



Delayed Discharge - Sustaining the Zero Standard

‘What Works’ : A Self Assessment Tool for Partnerships

May 2009

JIT has developed this short self assessment based on work undertaken to date in supporting health and social care partnerships achieve and sustain the delayed discharge targets /standards. The following are success factors that contribute to effective management of delayed discharge. The list is not exhaustive but reflects collated JIT learning from support to partnerships over the last three years. The self assessment will support the wider work around reducing length of stays and delays under 6 weeks and in short stay specialties and also contribute to the focus required on complex cases/exception codes.

Partnerships should develop an action plan to support key areas identified in the self assessment. Assessment template attached (see Annex A)

Success factors have been grouped as :

- Structure and process
- Policy and Protocols
- Pathways and Interventions
- Practice

JIT is available to provide focused support to Partnerships on delayed discharge along with attention to delayed discharge as part of a wider partnership support programme. <http://www.jitScotland.org.uk/supporting-partnership/work-areas/intensive-support-programme/>

Further information is available on the JIT website www.jitScotland.org.uk
and Delayed Discharge website : <http://www.scotland.gov.uk/Topics/Health/care/17420/8473>

For further information contact	Margaret Whoriskey	margaret.whoriskey@scotland.gsi.gov.uk	0131 244 3365
	Brian Slater	brian.slater@scotland@scotland.gsi.gov.uk	0131 244 3635

Theme and Criteria	Score	Action / comment	Lead
1. Structure and process			
1.1	Referrals to social work are made in line with local protocols and enable early effective discharge planning		
1.2	There is an effective system for ascertainment and monitoring of delays by bed managers / discharge co-ordinators across acute and post acute settings		
1.3	Operational leads from partner agencies meet the above staff weekly to verify, code and problem solve delays Data Definitions Recording Manual - http://www.isdscotland.org/isd/servlet/FileBuffer?namedFile=Revised_data_definitions_recording_manual_Oct07.pdf&pContentDispositionType=inline		
1.4	The multi-agency group works from the same documentation and produces reports that both agencies use for performance management		
1.5	Senior officers with authority to jointly agree and commission tailored care packages meet at least monthly to resolve Code 9 (complex needs) cases		
1.6	There is robust performance management and targeted case management by partnership delayed discharge leads and senior officers		
1.7	Partnership delayed discharge leads have effective links with housing services		
1.8	There is strong clinical leadership from medicine for the elderly and mental health services in discharge planning and managing delayed discharge.		

2.	Policy and Protocols		
2.1	Decisions for new 24 hour care are not made from acute settings		
2.2	There are joint admission, transfer and discharge protocols that clearly state roles, responsibilities and timescales CCD 9/2003 - Framework for the production of joint hospital discharge protocols - http://www.sehd.scot.nhs.uk/publications/CC2003_08.pdf		
2.3	There is joint guidance on 'moving on' and managing choice CCD 8/2003 – Choice of Accommodation: Discharge from Hospital - http://www.sehd.scot.nhs.uk/publications/CC2003_08.pdf Choice of Accommodation : Cross Border Placements - http://www.scotland.gov.uk/library/swsg/index-f/c099.htm		

2.4	<p>There are agreed local standards for the AWI process, underpinned by principles of minimum intervention</p> <p>CEL 11/2008 - Adults with Incapacity (Scotland) Act 2000: Part 5 code of practice - http://www.scotland.gov.uk/Publications/2008/06/13114117/0</p> <p>Adults with Incapacity (Scotland) Act 2000 – A short guide to the Act - http://www.scotland.gov.uk/Publications/2008/03/25120154/0 Code of Practice: For Local Authorities Exercising Functions under the 2000 Act - http://www.scotland.gov.uk/Publications/2008/03/20114619/0 Communication and Assessing Capacity: A guide for social work and healthcare staff - http://www.scotland.gov.uk/Publications/2008/02/01151101/0</p> <p>A number of other guides for practitioners, patients and carers are available from www.scotland.gov.uk/publications (search for 'adults with incapacity')</p>			
2.5	<p>There is an agreed escalation policy that manages up code 9 cases to the appropriate officer level for resolution.</p>			

Theme and Criteria	Score	Action / comment	Lead
3 Pathways and Interventions			
3.1	There is a clear referral pathway for timely access to non complex home care		
3.2	There is rapid access to a range of alternatives for avoidable emergency admissions and a menu of Intermediate care services		
3.3	Telecare resources can be offered to support managing risk		
3.4	There is AHP support for post acute care settings to build on any potential for late improvement in people experiencing delays		
3.5	CPN support is readily accessible to staff in non psychiatric settings including care homes		
3.6	The AWI pathway is mapped and cases proactively reviewed		

Theme and Criteria	Score	Action / comment	Lead
4 Practice			
4.1	Discharge planning extends to GP / Community beds and uses estimated date of discharge (EDD) to inform timing of referrals for care packages		
4.2	Staff know that EDD is distinct from clinically ready for discharge date		
4.3	Information about discharge is available to patients, families and their carers		
4.4	Clinical readiness for discharge is only applied once potential for return home has optimised and is revised as per guidance after a change in clinical condition / plans / new assessments		
4.5	Home care packages are proactively reviewed to create capacity as people improve at home after discharge		
4.6	<p>Choice issues are resolved through timely case conferences and staff are supported by health and social care managers to implement choice guidance</p> <p>CCD 8/2003 – Choice of Accommodation: Discharge from Hospital - http://www.sehd.scot.nhs.uk/publications/CC2003_08.pdf</p>		

<p>4.7</p>	<p>Operational leads make early contact with the delayed discharge leads from the partnership of residence when an out of area patient is delayed</p> <p>Choice of Accommodation: Cross Border Placements - http://www.scotland.gov.uk/library/swsg/index-f/c099.htm</p>			
<p>4.8</p>	<p>Decisions about NHS continuing care are made transparently and in line with CEL 6/2008</p> <p>CEL 6/2008 – NHS Continuing Healthcare - http://www.sehd.scot.nhs.uk/mels/CEL2008_06.pdf</p>			

Annex A

Self Assessment Tool Scoring

Criteria and Position Statements

Not met at all	0
Met in part or met by only some teams or in only some settings across the partnership	1
Met in full but not by all teams or not in all settings across the partnership	2
Met in full across all partnership teams and settings	3