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
1st Driver - Early Planning of Discharge							
Implement NHS Scotland pathway based planning model for discharges.	The Pathways Planning Model developed by NHS Scotland Centre for Sustainable Delivery builds on the Daily Dynamic Discharge approach and describes four pathways. Each pathway requires early discharge planning and as the complexity increases so does the requirement to strengthen the whole system approach to decision-making and planning. 1. Simple Discharge – no ongoing health and social care needs 2. Moderately Complex Discharge – known to Social Care, may need some input 3. Complex Discharge – likely to require significant Social Care input 4. End of Life – should follow a 'fast track' pathway	Oct-24	Ongoing	Add once completed	In Progress (major delay)	Claire Smith, Lead Nurse	**15.10.24** - Pathways model discussed with the group and how this would fit in with the development of the discharge tab on TRAK.**5.11.24** - NHSG has adopted a RAGG status for discharge planning in the TRAK discharge tab rather than implement the pathways model, would only be able to embed if change adopted by NHSG, may be opportunity to embed priciples of pathway model in the rationale for each RAG. CS to discuss with JM.
Implement daily dynamic discharge huddles	Implement the daily dynamic discharge approach from the 6 essential actions to improve the timeliness and quality of patient care by planning and progressing in parallel all treatment and necessary tasks to ensure discharge without delay. Implementation guidance can be found here https://www.gov.scot/publications/daily-dynamic-discharge-approach-guidance-document/documents/	Oct-24	Ongoing	Add once completed	In Progress (on track)	Claire Smith, Lead Nurse	**15.10.24** - Group discussed the concept and agreed in principle to develop a test of change in Muick ward. Agreed older adult best place to do this due to current capacity issues. To be discussed with other stakeholders for finals agreement, HIS have agreed to support. **5.11.24 -** HIS to co-design test of change with Muick MDT. CS contacting stakeholders, meeting planned for 19.11.24. CMHN and social work to also be included. JM asked to collate pre TOC data.
Embed criteria led discharge	Empower members of the multi-disciplinary team (MDT) to finalise a patients discharge without relying on one last review from a senior clinician. Use patient specific discharge criteria to ensure the entire team, including the patient are aware of what needs to happen before the patient can leave hospital.	Oct-24	Ongoing	Add once completed	In Progress (on track)	Claire Smith, Lead Nurse	**15.10.24** - Discussed within the group, concerns raised by CM due to risk of mental health patients on discharge. More information required on criteria led discharge, HIS may be able to support with evidence base/ rationale etc. **5.11.24** HIS have requested evidence base for criteria led disharge to be presented to clinicians. Have shared RCP's best practice, CS shared with group for review.

Improve the functionality and accessibility of TRAK for discharge planning	Development of the discharge tab on TRAK, Social work access to TRAK, review discharge checklist	01/09/2024	Ongoing	Add once completed	In Progress (minor delay)	Dr Chris McDonald/Kerry Ross	**1.10.24** Meeting set for next week to look at MHO access to EPR. Waiting for update information governance. **3.10.24** CM updated currently working on discharge tab for MH&LDS re suitability/ optimise usage. **15.10.24**Update from CM re meeting with NHS Lothian re discharge tab 30/10/24 **5.11.24**Tab is available in basic state for use by mental health services. Changes to it now need to be agreed by whole trak team as system used in ARI as well which will slow customisation. Could look at trialing the implementation of the basic functionality in muick as part of test of change.
Golden hour' MDT format	Embed principles to ensure prompt discharge and minimal waits and delays in the transfer of care. The order in which patients are reviewed in the ward rounds has an impact on how promptly appropriate tasks are carried out, which supports the optimal operational flow of patients and therefore quality of care; by discharging patients as soon as they are ready to go, thus ensuring timely admission to appropriate specialties. The order of the 'golden hour' round is always: – sick patients from overnight or anyone who the team are worried about – new patients who are unwell and have not been seen yet – patients who require a discharge review – patients who require discharge tasks to be completed – all other patients.	Oct-24	Ongoing	Add once completed	In Progress (on track)	Claire Smith, Lead Nurse	**15.10.24** - Discussed within the group, to potentially include in Muick test of change. **5.11.24** - **will be included in Muick TOC to embed best practcie and national guidance for early discharge planning.**
Improvement to compliance with planned date of discharge (PDD)	The PDD process to be consistently utilised across site. Review of current process for PDD's, education for staff and compliance monitoring.	Sep-24	Ongoing	Add once completed	In Progress (on track)	Johnny McCann	**1.10.24** JM and CS now have access to PDD compliance report on illuminate. PDD added to patient flow recording document as a prompt to ensure PDD is recorded. **15.10.24** In line with national guidance the PDD is to be set by the nurse admitting the patient and reviewed and updated at the MDT. Actions required- refresh guidance, PDD added to canned text.**6.11.24** Compliance currently at 40.1% First weekly compliance prompt sent to nursing and medical staff.
Standardised process for Core Discharge Documents (CDD's)	CDD's to be consistently completed within a set time frame from all relevant members of the MDT to avoid delays to discharge. Implement a best practice approach to improve communications and forward planning with a standardised process for discharge planning documents. CDD's to be sent to pharmacy 24 hours prior to discharge.	Sep-24	Ongoing	Add once completed	In Progress (on track)	Dr Chris McDonald, Fiona Raeburn	**1.10.24** CS has identified a pharmacy and medical rep for the group. Request has been made by pharmacy to complete CDD 24 hours prior to discharge.

Discharge before noon	Managing Capacity and demand at hospital level and ensuring admissions and discharges align is a key operational and performance goal. Afternoon peaks in attendances with a rise in required admissions is the norm for many hospitals. The same afternoon peak in discharges also occurs causing crowding to occur in Lochhead/ admission wards as patient flow slows down or stops. The solution is early in day discharge or transfer. A key improvement measure of the 6 Essential Actions to Improving Unscheduled Care. Aim for is 40% of ward discharge to occur before 12.00 midday. Achieving this goal will require the MDT to work together across the Daily Dynamic Discharge model and ensure all elements are in place. This includes communication of the discharge plan, and timely completion of the tasks necessary for discharge.	Oct-24	Ongoing	Add once completed	In Progress (on track)	Claire Smith, Lead Nurse	15.10.24 Discussed with group, conflicting views as preference is person centered discharge date. CS to review data and bring to next meeting. Consider inclusion in test of change. **5.11.24 - will be included in Muick TOC to embed best practcie and national guidance for early discharge planning.**
Review of discharge policy	Review of current processes and pathways for admission and discharge. Review of policies from other NHS boards. Update discharge policy to include national guidance and local practices	Sep-24	Ongoing	Add once completed	In Progress (minor delay)	Claire Smith & Fiona Tejeda	**1.10.24** CS and FT Fiona have met to start the review of the admission and discharge policy and shape terms of reference. Admission and Discharge Policies have been requested from other boards via HIS, none received as yet. **15.10.24** NHS Lothian Policy and patient information leaflet shared with the group for review.**5.11.24 ON PAUSE UNTIL AFTER TOC.**
2nd Driver - Prioritise the discharge of delayed patients							
Clear process, systems and pathways for adding patients to DD/DTOC lists.	Education for ward staff and community staff, speak with gram.delayeddischarges. Data input (HIS). Correct coding. Promote guidance and good language. Ensure MDT discussions. Repeat Day of Care Audit on a quarterly basis. Discuss with Dr Alastair Palin and Ruari McFie.	Sep-24	Ongoing	Add once completed	In Progress (on track)	Johnny McCann, Nurse Manager	**5.11.24** - Guidance required for staff to follow, consider an SOP. Date of next day of care audit to be confirmed.
Home First	Develop a “discharge to assess” model so that older people can be assessed for their long-term needs in their own home. Commission a dedicated “Hospital to Home” transition team to support older people going home to be assessed and supported in the days after discharge. Utilise intermediate care “step-down” beds to provide a halfway house between hospital and home, for those who need additional recovery time before going home.	Oct-24	Ongoing	Add once completed	In Progress (on track)	Claire Smith, Lead Nurse	**15.10.24** - Discussed within the group, to potentially include in Muick test of change.**5.11.24** - will be included in Muick TOC to embed best practcie and national guidance for early discharge planning.
Application for interim guardianship orders with delays	Education for staff around interim guardianship. Include in the discharge planning tab / discharge checklist	Sep-24	Ongoing	Add once completed	In Progress (on track)	Claire Smith, Lead Nurse	**1.10.24** VH to check if any learning resources for guardianship/ interim guardianship can be shared with staff. CS to delegate review of discharge checklist (and audit tool). Discuss discharge tab next week with Chris.
3rd Driver - Family Readiness for Discharge							

Ensure effective and inclusive engagement with the patient, family and carers throughout the discharge planning process	Communication between professionals and the patient, involvement of family and carers in these discussions, ensuring necessary information is available in different formats, making sure conversations are realistic and manage expectations, managing choice and brokering constructive conversations. Involve carers in early planning of discharge, consider use of Care Programme Approach (CPA) for more complex cases. From the moment a patient is admitted to hospital, the multi-disciplinary team, along with the patient, family and carers should begin to develop an understanding and expectation of what is going to happen during the stay in hospital. Discharge planning conversations are important to patients when they are admitted to or leaving the hospital setting to ensure a smooth, safe and supported transition from hospital to home. Effective and timely involvement of patient, carer and family members from the outset is therefore required as they are central to the decision making process being productive. This will also include Power of Attorney Welfare Guardians for patients who lack capacity.	Oct-24	Ongoing	Add once completed	In Progress (on track)	To be determined	15.10.24 - Discussed within the group, to potentially include in Muick test of change. **15.11.24 -** National guidance sourced, to be reviewed by the group.
Clinical teams to be consistent in approach making sure conversations are realistic and manage expectations, manage choice and brokering constructive conversations regarding discharge.	Support to have courageous conversations. Staff training opportunity. Awareness of policies & education. Consistency with guidance and timeline. The key message is that no person should suffer unnecessary delay in their discharge from hospital. Communication should be clear that the expectation is the patient goes home – "the best bed is your own bed". Active participation of patients and their carers is central to the delivery of good discharge planning.	Oct-24	Ongoing	Add once completed	In Progress (on track)	To be determined	**15.10.24** - Discussed within the group, to potentially include in Muick test of change. **15.11.24** - National guidance sourced, to be reviewed by the group.
4th Driver - Coordination of Care							
Implement 7 days discharges	Early planning of discharge would ensure all MDT members, patient and carers are fully involved in the discharge process. Link with community mental health teams and social care service	Oct-24	Ongoing	Add once completed	In Progress (minor delay)	To be determined	**15.10.24** - Discussed within the group, to potentially include in Muick test of change. Will be dependant on the adoption of criteria led discharge principles.
Patient Flow team input into supporting discharge without delay.	Patient Flow Team at Royal Cornhill Hospital (RCH), Social Work Colleagues & all teams involved to balance workload between admissions & discharges. Coordination with all teams involved (pathways). Explore reinstating the discharge coordinator role.	Sep-24	Ongoing	Add once completed	In Progress (on track)	Johnny McCann & Claire Smith	**1.10.24** recruitment paperwork done for discharge coordinator however finance remains a challenge. CS to discuss with JMc.

Technology enabled care (TEC)	Have a good understanding of telecare and what can be offered – to prevent over, under or inappropriate provision of telecare; be aware of ethics and issues of informed consent regarding telecare (for example for people with dementia); provide the level of information the telecare service requires to install equipment and initiate the service – this will often involve liaison with family and carers; provide the patient, and where appropriate, their family and carers, with information about the service so they fully understand they will have devices in their home that connect to an alarm receiving center, and that they will need to nominate key holders or contacts; inform the patient and where appropriate, their family and carers that a charge for telecare applies. Almost all telecare services in Scotland charge, however some offer a free trial period. Where there is a clear need for the introduction, or enhancement of telecare, early referral should be made, well in advance of discharge. Referrers should have a knowledge of telecare and an awareness of referral processes, and liaise with TEC/telecare service as required. Referrals should contain the right level of detail to allow timely and appropriate installations; liaising with families and carers.	Sep-24	Ongoing	Add once completed	In Progress (on track)	To be determined	**1.10.24** been shared with SCN's and attendance at event has been promoted.
Review weekly DD/ DTOC Meeting	Implement recommendations to improve format of the meeting, monitor and review. Consider escalation process.	Sep-24	Ongoing	Add once completed	In Progress (on track)	Johnny McCann/ Gordon Hay	**01.11.24** Data analysis will commence following final round of data collection from 6th Nov DD&DToC meeting. **15.10.24**- Test of change has been identifed and data collection has begun. HIS porviding support.
Simplified access to community / social care support.	Ensure community services have a simplified point of access. Where there is a clear need for on-going support on discharge, early referral for community services must be made, well in advance of discharge. Referrals should contain sufficient but concise detail to allow timely and appropriate interventions. Ensure that people already receiving community support are discharged as soon as it is safe to do so, with re-starts of care and minimal cancellation of existing services. Sitting alongside an Anticipatory Care Plan , an alert could be available on admission to inform ward staff the patient is already known to social work.	NOT STARTED	Add once complete	Add once completed	Not Started	To be determined	