Useful Telephone Numbers and Addresses

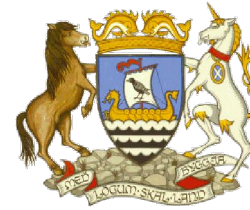
Duty Social Worker
Education and Social Care Department
Shetland Islands Council
92 St Olaf Street
Lerwick
Shetland
ZE1 0ES Tel: 01595 744400

Head of Community Care
Education and Social Care Department
Shetland Islands Council
Kantersted Office
Seafield Road
Lerwick
Shetland
ZE1 0WZ Tel: 01595 743819

Out of Hours Emergency
Tel: 01595 695611

Advocacy Shetland
Market House
14 Market Street
Lerwick
Shetland Tel: 01595 743929/743940

Care Commission
Rooms 205 & 222
Charlotte House
Commercial Road
Lerwick
Shetland Tel: 01595 696661



Older People

November 2009

Older People

The population in Shetland is ageing. Population projections for the next 10-15 years show a higher percentage increase in the number of people aged 60 and over than the Scottish average and at the same time, a significant drop in the adult working population.

The table below shows future changes anticipated from a baseline in 2004

Age	2004	2014	2024	Change
0-4	1253	1003	733	-42%
5-14	3011	2456	1867	-38%
15-29	3678	3324	2528	-31%
30-44	4885	3854	3192	-35%
45-59	4607	4764	4248	-8%
60-74	2971	3985	4241	43%
75+	1535	1838	2744	79%
	21940	**21224**	**19553**	-11%

The Council and Shetland Charitable Trust have invested significant resources in services used predominantly by older people. The level of service provision is higher pro rata than anywhere else in Scotland.[1]

The biggest challenge for the foreseeable future will be to maintain, with limited resources, both the level and quality of care the people of Shetland have come to expect.

Aims

[1]Audit Scotland

- To reduce unplanned, emergency and inappropriate admissions to hospital.
- To facilitate early discharge from hospital.
- To increase levels of independence, self-care and self managed care.

Assessment of Need

- To enable more older people to remain at home.

The needs of older people are wide-ranging. Many older people have physical disabilities; sight or hearing loss; or mental health problems as well as increasing frailty due to age.

A wide range of services is available to meet assessed needs. Each individual assessment of needs is completed by the most appropriate worker(s) depending on the particular circumstances of the older person. The lead assessor may be a social worker, occupational therapist or community nurse. Specialist assessments may be requested, for example, if the older person has dementia. All assessments are completed in accordance with Shetland's Single Shared Assessment (SSA)

Eligibility Criteria

Procedures.

Services will be offered to meet assessed needs in the following circumstances:

◊ to prevent admission to hospital or residential care;
◊ to facilitate discharge from hospital;
◊ to provide support to someone who is at risk of neglect or abuse.

Membership

Director of Clinical Services (chair)
Director of Nursing
Assistant Director of Nursing (Community)
CHP Lead Clinician
Consultant representatives
Head of Community Care
Service Manager, Community Care Fieldwork
Service Managers, Community Care Resources
Hospital Discharge Liaison Nurse
Health Service Liaison Social Worker
Senior Planning and Information Officer

Meetings

The group will meet on a regular basis, usually monthly. All meetings will be minuted. The minutes will be made available to staff of the NHS and the Council locally. Minutes will also be available to the public under the provisions of the Freedom of Information (Scotland) Act 2002.

Failure to agree

Any disputes regarding clinical issues for admissions to or discharges from hospital will be referred to the Director of Public Health. This is consistent with Scottish Government guidance published in Circular CCD 8/2003.

Where disputes involve Social Work issues, the Director of Public Health will consult the Council's Chief Social Work Officer.

Admission and Discharges Review Group

Terms of Reference

Purpose

To keep issues regarding admissions to and discharges from hospital under review.

Remit

- To regularly review, update and agree protocols for hospital admissions and discharges; reviews will usually be undertaken annually.
- To review the information required for submission to the Scottish Government on admissions and discharges and advise the NHS Shetland's information department of any changes required.
- To review aggregate information on admissions and discharges and contribute to service planning and developments set out in Shetland's Discharge Action Plan.
- To review issues of procedure from individual cases referred to the group; to reflect on what went well and any areas for improvement and to agree actions and timescales for changes.
- To disseminate information as appropriate and promote best practice.
- To agree criteria for long term care and continuing health care in line with national guidance.
- To review NHS HEAT targets on admissions and discharges and monitor performance against targets.
- To provide reports to Shetland NHS Board and Shetland Islands Council as required.

Services Available

Health Care

A range of health care services are provided in the community through the Community Health and Care Partnership (CHCP). These include:

- Primary medical services
- General dental services
- Community pharmaceutical services
- General ophthalmic services
- Community nursing & health visiting
- Podiatry
- Physiotherapy
- Occupational therapy
- Speech & Language therapy
- Orthotics
- Dietetics
- Mental health and psychological services
- The promotion of health and wellbeing.

Community nursing services include specialist nursing services - continence, palliative care and neurological conditions.

Long Stay Hospital

There are 16 beds providing a range of services for predominantly older people on Ronas Ward in the Gilbert Bain Hospital.

Services include long-term health care, assessment, slow stream rehabilitation and some palliative care.

Montfield Hospital

There are 18 long term care places in Montfield Hospital. 16 of these places have been set aside to create an Interim Placement Unit (IPU) supporting people who are ready for discharge from hospital in a more open and homely environment. The Day Hospital at Montfield provides health care needs assessments and treatment in a multi-disciplinary setting without the need for hospital admission.

Social Care

Residential and day care services are available for older people, some of whom may have dementia; and for adults with learning and physical disabilities. The establishments providing these services in Shetland are listed below with an indication of the numbers of places normally used for long term care and short breaks (respite).

Edward Thomason House, Lerwick
– specialist residential care for very frail older people
– 16 permanent places.

Taing House, **Lerwick**
– 16 permanent residential places
– 4 respite care places
– 12 day care places

Viewforth House, Lerwick
– specialist dementia unit
– 16 permanent residential places
– 4 respite care places
– 10 day care places.

STRATEGIC PLANNING GROUP FOR OLDER PEOPLE

REMIT

The Strategic Planning Group for Older People will take an over view of all older peoples' services. Having produced an older peoples' health strategy, the group will oversee the implementation and continued development of the strategy. In the longer term, it will be used to support the implementation of national policy such as Delivering for Health, and local longer term planning such as the 2020 vision project.

The Group will have a multi agency approach and include representatives from the Health Board, Council services and the Voluntary Sector, assisted by service users and carers.

The Group will advise local service planners and providers on the subject of older peoples needs and service provision. When fulfilling its responsibilities consideration will be given to:

- Relevant national policies;
- The findings of national monitoring;
- The findings of relevant needs assessment;
- Recommendation from the service, and from users and carers;
- Capacity within Older Peoples services;
- Making links to specialists services at a regional and national level;
- Agreeing joint spending plans;
- The variety of funding sources.

The Strategic Group for Older People will promote good communication between all agencies working on older people's service issues

Discharge Action Plan 2009-2010

18. LEAN Project and e-SSA	**B, C, D, E, F**	**2009/10 WER**	**Service Manager Communit y Care Fieldwork**	**People at risk of admission to hospital and those waiting to leave hospital**	**Reduction in time spent in hospital**	**Performance measures for SSA processes are part of local improvement targets**	**Resistance to change in frontline staff teams. Social workers unwilling to 'let go,' nursing staff and other professionals unwilling to use SSA processes.**

WER = Within Existing Resources
TBA = To be Advised

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Overtonlea, Levenwick
- 13 permanent residential places,
- 2 respite care places
- 12 day care places.

Wastview, Walls
- 13 permanent residential places,
- 2 respite care places,
- 12 day care places.

North Haven, Brae
- 13 permanent residential places,
- 2 respite care places
- 12 day care places.

Fernlea, Whalsay
- 8 permanent residential places,
- 2 respite care places
- 8 day care places.

Isleshavn, Mid Yell
- 7 permanent residential places,
- 3 respite care places
- 4 day care places.

Nordalea, Unst
- 5 permanent residential places
- 2 respite care places
- 8 day care places

Walter and Joan Gray Home, Scalloway
- 13 permanent residential places,
- 3 respite care places
- 10 day care places.

All the care centres are run by the Council with the exception of the Walter and Joan Gray Home in Scalloway, which is run by Crossreach.

Nursing needs in care homes are met by local community nursing services.

Social Care services available to support older people in their own homes include:-

- Care at Home Services providing high levels of personal care and help with domestic tasks
- Crossroads Care Attendant Scheme
- Meals on Wheels
- Occupational Therapy
- Aids and adaptations
- Lunch Clubs
- Community Alarm

These services are available to people in all community care groups depending on an assessment of individual needs.

Care at home services and meals on wheels are managed locally from care centres.

There are a number of voluntary organisations, which provide support to older people. These include:-

- Advocacy Shetland
- Age Concern
- Red Cross
- Senior Citizens Clubs
- Womens Royal Voluntary Service (WRVS)

Housing

King Erik House, Lerwick
– very sheltered housing, 16 flats

Sheltered housing
– 34 schemes, across Shetland.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
17. Implementation of the Delivery Framework for Adult Rehabilitation in Scotland	**B, D, E**	**TBA Staffing budget £12K**	**Director of Clinical Services**	**People with long term conditions, older people and people with specific conditions such as stroke will be assisted to maximise their functional abilities**	**Reduction in hospital admissions**	**Awaiting appointment of Rehabilitation co-ordinator**	**Lack of funds available to support appointment to post. Post may be unattractive in current format. Job description due to be approved by NHS and CHCP Management Teams**

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
15. Review of medication policies and procedures in all community care service areas	E, I – maintain health and well-being of service users	Recommendations of the review to be taken forward in 2009	Chief Pharmacist	Vulnerable people at risk of health impairment due to inappropriate medication regimes	Reduction in emergency admissions	Statistics on emergency admissions	Key risk is difficulty in implementing a more responsive and flexible medication system which promotes independence and self-managed care.
16. Develop a Palliative Care Strategy for Shetland	**B,C,D,E,F**	**WER New strategy document to be published late summer 2009**	**Director of Nursing**	**Better care and support for people with long term conditions reaching the end stage of life**	**Reduction in admissions to hospital and more flexible response to meet palliative care needs in the community**	**Numbers of deaths in hospital, care settings and at home**	**Difficult to ensure equitable service provision across Shetland**

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Funding 2009/10

Care Services at Home	
Personal Care Services	2,072,000
Domestic Tasks	849,000
Community Nursing	2,427,000

Residential Care	
Local Placements	11,841,000
Mainland Placements	299,000
Day Care	1,842,000
Interim Placement Unit (IPU)	799,000
Long Stay Hospital	671,000
Total	**20,800,000**

Unmet Needs

- There are on average 35 people on the waiting list for residential care, most of whom are aged 65 or over. The number of people waiting in hospital including in the IPU has increased to 19 during 2008/09.
- There are approximately 9 people on the waiting list for Care @ Home Services with a further 4 waiting for an increase of services to meet their changing needs.
- All the care centres are operating at capacity and providing care for people with higher levels of need than in previous years.

- It is becoming increasingly difficult to recruit health and social care workers and this is affecting the provision of care at home services.

Service Reviews

Work on the Long Term Care Review and Dementia Redesign Project was completed in 2007 and reported to the Council and Shetland NHS Board in January & February 2008.

The main findings were:-

- an additional 120 long term care places will be needed in Shetland by 2025
- the additional places should be a mix of residential care and supported accommodation / extra care housing; these should be co-located in localities wherever possible
- 50% of the additional places should be in or near Lerwick
- higher numbers of older people should continue to be supported in their own homes: the national target is 30% of all long term care places; locally the target is 40%
- all care settings should be dementia friendly
- a detailed training needs analysis should be carried out looking at upskilling the workforce to cater for higher dependency needs
- the workforce in all older people's care settings should be given additional training in dementia care
- specialist / dedicated resources should be used increasingly to provide training and peer support to colleagues who are providing care for older people with additional care needs for example due to dementia.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
13. Develop Joint OT **Resource Centre**	B,C,D,E,F,H	£2.5M capital over 2 years. Timescale TBA	Head of Community Care	Seamless services for people with disabilities and mobility problems. Reduction in waiting times	More people maintained safely at home and discharged timeously from hospital	Waiting lists for equipment and adaptations.	Risk of long delays due to oversubscribed Council Capital Programme
14. Develop Shetland Telecare Partnership	**C, D, E**	**Recruitment of dedicated project lead is due to be complete by July 2009. Budget £128K (central government funding.)**	**Service Manager Occupational Therapy**	**People with unpredictable care needs who require assistance or check visits may access assistance using new technology and equipment**	**Reduction in hospital admissions and earlier discharge from hospital or care centre settings**	**Data is collected nationally by the Joint Improvement Team**	**Delay in recruiting dedicated project lead**

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
11. Review of Accident and Emergency (A&E) procedures with a view to reducing unplanned admissions to hospital.	E, F	WER	Director of Clinical Services	People receiving assessment/ treatment in A & E supported to go home rather than admitted to hospital	Reduction in hospital admissions	No. of emergency admissions. Outcomes for patients in A & E.	Lack of staff time to complete the review and implement changes based on the findings.
12. Trips and Falls: Review of needs and services	E	TBA	**Assistant Director of Nursing (Community,) Service Manager OT**	People at risk of falling, supported to reduce risk	Reduction in hospital admissions	No. of emergency admissions due to falls.	Lack of resources to complete the review or implement findings

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Service Reviews (cont.)

In February 2009, the Council approved Proposed Work Plans to develop 120 additional long term care places by 2025. The work programme is attached to the Discharge Action Plan below.

The priorities for 2009/10/11/12 are to develop the temporary based care home at Montfield in Lerwick; replace Isleshavn in Yell and increase capacity in Lerwick while replacing the facilities at Viewforth dedicated to the care of people with dementia.

Discharge Planning

Shetland's Discharge Action Plan is wide-ranging and includes actions that combine to give a whole system approach to the challenges in this area. This combination of strategies should give the best performance in the long-term.[2]

The action plans for older people are incorporated in the Discharge Action Plan which is included below.

Further Reading

- NHS Shetland 2020 Vision of Shetland's Healthcare
- Health Strategy for Older people
- "Better Outcomes for Older People – Framework for joint Services" Scottish Executive May 2005
- "Moving On? An overview of delayed discharges in Scotland" Audit Scotland June 2005.
- Long Term Care Report
- Dementia Redesign Reports

[2] "Moving On? An overview of delayed discharges in Scotland" Audit Scotland, June 2005

Discharge Action Plan 2008-2009

Progress Report March 2009

A short life working group, led by the Chief Executive of NHS Shetland and the Executive Director of Education and Social Care for the Council, was set up in 2007 to drive forward the work needed to achieve the target set by the Scottish Government of zero discharges delayed over 6 weeks by April 2008. The group encouraged more flexible ways of working to support patients on discharge; sharing resources across both agencies and committing additional resources both human and financial.

There were discussions with representatives from the Scottish Government and subsequent changes made to the national coding structures for delayed discharges recognise the particular issues faced by remote and rural partnerships where it may not be reasonable or desirable for interim placements to be made outwith the NHS Board area, for example in the Shetland context to purchase interim residential care placements on mainland Scotland. With the introduction of the new code 71X and the work of the short life working group, Shetland's partners have been able to meet and maintain the national target of zero discharges delayed over 6 weeks.

The Joint Improvement Team of the Scottish Government visited Shetland during 2008/09 to discuss ways in which JIT could help with the work in Shetland around Delayed Discharges. Their report confirms that Shetland's local community based service models offer a sound basis for the next stages of service development that will continue to promote a shift in the balance of care away from hospital and institutional settings for the majority of older people and for people with disabilities or other long term care needs.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
9. Pilot generic support worker proposals linked to the locality based Care at Home Service.	B,C,D,E,F, G,H	**WER 2009/10 in small island localities**	Assistant Director Nursing (Community)	Improved service for up to 250 people receiving personal and/or nursing care in the community.	zero delayed discharge numbers maintained. Reduction in admissions to hospital and residential care.	No of people receiving care by number of hours received. Locality based information on care provision.	Difficulty in recruiting staff. **Lack of capacity at managerial level to take this forward.**
10. **Implement recommendations from the Review of Sheltered Housing completed in December 2008**	B, C, D, E, F, G, H	WER **3 pilot schemes to be implemented during 2009**	Snr. Housing Officer - Supported Accommodation	Better use of sheltered accommodation by vulnerable people living in the community. Shifting balance of care from institutional settings in longer term	Long term - contribution to keeping zero number of delayed discharged	Number of people supported at home and those in care homes / institutional settings	Key risks - Lack of resources to implement any recommendations.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
8. IPU **Review local Interim Placement Services including the Interim Placement Unit at Montfield Hospital**	B, C, D, F, H	WER Review summer 2009. IPU to be replaced by more appropriate services by April 2010	Director of Clinical Services	Patients discharged to **interim placements in community settings that are more appropriate than hospital interim placements.**	zero delayed discharge numbers maintained	Turnover in IPU Budget provision and spend ISD coding of delayed discharges **Indicator of Relative Need (IoRN)**	**Increasing demand as population ages outstrips pace of change in service provision. Delays in service developments e. g. Telecare and extra care housing due to lack of resources human and financial**

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009

Progress Report March 2009

The JIT will continue to support Shetland's health and care service partners by providing real, practical examples and resources. This will include support for information sharing through electronic single shared assessment; anticipatory care models for primary care to prevent admissions to hospital and Telecare developments.

The JIT have provided funding to Shetland's partners to support the work programme. An initial allocation of £30,000 has been made to support the work in delayed discharges and a separate funding allocation of £128,000 has been made for Telecare.

The Admissions and Discharges Group meets monthly to monitor the progress made regarding delayed discharges. There is a weekly meeting of staff directly involved in the allocation of resources to facilitate timely discharge from hospital.

The table below summarises the progress made on the initiatives identified in the 2008/2009 plan.

Discharge Action Plan 2008-2009 - Update March 2009

Targets for 2008-2009

- **Maintain zero discharges delayed over 6 weeks.**

INITIATIVE – Brief description only	National Priorities and Objectives	Timescales and Budget	Lead Responsibil-ity	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
1. Long Term Care Review: Develop a detailed action plan for 2010 – 2025 showing staged implementation of the findings of the review	*B,C,E,H*	*Plan to be drafted by June 2008. Detailed design for Isleshavn to be completed in 2008/09. £45K. Montfield Care Home to be developed and completed in 2009/2010 – cost £1.9M capital, £730K per annum revenue*	*Head of Community Care*	*Long term - projected increasing numbers of older people who need support will be maintained at home or in other community settings locally*	*Low/zero delayed discharge level maintained Number of emergency admis-sions reduced*	*No of people on waiting list for residential care.* *Levels of Need (IoRN)* *No of people receiving augmented care packages in the community*	***The Council has included an increase of 120 long term care places over the next 20 years in the corporate plan for 2008-2011. The Council has approved a prospective work plan giving details on nos of places in each locality and proposed timescales. Construction work at Montfield has started***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
6. Review of day hospital service for younger adults with physical disabilities to better target resources	B, C, D, F, H	TBA	Director Clinical Services	Improved services for patients resulting in early discharge and reducing re-admission rates.	zero delayed discharge numbers maintained	Admissions and discharges statistics. Waiting list	Opposition to any change in day hospital provision
7. Review of needs for specialist care services in the community for younger adults with physical disabilities (see also 6 above)	B, C, D, E, F, H	TBA	Head of Community Care	More appropriate service provision maintaining people at home or in other community settings.	Zero delayed discharge numbers maintained	Admission and discharge statistics. Waiting Lists. Unmet need.	Sustainability of preferred models e.g. specialist supported accommodation.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
4. Implement recommendations from day care review.	B, C, D, E, F, G, H	WER **Ongoing** Explore and pilot more flexible day care as part of high level care packages	Head of Community Care	Expect enhanced day care provision to increasingly support people with higher dependency needs enabling them to continue to live in their own homes.	No impact at this stage	Current use of day care services and levels of need. Waiting lists for day care services	Lack of political support for changes to use of day care. Service is being targeted at those with higher levels of need as part of individual care plans.
5. Review use of day hospital at Montfield	B, C, D, E, F, H	**Use day hospital to promote reablement, self-care and self-managed care**	Director of Nursing	People requiring high levels of care would benefit from sessional attendance at day hospital as part of agreed care plan	zero delayed discharge numbers maintained	Waiting lists for services which would enable people to stay at home or return home from hospital.	May be resistance from some service users to attend day hospital

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – Brief description only	National Priorities and Objectives	Timescales and Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
2. Dementia Services Redesign Project and Viewforth Services review and feasibility study. Links to Long Term Care Review at 1. above	*B, C, D, E, F, G, H*	*Implementation of Dementia Action Plan will be taken forward in 2008/09/10 Monitored by CHCP Management Team. Technical feasibility study on a replacement for Viewforth to be completed in 2008/09*	*Head of Community Care*	*Expect people with dementia to benefit from more efficient, effective service provision*	*Low/Zero delayed discharge numbers maintained*	*No of people with a diagnosis of dementia. Aggregate data from CareNap D No of people with dementia in specialist care settings*	***The design brief for Viewforth has been completed. The work plan for additional long term care places at 1. above includes upgrading existing facilities to specifications recommended for dementia. A no. of staff have been trained in this area.***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
3. Continuing review of admission and discharge protocols to improve processes and information sharing	*B, C, D, F, H*	*2008* *WER*	*Director of Clinical Services.*	*Improved patient experience on discharge from hospital. Provision of better information for patients and their carers at the point of discharge. Faster discharge from hospital*	*Low/Zero delayed discharge numbers maintained*	*No. of transfers offered and performance against 10/98 targets. Timescales from completion of assessment to allocation of a care home place and from allocations to discharge.*	*Revised protocols have been agreed and implemented from 1 April 2008.* ***Further work is needed to map business processes in preparation for introducing an electronic SSA process.***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
3. Continuing review of admission and discharge protocols to improve processes and information sharing	B, C, D, F, H	**Review protocols in light of eSSA project**.	Director of Clinical Services.	Improved patient experience on discharge from hospital. Provision of better information for patients and their carers at the point of discharge. Faster discharge from hospital	Zero delayed discharge numbers maintained	No. of transfers offered and performance against 10/98 targets. Timescales from completion of assessment to allocation of a care home place and from allocations to discharge.	Training programme will have resource implications including backfill for care workers. Work on the national Data Sharing Initiative run by the Scottish Government **has failed to deliver causing delays with eSSA.**

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

INITIATIVE – brief description only	National Priorities and Objectives	Timescales and Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
2. Dementia Services Redesign Project: Implementation of the Dementia Action Plan	B, C, D, E, F, G, H	Technical feasibility study on a replacement for Viewforth to be completed in 2009/10 - **£45K. Undertake dementia training programmes for staff across all older people care settings.**	Head of Community Care	Expect people with dementia to benefit from more efficient, effective service provision.	Zero delayed discharge numbers maintained	No of people with a diagnosis of dementia. Aggregate data from CareNap D No of people with dementia in **all** care settings.	As 2 above.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – brief description only	*National Priorities and Objectives*	*Timescales & Budget*	*Lead Responsibility*	*Who will Benefit and How*	*Impact of These Measures*	*Data Collected*	*Progress*
4. Implement recommendations from day care review.	*B, C, D, E, F, G, H*	*WER 2008/09 Explore and pilot more flexible day care as part of high level care packages*	*Head of Community Care*	*Expect enhanced day care provision to increasingly support people with higher dependency needs enabling them to continue to live in their own homes.*	*No impact at this stage*	*Current use of day care services and levels of need. Waiting lists for day care services*	***Service is being targeted at those with higher levels of need as part of individual care plans. Work has started on a project with WRVS to develop services outwith care centres.***
5. Review use of day hospital at Montfield	*B, C, D, E, F, H*	*WER 2008/09 work to link day hospital services to care plans supporting people at home to be piloted.*	*Director of Nursing*	*People requiring high levels of care would benefit from sessional attendance at day hospital as part of agreed care plan*	*Low/zero delayed discharge numbers maintained*	*Waiting lists for services that would enable people to stay at home or return home from hospital.*	***No progress made in 08/09 due to lack of capacity to manage the project.***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
6. Review of day hospital service for younger adults with physical disabilities to better target resources	*B, C, D, F, H*	*TBA*	*Director Clinical Services*	*Improved services for patients resulting in early discharge and reducing re-admission rates.*	*Low/zero delayed discharge numbers maintained*	*Admissions and discharges statistics.* *Waiting list*	***No progress made in 08/09 due to lack of capacity to manage the project.***
7. Review of needs for specialist care services in the community for younger adults with physical disabilities (see also 7 above)	*B, C, D, E, F, H*	*TBA*	*Head of Community Care*	*More appropriate service provision maintaining people at home or in other community settings.*	*Low/Zero delayed discharge numbers maintained*	*Admission and discharge statistics.* *Waiting Lists.* *Unmet need.*	***Intensive support team established to support care teams in the community.***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2009-2010

Targets for 2009-2010
- **Maintain zero discharges delayed over 6 weeks.**
- **Reduce to zero the numbers of people in interim placements in a hospital setting**

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Key risks
1. Long Term Care Review: **To begin implementation of the** detailed action plan for 2010 – 2025. **Proposed Work Programme approved by the Council is appended to the Discharge Action Plan**	B, C, E, H	Detailed design **and technical specifications** for Isleshavn to be completed in 2009/10. £45K. Montfield Care Home to be developed and completed by summer 2010 – cost £2.7M capital, £730K per annum revenue.	Head of Community Care	Long term - projected increasing numbers of older people who need support will be maintained at home or in other community settings locally.	zero delayed discharge level maintained. Number of emergency admissions reduced	No of people on waiting list for residential care. Levels of need (IoRN) No of people receiving augmented care packages in the community	The Council's Capital Programme is over-subscribed and there is a long waiting list of projects approved and waiting for availability of resources both financial and in terms of staff in capital projects and building services. This is likely to cause significant delays for any building projects.

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
13. Develop Joint OT Store and office base	*B,C,D,E,F,H*	*£2.5M capital over 2 years. Timescale TBA*	*Head of Community Care*	*Seamless services for people with disabilities and mobility problems. Reduction in waiting times*	*More people maintained safely at home and discharged timeously from hospital*	*Waiting lists for equipment and adaptations.*	***Project is delayed due to oversubscribed Council Capital Programme.***
14. Review of medication policies and procedures in all community care service areas	*E, I – maintain health and well-being of service users*	*Recommendations of the review to be taken forward in 2008*	*Chief Pharmacist*	*Vulnerable people at risk of health impairment due to inappropriate medication regimes*	*Reduction in emergency admissions*	*Statistics on emergency admissions*	***Some work has been done with different staff groups regarding training in medication systems.***

WER = Within Existing Resources
TBA = To be Advised

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
8. IPU · *Monitor demand and usage of IPU* · *Review following the development of Montfield Care Home*	*B, C, D, F, H*	*WER Review autumn 2009*	*Director of Clinical Services*	*Patients discharged to the IPU are cared for in a setting that will maximise their independence until substantive discharge arrangements are implemented.*	*Low/zero delayed discharge numbers maintained*	*Turnover in IPU* *Budget provision and spend* *ISD coding of delayed discharges*	***See 1. above. Future of the IPU to be discussed by CHP Committee on 19 March 2009.***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
9. Pilot generic support worker proposals linked to the locality based Care at Home Service.	*B,C,D,E,F, G,H*	*TBA 2008/09 in small island localities*	*Assistant Director Nursing (Community)*	*Improved service for up to 250 people receiving personal and/or nursing care in the community.*	*Low/zero delayed discharge numbers maintained. Reduction in admissions to hospital and residential care.*	*No of people receiving care by number of hours received. Locality based information on care provision.*	***Work on the job description and training needs has been completed. Detailed proposals will be presented to the CHP Committee in June 2009..***
10. Comprehensive review of sheltered housing schemes	*B, C, D, E, F, G, H*	*WER Target date for completion December 2008*	*Snr. Housing Officer - Supported Accommodation*	*Better use of sheltered accommodation by vulnerable people living in the community. Shifting balance of care from institutional settings in longer term*	*Long term - contribution to keeping low/ zero number of delayed discharged*	*Number of people supported at home and those in care homes / institutional settings*	***Review completed. The Council has agreed 3 pilots to begin implementation of the recommendations.***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.

Discharge Action Plan 2008-2009 - Update March 2009

INITIATIVE – brief description only	National Priorities and Objectives	Timescales & Budget	Lead Responsibility	Who will Benefit and How	Impact of These Measures	Data Collected	Progress
11. Review of Accident and Emergency (A&E) procedures with a view to reducing unplanned admissions to hospital.	*E, F*	*WER*	*Director of Clinical Services*	*People receiving assessment/ treatment in A & E supported to go home rather than admitted to hospital*	*Reduction in hospital admissions*	*No. of emergency admissions. Outcomes for patients in A & E.*	***The Admissions Protocol has been revised. Consultant physicians are supporting primary care services offering consultation in community settings for those at risk of admission.***
12. Trips and Falls: Review of needs and services	*E*	*TBA*	***Assistant Director of Nursing (community)***	*People at risk of falling, supported to reduce risk*	*Reduction in hospital admissions*	*No. of emergency admissions due to falls.*	***Work is in progress and will be launched during national falls week in June 2009.***

B – Tackle patients awaiting discharge; C – Reduce delays over 6 weeks; D – Reduce the number of acute beds occupied by patients delayed in hospital; E – Prevent unnecessary emergency admissions; F – Speed up assessment process and discharge planning; G – Ensure resources are available to fund care home and domiciliary care; H – Reduce delays over 12 months; I – other.