



**Delayed Discharge: Improving Outcomes
Round Table Event
Focus on Adults under 65**

Event Report

9th October 2009

**Ramada Hotel, West Mill Street
Perth PH1 5QP**

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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 Over 65s at the Barcelo Hotel, Stirling held on 26th May and 18th September 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 in relation to people under 65.
- Examine ways to reduce overall lengths of delays.
- Shorten delays under the Adults with Incapacity Act and understand the reasons behind these.
- Shorten delays for people identified as having 'complex' needs and understand the reasons behind these.
- 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, Context and Aims of Session**
Margaret Whoriskey ,JIT
- 10. 15** **Overview of Current Performance, Trends and Issues**

Brian Slater, Scottish Government
Ken Nicolson, ISD
- 10.45** **Views from the service**
Lance Sloan, Consultant Rehabilitation Medicine,
NHS Fife
Lindsay McNair, Head of Profession, Psychology,
NHS Greater Glasgow & Clyde
Liz Taylor, Aberdeen City
- 11.20** **Coffee**
- 11.35** **Feedback on issues and what is working**
Michael McCue, JIT
- 11:45** **Small group discussion – analysis of issues and
priorities**
- 12.45** **Lunch**
- 13.30** **Improving Outcomes – people with complex needs**
Chris Bruce, Scottish Government
- 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

Dr Margaret Whoriskey, Assistant Director of the Joint Improvement Team, opened the event by presenting an introduction to, background, context and aims of the session. She outlined the objectives of the day, highlighting the aspiration to review progress, consider salient issues and identify key actions against improving patient pathways and managing delay in both service responses and discharges.

Margaret continued by informing the attendees of the Joint Improvement Team's programme of service supports and development of related tools and materials in relation to the challenges of delayed discharge. She outlined JIT activity in terms of interface with the implementation of EDISON (Electronic Discharge for Scotland online) and contribution to related workstreams, including complex needs and adults with incapacity.

Margaret provided a focus on context, including a consideration of pivotal factors; related demographic changes, policy and legislation, evidence base, user/carer expectations, an outcomes focus and financial imperatives. She elaborated on the synergy of balance of care 'shift' - upstream - locality - responsibility and the associated reduction in pressure on traditionally over-burdened resources and services. Margaret then addressed 8 areas of improvement related to shifting the balance of care, including increased and improved joint working, maximising responsive services within the home setting and reducing 'unscheduled' admissions whilst also improving the patient's experience and pathway (flow) in episodes of scheduled care.

Against a backdrop of available information/data, and the implications of current demographics and prevalence, Margaret challenged attendees to identify and examine cross care group issues, and consider the support and action required to generate solutions to these challenges and realise the desired future models of care.

Overview of Current Performance, Trends and Issues

Ken Nicolson, Senior Statistician from the Information Services Division opened this session by discussing the findings from the 2nd Balance of Care / Continuing Health Care Census published July 2009.

See : <http://www.isdscotland.org/isd/5907.html>

Ken began by discussing Category A (meeting criteria for NHS Continuing Care) and Category B (did not meet criteria but had been in Hospital for over one year with no set discharge date) statistics. He went on to highlight important issues, including the fact that these statistics represented a 'snapshot' of the current position, that there was an increase in some specialities from 2008 to 2009 due to misunderstanding of the guidance issued, and that there were non-submissions and omissions from some NHS Board areas.

Ken continued by discussing the 399 patients in 2008, and 376 patients in 2009 returns that were Category B and over 18 but under 65 years. He then illustrated a statistical breakdown of these numbers for each of these years, by age group, speciality, length of stay and responsible Health Board area. Ken further illustrated the statistical relationship and comparison of returns from 2008 and 2009 against speciality and age group; median length of stay and age group ; median length of stay and speciality and median length of stay and responsible Health Board area. Ken concluded his presentation by pointing out that further two collections of continuing care data would be analysed from September 2009 and March 2010, and he discussed the prospective changes which might occur with respect to the findings of these statistical returns.

Brian Slater from the Scottish Government continued this session by delivering a presentation on the Delayed Discharges in NHS Scotland, July 2009 census figures. See <http://www.isdscotland.org/isd/6001.html>

Brian presented statistics on delayed discharges from September 2000 to July 2009, and asked if this was what success looked like? He continued by discussing individuals not included in these returns, specifically the Code 9 (excluding Adults With Incapacity) cases. Brian presented detailed information regarding the criteria for this classification and the cost of Code 9 category individuals across care groups and speciality. He highlighted an 'aggregate' cost of almost £7m, additionally pointing out that this total only considers those individuals of Code 9 classification who are aged under 65 years that we do not call delayed discharges. Brian then posed questions around the potential for alternative use of that resource and reasons why we cannot find alternative appropriate care settings for these individuals. Brian then considered whether we were actually counting everyone we should be in these figures. He alluded to the number of patients in hospital for more than a year who did not meet the criteria for NHS Continuing Care and explained we do not have accurate detail of the number of patients awaiting service re-provisioning, going through lengthy discharge planning or receiving services in integrated care beds. He then posed the questions:

- What is the true level ?
- What is the true cost ?

In conclusion, Brian discussed potential areas of redress, including, proactive vs. reactive strategies, whole systems approach to discharge management, early intervention and the prevention of unnecessary admissions. With respect to how we might approach this Brian gave final consideration to the impact of factors including, eligibility criteria, a National Framework, prioritising critical / substantial risk and associated resource factors.

Views from the service

The next session focussed on a series of presentations regarding the occurrence and management of delayed discharges within services and service systems.

Learning Disability Services - Dr. Lindsay McNair, Head of Profession, Psychology, NHS Greater Glasgow and Clyde

Lindsay kindly stepped in at short notice to deliver a verbal presentation regarding the key issues in the presentation and management of delayed discharges within services for adults with a learning disability.

Lindsay began by discussing the challenges to community - based (Tier 3) services with respect to both responsive capacity and competence in dealing with service users' mental health difficulties and challenging behaviours, resulting in pressure to admit to Tier 4 Board-wide In-patient services.

Lindsay discussed the challenge also facing In-patient services in terms of role and function, and this effectively responding to the assessment, treatment and rehabilitative requirements of service users. He continued by discussing a range of factors impacting on delayed discharges and effective/fluid discharge planning systems, including:

- Needs/risk assessment
- Development of care plan
- Identifying appropriate provider
- Any legal processes required
- Identifying property
- Funding by local authority
- Commissioning provider
- Recruiting team
- Training team
- Transition

Lindsay concluded his presentation by considering a range of general issues impacting upon delayed discharge, its prevention and management. These include:

- Complexity of system.
- Lack of system integration (no flow).
- Responsibility for system diffuse (linked to individual 'steps' and shared by key individuals).
- Perceived as 'safer' to have individuals in in-patient services, therefore a reduced motivation by community-based (Tier 3) services to expedite discharge.
- Delayed discharge priority versus competing range of priorities within the community (vulnerability / risk).
- Increased demand and reducing resources.

Rehabilitation Medicine - Dr Lance Sloan, Consultant, Rehabilitation Medicine, NHS Fife

Lance delivered a presentation outlining the perspective on delayed discharges from services for younger physically disabled individuals. He began by discussing the major service issues, including:

- The perception of rehabilitation medicine as a specialty.
- Services likely to have developed locally as opportunity arose.
- There is a significant variance in service provision between NHS Boards.
- Disability/rehabilitation services are not a National priority and are rarely part of the strategic planning of NHS Boards.
- There may be exclusion of relevant data, due to services often not being part of acute care of the elderly services.
- There is usually no discharge co-ordinator appointed, and frequently no social worker attached to the service.

Lance went on to discuss the major issues relative to patients and carers, including:

- Different family/carer needs and aspirations in a younger adult group.
- A person with a disability may have dependants.
- Carer stress.
- Alcohol/drug abuse more likely to be factors.

The presentation then focused on issues specific to discharge:

- The considerable costs of complex case management.
- Protracted debate concerning responsibility for funding.
- The role of the case manager/key worker.
- The limited discharge options for younger patients.
- The requirement for suitable housing or housing adaptation contributing to

delay.

- Care requirements - especially night-time supports.
- The requirement for flexibility of care.

Lance continued with a useful and informative overview of the Fife Rehabilitation Service, including in-patient services, details of current discharge delays and respective length of stay. He concluded his presentation by highlighting that for the financial year 2007-2008, the cost of delayed discharges to Fife Rehabilitation Service amounted to approximately £235k.

As Dr Tom McMillan (University of Glasgow) was unable to attend the event, Lance very kindly stepped in to present an overview of some of the issues around delayed discharges in services for people with Acquired Brain Injury (ABI) in Glasgow, and spoke about a short paper which Tom had forwarded prior to the day. Issues highlighted/discussed included:

- Of the 12 admissions to specialist rehab outside of NHS GG+C in 06-09 around 10% are delayed discharges costing about £2.2k per week
- For those admitted to the RFU in Edinburgh nearer to 50% are delayed (3-4 admissions per year). Delays here average around 12 months at a cost of around £3k per week
- These delays cause a chain effect in terms of moving folk from acute wards into rehab. For example if the average stay for acute is 6 weeks – a delay of 3 months adds 3 individuals to a waiting list that should only be 2 weeks.
- Problems are delays in allocating local social workers, difficulty in finding care home places, and at times funding for these.
- Hopefully, the problem will be eased in part by the opening of the new 25 bedded ABI rehab unit in Springburn in 2 weeks time, (around 21st October 2009) .
- It is hoped to open an enhanced care home for ABI in Glasgow early in 2010 –and the hope is to move people through to supportive living from there when possible (see McMillan TM, Laurie M (2004) ; ‘A survey of traumatic brain injury patients in nursing homes in Greater Glasgow’; Clinical Rehabilitation, 18, 132-138).
- Additionally, we have developed a head injury liaison nurse system – to identify cases needing rehab earlier and prevent so many returning to home without support.
- However, there remains an issue for the small number who are significant financially and require care. There seems to be insufficient allocation of funding for this group meaning that some who could return to the community are delayed in hospital and then revert to care homes.

Adult Social Work Services - Liz Taylor, Aberdeen City Council

Liz began her presentation by using services for people with a learning disability as a vehicle for outlining the challenges of delayed discharge management. She discussed the main ‘header’ challenges of:

- Increasing demand.
- Finite and stretched resources.
- Rising costs.
- Sharing responsibilities through Joint Working.
- The necessity for a Joint response to delayed discharges.

Liz then highlighted and discussed the main challenges associated with service demand, including :

- Demographics and increasing demand for services.
- Increasing complexity of support needs, for example, people with a learning disability who have additional needs related to mental health issues, homelessness, offending behaviour and/or alcohol/drug misuse.
- High expectations of supportive services from service users, families and professionals.

Liz then discussed related resource issues such as:

- No 'continuing care' services.
- No step up / step down resources.
- Needs around continuing rehabilitation.
- Shortfall in accommodation options.
- Timescales for commissioning and guardianship.
- Costs - needs and expectations versus resource transfer/budgets not matching these.

Liz concluded her presentation with a series of slides outlining the key issues challenges and potential facilitators around effective/responsive Joint working and Joint service delivery, with respect to the management of delayed discharges, including:

- Discharge planning and joint responsibilities.
- Realism in service/care planning.
- The balance of good outcomes and budgets.
- Discharge when ready - as a service principle.
- Effective multi-disciplinary working and the Care Programme Approach.
- Partnership in risk sharing.
- Essential Lifestyle planning as a useful tool.
- Ensuring Care Plan integrity through care providers.
- Housing Options Group - needs and resources.
- Significant Risk Advisory (Grampian).
- Joint Commissioning with an outcomes focus.
- Application of Fair Cost Model (Outcomes Logic Model).
- Dynamic approach to resource transfer.
- More innovative living options.
- Total Joint Planning and Joint Management of the 'system'.

Feedback on issues and what is working

Just over two weeks prior to this event, Mr Michael McCue, JIT Action Group member, wrote to thirteen of the event 'attendees' who were identified as having a significant remit around delayed discharges. The content of this communication centred on the following questions relating to same, with the intention of supporting JIT in its aspirations to have the event be as productive, informative and progressive as possible:

- How robust, sensitive and reliable do you consider your own service area (and other) Information systems to be in terms of capturing data on Delayed Discharges?
- How responsive and effective do you consider your own service area (and other) Management systems to be in terms of dealing with Delayed Discharges?
- What do you consider to be the key service issues and challenges in relation to responsiveness to Delayed Discharges?
- What are your own profession - specific contributions to the reporting on, and management of Delayed Discharges?
- Either within, or out-with your own area - are you aware of any examples of good practice/facilitative responses in relation to the reporting on, and management of Delayed Discharges?

In addition to the nine received responses from his short survey, Michael also used other sources for his presentation, including a 2008 Learning Disability Residential Services Beds Report, a 2009 National Conference Presentation on LD beds occupancy and type, and a 2009 Research publication by Perera et al. He then presented the following information:

Local Information Systems on Delayed Discharges

Positives :

- Generally better quality of information
- Better registration of Delayed Discharges
- Better information sharing across service partners

Enduring Issues :

- Classification of Delayed Discharge status
- Disputes around responsibilities
- Requirement for robust systems and active management
- 'zero' returns do not reflect reality of situation at ground level

Local Responsiveness to Delayed Discharges

Positives :

- Some systems are very responsive but require micro management
- Some systems appear effective and flexible
- Some Health systems timeously identifying Delayed Discharges

Enduring Issues :

- Delayed Discharges competing for funding with other service demands
- Delayed Discharges 'masked' by service 'euphemisms'
- Collective agreement on Delayed Discharge status can be slow
- Lack of proactive planning and management

Key Service Issues / Challenges

- Clear Inter-agency definitions and understanding
- Joint Commissioning with clear responsibilities
- Dysfunctional patient outcomes due to delay
- Lack of robust community based service alternatives
- Delays in patient journey - not only discharge
- Training around the CEL 10 Chief Executive guidance for frontline staff
- Delays in allocation of a Social Worker
- Competing demands for care package funding
- Availability of suitable / adapted housing
- Increasing demands against rising costs and finite or reduced funding
- High service user, carer, family and service staff expectations
- Joint service planning and service delivery
- Agreeing desired models of care at a macro level
- Agreeing financial frameworks and budgets
- Hospital closure 'hangover' in LD services
- Analysis of National variations in Delayed Discharge frequencies

Profession-specific contributions

- Documentation of Delayed Discharges and onward referrals
- Maintaining liaison with community-based services
- Screening, reporting and micro-management of Delayed Discharges
- Professional engagement and follow through from in-patient services
- Production / availability of regular data and supportive information
- Funded review of appropriateness of admissions to develop a responsive model of Case Management for individuals who have complex support needs and are at high risk

Good service/practice examples

- Models based on clear definitions and roles (Leeds)
- Planned discharge date given to service user within 48 hours
- Throughput of elderly patients - Acute Medicine for the Elderly Wards (England) NOT 'geriatric' wards
- Local micro-managed systems - resource intensive BUT effective
- Responsible Local Authority given 5 days to provide an appropriate community based care / support package, or meet costs associated with delays (Sweden)
- This concluded Michael's presentation.

Round table group discussion session (morning)

Those attending were invited to form groups to consider the following key tasks:

- Agree key issues and challenges.
- Analyse those issues and challenges within the context of their being client group specific or generic.
- Identify priorities for a 'shared' resolution within:
 - > A local focus
 - > A National focus
 - > A profession-specific focus

Round table group feedback (morning)

Following around one hour of deliberations, a summary of group feedback around **key** issues is as follows ;

GROUP 1

- Need to improve true Partnership working
- Young adult service under-funding
- There is substantial inequity in service access
- Services should be life-long with built-in periodic reviews
- Timescales for discharge planning should be better adhered to
- Develop better 'joint' care pathways between engaged services
- Get better at corporate risk assessment and risk management
- High priority for Commissioning process to be speeded up
- Review processes are also key issues

GROUP 2

- Shared responsibilities around discharge and discharge delays
- Better systems of referral and access to community-based supports
- Better co-ordination of and access to funding - D.L.A. / I.L.F.
- Consider the use of 'semi-formal' contract to expedite discharge
- Improve service 'in-reach' and 'out-reach' capacity of professional care staff
- Need to avoid unnecessary arbitration over assessed care needs
- Need to develop a housing register of existing adapted housing
- Ensure continuous assessment of needs to respond better to changes
- Speed up process of application for, and access to benefits

GROUP 3

- Develop and learn from better models of anticipatory care
- Better early detection and intervention strategies at National and Local service levels
- Better terminology sharing and role understanding between 'integrated' teams
- Need to develop re-ablement systems across all care groups especially older people
- Need to learn better from system inadequacies

GROUP 4

- Lack of sufficient focus at both National and Local levels
- Need to use information more effectively and proactively
- Need to improve access to multi-disciplinary teams to expedite safe discharge
- Need to improve Joint working at all levels and dimensions
- Need to use pooled budgets and Integrated Resource Frameworks

GROUP 5 :

- Shortage of appropriate/fit for purpose housing
- Adapted housing 'lost' to Local Authorities - how to re-establish?
- Improve/speed up access to Health and Social care equipment
- Use resource allocation 'panels' to expedite access
- Make funding approval/access more equitable Nationally

GROUP 6

- Greater transparency in service availability and access eligibility criteria
- Better use of resource transfer in following the patient
- Procure leadership/drive for change at a National level
- Robust reviews of longer term admissions and significant delayed discharges
- Allocate Social Worker earlier in care process

Improving Outcomes – people with complex needs

Chris Bruce, Scottish Government, delivered a presentation on an outcomes approach to community care and the implications of this approach for individuals with complex support requirements. Chris began his presentation by describing a process of putting individual outcomes at the heart of community care by:

- Using assessment, care plans and review to focus on outcomes
- Gathering data from individual interactions
- Presenting outcome data to management
- Investing to deliver personal outcomes

Chris made reference to the Adult Social Care Outcomes Tool (A.S.C.O.T.) and its influence on outcomes approaches, by using a 'top down bottom up' diagram to illustrate the relationships and dynamic between Joint Governance, Joint Management, Frontline Management, Direct Practitioners and people using support/services and their carers. He then used this diagram to illustrate the 'interface' and relationships between these elements and realising improved outcomes through an outcomes framework.

Chris went on to discuss the category of 'complex cases' with respect to their inclusion / exclusion from the delayed discharge census returns. He discussed the category of complex needs ;

- Cases where Partnerships are unable to, for reasons beyond their control, secure a patient's safe, timely and appropriate discharge from Hospital (Code 9)
- Census patients awaiting place or bed availability where no appropriate facilities exist (Code 24DX)

Chris pointed out that, prior to the July 2006 census, these individuals were included in the delayed discharge census totals (ISD definitions). He further emphasised the following ;

- At the July 2009 census, 20 cases were 'complex needs' (no secondary code) compared with 42 cases at the April 2009 census, and 17 cases at the April 2008 census.
- At the July 2009 census, there were 18 people under the age of 65 years awaiting placement availability in specialist residential facilities, where no appropriate facilities exist, compared with 22 at the April 2009 census.
- 10 of these individuals had been delayed for one year or more.

Chris then discussed the Continuing Healthcare census in relation to Category A and Category B patients. He highlighted that the census had collected data on some 3,284 patients, of whom:

- 86% were reported as NHS Continuing Care patients
- 14% did not meet the criteria for NHS Continuing Care classification but

- who have been in hospital for more than one year
- 82% of Category B patients were aged under 65 years
- 30% of all Category B patients were in General Psychiatry
- 25% of all Category B patients were in Learning Disability specialty in-patient beds
- 7 patients (Category B) were in Rehabilitation Medicine

In summary, Chris reported that, at July 2009, around 40 people (under 65 years) were reported as delayed in hospital but excluded from the census count because an appropriate move-on solution could not be found for them. Additionally, at March 2009, some additional 465 people had been in hospital for more than one year, and all were reported as still receiving appropriate treatment or rehabilitation. Chris continued by discussing some outcomes important to people using services in terms of quality of life, process and change. He then discussed delayed discharge in relation to an outcomes approach, pointing out that delayed discharge is one of 3 access measures and one of a total of 16 measures in the Community Care Outcomes Framework and requires to be seen in the round with other themes. See: <http://www.scotland.gov.uk/Topics/Health/care/JointFuture/NationalOutcomes>

Chris talked about the issue of delayed discharge status in specific relation to an outcomes framework. Also what had been achieved to date in relation to the response to delayed discharges, including:

- A 2002 delayed discharge action plan.
- An effective policy, changing the experience of care for over 3000 people at any one point in time .
- Continues to enjoy a high political profile.
- Based on social justice principles - fair treatment for all - hence zero standard.
- 2006 'final push' - decision to exclude complex cases now recorded as 'supplementary items'.

He then discussed what could potentially be achieved in future, including:

- Review reporting on Category B people from Continuing Care census.
- Agree to reduce number of 'complex cases' delayed for more than X months to zero by April 2011.

Chris concluded by discussing the requirements of the application of an outcomes focussed approach to complex cases, including locally funded plans with clear milestones and local Partnership commitment to deliver. In closing, he invited volunteers to sit on a short life working group to consider:

- Complex case reporting - Code 9.
- Non-availability issues - Code 24DX.
- Non - available/inappropriate interim placement (mostly over 65 years of age) - Code 71.

Round table group discussion session (afternoon)

Attendees again broke into small groups for the afternoon workshop session, inviting them to consider both short and longer term actions required to address the delayed discharge issue. Additionally, groups were asked to consider what would make a difference to how delayed discharges were managed locally. Groups 3 & 6 were asked to consider the aforementioned with respect to 'Prevention of Admission' ; groups 1 & 4 with respect to 'Early focus on in-patient episode' and groups 2 & 5 with respect to 'Discharge Planning'. The following feedback was received.

Prevention of Admission

- Outcomes approach in the community
- Using the C.P.A. with a broader group of people in the community
- Strategic planning for population
- National level DD targets for complex care / prevention of admission targets
- Single point of referral for NHS.
- Integrated Community Rehabilitation Teams
- Expansion of role of Primary Care SPARRA etc - more robust anticipatory plans
- Training for generic services regarding A.B.I. etc
- Step up and step down facilities
- Review how Day Hospitals are being used

Early focus on In-patient Episode ;

- Robust systems and processes
- Set goals early
- Joint Care Pathways
- Early Intervention
- Appropriate Social Work involvement
- Single point of contact
- Co-ordinated recording
- Improved options in the community
- Better use of resources
- Most effective location of care pathways
- Role of Liaison Practitioner
- Step down facilities
- Extend anticipatory care plan to include Hospital admission
- Virtual Ward Model
- Care Management across boundaries
- Regional Centres
- Effective liaison/agreement on pathways

Discharge Planning

- Improve communication / information systems
- Early notification to Social Work
- Early assessment, planning meetings EDD etc
- Hospital-based Social Work Discharge planning
- Extend role of Discharge Co-ordinator
- Admission and discharge protocols - link to EDISON
- Pre-admission for electives
- Continuity of placement / care package to facilitate timely discharge
- Discharge Co-ordinator - client group specific
- Outcomes focus to discharge planning
- Discharge planning across in-patient and Community services
- Longer term context - identify anticipatory care needs at outset

What would make a difference ?

- Discharge planning 'Best Practice Guide'
- Targets work - needs focus on individual and outcomes
- Evidence more than just targets
- Ward-based Social Work member of Team
- Training and education
- Communication
- Direct admission to non-acute areas

Feedback and agreement on next steps

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

List of Participants / Attendees

Name	Organisation
Karen Anderson	NHS Tayside
Chris Bruce	Scottish Government
Isla Bisset	Scottish Government
Liz Baikie	LUHT
Joanne Boyle	Edinburgh Council
Jennifer Dodds	Falkirk Council
Jane Davidson	JIT Action Group
Elena Geddes	Moray CHP
Derek Grant	JIT Action Group
Anna Grogan	NHS Forth Valley
Deirdre Gaillie	NHS Forth Valley
Gillian Crosby	Edinburgh Council
Alan Jones	Clinical Psychology
Kirsty Kelly	NHS Lothian
Georgie Madden	NHS Lanarkshire
Andy Martin	East Dunbartonshire
Caroline Mitchell	NHS Lanarkshire
Margaret Meek	NHS Lanarkshire
Wendy McConville	Clinical Effectiveness Facilitator
Michael McCue	JIT Action Group
Lindsay McNair	NHS Greater Glasgow and Clyde
Danny McGuinness	NHS Lothian
Dave MacKenzie	Dundee City Council
Ken Nicolson	ISD
Dr. Robert Prempeh	NHS Forth Valley
Margaret Purcell	GGC
Alison Phimister	NHS Highland
Alison Robertson	NHS Fife
Tommy Stevenson	NES
Stephen Shepherd	
Brian Spence	Scottish Government
Brian Slater	Scottish Government
Lance Sloan	NHS Fife
Dr. Stephen Smith	NHS Lothian
Ben Sutherland	NHS Fife
Chris Sutton	Stirling Council
Liz Taylor	Aberdeen City Council
Patricia Trehan	Argyll and Bute Council
Dr Robert Walley	NHS East and Midlothian Psychology Dept
Edmund Witkowski	NHS Borders
Alasdair Walker	NHS Grampian
Margaret Whoriskey	JIT
Karl Zaczek	JIT