Bundle Audit & Risk Assurance Committee 27 August 2019

4.6 Response to WAO Report: What's the hold up? Discharging Patients in Wales

Presenter: WAO/Joe Teape

What’s the hold up? Discharging patients in Wales (English)

What’s the hold up? Discharging patients in Wales (Welsh)

SBAR What's the hold up? Discharging Patients in Wales ARAC August 2019

What's the hold up? Discharging Patients in Wales HDdUHB Mgmt Response June 2019

WALES AUDIT OFFICE
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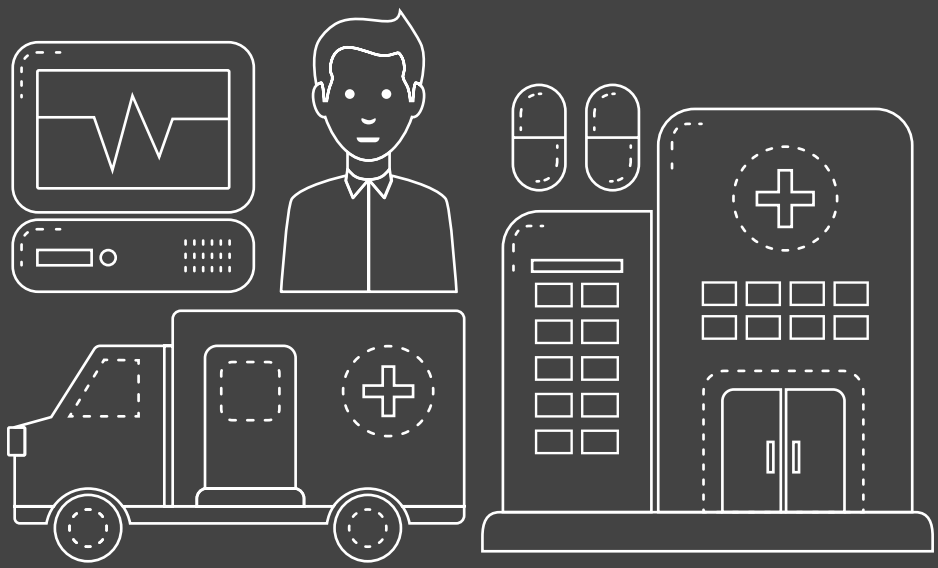
What's the hold up?

Discharging patients in Wales

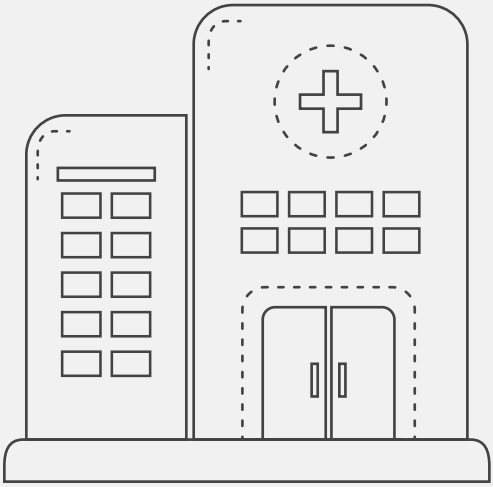


Background

One of the biggest challenges facing NHS bodies in Wales is the problem known as delayed transfer of care. This is when a patient does not need to be in that hospital any longer, but something is preventing them from moving on. When patients are not discharged from hospital promptly, the whole healthcare system 'backs up' as hospital capacity fills up and it gets harder to admit people who need hospital treatment. Clearly it is not good for the patient either – making it harder for them to regain their independence.

The Auditor General and others have focused on this challenge in a range of work with local NHS bodies and community organisations. The Auditor General's audit work was done during 2017, with further work on the Integrated Care Fund (ICF) carried out during 2018. This document complements our formal audit reports and highlights important issues that board members should be sighted of when seeking assurance that patients are discharged from hospital in safe and timely ways.

The findings from our discharge planning audits at health boards and Velindre NHS Trust are available on the Wales Audit Office website.

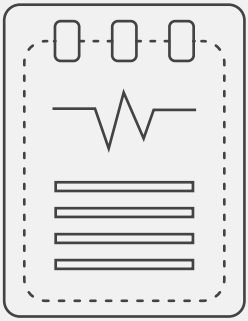


How NHS bodies and their partners are doing

Planning to discharge people from hospital is a theme in many delivery plans and strategies, not least winter plans. The sheer number of synergies and alignments needed for this planning creates problems of overcomplexity.

NHS bodies told us that across Wales, a shortage of home carers, a shortage of care home beds for people with dementia, and limited capacity across community reablement services are major factors in causing delays. Healthcare professionals need to work with others to find and plan solutions that meet peoples' needs on discharge and ensure the best recovery possible.

There have been many initiatives to improve discharge arrangements, such as the SAFER patient flow bundle, 'red2green',[1] 'end PJ paralysis'[2] and last 1000 days[3]. The Welsh Government has also created funding to foster greater collaboration between health, social care, housing and the third sector. For example, the ICF gives relatively short-term funding to initiatives to make sure only people who really need to be in hospital are there. During 2019, the Auditor General intends to publish a report on how this fund is being used by public bodies across Wales.



1 'red2green' is a visual system to identify wasted time in a patient's journey; patients on the red list no longer benefit from being in an acute hospital bed while those on the green list are still benefitting from their admission.

2 'End PJ Paralysis aims to get patients up and about and out of their pyjamas as soon as they are able to improve recovery and prevent complications.

3 The last 1000 days is a concept that reinforces the value of patients' time as the most important currency in healthcare and to create a sense of urgency to act.

Questions for board members on working with partners

- Does the Board receive information about the effectiveness of partnership working to support discharge planning arrangements and improve patient outcomes?
- Is the organisation evaluating what difference ICF funded initiatives have made in facilitating safe and timely discharge?
- Has the organisation mainstreamed successful ICF funded initiatives that support discharge planning?
- Is the organisation evaluating the impact of initiatives, such as the SAFER patient flow bundle, red2green, end PJ paralysis or last 1000 days, on patient flow and patient outcomes?

Encouragingly, we found relatively clear lines of accountability, and regular scrutiny of discharge planning performance. A range of information is generally available to support timely scrutiny and board members feel well informed. It is clear then, that leaders of Welsh NHS bodies generally understand the importance of effective discharge arrangements.

However, delayed transfers of care are the only national measure of discharge. They are regularly monitored, reported and scrutinised by health and local government bodies. Hospital IT systems can capture a range of data to support monitoring and reporting but, fewer than half of Welsh NHS bodies recorded whether a discharge was simple or complex while only a third recorded the date a patient was declared medically fit for discharge.

Questions for board members on information relating to discharge

- Is the organisation's patient information system supporting the accurate recording of data for monitoring and reporting on operational performance related to discharge planning?
- Is the organisation developing and implementing operational performance metrics and outcome measures to monitor the effectiveness of discharge planning arrangements, for example:
  - the number of patients discharged before midday;
  - the number of patients whose expected date of discharge is recorded;
  - the date patients are medically fit for discharge;
  - whether the discharge is simple or complex;
  - the number of readmissions avoided because of good discharge planning;
  - the number of patients who do not need longer term support;
  - the number of permanent placements in residential care settings avoided?
- Is the organisation regularly collating and reporting on patients' experience of being discharged from hospital?
- Is discharge planning performance, other than delayed transfers of care, regularly reported to the Board or its committees?

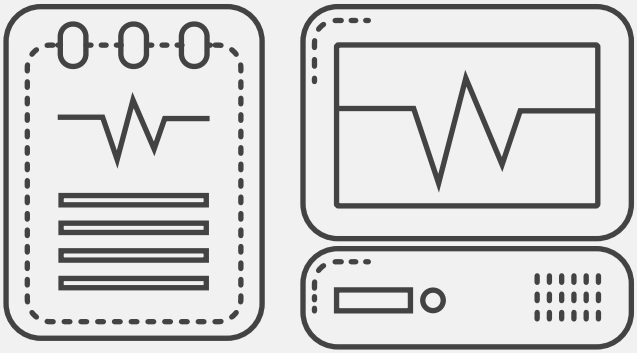
Steps towards improvement

Defined discharge pathways set out steps that healthcare professionals should take when discharging different types of patients. They can be very helpful. Most Welsh NHS bodies had set out some of these pathways, but they varied widely in approach and were not used consistently.

The Welsh Government is encouraging a new model where going home is the default pathway given most patients benefit from assessment in their normal place of residence with the ability to cope in familiar surroundings. The 'home first: discharge to recover and assess' pathway means patients are discharged home once they are medically fit and no longer need a hospital bed. Patients' immediate support needs will have been assessed prior to discharge and the necessary arrangements put in place. Ongoing assessment of patients' support needs can be safely continued at home by members of the appropriate community health and social care team. The approach means patients are not kept in a hospital bed longer than is necessary. We found that just four out of eight NHS bodies were using this model at all or some hospitals. The challenge is enabling community services to respond as soon as patients are discharged and making the discharge to recover and assess approach standard practice.

Questions for board members on pathways to support better discharge

- Is the organisation implementing the discharge to recover and assess pathway?
- Is the organisation identifying and addressing the barriers to implementing the discharge to recover and assess pathway?
- Is the organisation and its partners assessing the capacity of community-based services to underpin discharge to recover and assess pathways?
- Is the organisation evaluating the impact and outcomes of discharge pathways, including the discharge to recover and assess approach?



Across Wales, all NHS health boards operated one or more discharge liaison teams. These teams represent a significant investment of funding and have the potential to help things improve. But, we found that the teams tended to be available weekdays only, with a range of alternative arrangements for outside office hours. Most teams were nurse led rather than being truly multi-disciplinary. We also found that discharge lounges were often under-used. Discharge lounges can provide a suitable environment in which patients can wait to be collected, by either their family or hospital transport, or while medication is dispensed.

Questions for board members on discharge liaison teams and discharge lounges

- Is the organisation regularly reviewing the availability and capacity of the discharge liaison team(s) to provide support seven days a week?
- Is the composition of the discharge liaison team changing to ensure a multidisciplinary approach to discharge planning?
- Is the organisation actively promoting the use of the discharge lounge(s) to support patient flow and release beds promptly for patients waiting admission?
- Is the organisation monitoring and reporting on the efficiency and effectiveness of the discharge lounge(s)?

Important challenges

It is important that staff understand clearly how patients are discharged. We reviewed discharge policies and protocols and found that most NHS bodies set out their approach quite well.

Across Wales, ward staff are generally confident about what needs to be done to support safe and timely discharge, but staff cited several challenges that sometimes make it difficult. These challenges include: underestimating the time needed to effectively plan patient discharge; failing to start the discharge process on admission; discharge assessments undertaken only when the patient is declared fit for discharge; and reliance on temporary staff who may be unfamiliar with discharge processes and the availability of community services.

Questions for board members on improving discharge planning

- Is the organisation taking steps to encourage a culture where 'discharge planning is everyone's business' and a key part of the patient care continuum?
- Does the discharge planning process start on admission?
- Does the organisation know what the key barriers are to safe and timely discharge and is it addressing them?
- Is simple guidance available for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements?

Ward staff also speak of a culture of risk aversion, whereby staff are reluctant to discharge patients because they might be at risk for fear they would not cope at home. Whilst staff may be acting out of kindness, they may not be acting in a patient's best interest. Training and information are important tools in improving staff understanding of discharge arrangements and the range and capacity of community health and social care services available to support people in their own homes. There were a lot of materials and resources available, but they were usually locally-produced and not well promoted. We found that access to information on community services was often patchy and training was not done well or not sufficiently frequent. We also found that the discharge liaison teams played only a limited role in helping to train other staff.

Questions for board members on training and awareness raising

- Is information on the range and availability of community health and social care services readily available to ward staff when planning a discharge?
- Are staff involved in, or responsible for, discharge planning supported by regular training?
- Does the discharge liaison team play a role in training staff on discharge planning?

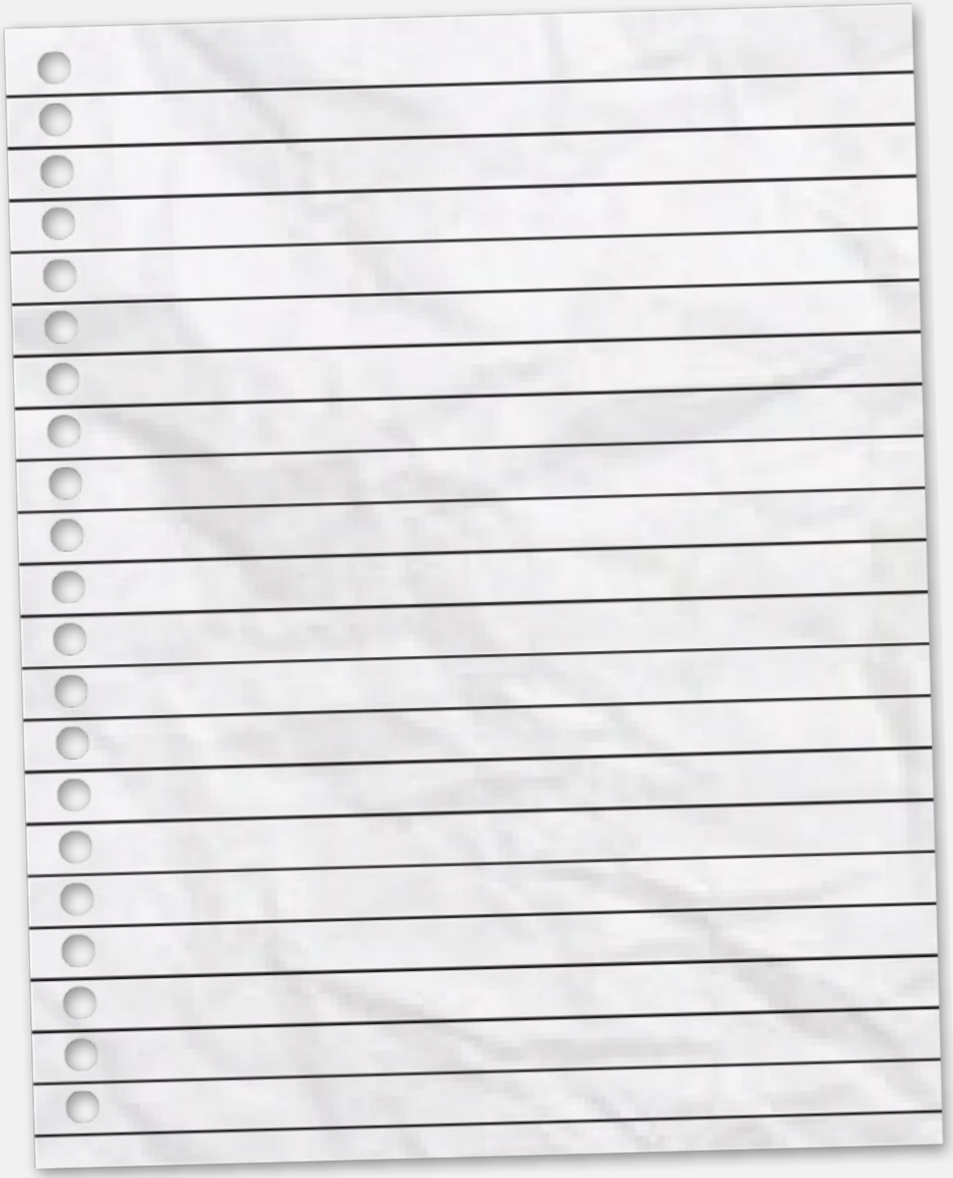
Patients and their families or carers need to understand the discharge process and the support that they can get when they leave hospital if recovery is to be maximised and readmission or long-term residential placement avoided. Across Wales as a whole, we found that the information given to patients and their families or carers was limited.

Questions for board members on patient engagement

- Is the organisation preparing general written information for patients and families on what they should expect from the discharge process and what is expected of them?
- Do staff talk with patients about 'what matters to them'[4] to ensure that discharge is safe, timely and effective?

4 'What matters to you' is a campaign to encourage and support more meaningful conversations between people who provide health and social care and the people, families and carers who receive health and social care.

Notes



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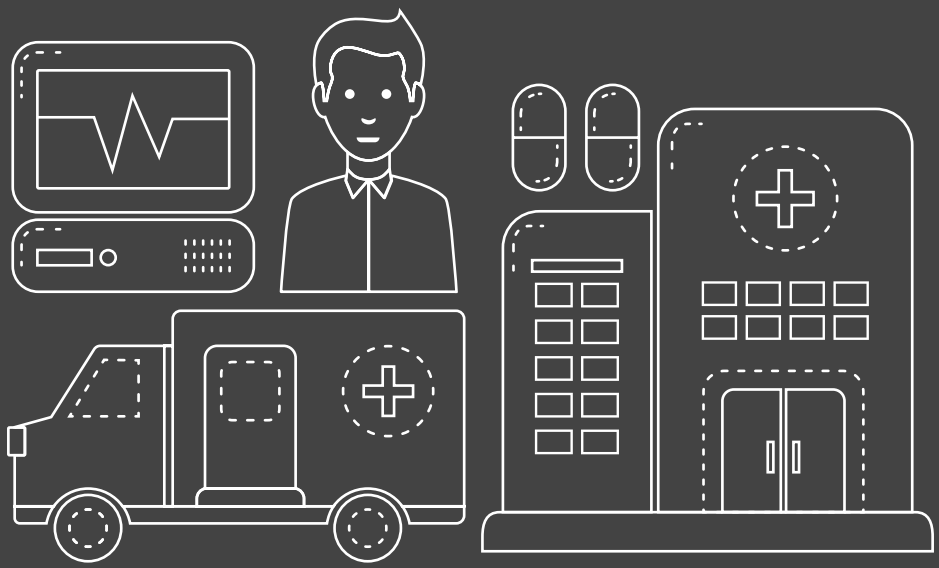
Beth yw'r oedi?

Rhyddhau cleifion yng Nghymru

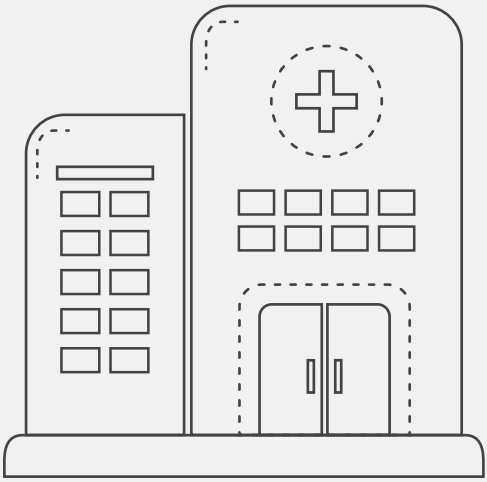


Cefndir

Un o'r heriau mwyaf sy'n wynebu cyrff GIG yng Nghymru yw'r broblem a adnabyddir fel oedi wrth drosglwyddo gofal. Mae hyn pan nad oes angen i glaf fod yn yr ysbyty hwnnw mwyach, ond bod rhywbeth yn ei atal rhag symud oddi yno. Pan na fydd cleifion yn cael eu rhyddhau o'r ysbyty yn brydlon, ceir 'ôl-groniad' yn y system gofal iechyd gyfan wrth i'r ysbyty lenwi ac mae hi'n mynd yn fwy anodd derbyn pobl sydd angen triniaeth ysbyty. Yn amlwg nid yw'n dda i'r claf ychwaith, gan ei gwneud yn fwy anodd iddo adennill ei annibyniaeth.

Mae'r Archwilydd Cyffredinol ac eraill wedi canolbwyntio ar yr her hon mewn amrywiaeth o waith gyda chyrff GIG lleol a sefydliadau cymunedol. Gwnaed gwaith archwilio'r Archwilydd Cyffredinol yn ystod 2017, a gwnaed gwaith ychwanegol ar y Gronfa Gofal Integredig yn ystod 2018. Mae'r ddogfen hon yn ategu ein hadroddiadau archwilio ffurfiol ac yn tynnu sylw at faterion pwysig y dylai aelodau bwrdd fod yn ymwybodol ohonynt wrth geisio cael sicrwydd bod cleifion yn cael eu rhyddhau o'r ysbyty mewn ffyrdd diogel a phrydlon.

Mae'r canfyddiadau o'n harchwiliadau cynllunio rhyddhau mewn byrddau iechyd ac yn Ymddiriedolaeth GIG Felindre ar gael ar wefan Swyddfa Archwilio Cymru.

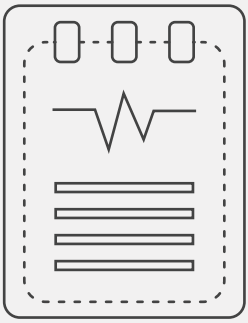


I ba raddau y mae cyrff GIG a'u partneriaid yn llwyddo

Mae cynllunio ar gyfer rhyddhau pobl o'r ysbyty yn thema mewn llawer o gynlluniau a strategaethau cyflawni, ac yn arbennig yng nghynlluniau'r gaeaf. Mae nifer enfawr y synergeddau ac aliniadau sydd eu hangen ar gyfer y cynllunio hwn yn creu problemau o orgymhlethdod.

Dywedodd cyrff GIG wrthym bod prinder gofalwyr cartref, prinder gwelyau mewn cartrefi gofal i bobl â dementia, a diffyg capasiti ar draws gwasanaethau ail-alluogi cymunedol ledled Cymru yn ffactorau mawr sy'n achosi oediadau. Mae angen i weithwyr gofal iechyd proffesiynol weithio gydag eraill i ganfod a chynllunio atebion sy'n diwallu anghenion pobl pan fyddant yn cael eu rhyddhau a sicrhau'r gwellhad gorau posibl.

Bu llawer o fentrau i wella trefniadau rhyddhau, fel pecyn llif cleifion SAFER, 'coch i wyrdd',[1] 'rhoi terfyn ar barlys pyjamas'[2] a'r 1000 diwrnod diwethaf[3]. Mae Llywodraeth Cymru hefyd wedi creu cyllid i feithrin mwy o gydweithredu rhwng meysydd iechyd, gofal cymdeithasol, tai a'r trydydd sector. Er enghraifft, mae'r Gronfa Gofal Integredig yn rhoi cyllid cymharol fyrdymor i fentrau i wneud yn siŵr mai dim ond pobl sydd wir angen bod yn yr ysbyty sydd yno. Yn ystod 2019, mae'r Archwilydd Cyffredinol yn bwriadu cyhoeddi adroddiad ar sut y mae'r gronfa hon yn cael ei defnyddio gan gyrff cyhoeddus ledled Cymru.



1 System weledol i nodi amser sy'n cael ei wastraffu mewn taith claf yw 'coch i wyrdd'; nid yw cleifion ar y rhestr goch yn elwa mwyach o fod mewn gwely ysbyty acíwt ac mae'r rhai ar y rhestr werdd yn dal i elwa ar gael eu derbyn i'r ysbyty.

2 Nod 'Rhoi Terfyn ar Barlys Pyjamas' yw cael cleifion allan o'u gwelyau ac allan o'u pyjamas cyn gynted ag y gallant wella adferiad ac atal cymhlethdodau.

3 Cysyniad sy'n atgyfnerthu gwerth amser cleifion fel yr agwedd bwysicaf ar ofal iechyd yw'r 1000 diwrnod diwethaf, ac i greu synnwyr o frys i weithredu.

Cwestiynau i aelodau bwrdd am weithio gyda phartneriaid

- A yw'r Bwrdd yn cael gwybodaeth am effeithiolrwydd gwaith partneriaeth i gynorthwyo trefniadau cynlluniau rhyddhau a gwella canlyniadau cleifion?
- A yw'r sefydliad yn gwerthuso pa wahaniaeth y mae mentrau a ariannwyd gan y Gronfa Gofal Integredig wedi ei wneud o ran hwyluso rhyddhau diogel a phrydlon?
- A yw'r sefydliad wedi rhoi mentrau llwyddiannus a ariannwyd gan y Gronfa Gofal Integredig sy'n cynorthwyo gwaith cynllunio rhyddhau yn y brif ffrwd?
- A yw'r sefydliad yn gwerthuso effaith mentrau fel pecyn llif cleifion SAFER, coch i wyrdd, rhoi terfyn ar barlys pyjamas neu'r 1000 diwrnod diwethaf, ar lif cleifion a chanlyniadau cleifion?

Yn galonogol, canfuom linellau atebolrwydd cymharol eglur, a chraffu rheolaidd ar berfformiad cynllunio rhyddhau. Mae amrywiaeth o wybodaeth ar gael yn gyffredinol i gynorthwyo craffu prydlon ac mae aelodau'r bwrdd yn teimlo eu bod yn cael digon o wybodaeth. Mae'n eglur felly bod arweinwyr cyrff GIG Cymru yn deall yn gyffredinol pwysigrwydd trefniadau rhyddhau effeithiol.

Fodd bynnag, oedi wrth drosglwyddo gofal yw'r unig fesur rhyddhau cleifion cenedlaethol. Maent yn destun monitro, adroddiadau a chraffu rheolaidd gan gyrff iechyd a llywodraeth leol. Gall systemau TG ysbytai gasglu amrywiaeth o ddata i gynorthwyo gwaith monitro ac adrodd, ond fe wnaeth llai na hanner cyrff GIG Cymru gofnodi pa un a oedd rhyddhau yn syml neu'n gymhleth gan, a dim ond traean wnaeth gofnodi'r dyddiad y datganwyd bod claf yn cael ei nodi fel bod yn feddygol barod i gael ei ryddhau.

Cwestiynau i aelodau bwrdd am wybodaeth yn ymwneud â rhyddhau

- A yw system gwybodaeth cleifion y sefydliad yn cynorthwyo'r gwaith o gofnodi data yn gywir ar gyfer monitro ac adrodd ar berfformiad gweithredol yn ymwneud â chynllunio rhyddhau?
- A yw'r sefydliad yn datblygu ac yn gweithredu metrigau perfformiad a mesurau canlyniadau i fonitro effeithiolrwydd trefniadau cynllunio rhyddhau, er enghraifft:
  - nifer y cleifion a ryddhawyd cyn hanner dydd;
  - nifer y cleifion y caiff eu dyddiad rhyddhau disgwyliedig ei gofnodi;
  - y dyddiad y mae cleifion yn feddygol barod i gael eu rhyddhau;
  - pa un a yw'r rhyddhau yn syml neu'n gymhleth;
  - nifer yr ailddderbyniadau a gafodd eu hosgoi oherwydd cynllunio da o ran rhyddhau;
  - nifer y cleifion nad oes angen cymorth tymor hwy arnynt;
  - nifer y lleoliadau parhaol mewn gofal preswyl a gafodd eu hosgoi?
- A yw'r sefydliad yn canfod ac yn adrodd yn rheolaidd ar brofiadau cleifion o gael eu rhyddhau o'r ysbyty?
- A yw perfformiad cynllunio o ran rhyddhau, ac eithrio achosion o oedi wrth drosglwyddo gofal, yn cael eu hadrodd yn rheolaidd i'r Bwrdd neu ei bwyllgorau?

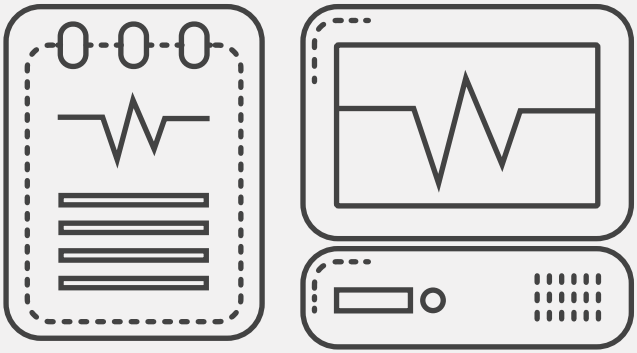
Camau tuag at wella

Mae llwybrau rhyddhau diffiniedig yn nodi camau y dylai gweithwyr gofal iechyd proffesiynol eu cymryd wrth ryddhau gwahanol fathau o gleifion. Gallant fod yn ddefnyddiol iawn. Roedd mwyafrif cyrff GIG Cymru wedi nodi rhai o'r llwybrau hyn, ond roeddent yn amrywio'n eang o ran dull ac nid oeddent yn cael eu defnyddio yn gyson.

Mae Llywodraeth Cymru yn annog model newydd lle mai mynd adref yw'r llwybr diofyn gan fod y rhan fwyaf o gleifion yn elwa ar asesiad yn eu man preswylio allweddol gyda'r gallu i ymdopi mewn amgylchedd cyfarwydd. Mae'r llwybr 'gartref gyntaf: rhyddhau i wella ac asesu' yn golygu bod cleifion yn cael eu rhyddhau gartref pan fyddant yn feddygol barod ac nad oes angen gwely ysbyty arnynt mwyach. Bydd anghenion cymorth uniongyrchol cleifion wedi eu hasesu cyn rhyddhau a'r trefniadau angenrheidiol wedi eu gwneud. Gellir parhau i asesu anghenion cymorth cleifion yn barhaus gartref gan aelodau'r tîm iechyd a gofal cymdeithasol cymunedol priodol. Mae'r dull yn golygu nad yw cleifion yn cael eu cadw mewn gwely ysbyty yn hwy na'r angen. Canfuom mai dim ond pedwar allan o wyth corff GIG oedd yn defnyddio'r model hwn ym mhob ysbyty neu mewn rhai ohonynt. Yr her yw galluogi gwasanaethau cymunedol i ymateb cyn gynted ag y caiff cleifion eu rhyddhau a gwneud y dull rhyddhau i wella ac asesu yn arfer safonol.

Cwestiynau i aelodau bwrdd am lwybrau i gynorthwyo rhyddhau gwell

- A yw'r sefydliad yn gweithredu'r llwybr rhyddhau i wella ac asesu?
- A yw'r sefydliad yn nodi ac yn mynd i'r afael â'r rhwystrau sy'n atal y llwybr rhyddhau i wella ac asesu?
- A yw'r sefydliad a'i bartneriaid yn asesu gallu gwasanaethau cymunedol i gynnig sail i lwybrau rhyddhau i wella ac asesu?
- A yw'r sefydliad yn gwerthuso effaith a chanlyniadau llwybrau rhyddhau, gan gynnwys y dull rhyddhau i wella ac asesu?



Ledled Cymru, roedd holl fyrddau iechyd y GIG yn gweithredu un neu fwy o dimau cyswllt rhyddhau. Mae'r timau hyn yn cynrychioli buddsoddiad sylweddol o gyllid ac mae ganddynt y potensial i helpu pethau i wella. Ond, canfuom fod y timau yn tueddu i fod ar gael ar ddiwrnodau gwaith yn unig, gydag amrywiaeth o drefniadau eraill ar gyfer y tu allan i oriau swyddfa. Roedd mwyafrif y timau dan arweiniad nyrsys yn hytrach na'u bod yn wirioneddol amlddisgyblaethol. Canfuom hefyd nad oedd lolfeydd rhyddhau yn cael eu defnyddio yn ddigonol yn aml. Gall lolfeydd rhyddhau gynnig amgylchedd addas lle gall cleifion aros i gael eu casglu, gan eu teulu neu gludiant ysbyty, neu tra bod meddyginiaeth yn cael ei dosbarthu.

Cwestiynau i aelodau bwrdd am dimau cyswllt rhyddhau a lolfeydd rhyddhau

- A yw'r sefydliad yn adolygu'n rheolaidd bod tîm(au) cyswllt rhyddhau ar gael ac yn gallu darparu cymorth saith diwrnod yr wythnos?
- A yw cyfansoddiad y tîm cyswllt rhyddhau yn newid i sicrhau dull amlddisgyblaethol o gynllunio rhyddhau?
- A yw'r sefydliad yn hyrwyddo'n weithredol y defnydd o lolfa/lolfeydd rhyddhau i gynorthwyo llif cleifion a rhyddhau gwelyau yn brydlon ar gyfer cleifion sy'n aros i gael eu derbyn?
- A yw'r sefydliad yn monitro ac yn adrodd ar effeithlonrwydd ac effeithiolrwydd y lolfa/lolfeydd rhyddhau?

Heriau pwysig

Mae'n bwysig bod staff yn deall yn eglur sut y mae cleifion yn cael eu rhyddhau. Adolygwyd polisïau a phrotocolau rhyddhau gennym a chanfuwyd bod y rhan fwyaf o gyrff GIG yn nodi eu dull yn eithaf da.

Ledled Cymru, mae staff ward yn gyffredinol hyderus am yr hyn y mae angen ei wneud i gynorthwyo rhyddhau diogel a phrydlon, ond cyfeiriodd staff at sawl her sydd weithiau'n ei gwneud yn anodd. Mae'r heriau hyn yn cynnwys: methu ag amcangyfrif yn ddigonol yr amser sydd ei angen i gynllunio rhyddhau claf yn effeithiol; methu â dechrau'r broses ryddhau wrth dderbyn; cynnal asesiadau rhyddhau dim ond pan ddatgenir bod y claf yn barod i gael ei ryddhau; a dibyniaeth ar staff dros dro a allai fod yn anghyfarwydd â phrosesau rhyddhau a'r gwasanaethau cymunedol sydd ar gael.

Cwestiynau allweddol i aelodau bwrdd am wella gwaith cynllunio rhyddhau

- A yw'r sefydliad yn cymryd camau i annog diwylliant lle mae cynllunio rhyddhau yn fusnes i bawb ac yn rhan allweddol o'r continwwm gofal cleifion?
- A yw'r broses cynllunio rhyddhau yn dechrau ar adeg derbyn?
- A yw'r sefydliad yn gwybod beth yw'r rhwystrau allweddol sy'n atal rhyddhau diogel a phrydlon ac a yw'n mynd i'r afael â nhw?
- A oes canllawiau syml ar gael ar gyfer staff nyrsio cronfa ac asiantaeth i'w caniatáu i gyfrannu'n effeithiol at drefniadau cynllunio rhyddhau?

Mae staff ward hefyd yn sôn am ddiwylliant o osgoi risg, pan fo staff yn amharod i ryddhau cleifion oherwydd y gallent fod mewn perygl gan eu bod yn ofni na fyddent yn ymdopi gartref. Er efallai fod staff yn gweithredu ar sail caredigrwydd, efallai nad ydynt yn gweithredu er budd pennaf claf. Mae hyfforddiant a gwybodaeth yn arfau pwysig wrth wella dealltwriaeth staff o drefniadau rhyddhau ac amrywiaeth a chapasiti'r gwasanaethau iechyd a gofal cymdeithasol cymunedol sydd ar gael i gynorthwyo pobl yn eu cartrefi eu hunain. Roedd llawer o ddeunyddiau ac adnoddau ar gael, ond roeddent wedi eu cynhyrchu'n lleol fel rheol ac nid oeddent wedi eu hyrwyddo'n dda. Canfuom fod mynediad at wybodaeth am wasanaethau cymunedol yn aml yn anghyson ac nad oedd hyfforddiant yn cael ei ddarparu'n dda neu nad oedd yn ddigon aml. Canfuom hefyd mai rhan gyfyngedig yn unig oedd y timau cyswllt rhyddhau yn ei chwarae o ran helpu i hyfforddi staff eraill.

Cwestiynau i aelodau bwrdd am hyfforddiant a chodi ymwybyddiaeth

- A oes gwybodaeth am amrywiaeth y gwasanaethau iechyd a gofal cymdeithasol cymunedol a pha un a ydynt ar gael, ac ar gael yn rhwydd i staff ward wrth gynllunio rhyddhau?
- A yw staff yn cymryd rhan mewn gwaith cynllunio rhyddhau, neu'n gyfrifol amdano, wedi ei gefnogi gan hyfforddiant rheolaidd?
- A yw'r tîm cyswllt rhyddhau yn chwarae rhan yn y gwaith o hyfforddi staff ar gynllunio rhyddhau?

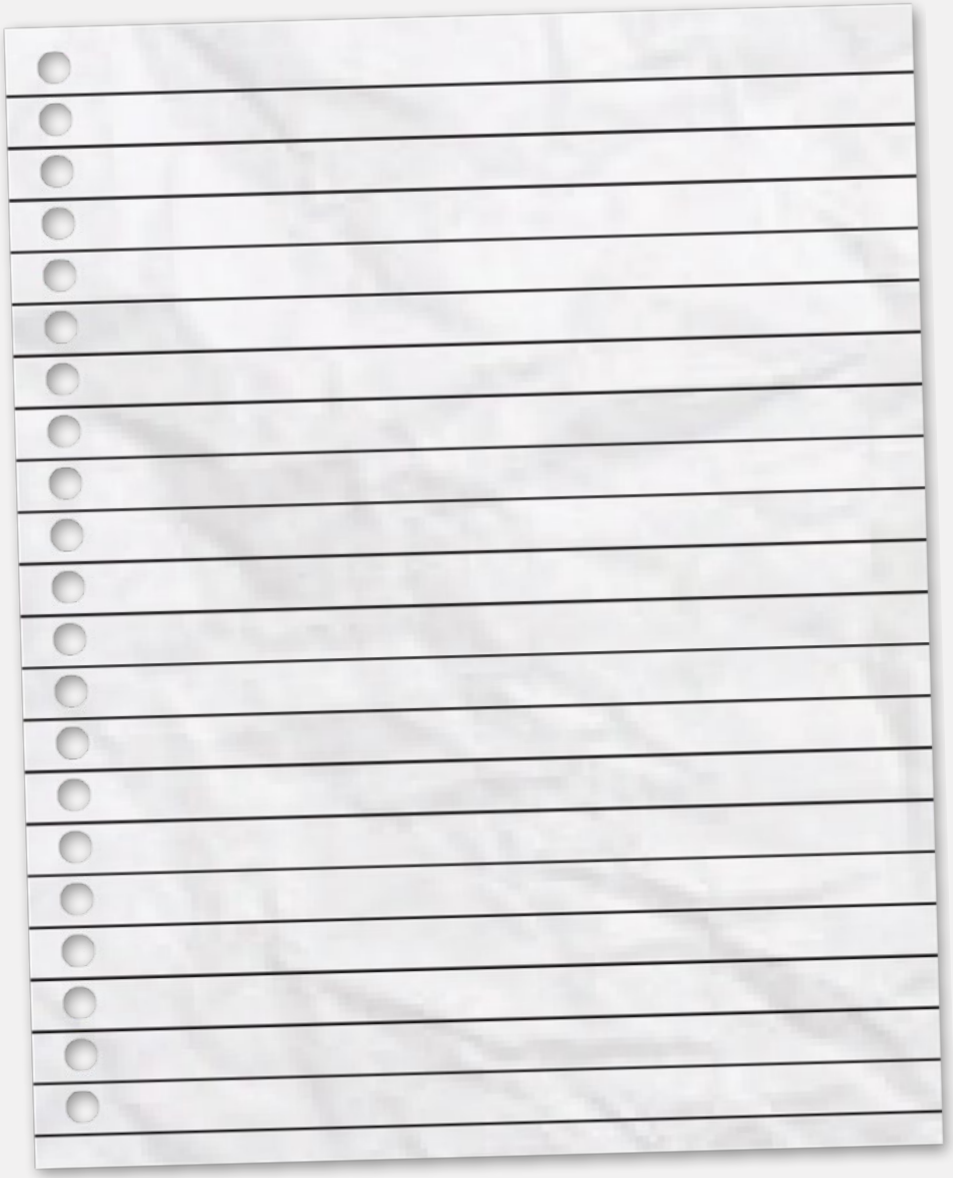
Mae angen i gleifion a'u teuluoedd ddeall y broses ryddhau a'r cymorth y gallant ei gael pan fyddant yn gadael yr ysbyty os yw gwellhad yn mynd i fod cystal â phosibl a bod lleoliad preswyl hirdymor yn mynd i gael ei osgoi. Ledled Cymru yn ei chyfanrwydd, canfuom fod yr wybodaeth a roddir i gleifion a'u teuluoedd neu eu gofalwyr yn gyfyngedig.

Cwestiynau i aelodau'r bwrdd am ymgysylltu â chleifion

- A yw'r sefydliad yn paratoi gwybodaeth ysgrifenedig gyffredinol i gleifion a theuluoedd am yr hyn y dylent ei ddisgwyl o'r broses ryddhau a'r hyn a ddisgwylir ganddynt?
- A yw aelodau staff yn siarad â chleifion am yr hyn sy'n bwysig iddyn nhw[4] i sicrhau bod rhyddhau yn ddiogel ac yn effeithiol?

4 Ymgyrch i annog a chefnogi sgyrsiau mwy ystyrlon rhwng pobl sy'n darparu gwasanaethau iechyd a gofal cymdeithasol a'r bobl, y teuluoedd a'r gofalwyr sy'n derbyn gwasanaethau iechyd a gofal cymdeithasol yw 'What matters to you'.

Nodiadau



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Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

PWYLLGOR ARCHWILIO A SICRWYDD RISG
AUDIT AND RISK ASSURANCE COMMITTEE

DYDDIAD Y CYFARFOD: **DATE OF MEETING:**	27 August 2019
TEITL YR ADRODDIAD: **TITLE OF REPORT:**	What's the hold up? Discharging patients in Wales – Wales Audit Office Toolkit
CYFARWYDDWR ARWEINIOL: **LEAD DIRECTOR:**	Joe Teape, Director of Operations
SWYDDOG ADRODD: **REPORTING OFFICER:**	Alison Bishop, Service Delivery Manager, Unscheduled Care

Pwrpas yr Adroddiad (dewiswch fel yn addas) **Purpose of the Report** (select as appropriate)
Er Sicrwydd/For Assurance

ADRODDIAD SCAA
SBAR REPORT

Sefyllfa / Situation

In March 2019 the Wales Audit Office (WAO), issued the "What's the hold up? Discharging Patients in Wales" report to NHS bodies, so that they could assure themselves that hospital discharge arrangements are safe and timely.

Both the report and supporting checklist were taken to the April 2019 Unscheduled Care Programme Board meeting. The attached action plan, with noted self-assurance and evidence, has been compiled by the acute hospital sites, community service teams and integrated social care teams.

The action plan has been circulated to the Executive Team for comment and the Audit & Risk Assurance Committee is asked to review the attached action plan, for assurance.

Cefndir / Background

During 2017, the Auditor General for Wales reviewed discharge planning arrangements at local health boards and Velindre NHS Trust. WAO issued Hywel Dda University Health Board a formal report of their findings, along with recommendations for improvement in January 2017.

The report produced in January 2017 contained 6 recommendations for the Health Board, centred around the following themes;

1. Discharge and transfer of care policy.
2. Implementation of the SAFER patient bundle.
3. Training on discharge planning.
4. Utilisation of discharge lounges.
5. Performance reporting.
6. Monitoring compliance with standards.

These themes are common across several reports received by the University Health Board over the past few years, from bodies such as the Delivery Unit, Healthcare Inspectorate Wales, etc.

Each county has been developing an integrated unscheduled care plan across the whole system, in partnership with Welsh Ambulance Services NHS Trust (WAST), Primary Care and Social Care colleagues. These plans have also formed the basis of the Health Board's annual plan and Integrated Medium Term Plan (IMTP).

As a result of the development of Wales-specific guidance on the SAFER patient flow bundle and other ongoing Delivery Unit support work, WAO issued a further complimentary report in March 2019.

Asesiad / Assessment

The themes detailed in the above section are core to the unscheduled care plans, and progress has been delivered since the initial report in January 2017.

The "What's the hold up?" checklist develops these themes further, and there are a series of questions around each theme where the board needs to seek assurance. Evidence to support this assurance has been provided in the attached action plan, along with self-assurance from the unscheduled care programme. The individual county integrated plans have also been provided as background to the evidence.

Whilst a number of the recommendations from the January 2017 report have already been actioned, work on others of the recommendations, for example implementing the SAFER patient bundle across all the acute and community wards, is work in progress. As such, whilst certain of the issues raised in the toolkit have been self-assessed as providing assurance, others have been identified as partial assurance and follow up actions identified.

Argymhelliad / Recommendation

The Audit & Risk Assurance Committee is asked to review this report and accompanying action plan and consider whether it provides the necessary assurance.

Amcanion: (rhaid cwblhau) **Objectives: (must be completed)**	
Committee ToR Reference Cyfeirnod Cylch Gorchwyl y Pwyllgor	4.4 The Committee's principle duties encompass the following: 4.4.1 Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical. 5.18 The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by: 5.18.3 review all External Audit reports, including agreement of the annual Audit Report and Structured Assessment before submission to the Board, and any work carried outside the annual audit plan, together with the appropriateness of management responses;
Cyfeirnod Cofrestr Risg Datix a Sgôr Cyfredol: Datix Risk Register Reference and Score:	Corporate Risk 629 – Unscheduled Care Score: 16

Safon(au) Gofal ac Iechyd: Health and Care Standard(s):	2. Safe Care 2.1 Managing Risk and Promoting Health and Safety 5. Timely Care
Amcanion Strategol y BIP: UHB Strategic Objectives:	4. Improve the productivity and quality of our services using the principles of prudent health care and the opportunities to innovate and work with partners.
Amcanion Llesiant BIP: UHB Well-being Objectives: Hyperlink to HDdUHB Well-being Statement	Improve Population Health through prevention and early intervention Improve efficiency and quality of services through collaboration with people, communities and partners

Gwybodaeth Ychwanegol: Further Information:	
Ar sail tystiolaeth: Evidence Base:	Contained within the report.
Rhestr Termau: Glossary of Terms:	Contained within the report.
Partïon / Pwyllgorau â ymgynhorwyd ymlaen llaw y Pwyllgor Archwilio a Sicrwydd Risg: Parties / Committees consulted prior to Audit and Risk Assurance Committee:	Executive Team Unscheduled Care Board

Effaith: (rhaid cwblhau) Impact: (must be completed)	
Ariannol / Gwerth am Arian: Financial / Service:	Financial impacts and considerations are inherent in the report.
Ansawdd / Gofal Claf: Quality / Patient Care:	Robust winter plans ensure patient care continues to be provided throughout the winter period.
Gweithlu: Workforce:	Use of agency resources to mitigate internal human resource capacity limitations details are contained within the winter plans
Risg: Risk:	The winter period presents heightened risk to the UHB with increased demand across the unscheduled care system.
Cyfreithiol: Legal:	Not applicable
Enw Da: Reputational:	There could be significant reputational risks for the HB and partners in the event of a major incident.
Gyfrinachedd: Privacy:	Not applicable
Cydraddoldeb: Equality:	Bespoke winter plans are in place for the three counties which reflect the needs of the population within each of these counties.

	Evidence	Self-Assessment		Follow up actions
		Assured	Not assured	
Information relating to discharge				
Does the Board receive information about the effectiveness of partnership working to support discharge planning arrangements and improve patient outcomes?	SharePoint has been developed across health and social care to monitor complex patient pathways and provide analysis on a county by county basis or a HB footprint of delays within the system. This system allows a timestamp for each part of the complex discharge to be entered and then provides information to the nature of delays across the pathway. This is in place across all 3 counties and ensures consistent reporting of complex discharges.	√		
	Each county reviews the relevant information to ensure that actions are taken and improvements are made			
	The USC Programme Board, with representation across health & social care, is sited on our partnership planning arrangements and provides check and challenge to the relevant counties as and when necessary.			
	As part of the USC programme a whole system pathway was developed of which discharge is component 6. Standards across key parts of this pathway, one of which was discharge, were developed with MDT front facing teams to define what good looks like for our population and associated actions to deliver this standard. This was approved at USC programme Board and the implementation of these standards forms the basis of integrated USC plans, by county, and the annual plan moving forward. a list of the local HB objectives can be seen in attached sheet and copies of the County Integrated USC Plans.			
	Performance is monitored through Executive performance reviews.			
Is the organisation evaluating what difference ICF funded initiatives have made in facilitating safe and timely discharge?	The outcomes framework developed by the Regional Partnership Board incorporates the evaluation of all ICF funded projects. These reports are submitted to WG through the Regional Partnership Board governance process.	Partial		
Has the organisation mainstreamed successful ICF funded initiatives that support discharge planning?	Elements of ICF schemes that support discharge planning have been transferred to core mainstream funding. The outcomes framework recently developed will support evaluation and continuation of schemes.	Partial		
Is the organisation evaluating the impact of initiatives, such as the SAFER patient flow bundle, red2green, end PJ paralysis or last 1000 days, on patient flow and patient outcomes?	The service improvement team works with individuals sites to collate the Red2Green data. IRIS has a dashboard report down to ward level which contains the following information which is part of the SAFER bundle; - Admissions - % discharges before midday (month on month comparison) - average LoS - % bed occupancy (month on month comparison)	√		
	In addition, the USC Board has a suite of whole system metrics that is reported monthly together with other data. This is reviewed at the monthly USC meetings and each County has an integrated USC plan with actions for improvement.			
Is the organisation's patient information system supporting the accurate recording of data for monitoring and reporting on operational performance related to discharge planning?	Welsh PAS does not provide the level of detail required to accurately monitor discharge planning in complex cases. Therefore the SharePoint system described above was developed to provide this additional level of detail.	√		
	Each acute site and Community Hospital is provided monthly with LoS data, stranded patient data (those patients with a LoS > 7 days), patients with LoS > 28 days for monitoring and review at the regular triumvirate and stranded patient review meetings.			
Is the organisation developing and implementing operational performance metrics and outcome measures to monitor the effectiveness of discharge planning arrangements, for example:				
- the number of patients discharged before midday;	This is recorded within the USC and IRIS dashboards. Standing agenda item at the USC Programme Board. Forms part of the acute sites patient flow dashboard that is reviewed as part of operational effectiveness	√		
- the number of patients whose expected date of discharge is recorded;	This is recorded within the USC and IRIS dashboards. Standing agenda item at the USC Programme Board. Forms part of the acute sites patient flow dashboard that is reviewed as part of operational effectiveness This is communicated on a daily basis in patient flow meetings	Partial		SOP required across the Health Board regarding how EDDs are set and whether EDDs are moved during the patient journey. Clinical engagement across the sites is variable.
- the date patients are medically fit for discharge;	This is recorded within the USC and IRIS dashboards. Standing agenda item at the USC Programme Board. Forms part of the acute sites patient flow dashboard that is reviewed as part of operational effectiveness This is reviewed on a daily basis	√		
- whether the discharge is simple or complex;	By exclusion - i.e. Complex discharges are recorded on Sharepoint		√	currently there is no mechanism for recording the type of discharge manually or electronically through PAS
- the number of readmissions avoided because of good discharge planning;	This is recorded within the USC and IRIS dashboards. Standing agenda item at the USC Programme Board. Forms part of the acute sites patient flow metrics that is reviewed as part of operational effectiveness	√		
- the number of patients who do not need longer term support;	This is recorded and is forming part of the Right Sizing Community Services data collection		√	work being developed with the Delivery Unit - initial scoping work has been undertaken and further work is being agreed and reported via the regional Partnership Board
- the number of permanent placements in residential care settings avoided?	The Right Sizing Community Services programme is determining measures that will support future models of service		√	
Is the organisation regularly collating and reporting on patients' experience of being discharged from hospital?	The Right Sizing Community Services programme is determining measures that will support future models of service		√	
Is discharge planning performance, other than delayed transfers of care, regularly reported to the Board or its committees?	Standing agenda item at the USC Programme Board. The County Director's quarterly report to Board presents regular updates on progress towards implementation of Integrated Community Models of service and patient pathways. Discharge planning performance is an integral element of this report.	√		

	Evidence	Self-Assessment		Follow up actions
		Assured	Not assured	
Information relating to discharge				
Pathways to Support better discharge				
Is the organisation implementing the discharge to recover and assess pathway?	All counties are implementing 'Home First' pathways as part of their current integrated USC plan and is an element of the Right Sizing Community services programme.		√	work being developed with the Delivery Unit - initial scoping work has been undertaken and further work is being agreed and reported via the regional Partnership Board
Is the organisation identifying and addressing the barriers to implementing the discharge to recover and assess pathway?	This is addressed through the programme of work in Right Sizing Community Services and Transformation programme 1 and 3.		√	
Is the organisation and its partners assessing the capacity of community-based services to underpin discharge to recover and assess pathways?	This is addressed through the programme of work in Right Sizing Community Services and Transformation programme 1 and 3.		√	
Is the organisation evaluating the impact and outcomes of discharge pathways, including the discharge to recover and assess approach?	This is addressed through the programme of work in Right Sizing Community Services and Transformation programme 1 and 3.		√	
Discharge Liaison teams and Discharge Lounges				
Is the organisation regularly reviewing the availability and capacity of the discharge liaison team(s) to provide support seven days a week?	All the teams are regularly reviewed and improvements to the service made as part of the whole system improvements.	√		
Is the composition of the discharge liaison team changing to ensure a multidisciplinary approach to discharge planning?	All of the teams take a multidisciplinary approach.	√		
Is the organisation actively promoting the use of the discharge lounge(s) to support patient flow and release beds promptly for patients waiting admission?	3 of the acute sites regularly utilise their discharge lounges, PPH, GGH & WGH. Glangwili triumvirate review the utilisation of the discharge lounge as part of their regular management meetings. PPH collect ultilisation by ward and this is discussed weekly with wards	√		
Is the organisation monitoring and reporting on the efficiency and effectiveness of the discharge lounge(s)?	see above			
Improving Discharge Planning				
Is the organisation taking steps to encourage a culture where 'discharge planning is everyone's business' and a key part of the patient care continuum?	A bi-lingual discharge leaflet was produced with USC partners and this is provided to patients within the first 24 hours of admission. Working with WAST postcards clearly setting out the HBs expectations in terms of home first are provided to patients. As stated above discharge is part of the integrated USC pathway. PPH has a discharge planning training programme held on a monthly basis	√		
Does the discharge planning process start on admission?	Discharge planning forms a core part of the nursing inpatient documentation and is commenced prior to admission in the A&E Department once the decision to admit is made.	partial		whilst this does form part of the nursing documentation audits preformed in the past have shown that there are varying degrees of compliance across the acute sites. Work is ongoing across all sites to ensure early conversations take place with patients and relatives to facilitate timely discharge.
Does the organisation know what the key barriers are to safe and timely discharge and is it addressing them?	As part of the county patient flow dashboard, referenced in line 17 above, the top 15 reasons for patients being discharged after the last EDD are reported. The SharePoint system, referenced in line 4 above, This system allows a timestamp for each part of the complex discharge to be entered and then provides information to the nature of delays across the pathway.	√		
Is simple guidance available for bank and agency nursing staff to enable them to contribute effectively to discharge planning arrangements?	Bank Staff are encouraged to attend our discharge planning training and support to facilitate ward discharges is provided by the senior sisters and charge nurse. Discharge planning is reviewed at ward level on a daily basis as part of board rounds	partial		varying compliance across sites. Being addressed as part of the operational effectiveness LOS work.
Training and awareness raising				
Is information on the range and availability of community health and social care services readily available to ward staff when planning a discharge?	Acute based inpatient areas are supported through in reach and Community Discharge Liaison multiagency teams through discharge planning mechanisms i.e. MDT meetings, with information on the range of services both statutory and 3rd Sector to support a safe discharge.	√		
Are staff involved in, or responsible for, discharge planning supported by regular training?	Regular training on discharge planning and complex care management is supported to ward based staff through Community Discharge Liaison teams, Social services and the Long Term Care Team support. PPH has a discharge planning training programme held on a monthly basis	√		
Does the discharge liaison team play a role in training staff on discharge planning?	Regular training on discharge planning and complex care management is supported to ward based staff through Community Discharge Liaison teams, Social Services and the Long Term Care Team support.	√		
Patient Engagement				
Is the organisation preparing general written information for patients and families on what they should expect from the discharge process and what is expected of them?	A bi-lingual discharge leaflet was produced with USC partners and this is provided to patients within the first 24 hours of admission. Working with WAST postcards clearly setting out the HBs expectations in terms of home first are provided to patients.	√		

	Evidence	Self-Assessment		Follow up actions
		Assured	Not assured	
Information relating to discharge				
Do staff talk with patients about 'what matters to them'4 to ensure that discharge is safe, timely and effective?	there has been a successful pilot of the 4 questions on 1 ward in PPH and this being rolled out across the hospital from August	partial		varying compliance across sites. Being addressed as part of the operational effectiveness LOS work and Withybush improvement program.

Step 1
Help me to remain independent

Strategic Objectives
• Single point of access to provide information, advice & assistance
• implement early conversations with patients

Step 2
Support me to support myself

Strategic Objectives
• Single point of access to provide information, advice & assistance
• implement early conversations with patients
• Education of public – alternative pathways, redirection, community pharmacy – consistent message
• Roll out of single patient plan staged approach stay well – anticipatory – advance care plans
• Undertake capacity & demand review & modelling in community services to inform IMTP

Step 3
Assess & monitor me

Strategic Objectives
• Single point of access to provide information, advice & assistance
• implement early conversations with patients
• Education of public – alternative pathways, redirection, community pharmacy – consistent message
• Roll out of single patient plan staged approach stay well – anticipatory – advance care plans
• Undertake capacity & demand review & modelling in community services to inform IMTP

Step 4
Step up my care

Strategic Objectives
• Fully integrated MDT single Point of Access to support intermediate care
• implement early conversations with patients
• Education of public – alternative pathways, redirection, community pharmacy – consistent message
• Roll out of single patient plan staged approach stay well – anticipatory – advance care plans
• Consistent definition and approach for CRT
• Develop & implement frailty model (guidance from frailty expert group)
• Undertake capacity & demand review & modelling in community services to inform IMTP

Step 5
Take me to hospital

Step 5a
Front Door

Strategic Objectives
• Education of public – alternative pathways, redirection, community pharmacy – consistent message
• Empower staff to manage family expectations and advocate for patient wishes
• Roll out of patient postcards what do I need to take into hospital
• Develop audio visual materials for ED screens explaining patient pathway
• Implement consistent fast track admission pathways e.g. stroke
• Define local redirection pathways link to national ABUHB work
• Implement consistent access to diagnostics 24/7
• Implement consistent access to mental health liaison 24/7
• Implement consistent access to mental health assessment room 24/7
• Embed culture of 'Think AEC first' & 'Home First'
• Develop & implement frailty model (guidance from frailty expert group)
• Develop & implement standards for specialty retrieval from ED
• Develop standard templates for discharge leaflets
• Consistent front door turnaround services Consider roll out of follow up phone call from MAST
• Implement e-discharge
• Undertake demand and capacity assessment for transport across UHB. & implement actions
•Develop new medical model passed over to TCS
• Implement Prof Hopkins nursing review

Step 5b
Inpatient stay

Strategic Objectives
• Implement: Meet and greet , Ward information for patients, including 'Who's Who', The 'what can you do?' conversation
• Implement: Early conversations with patients and families
• Implement: Clear consistent definition & process for EDDS
• Ensure consistent process to identify simple / complex discharges on admission
• Embed Red2Green, board rounds, 4 questions and SAFER patient bundle
• Avoid deconditioning - hydration stations & encourage moving
• Need to improve awareness re assistance with eating and drinking
• Reduce the number of medical outliers
• Improvement in performance against the National Audit of Dementia
• Implement: delirium screening, dementia-friendly nutrition and hydration, dementia friendly wards
• Maximise potential of discharge lounges across the UHB

Step 6
Get me home safely

Strategic Objectives
• Implement: Early conversations with patients and families
• Implement: Clear consistent definition & process for EDDS
• Ensure consistent process to identify simple / complex discharges on admission
• Implement: Discharge to assess pathways, ensuring they accommodate the needs of people with dementia
• Review of discharge information – understand blockages in current process (links to roll out of e-discharge in step 5a)
• Identify inpatient care co-ordinator
• Define DLN role in the Health Board
• Ensure consistent handover to community services

Step7 Continue to care for me

Strategic Objectives

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	USC	LOS / Bed Day Reduction	Links to other plans	Status	Next Action
STEP 1&2 Help me to remain independent & support me to support myself												
2.1	**Single point of access to provide information, advice & assistance**											
	Develop Single Point of Access wellbeing officers roles to deliver 'just checking' and 'MECC' calls routinely as outlined in the individual's Anticipatory Care Plan. Phased implementation across all GP practices over the year	Carms	County Director	County Regional Lead & PMO	Number of outbound calls as a % of people registered with 'stay well' plan, increased number of enquiries requiring information and advice from Delta Wellbeing.	Decreased avoidable admissions to hospital	Mar-20	Y		Annual Plan, Finance, Transformation		Please refer to Transformation Fund Programme One detailed plan
2.2	Refine single point of access to accommodate realigned intermediate care model	Carms	County Director	Head of Integrated Service	Reduced admissions and number of bed days occupied by > 75s admitted by Gen Med emergency (n= 87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Sep-19	Y		Annual Plan, Finance, Transformation		Implement refined model
STEP 3 Assess & Monitor Me												
3.1	Roll out of Fulfilled Lives Dementia initiative across the County	Carms	County Director	Head of Integrated Services	Reduced hospital admissions compared to control group. Reduced Care Commissioning	Improved wellbeing and independence of patients with dementia and their families	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Roll out plan supported by ICF dementia funding.
3.2	Undertake capacity and demand modelling for intermediate care in community services to inform IMTP and Transformation Business Cases	Carms	County Director	Head of Integrated Services	Provide data to support Transformation Fund business case	Increased 'Time Spent at Home'	Apr-19	Y	Y	Annual Plan, Finance, Transformation		N/A
3.3	Review ICF Proactive Care resource to support improved multidisciplinary assessment of patients identified as 'high risk' of admission to hospital. Realign and enhance to increase impact of the resource. Monitor Impact.	Carms	County Director	Head of Integrated Services	Number of GP practices (%) engaged, number of 'stay well plans' as a % of patients supported, cost containment of 3% growth in CHC and Social Care	Decreased avoidable admissions to hospital	Apr-19	Y	Y	Annual Plan, Finance, Transformation		See Detailed Programme Plan for 'Our Healthier Carmarthenshire'
3.4	Review of 'whole system' Chronic Disease Management in Health Board	Carms	Exec Director Primary Care & Community	County Director Carmarthenshire	Reduction in admissions to hospital for those with chronic disease - Basket of 8 tier one targets Improved prevention of chronic conditions	Improved wellbeing and independence of individuals with chronic disease	Jun-19	Y	Y	Annual Plan, Finance, Transformation		Inaugural meeting deferred
STEP 4 Step up my care												
Fully integrated MDT single Point of Access to support intermediate care												
4.1	Please see 2.2 above											
4.2	**Implement early conversations with patients**											
	Introduce 'Ticket Home' on Medical Wards; All Frail Patients to have Clinical Discharge Criteria agreed between Clinician, MDT, Patient and their Carer.	Carms	Acute GMs	Acute HoNs	Reduced Days Lost across the D/C pathway	Clearly communicated Discharge Destination, Clinical Discharge Criteria and Patient Plan (as per SAFER 4 Qs)	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Phased Implementation
4.3	**Education of public – alternative pathways, redirection, community pharmacy – consistent message**											
	Discuss public comms re 'care closer to home' with public as part of ' A Healthier Mid & West Wales'	All Counties	Comms Directorate		Reduced conveyance, presentation at ED	Changing Public Expectation	Mar-20	Y		Annual Plan, Finance, Transformation		Discuss comms with Comms
4.4	**Roll out of single patient plan (staged approach stay well – anticipatory – advance care plans)**											
	Regional Task & Finish Group to convene and agree Definitions and Templates for 'plans'	Carms	County Director	County Regional Lead & PMO	Agreed 'Regional' Offer re Intermediate Care and its Standards	Consistent and equitable intermediate care pathway across three Counties	Mar-19	Y		Annual Plan, Finance, Transformation		CARMS Group to agree Carmarthenshire definitions
	Roll out consultant review of care homes to other homes in the Llanelli Area	Carms	PPH GM		Beds days per care home	number of care home residence with advanced care plans hospital admissions per care home	Mar-20	Y	Y			discuss with 2nd largest care home in Llanelli
4.5	**Consistent definition and approach for CRT**											
	Intermediate Care Task and Finish Group to agree Regional Framework, Definitions and Templates for 'plans'	All Counties	USC Programme lead	USC Programme lead	Agreed 'Regional' Offer re Intermediate Care and its Standards	Consistent and equitable intermediate care pathway across three Counties	Mar-19	Y		Annual Plan, Finance, Transformation		Deferred due to minimal attendance
4.6	**Develop & implement frailty model (guidance from frailty expert group)**											
	TBC with Alison Bishop for Update											
4.7	**Undertake capacity & demand review & modelling in community services to inform IMTP**											
	Integrate all current intermediate care resources against four defined NAIC areas i.e. Crisis Response, Bed Based Care, Home Based Care and Reablement; this includes existing TOCALS and SCRAMS (need to encompass AEC principles)	Carms	County Director	County Regional Lead & PMO	Reduced admissions and number of bed days occupied by > 75s admitted by Gen Med emergency (n= 87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Mar-20	Y	Y	Annual Plan, Finance, Transformation		See 'A Healthier Carmarthenshire' programme plan

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	USC	LOS / Bed Day Reduction	Links to other plans	Status	Next Action
	Develop Crisis Response model against current baseline to reduce conveyance and admission avoidance by 10% in first year	Carms	County Director	Head of Integrated Service	Reduced admissions and number of bed days occupied by > 75s admitted by Gen Med emergency (n= 87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Sep-19	Y	Y	Annual Plan, Finance, Transformation		Progress & complete recruitment Please see detailed Transformation Plan for Programme 3 and 'Our Healthier Carmarthenshire'
	Continue to improve Reablement outcomes and increase to 55% requiring no care over next year	Carms	County Director	Head of Integrated Service	Increase percentage of service users requiring no care after the service to 55%	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Sustain ICF funding for additional OT resource to lead service
	Procure, commission bespoke nursing assessment beds in each locality to support step up bed based care	Carms	County Director	Head of Long Term Care	Reduced admissions and number of bed days occupied by > 75s admitted by Gen Med emergency (n= 87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Pending Agreement
4.8	**Improve ambulatory care provision**											
	Develop Ambulatory Care Services in PPH	PPH	PPH GM	Hospital Service Manager	0 days LOS	increase number of patients managed as ambulatory care	Mar-20	Y	Y			* visit to other units * develop business case for capital
4.9	**Improve access for patients who needs can be met by A&E / MIU (minors 4 hour performance)**											
	Develop alternative DVT pathway in Llanelli	PPH	PPH GM	Hospital Service Manager	4 hour breaches	reduce 4 hour breaches	Mar-20	Y	Y			part of improvement collaborative
	Increase capacity in PPH MIU through recruitment	PPH	PPH GM	Hospital Service Manager	4 hour breaches	reduce 4 hour breaches	Mar-20	Y	Y			ANP JDs finalised
	Ensure patients access their own GP where appropriate	PPH	PPH GM	Hospital Service Manager	4 hour breaches	reduce MIU attendances	Mar-20	Y	Y			feedback to individual practices
STEP 5	**Take Me To Hospital**											
STEP 5a Front Door	**Front Door**											
5.2a	**Empower staff to manage family expectations and advocate for patient wishes**											
	Discuss public comms re 'care closer to home' with public as part of TCS engagement	All Counties	Comms Directorate		Reduced conveyance, presentation at ED	Changing Public Expectation	Mar-20	Y		Annual Plan, Finance, Transformation		Discuss comms with Comms
5.3a	**Roll out of patient postcards what do I need to take into hospital**											
	Cost printing of 'postcards' to replace discharge A4 patient information and consider implementation	Carms	Acute GMs	N/A	Clear Messaging	Supports reduced LOS	Mar-19	Y		Annual Plan, Finance, Transformation		
5.4a	**Develop audio visual materials for ED screens explaining patient pathway**											
	Discuss with Comms and cost	All Counties	Comms Directorate	SDMs	Clear Messaging	Supports reduced LOS	Mar-19	Y		Annual Plan, Finance, Transformation		
5.5a	**Implement consistent fast track admission pathways e.g. stroke, #NOF**											
	Improve compliance against pathways	Carms	Acute GMs	SDMs	from xx to xx	Improves quality and safety / patient outcomes	Mar-20	Y		Annual Plan, Finance, Transformation		
5.8a	**Embed culture of 'Think AEC first' & 'Home First'**											
	Joint planning of Crisis Response to support implementation of nationally agreed AEC and Home first Principles (as outlined in 4.7 above)	Carms	County Director	County Regional Transformational Lead Nd PMO	Reduced admissions and number of bed days occupied by > 75s admitted by Gen Med emergency (n= 87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Mar-20	Y		Annual Plan, Finance, Transformation		Develop Business Case for consideration by Finance and Regional Partnership Board
5.12a	**Consistent front door turnaround services , Consider roll out of follow up phone call from MAST**											

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	USC	LOS / Bed Day Reduction	Links to other plans	Status	Next Action
	Extend TOCALS as part of intermediate care review (in step 4 above) to support AEC and 12 hour working	Carms	County Director	Head of Integrated Services	Reduced admissions and number of bed days occupied by > 75s admitted by Gen Med emergency (n= 87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Insufficient ICF to enhance to 7/7 - Enhance performance and link to development of Crisis Response
	Improve Therapy provision on weekend	PPH	PPH GM	physio lead PPH	increased weekend discharges	reduced LOS. Increased Weekend discharges	Mar-20	Y	Y	Annual Plan, Finance, Transformation		evaluation of June Pilot
5.2b	**Implement early conversations with patients**											
	Introduce 'Ticket Home' on Medical Wards; All Frail Patients to have Clinical Discharge Criteria agreed between Clinician, MDT, Patient and their Carer.	Carms	Acute GMs	Acute HoNs	Reduced Days Lost across the D/C pathway and 100% patients on SharePoint Working List have CCD	Clearly communicated Discharge Destination, Clinical Discharge Criteria and Patient Plan (as per SAFER 4 Qs)	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Phased Implementation
5.3b	**Implement: Clear consistent definition & process for EDDS**											
	Written Control Documentation Procedure for Delayed Transfers of Care and Discharge Planning approved and implemented via training.	All Counties	County Dir Carms	County Directors / Acute GMs	Accurate dataset within SharePoint, Days Lost reduction across D/C pathway (SharePoint)	Improved consistency, compliance and accurate reporting on SharePoint and WG DToC	Mar-19	Y	Y	Annual Plan, Finance, Transformation		Approval by Policy Group
5.4b	**Ensure consistent process to identify simple / complex discharges on admission**											
	Written Control Documentation Procedure for Delayed Transfers of Care and Discharge Planning approved and implemented via training.	All Counties	County Dir Carms	County Directors / Acute GMs	Accurate dataset within SharePoint, Days Lost reduction across D/C pathway	Improved consistency, compliance and accurate reporting on SharePoint and WG DToC	Mar-19	Y	Y	Annual Plan, Finance, Transformation		Approval by Policy Group
5.5b	**Embed Red2Green, board rounds, 4 questions and SAFER patient bundle**											
	Introduce 'Ticket Home' on Medical Wards; All Frail Patients to have Clinical Discharge Criteria agreed between Clinician, MDT, Patient and their Carer.	Carms	Acute GMs	Acute HoNs	Reduced Days Lost across the D/C pathway	Clearly communicated Discharge Destination, Clinical Discharge Criteria and Patient Plan (as per SAFER 4 Qs)	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Phased Implementation
	4 questions to be rolled out to all wards in PPH	Carms	Acute GMs	Acute HoNs	% of patients who can answer the 4 questions	+ clearly communicated and agreed patient plans reduce LOS		Y	Y	Annual Plan, Finance, Transformation		
	Effective board rounds on all wards every day	Carms	Acute GMs	Acute HoNs	Board round frequency Board round attendance	+ clearly communicated and agreed patient plans reduce LOS		Y	Y	Annual Plan, Finance, Transformation		
5.8b	**Maximise potential of discharge lounges across the UHB**											
	Increase use of discharge lounge	Carms	Acute GMs	Acute HoN	average xx% use of D/C lounge in PPH. Xx% increased use D/C lounge in GGH	Improved flow	Mar-20	Y	Y	Annual Plan, Finance, Transformation		develop reporting by ward on discharge lounge utilisation
	Increase rate discharges before 12 MD	Carms	Acute GMs	Acute HoN	Increase D/C before 12md by XX% in PPH. Increase D/C before 12md by XX% in GGH	Improved flow	Mar-20	Y	Y	Annual Plan, Finance, Transformation		
6.0 STEP 6	**Get me Home Safely**											
6.1	**Implement early conversations with patients**											
	Introduce 'Ticket Home' on Medical Wards; All Frail Patients to have Clinical Discharge Criteria agreed between Clinician, MDT, Patient and their Carer.	Carms	Acute GMs	Acute HoNs	Reduced Days Lost across the D/C pathway	Clearly communicated Discharge Destination, Clinical Discharge Criteria and Patient Plan (as per SAFER 4 Qs)	Mar-20	Y	Y	Annual Plan, Finance, Transformation		Phased Implementation
6.2	**Implement: Clear consistent definition & process for EDDS**											
	Written Control Documentation Procedure for Delayed Transfers of Care and Discharge Planning approved and implemented via training.	All Counties	County Dir Carms	County Directors / Acute GMs	Accurate dataset within SharePoint, Days Lost reduction across D/C pathway (SharePoint)	Improved consistency, compliance and accurate reporting on SharePoint and WG DToC	Mar-19	Y		Annual Plan, Finance, Transformation		Approval by Policy Group
	Business Case to Secure Band 7 D/C Coordinator in GGH	Carms	Acute GM / County Director	HoN and Head of Integrated Services	Improved coordination of discharge planning	Leadership of DLNs	Mar-19	Y	Y	Annual Plan, Finance, Transformation		Reviewing Job Description

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	USC	LOS / Bed Day Reduction	Links to other plans	Status	Next Action
6.3	**Implement: Discharge to assess pathways, ensuring they accommodate the needs of people with dementia**											
	Implement 'Home First' Pathways as outlined in Step 4 above (Carmarthenshire actions).	Carms	County Director	Head of Integrated Services	Reduced number of bed days occupied by > 75s admitted by Gen Med emergency (n=87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Mar-20	Y	Y	Annual Plan, Finance, Transformation		
	Develop business case for digitalisation of discharge planning coordination	Carms	Acute GMs	Acute SDMs	Reduced Days Lost across D/C planning process	Reduced LOS	Mar-20	Y	Y	Annual Plan, Finance, Transformation		
6.5	**Define DLN role in the Health Board**											
	Written Control Documentation Procedure for Delayed Transfers of Care and Discharge Planning approved and implemented via training.	All Counties	County Dir Carms	County Directors / Acute GMs	Accurate dataset within SharePoint, Days Lost reduction across D/C pathway (SharePoint)	Improved consistency, compliance and accurate reporting on SharePoint and WG DToC	Mar-19	Y	Y	Annual Plan, Finance, Transformation		Pending sign off by policy group
6.7	**Ensure consistent handover to community services**											
	Develop Procedure for use of SharePoint Working List. Gain Control Group and Policy Group approval and implement training to relevant staff	3 Counties	Control Group Chair	Craig Rees	Reduced number of bed days occupied by > 75s admitted by Gen Med emergency (n=87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Apr-19	Y		Annual Plan, Finance, Transformation		Pending sign off by policy group
7.0 STEP 6 Continue To Care For Me												
	Review of Palliative Care integrated 'whole system pathway' and develop strategy	3 Counties	General Mgr Ceredigion	N/A			Mar-20	Y		Annual Plan, Finance, Transformation		

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	Links to other plans	Status	Next Action
STEP 1&2 Help me to remain independent & support me to support myself										
2.1	**Single point of access to provide information, advice & assistance**									
	Building on the structure within Porth Gofal (multi-agency decision making), expand to provide 7 day working	Ceredigion	County Director / Director of Social Care	Local Authority	Reduce the number of requests going through to long term care.	Expand the measures to ensure sustainable health and social care services	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan. Regional funding required		Review current service and data collection
	• Undertake review of Porth Y Gymuned and 3rd Sector Integration Facilitators, which promote use of 3rd sector and community groups to enable personal and community resilience. (PYG team leader and 3rd Sector Integration Facilitators are currently funded with ICF).	Ceredigion	County Director / Director of Social Care	Local Authority	Numbers of individuals cases closed by Porth y Gymuned and not escalate to Porth Gofal	Increase numbers of calls closed by Porth y Gymuned	Jun-19	Annual Plan, CIP/Turnaround, Wellbeing Plan. Regional funding required		Review current service and data collection
	• Undertake review in relation to the 3rd Sector Community Resource team which supports patient flow out of hospital as well as preventing admissions. (Currently funded with ICF)	Ceredigion	County Director / Director of Social Care	Community General Manager	Number of individuals supported and sign posted to services	Review required to see if individuals after having support from the 3rd Sector CRT remain independent	Jun-19	Annual Plan, CIP/Turnaround, Wellbeing Plan. Regional funding required		Review current service and data collection
2.2	**Implement early conversations with patients**									
	The Home of Choice policy has been approved, but needs to be embedded and used in everyday practice	Ceredigion	County Director / Director of Social Care	Acute General Managers	Reduce length of stay and DTOC figures	Enable flow and engagement with patients and carers / families	Jun-19	Annual Plan, CIP/Turnaround, Wellbeing Plan. Regional funding required		Staff training and awareness programme needs to be developed and implemented
	Prevention programmes (funded through County discretionary ICF)	Ceredigion	County Director / Director of Social Care	ICF Project Leads	To link with Regional Framework	To link with Regional Framework	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Development of Regional Framework
	Porth Y Gymuned and 3rd Sector Facilitators - MDT pilot currently being funded by discretionary ICF.	Ceredigion	County Director / Director of Social Care	ICF Project Leads	Support patients to access community services to avoid reliance upon statutory provision	Appropriate care closer to home, community and individual resilience	Apr-19	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Review of current provision and determine approach for 2019-20
2.3	**Roll out of single patient plan (staged approach stay well – anticipatory – advance care plans)**									
	Future whole-system approach underpinned by MDT working and integrated IT systems (WCCIS)	Ceredigion	County Director / Director of Social Care	IT Regional Leads	Number of stay well, anticipatory and advance care plans	Reduce unscheduled admissions to hospital and re	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Procurement of IT, education and support
	• Develop community frailty model following evaluation of S Ceredigion model o N Ceredigion 2 frailty nurses 1 funded by community & 1 primary care o S Ceredigion 2 frailty nurses & 2 pharmacists funded by cluster funding due to finish March 19	Ceredigion	County Director/Community Head of Nursing	Community Head of Nursing	Frailty services should be part of the Community Resources working towards reducing the number of avoidable admissions to Acute Hospitals/reduce the time spent in Hospital	Frailty services should be part of the Community Resources working towards reducing the number of avoidable admissions to Acute Hospitals/reduce the time spent in Hospital	Jun-19	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Review of current provision and determine approach for 2019-20

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	Links to other plans	Status	Next Action
	Community Falls Clinic - MDT pilot currently being funded by discretionary ICF.	Ceredigion	General Manager Community & Primary Care	Physio Lead	Reduces the risk of harm from falls as a result of timely MDT prevention. Measured via reduction in the fear of falling	MDT approach to community falls clinic which includes access to NERs Postural Stability Instruction, therefore reducing the harm from falls therefore savings to acute and long term care services	Apr-19	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Review of current provision and determine approach for 2019-20
	Further develop anticipatory care plans for patients with dementia (funded by Regional Dementia)	**Hywel Dda Region**	**Director of Therapies Hywel Dda**	**Community & Primary Care Manager (Ceredigion /**	**Number of training sessions given to staff in relation to ACP planning**	**Increase the number of patients with ACP plans**	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		**Initiative funded via ICF due to commence April 19**
2.4	**Undertake capacity & demand review & modelling in community services to inform IMTP**									
	Ensuring that community Nursing are aligned to the DN principles and work also being undertaken around safe staffing levels / skill mix	Ceredigion	County Director	Head of Community Nursing	Measuring against the safe staffing Act Wales	The correct number / skill mix to provide the right level of care	Mar 19 (thereafter every 6 months)	Legislation		Review baseline
STEP 3 Assess & Monitor Me										
3.1	**Single point of access to provide information, advice & assistance**									
	Same as 2.1									
	Produce demand/capacity plan for Community Nursing/CRT/ART/dom care to include impact of proposed Unscheduled Care Hub in North Ceredigion	Ceredigion	County Director / Director of Social Care/Primary Care	Community General Manager	To be developed	Ensure we have got the right fit in relation to workforce and skills to reflect the proposed model	Jun-19			Review baseline
	Undertake DNS structure review – to include WCCS, implications of nurse staffing act, and develop future model – to include HCSW/admin roles and introduction of B7 management time in line with acute nursing principles	Ceredigion	Head of Community Nursing (Ceredigion)	Head of Community Nursing (Ceredigion)	Measure need to reflect the Nurse Staffing Act	Compliance with the ACT	Mar-20	Legislation		Review baseline
3.2	**Implement early conversations with patients**									
	Same as 2.2 and 2.3									
3.3	**Roll out of single patient plan (staged approach stay well – anticipatory – advance care plans)**									
	Same as 2.3									
3.4	**Undertake capacity & demand review & modelling in community services to inform IMTP**									
	Same as 2.4									
STEP 4 Step up my care										
4.1	**Fully integrated MDT single Point of Access to support intermediate care**									
	Same as 2.1									
4.2	**Implement early conversations with patients**									
	Same as 2.2 and 2.3									
	Utilize technology to engage and support patients and carers to self manage their condition	Ceredigion	County Director / Director of Social Care	Individual scheme leads	Reduce hospital admissions, outpatient appointments and reliance of medications	Care closer to home, reduction in travel (both staff and patients), empowerment of patients	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Some schemes require review / expansion, others are reliant on Transformational / ICF funding to pilot
4.3	**Education of public – alternative pathways, redirection, community pharmacy – consistent message**									

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	Links to other plans	Status	Next Action
	Intermediate care delivery (funded through County discretionary ICF)	Ceredigion	County Director / Director of Social Care	ICF Project Leads	To link with Regional Framework	To link with Regional Framework	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Development of Regional Framework
	Development of Integrated Care Centres	Ceredigion	County Director	Project Leads	Reduced activity on acute sites	Care closer to home	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Continuation of developments
4.4	**Roll out of single patient plan (staged approach stay well – anticipatory – advance care plans)**									
	Same as 2.3									
4.7	**Undertake capacity & demand review & modelling in community services to inform IMTP**									
	Describe shift of AA2A funded roles into core funding – enabler is closure of Tregaron beds. Following evaluation of benefits of services	Ceredigion	County Director	General Manager Community	Reduced length of stay and Tregaron bed activity.	Reduced admissions for those pathways that traditionally delivered in acute environment	Jun-19	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Review of current service
	Review the usage of the commissioned Nursing Home beds in light of all other developing Community services	Ceredigion	County Director	General Manager Community	Number of beds commissioned	Appropriate and timely assessment and care	Jun-19	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Review of current service
	Development of an urgent response service	Ceredigion	County Director / Director for Social Services	County Director / Director for Social Services	Number of patients receiving urgent care to avoid hospital admission or enable timely discharge	Appropriate and timely care at home	Mar-20	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Apply for short term funding to support the scheme (Transitional funding)
	Same as 2.4									
STEP 5 Take Me To Hospital										
STEP 5a Front Door										
5.1a	**Education of public – alternative pathways, redirection, community pharmacy – consistent message**									
	Develop further alternative pathways – neutropenic pathway into BGH, TWOC in community	Ceredigion	County Team	General Managers /Heads of Nursing	Number of pathways developed and implemented	Increase through put and possibly transfer some activity to the Community	Nov-19	IMTP		Review
	Develop Cardigan MIU with extended opening hours – access to diagnostics required	Ceredigion	County Director	General Manager Community	Number pf patients attending	Increase capacity and provide care closer to home.Extended opening hours would support Primary care and OOH	Jun-20	Annual Plan, CIP/Turnaround, Wellbeing Plan		Review

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	Links to other plans	Status	Next Action
5.2a	**Empower staff to manage family expectations and advocate for patient wishes**									
	Establish stable ward teams in the hospital through working with 3 agencies (partnership arrangement). Will enable the principle of every patient has a plan. 4 questions, red to green etc.	Ceredigion	Acute team	GM/HoN/Site Lead	AVLOS by ward and discharges before 12 midday	Improved capacity and flow available to reduce front door risk and reduce cost incurred through surge	May-19	USC plan, finance plan		Daily review
	Develop a discharge team for complex cross border patients through utilising existing posts and funding differently	Ceredigion	Acute team	GM/HoN/Site Lead	Reduce stranded patients and over all LOS for cross border patients	Improved LOS for this group by improved planning and management of complex needs	Sep-19	USC plan, finance plan		In progress
5.5a	**Implement consistent fast track admission pathways e.g. stroke, #NOF**									
	BGH already do direct to CT pathway for stroke.	Ceredigion	Acute team	GM/CDs	Stroke performance	Improved patient experience, clinical outcomes	Done	Performance	G	Daily monitoring
	Establish NOF pathway heralding from point of WAST collection and decision to convey	Ceredigion	Acute team	GM/CDs	Achievement of NOF pathway milestones	Improved patient experience, clinical outcomes	Done	Performance NOF database	G	Daily monitoring
5.5a	**Define local redirection pathways (link to national ABUHB work)**									
	Cardiology - care closer to home. Providing local CTA, pacing and cardioversion service. BGH consultants also working within wider HB cardiac plan and supporting development of CTA at PPH	**Ceredigion**	**Cardiology**	**GM/Cons**	**LOS, access to diagnostics for cardiac patients.**	**Part of Mid Wales work so benefits cross border patients too. Reduced pressure for repats out to ABMU & GGH**	**All in place by May 19. CTA commenced Mar 18**		**G**	**Daily monitoring. Pulling pts from central waiting list database**
5.6a	**Implement consistent access to diagnostics 24/7**									
	Links to 5.5 above.									
	Plans in progress to develop improved access to respiratory diagnostics									
5.7a	**Implement consistent access to mental health liaison & mental health assessment room 24/7**									
	Links to Dementia model/ Enlli project for BGH which will include MH / dementia care outreach for other wards & patients with a co morbidity of dementia	Ceredigion	MH team & COTE consultant	Liz Carroll/Hazel Davies for acute	LOS for dementia patients. Clinical outcomes	Right patient, right place. LOS for patient cohort. Testing the concept from June 2019	Late 2019		A	Now part of QI process and monthly project meetings with support in place
5.8a	**Embed culture of 'Think AEC first' & 'Home First'**									
	Established small AEC area within ED at BGH. At risk of becoming bedded. Long term plan to develop larger area on site and incorporate principle in to GP HWB as part of strategy	Ceredigion	PS/HD	TBC	Admission avoidance and LOS	Nationally identified AEC pathways established for most high volume conditions	In progress			
5.9a	**Develop & implement frailty model (guidance from frailty expert group)**									

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	Links to other plans	Status	Next Action
	Links to 4.7. Frailty ANP appointed and working as part of BGH senior team. With therapy support & investment establish a sustainable frailty team presence within ED.	Ceredigion	GM/KT/VJ	VJ	Admission avoidance for frailty, reduced LOS for frailty	Establish a principle of admission avoidance or elderly care short stay for frailty.	In progress	LOS plan, dementia model	A	SBAR from therapies to recruitment panel
	Increase therapy capacity	Ceredigion	GM/KT/VJ	KT	Appoint to 2 x B7 therapy posts	Linked to LOS plan and finance plan. Improve admission avoidance, reduce LOS and access to support through greater therapy input. BGH currently has only part time OT aligned to wards	Oct-19	LOS Plan.	A	As above
5.10a	**Develop & implement standards for specialty retrieval from ED**									
	Right patient right place - with stabilisation of ward workforce comes the expectation of wards to "pull" from front door to safeguard patients and ensure nursed in the correct specialty place	Ceredigion	HoN/Site Lead	DJ	CDU LOS	Improve flow by declaration of bed, selection and move of patient within 15-30 minutes of capacity becoming available	In progress	LOS plan	A	
5.12a	**Consistent front door turnaround services , Consider roll out of follow up phone call from MAST**									
	BGH as part of strategy to agree a plan for telemed support of MIUs in S Gwynedd & Mach	Ceredigion	County Director	GM as telemed lead for Mid Wales	Reduced minors attendance and reduce twilight/OOHrs impact of ED attends from Powys & S Gwynedd	Virtual medicine and expert tele advice to ensure majority of minors patients can gain care and support closer to home	In progress	Mid Wales plan, BGH strategy	A	Workshop Jun 19 Engagement with Powys & BCU in progress
	Review of site escalation meetings - reduced to 2. Move towards implementation of Daily Safety Huddle	Ceredigion	HoN	LQ	Improved flow, reduce 12 hour breaches, reduce ambulance delays, achieve morning discharges	Site plan for the day, understanding of the needed discharge profile daily Actions in train from first thing each day Medical engagement Written plan for night and weekend - links to on call management etc	In progress	LOS plan	A	Site meetings changed Feb 19 Move to Safety Huddle during summer 19 in time for winter
5.2b	**Implement early conversations with patients**									
	Every patient to have an active and proactive plan for discharge from point of admission	Ceredigion	HoN	HoN/GM	Improved LOS - achieve an AVLOS of 7.5 for the site	Achieve an AVLOS for site of 7.5 days (from 8.5)	In progress	LOS plan - nursing workforce plan	A	Training & embedding of partnership nurses (3 months)
	Establish a team to manage complex cross border discharges (engage with Powys & BCU)	Ceredigion	LQ	HoN/GM	Improved LOS - achieve an AVLOS of 7.5 for the site	Achieve an AVLOS for site of 7.5 days (from 8.5)	In progress	LOS plan. Mid Wales plan	A	Confirm with Powys, recruit OT, seek engagement from BCU
	Acute leadership at weekly Porth Gorfal meetings (links to 2.1 above). Management of complex discharge for Ceredigion patients	Ceredigion	LQ	HoN/GM	As well as above - regular review of LOS patients over 28 days. Reduce/eliminate long LOSs over 28 days	Achieve an AVLOS for site of 7.5 days (from 8.5)	Done	LOS plan	G	Well established
5.3b	**Implement: Clear consistent definition & process for EDDS**									
	EDD assigned for each patient at point of admission, monitor to EDD and measure constraints when not achieved (links to R to G work)	Ceredigion	HoN/GM	LQ	Achievement of EDD for % of patients	Achieve an AVLOS for site of 7.5 days (from 8.5)	In progress	LOS plan	A	Principle is well established but not meaningful
5.5b	**Embed Red2Green, board rounds, 4 questions and SAFER patient bundle**									

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	Links to other plans	Status	Next Action
	Red to Green principle in place as an aid to identification of constraints	Ceredigion	HoN	LQ	Improved LOS - achieve an AVLOS of 7.5 for the site	Achieve an AVLOS for site of 7.5 days (from 8.5)	In progress	Nursing workforce plan to stabilise ward teams	A	stabilise new partnership nurses as part of ward teams - 3 months
	Board rounds established on 3 wards. Potential for better management and comms for ward rounds where board rounds are not possible	Ceredigion	HDs	GM/HoN	Improved LOS - achieve an AVLOS of 7.5 for the site Number of morning discharges	Achieve an AVLOS for site of 7.5 days (from 8.5)	In progress	LOS plan, nursing workforce plan	A	Weekly / monthly data reviews to be presented at HMC
5.5b	**Avoid deconditioning - hydration stations & encourage moving (Need to improve awareness re assistance with eating and drinking)**									
	Links to Frailty and Elderly Care Short Stay Plan (4.7)	Ceredigion	HoN	VJ	Improved LOS	Achieve an AVLOS for site of 7.5 days (from 8.5)	In progress	LOS plan, nursing workforce plan	A	
5.6b	**Reduce number of medical outliers**									
	Dedicated project to review how we use planned care bed base and support plus grow planned activity	Ceredigion	GH/HDs	GM	Reduce medical outliers, drastically reduce/remove potential for elective cancellations	Establish a known bed base for each surgical sub specialty Separate elective and non elective bed base Establish surgical short stay, Gynae day case throughput Establish dedicated bay for colorectal surgery patients Support enhanced recovery for T&O & Urology Confirm agreed and supported growth - work with Powys	All in progress with detailed plans for each	LOS plan, nursing workforce plan, scheduled care theatre plan, Mid Wales	A	Data - real time audit to establish and confirm bed base Meet with HD commissioning/contracts & Powys
5.7b	**Implement: delirium screening, dementia-friendly nutrition and hydration, dementia friendly wards**									
	Links to 4.7 Frailty & Dementia model at BGH	Ceredigion								
6.0 STEP 6 Get me Home Safely										
6.1	**Implement early conversations with patients**									
	As above	Ceredigion								
6.2	**Implement: Clear consistent definition & process for EDDS**									
	As above	Ceredigion								
6.3	**Implement: Discharge to assess pathways, ensuring they accommodate the needs of people with dementia**									
6.4	**Identify inpatient care co-ordinator**									
6.5	**Define DLN role in the Health Board**									
6.7	**Ensure consistent handover to community services**									

Task & Sub Task	Task Description	Organisational Owner	Lead	Project Manager	Measure	Intended Outcome	Completion Date	Links to other plans	Status	Next Action
	Develop Procedure for DToC Validation and Reporting. Gain Control Group and Policy Group approval and implement training	3 Counties	Control Group Chair	N/A	Improved consistency and compliance of DToC reporting	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Apr-19	Annual Plan, CIP/Turnaround, Wellbeing Plan		
	Develop Procedure for use of SharePoint Working List. Gain Control Group and Policy Group approval and implement training to relevant staff	3 Counties	Control Group Chair	Craig Rees	Reduced number of bed days occupied by > 75s admitted by Gen Med emergency (n=87000)	Promotes the wellbeing and independence of older people and enhances unscheduled care performance and flow	Apr-19	Annual Plan, CIP/Turnaround, Wellbeing Plan		
	Accessing Alternatives to Admission - MDT pilot currently being funded by discretionary ICF.	Ceredigion	General Manager Primary & Community	Nursing Manager	Reduce number of unscheduled admissions / reduce LOS	Appropriate care closer to home	Apr-19	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Review of current provision and determine approach for 2019-20
	3rd Sector Community Resource Team - pilot currently being funded by discretionary ICF.	Ceredigion	General Manager Primary & Community	CAVO CEO	Enable timely discharge from hospital with access to support at home, information and advice	Maintaining independence and avoiding reliance u	Apr-19	Annual Plan, CIP/Turnaround, Wellbeing Plan, A Healthier Mid and West Wales, Regional Transformation		Review of current provision and determine approach for 2019-20
7.0 STEP 6 Continue To Care For Me										
	Review of Palliative Care integrated 'whole system pathway' and develop strategy	3 Counties	General Mgr Ceredigion	N/A						

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2.0 STEP 1&2 Help me to remain independent & support me to support myself												
2.1	**Patient education & self care :** Scope and develop opportunities for wider patient education for self care and care of LTC	Health Board	Claire Hurlin	Claire Hurlin	No. People attending patient education	To increase opportunities for effective self management in the community by empowered patients and reduce avoidable admissions and attendances at services	Mar-20		Footwise & Dementia Programmes			
2.2	**GMS referral to education :** Engage with GP practices to support effective referral to education programmes	Health Board	Claire Hurlin	Amanda Whiting / Lucie Jane Whelan	Increase attendance from Pembrokeshire patients	To ensure equitable access for all people to education support and programmes	Mar-20		Month on month improvement			
2.3	**Community Connectors :** Increase resilience & reach	Health Board / PCC / PAVS	Sue Leonard - PAVS	Michelle Copeman	The number of people accessing connectors	To increase the links between the population and available resources to support community resourcefulness and reduce social isolation	Mar-20		Community connectors in post & funded through PCC, HB & ICF - complete Additional connector bed through transformation fund - submission end May 2019	Y		
2.4	**Investors in Carers :** To build network of providers with Bronze Award	Health Board / PCC / Crossroads	Elaine Lorton	Pennie Muir	To increase the number of registered and connected carers Audit current IiC accreditation levels in Pembrokeshire	To provide greater personal resilience and support infrastructure for carers through a commitment by community service teams and commissioned providers to achieving Investors in Carers accreditation	Mar-20		Include IiC Bronze in all 3rd sector SLAs - end May 2019 Pembs development meeting 21st May 2019 SAVINGS PCT5 : Crossroads SLA duplication			Y
2.5	**GMS Sustainability :** To enhance GP Practice resilience and sustainability in order to improve access for the population	Health Board	Rhian Bond	Anna Swinfield	The % of practices assessed at amber or red risk	To have a resilient and sustainable GP service which offers good access and quality care for their registered and temporary resident population	Mar-20		Goodwick & Fishguard Merger completed March 2019 Tenby development pending procurement process - June 2019 Milford support & review Newport support	Y		
2.6	**Community Pharmacy Walk-in :** To increase access to minor illness, injury and emergency supply of medication through Community Pharmacies	Health Board	Rhian Bond	Angela Evans	The % of pharmacies offering enhanced services Two pharmacies developed into Pharmacy Walk in Centres	To enable rapid access for the resident and temporary resident population Full implementation of Choose Pharmacy and Pharmacy led Walk in Centres	Mar-20		5 pharmacies operating walk-in services - COMPLETE Report on activity - May 2019	Y		
2.7	**Integrated Community Networks**	Health Board	Jill Paterson	Elaine Lorton		To have thriving community based resource and wellness centres, connected to the wider network of services, which effectively meet the needs of the population	Mar-21		Initial ICN discussions held - COMPLETE Further development proposal from PAVS & PLANED - end May 2019 Recruitment to PM posts - job description complete and pending TRAC authorisation - July 2019			
2.8	**Tenby Hub :** Develop a new model for Tenby Hub building on the WIC evaluation & Managed Practice	Health Board	Elaine Lorton	Jane Phillips		Model for Tenby hub working collaborative with community, TCH staff, GMS, CP etc.	Sep-19		Pending update on procurement process for GMS - June 2019	Y		

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2.9	**Compassionate Communities :** Implementation of Compassionate Communities who publicly encourage, facilitate, support and celebrate care for one another A public health and community development approach to EOLC, enabling and supporting communities to become more knowledgeable around empathy and supporting each other around End of Life Care issues (dying, death, loss, caring and grief) and collaborating with their health and social care professionals	Health Board / Community Choice	Elaine Lorton	Luke Conlon		Compassionate Community Charter' launched for Pembrokeshire NOSDA (No One Should Die Alone) support in care homes for people dying alone. Pilot to be completed in 2 care homes in Pembroke/Pembroke Dock Dying Matters/Byw Nawr 2019 a National public health awareness campaign in Pembrokeshire May 2019 NOSDA (No One Should Die Alone), Volunteer support for people at risk of dying alone or with limited family. Pilot been completed in 2 care homes in Pembroke/Pembroke Dock and Haverfordwest and in South Pembs CRDU. Compassionate Neighbours, a Volunteer led and peer support network for Older and infirm people living alone in their own homes and living in South Pembrokeshire. Self care/Self Compassion. A peer led wellness training course for Unpaid Carers caring for someone in EOLC/Palliative Care	Jul-19		Dying Matters week - May 2019 No funding available to support commissioning this support and extending to North Pembrokeshire. Pending wider flow discussions June 2019			
2.1o	**Community Leg Ulcer Clinic** to improve care and outcomes for our communities	Health Board	Sonia Hay	Ceri Griffiths / Sarah Batty	Reduce leg ulcer related ED attendances	To improve care in the community for our population	Jun-19		Resource currently sources from core DN teams - COMPLETE 3 counties review - June 2019 Leg Ulcer clinics established in 6 locations across Pembrokeshire. Staffing model in development with substantive posts appointed to. Environmental audits ongoing with action plan in place to address issues			
3.0 STEP 3 Assess & Monitor Me												
3.1	**MDT** implementation across Pembrokeshire Practices	Health Board / PCC	Elaine Lorton	Amanda Whiting / Lucie Jane Whelan / Chris Davies	Number of practices running MDT approach	Implementation of the MDT approach across and with Pembrokeshire Practices to increase the care planning and proactive care co-ordination of frail and at risk patients	Mar-20		MDT Co-ordinator appointed - COMPLETE Implementation plan for N Pembs - 2 further practices by June 2019 Shared documentation for care plan - July 2019	Y		
3.2	**Integrated community resource teams**	Health Board / PCC / PAVS	Elaine Lorton / Jason Bennett	Locality Mangers & Locality Project Managers	Workforce model for each ICN	To ensure that integrated multi-disciplinary teams are wrapped around patient needs within the community with a clear and common vision, set of shared objectives and agreed MoU	Mar-20		Resource identification for the teams included in Annual Plan Discussions with all existing community teams to sense check the model and resource requirements - end June 2019 OCP for consultation to align existing nursing teams - end August 2019 Alignment of existing resource to ICN, Locality & Counties - Sept 2019 SAVINGS PCT1 - improve efficiencies through sickness reduction from 7% - 4.5% SAVINGS PCT2 - reduce travel expenditure SAVINGS PCT 4 - 3.5month slippage in implementing OCP	Y		Y
3.3	**Enhance dysphagia service** to Care Homes to reduce unscheduled care demand (see plan for detail)	Health Board	Alison Thomas			To reduce avoidable admissions from care homes	Sep-19		Pending detail from AT	Y		
3.4	**Long Term Condition Team :** to develop a combined integrated frailty and dementia screening into core patient assessments	Health Board	Ceri Griffiths			To reduce admissions to hospital for complex and frail patients	Sep-19		Development of team roles and structure	Y		
3.5	**Improving nutrition and hydration** in the community to reduce unscheduled care demand.	Health Board	Zoe Paul Gough			To reduce admissions to hospital for complex and frail patients	Sep-19		Funding for Dietician approved as part of Dementia Plan. (3 Counties) Recruitment in progress.	Y		

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3.6	**Review DES Care Homes** and identify areas of duplication i.e. Locality Frailty Nurses and Community Nursing assessments	Health Board	Rhian Bond	Ceri Griffiths / Anna Swinfield	Reduction in duplication	To increase capacity to support frailty across the system	Sep-19		Review of DES underway by GMS team - FYE data available July 2019			
3.7	Develop Falls Pathway	Health Board	Ceri Griffiths	Chris Davies	ICF outcome framework	To provide a central point for Falls referrals. Prevent unnecessary admission. Coordinate time appropriate response. Prevention agenda	Mar-20		Funding supported through ICF allocation. Project commencement from April 2019	Y	Y	Y
4.0 STEP 4 Step up my care												
4.1.1	**Single point of access** mechanism to all intermediate care services	Health Board / PCC	Elaine Lorton / Jason Bennett	Chris Davies		To ensure timely and response service and thereby reduce delays for patients	Jul-19		Central utilisation of IAA 111 alignment Development of a proposal for an integrated assessment & co-ordination centre as part of transformation bid - end May 2019			
4.1.2	**Promote IAA and 111** to population of Pembrokeshire	Health Board / PCC	Nick Davies / Jason Bennett	Chris Davies		To provide clarity for the population on access to services	Sep-19		Communication plan	Y		
4.1.3	**OOH care support** - rapid access	Health Board	Nick Davies			To avoid hospital attendance and admission	Jul-19		Implementation of plan	Y		
4.2.1	**Single assessment and care plan template** to be shared across system (linked to 3.1)	Health Board / PCC	Elaine Lorton / Jason Bennett	Chris Davies		To enable a single methodology for the proactive care planning, reactive implementation of plan and communication across the system	Sep-19		Group established to align referral information and scrutinise existing templates Prototype developed - trial in AMG and Barlow House	Y		
4.2.2	**Enhanced support to care homes** : cluster project	Health Board	Martin Mackintosh	Lucie Jane Whelan	Reduced admissions from Care Homes	To improve care planning for people in care homes	Jun-19		Review of cluster project	Y		
4.2.3	**Advance Care Planning :** align SLA for 3rd sector & delivery agreement	Health Board	Elaine Lorton	Annette Edwards / Ceri Griffiths	Increase number of palliative care patients with ACP	To increase proactive and preventative planning for end of life patients to enable improved patient & family experience	Sep-19		Palliative care group to review effectiveness of ACPs - Dec 2019			
4.3.1	**Central Intermediate Care Team :** Redesign the JDT, DLNs & MAST into a central team to support patient flow and intermediate care	Pembrokeshire	Sonia Hay / Jason Bennett	Chris Davies		Reduce length of stay and promote more effective and timely transfer to the community following inpatient stay	Sep-19		Option appraisal completed and implementation plan developed OCP for nursing resource - consultation completed Interviews for lead nurse - May 2019 Align wider team with clear set of expected outcomes - July 2019 Agree Sharepoint definitions & utilisation - May 2019 Agree complex discharge pathways - July 2019	Y		
4.4.1	Frailty Model within WGH	Health Board	Janice Cole-Williams	Claire Sims / Sonia Hay	Reduction in ED attendances >75s Reduction in length of stay >75s	To support those with the most complex needs in our communities.	Sep-19		Geriatrician of the Day service in place to maximise discharges and care packages will be a key enabler to the current capacity gap. Include in transformation fund bid - May 2019	Y	Y	
4.5.1	**Home first Admission discussions** to be held with patients and family to support Home First approach and manage expectations at time of admission on Sunderland Ward	Health Board	Jane Phillips	Yvonne Phillips	Reduction in LOS in SPH	To increase patient understanding of the rehabilitation plan to support a reduction in length od stay	Jul-19		Ward based implementation - complete Top review patient & family Feedback - June 2019	Y		

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4.6.1	**Community Care bed evaluation** over the winter period and identify a plan for effective utilisation and required resource throughout the year	Health Board / PCC	Sonia Hay	Caroline Martin		To clearly identify the benefits, opportunities and costs and identify a future plan for effective utilisation and appropriate beds and patients	Jun-19		Evaluation as part of winter review & liaison with LTC team Review to be completed by May 2019 Evaluation demonstrated positive outcomes for patients, reduced inpatient delays for ongoing care and conversion rate to CHC reduced. SAVINGS PCT3 - reducing LoS leading to reduced CCB			Y
4.6.2	**Commission Community Care Bed**s to support flow and D2RA model	Health Board / PCC	Sonia Hay / Chris Harrison	Caroline Martin / Ian Randall		To ensure commissioning of beds in the homes most likely to support the D2RA model	Aug-19		No funding available to support commissioning of spot purchased beds Reduction in SPH flow will be the alternative pathway for this group of patients			
4.6.3	**Bridging Care :** Evaluate the impact of the Care at Home Team, ART and the bridging care provision comparing in house with Carmarthenshire commissioned provision	Health Board	Sonia Hay	Claire Grehan / Mindy Hawkins / Caroline Martin		To clearly identify the benefits and future opportunities for development - Business Case / PID development	Jun-19		Evaluation - COMPLETED To compare outcomes at next USC Board - June 2019 SAVINGS PCT 6 - reduce CHC expenditure through use of CaHT & ART			
4.6.4	**WAST metrics :** Develop a set of shared and agreed metrics with WASt to understand conveyance and call frequency and type.	Health Board / WAST	Elaine Lorton	Christian Newman		A clear set of metrics to inform service development and enhance delivery of conveyance rate and resolve at scheme targets	Apr-19		Use of P16,17 & 18			
4.6.5	**ART :** Review and report on the outcomes of the service improvements made by ART & identify further opportunities	Health Board	Sonia Hay	Mindy Hawkins		To increase the impact and effectiveness of ART in supporting flow and enabling recovery at home	Aug-19		Business case development aligned to ICF outcomes - August 2019			
4.6.6	**Patient Flow Review Workshop :** Undertake whole system winter review workshop to assess capacity and demand challenges across system	Health Board / PCC / WAST	Joe Teape / Rose Jervis	Elaine Lorton		To improve understanding of the blockages and identify clear plans for mitigating these	Aug-19		To align with DU support work - acute flow & community capacity	Y		
4.6.7	**Therapies capacity and demand review** as part of modelling whole system approach to community services	Health Board	Claire Sims	Heads of Service		To clearly identify the benefits, opportunities and costs and identify a future plan inclusive of therapies	Jun-19		Further confirmation of data/information; building into County plans and therapy directorate plans			
4.6.8	**Rapid community response :** develop proposal for community rapid response supported by transformation funding	Health Board / PCC / 3rd Sector	Elaine Lorton	Sonia Hay, Jason Bennett / Michelle Copeman		To develop a proposal for the transformation scheme - rapid response in the community, enhancing ART, C@H, reablement and social worker intervention	Sep-19		Transformation proposal to be developed - June 2019 Re profiling the funding within the plan to fit reduced quantum Implementation September 2019	Y		
5.0 STEP 5 Take Me To Hospital - ALL USC Priorities												
5.4a.1	GP at front door	Health Board	Janice Cole-Williams	Janice Cole-Williams	Improvement in 4 hour target	To improve minor flow through ED	Jun-19		Complete	Y	Y	
5.7a.1	Resolve the current temporary Paediatric pathways to a sustainable solution.	Health Board	Janice Cole-Williams			To improve pathway and experience for patients and families	Sep-19			Y		
5.7b.2	Surgical assessment unit	Health Board	Janice Cole-Williams			To reduce the time spent for patients in the emergency department and allows for patients to be discharged and return to the unit for any follow-up review without going through the emergency pathway	Jun-19		To review pilot and share lessons learnt			
5.8a.1	Ambulatory Care Unit scope to extend & utilisation increased	Withybush	Janice Cole-Williams	Bethan Andrews	avoid attendance to A&E by direct GP referral to AEC	Reduced A&E attenders for AEC specific conditions Improved A&E 4 hour performance	Jul-19		review AEC baseline matrix provide by DU transfer of GP referral calls to AEC/Assessment unit staff	Y	Y	Y
5.8a.2	Develop 5 rooms in ACDU (adjacent to Ambulatory Care Unit) to return to assessment/decisions area (max stay 72 hours)	Withybush	Janice Cole-Williams	Janice Cole-Williams	avoid attendance to A&E by direct GP referral to assessment unit	Reduced admissions Reduced LOS More timely patient assessment and initiation of treatment plan	Sep-19		workshop held , in conjunction with AFN, to develop understand current pathway and develop future model Implementation outstanding due to flow issues through inpatient areas		Y	

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5.8a.3	Implement 'Hot' clinics, to run on post take afternoons	Withybush	Janice Cole-Williams	Sally Farr	avoid admission to inpatient bed by discharging and returning to dedicated hot clinic slot	Reduced admissions Reduced LOS	Jul-19		Hot clinic utilisation to be reviewed July 2019		Y	
5.8a.4	Reopen SAU/GAU unit and trial orthopaedics referrals attending	Withybush	Janice Cole-Williams	Janice Cole-Williams	avoid A&E attendance & therefore reduce waiting times in A&E	Reduced A&E attenders for GP direct referrals Improved A&E 4 hour performance	May-19		Reopened May 19		Y	
5.8a.5	Develop front door GP triage model to include APP/ANPs	Withybush	Janice Cole-Williams	Carol Thomas	Avoid admission	Reduced admissions Improved 4 hour minors performance	May-19		AP to cover evening shifts when GP not working		Y	
5.10a.1	Development of Frailty Pit Stop Model at front door to support with enhancing discharge within 72 hours for frail population	Health Board	Claire Sims / Janice Cole-Williams		Reduction in LOS for people over 75 years Reduction in ED attendances for people over 75 years	To increase the number of people able to return home within 72 hours, reduce deconditioning and LOS	Dec-19		Finalise business case; business case finalised and incorporated in transformation proposal	Y	Y	
5.10a.2	Improve redirection and utilisation of services outside of the Emergency Department in all OOH services, GP stroke's, Community Pharmacy, Frailty Clinics, Mental Health and Learning Disabilities	Health Board	Janice Cole-Williams		Reduction in ED minor attendances	To increase the number of people accessing appropriate alternative community services	Jul-19		Review of existing pathways	Y		Y
5.2b.1	**Community Hospital Referrals :** Revise ward criteria and develop cohorting model for Sunderland Ward to enhance reablement	Health Board	Elaine Lorton / Sonia Hay	Jane Phillips	Reduce LOS	To most effectively manage the care of patients and utilise the beds for the most appropriate patients to reduce system LOS and reduce WGH surge and outliers	Dec-19		Audit complete Referral criteria in draft form - pending WGH feedback and flow workshop May 2019 ICF capital funding approved - pending work programme - June 2019	Y		
5.2b.2	Align with TCS pathway review/ workforce redesign for the future - introduction of Physicians Associates on the medical wards and Emergency Department, Advanced Nurse Practitioners, Emergency Nurse Practitioners and Care of the Elderly / Rehab departments and initiate service redesign in line with our strategy.	Health Board	Janice Cole-Williams			To ensure appropriate staffing to meet patient needs across the acute system	Dec-19					
5.2b.3	Improve Cardiology services commissioned to ABMU	Health Board	John Evans		Reduce patients waiting for transfer to ABMU	To provide more timely access to treatment for cardiac patients	Jul-19		Pending review of pilot	Y		
5.2b.4	Level 1 area to reduce admissions into Critical Care Unit	Health Board	Janice Cole-Williams		Reduced CCU admissions	To improve critical care flow and capacity	Jul-19			Y		Y
5.3b.1	**Managing Expectations - Community Beds** : Patient leaflet and initial meet and greet implemented on SPH & PHC	Health Board	Elaine Lorton / Sonia Hay	Jane Phillips	Reduction in LOS	To manage expectation and support home first and discharge flow	Jun-19		Draft patient leaflet complete - pending CHC feedback - June 2019 Service Improvement plan in place to reduce LOS, improve patient experience, improve family/carer involvement. Referral processes reviewed, prioritisation criteria implemented to ensure most appropriate transfer of patient offered bed in priority order			Y
5.4b.1	**Stranded Patient MDTs :** Implementation of SAFER in Sunderland & Park House Court	Health Board	Elaine Lorton / Sonia Hay	Jane Phillips	Reduction in LOS	To improve flow, patient experience and reduce LOS in Community hospital beds	Sep-19		Board rounds implemented Senior MDT WASH review to be implemented May 2019 Seen a reduction in LOS - to maintain, monitor	Y	Y	Y
5.4b.2	**Review of clinical criteria for discharge from acute** - and continuous reablement in WGH prior to transfer to SPH/PHC/ICB including booking ortho FUP and initiating reablement	Health Board	Elaine Lorton / Sonia Hay	Jane Phillips	Reduction in LOS	To improve flow, patient experience and reduce LOS in Community hospital beds	Sep-19		Referral audit analysis - complete and feedback to therapies & acute	Y		Y

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5.4b.3	**Implementation of functional criteria for discharge** in WGH and rehabilitation plans to support continuity of care at transition between wards and units	Health Board	Claire Sims / Sue Griffith		Reduction in LOS	To improve flow, patient experience and reduce LOS in Community hospital beds	Dec-19		Referral audit analysis Improvement work ongoing to implement and embed in practice	Y		
5.4b.4	**Ward 10 relocation** to ward 9 & reduced beds	Health Board	Janice Cole-Williams			To improve hospital environment and management of patients	May-19		Ward move to commence April 2019			Y
5.5b.1	**Increase access to therapy plans** and interventions including use of activity groups	Health Board	Claire Sims / Sue Griffith		Reduction in LOS	To improve patient flow, patient experience and reduce LOS	Dec-19		Finalise business case for frailty pitstop Improvement work commenced to test viability. Embedded in transformation proposal to enable roll out			Y
5.5b.2	Identify wards for the implementation of a **Hydration Station** and integrate into routine patient mobilisation activities. Implement a whole ward team approach to optimising hydration 'but first a drink'	Health Board	HoN		Number of patients accessing own drinks. Number of UTIs linked to poor hydration	To empower patients to improve their hydration status. Reduce repeat admissions linked to dehydration/UTIs	Dec-19		TBC			
5.4b.4	**SAFER bundle** to be reintroduced & process to embed across all wards to commence	Withybush	Janice Cole-Williams	Janice Cole-Williams	Reduced stranded patients	Reduced LOS Increased number of discharges before noon	Jul-19		Commence on medical wards in the first instance Start a perfect week where all discharges go to discharge lounge (with the exception of significantly confused patients) - planned for week commencing 15/07/19	Y	Y	
5.4b.5	**Red2Green focus** to restart enabling understanding of constraints across inpatient areas	Withybush	Janice Cole-Williams	Janice Cole-Williams	Greater understanding of constraints relating to stranded patients	Reduced number of stranded patients Reduced occupied bed days of stranded patients	Jul-19		Commenced June 2019 - themes to be included in improvement programme steering group	Y	Y	
5.4b.6	**Extend Home Support Team** service to Wards 10&12 to support earlier discharge, noting suitability even in the event of no capacity	Withybush	Janice Cole-Williams		reduced stranded patients	Reduced LOS Increased number of discharges before noon	Jul-19		Ward move to commence April 2019 Weekly stranded patient reviews in place	Y		
5.4b.7	**DLN ward alignment :** increase capacity within DLN team, each DLN having dedicated areas to link with & support	Withybush	Janice Cole-Williams		greater understanding of constraints relating to stranded patients	Reduced number of stranded patients Reduced occupied bed days of stranded patients	Jul-19		Each ward has a named DLN & SW - complete Review effectiveness and focus of support	Y		
5.4b.8	**Mental capacity act assessments :** increase confidence in undertaking mental capacity assessments within health and social care teams. Specialist team to carry out complex assessments only	Withybush	Janice Cole-Williams	Carol Thomas	Reduced stranded patients	Reduced LOS Increased number of discharges before noon	Aug-19		Bespoke training sessions for core group of staff on mental capacity assessments so as to reduce waits for the mental capacity assessor to undertake capacity assessments - to commence August 2019	Y	Y	
5.6b.1	**Implement HB mealtime co-ordination best practice** (WCO pending approval) to ensure appropriate level of meal, snack and beverage support for all patients who require assistance.	Health Board	HoN		Improved nutritional status	To reduce malnutrition risk. To reduce LOS			Approval of WCO & implementation			
5.6b.2	Implementation / roll out the ward based system approach to the **optimisation of nutrition and hydration** integrated with work to avoid deconditioning: MDT, using QI methodology, Support Worker development	Health Board	HoN / Dietetics		Improved nutritional status	Reduced LOS				Y		
5.7b.1	Embed the availability and appropriate use of **finger food menus** and enhanced food access to support improved nutrition for people with Dementia	Health Board	Tim Baines / Head of Dietetics		Uptake of finger food menu Increased nutritional intake	To reduce malnutrition risk						
5.8b.1	**CRDU development** : Utilise CRDU as discharge lounge for SPH patients	Health Board	Elaine Lorton / Sonia Hay	Jane Phillips	Earlier discharges in the day	To improve transfers from WGH	Sep-19		New CRDU Manager in Post - April 2019 Review of CRDU function & staffing with a view to aligning function & resource - June 2019			
6.0 STEP 6 Get me Home Safely - All USC Priorities												

Patient Flow Action Plan 2019-20 : Pembrokeshire												
Task & Sub Task	**Task Description**	**Organisational Owner**	**Lead**	**Project Manager**	**Measure (where appropriate)**	**Intended Outcome**	**Completion Date**	**Status**	**Next Action**	**USC**	**LOS**	**Finance**
See 2.6	**Community Pharmacy Walk-in :** To increase access to minor illness, injury and emergency supply of medication through Community Pharmacies	Health Board	Rhian Bond	Angela Evans	The % of pharmacies offering enhanced services Two pharmacies developed into Pharmacy Walk in Centres	To enable rapid access for the resident and temporary resident population Full implementation of Choose Pharmacy and Pharmacy led Walk in Centres	Mar-20		5 pharmacies operating walk-in services - COMPLETE Report on activity - May 2019	Y		
6.2.1	**Ensure EDDs defined and shared** with patients on all acute and community units	Health Board	Janice Cole-Williams, Sonia Hay	Senior Sisters / Jo Riggs	Reduced LOS Accurate capacity predictions	To improve flow and Length of stay	Jun-19		SPH Board rounds - review of EDD - May 2019 SPH stranded patient review - May 2019 Reduction in LOS noted in SPH in June since introduction of Reviews Improvement programme workstream on EDDS on Ward 12 - commence July 19	Y	Y	
See 4.6.1	**Community Care bed evaluation** over the winter period and identify a plan for effective utilisation and required resource throughout the year	Health Board / PCC	Sonia Hay	Caroline Martin		To clearly identify the benefits, opportunities and costs and identify a future plan for effective utilisation and appropriate beds and patients	Jun-19		Evaluation as part of winter review & liaison with LTC team Review to be completed by May 2019 Evaluation demonstrated positive outcomes for patients, reduced inpatient delays for ongoing care and conversation rate to CHC reduced. SAVINGS PCT3 - reducing LOS leading to reduced CCB			
6.4.1	**Social Work Capacity :** Align named social workers to medical wards	PCC	Jason Bennett	Susan Zatac		To improve communication and proactive planning to enable patients to return home	Jul-19		Assess impact	Y		
6.5.1	**Named co-ordinators :** Develop processes for new central team including the role of named co-ordinators	Health Board / PCC	Sonia Hay / Jason Bennett	Caroline Martin / Sue Zatac		To ensure continuity of care planning, seamless communication and accountability	Jun-19		Named DLNs aligned to wards - COMPLETE Review effectiveness & impact - June 2019 Develop function of DLNs following flow workshop - May 2019			
6.5.2	**Intermediate Care Service :** Develop Business Case for 7 day Intermediate Care Service	Health Board / PCC	Sonia Hay / Jason Bennett / Claire Sims	Chris Davies	Implementation of Weekend Management Plans - Increased weekend discharges	To increase access to support for complex discharge pathways, particularly at weekends and in the evening to enable increased family discussion	Sep-19		Develop proposal for co-ordinated assessment and support through the Transformation Fund - May 2019	Y	Y	
6.6.1	**Review complex discharge pathway**s to identify improvement to support timely and safe transfer home	Health Board / PCC	Sonia Hay / Janice Cole-Williams / Jason Bennett		Reduce time between medically optimised and transfer	To reduce the number of days people stay in hospital once medically optimised	Aug-19		Following system flow workshop - May 2019 SAVINGS PCT7 & PCT 8 : review PCC expenditure & outcomes SAVINGS PCT9 - review capacity for community beds in Tenby & South Pembs. Transfer to SPH delays reduced since introduction of Stranded Review project plan	Y		Y
6.6.2	**Rightsizing Community Capacity** - pilot with DU to review flow into community and identification of improvement or commissioning activity	Health Board / PCC / 3rd Sector	Elaine Lorton	Sonia Hay / Jason Bennett / Claire Sims / Michelle Copeman / Bethan Andrews / Seb Neale	John Bolton model	To enable appropriate development of community capacity to meet unscheduled care demands	Sep-19		Initial DU meeting to agree scope and process - COMPLETE Initial collation of available data - May 2019 Map and gap process - June 2019 (3 counties)	Y		

Patient Flow Action Plan 2019-20 : Pembrokeshire												
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6.7.1	Review and implement consistent process for **FNC and CHC**	Health Board	Jill Paterson	Vicki Broad		To ensure timely, consistent and supportive process to reduce delays in patients returning home	Jul-19		Agree Sharepoint pathway implementation for WGH LTC Pathway presented to WGH staff on 31st May Pathway referral commenced through SharePoint from 3rd June Referrals have been received from Wards 4,7,8,11,12 Sunderland and Tenby C. Communication re cases is updates live on SharePoint and the LTC Service holds data that can be shared	Y		
6.8.1	**Dom Care Packaged Capacity** : Review and map challenges with existing domiciliary care provision	PCC	Jason Bennett / Chris Harrison	Ian Randall		To develop a clear and timely set of actions to reduce the number of people waiting packages of care, and the time they are waiting	Aug-19		In house provision commenced Further & ongoing recruitment to in house - July 2019 Recruitment event - July 2019 Review capacity for winter & potential for Bridging Care - August 2019			
6.8.2	**Implementation of releasing time to care principles** in all settings	PCC	Jason Bennett	Sonia Hay / Jason Bennett		To share positive learning across the Health Board and implement any further developments which will support patient flow.	Jul-19		Acute implementation	Y		
6.8.3	**Early Supported Discharge Team**	Health Board	Janice Cole-Williams	Carol Thomas	Reduction in days in hospital when medically optimised	To improve the flow home of patients who are medically optimised.	Jul-19		Review and lessons learnt from pilot Notice to be provided to Home Support Team to bring established beds back into Ward 1.	Y	Y	
7.0 STEP 6 Continue To Care For Me												
7.1	**SLA Review :** We will agree new SLAs with third sector providers to deliver aligned and co-ordinated Palliative Care Services	Health Board	Elaine Lorton			Ensure alignment and consistency of delivery for palliative care patients	Jul-19		Finalise SLAs			
7.2	We will review our Integrated Team model and resource for the delivery of Palliative Care in the community and acute setting	Health Board	Elaine Lorton			To ensure appropriate levels of care are available across the system	Sep-19		Skill mix and referral review			
see 4.2.3	**Advance Care Planning :** align SLA for 3rd sector & delivery agreement	Health Board	Elaine Lorton	Annette Edwards / Ceri Griffiths	Increase number of palliative care patients with ACP	To increase proactive and preventative planning for end of life patients to enable improved patient & family experience	Sep-19		Palliative care group to review effectiveness of ACPs - Dec 2019			
7.3	Agree across all integrated providers, a clear palliative care strategy and implementation plan for Pembrokeshire	Health Board	Elaine Lorton			To have a clear and aligned whole system plan for end of life care	Dec-19		Palliative care strategy group to develop			
7.4	We will develop any required Business Cases to support delivery of the agreed Palliative Care Strategy	Health Board	Elaine Lorton			To ensure our strategy is appropriately resourced to meet patient needs	Mar-20		Pending strategy			
	Early therapy and geriatrician review of over 65yrs to support implementation of functional and clinical criteria for discharge	Health Board	Janice Cole-Williams / Claire Sims	Bethan Andrews / Claire Sims	Reduction in LOS in over 65yrs	To improve the flow of patients across medical inpatient areas with clear functional criteria for discharge being determined at an early stage	Aug-19		Perfect week started 1st July 2019 - OT, PT, Geriatrician & PA consistently present at the front door / ACDU assessing all patients referred to medicine aged over 65yrs	Y	Y	