DELAYED DISCHARGE LEARNING NETWORK

1. Introduction

In recognition of the significance for the NHS of the issue of delays in discharge from acute hospitals, the Minister for Health, Susan Deacon, set up a short-life working group in July 2000 to look into developing a Learning Network for Delayed Discharges. The aim was to look at what learning could be shared from around Scotland that would help health and social work improve the processes.

The group was asked to report by October 2000.

1.1 Remit

The remit set for the group was very focused to reflect the timeframe and in recognition that delayed discharges can only be solved in the main in the local context:

Develop a learning network of information across Scotland on Delayed Discharges. This should include actions taken by Health and Social Work that have been effective and those that were not, to allow lessons to be shared.

Membership of the group is set out in Appendix 1.

1.2 Summary of Recommendations

This report contains a baseline statement about current good practice and who to contact for further details in Section 6.

Section 7 sets out recommendations to establish a learning network. These are summarised below:

- A network should be established to enable exchange of good practice and effective ways of working on delayed discharges. While recognising the impact of local circumstances, lessons from different areas are transferable.
- The network should involve both a web site of information and also workshops and conferences to allow discussion and training.
- The ISD data collection should be developed to enable effective comparisons and performance management across Health Board areas.

- A National Framework for Services to Older People should be developed for Scotland that would incorporate the issues pertinent to delayed discharges.

Section 5 sets out the core issues for partner organisations to work through to clarify if they are taking appropriate steps, either individually or collectively, to improve the delayed discharge situation locally. A draft checklist, in Appendix 2, has been drawn up to provide a tool for partner agencies in reviewing their processes.

1.3 Process

To develop an approach to a learning network the Group identified the issues behind delayed discharges and how information exchange on good practice could be established in an appropriate and effective way for Scotland.

The Group did a "desk top" exercise seeking information from each of the 15 Health Boards and their Social Work partners to find out what the position and experience was generally. The issues were explored in more depth by detailed discussions with 5 Health Board areas. The focus was on:

- Numbers of delayed discharges in the area using the data returned to ISD as part of the recent national census ie the size of the problems locally.

- Where interventions or actions had been taken which were successful in reducing the numbers of patients waiting and the length of delay.

- Interventions that did not achieve the intended outcomes or were not as effective as anticipated and what lessons can be drawn from these experiences. It should be noted that no-one shared any such experiences.

1.4 Background and connected National Work

It was recognised that at the same time as the work of the Delayed Discharge Learning Network Group, a number of other pieces of work were in hand that were relevant and connected to the work. These other processes have set and continue to set the agenda for the work of the NHS and Local Authorities which has an impact on delayed discharges.

A short life Winter Performance Group was established by the Minister to make recommendations on improving the management of the patient journey during the winter. This Group set out its recommendations in a report and at the national conference in September 2000. The Recommendations around delayed discharges are summarised here in Section 2.3 and the full report is available for the Scottish Executive Health Department (SEHD).

From April 2000 the national organisation Information and Statistics Division Scotland (ISD) had set up a reporting system on delayed discharges from all Health Boards. The first quarter report has been compiled although not published. It will provide useful information that will enable Health and Social Work across Scotland to analyse the local experience and monitor the impact of actions taken to improve the management of the patient journey through the NHS and partner social care services.

The Joint Futures Group was established by the Minister for Health to develop Scotland's response to the Sutherland Report on the Long Term Care of the Elderly. This Group has presented in a series of conferences some of the emerging themes and indicated that the final report due in November 2000 will focus particularly on issues relating to older people.

2. Context

The DDLN Group's thinking was informed by other reports that captured important facts or approaches. In particular these were:

- While not all delayed discharges relate to older people, it is clear from research literature, data and experience in services in Scotland that older people account for the majority of cases where there is significant delay. The delayed discharges information collected by ISD was based on a very wide definition of "delay" but within the figures it is evident that the majority of problems being experienced were around the management of older physically frail people or with the mentally frail older people.

- The management of delayed discharges has to be seen in the broader context of avoidance of unnecessary admissions to hospital not simply swifter discharge.

- The management of emergency admissions to hospital has also to be considered.

Two reports were found to provide a useful framework for considering the complex issues of more effective management of the journey of older people through health and social work services. The Audit Commission briefing in June 2000 *The Way To Go Home* and a report from the NHS in Lothian on *Promoting Acuity in Acute Care.* The third report from the Winter Performance Group sets out actions for Health Boards and Councils to address.

2.1 Audit Commission Report - *The Way To Go Home* June 2000 (England and Wales)

This report set out some key facts pertinent to delayed discharges.

That older people are major users of hospital services:

- Two thirds of hospital beds are occupied by people aged 65 or over.

- Two thirds of social services expenditure on people over 75 goes on residential and nursing home care.

- The numbers of older people are growing, thus increasing pressures on these services.

That effective rehabilitation can help people to stay at home or return home after hospital, and reduce admissions to residential homes and nursing homes. That requires a range of services including the following:

- Multidisciplinary teams working in people's own homes to prevent admissions and help people home after hospital.

- After acute care, access to an intensive multidisciplinary rehabilitation programme.

- Once medical problems have stabilised, places in homely settings for more active rehabilitation and confidence building before a move to place of permanent residence.

That well-integrated care requires:

- Processes and services clearly linked (within health, within social work and between the organisations).

- Care co-ordinated by multidisciplinary teams within a framework of a joint investment plan.

2.2 *Promoting Acuity in Acute Care,* Lothian, 1998

This report usefully set out a framework to consider the effective use of acute beds with particular reference to the management of older people. The framework and focus has been used in the joint planning of older people's services in the Lothians.

Avoidance of unnecessary admission through:

- Combined "risk management" approach by primary and secondary care that requires good communication.
- Prompt access to acute sector diagnostic facilities and expertise without recourse to admission.
- Co-ordinated and accessible multi-agency domiciliary support and monitoring of patients at home with sub-acute or acute illness.

Optimal rehabilitation and discharge management to compress home-to-home acute stay so minimising deterimental impact of hospital stays on older people, reducing delays and improving patient flow through acute beds by:

- Prompt multidisciplinary assessment and rehabilitation.
- Rigorous discharge management with community service provision.
- Follow up to ensure patient welfare and service delivery.

Provision of ready access post-acute rehabilitation facilities for patients unable to be discharged but no longer requiring acute care:

- Geriatrician-led multidisciplinary rehabilitation in post acute care to maximise any chance of discharge home.
- Placement services for stabilised patients who cannot go home.
- Terminal care services in circumstances more appropriate than those of acute hospital care.

2.3 *Lessons from Winter 1999/2000* – Winter Performance Group, Scottish Executive

This report set out issues around delayed discharges particularly where they impacted on the ability of the acute sector to manage during the winter. It included several recommendations on the improvement of discharge to prevent delays.

The recommendations on discharge procedures and delayed discharges focused on managing the winter were:

- Local Health systems and Local Authorities should establish joint protocols with agreed standards and monitoring arrangements – including social work assessment for timing the various stages of discharge planning and implementation.

- There needs to be liaison with GPs, community nurses and other primary care staff on input to local arrangements.

- Consultant ward rounds should be undertaken on a daily basis. The timing of ward rounds should be reviewed wherever possible to take place early in the day in order to allow time to organise discharges.

- Social Work Departments should be integral to winter planning, which should be part of the overall local system for joint working.

- Local health systems and Social Work should together consider forming multidisciplinary teams to focus on discharge planning. Should this prove impracticable, each hospital should have a senior member of staff charged with liaising with Social Services over discharge planning.

- Wherever possible a patient's social circumstances should be assessed on admission and patients given an expected date of discharge at that time.

- Acute and Primary Care Trusts should work together to create discharge facilitators to be based in each acute hospital who will be responsible for strengthening liaison arrangements between community and practice

nurses and acute services to ensure the smooth and prompt discharge of patients.

- Logistics for a patient's discharge should be considered on admission, and health and social care staff concerned with the patient should know of any decisions to be made and when these need to be acted upon.

- NHS Trusts and Island Health Boards should consider the further development of delayed discharge lounges to accommodate those ready for discharge where the availability of transport or drugs etc is likely to cause delay.

- The SEHD should review existing guidance on, and the interpretation of, the direction of choice that has been issued to Local Authorities. The review should ensure that guidance is sufficient and appropriate to enable the effective management of this issue in winter 2000/01, whilst recognising that decisions need to be sensitive to the interests of patients.

3. Sizing the Problem: ISD National Data on Delayed Discharge

The Information and Statistics Division set up a mandatory process in April 2000 for the collection of data on delayed discharges. The first census in June 2000 using the agreed definitions, was a trial to ascertain how robust the collection of information was and whether the national definitions and guidelines needed further clarification.

ISD are taking forward work to resolve some of the issues that emerged from the trial census. There are two strands to this - the first around the data recording including the consistency of application of the definitions and the robustness of the definition categories, the second around the analysis needed to enable the data to be used for comparative purposes and to inform performance management.

Findings will be set out in a detailed report but included the following issues:

Clarification of definitions, codes and recording rules:

- ensuring clearer definition of patient choice
- capturing data on patients receiving NHS continuing care
- referral dates for social work assessment

Broader management issues:

- Greater clarity on the bed labels or definitions to allow comparisons across Scotland (acute, post acute, community hospital, GP bed etc).
- Include number of nursing home and residential home places available.
- Relative levels of NHS provision available.
- Local Authority population comparators.

More general learning included the implications of the absence of electronic systems of data collection makes it difficult for health and social work to make the returns within the timeframes set.

In addition, it is clear that the pressure on services of delayed discharges is experienced differently in different parts of the country. The Winter Performance Group Report indicated that many Health Boards reported high levels of delayed discharges in 1999/2000 as a result of the combination of the number of elderly patients admitted to hospital for treatment and the inability of Local Authorities to provide care in nursing or residential homes.

Many Health Boards had reported that this was a problem that had been building up throughout the year. The DDLN Group found that the position varied across Scotland but that the problem of delayed discharges was not simply a product of the winter months.

4. Key National Strategic Issues

4.1 Differences across Scotland

The experience of delayed discharges differs across Scotland. It is evident from the data that some areas are experiencing more difficulties than other areas. There are also differences in both how organisations have tackled the issues and in how successful the measures taken have been. The findings of the Group suggest that some of these differences mean that it would be difficult to achieve a “single solution to fit all”.

4.2 Geography

The geography and infrastructure of different localities has an impact on the types of service configurations that have evolved. The importance of these factors has been recognised in other policies and approaches to the health services, for example the Arbuthnott Report took factors such as remoteness and rurality into account when determining the resource allocation formula for the NHS in Scotland. The factors impacting on the shape of services and challenges to be addressed include whether an area is rural or urban; the size of the population settlements such as village, town or large city; the degree of remoteness and the road and transport links. In the 5 Health Boards and their Local Authority partners visited there were differences both between Health Board areas and within the boundaries of the Boards and Councils.

It was evident that in certain parts of the Councils/NHS in Scotland the boundaries between organisations are very complex. Particularly where there are small organisations with several partnership areas to work in this can stretch staff resources. This impacts on the ease with which it is possible to achieve the effective relationships that are essential to good joint working on delayed discharges.

The Group would recommend that these factors are recognised when comparing performance across and between different organisations.

4.3 Population Profile

Health Boards and their Councils raised the impact that the profile of older people particularly over 75 years had on the experience of delayed discharges leading to variations between different areas. Other population factors that were perceived as having an impact on management of older people and delayed discharge were the overall size of the population, the % of people in the “carers” age bracket and the social deprivation experience of the population. The impact of such differences would need further exploration when monitoring and comparing performance across organisations and areas.

4.4 Configuration of services and level of resources

There were important differences in the current baseline of services between the Health Board areas visited. This reflected the historical evolution of patterns of provision, the funding levels to Health Boards and Councils, levels of Resource Transfer between health and social work and the number and types of beds in statutory and private sectors.

- Dumfries & Galloway NHS has both community hospitals and a district general hospital and within the area the community hospital beds are used differently depending on the geographical proximity to the DGH.

- Greater Glasgow Health Board indicated it has approximately double the UK average number of NHS continuing care and nursing home beds. This provides a model of care which partners wish to change. It is in contrast to the experience of places such as the Lothians where the number of NHS continuing care places has been the subject of planned reduction and resource transfer to Social Work to fund a new model of care.

- Some areas have few private NH beds because public sector provision has been and remains high or the areas have not been geographically or financially attractive to the private providers or local approach has been not to encourage large-scale private providers.

- The private nursing home market place is emerging in some areas as a significant issue, for example where there is low availability of places or where the market place is changing with providers closing. Pricing in the private sector was also reported as an important factor.

4.5 Patient Choice of Nursing Home Place

There were important differences across Scotland in how Local Authorities were handling the question of patient choice of nursing home. Some had put in place agreements about managing patient choice to ensure that the delay or wait while waiting for the nursing of choice was not in a hospital bed. This is seen as a very sensitive issue that would benefit from national guidance.

4.6 Evaluation

It is clear from the discussions and responses from the health and social work organisations that while many of the initiatives introduced to manage delayed discharge are helping to improve the problems there has been little evaluation or audit of outcomes. The introduction of evaluation and audit would allow better comparisons between the models of care to assess their cost and clinical effectiveness. This would need to address or include the

implications of frailty and dependency such as the effectiveness and affordability of community packages of care for the frailest of older people or the optimum availability of and access to acute hospital provision.

4.7 Other Issues

Health Boards and their partners raised a number of specific issues that had impacted on the local ability to achieve improvements.

- The absence of an overarching, national policy approach to care for older people – it was suggested that a National Framework for Older People along similar lines to that for Mental Health Services would be beneficial.

- Not all areas had a local joint strategy for older people – where these existed they provided a mechanism to put in place an agreed vision for services, high level commitment to delivering the strategy and funded action plans that organisations were signed up to financially, organisationally and politically.

- Public expectations and demand for health and social care – expectations are high and this puts Health and Local Authority resources under increasing strain as the older population increases.

- Joint training at all levels between Health and Social Care would benefit understanding and good practice.

5. Key Actions to Reduce Delayed Discharges

Reducing delayed discharges should begin with the principle that, wherever possible, we should prevent admission in favour of supporting people in their own home.

There is no single solution to the problem of delayed discharges. However, there are a number of key issues which it is essential to consider when developing plans to address delayed discharges. The key issues include:

- An effective framework for managing older people's health and social care needs.
- An approach to managing health problems including preventing admission with effective crisis support in the community and effective discharge arrangements so that acute admissions of older people are not delayed in hospital.
- Effective discharge arrangements within hospitals and between health and social work.
- Effective management of complex packages of care for older people in the community.
- Integrated health and social care both for strategic planning, operational planning and the provision of services.
- Good relationships between key statutory agencies at an individual and corporate level.
- Effective clear communications between professionals and with the users of services.
- Adequate and varied supply of alternative provision outside of hospital in particular nursing home provision.

Section 6 sets out in more detail the achievements in Scotland so far and highlights good practice across the country in developing services that effectively address the needs of older people and reduce the delay in discharge from hospital.

6. Improvements Achieved in Scotland so far

6.1 Prevention of Admissions

All areas recognised the importance of preventing inappropriate admissions because of the impact that hospital stays had on older people making it harder to discharge to home and increasing the risk of a person ending up in care other than in their own home.

- **Ayrshire & Arran Acute Trust – Hospital Rapid Response Team** - The Rapid Response Team in South Ayrshire is a dedicated multi-disciplinary team working together to prevent hospital admission and to facilitate the earliest possible discharge from hospital. Following a successful evaluation, Ayrshire & Arran Health Board has agreed with the three Ayrshire Local Authorities, the Acute and Primary Care Trust to extend this service across Ayrshire with a multidisciplinary team based at both Ayr and Crosshouse Hospitals.

  Contact - Jackie Lunday, Crosshouse Hospital 01563 577125

- **Lothian University Hospitals NHS Trust Safe Home and Acute Medical Admissions Unit** – allows the management of medical risk through a 24 hour or less admission to hospital where diagnostic tests are available and provides an emphasis on safe supported discharge home from AMAU.

  Contact – Fiona Murray 0131 536 3629

- **Lothian Primary Care Trust with Edinburgh City Council Joint Crisis Care services** – the joint service has been developed to include crisis home care and nursing care to prevent hospital admission

  Contact – Jeanette Bell 0131 537 3291

- **Aberdeen Augmented Care Scheme** - Schemes developed jointly to enable early discharge from hospital or prevent admission. Primary Care Trust increased day, night and PAM services. The Council provided home carers offering an enhanced range of services, as and when required, up to 24 hours a day including “on call” for overnight carers, increased care management and occupational therapy. Jointly provide an increased range of occupational therapy/district nursing aids and equipment.

  Contact - Carol Valentine, Social Work Manager 01467 628037

- **Borders : Clinic for Falls, Fits, Faints and Funny Turns** - A one stop clinic held within the Day Hospital, Borders General Hospital. Patients are investigated for causes of falls, fits, faints and funny turns. Follow up appointments for review are arranged if necessary.

  Contact : Dr P. Karanuratne / Sister Marie Drover 01896 826585

6.2 Improved Discharge Arrangements

Discharge arrangements are a key aspect of improving the patient flow through the various elements of care. It can be seen from the delayed discharge information that delays happen at many of the service interfaces, ie both within the NHS as well as between the NHS and Social Work. Some of the effective provision that has been developed demonstrates the following features:

- Good communications.
- Clear joint systems including multidisciplinary teams and protocols.
- People with clearly identified responsibility for making things happen.
- Clear standards, especially timeframes, as part of the joint protocols.
- Effective monitoring of the standards and leverage to take action where the agreements are not met.
- Adequate alternative provision available outside hospital.

There are joint standards for discharge arrangements across Scotland but it was apparent that this reflects local negotiation rather than a national standard. For example in Lothian one current standard is to achieve discharge no longer than 6 weeks after the patient has been assessed by the multidisciplinary team as ready for discharge. This should be looked at when trying to achieve more consistent performance in Scotland.

There were different target groups for the discharge schemes. Some focused on the relatively short stay acute patients giving greater turnover in the acute beds. Other schemes were targeted on the patients who require complex or intensive packages of care or alternative accommodation who tend to fall into the population of longer delays beyond the average 6 weeks after being assessed ready for discharge.

Most areas had actions to illustrate that the importance of good joint discharge arrangements were recognised and had developed protocols and new service arrangements to deliver improvements.

- **Dumfries and Galloway Partners in Care Discharge Protocol** - A Partners in Care Discharge Protocol has been developed to ensure safe, appropriate and timely discharges from hospital through the delivery of seamless, effective services.

  Contact : Jennifer Wilson, Corporate Services Manager 01387 272702

- **Improved and joint care management arrangements : shared assessment West Lothian** - Establishes a framework within which non-complex cases can be assessed and the care planning process initiated that avoids the "duplication" of a second assessment in order to access resources managed/purchased by another agency. For complex cases this establishes a framework that allows joint review and shared responsibility for resource provision.

  Contact : Sally Lee, Location Manager NHS 01506 634980
  Ian Quigley, Senior Manager SW 01506 777328

- **West Lothian Council** has developed a local policy on the management of patient choice of nursing homes which, while maintaining choice, also allows some flexibility and reduces the time of delay in hospital.

  Contact - Margery Naylor 01506 777331

6.3 Joint Budgets

An important feature of joint working is the ability to share resources to enable staff working to develop care packages or alternative provision to respond flexibly to demand. The experience and language around joint budgets and funding is important. In most instances it has been a budget constructed to fund a specific team with partners sharing the costs.

In other instances projects are looking at managing financial risk together, managing the money as a single entity for whichever application.

- **City of Edinburgh and Lothian Primary Care NHS Trust Community Rehabilitation Team** – jointly funded providing for up to 6 weeks support in own home to enable safe early discharge from hospital (evaluation available) impact has also been to reduce level of on-going intensive care packages required.

  Contact – Jeanette Bell 0131 537 3291

- **Angus** – a charitable trust bringing together Scottish Homes, Health, Social Work and Housing was set up to facilitate joint working and budget management to provide extra care housing with 24 hour cover for frail

elderly people. The extra care housing provides an alternative to residential or nursing home care and for the resettlement of elderly people from hospitals in Tayside.

Contact – Neil Clapperton, Housing Department 01307 473986

- **Aberdeen City Pooled Budget for Rapid Response Team** - Rapid Response Team develop community based care packages to avoid admission, facilitate discharge from hospital and provide service within 24 hours of referral using pooled resources. Where clients need more than one service, intensive care packages are limited to 21 days and where available 24 hours a day. Home care is provided free for the first 2 weeks.

  Contact : Kathleen Sinclair, Project Manager 01224 558324

- **Tayside Pilot Project on a Single Assessment Process with Shared Budget** - the development of a protocol to allow quicker access for assessment and provision of services. District Nurses and Home Care Organisers can access services direct without having to make a referral to the care management team. Pilot begins on 27th November 2000 for 3 months.

  Contact – Sandra McKinlay/Christine Bradbury, Joint Project Co-ordinators 01382 438379

6.4 Improving processes in community care

In addition to improving the actual discharge arrangements, good on-going joint working and services in the community are a vital part of the improved management of patients and clients through the system and into the most appropriate form of care and support.

- **Glasgow City Council – Review of Care Packages –** A review of care packages is undertaken following hospital discharge. Non-complex packages where home care is required, nursing staff in hospitals arrange home care prior to discharge without referral to social work. Within 3 days of discharge from hospital, the local area social work team will complete a full assessment to ensure the care package is appropriate. For discharge to residential or nursing homes, a social worker will review the placement within 4 weeks to confirm whether the placement is appropriate or arrange a further review. For complex home care packages, the case is immediately transferred to the local area social work team who monitor and review the package against the hospital social work assessment.

  Contact – Sheila Gillies, Health Sector Manager, Glasgow City Council 0141 287 8715

6.5 Joint Planning Arrangements

Where partners had developed good relationships locally there was clear evidence that it allowed for greater creativity and success in addressing problems of delayed discharges. All partners had joint officer level planning arrangements in place but the relationships were of different qualities. This reflected the fact that the boundaries were complex between partners as well as the human relationships. Some areas had engaged joint planning at political/non-executive level which assisted the development of relationships.

- Joint planning processes – Dumfries and Galloway Health Board have membership of the Social Work Committee and this has enabled the development of closer understanding and working relationships.

  Contact – Thea Stein 01387 272700

- Joint strategies for older people – in the Lothians the 4 Councils, 3 Trusts and Health Board have had a Joint Strategy for Services to Older People in place for 5 years providing an important framework of agreement for remodelling services. A recent review has strengthened the agreements and enabled work on joint budgets and provision to move ahead.

  C*ontact – Effie Alexander 0131 536 9319*

- Resource Transfer principles agreed and resource shifting to deliver strategy e.g. Lothian £11.2m into Councils and £5m into primary and community health care to develop the alternative provision to maintain older people in own homes and prevent inappropriate admissions to hospital.

  Contact - Ray Flint 0131 536 9289

- Greater Glasgow Health Board/6 Local Authorities have joint discharge policy and a standard to achieve discharge 35 days from referral which is underpinned by the resource transfer arrangements

  Contact – Catriona Renfrew 0141 2014607

7. Proposals for Establishing a Learning Network

7.1 Lessons from the initiatives and experiences of the organisations across Scotland are transferable and should be shared. This should include not only good practice and what works but also the impact of local configuration of services and circumstances and any actions that have not been effective. It is recommended that a Learning Network should be established.

7.2 It is recommended that the Learning Network should take the form of a managed web site organised for the whole of Scotland by the Scottish Executive through the SHOW site. Health Boards and their Local Authority partners through COSLA should be required to provide the examples of good practice with contact points. This would provide a contact point within the Scottish Executive for this work.

7.3 Good practice sharing sessions should be set by the Scottish Executive and COSLA in the form of regular workshops and conferences.

7.4 Further work should be undertaken by ISD with health and social work to develop the data on delayed discharges to allow effective comparisons to be made between areas and to enable further analysis and evaluation of specific aspects of practice, resources or population factors. The services in health and social care should develop better arrangements for evaluation of services and audit of outcomes of the provision.

7.5 Further work on the development of clinical (professional) quality standards, performance measurement indicators and a check list for addressing strategic and operational planning processes. Specifically, work to develop the check list outlined in Appendix 3 should be taken forward by the Scottish Executive Joint Futures Unit.

7.6 It is recommended that the Scottish Executive should consider the development of a National Framework for Older People which could incorporate pertinent issues around delayed discharges.

As indicated in Section 4 there is no single, simple solution to the issue of delayed discharges. However, there are some important actions already taking place throughout services in Scotland and there would be benefit from sharing them. The recommendations of the Group set out some steps to enable this to happen.

Appendix 1

Delayed Discharge Learning Network

Membership

John Ross, Chairman, Dumfries and Galloway Primary Care NHS Trust

Janet Kells, Director of Social Inclusion and Community Care, Lothian Health

David Kelly, Corporate Manager Community Services, West Lothian Council

Councillor Rita Miller, Convenor of Social Work, South Ayrshire Council

Appendix 2

DRAFT Checklist for Improving Delayed Discharges

A checklist should be developed to act as a framework and prompt for partners involved in the complex, multifaceted issue of delayed discharges. The approach should be not simply one of a "disposal" mindset but should reflect a "whole system" approach. The context should be to address the longer term agenda for managing older people and those with complex needs.

- Supporting people in their own homes wherever possible.
- Effective pathways through services and with the appropriate balance between prevention, treatment and care.
- Ensuring new ways of working are supported both in the management of provision and the type of services including use of "Smart" technology.

The checklist should differentiate between actions that are imperatives which apply across the board and actions that will reflect differences in local circumstances.

1. Essential actions to be addressed by all partners will include:

- Formal agreements on strategies for services for Older People including actions to address delayed discharges, joint resource frameworks and budgets, plans to address gaps in services and action plans that are linked to budget setting processes within partner organisations.
- High level ownership and formal agreement to these strategies and actions – political and managerial.
- Local agreements on patient choice for long term care, including nursing home placements, that are jointly operated by health and social work partners.

2. Prevention of inappropriate hospital admissions – actions may have local solutions but should address the following issues:

- Joint ownership of the numbers and data analysis.
- Joint agreement on the access to and range of services required locally.

Such services could include:

- Rapid response teams.
- Integrated crisis home services.
- Augmented care schemes.
- Effective joint aids and adaptation arrangements.
- Joint emergency or out of hours arrangements.
- Effective communication on what services are in place to enable good use by GPs, social workers and hospital staff.
- Joint training on risk assessment.

3. Services and arrangements for effective discharges

- Joint agreement on numbers and analysis of reasons for delay.
- Joint agreement on the standards for and range of services to achieve effective discharges.

Such services could include:

- Standards for each step of the patient pathway.
- Joint agreement on referral arrangements inside hospital, between acute and primary care and between health and social work.
- Strengthened PAMs and rehabilitation services.
- Daily ward rounds for discharge, discharge lounges and improved transport.
- Contracts between Social Work and private nursing homes.
- Unified assessment processes.

4. Strategic and Operational Management issues

- Agreement on joint, integrated management of key/all services.
- Joint assessment and care management agreements in place.
- Joint integrated budgets with agreement on managing the demand when it outstrips funds available
- High level as well as operational joint working including political links between Health Board, Trust Board and Local Authorities including cross membership.
- Joint performance management targets between partners and with Scottish Executive.
- Community Care Plans linked to HIPs and to budget setting.