

# **DELAYED DISCHARGE LEARNING AND SHARING EVENT**

**A conference attended by over 130 participants, representing local authorities and the NHS, with an interest in Delayed Hospital Discharge in Scotland.**

## **CONFERENCE REPORT**



**26 May 2009  
Macdonald Inchyra Grange Hotel, Polmont**

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## PROGRAMME

- 9:30 Coffee and registration
- 10:00 Introductions  
*Brian Slater, Delayed Discharge Manager, Scottish Government*
- 10:10 Keynote Speakers  
*Shona Robison MSP, Minister for Public Health and Sport*  
*Councillor Tim Brett, COSLA*
- 10:40 Open Discussion
- 11:00 Morning workshops
- 12:00 Lunch
- 1:00 Delayed Discharge – the financial cost  
*Simon Steer, Scottish Government*
- 1:25 Delayed Discharge – the human cost  
*Chris Bruce, Scottish Government*
- 1:45 Afternoon Workshops
- 2:45 Workshop summary
- 3:00 Launch of available tools – Joint Improvement Team  
*Douglas Hutchens, Anne Hendry, Jane Davidson*  
Admission, Transfer and Discharge Protocols: Best Practice Template (*JD*)  
Evaluation Framework (*DH*)  
Pathway Audit (*AH*)  
Self-Assessment Tool (*AH*)
- 3:15 Close – coffee available

## INTRODUCTION

### **Background**

The event was organized by the Scottish Government Delayed Discharge Branch to provide local authority and NHS practitioners with an opportunity to share knowledge and experiences in dealing with delayed hospital discharge in Scotland. It was timed to coincide with the publication of the latest census on delayed discharges in Scotland (April 2009) which showed that there were no patients delayed for longer than the agreed 6 weeks discharge planning period.

This was only the second time that a zero level had been recorded.

The Minister for Public Health and Sport attended the event. COSLA were represented by Councillor Tim Brett.

### **Objectives of the event**

The event provided an opportunity for professionals to discuss how to sustain the zero standard beyond April. The particular aims were to:

- ✚ Share experiences across Scotland about progress and challenges in tackling delayed discharge.
- ✚ Consider the steps that need to be taken to achieve the zero targets.
- ✚ Consider how current practices could be changed or adapted to meet future needs of Scotland's older people.
- ✚ Consider how services could be developed to reduce avoidable admissions and facilitate early hospital discharge.

Details of previous Learning and Sharing events can be found on the Delayed Discharge pages of the Scottish Governments website at:

<http://www.scotland.gov.uk/Topics/Health/care/17420/8473>

### **Opening**

Brian Slater opened the event by welcoming delegates. He said he was delighted that the Minister was able to attend, showing the priority that she gave to delayed discharge. He also thanked Councillor Brett for stepping in to speak having agreed at a late stage to replace Councillor McChord who was originally meant to represent COSLA.

Brian explained that the programme was based around workshops. Feedback from previous events had highlighted that the workshops were the most appreciated parts of the day. Today's workshop themes were based on previous suggestions.

## KEYNOTE SPEAKERS

The Minister for Public Health and Sport, Shona Robison MSP, said:

“Thank you for once again inviting me to be with you today.

This event was planned some time ago. It was deliberately timed to coincide with the publication of the April delayed discharge census. That was in the hope, and expectation, that the census would show a return to the zero position.

I am delighted that this is indeed the case. It gives me the opportunity to thank you all for the hard work that you have put in during the lead up to the census. But not just this census. I realise the huge effort that has been put in over the years.

I am pleased to be sharing a platform with COSLA at this event. I know there were some concerns when the delayed discharge funding was moved from health to local government. Repeating the zero achievement for a second year demonstrates that these concerns were unfounded.

When I entered the Scottish Parliament at its advent in 1999 we still referred to those patients delayed in hospital as “bed blockers”. An offensive and pejorative term that suggested it was the fault of the patient, denying a bed for someone else.

At that time, and for a number of years after, we counted delayed patients by the thousands. The average length of all delays was over 150 days, a quite staggering amount of time spent in hospital by people who should not have been there.

To get to the situation where they were counted in hundreds was a start. To record none this April, for the second year running, is a great achievement.

Importantly the average length of delay has reduced to 23 days. That is still too long in too many cases. I realise that in many situations the individual will need time to make life changing decisions. That is only right and reasonable. But there are other cases where someone may be able to return home, with a little help. We must focus on those patients and not leave them languishing in hospital.

All of us who have been involved in the care business, as I was before entering Parliament, will have seen how quickly somebody’s condition can deteriorate lying in a hospital bed. How quickly the hope can turn to dread and expectation turn to trepidation.

When I spoke at this event last November I acknowledged the tremendous achievement made by you all. This year I not only want to restate that

acknowledgement but, lest there be any doubt about the value and importance I attach to achieving this standard, offer you fulsome praise. You have done a tremendous job – I congratulate you as you should congratulate each other, because it is a partnership achievement. The credit for this achievement is entirely due to the tireless, hard working and particularly caring approach taken by staff on the ground.

But I make no apologies for suggesting that we can do more. If we all agree that patients should not languish in hospital for lengthy periods then we all have a duty to aspire to make that the reality. We have managed it twice now in April last year and again this year. We must move to a situation where that is the norm.

Can I also make it clear - this is not a party political issue. Tim Brett is from a different political party. But we share this platform today with a common theme. I have heard no opinion in either Parliament or in local government chambers across Scotland suggesting that leaving people in hospital after treatment is right or reasonable.

There may be different views about how we go about achieving our goal but at least it is a common goal.

There may be for instance a differing view on where the best place for on-going care should be. Should an assessment of need be carried out immediately and a patient moved to the community? Or might it be better to spend a little longer in a hospital setting to ensure every medical avenue is explored and exhausted before any final move takes place?

There is no single right or wrong choice. Each individual case should be a matter for professional judgement. What we have to do is make sure we have the right mix of professionals in order to make that judgement and make sure the decision is tailored to the individual concerned. We must take every opportunity for people to return to where they entered hospital from and not make blanket decisions on where, and how, we care for people.

I am sure the representatives here today from Scottish Care would wholeheartedly agree that the independent care home sector has to adapt to meet future care needs. We do not want to lose care home providers – they have a vital role to play. It is also important that providers are seen as partners in the delivery of care. Professional health input to care homes might prevent an older person coming in to hospital in the first instance.

We must also work together to help those care homes that are at the lower end of the Care Commission's grading system. It is in everyone's interests to make sure that each and every home is as good as it can be, to strive to a situation where the grading system will be irrelevant when it comes to choosing a care home because all will be of a high quality.

When I was at this event in November I alluded to the money available from the Joint Improvement Team to fund three intermediate care demonstrators. I

am pleased that some extra money was found and that five projects were able to be funded. I look forward to hearing more about these as they develop.

I am taken with the concept of intermediate care in tackling delayed discharge. I am not sure that the setting of care is as important as the type of care. Again, I would say to care home providers “you have play a role to play here”. You have the beds, the facilities, the capacity to provide this level of care that can move people out of hospital and help improve people’s chances of returning home. Likewise this can be used to prevent avoidable hospital admissions. Community Hospitals are similarly well placed to provide this level of care.

I am aware that tackling delayed discharge is not just about having no-one delayed over 6 weeks. It is certainly not just about having no-one delayed at April. Last year we successfully freed up every short-stay bed. Unfortunately, that has not been repeated. These are the most needed beds and the recent swine flu scare has shown why we must keep our acute beds available for emergencies. There were 33 short-stay delays at the April census. These should be avoidable, especially if we build up our intermediate care capacity, both within and outwith the NHS.

There are also an increasing number of patients outwith the zero standard due to the complexities of their needs. That is entirely reasonable but we must also work to reduce these delays, reduce the length of stay in hospital and tackle and challenge the complexities involved. The number of patients delayed under the Adults with Incapacity Act is another concern. I know that there is little you can personally do. Legal processes can take some time. But in these cases too there is both a financial cost to the NHS, with beds occupied for many months by people who may better be moved on, and in terms of human cost to those individuals who would be better placed elsewhere.

These are all issues that I look forward to discussing with local government and NHS colleagues so that we can jointly make sure that we are all getting the best value from the public pound. Remaining in hospital is not a cost effective option when the alternative options in the community are not just more appropriate but cheaper too.

Obviously funding can be a contentious issue, especially when it comes down to arguing about whose pound it is. But we must get away from the argument that it is my pound or your pound. It is the people’s pound so lets use it wisely.

Many of you will be aware of the Integrated Resource Framework, a mechanism for tracking and using resources to best effect across health and social care. I will shortly announce details, along with COSLA, of pilot schemes to test out the Integrated Resource Framework.

But it is the human cost that worries me more than the financial cost. Staying in hospital for longer than needed can lessen an individual’s life skill.

People's mental and physical condition can very quickly deteriorate when not in the right setting. And when someone's treatment is complete, hospitals are seldom the right setting.

That is why I also commend to you the work that is being developed on mutual care – a new approach designed to optimise people's independence.

I do not think we have ever been better placed to jointly deliver our shared agenda. I am privileged to chair the Ministerial Strategic Group on Health and Community Care. This is made up of elected Council members and NHS Board Chairs and supported by Government, COSLA and NHS officials. I see at every meeting the willingness and determination to meet the challenges that our future demographic trends will throw at us. This was further emphasised at a joint leadership summit last week, where I had the chance to discuss these challenges with key local authority and health board leaders. At that event we witnessed a common sense of purpose and commitment that drives us all in public life.

One area where there is already co-operation between the Government and COSLA is the Joint Improvement Team. The JIT has been working with an increasing number of partnerships in the last year. I know from speaking with Board Chairs and with Council leaders how helpful this collaboration has been.

The input from the JIT as a critical friend has been invaluable in many partnerships achieving this zero position at the April census. I would certainly encourage any partnership which does find itself in difficulties to invite the JIT to assist. It also makes sense that some of the tools that the JIT has developed in working with partnerships be made widely available with or without the JIT's involvement. More details of these will be announced later in the day.

Before I finish I would like to briefly mention the work that the Scottish Government and local government are jointly working on to take forward the recommendations from Lord Sutherland's Independent Funding Review of Free Personal and Nursing Care.

This year and next year we have committed to providing local authorities with an additional £40 million to ensure that free personal and nursing care continues to be delivered equitably and fairly across Scotland.

We are working in partnership with local government to take account of continuing demographic pressures and are looking at new approaches to long-term care, for example through preventative services, such as Telecare, to ensure that our care services are sustainable for the future.

We introduced new legislation from 1 April to clarify the policy on charging for food preparation so that there is now no longer any doubt that councils should not be charging clients for this service under the free personal care policy.

We have developed with COSLA a consistent eligibility framework to be operated by all councils for access to social care services and standard maximum waiting times for access to personal and nursing care services which will be applied across Scotland. We are in the process of consulting stakeholders on these proposals with a view to implementation on 1 December.

Taken together I believe that these measures will deliver improved outcomes for our older vulnerable people and their families.

I look forward to seeing the report from today's conference. I wrote to all partnerships at the end of last year saying that we had to jointly develop a sustainability plan to keep our progress on delayed discharge going. You need to be the architects of that plan. You are the experts. I hope you use the time today effectively. There is a range of interesting workshops and I look forward to hearing the outcomes.

Thank you."

Councillor Tim Brett spoke on behalf of COSLA, and said:

“I speak to you today as a member of COSLA’s Health and Well-being Executive Group and I’m very pleased to have the opportunity to offer COSLA’s view on one of the more challenging agendas within health and social care.

I also know from previous discussions with the Minister that she is really passionate about the issue of delayed discharge. She has encouraged debate at the Ministerial Strategy Group for Health and Social Care, which involves three other COSLA politicians and four health board chairs. The dialogue has been productive, highlighting the importance of partnership and developing constructive relationships.

In speaking to you today, I want to express two central messages. First, the successful delivery of delayed discharge must be taken forward as part of a much wider reform agenda, which has been hastened by the challenge of demographic change. Second, while we should be looking to eliminate delayed discharges from hospital, this has to be taken forward in the context of improving patient outcomes.

Let me turn first to the demographic challenge. The sheer weight of numbers that underpins future population change and the resultant pressures on public finance means that we will have to consider radical reform. The population aged over 85 will rise by 38% by 2016 and by a staggering 144% by 2031. What is more, there is strong evidence to suggest that a structural gap in public finance is opening up, which will reach 6.3% of national income by 2017/18. To put it another way, demand is projected to increase dramatically and our spending power is projected to reduce dramatically.

I mention this today because the delayed discharge policy gets to the heart of the reform agenda. However, I would venture that the big prize is not in the expeditious release of older people from hospital; it is in the prevention of those people entering hospital in the first place. In order to achieve this, we need to fundamentally re-shape health and social care, placing a stronger emphasis on prevention. This will doubtless impact on the current pathways into hospital care. We need alternative solutions. That is why I would like to see the care home sector diversify and provide more specialised services. We will need more rehabilitative care, more step up and step down care, more ‘out of hospital care’. We need better end of life care – too many people come to hospital at the end of their life to die, when another setting would be more appropriate. And, of course, we need much more care at home.

All of this raises political questions about how the reform agenda knits together. For example, how would the public feel about a reduction in the capacity of Accident and Emergency services in order to shift the balance of care? How will we create incentives for the social care market to respond to our new requirements? How much of our future health and social care can we afford to fund from public finance alone?

This type of debate needs to be extended beyond politicians and our officers. This type of debate needs to be cast beyond voluntary and private sector interests. This type of debate needs to be public, it needs to be frank and it needs to be now.

In debating the assumptions that lie beneath the policy drivers mentioned above, we should be working towards a coherent vision and strategy for the development of older people's care in Scotland. Unless we have that vision – and unless that vision is accompanied by political leadership – we will be constrained in optimising the outcomes of the people who use health and social care services across Scotland.

Having alluded to the broader demographic challenge let me now focus on delayed discharge. Delegates today will be very aware of the changes to the policy in recent years. Historically, the finances supporting delayed discharge were administered through NHS Boards. However, a decision was taken prior to the last spending review that the delayed discharge policy would work more effectively if the resources identified to support it were administered by local government rather than NHS Boards. The thinking was that councils more than NHS Boards are able to control the levers that facilitate release from hospital. To that end, a total of £29 million was built into the baseline local government settlement in order to progress the delayed discharge policy.

Some people feared that local government would spend this on roads or schools – which would have been our prerogative. But the new approach to delayed discharge has worked well and it shows that the transfer of resources can lead to improved performance for both the NHS and Local Government. We should feel pleased that partnerships have achieved the zero position again at the April census.

Along with the transfer of resources, a different political climate was established, and a new relationship developed between the Scottish Government and Scottish Local Government. We moved away from previous central government controls like ring-fencing and partnership performance targets, towards a more mature relationship based on the delivery of outcomes. At around the same time, the zero target previously identified within the NHS HEAT system was abolished and a 'standard' put in its place. In other words, it was expected that the norm would be to have no delayed discharges.

We all agree that this was an important development but it has also created new challenges. For example, we now have quite different accountabilities for health and local government. Delayed discharge has historically featured as a target within the HEAT structures for the NHS, and Scottish Government Ministers have given clear instruction to the NHS that the zero standard should be maintained. However, the relationship between the Scottish Government and local government is different – it is defined by the Concordat with COSLA and Single Outcome Agreements with each council. Most local authorities included the standard within their SOAs but its inclusion is not a

prerequisite. So we need to work creatively to ensure that the tension between HEAT and SOAs is managed through effective partnership working.

In delivering on this partnership agenda, it is clear that no council or health board wants to see an older person remain in hospital for longer than absolutely necessary. The evidence tells us that the best outcomes are achieved where an older person receives care in their own home; and it normally requires considerably less resource than acute sector provision. So expeditious release from hospital is important – but the driver must always be to maximise or improve outcomes. We need to be careful therefore that the zero standard does not result in perverse outcomes. For example, we should resist older people being inappropriately placed in care homes if it would be better for them to return to their own home – even if this takes a few extra days and even if this demits from our national targets. We need to be aware of the unintended consequence of manoeuvring older people around the social care system in order to achieve a political priority. Of course we should aspire to a zero standard, but only if this leads to better outcomes.

Let me put this another way: we need to protect the ability of partnerships to deploy a whole systems approach. We need to consider delayed discharge in the context of the rehabilitative support mechanisms that can be put in place following release from hospital. And – as I mentioned earlier - we need to consider the pathway into hospital in the first place. Some incidents and accidents certainly require hospital admission, but surely not all. Older people should be visiting hospital for life-changing interventions like hip replacements; not because there are no viable rehabilitative care alternatives.

With a growing number of older people, there will be increasing pressure on local government and the NHS to get this right. In order to do that, we need to reflect on the deployment of our mutual resources. We need to explore new initiatives like the Integrated Resource Framework, which promises to append public finance to the patient's journey; and we need to reflect on whether the financing of additional tasks for one part of the public sector may result in resource savings elsewhere – and if so how to make the compensating transfer of resources. This is especially important given the financial projections I touched on earlier.

Overall, we need to put the delayed discharge issue on a more stable footing, and ground it in the partnership approach between the Scottish Government and COSLA. No council wants to see older people remain in hospital unnecessarily and will of course do everything possible to work with NHS partners to facilitate a move to a more appropriate care setting. But all of this comes with a health warning - the delayed discharge policy is only as good as the outcomes it achieves.

Thank you.”

## QUESTIONS & ANSWERS

The Minister and Councillor Brett took questions from the floor.

Sheena Macdonald said that the constraints of the current GP contracts meant there were few opportunities for GPs to engage in wider issues such as delayed discharge, although idiosyncratic decisions effected delays – such as avoidable admissions. She asked whether the Scottish Government intended to look at GP contracts?

The Minister said that the wider agenda of promoting independence and keeping people in their own homes could not be achieved in isolation, without discussing the role of GPs. She meets regularly with the Royal College of GPs and had discussed recently how to develop models of care to support care home staff. She gave an example of end of life care being provided in hospitals because care home staff did not feel they had the necessary skills.

Frances Smith was interested to hear views on the role of community hospitals. She asked, with the Government strategy on community hospitals three years old, were there plans to review this?

The Minister responded that this would be looked at as part of a wider look at where and how care is provided. She added that community hospitals were well placed alongside a reformed care home sector to provide rehabilitation, step-up and step-down care.

Councillor Brett added that Fife had a good network of community hospitals that worked very well.

Jane Davidson said that there were many patients delayed right up to the end of the 6 week period (and sometimes beyond) awaiting funding. There were also many complex needs cases that were down to non-availability of public funding. She asked Councillor Brett if he thought that was reasonable?

Councillor Brett stated there was no quick fix for this and that there was a need to re-visit how delayed discharge money had historically been used to make sure partnerships still got best value. In his Council he would ask NHS Fife if that they had two whole wards filled with delayed discharges how joint resources could be better used.

The Minister added that the Integrated Resource Framework should assist in identifying finance issues and using the public pound better.

Margery Naylor commented on the joint multi-agency inspections of services to older people (MAISOP) that had been done by SWIA and NHS QIS in two health board areas, Tayside and Forth Valley, which included six councils. She said that there were clear practical examples in the reports that could benefit other partnerships. She asked if details of those reports could be promoted to encourage shared learning.

<http://www.swia.gov.uk/swia/576.212.html>

Councillor Brett said that we were sometimes not good at learning from others although Scotland was small enough to bring together the expertise such as was in the room at this event. He also praised the joint improvement team in sharing good practice.

Anne Hendry was encouraged by the Minister's reference to the review of older people's services but highlighted that the dependency of older people evolves from progression of a range of long term conditions that develop through middle life. She suggested that this review could be supported by the work of the national programme to improve the health and wellbeing for people with Long Term Conditions in Scotland.

The Minister agreed and said that it would be important for the review to work with the Long Term Conditions Collaborative and with Long Term Conditions Alliance Scotland. Enabling people to self-manage is important for promoting independent living as is early intervention through a proactive and anticipatory approach to care. It will be important to engage the over 50s in the debate on the future care of older people.

Rona Laing said that work must include informal carers and suggested that carers' issues be included in future events.

The Minister said it had been remiss that this was the first mention of carers all morning. They were true partners in the delivery of care but it was vital to listen to their views – we can't just say to carers "it is your responsibility". She added there had been some progress with respite care but more needed to be done.

Councillor Brett suggested that carers views could be sought as part of health questionnaires.

## PRESENTATIONS

### DELAYED DISCHARGE – THE FINANCIAL COST

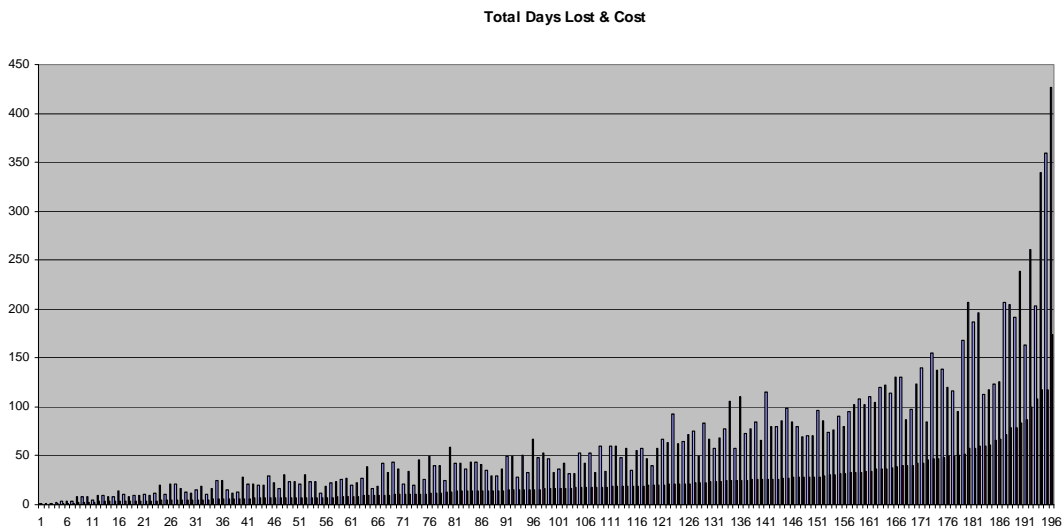
*Simon Steer (Scottish Government)*

In Scotland, NHS Boards and their Council partners are committed to various constructs for joint services which are generally referred to as “community care partnerships”. It could be argued that although the concept of partnership working is understood, and that operational staff generally work well together, these strategic partnership arrangements do not always have a complementary and cohesive approach to planning and investment.

Experience suggests they sometimes evidence unilateral decision making by one part of the health and social care system that has a direct impact on the ability of others to deliver the care required by individuals and their carers/families. As part of the broader discussion about resource realignment engendered by the development of the Integrated Resource Framework, we may wish to consider a more analytical approach towards the transactions that take place within the sphere of Partnership Working. Delayed Discharge appears to be an excellent place in which to start such an approach.

This session examines the actual use of resources by one NHS Board and Council to achieve an agreed target/standard for delayed discharge and asks the question, “**are local citizens getting the best value for money for their tax £s spent on delayed discharges in this area?**”

#### The Financial Cost Of Delayed Discharge



The slide above shows the number of bed days lost and the related site and speciality specific costs for one Scottish partnership. Unfortunately, this slide shows the inaccessibility of such data, and we therefore need to break this information into some more easily digested headlines; which are: 12,512 Bed Days lost ..... at a cost of £4.7m.....or the equivalent of 1.14 thirty bed wards.

To make further sense of these figures, we can examine some of the potentially contentious codes as in Table 1.

<b>Table 1: Cost of Selected Delays</b> (07/08 NHS Book Costs excluding labs & theatres inflated to provide 08/09 costs.)		
<b>Code</b>	<b>Bed Days</b>	<b>Cost £</b>
<i>11 A &amp; B Assessment</i>	2735	985,457
<i>23 Awaiting Public Funding for Care Home placement</i>	1856	658,780
<i>71 Choice</i>	1495	544,671
<i>24 Awaiting Placement Availability</i>	2709	1,004,999
<i>25D Awaiting completion of social care arrangements</i>	874	290,836
<i>25E &amp; F Awaiting Equipment/Adaptations or specialist housing</i>	960	318,749
<i>51X Delays due to incapacity</i>	7018	2,371,859
<i>71X Choice Exception</i>	1138	555,806

The table above raises questions regarding the best use of resource, let alone the impact on patient care.

The financial impact of the exempted “X” codes is particularly poignant, and a further consideration of national information allowed a focus on 93 patients out of a total 118 provided the following average costs.

- Psychiatry of Old Age 15 @ 125.6 days: £32k
- General Psychiatry 25 @ 250.8 days: £82k
- Geriatric Medicine 45 @ 120.4 days: £26k
- Learning Disability 8 @ 512 days: £348k

The above information, makes it clear that whilst the zero standard has again been achieved, the costs of inappropriate care in the system remain very significant. To this end, it is important to reflect on delayed discharge in both volume and cost terms, and to consider the agreements and drivers in place.

## **CONCLUSION**

Across Scotland, Partnerships have described their targets and the expected benefits and outcomes for people. We can be relatively confident that they would recognise the agreed generic priorities around supporting people to live as independently as possible at home, or as close to home as possible, for as long as possible. Nevertheless, the current approach of aligning budgets appears to be maintaining a significant level of cost shunting in the delayed discharge arena. Whilst the Scottish population may well be supportive of our aims, we have to ask, would they take the view that we are investing their collective local and national tax £s in the most efficient and effective manner, given that there is every reason to believe that the cost shunting behaviours described in this session will be replicated in many, if not all, Partnerships.

## DELAYED DISCHARGE – THE HUMAN COST

*Chris Bruce (Scottish Government)*

Chris explained about the outcomes approach to community care and the implications for delayed discharges with complex needs.

The outcomes approach put individuals at the heart of community care by:

- Using assessment care plans and review to focus on outcomes.
- Gathering data from individual interactions.
- Presenting outcome data to management.
- Investing to deliver personal outcomes.

He also explained what we meant, in terms of delayed discharge, by “complex needs”. Several years ago when the zero target was announced a new code, code 9, was introduced for patients with complex needs. These were cases where partnerships were unable, for reasons beyond their control, to secure a patient’s safe, timely and appropriate discharge from hospital. Prior to July 2006 such patients were recorded as delayed discharges. They were now still recorded but reported separately within the census.

He provided a breakdown of the codes and looked at how the numbers compared with the year before.

- In January 2009 there were 36 complex needs with no secondary code compared with 9 in 2008.
- There were 27 patients awaiting a specialist place availability when no such facility existed, compared with 24 in 2008.
- 5 of these 27 had been delayed for more than a year.

Chris went on to provide details of the first continuing care bed census. This counted the number of patients receiving NHS continuing care under the terms of national guidance (category A). It also counted patients who did not meet the continuing care criteria but who had been in a hospital for more than a year.

Overall, the census collected data on 3,225 patients. 2,715 (84%) were reported in category A and 510 (16%) in category B. The majority of category B patients (72%) were aged under 65. 45% were in general psychiatry.

In summary Chris said that 63 patients were reported as delayed in hospital but excluded from the standard because we couldn’t find alternative settings. At the same time, 510 people had been in hospital for more than a year but still receiving appropriate treatment or rehabilitation.

Chris then explained the outcomes approach to community care.

## Outcomes important to service users

### Quality of Life

- Feeling safe
- Having things to do
- Seeing people
- As well as can be
- Life as want (including where you live)

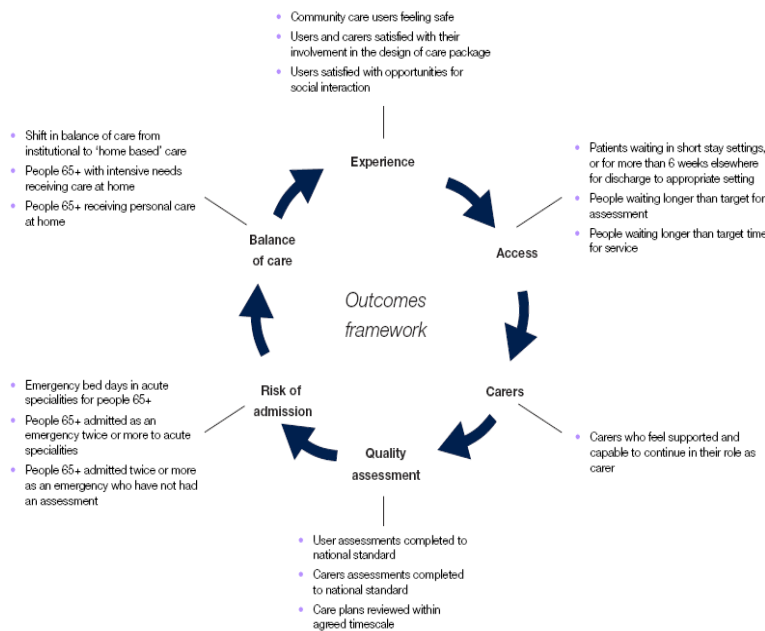
### Process

- Listened to
- Having a say
- Respect
- Responded to Reliability

### Change

- Improved confidence
- Improved skills
- Improved mobility
- Reduced symptoms

Delayed discharge is one of the 16 measures in the Community Care Outcomes Framework. As one of the three access measures it needs to be seen in the round with other themes.



The Community Care Outcomes Framework was developed over 18 months through active work with 7 Early Implementer Partnerships and a variety of other stakeholders, answering calls from local partnerships who wanted to see an outcome-focussed approach to monitoring joint performance in community care. Definitions were tested and refined and 13 were published in December 2008. The use of the Framework is on a voluntary basis through local partnerships, with no new national reporting.

Chris praised the great achievements made in reducing delayed discharges, which had made a real impact on individual's lives. He argued that the exclusion of complex needs patients had removed a lever from clinicians and staff trying to move people on. Emphasising that it was a purely personal view, he suggested bringing such cases back in to the main part of the delayed discharge census.

He recommended agreeing what a reasonable length of delay was for complex needs cases and then setting a target to reduce delays over that period to zero by April 2011. This would also mean reviewing the 510 category B patients from the continuing care census.

Bringing his presentation to a conclusion, Chris said that what was required would involve:

- Outcome focussed work with each delayed individual and their family/carers.
- A local partnership commitment to deliver.
- A local, funded plan with milestones and timescales.
- Fit with broader local plans for investment/commissioning.

Chris was sure that the issue would continue to enjoy a high political profile and that with everyone's best efforts, the achievements on delayed discharge could be replicated for the complex needs cases.

- **Morning workshops**

## **ROLE OF HOUSING IN DISCHARGE PLANNING**

*Amanda Britain (JIT)/Isla Bisset (Scottish Government)*

This workshop considered how housing agencies could be more involved in discharge planning to do away with lengthy delays for re-housing in specialist housing provision or awaiting adaptations to existing housing. It also considered the potential for telecare to help tackle delayed discharge.

The following points were made during the discussion

- A major constraint was the lack of supply of suitable housing to which people could be discharged: this referred both to specialist housing (such as in relation to housing with care) but also to alternative mainstream housing of the right size and type for the person concerned (such as ground floor, level access housing). Current priorities for housing investment
- Housing allocations were complicated and made the process of finding a suitable house in the social rented sector (council and RSL) more difficult and more time consuming, with a separate application having to be made to each housing organisation in most areas of the country. 'Medical priority' took time to be awarded and the process was not clear or transparent to partners in health and social care. In some areas, a common application form had been introduced with the information share amongst social housing providers and this significantly reduced the complications.
- It was noted that those in hospital who could not be discharged to their existing home because it was no longer suitable would probably be considered to be homeless and get priority for a social rented property. This was not common knowledge amongst health and social care partners.
- It was generally agreed that improvements were needed and could be made in relation to housing adaptations
  - There were sometimes difficulties in the relationship between the hospital based OT service and the community OTs
  - Lack of funding for adaptations generally caused delays and difficulties
  - Some of the difficulties related to the number of services which had to be involved (not just housing, health and social care): some of the delays related to getting building warrant or planning permission, but these services were rarely included in discharge planning.
- Those attending the workshop mostly had a positive working relationship with their partners in housing, and noted that this had improved over recent years.

- Telecare and telehealth were both considered to have a role to play in avoiding the need for hospital admission and in supporting hospital discharge (such as by providing reassurance to informal carers). But it had to be accompanied by a good response service.
- Step up/step down provision (intermediate care) could also have a role to play in assisting discharge where a delay in getting a major adaptation completed or in finding a suitable alternative house was unavoidable. While not ideal (discharging straight home being better) this would be preferred by most people to having to remain in hospital.

## **HEALTH/LOCAL GOVERNMENT – ARRANGEMENTS SINCE THE CONCORDAT**

*Ron Culley (COSLA)/Chris Bruce (Scottish Government)*

Ron Culley and Chris Bruce introduced the workshop by explaining the Concordat arrangements, which had ensured that councils received more generous funding and more control over the way they could deliver services, in return for agreeing to hold steady their council tax. These agreements had been set out in Single Outcome Agreements (SOA). They then asked the workshop participants to discuss the question ‘what difference had the Concordat made at the local level?’

### **At the local level**

The participants painted a mixed picture. Some thought that there were signs that better relationships were developing at the local level and there was more joint discussion since the Concordat. One person said that there was a better understanding of financial realities because of working together in their CHCP.

Some thought that there was a greater emphasis on preventative work, largely because of the shared recognition of the demographic pressures, especially for older people. In Fife some funding had been devolved to the local level and this had led to real innovation in developing more flexible care services at home rather than using care homes.

Most thought that there was a much greater emphasis on better outcomes for people who use services and that this was underpinned and driven by the work of the Scottish Government on outcomes in the SOAs and the National Outcomes Framework for Community Care. Chris Bruce explained the way that the work relating to the Framework was being progressed across Scotland.

Many described the tensions around joint working in relation to delayed discharges. Some said that there had not been much difference at the local level but there had been much more discussion at a strategic and senior manager level. Many agreed that politicians needed to be more realistic with the public about what services could be provided in view of the credit crunch, both in relation to local constituents and nationally. Other tensions included:

- The complexity of joint arrangements and structures which made decision making protracted
- The focus on simplistic targets eg the zero standard for delayed discharges which could distort decision making and care arrangements
- The strength of the acute sector, the way it tends to drive the system and attract resources
- The mutual suspicion between health and social work eg health services feeling that councils had benefited from the transfer of delayed discharge funding to councils through the Concordat

- Partnership fatigue – ‘we have seen it all before and it never gets any better.’
- The difficulty of several small councils having to relate to one large NHS Board
- The complexity of trying to manage health HEAT targets and council SOA targets when they were not the same
- The limitations about what could be achieved because so much of the funding is already tied up in services
- The unintended consequences that can arise from slavishly following targets.

However, the discussion was energetic and overall people felt that things were getting better, albeit slowly.

Participants agreed that one helpful approach is to focus on whole system reporting, so that the performance of a partnership in relation to delays in discharge from hospital is seen in the context of its performance in improving other important outcomes for local people. The Community Care Outcomes Framework offers one methodology for doing this.

## INFORMATION SERVICES

*Peter Knight (Scottish Government)/Douglas Hutchens (JIT)/Anne Stott (ISD)*

Delayed Discharge Definitions and Data Recording Manual is comprehensive and welcomed but is relatively inaccessible for practitioners on the ground.

- Develop an accessible version that supports discharge planning on the ground by highlighting common codes and helping staff understand reasons for delay and solutions. Jenny Mackenzie has developed such a document for Lothian. She agreed to share with Douglas and progress this through EDISON user group.
- Consistency of coding was highlighted as a major issue. A training workshop should be held for each partnership on the application of codings.
- Historic codes no longer used should be removed from the guidance.

Complex care – difficult to envisage additional secondary codes that would catch all circumstances. Need to keep free text narrative.

- Request more stretching evidence of what is happening to escalate and resolve by next quarterly census in section headed 'what is happening'. Scottish Government to follow up on cases where the delay crosses two quarterly census returns and ISD feedback information on this.

People who were previously in receipt of NHS continuing care who have now improved to a level where their needs can be met in community. Not realistic to apply 6 weeks standard to their discharge. Concern that they would not be best coded as a code 9.

- Concept of resettlement could be introduced for this cohort as an additional section in 2.6 of the Manual. Capture information locally but not routinely part of national reporting. Information could be accessed for occasional sampling census linked to look at trends over time.
- EDISON can support local performance management of these individuals through a locally agreed code. Partnership sets estimated date of discharge on a case for case basis in the context of the complexity of the individuals needs and the commissioning package. Only exception reporting centrally where the partnership agreed Estimated Date of Discharge has not been met.

Bed days lost – welcomed as feed back with caveat that the under 6 weeks is a dynamic group whose status and coding changes frequently. Validity will depend on QA of data – more challenging to verify the under 6 weeks delays. Having said that would be good to feed back the bed days lost in short stay specialty settings and bed days lost here waiting to return home.

Data Recording Manual – is there potential to incorporate into the EDISON system?

**Action: ISD and the Scottish Government will issue a slightly amended Data Recording Manual in time for the July census. Taking account of the wider issues highlighted at the workshop the manual will be further reviewed and discussed to be finalised in time for the January 2010 census.**

## **INTERACTION WITH CARE HOME PROVIDERS**

*Ian MacMaster (Scottish Care)/Derek Grant (NHS Grampian)*

The discussion ranged across a variety of topics and highlighted significant variations across the system nationally. Specific areas for discussion included:

Patient ready for discharge, care home not ready to accept.

- In the main planned discharge from hospital seemed to work reasonably well but there were a number of examples given where there had been unhelpful positions taken or communication had not been effective.
- In one example a discharge had been planned and moved on to implementation. The patient was returned to hospital by the care home because funding was not in place. Other examples were given where placements had proceeded on that basis.
- However with some authorities placing a limit on the number of placements they can fund this can build in delays which cannot be resolved by care homes. In one area care homes will not proceed to visit and engage with the service user until funding is confirmed but this did not seem to be the position nationally.
- The point was also made that effective discharge arrangements can be jeopardised by poor information e.g. no care plan available to care home. In all cases where Free Personal Care/nursing care is being assessed a Single Shared Assessment is provided for a care home by social work. This forms the basis for the home to create an individual Care Plan. This may possibly refer to lack of information on discharge proforma such as MRSA or CDiff being omitted from the form, or diseases which patient/resident is suffering.
- Other issues raised included the increasing use of interim placements in one area and the impression gained that for some care homes self funders were more attractive and so were often placed more quickly than those whose funding would have a local authority element. In one area there is intermediate care provision provided by the NHS and it was thought that this could be a valuable service opportunity for care homes if staff had the relevant skills and training. It was noted that this was a model which could be rolled out as it saves on the cost of hospital bed.

### Communication

- Local authorities create provider forums, some better attended and more open and receptive to contribution than others. Shared training may indeed offer a way forward. Some local authorities and local care home providers meet regularly to discuss/review issues of mutual concern. Some CHPs do provide advice/guidance/geriatricians to care home.
- Some partnerships actively engage with care homes to attempt to identify and address communication issues through one to one engagement while others have developed provider forums. It would

appear there is significant variation in levels of engagement between partnerships and care homes and this was identified as an area that would benefit from further attention. Shared training was identified as one way of developing closer relationships and a better understanding of respective roles and challenges.

Should Care Home Providers be part of the multi-disciplinary team?

- Currently discussion and effective communication regarding resources is limited or non-existent, and shared engagement in professional agendas is variable. There needs to be greater engagement by care home providers in discharge planning and other policy development and partnerships need to find more effective ways of achieving this, a unanimous feeling amongst the group. Providers being part of the 'Resource allocation panels' may be a step forward. Providers are aware of limitations on budgets but transparency of allocation of budgets may work in favour of all stakeholders.

The potential for geriatricians to provide support and engage with care homes to a greater extent.

- While there was general agreement that greater opportunity to engage with geriatricians could be helpful to care homes it was also clear that there was an appreciation of the potential value of engagement with the wider health care team. There was also a view that lack of capacity in the system would make it difficult to significantly extend the geriatricians role. It was acknowledged that care homes did not always receive the right level of support and the position is obviously variable across the country. However one area has invested in a health support team which does engage with care homes and has achieved a positive impact and improved outcomes for service users.
- The enhanced GP contract was also identified as a useful vehicle for improved service to residents of care homes bringing a more direct and consistent service to residents. It was also confirmed that this did not exclude the potential for service users to maintain their relationship with their existing GP following admission to a care home.
- Overall a view that greater engagement with health professionals could provide valuable support to care home staff and better outcomes for residents and this is done in a variety of ways across the country.

Equipment for care homes

- Agreement that there is a need to find a solution to the problem where the provision of equipment is leading to delays in discharge. Some discussion about the potential short term loan of equipment to care homes to facilitate early discharge. At the present time it seems that some local authorities will not maintain equipment placed in care homes and this may be a barrier to this kind of initiative.

- Examples were given where providers had met the cost of expensive and specialist equipment while others spoke of local authorities being “held to ransom”. On that basis it is not possible to generalise.

**Action: An Equipment Protocol Working Group has been established by the Scottish Government and this may provide valuable input and guidance in this area.**

## **MANAGING PATHWAYS THROUGH THE ACUTE SECTOR**

*Dr Emma Reynish (NHS Fife)/Simon Steer (Scottish Government)*

Emma Reynish introduced the workshop by describing the way that people enter the acute system.

The pathway commended via a “front door” from home or care home and not via A&E but direct to wards. Following this, at the point of medical fitness, the discharge planning process commenced.

The pathway is not fixed but needs to reflect social circumstances, social care and families, including carers’ issues.

Questions raised included “is this all about identifying a bed and is A&E the real front door?”. “Are these admissions or are they people who need assessment?”. “Do we lack imagination and what is on the shelf”? There is an inconsistency about availability.

So we need to move from a medical, linear, pathway to a holistic, multi-disciplinary pathway that is much more flexible and responsive. Examples were given of rapid holistic assessment using anticipatory care methodologies but signposting of services remains medically led. There is also a large difference between risk taking and social work and medical professionals around patients lifestyles, eg home hygiene. For a range of reasons make “boarding” patients areal problem.

- . Information and cooperation is lost within moves
- . Moves are very bad for patient outcomes
- . patients who are boarding also end up being at the bottom of priorities

The medical model also tends to reinforce that the patient cannot be looked after at home.

Emma confirmed that in Fife all “front door” over 65 assessments will be both a medical assessment and a geriatric assessment.

The group was asked what improvements could be made.

- Don't board
- Reduce duplication of assessment and recording
- Increase professional and social acceptance of risk
- Clearer expectations for patients about how/when to go home.
- Reduce criteria led services
- More anticipatory action
- Improve channels of communication
- Challenge articulate relatives and carers
- Robust alternatives to admissions
- Clinically – not medically – fit for discharge
- Focus on discharge dates – EDD

- Support for carers
- Training for staff
- Include social work
- It needs a cultural shift
- Supported discharge teams

## **ADMISSION, TRANSFER AND DISCHARGE PROTOCOLS**

*Jane Davidson (JIT)/Dr Sheena MacDonald (NHS Borders)*

A draft 'best practice template' was distributed. This had been prepared by a short-life working group (SLWG) and was based on evidence collected from existing protocols across Scotland.

Following a lengthy and productive discussion various changes and additions were suggested. These have been incorporated in a final version agreed by the SLWG.

The final template is available on [www.....](#)

## Afternoon workshops

### **COMMUNICATIONS WITH PATIENTS/FAMILIES/CARERS**

*Derek Grant (NHS Grampian)/Ruby Rawcliffe (JIT)*

The group was invited to discuss how partnerships can manage and help families to make choices.

- Everyone in the partnership who is involved in the discharge process, should know that process. Nurses, ward managers, doctors, care managers. It should be clear to relatives who they should be speaking to – named nurse, care manager. How to contact them
- Good effective communication, both **written** and **verbal** is crucial from early in the admission
- There should be proper accommodation for private conversations. The time to have the conversation should be seen as important, and the time should be protected
- Interruptions should not be allowed
- Should standardise the process as much as is possible
- Sometimes decisions are made before the assessment is done. Wrong.
- Have nursing or social work staff ever visited a care home? It would aid decisions with relatives
- Care home vacancies placed on computer systems of social work/hospitals
- Mental health placements are difficult, start early
- The early message should be that staying in hospital is not a good choice
- Getting ‘letters’ around choice issues sent out at the correct time is very important
- Hospital based social work best placed to promote choice
- Spread the concept of ‘choice issues’ through the use of focus groups and external agencies
- In some areas primary care have strong contacts into hospitals
- Interim placements can cause difficulties with funding issues

The group was invited to suggest how best families can be informed of the dangers of remaining in hospital.

- Real difficulties in getting families informed of the dangers of elderly patients remaining in hospitals
- Many concerns about responsibilities over infections ie hospital, individual staff?
- Families often see hospital as a comfortable place. 24 hour care, no financial costs, and no perceived guilt on their part with regard to friends/relatives
- Scottish Government need to give a clearer message around not needing to stay in hospitals
- We need to get better at meaning what we say
- Focus on quality of life in care homes, as opposed to negative aspects of hospital
- Too much variance in standards of care homes. Care Commission ‘sit on the fence’

The group was invited to discuss how this works in reality and make suggestions for improvements.

- Flowcharts/guidelines work if you buy into them

- Sometimes a care home placement can meet previously unmet need
- Use of advocacy patchy - some ex-service users have personal agendas
- Our information around protocols must be sound
- No criteria/guidelines can cover all eventualities – and that very often is the cause of the delays
- Relatives often only see their need, not the bigger picture

## **REDUCING CODE 9s**

*Jane Davidson (JIT)/Chris Bruce (Scottish Government)*

The number of “Complex Cases” being declared by partnerships in the Delayed Discharge census is increasing, although there is no increase in the overall number of patients going through hospitals.

Participants suggested that there is a lack of performance management around complex cases – from before admission onwards through to discharge planning. It is far too easy to come up with a reason to exclude someone, when best practice would suggest that everyone should have an estimated date of discharge agreed within 48 hours of admission, and everyone should work together to facilitate this from that point onwards. There is lots of money tied up in this – we fill available beds, rather than closing them and releasing funds for community services.

The group discussed the appropriateness of regional services for particular needs, and agreed that there is a political will needed to move people a long way from home.

After some candid discussion in the group, it emerged that it may be interesting to track whether all patients coded 9 with no secondary code at the April census are still code 9 in July? This would demonstrate whether partnerships still have a perception of an annual target rather than a standard at all times.

After a range of discussion about the particular excluded codes, it was suggested that Scottish Government should set up and support a short life working group – “Managing Complex Care”. This group would maintain a focus on outcomes for individual patients, and the aim would be to hold one (or more) meeting of the group per exception code, working to a timeframe of 2011 by which time exclusions would have been brought to an absolute minimum, eliminating codes wherever possible. (The introduction of new exception codes was discussed but not supported by the broader group.)

The Managing Complex Care Group would perhaps work best as a core group plus co-opted experts. It needs to include providers as well as councils and NHS bodies. The group could set standard(s) for particular codes.

Suggestions that were made about each of the exclusion codes were as follows:

### Code 51X

Private applications are outwith the direct control of local community care partnerships – hence this is a national issue and the Scottish Government should consider whether it needs to re-visit the wording of the Adults with Incapacity Act.

However in many cases more focussed action could be taken to reduce the length of delays coded 51X – should we set percentage reductions over time e.g. 20% reduction by January 2010

The Group might produce of a Resource Pack for navigating Adults with Incapacity territory, setting out processes and timescales, and promoting Anticipatory Care Planning. This should involve the Multi-Disciplinary Team as early as possible. It would also help to promote appropriate use of Power of Attorney to avoid the need for Guardianship applications.

### Code 71X

Fife have developed process maps for Choice – these might usefully be replicated for use in other partnerships. There is evidence that patients, and consultants, may benefit from better advice about choosing a care home.

People delayed for choice reasons are not all the same – so it may be inappropriate to set a blanket target for maximum length of delay, how about setting an individual date and then measure whether this is delivered?

### Code 9

Complex codes are not all the same – so it may be inappropriate to set a blanket national target for a maximum delay, how about agreeing an individual date for each patient and then measure whether this is delivered?

The Managing Complex Care Group might also introduce a Standard Reporting Form for Code 9, which starts with the agreed outcome(s) for the patient. If local partnerships set individual discharge dates – these could be recorded and the agreed plan to achieve this date could then be regularly updated in the supporting text. We might need new guidance re text supporting code 9 declarations. There may also be chance to use the submitted narrative better – could ISD monitor it? Is there a more appropriate monitoring body?

Tayside's "SDG codes" (Service Development Group) allow the partnership to use EDISON to monitor people not officially delayed as plans are developed for the individual patients. That may be of interest to other partnerships.

### Continuing Health Care Category B

The Managing Complex Care Group may also wish to consider actions in relation to patients falling into this category – those in hospital for more than a year but not meeting the Continuing Health Care criteria.

The workshop group heard about Cornhill Hospital, where they brought the Multi-Disciplinary Team to bear on those who may soon be ready for discharge, developed individual plans, and then declared people ready for

delay at conclusion of this process. (Another option is to use a reprovision code.) Again, this process can be recorded on Edison.

Jane and Chris thanked the participants and promised to take back all of the action points.

**Action: Scottish Government to consider setting up a short-life Managing Complex Care Group, as per the notes above.**

**Action: It would be useful to map current availability and arrangements for specialist regional services via the Managed Care Networks.**

## **GP ISSUES**

*Dr Sheena MacDonald (NHS Borders)/Douglas Hutchens (JIT)*

- Would be useful to give GPs “patterns of referral” information
- There needs to be an honesty around the end of life discussion with relatives and patients rather than just admitting to hospital
- As hospital is perceived as a “safe place” there is public pressure on GPs to admit – there needs to be education for public based on evidenced research
- One area of good practice is community care assistants who support the GP community team and are clearly understood by the public
- Digital stories set up by telecare programme is a useful method of public education
- There needs to be a strengthening of primary care leadership in the partnership
- There needs to be a greater understanding and sharing of risk between GPs, secondary care and other primary care/social care teams
- Enhanced use of community care teams to support, using psycho-social model – this should not be a 9-5 Monday to Friday service
- Why patients are admitted – there is confidence in local teams but this local confidence is not shared in the out of hours team, although they have the appropriate knowledge and skills
- There is a conflict with the GPs contract, which is not designed to support whole patient journey and does not have “creative time” with patients
- Alternatives include development of shared risk between primary and secondary care and joint education, including protocol development
- Work needs to be commissioned to understand the issues which would allow alternatives to be developed
- Palliative care needs to be developed to allow more to be provided in the community supported by the community team
- It should be recognised that no one size fits all
- A constructive use of community hospitals would help clinical assessments, involving GPs and so would allow patients to be cared for at home more readily
- Involve GPs in research – capture GPs views, why do GPs make the decisions they do
- Involve GPs in enhanced services of care homes to allow this to be mainstreamed, with GPs remuneration being led nationally to allow this to happen

## **NHS CONTINUING HEALTH CARE**

*Brian Slater (Scottish Government) Dr Anne Hendry (NHS Lanarkshire)*

Need for awareness raising among clinicians, practitioners and managers working with the key care groups and leading on Delayed discharge.

Need to identify ways to embed its use into local systems so this it is not burdensome and its use can support prospective data on incidence of new NHS continuing care and also on shifts in balance of 24 hour care from hospital to care homes / care at home.

Used at entry to NHS continuing care but also when multi-agency group agrees that person needs to progress to long term institutional care. That will help avoid new entrants to 24 hour care slipping thro the net for specialist led MDT assessment and rehab.

Training should be the remit of professional groups – as form is signed by consultants / GpsWI the training rests with deanery / college groups / specialist professional societies.

Regional events would be good way of taking forward awareness raising and having local systems identify what they need to do for local implementation. Might also be useful to combine this with an event on the continuing care census and to explore the Category B group and ways forward.

Communities of interest can be accessed through

- Medical Directors
- Directors of Nursing
- AHP leads and Rehab Coordinators
- ADSW
- BGS Scotland
- Royal College of Psychiatry – Old age subgroup
- Mental Health Delivery group
- LD
- Rehab consultants
- Royal College of GPs – perhaps the subgroup on Care Home medicine?

**Action: ISD and the Scottish Government will run a seminar in September for NHS officials charged with collecting data for the NHS Continuing Health Care bed census. Local authority colleagues will be invited.**

**Action: The Scottish Government will run regional awareness sessions for health and social care professionals involved in the decision making process around eligibility for NHS Continuing Health Care. This will include further explanation of the Assessment Summary.**

## **NEW APPROACH TO JOINT WORKING**

*Alison Taylor (Scottish Government)/Ron Culley (COSLA)*

The group was asked “why haven't we made more progress on this already?”.

- We've been focusing on quick fixes rather than an overview for the longer term.
- The infrastructure imposes lots of little spending pots that militate against joint working.
- We don't focus on the individual, but rather on services.
- Managing integrated service structures - hindered by different budget streams and cultures across health and social care.
- The world would look better if health operated more like local government, with less focus on centrally imposed targets.

It was suggested that we need to tackle the myth of ever expanding provision of free health care. Expectations are too high - people expect someone else to fix their problems rather than looking after them themselves. We need a discussion about how people use the wealth they've accrued to look after themselves in old age - and it would help if there were more transparency around the costs of care now.

One integrated service across health and social care would help - but would it actually save money? Even if full integration isn't possible, more transactable resource would help.

There is currently no financial incentive to get people out of hospital and into the community - from the local government perspective.

We need to find creative ways of enabling carers to care - example given of scheme in Italy where money for caring is paid to the carers' employers, allowing them to be released to care for relatives while their positions are back-filled on a part time basis.

## **FOLLOWING THE MONEY**

*Simon Steer (Scottish Government)/Peter Knight (Scottish Government)*

The workshop explored the themes of the presentation in greater detail, with the bulk of discussion centring around the technicalities of developing unit costs and the methodologies used to establish the cost base.

Key points were:

- Agreement that occupied bed days, rather than snapshot census information, are more useful measures of both patient experience (how long are they in the wrong place) and the resource cost to the system.
- This monitoring and analysis requires to be applied the “X” codes...because they are still in beds.
- There is a need to develop a far better understanding of cost in Local Authorities, and to this end there was complete support for the development of national guideline/benchmark social care costs.
- To understand the true (resource) impact of delayed discharge, reporting at a local level requires to convey activity, cost and variation.
- To this end, the Integrated Resource Framework was seen as offering a complementary methodology.

## **CONCLUSION**

Winding up the event, Brian promised that a full report would be made available to delegates.

He also announced various tools which would be made available on the Joint Improvement Team website <http://www.jitscotland.org.uk/action-areas/delayed-discharge/>. These were:

### **Outcome Based Evaluation Framework**

This had been developed on the back of requests from partnerships that the JIT was involved with which were looking to evaluate existing initiatives. This was becoming more important following the transfer of finances to local authorities as partners would want to ensure they were getting full value for money.

### **Pathway Review**

This had been designed to investigate the patients pathway and was used as a retrospective tool after discharge had occurred. The idea was to learn from these and put corrective measures in place.

### **Self-Assessment Tool**

This had been used at one recent partnership who had found it an 'eye-opener'. Partnership officials scored themselves against a number of questions to highlight where gaps existed.

Brian added that the report itself and the final 'Admission, Transfer and Discharge Protocols: Best Practice Template' would be made available on the Scottish Government website, as well as, for ease of finding everything together, on the JIT site.

The protocols can be found at:

<http://www.scotland.gov.uk/Topics/Health/care/17420/Protocols>

He thanked everyone for coming and wished them a safe journey home.

## DELEGATE LIST

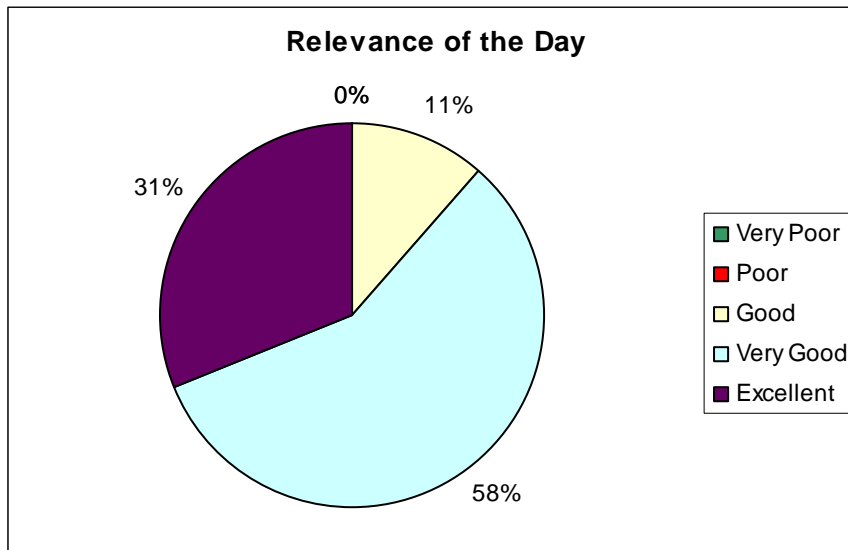
Abbott	Fiona	NHS Tayside
Anderson	Gina	Falkirk Council
Anderson	Karen	NHS Tayside
Barnes	Ronnie	West Lothian Council
Beattie	Valerie	Stirling Council
Billings	Barbara	Inverclyde Council
Bisset	Isla	Scottish Government
Boag	Marie	South East CHCP
Bonar	Annette	East Renfrewshire CHCP
Britain	Amanda	JIT
Brown	Andrew	North Ayrshire Council
Bruce	Chris	Scottish Government
Bryce	Katie	Edinburgh Council
Burke	Winnie	Renfrewshire Council
Carstairs	Lynne	Clackmannanshire Council
Cassidy	James	NHS Forth Valley
Cavers	Shona	Scottish Borders Council
Christie	Carol	
Clipston	Elaine	NHS Borders
Cook	Katie	Fife Council
Cooper	Linda	East Renfrewshire Council
Cowan	Grace	South West CHCP
Craig	Linda	NHS Forth Valley
Culley	Ron	COSLA
Currie	Maire	NHS Ayrshire and Arran
Cushley	Kenny	NHS Lanarkshire
Dall	David	Fife Council
Davidson	Shirley	City of Edinburgh Council
Davidson	Jane	JIT
Dean	Anne	East Renfrewshire CHCP
Dickson	Linda	East Renfrewshire CHCP
Dodds	Jennifer	Falkirk Council
Donald	Doreen	Angus CHP
Donnelly	Joe	NHS Tayside
Dorricott	Iain	NHS Tayside
Dougall	Gillian	West Lothian Council
Dryburgh	Jackie	South West CHCP
Duncan	Moira	Fife Council
Durham	Diane	Scottish Borders Council
Edgar	Gail	NHS Dumfries and Galloway
Edwards	Paul	NHS Lothian
Farrell	Marie	NHS Greater Glasgow & Clyde
Farrer	Keith	NHS Grampian
Ferguson	Christine	Shetland Islands Council
Forsyth	Gordon	Scottish Borders Council
Francey	Mary	North Ayrshire Council
Giallie	Deirdre	NHS Forth Valley
Gibson	Judy	JIT
Grant	Derek	NHS Grampian
Gray	Angela	NHS Lanarkshire
Gray	Gordon	NHS Lothian

Grogan	Anna	NHS Forth Valley
Groves	Gail	NHS Grampian
Heaney	David	NHS Lothian
Hendry	Anne	JIT
Hutchens	Douglas	JIT
Hutchison	Ann	Dundee City
Jardine	Dot	NHS Greater Glasgow & Clyde
Johnston	Colin	Perth and Kinross Council
Jones	Tracy	East Renfrewshire Council
Kennedy	Linda	Angus CHP
Knight	Peter	Scottish Government
Lawson	Joan	Borders Voluntary Community Care Forum
Lefvre	Astrid	Highland Council
Liddle	Carole	City of Edinburgh Council
MacDonald	Sheena	NHS Borders
Mackay	Alison	NHS Highland
Mackenzie	Dave	Dundee City Council
MacKenzie	Jenny	NHS Lothian
MacKenzie	Colin	NHS Grampian
MacLean	Catriona	NHS Lothian
MacMaster	Ian	Scottish Care
Madden	Gwen	East Renfrewshire Council
Madden	Georgie	NHS Lanarkshire
Malone	Karen	NHS Lanarkshire
Marshall	Carolyn	Aberdeenshire Council
Martin	Andy	East Dunbartonshire Council
Martin	Peter	ISD
Matthew	Cameron	NHS Grampian
McClune	Martyn	NHS
McCready	Gillian	Inverclyde Council
McGinley	Patricia	NHS GGC
McGowan	Sylvia	City of Edinburgh Council
Mclver	Jane	NHS Borders
Mitchell	Morag	NHS Grampian
Mitchell	Fraser	Fife Council
Moore	David	Stirling Council
Morley	Helen	Renfrewshire Council
Muir	Sue	Perth and Kinross CHP
Munro	Janet	Perth and Kinross Council
Naylor	Margery	JIT
Nixon	Sarah	NHS Lothian
Oakley	Crispin	Perth and Kinross
Oswald	Peter	NHS Tayside
Petrie	Pam	
Phillips	Amy	Scottish Government
Powell	Ian	NHS Grampian
Quinn	Catharine	NHS Lothian
Quinn	Maggie	South East CHCP
Rawcliffe	Ruby	JIT
Reid	Sandy	Aberdeen City Council
Reid	John	West Lothian Council
Reynish	Emma	NHS Fife
Robertson	Gail	NHS Dumfries and Galloway
Robertson	Amanda	

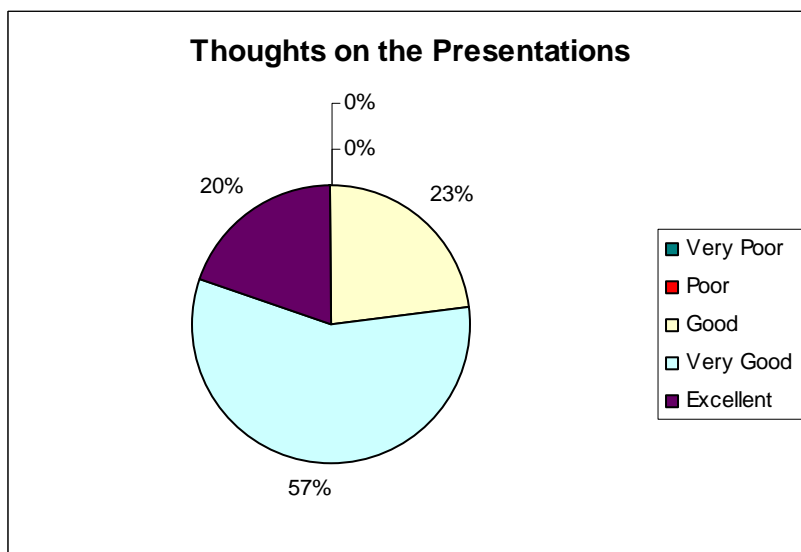
Robinson	Neal	Fife Council
Rose	Sue	City of Edinburgh Council
Sheridan	Lorraine	Ayrshire and Arran
Sinclair	Anne	NHS Ayrshire and Arran
Slater	Brian	Scottish Government
Smith	Hazel	NHS Highland
Smith	Frances	Scottish Association of Community Hospitals
Sopocko	Edyta	Dundee City Council
Spence	Lorraine	East Renfrewshire Council
Steer	Simon	Scottish Government
Stevenson	Mitch	NHS Tayside
Stott	Anne	ISD
Sutton	Christine	Stirling Council
Taggart	Maureen	NHS Lanarkshire
Taylor	Rae	NHS Tayside
Taylor	Alison	Scottish Government
Towle	Jennifer	NHS Tayside
Vance	Liz	South Ayrshire Council
Watson	Helen	NHS Fife
Wilson	Rena	NHS Ayrshire and Arran
Wright	Josephine	East Renfrewshire Council

## EVALUATION OF EVENT

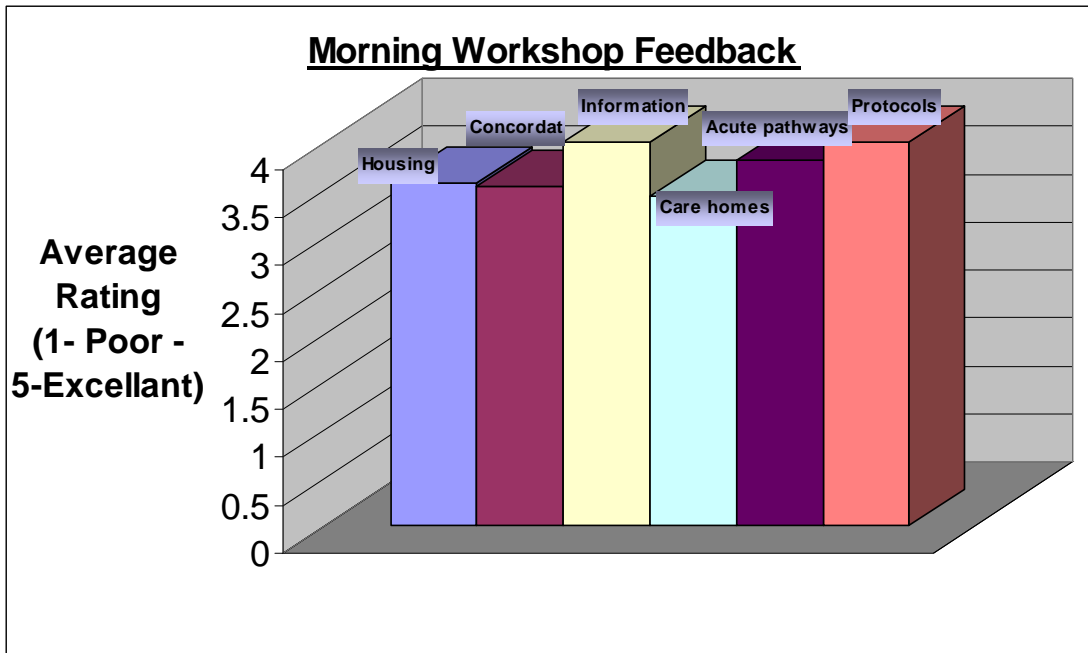
65 feedback forms were returned evaluating different aspects of the day.



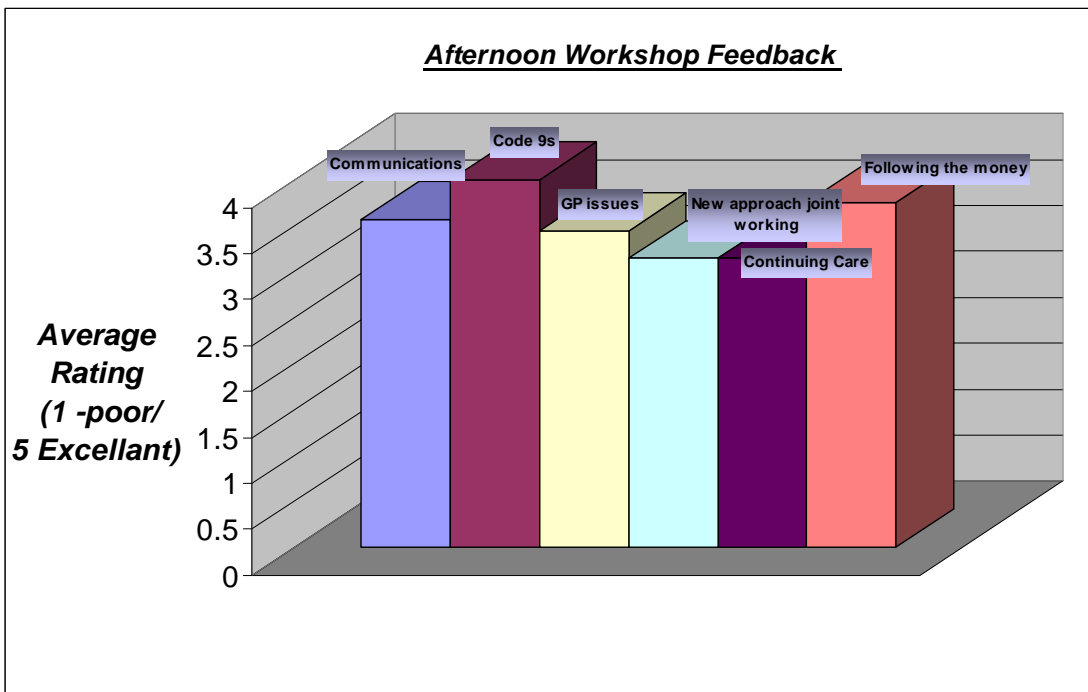
Delegated were asked how relevant the programme had been. 19 people reported it excellent, 35 thought it had been very good with another 7 saying it was good. No-one thought the event had been poor. The average rating was 4.2 out of 5.



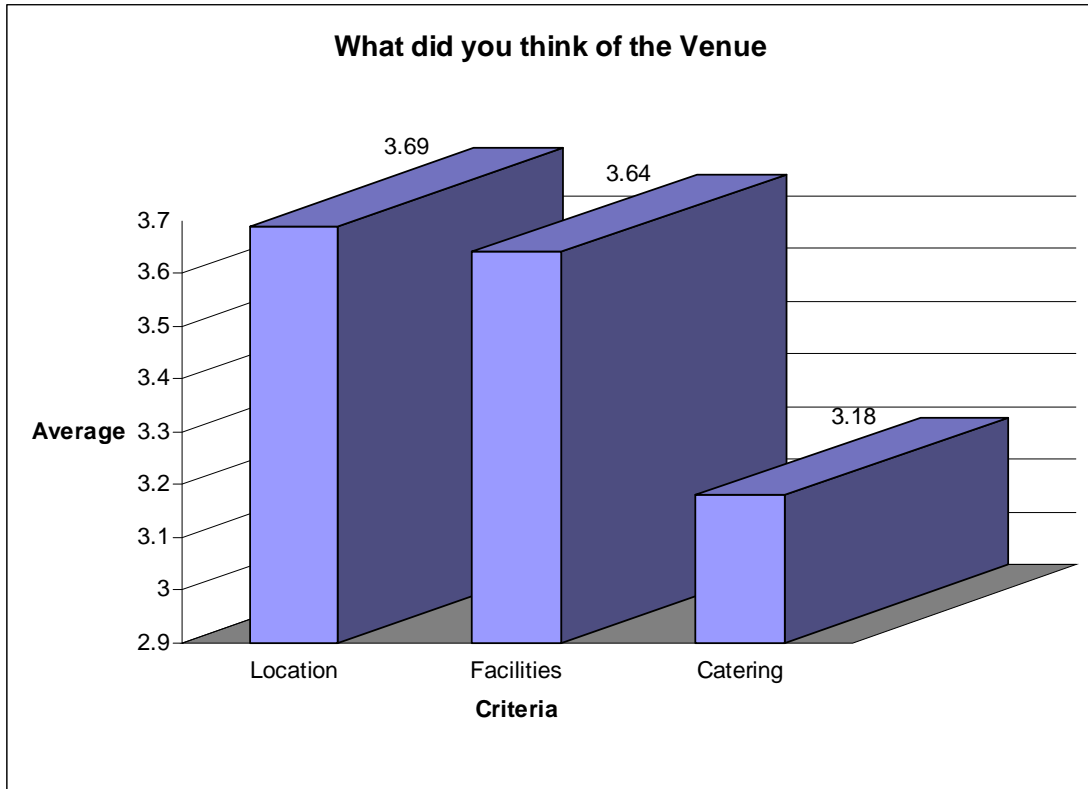
Delegated were asked to comment on the presentation they had heard. Again no-one thought these were poor. 12 reported excellent, 35 said very good and 14 said good. The average rating was 3.97 out of 5.



Delegates were asked to rate the workshops. The workshops on protocols and information scored highest with an average of 4.0, with the acute pathways workshop next on 3.82. There were no workshops in the morning that delegates rated as poor (scores 1 or 2). Overall, 5 people thought their workshop as excellent, with 40 thinking them very good and 18 saying good.



The highest rated workshop in the afternoon was on complex needs with an average score of 4 out of 5.6 people thought the afternoon workshops were excellent, 26 very good and 25 good. However 6 people thought they were poor and 2 thought very poor.



This was the first time that a delayed discharge learning and sharing event had been held at the Macdonald Inchyra Grange Hotel. Overall, the evaluation of the facilities was very positive, with the location scoring particularly high.