APPENDIX 2

ACTION PLAN – REDUCING DELAYED DISCHARGES IN MORAY

Context

Moray delayed discharges remain higher than national averages. Aim to tackle issue with a 2 phased approach. Phase 1 = Current Delayed Discharges (actions 1 to 5) and Phase 2 = Prevention of future Delayed Discharges (remaining actions)

Action	Task	Lead/Support	Target for Completion	Resource Required	Notes	Actual Completion Date	RAG
PHASE 1 (Reduce Delayed Discharges to March 22 average levels 46)							
1.	Create more Care at Home Capacity Create more capacity in the Access Team	Roddy Huggan/Tracie Wills Jane Mackie Lesley Attridge	26/07/22 Revised Date – 01/09/22 Date Revised 01/12/22 01/09/22	Commissioning Team, internal and external providers	Contractual negotiations ongoing		
Update	27/07/22 – Contracts should be in place by the end of the week which should increase care at home capacity						

	03/08/22 - Two Consultant Practitioners to support Access Team temporarily 09/08/22 - LAt highlighted at Response Group that POC information going to external provider does not give them enough information to progress the POC – LA to investigate and feedback. Resolved 10/8/22 22/08/22 - RH confirmed that contractual issues remain, and process has not been fully resolved. Information has been given to providers and some capacity has been created, although not as much as first thought. Legal processes continue. 22/09/22 - Contractual issues remain, completion date revised. 10/10/22 - Contract progressing, initial process will complete this week. All providers attending daily resource group to share capacity. 03/11/22 - Contractual processes are continuing.						
2.	Divert Capacity to Delayed Discharges as a priority. Meet with CITY colleagues around 1 stop allocation of care, prioritise DD's and Palliative Care/EOL patients supported by National Care Eligibility Criteria Carers who cannot drive, support transport needs Process in place for carers to identify increase and	John Campbell Alison Smart/Laura Sutherland/Jamie Fraser Cheryl St Hilaire John Campbell	27/07/22 22/09/22 11/08/22 01/12/22	Care at Home Services Home First Team Volunteers Carers	Need to change the current process Completed Transport for carers who don't drive to increase hours of care at home		

	decrease of care at home POC				Potential release of care at home hours		
Update	01/08/22 - AS/LS met with JC, legal issues around prioritising care for DD's, discussed with CITY colleagues who use Eligibility Criteria to prioritise care for DDs, AS/LS/JF to meet with CITY to confirm process. 03/08/22 - Home First Team to spend day in CITY meeting those involved in the allocation of POC on 26/08/22 - invitation open to anyone who wants to attend. 22/08/22 Main focus the prioritisation of care, produce a service level agreement to give direction to front line staff about priorities for the allocation of care when it is available. JC to discuss Nationally. 26/08/22 - Visit to Aberdeen City Team, discussed case prioritisation, confirmed that Delayed Discharges, EOL and Crisis in the community are prioritised for care – a separate list is developed via Care First and a dedicated care at home team manages this list. To go onto the list, cases are reviewed and signed off by a senior manager. Planned meeting for 06/09/22 to discuss and to take forward actions. 21/09/2022 - Stakeholder workshop for care at home planned. Outcome - Plan to implement prioritisation of DD's, EOL and Crisis in the Community for care at home resource by having a daily meeting (Dynamic Resource Allocation Consortium) to allocate available care at home resource to DD's, EOL and Crisis in the community, based on assessment and professional judgement. Work to be done around ensuring that if care is allocated through this group, patients are ready to go home with that care, Jim Brown will focus on this for Community Hospitals, Laura and Alison will focus on DGH. Aim to have group running in 6 weeks, in time for winter period. Other areas discussed, employ nurses to support conversations with patient and families around realistic care at home needs. Follow up workshop 4th October. 10/10/22 - awaiting Care First facility to be in place to provide senior decision-making audit trail around the prioritisation of care, once this is in place a list will be created of the those in the prioritisation groups and senior decision makers can decide how the available resource is distributed. 03/11/22 - Priorities embedded, prevention added as 4th priority. Teams beginning to use the priorities to help make decisions about resource allocation, still need to implement Care First process to allow senior decision maker authorisation.						
3.	Assess capacity of CRT, divert capacity to discharging delayed patients (action 1 and 2 will support onward	Anita Gouldsbrough	27/07/22	CRT team	A temporary measure to reduce the delayed discharges	09/08/22	

	care requirement if required two weeks from discharge) and supporting at front door of ED to avoid unnecessary admission						
Update	29/07/22 - Capacity in CRT to support the discharge of those delayed in DGH – Kay McInnes to progress with Anita Gouldsbough 01/08/22 -3 Patients identified to be discharge from DGH 09/08/22 - Process in place for KI and AG to discuss capacity in CRT 30/08/22 - The requires to be reviewed and meeting set up to discuss with C@H and ability to pick up work after 2 weeks						
4.	Continue to use D2A to provide early supported discharge from DGH	Dawn Duncan/Katie Parry	27/07/22	D2A team		22/08/22	
Update	29/07/22 - currently working with patients of a higher acuity than normal and at full capacity. If START resource is freed up, the pathway from D2A to START/Care will create capacity and flow. AHP services in Community Hospitals continue to regularly review patients –these patients are on maintenance programmes 22/08/22 - D2A has supported appropriate discharges from DGH/ARI/CH when possible.						
5.	Monday Huddle – redesign process	Jim Brown/Lisa Anderson/Kay McInnes	01/08/22 Date revised – 31/11/22	DD Team	Ensures actions are captured and managed appropriately, detailed DD trajectory information needs to be available for SLG and SLT to see at any time		
Update	02/08/22 - LS/AS/JF to meet with JB and LA to develop the DD information and action process.						

	03/08/22 - Met with LAn and JB – test of change for huddle, use a problem-solving approach, plan to implement in 3 weeks, ensure senior decision maker for each patient 19/8/22 - Met with JB/LAn/LA/Wendy Hulley – decided to incorporate WH's report but not ask Wendy to be part of huddles. Actions to be added to the report to promote accountability. Email to go out communicating changes to core meeting. Review at the end of October. Delayed Discharge Lead to manage Delayed Discharge Processes and feedback to daily response group. 30/08/22 - DD Lead has added Community Hospital MDTs, cases of unmet need with NHS Teams and discharges that didn't go to plan to portfolio. To commence this work in two weeks. Communication out to Senior Managers for onward discussion with teams. 30/08/22 - Discharge without Delay Programme via SG – will focus on 3 main aims, 1. Plan for discharge from admission 2. Ensure that protected time is given to MDTs and discharge planning 3. Employ Home First Principles. A review will take place regionally to look at the Moving on Policy, Criteria for admission to Community Hospitals, access to data for staff involved in QI work and a review of services and infrastructure around patient flow. 22/09/22 - Jim Brown will focus on community hospital MDT's and flow through community hospitals. 10/10/22 - holiday cover required, LA and JB off at the same time, no one to collect DGH data and monitor the DD lists 03/11/22 - Meeting more action focussed, MDT decision making around allocation of resource.						
6.	Daily meeting to discuss unmet need and DDs with all providers Implement a Care Navigation Centre that holds all available Care at Home availability	John Campbell, Care & Home Working Group Care & Home Working Group	31/10/22 31/10/22		Will improve access to information and improve access to care at home Create a one stop Centre that holds all care at home capacity in the system, can be access by all professionals		

Update	22/09/22 - Care at Home Working Group – Initial Workshop held 21/09/22, focus on prioritisation of DD's, EOL and Crisis in the Community – group to meet daily to allocate resource based on a list of all DDs, EOL and Crisis in the Community. Decisions will be based on assessment and professional judgement. Care will be allocated to DDs, EOL and Crisis in the Community with the expectation that the patient is ready to use the care within 24hrs of the offer. This requires work with Community Hospitals (Jim Brown) and DGH (Laura Sutherland and Alison Smart) around patient readiness to go home, this will need to improve, it is hoped as care become more available to the prioritised groups that discharge planning can be more effective. The Dynamic Resource Allocation Consortium will have access to all available care and care home availability and be reactive to system wide pressures, the group will self-manage and include Allied and have access to staff plan. Plan to go live in 6 weeks in time for winter pressures. Group will meet every two weeks to progress the daily meeting and to consider care enablement, RAM, Access, and interim beds. It will also consider Moray response to winter planning. 10/10/22 - daily resource group meeting due to current pressures, this will become the Daily Resource Allocation Consortium and include everyone who has capacity to discharge without delay. 03/11/22 - Daily meeting in place and beginning to break down the silo working, MDT discussions taking place about the distribution of available resource. Still not fully represented by C@H option 3 providers.						
7.	Communication – Public, MSP's and HSCP Moray Teams	SLG			Develop a collective concern for Delayed Discharges, ensure understanding of the reality		
Update							
8.	Challenge 4 x a day care and consider TEC, Medicines Management, and single-handed risk assessments (Aberdeenshire Model)	SLG			Patient Centred Care Develop processes to support staff		

Update	30/08/22 - Awaiting introduction of Medicines Management training for HCSW's. Data sharing impact assessment being undertaken to allow GP Practices to have client information to support medicines reviews. 10/10/22 - meeting with colleagues in Aberdeenshire around single-handed assessment arranged for 26/10/22 03/11/22 - Single Handed assessment training for 10 available from Shire – LS to discuss with Sean to progress						
9.	Analyse 'transfers of care' (D2A, START, BROKERAGE, CRT, DN, FNCT, VARIS, LOXA, JUBILEE CT, CARE HOMES	AS/LS/JF			Be clear on the pathway for patients when transitioning		
Update	21/09/2022 - Workshop organised to review current processes 10/10/22 - Workshop 1 discussed the prioritisation of care and detailed a process going forward, although there is housekeeping required, team hope to get prioritisation of care in place in 6 weeks. Workshop 2 discussed the Care Enabler/Assessor (CE/A) role and agreed to wait for the evaluation. CE/A does save the SW time but can create double the work in some cases. Not enough CE/A at the moment to make the system work, creates delays of up to three weeks for assessments. SW have supported CE/A role during periods of leave. Workshop also discussed Care Home referrals, agreed to meet with Care Homeowners and Managers to ensure a streamline approach to securing a Care Home bed for HSC Moray. The workshop also discussed interim beds, need clarity on the SG monies and what we can use the money for. Next workshop will be to review work from the previous two and will be held on the 26/10/22. 07/11/22 - Meeting with Graeme Hoyle to progress discussions around Hosptial at Home model in Moray.						
PHASE 2 (Reduce Delayed Discharges to 10)							
1.	Establish Targets for Unmet Need	Home First Team	September 22		Develop an alert system so that action can be		

					taken when unmet need reaches a warning level		
Update	30/08/22 - Delayed Discharges to be set at 10 20/09/2022 - At a Glance dashboard created to allow instant system flow awareness, out for consultation. 07/11/22 - awaiting progress of discussion around acceptable benchmarks, suggest a two-phase approach similar to delayed discharges.						
2.	Produce a Dashboard to measure and assure	Home First Team	August 22		Ensure assurance that DD systems and processes are working	22/08/22	
Update	22/08/22 - Dashboard completed, discuss with SLT and produce weekly at Monday Response Group						
3.	Carry out a Self-Assessment of all Delayed Discharge processes focussing on: - • Leadership and Performance • Engagement and Accountability • Improving practice • Demand and Capacity (develop a meaningful Delayed Discharge Pathway) • Family and Friends involvement • Workforce Planning • Use of Technology • Health Inequalities	Home First Team	November 22		Have a baseline of where we are now and plan for what we need to do		
Update	22/09/22 (Early Findings)						

	• Significant concern across all services around duplication of patient contact. GP's and DN's have a sense that new developments risk undermining their role. • Core services are good in Moray, but additional 'new' services and projects have created blocks, confusion, inequity and dissatisfaction • Temporary projects have taken vital staff groups away from core services, leaving them with vacancies. • Temporary funding runs out and there is no sustainable funding so projects will stop • Terms and conditions for fixed term and seconded staff, risk that staff are being disadvantaged by short term projects • Lack of improvement methodology in projects has led to inability to identify if there is any impact of short term funded projects • Current projects in the main do not impact on the whole system • Lack of knowledge or understanding of data and use of DD targets and 4-hour target as high-level targets for all services • Lack of engagement of staff in DD and 4-hour data, now way of knowing what impact their service is having • Lack of engagement in how data should be used to gage performance of a service and of the system • Front line staff trying to distribute scant resource, no consistency or equity, 'feels like a scattergun approach to allocation of health and social care resource'. • Staff critical of how services have been commissioned • High levels of duplication • Low investment in core services in favour of short term funded projects • No overall lead for Frail Elderly pathway • DGH trying to solve all issues at the front door (ED) when issues need to be solved in the Community • Apart from core services, 'new' services and projects are not joined up and therefore there is a risk that patients will have different experiences of health and social care input 07/11/22 - Report to be compiled and submitted to SLG and SMT for November 22						
4.	Tackle the medium to low waits for assessment in the community by utilising: - • Realistic Medicine • 3 Conversation Model	SLG	December 22		Ensure Medium and Low waits for SW assessment do not occur due to slick transfer of		

	• 3rd Sector • Volunteering • SDS (implementing March 2022 guidance)				care to services other than Care at home, avoid disabling the family and those that care for an individual		
5.	Divert resource to reviewing current care packages to create capacity Ensure carer involvement in the review of packages of care MDT discussions if we believe we can reduce packages of care	SLG	December 22		There are 271 outstanding reviews, undertaking these could increase available capacity		
6.	OT in Primary Care addressing unscheduled care and frailty. Twice weekly huddles with Local Authority OT to prevent duplication Analyse OT unmet need, particularly critical	Dawn Duncan AS/LS/JF	December 22		Upstream management of patients who may be admitted		
7.	Recruit to a team of 'generic HCSW's who can participate in all areas of the delayed discharge pathway	SLG	January 23		Always have a team available to manage periods of		

	LANARKSHIRE MODEL or FORRES Model				increase activity (Winter)		
8.	Make SDS implementation a priority (divert the Quarriers SDS post from Hospitals to the community). Make SDS mandatory training for those who discuss discharge with patient and families. Aim to reduce care hours required by using SDS creatively	Michelle Fleming	October 22		The key to reducing waits for care, evidence shows that even those assessed for high levels of care at home can be safely managed using alternative solutions		
Update	07/11/22 - Aspire to have 85% of nursing staff in Community Hospitals complete SDS training on TURAS - HCSW from Community Hospitals have volunteered to be SDS champions for their areas						
9.	HR and Recruitment to apply 'special measures' to recruitment of all frontline vacancies in Moray	HR Hub	November 22		Make every opportunity for recruitment count, get people quickly into post before they find other employment		
10.	Scale up intermediate care (hospital without walls)	Home First Team	October 22		Have a suite of options for patients other than admission to hospital or care at home		
Update	07/11/22 - Discussions ongoing with GH from geriatric team. Current model needs development. Current plan estimated to be rolled out in 10yrs, plan to reduce that timescale considerably. Geriatrics to work more closely with D2A and CRT, less activity at the front door for geriatric assessment as this is too late. Discuss with Community and primary care teams as to how to progress						

	early geriatric interventions. 'One stop' telephone number in place, just for DGH for now but encouraging role out across Moray. Need to change focus of H@H from an acute model to a community model. Move away from rigid thinking around H@H model, the requirement of an acute Geriatrician 'in charge' of patient care in the community needs adaption as it is preventing progress. This is being challenged in favour of a MDT model. Progressing discussions around dedicated Geriatric Care Home beds for geriatric rehabilitation and assessment.						
11.	Increase screening for Frailty (Frailty Team) Develop 'outreach' support in the community	Frailty Team	November 22		Re-look at over 75 community assessments – this can be done in conjunction with flu/adult/COVID immunisations, manage problems before they become a crisis or look at ways of identifying at risk individuals in some way to ensure they are supported.		
12.	Review discharge planning and the role of MDT's and golden ward rounds, Huddles	Home First Team	October 22		What are the outcomes from these? What do we achieve?		
Update	22/09/22 - Jim Brown to support MDTs in Community Hospitals and LS/AS to support DGH 07/11/22 - Report to be completed for SLG and SMT						

13.	Assess Moray's risk averse status amongst front line staff and manage results	Home First Team	October 22		Varying levels of risk appetite amongst frontline staff, need to have a standardised approach within a governance framework		
Update	07/11/22 - Single handed training for 10 staff to be offered by Shire for Moray Staff. Encourage, C@H leads and OT's to parcipate. Huge gains reported in Shire reducing 2 carer per visit requirement.						
14.	Criteria Led Discharge Pilot DGH	DGH	October 22		Potential for reducing delays to discharge, will improve early pharmacy and transport requests		
Update	22/09/22 - Early progress in Community Hospitals, supported by Jim Brown						
15.	Combine H@H and HWW and develop Virtual Community Wards in specific localities	Home First Team	November 22		Potential for reducing delays, patients return home earlier with medical support and review		
Update	07/11/22 - Staff report huge confusion over numerous models. Plan to combine H@H and HWW ongoing, some resistance due to rigidity of thinking around H@H. Break down barriers to progress and develop Moray model for H@H that uses the Virtual Community Ward model operationally,						