

# Ensuring the effective discharge of older patients from NHS acute hospitals



REPORT BY THE COMPTROLLER AND AUDITOR GENERAL  
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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 older<sup>1</sup> 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 Plan<sup>2</sup> and the National Service Framework for Older People<sup>3</sup>, 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.

<sup>1</sup> The Department of Health define "older" as 75 and over.

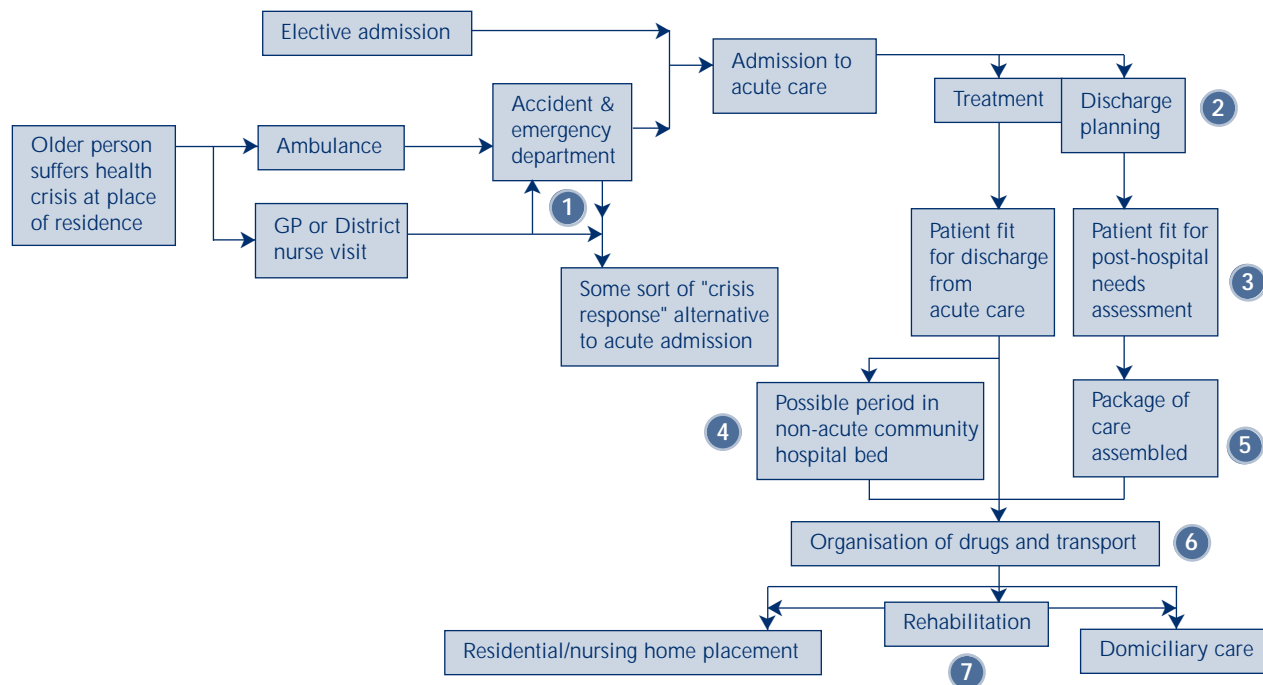
<sup>2</sup> Department of Health (2000). *The NHS Plan. A plan for investment. A plan for reform.* Cm 4818.

<sup>3</sup> 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 charges 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.

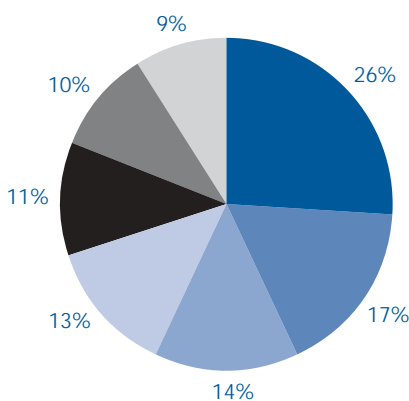
### 1 A representative care journey for an older person suffering a health crisis, or entering hospital for an operation or medical treatment (elective admission)



#### What can contribute to delayed discharge?

- 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.
- 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.

## 2 Departmental data on delayed discharge, and relationship to whole system causes



Department of Health categories	Whole system causes (Figure 1)	
Awaiting nursing or residential placement	5	7
Awaiting assessment of needs	2	3
Awaiting further NHS care	4	7
Awaiting public funding	7	
Other reason		
Awaiting placement of patient's choice	5	
Awaiting domiciliary care	5	7

### 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 1999<sup>4</sup>, 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

<sup>4</sup> 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 care<sup>5</sup> 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.

<sup>5</sup> 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.

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- 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).