**Discharge Action Plan** **Stretch aim: Reduce unscheduled bed-days in hospital care by 10 percent**

| | AMBITION | ACTION | LEAD | TIMESCALE | UPDATE | RAG STATUS |
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| 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 | EM | Monthly | Achieved | |
| | | Clinical Lead for Delayed Discharge identified to lead engagement with clinical staff, as required | EM | Achieved | Achieved | |
| | | Executive Lead for Delayed Discharge identified to lead management of system and report on performance | KB | Achieved | Achieved | |
| | | Effective succession planning to ensure that discharge planning manager is secured in post | CC | 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 | LPG IJB link officers | September 2017 | 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. Carer Information Strategy Group directing use of funds to help support carers in their roles and with decision making. | |
| | | Build up support offer to unpaid carers in response to Carers Act. | EM | May 2017 | The readiness tool issued nationally is being issued to support work with the Carers Information Strategy Group to enable prioritisation and sequencing of preparatory work to address the legislative requirements. | |
| | | Multi-disciplinary training for acute, community and externally commissioned services and staff teams on the Carer's Act implications. | EM | October 2017 | The Dynamic Discharge workshop on September the 11th will provide training for the target audience building on the issues raised at the Delayed Discharge Seminar and identifying future training needs | |

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| 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 | RC | September 2017 | Reschedule to connect with intermediate care development and incorporate feedback from the LPGs. | |
| | | Acute based documentation to be revised to make explicit the identification of an informal carer and their involvement in the discharge process | JM | July 2017 – Update November 2017 | The established use of a 'Communication Sticker' continues to be implemented pending a revision to the Integrated Assessment Document | |
| 4 | To improve our overall understanding of our local system | Development and dissemination of management information | MM | Monthly | 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 | MM & KB | March 2018 | Work is being done to refine the SPARRA data and incorporate primary care information | |
| | | To track no. admissions from care homes and explore protocols to avoid admission | RC/MM | Ongoing | Subject to ongoing review but no issues identified. Provision of IV fluids being administered in residential setting is being discussed with community nursing. | |
| 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 | KB/MM | March 2017 | See update for action 5. | |
| | | Anticipatory Care Plans become more widely used, especially for people with Long Term Conditions or who have palliative care needs | KM/KB | March 2017 Update November 2017 | The Group leading on this are considering the recently issued national document with planning underway to engage with all stakeholders following an audit of activity. | |

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| | | 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. | KB/StM/ SMacA | April 2019 | Project progressing as detailed in the Report to ICMT with the support of the external funding. | |
| 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 | KS | March 2017<br><br>Update September 2017 | Dynamic Discharge event to identify a vehicle for sharing updates. Weekly Delayed Discharge meeting used as a routine mechanism for service updates. | |
| | | Work with nursing and medical staff on a policy of 'decide to admit' rather than 'admit to decide' | KB | March 2017 | Multi-disciplinary work has halted on further development of a draft policy, with the work to continue in line with intermediate care service established and OOH review timescales identified. | |
| 8 | All patients are given an Estimated Date of Discharge | The use of Estimated Date of Discharge is applied against objective criteria | MM/KB | December 2016 Update October 2017 | A review of use to be undertaken by the Patient Flow Manager to identify any application issues | |
| | | 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. | JM &MS | June 2017 Update October 2017 | PDSA underway for structured ward rounds and learning will inform future actions. | |

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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 | MS/SS | October 2017 | The Intermediate Care reform encapsulates bed based and responsive teams. | |
| | | Light-touch early assessment by MDT devised to support discharge planning, with defined timelines | MS/SS | Achieved | 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 | JM/AM/MC | May 2017<br><br>Update October | Work underway within WI Hospital as defined in the scope of the brief for the works. | |
| 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 | PD/MS | Complete | Patients are escalated for review if their needs change and each inpatient's care plans are subject to a MDT discussion on a weekly basis | |
| | | Leadership work to be undertaken across MDTs on risk appetite and managing difficult conversations. | EM | September 2017 | Workshop supported by external facilitation to enable multi-disciplinary discussion on risk appetite and difficult conversations. Need for future external assistance under review. | |
| 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 | PD/MS/JM | Ongoing | 6EA group reviewing data and improvements noted. | |
| | | Criteria-led discharge to continue to be developed | JM/RC/CC | June 2017 | See previous comments for action 8. | |
| | | Transportation options are clearly understood by all staff involved in the discharge process | | March 2017 | Engagement with SAS undertaken with the Nurse Director and Chief Officer. Any issues to be escalated to hospital manager. | |

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| | | Ensure that effective records are maintained within case notes | AM/KB | April 2017 | Revised system being trialled in WI Hospital. | |
| | | Ensure that we have an agreed escalation process and that all parties understand it | LM/EM | Achieved | 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. | |
| | | Engage consultants to discuss discharge process with reference to 'Day of Care' survey and to ensure that decisions not to discharge are specifically justified | AM/KB | Achieved | This process will be considered in conjunction with the PDSA on structured ward rounds and the on-going activity in relation to frailty assessments. | |
| 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 | PD/EM/JM | October 2017 | Investment confirmed and regulator services engaged in the registration of the service. | |
| 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. | PD/KB | October 2017 | Subject to further workforce planning discussions. | |
| | | 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. | LPG IJB Link Officers and KS | October 2017 | Will require consideration of the range of existing commissioned services and the scope to re-design investment and access external support via funding or voluntary efforts. Engagement with land owning trust through Locality Planning groups is variable. | |

| Names | Abbreviations | Names | Abbreviations | Names | Abbreviations | Names | Abbreviations |
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