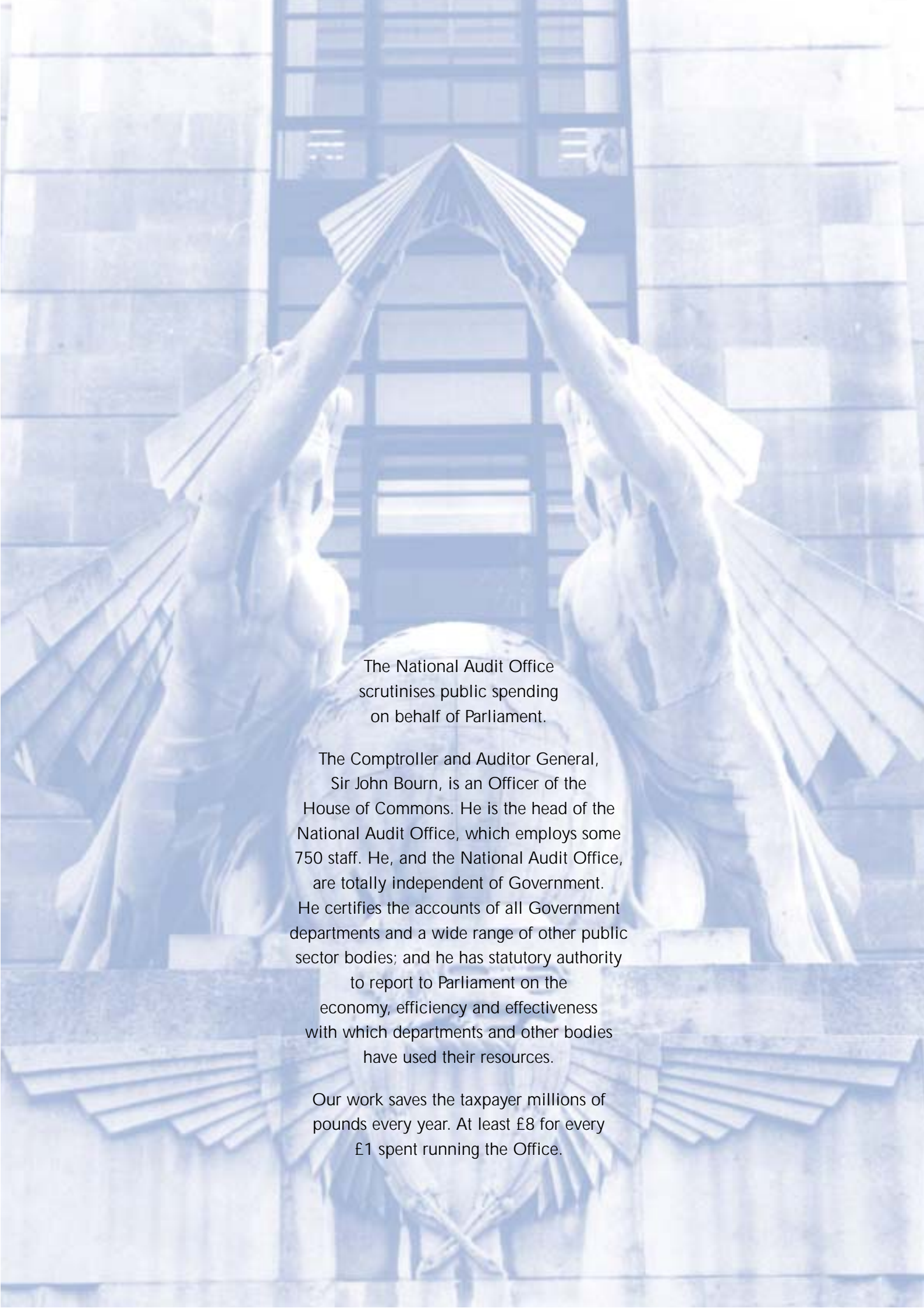


Ensuring the effective discharge of older patients from NHS acute hospitals

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL
HC 392 Session 2002-2003: 12 February 2003





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HC 392 Session 2002-2003: 12 February 2003

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This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act.

John Bourn

Comptroller and Auditor General

National Audit Office
31 January 2003

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summary & recommendations



- 1 The majority of older people who are discharged from National Health Service (NHS) acute hospitals are dealt with promptly. However, the Department of Health (the Department) estimate that in September 2002 some 8.9 per cent of older¹ patients occupying NHS acute care beds had already been declared fit to leave hospital, but had not yet done so for a variety of reasons. This equates to more than 4,100 older patients on any given day, although this is significantly lower than at the same point in 2001. Delays in discharge from hospital can undermine people's quality of life and increase dependence on institutional care. They are also costly to the NHS, and interfere with attempts to improve patient care and meet stretching targets.
- 2 The effective discharge of older patients from hospital is not wholly about what happens there, although there is much that hospitals can do to ensure procedures for handling patients are efficient. The provision of care in the community, often outside the NHS, can exert a greater influence on levels of delay because without somewhere to discharge to, hospitals have little option but to retain patients pending decisions being taken elsewhere. The most common causes of delay are patients awaiting placement in a nursing or residential home, and awaiting assessment of their needs. Common points at which delays can occur are shown in [Figure 1 overleaf](#).
- 3 The Department do not gather data on all of these causes, some of which are impossible to quantify. Departmental data analyses causes of delayed discharge not wholly attributable to actions in NHS acute care. The most recent data are shown in [Figure 2 overleaf](#), together with an indication of where in the system shown in Figure 1 these specific problems commonly occur.
- 4 The Government aims to end widespread delayed discharge by 2004. This ambition is reflected in longer-term initiatives to develop older people's services such as those detailed in the NHS Plan² and the National Service Framework for Older People³, and in targeted, shorter-term initiatives. Most recently, the Community Care (Delayed Discharges etc) Bill, which at the time of publication was before Parliament, proposes financial charges for Councils that do not provide the community care services their residents need in order to be safely discharged from hospital. In January 2003 the Department issued a guide 'Discharge from hospital: pathway, process and practice', designed to assist those working across the health and social care sectors to improve local hospital discharge policy and practice.
- 5 This report takes three perspectives on the problem of delayed discharge: whether NHS acute hospitals are handling the discharge of older patients efficiently (Part 2); whether the NHS and others are working well together (Part 3); and what is being done to develop appropriate capacity in health and social care (Part 4). Our methodology is outlined in Appendix A.

¹ The Department of Health define "older" as 75 and over.

² Department of Health (2000). *The NHS Plan. A plan for investment. A plan for reform. Cm 4818.*

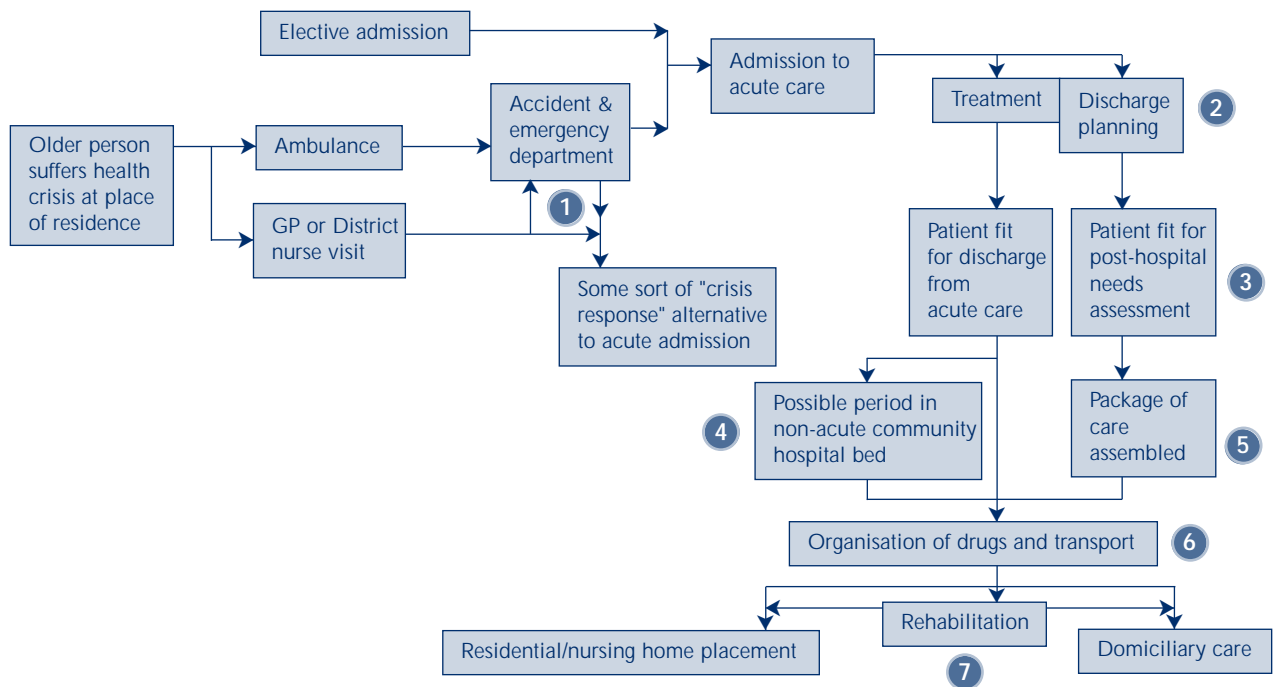
³ Department of Health (2001). *National service framework for older people.*

On the measurement of delays in the discharge of older people from NHS acute hospitals

- 6 The Department have collected data on delayed discharges since 1997. Historically, hospitals have applied a range of interpretations for when a delay begins and, although the Department issued a standard definition in April 2001, a number of problems remain. Only 27 per cent of Trusts responding to our survey indicated they were following the definition in full. Twenty two per cent of Trusts allow a 'breathing space' of some kind before declaring a discharge to be delayed (9 per cent of trusts reported a delay as starting seven days after the official definition). There are also discrepancies between data reported by acute trusts to the Department and quarterly data collected and reported by Primary Care Trusts through Strategic Health Authorities. For the effective implementation of the financial changes proposed in the Community Care (Delayed Discharges etc) Bill from April 2003, it will be important that the data needed is reliable enough to provide easy agreement on the number of delays at local level between the NHS and social services departments.

- 7 The impact of problems with data collection is difficult to gauge, as the effects of some types of error may be compensated for by others. However, a significant number of health and social care communities appear not to have accurate data on which to base key decisions about the care of older people. Moreover, central monitoring of delayed discharges focuses on acute and general beds in NHS acute trusts, and excludes other non-acute beds.

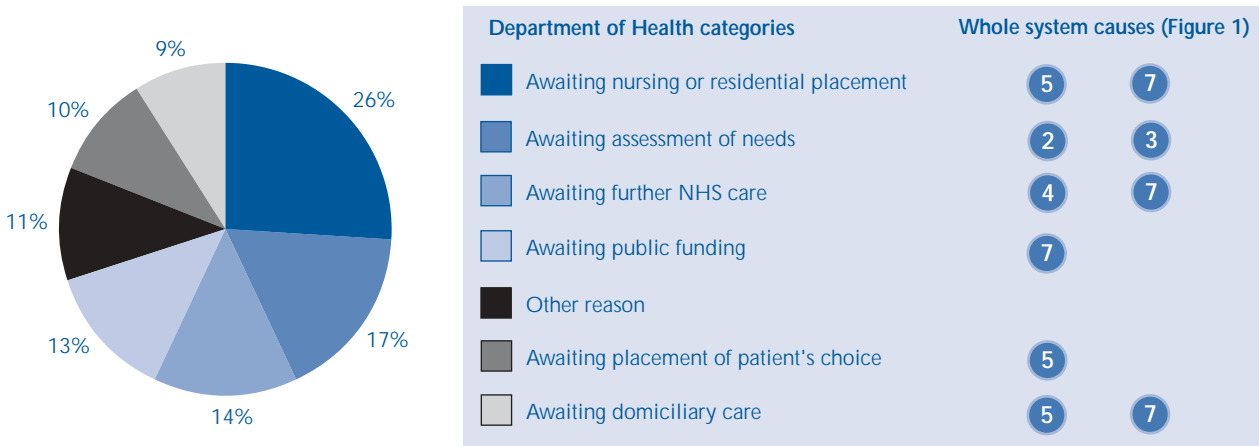
1 A representative care journey for an older person suffering a health crisis, or entering hospital for an operation or medical treatment (elective admission)



What can contribute to delayed discharge?

<ul style="list-style-type: none"> 1 Absence of alternatives to acute care. 2 Poorly co-ordinated or tardy discharge planning. 3 Delays in starting or completing needs assessments. 4 "Bottlenecks" in post-acute hospital care. 	<ul style="list-style-type: none"> 5 Delays in preparing packages of care due to funding and workforce constraints. 6 Poorly co-ordinated or tardy preparation for day of discharge. 7 Lack of capacity in post-acute care in all health, social services and independent sectors.
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2 Departmental data on delayed discharge, and relationship to whole system causes



NOTE

The absence of alternative to acute care, 1 in Figure 1, is a contributory factor to all categories of delay. Delays caused by poor co-ordination or tardy preparation for the day of discharge 6 are not identified separately.

Source: Department of Health/NAO, data as at September 2002

On working within acute hospitals to reduce delayed discharges

- 8 If older patients are to be discharged from hospital promptly, hospitals need to plan early and involve a wide range of relevant parties, as well as ensure that someone is responsible for co-ordinating the discharge process. There is still scope for earlier consideration of discharge. The proportion of Trusts starting discharge planning at the earliest possible stage has fallen since we surveyed the sector in 1999⁴, although the presence of a discharge policy, confirming roles and responsibilities, is now virtually universal.
- 9 Around two-thirds of acute trusts had conducted exercises to map older patients' pathways through hospital care and to identify bottlenecks, and a number consequently identified removable obstacles preventing discharge. Eighty-two per cent of acute trusts now have a discharge co-ordinator (70 per cent in 1999), and two-thirds have gone further and set up a discharge team.
- 10 Before a patient can be discharged, an assessment must be carried out of their medical, functional, social and psychological needs. Nationally, 17 per cent of all delayed discharges are attributable to delays in assessments, although the time patients wait for assessments has reduced as a result of the additional Building Care Capacity Grant funding made available in 2001-02 and 2002-03 (see paragraph 24). Although the process should start early for both planned and emergency admissions, three out of 10 Trusts did not begin assessments even for planned admissions until during the patient's stay in hospital. For emergency admissions, 56 per cent of acute trusts began the process on the day of admission (compared with 40 per cent in 1999). Shortages of occupational therapists or lack of integrated therapy services are a recurring cause of delays in completing assessments in some areas.

Delayed discharge often occurs within acute hospitals because of:

- delays in initiating discharge planning
- poor coordination between hospital staff during care
- competing priorities for staff time
- delays in carrying out assessments due to resource shortages and poor communication
- delays in making drugs available for patients to take away
- transport not being available to take patients home
- shortages of specialist staff

⁴ Inpatient admissions and bed management in NHS acute hospitals (HC254, 1999-2000).

- 11 The Department plan to introduce a Single Assessment Process to make assessment more efficient and more focused on the patient. The original target of April 2002 for its introduction has been changed to 2004 to reflect the complexities of the task. The timing of this will match the introduction of the Health Record Service. One-quarter of acute trusts currently have a system of joint records with social services (allowing access and input), mostly paper-based rather than electronic. Most trusts with a system of joint records had detected a positive impact on discharge rates and were more likely to have made good progress with the Single Assessment Process than those without.
- 12 Involvement of patients and carers is key to timely and appropriate discharge of older patients. Trusts told us that they involved patients and carers in decisions about post-discharge arrangements, although many patients and carers do not see it that way, with significant numbers of carers concerned about lack of consultation prior to discharge, and about not receiving a copy of the patient's discharge plan. The National Service Framework for Older People has specific milestones for this, so that by April 2003 "systems exploring the user/carer experience will be in place in the NHS and social care, and by April 2004, systems to explore this must be in place in Primary Care Trusts."
- 13 In the second quarter of 2002-03, just over 8 per cent of older patients were re-admitted to hospital as an emergency within 28 days of their original discharge. While the rate of re-admissions has changed little in percentage terms since 1997, the actual number of re-admissions has increased at a steady rate in line with overall hospital activity. While emergency re-admissions may indicate a problem with discharge procedures, in only around one-fifth of acute trusts were those responsible for co-ordinating discharge monitoring re-admission rates or causes.

On health and social care agencies working together to reduce delayed discharge levels

- 14** Effective discharge involves a wide range of agencies, including the NHS, local authority social services and housing departments and independent care providers. Many delays arise from inadequate co-ordination between them. The health and social care sectors have developed separately, and have different funding and accountability arrangements. Cultural differences need to be overcome if the different players are to work together, and all parties agree that incompatible administrative systems, as well as the lack of common geographical boundaries, are obstacles to joint working. Both acute and Primary Care Trusts consider informal communication to be the most effective way of overcoming difficulties.
- 15** The Department are encouraging joint working through legislation and spreading good practice, but with mixed results to date. The Health Act 1999 allowed health and social care bodies to form partnership arrangements by pooling funds, allowing one local organisation to be lead commissioner of services on behalf of others, and by integrating services into a single provider organisation. There has been limited use of these flexibilities for older people's services, compared with services for other sectors. We found some reluctance to pool budgets as a way of using funds efficiently for the benefit of the whole system.
- 16** The Government is also encouraging collaboration between health and social care organisations through the creation of Care Trusts under the Health and Social Care Act 2001. The Department view Care Trusts as a way of enabling service provision for older people and their carers to be designed in a coherent way from hospital admission through to sustained care at home. Care Trusts can commission and provide services on both sides of the health and social care boundary (with delegated authority from local authorities). Five demonstrator sites have operated since October 2002, one with older people's services as a particular priority area.
- 17** In January 2002, the Department also established the Health and Social Care Change Agent Team to assist certain localities to develop more effective whole health and social care systems, with a particular emphasis on tackling delayed discharges. The action plans developed so far by the Team had been well received by the health and social care communities we visited.
- 18** In April 2002, the Government announced that it was considering introducing a system (similar to that introduced in Sweden in 1992) of reimbursement at the point when responsibility for a patient's care transfers from the NHS to social services. Where the patient is not discharged within a day of being designated fit for discharge, and the acute provider can demonstrate that this is due to lack of social care support, social services will be required to reimburse the acute trust for the costs incurred. Legislation was introduced into Parliament in November 2002. Should the Bill become law, the Department will need to be alert to any unintended impacts resulting from the introduction of this system, such as creating perverse incentives for social services departments to place people in the most readily available, rather than the most appropriate, type of care.

Delayed discharge occurs at the interface between health and social care communities because:

- networks of organisations providing care are complicated
- health and social care organisations can have differing goals and incompatible methods of working
- sectors do not share resources to correct imbalances

On developing appropriate capacity in health and social care to reduce delayed discharges

19 Department of Health statistics show that lack of capacity in long-term residential and nursing care⁵ places is the leading factor in delayed discharges in England. In September 2002, 26 per cent of patients whose discharge had been delayed were awaiting a placement in a residential or nursing home, and a further 10 per cent were awaiting placement in a particular home of their choice. Since 1998 there has been a gradual decline in the number of residential care places (by 2 per cent) and nursing beds (by 10 per cent), and supply problems are particularly acute in London and the South-East and Eastern England.

Delayed discharges result from lack of capacity in post-hospital care caused by:


- underdeveloped residential and nursing care capacity (or equivalent alternatives)
- lack of funding for care packages
- lack of intermediate care provision and service transparency

20 The main alternative to long-term residential care is to support people through intensive home care. The number of people supported in this way has increased slightly from 267,000 to 284,000 between 1998-99 and 2001-2 and the ratio of intensive home care relative to admissions to residential and nursing care is also increasing.

21 The Department used to fund personal social services expenditure through a mixture of revenue support grants (calculated using the Standard Spending Assessment formula) and a series of special or specific grants. The Standard Spending Assessment, which formed the bulk of social services' allocation from the Department of Health, is compiled from separate formulae for services for children, older people, and other adults. Councils are entitled to re-allocate between categories and, in recent years, most have spent less on older people than the formula indicated.

22 From 2003-4, the Standard Spending Assessment is replaced by the "formula grant system", which reflects past spending patterns, rather than providing guidance for the uses of funds allocated, as intended by the previous system. Most councils will spend more on older people's services in 2003-4 as a result of the implications of the Community Care (Delayed Discharges) Bill. The total older people's formula grant for 2003-4 is £4.9 billion. Aside from the formula grant, councils will be granted £336 million in 2003-4 through ring-fenced schemes intended to promote hospital discharge or avoid admission. In addition, there will be a maximum grant of £100 million to social services for each full year between 2003-6. Councils will be able to use any balance of the grant not needed to reimburse the NHS for delays to invest in services.

⁵ Under the Care Standards Act 2000, from April 2002 all nursing and residential homes are 'care homes', with some registered separately as providers of nursing care.

- 
- 23** The NHS is keen to develop intermediate care as an alternative for those people who would otherwise be held in hospital, or admitted to a hospital or equivalent inappropriately. The Department created more than 2,700 new intermediate care beds between March 2000 and March 2002. Nevertheless, according to our survey, a majority of acute trusts have patients whose discharge is delayed due to a lack of intermediate care facilities at least once a week. This arises because in the past, facilities have been developed in many health and social care communities but without joint planning between health and social care agencies. As a result, facilities may overlap or lack visibility to one sector or the other. In addition, facilities have developed at very different rates across England.
- 24** Some £300 million was allocated to local authorities for the period 2001-02 to 2002-03 through the Building Care Capacity Grant to help reduce delayed discharges. This was linked to a new agreement between the statutory and independent social care, health care and housing sectors on building capacity and partnerships in care. In 2001-2, local authorities comfortably exceeded their target of reducing the number of delayed discharges by more than 1,000. Funding paid for more residential and nursing care places, and for increased fees for such placements, but was used less to support people in the community through intensive home care or adaptive equipment for the home, and least of all on preventive measures to avoid hospital admission.
- 25** The role of the independent sector (private-sector providers and voluntary organisations) is crucial to developing longer-term solutions to capacity problems. This sector now provides all nursing home places, some 80 per cent of residential home places, and half of local authority-purchased home-care contact hours. Fee levels remain the major source of tension between the sector and commissioners of health and social care. There is also some reluctance to expand their involvement in the intensive home-care sector.
- 26** A more healthy older population puts less strain on the health and social care system. Among the Primary Care Trusts we surveyed, preventive services of all kinds were their main priority in the development of older people's services, reflecting a common view among health and social care professionals that the best way of avoiding delayed discharges is to avoid unnecessary admissions.

Recommendations

27 As a result of our examination, we recommend:

For the Department of Health

- (a) In order to ensure that health and social care communities have accurate information on which to base key decisions about the care of older people, the Department should ensure that they have a single robust method for the collection of data on delayed discharges. This should include checks on the consistent application of key definitions, to be carried out through existing statutory inspections. The Department should also establish the extent of delayed discharge in non-acute beds and take action as necessary (paragraphs 1.8-1.9).
- (b) To satisfy themselves through the Directorates of Health and Social Care that acute trusts are making sufficient progress towards meeting the target for implementation of the Single Assessment Process, the Department should be proactive in identifying any common difficulties, and in advising local health and social care communities how these might be overcome (paragraphs 2.14-2.15).
- (c) The Department should pursue vigorously the development of the Health Record Service and integrated care records to the existing timetable, and, in the meantime, encourage NHS bodies and social services to work closely to share information (paragraph 2.14-2.17).
- (d) The Department should review their targets for the recruitment of occupational and physiotherapists, given that services seem to be expanding faster than the pace of recruitment (paragraph 2.20).
- (e) In considering the implementation of any system of reimbursement by social services departments of the costs of delays for which they are deemed responsible, the Department should be alert to experience in Sweden and to possible undesirable outcomes such as placements in inappropriate settings (paragraph 3.23-3.25).
- (f) The Department should ensure that increases in provision of intermediate care should address current inequalities at local level as well as meeting national target levels, and that these targets take into account all intermediate care provision, whatever the source of funding (paragraphs 4.16-4.20).

Recommendations

For NHS Trusts

- (g) Where they are not doing so, Trusts need to:
- circulate their discharge policy more widely outside the Trust (paragraph 2.4);
 - begin their discharge planning and assessment of patients' needs at the earliest possible time (paragraphs 2.5 and 2.10);
 - map older patients' pathways through hospital care as an aid to identifying bottlenecks within the system (paragraph 2.6); and
 - involve key groups within the Trust in decisions on discharge and assessment (paragraphs 2.7 and 2.11-12).
- (h) The involvement of patients and their carers is central to timely and appropriate discharge. Trusts should examine current practices for involving patients and carers to ensure they are meeting expectations. Discussions should include providing full information on options available and supplying patients and carers with a discharge plan (paragraphs 2.22-25).
- (i) Where they are not already doing so, discharge co-ordinators and teams within Trusts should monitor both the rate and causes of emergency re-admissions, so that they can identify any problems with how such patients were originally discharged (paragraphs 2.26-27).
- (j) Primary Care Trusts should examine progress in improving the organisation of equipment services in the light of the Audit Commission's two reports on the subject and the evidence that shortcomings in such organisations continue to be an obstacle to patients returning home (paragraph 4.8).
- (k) Residential and nursing home shortages will only be tackled with the full involvement of the independent sector. NHS Trusts and Primary Care Trusts should involve independent providers more in planning and developing older people's services (paragraphs 4.26-4.29).

For Strategic Health Authorities

- (l) To ensure that intermediate care services fulfil their key role in providing alternatives to an extended stay in acute care, Strategic Health Authorities should obtain a clear picture of the type of service available across their area as soon as possible, and communicate their availability to the professional groups involved in the care of older people (paragraphs 4.18 and 4.20).



Part 1

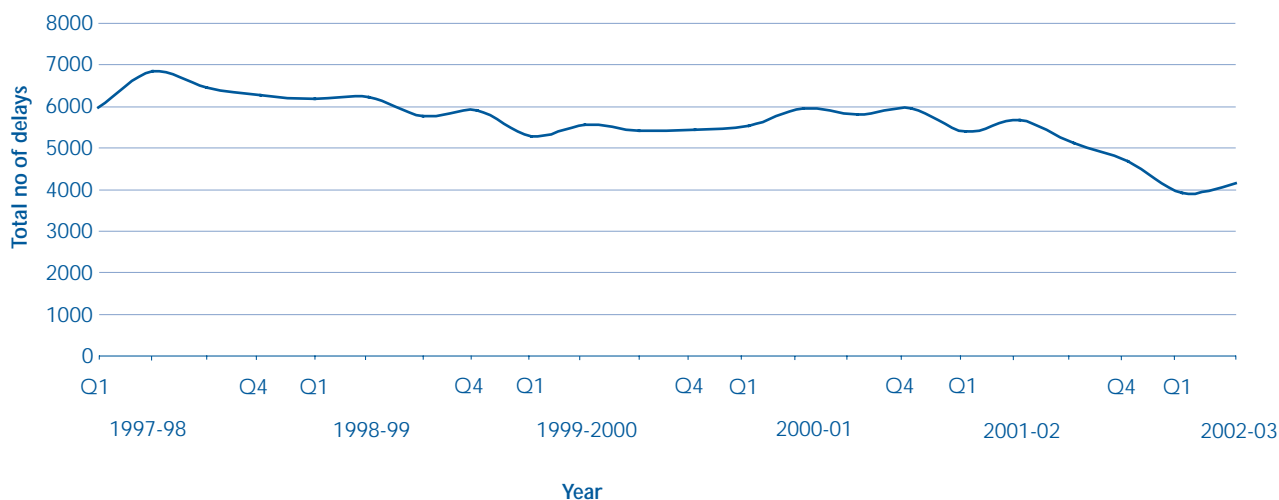
Delays in the discharge of older people from NHS acute care

- 1.1 The majority of older patients⁶ are discharged from acute NHS hospital care promptly. However, a significant number occupying adult and general NHS acute beds and already declared fit and safe to leave hospital, had not yet done so.⁷ Such delays are harmful to the patient and costly for the NHS. Reducing these delays is a high priority for the Government. This report examines what the Department of Health (the Department), the NHS, and a range of other organisations, have done to tackle delays in the discharge of older patients.
- 1.2 To undertake this examination, we surveyed NHS acute trusts and the first wave of Primary Care Trusts (created on or before April 2001), and visited a sample of local authority social services departments. We worked closely with the Audit Commission⁸, carried out qualitative research into the impact of delayed discharges, and interviewed a range of professionals in the field. We also compared discharge arrangements in hospitals now with those at the time of our previous report *Inpatient Admissions and Bed Management in NHS Acute Hospitals*⁹ in 1999. Our methodology is set out at Appendix A.
- 1.3 People aged 65 years and over are the main users of the NHS, especially of acute care in hospitals. Although they currently make up just 16 per cent of the national population, they occupy almost two-thirds of general and acute beds¹⁰ and are three times as likely to be admitted to hospital as the population as a whole. Significantly for this study, on average an older person admitted as an emergency will stay in hospital more than 50 per cent longer than the average length of stay for all adults and, as a planned admission, more than 150 per cent longer.¹¹
- 1.4 The Department reported that in September 2002 some 8.9 per cent of older patients occupying NHS acute care beds had their discharge from hospital delayed, equating to some 4,150 older patients on any given day.¹² This represents a reduction of some 1,500 patients from the same point in 2001 and 2,700 from the same point in 1997 (see **Figure 3**). This was out of a total of 5,384 people of all ages delayed (or 5.1 per cent of the total hospital population). Following NHS reorganisation in April 2002, the Department have experienced considerable problems collating data for June and September 2002, and were cautious about the completeness and the accuracy of the data collected. For example, the figure for September was arrived at by extrapolating from actual data returns to compensate for the 27 Primary Care Trusts that did not return data. Only seven such Trusts had no older patients whose discharge was delayed on the day surveyed.
- 1.5 The extent of delays experienced by people varies. As at September 2002, one-quarter were for under eight days, but one-third were for more than 28 days. There is also considerable regional variation within these statistics, including between adjoining areas. The former NHS Eastern region, for example, experienced levels of delayed discharge more than twice those of Trent in 2001-2. The problem is not restricted solely to England. The rates of delay in Scotland are very similar, and delayed discharge has also been a high profile issue in other countries, for example, Sweden.

Older patients are more likely to experience a delay in their discharge from hospital

6 Note: for statistical purposes the NHS defines the older people as those over 75 years of age. There are over 45,000 older patients in hospital on any one day.
7 Department of Health (2002). *NHS Quarterly Review, June - September 2002*.
8 Audit Commission (2002) *Integrated services for older people: building a whole system approach in England*.
9 National Audit Office (1999). *Inpatient Admissions and Bed Management in NHS Acute Hospitals - HC 254, Session 1999-00*.
10 Department of Health (2000). *Findings of the National Beds Inquiry*.
11 Harper, P R and Shahani, A K (2002). *Modelling for the planning and management of bed capacities in hospitals. Journal of the Operational Research Society, Vol.53, No.1*.
12 Department of Health (2002). *NHS Quarterly Review, July-September 2002*.

3 Level of delayed discharges



Source: Department of Health

Accurate measurement of delayed discharges has proved difficult

1.6 NHS acute trusts collect and report data on delayed discharges weekly. The Department also receive quarterly data returns from Primary Care Trusts which are used for all public statements about levels of delayed discharges. In addition, the Department monitor performance through data collected via Hospital Episode Statistics.

1.7 Broadly speaking, a patient becomes a "delayed discharge" when, although declared ready and safe to leave hospital, they do not, or cannot, do so. The Department have collected data since 1997. Although historically hospitals have applied a range of interpretations, to achieve consistency the Department issued a standard definition of a delayed discharge in April 2001¹³.

1.8 Despite this, a number of problems remain. In particular:

- our survey of NHS acute trusts showed that only 27 per cent were following the official definition in full, while 5 per cent did not make any specific comment about whether they were adhering to any aspect of it. Twenty two per cent qualified their definition of a delayed discharge by including a "breathing space" of 24 hours or more - nine per cent specifying 7 days;
- weekly and quarterly data returns are returned by providers (acute trusts) and commissioners (Primary Care Trusts) respectively. The Department spend some time validating the quarterly returns before

issuing quarterly figures. Setting targets for reductions in delayed discharges during 2001-2 exposed some disagreements between some social services departments and the Social Services Inspectorate over the level of delayed discharges shown in the weekly returns; and

- there have been problems with quarterly data collection since the transfer of functions from health authorities to Strategic Health Authorities in 2002 and, in particular, the involvement of Primary Care Trusts in co-ordinating data collection from NHS acute trusts in their area. The Department attached caveats to delayed discharge statistics for the first two quarters of 2002-03. Continued inaccuracies in this data could affect the effective implementation of the Community Care (Delayed Discharges etc) Bill, if it becomes law from April 2003, as the data will form the basis for calculating reimbursements payable by Councils to acute hospitals as part of the new arrangements (see paragraphs 3.21-3.25).

1.9 The impact of problems with data collection and accuracy is difficult to gauge, as the effects of some errors may be compensated for by others. However, it is evident that some health and social care communities do not have accurate data on which to base key decisions about the care of older people. In addition, central monitoring of delayed discharges covers acute and general beds in NHS acute trusts (but not non-acute trusts), while excluding 50,000 other beds (non-acute, mental health and community beds)¹⁴. Local exercises to collect more comprehensive data show that delayed discharges occur for all types of bed (see Case Study on South West Peninsula and Dorset and Somerset Strategic Health Authorities on page 15).

¹³ The current definition is in Department of Health (2002). *Services for Older People - 2002-3 Data Definitions*. "A delayed transfer occurs when a patient is ready for transfer from a general and acute hospital bed but is still occupying that bed. A patient is ready for transfer when: a clinical decision is made that the patient is ready for transfer; a multi-disciplinary team decision has been made that the patient is ready for transfer; and the patient is safe to discharge/transfer."

¹⁴ Department of Health (2001). *Hospital Episode Statistics, 2000-01*.

The effective discharge of older patients from NHS acute hospital care involves a range of different agencies

1.10 Delayed discharge is not wholly, or even predominantly, about what happens in hospital. Internal hospital processes such as the co-ordination of discharge planning and the availability of transport to take patients home, play a part, and there is much hospitals can do to ensure their discharge procedures are efficient. However, the provision of care in the community can exert greater influence on levels of delayed discharge and the length of delay¹⁵. Without somewhere to discharge to, hospitals have little option but to retain patients.

1.11 Most episodes of hospital care will, therefore, involve a range of staff from different NHS organisations and other non-NHS agencies (Figure 4). Patients may be discharged from hospital to their own home or to residential care, and in many cases require further 'intermediate' care¹⁶ in the community. Thus, discharge from acute hospital care marks the boundary between NHS acute care and the more specialised continuing and community health services of the NHS, local authorities and the independent sector.

1.12 In January 2003 the Department of Health issued a guide, 'Discharge from hospital: pathway, process and practice' designed to assist health and social care commissioners, managers and practitioners working in the statutory and independent sectors to improve local hospital discharge and practice. This builds on the 'Hospital Discharge Workbook' published in 1994.

There are multiple causes of delayed discharges

1.13 The Department analyse the main causes of delay. While older people are not identified separately, the information is nevertheless useful, since delayed discharges for those aged over 75 make up some 77 per cent of the total. Nationally, the most common causes (together accounting for 70 per cent of total delays) are patients awaiting: public funding; a care home placement; assessment; and transfer to further NHS care (Figure 5). Figure 1 on page 2 shows where these problems may occur in a simplified care pathway that many older patients will follow. We examine in more detail four areas of England where one of these four causes is a particular problem in the case studies on pages 14 and 15.

4 Roles of the key agencies involved in the discharge of older patients

Department of Health: responsible for managing the overall health and social care system, developing policy and managing change at the national level, as well as regulating and inspecting the NHS.

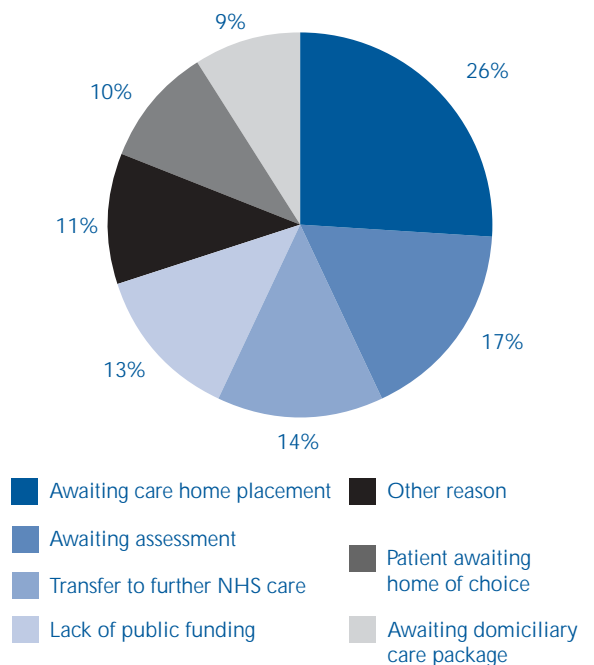
NHS acute trusts: Providers of hospital care, usually offering a general range of services to meet most people's needs.

Primary Care Trusts: Commissioners of healthcare and providers of it for those who do not require hospital care. Responsible for planning and securing health services and improving the health of the local population. Responsible for integrating health and social care.

Local authorities: Social services departments commission and provide community care, either short - or long-term, in the home or in residential/nursing care. Housing departments provide some sheltered housing places and arrange for adaptations to homes.

Independent (including voluntary) sector: The independent sector provides the bulk of the residential (long-term non-medical care for those who cannot be supported at home) and nursing (nursing care in a residential setting) in a care home. In addition, the voluntary sector - bodies such as Help the Aged and Age Concern - represents older people's interests.

5 Causes of delayed discharge (all ages) - 30 September 2002



Source: Department of Health

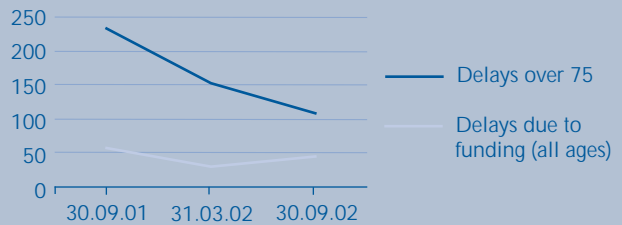
15 Including factors such as resource constraints in social services departments, capacity in the local residential care sector and exercise of patient choice of care home to which they are discharged.

16 The Department of Health defines intermediate care as care which is: targeted at people who would otherwise be held in hospital or admitted to a hospital or similar inappropriately; delivered through a care plan resulting from comprehensive assessment; aimed at maximising independence; normally time-limited to six weeks; and involves cross-professional working (Health Service Circular 2001/001).

Health Authority case studies: how different causes imp

CHESHIRE AND MERSEYSIDE STRATEGIC HEALTH AUTHORITY

- funding problems in the local health and social care community



September 2002

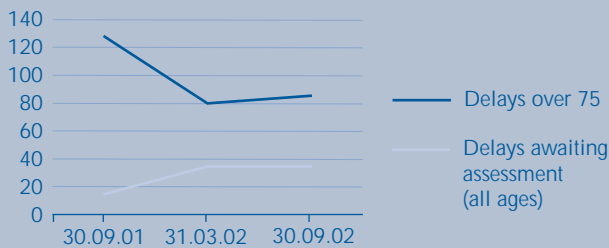
Total number of people over 75 whose discharge is delayed	107 (5.6 per cent)
Number delayed awaiting public funding (all ages)	44 (26.2 per cent of the total)
National average percentage of delays awaiting public funding	12.9 per cent

Within this Health Authority area the number of delayed discharges among older people more than halved between September 2001 and September 2002. Building Care Capacity Grant (paragraph 4.21) money has been used to fund a range of improvements including equipment services, therapist assessments, alternatives to emergency admission, more domiciliary care and assisted discharge schemes. Change Agents have worked with delay "hotspots" to set up whole systems, integrated approaches to discharge and to encourage the development of strategies for older people's services across health and social care communities. Nevertheless, delays caused by severe

budgetary pressures among some councils within the Health Authority area remain and are difficult to remove, even through the measures above, because the issues involved run wider than health and social care of older people. A series of high level meetings have recently taken place between representatives of health and social care within the most challenged areas of the Authority. On the other hand, the level of delays "awaiting funding" can rise and fall sharply in the short term, and weekly monitoring returns at the beginning of 2003 indicated that the problem had declined appreciably in this Health Authority area since September.

COUNTY DURHAM AND TEES VALLEY STRATEGIC HEALTH AUTHORITY

- backlogs of people awaiting post-hospital needs assessments



September 2002

Total number of people over 75 whose discharge is delayed	86 (5.6 per cent)
Number delayed awaiting assessment of care needs	34 (30.9 per cent)
National average percentage of delays due to assessment	17.3 per cent

Building Care Capacity Grant (paragraph 4.21) has had a very beneficial effect in this local health community, with delayed discharges falling by more than one third in the latter half of 2001-2. However, at the same time a backlog of needs assessments became, and has remained, a prominent issue in the area covered by the Authority. In September 2002 the problem was mainly located in the Tees Valley area, although delays in individual cases were generally of days rather than weeks. There were two main causes. These were:

- inappropriate referrals for assessment, although a push to integrate hospital-based social workers better within multi-



disciplinary teams has improved the quality of assessment referrals and discharge decisions; and

- a shortage of occupational therapists for assessment work.

Thanks to their history of strong working relationships, the council and the local Primary Care and acute trusts were able to respond by setting up an integrated occupational therapist service with additional resources. A joint manager was appointed in December 2002, and there remains a continuing need for specialist nursing staff to carry out assessments of the elderly mentally ill. By the end of 2002, local monitoring was recording a significant impact on delays from the above changes.

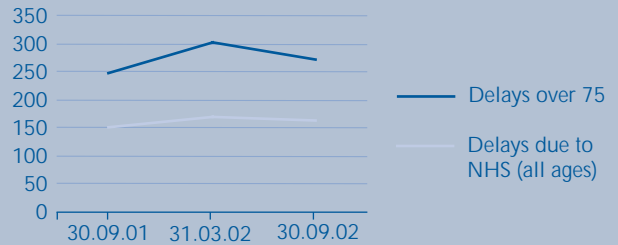
Impact on delayed discharges

SOUTH WEST PENINSULA AND DORSET & SOMERSET STRATEGIC HEALTH AUTHORITIES

- problems of bottlenecks within the system



The rural nature of the South West of England means that acute trusts draw their patients from wide geographical areas. Once patients no longer require acute care, it is common practice to discharge them to one of a network of community hospitals closer to where they live. However, delays in discharging people to these community hospitals is an issue right across Dorset, Somerset, Devon and Cornwall, and accounts for the high proportion of delays "due to NHS care" in the South West. Community hospitals are experiencing their own delayed discharge problems, but the extent of these is not clear because data on delayed discharges is not currently collected in non-acute settings in the same way as acute (see paragraph 1.9).



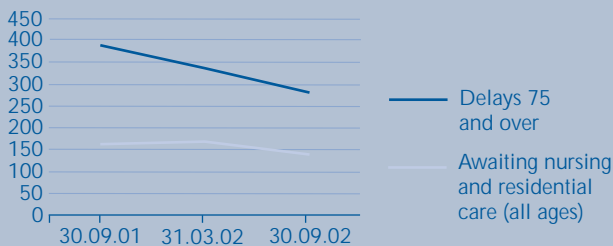
September 2002

Total number of people over 75 whose discharge is delayed	271 (10.5 per cent)
Number delayed awaiting further NHS care	164 (47.7 per cent of the total)
National average percentage of delays awaiting further NHS care	14.1 per cent

Hence, although the underlying causes of delayed discharge in the South West may appear very similar to other parts of the country, some causes are hidden because they are being experienced by the community hospitals rather than acute hospitals. For the same reason, the proposed system of "reimbursement" will not have an impact here, because the official cause of delay is the NHS Community Hospital, not the absence of appropriate post-hospital care. South West Peninsula and Dorset & Somerset Strategic Health Authorities are currently reviewing data collection on delayed discharge, with a view to getting a clearer picture of what is really happening across the whole health and social care system.

HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HEALTH AUTHORITY

- problems of under-capacity in nursing and residential care



September 2002

Total number of people over 75 whose discharge is delayed	282 (15.6 per cent)
Number delayed awaiting nursing and residential care (all ages)	140 (38.4 per cent)
National average percentage of delays awaiting nursing and residential care	25.5 per cent

Building Care Capacity Grant has had a continuing beneficial impact on this area over the 12 months since it was introduced. Overall delays for people over 75 fell by over one-quarter between September 2001 and September 2002. However, the major cause of delay remains a shortage of affordable nursing and residential care places. There have been significant home closures, caused by high property prices, the cost of new care standards, uncertain commissioning arrangements and difficulties in recruiting staff (covered in paragraphs 4.9, 4.27 and 4.29 of our report). Despite recent fee increases, many private "self-funders" and those from London boroughs are willing and able to pay more (see paragraph 4.4). Local councils are addressing the problem through a range of initiatives including:



- targets to promote the independence of older people in local public service agreements;
- proposals to increase nursing home capacity using NHS and council facilities;
- conversion of council residential beds to extra care sheltered housing;
- provision of new public sector nursing home provision jointly funded by County Council and Primary Care Trust;
- work with the Change Agent Team.

Nevertheless, progress in making and maintaining reductions in the level of delays has varied from area to area, as the underlying causes described above continue to exert pressure on the system.

1.14 While the Department's data covers the main causes of delay, there is considerable variation in the extent of each factor across the country. People awaiting a care home placement, for example, accounted for one-third of delayed discharges in the former Eastern region but only 15 per cent in the North West. Discussions with staff within local health communities also highlighted that a complex network of (often interdependent) local causes had an impact within a single area (see [Figure 6](#)). A breakdown of the variations across Strategic Health Authorities, based on the most recent reliable figures, is shown at Appendix B.

Delays in discharge can have significant impacts on patients, their carers and the wider NHS

1.15 As noted in paragraph 1.5 the length of time discharge can be delayed varies considerably. Many are short - typically over one weekend - caused, for example, by a lack of social care help for the person returning home. However, some 34 per cent last for more than one month. [Figure 7](#) highlights two examples of longer delays being caused, in part, by a lack of information on their options being given to patients and carers.

1.16 Prolonged and unnecessary hospital stays (even for only a few days) can have a range of effects. In particular, they can:

- result in increased dependency, making long-term institutionalisation more likely, loss of patient confidence in their ability to cope, depression, loss of choice and control, and increased chance of contraction of a hospital-acquired infection;
- have an adverse effect on the use of NHS resources. The NHS Confederation has calculated that delayed discharges account for around 2.2 million lost bed-days for all types of NHS bed each year.¹⁷ Various estimates of the annual cost have been made, ranging from the Department's £220 million to the Health Select Committee's £720 million;
- cause other patients to wait longer for care elsewhere in the system, extend waiting times, lead to cancelled operations, and increase the risk of trolley waits for admission; and
- affect NHS staff. A report in 2001¹⁸ examining stress among charge nurses and ward sisters found they experienced particular difficulties handling patients who were in the wrong place at the wrong time.

6 Factors influencing delayed discharge in local health communities

When we spoke to and visited one local health community the parties involved identified a variety of factors influencing high levels of delayed discharge. These were:

Internal hospital factors

- Clinical professionals not focusing on the whole patient experience, simply on a particular ailment.
- Heavy workloads meaning that discharge planning was not prioritised.
- Shortage of specialist staff.

Relationship factors

- Over-complicated access arrangements for intermediate care.
- Lack of support for carers.
- Occupational therapists under-staffed and over-compartmentalised.
- Assessment process slow and cumbersome - single assessment tool problematic.
- Lack of single patient record.
- Inconsistent definition between sectors.
- Additional funding for intermediate care not ring-fenced.

External factors

- Overall lack of social services funding and competition with other priorities (especially children).
- Lack of capacity in residential sector.
- Shortage of qualified social workers and high-calibre care assistants;
- Patients waiting for their preferred residential home.

Delayed discharges arising despite:

- Well-established programme of joint delivery of health and social care for older people.
- Excellent personal relationships between health and social services at senior level.
- Vital contribution from geriatricians.
- Discharge planning increasingly inclusive of all sectors.

1.17 There is also concern from carers of older people (primarily family and friends) about the ways in which discharge is handled. In 2001, the Carers National Association reported that, in their view, the problem of discharge had got worse in recent years despite government guidelines, with fewer consultations with carers prior to discharge, fewer patients and carers receiving a discharge plan, and less attention paid to the wishes of patients and carers.¹⁹

¹⁷ House of Commons Health Committee (2002). *Delayed Discharges. Third Report of Session 2001-02, HC 617 - paragraph 31.*

¹⁸ Policy Studies Institute (2001). "Stress among ward sisters and charge nurses".

¹⁹ Carers National Association (2001). "You can take him home now". *Carers' experience of hospital discharge.*

7 Examples of the delays in discharge from acute care experienced by two older patients

Example 1

Mrs A is an elderly woman who lives with her husband in their family home. Mrs A had a history of health problems and regularly received care at the local hospital. Following a fall, she was admitted. During her stay on the rehabilitation ward, decisions about appropriate discharge arrangements were made, but with only limited discussion about the options available, other than discharge to a nursing home. Mrs A and her husband were adamant that she should return home, but for a number of weeks there were delays in getting hold of equipment and adaptations to support Mrs A at home. Eventually, she was discharged back home with the support of her husband and a suitable care package.

Example 2

Ms B lived alone in her own first-floor flat prior to her hospital admission. Through her GP's referral she was admitted into hospital and diagnosed as having had a stroke. After admission and a stay in the rehabilitation ward, it was agreed that residential care would be the appropriate discharge option. There followed a long wait, caused by a lack of social services funding. Ms B was transferred seven times during her hospital stay, where she became depressed and suffered a further stroke. The frustration and uncertainty felt by Ms B and her family whilst waiting for funding eventually caused them to seek alternative solutions for payment. Ms B and her family were not offered any information or any explanation about other solutions or discharge options for Ms B beforehand by the NHS or social services.

Source: Tyrer, J & Sandys, M - Caught in the system: a study of delayed discharge

A range of government initiatives aim to address the problem of delayed discharges

1.18 The Government aims to end widespread delayed discharge by 2004²⁰ and reduce them to minimal levels by 2006²¹. This ambition is reflected in both longer-term initiatives such as the NHS Plan²² and the National Service Framework for Older People²³, and in targeted shorter-term initiatives such as the Building Care Capacity Grant²⁴ (see Part 4). In addition, a range of wider initiatives have a direct and indirect impact on delayed discharges. For example, in July 2002 the Secretary of State announced an additional £1 billion for older people's services over the period 2003-6 (Figure 8 overleaf).



²⁰ Department of Health (2000). *The NHS Plan. A plan for investment. A plan for reform.* Cm 4818.

²¹ Department of Health (2002). *Planning and policies framework 2003-6.*

²² Department of Health (2000). *The NHS Plan. A plan for investment. A plan for reform.* Cm 4818.

²³ Department of Health (2001). *National service framework for older people.*

²⁴ Department of Health (2001). *Building capacity and partnership in care. An agreement between the statutory and the independent social care, health care and housing sectors.*

8 Key Government initiatives to tackle delayed discharges

Initiative	Main features
NHS Plan	<p>The Plan pledged that health and social services would put older people at the centre of service delivery through:</p> <ul style="list-style-type: none"> ■ assuring standards of care - through the National Care Standards Commission; ■ extending access to services - through a Single Assessment Process for health and social care and the launch of Care Direct to provide advice on health and social care; ■ promoting independence - in the future emphasis should be on encouraging independence rather than institutional care, and providing high-quality support at home. £150 million would be made available in 2000-01 and £900 million for intermediate and related services from 2001-02 to 2003-04 to assist this; and ■ fairness in funding - in response to the report of the Royal Commission on Long Term Care²⁵, the value of a person's home would be disregarded for the first three months after their admission to residential or nursing care. Nursing care in nursing homes would be fully funded²⁶. These measures were expected to cost some £360 million to 2004. The Government decided not to fund personal care²⁷, unlike in Scotland.
National Service Framework for Older People	The National Service Framework emphasises the importance of building up capacity in the intermediate care sector, and of other areas relevant to delayed discharge such as the patient's experience of care, the improvement of in-hospital assessment, and prevention being more cost-effective than cure.
'Building care capacity' grant	A £300 million grant was designed to release 1,000 additional beds in NHS hospitals by March 2002, and to reduce the number of older people remaining in hospital unnecessarily through lack of intermediate care provision by 2,300 during 2002-03. £100 million was to be spent in 2001-02, and £200 million to 2002-03. The majority of the money was allocated to local authority social services departments, with the remainder being allocated to Health and Social Care Change Agents (see paragraph 3.18), to facilitate improvements in health and social care communities with specific problems.
Increased personal social services funding and a system for reimbursement around discharge from hospital	In the Budget statement of April 2002, the Government announced a 6 per cent real-term average annual increase in expenditure on social services from 2003-04 to 2005-06. In his statement on older people's services in July 2002 ²⁸ , the Secretary of State said that £1 billion of this overall increase will be used to develop services for older people, including intermediate care, home care, care homes, extra care housing, community equipment, services for carers and a rapid expansion of the direct payments scheme ²⁹ . To accompany these extra resources, the Government intends, subject to legislation, to introduce by April 2003, a system of reimbursement at the point when responsibility for a patient's care transfers from the NHS to social services.

Source: National Audit Office

We have built on other examinations

1.19 In 2000, the NAO reported on the subject of *Inpatient Admissions and Bed Management in NHS Acute Hospitals*³⁰, including practices for discharging patients. The Committee of Public Accounts subsequently produced their own report in 2001³¹. Where appropriate, we have made explicit comparisons in Parts 2 and 3 between 1999 and 2002, and comment on progress made against the Committee's conclusions and recommendations (see Appendix C).

1.20 In undertaking our work, we have also taken into account the work of the Audit Commission, which reported in October 2002 on *Integrated Services for Older People: Building a whole system approach in England*. This highlights the importance of those providing services for older people working together if they are to meet people's needs and aspirations effectively. We also took account of the work of the House of Commons Health Committee's report *Delayed Discharges* (3rd Report 2001-02 HC 617). Appendix D summarises the main recommendations from these examinations.

25 The Royal Commission on Long-Term Care was set up in April 1998 to recommend how the cost of long-term care for the elderly should be apportioned between public funds and individuals. It reported in March 1999.

26 Through three bands of weekly funding (assessed by a nurse): currently £35, £70 and £110.

27 Defined by the Royal Commission on Long-Term Care as "non-medical services that involve close personal care and touching".

28 *Expanding Services and Increased Choices for Older People (investment and reform for older people's social services)*, Tuesday 23rd July 2002. DoH Press Release: reference 2002/0324.

29 Defined by the Department of Health as "cash payments in lieu of social care services".

30 National Audit Office (2000). *Inpatient Admissions and Bed Management in NHS Acute Hospitals - HC 254, Session 1999-00*.

31 Committee of Public Accounts (2001). *Inpatient Admission, Bed Management and Patient Discharge in NHS Acute Hospitals - HC 135, Session 2000-01*.

Part 2

Working within acute hospitals to reduce delayed discharges

- 2.1 Part 1 looked at the record of delayed discharge of older people from NHS acute trusts and the causes of those delays. This Part examines progress made within acute hospitals to reduce unnecessary delays in the discharge of older people to the next stage of care. It provides the opportunity to examine progress within hospitals since we last reported on discharge practices in early 2000³².
- 2.2 Although the needs of patients are varied, much about their condition and required treatment is predictable, and plans can be made for when they are ready to move to a more appropriate setting. Planning in hospital needs to start early, and to involve a wide range of relevant parties, both inside and outside the NHS, and in both medical and non-medical roles. Much can be done to overcome the minor obstacles within hospital that can lead to delays.
- 2.3 In 1994 the Department issued the Hospital Discharge Workbook to encourage "the development of systematic arrangements for the discharge of patients from hospital". It identified the main problem areas as administrative inefficiency and poor communication and co-ordination. Development of a hospital discharge planning policy - setting out the good practice in patient care that will be applied to all patients discharged - has become widespread. Discharge planning policies are now almost universal within Trusts (compared with 77 per cent of Trusts in 1999). **Figure 9** outlines a good-practice example of the sort of discharge policy
- developed by almost all hospitals, and the example below illustrates the impact that effective discharge planning has had at the same NHS Trust.
- 2.4 Acute trusts should circulate their discharge policy to those involved in discharge outside the Trust so that all are clear what is expected of them, and what they can expect from the hospital. Currently, the extent of circulation varies. Social services, in particular, are likely to be provided with the policies of hospitals in their area, but other parties are much less likely to have seen it. For example, fewer than 30 per cent of Trusts circulate the policy to local general practitioners.
- 2.5 Currently, planning for discharge only begins before the patient arrives in planned admissions in just over half of Trusts (69 per cent in 1999), and on admission for emergencies in under half of Trusts (74 per cent in 1999). Setting a target date also helps staff to focus on discharge in the face of other demands on their time. According to our survey, a provisional date was not set at the time of planned admissions in nearly three out of ten acute trusts, and for emergency admissions in nearly eight out of ten.

Discharge planning could be more timely

- 2.3 In 1994 the Department issued the Hospital Discharge Workbook to encourage "the development of systematic arrangements for the discharge of patients from hospital". It identified the main problem areas as administrative inefficiency and poor communication and co-ordination. Development of a hospital discharge planning policy - setting out the good practice in patient care that will be applied to all patients discharged - has become widespread. Discharge planning policies are now almost universal within Trusts (compared with 77 per cent of Trusts in 1999). **Figure 9** outlines a good-practice example of the sort of discharge policy

EXAMPLE

Discharge planning at St Mary's Hospital Trust

Discharge planning at St Mary's Hospital has reduced levels of delay from about 50-60 per week in the mid 1990s to about 10-15 now. They have adopted an integrated team approach, empowering ward staff and changing the culture, particularly among clinicians.

Source: Audit Commission

The quality of liaison within acute Trusts remains variable

- 2.6 Identifying potential problems and having someone responsible for dealing with them is also important. Some two-thirds of acute trusts told us that they have conducted exercises to map older patients' pathways through hospital care as a diagnostic aid to identifying bottlenecks. A number discovered problems this way. For example:
- a recurring theme identified by several Trusts concerned delays resulting from waits for tests and communication of test results, especially if tests were carried out in a physically separate location;
 - a hospital in the North West identified in a December 2001 exercise that one-third of all "medically stable" patients could have been returned

9 Example of a discharge planning policy

St Mary's NHS Trust Discharge Planning Processes

Within the first 24-48hrs

- 1) Admitting nurse commences discharge planning documentation, ensuring that details/contacts are recorded.
- 2) Current home/housing situation and existing community support services identified.
- 3) Assessment of the need for Social Services referral/identification of borough of residence.
- 4) Identify the need for referrals to other members of the hospital multidisciplinary team, e.g. occupational therapist, physiotherapist, etc. Refer as necessary.
- 5) If discharge appears to be complex or problematic, contact the discharge team as soon as possible.

From 2 days onwards

- 1) Ensure multidisciplinary referrals have been received, identify allocated worker and regularly update on patient's condition.
- 2) Assess the need for a Network Meeting, co-ordinate with both hospital and community professionals, include where appropriate the patient and their family/carer.
- 3) Hold network meeting, aim to establish the patient's needs, how they will be met, and who is to provide services. Also set a discharge date, or dates for further meetings if necessary.
- 4) If no network meeting necessary, liaise with the multidisciplinary team to identify needs, set up services and establish discharge date.
- 5) Ensure all members of the multidisciplinary team are aware of the discharge date; social services will need at least three working days notice.
- 6) Establish GP; if the patient is not registered this will need to be done prior to discharge.

48-24 hours prior to discharge

- 1) Patient confirmed as medically fit for discharge.
- 2) Doctors to write up tablets to take away, ideally 48 hours prior. Medication to be explained to the patient or carer.
- 3) Referral to district nurses to be made, ideally 48 hours prior.
- 4) Assess the need for transport, and fax booking form, **at latest 24 hours prior** (e.g. morning transport must be booked before 1pm the day before).
- 5) Confirm social services provision and any necessary occupational therapy equipment is in place.
- 6) Inform patient and next of kin, giving 48 hours notice if possible.
- 7) Return patient's property, and ensure they have access to their accommodation, ie are in possession of their keys, or will be met by family/carer.

Source: St Mary's NHS Trust

home or to the care of their GP had it not been for internal delays such as awaiting tests or results. In response, the Trust identified as a key area for development the fostering of a culture that would "pull" patients through the system and challenge existing care pathways to "manage", rather than "react to" patient care. This is being done, besides other more immediate measures, through a project to redesign the whole system of care within the Trust;

- one London acute trust identified the need to reorganise junior doctors' working practices so that they could be present at multi-disciplinary team meetings to discuss discharge. This dramatically reduced the delayed discharge rate.

2.7 The absence of medicines to take home is a common cause of short-term delays, as hospital pharmacies often receive little warning of discharges. They are only involved in the decision about the date of discharge in

44 per cent of acute trusts. And the transport department is only involved in decisions in 62 per cent of Trusts. Physical isolation of the transport department, lack of adequate warning from ward staff that the patient was ready to leave, and limited hours of operation were all reported as problems.

2.8 Having someone to co-ordinate discharge and deal with (often minor) obstacles is now widely seen as essential. Eighty-two per cent of acute trusts now have a discharge co-ordinator, whose role is to improve the effectiveness of discharge, an increase from 70 per cent in our 1999 survey. These co-ordinators should be easily accessible to staff responsible for patients and kept informed about patients daily. Three-quarters of discharge co-ordinators have informal daily contact with the wards. Two-thirds of Trusts have gone further and set up a discharge team, as recommended by the Department's Health and Social Care Change Agent Team³³.

³³ Paragraphs 3.18 to 3.21 give further details of the Change Agents' role.

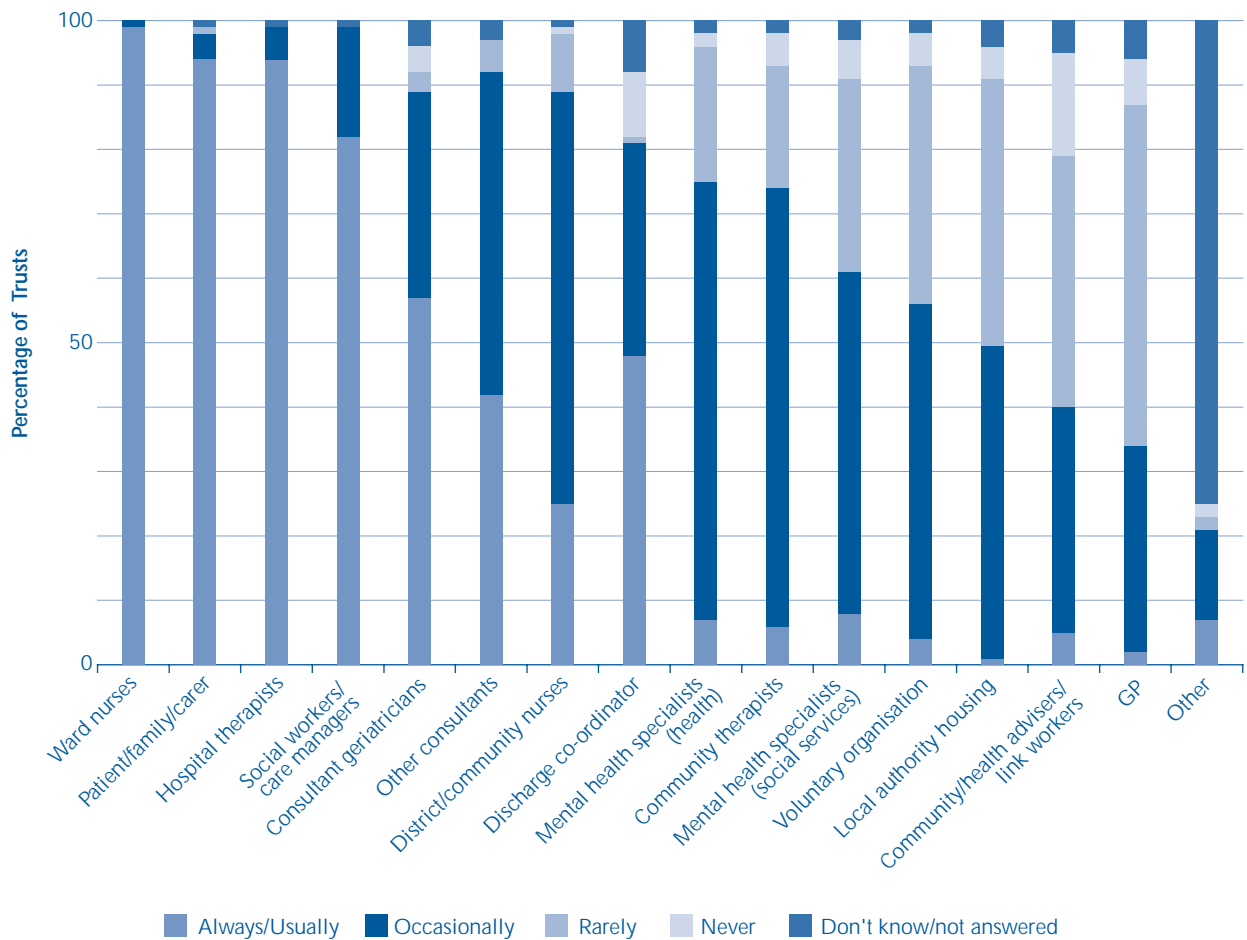
Delays in starting and completing assessments are the main cause of delayed discharges within the hospital

2.9 Before a patient can be discharged, an assessment must be carried out of their medical, functional, social and psychological needs. Multi-disciplinary assessments are seen as best practice for those with complex post-hospital needs, but may involve between five and 10 staff from hospital, community and social services. Awaiting completion of an assessment accounts for 17 per cent of all delayed discharges of older people, arising usually from delays in starting the assessment process (due to staff shortages or the non-availability of existing care plans) and the length of time taken to conclude it.

2.10 The assessment process should start early but, even for planned admissions three out of 10 Trusts do not currently begin them until some point during the patient stay. For emergency admissions, arrangements are improving. Whereas in 1999 only 40 per cent of Trusts commenced the assessment process on admission, the figure has now risen to 56 per cent. However, it is not uncommon for local social services to allow themselves a period after a patient is designated fit for discharge to complete arrangements for care, sometimes with agreement from the acute Trust.

2.11 Not surprisingly, key hospital staff and patients and their carers were most frequently involved in assessments in hospital (Figure 10), although among non-health staff, social workers are the only frequent participants. Even a hospital's own discharge co-ordinator is likely to be regularly involved in fewer than half of locations.

10 Professionals involved in the assessment of older patients' needs



Source: National Audit Office trusts survey

2.12 Given their likely prior knowledge of the patient, it is surprising that our survey found that district nurses and GPs are unlikely to be involved in assessments. The NHS Alliance, which represents primary care organisations, attributes this to heavy demands being made on the time of these staff. In the light of this, we asked whether the patient's existing care plan (which outlines the needs of the patient with the intended actions and the professionals involved) was available at the start of the assessment process. In more than 50 per cent of Trusts it was rarely or never available, which could unnecessarily increase the time taken to complete the assessment. The example below shows how one health and social care community ensures that the necessary information is available when required.

EXAMPLE

The role of the "tracker" nurse in Cambridge

A "tracker nurse" from the community in Cambridge follows older people through the hospital system to make sure that information that is held by community services transfers with them. This reduces delays in transfers and ensures that information on the older person is available immediately when it is required.

Source: Audit Commission

The introduction of the Single Assessment Process is intended to make assessments more efficient, but progress has been slower than originally planned

2.13 The Department plan to introduce a Single Assessment Process, to make the task more efficient and more focused on the patient by:

- simplifying the process to avoid duplication and wasted effort; and
- standardising approaches to ensure that assessments are genuinely needs-led and do not reflect the priorities of assessors.

One by-product of the introduction of the Single Assessment Process should be to allow greater use of care workers such as care assistants in assessment processes and to encourage more multi-disciplinary team working between sectors.

2.14 The National Service Framework for Older People required that the Single Assessment Process be introduced from April 2002. However, because of the complexities of the task, detailed guidance published subsequently specified

that full implementation is now required by April 2004. The timing of this will match with the introduction of the Health Record Service (see paragraph 2.16). Progress is shown in [Figure 11](#). Trusts and their partners are most advanced in the areas of developing shared aims and objectives, and least where agreement is required on detailed operational issues around working responsibilities and the role of clinicians.

2.15 Only 5 per cent of NHS Trusts did not have barriers to overcome in implementing a Single Assessment Process at the time of our survey. The main ones cited by acute trusts were shortfalls in health and social services funding and staffing³⁴. Unwillingness to co-operate was rarely an issue. The other main concern - for over 40 per cent of Trusts - was dissatisfaction with the tools available. Although the Single Assessment Process can be paper-based, most organisations see the benefit of developing it in electronic form at the earliest opportunity. One type of off-the-shelf software tool is preferred by over one-third of respondents, while another one-quarter are developing their own.

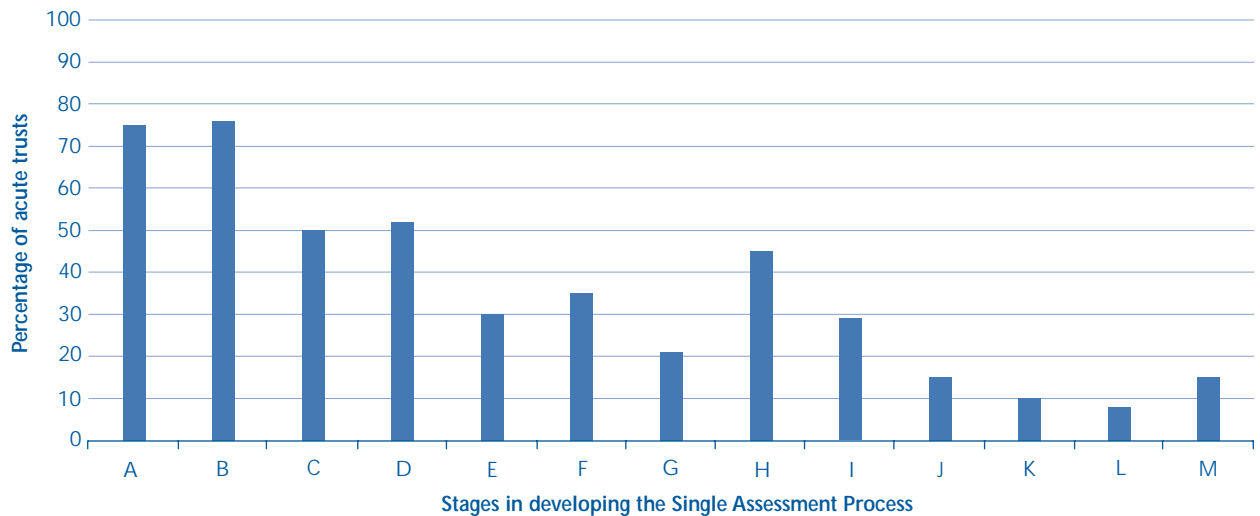
2.16 All the agencies with whom we spoke emphasised the importance of joint electronic record systems, offering access and input to patient records, to optimise the assessment process. This is a wider NHS issue, of which the Single Assessment Process is only one element. As part of delivering the NHS Plan, the Government is committed to all hospital sites having basic Health Record Service functionality by the end of 2005, working towards the development of integrated care records services whose main elements are expected to be in place by 2008.

2.17 One-quarter of acute trusts currently have a system of joint records with social services, although these are largely paper-based rather than electronic. Fewer than 10 per cent of Primary Care Trusts have an electronic system. Most Trusts with a system of joint records had detected a positive impact on the rate of discharge, and were more likely to have achieved each step of the Single Assessment Process than those without.

Shortages of specialist staff increase the risk of delayed discharges

2.18 Two groups whose shortages have a particular effect on delayed discharge are social workers and therapists. Both are heavily involved in the assessment process. In our survey, shortage of social services staff, occupational therapists and physiotherapists affected discharge rates in the opinion of 63, 61 and 57 per cent of Primary Care Trusts respectively, compared, for example, with only 15 per cent that thought the same was true for shortages of consultants.

11 Progress towards the Single Assessment Process



- A Agreed on the outcomes that need to be achieved through the implementation of the Single Assessment Process.
- B Agreed on the shared values that underpin the joint approach of assessment and planning.
- C Reviewed the terminology in local use to describe assessment and other care processes, and agree a common language.
- D Identified how older people currently move through the system, from point of access to delivery of a service and, as part of this, mapped current systems of assessment and care planning.
- E Estimated the types and numbers of older people needing help and the type of assessment they receive.
- F Agreed the stages of assessment, care planning and care management.
- G Reached an understanding of how medical diagnosis fits within the Single Assessment Process.
- H Agreed the domains and sub-domains of the overview assessment.
- I Work to, or adopted, a common approach to assessment. Agreed the assessment tool or approach used for the overview assessment.
- J Agreed joint working arrangements for assessment and care planning, and protocols for the involvement of professionals in these processes.
- K Work to an agreed single assessment summary for the collection of information on older people who are assessed, whether or not they go on to receive services.
- L Agreed and implemented a joint staff development strategy.
- M None of the above.

NOTE

These stages are broadly in chronological order, but some can be progressed simultaneously.

Source: National Audit Office survey

2.19 These shortages remain a problem, despite an increase in the numbers of physiotherapists by 14 per cent and occupational therapists by 21 per cent between 1997 and 2001. A panel of experts, the Older People's Care Group Workforce Team, has been set up in association with the National Service Framework for Older People to look at these issues. It has advocated increases in the number of training places for occupational therapists and physiotherapists, which have grown by 22 and 25 per cent between 1998 and 2001. The numbers of social work staff working with adult/older clients has also increased in recent years.

2.20 The NHS Plan pledged 6,500 more therapists and other health professionals by 2004. By September 2002 there had been an increase of 1,140 physiotherapists and 1,250 occupational therapists, part of an overall increase of 3,400 professional staff. Despite this

increase in posts, three-month vacancy rates for occupational therapists in the NHS rose from 2 per cent to 4.1 per cent between 1999 and 2001. The number employed in generic and adult services roles in local authorities remained static.

2.21 There is, however, scope for making more of existing resources. Occupational therapists are employed by the NHS and community services in many areas. Reviews by the Department of Health Change Agent Team (see paragraphs 3.18-3.20), the Social Services Inspectorate and the Commission for Health Improvement, as well as internal hospital reviews, have identified unequal workloads, duplication of work and delays in hand-over of patients from one group to the other. Combined therapy services are increasingly seen as appropriate, and more integrated working between therapists is recommended by the Change Agent Team.

Patients and carers believe they should be more involved in discharge planning

2.22 Older patients are often making major decisions about their future when leaving hospital, and need time to consider their options when considering a discharge or care plan. Although patients and carers should have the option of being fully involved in the care plan, for many patients being kept abreast of developments is often enough.

2.23 Almost all the Trusts surveyed said that they did consult patients and carers during the hospital discharge process. However, other research³⁵, confirmed by our consultation with older people in conjunction with the Audit Commission, suggests that relatively few patients and carers have been actively involved in decisions about post-discharge arrangements. **Figure 12** summarises the main concerns for patients and their carers. Problems with any of these can cause stress and anxiety, and may result in deterioration, rather than improvement, in health.

2.24 Many carers considered that they had had little involvement and information prior to discharge. In particular, many said they were not consulted prior to a patient being discharged (with the proportion consulted apparently falling between 1998 and 2001³⁶), and only one in five received a copy of the discharge plan. In contrast, when the Trusts were asked about the involvement of carers, 98 per cent considered they had consulted them. This disparity in perceptions emphasises the need for trusts to improve communication with patients and carers. The example below illustrates how the concerns of patients and their carers can be taken into account.

EXAMPLE

Taking the needs of patients and carers into account

Northumberland Health Authority and Northumberland County Council have published a joint "Hospital Discharge Agreement". It covers discharge policies, procedure and practice in all hospitals. Carers were involved in its production and their needs and those of the patient are central to the discharge agreement.

Source: Carers UK

12 Main concerns for patients and carers

Many consider they are poorly informed about:

- the range of care services available;
- whom to contact for additional help;
- the level of involvement in discharge planning;
- the provision of services they will receive after they leave hospital; and
- receipt of services such as aids and adaptations or day care services.

2.25 The desire of a patient or carer for admission to post-hospital care of their choice is a factor in delayed discharge. This is becoming more significant as the number of delayed discharges decreases, since it is unaffected by short-term additional funding and is linked more to the declining choice of care homes in many areas. This is a particular challenge in areas where there are large numbers of "self-funders"³⁷. Hospitals are increasingly moving towards a policy of "interim placements" for patients facing a long wait for the home of their choice. This has to be balanced against the acknowledged health dangers of moving frail older people with dementia between places of residence. Thirty-seven per cent of acute trusts have a policy for "difficult to place" patients - with those having a higher proportion of older patients and higher levels of delayed discharge more likely to have one.

Rising re-admission rates are a risk when the emphasis is on discharging patients quickly

2.26 Patients being re-admitted to hospital within a short period of time may be an indicator of problems with the original discharge processes or poor quality services. In the second quarter of 2002-03, just over 8 per cent of older patients were re-admitted to hospital as an emergency. The Department's measure of an emergency re-admission cuts off at 28 days after the original discharge.

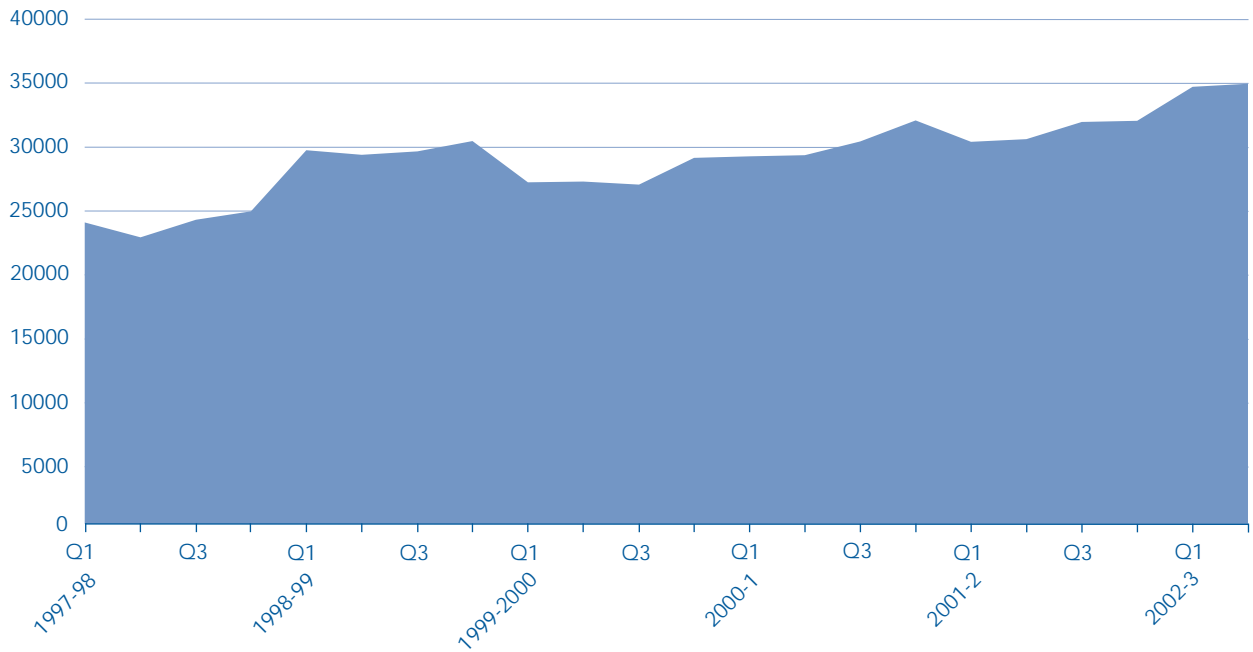
2.27 While the proportion of emergency re-admissions has not changed greatly since 1997, there has been a steady increase in the number as hospitals have dealt with more patients (see **Figure 13**). We found that those responsible for discharging patients monitored emergency re-admissions in only 17 per cent of acute trusts, and that slightly more monitored the causes of re-admission.

35 For example, Carers National Association, June 2001, "You can take him home now" Carers' experiences of hospital discharge. Published by Carers Health Matters.

36 Carers National Association, *ibid*.

37 "Self-funders" are people who do not rely on local authority financial support for residential care and are often in a position to "outbid" others for places in the most desirable homes.

13 Number of emergency readmissions of over 75s within 28 days



NOTE:

For 2002-3 figures, the same caveats about completeness and accuracy apply as for delayed discharge data (paragraph 1.8).

Source: Department of Health



Part 3

Co-ordinating health and social care agencies to reduce delayed discharge levels

3.1 Part 1 showed that the effective discharge of older patients can involve a wide range of agencies. Many of the causes of delayed discharge - particularly, those leading to longer delays - arise from a lack of co-ordination between different health and social care agencies. This Part examines progress in developing co-operation.

There are significant benefits from joint working, but a number of obstacles need to be overcome

3.2 For several years, the Government has encouraged better co-ordination and co-operation, in order to improve the delivery of public services and focus on users. The Audit Commission's report *Integrated services for older people: building a whole system approach in England* (2002) highlights the relevance of closer working for older people's services. This is particularly because older people's needs are complex and varied. The Audit Commission have suggested that "with so many players involved, it is all too easy for services to suffer from fragmentation, duplication and a lack of direction and co-ordination." The Government's National Service Framework for Older People also recognised the need for co-operation across boundaries to help improve healthcare. The Social Services Inspectorate's national inspection report, *Improving Older People's Services: Policy into Practice*, published in October 2002, observed that continuing problems with arrangements for hospital discharge often related to communication between NHS and social services staff.

3.3 In some areas, there is a history of joint working across the health and social care boundary, as well as recognition among professional groups that collaboration will help to achieve a more seamless, patient-centred approach. The Audit Commission highlighted the features of successful whole systems working (Figure 14). For many communities, however, different accountabilities and funding systems mean there are considerable differences to overcome before a joint approach can be adopted.

14 Whole systems working takes place when...

- Services are organised around the user.
- All of the players recognise that they are interdependent and understand that action in one part of the system has an impact elsewhere.
- The following are all shared:
 - vision
 - objectives
 - action, including redesigning services
 - resources; and
 - risk.
- Users experience services as seamless and the boundaries between organisations are not apparent to them.

Source: Audit Commission

3.4 Joint working has the potential to benefit older people by increasing the likelihood of providing the right support at the right time, and by addressing the whole range of their needs. Figure 15 overleaf illustrates two cases - multi-agency teams working to improve services for older people in the Midlands, including tackling delayed discharges, and a jointly run project in Sefton to overcome minor barriers to discharge.

Acute and Primary Care Trusts have different perspectives on the barriers to joint working

3.5 Acute and Primary Care Trusts see funding and staffing shortages in social services as the most important issues influencing joint working. Both acute trusts and Primary Care Trusts saw funding constraints in social services as a major problem, although, as Figure 16 overleaf shows, there are some different perspectives on the barriers to joint working.

15 Two successful collaborative initiatives

1 The Trent Health and Social Care Collaborative

Three collaboratives dedicated to services for older people were established in 2001, located in the former NHS regions of Trent, London and North West (England). The 12 teams that made up the Trent programme were formed in August 2001. Although the programme formally ended in July 2002, the individual teams continue to work together. The teams from across the Trent region are made up of multi-agency teams of frontline staff from across health and social care agencies. The teams had four aims:

- to reduce delayed discharges from hospital;
- to use information intelligently;
- to reduce wastage of resources; and
- to enable more older people to live or be cared for in the place of their choice.

One of the successes of the Trent programme has been the extent of commitment and breadth of involvement within the teams. Each team includes all local agencies in primary, secondary and social care, as well as service users. The latter have contributed a great deal, both within their local teams and collectively, and also feel they have benefited from the experience.

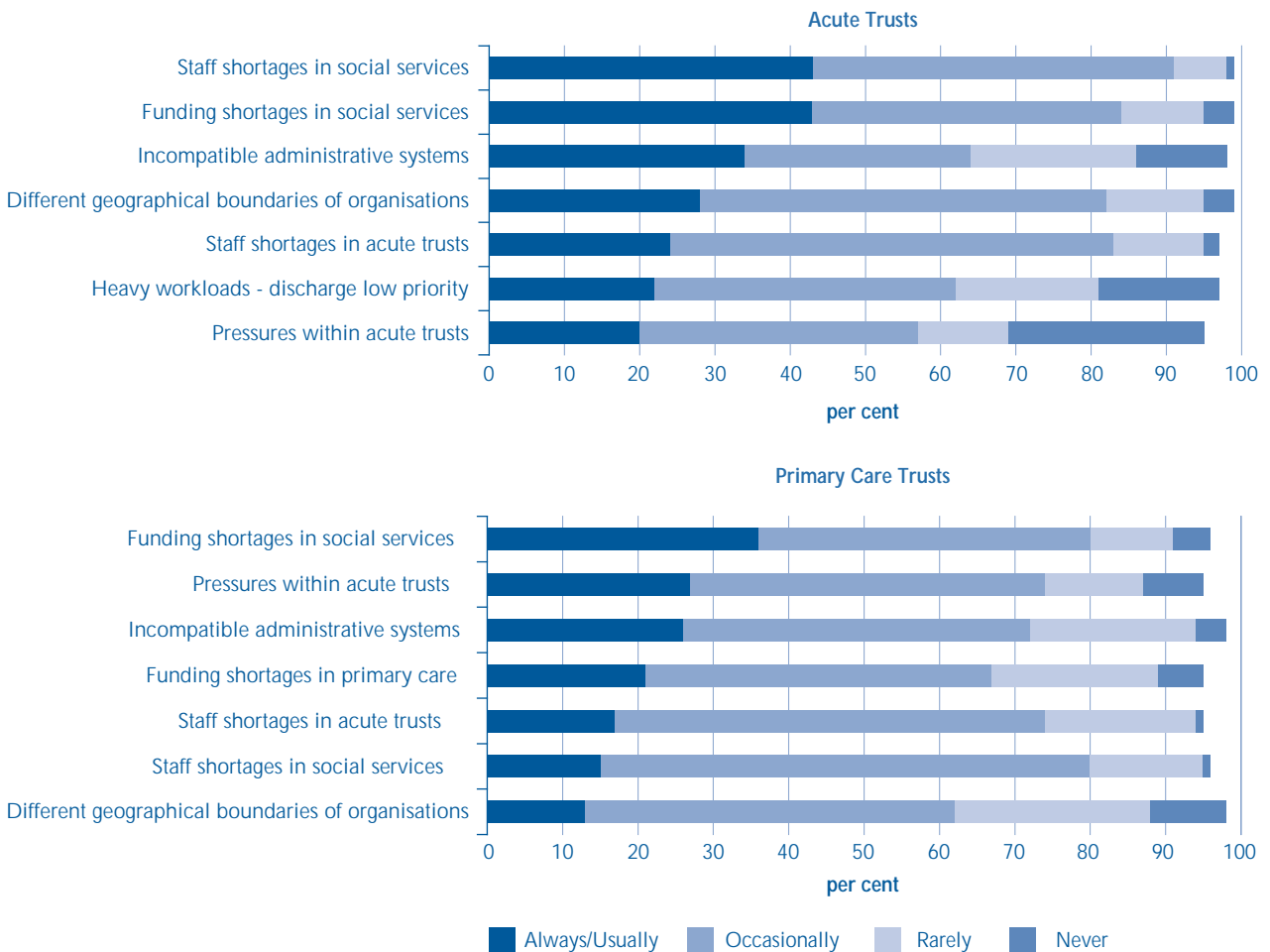
While most of the Trent Collaborative schemes under way are small, all are achieving results of different types, from raising awareness and helping older people to make more informed decisions through patient information videos, all the way to proactive early discharge schemes.

2 Sefton home-adaptation project

In Sefton, Anchor Staying Put (a voluntary agency) is involved in a hospital discharge project, in partnership with Care and Repair, the local social services department and the acute trust. It speeds up transfers by installing minor adaptations in the home, as well as carrying out a welfare benefits check and exploring other possible needs. Over 1,000 older people have benefited from the scheme to date. A parallel project, the Healthy Homes Initiative, provides a similar service to people moving out of intermediate care services.

Sources: (1) National Audit Office and (2) Audit Commission

16 Main barriers to joint working - perceptions of Acute and Primary Care Trusts

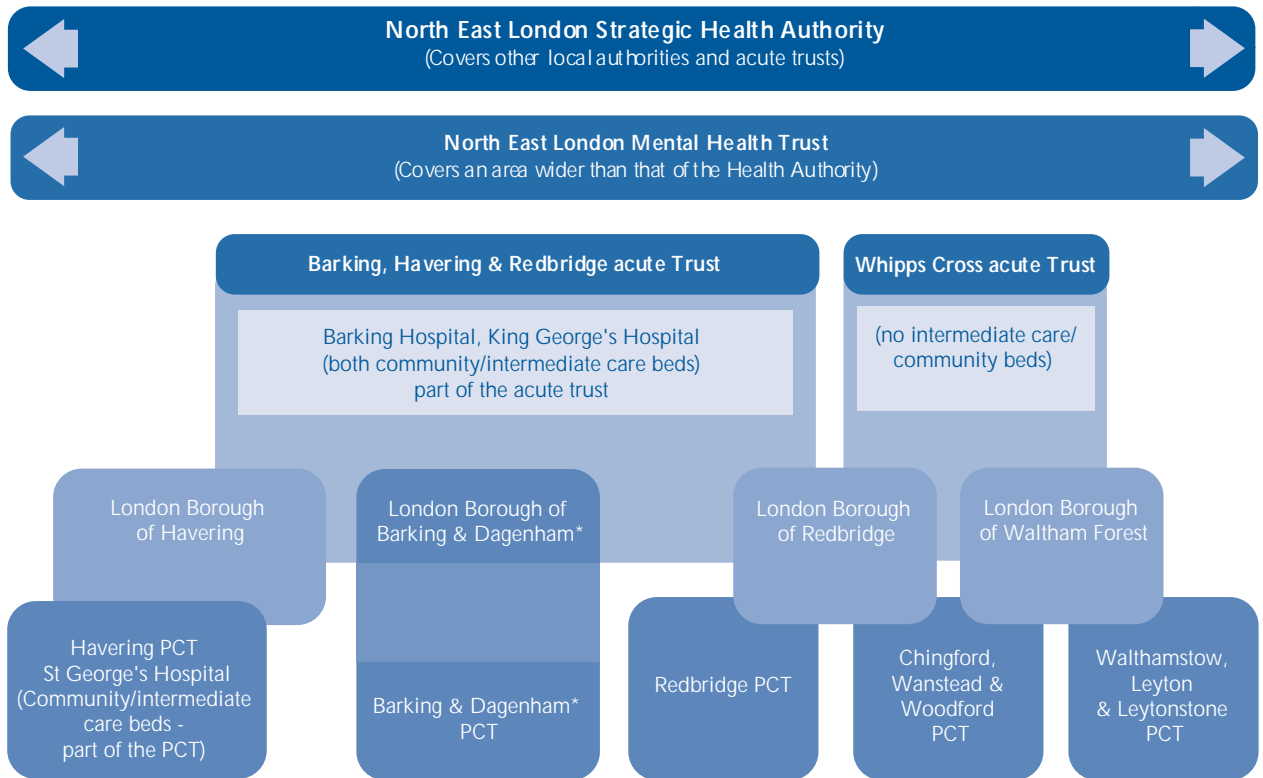


3.6 Both types of Trusts agree that incompatible administrative systems are a barrier, with 75 per cent of acute trusts and 91 per cent of Primary Care Trusts not operating any joint system of patient records with social services. The lack of common geographical boundaries is also a problem, and social services departments emphasised the disadvantages of interacting with a number of acute trusts. In situations where such departments were one of an acute trust's smaller customers, many felt this had an adverse impact on their bargaining power and ability to obtain timely and accurate information. An illustration of the complicated inter-relationships that may need to be negotiated within a local health and social care community are shown in **Figure 17**.

Organisations are becoming better at working together to reduce delayed discharges

3.7 Eighty-seven per cent of acute trusts considered that their contacts with social services and Primary Care Trusts were helpful in addressing delayed discharges and in improving processes for discharging older patients. Both types of Trusts emphasised the importance of communication in overcoming difficulties in joint working (**Figure 18**).

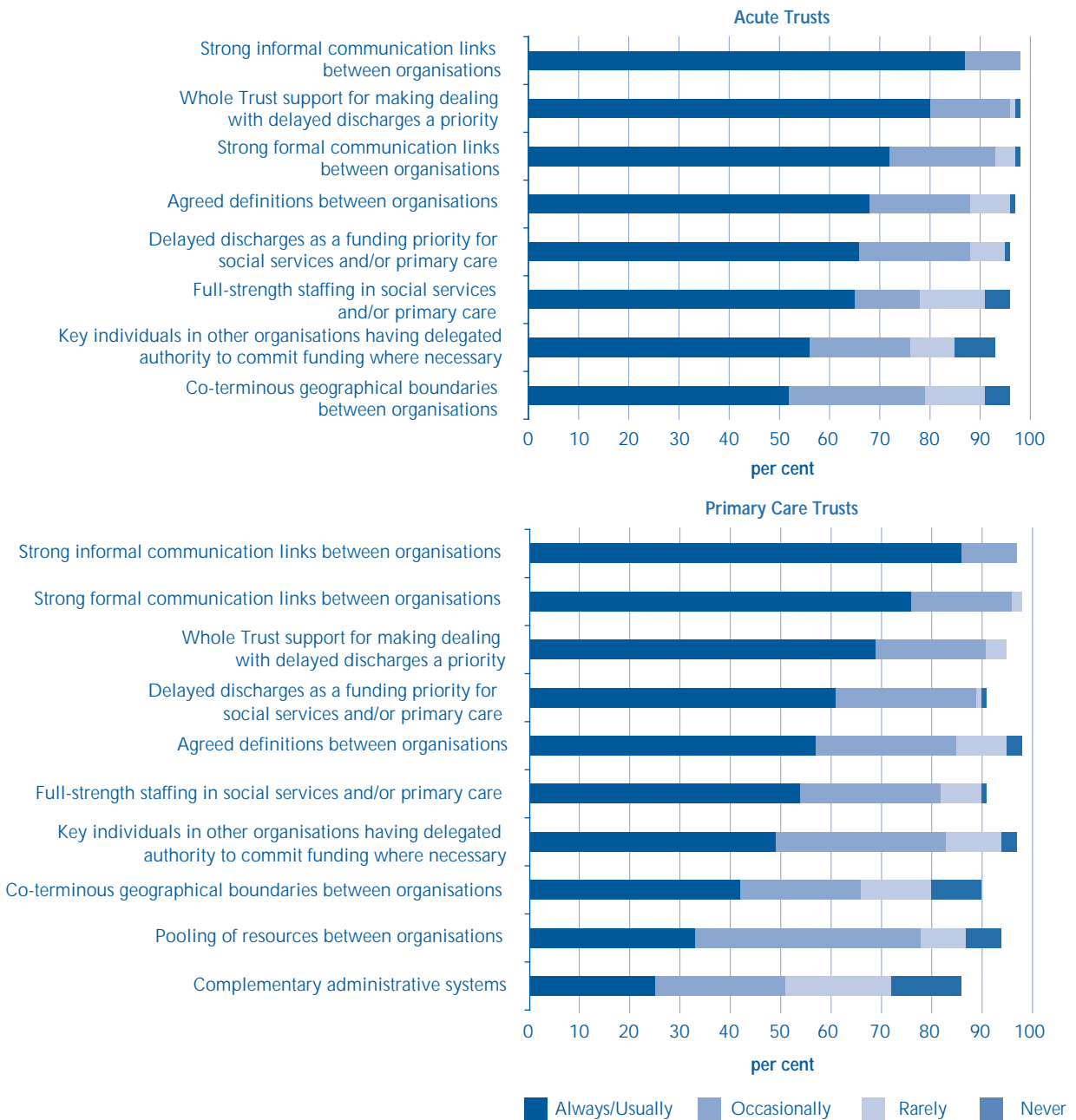
17 Health & Social Care organisations in part of East London



Source: London Borough of Redbridge

* Shared management

18 Effective methods for overcoming difficulties between organisations



Source: National Audit Office

3.8 The majority of social services departments we consulted were also positive about their relationships with much of the health sector, citing recent improvements where relationships had been strained in the past. They felt that Primary Care Trusts would become effective partners as they developed from Primary Care Groups. However, social services departments considered their relationships with acute trusts to be generally less strong than acute trusts did.

Successful joint working requires a number of elements to be in place

3.9 In their work, the Audit Commission identified that successful whole systems working is the product of local circumstances and external factors, combined with a number of internal factors specific to the way in which the care communities worked (Figure 19).

The Department are encouraging joint working through legislation and spreading good practice, but with mixed results to date

3.10 Section 31 of the Health Act 1999 allows health and social care organisations to form partnership arrangements by:

- pooling funds between organisations;
- delegating functions, allowing one local organisation to be lead commissioner of overlapping or related services on behalf of others;
- integrating services into a single provider organisation.

The process of introducing the Single Assessment Process should also lead to improvements in joint working.

3.11 By the end of November 2002, 183 schemes under the 1999 Act had been notified to the Department (notification is not mandatory). Some 35 related to older people's services (30 of which set up pooled budgets). However, some others address intermediate care as a sector rather than through specific age groups. Some of the schemes for older people may have subsequently ceased operation or changed focus.

3.12 Although lack of resources and an imbalance of funding was a continuing concern among all sectors that spoke to us, there also appears to be some reluctance to pool budgets as a means of using funds efficiently for the benefit of the whole system. Social services departments reported some unwillingness on behalf of council members to place funds outside their control, and to date neither acute nor Primary Care Trusts have made much of these agreements.

3.13 A recent examination of the early schemes³⁸ found that, although it is too soon to point to many improvements for service users as a result of the flexibilities, progress could be seen through:

- reduced duplication and better use of resources by being able to take advantage of either local authority or NHS systems or processes, depending on which offered the best "deal"; and
- the improved availability of funding.

In addition, the emphasis on organisational and professional boundaries was being replaced by a stronger whole system approach and a focus on the needs of the service user.

19 Figure 19: The main factors associated with successful joint working

- **strong leadership:** including modelling and acting as a champion for partnership behaviours, so that working across boundaries is seen as normal, developing healthy relationships with peers across the system, taking joint responsibility, and creating a culture in which joint working can flourish, identifying "win-win" situations.
- **a supportive organisational culture:** including genuine commitment to placing older people at the centre of all that is done. A "can-do" approach, willingness to take sensible risks, a flexible, pragmatic working style, openness to new ideas, and an entrepreneurial approach to taking advantage of new sources of funding.
- **easy flows of information between organisations and professionals:** assisted by different agencies and teams having mechanisms in place to access information on progress, and by management sharing information on trends and local population service use to inform planning.
- **staff with the right skills and experience:** delivering integrated care will require a joined-up approach to the workforce. This approach should include a joint strategy for recruiting and re-training staff, and flexible use of scarce resources through the development of new roles.
- **teamworking:** multi-professional/multi-agency teams are an important route to delivering integrated care. It is worth investing in team development at an early stage, to clarify roles, responsibilities and ways of working.

Source: Audit Commission

38 National Evaluation of Notification for Use of the Section 31 Partnership Flexibilities of the Health Act 1999, Nuffield Institute for Health/National Primary Care Research and Development Centre, 2002, summarised in *Integrated Services for older people: Building a whole system approach in England*, Audit Commission, 2002.

- 3.14 Another approach to partnerships being promoted by the Department of Health is the creation of Care Trusts, established under the Health and Social Care Act 2001. The Department view such Trusts as a way of allowing service provision for older people and their carers to be provided in a coherent way, from hospital admission through to sustained care at home. Care Trusts can commission and provide on both sides of the health and social care boundary (with delegated authority from local authorities).
- 3.15 Four demonstrator sites have operated since April 2002 and another followed in October. Of the first four, one, based in Northumberland, has older people's services as a priority. In October 2002, Witham, Braintree & Halstead Care Trust became the first to focus specifically on older people's services. There has been some reluctance to organise into Care Trusts. Of the 13 local authorities with whom we discussed this issue, only one has definite plans to introduce a Care Trust. As Northumberland County Council told the Audit Commission, however, for them it was a natural progression, following some years of the Health Authority and County Council working closely together.
- 3.16 For those without a tradition of co-operation, significant cultural change may be required. Common reasons for not considering Care Trusts are demands on the time of postholders in other organisations, concerns at arrangements for sharing risk, lack of co-terminosity between organisations, and a desire to avoid a further administrative change.
- 3.17 As part of the conditions for Building Care Capacity Grant, local authorities most "at risk" from delayed discharge had to provide details of their consideration of Care Trusts. Very few planned to consider it before 2004-5. In October 2002, the Department launched the Integrated Care Network to co-ordinate existing initiatives to promote integrated planning and delivery of local authority and NHS services.

The Department set up the Change Agent Team to support particular localities that wanted help to function more effectively as a whole system

- 3.18 In January 2002, the Department established the Health and Social Care Change Agent Team, as part of the Building Care Capacity investment to improve discharge from hospital (see paragraphs 4.21-25). The main purposes are to:
 - offer targeted intervention to help eliminate delayed discharges;
 - support implementation of the key aspects of the National Service Framework for Older People that have an impact on delayed discharges; and
 - develop a single system of health and social care, including intermediate care, and ensure also that opportunities are considered for developing care trusts³⁹.
- 3.19 The Change Agents are a team of experienced managers in health and social care from a variety of backgrounds, supported by a reference group of experts. Their overall objective is to work with health and social care communities to identify and tackle the underlying causes of delayed discharge by examining four key elements within local health and social care communities (Figure 20).
- 3.20 In the first wave of activity, the Team received 39 expressions of interest from health and social care communities, from which 10 areas were selected. In addition, they initiated a project to look at capacity across London and the South East. A second wave of work is now under way in areas with problems related specifically to delayed discharge. Feedback from localities visited by the Change Agent Team has been very positive. The Department are publicising nationally lessons learned from its work.

20 Change Agents in action

Area of examination	Key messages
Funding related to capacity requirements, including the costs of service change	<ul style="list-style-type: none"> ■ Need to avoid short-term measures that undermine long-term change
Structures for joining up planning and service delivery	<ul style="list-style-type: none"> ■ More scope to use pooled budgets ■ Need for better joint working / whole systems approach
Increasing capacity across the system to meet assessed need	<ul style="list-style-type: none"> ■ Need better understanding and co-ordination of intermediate care provision ■ Scope to develop more specialist intermediate care for the elderly mentally ill
Delivering the right care at the right place at the right time for users	<ul style="list-style-type: none"> ■ More work needed on mapping discharge processes ■ More support needed to keep people at home

The Department are considering a system of reimbursement for delayed discharges

3.21 In April 2002, the Department announced that they were considering a new legislative approach to reducing levels of delayed discharge. The consultation document⁴⁰ stated that "Good joint working will continue to underpin success [in reducing delayed discharges]. [The Department] wish to clarify who is responsible for stages of care, so that partners can work together ... rather than arguing over responsibility or having an incentive to let one partner's budget carry the costs to avoid the costs to the other." The "aim is to focus attention on the needs of the patient by introducing a financial incentive to ensure patients receive the right level of care in the right place at the right time."

3.22 The Community Care (Delayed Discharges etc) Bill received its first reading in November 2002. It proposed that:

- hospitals will notify social services as soon as they are aware that a patient requires social services' care after discharge;
- a care plan for discharge will be produced within a minimum of three days of the above;
- if the patient is not discharged within a day of being designated fit for discharge, and the acute provider can demonstrate that this is due to lack of social care support, the social services authority will be required to reimburse the acute trust at a rate of £120 per day in London and the South East and £100 elsewhere.

In addition, there will be a £100 million grant to social services for each full year of the scheme.

3.23 The impetus for this initiative came from the Wanless Report's recommendation that the merits of the system adopted by Sweden in its 1992 Adel reforms⁴¹ should be explored. In Sweden the results were dramatic. The improvements that resulted were:

- delayed discharges in acute care fell from 15 per cent in 1990 to 7 per cent immediately following the reform;⁴²
- specialist housing alternatives for the elderly increased considerably; and
- local authority care providers employ more qualified nurses.⁴³

3.24 However, officials of the Swedish Ministry of Health and Social Affairs told us that there were other consequences. These included:

- greater demands on resources at local authority level, which had led to concentration on the more needy. From 1997, grants to local authorities were increased to help meet the costs; and
- a lack of medical support from GP-led primary care for those discharged more promptly into the community. In 1998, a National Action Plan was introduced to address, among other things, GP shortages.

3.25 There is potential for the proposed scheme to have a positive impact in reducing delayed discharge. However, on the basis of concerns raised by numerous bodies that we spoke to in England, the Department should be alert to possible undesirable outcomes such as:

- perpetuating historical funding imbalances between the acute and social care sectors, and reducing funds available for the commissioning of older people's services;
- creating perverse incentives for social services departments to place people in the most readily available, rather than the most appropriate, type of care;
- causing patients in acute care to be prioritised over those in non-acute; and
- penalising good-quality social services departments for situations beyond their control.

40 Consultation on reimbursing for delayed discharges, Department of Health, July 2002.

41 Securing our future health: taking a long-term view, Report to the Chancellor of the Exchequer by Derek Wanless, April 2002.

42 Integrated care for the elderly, Andersson and Karlberg, International Journal of Integrated care, November 2000.

43 The Adel Reform final report, Swedish National Board of Health and Welfare, 1996.



Part 4

Reducing levels of delayed discharges by developing appropriate care capacity

4.1 Part 1 highlighted a need to generate increased capacity in the health and social care system in order to resolve the underlying causes of delayed discharge. A lack of capacity in long-term residential and nursing care is the main cause of delayed discharge. This Part considers the constraints on capacity, initiatives to target additional resources at the health and social care system, and longer-term solutions to developing appropriate capacity.

In some parts of the country, there are severe capacity problems in residential and nursing care leading to delays in patient discharge

4.2 Around one-quarter of delayed discharges result from patients awaiting a placement in residential and nursing homes⁴⁴. A further 11 per cent await a home of their choice. In recent years, the number of residential care and nursing beds has fallen, although at different rates (**Figure 21 overleaf**). While the number of residential care beds dropped by 2 per cent compared with the 1998 peak, the number of nursing care beds fell by 10 per cent⁴⁵.

4.3 Residential care provision is not uniform across the country. The Personal Social Services Research Unit examined the balance of demand and supply by region at 90 per cent occupancy rates (a figure considered appropriate as it allows homes to respond to fluctuating demands without having consistently under-used resources). The results (**Figure 22 overleaf**) show that, while in several regions supply and demand are roughly in balance, this is not the case elsewhere.

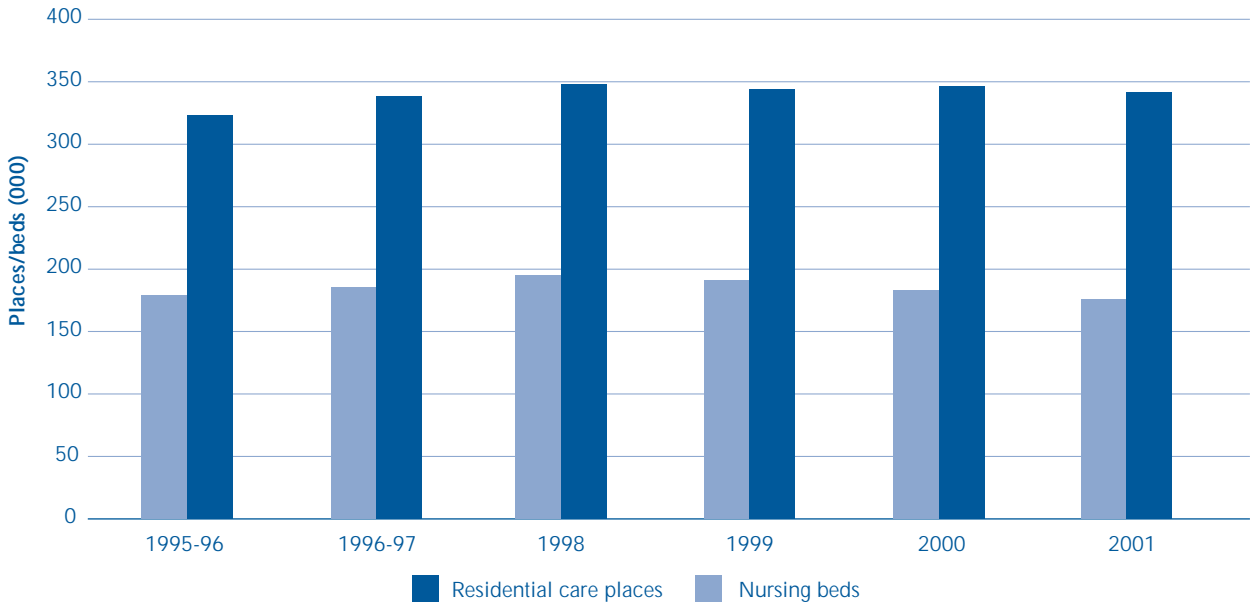
4.4 For London and the South East as a whole, demand exceeds supply. There is a particular shortage of beds affordable to councils. Occupants of homes in the South East are much more likely to be self-funders (paying fees from their own resources) and to be able to pay more than council clients. In addition, a severe shortage of care homes in the capital means that London boroughs seek to place their clients outside the capital. The revenue support grant for London boroughs reflects the higher costs of care in the capital, and this allows these boroughs to pay higher care home fees than local authorities in popular locations in the rest of the South East, especially on the border with London. This results in delayed discharges in areas with supply problems (**Figure 23 overleaf**).

4.5 Research by the Personal Social Services Research Unit indicates that the population of people over 65 has remained static in recent years, thus reducing pressure on the system. However, they predict that between now and 2020 the number of people over 65 in institutional care could increase by 23 per cent, although this is very sensitive to assumptions about future levels of dependency and changes to the pattern of service delivery.

⁴⁴ Department of Health data only analyses causes for all ages.

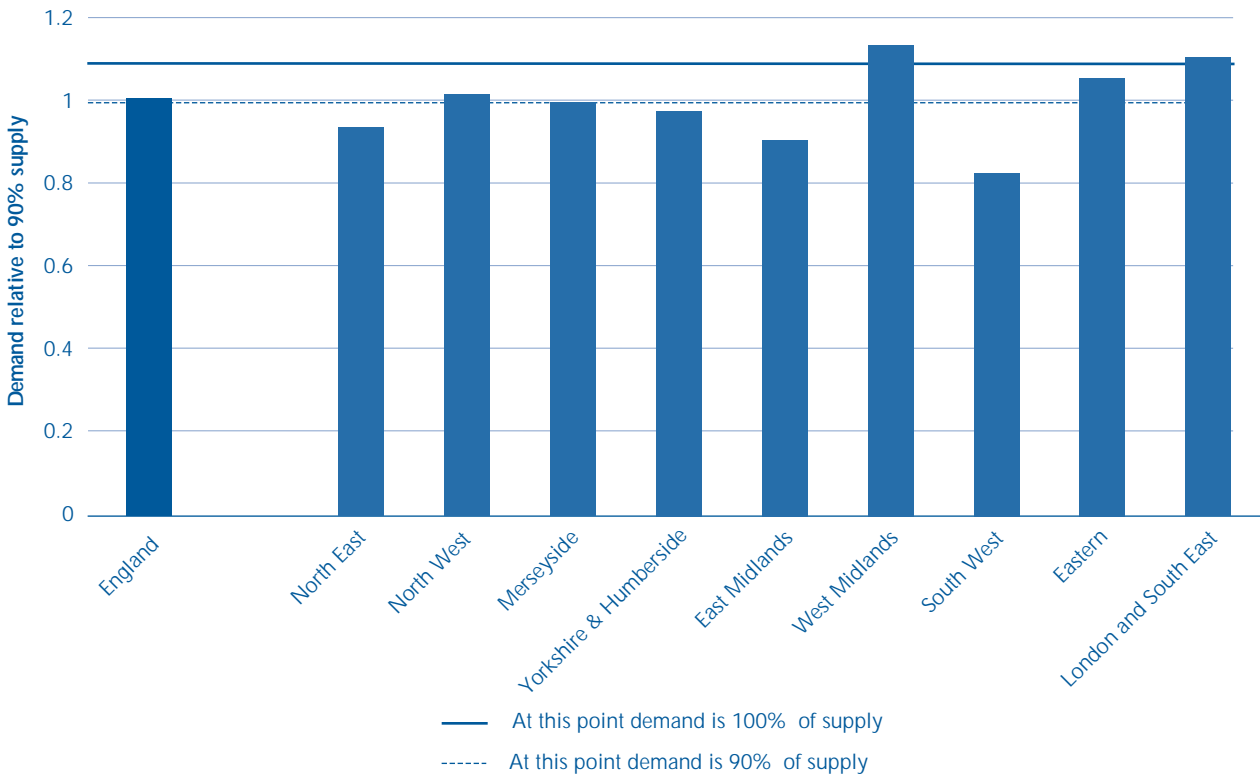
⁴⁵ All figures in this section, unless otherwise stated, are from 'The residential care and nursing home sector for older people: an analysis of past trends, current and future demand', Personal Social Services Research Unit, 2002.

21 Number of residential care places and nursing beds available, 1995-2001



Source: Personal Social Services Research Unit

22 Demand for residential/nursing care relative to supply



Source: Personal Social Services Research Unit

23 Delays awaiting a care home in regions with capacity problems, 30 September 2002

Former NHS Region	Proportion of delayed discharges attributable to waits for a care home
London	28%
South East	33%
Eastern	27%
West Midlands	17%*

* Here 24 per cent of delayed discharges were still awaiting assessment (an earlier stage in the care pathway).

24 Number of older people supported in residential and nursing homes and through intensive home care

	Approximate number of people over 65 supported	Percentage supported through intensive home care
1999	267,000	23
2000	277,000	25
2001	277,000	26
2002	284,000	27

Home care has begun to substitute for residential and nursing care and to increase capacity in the sector, but only slowly

- 4.6 Domiciliary care allows people to be looked after in their own home. Many people prefer this, as long as they are well supported. The Government is also keen to promote independence. Most domiciliary care is of a low-level type, amounting to one or two hours a day, which is not a direct substitute for residential care. The proportion of people supported in their own home in England has remained largely unchanged in recent years - 85 per 1,000 of the population aged 65 or over in 2001-02. The Department's Social Services Inspectorate⁴⁶ considers that this failure to enable older people to continue living in their own homes is due to a failure to develop commissioning arrangements following from a reliance on services provided by councils themselves (who have historically made large investments in residential facilities), as well as unreliability in the delivery of domiciliary care.
- 4.7 A direct alternative to residential care is provided by intensive home care. Although the overall level of domiciliary support is static (see paragraph 4.6), the percentage of support provided by intensive home care is increasing (Figure 24). However, this has been of limited help in reducing delayed discharges, as overall capacity has increased very slowly in this area.
- 4.8 Also working against discharge into domiciliary care are problems with provision of community equipment to enable the frail to live at home. An Audit Commission report in 2000⁴⁷ considered the organisation of equipment services poor and called for urgent action to improve standards and make equipment services an important component of strategies to promote independence. In their follow-up report⁴⁸, the

Commission found services still had low priority, despite the promised injection of £105 million over three years from 2001-02. In our survey, 40 per cent of Primary Care Trusts felt that equipment shortages hindered discharge. The Government intends to provide ring-fenced funding from April 2003 for up to half a million pieces of equipment free at point of delivery by 2005.

- 4.9 Finally, both residential and home care capacity are constrained by the shortage of care assistants in the public and private sectors, who carry out many of the more basic but vital tasks. Potential applicants in some parts of the country are currently able to earn higher wages by working, for example, in supermarkets.

Most funding for older people is transmitted to local authorities through the Standard Spending Assessment, but this can be re-allocated to other uses

- 4.10 Funding remains the major issue in considering pre- and post-acute services for older people. In our survey, Primary Care Trusts in their position as commissioners of community and, increasingly, acute older people's services, saw funding shortages in social services as the most significant problem in dealing with other agencies⁴⁹ and in developing better services for older people⁵⁰.
- 4.11 Social services funding, in particular, has proved problematic. The NHS and Community Care Act 1990 put more of the onus on social services departments to administer and finance community care. Since then, local authorities have argued that funding has never matched these commitments and have increasingly both cut back on the range of services provided for older people and tightened the criteria of qualification for provision.

46 *Improving older people's services - inspection of social care services for older people, 2001.*
 47 *Fully equipped - the provision of equipment services to older or disabled people by the NHS and social services in England and Wales, Audit Commission, 2000.*
 48 *Fully equipped 2002 - assisting independence, Audit Commission, 2002.*
 49 *37 per cent always/usually and 43 per cent occasionally a factor.*
 50 *54 per cent always/usually and 37 per cent occasionally a factor.*

4.12 Until 2003-4, the Government has provided funds for personal social services expenditure by councils through a mixture of revenue support grants (calculated using the Standard Spending Assessment formula) and a series of special or specific grants. There were three Standard Spending Assessment formulae, covering services for children, older people and other adults' services, which together produced a total funding figure for each council. However, councils were able to spend more or less on each of these services than was indicated by the formulae. For example, in 2000-01, councils nationally spent £700 million (14 per cent) less on older people's services than the Standard Spending Assessment formulae⁵¹. Councils have frequently spent less than the indicative amount for older people. Grants, on the other hand, have specific conditions attached as to how they can be spent.

4.13 From 2003-4, the revenue support grant is allocated using the new "formula grant system" which reflects past spending patterns. This is a shift in approach by the Department, from allocations that are intended to guide council spending priorities to allocations based on past behaviour. The formula grant for 2003-4 for older people is intended to provide councils with an increase of six per cent on their actual spend on older people's services in the previous year, less a sum representing expenditure on nursing care, which will be funded directly by the NHS from April 2003. The implications of the Community Care (Delayed Discharges etc.) Bill are that spending by many councils on older people will increase in 2003-4 in order to avoid financial penalties arising from the new system, or to pay the reimbursements to the NHS that result. Revenue support grant allocations for older people's services up until 2002-3 and formula grant for 2003-4, together with specific grants, are summarised in Appendix E.

4.14 Social services departments told us that they were often dependent on ring-fenced grant funding to develop capacity in older people's services. However, the system made it difficult to plan because grants were often short term - one to three years. Commitments entered into then had to be maintained out of the Standard Spending Assessment. In total, the amount granted through schemes intended to promote hospital discharge or avoid admission will be £336 million in 2003-4. In addition, there will be a £100 million grant for each full year of the new reimbursement arrangements, representing the potential cost of charges, which councils will be able to spend on services if not needed to pay charges (see Appendix E).

The Department are committed to developing intermediate care services to minimise older people's stays in acute hospital settings

4.15 The Department define intermediate care as that targeted at people who would otherwise be held in hospital, or admitted to a hospital or similar, inappropriately. Intermediate care is delivered through a care plan drawn up following a comprehensive assessment, and is aimed at maximising independence. It is normally time-limited to six weeks, and involves cross-professional working⁵². Intermediate care can:

- provide patients with the opportunity to receive appropriate clinical care without admission to acute care;
- free up acute beds more promptly by allowing post-acute rehabilitation to take place in a more appropriate environment; and
- reduce the pressure on nursing homes by rehabilitating patients so they can be supported in the community for longer.

4.16 The NHS Plan set targets for the expansion of intermediate care services. By 2004, the aim is that there will be 5,000 extra intermediate care beds and 1,700 extra supported non-residential intermediate care places, together benefiting some 150,000 more older people a year. In addition, rapid response teams and other avoidable admission prevention schemes will benefit a further 70,000 people a year, compared with 1999-2000. The Department announced that £150 million had been made available recurrently to the NHS from 2000-01 for intermediate care spending. This money was not ring-fenced within NHS budgets and, although details of the schemes that benefited are not available, good progress is being made towards the achievements of the targets.

4.17 As part of the wider investment announced in the NHS Plan for services to promote independence for older people, additional resources for intermediate care were issued to the NHS in 2001-02 and will continue up to 2003-04 to help meet the relevant targets and objectives in the NHS Plan. The total additional NHS investment in intermediate care is £176 million in 2001-02, around £270 million in 2002-03 and around £405 million in 2003-04.

51 Association of Directors of Social Services budget survey.

52 Health Service Circular 2001/001.

4.18 The Department had a target of increasing the number of intermediate care beds by 1,500 above the March 2000 figure by March 2002. In the event, the increase was over 2,700. However, there are considerable disparities in NHS-funded provision between areas (Figure 25). For example, the proportion of intermediate care beds to older patients was three and a half times higher in the former Trent region than in Northern and Yorkshire Region. In addition, there is non-NHS funded intermediate care across England, and consequently the pattern of intermediate care services in many areas is not transparent to local commissioners and those making referrals⁵³. Three-fifths of acute trusts told us that they had patients whose discharge was delayed while securing transfer to a "step-down" bed at least once a week, and a further 28 per cent experienced it daily. Local reviews by health and social care communities have found that therapists are often the most enthusiastic referrers to intermediate care facilities, so the shortages of such staff described in paragraphs 2.18-2.20 can contribute to under-use of these facilities.

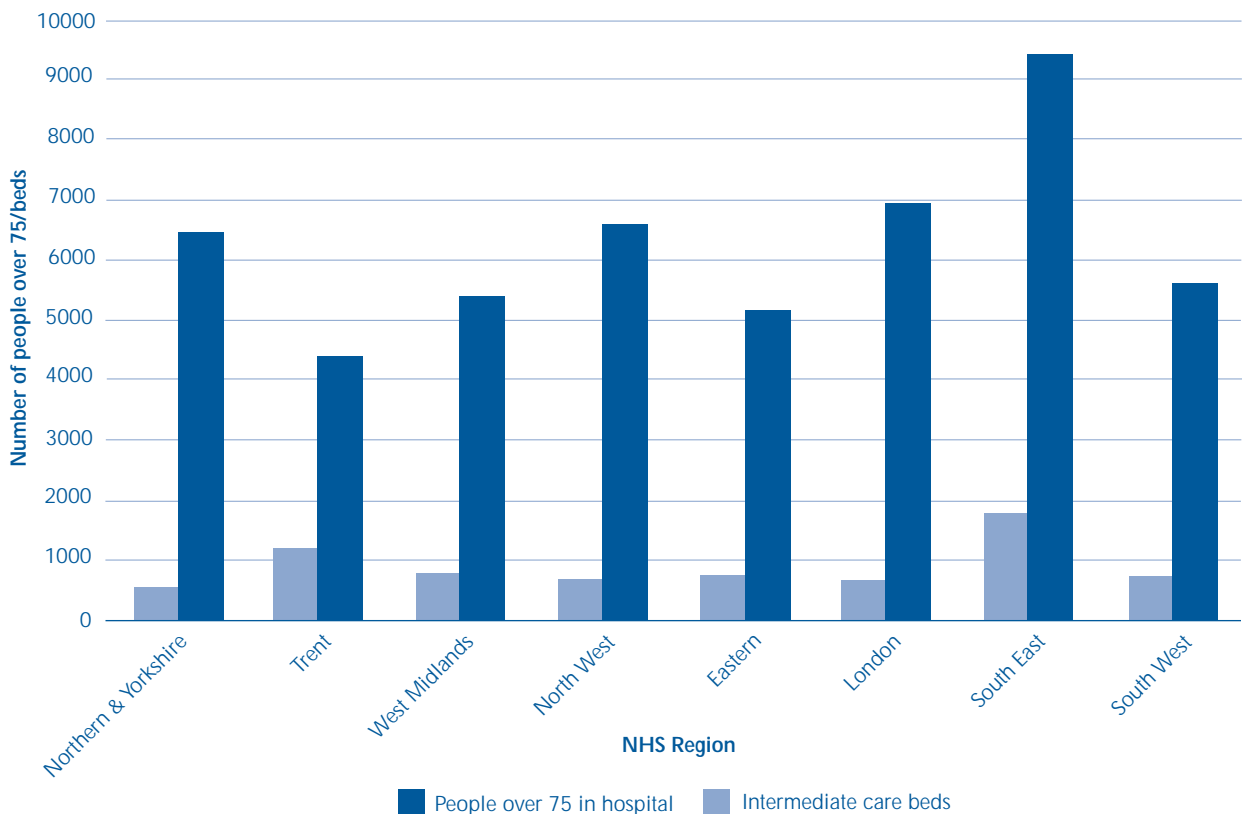
4.19 While there have to date been few evaluations of the impact of intermediate care schemes, those undertaken have shown useful results. For example:

- Epping Forest Primary Care Trust launched an older people's support service in June 2001, influenced by partnership working with Essex social services, Epping Forest District Council and Epping Forest Council for Voluntary Services. Its aims are to promote independent living, avoid hospital admissions and facilitate timely discharge from hospital. The service calculated that, in its first year of operation, it saved 7,000 bed days with a budget of £400,000.
- The Collaborative Community Rehabilitation Team, set up by Bexhill and Rother Primary Care Trust, East Sussex County Council, Social Services, and Hastings and St Leonards Primary Care Trust, enabled 98 timely discharges and prevented 62 hospital admissions in the period January to June 2002, from an annual pooled budget of £425,000.

4.20 Despite these successful examples, there have been difficulties in developing efficient and comprehensive intermediate care services in the past. In particular:

- funding may be time-limited, either because an important grant is no longer paid or because the scheme is funded at short notice;
- development has been fragmented and opportunistic in some areas, leading to difficulties in planning equitable access for users across a community; and

25 Number of NHS intermediate care beds to older people in hospital, 31 March 2002



Source: Department of Health

53 Care home environments, rehabilitation and older persons: A survey of current provision in England, Ward, Severs and Dean, MCC: Building knowledge for integrated care, February 2002.

- referral rates to individual schemes vary between and within professional groups, because of concerns about the implications for their workload, reluctance to accept the professional judgement of others, and a lack of awareness of new developments in care of older people.

The Building Care Capacity Grant, introduced during 2001-02, reduced the headline rate of delayed discharge sharply by April 2002

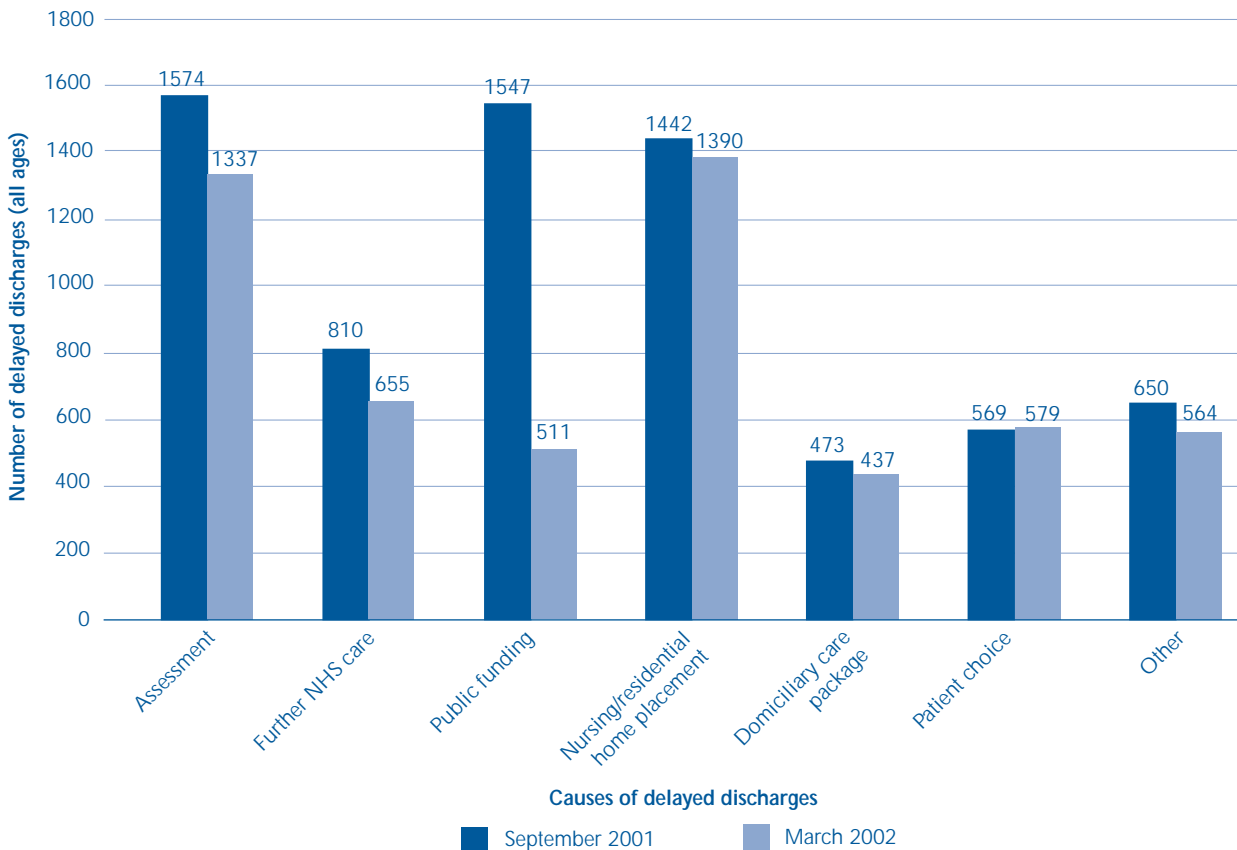
4.21 In September 2001, the Building Care Capacity Grant was introduced to try to reduce further the level of delayed discharges. Some £90 million was allocated to local authorities to be spent by the end of March 2002 on initiatives in their area, and £10 million for setting up the Change Agent Team (paragraphs 3.18-20). A further £200 million was allocated in 2002-03. All local authorities with social services responsibilities received money, but 55 were designated "hotspots"⁵⁴. These councils were required to agree targets with the Department, and were monitored weekly by the Social Services Inspectorate. They also had to submit a report on how they would implement good-practice partnership working in commissioning services.

4.22 The Social Services Inspectorate reviewed the results for 2001-02 (Figure 26). The aim was to reduce the number of delayed discharges by 1,000 during the year. The figure reported - 1,247 - comfortably exceeded that, although the effect on the main causes of delayed discharges varied (Figure 27). Unsurprisingly, the most significant effect was on delays for those awaiting public funding (a fall of two-thirds), although the funds also helped reduce delays in the assessment of older patients' needs (down 15 per cent).

26 Main findings from Social Services Inspectorate reviews of Building Care Capacity Grant, 2001-2

- The grant was successful in its primary objective of significantly reducing the rate of delayed discharge.
- There was an inherent tension between the need to reduce delayed discharge as quickly as possible and wider government objectives of promoting independence by diversifying service provision.
- Social services departments had limited control over the ability to reduce delayed discharges of some kinds.
- Understanding patient flows through the whole system is vital for all partners in the systems.

27 Impact of Building Care Capacity Grant 2001-02



Source: Department of Health

54 Selected on the basis of: rate of delayed discharge, how deep-seated the problem was and whether the local council was deemed "high risk".

28 Breakdown of spend of Building Care Capacity Grant 2001-2

Area of spend	"Hotspot" Councils	Other Councils
Buying more residential/nursing care placements	32%	52%
Increased fees for residential/nursing care providers	20%	16%
Intensive home care packages	16%	19%
Improved assessment capacity/processes	14%	1%
Preventative services*	10%	
Community equipment*		5%
Other (including community equipment)*	8%	
Other (including preventative services)*		7%

*Information was collected on a different basis in the two exercises.

Source: Department of Health

4.23 The aim in 2001-2 was a reduction of 25 per cent in delayed discharges for "hotspot" councils, while other councils were set a target of 20 per cent. Ninety per cent of councils exceeded, met or "broadly met" their targets. Fifteen councils (ten per cent) missed their targets (of which six were "hotspots"). Common problems included: a lack of capacity in residential/nursing care and a lack of alternative services; insufficient capacity for the elderly mentally ill; and issues around patient and family choice. One-third of those with missed targets were in the South West. The Social Services Inspectorate has agreed a new set of targets with councils for 2002-3.

4.24 Much of the funding was used to buy care home placements (Figure 28 shows the proportion of spend on different types of initiative). Social services departments told us that this was partly because this was the quickest way for many authorities to move people out of hospital. The problem with care home capacity is illustrated by the fact that the high proportion of grant spent on these placements reduced the headline level of delay awaiting placement by only 4 per cent. Some social services departments consider there is limited scope for further reductions in 2002-3 because of the need to maintain the commitments already made.

4.25 Despite the number of delays caused by assessments, little money was put into increasing capacity in this area. Money was also less likely to be spent on supporting people in the community through intensive home care or adaptive equipment for the home, and least of all on preventative measures to avoid hospital admission.

The independent sector is a major provider of care, but is not optimistic about increasing capacity

4.26 Longer term solutions depend on re-engineering service provision. The independent sector (private sector providers and voluntary organisations) is crucial if capacity in care homes and home care provision is to be increased. The sector now provides all nursing home places, some 80 per cent of residential home places, and half of local authority-purchased home care contact hours.⁵⁵

4.27 However, research⁵⁶ suggests that nearly 21,000 residential and nursing beds have been lost in the independent sector between 1997 and 2001, predominantly because:

- in the past, local authority prices have not kept pace with increasing costs in those areas. This has coincided with large increases in property values, which has made it more attractive for some smaller home owners to sell up and move out of the business; and
- more recently, the cost implications of new National Minimum Standards for care homes, introduced under the Care Standards Act 2000, which make specific requirements for the physical environment of home occupants, to be implemented by 2007. The Department announced in July 2002 that it would consult on proposals to make these standards good practice rather than compulsory for existing care homes.

⁵⁵ Care of elderly people market survey, Laing & Buisson, 2001.

⁵⁶ Care home closures: the provider perspective, Personal Social Services Research Unit, February 2002. In addition, 13,600 local authority beds were lost during that period.

4.28 Representatives of the sector told us that fee levels remain the major source of tension between them and health and social care commissioners. They consider that, for some years, local authorities have been paying rates that produced an inadequate rate of return for providers and which put local authority clients at a disadvantage in competition with "self-funders". They also told us that it will require a considerable investment to compensate for this, since 70 per cent of providers' costs are staff-related and annual turnover is about 20 per cent per annum.

4.29 Sector representatives also expressed a reluctance to expand involvement in the intensive home care sector. In particular:

- complex domiciliary packages were unattractive compared with residential care, because they were more costly to provide and more complicated to deliver;
- they were reluctant to invest in new capacity while commissioners appeared orientated towards the short term. A Government-initiated national-level agreement between the major partners⁵⁷ was considered encouraging, but at local level commissioners appeared reluctant to involve providers other than to ride out short-term crises. However, there are encouraging signs that commissioners are adopting block contracts to purchase placements, which provides more security for providers, and are more willing to vary fee rates in response to local market pressures; and
- although Primary Care Trusts purchase a range of services from the independent sector, they were singled out as being particularly difficult partners to engage with, possibly because of current constraints in management capacity.

The Government's "Supporting People" initiative is aimed at keeping vulnerable people in the community

4.30 From April 2003, the Government will introduce a new funding framework, the Supporting People initiative. Social services departments told us that they viewed this as a major step forward in developing extra care sheltered housing (specially designed self-contained housing with a range of communal facilities, dedicated care teams, and personal care supplied either by the housing provider or on a contract with another agency or social services). This initiative is for housing-related services for vulnerable

people, to enable them either to remain independent or to gain independence in their own home. Existing funding streams for housing-related support services will be brought together in a single grant payment to providers. Support for older people to maintain their independence in the home is one strand of this.

4.31 Co-ordination with Primary Care Trusts will be important. Three-quarters of such Trusts surveyed told us that they were currently involved in activities to maintain independence through better housing. One priority issue will be provision of community equipment services, which have been neglected in the past (paragraph 4.8). However, nearly half of Primary Care Trusts surveyed told us that they believe that they do not yet have a clear view of housing provision in their area.

4.32 The Department and councils are also keen to develop extra care sheltered housing as another alternative to residential care. It offers scope for an older person to have a "home for life" in an environment flexible enough to cope with fluctuating levels of dependency. Research carried out in 1999⁵⁸ established that only about 0.2 per cent of people over 65 were currently occupying such accommodation.

More can be done to avoid older people being admitted to hospital in the first place

4.33 In many cases admission to hospital is essential, and the care provided can only be offered in an acute setting. However, hospital is not always the safest place for people, given the risks of acquiring an infection and losing independence, and the possibility that discharge will be delayed once a period of acute care is complete. In re-engineering service provision for older people, it is important to recognise the desirability of avoiding having to admit them to hospital, and finding alternative ways to treat them. This can involve health promotion and healthy lifestyles, interventions allowing older people to engage in the community life, and support for older people with long-term illness. [Figure 29](#) illustrates some initiatives under way within health and social care communities across England.

⁵⁷ *Building Capacity and Partnership in Care, October 2001.*

⁵⁸ *With Respect to Old Age: Long Term Care - Rights and Responsibilities, The Royal Commission on Long Term Care, 1999.*

29 Initiatives being taken to avoid having to admit older people to hospital

Preventing falls: Falls are a major cause of disability and mortality due to injury in older people aged 75 years and over in the UK. In 2001-02, 134,000 people over 60 were admitted to hospital following a fall⁵⁹. Some health and social care communities have sought to reduce admissions arising from falls, but to date the only dedicated rapid-access "faints and falls" day-case facility is at the Royal Victoria Infirmary, Newcastle. This unit saves around 18 bed-years⁶⁰. Only one-third of referrals to the day-case facility were subsequently treated as emergencies, and the average length of hospital stay for emergency admissions was under three days, compared with 10 days elsewhere. According to our survey, over 95 per cent of Primary Care Trusts are currently involved in falls prevention work.

Problems with medicines: Four in five people over 75 take at least one prescribed medicine, with 36 per cent taking four or more⁶¹. Older people often fail to follow recommended dosages or continue to take medicines for an unnecessarily long period. The National Service Framework for Older People recommended that by 2002 all people over 75 years should normally have their medicines reviewed at least annually, those taking four or more every six months. We found that, currently, only around 7 per cent of Primary Care Trusts are monitoring admissions of older people following adverse drug reactions.

Supporting older people in the community: A more healthy older population puts less strain on a health and social care system struggling to cope with the demands made upon it. Preventive health checks on those over 75 years are universal in 20 per cent of Primary Care Trusts, and undertaken by some GP practices in nearly all other Primary Care Trusts. A short-term case management pilot in a GP practice in Cheshire reduced use of hospital beds by over 40 per cent among vulnerable older people. Almost all Primary Care Trusts are involved in preventive activities more generally, and over 40 per cent of Primary Care Trusts expressing a view in our survey felt that this had reduced unnecessary hospital admission. A new network of Healthy Living Centres, funded by the National Lottery New Opportunities Fund, is being set up across the country. There are currently 188, of which 10 are aimed specifically at older people, and a further 48 have the older people as a key target group. Projects for older people include exercise and fitness programmes, and healthy eating initiatives.

Source: National Audit Office

⁵⁹ Department of Health Hospital Episode Statistics 2001/02.

⁶⁰ Kenny, O'Shea, Walker. *Age and Ageing* 31 (2002). *Impact of a dedicated syncope and falls facility for older adults on emergency beds.*

⁶¹ Department of Health (2001). *Implementing the medicines-related aspects of the National Service Framework for older people.*



Appendix A

Methodology

- 1 We adopted a variety of methods to collect evidence to assess the progress in reducing the delays in discharge. These are summarised below:

Analysis of Department of Health and local authority discharge data

- 2 We analysed the Department's quarterly delayed discharge and other data in order to gain a comprehensive overview of the current position, regional trends, and trends over time. We also analysed local authority data such as the level of provision of residential and domiciliary care, and funding levels of older people's services. Where possible, we cross-checked between data from different sectors in order to gain some insight into how the patterns of care provision can influence delayed discharge levels.

Surveys of NHS acute Trusts and NHS Primary Care Trusts

- 3 We commissioned Taylor Nelson Sofres to undertake a postal survey of 171 NHS acute trusts. The key issues addressed were: causes of delayed discharge; communication and relationships between professionals and organisations; involvement of patients and carers; assessment processes; and funding concerns.
- 4 Taylor Nelson Sofres also surveyed 162 Primary Care Trusts established on or before 1 April 2001. Our survey gathered information on planning, and the pattern of services to help relieve pressures on acute trusts and avoid hospital or residential/nursing care admissions.
- 5 The surveys were carried out in July and August 2002. Response rates were 99 per cent (for acute trusts) and 97 per cent (for Primary Care Trusts).

Visits to a sample of social services departments

- 6 We undertook in-depth interviews with staff at 16 local authority social services departments to see how levels of delayed discharge affected them and discuss the effect of recent initiatives. The authorities visited were: Birmingham, Blackburn with Darwen, Cambridgeshire, Camden, Halton, Kensington and Chelsea, Leeds,

North Somerset, Northamptonshire, Peterborough, Redbridge, Richmond on Thames, Salford, Somerset, Surrey, and West Berkshire

Literature review and existing research

- 7 We reviewed and analysed existing departmental and official publications, academic research and also material from our previous study (*Inpatient Admissions and Bed Management in NHS acute hospitals HC 254, Session 1999-2000*).

Work-shadowing

- 8 We were able to discuss in detail the causes of delayed discharge during visits to Peterborough Hospitals NHS Trusts at the invitation of the Chairman and Chief Executive. We held discussions with representatives of the local health community (from acute and primary care health sectors and social services). In addition, a member of the NAO team shadowed one of the intermediate care co-ordinators over a two-day period to gain first-hand experience of the pressures and problems associated with discharging patients from hospital.

Building Care Capacity Grant

- 9 We examined the evidence the Department of Health collected as part of their monitoring of the use of Building Care Capacity Grant. This included the submissions made by the 55 worst-affected local authorities concerning commissioning strategies, consultation, recruitment and retention, involvement of the independent sector, and innovative partnership arrangements. All authorities were required to report back by May 2002 on how successful they had been in reducing delayed discharges.

Focus Groups - The patient/carer experience

- 10 We undertook a literature review on patient and carer experience, researching from mainly academic and voluntary sector sources. Following this, we carried out two focus groups of older people in Leeds, jointly with the Audit Commission. The discussions explored their experiences and the concerns they had with the services they were receiving.

Examination of evidence gathered by the Audit Commission on whole-systems working

- 11 We worked closely with the Audit Commission team which prepared the report *Integrated services for older people: building a whole system approach in England*, published in 2002. This included information sharing and joint visits to sites. The Audit Commission provided detailed illustrations of real-life partnership best practice and the key ingredients for good partnership working. We have drawn on the findings from the Audit Commission's work in our report. We would like to thank the Audit Commission team of David Browning, Jane Carrier and Peter Scurfield.

Interviews with a range of third parties

- 12 Throughout the study we undertook interviews with a range of third parties. These included academics researching in the health and social care field, representative bodies for independent sector providers of nursing and residential homes, the Association of Directors of Social Services, representative bodies for patients and carers, the Centre for Policy on Ageing, the Policy Research Institute for Ageing and Ethnicity, and follow-up meetings with Departmental policy staff.

Reference panel

- 13 We organised a reference panel, which provided valuable feedback on our proposed approach and initial findings. The members of the panel were:

Jane Carrier, Senior Manager, Audit Commission

Dr Gillian Dalley, formerly Director, Centre for Policy on Ageing

Caroline Durack, Discharge Team Manager, St Mary's NHS Trust, London

Ken Foote, Director of Social Services, Blackburn with Darwen Trust

Angie Glew, Transfer of Care Partnership Lead, Peterborough Hospitals NHS Trust

Debbie Gray, Operational Manager - Elderly Services, Lancashire Care NHS Trust

Ann Mackay, Executive Director, Community Care, Independent Healthcare Association

Anne McDonald/Helen Robinson, Department of Health

Dr Ronald MacWalter, Consultant in Stroke/General Medicine - Tayside University Hospitals Trust (representing the British Geriatric Society)

Ms Hilda Parker, Research Fellow, Nuffield Community Care Studies Unit, University of Leicester

Appendix B

Rates and causes of delayed discharge as at September 2002

Note: Data for causes relate to delayed discharges of patients of all ages. However, 77 per cent of those whose discharge was delayed are over 75, meaning that the data provides a sound indication of the problem for older patients.

	People delayed due to Awaiting Completion of Assessment	Awaiting public funding	Awaiting further NHS care	Awaiting residential home placement	Awaiting domiciliary package	Patient/ Family exercising choice	Other	Over 75s Delayed discharge rate
England	17.3%	12.9%	14.1%	25.5%	9.2%	10.2%	10.8%	8.86%
Directorates of Health and Social Care								
South	12.8%	10.2%	19.2%	31.1%	7.9%	8.4%	10.4%	12.08%
London	23.7%	7.3%	14.1%	27.8%	5.8%	10.5%	10.8%	9.61%
Midlands	22.5%	9.6%	12.4%	22.2%	12.4%	9.5%	11.4%	8.90%
North	13.9%	25.3%	7.7%	18.7%	9.4%	14.1%	10.9%	5.77%
Strategic Health Authorities								
North West London	19.2%	14.0%	14.5%	23.3%	3.6%	16.1%	9.3%	21.12%
Hampshire and Isle of Wight	21.3%	3.3%	13.8%	38.7%	12.2%	5.0%	5.8%	15.64%
Somerset & Dorset	5.0%	2.5%	66.0%	14.5%	3.8%	2.5%	5.7%	15.51%
Surrey and Sussex	12.2%	17.8%	11.4%	27.0%	7.5%	7.5%	16.5%	14.28%
Bedfordshire and Hertfordshire	11.5%	35.2%	0.0%	20.5%	14.8%	9.0%	9.0%	13.97%
Avon, Gloucestershire & Wiltshire	6.8%	13.5%	8.9%	38.4%	11.8%	14.8%	5.9%	13.64%
Leicestershire, Northamptonshire & Rutland	22.1%	0.8%	16.0%	26.7%	11.5%	13.7%	9.2%	12.09%
Norfolk, Suffolk and Cambridgeshire	24.3%	3.8%	18.8%	25.3%	14.9%	1.7%	11.1%	11.54%
Coventry, Warwickshire, Herefordshire and Worcestershire	40.7%	0.0%	14.2%	22.1%	8.0%	5.3%	9.7%	11.08%
South West London	31.9%	0.0%	4.3%	42.6%	2.1%	8.5%	10.6%	10.55%
Thames Valley	16.8%	9.7%	10.2%	38.8%	4.6%	7.1%	12.8%	9.43%
North East London	26.5%	2.8%	13.3%	27.1%	7.7%	6.1%	16.6%	8.94%
Birmingham and the Black Country	26.9%	18.5%	8.8%	10.4%	14.8%	9.1%	11.4%	8.37%
Essex	31.6%	4.6%	3.3%	33.6%	7.9%	11.8%	7.2%	8.37%
Kent and Medway	9.9%	5.8%	18.0%	32.6%	3.5%	19.2%	11.0%	8.05%
North and East Yorkshire and Northern Lincolnshire	10.5%	38.9%	3.1%	13.0%	6.8%	19.8%	8.0%	7.79%
South West Peninsula	10.7%	11.8%	33.1%	21.9%	6.7%	5.1%	10.7%	7.23%
Shropshire and Staffordshire	6.3%	4.5%	9.9%	32.4%	10.8%	18.9%	17.1%	6.88%
North Central London	20.9%	2.7%	26.4%	33.6%	3.6%	0.9%	11.8%	6.86%
South East London	25.6%	9.8%	9.1%	25.6%	8.5%	15.9%	5.5%	6.84%
Greater Manchester	4.3%	26.6%	14.9%	25.0%	13.8%	5.9%	9.6%	6.25%
County Durham & Tees Valley	30.9%	33.6%	3.6%	8.2%	3.6%	7.3%	12.7%	5.63%
Cheshire & Merseyside	10.7%	26.2%	4.2%	19.6%	10.1%	10.7%	18.5%	5.60%
South Yorkshire	38.1%	3.1%	7.2%	19.6%	12.4%	13.4%	6.2%	5.49%
West Yorkshire	14.0%	3.7%	6.5%	31.8%	7.5%	25.2%	11.2%	5.46%
Northumberland, Tyne and Wear	4.0%	25.7%	11.9%	5.0%	7.9%	33.7%	11.9%	4.93%
Cumbria & Lancashire	10.9%	33.6%	9.1%	24.5%	10.9%	3.6%	7.3%	4.67%
Trent	6.2%	5.4%	25.4%	17.7%	10.8%	16.9%	17.7%	4.49%

Prepared by the NAO from Department of Health data

Appendix C

Action in response to Committee of Public Accounts' recommendations on patient discharge in *Inpatient Admissions, Bed Management and Patient Discharge in NHS Acute Hospitals* (HC 135, Session 2000-2001)

Committee of Public Accounts conclusions and recommendations	Government response	Current situation
<p>(ix) Over 2 million bed-days are lost each year because of delays in discharging people who are fit to leave hospital. The key internal factors in these delays are poor co-ordination within hospitals, arising from the timing of decisions to discharge, and delays in the provision of transport and pharmacy services. The NHS Executive are working closely with hospitals to bring about the necessary changes to their internal systems and traditional patterns of working, to enable patients to leave hospital promptly once they are fit to do so.</p>	<p>Health Authorities are performance-managed on their rate of delayed discharge. Whenever prolonged delays in discharging patients or excessive numbers of delayed discharges are identified, the causes are reviewed by NHS Executive Regional Offices working, where appropriate, with the Social Care Regions (and the Social Services Inspectorate), and action taken to reduce the number of beds blocked. During [winter 2000/1], teams have been visiting health and social care communities where there are particular problems with delayed discharge and helping them redesign those parts of the system, both within hospital and at the interface with other services, that cause bed-blocking. This is helping bring about the changes needed.</p>	<p>Subsequently, there have been a number of initiatives aimed at reducing delayed discharges, some of which have impacted directly on the internal discharge processes within hospital. They include the work of the Department's Change Agents, a team of experienced managers in health and social care who work with health and social care communities to identify and tackle the underlying causes of delayed discharges.</p> <p>However, we found (Part 2) that there is still more progress to be made, including a need to begin planning discharge at an earlier stage, to assess patients' needs more quickly, and to identify and address bottlenecks in the discharge process.</p>
<p>(x) Many delays in discharging patients arise because of delays in assessing the ongoing care needs of older patients and difficulties in finding them places in community facilities that are most appropriate to their needs. The cost to the NHS of continuing to accommodate these patients, at around £1 million a day, is money that could be better spent on the treatment and care of new patients.</p>	<p>The Department agrees that this money would be better spent on providing more appropriate types of care for patients ready to be discharged. That is why the National Service Framework for Older People will outline a Single Assessment Process for the health and social care needs of older people. This will both streamline the process and improve the care packages that older people receive. Investment in intermediate care will increase capacity, allowing older people to receive care in settings more appropriate to their needs. The NHS Plan makes clear that intermediate care services are to be developed as a priority service for older people, with an extra 5,000 beds and 1,750 places by 2004, together benefiting some 150,000 more older people each year.</p>	<p>The National Service Framework required the introduction of a Single Assessment Process from April 2002. Subsequent guidance specified that full implementation is required by April 2004 as an acknowledgement of the complexities of the task, and to re-align the timetable more closely with the introduction of the electronic Health Record Service. Trusts and their partners have made variable progress in tackling the different stages in developing a Single Assessment Process, and most still have significant barriers to overcome.</p> <p>The development of comprehensive intermediate care services is still at an early stage, and there are considerable disparities of provision between regions. While the few evaluations of existing intermediate care schemes have shown positive results, nearly 90 per cent of Trusts experience delays in securing the transfer of older patients to intermediate care at least weekly.</p>

Committee of Public Accounts conclusions and recommendations

Government response

Current situation

(xi) Providing good quality services to patients depends crucially on a strong partnership between hospitals, general practitioners and social services departments. Health authorities have a pivotal role in sponsoring close collaboration between the parties involved, and in bringing forward practical solutions to overcome the administrative barriers to joined-up working. We therefore welcome the injection of £365 million to encourage the provision of more cost-effective community facilities and models of care. Targets have been set to achieve a 30 per cent reduction in the number of delays by 2003 and further measures have now been proposed to achieve timely discharge of patients and closer integration of health and social services.

During 2000-01, further money, a total of £134 million, was allocated to help expand capacity at various points in the system and reduce "bed-blocking". This included investment in transitional care to tackle delayed discharges and initiatives for recruitment and retention of key staff. An additional £100 million has been allocated to local councils with social services responsibilities to maintain the additional services next year (2001-02).

The overall rate of delayed discharge for over-75s for England decreased from a projected rate for 2000-01 of 12.05 per cent from data collected in the second quarter (September 2000) to a projected rate of 11.45 per cent following the data collection for the third quarter (December 2000).

In September 2001 the Department introduced the Building Care Capacity Grant for local authorities with social services responsibilities, to reduce the level of delayed discharges. The grant of £300 million over the two years 2001-02 to 2002-03 was linked to a new agreement between the statutory and independent social care, health care and housing sectors on building capacity and partnerships in care. The headline rate of delayed discharge dropped sharply by April 2002, comfortably exceeding the target of 1,000 for the year. This improvement has been sustained into 2002-03, with the Department estimating that 8.9 per cent of older patients had their discharge delayed by September 2002.

(xii) Discharge co-ordinators are effective in building bridges between all care providers to achieve appropriate and prompt patient discharge from hospital. Seventy per cent of NHS Trusts now have discharge co-ordinators and we look to the NHS Executive and Health Authorities to spread this good practice to the remaining 30 per cent of Trusts.

The Department's Winter & Emergency Services Team, the National Patients Access Team and regional teams have been supporting Trusts in improving their performance over the winter period. This has included spreading this good practice to the remaining Trusts. Guidance to be issued later this year will reinforce the message that Trusts should have discharge co-ordinators to manage complex discharges and monitor progress with delayed discharges.

We found that 82 per cent of acute trusts now have a discharge co-ordinator, while two-thirds have gone further and set up a discharge team.

Appendix D

Key points from other recent work

House of Commons Health Committee (2002). Delayed Discharges. Third Report of Session 2001-02, HC 617

- 1 In December 2001, the Health Select Committee announced its inquiry into delayed discharges. The areas covered by the inquiry were: delayed discharges, access to rehabilitation, intermediate care, home care and other social services interventions, both to facilitate timely discharge and to avoid inappropriate admissions; inter-agency co-operation; communications, including telemedicine and telecare; the management of appropriate alternatives to hospital admission; and the impact on patients, staff and carers of delayed discharge.
- 2 The Committee made a number of conclusions and recommendations, including:
 - i. the Committee commented on the importance of not using the term "blocked beds" to refer to patients ready for discharge who are still occupying hospital beds, as this could imply that patients are themselves responsible for the delay;
 - ii. despite the Department introducing a definition of delayed discharges in April 2001, it was felt that in practice there are still variations in the definition. The Committee believed further clarification of the definition, and further guidance on its application, is required;
 - iii. the Committee welcomed the downward trend in the rates of delayed discharge but questioned the reliability of the data. The Committee recommended that the Department's collection of data on the delayed discharge patient population should display a more comprehensive and refined picture;
 - iv. it is essential that patients be partners in the discharge process;
 - v. the Committee felt that the management of discharge needs to be changed substantially in many hospitals. They have suggested that best practice should involve a multi-agency team actively managing all aspects of the discharge process. The leader of this team should be appointed jointly by the NHS and councils with social services responsibilities. The Committee further believe that even though good systems are in place, there is a danger that they could become stagnant and ineffective, and therefore recommend that discharge procedures be a focused element of clinical governance reviews undertaken by the Commission for Health Audit and Inspection in the NHS, as well as other inspection procedures undertaken by equivalent bodies for social services and the independent sector;
 - vi. the Committee reinforced the need for a revision, now under way, of the Hospital Discharge Workbook originally published in 1994. The Committee also recommended that new statutory guidance be issued on health and social care responsibilities for hospital discharge;
 - vii. building capacity in any other sectors was noted to be potentially risky since it could essentially feed the problem of delayed discharge. Therefore, breaking the cycle was emphasised through the development of alternative facilities in the community ensuring avoidance of inappropriate admission and timely discharges are supported;
 - viii. with regard to the proposal to introduce a system of reimbursement at the interface between health and social care, there should be full consultation on the mechanisms to deal with delayed discharges. The Committee noted the risk that perverse incentives might be created that could undermine partnerships and foster an unproductive culture of "buck passing" and mutual blame between health and social care; and
 - ix. the Committee emphasised and urged the need for integration of health and social care and their linkages with related services such as housing. Without this, they felt that services can be fragmented and service users faced with services that fail to address their needs comprehensively.

Audit Commission (2002). *Integrated services for older people: Building a whole system approach in England*

3 The key messages arising from the Audit Commission report were as follows:

- whole-systems working is a method of working that requires everyone to agree on the direction and approach - a strategic vision, where everyone is clear about their own contribution towards achieving this and about others who can help;
- whole-systems working is important in older people's services because of the complexity of their needs. An older person will need support and information at any one time from a range of different agencies, and their needs may change and fluctuate from day to day;
- an early step in whole-systems working is to understand the local system and improve the way it operates by mapping existing services, referral patterns and routes. This will highlight any bottlenecks within the system, as well as any duplication or gaps in services;
- a successful system of care, in which services are organised around the older person, requires three key elements:
 - a shared vision, which is rooted in the views of older people;
 - a comprehensive range of services, including preventive services, that are delivered by flexible, multi-professional teams; and
 - a way of guiding and accompanying older people through the system to ensure that they receive what they need, when they need it;
- the whole system will only operate smoothly if it contains both an appropriate local balance of services and clear processes for getting into and moving around these services;
- a strong national emphasis on reducing delayed transfers of care has meant that a large amount of attention and resources have been focused on getting people out of hospital, often at the expense of more preventive activities;
- leadership at a senior level is key in developing a whole-system approach;
- whole-system working requires information to flow easily between organisations and professionals, especially information on trends and service use by the local population that will inform whole-system planning and service development.
- delivery of integrated care and a whole-system approach to older people's services requires a joined-up approach towards the workforce, which brings together local authorities, the voluntary and independent sectors and the NHS, including a joint strategy for recruiting and retaining staff, across the system;
- a whole-system approach should result in fewer crises, in more older people living independently, and in fewer admissions to residential and nursing home care; and
- over time, it is important to move towards an integrated system of monitoring and performance measurement that captures both performance across the system and the impact on older people's quality of life.

Appendix E

Personal social services allocations for older people 2000-01 to 2003-04

Revenue Support Grant	2000-01 £m	2001-02 £m	2002-03 £m	2003-04 £m
Standard Spending Assessment Allocation to guide council spending priorities	5010.2	5247.7	5488.2	
Formula Grant allocation to reflect past spending patterns ¹				4893.2
Comparable figure to Formula Grant allocation for 2002-3			4620.1	

NOTE

- 1 This figure is derived by taking predicted actual spend by councils on older people in 2002-3, including promoting independence grant and Building Care Capacity Grant, less funding for free nursing care (which is provided by the NHS from April 2003).

Revenue grants to promote discharge and avoid hospital admission	2000-01 £m	% change between years	2002-02 £m	% change between years	2002-03 £m	% change between years	2003-04 £m
Access & Systems Capacity	-		-		-		170
Promoting independence	181.5		141.8		112.1		-
Carers	28		39.2		47.6		75
Mental Health ¹	63.1		-		-		-
Building Care Capacity	-		90		190		-
Performance Fund	-		-		45		86.4
Care Direct	-		2		10		4.5
Delayed Discharge	-		-		-		100 ²
TOTAL	272.6	0.1	273	79.7	404.7	7.7	435.9

NOTE

- 1 Mental health grant continues but no longer contains an element for older people.
- 2 £100 million is the maximum payable if the new reimbursement arrangements are operational from 1 April 2003.

Source: Prepared by NAO from Department of Health data