Discharge Action Plan: Stretch aim & Local Targets: Reduce unscheduled bed-days in hospital care by 10 percent; 10 patients over 2 weeks; 600 occupied bed days per month

	AMBITION	ACTION	TIMESCALE	UPDATE	RAG STATUS
1	To ensure that delayed discharge is understood to be a central priority of the health and social care partnership.	Monthly reports to Integrated Corporate Management Team, Co-chaired by the two Chief Executives.	Monthly	Achieved.	
		Clinical Lead for Delayed Discharge identified to lead engagement with clinical staff, as required.	Achieved	Roles and responsibilities to be approved as advised in the Internal Audit Report December 2017 – draft from ICMT consideration.	
		Executive Lead for Delayed Discharge identified to lead management of system and report on performance.	Achieved	Roles and responsibilities to be approved as advised in the Internal Audit Report December 2017 - draft from ICMT.	
		Effective succession planning to ensure that discharge planning manager is secured in post.	*April 2017*	*Achieved.*	
2	To ensure that we are engaging effectively with carers and families to support discharge processes.	Strengthen public information about care options.	Review October 2018	LPG leads to continue to monitor meeting agendas to enable the detail of the Action Plan to have relevance with communities and the public in general. Chief Officer article available in the local press to update the general public on care options and the fundamental drivers being progressed through integration.	
		Review the ward based information shared with patients and their carers to reflect the discharge process in general and the potential for discharge to be actioned at short notice, as resources permit.	May 2018	Leaflets were considered during the multi-disciplinary training session in April inclusive of carer representation. Documents are currently in final draft due to be released end of June.	
		Build up support offer to unpaid carers in response to Carers Act.	Review October 2018	Eligibility Criteria approved an agreement from IJB to allocate £50k of the £117 available to implement carer planning via the social work team. Agreement to progress a framework of monitoring for all resources deployed to support carers to address unmet need across the spectrum of eligibility criteria. Data analysis underway to monitor, report and project need and unmet need.	

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		Multi-disciplinary training for acute, community and externally commissioned services and staff teams on the Carer's Act implications.	Review October 2017	Multi-disciplinary event completed in April 2018 Carer information Strategy Group providing an inclusive forum for internal and external service partners to identify and address training issues. Learning from the event to be shared with all Carer partner organisations and Locality Planning Groups.	
3	To ensure that we are engaging effectively with carers and families to support discharge processes.	Develop a position statement to be used by the media to better describe how we want to use our health and social care capacity.	Review October 2018	Chief officer blog utilised weekly to provide information on the whole system activity; press article issued.	
		Acute based documentation to be revised to make explicit the identification of an informal carer and their involvement in the discharge process.	Review December 2018	The April training event included activity on the use of documentation and further refreshing of documentation is being led through the Excellence in Care Pilot	
4	*To improve our overall understanding of our local system.*	*Development and dissemination of management information.*	*Monthly*	*Complete - Routine and non-routine reports in use. Whole system analysis being considered for local and national benchmarking.*	
5	To use management information more effectively to drive service improvement.	ISD GP Cluster Activity to provide additional data sets to support service planning and prevent admissions	Update June 2018	Cluster activity on-going with datasets being refined.	
		To track number of admissions from care homes and explore protocols to avoid admission.	January 2019	Further work on this being discussed with the locum Consultant Geriatrician and will be progressed towards the end of the year and into 2019. Data reports in production to aid the analysis of admissions and application of criteria for potentially preventable admissions.	

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		Local performance target to be set to reflect the recommendation of the internal audit report and enable a local measure to be applied to reporting processes.	Implemented January Reviewed weekly/ monthly	Targets have been set at 600 occupied bed days per month and 10 patients delayed over 2 weeks. The targets are included in reporting with the patient numbers monitored weekly through the circulation of the weekly detailed report. Current factors impacting on the target are the management of the discharge of the winter surge in admissions, the long term patient discharges and the prioritisation of medical bed discharges to support hospital flow.	
6	We prevent people being admitted to hospital where they can be supported in community settings.	Ensure that SPARRA (Scottish Patients At Risk of Readmission and Admission) data is used by all primary care teams.	October 2018	Being progressed through the development of eFrailty as part of HIS initiative prior to the installation of SPIRE through local development. This will involve development and benchmark testing with GP cluster to stratify and validate the data.	
		Anticipatory Care Plans become more widely used, especially for people with Long Term Conditions or who have palliative care needs.	June 2018	Local ACP work proceeds and has developed and tested a local form. It requires a roll-out of training. It also requires improvements in IT provision to enable sharing of important data between sectors. Results of national work relating to a more shared approach to KIS pending. More work requires to be done to agree a plan for specific or universal implementation and the associated training requirements	
		The Out of Hours Review aims to create a robust, reliable, self-sufficient, urgent and emergency care team to provide a resource able to flex to meet clinical and care need to assess and manage patients at home or in a homely environment as far as possible and only admit when clinically appropriate.	Review July 2018	Monthly meetings continue and work has been divided into workstreams. Project manager awaited to help drive the work. It requires multi-sector working and engagement with SAS is being progressed. Workforce engagement underway.	

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7	To ensure that hospital receiving services are well-equipped and well-informed in the provision of ambulatory care.	Ensure that A&E and assessment staff have up to date information about care options, support and transport, including rapid response and Out of Hours options.	Complete/ on-going	The recent training event shared the scale and scope of services available. Routine updates will be issued through service management and new service provision referral routes and eligibility issues to all acute and community service leads and partners.	
		Work with nursing and medical staff on a policy of 'decide to admit' rather than 'admit to decide'.		The proposed work with the Consultant geriatrician and the Structured Ward rounds are sources for learning to be utilised to enhance staff awareness and training.	
8	All patients are given an Estimated Date of Discharge.	The use of Estimated Date of Discharge is applied against objective criteria.	June 2018	Weekly monitoring of performance by ward shared with relevant staff. All patients monitored through the 'potential delayed discharge' are only considered with an EDD. Process and IT issues have been identified and solutions being sought to improve the recording and reporting of data.	
		Develop MDT ward rounds (involving a physician, OT and SCN) to support proactive discharge planning and consider the development of the Discharge to Assess risk assessment currently in draft form.	Review October 2017	Currently in the third phase of test, Structured Ward round approach being developed as a blended model merging the associated principles of dynamic discharge, professional and OPAH standards. Multi-disciplinary work has halted on further development of a draft discharge to assess policy, as existing processes and documentation can enable discharge to assess. The ward rounds, day of care audit and weekly meetings are the forums to reinforce the potential for such a discharge.	

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9	People's long-term care needs are only assessed at a point where they have had an opportunity to regain a level of independence.	A presumption in favour of assessment at home will be implemented, linking with wider reforms around intermediate care.	Review October 2018	The Intermediate Care reform encapsulates bed based and responsive teams. Intermediate Care service registered with staff induction on-going and recruitment pending to complete staffing schedule. Service operational with bed based service to begin on conclusion of recruitment. Colocation of team complete.	
		Light-touch early assessment by MDT devised to support discharge planning, with defined timelines.	*Complete*	*Existing assessments tools are being used with potential delayed patients escalated to the weekly meeting to ensure MDT engagement on a proactive basis.*	
		Plans will be put in place to optimise the activity of patients in the hospital, to ensure physical independence is maintained.	Review June 2018	Upgrade works complete, café activity on-going and An Lanntair project evaluation project complete. Proposals for activity co-ordinator and additional porter assistance for wards being developed. Individual care plans and activities for patients on-going with support from AHPs. Social care knowledge of patients shared to assist in the maintenance or restoring of independent skills.	
10	People's long-term care needs are only assessed at a point where they have had an opportunity to regain independence.	Pre-existing care packages are kept open until such times as a full assessment has been done, subsequent to reablement process. Leadership work to be undertaken across MDTs on risk appetite and managing difficult conversations.	Complete April Review June 2018	Patients are escalated for review if their needs change and each inpatient's care plans are subject to a formal MDT discussion on a weekly basis. Leadership activity followed up during the April multi-disciplinary training session. Learning from the winter planning process shared with Service and Corporate Management for action as appropriate.	

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		The timing of undertaking an assessment and the process of reviewing an assessment are reviewed to ensure referrals are submitted and actioned appropriately with service requests considered for the most appropriate level of support.	May 2018	This action has arisen from the Winter Planning De-brief and through discussion at the weekly discharge meeting. The submission of referrals when a patient is not at the optimum functioning is an issue addressed through a meeting of service leads and the process of reviewing aspects of an assessment through multi-disciplinary input is being streamlined.	
11	Patients are discharged safely and as quickly as possible back to their place of residence.	Arrangements are put in place to increase the number of weekend discharges and before noon.	Ongoing	6EA group reviewing data and improvements noted. Currently operating at 30% before noon. Improved performance before midday discharges in simple discharges with no other service dependencies. When other agencies are involved more challenging i.e. Flight times to OUAB, Air Ambulance, SAS transport with single man crews. Aligning social care support services is addressed through on-going contact of the planning at the weekly meeting. Complexity can occur for such discharges when including transportation. Opportunities/Challenges detailed at huddle and reasons why 12 midday target cannot be achieved – Where possible focussed action to facilitate pre noon discharge taken forward through am and pm huddles.	
		Criteria-led discharge to continue to be developed.	June 2017	See previous comments for action 8.Patients identified for potential criteria led discharge are added to the discussion list for the afternoon huddle.	
		Transportation options are defined and clearly understood by all staff involved in the discharge process.	Complete SLA subject to further discussion	Winter Planning and Public Holiday scheduling taking into account transport booking requirements and availability. Issues regarding SLA arrangements being pursued as a separate issue and escalated via CMT due to the arrangements proving to be routinely problematic.	

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		Ensure that effective records are maintained within case notes.	Review December	Revised system being trialled in WI Hospital as previously referenced – Excellence in Care Pilot.	
		Ensure that we have an agreed escalation process and that all parties understand it.	Achieved Review June 2018	Staff are clear on the discharge process and the weekly meeting facilitates discussion on patients not delayed and community pressures. Escalation procedures for social care beds are included in hospital bed management procedures. Winter planning de-brief to be further considered in this context. Bed Management Plan currently being reviewed to enhance the actions associated with triggers across acute and community services.	
		Engage consultants to discuss discharge process with reference to 'Day of Care' survey and to ensure that decisions not to discharge are specifically justified.	Review December	This process will be consider in conjunction with the PDSA on structured ward rounds and the on-going activity in relation to frailty assessments. See Excellence in Care reference.	
12	The over-arching reforms set out in the strategic plan to develop intensive reablement services and step-up / step-down intermediate care is delivered.	Intermediate Care Services are developed including a blue print for a bed based intermediate care service in Stornoway.		See update for Action 9	
13	Community capacity is developed by looking at innovative ways to support more care at home packages.	Flexible recruitment of homecare workers and healthcare assistants for deployment in different settings.	Review October 2018	Re-design for homecare workforce and management complete. 30 apprenticeships being developed for Locality Services and spectrum of training and experience within health and social care will feature to provide a quality training experience.	
		Focused engagement with communities, specifically trusts and charitable organisations to be actioned to identify the range of supports to be considered on a sustainable basis.	Review October 2018	Conclusion of discussions to be portrayed in the Locality Plans to seek agreement on actions to be addressed and monitoring of progress.	

Names	Abbreviations	Names	Abbreviations	Names	Abbreviations	Names	Abbreviations
Emma Macsween	EM	Jimmy Myles	JM	Sonja Smit	SS	Susan MacAulay	SMacA
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