Created 09.07.24

**ACTION PLAN FOR DISCHARGE WITHOUT DELAY - ABERDEEN CITY**
Reminders Sent - Mondays
Updates Requested By - Wednesdays
SLWG Meetings - Thursdays

**AIM - TO HAVE A DELAYED DISCHARGE RATE OF LESS THAN 20.8 PER 100,000 BY OCTOBER**

| PROJECT OBJECTIVE | KEY ACTIONS | Start Date | End Date | Actual Date | RAG Status | Lead Officer | Update | Potential Cost |
|---|---|---|---|---|---|---|---|---|
| **1st Driver - Early Planning of Discharge** | | | | | | | | |
| Care Management involved with multidisciplinary team (MDT) on discharge plan from admission | Top 3 areas to be targeted for resourcing from Social Work - ED/AMIA/402/403 | 1.8.24 | 31.8.24 | 15.08.24 | Completed | Hospital Social Work Service Manager | Resource allocated to ED/AMIA. 402/3 Boarders have discharge plans in place- in progress<br>15/08 - Staff aligned to this and regular meeting with discharge focus. ED now also has SW aligned. All front doors now covered. | HSCP |
| Planned Date of Discharge to start on day one of admission | Check metrics for compliance | 25.7.24 | 30.9.24 | *Add once completed* | In Progress (on track) | Chief Nurse | Have asked Service Managers of Frailty and Rehab to look at SLWG to embed PDDs and CLD - will get regular updates and reporting.<br>15/8 - Focus on accuracy as opposed to just having a date. Need to ensure at weekly MDT these are updated robustly. PDD first estimate after 48hr assessment.<br>22/08 - No PDD's improvements, ongoing. Louise on it from Quality perspective - it will progress.<br>27/8 Discussion taking place at MDT to aid discharge plan and planned date of discharge (PDD) being set. Regular PDD being shared to help improve performance.<br>2/09 - PDDs are a regular agenda item at MDTs to ensure being discussed. Accuracy being monitored | None |
| | Target areas where performance is lower (304/RWH/WE) | 25.7.24 | 30.9.24 | 31.08.24 | In Progress (on track) | Chief Nurse | As per SLWG highlighted above.<br>15/8 Meetings have started.<br>27/8 Update as above<br>12/09 - continuing to work with RW and 102 in particular to try to ensure accuracy of PDD, this is slowly improving. | None |
| Implement discharge to assess at Rosewell House | Proposal to be created | 25.7.24 | 29.7.24 | 29.7.24 | Completed | Hospital Social Work Service Manager | Proposal declined, no further action. | NHS |
| | Resource reconfiguation | 25.7.24 | 30.09.24 | Add once completed | In Progress (on track) | Hospital Social Work Service Manager | Meeting arranged to discuss.<br>15/8 - Meeting arranged.<br>29/08 Meeting planned for the 16th Sept - in progress<br>2/09 - work to start on 24/09 testing discharge to assess from front door | None |
| | *MDT discussion on Home with TEC/AHP/RF support* | 25.7.24 | 30.09.24 | Add once completed | In Progress (on track) | Hospital Social Work Service Manager | Daily screening panel on all care requests to look at alternatives to care (TEC)<br>15/8 - trend showing increase in referals. Exploring options around information sharing around new and emerging TEC.<br>29/08 - still promoting, every single request for Care Package to be offered Tec<br>12/09 - Colleegue identified to do assessments with OT at Rosewell - spent 2 days a week at Rosewell, to source patients to go home with TEC. | HSCP |

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| **2nd Driver - Prioritise the discharge of delayed patients** | | | | | | | | |
| Utilise ward huddle in high referring areas to identify the appropriate placement of citizens | *Present in high referring wards (102/RWH)* | 09.07.2024 | 30.8.24 | *Add once completed* | In Progress (minor delay) | Hospital Social Work Service Manager | 15/8 - not specific trend around 1 area, work started around increasding knowledge on "what is a delay"<br>29/08 - Care Management (CM) alligned for 102, Intermediate care provided at Rosewell not rehab.<br>05/09 - Ongoing | None |
| Progress interim guardianship for those with delays (current 6) | *Dedicated MHO* | 09.07.2024 | 16.7.24 | 16.7.24 | Completed | Hospital Social Work Service Manager | | HSCP |
| Educate staff on appropriate addition to DD list and collaborate with wards to embed learning | Training for ward staff (starting with 402/403) | 25.7.24 | 31.8.24 | *15.8.24* | Completed | Hospital Social Work Service Manager | High staff turnover on ward contributing, key staff identified to embed.<br>15/8 - work started with appropriate stakeholders, update on any tolls needed and other can support roll out in frailty / rehab | None |
| Understand improved guardianship processes in Moray and share learning | Investigate Moray actions around this | 25.7.24 | 6.9.24 | *Add once completed* | In Progress (minor delay) | Strategic Home Pathway Lead | 29/08 - presentation on the 2nd September 2024 | HSCP |

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| **3rd Driver - Family Readiness for Discharge** | | | | | | | | |
| Progress TOC with 50 applicants for PoA | Contract construction with third sector provider | 25.7.24 | 31.08.25 | *Add once completed* | In Progress (minor delay) | OOH SW Service Manager | 29/08 - Met with Solicitor - in progress<br>2/09 not started yet, further meeting next week to discuss this. | Funded |
| Home for Lunch on discharge date | RWH/WE to be encouraged to work towards this via working with daily huddles | 25.7.24 | 30.9.24 | *Add once completed* | In Progress (on track) | Chief Nurse | 15/8 - discussions have been had with teams and linking in with CLD. Need for more focus on preparation.<br>22/08 - No data to show improvement, same as the PDD. 27/8 Discussed at AM hiddle and asking reception staff to question when booking 'why not AM' SCNs also reminding staff all staff to be organising discharges AM 29/08 - more work required to make that happen and more look at data JW to update.<br>12/09 - have started to look at themes following a staff survey of why this is not happening and doing targeted work areas with a QI approach. | None |
| Work with clinical teams on courageous conversations re. discharge | Training for Junior Doctors to be revisited | 25.7.24 | 13.9.24 | *Add once completed* | In Progress (on track) | Clinical Lead Geriatrician | 15/8 - SA will explore possible teaching sessions.<br>27/8 A date has been organised for attendance at the Grand Round and update on TEC.<br>29/08 - 18th Sept training/presentation, NMc to organise someone to present | None |

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| **PROJECT OBJECTIVE** | **KEY ACTIONS** | **Start Date** | **End Date** | **Actual Date** | **RAG Status** | **Lead Officer** | **Update** | **Potential Cost** |
| **4th Driver - Coordination of Care** | | | | | | | | |
| Review Enhanced Community Support huddles for areas of improvement | Developing MDT around regular admissions/readmissions | 25.7.24 | 30.9.24 | *Add once completed* | In Progress (on track) | Hospital Social Work Service Manager | Identify high traffic areas. Shirley will seek data from Matthew Toms.<br>22/08 - LB on AL for 2 weeks Louise McMann to report on it from BAC side. Update next week as time required. 29/08 - ongoing<br>05/09 - Ongoing | None |
| Develop a clear pathway for social admissions | SAS devices with details on how to deal with social admissions | 09.7.24 | 30.9.24 | *30.08.24* | Completed | OOH SW Service Manager | JRCALC updated to include OOH SW. | None |
| | Care Homes Prof to Prof through FNC | 01.6.24 | 31.8.24 | 31.7.24 | Completed | Care Home Lead Nurse | This is established within all areas of Grampian. Inital phase 13th July 23 for City then Shire & Moray on board from Oct 23 Further work to establish pathways to support Care Home residents remaining at home. Restore 2 training in progress with Care Home Staff<br>15/8 - some additonal piece of work looking at GP care home links and homely remedies type options. | None |
| Implement critieria led discharge in every area | Rosewell House / Woodend to implement via SLWG including junior Drs | 25.7.24 | 30.9.24 | *Add once completed* | In Progress (on track) | Chief Nurse | Meeting arranged to discuss. PDD/CLD lunchtime discharge all same project.<br>27/8 CFD being discussed at MDTs and regular review. A review of current discharge paperwork is being undertaken to ensure it is a meaningful aid.<br>12/09 A SOP and flowchart is being created to support the work around CLD and will be tested in areas to support its value/use. From there we will slowly roll out CLD. | None |
| Whole system flow team engagement with social work | Improve positioning using new Whole System Flow (WSF) Hub | 25.7.25 | 30.9.24 | *Add once completed* | In Progress (on track) | Strategic Home Pathway Lead | Hub established and building knowledge and relationships 29/08 - ongoing, staff to base there more offten<br>05/09 - Ongoing | None |
| Scaling up prevention and | Business Case for scaling up under construction | 25.7.24 | 31.8.24 | 23.8.24 | Completed | CSWO - Adult | Prepared for IJB 24 September. | HSCP |

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|---|---|---|---|---|---|---|---|---|
| expediting discharge via use of TEC | Target consultants with information on changes in provision of care via the Consultant's Grand Round | 25.7.24 | 31.8.24 | *Add once completed* | In Progress (minor delay) | Hospital Social Work Service Manager | 15/8 - CB will explore individuals to present<br>29/08 - will be part of the 16th Sept discussion | None |