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							
1.	Create more Care at Home Capacity Create more capacity in the Access Team	Roddy Huggan Jane Mackie Lesley Attridge	26/07/22	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						
2.	Divert Capacity to Delayed Discharges as a priority.	John Campbell	27/07/22	Care at Home Services	A temporary measure to reduce		

	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 decrease of care at home POC	Alison Smart/Laura Sutherland/Jamie Fraser Cheryl St Hilaire John Campbell	 11/08/22 11/08/22	 Volunteers Carers	the delayed discharges Transport for carers who don't drive to increase hours of care at home 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.						
3.	Assess capacity of CRT, divert capacity to discharging delayed patients (action 1 and 2 will support onward care requirement if required two weeks from discharge) and supporting at front door	Anita Gouldsbrough	27/07/22	CRT team	A temporary measure to reduce the delayed discharges	09/08/22	

	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						
4.	Continue to use D2A to provide early supported discharge from DGH	Dawn Duncan/Katie Parry	27/07/22	D2A team			
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						
5.	Monday Huddle – redesign process	Jim Brown/Lisa Anderson/Kay McInnes	01/08/22	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						

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 SLG			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							
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-	SLG			Patient Centred Care		

	handed risk assessments (Aberdeenshire Model)				Develop processes to support staff		
Update							
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							
PHASE 2							
1.	Establish Targets for Unmet Need	Home First Team	August 22		Develop an alert system so that action can be taken when unmet need reaches a warning level		
2.	Produce a Dashboard to measure and assure	Home First Team	August 22		Ensure assurance that DD systems and processes are working		

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	Home First Team	August 22		Have a baseline of where we are now and plan for what we need to do		
4.	Tackle the medium to low waits for assessment in the community by utilising: - • Realistic Medicine • 3 Conversation Model • 3rd Sector • Volunteering • SDS (implementing March 2022 guidance)	SLG	August 22		Ensure Medium and Low waits for SW assessment do not occur due to slick transfer of 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	SLG	August 22		There are 271 outstanding reviews, undertaking these		

	Ensure carer involvement in the review of packages of care MDT discussions if we believe we can reduce packages of care				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	August 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 LANARKSHIRE MODEL	SLG	August 22		Always have a team available to manage periods of 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	August 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		

9.	HR and Recruitment to apply 'special measures' to recruitment of all frontline vacancies in Moray	HR Hub	August 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		
11.	Increase screening for Frailty (Frailty Team) Develop 'outreach' support in the community	Frailty Team	October 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		
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?		
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		
14.	Criteria Led Discharge Pilot DGH	DGH	October 22		Potential for reducing delays to discharge, will improve early pharmacy and transport requests		
15.	Combine H@H and HWW to produce a Virtual Community Ward	Home First Team	October 22		Potential for reducing delays, patients return home earlier with medical support and review		