

## AFTERNOON WORKSHOPS

### 1. At April 2008 will there be patients for whom it might not be safe or reasonable to discharge within 6 weeks?

Workshop A	Yes
Workshop B	Yes
Workshop C	Yes
Workshop D	Yes
Workshop E	Yes

### 2. If so what are the likely reasons?

- |            |  |
|------------|--|
| Workshop A | <ul style="list-style-type: none"><li>• Homes unsuitable to return to (homeless)</li><li>• Family refusal to co-operate</li><li>• Extremely challenging behaviour</li><li>• Financial</li><li>• Specialist equipment or major adaptations</li><li>• Remote/rural area may not have suitable care home place near family</li></ul>  |
| Workshop B | <ul style="list-style-type: none"><li>• Psychiatric patients and patients with severe dementia, schizophrenia and other mental illnesses.</li><li>• Lack of specialised facilities to accommodate these patients, so it would not be safe to move them from hospital. These types of patients often deteriorate over time and by the time a place does become available the patient needs more extensive care and that place is no longer appropriate.</li><li>• Under-65 age group with physical disabilities, brain injuries – basically all young chronically ill patients – are another group where no appropriate facilities exist. Often housing redesign is required but this can take months to allocate housing or make adjustments to homes. Can take as long as 9 months to do this and it is not appropriate for these patients to be placed in nursing homes for elderly.</li></ul> |
| Workshop C | <ul style="list-style-type: none"><li>• Complex cases.</li><li>• Finance.</li></ul>  |
| Workshop D | <ul style="list-style-type: none"><li>• Lack of care home capacity (particularly on Islands)</li><li>• Carer unwell – cannot discharge home.</li><li>• Homelessness</li><li>•</li></ul>  |
| Workshop E | <ul style="list-style-type: none"><li>• In Edinburgh there are patients who cannot be coded 'Complex Needs' as the reason for delay is complex but not complex enough.</li><li>• There is the issue of people awaiting adaptations to their home who could perhaps be placed in an interim facility. Who should pay for it? If the patient is an owner/occupier would they be expected to pay for the interim care as well</li></ul>   |

- as their mortgage?
- In the Western Isles there are patients where there are no places available due to lack of care home places.

**Several issues were discussed at the recent National Advisory Group on Delayed Discharge Information meeting. Discuss the following briefly and indicate as a group if you agree with the decisions (Q3 – 5):**

- 3. At the meeting the Group agreed that a “common sense” approach was needed in interpreting the definitions. For example, in terms of healthcare delays there is a need to distinguish between patients “awaiting transfer but receiving appropriate care” and those “awaiting transfer to receive appropriate care”.**

Workshop A General agreement, but concerns about access to short-stay beds.

Workshop B Agreed.

Workshop C Agree, where they are receiving appropriate care if delayed for healthcare reasons.

Workshop D

- Discussed how exceptions may be viewed by senior management, elected members, public bodies.
- If patients are receiving appropriate care they should not be counted as a delay.
- If they are not getting the appropriate care they are delayed.
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Workshop E

- There was no consensus to the question.
- Some thought that all should be reported and identified regardless of whether receiving appropriate care in the wrong facility or awaiting appropriate care in a different facility.
- The feeling was if these patients are not being reported partnerships will not get the funding they require.
- Some areas were including those that were receiving inappropriate care and not including people receiving rehab in an interim facility.

- 4. The Group also agreed that patients at home on trial (on-pass) would either technically not be ready for discharge as still under the direction of a consultant or part of a planned discharge process. In neither case should the patient be considered a delayed discharge.**

Workshop A Agreed

Workshop B Agreed that any patients home on trial would not be counted as delayed discharges. But keen to stress that a patient returning to hospital after a failed home trial should retain their original ‘ready for discharge’ date. Also some expressed a dislike of the use of the term home ‘on-pass’ as it has negative connotations attached.

Workshop C Agreed

Workshop D Agreed

- Workshop E
- Differences throughout Partnerships and some not happy if these cases are not counted on a list. Some would use the bed if required.
  - Clinical decision should precede the coding not the other way round. Work should be done around linking up work streams (readmissions, Community Health Partnerships and unscheduled care).

**5. There was also discussion about whether the length of delays should continue or re-start when a patients' health needs change (injury or illness). It was agreed that when the change occurs only for a few days the clock should continue, for longer the clock would re-start.**

Workshop A            Agreed – need for more guidance.

Workshop B            Agreed – and general good reaction to the fact that this guideline is being issued. As it was pointed out that some areas thought that, against their better judgement, they had to always give a new 'ready for discharge' date to a patient even if the illness was minor/short term.

Workshop C            Agreed

Workshop D            ?

Workshop E            The group felt few days should be quantified as few is too ambiguous

**6. Is it right to discharge a patient to an interim care home if that home is a large distance (for example 100 miles across the Highlands or off the islands to the mainland) and may include arduous travel arrangements for family visits?**

Workshop A            Not discussed

- Workshop B
- It is not only interim care home placements that can cause this problem. Often the first or only choice (which may be the permanent placement for a patient) could be on a different island or a long distance away.
  - It is difficult to place a limit on what is or is not reasonable. Some may find 30 or 40 miles unreasonable and in certain parts of the country people might be unwilling to move 7 miles up the road to a neighbouring town.
  - Overall it was agreed that it would be unreasonable to force a patient to move far away from home and away from family and friends. But while being reasonable to patients in such situations who have a genuine grievance with being moved so far from home - there must be no room for a soft approach towards patients who refuse to move 7 miles or even 30 miles.
  - If anything a tougher stance is needed for these patients

and the choice guidelines already in place need to be enforced when patients refuse to leave hospital.

- Workshop C            No
- Grading of care homes in future will cause problems. Patients will want highest graded home and not accept interim 'low grade' home.
  - Self funders may choose home costing £500 per week, but interim placement may cost £600 per week.
- Workshop D            Should still be a delayed discharge.
- Interim placement in rural areas – no easy answer – not acceptable but no easy answer.
- Workshop E
- The problem is not only a major issue in the islands it is just as difficult to deal with out of area placements in the cities. The difficulty is in telling the families (who are often elderly themselves) that their relative can only be placed in a facility several miles away. Partnerships have offered transport for visits but families do not want them placed out of the area.
  - The other point discussed was patients placed in the interim. Even though they are medically stable and clinically fit, is it really the best policy to move often, frail elderly people several times before they can be permanently placed?
  - The group felt that England's reimbursement policy had had large coverage in the press but Scotland's issue with placing patients out of the area of choice was largely unknown. The group felt the Scottish Executive should take this up.

**7. If the alternative is to remain in a hospital setting, is this agreeable, and**

- Workshop A            Not discussed
- Workshop B            It is not agreeable but if the only other option is to remain in hospital then it is better than moving the patient a long way (ie 100 miles or to a different island).
- Workshop C            Yes – but not acute.
- Workshop D            Not discussed
- Workshop E            Not discussed

**8. Is such a patient still a delayed discharge?**

- Workshop A            Not discussed
- Workshop B            Group undecided whether such a patient should be considered a delayed discharge. If there is no option deemed 'reasonable' then it is up to the relevant authorities to offer a reasonable option. Need to look beyond care homes especially in remote areas and see what other housing options can be offered.
- Workshop C            No – but need to record somewhere.

Workshop D            Agreed it was still a delayed discharge.  
Workshop E            Not discussed

**9. Would the definition be less ambiguous if related to “a more appropriate stage of care” rather than the “next stage of care”.**

Workshop A            Yes

Workshop B            Yes

Workshop C            No

Workshop D            Not discussed

Workshop E            • The group had no strong feelings about the definition only that they felt the time should be used to discuss other issues. They didn't feel adding a few more words would help the understanding of the definition.

**10. Would the definition be clearer if any of the following words were added: “Safe”, “Reasonable”, “Appropriate”.**

Workshop A            Safe (appropriate use)

Workshop B            These words would help and encourage a common sense approach - but it is dangerous to have phrases such as 'reasonable' or 'appropriate' that are left to local interpretation.

Workshop C            Yes – emphasis multi disciplinary team decision.

Workshop D            Safe and appropriate to a patient's needs

Workshop E            Not discussed

**11. Can it be left to local interpretation of the current definitions in order to adopt a “common sense approach”.**

Workshop A            No – might sustain national inconsistency

Workshop B            It must be fair and equitable to patients in all parts of the country and not different rules for some patients who have difficult/stubborn families or who have a sympathetic person making the decision.

Workshop C            Difficulty in bringing consultants on board.

Workshop D            Need guidance to be clear.

Workshop E            Not discussed.

