



**Delayed Discharge: Improving Outcomes
Round Table Event
Focus on Older People**

Event Report

18th September 2009

**Barcelo Stirling Highland Hotel, 29 Spittal Street
Stirling FK8 1DU**

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Participating Organisations

- Association of Directors of Social Work
- CHP Association
- AHP Directors of Scotland
- Heads of Clinical Psychology Services
- Information Services Division
- Joint Improvement Team
- Mental Welfare Commission
- N.H.S. Quality Improvement Scotland
- Mental Welfare Commission
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Psychiatry
- Scottish Care
- Scottish Centre for Telehealth
- Scottish Government

Background and Context

This round table event represented one of a series of events organised by the Scottish Government's Joint Improvement Team and Delayed Discharge Unit, following on from 'Delayed Discharge : Supporting A Joined Up Approach', a National round table gathering of representatives from the Scottish Government, Professional Associations, Scottish Education, the NHS and Local Authority organisations held on 2nd October 2007 in Perth.

Related events included a Delayed Discharge Learning and Sharing day at the Inchyra Grange, Polmont and a Delayed Discharge round table event for Under 65s at the Ramada Hotel, Perth held on 26th May and 9th October 2009 respectively.

For most patients following completion of health and social care assessments, the necessary care, support and accommodation arrangements are put in place in the community without any delay in the patient's safe and appropriate discharge from hospital. A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave the hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available to purchase a care home place. 'Delayed discharges' data has been collected nationally since September 2000 according to national standard definitions and data recording criteria. The national definitions allow for a consistent approach to a patient being considered 'ready for discharge' i.e. the patient is clinically ready to move on to the next stage of care. For most Local Authority partners there is an accepted period beyond the clinically ready for discharge date during which all assessment and follow-on arrangements are put in place. The common period for local discharge planning is six weeks. Since April 2004, the main focus of the reported figures from the Information Services Division of NHS National Services Scotland has been on the number of patients who have been waiting more than six weeks for discharge, as at the census date.

In October 2001 there were 2,162 patients delayed across Scotland for longer than 6 weeks. In April 2009, for the second year running, there were none. Is that an accurate picture of the improvements in tackling delayed discharge or a one off each April? Does it take sufficient account of younger people (under 65) and people with specific needs (e.g. learning disability; acquired brain injury; early onset dementia, complex mental health issues). Can we do more? These were some of the questions posed to prospective attendees prior to the round table event.

Particular focus was placed on the event objectives, which included the intention to:

- Review progress with sustaining delayed discharge standards.
- Examine ways to reduce overall lengths of delays.
- Shorten delays under the Adults with Incapacity Act and understand the reasons behind these.
- Identify how to improve the patient's pathways.
- Consider ongoing /emerging issues.
- Take account of interface with continuing care guidance.
- Identify key actions and next steps.

The seminar was organised to facilitate shared learning with a series of short presentations from a range of stakeholders and small group discussions. Consideration was given to taking forward key actions from the event.

Event Programme

- 9.30** **Arrival & Coffee**
- 10:00** **Introduction and Aims of Session**
Margaret Whoriskey ,JIT
- 10:10** **Bigger Picture – Reshaping Services for Older People**
Mike Martin, Deputy Director, Partnership Improvement
and Outcomes Division
- 11:00** **Overview of Current Performance, Trends and Issues**
Brian Slater, Scottish Government
- 11:20** **Adults with Incapacity Act – brief overview of issues**
Donny Lyons Director, Mental Welfare Commission
- 11:30** **Views from the service**
David Findlay, Old Age Psychiatrist, NHS Tayside
Emma Reynish , Geriatrician, NHS Fife
Joe McElholm, Manager of Older Adults and Home Care North
Lanarkshire
- 12:00** **Small group discussion – analysis of issues and priorities**
- 12.45** **Lunch**
- 13.30** **Care Pathways and Reshaping Older People Programme**
Anne Hendry , JIT Associate
- 14.00** **Small Group Discussion - What needs to happen**
- 15.00** **Feedback and agreement on next steps**
Brian Slater and Margaret Whoriskey
- 15.30** **Close**

Introduction, Context and Aims of Session

The event was organised by the Joint Improvement Team to provide an opportunity for local authority, NHS and professional organisations to share experiences that they have in relation to services for older people, in particular, relating to understanding and reducing delayed discharges.

Dr. Margaret Whoriskey welcomed the delegates and outlined the aims of the day which were to:

- Review progress with sustaining delayed discharge standards
- Examine ways to reduce overall lengths of delays
- Consider how to shorten delays under the Adults with Incapacity Act and understand the reasons behind these
- Identify how to improve the patient's pathways
- Consider ongoing /emerging issues
- Take account of interface with continuing care guidance

She also provided background to the JIT's approach to helping local partnerships tackle delayed discharges:

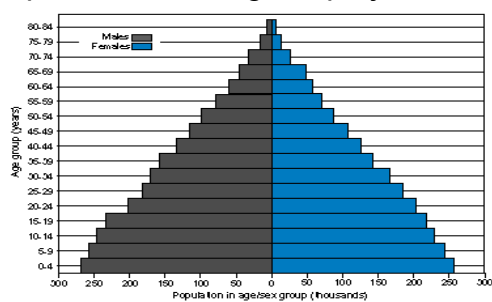
- Support to specific health and social care partnerships – care pathways; procedures; service redesign
- Materials and tools – website
- Contributing to implementation of EDISON
- Contributing to work on complex needs and AWI

Bigger Picture – Reshaping Services for Older People

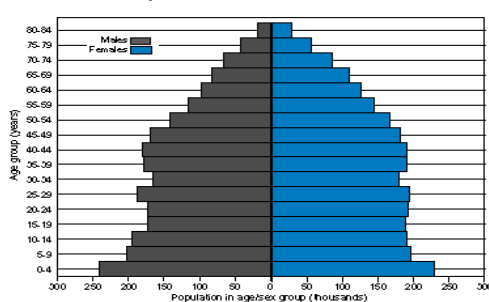
Mike Martin (Deputy Director, Joint Improvement Team)

Changing shape of Scotland's population

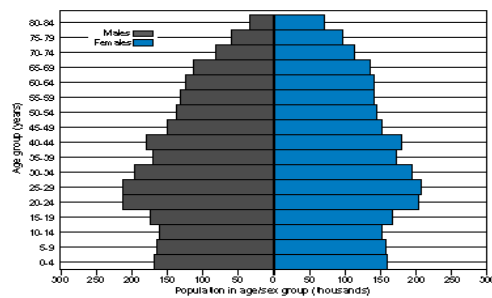
Mike's presentation began by highlighting the changing shape of Scotland's population showing the projections for the future up to 2031:



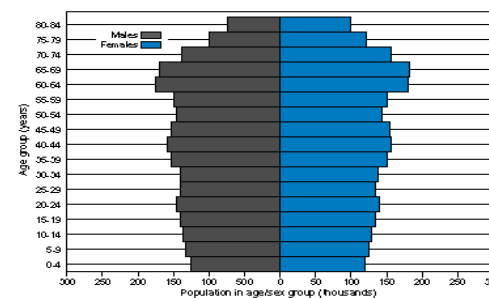
1911



1951



1991



Projection to 2031

Scotland's 65+ populations are projected to rise by 21% from 2006 – 2016 and by 62% to 2031.

For the 85+ age group specifically, a 38% rise is projected by 2016 and by 144% to 2031.

Mike went on to explain the impact this would have on emergency bed numbers for older people, suggesting that by 2031 we would need double the amount of emergency bed numbers. He went on to explain that this would also result in a huge increase in the level of home care provision and care bed homes for community care services.

This would lead to an estimated 74% rise in health and social care expenditure by 2031.

What would this mean for Scotland ...?

- A new 600 bed hospital every 3 years for 20 years
- A new 50 bed care home every 2 weeks for 20 years
- £2.8 billion investment in sheltered housing to “stand still”
- Virtually all school leavers into the care sector by 2030

This would require additional spending of £1 billion over the next 10 years and Mike questioned how that could be achieved when there would be an estimated 8% reduction in public expenditure.

Mike described how services are currently provided and demonstrated how we should start to shift the focus on that provision to meet the demands of the future and outlined the eight work streams looking at Reshaping Care for Older People.

- I. Vision and engagement
- II. Care at home – a mutual care approach
- III. Care homes
- IV. Care pathways
- V. Planning for ageing communities
- VI. Workforce
- VII. Healthy life expectancy
- VIII. Demographics and funding

Mike was clear that this work had to be outcome focused asking the following questions. How well do our services help achieve our policy goals? How can we help people stay out of the formal care system? How can we support self-care? Is it a change of philosophy and approach – support not services? We are doing it now – in pockets – what’s stopping the spread?

Mike highlighted some of the emerging ideas with integrated support across agencies - telehealth, telecare, appropriate rapid response services 24/7, anticipatory care, and re-enablement approach to care in the future.

In light of the projected increase in home care services Mike asked the audience to consider variances across Scotland and also the current and future workforce requirements.

Mike described the programme of events that have been held in relation to reshaping care for older people and the timetable attached to them. He covered the fact that it is not only health and social care services that are important in this work but also the private and voluntary sectors - all working together to influence change for older people in the future.

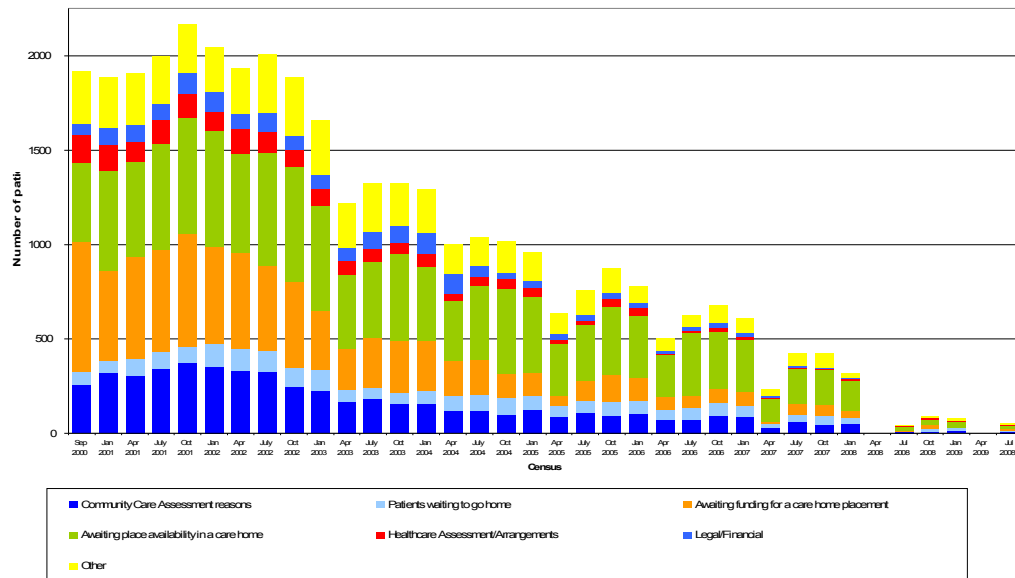
Finally Mike stated that we need to model the costs and the funding options for the size and scope of care services we will need over the next 20 years.

Overview of Current Performance, Trends and Issues

Brian Slater (Scottish Government, Delayed Discharge Policy Manager)

Brian highlighted the performance, trends and issues in relation to delayed discharges.

He began by showing a graph outlining the performance in reducing the number of patients delayed for longer than the agreed 6 week discharge period:



This showed that the expected standard of zero delays had been achieved at the April census in both 2008 and 2009.

He also explained that we had recently started collecting information on the number of NHS continuing care patients in Scotland. This national census also collected data on patients who did not meet the NHS continuing care criteria but who had been in hospital for over 12 months, and who did not have a discharge date referred to in the census as 'category B'.

The census showed that, of those meeting the criteria, 40% were in Psychiatry of Old Age, 37% were in Geriatric Medicine and 12% were in Rehabilitation Medicine.

In Category B 30% were in General Psychiatry, 25% Learning Disability, 20% Forensic Psychiatry and 17% in Psychiatry of Old Age.

Brian then highlighted the patients who were outwith the expected zero standard, due to the complexities involved in their discharge arrangements (code 9s). The July quarterly delayed discharge census showed that those delays, recorded and published separately within the census were:

- Adults with Incapacity (205)
- Choice (79)
- Specialist facility over 65 (8)
- Specialist facility under 65 (18)
- Code 9, no secondary code (20)

In the AWI group Brian explained the issues surrounding some of those patients and the need for a clearer understanding across agencies of how the process should work. He explained that the process should take 12 weeks to complete.

At the July census there were 102 patients delayed longer than 12 weeks going through the AWI process. These patients alone accounted for a staggering 17,472 bed days. This equates to an annual cost to the NHS of around £12 million.

Brian announced that a short life working group was being established to review the processes and systems in place and hopefully produce some guidelines to assist and support boards through what seems to be a problem for some areas. The first meeting of the group would be on 22 October.

Brian finished by reminding the audience of the JIT and Scottish Government web sites which contained a number of tools that have been developed to support partnerships

<http://www.scotland.gov.uk/Topics/Health/care/17420/9205>

<http://www.jitscotland.org.uk/action-areas/delayed-discharge/>

Views from the Service

David Findlay
Old Age Psychiatrist, NHS Tayside

David began by discussing that within Old Age Psychiatry delayed discharge appears to receive less attention than in the acute sector. This is despite a greater proportional impact of each bed day lost on the overall bed numbers, which are lower than in the acute sector. Within Medicine for the Elderly the issue can seem more serious at times especially as the pressure mounts to transfer patients out of general medical beds. Both these services characteristically provide a liaison service to each other with a view to minimising unnecessary transfers or delays due to remediable medical or psychiatric complications.

David's view was that the acute sector, especially in the form of large teaching hospitals, can act as a resource drain on other local services and, paradoxically, this can extend to the provision of liaison input which may be seen as a someone else's responsibility by both the acute hospital and the Community Health Partnership (CHP). David also felt that Shifting the Balance of Care has had variable impact across Scotland and intermediate care or step down options can be particularly deficient in those very urban environments served by large teaching hospitals.

David view was that this was very true in respect of dementia, whether already known or diagnosed. During the admission in question, an effective Old Age Psychiatry liaison service can help minimise unnecessary transfers, unless "boarding" is part of the culture of the hospital, and assist with the behavioural problems which often arise during a prolonged stay in such an unsuitable environment for cognitively impaired individuals. The risks of hospital acquired infection, antipsychotic medication and even inappropriate institutionalisation in a care home mean that rapid discharge home or to a more "homely" setting is best for both the patient and the service.

The above issues are accentuated when someone is waiting in an acute hospital environment for nothing other than the Welfare Guardianship arrangements deemed necessary for transfer to an alternative setting. If Section 13ZA is deemed inappropriate months can pass while a possibly reluctant family, and a solicitor for whom this work may be relatively low priority, pursue an application which could still run foul of a Sheriff on technical grounds. Ironically, given limited knowledge about Adults with Incapacity (AWI) legislation, or interest in at virtually every level until comparatively recently, this protracted stay may not involve use of a Section 47 certificate and care plan. This is despite the location contravening AWI principles in terms of benefit and least restrictive option. David was very strong on this point and felt we must in the future do better, together and across all agencies.

David finished by stating that although we are aware that depression is more common than dementia in older people, and all too prevalent in conjunction with carer burden, little practical use is made of this knowledge in general wards or the care homes to which hospital stays so frequently lead. If the initial option of return home is passed over despite good recovery by the patient from an undercurrent

illness, perhaps because stressed relatives did not previously feel adequately supported, it may well not be possible to retrieve the situation within the general hospital setting. He was very clear that the interaction of a dependency culture and a blame culture can result in significantly risk-averse behaviour, often in the teeth of the patient's stated wishes.

Emma Reynish
Consultant Geriatrician at Victoria Hospital, Kirkcaldy

Emma gave a personal view from a Geriatric Medicine perspective.

She discussed a Research Review on Tackling Delayed Discharge written by the Scottish School of Primary Care in 2004 which highlighted the fact that a combination of individual, medical and organisational factors interact to put people at risk of delayed discharge.

The review identified that older people, those with multiple pathology, and those with some specific conditions (such as neurological deficit and stroke) are most at risk. The evidence indicates that age is the strongest predictor of delayed discharge. 1.3% of patients aged 65 to 69 experienced delays compared with 9.5% of those aged 90 years old and over. (ISD, 2004).

This outlined the fact that frailty and complexity in the organisational structures for treatment and ongoing care and management of discharge were some of the outstanding issues.

Emma then defined frailty in terms of:

Dependency (chronic limitations on activities of daily living (ADL) with one or more of the following domains impaired: - functional, cognitive, social)

Vulnerability ("running on empty") an overall loss of physiological reserves and functional stability

Co-morbidity

This was not based on age or on an acute illness and did not justify acute hospital admission.

She went on to give a scenario of Mr and Mrs Smith. Although treated for osteoporosis, Mrs Smith was healthy, fully independent and was her husband's main carer. She managed all the housework, did the shopping by bus and took over the management of family finances five years ago. Mr Smith was frail with poor mobility. He had diabetes and chronic kidney disease and his memory was fading. He refused help for personal care and was looked after by his wife.

Emma explained how equilibrium could be disturbed, often by a small change in circumstances. In the scenario, Mrs Smith has a fall and fractures her hip. She is admitted to hospital and requires prolonged rehabilitation. Mr Smith is unable to cope at home and is admitted as an emergency to hospital as it is "unsafe to stay at home". The time he spent in hospital increased his frailty. He got confused and wandered. He was dehydrated with worsening Chronic Renal Failure, had a poor

appetite and needed assistance with ADL. Emma was very clear that if admission is necessary then we should aim to treat then discharge as soon as possible.

Emma also spoke at this point of the organisational structures involved and the management, co-ordination and communication required to achieve a safe discharge.

Information sharing was high on Emma's agenda and the lack of formal arrangements for information sharing and the differing and unconnected paper / electronic systems that mean agencies cannot "talk" to each other.

Emma then stated where we should go from here. She felt that we must recognise that delayed discharge is a symptom of demographic trends. There has to be a radical service redesign to meet their needs at home and all of us involved in older people's care must be more proactive not reactive and that we have to improve working between health and social care. Emma's final comment was that acute admission should only be for those with acute medical pathology needing hospitalisation.

**Joe McElholm,
Manager, Older Adult Services, North Lanarkshire Council**

Joe provided a view from the social work service saying there is optimism about future possibilities despite current barriers and frustrations.

He emphasised the need for dialogue around process mapping and change management not only in social services but across our organisations.

Joe then discussed the need for effective efficient resource utilisation by improving our communication strategies thus reducing the need for premature decision making, he was concerned that over prescribing /provision for care home placements and many more things result in a diversion of social work resources.

He emphasised the need for a multidisciplinary team approach, highlighting the need for respect for, and trust in, social work's role and contribution. This would be evidenced by greater sharing of decision making on when safe discharge can be achieved. Joe said we could also evidence this by the development of more joint approaches to rehabilitation during the discharge planning phase, and lastly by improved communication across health interface – e.g. acute/primary nursing, different consultant leads.

Joe then proceeded to discuss risk and the need to build shared approach to risk management, recognising that patient/family are partners in sharing the risk and that greater recognition of that person's functioning in hospital environment may not reflect their coping abilities in a home environment

Joe highlighted that greater awareness of how developments in the community, e.g. assistive technology/overnight services provide new ways of managing risk

Systems Based Approach – Service Redesign: Joe felt this was the way forward and that some of the solutions - alternative models of intermediate care, joint rehabilitation approaches, integrated day services would support a better future for older people. With the shared commitment of practitioners /managers/politicians it is possible to make changes.

Round table group discussion (morning session)

The main themes from the morning discussion groups were:

- No admission to general acute wards for the older person
- Simple /reliable alternatives to admission that were 24/7
- More in-reach services
- No discharge to care homes from acute wards and also to tackle over prescribing of homecare/institutional care through education, rotation and role shadowing opportunities.
- Stop premature decision making, particularly in the acute sector.
- Frailty pathway requires to be developed.
- More anticipatory care
- Empowerment (due to the fact that we have increased expectations)
- Telehealth/Telecare
- Better use of the voluntary sector
- Correct processes and protocols applied to improve patient flow through the system.

Lastly, every group highlighted the need for improved communication and partnership to build trust and manage change together.

Care Pathways and Reshaping Older People Programme

Dr Anne Hendry
JIT Associate

Anne gave a presentation on the current work stream on transforming care pathways to deliver better outcomes and high quality care for frail older people. The focus of the work stream is on frail older people who experience transitions in their care and support needs and require cross system multi-professional and multi-agency response.

This work is evidence based and Anne described the three underpinning principles – quality, value and integration. She said that there were three characteristics of high quality pathways.

- Early identification of older people at risk in the community
- Early intervention to reduce escalation of dependency
- Early effective Management to optimise return home from hospital

Anne then discussed how the group proposed this could be achieved by:

- Delivery of co-ordinated team based care across the sectors
- Enhance outreach of specialist support in community settings
- Streamlining access to services, both in and out of hours.
- Building a workforce capable of enhanced skills and joint working
- Use the telehealth and ehealth solutions that are currently emerging

She outlined the ten improvement actions for complex care identified by the Long Term Conditions Collaborative:

Stratify your population and identify those at High Risk
Target and deliver a proactive Care Management approach
Introduce Anticipatory Care Plans
Communicate and share data across the system
Develop Intermediate Care alternatives to acute hospital care
Provide Telehealth and Telecare support
Develop a falls prevention pathway and services
Provide Pharmaceutical care for older people
Ensure timely access (to flexible homecare and carer support)
Promote mental health and wellbeing in later life

Anne was clear that we had to achieve this by focussing on patient centred care, being holistic in our approach. The implementation of anticipatory care and continuing to be outcome focused to achieve our goals was the future.

Afternoon discussion groups were asked to return with their three priorities on what needs to happen next. The main themes were:

- Early Identification of frail older people at risk
- Risk prediction e.g. Using SPARRA data
- Care Management - Use local community resources more effectively for low-level interventions to create capacity for care management and support for people with complex needs.
- Anticipatory care plans
- Education & training
- Improve read only access to shared assessments in hospital
- Use existing networks across Scotland
- Improve record keeping
- Early intervention that reduces the need for escalation and dependency
- Flexible use of resources
- Do not “Medicalise” everything

- More use of on line /web based systems.

Conclusion

Margaret Whoriskey closed the event by thanking everyone for their attendance and participation. Margaret added that a written report of the event would be prepared and circulated and that the Joint Improvement Team and the Scottish Government would continue to keep the delayed discharge agenda active in their work programmes.

List of Participants / Attendees

Karen	Anderson	NHS Tayside
Michelle	Armour	NHS Highland
Sandra	Auld	Telehealth
Brian	Chapman	British Geriatrics Society
Susan	Connaghan	NHS GGC
Jane	Davidson	JIT Action Group
Jim	Dean	ADSW
David	Findlay	NHS Tayside
Elena	Geddes	Moray Community Health
Janice	Gorman	Aberdeen City Council
Derek	Grant	NHS Grampian
Rob	Harper	Scottish Care
Anne	Hendry	JIT Associate
Marie	Jeffrey	ADSW
Ken	Laidlaw	Clinical Psychology
Alison	Mackay	NHS Highland
Alasdair	Maclullich	Geriatrics Medicine Edinburgh University
Mike	Martin	JIT/ Scottish Government
Peter	Martin	ISD
Bill	Matthewson	Royal College of General Practitioners
Michael	McCue	JIT Action Group
Joe	McElholm	ADSW
Gillian	McReady	Inverclyde Council
Margaret	Meek	NHS Lanarkshire
Caroline	Mitchell	NHS Lanarkshire
Donald	Mowat	NHS Grampian
Douglas	Philips	JIT Action Group
Jillian	Rae	NHS Forth Valley
Emma	Reynish	JIT Action Group
Brian	Slater	Scottish Government
Chris	Sutton	Stirling Council
Margaret	Whoriskey	JIT
Sylvia	Wyatt	Scottish Government