OPTIMISING WHOLE SYSTEM DISCHARGE PLANNING - SELF-ASSESSMENT TOOL

Background

As part of the unscheduled care “Building on Firm Foundations” programme, a work stream on “optimising discharge” made a number of recommendations for health and social care partnerships. These have been described in a one-page driver diagram (see annex A) with the following key aims.

Home should be the default position for all people leaving hospital	• This will mean partnerships must adopt a Home First approach, asking “why not home, why not now” at every stage of a person’s hospital journey. A range of intermediate care services will need to be developed and an assertive attitude taken to risk.
All parties work towards an agreed Planned Date of Discharge	• This will require everyone working as one team with a shared goal, working towards the PDD rather than from the ready for discharge date. Early referral will be needed for any on-going support needs.
People should not be assessed for their long-term support needs in an acute environment when at their most vulnerable.	• Partnerships should adopt “Discharge to Assess” as an ethos and commission dedicated “Transition Teams” to provide immediate support on discharge. As a rule, no-one should transfer directly from an acute setting to a long-term residential care setting without all options to go home being exercised.
Decisions are made and discharge occur across seven days.	• This will need decision makers and decision making processes in place across seven days and for providers to be available for new starts or re-starts of community based care. Transition Teams should be available to support weekend discharges. Pharmacy and transport must also be available, along with technology and other equipment to support safe discharge. Early discharge planning should support timely ordering and availability.
There is good communication between professionals and with the patient, family and carer.	• Community supports must have a single point of contact and access, and be readily accessible. Patients, family and carers should be involved in discharge planning with good, accessible information on what will be available to support discharge arrangements.
There is robust data and a series of indicators by which to measure performance and identify concerns.	• There must be a single, agreed, version of the truth, with accurate numbers and coding, to fully understand the key indicators of successful performance. SMART (Specific Measurable Achievable Realistic Timely) objectives should be set to measure the impact of these key aims.

The work stream also pledged to develop a self-assessment “what works” template so that partnerships could reflect progress against the various drivers.

Purpose

Self-assessment is widely used across public services and the private sector. It allows organisations to identify their strengths and weaknesses, highlighting areas where improvements could be made, resulting in actions being developed to make those improvements which are then monitored against a set of agreed indicators to measure progress.

The tool is intended to allow health and social care teams and managers to continually test their discharge planning arrangements and put remedial actions in place where it is demonstrated there are shortcomings. It is meant for internal use locally and should not be used as a critique of individual or team performance. Neither should the scoring be used in any way to belittle those involved in the operational frontline. Rather it is intended to assess the whole system and be used as an aide to improvement.

Who should use the tool

Delayed discharge is recognised as a whole system problem that requires a whole system solution. It is important therefore that responses to the tool are from a range of people involved in discharge planning. The template can be completed as an individual survey and the scores aggregated to obtain an average score for each intention. One particularly effective method for completing it is to hold facilitated staff focus groups to discuss and agree a score for each intention. This has the benefit of promoting open and honest discussion, although care needs to be taken to avoid blame being pointed at one part of the system.

How to use the tool

The tool is divided in to six broad themes, representing they key aims within the driver diagram. This is then broken down in to the primary and secondary drivers from the driver diagram and supplemented by other recommendations from the optimising discharge work stream report. The “status” column should be used to assess the partnership’s current status against each intention. A score from 0-5 should be set against each driver with “0” meaning the driver is not in place at all and “5” meaning it is wholly embedded in the system. The “impact” column should be used to consider the impact of each intention, either anticipated where it is not yet in place or anticipated where it is still to be established. Subsequent improvement actions should focus on those intentions that score low in status and high in impact.

Improvement actions should be well described and documented, have an agreed timeline for delivery and a nominated official to lead the work. Progress should be measured against national data where available or against agreed local indicators.

The scoring methodology is described in more detail below.

STATUS SCORING		IMPACT SCORING	
0	The current status is not defined locally or not known	0	There would be no impact at all adopting this intention
1	There is an informal understanding of the intention but no formal description in place	1	There would be minimal impact from this intention
2	This intention is well documented and understood	2	This intention would improve the current position but not be a priority
3	The intention is well defined locally and carried out routinely	3	The intention would show a significant impact
4	The intention is regularly measured and monitored, and actions in place where necessary	4	The intention is necessary and vital for improvement
5	The intention is embedded, consistently meeting needs	5	The intention is essential in order to provide better outcomes

Measure might include, but not exclusively:

- Delayed discharge number
- Delayed discharge bed days
- Overall occupied bed days
- Proportion of bed days that are delay
- Proportion of all discharges that encounter a delay
- Date of referral (c/w date of admission, ready for discharge date, actual discharge date)
- Planned Date of Discharge (c/w date of admission, ready for discharge date, actual discharge date)
- Proportion of PDD met (not met by how long?)
- Readmission rates

THE TOOL

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
Home is the default position for all people leaving hospital						
A "Home First" approach should be adopted, asking "why not home, why not now" at every point of a patient's journey						
A range of intermediate care services should be developed						
An assertive attitudes towards risk management should be taken						
Long lengths of stay should be avoided with a quick turnaround from admission						
A reabling approach should be taken, with patients helped to stay active in hospital						
Clear information and advice should be available on the effects of "bed rest" and the benefits of activity and rehab						
Unnecessary transfers in, or to other, hospitals should be avoided						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
All parties work to an agreed Planned Date of Discharge (PDD)						
Involve patients, families and carers in discharge planning arrangements						
Discharge planning should be started early in the patient journey, preferably on admission						
Everyone involved in discharge planning should work as one team, with common goals, including the core message that “no delay is acceptable”.						
There should be early referral to, and involvement of, social work teams						
Referrals should contain sufficient but concise detail to allow timely and appropriate interventions						
Dedicated social work teams dealing with hospital discharge are known to work						
Everyone should have clear roles and responsibilities, and an understanding of others’ roles						
There should be a designated senior person to manage discharge performance, with oversight of the Hub (where applicable) and delegated authority to make and						

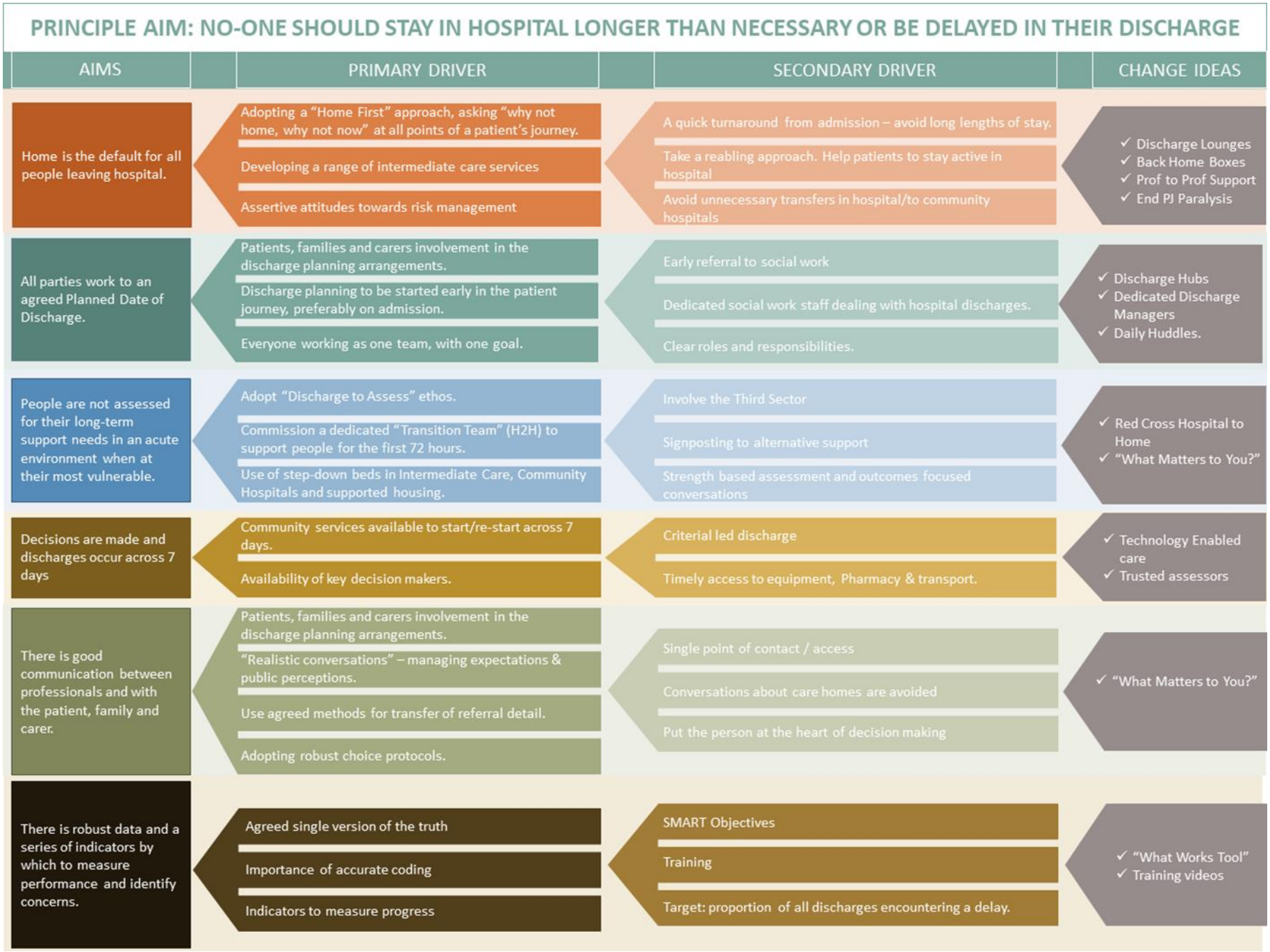
challenge decisions.						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
People are not assessed for their long-term needs in an acute environment what at their most vulnerable						
A “Discharge to Assess” ethos should be adopted						
All staff adopt the key message that “the best bed is your own bed”						
Consider commissioning a dedicated “Transition Team” (Hospital to Home) to support people for the first 72 hours						
Consider the use of “step-down” beds in intermediate care facilities, community hospitals or supported housing						
Consider using the third sector within the wider Hospital to Home support						
Ensure easy signposting to alternative supports						
Carry out “strength based” assessments and outcomes focussed conversations						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
Decisions are made and discharges occur across seven days						
Community services should be available to start or re-start across seven days						
Wherever possible existing packages of care should be kept open to avoid any delay						
Key decision makers should be available at weekends and public holidays						
Have guidelines in place for Criteria or Nurse Led Discharge						
Ensure timely access to equipment, pharmacy and transport						
Telecare providers must be kept informed of discharge dates and notified of any changes to prevent any installation delays						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
There is good communication between professionals and with the patient, family and carer						
Ensure “realistic conversations” with patients, families and carers, that manage expectations and perceptions						
Use agreed methods for rapid transfer of referral details						
Ensure robust choice protocols are in place with an escalation policy						
Create a single point of contact/access that is well known to ward staff						
Avoid conversations about care homes prior to any assessment						
Put the person at the heart of decision making						

Theme/intention	Status score	Impact score	Action	Measures	Lead	Timeline
There is robust data and a series of indicators by which to measure performance and identify concerns						
Ensure there is an agreed, single version of the truth						
Accurate coding is key to having the correct knowledge of the problem						
Adopt a set of indicators to measure progress						
Ensure the PDD and referral date are accurately recorded and monitored						
Adopt SMART objectives for all actions and objectives						
Provide adequate training for all staff involved in discharge planning						
Adopt local improvement measures and targets. Where possible make these “positive” targets such as “increasing the proportion of all discharge that encounter no delay”						
Chief Officers have processes in place to allow them to “sign off” the validated data						


PRINCIPLE AIM: NO-ONE SHOULD STAY IN HOSPITAL LONGER THAN NECESSARY OR BE DELAYED IN THEIR DISCHARGE
AIMS
PRIMARY DRIVER
SECONDARY DRIVER
CHANGE IDEAS
Home is the default for all people leaving hospital.
Adopting a "Home First" approach, asking "why not home, why not now" at all points of a patient's journey.
Developing a range of intermediate care services
Assertive attitudes towards risk management
A quick turnaround from admission – avoid long lengths of stay.
Take a reabling approach. Help patients to stay active in hospital
Avoid unnecessary transfers in hospital/to community hospitals
✓ Discharge Lounges
✓ Back Home Boxes
✓ Prof to Prof Support
✓ End PJ Paralysis
All parties work to an agreed Planned Date of Discharge.
Patients, families and carers involvement in the discharge planning arrangements.
Discharge planning to be started early in the patient journey, preferably on admission.
Everyone working as one team, with one goal.
Early referral to social work
Dedicated social work staff dealing with hospital discharges.
Clear roles and responsibilities.
✓ Discharge Hubs
✓ Dedicated Discharge Managers
✓ Daily Huddles.
People are not assessed for their long-term support needs in an acute environment when at their most vulnerable.
Adopt "Discharge to Assess" ethos.
Commission a dedicated "Transition Team" (H2H) to support people for the first 72 hours.
Use of step-down beds in Intermediate Care, Community Hospitals and supported housing.
Involve the Third Sector
Signposting to alternative support
Strength based assessment and outcomes focused conversations
✓ Red Cross Hospital to Home
✓ "What Matters to You?"
Decisions are made and discharges occur across 7 days
Community services available to start/re-start across 7 days.
Availability of key decision makers.
Criterial led discharge
Timely access to equipment, Pharmacy & transport.
✓ Technology Enabled care
✓ Trusted assessors
There is good communication between professionals and with the patient, family and carer.
Patients, families and carers involvement in the discharge planning arrangements.
"Realistic conversations" – managing expectations & public perceptions.
Use agreed methods for transfer of referral detail.
Adopting robust choice protocols.
Single point of contact / access
Conversations about care homes are avoided
Put the person at the heart of decision making
✓ "What Matters to You?"
There is robust data and a series of indicators by which to measure performance and identify concerns.
Agreed single version of the truth
Importance of accurate coding
Indicators to measure progress
SMART Objectives
Training
Target: proportion of all discharges encountering a delay.
✓ "What Works Tool"
✓ Training videos