Agenda Item No 13

Appendix 1 to Report IJB 29/19

ANGUS HEALTH AND SOCIAL CARE PARTNERSHIP

Performance Report: Effective Discharge

March 2018

Angus Health and Social Care Partnership

Effective Discharge

1. Introduction

Timely discharge from hospital is an important indicator of effective management of the discharge pathway and is a marker for person centred, effective, integrated and safe care. Older people may experience functional decline as early as 72 hours after being clinically ready for discharge and the risk increases with each day delayed in hospital. This increases the risk of harm and of a poor outcome for the individual and further increases the demand for more intensive support at home or likely admission to a care home.

At present in Angus patients can only be discharged safely when an assessment of need has taken place and when suitable services or community resources are in place to ensure the person's wellbeing. This process can involve complex decision making including: comprehensive needs assessment; care planning; individual choice for patients; risk management; family inputs; and the matching of need to resources, such as personal care at home and care home availability and choice.

A 'delayed discharge' is where a patient remains inappropriately in a hospital bed, no longer receiving treatment but merely waiting for an appropriate place in the community, then they are to be classified as a delayed discharge (Delayed Discharge Definitions Manual – Effective from 1st July 2016, ISD).

For public reporting purposes delayed discharges are reported (from April 2016) in three main categories – health and social care reasons; patient and family related reasons; and code 9. Delays reported under 'Health and Social Care' reasons are those where the patient remains inappropriately in hospital after treatment is complete and is awaiting appropriate arrangements to be made by the health and social care partnership for safe discharge. This information is used for a variety of purposes including:

- Monitoring policy obligations both locally and nationally
- Helping to troubleshoot in partnership areas with specific problems
- Facilitating benchmarking with other areas
- Providing useful dialogue across health and social care agencies
- There can be a number of factors which contribute to delays in timely discharge which are recorded as health and social care reasons. Each person affected by a delay may be affected by one or more these factors. These include:
- Delays in the assessment processes. This is more likely when the patient was not known to services prior to admission;
- Availability of appropriate services to support an individual on discharge, in particular home care or a residential/nursing care placement;
- The appropriateness of the accommodation and the need for equipment and or adaptations
- The timescales associated with legal processes for those who no longer have capacity(Complex Delays /Code 9)
- Family or patient choice for example where the patient or their family decline to leave hospital until a number of resources have been viewed.

Most delays affect people who are over 75. Delays in discharge happen in only a small number of admissions in an emergency. Delays affecting people who are over 75 have been increasing in Angus during 2017/18. This report aims to set the context to that changing picture and set out

the steps that are being taken to address the situation. This report uses data that shows the full year effect unless otherwise stated.

2017/18 quarter definitions:

Each quarter reflects the full year performance to the end of that quarter.

Quarter 1 – 1st July 2016 to 30th June 2017

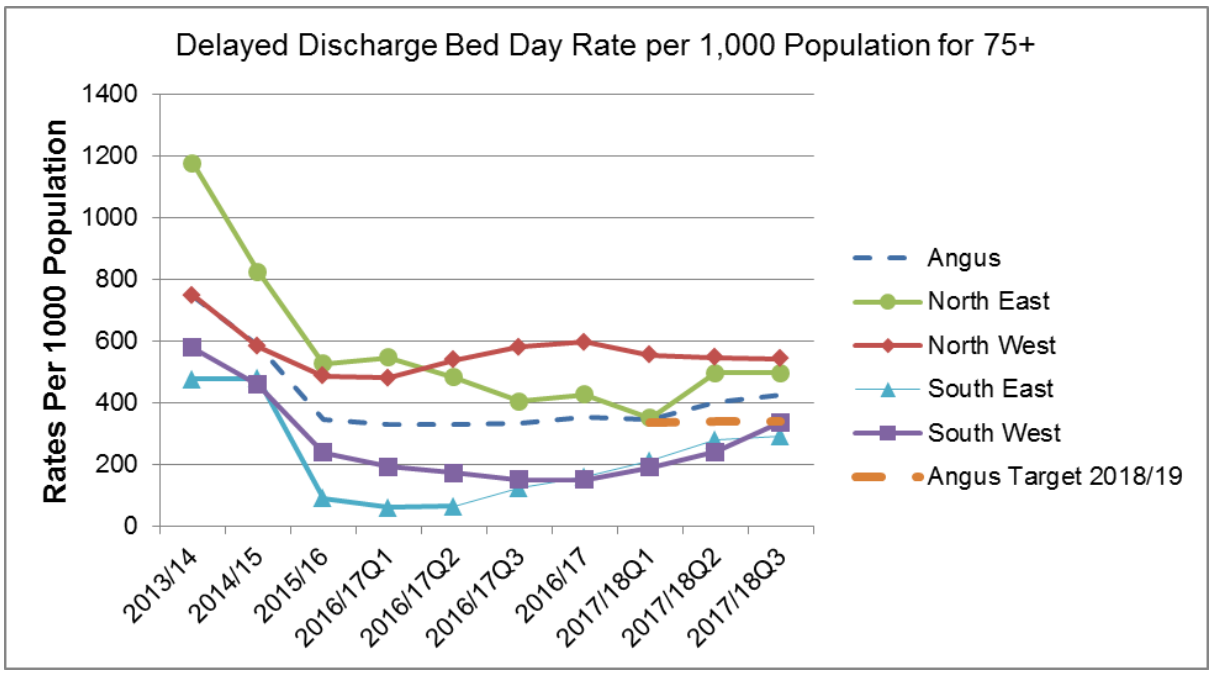
Quarter 2 – 1st October 2016 to 30th September 2017

Quarter 3 – 1st January to 2017 31st December 2017

2. Current situation in Angus

Rates per 1,000 populations are used to allow a direct comparison of the performance between Angus and its constituent localities. Bed day rates (Total number of bed days in each locality divided by the number of 1,000 75+ population in that locality) associated with delayed discharge improved between 2013/14 and 2015/16. From that point delayed discharges have been subject to fluctuation each quarter. Overall in 2017/18 there has been a reduction in performance (Graph 1) with an increasing rate of bed days associated with delays in timely discharge. This has been particularly pronounced in the South localities, which has meant that we have performed less well in relation to our target performance.

Graph 1: Rate of bed days due to delayed discharge in over 75 population



Source: ISD LIST

In 2017/18, each quarter has been affected by fluctuations but these show an overall trend of more bed use when compared to the previous quarter and when compared to the same quarter in 2016/17. There are variations between localities (see Table 1), with the North West locality seeing improvement whilst all other localities have seen a deteriorating picture. The South East locality has seen the most marked decline in performance when compared to 2016/17. The SE locality has the lowest rate of personal care uptake and the highest rate of people living in a care home. This may be a result of levels of deprivation and people living alone. We need to understand this issue further.

Table 1: Fluctuations in delayed discharge for people over 75 in 2017/18

	Percentage change in delayed discharge in 17/18 compared to **same** quarter in 16/17			Percentage change in delayed discharge compared to **previous** quarter		
	Q1 (Jul to Jun)	Q2 (Oct to Sep)	Q3 (Jan to Dec)	Q1 (Jul to Jun)	Q2 (Oct to Sep)	Q3 (Jan to Dec)
Angus	↑ 4.16	↑21.8	↑27.0	↓2.1	↑16.7	↑5.7
North East	↓35.5	↑2.7	↑22.0	↓17.6	↑40.5	No change
North West	↑15.3	↓1.5	↓6.9	↓6.9	↓1.6	↓0.8
South East	↑248	↑382	↑138	↑33	↑33	↑3.5
South West	↓0.9	↑38	↑120	↑27	↑25	↑40.2

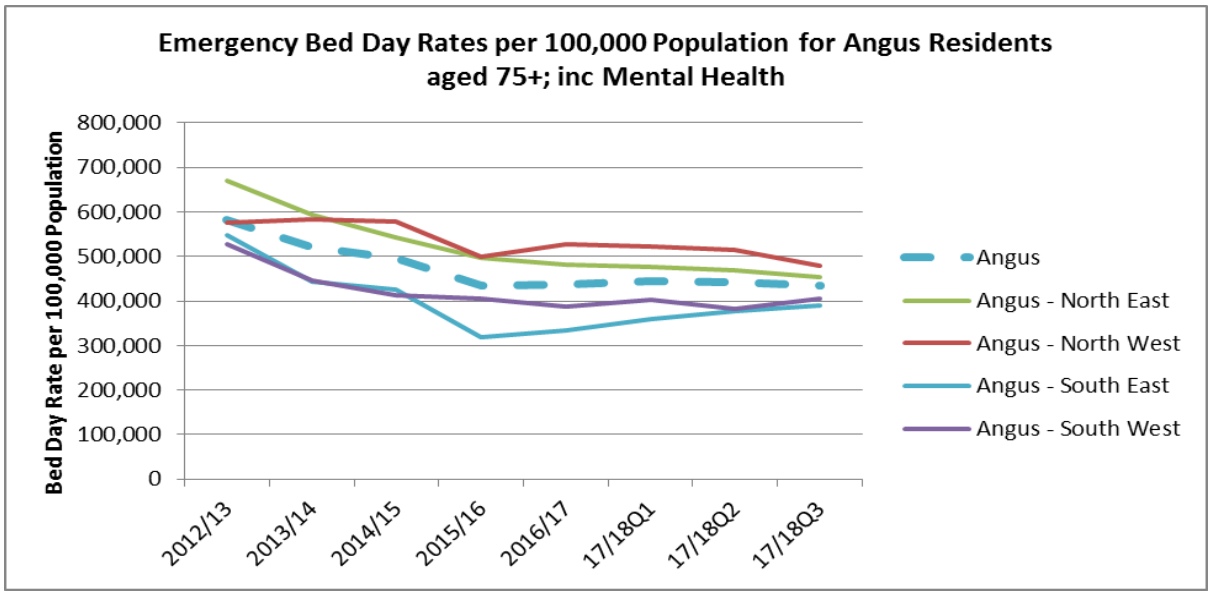
Note:

*↑ indicates a **deterioration** in performance in relation to delayed discharge (more days associated with delayed discharge)*

*↓ indicates an **improvement** in performance in relation to delayed discharge (fewer days associated with delayed discharge)*

The deterioration in performance is set within a context of a emergency admission rates remaining similar for the over 75 population (Graph 2). There continues to be variation in admission rates for people aged over 75 with an improving performance evident in the North Localities.

Graph 2: Bed days following an admission in an emergency for people over 75



Source: ISD LIST

Summary of current situation

In 2016/17 there were:

- 99,247 bed days used following an admission in an emergency. Of those 37,265 were used by people over 75. (37.5% of all bed days used)
- 6,259 bed days lost to delayed discharge - all adults. Of those 4153 bed days lost related to people over 75's (67% of all bed days lost)
- Bed days lost to delayed discharge account for around 6% of bed days used following an admission in an emergency (all adults)
- In relation to people over 75 bed days lost to delayed discharge accounts for 11% of bed days for over 75 following an emergency admission.

At Quarter 3 2017/18 there were:

- 98,235 bed days used following an emergency admission. Of those 37,023 were used by people over 75 (37.6%)
- 5005 bed days lost to delayed dischaarge for people over 75 or 13.5% of all bed days used in an emergency for people aged over 75.

This report is therefore focused on delays affecting people aged over 75 and complex delays. Complex delays (affecting both over and under 75's) account for 39% of bed days lost to delayed discharge.

3. People affected by delays

Whilst rates allow for a direct comparison in performance, it is also useful to understand the number of people actually affected by delays in timely discharge. In relation to the number of people aged 75 years and over affected by delays, the most improvement was seen during 2016/17 when 245 people were affected by a delay (Table 2). By contrast, each quarter of 2017/18 has seen an increase in the number of people affected by a delay in timely discharge. Performance has returned to a similar level to that of 2015/16. 2015/16 has therefore been used in this report as the baseline year for performance throughout this report.

Table 2: Delayed Discharge Admissions aged 75+ (full year affect)

	2013/14	2014/15	2015/16	2016/17	2017/18 Q1	2017/18 Q2	2017/18 Q3
Angus	395	376	284	245	257	279	287
Angus- North East	136	132	108	84	77	87	90
Angus- North West	138	117	111	99	96	95	81
Angus- South East	53	61	17	26	36	42	45
Angus- South West	68	66	48	36	48	55	71

Source: ISD LIST

Delays are measured using a census date which is the last Thursday of every month (Table 3). This date is set nationally to enable comparison between areas at a national level. Census data is available to January 2018. This shows early improvement in delayed discharges in Angus with fewer episodes and bed days lost than in January 2017. This is expected to continue.

Whilst performance in Angus has declined in 2017/18 Angus continues to compares favourably at both a local and national level (see Section 5).

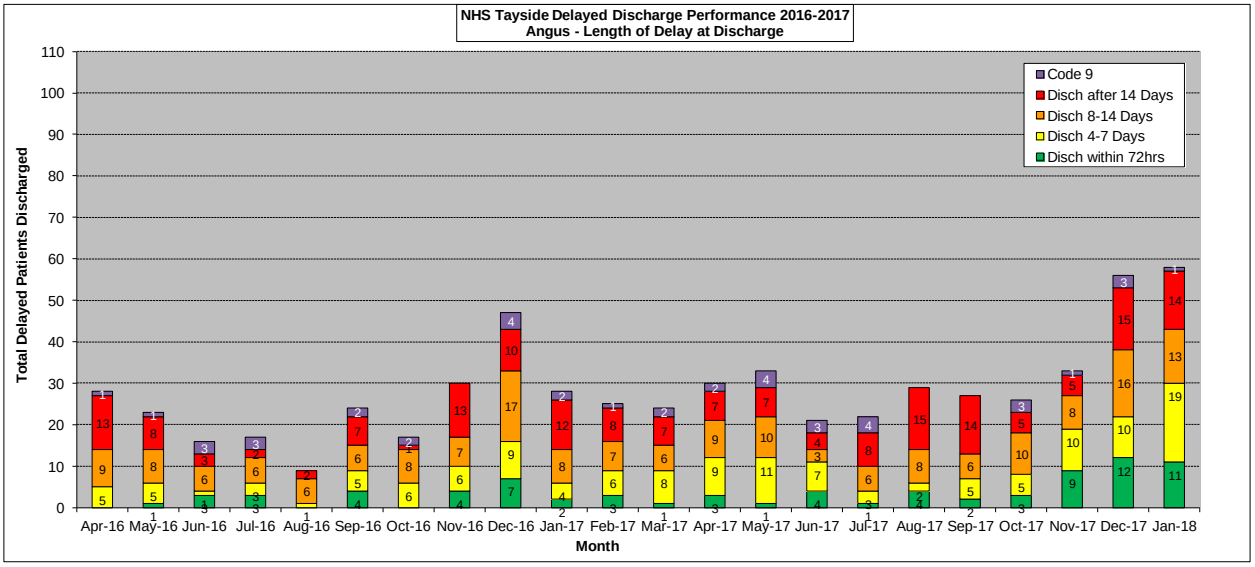
Table: 3 Delay Episodes in Angus at census

	2016						2017											
Location of delay	*Jul*	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Total delays [2]	***9***	***14***	***14***	***17***	***23***	***17***	***21***	***15***	***14***	***14***	***17***	***20***	***31***	***23***	***19***	***19***	***26***	***25***
Acute [3]	4	2	1	5	7	7	6	5	3	6	6	10	14	13	8	9	9	7
Community (GP led) [4]	2	6	3	2	4	1	6	1	2	2	5	-	1	2	2	2	6	5
Community (not GP led) [5]	3	6	10	10	12	9	9	9	9	6	6	10	16	8	9	8	11	13

Source: ISD Scotland

The number of delays at census has been higher than the same period in the previous year and higher than the monthly average in 2016. Fluctuations in the complex delay position are evidenced in the length of delayed discharge (see Graph 3). A comparison to performance in Scotland is provided in section 5 of this report.

Graph 3: Angus Partnership - Length of Delay at Discharge



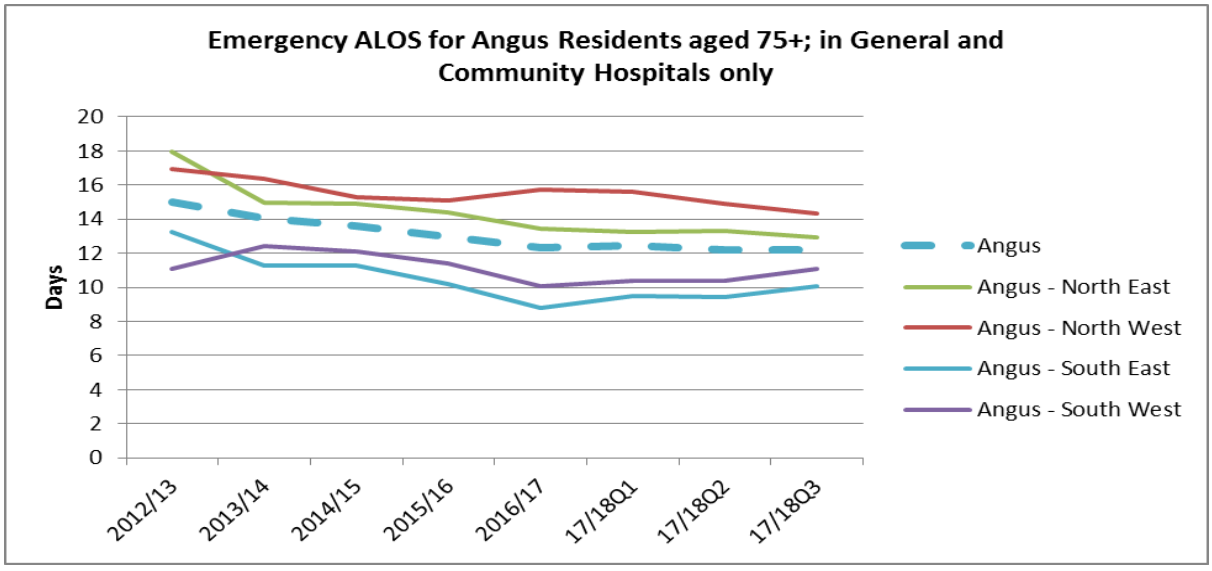
Source: NHS Tayside Edison

There is no typical pattern to the length of delay at discharge. However, it is acknowledged that that this position has continued to deteriorate from November 2017.

4. Average Length of Stay when affected by a delay in discharge

The average length of stay in hospital by an older person affected by a delay (including Code 9 delays where they affect an older person) improved up to 2016/17 and has remained relatively static from that point, although there are variations across Angus localities. People in the South East and South West have seen their length of delay increase whereas the length of delay in the North East and North West localities has continued to improve. Delays in the North localities are longer.

Graph 4: Average length of stay for people over 75 affected by a delay in general and community hospitals



Source ISD LIST

Average length of stay for people over 75 years is further broken down for census reporting (Graph 4). Graph 4 on page 6 shows the length of delay in each Locality, with a high proportion delayed more than 72 hours. Delays of this length impact on an older persons opportunity for rehabilitation and affect muscle mass and bone density.

5. Reasons for delays

Improving our understanding around the reason for delays (Table 4) has prompted the development of an improvement plan. The detail of the delayed discharge improvement plan is provided in Appendix 1. The reason for the delay is also collected at the monthly census. The most common reason for delay is the non-availability of care provision at home at the time required.

Table 4: Reason for delay

	2016						2017											
Reason for delay	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Assessment	-	2	-	3	3	3	1	2	1	3	2	3	3	2	3	1	1	7
Care at home	3	4	5	7	6	4	9	5	4	5	7	9	14	11	6	7	16	14
Care home	-	-	2	1	5	2	3	3	3	2	3	1	6	2	2	3	3	-
Family reasons	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	1	-	1
transport	-	-	-	-	-	-	-	-	1	-	-	-	-	-	-	-	-	-
Complex (code 9)	6	7	7	6	8	6	7	5	5	4	5	7	8	8	8	7	6	3

Source: ISD Scotland

5.1 Assessment

Specific care management posts were established to support effective discharge for individuals who were not previously known to care management and therefore had no named worker.

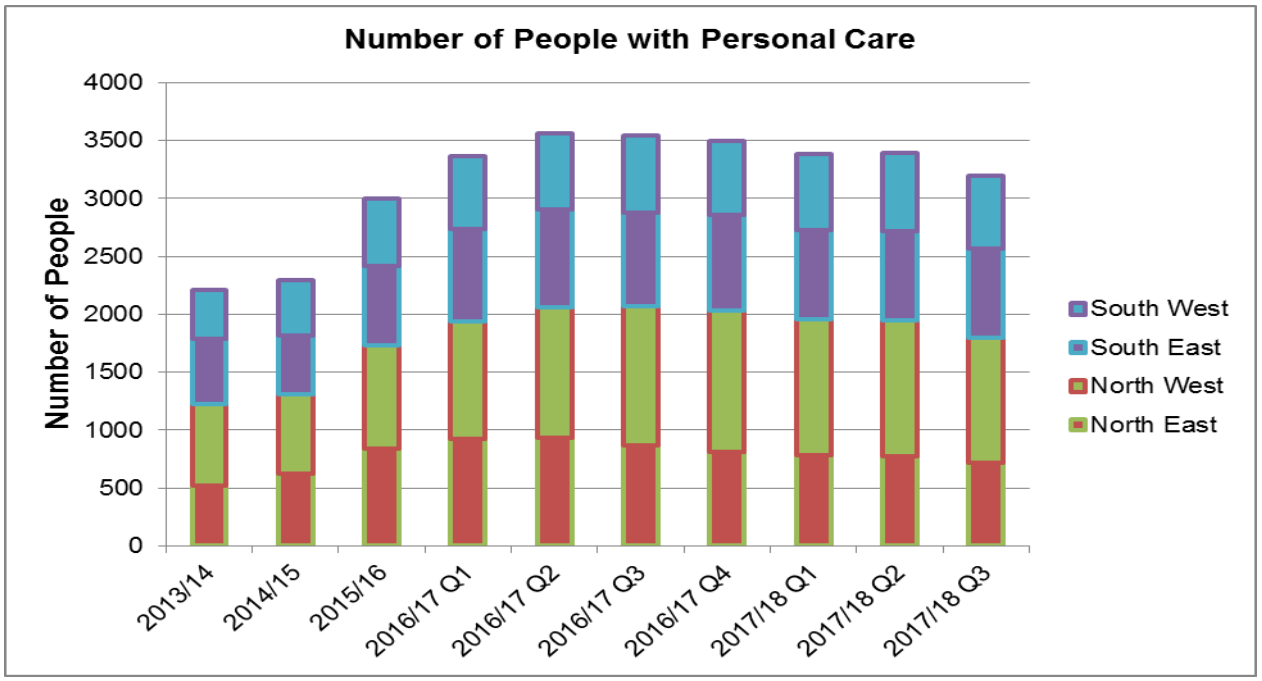
Discharge from Ninewells is co-ordinated by the Discharge Co-ordinators based within Ninewells Hospital. We have a Home Care Assessor working alongside the Discharge Co-ordinators in Ninewells Hospital two days per week. From the end of April, a Care Manager will be seconded to Ninewells Hospital two days per week to assess if there is a need for a Care Manager presence in Ninewells Hospital.

Care Managers supporting hospital discharge are part of a wider care management team which undertakes assesment, care planning and reviews.

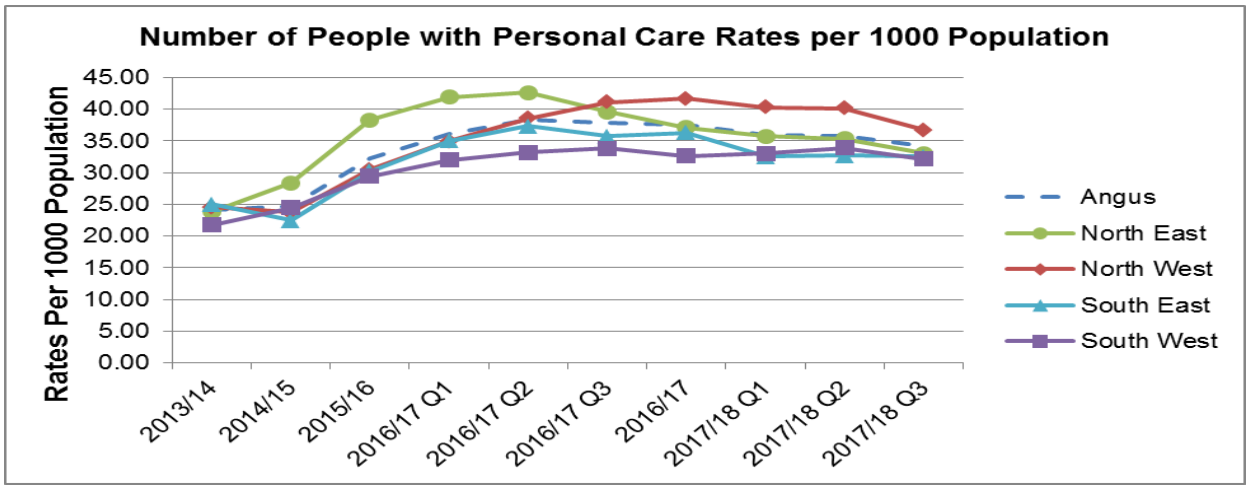
5.2 Care at home arrangements

Demand for personal care to support people to live independently has been rising from 2014/15 through to quarter 2, 2016/17, following which there has been an equalising of demand. Graphs 5 to 9 show the number and population rate of people receiving personal care and the number of hours and population rate of hours of personal care delivered. Each quarter shows a full year effect.

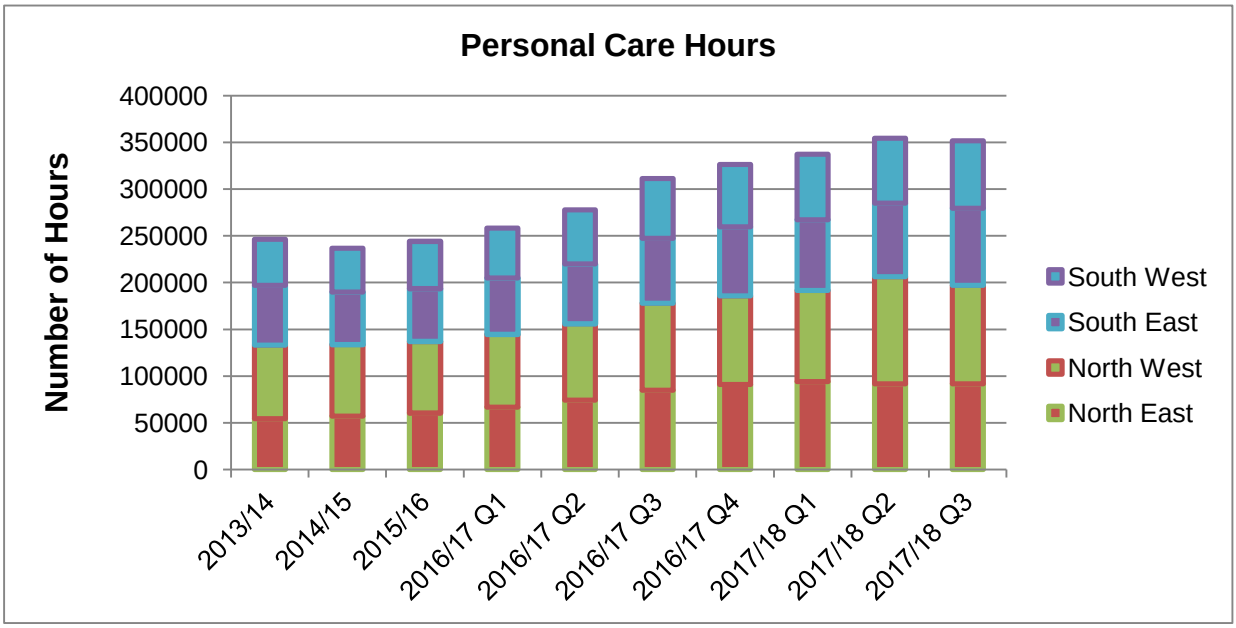
Graph 5: Number of people receiving personal care at home



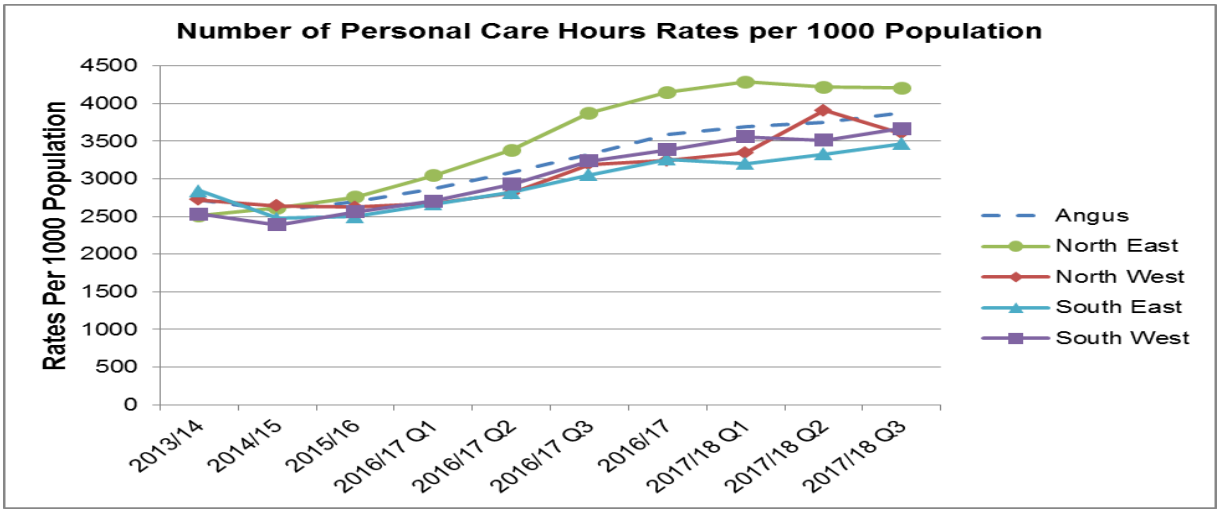
Graph 6: Rate of people receiving personal care at home



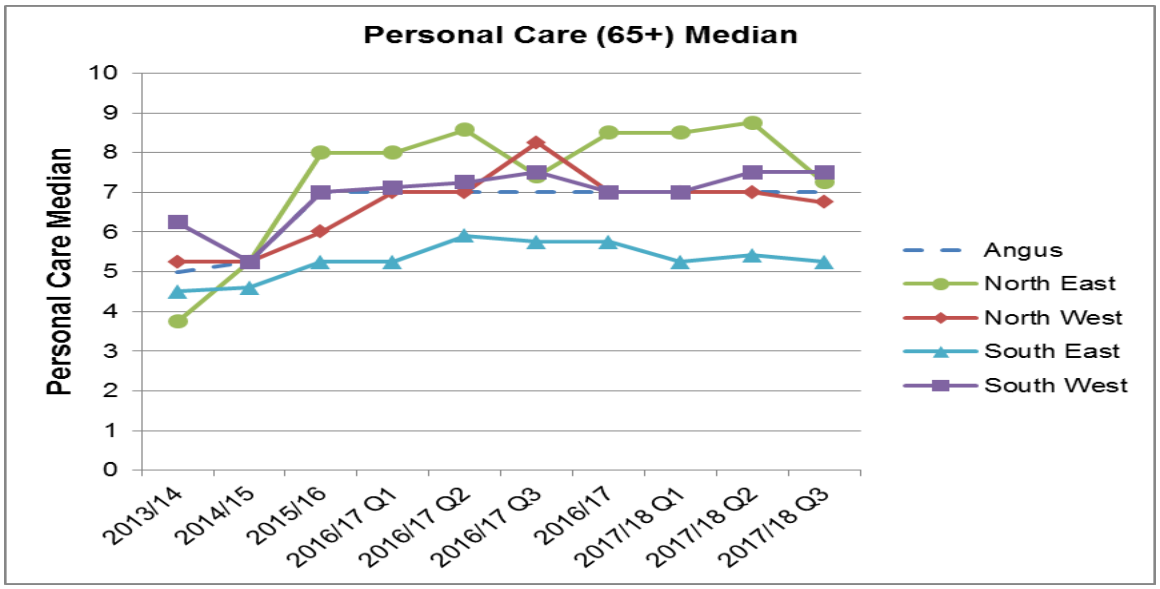
Graph 7: Number of personal care hours delivered by locality



Graph 8: Rate of personal care hours



Graph 9: Typical personal care package per week



Shifting the balance of care from in-house to independent sector providers at the same time as addressing increasing demand, has placed pressure on service capacity and availability.

There is evidence that the Enablement and Response Team (ERT) has also been continuing to meet long term care needs whilst the independent sector service have been developing to meet demand. This has affected the ERT's ability to divert people away from long term services. Unfortunately, this means that ERT has been less able to respond to support the effective discharge and enablement following discharge, as capacity within the service has been compromised. It is anticipated that this temporary situation arising from the delay in introducing ERT will be resolved as implementation is progressed.

5.3 Care Home provision

AHSCP typically supports approximately 760 people aged over 75 in care homes. The majority are placed in care homes within Angus. Some are placed out of area to be near family. The partnership is committed to continuing to have the same number of care home placements. The effect of that will be to see a decline in the proportion of the population supported in care homes and more being supported at home. So far, we have been reasonably successful in this regard.

The average length of stay in a care home has declined to 17 months from nearly 2 years in 2015/16. The average age of a care home resident is now 84.7 years, 2 years older than in 2015/16.

Angus Care Homes have very high occupancy rates, usually 95% and above. Ensuring that places are available when and where needed is therefore challenging. Where places are available they may not be in the area required for particular individuals or in the locale preferred by them, may not be able to meet the needs of the individual (for example in relation to dementia care) or may not be the first choice care home of the person to be discharged. Occupancy in Angus is also affected by the proportion of placements made by other authorities; typically, 20% of the beds in Angus are taken up by placements from other partnership areas. Non-Angus placements in Angus care homes have been as high as 60% in Monifieth. Angus does place out of area where no placement can be found or where family have moved and a placement elsewhere supports family contact. Our data does not help us understand how many placements are made outwith Angus due to the choice of the individual or due to necessity.

The Scottish Government has guidance to support choice on discharge from a hospital, commonly known as the "choice protocol." **(Scottish Government Guidance on Choosing a Care Home on Discharge from Hospital December 2013**).

The Guidance states:

'The potential for recovery, rehabilitation and reablement will be fully considered before any decisions are made on long term care plans. The aim should always be to return home if possible and appropriate. Wherever possible, decisions about long term care should not be made in an acute hospital setting. Ideally, the patient should be discharged to a more appropriate non-acute setting such as a community hospital, or intermediate care facility for further rehabilitation and assessment.'

In practice it is likely that for some individuals with very complex needs, and for some individuals who are known to services and where the home situation has deteriorated, there will always be a need to place in a care home directly from hospital.

Intermediate Care can support effective discharge by providing rehabilitation for a short period of time in a more homely setting. Intermediate care is provided in conjunction with care homes and is currently located in the South East Locality. Plans are underway to make intermediate care available in the North East locality as part of the delivery of the Angus Care Model.

5.4 Family Reasons

Family reasons for delay generally relate to a lack of progress in seeking guardianship or refusing a move to an available care home for either long term care, respite or intermediate care.

The Choice protocol states '*Patients, family or proxies will need to choose a care home which is able to meet the patients assessed needs. They can choose up to three homes, one of which should have a suitable vacancy that will be available within a reasonable period. This should be done in consultation with social work or social care staff*.

A person is not entitled to remain indefinitely in hospital once they are ready for discharge. Failing to make a choice of care home, or reluctance to co-operate with the discharge process should not prevent discharge taking place'

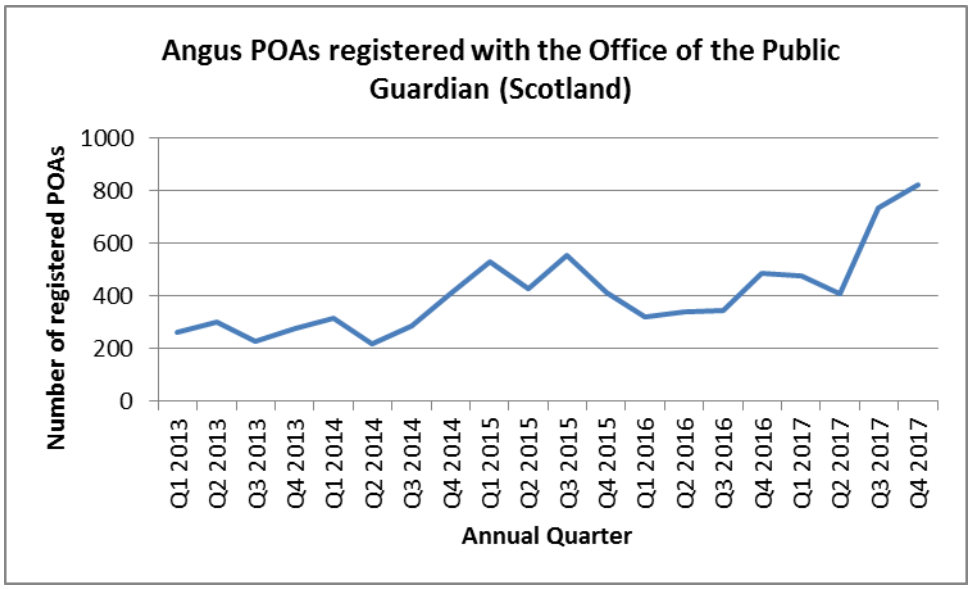
In practice in Angus people are asked to make 3 choices of care home, one of which must have a vacancy. The person is supported for a maximum of 7 days before they must move from hospital to the care home with a vacancy when their first choice care home has no vacancy. This could be on a respite basis until a placement becomes available at the preferred choice.

5.5 Complex delays

Complex delays very often relate to individuals who do not have capacity. Discharge decision-making is a complicated interplay of needs assessment, choice, legal powers (Guardianship and Power of Attorney) and the availability of specialist resources, some of which need to be commissioned out of area or specially built. Some service users present a risk to others in the community and multi-agency risk management planning is essential.

Angus has had some success, following the introduction of the annual campaigns, in improving the number Power of Attorney (POA) registrations with the Office of the Public Guardian. Since 2014 there has been a near 100% increase in POA registrations.

Graph10: Power of Attorney registrations in Angus



Source: Office of the Public Guardian

The Choice protocol offers further guidance on issues of capacity.

'If an incapable adult has no attorney with suitable powers, it may be necessary for someone to apply to the court for a guardianship order on the adult's behalf. A good practice guide *has been designed to assist with this process. However, where the adult does not object and there is agreement as to the need for a care home, section 13ZA of the Social Work (Scotland) Act 1968 can be used.*

We do use 13ZA but there are conditions prescribed in law which we must follow, whilst also taking into account the European Court ruling in the Cheshire West case. Each situation is assessed on a case by case basis. For more information about 13ZA you should contact Heads of Community Health and Care Services.

The total number of bed days lost due to complex delays is similar in quarter 2 and 3, 2017/18 (Graph 11). The average length of stay for an individual with complex delay has more than doubled when compared with the baseline year 2015/16. There is variation between localities with the North West locality experiencing the biggest increase in average length of stay for complex delays (Table 4, Page 6).

Graph 11: Bed days lost to Complex (Code 9) delays

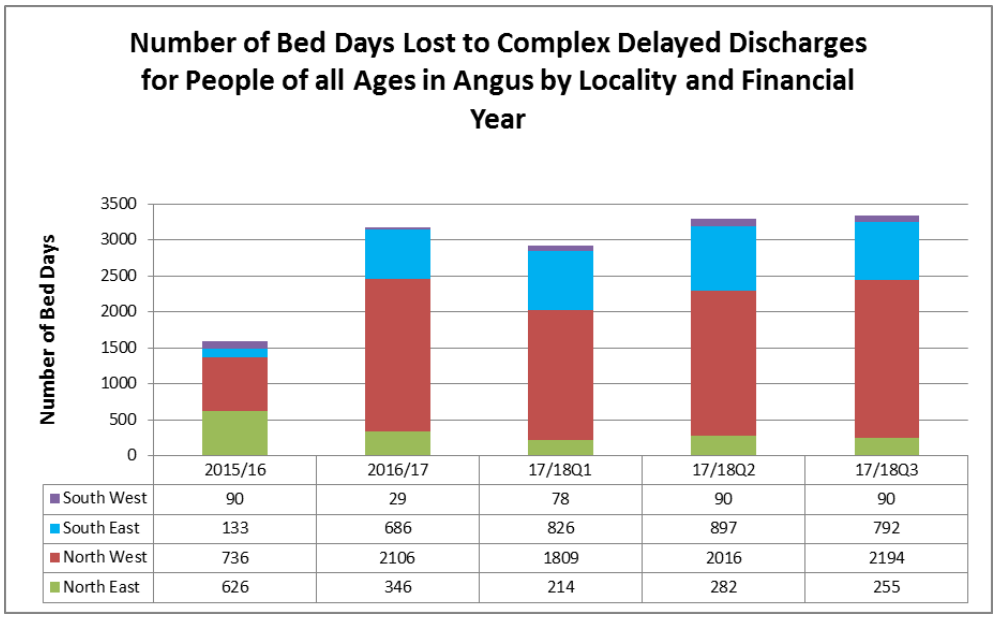


Table 5: Average length of stay in hospital by someone affected by a delayed discharge

Delayed Discharge Average Length of Stay for People with Complex Needs All Ages

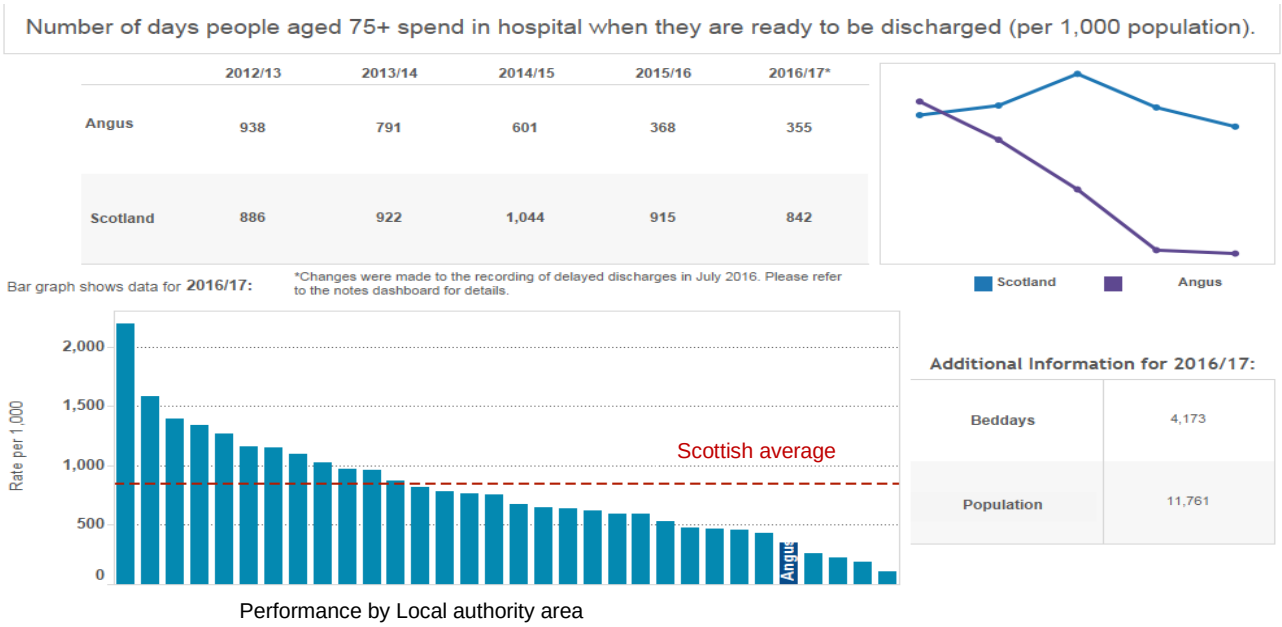
	2015/16	16/17Q1	16/17Q2	16/17Q3	2016/17	17/18Q1	17/18Q2	17/18Q3
Angus	**40.6**	**48.1**	**62.9**	**75.1**	**93.1**	**81.3**	**84.2**	**90.0**
Angus - North East	39.1	38.7	42.7	36.7	49.4	53.5	56.4	51.0
Angus - North West	40.9	58.2	83.0	100.7	131.6	95.2	112.0	115.5
Angus - South East	66.5	52.3	68.6	90.8	85.8	91.8	74.8	88.0
Angus - South West	30.0	41.0	39.0	45.0	9.7	19.5	22.5	22.5

Source: ISD LIST

6. National Picture

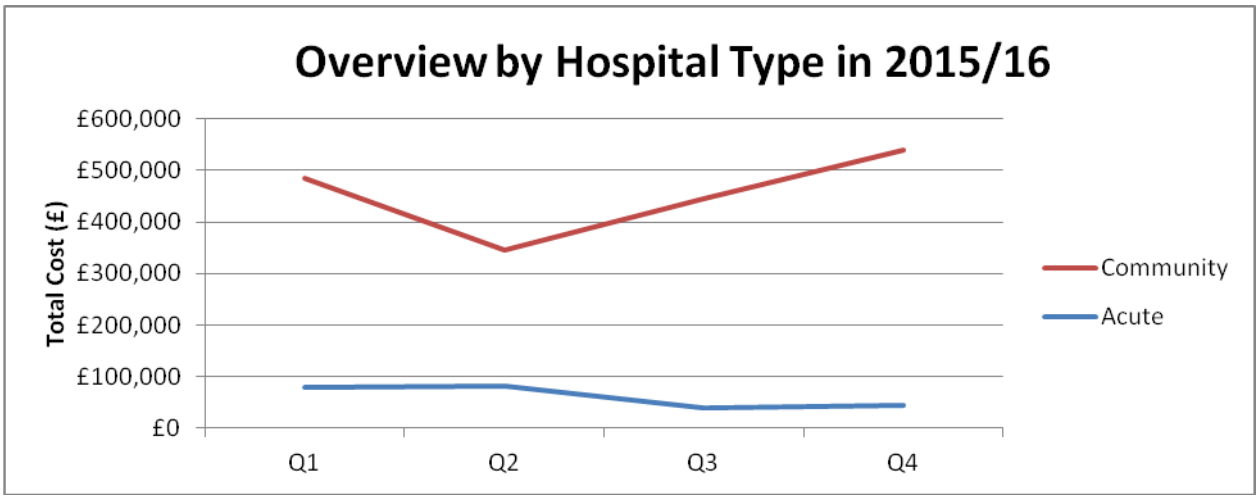
ISD produce information which allows comparison across all Health and Social care Partnerships. National data for 2017/18 will not be available until September 2018. Angus performs well when compared with the Scottish average for delayed discharge.

Chart 1: Angus performance in relation to delayed discharge compared to Scotland in 2016/17



Source: ISD Tableau

Chart 2: Cost of Delayed Discharge in Angus



	Q1	Q2	Q3	Q4	Annual
Community	£485,195	£345,558	£444,114	£538,505	£1,813,372
Acute	£78,925	£80,844	£39,565	£43,489	£242,823
All Hospitals	£564,120	£426,402	£483,679	£581,994	£2,056,195

Source ISD Tableau

The breakdown for each of the specialities is not available at this time.

7. Recent Operational Experience-Autumn 2017 and Winter 2017/18

Whilst all of the issues in discharge planning outlined above are relevant in general terms, during the period reported in the quarter 3 performance report, a number of unusual short term factors came together which directly impacted on our delayed discharge performance:

1) Freezing weather led to a high number of hospital admissions due to falls and resultant injuries.

2) An outbreak of influenza occurred in Angus, affecting our vulnerable service users (e.g. people with COPD) adversely and led to increased hospital admissions.

3) The new Enablement and Response Team (ERT), delayed by five months, commenced on 27-11-18, bringing it nearer to the winter surge period than would have been the case had its introduction gone to plan. Not surprisingly with a new service, it encountered a number of teething problems in operational delivery. (These have been and are being addressed.)

4) The ERT suffered from reduced capacity due to a backlog of long term cases which had not yet moved across to private providers and because of flu amongst staff leading to sickness absence, particularly in Arbroath and Carnoustie. This occurred at a time of peak demand for discharge.

5) The tendering process for developing the new home care framework was underway at this time. It meant that providers were unlikely to invest in a particular geographical area until it was clear that they would be one of the approved providers following the tender exercise. This led to some difficulties accessing new provision for emerging discharge cases.

How did services respond?

Services deployed a number of measures to try to militate against the challenging conditions which contributed to the increase in delayed discharge.

- Delayed discharges, particularly from Ninewells, were given the highest priority in allocation in the ERT. Significant additional resource was allocated to the matching process between cases and private providers/ERT.
- We subsidised respite provision to allow "step down" to residential care to take place more quickly.
- An enhanced payment was made to providers to allow for additional uptake in hard-pressed areas, for example to assist with recruitment of additional staff.
- Staff in ERT was invited to work additional hours to cover the increase in demand and staff sickness, and there was a positive response to this.
- Daily teleconferences were held locally between the consultant for MFE, lead clinician for Angus, heads of service and operational managers to manage throughput and prioritisation. These connected with three times daily teleconferences at Ninewells.

These measures did incur additional expenditure for community-based services and this was funded through the Delayed Discharge Fund.

8. Emerging issues highlighted by the winter "surge" in demand-learning points

A number of issues were identified from the activity described above which will require attention for future planning:

1. In future years, we can allocate some of these methods within our winter plan and apply them if or when necessary.

2. There is a risk to the wellbeing of patients who are being discharged at pace if assessment is not sufficiently robust and if resources to meet need are not fully in place. Risk management is required and the ability to draw on community resources, as well as family.

3. There is a need for clear priorities for allocation of cases in ERT and with private providers; this needs to be adhered to generally but with some flexibility to adapt to shifting need.

4. We plan to locate a care manager in Ninewells hospital to support quality of assessment and efficiency in discharge pathways.

5. We will permanently increase our admin resource in the matching process between service users and resources.

6. The teleconferences were effective but very resource intensive and unsustainable in their current format. The whole system, safety and flow framework sets out the requirements for daily multi-agency/partner organisation conference calls. We need to review our attendance, who contributes and what information is required to ensure attendees provide an accurate report of capacity, safety, flow and workforce as required.

9. Conclusion

The number of delayed discharges remains relatively small compared to the overall position in Scotland. Regardless, the associated cost to the system and the impact on individual service users/patients mean that we need to continue to rigorously address delays in order to sustain performance. To ensure that people are returned to the greatest possible level of independence, discharge within 3 days of their clinically fit date is very important. An improvement plan is in place to ensure that we continue to address the impact of delayed discharge. This improvement plan is provided in Appendix 1.

ANGUS Health & Social Care Partnership

Effective Discharge Pathway Improvement Plan

RAG Status

Red	Action at risk of not being completed
Amber	Action maybe at risk if issues not addressed
Green	Action on schedule or completed

	Ambition	Action	Timescale	Progress Update	RAG Status
Leadership		Executive Lead for Effective discharge pathway identified to lead management of system and report on performance	Achieved		Green
		Establish an Effective Discharge Group (EDG) bringing together representatives of Angus Health and Social Care Partnership, Third and Independent Sectors directly or indirectly involved in the hospital discharge process to oversee and monitor progress in relation to an effective discharge pathway.	Monthly meetings	Role and remit of EDG currently being revised. EDG to focus on: Preventing unnecessary admission to hospital Ensuring an effective discharge pathway Reduction in avoidable readmissions Complex discharges Palliative care and end of life	Amber

	Ambition	Action	Timescale	Progress Update	RAG Status
Communication	To ensure that we are engaging effectively with patients, carers and their families to support a person centred, safe and effective discharge process	Strengthen public information about effective discharge pathway	March 2018	'Discharge from Angus Hospital' leaflet has been developed to help patients, family and carers understand the discharge pathway. North East Locality Public meeting in February 2017 and 'Continuing the conversation' public meetings in October and December 2017 provided a forum to discuss effective discharge planning.	Amber Amber
		Build awareness for unpaid carers in discharge process in response to the Carers (Scotland) Act 2016, which places a responsibility on Angus HSCP, working in partnership with NHS Tayside to ensure that, before a cared-for person is discharged from hospital, it involves any carer of that person in the discharge.	June 2018	Carers' questionnaire developed to be completed in all wards twice a year. Initial results from Ward 2 and Stroke Rehabilitation Unit reveal that 100% of carers felt consulted and involved in their cared-for person's discharge.	Amber
		Raise awareness of importance of having a Power of Attorney (POA) to reduce number of bed days lost due to Guardianship.	Next campaign to be confirmed	Working with Glasgow HSCP, Angus leads the Tayside Power of Attorney Campaign. Since the first TV campaign in 2014 there has been a 99% increase in the number of Angus adults applying to the Office of the Public Guardian for Power of Attorney.	Amber

	Ambition	Action	Timescale	Progress Update	RAG Status
Performance Information and Analysis	We use robust and reliable data to inform our performance in relation to delayed discharge.	Understand reason for all Angus patients delayed in hospital and agree appropriate actions		Suite of measures agreed and reviewed, daily, weekly and monthly as appropriate to enable greater understanding at locality level.	Green
				Work currently underway to understand: • Why cases are not being closed • Reason for unusual level of referral to care management from NW Locality during January 2018	Amber
				Impact of enablement: What % of people have reduced level of need after enablement.	**Amber**
		Monitor number of Angus patients delayed in NWH		Daily update from Angus Discharge Team in NWH of Angus patients delayed in NWH, reasons for delay and actions being taken to expedite discharge.	Green
				Daily conference call between Angus and NWH to expedite discharge of Angus patients delayed in NWH.	Green
				Daily monitoring of patients delayed in Angus Hospitals, reasons for delay.	Green
				Weekly submission of data from all Angus wards for all discharges to gain understanding of number discharged within 72hrs of PDD vs number of delays.	Green

	Ambition	Action	Timescale	Progress Update	RAG Status
Front door	To ensure that unnecessary admission to hospital is avoided	Enhanced Community Support (ECS) to be embedded across Angus	October 2018	ECS for older people embedded across South Angus localities. Rolling out across NE Locality and now extending to NW locality.	Amber
		Enablement and Response Team (ERT) introduced across Angus	November 2017	ERTs became operational 27.11.2017 when surge in demand arose. ERT not yet running at target efficiency, and 50% capacity in SE and SW still used on long-term care cases. Potential capacity of ERT to deliver enablement and prevent admission has been compromised due to ERT focusing on supported discharge. Review of service completed 28.02.2018 and action plan developed to maximise capacity and flexibility has been developed.	Amber
		Embed the ethos of 'decide to admit' rather than 'admit to decide'	April 2018	Day of Care Audit carried out on 07.11.2017. This revealed that 49/74 people admitted to an Angus hospital had the potential for community intervention earlier in their journey which could have avoided need for hospital admission.	Green

	Ambition	Action	Timescale	Progress Update	RAG Status
Admission/Readmission	All patients, where appropriate, are given a planned date of discharge (PDD) within 48 hours of admission	Ensure all patients, where appropriate, are given a PDD which is agreed with clinical staff and social work.	Achieved	PDD is applied routinely to all patients, where appropriate.	Green
				As a minimum standard in Angus hospitals, PDD is reviewed/updated twice weekly at discharge board rounds and multidisciplinary team meetings. Often updated more frequently as services become available	Green
	We will understand the reason for readmission and make plans to address any inappropriate readmission to hospital within 28 days.	Test of change in Stracathro Hospital. All discharges from Ward 2 Stracathro who are readmitted within 28 days to any hospital are reviewed.	June 2018	An evaluation report of all readmission since November 2017 is being compiled.	Amber

	Ambition	Action	Timescale	Progress Update	RAG Status
Assessment	Minimise delays to the Guardianship process.	Appoint Mental Health Team Manager with specific remit to reduce length of time someone waits for Guardianship.	Achieved		Green
		Raise awareness of Guardianship process	June 2018	All community staff (social work and nursing) to receive Adults with Capacity training. To date 50 staff have received training.	Amber
		Improve Guardianship process so that all cases are identified and processed without delay in line with legal requirements	June 2018	Every case identified since June 2017 has been allocated within 48 hours and the MHO reports completed within the legally required 21 days with the exception of one. In this case the private solicitor has yet to request medical reports, therefore there is no further action the MHO Service can take at this time. All other DD/Guardianship cases are either with the solicitors or the Courts meaning we have completed our work on these cases. Currently 3 Angus patients delayed awaiting Guardianship.	Amber
	Assessment of need is carried out when a person has had an opportunity to regain a level of independence.	Improve timely assessments of people admitted to Ninewells	November 201	Test of change to appoint part-time Home Care Assessor to work alongside the Angus Discharge Team in NWH.	Green
			March 2018	Test of Change to appoint Hospital Care Manager (HCM) for 2 days per week to work alongside Angus Discharge Team in NWH and provide liaison for complex discharges.	Amber
	Minimise delays to care home assessment procedures	Eliminate unnecessary delays in care home admissions	June 2018	Review role of HCM in NHW in relation to reducing length of stay of Angus patients in NWH and number and length of delays. Meetings being arranged to discuss improvements to this process	Amber

	Ambition	Action	Timescale	Progress Update	RAG Status
Discharge	People who are ready for discharge are discharged safely.	Ninewells Hospital Discharge Team to oversee early discharge planning of Angus patients in Ninewells (NW) Hospital leading to improved information gathering	Ongoing	Daily status updates provided of all Angus patients delayed in NW	Amber
				Daily teleconferences between NW and Angus teams to expedite any delays. Approach to be reviewed as very labour intensive.	Amber
		Ensure there are no delays with accessing equipment	Achieved	Dundee and Angus Joint Equipment Store established in November 2016. From 01.01.18 – 25.2.18, 1575 people received equipment, 79% of which was delivered within 1 – 3 days (average 1.59 days).	Green
		Hospital Care Managers (HCM) oversee discharge of patients in Angus Hospitals	Achieved	Review of HCM role undertaken in October 2016 concluded that the role is valued by colleagues, patients and carers. The role makes a strong contribution to the effectiveness of the hospital discharge process in Angus.	Green
		Discharges from Ninewells are given the highest priority.	Achieved	Significant additional resource was allocated to the matching process between cases and private providers/ERT.	Green
				Subsidise respite provision to enable 'step-down' to residential care.	Green
				Enhanced payment made to providers to allow for additional update in hard-pressed areas.	Green
				Positive response to ERT staff being invited to work additional hours.	Green
		Test of change for backup ERT rota to ensure senior member of staff available on Friday afternoon.	June 2018	Discussions underway	Amber
	Improve quality of discharge from Ninewells Hospital to an Angus Care Home	To record all issues relating to discharge for 3 months.	June 2018	Recording forms to be circulated to all providers. Meeting to be set up with NHS Tayside Nursing Director and Scottish Care Integration Lead.	Amber

	Ambition	Action	Timescale	Progress Update	RAG Status
Service Redesign	As set out in the Angus Strategic Plan our aim is to have all Angus patients discharged within 72 hours of being assessed as ready for discharge.	7 day working for Physiotherapists and OTs	November 2018	Since 6 Jan 2018, 4 hours of inpatient rehabilitation has been provided at Arbroath Infirmary, usually by a Physiotherapist and generic support worker. Discussions are ongoing to support 7 day AHP support across Angus with aim to have cover in place for 2018/19 winter period.	Amber
	Community capacity is developed by looking at innovative ways to support more care at home packages	Deliver greater availability within care at home services through Help to Live at Home Programme.	April 2018	Fair cost of care/new contracts in place from April 2018. There will be 3 x SDS 'Option 3' providers per locality, plus specialist providers. This will create better opportunities for partnership working and prioritisation of care at home packages. Alternative provider organisations/choices will remain available to accommodate SDS options.	Amber
		Enablement and Response Team launched in November 2017 bringing together community alarm, prevention of admission and early supported discharge.	November 2017	In addition to all long-term care delivery through independent providers, the ERTs will provide preventative enablement, and respond to short-term care needs including facilitating hospital discharge and providing community alarm response.	Amber
		Develop clear priorities for allocation of cases in ERT and independent providers	March 2017	Discussions underway	Amber