-DELAYED DISCHARGE

Report of the Expert Group

Executive summary

It is acknowledged that delayed discharge is a common problem in most European nations, and one that very few countries have managed to successfully tackle. While delayed discharge can frequently be a very complex issue, if we are to resolve the problem then we need to both unpick and simplify it and view it as a compelling quality and efficiency imperative. It is worth recalling the words of the then Minister for Health, when launching the 2002 Action Plan, who said, "we are making it clear that action should not be motivated merely by beds, budgets and statistics but by the need to provide person-centred solutions to the problem. This is not just an exercise in reducing numbers – it must be about improving lives".

There is evidence and a broad understanding of the type of interventions that can make a difference. The group did not feel it necessary to 'reinvent the wheel' but did want to reinforce the value of some of these initiatives. These are included as a range of reiterated messages throughout the report. More importantly the report attempts to address what is stopping existing initiatives from working to maximum impact.

There is a uniform agreement on the outcome we are trying to achieve – to enable and support people to remain in their own home, as independently as possible, for as long as possible. When this is not possible then we should care for people in as homely a setting as possible. This will seldom be a hospital bed.

While this report reflects on the significant success over the last few years in achieving the zero standard in delayed discharges beyond the agreed 6 week timescale, the expert group is of the view that this achievement obscures the contention that:

- A 6 week delay in nearly all cases of hospital discharge is still too long.
- A focus on the census points, in particular at April, leads to delayed discharges falling at that census point and rising again thereafter.

In view of the above, the expert group is of the view that a radical rethink of performance monitoring is required and that this should take the form of recording and managing reductions in the level of bed days lost to delayed discharge. This is a more accurate whole system measure.

Trends in the Management of Delayed Discharge

Discussions with managers involved in the delayed discharge agenda suggest that whilst a range of codes and explanations may be in use, the cause of delays can be split in to five broad categories which have a degree of interdependency:

<u>Pathways</u> – too many people are admitted to hospital when there could be safe and effective viable alternatives; too many people are moved inappropriately around the

hospital system; too many people remain in hospital because there is a perceived 'risk' in discharging them.

Process - which might include all delays in assessment as well as issues such as Adults with Incapacity. Process delays are compounded by system problems.

Systemic – the patient who is in hospital is considered to be "safe" and ceases to be a cause for concern and focus for community staff who move on to the next crisis, reducing the priority of patient discharge.

Capacity – which would include patients delayed awaiting care home availability (although data suggests this may in some areas be driven by flawed process rather than a local lack of provision), care at home capacity or access to specialist services, such as younger adults with brain injuries.

Resources – There has been a growing rise in the number of patients delayed awaiting funding. However, this has the effect of transferring cost to the NHS where the cost of inpatient care is far greater. This is not a good use of scarce public resources.

Analysis of trends of delayed discharge performance over the last few years also suggests a sixth reason for delays, in the form of target related behaviours. The number of delays tends to peak between census points, suggesting that rather than maintaining a consistent priority position, there is a focus on delayed discharge when a census is in sight. While a target based approach can effectively drive behaviour it is essential we use the right targets.

Success Factors in Managing Delayed Discharge

Notwithstanding the issues raised above, there are a number of positive contributions that can be made to improve delayed discharge performance. Over the years, our understanding of the "whole delayed discharge system" has become increasingly refined, with tools such as EDISON enabling a detailed understanding of the system and process relationships, whilst more accurate use of codes has enabled causal trends to be interrogated in greater detail. This knowledge base combines with emerging evidence that a whole raft of initiatives, from improving communication, to reablement and intermediate care can have a significant impact on delays by reducing avoidable emergency admissions and facilitating discharge.

Previous recommendations, dating back some 10 years from the Delayed Discharge Action Plan, Audit Scotland report and Delivering for Health, remain relevant but have shown only limited impact. These include:

- taking a whole systems approach,
- more co-ordinated rehabilitation encompassing hospital, community and care home based services
- review the funding regime between local authorities and NHS Boards around the care of older people
- develop more support at pre-admission and admission stages
- stronger liaison between NHS and social work emergency services for older people to head off avoidable hospital admission

- introduce discharges at weekend.

If we know what we need to do; then what is it that stops consistent performance against the zero delay target, and what is it that consistently good performers do differently?

There are some key enablers and influencers in terms of modifying behaviours to attain targets and to lever a more sustainable whole system appreciation and addressing of the costs associated with delayed discharge (both personal and systemic).

Delayed Discharge Leads

The over-riding factor in managing both census performance and longer term system change is strong local leadership, interest and expertise in the delayed discharge agenda. Partnerships need to develop local 'leads' for delayed discharge as individuals who are more than an administrative contact point for the Scottish Government. Successful delayed discharge leads tend to be a senior executive within each organisation, reporting to a joint committee or group and often supported by a dedicated individual working in a post which is explicitly empowered to make a difference on behalf of the partnership. They maintain a consistent interest in the agenda throughout the year (not just at census point), and tend to have an expert knowledge of trends and opportunity costs, as well as an in depth knowledge of individuals, the reason for their delay and solutions.

These individuals are in a strong position to challenge issues such as poor discharge planning; ineffective processes; capacity problems; attitudes to risk and tolerance of delayed discharge. Where these individuals are empowered and active they promote a reduced tolerance of delayed discharge and it's causes across the system. They are critical in establishing a foundation for the wider system change that is required by partnerships.

Practical Application

There is evidence to suggest that where good management and leadership is in place, the practical application of "Admission, Transfer and Discharge" protocols will become embedded in practice in such a way as to ensure that staff, patients and families are clear from the outset that remaining inappropriately in hospital, once treatment is complete, is not an option.

Such an approach is critical in ensuring that the 'choice' issue is addressed early in the process in an effective and sensitive manner. However, management of choice also requires robust political and clinical leadership to ensure that patients are not delayed in hospital for anything other than clinical appropriateness.

Culture Change

Sustaining delayed discharge performance beyond the current 'census focus' requires a culture change to one that assumes, where possible, patients should be discharged back from where they came, and without needless delay. It is well

established that even delays for much less than six weeks can be harmful and debilitating. There is an aspiration to achieve such a change in culture and to operate from a default position that patients will, wherever possible and safe, return to the home they were admitted from. This would mean that in most cases community care and support needs should not be assessed in an acute setting and that, unless unavoidable, no-one should move directly from an acute bed to a long-term care home placement. It is expected that the Reshaping Care Change Fund will provide an opportunity to promote such a shift in culture.

Several partnerships have indicated through their Change Plans that they are aiming for large percentage reductions in bed days lost to delayed discharges. This kind of target reflects the level of radical thinking that is required to address this complex issue. Some partnerships are also targeting significant reductions in the volume of patients admitted directly to long-term care home places from the acute sector.

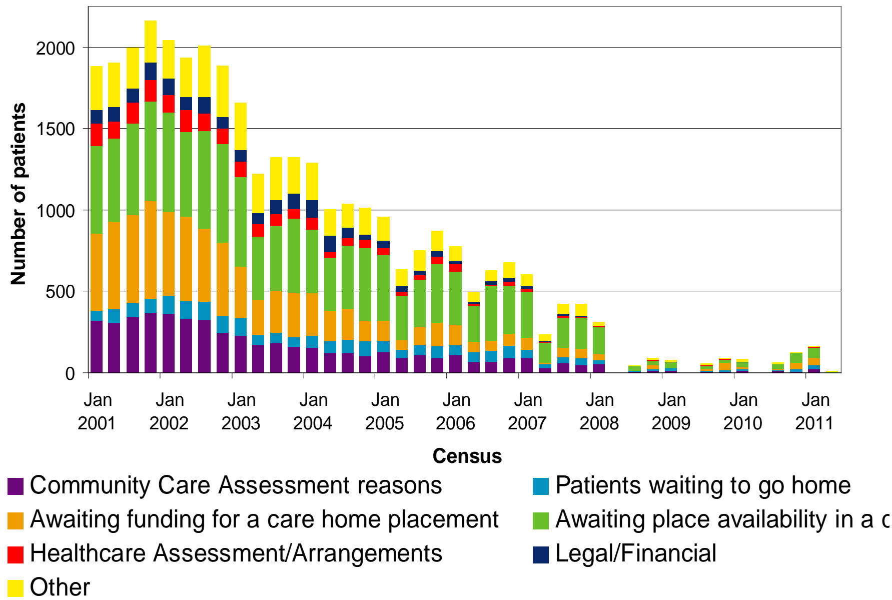
Conclusion

The key to successfully tackling delayed discharge is to develop and empower a cohort of motivated leaders with the skill set to lead the agenda locally, systematically implement the evidence based interventions, manage short term, target related performance, and connect this with longer term sustainable system change through the Change Fund plans. This should be underpinned by a strong performance measurement ethos

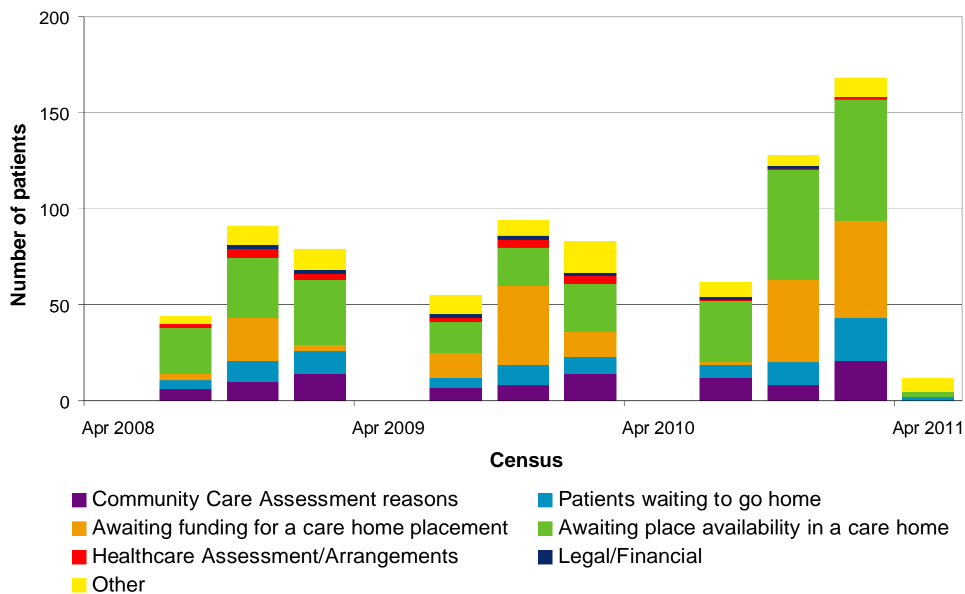
The expert group members agreed that while it is important to maintain a focus on sustaining the current zero target, work should progress to reduce the overall maximum lengths of delay from the current accepted 6 week and move to a target of reducing bed days lost. Indeed many partnership Reshaping Care change plans have set local improvement targets to reduce the overall bed days lost to delayed discharge.

1. Introduction

Significant progress has been made since delayed discharge figures peaked in October 2001. At that time there were 2,162 patients delayed for more than 6 weeks and the average length of delay was 153 days. This compares with April 2011 when 12 patients were delayed for more than 6 weeks and the average delay was 22 days.



The current expected standard to be achieved at all times is that no patient should be delayed for longer than the agreed 6 week discharge planning period. This 'zero standard' on over 6 week delayed discharges was achieved at the April census points in 2008, 2009 and 2010. However since first achieving the zero target in April 2008, the performance has not been sustained at other times of the year.

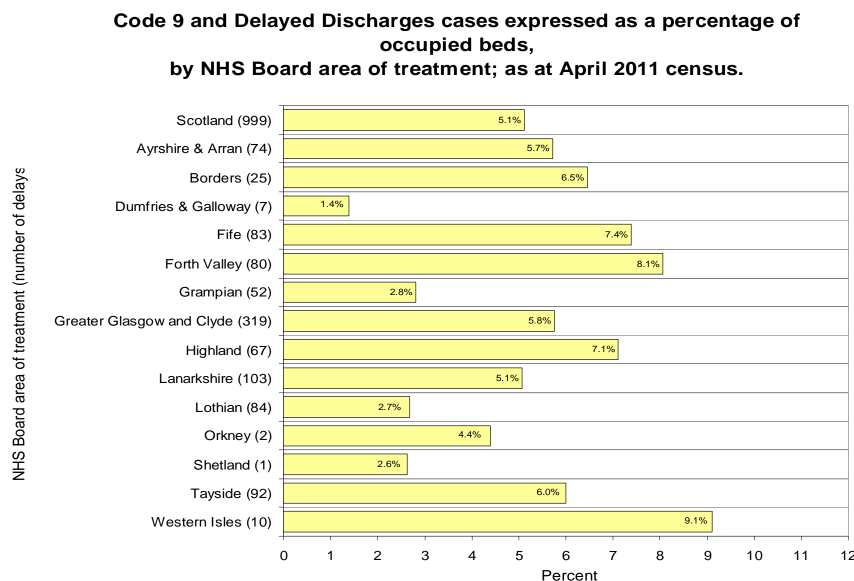


The total number of patients delayed at April 2011 for any duration was 665. More than half of these were awaiting a community care assessment with an average delay of 18 days. Of these, 61 patients were awaiting *commencement* of the assessment process waiting an average 12 days. 188 patients were awaiting a care home place becoming available. 56 patients were waiting to go home (with specialist housing provision accounting for average delays of 42 days) and 38 were awaiting funding. There were 11 cases listed under 'patient/carer/family related reasons' (with the longest average delay of 46 days) of which 8 were exercising their statutory right of choice (which accounted for 7 of the 12 delays over 6 weeks). These reasons are examined in section 14.

3.4% of all occupied hospital beds were occupied by an individual awaiting discharge. To emphasise the scale of the problem in certain areas, the percentage of occupied beds taken up by patients delayed in Fife at the January 2011 census was 13.9% - and this did not include the code 9 patients[1]. The majority of code 9 cases involve guardianship issues under adults with incapacity legislation and this is discussed further at section 14. The complexities involved in the other code 9 cases were investigated by a separate group and their recommendations are listed at annex C.

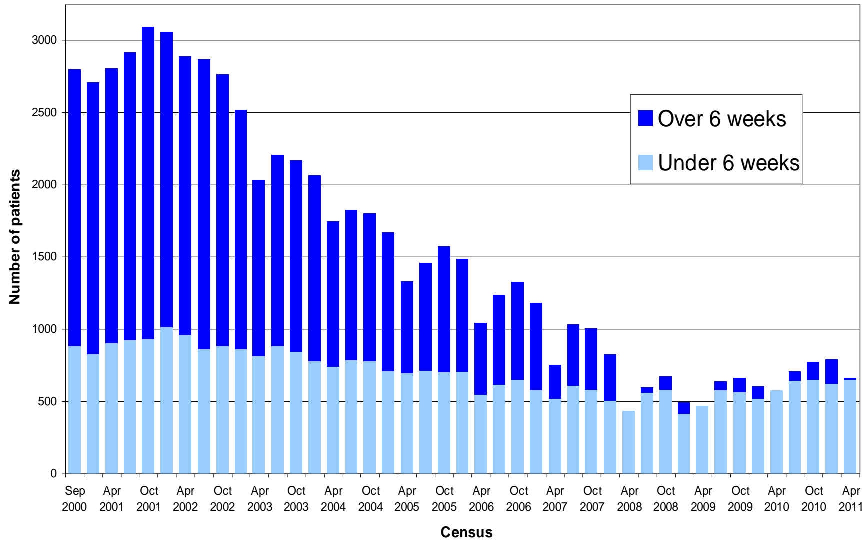
When the code 9 cases are included, the level of occupied beds occupied by a delayed discharge patient increased to 5.1%. In Western Isles nearly one in 10 beds were unavailable. In Greater Glasgow & Clyde this was the case with 319 beds.

Interestingly Dumfries & Galloway, one of only two partnership areas that failed to achieve the expected zero standard at the April 2011 census, has no code 9 cases and is the lowest for number of beds taken up overall by delayed discharges. A partnership that is deemed to have failed the headline target is in fact by another measure the best performer. Measures and targets are discussed in section 7.

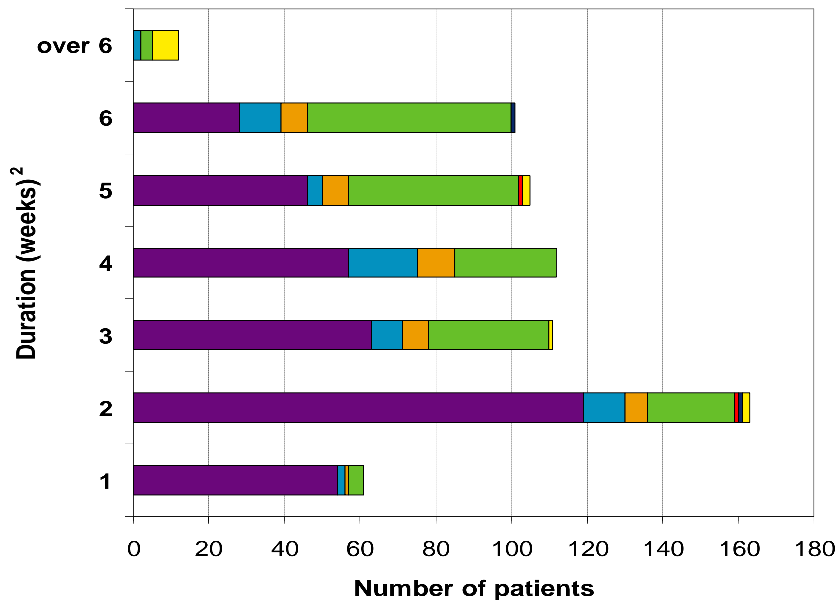


[1] Code 9 cases are where timely discharge is outwith the immediate control of NHS Boards or local authorities – such as guardianship applications being processed or waiting on specialist facilities that do not currently exist.

The following chart makes it clear that while the over 6 week delays have significantly reduced, there has been little progress in the level of delays under 6 weeks. While this may be understandable given the emphasis in tackling the longer delays it cannot be right that discharging a patient on day 43 is a failure while discharging the same patient on day 41 would be deemed a success.



The following chart shows the number of delays broken down by length of delay and by reason:



We need to move away from a perception that 6 weeks is a reasonable period to complete discharge arrangements. This should be the absolute maximum in all cases and should not be exceeded at any time. We consider that in the majority of cases there should be no delay at all and where there are complicating circumstances **a perception needs to be promoted that 2-3 days should be considered a reasonable period for someone to return home.**

2. Background

The national Delayed Discharge Action Plan was issued in March 2002[2]. Backed initially by £20m the early target was to reduce the total number of delays by 1,000 (the rationale being that £20,000 purchased one care package). This target was met with the total (including under 6 weeks) reducing from 3,116 to 2,066. The funding available was increased to £30m from 2003/04 and partnerships were asked to set their own target reductions. Some were more ambitious than others. In April 2004 the total number of delays had reduced to 1,785. The following year, to counter the perceived lack of ambition, Ministers set a target reduction of 20% to reduce the totals delays to 1,428 by April 2005. The actual reduction was 18.1% although the over 6 weeks fell by 28.6%.

Audit Scotland[3] criticised previous methodology as potentially penalising partnerships that performed well whilst leading to less challenging targets for those that did not achieve their targets. Ministers agreed that the 20% reduction targets for April 2006 should therefore be set against April's target outcomes rather than the actual annual outcomes. This effectively meant that the two partnerships who failed to achieve the initial target (Grampian and Greater Glasgow) had to achieve a greater reduction.

This target was achieved across Scotland with a 21.7% reduction in the number of patients delayed over 6 weeks to 498. With an increased focus on the over 6 weeks delays it was agreed that a target that reflected the reality of what we were trying to achieve should be agreed. The zero target was set to be delivered by April 2008, with a 50% reduction to be achieved by April 2007. To make this practical, a new delayed discharge code (code 9) was introduced that excluded from the target arena, delays whose discharge was outwith the immediate control of the NHS or council. These included patients who may require guardianship under Adults with Incapacity legislation or who may require care in specialist facilities that were not in place.

3. What has worked?

Research[4] was carried out in 2004 to look at what had worked in the opening few years of the Action Plan. The report was fairly inconclusive stating that there were a wide range of initiatives, many with a high level of interdependency and that it had been difficult to evaluate and monitor the success of these on their own. It suggested that a whole system approach remained largely an aspiration for most partnerships.

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[2] Delayed Discharge Action Plan, Scottish Executive, March 2002
[3] *Moving On? An Overview of Delayed Discharges in Scotland, Audit Scotland*
[4] A Research review on tackling delayed discharge, Scottish Executive, March 2004

Audit Scotland produced a whole system handbook[5] following work with NHS Tayside, but this has not been adopted. The accompanying report[6] provided a similar message to the research in 2004, that a whole system approach was required.

Since 2005, the Joint Improvement Team (JIT), working closely with local partnerships, has built whole system improvement capacity by developing an Action Group of health and social care practitioners, managers and information experts from across Scotland. A subgroup of the JIT Action Group has worked closely with the policy lead for delayed discharge to identify good practice in preventing delayed discharges and to develop a suite of practical tools[7] to support all partnerships. These include the Delayed Discharge: What Works guidance; a pathway audit tool; an evaluation framework; guidance on moving on and managing AWI; and a good practice template[8] for developing discharge protocols (issued in October 2009). Other related improvement support includes the JIT work programmes on Intermediate Care, reablement and telecare.

In addition to providing this general improvement support, the JIT regularly responds to requests for intensive, focused support to help partnerships to tackle local delayed discharge problems. This has successfully been undertaken in several partnerships through a 'critical friend' approach, described by one partnership in an independent evaluation[9] as 'the invitation to bring the JIT in was to get effectively some independent facilitation, direction, coaching, mentoring into all that we were doing, and also to try and learn from good practice that was happening in other places, whose performance was evidently a lot better than ours.'

The JIT and policy leads collaborate to support and facilitate Delayed Discharge Learning and Sharing events[10] which have proved a popular and effective way of sharing good practice. Events are usually attended by about 120 health and social care practitioners. In addition to the specific issues addressed at each event these have helped practitioners get to know each other and enabled collaborative problem solving.

Another proven success has been where partnerships have shown clear local leadership and ownership of the problem. This can be at several levels – senior executives (and elected members) in health boards and councils who have authority and can hold those charged with delivery responsible; an accountable joint Committee to oversee actions; or a single, authorised officer with responsibility to deliver.

In addition, it is generally accepted that target setting has been successful and has focussed minds and that access to the additional funding has also been beneficial. This report will develop these themes and examine if any can be taken further or re-invigorated.

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[5] Moving on?
[6] Audit Scotland
[7] JIT tools
[8] Good practice guide: admission, transfer and discharge protocols
[9] JIT Expert Review
[10] Learning & Sharing

4. Other UK nations

Comparisons have often been made with the situation in England. However, in England only delays in the acute sector are counted. Excluded from the statistics are intermediate care beds, rehabilitation, continuing care and other GP/nurse led beds. They do not include delays of patients moving from one acute bed to another, even if these beds are in a different Trust. Also excluded from the data are maternity, psychiatry and learning disabilities facilities. Direct and relevant comparisons are not therefore possible.

In England, under the Community Care (Delayed Discharges) Act, there is a financial obligation for local authorities to reimburse NHS Acute Trusts if arrangements for social care services are the only reason for delay in discharge. In introducing the system local authorities were provided with very significant additional funding which could either be used to address the delayed discharge problems or "pay the fines" where these measures failed.

Over the initial 6 month period to March 2004, there was a reported 25% reduction in acute delayed discharges. Despite this, there is no clarity as to the specific reasons behind the immediate reduction and there were complaints from organisations representing service users and carers as to the appropriateness, volume and quality of the community services provided on discharge. Indications are that since the early reductions in 2004 the numbers have levelled out. Recent reports stated that the problem was escalating in England.

The new Westminster coalition government recently introduced a revision to the operating framework for the NHS in England[11] which made hospitals responsible for on-going care of patients for 30 days after discharge. The aim of this is to encourage reablement and post-discharge support and prevent avoidable readmissions by withholding tariff payments when this occurs. Increased rates of readmission might have been a side effect of the introduction of reimbursement.

The Department of Health recently updated its guidelines on delayed discharge with a focus on intermediate care.[12] It had previously commissioned an academic study of the differences in approach between England and Scotland[13] (known as the 'Jigsaw report') which highlighted that both had achieved some success but neither had yet successfully addressed whole system change. Part of the methodology used by the researchers was to follow up care of discharged patients. This effectively highlighted the human cost of the problem.

The Welsh Assembly Government has visited Scotland on several occasions to learn from partnerships here as to how to tackle delayed discharges and are still in contact asking for advice on specific issues. The range and level of the problem in Wales is broadly similar to Scotland.

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[11] Revision to the operating framework for the NHS in England, DoH (page 12)
[12] Ready to go? DoH, march 2010
[13] Reimbursement in practice, University of Leeds, January 2008

The Welsh Assembly Government has produced a useful guide[14] to delayed discharge. In addition the Wales Audit Office has undertaken several studies[15] into the cause of the problem in Wales.

Performance in Northern Ireland has often been held up as exemplary. A member of the group visited Belfast to discuss the issues with them. While there is much to admire – and a single, unified health and social care system might help alleviate many of the issues – it is again difficult to make comparisons because of the different data collected. In Northern Ireland delays are only counted from acute hospitals, indeed a list of only 17 hospitals. Mental health and learning disability specialties are excluded.

However, there are very tight targets to be achieved[16].

- 90% of patients with continuing complex care needs will be discharged from an acute setting within 48 hours of being medically fit, and no complex discharge will take longer than seven days – in all cases with appropriate community support.

A discharge is defined as complex when it can only take place following the implementation of significant (7 hours +) home based or other community based service (including residential or nursing home services).

- All other patients will be discharged from hospital within six hours of being declared medically fit.

This includes all patients involving reactivation of an existing care package, the need for non complex care packages, or equipment provision.

These targets are generally achieved with a compliance rate of around 95%. However, most patients are transferred to intermediate care beds or post-acute settings at which point there is no on-going data collected on the patients. In other words the vast majority of delays in Scotland would not be registered in Northern Ireland.

5. Policy ambition

Despite the excellent achievements each April it is estimated that delayed discharges still use up an estimated 219,000 bed days. This does not take account of the cost of code 9 delays. It is clear therefore that delayed discharge remains a serious problem and one that will be exacerbated by future financial difficulties.

Unnecessary time spent in hospital can lead to a significant deterioration in a person's physical and mental health, with a potential loss of independence. This in turn will lead to a greater use of institutional care, at a higher cost to local authorities.

[14] Passing the Baton, Welsh Assembly Government
[15] Wales Audit Office
[16] Northern Ireland codes

The risk of becoming a delayed discharge increases when a patient is admitted as an emergency, and the longer the delay the greater the chance of dependency and institutionalisation. The admission itself is therefore expensive, and its outcome may be too – in financial and human terms - if eventual discharge is to a care home setting in circumstances where greater support upstream might have helped to prevent an avoidable admission, at lower cost. Unplanned admissions can be avoided with better integrated community health and social care services and if local clinicians and the ambulance service can be provided with safe and effective alternatives to emergency admission. The challenge for local and national professional and political leadership is the public perception of disinvestment in the NHS, albeit in the face of investing upstream.

Significant reductions to delayed discharges and avoidable admissions have been proposed as part of discussions around the impact of the spending review. This will require resources to be invested in 'step-up' and 'step-down' services. Current work on the Integrated Resource Framework should have established the totality of the resource across the whole system on older people's services. Each local partnership should therefore have an awareness of the total envelope available across the spectrum of services. It is within these resources that money should move from secondary care to primary and community care, with investment in intermediate care, reablement home care services, anticipatory care and telehealthcare along with longer term health improvement measures.

There are over 500,000 emergency hospital admissions per year. Taking a percentage of those that will be over 75, it is then estimated that 80% of those will involve routine discharge with 20% requiring social work involvement. If social care budgets reduce by 15% then an equivalent increase in the non-routine discharges could lead to numbers over 6 weeks increasing at a rate of 60 per week. This will quickly lead to severe difficulties for both health and social care systems at significant financial and human cost.

There could also be an impact on care home providers. Given that in some areas around 70% of care home admissions come from an acute hospital there could be a significant reduction in care home placements. We are aware that several providers are dependent on complex revolving credit arrangements so any income reduction will jeopardise the liquidity and viability of some major national providers.

The immediate policy goal is therefore to re-achieve and sustain the zero standard over 6 weeks. In the future it is proposed that improvements will move us closer to an aspiration to have delays of days rather than weeks.

6. Change Fund

Ministers and COSLA leaders agreed that pooled budgets should be established within all partnerships to focus on shifting the balance of care for older people from institutional to primary and community care settings. A 'change fund' of £70 million was allocated centrally in 2011/12 towards these budgets to cover double running costs in the first year. Local change plans[17] have been agreed locally that should

[17] Local change plans

deliver redesigned services aimed at reducing avoidable admissions and further reductions in delayed discharges.

7. Targets

The group was asked to look at targets, whether to retain the current zero standard at 6 weeks, reduce the period to 5/4/3/2 weeks or move to a different method of measuring delayed discharge. It was also asked whether to return the Adults with Incapacity delays and other code 9 cases to the target arena.

When the zero target was set several patients were excluded (code 9). There is a feeling that this has resulted in this cohort no longer being under the spotlight. A separate short-life working group has been exploring the reasons behind these delays. This group looked at whether there would be merit in returning this cohort to the target arena. It decided, reluctantly, that this would not be possible due to the variety of complexities involved. **However, the group felt that the code 9 cases needed more robust challenging and should be kept under regular review with much more focus.** Further recommendations from the short-life working group are attached at annex C along with a list of members of that group.

In terms of measurement, **the group recommends that a zero target and subsequent standard remain fit for purpose. However, a more appropriate measure to assess partnership performance would be 'bed days lost'** (the days between the 'ready for discharge' date and the actual date of discharge on an accumulated basis) This represents the opportunity cost of having an individual remain in hospital when another setting would be more appropriate. It would provide a truer picture of the cost of delayed discharges in both financial and personal outcomes.

17 of 32 partnerships included 'bed days lost' as a measure for improvement within their change plans. Local change plans produced a range of trajectories to reduce these. Many merely plan to make reductions without quantifying these, others aim to reduce them by between 10% and 50% in the first year with further reductions in future years.

Some partnerships aim to include all delays, others do not include the code 9 cases currently excluded from the zero standard. There is a strong argument for each – including all delays shows the real affect on the hospital system; in addition in all these cases we are talking about patients who no longer require to be in hospital. However, the code 9 cases by definition are those that are outwith the control of the partnership and it would seem perverse to therefore hold them to account for these. There would be benefit for both to be measured, one total to include all accumulated bed days with a second removing the code 9 delays.

Targets have undoubtedly helped in the past, as discussed in section 2. Had ambitious targets not been set in the past then it is unlikely that the progress we have seen would have been achieved. **If we move to a measure of bed days lost then Ministers and Council Leaders will want to consider whether to ask local partnerships to set their own trajectories or work to a percentage reduction.**

Some local systems will be better established to make reductions than others but may not show sufficient ambition in setting trajectories that are readily achievable rather than challenging and more desirable. COSLA is keen that a national system of benchmarking should be adopted, where success is defined by the best performing partnerships.

Ministers and Council Leaders will also wish to consider whether to retain the existing zero six week standard and whether 6 weeks is still the correct absolute maximum period in which discharge arrangements should take place. The group discussed at length the merits of reducing the 6 week discharge planning period. There was a common view that in the majority of cases this would be beneficial. However, in some limited cases patients are being asked to make life changing decisions, involving choosing a setting that will likely be their home for the rest of their lives. In order to offer their statutory rights of choice of accommodation, fully involve families in the process and make the necessary financial arrangements, the group felt that the full 6 week period was sometimes needed, noting that staying in an acute bed was wholly inappropriate during this period.

It is vital that patients' care does not suffer because of the targets established. The reason for having targets and the underpinning policy behind achieving them is that no-one should stay in a hospital bed once treatment is complete. Care must be taken to avoid rushing patients through the system in order to free up beds. Having a 'zero' target may have the unwanted effect of discharging patients too early which might not be in the patient's best interest and could lead to emergency re-admission. No patient should be discharged before they are clinically ready and it is safe and appropriate to do so.

Conversely any target to achieve zero over a set number of weeks can lead to this becoming the norm rather than the maximum. As mentioned in section 1 it cannot be acceptable that discharge on day 41 is acceptable as long as it is not one day longer. Any move to 4 weeks might similarly mean that discharge on day 27 is acceptable but discharge on day 29 is not. **A culture and behaviour change is required so that any delay for a day longer than is necessary is deemed unacceptable and that the norm should be discharge within hours and days rather than weeks.**

The group generally felt that a case could be made for establishing a zero standard at a reduced number of weeks. In the first instance, noting the proviso above that some patients may need longer, it was felt that a move to reducing all delays to a maximum of 4 weeks would be a step in the right direction.

Maximum timescales should be agreed locally for various scenarios – commencement and completion of assessment, discharge home (including provision of equipment and adaptations), choosing and moving to a care home, accessing funding, dispute resolution). These scenarios are examined further in section 14.

Steps will need to be taken to ensure there are no perverse side effects to these timescales. While it is reasonable to think that a patient should be discharged to their own home with only minor equipment and/or care needs within two days, we need to

be careful that missing that timescale does not lead to an assumption that the patient can no longer go home leading to inappropriate admission to institutional care.

8. Data / Information

A mandatory national data recording system was introduced in 2000. Information is collected and published on a quarterly basis by ISD Scotland[18].

One of the major causes of over 6 weeks delays recently has been awaiting funding for a care home place. Statistics suggest that care home places were available in most of the country. In discussion, the Expert Group suggested the reasons there were so many patients delayed awaiting a care home place included funding, choice and a lack of Elderly Mentally Infirm (EMI) beds. However, there are codes for all of these that are separate from availability codes. These are available on page 22 of the Definitions and Data Recording Manual[19] .

Having the correct data is the intelligence that partners need to solve the problem. The Group recommends that codes are applied more rigorously so that there is an accurate snapshot picture at each census.

NHS Tayside developed software to capture data on all patients delayed, involving both health and social work input to track the pathways of delayed patients. This system was initially purchased by the partnerships in Fife and Ayrshire & Arran and following approaches from other partnerships was rolled out across Scotland in 2009. The system, EDISON, is now hosted by ATOS Origin and work has been ongoing to advance the reporting elements. The full system should be available to go live in the summer incorporating a Business Objects reporting function. This will improve the 'real-time' information available to partners, which in turn will allow more accurate and up to date information to be supplied as part of NHS Boards situation reports during the winter months, provided to Ministers under winter planning arrangements.

More importantly it will enable better sharing of information between partners to speed up assessment and discharge planning.

EDISON will also be important in collecting information on accumulated bed days lost to delayed discharge. The quality and accuracy of the data collected by ISD for the quarterly census is the envy of other nations. Indeed, the Welsh Assembly Government has based its data collection on the census in Scotland. If we are to move to different performance measures consideration will need to be given to quality assurance of data and ensure we do not lose the integrity that the quarterly census has.

EDISON should be further developed to provide accurate collection of data on 'bed days lost'.

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[18] ISD Scotland, Delayed Discharge Section

[19] Definitions and Data Recording Manual, ISD/Scottish Government, July 2010

The input and updating of data to the system must be accurate and timely so that ad hoc reports may be available to answer a range of queries that may arise.

The group discussed other datasets that should inform the delayed discharge agenda and what in addition would be useful. Some partnerships had good information about patients admitted to hospital and the group felt that **more rigorous data about flow between hospital and care homes was required**. This might establish how many patients are transferred directly to a care home from an acute setting and how many people are admitted to hospital from a care home, particularly a home with nursing care provided.

A range of information provided through the inspection regimes and the Integrated Resource Framework were discussed. The group felt that this provided a wealth of information and examples of variation that would be useful for partnerships to discuss at a local level. Much of this has now been provided as part of the materials provided for work on change plans but it is worth re-emphasising that **partnerships should make the best use of data, including their IRF mapping, to examine and explore causes of variation.**

9. Leadership/ownership

Successful partnerships in the past have always shown strong leadership. There is usually a steering group to oversee progress, chaired at Director level. There has also been success when day to day management has been in the hands of a single, empowered individual. A contrasting view is that this can lead to delayed discharges being seen as one person's responsibility rather than everyone's. However, it should be possible to do both with a named person ensuring others' involvement.

Many areas had a single empowered lead, co-ordinating discharges with the knowledge and authority to challenge decisions. In some areas this person also had a budget with which to directly purchase short-term care. This person would be responsible for collating the delayed discharge lists, maintain oversight of the codes, analyse intelligence, work with managers to resolve blockages, brief Chief Executives, Leaders and Chairs, and be the contact point with the Scottish Government. The person should be empowered to deal with problems, have the requisite authority, and accompanying budget where possible.

This post should be supported by a good administrator with overall responsibility for information requirements, including oversight of information systems to ensure the accurate collection and updating of data.

It will be equally important that local authority elected members and NHS Board members take a key leadership role and that a designated member becomes a 'champion' in driving delayed discharge performance.

The group recommends that leadership of the delayed discharge agenda should be improved at several levels.

In order to create a consistent approach the individual lead officers from each partnership should be brought together for a dedicated training day, co-ordinated by the Scottish Government and involving the Joint Improvement Team. This training should take on the principles outlined in this report and ensure that all areas are driven by the same aims. This should also help achieve the culture change required to discharge people in days rather than weeks. The lead officers should address the recommendations in this report but also, recognising that many pockets of good practice exist, learn from each other. Attendance from every partnership will therefore be important.

The Scottish Government and JIT should facilitate a dedicated learning session at a venue accessible to all.

10. Resources

Reduced funding available for community care may to lead to reduced home care budgets and reduced care home budgets. This reduction in services in the community will mean fewer packages available for people coming out of hospital leading to an increase in delayed discharges. It is also possible that less community provision will mean more people being referred for hospital admission – at a time when there will be fewer beds available because of the delayed discharges. Elective procedures may be cancelled leading to an inability of the NHS to meet waiting times targets.

The Delayed Discharge Action Plan suggested in 2002 that "a review of the funding regime between local authorities and NHS Boards around the care of older people needs to be undertaken to consolidate and accelerate the joint future agenda". The Multi Agency Inspection reports also highlighted the need for a better understanding and use of resources for older people. The Integrated Resource Framework has moved this forward but many barriers still remain to integrated budgets.

Costing work had been carried out as part of the IRF mapping process in Highland, Grampian and Orkney to calculate the cost of delayed discharges. The IRF team and ISD are working with NHS Tayside initially to further develop this exercise. If this is successful the central team will be able to provide this for every partnership.

11. Preventing admissions/Reducing re-admissions

In order to reduce delayed discharges it is widely accepted that the 'front-door' issues need to be addressed as well as the 'back-door'. Ways of preventing avoidable admission must be explored. Small levels of care can prevent expensive hospital care and subsequently more expensive social care. However, identifying those in need and providing care and support can be difficult given constraints of the current eligibility criteria – ie care needs at the pre-hospital pathway stage are unlikely to be deemed critical.

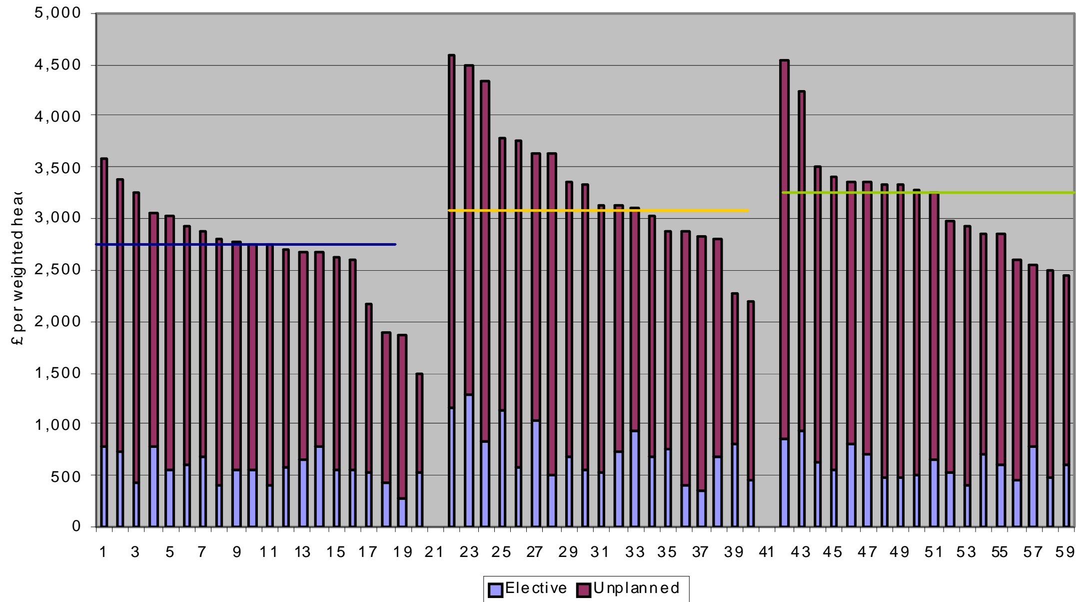
The Delayed Discharge Action Plan recommended that "local authority/NHS partnerships need to develop more support at pre-admission and admission stage, and stronger liaison between NHS and social work emergency services for older people to head off avoidable hospital admission".

The Department of Health in England has also published a report on prevention and early intervention[20]. An Action Plan for Long Term Conditions[21] published in 2009 and work is also ongoing in Scotland to reduce avoidable unscheduled admissions[22]. The group did not want to replicate this work but did want to emphasise the importance of tackling the 'front door' as well as the exit. However we would highlight existing things that are being done and the emerging evidence of impact on 65+ emergency bed day rates :

- Increasing access to integrated community based urgent care systems, in hours and out of hours. This requires acute clinicians, SAS and NHS24 to work even more closely together with primary care and social care partners.
- Improving access to information, which informs people about what health and social care services are available locally. This will help ensure that they access the most appropriate services and receive the most appropriate care.
- Agreeing care plans with patients, carers and extended community teams that will anticipate crises and avoid some A&E attendance/admissions particularly for those with long term conditions and those who are in the last year of life. Measures could include home physiological monitoring and remote Telehealth and Telecare support.
- Identifying and targeting those people who are at risk of admission, and providing appropriate information, support and proactive, coordinated care for them in the community.
- Providing 'intermediate' care responses to prevent admission, managing more people locally and speeding up discharge.
- Increasing the capacity of emergency response teams using non medical practitioners where appropriate e.g. See and Treat teams.
- Developing care pathways across health and social care systems with the help of Scottish Ambulance Service and NHS24, to help ensure that only people who need specialist care are taken to acute hospitals.
- Delivering better pharmaceutical care to help increase concordance and avoid the effects of poly pharmacy.

Particular emphasis should be given to tacking the high level of admissions from care homes. Geriatricians, GPs, community nurses, community mental health teams and palliative care services should work with care home providers to assist with training and improving procedures.

[20] Improving care and saving money, DoH, January 2010
[21] Long Tern Conditions: A National Action Plan June 2009
[22] Unscheduled care



This chart shows weighted per capita expenditure for people aged 75+ for all admissions from practices across three CHPs in one partnership, including a split between elective and unplanned admissions.

The data is for 2008/09, and material variation is evident across the CHPs and between practices within CHPs. If all practices above the first quartile could attain first quartile performance (£2702/capita) there would be a saving of £11.2m across the Health Board.

Also striking is the proportion of the total per capita cost that is driven by unplanned admissions; of the total £88m, 78% is due to unplanned admissions.

- **Partnerships should use variation to challenge differing practice.**
- **Alternatives to hospital admission must be developed and accessible to GPs.**
- **Full use should be made of appropriate step-up facilities including community hospitals to avoid admission to acute hospitals.**
- **A ‘gatekeeping’ function should be established at A&E with the ethos of ‘decide to admit’ rather than ‘admit to decide’. This could be primary care based teams with a knowledge of community options that could triage and manage risk.**
- **Better use should be made of Day Hospitals and 23 hour beds.**
- **Links should be improved between acute hospitals, NHS24 and SAS.**
- **Risk prediction and case / care management should be further developed.**
- **Intermediate care options, including ‘virtual wards’ and specialist integrated community teams should be explored.**
- **The use and sharing of Anticipatory Care Plans should be expanded.**

12. Patient pathway

Older people can often end up with a lengthy delay because of inappropriate 'signposting' on admission. While admission to an acute medical unit will mean immediate access to clinical staff and rapid diagnosis, these units can increase length of stay, risk of delirium and probability of becoming a delayed discharge. Early involvement of a geriatrician and targeted flow to a geriatric assessment unit can avoid these outcomes.

Delays during medical assessment and treatment remain largely unquantified. Anecdotal evidence suggests that older people can stay on wards awaiting specialist intervention or moves to an appropriate ward for diagnostics or rehabilitation.

In Northern Ireland all in-patients should have a discharge focussed treatment plan within 24 hours of admission which should include an Estimated Date of Discharge.

- **Early application of frailty screening criteria should prompt early flow to specialist geriatric teams when required.**
- **Estimated Date of Discharge (EDD) should be routinely set.**
- **Although ultimately for the clinician in charge, clinical readiness for discharge should be a MDT decision.**

The Joint Improvement Team has designed a tool to review whether the patient's journey and discharge could have been improved. In addition, the Long Term Conditions Collaborative has developed a number of improvement actions for people with complex needs that is more widely appropriate. These can be found at http://www.jitscotland.org.uk/action-areas/delayed-discharge/

13. Protocols/Processes/Communication

Local protocols have been required to be in place since the issue of circular CCD9/2003[23]. These are not routinely followed and in many cases have not been updated to take account of new policy initiatives or changes in legislation.

Protocols should be refreshed where necessary – to form Admission, Transfer & Discharge Protocols. These should be working documents, audited on a regular basis. Compliance should be checked and EDISON would appear to be an appropriate system for doing this.

Some ward staff have advised that they were unaware of protocols - it would be useful to provide dedicated training in order to raise awareness. Indeed, poor communication was identified as a recurring theme throughout the group's deliberations. This included between agencies and teams and with patients and carers.

Awareness training should be provided when protocols are re-launched.
Flowcharts should be updated or developed as part of revised protocols. These should be available and displayed in wards.

[23] Framework for the Production of Joint Hospital Discharges, January 2004

Good communication should be a pre-requisite for co-ordinating a patient's journey, none more so than around the discharge process. Poor communication can lead to unrealistic expectations that patients can remain indefinitely in hospital. A leaflet explaining what a patient may expect in hospital should also specify what should be their own responsibilities.

Communication should be improved with patient/families/carers including managing expectations. The role of consultant medical staff is key in regards to setting post-treatment care.

In addition, communication between health and social work, and between social work and housing and the independent sector can be poor. Technology should not replace personal contact - EDISON should therefore not be relied upon as the tool to alert social work to the possible care needs of individuals.

There have also been several lengthy delays where the patient's local authority of residence is outwith the Board area of the hospital of treatment. In such cases, where there may be on-going care needs, it is important that immediate contact is made with both the local authority of residence and also the lead officer at the individual's local NHS Board.

Communication between agencies needs to be better.

Several partnerships use discharge lounges in larger acute hospitals where patients can be collected. These can only function efficiently with co-operation from pharmacy and transport services.

In Northern Ireland, nurse led discharge has been introduced to ensure an increased rate of discharge over the weekends and public holidays.

These sort of initiatives work in some areas but not in others. The group did not want to be prescriptive in what should be adopted and felt that this should be left to local decision. However, initiatives such as these should be considered and where appropriate locally incorporated in to discharge planning procedures and outlined within the protocols.

14. Delayed discharge by reasons

The group considered the range of reasons for delays at the January 2011 census, when there were 790 delayed discharges, 168 over 6 weeks.

Waiting for assessment – 387 in total, 21 had waited more than 6 weeks for the process to be completed.

More than half of all delays were going through the community care assessment process. Patients who are delayed under three days are not included in the census so all of these patients are already three days past being clinically ready for discharge.

Assessment should start as early as possible in the patient's journey, preferably on admission to hospital or pre-admission where applicable. It should involve all necessary disciplines, be person-centred, make provision for risk assessment and fully involve families and carers, including an assessment of their needs.

In some cases patients were being assessed for their long-term needs in an acute bed at which point the patient will be at their most dependent with a likely outcome of the assessment being a high level of care needs. Although recognising that for some people an immediate assessment that will result in further institutional care is the proper course of action, where possible, an assessment should be carried out in an individual's own home or step-down facility to best gauge what they can cope with and what they need help with. This would fit with the reablement approach of maximising independence and quality of life for service users. Where it is not possible to assess in a person's home then this should be done in as homely setting as possible, taking account of the need to carry out the assessment in a timely manner. The longer someone waits for an assessment increases the risk of their needs becoming greater.

Patients should not have their long term care needs assessed in an acute bed unless unavoidable and appropriate due to the clear levels of future care required.
The default position should be that the patient is discharged to the accommodation they occupied prior to admission. Only if this is not possible should alternatives be investigated.

In that regard, the group supported the reshaping care 'Programme for Change'[24] and repeat the aspiration in full:

"We will ensure older people are not admitted directly to long term institutional care from an acute hospital. Currently too many older people are discharged from hospital to a care home at a time when their confidence is low following an acute illness. The presumption should always be that an older person will be discharged to their home or, where their needs make this inappropriate, we will promote intermediate care. We will also ensure that all community care assessments are completed at home or in an intermediate care setting."

Waiting more than 6 weeks for the assessment to take place is totally unacceptable. Each case would need to be seen on its merits but in general assessment should commence and be completed within days. The group felt that reasonable (maximum) timescales for assessment were commencement within 48 hours and completion within 5 days for routine cases and 14 days for non-routine cases. While there was no appetite to set national timescales the group felt that local protocols should set out agreed maximum timescales, with local audit to ensure the maximum does not become the norm.

Timescales for each stage of the assessment process should be agreed

The result of an assessment is often pre-judged. In some cases patients have been referred for 'an assessment for a care home" pre-supposing that a care home will be

[24] Reshaping Care for Older People: A Programme for Change 2011-2021

the outcome. In other cases, medical staff have informed a patient that they will be moving to a care home thereby influencing the final decision for social care professionals. It is important that all people involved in the assessment process, and the wider discharge process, start from the presumption that the patient will return home.

For simple homecare requirements and minor equipment provision it may be appropriate to allow for a system of self-assessment that would allow immediate discharge without social work assessment staff involvement.

Where appropriate a form of self-assessment should be introduced.

An interim, quick and easy, assessment should be developed that can be undertaken by any appropriate member of the MDT.

Awaiting funding – 83 patients were awaiting funding for a care home place, 51 over 6 weeks. There were no patients recorded as waiting for funding for any other care package.

It is expected that, if coded appropriately, the number of patients awaiting funding will increase. This is not an effective use of the public pound, given the differences in cost of care in a hospital and a care home.

Use the information available through the IRF mapping to establish the true cost of delayed discharge. The IRF mechanisms should be used to make better use of joint resources.

Place availability – In addition to the funding issue, 195 patients were waiting for a care home place becoming available, 63 over 6 weeks (a further 9 were delayed under choice, 7 over 6 weeks, so effectively also waiting for a place). Statistics have regularly shown that care homes run at a 10% vacancy rate.

There are areas of the country where availability is limited, or where places are only available at a rate far higher than the National Care Home Contract (NCHC) rateoutwith the rate the local authority is willing to pay. There are also areas where capacity is limited for lengthy periods because of a moratorium on placements due to ongoing SCSWIS investigations. Some people have told us that these investigations are taking longer than needed or that the moratorium is not lifted once improvements have been made.

It might also be that some people are assessed as needing a care home because of the length of delay or inappropriate pathway through hospital. There is, as mentioned earlier, anecdotal evidence that suggests a mind set of ‘assessing for a care home’ rather than a default position of someone going home. It has also been suggested that ward staff sow the seeds of the necessity for a care home move too early in the process. Data shows huge variance in the level of care home capacity, care home placements and lengths of stay. The group felt that better quality of information was needed to properly inform the appropriateness of care home placements. This would be needed in order for partnerships to effectively plan future capacity requirements.

Collect information on whether people are appropriately in care homes – using IoRN/SCRUGS[25] methodologies – to include length of stay data broken down by local authority, care home.

While the SCRUGS data suggest there is a high percentage of care home residents with relatively low levels of need, there is also a number with extremely high levels**.** It is important therefore that people with highly complex needs whose needs might only be met with on-going specialist clinical care are not placed in care homes without an assessment for eligibility to NHS Continuing Healthcare.

Promote a better understanding of NHS continuing healthcare eligibility[26].

Care home providers have indicated a willingness through their involvement in the reshaping care programme to redesign their services to take shorter term residents. This could be providing more intermediate care services, step-up and step-down care.

COSLA is currently undertaking a review of the National Care Home Contract. It is clear that the current contract does not deliver the flexibility of responses that local authorities and Health Boards will increasingly need from voluntary and private sector care providers into the future. We are therefore working towards a future contract and service specification that provides a stronger sense of the outcomes we want to drive, and the pathways we want to exist at the interface of health and social care.

Part of that work will involve the development of service specifications to prevent hospital admission and facilitate hospital discharge. Our aspiration is to encourage specialisation within the residential sector so that care homes can accommodate emergency admissions (as an alternative to A&E) and rapid discharges (where a return home is not possible in the short term). In respect of the latter, our work will look at a number of issues, including how to incentivise care homes to provide a rehabilitation service, such that the care home does not become a final destination but a stop-off point on a care journey which leads back home.

Where a local partnership has identified a local need for residential step-down care, dedicated care home places could be identified and developed to provide specialised rehabilitative care. This will be developed within the context of a revised National Care Home Contract. COSLA and care home providers will advance this work with a range of partners including ADSW, Scottish Government, and NHS Scotland.

Several partnerships have advised that a very high percentage of care home admissions are direct from an acute hospital. The group agreed that this should not occur unless assessed as appropriate for the individual patient.

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[25] SCRUGS/IoRN/Care home staffing project

[26] Guidance on NHS Continuing Healthcare, CEL 6 (2008)

Patients should not be admitted directly from an acute setting to a long-term stay in a care home, unless unavoidable and appropriate.

Guidance on equipment & adaptations[27] refers to equipment being made available free of charge for a period of 4 weeks (page 54). This should not therefore be a reason for delay.

Avoid inappropriate care home placements by improving enhanced home care, improved rapid response services, equipment and adaptation provision. Adopt a reablement approach and start this within hospital.

Waiting to go home – 102 in total, 22 over 6 weeks. These include equipment provision, housing adaptations, procurement, home care packages. Housing adaptations account for the longest delays with an average of 56 days.

Having agreed that the intention is to care for as many people at home as possible, then a housing related delay must be tackled to avoid the person losing the required skills to function at home This could lead to entry to long-term institutional care at great cost to the individual's quality of life and also in terms of longer term costs to the local authority.

In many areas, appropriately trained NHS staff can order health and social care equipment directly from joint stores. However, the wait for major housing adaptations and re-housing remain an issue. Anecdotal evidence suggests that patients who could be discharged home or to an interim setting are not being discharged as they may lose priority for the adaptation or re-housing.

In some areas a care package is removed after a set period of days (which differs from 10-28 days). If arrangements are not in place within that period it can build in another lengthy unnecessary delay as another assessment takes place and an alternative care package is put together. However, extending this period may lead to homecare services becoming less productive.

Agree local timescales for cancellation of existing care packages, which might be based on improved use of EDD.

Some partnerships have a policy where homecare can be purchased directly by NHS staff. In some cases this is limited (up to 14 hours per week in one partnership) and in others there is no limit. The latter could lead to unregulated spend (and overspend) in local authority home care budgets. However, it would appear to be a practice that can speed up discharge considerably and the risks of abandoning it will inevitably lead to further delays. A compromise might be to continue to allow NHS staff the option of commissioning services but build in a review period after an agreed number of days. This might mean information being made available to patients clearly stating they will be entitled to x for y number of days/weeks after which it will be reviewed or withdrawn.

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[27] Guidance on the provision of equipment and adaptations

There should be local agreement on direct purchase of home care by ward staff with set timelines and built in review process.

Delays for housing reasons are few but can involve the longest waits. Dedicated intermediate care beds would be a better solution that waiting in an acute ward, although other more homely interim settings should be investigated. The improvements in telecare and telehealth should enable more people to remain in their own homes but these need to be supported by a good response service.

A major constraint was the lack of suitable housing – both housing with care and mainstream housing of the right size and type – which makes it very important that housing colleagues are engaged at delayed discharge and capacity planning fora.

In cases where someone cannot be discharged home because their house is no longer suitable they might be considered ‘homeless’ and get priority for a social rented property.

Better engagement with housing is needed.

Healthcare delays – only accounted for 8 delays at January, one over 6 weeks. In some cases this is due to arrangements not being in place in others it is a lack of NHS beds due to blocks down the line. However, there is the possibility that these increase as numbers increase causing blockages in the acute sector.

Legal/financial, Disagreements, Patient reasons – 12 in total, 9 over 6 weeks. Choice is the main reason. Code 71X is increasingly being used where the rurality of interim moves is not the issue – eg consultants saying an interim move is not in the interests of the patient. Increasingly, consultants are saying an interim move will adversely impact on the patient yet they experience multiple moves within the hospital while waiting for the single choice of care home. This cannot be good for the patient. If an interim move is of genuine risk to a patient the consultant and MDT should seriously consider whether a patient is actually clinically safe to discharge. If not, they should not be on the delayed discharge list.

Some partnerships have said that the code will either be 71X or place availability leaving code 71 redundant. However, code 71 should be used where the principal reason is the patient exercising their statutory right of choice. Three choices of care homes should be identified and if these are not going to be available then a move to another care home that can meet the assessed needs of the individual should be managed. This is an emotive issue but the 6 week timescale should be ample to complete it if the process is started early and is managed sensitively, with good information to, and regular contact with, the patient and families.

The choice policy should be reinvigorated at a local level with senior ownership among health and social care executives and medical practitioners. A national message that a patient does not have the right to remain indefinitely in hospital would be helpful.

In cases of disagreement some will be between agencies. Others will be while finances of a possible self-funder are examined.

In cases of disagreement, the patient should be discharged while resolution is sought.

Short-stay delays – 87 in January and not achieved at April either. 48 patients were delayed waiting for an assessment, and a very lengthy delay was waiting for housing adaptations.

Improve use of intermediate care as step-down.

As discussed earlier this could be provided in care home settings. Also as discussed earlier, patients should not be assessed for long-term needs in an acute setting nor should they move directly from an acute bed to a long-term care home placement.

Adults with Incapacity – 181 at January, which was unusually low. However, 45 were delayed longer than 6 months, with one more than a year. The process should not take more than 3 months but at January 62% of the total had waited longer than that. In terms of occupied bed days lost, this is where the real problem lies.

New guidelines[28] issued last year following progress in Lothian where revised processes led to the following reductions between 2008 and 2009:

- 75 patients delayed down to 60
- 7275 bed days down to 4719
- Average length of delay down from 97 days to 79 days

Some areas have a particular problem with AwI delays. There is a reluctance in some areas for social work teams to use the powers under section 13ZA of the Social Work Act, with the alternative being to pursue lengthy guardianship orders. Once down that route there can be lengthy process delays and several blocks, including a shortage of Mental Health Officers and overtly time consuming procedures which have to be followed. Guardianship is not a high priority for the legal profession and there are few solicitors specialising in this area, which can often involve actions for legal aid. The legal system can be bureaucratic and one small glitch might mean the whole process having to be started again.

Two things could ease the problem. An increase in the use of s13ZA would undoubtedly help but that is really a matter for local Social Work Departments. An increase in the number of people applying for Power of Attorneys would make the biggest difference. A lack of capacity does not only become an issue following hospital admission, yet it is once they have entered hospital that difficulties arise with concerns around deprivation of liberty. This can mean someone who lacks capacity cannot be placed in a care home setting, although it will be the most appropriate setting.. These actions are outwith the scope of the delayed discharge expert group to influence, so merely highlight the controversies involved and suggest that these should not be beyond solving. **It is recommended that a dedicated group be established to look at where the blockages in the process are occurring and**

[28] Good practice guides: patients who may lack capacity

work with colleagues in health, social care and the justice system to improve the situation.

The group did feel that if guardianship was required there were a number of unnecessary delays within the process. However, such process intricacies should be able to be worked through and a fresh look at these may assist. One way of doing this might be for **partnerships experiencing difficulties with AwI to invite support through the Joint Improvement Team which has recently recruited people with expertise in this issue drawn from successful partnerships.**

15. Learning/Training/Good Practice

Operational staff have commented on the large amount of sharing good practice that occurs. There now exists a network of staff inter-connecting with each other to exchange ideas and discuss solutions to unusual scenarios. This has developed from the bi-annual learning and sharing events that were held over a number of years. There has not been a dedicated delayed discharge event since 2009. The group did not feel that it was necessary to reinstate the regularity of these given the informal network that has grown out of them. In addition, there were now well attended Reshaping Care Improvement Network events.. However, with a national framework on intermediate care due to be completed in the autumn and with the changes proposed within this report to be discussed widely it is recommended that **an Improvement Network event be held in October and have a dedicated focus on delayed discharge / intermediate care.** This should include early lessons arising out of the change plan proposals.

All the change plans are available on the JIT website. It would seem logical for good practice arising from these to also be promoted via the website.

As mentioned earlier, the informal network of delayed discharge expertise was welcome. This could be further developed under a programme of job shadowing so that staff from one partnership could spend time working in another partnerships so that different work practices could be shared.

Recommendations

Targets and Measurement

A zero target and subsequent standard remain fit for purpose. However, a more appropriate measure to assess partnership performance would be 'bed days lost'.

If we move to a measure of bed days lost then Ministers and Council Leaders will want to consider whether to ask local partnerships to set their own trajectories or whether to impose a percentage reduction.

Ministers and Council Leaders will also wish to consider whether to retain the existing zero six week standard and whether 6 weeks is still the correct absolute maximum period in which discharge arrangements should take place.

Maximum timescales should be agreed locally for various scenarios – commencement and completion of assessment, discharge home (including provision of equipment and adaptations), choosing and moving to a care home, accessing funding, dispute resolution).

Timescales for each stage of the assessment process should be agreed.

Process

A culture and behaviour change is required so that any delay for a day longer than is necessary is deemed unacceptable and that the norm should be discharge within hours and days rather than weeks.

A perception should be promoted that 2-3 days be considered a reasonable period for someone to return home.

Patients should not have their long term care needs assessed in an acute bed unless unavoidable and appropriate due to the clear levels of future care required.

The default position should be that the patient is discharged to the accommodation they occupied prior to admission. Only if this is not possible should alternatives be investigated.

Patient should not be admitted directly from an acute setting to a long-term stay in a care home, unless unavoidable and appropriate.

Leadership of the delayed discharge agenda should be improved at several levels.

The code 9 cases needed more robust challenging and should be kept under regular review with much more focus.

Alternatives to hospital admission must be developed and accessible to GPs.

Full use should be made of appropriate step-up facilities including community hospitals to avoid admission to acute hospitals.

A ‘gatekeeping’ function should be established at A&E with the ethos of ‘decide to admit’ rather than ‘admit to decide’. This could be primary care based teams with a knowledge of community options that could triage and manage risk.

Better use should be made of Day Hospitals and 23 hour beds.

Links should be improved between acute hospitals, NHS24 and SAS.

Risk prediction and case / care management should be further developed.

Intermediate care options, including ‘virtual wards’ and specialist integrated community teams should be explored.

The use and sharing of Anticipatory Care Plans should be expanded.

Early application of frailty screening criteria should prompt early flow to specialist geriatric teams when required.

Estimated Date of Discharge (EDD) should be routinely set.

Although ultimately for the clinician in charge, clinical readiness for discharge should be a MDT decision.

Where appropriate a form of self-assessment should be introduced.

An interim, quick and easy, assessment should be developed that can be undertaken by any appropriate member of the MDT.

Where a local partnership has identified a local need for residential intermediate care, dedicated care homes could be identified and developed as hubs to provide this. This might provide everyone with the opportunity for recovery, rehabilitation and reablement before confirming long-term care home requirement.

Avoid inappropriate care home placements by improving enhanced home care, improved rapid response services, equipment and adaptation provision.

Adopt a reablement approach and start this within hospital.

Agree local timescales for cancellation of existing care packages, which might be based on improved use of EDD.

There should be local agreement on direct purchase of home care by ward staff with set timelines and built in review process.

Better engagement with housing is needed.

The choice policy should be reinvigorated at a local level with senior ownership among health and social care executives and medical practitioners.

A national message that a patient does not have the right to remain indefinitely in hospital would be helpful.

In cases of disagreement, the patient should be discharged while resolution is sought.

Improve use of intermediate care as step-down.

A dedicated group be established to look at where the blockages in the guardianship process are occurring and work with colleagues in health, social care and the justice system to improve the situation.

Partnerships experiencing difficulties with AwI to invite support through the Joint Improvement Team which has recently recruited people with expertise in this issue drawn from successful partnerships.

Information

Having the correct data is the intelligence that partners need to solve the problem. Codes should be applied more rigorously so that there is an accurate snapshot picture at each census.

EDISON should be further developed to provide accurate collection of data on 'bed days lost'.

The input and updating of data to the system must be accurate and timely so that ad hoc reports may be available to answer a range of queries that may arise.

More rigorous data about flow between hospital and care homes is required.

Partnerships should make the best use of data, including their IRF mapping, to examine and explore causes of variation.

Partnerships should use variation to challenge differing practice.

Use the information available through the IRF mapping to establish the true cost of delayed discharge. The IRF mechanisms should be used to make better use of joint resources.

Collect information on whether people are appropriately in care homes – using IoRN/SCRUGS methodologies – to include length of stay data broken down by local authority, care home.

Communication

Protocols should be refreshed where necessary – to form Admission, Transfer & Discharge Protocols. These should be working documents, audited on a regular basis. Compliance should be checked and EDISON would appear to be an appropriate system for doing this.

Flowcharts should be updated or developed as part of revised protocols. These should be available and displayed in wards.

Communication should be improved with patient/families/carers including managing expectations. The role of consultant medical staff is key in regards to setting post-treatment care.

Communication between agencies needs to be better.

Promote a better understanding of NHS continuing healthcare eligibility.

Learning and Training

The Scottish Government and JIT should facilitate a dedicated learning session in the autumn at a venue accessible to all.

Awareness training should be provided when protocols are relaunched.

An Improvement Network event be held in October and have a dedicated focus on delayed discharge / intermediate care .

Key Principles

- Strong leadership and ownership of the agenda is needed at all levels across organisations.
- Partnerships must take a person-centred approach to tackling the delayed discharge problem, a year round problem and not just one at census time.
- Hospital admissions should be avoided where appropriate and effective discharge facilitated by a 'whole system approach' to assessment processes and the provision of services in the community.
- Active participation of patients and their carers is central to the delivery of care and discharge planning.
- Discharge is a process and not an isolated event. It has to be planned from the point of admission (or before) ensuring that patients and their carers understand and are able to contribute to care planning decisions as appropriate.
- The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the 'patient journey'.
- Staff should work within a framework of integrated multi-disciplinary and multi-agency team working to manage all aspects of the discharge process.
- Effective use should be made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately and individuals achieve their optimal outcome. Going home should be adopted as the default position.

- Acute hospitals are unlikely to be the optimum settings for assessing someone's long term care needs.

Delayed Discharge Expert Group - Membership

Peter Gabbitas (Chair) holds a joint post as Director of Health and Social Care at NHS Lothian and City of Edinburgh Council

Brian Slater is the policy lead for delayed discharge at the Scottish Government

Ron Culley is the health and wellbeing lead at COSLA

Dr Sheena MacDonald, is a Senior Medical Advisor at the Scottish Government. She is also a GP in the Borders

Simon Steer, NHS Highland/The Highland Council is on secondment part time to the Scottish Government to lead on the Integrated Resource Framework

Stan Smith, is an Associate with the Joint Improvement Team

Representing NHS Chief Executives
Rosemary Lyness, Director of Acute Hospital Services at NHS Lanarkshire/
Roy Garscadden, Planning Manager, NHS Lanarkshire

Representing SOLACE
Colin Mackenzie, Chief Executive, Aberdeenshire Council

Representing NHS Management
Liz Moore, Healthcare Director, NHS Ayrshire & Arran

Anne Harkness, Director of Rehabilitation and Assessment, NHS Greater Glasgow & Clyde

George Cunningham, CHP General Manager**,** NHS Fife

Representing ADSW
John Gilruth, Acting Head of Community Care, Perth & Kinross Council

David Crawford, Executive Director of Social Care Services, Glasgow City Council

Harry Stevenson, Executive Director of Social Work Resources, South Lanarkshire Council

Representing British Geriatric Society
Dr Brendan Martin. Consultant Geriatrician, NHS Lanarkshire

Representing Association of CHPs
Bill Nicoll, General Manager, Perth & Kinross CHP

Representing Allied Health Professionals
Karen Anderson, AHP Manager, NHS Tayside

Annex C

Short life working group on Complex delays

Recommendations for Health and Social Care Partnerships and the Scottish Government

Recommendations for local partnerships

Partnership commitment to minimising delayed discharge

1. NHS Boards and local authorities are already working together as partnerships to minimise delays in discharge from hospitals. However there are a number of patients delayed who are excluded from the standard of "zero delays" because they fall into the category of complex cases.

Focus on individual outcomes

2. Consider the personal outcomes for patients delayed in hospital and excluded from the count of delayed discharges because they are "complex". This may involve a refreshed local process for establishing and improving personal outcomes for each of these patients, and reviewing progress with this.

Identify which individuals are affected

3. Consider the various sources of information available to them, including the delayed discharge census, the continuing care census (particularly patients in Category B, resident in hospital for more than one year) and the Royal College of Psychiatrists' learning disability survey, and review their reporting of complex delays in order to be explicit and consistent about who is included. (It may be anticipated that there will be an increase in the reported numbers of complex delays across Scotland as a result of this action)

Monitor performance against target timescales

4. Develop, agree and set local measures and targets that reflect people's particular needs, for example Autism, Acquired Brain Injury or Forensic issues for reducing the length and number of complex delays in the local area. No national targets are proposed for this group – but transparent and explicit reporting is now in place through the reporting of Code 9 delays through ISD, so progress can be tracked at an individual, local, and national level. Local targets might be set for each complex/excluded delay coding group - and should be embedded as part of joint capacity and commissioning plans.

5. Use EDISON to record and monitor the individual progress of these complex cases through the use of appropriate coding.

Improve systems to optimise flow

6. Develop transparent joint funding arrangements and implement these quickly and consistently to facilitate timely discharge.

7. Review and improve where necessary the local systems for reducing the length and number of complex delays in local hospitals.

8. It will be important to prepare and support individuals through transition from children's services to adult services, and/or from adult to older people services, which may result in delays in transfers of care. Policy and practice will vary from one local area to the next but transition is a known factor in many complex delay cases.

Compare performance with others

9. Consider the benefits locally of taking part in peer visits to other partnerships to bring a constructive challenge and review to each local complex delay system. Facilitation for these visits may be available through the Joint Improvement Team.

Recommendations for national implementation

Scottish Government should work with NHS Scotland Information Services Division, NHS Boards and local authority partners to

10. Raise the profile of Complex Case Delays by taking an annual report to the NHS Scotland Chief Executives Group and to SOLACE, setting out the human and financial costs of these delays, opportunities and progress in reducing such delays.

9. Ensure clarity in the use of appropriate codes in ISD Delayed Discharge Census to reflect new plans and expectations for individuals experiencing delays.

10. Map delays coded as awaiting specialist services, and review current use of out of area placements or national resources.

11. Highlight / publicise information where shared services are being developed and offer support to local partnerships to link local data. Identify and promote good practice tools and approaches.

12. Provide support, through the JIT to facilitate peer visits between local complex delay management groups as appropriate.

Short Life Working Group on Complex Delays

Membership

Chris Bruce (Chair)	Scottish Government
Isla Bisset	Scottish Government
Keith Bowden	NHS Forth Valley Learning Disability & Psychology Dept
Gillian Crosby	City of Edinburgh Council, Disability Services
Jane Davidson	Joint Improvement Team
Sandy Dustan	NHS Grampian
Richard Fowles	SWIA
Ryan Gunn	Scottish Government Adult Care & Support
Anne Harkness	NHS GG&C Rehabilitation & Assessment
Sally Lakeman	Community Care Providers Scotland
Ros Lyall	Mental Welfare Commission
Michael McCue	Joint Improvement Team
Alex McMahon	NHS Lothian
Elaine Parry	ISD
Neill Simpson	Royal College of Psychiatrists
Lance Sloan	NHS Fife, Fife Rehabilitation Service