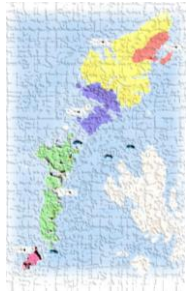

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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

Discharge Action Plan

	Ambition	Action		Timescale	Progress Update	RAG Status
Leadership	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		
		Executive Lead for Delayed Discharge identified to lead management of system and report on performance		Achieved		
		Clinical Lead for Delayed Discharge identified to lead engagement with clinical staff, as required		Achieved		
		Effective succession planning to ensure that discharge planning manager is secured in post		September 2016	Second recruitment process underway. Deadline 28th November 2016.	

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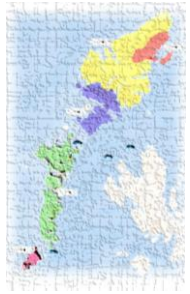
	Ambition	Action		Timescale	Progress Update	RAG Status
Communication	To ensure that we are engaging effectively with carers and families to support discharge processes	Strengthen public information about care options		October 2016	The Locality Planning Groups agendas are exploring the local and broader challenges facing health and social care. AGM's of key stakeholders included discussion on models of care, capacity and public expectation. Communication plan being implemented for Residentail Care Review. Press interest in matters such as delayed discharge and residential care resources have enabled responses to contextualise service pressures with service improvement actions being undertaken.	
		Build up support offer to unpaid carers in response to Carers Act		March 2017	Carer Information Strategy Group has prioritised local actions to inform a revised outline of a local Carer's Strategy to be considered in December 2016.	



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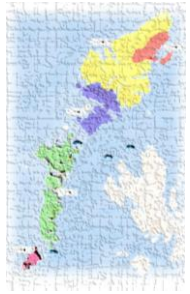
WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

	Ambition	Action		Timescale	Progress Update	RAG Status
Communication	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		7th November	Chief Officer has prepared a draft and is following up with stakeholders.	
		For the above to be communicated to weekly discharge meeting		3rd November	Head of Service providing the link with the weekly meeting and revising the agenda to capture whole system pressures.	
Analysis and Prevention Tools	To improve our overall understanding of our local system To use management information more effectively to drive service improvement	**Development and dissemination of management information**		Initial collation – August 2016 Updated monthly thereafter	Work has been completed to enhance management information for service areas and developing the Key Deliverbales. More work to be done to define and deliver a dashboard for routine oversight of performance.	
		To track no. admissions from care homes and explore protocols to avoid admission		7th November	Complete. No issues identified.	



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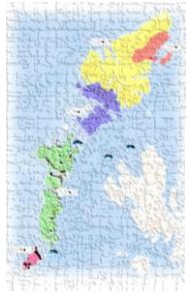
WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

	Ambition	Action		Timescale	Progress Update	RAG Status
	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 2016	An alternative to SPARRA is being considered to provide more effective data sources to be considered by primary care. ACP's are the focus of primary care cluster activity. Work completed to enhance access to KIS. Consideration of targetted ACP development in relation to long term conditions.	
		Anticipatory Care Plans become more widely used, especially for people with Long Term Conditions or who have palliative care needs		March 2017		
Front Door	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		October 2016, then regular updates	Complete – noting that enhancing existing services such as rapid response will require further work when appropriate.	
		Work with nursing and medical staff on a policy of 'decide to admit' rather than 'admit to decide'		March 2017	Multi-disciplinary work on-going in relation to managing risk and use of resources.	



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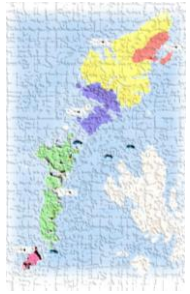
WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

	Ambition	Action		Timescale	Progress Update	RAG Status
Admission	All patients are given an Estimated Date of Discharge	The use of Estimated Date of Discharge is applied against objective criteria Training needs of clinicians are addressed in respect of estimating discharge date		December 2016 December 2016	Further work to be done to develop improvement activity for the application of EDD and training needs.	
		Ensure that all patients are given an Estimated Date of Discharge and develop MDT ward rounds (involving a physician, OT and SCN) to support this process		8th November 2016	As above	
Assessment	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 early supported discharge Light-touch early assessment by MDT devised to support discharge planning, with defined timelines		December 2016 December 2016	Initial progress identifies opportunities to enable more assessments at home, however risk management criteria and resources are still to be considered. Triaging of referrals being planned for trial with social work and OT.	
		Plans will be put in place to optimise the activity of patients in the hospital, to ensure physical independence is maintained		October 2016	Capital budget for hospital works identified. Application for external resources to enhance reablement training for staff and activity opportunities for patients has been submitted.	



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WESTERN ISLES HEALTH AND SOCIAL CARE PARTNERSHIP

	Ambition	Action		Timescale	Progress Update	RAG Status
Assessment	People's long-term care needs are only assessed at a point where they have had an opportunity to regain a level of independence	Pre-existing care packages are kept open until such times as a full assessment has been done, subsequent to reablement process		December 2016	Service request for ceasing services issued on the basis of assessment.	
Discharge	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		October 2016	6EA group reviewing data and improvements noted. Services operating on the basis of minimum notification period.	
		Criteria-led discharge to continue to be developed		March 2017		
		Transportation options are clearly understood by all staff involved in the discharge process		October 2016		
		Ensure that effective records are maintained within case notes		1st November 2016	Revised system being trialled in WI Hospital	

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	Ambition	Action		Timescale	Progress Update	RAG Status
		Ensure that we have an agreed escalation process and that all parties understand it		7th November 2016	Draft Social Care escalation plan circulated for comment to enhance the submission of the winter plan.	
		Engage consultants to discuss discharge process with reference to 'Day of Care' survey and to ensure that decisions not to discharge are specifically justified		1st November 2016	Auditing tool being used daily	
Service Redesign	The over-arching reforms set out in the strategic plan to develop intensive reablement services and step-up / step-down intermediate care is delivered	The early supported discharge team is augmented with home care coordination and assessment and care management capacity to deliver a multi-disciplinary approach		October 2016	Reports approved by the ICMT in November 2016 and further reports being considered at the December 2016 to seek approval to enhance existing intermediate care provision and core services such as care at home.	
		A blue print is developed for bed based intermediate care in Stornoway		December 2016		
	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		October 2016