safer discharges • Communication campaign to allow all involved in discharge to know technology available and a clear pathway for referral • Use an approved temporary housing whilst adaptations/changes are being made to peoples homes	**Jan 2023**	• Increased use of technology within peoples homes allowing for quicker discharges. • Less waiting time from referral to completion for adaptations to be made in a persons home • Improved access and use of extra care facilities • Use of DFG top-slicing for additional housing related initiatives