

# **REPORT OF THE TRIPARTITE WORKING GROUP ON DELAYED DISCHARGE**

## **CHAPTER 1 – INTRODUCTION**

### **Terms of reference and membership**

The Tripartite Working Group was established in December 2003. The group was made up of senior representatives from the Scottish Executive, health boards and local authorities to look at the issues of patients awaiting discharge. Our chairperson until December 2004 was Jinny Hutchison, who was then Head of Community Care Division 1 within the Scottish Executive. Shaun Eales, Head of Branch 1, within that Division, chaired subsequent meetings. The full membership of the group is set out in annex A.

We were asked by Tom McCabe the then Deputy Minister for Health and Community Care to conduct a full and frank exploration of any barriers impeding hospital discharge, and all the options available to tackle them. Nothing was to be ruled out in our efforts to reduce the numbers of people delayed in inappropriate hospital settings. Additionally, we were asked to look specifically at:

- The scope for reducing to zero those delayed over 6 weeks;
- Improving central management information systems;
- Incentives for those Partnerships who are performing well;
- Penalties for those who don't deliver; and
- Establishing more realistic targets at regular intervals.

### **Policy context**

An Action Plan on Delayed Discharge was launched in March 2002 providing £20m for local authority and NHS Board partnerships. The plan outlined a range of key long and short-term actions to ensure timely, appropriate and safe transfer to the next stage of care. An ambitious target of reducing by 1,000 the overall number of delayed discharges was met and exceeded by 50 in April 2003. By October 2004 figures for delayed discharge show a year on year decrease of 13.7% (1,908 patients) in the overall number of patients ready for discharge compared to 2,210 patients in October 2003.

The number of patients delayed for more than 6 weeks has almost halved since the launch of the Delayed Discharge Action Plan.

### **Resources**

Spending Review 2002 committed £30m per annum to local authority and NHS board partnerships in 2003-04 and for the following 2 financial years. Spending Review 2004 will continue this level of funding in each year until 2007-08. These resources are distributed to partnerships through NHS Boards, under the Arbutnott formula, and are used to ensure implementation of Local Joint Action Plans.

## **Way of working**

We had a substantial remit to cover and we met on 11 occasions between December 2003 and March 2005. The group represented a wide range of interests and included COSLA, Social Work, Housing, the Scottish Executive and the NHS in Scotland.

Members were invited to make presentations, produce information and offer analysis to help inform the work of the group. Our discussions were open, direct and probing but at all times constructive.

## **Research**

It was unrealistic to commission any new research in the limited time available to us. We therefore had to rely on existing documentation. Members of the group were however tasked with producing a range of material to develop thinking.

## CHAPTER 2 – REPORTING CENSUS RESULTS

### Ready for discharge date

A national agreement between the Scottish Executive, NHS Boards and local authorities states that a period of 6 weeks is considered appropriate to plan the assessment and delivery of care for patients after they have been declared ready for discharge from hospital.

We considered the possibility of reducing the reasonable discharge period from 6 weeks to 3 weeks (as in England) but this was rejected. The 6 week planning period is considered by the practitioners to be a fair and realistic time in which to organise often complex care home packages, find an older person suitable accommodation in a care home or help some patients to make life changing decisions. However, the group agreed that all agencies involved should co-ordinate their efforts to ensure the safe discharge of all patients is undertaken as soon as possible.

Should Ministers decide to change the timescale for counting delays to one beyond the date the patient was clinically deemed ready for discharge, this could be perceived as central interference to manipulate the figures in order to show them in a better light. The group considered that a sensible position would be to put a greater emphasis on those patients delayed for 6 weeks and more.

The Executive should however continue to collect and publish data recording the first date the patient was clinically ready for discharge. This approach will ensure consistency in the collection and presentation of the figures throughout Scotland. **Ministers have accepted this earlier recommendation from the group and it has since been implemented.**

### Presentation

The national quarterly census is undertaken by the Information Services Division of NHS National Services Scotland to measure the number of patients ready for discharge and the main causes for these delays. This mandatory census started in April 2000. In essence, what we publish is a simple head count of the patients deemed clinically ready for discharge. This is a rather unsophisticated and blunt approach to cover a very complex area. There is also likely to be variations in the census figures depending on the census period. For example, we know from recent censuses that there is likely to be a fairly sharp rise in the numbers of patients ready for discharge in the summer and winter months. This method of reporting takes no account whatsoever of hospital activity. It is therefore very difficult to make sense of one set of statistics in isolation of other activities which are inextricably linked and interdependent.

There is little to be gained from this method of reporting which detracts from the significant inputs from the NHS and local authorities. We believe a more sophisticated approach to counting delays should be put in place. This could be achieved in a number of ways but the activity of partnerships should be made clear. There are a large number of performance indicators which could be used to add value to the current dataset. For example, we might consider using some or all of the following indicators:

- Measure occupancy levels of patients awaiting discharge in acute beds.

- Measure the effect of blockages in the system on elective surgery.
- Measure the number of preventative emergency admissions.
- Highlight the beneficial effects of rapid response team intervention.
- Identify availability of care home places.
- Consider the number of elderly patients who do not experience a delay in discharge.

The group discussed the development of a suite of performance indicators across the whole range of discharge activity. In doing this we recognised the need for a systems approach to monitoring discharge performance and we needed measures for system inputs, activity and performance. The performance component of the framework would build on the existing headline indicators but also include a number of new measures that attempted to measure efficiency of the whole discharge process.

#### Inputs

- Number of emergency admissions.
- Number of referrals for community care assessment (CCA).

#### Activity

- Number of community care assessments completed.
- Number of discharges completed after CCA.

#### System Performance

- Total number of patients assessed as ready for discharge.
- Total number of patients assessed as ready for discharge and delayed in excess of 6 weeks.
- Total number of patients assessed as ready for discharge and delayed by more than 1 year.
- Total number of patients delayed in acute beds.
- Total number of patients delayed expressed in ‘occupied bed days’.
- ‘Average length of stay’ for patients assessed as ready for discharge.

On submitting quarterly census information Partnerships should also be asked to submit a commentary/exception report detailing performance for the quarter completed, including explanations for movements (positive and negative), exceptional items and updated projections for the year end.

The group **recommended** that a suite of indicators be introduced to best capture delayed discharge figures in the context of overall activity.

### Central Management Information Systems

It has been reported that those delayed in hospital for whatever reason occupy expensive acute beds. It would then follow that such blockages would have a significant impact on patients requiring elective surgery. Waiting lists and waiting times would grow significantly. But this is not the case. In order to put the bed numbers into context we **agreed** that it would

be necessary to clearly identify the number of patients delayed in the acute and non-acute sectors. These figures are currently being collected and validated prior to publication.

Ministers will also wish to be aware that we **recommended** the introduction of a new coding to enable Partnerships to identify those delayed under the Adults with Incapacity Act. This was accepted and the information forms part of the existing census returns.

We believe that both these measures will offer greater transparency and more effective monitoring of performance.

As part of the move to outcomes in Joint Future, the Scottish Executive has developed a 'whole systems indicator' (JPIAF 10) that invites local partnerships to examine their performance on a number of measures - including delayed discharge - across the piece. It was introduced on a trial basis in 2003-04 and will be mainstreamed in 2004-05. This will drive Partnerships to consider how delayed discharges relate to other parts of the system, and to consider different ways of delivering the desired results.

## CHAPTER 3 - WHOLE SYSTEM APPROACH

A whole system approach or whole systems working, puts the patient or service user at the centre of the service provision. The users' experience will define the effectiveness of the system. The whole system is not simply a collection of organisations which need to work together, but a mixture of different people, professions, services and buildings which have patients and service users as their unifying concern and deliver a range of services in a variety of settings to provide the right care, in the right place, at the right time.

We are in no doubt that the way ahead for Partnerships is to adopt a whole system approach. Audit Scotland is currently reviewing patients ready for discharge in Tayside as part of its performance audit programme of work. The key focus of this study is to determine:-

*"What is the best distribution, redesign or development of capacity that minimises the number of patients whose discharge is delayed and maximises outcomes and value for money?"*

This model critically takes into account the increasing proportion of older people in the population. They have also focussed on key areas affecting delayed discharge such as chronic disease management, admission avoidance schemes, reducing assessment times, attitude to risk management and specialist housing/care home provision.

Audit Scotland are aiming to publish their final outputs in spring/summer 2005. This will include a handbook including examples of best practice and guidance on how to evaluate local initiatives aimed at tackling delayed discharges. It will also be followed up by seminars/visits with local partnerships to publicise and share their work.

The focus of the Audit Scotland study is key to tackling the issue of delayed discharge. While the tripartite group has recommended certain changes during the life of the group, and is recommending further changes in this final report, it is suggested that awaiting the outcome of the Audit Scotland study may significantly inform the debate and lead to greater clarity regarding the efficacy of future investment decisions.

## CHAPTER 4 – GUIDANCE AND PROTOCOLS

### Choice of accommodation

Health Department circular CCD8/2003 of 13 January 2004 outlines how local authorities and NHS boards should actively manage choice of care homes for older people moving from hospital, in a way which is consistent and fair and which minimises delays.

In discussion we established that some Partnerships are comfortable with the guidance, but others are reluctant to enforce it. It seems that there is a variation in the application of the guidance depending upon legal opinion locally. As a result, some Partnerships are treading warily and have some patients unnecessarily occupying hospital beds, while others are making it clear to patients that they must move on to the next stage of care. The group invited Executive officials to consider whether it would be possible to strengthen the guidance. The Office of the Solicitor to the Scottish Executive (OSSE) subsequently advised that in their opinion it is implicit in the circular that staff are required to advise the patient that he or she is not able to stay in hospital indefinitely. As a group we **agreed** that the guidance should remain unchanged.

We also considered whether someone exercising their right under the choice guidance should be classified as a delayed discharge. There were 172 patients in this category at the October 2004 census and this trend seems to be increasing.

There is a variety of reasons for people falling into this category. Some patients might be waiting on a vacancy in their chosen care home. But there are more complex cases involving family disputes which prevent the person entering a care home timeously.

The group **agreed** that the data collection system should remain unchanged. We also **recommended** that the Scottish Executive should assess the implementation of this guidance across Scotland and obtain fuller information about patients delayed for this reason. At the same time, the Executive should assess whether all Partnerships have put in place local discharge protocols.

### Local joint action plans

Each Partnership is required to submit annually Joint Action Plans to the Scottish Executive which detail the range of measures that are to be used locally to reduce the number of patients awaiting discharge and at what cost.

Alterations have been made to the 2004-05 plans following a research report<sup>1</sup> which highlighted flaws in the information sought from Partnerships. The revised plans will capture more meaningful and robust data which will result in more effective monitoring of performance. These were **approved** by the group. Future plans and reports should capture the performance indicators suggested by the group.

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<sup>1</sup> [\*Scottish School of Primary Care 2004: A Research Review on Tackling Delayed Discharge\*](#)

## CHAPTER 5 - RESIDENTIAL CARE CHARGING POLICY

We discussed whether there is currently a financial incentive for patients awaiting discharge to remain in hospital, rather than moving to a care home. We considered current residential care charging rules and discussed how, and in what circumstances, the group might recommend that such rules should also be applied to certain patients awaiting discharge.

Residential care charging rules aim to ensure the residents make a fair contribution towards the cost of their care. The rules are complex, but in simple terms:

- Those with assessed capital over £19,000 or with very high income receive a personal care payment of £145 per week (over 65s only) plus, if necessary, a nursing care payment of £65 per week (all ages). They are responsible for meeting their remaining accommodation costs in full.
- The value of a resident's home can be included in the assessment of his or her capital only:
  - after 12 weeks of a permanent care home placement; and
  - where the home is not occupied by a spouse or partner, or certain classes of relative or carer.
- Local authorities provide additional support to other residents, based on a financial assessment, prescribed in legislation.
- Such residents normally contribute all of their income towards their fees, less a weekly personal expenses allowance of £18.10 for newspapers, toiletries etc.
- They also contribute a small amount (up to £30 per week) from capital between £11,750 and £19,000.

The only purpose in introducing accommodation charges for certain patients awaiting discharge would be to remove the current financial incentive for them to avoid paying care home fees by delaying their discharge to residential care.

Some members raised concerns about the NHS continuing to look after and pay for patients who are clinically ready for discharge but waiting for the first choice of care home to become available.

There are 2 options for applying charges. Both are likely to require legislation.

The first would be to find a way of formally discharging certain patients from the NHS to the local authority, even though they remained physically in the hospital setting. This would be a way of taking advantage of existing residential care charging rules and local authority expertise. There are a number of practical difficulties however. It would create a confused situation, with the local authority assuming responsibility for a person's care, even though the NHS was providing it. It would also have the unintended consequence of creating additional costs for the local authority, which would have to pay for the total costs of care and accommodation, the patient only being charged for his/her assessed share. The question of

total fees would also need to be considered as a hospital placement costs considerably more per week than is currently charged in care homes.

The second and potentially better option might be to enable the NHS to charge in certain circumstances. This would avoid the confusion noted above and provide greater flexibility in how to assess the contribution a person should be asked to make. At its simplest, it might involve asking a person to contribute his/her weekly income, less any financial commitments such as to dependent relatives or for housing costs. The administration of such charges could be costly as new systems would need to be established for what might be quite small numbers of people. It is hard to estimate the average size of charges. Basic weekly benefit levels for older people are around £105 and average weekly income is £193. Subtracting a weekly personal expense allowance of £18 would leave average charges between £87 and £175, less any allowance for dependent relatives or housing costs.

There is no doubt that such changes, however restricted in scope, would be controversial, as they could be seen to undermine the principle that NHS services are free at the point of delivery. The Executive could also be portrayed as shifting the responsibility for delayed discharge problems from the statutory agencies to vulnerable patients. As noted above, legislation would almost certainly be required and it is difficult to predict when it would be possible to find a slot in the Parliamentary timetable.

As a group, we acknowledged that it would be possible to introduce charges for certain patients awaiting discharge. But we equally acknowledged the significant practical and presentational obstacles in delivering such a policy. The group noted a disincentive already exists to long-term patients remaining in hospital as their pension is reduced after a number of weeks. We **recommend** that the current residential care charging rules should not be extended.

## CHAPTER 6 - MEETING COMPLEX NEEDS

In discussion, local authority and health representatives confirmed that they remain supportive of Executive policy for caring for more people at home but not at any cost. They are finding it difficult to meet the costs of expensive care at home packages for people with high levels of disability or complex needs.

These clients are often delayed in hospital unnecessarily for many months and sometimes years until appropriate funding arrangements can be put in place. Local authorities claim that the costs are putting a great strain on their budgets and placing an unwelcome burden on social workers. They are left with the choice of approving the more costly cases or finding the individual a suitable care home at a fraction of the price of keeping them at home. But this is not solely a financial issue. There are a small number of clients in each Partnership area who require highly complex packages. The group generally felt that this client group had been let down and much more effort is required to move them into a more appropriate setting.

The principle supporting the policy of caring for people with complex care needs in their own homes is endorsed by the group. But we acknowledge that some people will need to receive care in an institutional setting because of the costs of alternative care .

The group however have highlighted a number of challenges in delivering this approach which require to be addressed.

People with complex care needs are normally highly dependent individuals with multiple needs who require ongoing support for a significant period of their lives.

It is acknowledged that this group is not a homogeneous group but one which includes people of all ages and individual need.

This group of people are a relatively small proportion of the total number of people delayed unnecessarily in hospital. It is important however to acknowledge that individuals in this group tend to be those delayed in their discharge for longer.

This situation arises for a number of reasons. The availability of suitable support within an area, the high cost of the care package and difficulties in co-ordinating the ongoing care needs of individuals all contribute to extended delays in discharge.

Care options for this client group are often very limited and in some areas are not available. Care options tend to focus on care at home which can be highly expensive, in specialist care homes or general care homes adapted for this purpose, or in small high-cost group living units. The group recommend that partnerships review how the needs of this particular group of people are addressed within locality. We **recommend** that:

- A needs assessment is carried out which clearly indicate the current and future needs for this client group.
- A policy on funding complex care packages at home should be agreed with local partners. This should clearly state the upper limit for funding care at home.

- A review of the co-ordination and management of care should be undertaken to ensure people requiring services from many different providers over a long period of time have a co-ordinated and managed approach to their care and discharge from hospital.
- Appropriate referral pathways are put in place and there is clarity about how to access services. We recommend that consideration is given to the implementation of appropriate education training and information for patients, their carers, families and professionals on how to deal with the needs of people with complex care.

We considered a paper from Analytical Services Division which provided details and information on age groups and client groups unnecessarily delayed in hospital. This information revealed that the problem involving complex cases was not just about older people. It was often much younger people with severe learning disabilities or mental health problems. We are aware that some of these people have Acquired Brain Injury. However the current data collection cannot accurately identify these people as they may be classified under a number of different specialities. We **recommend** that data should be collected on people with learning disabilities, mental health problems, acquired brain injuries or other complex needs to ensure that they receive care in the most appropriate setting as quickly as possible.

## CHAPTER 7 - TARGET SETTING

In 2003-04 partnerships were asked to set realistic local targets for their areas. This resulted in a national reduction of 278 (13.5%).

Ministers however made it clear that they wanted to deliver tangible, sustainable results. They sought a more focused approach and in accordance with Ministerial wishes we accepted a 20% national reduction for 2004-05. We **agreed** that the results of the April 2004 census should be used as the starting point. The results of that census would mean that we would be looking for a reduction from 1,784 patients unnecessarily delayed to 1,426. Furthermore, we **agreed** that within the national target, partnerships would be invited to make 20% reductions for those delayed over 6 weeks and, in future, targets should apply to those delayed in the acute sector. Partnerships would also be advised that any delays over 12 months would be considered unacceptable.

While members accepted the targets set for 2004-05, some considered that the future improvements were not sustainable without additional resources. We discussed linking targets to resources and whether this was covered by the whole system work being done by Audit Scotland in Tayside. Others believed that the wrong information is being collected with which to measure performance. Numerical targets did not show the improvements being made or the level of effort that is put in.

The group discussed a number of options in respect of target setting. This was in the knowledge that the current 'blanket' 20% annual reduction was not sustainable over time and did not:

1. take account of the relevant performance of partnership areas and therefore the areas where greater improvement could be delivered;
2. reflect local circumstances that would impact on the in-year potential for improvement.

The focus of discussions led the group to **recommend** that annual 'target setting' should be devolved to local Partnerships with external scrutiny from the Scottish Executive aimed at testing the rigour of local arrangements for managing delayed discharge. It was argued that such an approach would deliver greatest improvement and both a local and national level for the following reasons:

- Targets would reflect local circumstances and should be 'realistic'.
- Targets would be set within a longer term strategic vision for improvements in wider system and delayed discharge performance.
- There would be local ownership of the process and greater potential for delivery.
- National target setting could be informed by local arrangements with, therefore, greater confidence of attainment.
- There would be a clearer route for Ministerial intervention if partnerships were seen to be failing to deliver delayed discharge improvement.

In proposing this solution group members were mindful of the need to deliver improvements on a Scotland wide basis. Both within partnership areas and at a national level, improvement needed to be both ambitious and achievable. The proposal involves partnerships presenting, on an annual basis, detailed delayed discharge implementation plan that would be evaluated/scrutinised by the Scottish Executive. The format of Delayed Discharge Action Plans would need to be reviewed in light of this proposed 'heightened' level of scrutiny. The evaluation and approval process could be delivered at 2 levels:

- Firstly, at a partnership level taking account of the current performance within the partnership, the projected in-year partnership improvement, and the longer term strategic vision for delayed discharge performance. To deliver this element the Joint Future Unit would need to take a view on the 'relative' performance of individual partnerships. If partnerships were assessed as 'not delivering' they could be referred to the Joint Improvement Team as part of the Ladder of Support and Intervention).
- Secondly at a national level assessing that all of the partnership submissions deliver a significant and 'acceptable' national improvement target.

## CHAPTER 8 - FINANCIAL PENALTIES/INCENTIVES

We were asked to consider the issue of penalties and incentives, in the light of policy adopted by the Department of Health.

In England, under the Community Care (Delayed Discharges) Act, there is a financial obligation for local authorities to reimburse NHS Acute Trusts if delays in social care assessments and arrangements for social care services are the only reasons for the delay in discharge.

There are specific criteria to be met eg the payment must relate to an “acute” patient, but the key point is that the local authority is “fined” between £100 and £120 per day for each delayed discharge. In introducing the system local authorities were provided with very significant additional funding which could either be used to address their side of the delayed discharge problems or “pay the fines” where these measures failed.

Over the initial 6 month period to March 2004, there has been a reported 25% reduction in acute delayed discharges. Despite this, there is no clarity as to the specific reasons behind the reduction and there have been complaints from organisations representing service users and carers as to the appropriateness, volume and quality of the community services provided on discharge.

Uncertainties remain as to whether it is the nature of the scheme itself, or the significant new financial investment which is responsible for the relative success. Others are suggesting that it is attributable to improved joint working between the agencies or even that it is simply a continuation of an already downward trend.

While the introduction of the system of both funding and fining local authorities in England, has coincided with a significant reduction in acute delayed discharges, there are competing explanations as to why this is the case. Over the course of the coming year it should become clearer as to whether the introduction of the concept of fines on local authorities has in itself had any positive impact. Greater clarity should also be achieved on whether improved hospital throughput is being achieved at the expense of adequate and appropriate community care packages.

We believe that further time and analysis will be required to determine the key success factors if any, in what is a complex system of admission, assessment and discharge.

In Scotland, between October 2003 and October 2004, there has been a drop of 13.7% in delayed discharges. This is not directly comparable with the English situation. The Scottish figures do not refer only to acute beds where the implications for the treatment of other patients can be most significant. Data which differentiates between delayed discharges in this way, is only now being collected in Scotland.

Reductions in delayed discharges have already been incentivised in Scotland through the injection of new funds which are paid to NHS boards but are only released by the Executive following approval of jointly agreed action plans.

This has been strengthened by 20% reduction targets and a clear intent to make new resources dependent upon successful delivery of these targets. The move away from

measurement of partners' performance based on processes and structures, to actual outcomes which include delayed discharge targets, will further reinforce accountability mechanisms.

There is an obvious logic to holding whole partnerships accountable to the Executive in this way – rather than simply one partner being held accountable to the other, as is the case with the English scheme.

Audit Scotland's Whole Systems Modelling recognises that this is a complex matrix of activity where for example, risk assessments of General Practitioners and their use of Accident and Emergency admissions, can have a significant impact on the demand for social services assessments and consequently in delays and discharge at the back end of the process. This work by Audit Scotland should provide a first ever analysis of the interactions and causal relationships within the whole system and provide clear guidance on where and how resources can be applied to optimum effect.

The new Joint Improvement Team will also shortly be working alongside local partnerships to help achieve improved performance in key areas including reductions in emergency admissions, more effective home support services, faster assessments etc. The clear expectation is that this activity will also have a positive impact on delayed discharges. The Joint Improvement Team will also be informed by the emerging evidence from the Audit Scotland study, new information from the delayed discharges best practise network and the partnership action plans and performance framework.

The impending introduction of Community Health Partnerships will also provide even further opportunities for whole systems service redesign although it is anticipated that significant progress will already have been made in key areas before they become fully operational.

The financial incentives in Scotland are being paid through the NHS Partners but it is the whole partnership which currently stands to be penalised if agreed targets are not met. As all partners have a critical role to play in long term and sustainable improvement, this appears to be a more sensible approach.

Accountability mechanisms through JPIAF, delayed discharge action plans and the "Ladder of Support and Intervention" are now in place and partners will be both informed and supported by the work of Audit Scotland and the Joint Improvement Team.

While it would be possible to devise a system of "fines" based on allocating responsibilities to various parts of the system eg local authorities, GPs, care homes, consultants etc there is nothing to suggest that this would either improve accountability or behaviour of individual partners or improve the climate for the development of joint working in general and CHPs in particular.

While there may be disagreement about the adequacy of investment to tackle delayed discharges, it is clear that financial incentives and penalties are already appropriately targeted within the system in Scotland. These are backed up by monitoring and accountability mechanisms and subject to support and intervention where necessary.

We believe that it would be counterproductive to adopt the system operated by the Department of Health in England and we **do not recommend** its implementation in Scotland.

## CHAPTER 9 - INTERIM SERVICES

### Care beds

Patients whose discharge from hospital has been delayed and who are assessed by social work departments as requiring social care have a legal right to that social care. However, where all available care home placements are full and no spare capacity can be identified in community settings, Partnerships can be faced with a situation whereby they have to leave the patients in hospital wards until such time as a suitable care home place becomes available.

In certain parts of Scotland where there has been, for various reasons, a contraction in the voluntary and private sector care home market leading to the loss of care home beds over recent years, this is a particularly significant and intractable problem.

The Delayed Discharge Action Plan suggested that Partnerships consider the use of interim or convalescent beds to alleviate their delayed discharge problems. In the light of this suggestion, some Partnerships have re-opened NHS wards to meet the shortfall in capacity.

In some areas, the NHS appears to be the only remaining source of suitable buildings which are appropriate for the provision of accommodation for the care of frail people with a range of physical needs and which can be made available.

We discussed the potential for significantly increased short term flexibility in order to:-

- Bring back into emergency use, as a registered interim/waiting social care home placements, previously closed continuing care wards in various hospital locations.
- Close, upgrade, reclassify and register as social care home waiting facilities, various existing continuing care wards in a number of hospital locations which are currently occupied by large numbers of social care assessed patients whose discharge is significantly delayed because of the current shortages in the care home market.

Given the published standards for care homes this will require substantial flexibility in approach from the Care Commission on matters such as room size, en suite facilities, room sharing, privacy etc for time-limited periods.

Whilst such interim measures may not be able to comply with every element of the new care home standards, they will, nevertheless, be relatively short term because of their nature and given the current position they will be more appropriate than leaving patients inappropriately occupying NHS hospital beds well beyond the completion of their medical treatment.

In discussion, we acknowledged that these interim arrangements would alleviate many of the problems posed on partnerships by lack of capacity. We were however concerned about the issues surrounding the relaxation of standards. In essence, partnerships would be required to approach the Care Commission to ask them to relax what were generally agreed as reasonable standards. This was considered to be inappropriate. We also reflected on the need for maintaining a high level of care home beds. The Range and Capacity Review highlighted SCRUGS data which suggested that 58% of care home residents had low to moderate dependency levels. Despite this, it was acknowledged that there were still genuine demands for care homes. While people with high levels of dependency can and are being looked after

at home, the limiting factor in these cases is often financial viability and most councils have some limit beyond which the relative cost of a care home bed is the only defensible best value option. It was generally felt that intermediate care facilities or rehabilitation/convalescent beds were needed to help people move back to their homes.

As a group, we are uncomfortable with any suggestion of relaxing agreed care standards for whatever reason. Furthermore, a major constraint in developing interim care beds is that they do not currently meet Care Commission standards for care homes. We **agreed** that it would be too expensive to convert the wards to meet these standards. We therefore **recommend** that local systems only consider transforming NHS wards into interim care beds for patients who are ready for discharge in circumstances where they can meet national care standards at a reasonable cost.

## **Standards**

Our conclusion on interim care beds was informed, in part, by the evidence provided by Adam Rennie, Head of Community Care Division 2 at the Scottish Executive Health Department. Mr Rennie attended the meeting of the group on Wednesday 10 November 2004.

Mr Rennie explained that he was present in a dual role – as sponsor of the Care Commission and also as Chair of the National Care Standards Committee. He clarified that it was Ministers and not the Care Commission who needed to be persuaded to make changes to the standards. There had been previous examples such as Mayburn House in Midlothian where Ministers had relaxed some aspects of the standards as a short-term measure to tackle delayed discharge. Mr Rennie recorded that he would be happy to put any propositions to Ministers if the group made a suitable case.

In discussion, we agreed that the standards were appropriate and that certain leeway was already being applied at local levels. It was acknowledged that this issue had been raised because of difficulties in Lothian and it was therefore the responsibility of the Lothian Partnership or indeed any other partnership to make any such approaches to Ministers.

## **Intermediate care**

Intermediate care has been described by the Department of Health as “services” which:

- Are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute in-patient care, long-term residential care, or continuing NHS in-patient care.
- Are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- Have a planned outcome of maximising independence and typically enabling patients/users to resume living at home.
- Are time-limited, normally no longer than 6 weeks and frequently as little as 1-2 weeks or less.

- Involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

There are various models of intermediate care being implemented in Scotland. The 2 most popular models are:

- a. Hospital based intermediate care.
- b. Community based intermediate care.

Hospital based intermediate care is where a patient is transferred from an acute bed in an acute hospital to a community hospital for a period of active rehabilitation prior to discharge home.

Community based intermediate care is where individuals may be admitted from either their own home or discharged from hospital to a community facility for a period of further rehabilitation or more intensive care support for a time limited period.

The service is available to older people who have been assessed as medically stable but require specific rehabilitation and personal care to recover and rebuild confidence in order to be able to return to live independently.

It is clear from the evidence to date that intermediate care facilities have achieved the following:

- Prevented prolonged unnecessary stays in acute hospital.
- Prevented acute hospital admissions.
- Reduced the number of delayed discharges.
- Reduced the number of individuals admitted prematurely to a care home.

Intermediate care has grown rapidly in England in response to recent Government initiatives (including £405m for NHS and an extra £1bn a year by 2006 for social care services). An extra 3,300 intermediate care beds have been established in the period 2001-03.

Although the Scottish Executive had decided not to promote intermediate care in the same way as it has in England, it is **recommended** that the development of intermediate care facilities should be further explored as this would assist in supporting the Executive's objectives both for delayed discharge and the Joint Future Agenda.

## CHAPTER 10 – SUMMARY OF RECOMMENDATIONS

- Chapter 2 We recommend that the Scottish Executive should continue to collect and publish data recording the first date the patient was clinically ready for discharge, but greater emphasis should be placed on those delayed for 6 weeks or more.
- Chapter 2 We recommend that a suite of performance indicators should be introduced to best capture delayed discharge figures in the context of overall hospital and local authority activity.
- Chapter 2 We recommend that the Scottish Executive should collect and publish data which clearly identifies the number of patients delayed in the acute and non-acute sectors.
- Chapter 2 We recommend the introduction of a new coding to enable Partnerships to identify those delayed under the Adults with Incapacity Act and for results to be published.
- Chapter 3 We recommend that the way ahead for Partnerships is to adopt a whole system approach to tackling delayed discharges – noting that the Audit Scotland study is aiming to publish its findings in Spring/Summer 2005.
- Chapter 4 We accept that the guidance contained in circular CCD 8/2003 of 13 January 2004 is fit for purpose, but recommend that the Scottish Executive should assess the implementation of the guidance across Scotland and obtain fuller information about patients delayed for this reason.
- Chapter 5 We recommend that the current residential care charging policy rules should not be extended.
- Chapter 6 In relation to people with high levels of disability or complex needs, we recommend that partnerships review how the needs of this particular group of people are addressed within locality. We recommend that:
- A needs assessment is carried out which clearly indicate the current and future needs for this client group.
  - A policy on funding complex care packages at home should be agreed with local partners. This should clearly state the upper limit for funding care at home.
  - A review of the co-ordination and management of care should be undertaken to ensure people requiring services from many different providers over a long period of time have a co-ordinated and managed approach to their care and discharge from hospital.
  - Appropriate referral pathways are put in place and there is clarity about how to access services. We recommend that consideration is given to the implementation of appropriate education training and information

for patients, their carers, families and professionals on how to deal with the needs of people with complex care.

- Chapter 6 We recommend that data should be collected on people with learning disabilities, mental health problems, acquired brain injuries or other complex needs to ensure that they receive care in the most appropriate setting as quickly as possible.
- Chapter 7 We recommend that annual target settings should be devolved to local Partnerships with external scrutiny from the Scottish Executive.
- Chapter 8 Detailed consideration was given to the issue of penalties and incentives and we recommend that it would be counter productive to implement such a policy in Scotland.
- Chapter 9 We recommend that local systems consider transforming NHS wards into interim care beds for patients who are ready for discharge in circumstances where they can meet national care standards at a reasonable cost.
- Chapter 9 We recommend that the development of intermediate care services should be explored as this would assist in supporting the Executives objectives both for delayed discharge and the Joint Future Agenda.

## ANNEX A

### List of membership

|                 |   |
|-----------------|---|
| Jinny Hutchison | Scottish Executive (Chair until December 2004)                    |
| Shaun Eales     | Scottish Executive (Chair from January 2005)                      |
| Brian Slater    | Scottish Executive (Secretariat)                                  |
| Ron Ashton      | Association of Local Authority Chief Housing Officers             |
| Ray Flint       | NHS Lothian   |
| Anne Hawkins    | NHS Forth Valley  |
| Ian Aitken      | NHS Forth Valley (deputised for Anne Hawkins at several meetings) |
| George Hunter   | Association of Directors of Social Work                           |
| Alexis Jay      | Association of Directors of Social Work                           |
| Alan Mckeown    | CoSLA   |
| Alex Mckenzie   | NHS Greater Glasgow   |
| Margery Naylor  | Joint Future Unit, Scottish Executive                             |
| Julie Rintoul   | Analytical Services Division, Scottish Executive                  |
| Joanne Sharp    | NHS Ayrshire & Arran  |