

Scottish Community Care Benchmarking Network



Benchmarking Project “Faster Access to Services: The Delayed Discharge Process”

Contents

	Page
1. Introduction	3
2. The National Picture	5
3. Phase 1: Survey	6
4. Phase 2: Site Visits	12
5. Conclusions	29
Appendix A: Delayed Discharge Data, April 2008 to April 2012	31
Appendix B: Questionnaire	33
Appendix C: West Lothian Partnership: Hospital Discharge Process – July 2012	42
Appendix D: Faster Access Benchmarking Group Members	43

1 Introduction

1.1 Background

In August 2001, the Minister for Health and Community Care asked the Head of the Scottish Executive Health Department to consider the problem of delayed discharges in Scotland and to report on both the short and longer term actions needed to resolve this problem.

When he reported in March 2002¹, the most current delayed discharge census showed that 2,191 people were waiting over the agreed 6-week assessment and discharge-planning period and of these, 300 had been waiting over a year. His report highlighted that the majority of delayed discharges were experienced by older people, mainly those over the age of 75, and that delays could undermine their confidence and independence whilst increasing their inability to care for themselves or to be cared for in their own home or in a place in their own community.

The report highlighted the increasing number of older people in Scotland and warned that, with this growth, the problem of delayed discharges would worsen significantly without effective action.

Following publication of the report, the Scottish Executive launched a Delayed Discharge Action Plan and allocated £20 million to Local Authority and NHS partnerships to implement it through local plans to reduce the number of people waiting for discharge from hospital. Partnerships were held accountable for making progress on reducing delayed discharges through a series of targets culminating in a target of zero delays over 6 weeks to be achieved by April 2008.

The standard that no patient should be delayed in hospital for longer than 6 weeks from when they were clinically ready for discharge has remained in place since 2008 and a report by a Joint Improvement Team (JIT) Expert group published in July 2012² acknowledged the significant success over the last few years in achieving this zero standard but made the point that “this achievement obscures the contention that a 6 week delay... is still too long”.

In October 2011, two new targets were announced by the Scottish Government. These are that by April 2013, no patient should wait more than 4 weeks from when they are clinically ready for discharge and subsequently by April 2015 no patient should wait more than 2 weeks until discharge.

Latest General Register Officer for Scotland (GROS) projections indicate that the growth in the number of older people is accelerating, with the following rises projected between 2010 and 2025:

- 35.4% in the over 65s
- 45.2% in the over 75s
- 67.3% in the over 85s

¹ <http://www.sehd.scot.nhs.uk/publications/dc20020305delaydisch.pdf>

² <http://www.jitscotland.org.uk/downloads/1342708137-report%20of%20the%20expert%20group.pdf>

It is therefore clear that the health and social care system needs to continue to work effectively, and in partnership, to meet the new targets and ensure that older people are not detained in hospital for any longer than they need to be.

1.2 Purpose

This benchmarking project was initiated in 2010 with the purpose of comparing the performance across Scotland and identifying and sharing best practice in relation to the prevention of delays beyond 6 weeks for the discharge of patients from hospital to a more appropriate care setting.

1.3 Scope

The scope of the project was to examine the quarterly census data from each Local Authority/NHS Board to identify any trends and variances. The project did not exclude any service user groups or age categories. Although the measure looked at patients delayed for more than 6 weeks, the data for patients delayed less than 6 weeks was also examined as it was felt that there could be correlation between the data sets.

The project proposal also envisaged looking at re-admission rates in those areas which consistently reported no delayed discharges over 6 weeks to see if there was any suggestion that patients were being discharged too early. However, this did not prove possible, mainly because of the unavailability of such data and time constraints.

1.4 Methodology

A survey was issued to all members of the Network asking for local information on the hospital discharge process, destinations and background information about impediments to speedy discharges. The report on the findings of the survey³ noted examples of good practice and made a number of recommendations, including asking partnerships who have consistently achieved the zero delays target to share “best practice” with other partnerships.

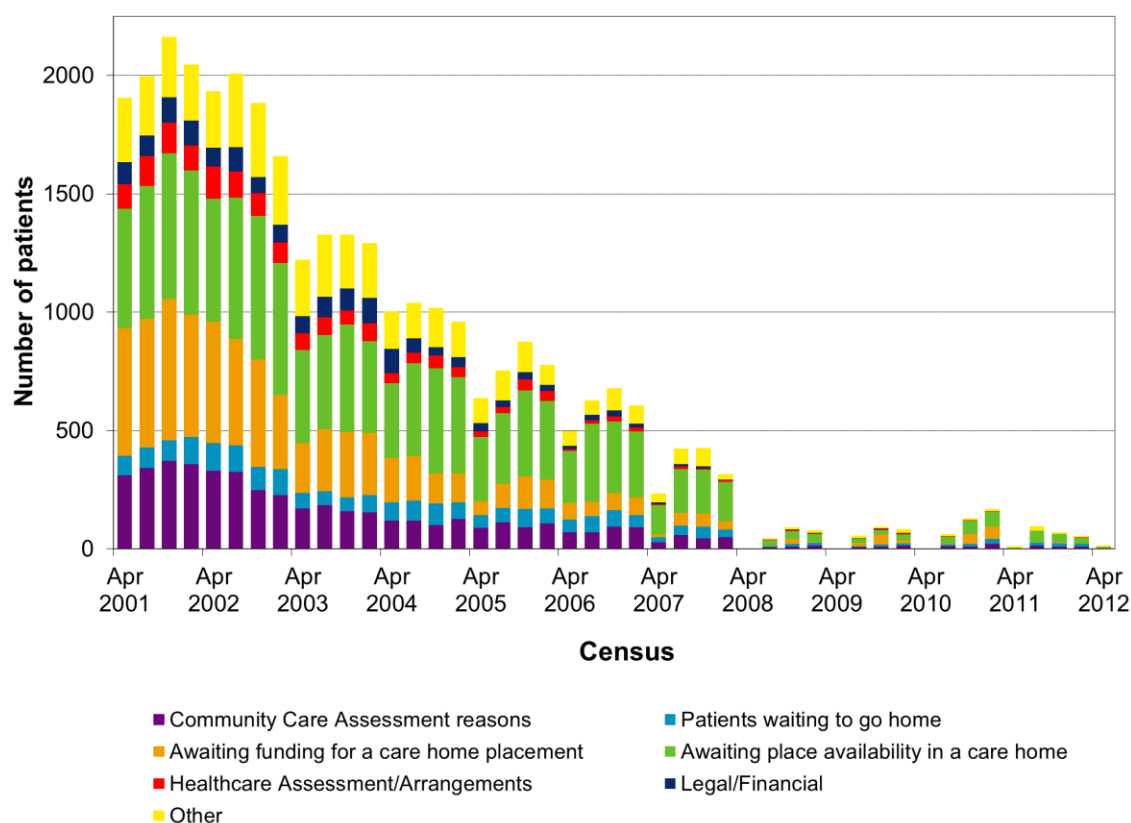
Following this up, the benchmarking group carried out site visits over the period March to May 2012 to three “best performers”. This report covers the findings of both parts of the exercise: the survey and the follow-up site visits.

³ <http://benchmark.shbvn.org/sccbn/Members Document Sharing/Project Group 1 - Faster Access - the Delayed Discharge Process/The Delayed Discharge Process Report - 30 March 2011.doc>

2 The National Picture

Since the April 2002 census and for each quarterly census thereafter we have seen a decreasing rollercoaster effect with the number of delayed discharges falling at the point of the April census each year, but rising again in each of the three intervening quarterly censuses. In April 2008 the census revealed that the target of no patients delayed greater than 6 weeks had been achieved. This position was repeated in each of the following two April censuses (2009 and 2010); however, in each of the following years, whilst the number dropped in April, the zero standard was not achieved nationally, and the rollercoaster picture continues to be evident, see Fig.1 below:

Figure 1: NHS Delayed Discharges that are outwith the six week discharge planning period by principal reason for delay: Scotland; April 2001 to April 2012.



Over the period April 2008 and July 2012, whilst a number of Partnerships have reported very low numbers (i.e. 1 or 2), only four partnerships: Clackmannanshire, East Ayrshire, Moray and Shetland, have reported no delayed discharges over 6 weeks. It should be noted that the populations of these Councils are relatively low:

Clackmannanshire	50,770 of which 8,314 (16.4%) aged 65 and over
East Ayrshire	120,200 of which 21,420 (17.8%) aged 65 and over
Moray	87,260 of which 16,860 (19.3%) aged 65 and over
Shetland	22,500 of which 3,855 (17.1%) aged 65 and over

Populations based on the GROS 2011 mid-year estimates and can be compared to the proportion of people aged 65 or over in the national population of 17.0%.

3 Phase 1: Survey

3.1 Questionnaire responses

Questionnaires (attached at Appendix B) were issued to all partnerships (32) with a request in early 2010. A total of 14 fully completed (a return rate of 41%) from the following partnerships:

Aberdeen City CHP/Aberdeen City Council	City of Edinburgh Council
Aberdeenshire CHP/Aberdeenshire Council	Glasgow City Council
Clackmannanshire/NHS North Valley	Inverclyde Council
Dundee Council/NHS Tayside	NHS Lothian
East Ayrshire Council	Midlothian Council
East Renfrewshire CHCP	Moray CHCP
	North Lanarkshire Council/NHS Lanarkshire
	West Lothian Council

Western Isles returned the questionnaire blank but did provide a very comprehensive Joint Discharge policy for their hospital patients which included flow charts, eligibility requirements, sample letters and assessment of risk.

3.2 Survey Findings

3.2.1 Discharge Planning

Eight Partnerships reported that discharge planning begins at the point of admission or shortly thereafter while in six areas it starts when medical fitness can be estimated or has been confirmed.

3.2.2 Provision in place to be able to discharge patients back home

The following services were mentioned:

- Telecare/assistive technology
- Telehealth
- Community Alarm
- Rapid response service
- Out of Hours response service
- Day care service
- Respite Care
- Adaptations and Equipment
- Occupational Therapy and Physiotherapist input

- Joint Equipment Stores
- Flexible and adaptable home care service (incl. overnight)
- Home from Hospital Home Care Team
- Anticipatory Care Plans
- Early Supported Discharge
- Provision of intermediate care beds
- Intermediate care services – step down /step up services
- Management of Long Term Conditions
- Specialist Gerontology Assessment
- Geriatric Liaison Nurse to follow up service
- Sheltered Housing
- Slow stream rehabilitation
- NHS community care assistants
- NHS contract with a care home for step up and down led by patient's district team
- Formulation of a "Hub" in the District General Hospital creating a team who are experts in discharge and intermediate care and who have links with all service providers and teams
- Multi-disciplinary teams
- Multi-professional rehabilitation and enablement service
- Specialist nurses, CPNs and District nurses

There was no consensus on which services were thought to be most effective although equipment and adaptations, flexible home care, reablement and Telecare were most often mentioned.

3.2.3 Shifting the Balance of Care

The delayed discharge process has direct linkage to the Shifting the Balance of Care agenda as unacceptable periods of time in hospital can weaken confidence and independence resulting in an inability for individuals to care for themselves or to be cared for in their own home.

Seven Partnerships reported that they had seen a shift in the balance of care with more people receiving intensive levels of support at home (10 or more hours a week). Factors identified as contributing to this shift, enabling people to stay in their own home longer, included:

- Development of a community-based reablement approach
- Telecare
- Anticipatory care plans
- Self-care
- More person centred assessments

- A reduction in emergency bed days for older people.

Two partnerships reported that there had not been a noticeable shift and one partnership said that there had been no growth in care home places over the past year although occupancy rates in care homes had not decreased significantly. One partnership was able to report that their use of care homes beds had reduced along with a reduction in the number of NHS long stay beds.

3.2.4 Examples of good practice

Whilst, unfortunately, returns weren't received from any of the four councils achieving zero delayed discharges over the 4 years 2008 to 2012 returned survey forms, the following examples of good practice were identified by those that did respond as contributing to speeding up hospital discharges (these are not presented in any order of importance/priority):

- Good effective communication between the acute sector and primary care and between health and social care
- Anticipatory care planning and preventing unplanned hospital admissions
- Quick access to telecare, equipment and adaptations
- Quick access to flexible home care (same day in some areas)
- Check-up visits after discharge
- Good joint planning/partnership working (regular meetings at operational and managerial level)
- Reablement and rehabilitation
- Keeping people independent and focusing on family and community capacity as services cannot provide everything
- Specialist gerontology assessment within 24 hours including pharmacy
- Early planning for discharge (on admission if possible) involving patient and carer and identifying any 'blocks' to eventual discharge early
- Meetings with discharge co-ordinators at midpoint to resolve any anticipated issues
- Availability of step-down facilities
- Speedy involvement from social work/care management and agreed assessment/discharge timescales
- Early identification of an increase in needs requiring social work input
- Responsive pharmacy service – quick turnaround of discharge prescriptions
- Early Supported Discharge team communicating with wards daily
- Involvement of housing (allocation of sheltered and very sheltered housing)
- Direct access to home care services (rapid response)
- Adopting a whole systems approach with all staff involved with a patient having a role in ensuring discharge is facilitated within the agreed timescales.
- Prioritisation of delayed discharges

- Co-location of social and community nursing staff

3.2.5 What are the major barriers to timely discharge?

Respondents also identified the following barriers to timely discharge:

- Families who hold Welfare Power of Attorney invoking the choice protocol
- People lacking capacity to make decisions about their future care and requiring to go through the guardianship process which can be very lengthy
- Lack of appropriate care home provision for people under 65
- A high proportion of delayed discharges are people waiting on care home places and there is a lack of availability of step-down beds.
- Bed closures creating pressure in acute and the community
- Lags in service redesign
- Standardisation across large NHS Board areas not fitting with local circumstances
- Freeing up rapid response time and reviewing capacity
- Unavailability of resources (funding, home carers, care home places)
- Poor communication between acute and primary care and between health and social care
- Current financial climate
- Demographics: the increasing number of older people
- Clinical staff not always providing support to care managers to implement the Moving On policy
- The use of 'boarding' in acute hospitals which can cause major delays
- Lack of elderly mental impairment (EMI) places at COSLA rates
- Unwillingness/reluctance of patients, carers, relatives to go to an interim place
- Pressure on staff to consider and reconsider priorities
- Increases in referrals

3.2.6 Examples of future plans

Asked about future plans that might impact on delayed discharge, respondents provided the following examples:

- Linking the Home from Hospital Team into doing more prevention of admission work with GP practices
- Continuing to roll out an enablement model across home care teams with AHP support
- Increasing the number of people who are completing their Social Work assessment in a non-hospital environment
- Care management by community nursing
- Extension of Telehealth

- Changing current team structures and functions to emphasise the importance of keeping people independent and well informed and developing processes that build on community and family capacity through partnership.
- Rolling out anticipatory care planning
- Culture change e.g. reablement programme, people taking more responsibility for their own health
- Rolling out electronic Single Shared Assessment (eSSA) across health and social care
- Integrated Resource Framework
- Continuing with interagency working
- Development of a community based “Single Point of Contact” pathway to ensure best use of existing resources across health and social care. This will provide a rehabilitation and reablement service to facilitate speedier discharge and prevent emergency and repeat admissions
- Looking at systems relating to admission and pathways to discharge to improve flow
- Earlier intervention in discharge planning
- Speedier Adults with Incapacity (AWI) process
- Planned improvements in electronic information sharing
- The use of 13ZA legislation instead of seeking Guardianship Orders (not always appropriate and need careful monitoring)

3.2.7 Budget constraints

Asked about the impact of budget constraints, respondents identified the following:

- A reduction in home care availability will have significant impact
- Less money allocated for care home places
- Reduction in the workforce (both health and social care)
- People going to a care home instead of being cared for at home if this is less costly
- Slowdown of allocation of community resources leading to increase in bed days
- Gaps developing across agency boundaries as agencies are required to absorb budget cuts
- Priorities to be reviewed and reconsidered

One Partnership noted, very positively, that increased financial prudence does encourage staff to think more creatively to find solutions. Another Partnership mentioned the Change Fund and how this should present Partnerships with opportunities to develop new services for which there was previously no money.

The Reshaping Care for Older People agenda restates the need for clear and agreed pathways for all older people, particularly those with complex care and support needs, to enable them to move smoothly through the care system, accessing timely and effective community and hospital care as necessary.

The use of SPARRA data to identify those with long term conditions can be invaluable as a tool to identify those at risk and prevent unnecessary hospital admissions.

3.3 Conclusions drawn from survey responses

Whilst we have noted that the partnerships that have managed to maintain zero delayed discharges are predominantly rural with relatively low populations, there are a number of other partnerships with a very good track record very few delayed discharges.

The national data shows that there is additional emphasis placed each year on the April census as the figure has been zero for the past three years with increases in the following three quarters. It could be surmised from this that additional emphasis is put into reducing the figure for this census as it is this end-of-year figure that is primarily used to judge the performance of councils and the NHS.

It is clear from the responses that there is recognition that it is not just about numbers and that delays in the transfer to the next level of care can have a huge impact on the independence of vulnerable and frail people which then impacts on the wider system. The responses highlight much good practice which has had a positive impact and which could be replicated elsewhere.

3.4 Recommendations/Next Steps

Based on the findings of the first phase of the exercise, the benchmarking group recommended the following steps to the SCCBN:

- Partnerships should consider how the Change Fund could assist them in reducing delayed discharges.
- Consideration should be given to reporting the total number of people that have a delayed discharge at any point in time rather than at snapshots each quarter. This would provide a clearer picture of the numbers of people that are delayed in hospital.
- Partnerships should consider the cost of delayed discharges to the NHS and the whole impact such delays have on the whole health and social care system. By reducing delayed discharges, savings could then be used to provide better support in the community.
- ISD should be asked to provide access to the monthly delayed discharge data to SCCBN members to get a more accurate picture across Scotland.
- Partnerships should consider if the 6 weeks target could be reduced to 4 weeks, 3 weeks or even 2 weeks (since this survey was carried out, the Scottish Government has reduced the 6 week target to 4 weeks by April 2013 and 2 weeks by April 2015).
- Those partnerships that have managed to achieve zero delayed discharges since April 2008 should be asked to share best practice with other Partnerships.

4 Phase 2: Site Visits

4.1 Background

In following up the final recommendation above, the Group carried out site visits over the period March to May 2012 to three “best performers”:

- West Lothian
- East Ayrshire
- Moray

The visits were followed up by two further events:

- A workshop in June 2012 to feed back to the participating partnerships and confirm our findings and discuss the lessons learned.
- A second workshop in July held with representatives of West Lothian partnership to map the West Lothian hospital admission to discharge process. The resultant process map is attached at Appendix C.

4.2 Purpose

The purpose of the visits was to examine local structures, processes, culture and practice; to identify the key factors contributing to these partnerships success in this area, with the aim of sharing best practice.

In essence, we were looking at causal relationships, often referred to as attribution or contribution in the health and adult care world.

The visits looked at some or all of the following questions:

- What does success look like?
- What did the partnerships measure (as well as delayed discharge)?
- How were those measurements embedded in the service or project?
- ‘Impact’ – how has it (the service, project, etc.) benefitted the user/patient group, the community, and the respective organisations?
- Where there any:
 - unintended benefits
 - unintended consequences anticipated
 - unintended consequences not anticipated?
- Is there anything that you did differently – why?
- Is there anything that the partnerships would do differently – why?

The site visits were structured around specific questions drawn up following a workshop in November which was held to prepare for the exercise. These were intended to provide guidance and a focus for the visits rather than be prescriptive. The questions provide the structure for this report.

4.3 Systems

4.3.1 Telecare/Community Alarm/Assistive Technology

Community alarms plus a range of telecare services are available in all 3 areas. Access to community alarms is generally via self-referral or professional referral with a professional assessment required for add-ons.

West Lothian emphasised the importance of cross-referral between Telecare, Falls Prevention and District Nursing to support early identification and intervention and ongoing patient care. A holistic assessment is undertaken so that all the client's care needs can be identified; this incorporates the provision of small core technology packages. The Home Safety Service also offers additional peripheral units including more sophisticated technology e.g. "Just Checking", and a "GPS Tracking System". Telehealth is in place with a focus on COPD/CHD.

In **East Ayrshire** the basic community alarm package, which includes community alarm, smoke detector and carbon monoxide detector, is provided at a flat rate of £3 per week (not means-tested) and peripherals are provided free of charge. There are 12 telehealth units in place, supported by a GP practice, and a GPS "Buddy System" is being piloted with a patient with dementia.

In **Moray**, as of 1 April, all referrals go through a single point (the Access Team). In 2011 all Moray Council sheltered housing units were upgraded with individual dispersed telecare units. There is no charge for the equipment itself; however, there is a charge of £15 per quarter in respect of the 24 hour, seven days a week, alarm monitoring service currently provided by the Regional Communications Centre (RCC) in Aberdeen. A Health Outlook Service, formally adopted by NHS in Moray in October 2011, allows patients with COPD to register with a locally co-ordinated service which relays warnings from the Met Office of weather conditions which may trigger attacks to enable them to take preventative/self-care steps. Moray acknowledges the value in prevention and anticipatory care of add-ons to the community alarm system e.g. bed sensors, 'just checking' and property exit sensors and is currently working on a locally based dedicated response system linking closely with the SAS and OOHS.

4.3.2 Out of Hours Response Services

The majority of out-of-hours (OOH) referrals in **West Lothian** come through the Social Care Emergency Team (SCET) and CareLine, a 24 hour single point of access service that responds to Home Safety Service Alerts. An Out-of-Hours District Nursing Service operates in evenings, weekends and provides overnight emergency cover. This service can admit directly to a Care Home on a short term basis, should this be seen as necessary to avoid hospital admission and has rapid access to aids and equipment except those requiring a specialist assessment.

A Crisis Care Service has been established which involves working in partnership with community nursing services to provide a 24/7 service for people who are experiencing a health or social care emergency, to deal with the immediate crisis in their own home. The service aims to provide treatment and arrange short-term support services (up to 5 days) to support people at home.

In **East Ayrshire** calls go through the Risk Management Centre who will contact the service user's named responder. If a named responder is not available the Risk Management Centre will contact the Emergency Response Team who will respond to the call both in and out of hours.

The OOH Service in **Moray** is provided by a Duty Social Worker or Duty Team Manager. Referrals come into the home care team via email. The desk is currently covered 8am to 8pm; however, Moray are looking to amend job descriptions to extend cover to 7am to 11pm. Marie Curie provides the OOH Nursing service across Grampian (including Moray) and G-MED provide the OOH medical service. There is also a team of carers who provide cover out of hours. These individual services (with the exception of social work) are co-located (Emergency Care Centre at Dr Gray's Hospital). Having the planned locally based dedicated response system should ensure clearer communication links with day services and provide improved information on the client group.

4.3.3 How does communication work between day staff and OOHS and vice versa?

In **West Lothian** CareLine puts all referrals onto SWIFT and passes all relevant information to either the Crisis Care Service or the OOH Nursing Service to enable initial response with the aim of preventing hospital admission. The Crisis Care Service has a twice daily handover meeting to ensure consistency of practice.

Responding staff in **East Ayrshire** complete situation reports which care managers read each morning, sign-off and input to SWIFT. The OOH Service also uses NHS 24 if a person needs out of hours health care until the appropriate care package is implemented and vice versa.

In **Moray**, OOH Social Work staff report in the morning directly to the Senior Social Worker within the appropriate area. District nurses communicate directly with Marie Curie staff at the end of the shift and vice versa. G-MED data is passed on each morning to the GP practices. Any recurring referrals are highlighted at practice meetings, allocation meetings, district nurse team meetings and multi-disciplinary meetings if necessary.

4.3.4 Do they have access to the client database?

In **West Lothian**, the Crisis Care Service has access to SWIFT whilst District Nursing Services have access to TRACK which includes emergency care summaries (usually generated by GPs).

The OOH Service in **East Ayrshire** does not have access to SWIFT whilst out of the office; however, the Risk Management Centre can check information on SWIFT for them.

OOH social work staff in **Moray** have remote access to the Carefirst database. G-MED and Marie Curie have access to summarised patient data from the practice information database. This may or may not include an anticipatory care plan or palliative care summary.

4.3.5 Does the client record include a care plan?

Generally, yes.

In **West Lothian** the care plan is a word document which is attached to the Single Shareable Assessment and can be accessed by the Crisis Care Team. West Lothian is developing the use of a "Safe-at-Home" tool and looking to use a tablet for client recording through the Crisis Care Team.

4.3.6 Does the care plan have a contingency or anticipatory care element to the plan?

Anticipatory care planning is in the early stages of development in each of the three areas. In **West Lothian**, Anticipatory Care and Crisis Intervention plans are on the

Health “Track system” and the Care & Support Plan is shared between Health and Social Work. **East Ayrshire** is beginning to implement shared anticipatory care planning and a few anticipatory care plans are in place in **Moray**, where there is an agreed anticipatory template and systems are being further developed for sharing this information.

4.3.7 Weekly Allocation Meeting

West Lothian has a number of approaches to allocation and discharge planning. Allocation is a delegated responsibility of all Team Managers who ensure that the case is allocated immediately. A multi-disciplinary team meets weekly to discuss any cases where there is an early indication that there may be obstacles to discharge.

In addition:

- There is sharing of staff across services at peak times to support discharge;
- SSA protocols empowers key health staff to access home care directly e.g. Health Liaison Nurse.
- West Lothian prioritises resources which are required to support discharge. Decisions regarding resources are delegated to the Care Managers or for higher tariff resources their Team Managers
- West Lothian has a well-established assessment process for core equipment which can be accessed through the Joint Equipment Store

East Ayrshire does not hold weekly allocation meetings for people returning home as there are no significant resource limitations. Care at home packages are put in place within 24 hours of referral. Weekly resource allocation meetings are held to authorise and fund care home placements. In East Ayrshire the main focus of the newly established Intermediate Care and Enablement Service (ICES) is to facilitate early discharge from hospital and to prevent unnecessary admissions from the community. The ICES team holds daily allocation meetings using EDISON and IoRN scores.

In **Moray**, an allocations group meets once a week (each Monday) at which social workers present their cases for care home places/funding. A lot of decision making is made by the individual and social worker, with specialist advice and support considered, based around the need of the client. This includes hospital and community clients and ensures that places are allocated appropriately.

4.3.8 Dedicated Home from Hospital Team

In **West Lothian** there is a dedicated Assessment and Care Management Team based at St John's Hospital. For the past ten years the service has benefited from a small targeted reablement service however in 2012 West Lothian redesigned the in-house Homecare Service to provide a Universal Reablement Service for all hospital discharges. There is an NHS Intensive Care Management Team with a Band 7 District Nurse who refers as required for specialist assessment and support including rapid access to social work services. Hospital and Community OTs work to the same care principles thereby providing a seamless service.

In **East Ayrshire** the Intermediate Care and Enablement Service (ICES) has replaced both the Home from Hospital and the Rapid Response Teams. It is a multi-disciplinary team which includes allied health professionals, social work staff, enablement carers, consultant geriatricians, community pharmacists and nursing staff. The team is based in two community hospitals in East Ayrshire and provides assessment, rehabilitation and

intermediate care services to people in their own homes where possible. ICES also augments locality services to ensure that there are no delays for people going home from hospital and that maximum independence is encouraged, resulting in lower levels of support being required in the longer term.

In **Moray** the Home from Hospital Team is a small designated team of home carers who help someone recovering from a stay in hospital, once they have returned home, for a period of up to 28 days. The team assesses the needs of the person and adjusts the time and package to meet their needs, which can result in reductions or increases in the support provided over the period of time that the team visit.

4.3.9 Access to Home Care

How does it work?

Referrals in **West Lothian** are routed directly to a Service Matching Unit (SMU) which matches assessed needs to a wide range of services that have been commissioned/procured and for which there are framework agreements in place. The SMU acts as a “broker” for the procurement of services, reducing administration burden of assessment and care management staff. The SMU has a system in place for tracking timeframes from referral to service delivery and offers a real time alert to managers of any anticipated delay in securing services. Once the client is discharged the care package continues to be monitored and will be reviewed within six weeks.

In **East Ayrshire**, referrals for home care can be made directly to locality (area) teams or through ICES. Rehabilitation and reablement will be provided if required. No service user is delayed going home and home care and a community alarm package is in place within 24 hours of referral. To ensure sustainability, a comprehensive review of Care at Home Services was carried out in 2009-10. This included a review of all care at home packages and resulted in a significant reduction in direct and indirect home care hours. East Ayrshire now has an independent review team reviewing the needs of service users both at home and in care home settings.

In **Moray** home care is largely in-house supplemented by 2 external providers. The service provider reviews packages of care twice a year. Access to homecare is now through a single point, the ‘Access Team’, where service users are allocated to the most appropriate team.

What services/skills training in home care?

All home care staff in **West Lothian** are trained to SVQ Level 2 in Health and Social Care. A comprehensive training and refresher programme including food hygiene, moving and handling, medicating, and child and adult protection are well embedded. Having recently introduced a Universal Reablement Service, a bespoke training programme is currently being delivered to support staff to develop those skills. In addition, a skills based dementia programme has recently been delivered to staff. A programme of research to evaluate the effectiveness of transfer of skills from training to practice is planned in the very near future supported by IRISS.

In **East Ayrshire**, as part of a five year programme, personal carers are trained to SVQ level 2 in Health and Social Care. The induction programme provides training in all aspects of their caring role including food hygiene, moving and handling, medicating, falls prevention, enablement and child and adult protection. In addition to this specialist training is provided in specialist areas such as palliative care and dementia.

Moray provides reablement training to all home care staff in the form of a 4 week programme consisting of 3 weeks training followed by 1 week shadowing a team leader. In addition, Home Care Organisers are trained as “key handlers” which equips them to carry out “moving and lifting” assessments and to order some equipment including profiling beds.

How is effectiveness measured for all of the above?

West Lothian is finalising a performance framework for the Reablement Service which includes:

- staff consultation
- customer consultation
- no of people delayed in hospital
- ratio of people in care homes
- no of hours of care
- no of clients
- average hours per client

In terms of outcomes, ‘Talking Points’ questions are embedded in the Single Shared Assessment Process and review forms have recently been updated to incorporate Talking Points and are currently being piloted in the Adults and Older People’s Service.

In **East Ayrshire**, there is regular reporting on performance, finance and resources to all tiers of management. Monthly reporting to Directorate, Chief Executive and elected members is carried out through the council’s electronic performance management system. Indicators include:

- numbers of home care service users
- hours of care, levels of care
- percentage of personal carers qualified
- information on numbers in care homes.

Effective use has also been made of data from EDISON which has been used to track delayed discharge in East Ayrshire for many years.

Talking Points is being developed as a further means of measuring outcomes for service users and is being piloted by the ICES team.

The practice of holding integrated team meetings based in GP practices has been embedded within operational arrangements for many years and has encouraged information sharing and collaborative working.

Moray monitors CCOF measures, financial measures and the number of hours of reablement. Following the implementation of the redesign of Adult Community Care Services on 2 April 2012, a local reablement performance indicator has been developed. This focuses on the hours saved and the cumulative annual financial savings that have been accrued. The indicator is reported to Committee and is also a key internal management measure. Training evaluation through the Public Service Improvement Framework (PSIF) and personal development (ERDP)/supervision underpin the training process.

4.4 Process

4.4.1 What is it about your management process from top to bottom that supports and drives the Delayed Discharge agenda?

There has been joint and close working relationship between Social Work and Health in **West Lothian** in since the 90's. The SSA is used as a multidisciplinary tool with care plans passing between Health and Social Work. There is good communication from top to bottom with joint working, learning and training ensuring that agreed working processes are embedded into practice.

Communication and joint working at ward level drive the discharge process. A key factor is the fact that 'everyone knows one another'. Everyone involved with the patient knows their journey and discussions and meetings take place on the patient's plan more or less as soon as they are admitted to hospital.

Delayed Discharge performance continues to be very high on the agenda. Performance reports are regularly tabled at the Community Health and Care Partnership (CHCP) Sub Committee and at the Social Policy Development and Scrutiny Panel. The CHCP is aware of the new delayed discharge targets and measures have been put in place to ensure that performance continues to improve.

In **East Ayrshire** reducing delayed discharge is a long term priority. There are named NHS and Social Work leads who account directly to the CHP Director and Local Authority Chief Executive. There is a Pan-Ayrshire Delayed Discharge Group and a joint training plan has been developed and delivered on a Pan-Ayrshire basis.

There is clarity amongst staff at all levels which leads to consistent communication with families.

The keys to success are seen as:

- The priority accorded to Delayed Discharge
- Strong management and leadership
- Joint working with partners
- Scrutiny of practice by senior management
- 'Learning and Improving' culture supported at all levels
- Trust at all levels
- Financial resources made available and supported by elected members

Delayed discharges have been a priority in **Moray** for over 10 years with a focus on partnership working:

- Robust links with acute care providers around the discharge process;
- Robust links with care home owners – availability of care home beds (including NHS funded step up/step down beds) – supported by GPs and District nurse.
- Development of virtual medical ward using beds in all 5 community hospitals.
- Daily discharge meetings within Acute (Dr Gray's Hospital) to plan discharges and highlight any delays.

- Weekly discharge meetings within community hospitals planning discharges and highlighting any delays.
- Twice daily bed states sent out to appropriate managers across health and social care.
- Weekly social care allocations meeting discussing clients at risk of delay
- Good escalation processes/procedures
- Discharge Officer playing a key role in the communication and co-ordination across health and social care.
- Monitoring discussed/reviewed at partnership level and appropriate actions cascaded.

4.4.2 How do your joint working/screening/assessment arrangements work?

In **West Lothian**, the Acute Discharge Facilitator uses a traffic light system which prompts formal discharge planning. A Staff Liaison Nurse reviews the person's circumstances using patient notes, consulting with community staff and utilising personal contacts to determine personal circumstance to inform discharge planning. For more complex cases there are frequent multidisciplinary case conferences, to plan for and address the person's needs and circumstances. These are attended by district nursing staff and families.

In **East Ayrshire**, individual circumstances are considered by the multi-disciplinary team. The Care Manager meets with the family, a letter is sent and the consultant then sets the discharge date. Discharge planning starts as soon as the person is admitted to hospital. The patient's consultant is included in multi-disciplinary meetings.

In **Moray** discharge planning commences on admission to hospital and an estimated date of discharge is set. Multi-disciplinary assessment is carried out and a treatment plan commenced. Regular discharge planning meetings are held to ensure estimated dates of discharge are met. An operation support team at Dr Gray's Hospital monitors acute bed availability, community bed availability and transfers, and escalation procedures are in place.

4.4.3 How does communication/joint working at ward level drive discharge

In **West Lothian** a traffic light discharge system is used with 'green' indicating that a patient is ready for discharge within the next 48 hours, at which point the Acute Discharge Facilitator is informed and a note is taken of what equipment may be needed for the person following discharge. The Acute Discharge Facilitator holds discharge planning meetings with appropriate leads for reablement, OT etc.

The level of communication is proportional to the complexity of the case and is always under review:

- Care at Home restarts – administrative staff are trained to organise.
- Jointly agreed referral pro forma for simple cases that don't require any discussion
- Identified liaison worker for wards with high volume discharge and complex cases
- Multi-disciplinary meeting for complex cases
- Weekly discharge planning

The multidisciplinary team drives the process in **East Ayrshire**. In addition, joint training is viewed as very important, with a re-vamped training package introduced across Ayrshire last year.

In **Moray**, there is good communication across all disciplines. Community Care officers attend weekly multi-disciplinary discharge meetings held in each Community Hospital. Referrals are made to the Access Team from Dr Gray's Hospital. There is also active communication between the Home Care Team and hospitals.

4.4.4 Are hospital discharges prioritised over other competing demands for resources?

In **West Lothian**, whilst the local authority prioritises hospital discharges for packages of care, this is not seen to be at the cost of urgent packages of care in the community, often required to prevent hospital admission. Each case is looked on individually and resources negotiated where necessary.

In **East Ayrshire** and **Moray** the view was that hospital discharges were not prioritised ahead of other competing demands.

4.4.5 How do you manage referrals to SW to optimise the assessment time?

In **West Lothian**, meetings take place on the patient's plan more or less as soon as they are admitted to hospital. In **East Ayrshire** Social Work staff are informed in advance of estimated date of discharge. In **Moray**, referrals to Community Care are made through the new Access Team – a single point of contact – and forwarded to the most appropriate locality officer based on the estimated date of discharge.

4.4.6 How do you measure if a service user is meeting their personal outcomes following discharge?

In **West Lothian** the 'Talking Points' approach has been built into the Single Shared Assessment which also incorporates Community Care Outcomes indicators enabling the capture and reporting of these measures. The review process has recently been updated to incorporate Talking Points and is currently being piloted before going live electronically. Staff guidance on this approach has also been produced. All cases are reviewed within six weeks.

In **East Ayrshire** the Intermediate Care and Enablement Services (ICES) is developing the use of Talking Points as part of the assessment and review process. Work is in progress to integrate Talking Points into Single Shared Assessments on SWIFT. Service users' satisfaction is incorporated in the single shared assessment and review forms and there are regular surveys of home care service users' views.

In **Moray**, all patients/clients coming out of hospital requiring community care go through the reablement service (up to 6 weeks period). Outcomes are planned with the client and reviewed during this period. This may result in no further care being required, or the client moving to mainstream services. This is then reviewed by social workers as part of regular client reviews.

4.4.7 How is effectiveness measured for all above?

In **West Lothian** effectiveness is measured using:

- user and carer service reviews
- service user and carer satisfaction surveys
- CSE compliant

- Performance framework for Change Fund Initiatives

East Ayrshire measures the overall benefits to patients, service users and carers through reviews, carers support plans and service user satisfaction surveys. In addition, consultation with service users takes place at the Annual Older People's Conference.

In **Moray** the impact of reablement is measured by the % re-abled through the Home from Hospital Team. Satisfaction is gathered through the home care satisfaction survey based on the CCOF measures.

4.4.8 What have been the overall benefits to patients, service users and carers?

West Lothian has consistently achieved zero delays in the annual census since 2008 with performance consistent throughout the year. Service users benefit from fewer unnecessary days in hospital, and users and carers have fast access to equipment including SMART technology and services.

East Ayrshire has sustained zero delayed discharges since 2007. No service user is delayed returning home with home care and community alarm packs in place within 24 hours of referral. East Ayrshire is currently in the process of purchasing a small number of assessment and rehabilitation beds from the independent sector, the ultimate aim being to ensure that no-one will go straight from hospital to care home.

In **Moray** there were 80 recorded delayed discharges recorded in Moray in 2002 with 8 out of the 80 waiting more than a year to be discharged from hospital to an appropriate setting. This has been reduced to zero. Approximately 50% of patients provided with a reablement service by the Home from Hospital Team do not need any care after their intervention. Patients are receiving care closer to their own home, through the use of community hospitals, and experience a smoother journey through services. In the Elgin area, where there is no community hospital, the number of step-up/step-down beds has been increased to provide an option closer to home.

4.4.9 How do you measure the benefits to patients, service users and carers?

West Lothian uses Reshaping Care Core Measures, Talking Points, Change Fund and a reablement performance framework. An outcome focused contract has recently been developed with Carers of West Lothian whereby they are monitored on carer outcomes achieved.

East Ayrshire uses core measures from the Reshaping Care framework:

- Number of people being maintained in own homes
- Number of people in receipt of personal and nursing care
- Numbers in receipt of services in evenings/weekend
- Expenditure
- Community Care Outcomes Framework
- CCOF
- HEAT Targets

Moray uses the CCOF measures, financial measures and the number of hours for reablement. Quarriers are contracted to provide support to carers, carrying out carers assessments, providing training and carrying out carers satisfaction surveys. The patient admission document includes a satisfaction form, completed by each patient on

discharge, which is collated and regularly reviewed by the ward manager and action taken as appropriate.

4.5 Culture

4.5.1 Do you have a designated officer and Health counterpart responsible for Delayed Discharge?

In **West Lothian**, there is an emphasis on partnership working at every level has led to the development of a culture of trust, openness and honesty. There is a designated Hospital Discharge Team on which Social Work, Community Health and Hospitals are represented. Performance Reports including Delayed Discharge are regularly reported to the Community Health and Care Partnership Sub-Committee and the Council's Policy Development and Scrutiny Panel.

The **East Ayrshire** Adult and Older People Group (part of the CHP structure) is co-chaired by the senior Health and Social Work managers with lead responsibility for delayed discharge performance

In **Moray**, the Delayed Discharge Officer role has developed into an Intermediate Care Development Officer role around alternatives to hospital admission. The cross boundary liaison nurse was no longer required as the operational support team took over the bed management role.

4.5.2 Are there any multi-disciplinary groups which support the responsible officers?

In **West Lothian** the governance structure for CHCP is multi-disciplinary at all levels from operational to strategic. Issues that cannot be resolved by operational staff are escalated to the appropriate level in the CHCP management structure.

Multi-disciplinary working is embedded in the culture of **East Ayrshire** from strategic to operational level. The Pan-Ayrshire Delayed Discharge Group meets monthly to identify/resolve issues and discharge planning groups meet at hospital sites. A social work team is based in the acute hospital.

In **Moray**, multi-disciplinary planning meetings report any impending delays weekly which in turn are closely monitored in each community hospital and reported to the weekly resource allocation group for discussion. The allocation group allocates places in care homes depending on need.

4.5.3 Who decides on the estimated discharge date for a patient?

In **West Lothian** the discharge date is determined by a responsible clinician however a referral will in most cases have been made in advance of that determination.

In **East Ayrshire** the consultant takes the final decision, in consultation with the multi-disciplinary team.

In **Moray** the estimated date of discharge is set on admission to hospital by the multi-disciplinary team, this is reviewed on a regular basis depending on the person's progress.

4.5.4 What steps are you taking to reduce the delayed discharge time from 6 weeks to 4 weeks?

West Lothian is already achieving the 4 week target. Initiatives which aim to drive further performance improvements include:

- A move from a targeted to a universal reablement service
- A Specialist Dementia Support Team, identifying people in acute services with symptoms of delirium or dementia and offering an early intervention service
- Home from Hospital Service – a comprehensive service offering practical support in the home in the immediate post discharge period

East Ayrshire is reviewing referral and assessment processes within the hospital setting to refine the process and improve timescales. Through the development of ICES people who require assessment of their long term needs will be discharged from hospital and will be assessed in their own homes or in a care home setting. East Ayrshire is currently in the process of purchasing a small number of assessment and rehabilitation beds from the independent sector for this purpose. Progress has already been made with only two people waiting over four weeks at the last census.

Moray has always taken a 'planning ahead' approach to delayed discharges and has been focusing on the 4 week target for the last year and therefore is in a good position to achieve the target of 2 weeks. The Moray approach is that the patient will not be in hospital any longer than is required and the patient is engaged in the planning process around the estimated date of discharge.

4.5.5 Where is the Delayed Discharge measure reported and what are the audiences e.g. SOA – Single Outcome Agreement, Community Plan?

In **West Lothian** there is a suite of strategic indicators including Delayed Discharge that is reported through a broad range of governance bodies.

In **East Ayrshire** delayed discharge measures are reported in the SOA, Community Plan, and monthly management reports, and in the Council's electronic performance management system (CORVU).

In **Moray**, reporting is to NHS Grampian board level meetings and, at partnership level, at Health and Social Care Partnership meetings.

4.5.6 What involvement do the Head of Service and CSWO have in the monitoring of delayed discharge figures?

There is keen interest at Head of Service/CSWO level in all three partnerships. Headline figures are included in regular management reports plus exceptions reporting on any specific issues.

4.5.7 How is delayed discharge managed at strategic partnership level?

In **West Lothian**, there is an emphasis on partnership working at every level has led to the development of a culture of trust, openness and honesty. The delivery of delayed discharge standards is driven by the Lothian Delayed Discharge Partnership. The Partnership includes NHS Lothian, West Lothian CHCP and West Lothian Council as well as each of the Community Health Partnerships and councils within the Lothian NHS Board area. A range of strategies is in place to support different population groups such as older people, to remain at home with adequate support where this is appropriate e.g. universal reablement, flexible respite.

In **East Ayrshire**, delayed discharge is managed through the CHP. This is supported by internal reporting, which now includes the 4 week and 2 week standards. Reports are provided to Senior Management Team meetings and reported to Health on an exceptions basis.

In **Moray**, delayed discharges are considered at Board level in NHS Grampian, at Health and Social Care Partnership meetings at Partnership level and at Joint Performance Management Group meetings.

4.5.8 What capacity planning has been carried out to ensure that there are sufficient resources (e.g. care beds, care hours) to meet the growing demand of services due to demographic changes?

Capacity planning has been embedded in **West Lothian's** strategic planning processes since it first launched its Opening Doors Strategy in the 90's, introducing the Smart Technology Programme. Three year service plans are contextualised with analysis of local demographic and demand trends which are then linked to the need for changing service models. West Lothian CHCP is in the process of completing Joint Commissioning Strategies, with one of the significant features being analysis of likely future demand for services. The trend for projected demand for care at home services was modelled in the financial plan and benchmarked against a number of scenarios including the impact of 'doing nothing' against current service models.

East Ayrshire produces a "Social Work Sustainability" report, which includes demographic profiling. They are clear about existing/future capacity requirements and resource availability. Whilst, their care home places are all purchased, home care is a mixed economy, generally purchasing more stable care packages and keeping more complex cases in-house. Around 37-38 continuing care beds have closed recently but this has not had an effect on delayed discharges.

Moray CHSCP is making good progress in the development of a Joint Commissioning Strategy for Older People. This work will detail a 10 year plan and identify any system redesign and disinvestment in order for Moray to shift the balance of care and resources and improve outcomes for older people. It will also inform the details of Change Fund spend over the next 3 years.

4.6 Practice

4.6.1 Where do assessments take place?

In **West Lothian** the initial assessment begins in the ward. Assessments are generally faster than in the community as patients are on site, relatives visit regularly and Occupational Therapists, doctors and other professionals are available; however, recognising that assessing outwith the service user's environment can contaminate the assessment, West Lothian continues to monitor and assess how the service user is coping in their own home.

East Ayrshire will assess in the acute hospital but prefers to assess in a community hospital. The aspiration is that no older person will be discharged directly from acute hospital into a care home.

In **Moray** the initial assessment begins in the ward, with further multi-disciplinary assessments carried out, if appropriate, during the hospital stay.

4.6.2 At what point does the multi-disciplinary planning for discharge begin?

The practice in all three partnerships is to begin planning for discharge at the point of admission to hospital and all agencies are involved in the process.

In **West Lothian** ward staff use a traffic light system to track progress towards discharge and trigger action. Care managers stay involved during the hospital stay and the exit

strategy is part of the discharge plan. They look to adopt a multi-agency reablement approach during a patient's stay to maximise their independence on discharge.

In **East Ayrshire** the Discharge Co-ordinator, based in hospital, performs a pivotal function (both strategic and operational), liaising with Social Work, Health and other service providers. SPARRA data is used.

In **Moray** multi-disciplinary planning for discharge begins on admission and continues at weekly and daily discharge meetings.

4.6.3 Do you have supported discharge reablement?

West Lothian has delivered a targeted reablement service for the last ten years. As of 1st April a universal reablement service has been implemented and is available to adults who reside within West Lothian who are assessed as being eligible for community care.

In **East Ayrshire** residential intermediate care unit was closed in 2011 and the aim now is to undertake rehabilitation and reablement in a person's own home wherever possible.

In **Moray** all patients requiring community care are discharged home with the 'Home from Hospital' Team. This team focuses on re-abling patients for a period of up to 6 weeks.

4.6.4 Do they have an assessment role? If yes, please describe

In **West Lothian** the Reablement Team has an assessment and care manager function.

In **East Ayrshire** the ICES Team carries out assessments and provides intermediate care to people in their own home.

In **Moray** the Home from Hospital Team supports patients to achieve their agreed outcomes.

4.6.5 How does your Partnership manage potentially avoidable hospital admissions?

Having made progress on getting patients out of hospital, **West Lothian** is now focussing on preventing unnecessary hospital admissions and re-admissions. Action includes:

- Investment in Telecare to support independence. Telecare needs are built into the SSA and a home safety package is offered to everyone.
- Intensive Care Management (Virtual Ward): a new project similar to Hospital at Home which identifies those who are 50+ with long term conditions and who have had more than one admission to hospital using 'real time data', rather than SPARRA. The Intensive Care Management Team comprises a nurse, a physiotherapist and an occupational therapist.
- A Crisis Care Team has recently been established consisting of 2 carers working over 48 hours to pick up emergency care for up to 5 days.
- From 1st April 2012, the Reablement Team and the new Crisis Care Team will be linked and will give overnight support for up to 5 days.

East Ayrshire has been developing an integrated whole systems approach. This is still evolving but is underpinned by a personal outcomes philosophy. They are developing the role of ICES as a single point of contact and are planning a publicity campaign to promote this to GPs. East Ayrshire is also purchasing a small number of assessment

and rehabilitation beds from the independent sector for those people who cannot initially be supported at home.

Moray is seeking to develop an anticipatory approach to the care needs of the population. This includes the management of long term conditions, self-care, and the development of anticipatory care planning across the system. It also includes improved assessment processes at the front door of A&E and a flexible approach to finding solutions.

4.6.6 Do you have an intermediate provision?

In **West Lothian** a residential resource is utilised for those who require a care home placement, where one is not immediately available. The unit mainly functions as a 'step down' care unit. There is no time limit to stays in the unit; however, there is a charge, which is means-tested.

In **East Ayrshire** Intermediate Care is provided in the community by the ICES team. A small number of assessment and rehab beds are being purchased from the independent sector for those people who cannot initially be supported at home. The overall aim is that no-one will go straight from an acute hospital into a care home.

Moray's Intermediate Care Services consist of the "Home from Hospital" team who provide an intensive enablement service post-discharge; and flexible use of care home beds in the "Step beds" (step-up/step-down) which can be used during crises or palliative care as alternatives to a hospital admission.

4.6.7 What are the criteria for admission and discharge?

In **West Lothian** admission to hospital is health-led. Discharge is governed by medical fitness: a patient has had the necessary in patient treatment and has reached a stage of stability and discharge from hospital should aid recovery. Patients are risk-assessed by the District Nurse Liaison who will order any necessary equipment and liaise with the District Nurses with regard to community nursing needs.

East Ayrshire has flexible criteria for admission and discharge. Overnight support will be provided in people's homes if required and, as described above, assessment and rehabilitation beds are available if required.

In **Moray**, Dr Gray's Hospital admits clients for acute care. This is done through the Emergency Care Centre (A&E) and patients are assessed and admitted appropriately dependant on need. GP acute beds in community hospitals have specific admission criteria.

4.6.8 How do you prioritise home support for complex care packages in the community along with facilitating packages of people being discharged from hospital?

In **West Lothian**, the local authority prioritises hospital discharges for packages of care. There is both political and senior management backing to ensure that people are not unnecessarily delayed in hospital. They do see this as negating the need for urgent packages of care in the community, often required to prevent hospital admission. Each case is looked on individually and priorities negotiated where necessary.

East Ayrshire use Eligibility Criteria if necessary, but have no requirement to prioritise. As described above, they will put 24 hour packages into homes to avoid admission or can make use of assessment and rehabilitation beds if required.

Moray prioritises according to each client's need.

4.7 Critical Success Factors

4.7.1 Factors identified during visits

The following factors were identified by partnership representatives on questioning by the review team.

West Lothian

- The flow of information and communication between team leaders (West Lothian do not have EDISON)
- Ownership of delayed discharge as a priority at the top level
- Multi-disciplinary communication arrangements
- Political i.e. elected member backing
- Support from senior managers
- Hard work and dedication
- Constantly working to simplify assessment
- Managing workloads
- Constantly developing skills/mix in assessment and provision
- Service Matching Unit (one stop shop)

West Lothian's "Moving on" policy document is available.

East Ayrshire

- Senior Management Leadership
- Culture – all staff highly motivated
- Staff are confident and are trusted to do well because they are supported
- Availability of resources
- Historical use of EDISON system
- Capacity Planning
- Political support

Moray

- Joint approach:
 - Collective responsibility – improved understanding of each other's roles
 - Delayed Discharge Officer – now part of the role of the Intermediate Care Development Officer
 - Allocations Group (Community Care)
 - Multi-disciplinary teams
- Home from Hospital Teams have made a big impact – lots of support provided and then reduced quickly. Flexible carers working on shift.

- Assessment for care home admission carried out in community hospitals rather than acute hospital.
- Early identification and resolution of issues that might impact on discharge – whole team is responsible for identifying and reporting any issues early before a patient becomes delayed. Weekly MDT meetings.
- Benefits of being a small authority because you know the people, where they stay and their story/journey.

4.8 Common factors

The site visits revealed that, whilst the approaches in each of the three partnerships are not identical, there are nevertheless a number of common factors, listed below, which contribute to their success and should be considered by other partnerships looking to improve their performance:

- Strong leadership
- No funding issues
- Size – small authorities with a single acute hospital; staff know each other and know their service-users
- Reablement as the default home care model
- Collective responsibility – no blame culture
- Designated Health and Social Work leads who take personal responsibility for resolving issues and ensuring that the system works, and in Moray the creation of a joint Delayed Discharge Manager post
- Good communication between agencies and with providers.
- Regular joint meetings and multi-disciplinary working at strategic and operational levels
- Multi-disciplinary teams to both facilitate discharge and avoid unnecessary admission
- Use of intermediate provision (Craigmail in West Lothian, ICES in East Ayrshire, Step-up/Step-down beds in Moray) and community hospitals (in East Ayrshire and Moray) to allow people to be discharged from acute hospitals for assessment and to allow services and/or adaptations to be put in place or placements agreed prior to return home or admission to residential care.
- Actively working to prevent unnecessary admissions.

5 Conclusions

5.1 Good practice

This benchmarking project has given us a great deal of information on hospital discharge practice across the country. The findings of the site visits reinforced those of the earlier survey and are entirely consistent with the conclusions and recommendations of the JIT Delayed Discharge Expert Group Report published earlier this year.

The good practice points identified in the course of both parts of this benchmarking exercise are summarised below. This list should in no way be regarded as prescriptive, rather it should be considered as a menu, which might be used to review local practice and selected from and adapted as appropriate:

- Strong leadership:
 - Prioritisation of delayed discharges
 - Emphasis on collective responsibility
 - Designated Health and Social Work leads, or a joint lead, who take personal responsibility for resolving issues and ensuring that the system works
 - No blame culture
- Good joint planning/partnership working (regular meetings at operational and managerial level)
- Effective communication:
 - Between the acute and primary care
 - Between health and social care
 - Between agencies and providers
- Multi-disciplinary teams – to both facilitate discharge and avoid unnecessary admission
- Actively working to prevent unnecessary admissions:
 - Anticipatory care planning
 - Crisis care
 - Intermediate provision, either at home or in “step-up” beds
- Early planning for discharge (on admission if possible)
- Adopting a whole systems approach with early social work/care management and patient/carer involvement in ensuring discharge is facilitated within agreed timescales.
- Quick/direct access to flexible home care, telecare, equipment and adaptations
- Early and agreed assessment/ discharge timescales
- Specialist gerontology assessment within 24 hours including pharmacy
- Responsive pharmacy service – quick turnaround of discharge prescriptions

- Reablement as the default home care model
- Development of intermediate provision
- Focus on keeping people independent through building family and community capacity
- Involvement of housing (allocation of sheltered and very sheltered housing)
- Co-location of social and community nursing staff.

5.2 Measurement

Our analysis of delayed discharge performance highlighted the rollercoaster effect of partnerships attaining the delayed discharge target at the point of the April census each year, with numbers rising in the intervening quarters. This is a pattern that the Delayed Discharge Expert Group has also acknowledged in its report. The Group concluded that it is important to maintain a focus on sustaining the current zero target, whilst working to reduce the overall maximum lengths of delay from the current level of 6 weeks and moving to a target of reducing bed days lost, pointing out that many partnerships' Reshaping Care change plans have set local improvement targets to reduce the overall bed days lost to delayed discharge.

Rather than continuing to use a quarterly snapshot, we would promote a move to a count of the total number of people whose discharge has been delayed beyond the current standard (6 weeks/4 weeks/2/weeks) at any point in the period (quarter/year), which would complement a "bed days lost" target. This would provide a clearer picture of the numbers of people that are delayed in hospital and would counteract the possibility that the bed days lost measure could hide individuals whose discharge has been unreasonably delayed.

APPENDIX A Delayed Discharge Data, April 2008 to April 2012

Local Authority of residence	Delay	Apr 2008	Jul 2008	Oct 2008	Jan 2009	Apr 2009	Jul 2009	Oct 2009	Jan 2010	Apr 2010	Jul 2010	Oct 2010	Jan 2011	Apr 2011	Jul 2011	Oct 2011	Jan 2012	Apr 2012
East Ayrshire	>6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	<6 weeks	15	16	11	10	8	15	15	22	11	28	11	14	20	20	14	9	10
North Ayrshire	>6 weeks	0	0	12	9	0	11	0	0	0	0	1	0	0	0	0	0	0
	<6 weeks	19	20	18	20	16	22	14	22	23	13	16	20	32	25	24	16	17
South Ayrshire	>6 weeks	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0
	<6 weeks	12	12	15	16	9	9	18	17	12	14	20	19	15	15	17	14	7
Scottish Borders	>6 weeks	0	0	4	1	0	1	1	6	0	4	14	7	0	7	0	0	0
	<6 weeks	18	19	6	12	14	17	26	13	19	9	38	15	21	25	9	8	10
Dumfries & Galloway	>6 weeks	0	0	4	0	0	0	0	1	0	1	4	3	6	0	1	1	1
	<6 weeks	4	4	1	3	3	5	4	0	2	3	7	7	1	5	6	2	1
Fife	>6 weeks	0	0	2	1	0	0	1	1	0	10	26	65	0	5	8	10	0
	<6 weeks	42	45	77	48	57	62	72	52	87	90	76	100	62	68	52	56	66
Clackmannan-shire	>6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	<6 weeks	0	8	6	6	0	0	3	2	14	7	5	6	8	1	3	2	8
Falkirk	>6 weeks	0	2	0	0	0	0	0	1	0	0	9	10	6	8	4	0	0
	<6 weeks	9	11	13	10	16	17	19	19	31	28	19	21	22	15	18	24	21
Stirling	>6 weeks	0	3	8	0	0	0	0	3	0	5	0	0	0	4	0	0	0
	<6 weeks	10	7	10	3	12	3	11	11	10	11	16	5	13	11	11	5	7
Aberdeen City	>6 weeks	0	1	0	0	0	0	3	12	0	2	1	1	0	0	2	0	0
	<6 weeks	19	24	29	18	22	18	21	26	19	13	12	16	18	17	19	25	21
Aberdeenshire	>6 weeks	0	0	0	0	0	0	0	0	0	0	1	2	0	0	0	0	0
	<6 weeks	15	21	15	14	12	14	6	10	11	17	22	12	9	6	10	11	17
Moray	>6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	<6 weeks	2	4	8	2	6	5	0	2	2	2	1	1	2	1	1	1	1
East Dun-bartonshire	>6 weeks	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0
	<6 weeks	6	10	10	9	6	7	6	9	6	15	4	11	13	6	11	7	12
East Renfrewshire	>6 weeks	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	<6 weeks	7	6	7	8	7	9	10	5	8	6	11	8	5	14	8	5	10
Glasgow City	>6 weeks	0	1	11	14	0	11	10	7	0	12	39	22	0	22	17	8	2
	<6 weeks	47	56	65	48	58	79	82	71	65	115	116	82	130	111	108	79	76
Inverclyde	>6 weeks	0	4	0	0	0	2	6	1	0	0	0	0	0	0	0	0	0
	<6 weeks	10	9	13	7	12	13	14	7	9	13	16	11	7	15	7	11	9
Renfrewshire	>6 weeks	0	3	6	10	0	9	19	14	0	0	1	2	0	3	2	3	0
	<6 weeks	13	21	23	20	20	35	27	22	31	39	26	36	29	35	38	31	36

Local Authority of residence	Delay	Apr 2008	Jul 2008	Oct 2008	Jan 2009	Apr 2009	Jul 2009	Oct 2009	Jan 2010	Apr 2010	Jul 2010	Oct 2010	Jan 2011	Apr 2011	Jul 2011	Oct 2011	Jan 2012	Apr 2012
West Dunbartonshire	>6 weeks	0	0	0	0	0	0	0	0	0	1	1	2	0	2	2	2	1
	<6 weeks	10	15	9	13	15	11	14	13	8	15	13	14	22	12	15	20	10
Argyll & Bute	>6 weeks	0	3	1	0	0	1	12	5	0	0	0	0	0	0	0	0	0
	<6 weeks	16	17	19	14	21	18	14	16	16	12	10	6	7	5	9	4	2
Highland	>6 weeks	0	0	6	12	0	5	14	17	0	9	15	17	0	10	4	7	0
	<6 weeks	13	19	14	9	15	25	28	27	18	22	22	29	27	22	24	18	29
North Lanarkshire	>6 weeks	0	0	0	0	0	3	4	2	0	1	0	2	0	4	4	5	2
	<6 weeks	15	16	21	6	10	18	20	28	18	12	23	14	29	34	35	24	21
South Lanarkshire	>6 weeks	0	2	2	0	0	0	10	1	0	1	2	10	0	3	3	4	5
	<6 weeks	28	35	32	29	29	40	40	32	40	40	33	57	51	37	43	39	33
City of Edinburgh	>6 weeks	0	1	5	6	0	3	8	6	0	11	8	13	0	25	17	12	1
	<6 weeks	39	58	49	35	27	49	40	35	48	61	39	32	36	50	52	34	43
East Lothian	>6 weeks	0	4	13	13	0	5	4	3	0	2	1	2	0	0	0	0	0
	<6 weeks	4	19	21	13	13	23	15	9	11	12	11	13	8	11	15	7	6
Midlothian	>6 weeks	0	6	5	3	0	0	0	0	0	1	0	0	0	0	0	0	0
	<6 weeks	6	19	18	3	12	10	8	4	6	7	9	3	5	9	5	6	5
West Lothian	>6 weeks	0	0	0	0	0	2	0	0	0	0	0	0	0	1	0	0	0
	<6 weeks	0	1	0	0	0	0	2	0	0	1	8	0	0	1	0	0	0
Orkney	>6 weeks	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
	<6 weeks	0	0	1	0	0	1	0	0	2	0	3	0	2	2	0	0	0
Shetland	>6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	<6 weeks	0	0	2	2	0	0	1	0	0	1	0	0	0	1	2	0	1
Angus	>6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
	<6 weeks	26	18	20	14	13	19	9	19	12	9	18	22	22	20	11	22	16
Dundee City	>6 weeks	0	12	8	6	0	0	1	2	0	0	1	6	0	1	5	1	0
	<6 weeks	14	15	21	12	10	17	8	13	12	13	22	19	10	8	15	19	17
Perth & Kinross	>6 weeks	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0
	<6 weeks	12	30	30	8	20	18	21	13	24	15	16	23	25	24	24	17	9
Comhairle nan Eilean Siar	>6 weeks	0	0	0	1	0	1	1	0	0	1	3	2	0	0	0	0	0
	<6 weeks	0	0	3	0	0	0	0	2	3	3	5	4	2	1	0	1	0
Not Identified	>6 weeks	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	<6 weeks	3	2	0	1	5	0	0	2	1	0	0	2	0	0	0	0	0

Questionnaire: SCCBN Sub-group, Delayed Discharges.

Name of person completing questionnaire.....

Job Title.....

Email Telephone number

Local Authority.....Health Board

Does your authority work as a CHP or CHCP? (Delete as necessary)

If possible would you please return a copy of your local Discharge Policy with your completed questionnaire?

+

We are seeking completion of this questionnaire on behalf of the Scottish Community Care Benchmarking Network.

Our contact details are:

Hamish Fraser (Group Leader), Midlothian Council Hamish.Fraser@midlothian.gov.uk

Tricia Mullen, NHS Greater Glasgow & Clyde Patricia.Mullen@ggc.scot.nhs.uk

Lesley Carnegie, Stirling Council carenegiel@stirling.gov.uk

Pat Trehan, Argyll & Bute Council pat.trehan@argyll-bute.gov.uk

Rieta Vilar, NHS Grampian Rieta.vilar@nhs.net

Fiona Hume, NHS Lothian Fiona.Hume@nhslothian.scot.nhs.uk

Ian Nicol, City of Glasgow Council ian.nicol@glasgow.gov.uk

Julia Daglish daglishj@stirling.gov.uk

PLEASE RETURN YOUR QUESTIONNAIRE TO Hamish.Fraser@midlothian.gov.uk

1. Delayed Discharges over 6 weeks.

- I. Please insert in the table below, the numbers of Delayed Discharge patients over 6 weeks, at the quarterly census date:

Apr 2009	Jul 2009	October 2009	January 2010

- II. Please insert in the table below the numbers at each quarter, against the relevant category, a key to the codes is supplied below:

	Apr 2009	Jul 2009	Oct 2009	Jan 2010
Not coded				
Code 9				
Code 9/51x				
Code 9/71x				
Code 11A/11B				
Code 23C				
Code 23D				
Code 24DX, 24EX or 42X				
Other code: please insert code and number of patients.				

Key to codes:

9 – Complex needs

9/51x – delayed due to requirements of AWI Act

9/71x – an interim move under choice of accommodation guidance is deemed to be unreasonable for the patient

11A/11B - Awaiting completion of a social care assessment

23C – Non availability of public funding to purchase a care home place

23D – Non availability of public funding to purchase any other care package

24DX, 24EX, 42X – patient awaiting place/bed availability in specialist residential facilities where no appropriate facilities exist in the NHS Health Board area

III. What were the final destinations for these patients when they were discharged?

	Apr 2009	Jul 2009	Oct 2009	Jan 2010
Own home				
Supported Housing/Progressive Care				
Residential Care				
Single Care				
Nursing Care				
Out of area placement				
Other				

- IV. If the patient is being discharged to their own home, what circumstances will apply on discharge:

Alone	
Informal/family carer	
Intermediate/short term care (up to 6 weeks)	
Community Care Package	
Not known	

Please **bullet point** below any issues you wish to highlight, or comments you wish to make:

2. Delayed Discharge under 6 weeks:

- i. Please insert in the table below, the numbers of Delayed Discharge patients under 6 weeks at the quarterly census date:

Apr 2009	Jul 2009	October 2009	January 2010

- ii. At what stage does planning for discharge, including assessment for care, commence?
(please tick the statement that is 'best fit' with your policy)

Anticipatory Care Planning is used to plan in case of hospital admission	
Discharge planning begins at the point of admission	
Discharge planning begins shortly after admission	
Discharge planning begins when medical fitness can be estimated	
Discharge planning begins when medical fitness has been confirmed.	
Other (please write a short comment)	

- iii. If the patient is thought to need some form of care after discharge, what is the target duration of your assessment period

- iv.

Please list below the provisions you have in place to support patients to return to their own home e.g. assistive technology, adaptations and equipment; step up/step down care.

- v. From the list above, which three provisions would you prioritise as the most effective in enabling patients to return home?



- vi.

Has there been a shift in the Balance of Care, away from institutional care and towards care in the community, over the 4 quarters? If so, what has changed?

vii.

How well do you think you do at getting people out of hospital when they are medically fit? What do you do that facilitates this?

3. **The Future:**

i.

In your area, are there any major obstacles to timely discharge? If so please give two key points:



ii.

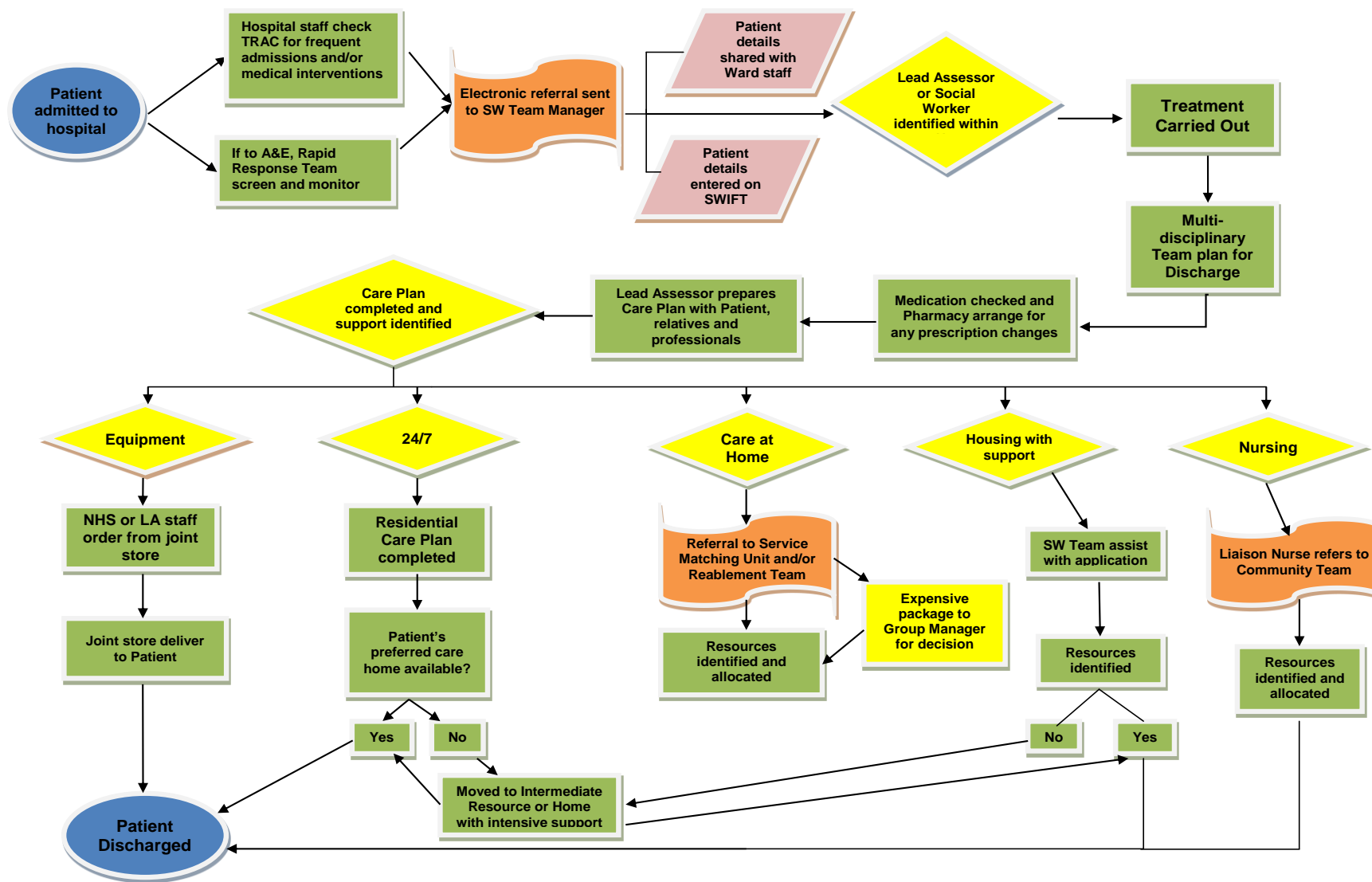
Do you have any future plans that might impact, positively or negatively, on Delayed Discharge?

iii.

How do you think budget constraints might impact on Delayed Discharges?

- iv. Would you be willing to meet to give us further views on what does or doesn't work?
YES?NO

Appendix C West Lothian Partnership: Hospital discharge process – July 2012



Legend: Start or Finish Point: Process: Data Input: Document: Decision:

Appendix D Faster Access Benchmarking Group Members

Hamish Fraser, Midlothian Council
 Rieta Vilar, NHS Grampian
 Patricia Mullen, NHS Greater Glasgow and Clyde
 Lesley Carnegie, Stirling Council
 Julia Daglish, Stirling Council
 Fiona Hume, NHS Lothian
 Pat Trehan, Argyll and Bute Council
 Ian Nicol, Glasgow City Council

Site Visits

<i>Visiting Teams</i>	West Lothian	East Ayrshire	Moray
Hamish Fraser, Midlothian Council	✓	✓	
Teague McFadden, Glasgow City Council	✓	✓	
Louise Weymes, Fife Council	✓		
Jennifer Siencyn, East Dunbartonshire Council	✓	✓	
Gordon Smith, Scottish Community Care Benchmarking Network (SCCBN)	✓	✓	✓
Jayne Lewis, SCCBN	✓	✓	
Kimberley Alexander, SCCBN	✓	✓	✓
Ian Nicol, SCCBN		✓	✓
Rieta Vilar, NHS Grampian – Aberdeenshire			✓
Margaret Laird, Highland Health and Social Care Partnership			✓
Simon Steer, Highland Health and Social Care Partnership			✓
Tanya Capp, Highland Health and Social Care Partnership			✓

Partnership Teams (either in attendance or providing input to the final report)

West Lothian: Pamela Main, Gill Cottrell, May Melrose, Sue James, Maggie Williamson, Susan Brown
 East Ayrshire: Anna Aitken, Helen McGee, Joanne Hughes and Jackie Kerr
 Moray: Elena Geddes, Margaret Slorach, Jacqui Short, Jane Mackie, Robin Paterson, Sandra Gracie