Delayed Discharges

Findings and Recommendations of the Scrutiny Panel

1. Panel Membership

Councillors   M Hewitt (Chairman)
               C Mills (Vice-Chairman)
               Mrs J Green, P Paisey, Mrs I Evans, P Edge
               C Humphries (WCC)
               Councillor J P Thomson (WCC)

Terry White, Chairman Patients' Forum, Linda Griffiths, Users Network.

2. Terms of Reference for the Review

(1)   To determine the extent and trend of delayed discharges from Salisbury District Hospital (SDH).

(2)   To use the Change Agent Team (CAT) report recommendations as the basis for monitoring progress in reducing delayed discharges.

(3)   To investigate care pathways for patients; including the distinct stages of pre-hospital admission, care once admitted to hospital and the post-discharge situation.

(4)   To give some consideration of the contributory factors including the treatment of patients with general malaise/"no defined diagnosis".

(5)   To determine the areas of responsibility with regard to delayed discharges in particular; GPs, Salisbury District Hospital (SDH), the Avon & Wiltshire Partnership (AWP), the Hants & Dorset Primary Care Trust, the South Wilts Primary Care Trust (SWPCT) and Wiltshire County Council's Department of Adult and Community Services (DACS).

The main tool the group decided to utilise was to interview stakeholders including officers, representatives from the SWPCT, representatives from SDH and WCC officers who have responsibility for provision of health care and for placements for people with differing care needs.

3. Findings of the Change Agent Team and Other Literature

1. The Health Scrutiny panel used the CAT report to define the scope of the review. The CAT report identified that in March 2003 there were 38 delayed transfers of care at SDH. This accounted for 75% of all delayed transfers of care in the County. However, it did also note that this number had been falling since October 2002 after having risen sharply in July 2002.

2. The CAT report identified many reasons for the delayed transfers of care from SDH.
    1. It indicated that a great number of delayed transfers of care involved patients with mental health problems. This was often the result of confusion between different organisations about where the patient needed to be placed or a lack of willingness to take ownership of the problem.
    2. There were a large number of delays caused by patients awaiting a DACS funded placement in March 2003.
    3. In South Wiltshire there was a lack of placements for longer-term care in the independent sector. There were a high proportion of privately funded placements but that these were often above the ability of DACS' to purchase.
    4. There was often little or no consideration given to extra care housing as an alternative to hospital admission. Domiciliary care and housing schemes needed to be improved.
    5. One of the main criticisms that the CAT report made was the lack of co-ordination between all stakeholders in the admissions process both at a senior strategic and an operational level. This had led to a culture of blame and a reluctance to take ownership of the problem. One possible approach to this problem could be to look into pooled budgets.

3. The Democratic Health Network produced a Policy Briefing on delayed discharges in September 2003. The briefing identified the following issues:
    1. That people were commonly experiencing delayed transfers of care because they were awaiting an assessment of needs or a care home placement.
    2. That PCTs should work to best practice by providing early assessments of need and discharge planning and also by mapping patients' journeys to identify problems in the systems.
    3. Transport providers should be engaged by PCTs.
    4. That a shortage of equipment to support people at home increases delayed discharge.
    5. There is a possible connection between early discharge and readmission. Readmission rates for older people increased by approximately 30% nationally between 1997-2002. There is a lack of understanding about the reasons for this.
    6. That delayed discharges in mental health beds should be examined.

4. A Local Government Association briefing identified that a key cause of delayed discharge was inappropriate admission through a lack of alternative provision.

4. Statistics By Mike Hennessey from DACS

These figures demonstrate the number of delayed discharges for which Wiltshire was responsible.

1. Fig 1 Demonstrates how changing practices and additional investment made by the partners within South Wiltshire brought about significant success in tackling the issue of Delayed Discharges between October 2002 and July 2003, with a steady and more or less consistent reduction in the number of people in acute beds whose discharge was delayed.

	October 2002	January 2003	March 2003	May 2003	July 2003
Completion of Assessment	7	7	2	1	1
Awaiting Public Funding	16	12	10	9	9
Awaiting NHS non Acute transfer	1	0	1	1	1
Awaiting Nursing Home Placement	8	7	8	8	5
Domiciliary Care	0	3	1	0	2
Patient Choice	5	0	1	0	2
Other	4	2	2	0	0
Total	**41**	**31**	**25**	**19**	**20**

2. Fig 2 Shows the position since October 2003 when shadow arrangements for the Community Care (Delayed Discharges) Act were implemented. This act allows for a scheme of re-imbursements whereby the hospital can levy fines against DACS if a patient has to remain in hospital because of a lack of care placement. Note that during October 2003, the Department of Health revised the definitions relating to reasons for delay and those revised definitions have been in use since then.
These revised definitions included the following amendments:
Previous categories of delay included separate categories for patients waiting assessment for less than 7 days and patients waiting an assessment for more than 7 days. This has been combined into one category for any patient awaiting an assessment. Previously, there was one category for patients awaiting a nursing home or residential home placement and this was separated into one category for patients awaiting a nursing home placement and one for those patients awaiting a residential home placement. Other categories have been added for those patients awaiting community equipment and another one for those awaiting housing. The previous catch-all category which included all other delays has now been named disputes between health and social care. Another change in October 2003 was the necessity to identify the liable organisation. It is no longer acceptable to identify a delay without agreeing responsibility for reimbursement.

	October 2003	January 2004	March 2004	April 2004	May 2004
Completion of Assessment	2	2	0	0	n/a

Awaiting Public Funding	9	4	2	1	n/a
Awaiting NHS non Acute transfer	1	1	1	1	n/a
Awaiting RCH	0	1	2	0	n/a
Awaiting Nursing Home Placement	3	3	5	2	n/a
Domiciliary Care	1	1	3	2	n/a
Patient Choice	2	1	1	1	n/a
Dispute	0	0	0	0	n/a
Housing	1	0	0	0	n/a
Total	**19**	**13**	**14**	**7**	n/a

3. Following the consideration of these statistics the panel decided to interview the following people; Dawn Hales the Promoting Independence Manager for SWPCT; Frank Harsent, the Chief Executive of Salisbury District Hospital; John Nicholas, Chief Executive of South Wiltshire PCT; Housing officers from SDC; DACS representatives from WCC; Helena Mckeown a GP from Salisbury; Clair Wheeler from Supporting People; and Louise Carey Principal Sports Development Officer at SDC.

4. The panel decided that they should first investigate how this reduction had been achieved by interviewing a PCT representative to clarify what steps had already been taken at the hospital. The early indications were that many steps had been taken by the PCT and it was the pre and post admissions steps of the process that needed attention. Therefore the role of DACS and SDC in further preventing admissions may be crucial.

5. Interview With Dawn Hales the Promoting Independence Manager for SWPCT 4th May 2004
This interview highlighted the following issues:
1. The complexity of all the different organisations working through the South Wiltshire PCT caused a blame culture to flourish and discouraged partnership working. Historically each organisation had its own budget and was working to reduce delayed discharges from its own perspective.
2. The intervention of the Change Agent Team and user feedback was crucial to changing this culture.
3. The primary motivator of change was the system of reimbursements that got the different organisations working together.
4. A pioneering structure of integrated management has created the senior support that the different organisations need to make funds available where they are most required and this has improved the situation greatly.
5. These changes encouraged joint ownership of the problem of delayed discharges and this lead to the creation of HAT. HAT is focused on keeping people in the community, thereby reducing the number of hospital admissions in the first place, but also aims to return people to the community as quickly as possible to prevent them becoming institutionalised.
6. One of the main process changes has been to begin the assessment for older patients immediately upon or before their admission to hospital so that future caring needs can be identified well in advance.
7. The hospital has responded to the CAT finding that there are fewer acute beds in SDH than the national average, by ensuring that acute beds are no

longer used for long term care and are kept for the acute cases for which they are really needed.

8. Systems are now in place to monitor the demand for different types of care placement such as residential care, nursing home placements and crisis beds.
9. There is a greater understanding of the whole system approach to care.
10. Further work is needed to ensure that adequate resources are made available where they are needed. Creativity is essential in investigating the best method of care for people. Budgets need to be flexible enough to allow money to be directed where it is most required.
11. Housing is a major area in which many different organisations could work together to try to maintain people in their own homes rather than admissions to hospital ever taking place. These organisations could include not only the PCT, DACS, SDH and SDC but also such groups as the Aids Loan Service which provides equipment to help support independent living and occupational therapists.
12. Trying to get all the relevant parties together to discuss what needs to be done had proved difficult in the past.
13. The items identified within the Democratic Health Network's report on best practice have all now been implemented by the PCT.

6. Interview with the Chief Executive of SDH 20th October 2003 and 29th June 2004

During this interview the following points were made:

1. In 2003 many patients were experiencing delayed transfers of care and several of these patients were experiencing delays greater than 28 days.
2. Institutionalisation can occur when a patient remains in hospital for longer than necessary. This is obviously bad for the patient and makes it less likely the patient will leave hospital care. Hospitals should only be used where a patient requires specialist care.
3. There has been a huge reduction in the number of delayed discharges. This is largely a result of the partnership working between the SWPCT, DACS and SDH. Part of this process has been the creation of the Hospital Alternatives Team (HAT). This team has two priorities. One priority is to reduce the number of admissions to hospital and the second priority is to move patients on to other types of care.
4. The lack of mental health placements is one of the major difficulties facing the health service in South Wiltshire as a whole. As these patients usually have very complex problems moving them on can often prove difficult. There have even been cases where patients have been referred to SDH from the Old Manor for a physical illness but then could not go back because the Old Manor was full.
5. The geography of the area creates problems for health care provision as many patients are geographically remote from health care facilities. This is especially true of patients with spinal problems as Salisbury is the regional spinal treatment centre and there is no incentive for other areas to take their patients back quickly.

6. In the future, community matrons will be responsible for undertaking regular assessments of elderly people in the community so that any potential problems can be identified early. The intention is that this will prevent people being admitted to the hospital in the first place.

7. Interview with John Nicholas 11th June 2003 and 20th October 2003

1. Many of the patients who have been given the label 'mental health' did not enter hospital for that reason. That is a label they would have acquired after admittance.
2. When interviewed Mr Nicholas stated that a new team was currently being set up with the purpose of offering alternatives to hospital for people needing care, this team has now been established and is entitled the Hospital Alternatives Team.
3. It is important that a menu of options is offered to GP's who want a first point of contact.
4. John Nicholas advised that the changes proposed at Fountain Way (previously the Old Manor site) would focus mainly on the rehabilitation unit which is at present housing people who are not getting better and are no longer in need of medical treatment. Therefore these people would be better placed elsewhere. This should free up more medical beds and should not have a negative impact on the delayed discharge statistics.

8. Interview with a GP from Salisbury 8th June 2004

Helena McKeown, a GP from Salisbury
1. Helena McKeown commented that wardens in sheltered housing schemes were excellent in Salisbury and the communication between wardens and GPs was also excellent.
2. One of the issues raised by the Older People's Steering Group was a lack of care workers. More innovative ways of working need to be investigated such as subsidised housing for care workers. She noted that at present elderly people are very reliant on voluntary carers such as their neighbours. This is an important issue as the people who remain in their homes rather than be admitted to hospital are often much more ill than in the past and neighbour care is not always enough.
3. Many wardens now refuse to dispense drugs to elderly people because of an increasing fear of liability and litigation. She commented that one of the major factors in delaying discharges from hospital is that people cannot manage their own medication and therefore this has had a big impact. Getting pharmacies to deliver medication to people's homes would also alleviate many problems.
4. Transport to and from hospital, GPs surgeries and pharmacies is often a problem for elderly patients.
5. Helena McKeown confirmed that GPs have had experience of poor communication from Salisbury District Hospital and were often not informed when their patients had been discharged.

9. Interview with Clair Wheeler of Supporting People 8th June 2004

1. Tightening pressures on budgets meant that the opportunity for future service development would be limited.
2. Clair Wheeler stated that much of the funding had historically been attached to housing needs and therefore to rented accommodation. However, investigations are underway to attempt to make the services more widely available, for example to people in private accommodation. Supporting People provides low-level housing-related support which is designed to give people who are perfectly healthy but need help with independent living skills the opportunity to remain at home. She stated that this will become increasingly important in the next eighteen months with schemes such as Lifeline being reviewed and utilising assistive technology as far as possible will become crucial.

10. Interviews with WCC DACS officers May and June 2004

1. Mike Hennessey stated that the improvement in figures had come about for a number of reasons:
   i.   One reason was the purchase of additional enhanced residential care beds for people with mental health needs, increasing the number of rehabilitation beds available and gaining agreement and clarity around definitions in use and thus improving the quality of data.
   ii. The County Council made available resources from its Access and Systems Capacity Grant and the Residential Care Allowance Grant to ensure that, in addition to the planned capacity, additional Nursing and Residential Home places have been commissioned and purchased.
   iii. The County Council has increased fees for the residential and domiciliary care providers above the rate of inflation in order to help stabilise and secure the market and remain competitive with an active private market.
   iv. Joint working has led to a greater clarity around the process of agreement between the health and social care community of the numbers of people whose transfer of care is delayed and the reason for the delay.
   v.   An analysis of patient pathways undertaken in July 2003 led to some specific areas to be addressed, particularly the role of the Mental Health Liaison Service and support for carers.
2. There has been a huge improvement on the situation eighteen months ago which showed that some really good work had been done. Preventing people becoming institutionalised in hospital by developing extra care housing services was crucial, and this is progressing well.
3. Chris Chorley, Assistant Director of DACS, stated that high-level community care is a viable alternative to hospitalisation if it is focused for a limited crucial period. However, this type of care could not be an ongoing arrangement as it is very expensive. If a person requires this level of care on an ongoing basis other methods of care provision must be considered.

4. Chris Chorley stated that there is currently very little information on intermediate care schemes for patients with mental health problems.

5. Chris Chorley stated that the County Council is maintaining funding to the voluntary sector at a time when there is increasing pressure on budgets and resources and this shows a major commitment to the prevention of ill health and hospitalisation. However, he stated that it is necessary to ensure that the grant aid that is being provided to voluntary organisations is in turn providing the necessary support to the community, although he stated that there is no clear way to measure this.

11. Interviews with SDC Housing Officers May and June 2004

1. Debbie Dixon commented that the ODPM has worked with the Department of Health to attempt to address the issue of housing for key workers and has identified some potential land for development in Salisbury. She further stated that the South Wiltshire Strategic Alliance may well adopt affordable housing as one of its key local priorties.

2. James Hudson, Private Sector Housing Officer for SDC, commented that the Community Scheme Managers (CSMs) are excellent but people need to be educated as to the role of the CSMs in sheltered housing. CSMs are often not informed when a person is admitted to hospital, often for a fairly serious course of treatment, or about any medication they may have subsequently been prescribed. Sometimes they are not even aware of when people were discharged from hospital.

3. Andrew Reynolds commented that while Salisbury District Council is behind other districts in the development of extra care housing, there has been discussions with the PCT and DACS to investigate new schemes and a paper is being submitted to Salisbury District Council's Cabinet concerning this issue in the next month. He stated that he expects much work to be done on this issue over the next two years.

4. Andrew Reynolds commented that it is difficult for SDC to become involved in operational issues surrounding delayed discharges for clients with acute and/or complex needs as placements are the responsibility of DACS. However, he emphasised that SDC is responsible for sheltered housing and the work that is ongoing with the HAT staff is proving to be very fruitful.

5. Andrew Reynolds added that all tenants in sheltered housing schemes have an assessment every three months. The aim is to change the emphasis from an informal CSM fulfilling a similar role as a concerned neighbour, to a much more professional role. However, this is a new programme and therefore it is difficult to tell at this early stage what impact this has had on delayed discharges. One area that Andrew felt is yet to be fully explored is that of people who live in private accommodation. At present the CSM scheme is generally only applicable to people who live in Council provided accommodation. Although a Community Warden Scheme was piloted, a lack of capacity thwarted the programme.

12. Interview with Louise Cary of SDC 8th June 2004

1. Louise Cary stated that the exercise programme founded by SDC was initially based on patients who had suffered falls. However, referrals have started to come from a wider range of sources including some from GPs. She noted that another issue is the limited number of professionals able to run these classes. However, she stated that her department have recognised this problem and SDC would like to link up to GPs and groups such as Age Concern to publicise the details more widely.
2. There are also exercise programmes run by the hospital for elderly or mobility impaired people.

13. Findings

1. Much work has already been undertaken on the issue of delayed discharges in SDH and the number of delayed transfers of care is declining at a steady rate. Chris Chorley could announce that the number of delayed discharges has reduced from 38 in March 2003 to only 8 delays in June 2004. *4.1, 4.2, 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.8, 5.9, 6.3, 10.1, 10.2, 11.4.*
2. This reduction has come about as a result of a number of factors:
   i. Inter-agency working has now created many more links between all stakeholders and an emerging theme from the interviews was that the intervention of the HAT team has been a very positive outcome. *5.5, 6.3, 10.1. iv*
   ii. These interagency links has allowed discharge planning to begin at a much earlier stage and therefore reduce the number of delays dramatically. *5.6*
   iii. This partnership working has also created an atmosphere in which there is a greater understanding of the whole system approach to care. *5.9, 10.1.iv, 11.4*
   iv. This joint working has allowed stakeholders to identify more innovative ways of working. *5.10*
   v. Reimbursements have been crucial to reducing the numbers of delayed discharges.*5.3*

3. The issue of patients with mental health problems has not been fully explored. There are still too few placements for patients with mental health problems. When a patient has physical problems they can be adequately cared for in hospital but when the physical problem is resolved there is often nowhere for the patient to be treated for mental health issues. The few mental health placements that do exist get filled very quickly. *6.4, 7.1, 10.4*

4. The majority of work left to be done is in preventing admissions, seeking alternatives to hosptialisation and post-hospital care. *5.7, 5.11, 6.2, 6.6, 8.2, 8.3, 10.2, 10.3, 11.3, 11.4, 11.5*
5. There is little provision for people who live in private accommodation. The CSM
   scheme can generally only be provided for people who live in council accommodation. The need to remedy this situation was highlighted by Supporting People, SDC Housing Department and the GP interviewed as a major obstacle in providing care to patients in the community. *8.2, 9.2, 10.5*
6. A culture change is occurring where hospitals are not necessarily being viewed as the automatic place for elderly patients who require long-term care. Intermediate care and high level care for limited periods can be readily provided within the community. However, if the care needed is of a high level for an extended period then it would be difficult to provide this in the community. *5.7, 6.2, 10.2, 10.3*
7. Care in the community can be an expensive option which is why long term high level care is often inappropriate. However, for short periods this care can be provided at a rate which compares favourably to that of hospitalisation. However, it is now accepted that community care is not necessarily a cheaper option than hospitalisation but does confer many additional benefits. The main benefit is that people often become institutionalised once they are admitted to hospital and therefore the likelihood of effective rehabilitation and maintained independence increases if they can be cared for in their own home. *5.5, 6.2, 10.3*

14. Conclusions

1. The panel felt that there is a need for some spare capacity to help support the reduction in delayed discharges.
2. It is difficult for local district councils to become involved in operational issues surrounding delayed discharges for clients with acute and/or complex needs as placements are the responsibility of DACS. *11.4*
3. Whereas stakeholders did not have a great deal of communication a few years ago there is much more focus on partnership working now and a holistic approach to elderly care. *5.3, 5.9, 10.1.iv, 11.4*
4. The lack of a coordinated medical/mental health package is a serious barrier to effective use of the acute hospital beds. 6.4, 10.4
5. The panel do not wish the focus to be on moving people before they are ready and before other appropriate care is available, as there is a suggested link between early discharge and quick readmission. Therefore the need to ever be admitted should be eliminated as an ideal target. *3.5, 5.5*
6. A method of assessing people early whilst they are still living in the community is necessary. 6.6

7. The panel recognise the work already done and think that the good work should continue. *5.2, 5.3, 5.4, 5.5, 5.6, 6.3, 7.1,10.1, 10.2, 11.4*

15. Recommendations

1. The Health Scrutiny Panel would like to recommend to Wiltshire County Council the following:
    i. That patients are treated as individuals not as a category of patient and therefore that an assessment is done of the best care package to suit that individual.
    ii. That a single criteria to assess whether or not someone is a delayed discharge is used by all the organisations that collate the data.
    iii. That the assessment of patients' needs is done at the earliest possible stage and that this assessment should involve all stakeholders including local authority housing officers. *5.6, 5.12, 6.6, 11.2*
    iv. That the County Council recommend that the government investigate the possibility of pooling the relevant budgets so that greater financial flexibility is available to move monies to fund whichever care package is thought best for patients regardless of who would actually provide that service. *5.4, 5.10, 9.2*
    v. In order to provide a holistic community care package all agencies involved should regularly monitor their processes in the services they provide. Within individual agencies inter departmental cooperation and coordination is equally necessary. *5.12, 8.3, 12.1*
    vi. That SDH analyses its own internal processes to determine how many patients' treatment is being delayed either within the hospital or between other hospitals. *6.3*
    vii. That the County Council recommend to the secretary of state that the government gives the same priority to delayed discharges from mental health beds as from medical beds to complete the delayed discharges reduction programme. 6.4,*10.4*
    viii. That the County Council support the proposals of the Avon, Wiltshire and Gloucestershire Mental Health Trust to create a low level secure unit for long-term care in the area to free up some mental health beds within the Wiltshire and Swindon area. 6.4, 7.4
    ix. That proposals to encourage patients from out of area to be reinstated in their own area quickly be investigated. 6.5
    x. That this review be revisited in 18 months – 2 years time to monitor the outcomes of this review and that monitoring statistics be recorded over this period. The panel would also like to see statistics on readmission rates produced for this period as well. *3.5*
    xi. That greater partnership working be encouraged between WCC, SDC, SDH and SWPCT to provide more extra care housing for elderly/ vulnerable people (also recommended to SDC).

xii. That greater partnership working be encouraged between the different organisations to encourage exercise programmes for elderly people to aid prevention of admittance to hospital.

2. The Health Scrutiny Panel would like to recommend to SDC's Cabinet the following:

i. That the housing department be asked to further its investigations into adapting housing to allow individuals to stay in their homes. The panel recognises that all new houses are required to be planned in such a way that they can be adapted at a later date if required. *5.11, 11.3, 11.5*

ii. Local authorities liaise with pharmacy organisations to expand schemes to deliver medicines to people who have difficulty in visiting a local pharmacy. 8.*3*

iii. Cabinet should always expand and encourage schemes such as the Link Scheme. 8.*4*

iv. That SDC investigate provision for people who live in private accommodation. The schemes that do exist can generally only be provided for people who live in council accommodation. 9.*2, 11.5*

v. That SDC investigate the possibility of providing every elderly person who lives alone with the LifeLine facility.

vi. That greater partnership working be encouraged between WCC, SDC, SDH and SWPCT to provide more extra care housing for elderly/ vulnerable people (also recommended to WCC).

Glossary

AWP – Avon and Wiltshire Partnership
CAT – Change Agent Team
CSM – Community Scheme Managers
DACS – Department of Adult and Community Services at Wiltshire County Council (formerly Social Services)
HAT – Hospital Alternatives Team
ODPM – Office of the Deputy Prime Minister
PCT – Primary Care Trust
SDC – Salisbury District Council
SDH – Salisbury District Hospital
SWPCT – South Wiltshire Primary Care Trust
WCC – Wiltshire County Council