8b Supporting Proactive and Safe Discharge – HWLH

Indicator Name	Supporting Proactive & Safe Discharge
Indicator Weighting	0.75%
Description of Indicator	1. Improve inpatient experience and outcomes by ensuring that effective rehabilitation is in place every day so that patients achieve their agreed goals and can return to their home as soon as possible. As part of the SAFER patient flow bundle 'Red and Green Bed Days' are a visual management system (VMS) to assist in the identification of wasted time in a patient's journey. The system is applicable to in-patient wards in acute and community settings. This approach is used to reduce internal and external delays (NHS Improvement Programme). Evidence suggests that every day a patient spends in our care must be meaningful to their progress toward returning home. R2G days was introduced originally in 2016/17, a scoping exercise by visiting all inpatient wards identified: • Staff have not had sight of any performance reports and therefore not confident that the data was being used • There is no feedback data which ward staff can view to establish their ward specific R2G performance • Reports could be better used for discussions by teams and used as a tool for escalation to senior managers to address specifically the Red reasons • There is no standard operating procedure in place to guide staff The re-launch will enable us to identify areas of good practice, and lay the foundations for continuous improvement. The project will design and deliver a standard approach for the management of inpatient bed stays across SCFT to ensure that patients are returned home as soon as possible. This will apply to adult patients only. Each in-patient unit will have a Red2Green facilitator (super user) who will support and train staff on the R2G system. In turn they will be supported by senior operational staff member who will adopt the R2G Lead in each area. There will be a standard policy and procedures on management of stays, guidance materials on use of the Red to Green management system and access to training and support. Following the relaunch of Red to Green across the trust: • All in-patient wards will conduct a daily Board Round' each morning to identify R2G status of each patient • All staff will work to a collective set of R2G standards

	• A R2G system information pack will be included in staff induction programme • The change will be sustained and will form part of business as usual working across SCFT 2. Improve processes for step up admissions to HWLH in patient units • Locality Community hospital improvement programme in place with focus on improved patient flow to ensure capacity for step up admissions and reduction of delayed transfers of care • Bedded units prioritising Community step up referrals daily
Milestones	**1.** Quarter 2 Establish a project group to manage the re launch Introduce standard policy and procedures on management of stays, guidance materials on use of the Red to Green management system and access to training and support. Appoint super users for each area Agree implementation schedule for the Phased rollout of Red to Green at each inpatient unit with named lead facilitators on site to champion the use of the Red to Green system and adherence to the policy and processes. Start cascade of training to ward staff Quarter 4 Complete the roll out to all inpatient units Update the admissions, Discharge and Transfer Policy to reflect R2G Produce an evaluation to demonstrate the effect of the changes **2.** Quarter 1 & quarter 2 Continued focus on links with local GP's to support effective communication re bed capacity to support Community Step up: o Attendance at GP locality meetings , o Locality Senior Management team contact details circulated to local GP's to trouble shoot any required step up admissions, o Wards proactively contacting GP practices to advise of capacity for step up o GP communication October 2018 (Via CCG weekly newsletter) to promote step up facility. • Daily SMT led calls in-place with all wards to support effective and proactive admission and discharge planning ensuring capacity to facilitate step up

	• Joint working in place with inpatient units and Frailty Nurses in community nursing teams to support effective patient step up admissions <u>Quarter 3</u> Targeted work with Joint Community Rehab (provided by ESHT and Adult social care) to improve direct referral into in-patient units supporting effective communication and joint Primary care working.