REIMBURSEMENT IN PRACTICE:
THE LAST PIECE OF THE JIGSAW?

A comparative study of delayed hospital discharge in England and Scotland

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Executive Summary

1: The Study
This is a comparative study, carried out in England and Scotland, of the implementation and impact of different policy approaches to tackling the problem of delayed hospital discharge. The study was commissioned by the Department of Health to evaluate the policy of reimbursement. This was introduced in England in 2003, and was considered but rejected in Scotland where Joint Action Planning (JAP) was implemented in 2002.

2: Key differences between England and Scotland
In both countries, the broad thrust of policy on delayed discharge is similar to the extent that measures are to be taken collaboratively across the whole system, albeit focused mainly on the acute hospital sector. Both initiatives are accompanied by additional funding to enable service development. But there are also key differences of philosophy and content.

In Scotland, the Delayed Discharge Action Plan launched in March 2002 placed the onus on Health Boards and Local Authorities in Health Board areas (15 at the time) to co-operate and agree Joint Action Plans to reduce the number of delayed discharges. A later national agreement between the Scottish Executive, NHS Boards and local authorities stated that discharge from hospital should take no longer than six weeks from the time that the patient is deemed fit for discharge. Consequently, measures to tackle delayed discharge have until recently been targeted principally at reducing delays of six weeks or more. However, from May 2006 a new directive was introduced in which care settings were categorised as either ‘short stay’ or ‘non-short stay’ specialties. For short stay specialties (such as ‘general medicine’) the time limit for assessment and arranging transfer of care would be three days, with six weeks continuing to apply to non-short stay specialties (such as ‘geriatric medicine’).

In England, measures to tackle delayed discharge have been targeted exclusively at the acute sector. There are statutory duties around what is expected of different parties in the hospital discharge process (i.e. minimum timescales for completing assessments and facilitating discharge). Here, social services can be held liable to charges of £100 per day (£120 in London) if the two day time limit is exceeded and a patient is found to be occupying an NHS acute hospital bed for the sole reason that they are awaiting community care assessment and the delivery of community care services. The charge applies from 11 am on the day after the proposed discharge date identified by the NHS in the discharge notification (Section 5), or three days after social services have been given an assessment notification (Section 2) of a patient’s likely need for community care services, which ever is later. This is the essence of the policy of reimbursement introduced in England as part of the 2003 Community Care (Delayed Discharges, etc) Act.

In Scotland, there are no penalties if an individual delay exceeds either the three day or six week time limit. However in April 2002 the Scottish Executive made it clear that the new delayed discharge monies would not be provided if an NHS Board or local authority diverted these away from reducing delays. Further where partnerships ‘fail to deliver’ on this objective further funds would not be released. Performance in planning and outcomes is closely monitored by an Executive Support Team.

These differences in content reflect different approaches to change management. In Scotland, whilst the policy outcomes and success targets are clearly stipulated, the delivery mechanisms are to be locally determined through partnership agreements. In England, national policy paid explicit attention not only to the outcomes and targets but to the precise
mechanisms to effect change in relation to delays. Whereas the lens for tackling delays in Scotland was wide-angled, in England it was targeted specifically at the acute sector.

The overall aim of the study was to compare and contrast policy approaches and implementation strategies to tackle delayed discharge for older people in England and Scotland, thereby highlighting the process and impact of reimbursement. In particular our research was tasked with unearthing the experiences of older people delayed in hospital and their families, who are often excluded from debate.

3: Method
The study was completed by researchers from the Universities of Stirling, Leeds and King’s College London between 2005 and 2007 and was based in five field work sites (three in England and two in Scotland). Data collection methods in each site included: examination of relevant policy documents relating to delayed discharge, national and local statistical data on delayed discharges, emergency medical admissions and re-admissions of older people, semi-structured interviews with strategic managers in health and social care (n=56), with older people delayed in hospital (n=67) and their carers (n=40) as well as with operational staff involved in discharge planning (n=132).

4: National Trends in Delayed Discharge
In both England and Scotland, rates of delayed discharges have fallen dramatically since 2001. Significant variations in the way the data are collected make direct comparison of effectiveness of the two policies problematic. Most commentators agree that it is difficult to ascertain the extent to which the Community Care Act contributed to the decline in delays in England because of the impact of other prior and concurrent measures such as intermediate care and admission avoidance initiatives. The focus of Joint Action Plans is considerably broader than reimbursement and Scottish achievements in reducing delayed discharges appear to be more closely linked with Joint Action Plans and the accompanying resource investment. Even so, it is difficult to discern which initiatives or which bundles of initiatives contained within the Joint Action Plans have been most effective given the diversity of approaches to solving the problem across Scotland’s NHS Boards and local authorities.

In England, the proportion of reimbursable delays has fallen within an overall decline. The main reasons for delays numerically are waiting for further NHS care and community care assessments not solely the responsibility of social care, while patient choice remains a key cause of delay. In Scotland, the main cause of delay remains waiting for a place in a care home, with significant inroads made into waits for funding and community care assessments.

English data report bed days lost rather than individual lengths of delays as in Scotland. From observations on our study sites, however, we concluded that health and social care systems in both countries are still challenged by some lengthy delays especially in complex cases. This is a central theme of the service user experience and outcomes in the study.

5: Local Implementation and Partnership Working
Overall, in our English sites, we found quite different styles of implementation at strategic and operational levels, ranging from close adherence to nationally outlined reimbursement processes, to adoption of a partnership agreement with joint investment plan, which obviated the necessity for financial reimbursement. Consequently, the amount of money changing hands through reimbursement varied yearly within sites and between sites, though overall, little or no money was paid in ‘fines’ with the exception of one site.

In Scotland, the local partnerships also varied in their emphases on service development within their Joint Plans, based on perceived local needs. Strategic managers in Scotland tended to have a more consistently positive view of partnership working around delayed discharge than their counterparts in England. Even so, there were tensions between NHS
and local authority partners around finance both about the adequacy of additional funding in light of a target of zero six week plus delays by April 2008 and about perceptions of local allocation – particularly in the context of the policy on free personal and nursing care and the increasing demands placed on it.

The experience of Joint Action Planning points to the significance of a policy that encourages and incentivises shared responsibility for the problem of delayed discharges – whatever their nature and source. As respondents here argued, the Scottish policy was not without its ‘sticks’ as well as ‘carrots’. However, the ‘stick’ in Scotland, namely, ‘naming and shaming’, close scrutiny from the centre by the Executive (particularly in the run up to the publication of the number of delays in each partnership) and the threats around funding was directed at the partnership as a whole and not at one member of the partnership. In England, whilst it was feared that reimbursement might set partners against each other, the evidence from this study suggests that such a conclusion is too simplistic. Moreover, we found that partnership working is fluid with shifts and changes arising in light of financial imperatives and resource.

There is evidence that Joint Action Planning in Scotland is developing capacity and partnership between health and social services at a strategic level to identify the main causes of delay and inform commissioning.

In England, there was general agreement that reimbursement has been a spur to focus on the problem of delayed discharge and to bring partners to the table. However, there was much less consistency about the overall benefits of reimbursement and some concerns about unintended consequences in the wider system. Perceptions also differed depending on managers’ location in the system. Hospital managers and clinicians welcomed reimbursement’s impact on patient care by reducing delays. Others cited the shifting of delays to other parts of the system and inequities in access to follow-on services for groups such as older people with mental health problems.

A major critique of reimbursement was that it contributed to the speeding up of patient throughput in acute care, encapsulated in the comment *spinning the carousel faster*. Even so it is arguable that this process is not simply a consequence of reimbursement but also reflects wider changes in the use of acute hospitals. The paradox illustrated by our study is that alongside the simultaneous speeding up of patient throughput, there is the continued existence of a group of patients with lengthy acute episodes whose often complex and multifaceted needs challenge the capacity and comprehensiveness of the service system to respond. The issue then is how far it is sufficient to locate solutions to this speeding up solely at the entry and exit points of the acute hospital as opposed to more investment in resources for rehabilitation and community based provision. This was equally an issue for strategic managers in Scotland as it was in England.

6: Operational Issues

Looking across both countries, the key differences made by reimbursement appear to be in clarifying processes for assessment and discharge and creating auditable systems to facilitate these.

On the ground, many staff in English sites considered that reimbursement has created a bureaucracy of considerable proportions. This causes difficulties on the wards where there is a high turnover of staff and therefore a lack of familiarity with the required protocol.

Generally, the Section 2 or notification of need for assessment for support on discharge was seen as a helpful facet of reimbursement. By contrast, the Section 5 was a potent source of tensions between operational staff, and symbolic of the way in which reimbursement has, from the social work perspective, cast them as being personally responsible for delays. There was potential, too, for gaming and loopholes in the system which reduced its
effectiveness, of which ‘patient choice’ was seen as a prime example: since under the rules of reimbursement, where once an offer of a specific placement or bed has been made and refused, the patient’s delay becomes non-reimbursable. This brings to the fore competing priorities and pressures within a health and social care economy arising from policy and emerging at different time points as well as different parts of the system. In principle, service providers may promote and are mandated to provide opportunities for patients to exercise choice but in doing so, it may exacerbate immediate pressure on one part of the system, whilst relieving it in the short term elsewhere.

This sense of blame among social services staff shaped relationships between them and health practitioners in the acute hospital at a general level, although for individual patients, there was evidence of good multi-disciplinary working and understanding of the respective pressures under which different professionals worked. Even so, whilst formally reimbursement required the discharge decision to be made within the multi-disciplinary team, therapists and social workers felt the need to continually reinforce this as an aspect of practice.

In the Scottish sites, although Joint Action Planning was viewed by senior managers and planners as promoting partnership working at strategic level and contributing to reducing delays, practitioners were more ambivalent. The decision on discharge was often the site of cultural and professional disputes linked with a continued dominance of medical professionals in decision-making and social workers challenging a too medicalised view of fitness for discharge. This co-existed with a perception articulated by some social workers that their role and responsibilities were not effectively understood or appreciated by other hospital staff engaged in the discharge planning process. This was especially the case in the acute sector when pressure on ‘freeing up’ beds was intense. Alongside a general view that all aspects of multidisciplinary working at practice level were improving in Scotland, there were concerns expressed about delays in community care assessments, about stop/go processes in acquiring funding for care packages, and securing access to care home places.

7: Patients’ and Carers’ Experiences

We would stress that since our focus was on delayed discharge, the views presented here are not representative of the wider hospital discharge experience in either England or Scotland. The sampling strategy employed – focus on those delayed over six weeks in Scotland and those that might be termed ‘complex discharges’ in England – places the spotlight on individuals who provide a critical test for acute discharge policies and processes.

Even so, from the perspective of our sample of older people and their families in England and Scotland, there is still much to do to improve the experience of planning for, and moving from acute hospital care. In speeding-up the system to deliver appropriate and timely discharge – a priority shared by older people - the challenge for staff was how to balance the tensions between system pressures and their wish to provide dignity and person centred care.

Significantly, the more relaxed time frame for discharge planning on non-short stay wards (six weeks) in Scotland did not deliver this – older people in our sample were located on ‘holding wards’ for long periods to await social care assessment or care packages.

It is in the requirement to move on to an interim location as part of making more effective use of acute beds, that the tension between system-led and user-centred approaches to discharge planning assumes its most intense form. Interim beds were used in both England and Scotland. Practitioners saw the benefit to patients of these facilities and welcomed their use if individuals received, for example, rehabilitation, further assessment or convalescence but not if they were deployed to ‘warehouse’ people whilst they waited for a care home
placement or a home care package. It is in this context we would argue the need to extend the Dignity in Care Agenda, launched in England in 2006 beyond its emphasis on interaction between staff and patients to encompass organisational systems and processes of care.

Patients delayed for lengthy periods (strongly articulated by our Scottish sample of over six-week waiters) experienced low mood, loss of control, boredom, frustration and loss of confidence. Despite awareness and concern among hospital staff of the consequences of delayed discharge on patients, there were few examples of any consistent action being taken to mitigate the risks beyond securing the actual discharge itself. In both countries, some carers expressed concern over the frequency of moves to different wards within the same hospital. Whilst they acknowledged that was down to pressure on beds, the practice was were perceived as having a negative impact on their relative.

In both countries, patients and carers’ experiences of discharge planning were variable, with stories of helpful relationships with staff but also stories of lack of involvement and communication about how far progress to leave hospital had been made. In England, few older people and their families were aware of the reimbursement policy, although many of them talked of pressures on acute beds and the need to move on so others could be admitted. They did, however, sometimes pick-up on the fact that staff were under considerable pressure to move them on. For family carers, the discharge process was often very stressful and at points they felt a sense both of powerlessness and of having to fight to achieve what they considered would be best for their relatives. These areas of conflict arose particularly in care planning meetings, over finances and levels of care and around moves into interim care.

The patients in our sample represent core NHS service users. Many were very old and had chronic health conditions, many were frail and often in the last years of their lives. What is evident in many patients’ stories is that decision-making on discharge is affected by an interplay of factors - personal preferences, needs and desires of users and carers that may also conflict, and different professional perceptions about how best to meet needs. These were played out in the context of system pressures, service capacity and discharge processes. And as already mentioned, the conception of ‘patient-centred care’ and ‘choice’ does not take account of this complexity and the current focus on addressing the system and capacity constraints make such rhetoric appear hollow.

8: Conclusion
A key conclusion from our study – applicable to both England and Scotland – is that the specific policy solutions put forward to tackle delayed discharges, namely reimbursement and Joint Action Planning, have had some success but in themselves are insufficient to address the wider system changes resulting from the re-shaping of acute care. There is need to extend the policy, resource and service lens from a primary focus on the entry and exit points of the acute hospital to the wider health and social care economy to develop a broader repertoire of rehabilitation, intermediate and transitional care provision as well as long term community infrastructure. This will require whole system working and joint investments, encompassing not only the marginal additional growth money but also shared decision-making around mainstream budgets. Specifically, we consider that the following require addressing:

- The engagement of members of the multi-disciplinary team, including social workers, at an early stage in the patient episode to identify needs, wishes, support and interventions to optimise options for recovery and discharge;
- Prioritising and maintaining emphasis on multidisciplinary decision-making around the process and timing of discharge;
- Building on systems which have grown up to monitor and respond to delays to include wider aspects of patient flow such as discharge coordination, multi-agency
review of all patients who are delayed across the system, information gathering on the causes, length and types of delays which follow the patient through the system;

- Reviewing the reimbursement notifications procedures to ensure that timescales are sufficiently flexible around assessments of the most complex cases;
- Reviewing the purpose and use of interim care with a special focus on the needs of the people with complex needs; notably older people with mental health problems, younger people with high-level physical disabilities and the older old toward the end of their life;
- Considering how the policy of dignity in care could be extended from its current emphasis on staff/patient interaction to include strategic pathways planning which ensure that the context designed for care is one where dignity can be maintained;
- Exploring the relationship between emergency re-admissions to acute hospital, ‘independent discharges’ and the raising of the eligibility criteria for home care.

With regard to reimbursement specifically, our findings indicate that it is a policy of which significant features have had their day. Whilst it is important not to divert organizational ‘gaze’ from the causes and remedies for delays, focus needs to be on systems and processes that contribute to, and flow from, a sense of joint ownership and responsibility of the problem at strategic and operational levels. To answer the question posed in the title of our study then, we conclude that not only does the reimbursement piece not quite fit the jigsaw, but in trying to complete the puzzle, we have discovered that the jigsaw is considerably larger than this piece was intended to fill!

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1 Introduction

1.1 Overview

This report presents key findings from a comparative study across England and Scotland of the implementation and impact of two different approaches to tackling the problem of delayed hospital discharge. The research was commissioned by the Department of Health to evaluate the policy of reimbursement. This was introduced in England in 2003, but not in neighbouring Scotland where a different approach, namely Joint Action Planning (JAP) was adopted in 2002.

The introduction of devolved forms of government in Northern Ireland, Scotland and Wales has accentuated and extended intra-UK differences in the organisation and delivery of health and social care services on the one hand, and in policy formation and implementation strategies on the other. According to Alvarez-Rosete et al. (2005), devolution has resulted in natural experiments of divergent policies across the UK. However, they describe their astonishment at the difficulty and in some cases impossibility of obtaining valid comparable basic statistics on the NHS in the four countries which nullify attempts at effective scrutiny and learning. This is particularly apt to delayed discharge where there are very different approaches not only in tackling the “problem” but also to defining and measuring it (National Audit Office 2003, Vetter 2003).

Despite these limitations, comparative studies in health and social care can enrich the scientific and political debate (Leichsenring et al. 2004). This study undertaken between 2005 and 2007 contextualises the latest national statistics on delayed discharge from Scotland and England in terms of five local case studies (three in England and two in Scotland); drawing-in a wide range of different perspectives to explore how reimbursement and Joint Action Planning are working in practice. A distinctive feature of the study is the incorporation of the views of the ‘oldest’ older people whose voices are seldom heard. Data collection methods in each site included: examination of relevant documents relating to delayed discharge; observations of key meetings and practices; semi-structured interviews with strategic and operational managers in health and social care (n=56), with service users and their carers (n=106); as well as with operational staff involved in their care and discharge planning (n=132). Ethical approval for the study was secured from COREC (Ref: 05/MRE 10/92). Appropriate local research approval was also obtained in each of the five sites.
The overall aim of the study was to compare and contrast policy approaches and implementation strategies to tackle delayed discharge for older people in England and Scotland, thereby highlighting the process and impact of reimbursement.

The objectives of the study were threefold:

- To examine how policies to reduce delayed discharge are being implemented;
- To assess the impact of the policy of reimbursement on inter-organisational relationships, service development and practice to secure a reduction in delayed hospital discharges;
- To explore the impact of reimbursement on the experiences and outcomes for service users who are at risk of, or subject to delay.

In the remainder of this chapter we review the policy background surrounding delayed discharge, presenting an overview of the key differences in management and practice between England and Scotland. In Chapter 2 we examine relevant literature as well as national trends in delayed discharges and acute care more broadly to contextualize the study. In Chapter 3 we describe the approach to these policies locally, considering strategic agreements and partnerships across the five case study areas. In Chapter 4 we consider how reimbursement and Joint Action Planning have been implemented in practice in our sites and the perceived impact on inter-agency relationships, negotiation and decision-making around assessment and discharge planning for individual patients. Chapter 5 focuses on the understanding and experience of delayed discharge from the perspectives of older people and their families. In the final chapter, we draw the various threads of the study together and consider the implications for policy.

1.2 Delayed discharge

Delayed discharge from hospital has been identified as a problem in the UK since the birth of the welfare state (Schimmel 1964). Delays were commonly understood as problems associated with the care of older people who have on-going need for support (Henwood, 2006). For older people, remaining in hospital for longer than necessary poses particular risks: hospital acquired infections; falls; loss of mobility; social isolation; depression and loss of independence (Booth and Mead, 2007). In light of evidence gathered in this study, we suggest that the problem is wider in that delays are also associated with people with complex needs, including younger people with disabilities.

The research literature on hospital discharge goes back at least thirty years and there is consistency in the research findings, which continue to report on breakdowns in routine
discharge arrangements (Department of Health, 2003a). There have been a number of systematic reviews of the evidence which have sought a range of perspectives:¹ [1] Parker et al. (2002) review clinical trials relating to interventions to improve the discharge of older people from inpatient hospital care; [2] Glasby et al. (2004, 2006) describe studies published since 1993 which focus on the rate and cause of delayed discharges for older people in the UK; [3] Hubbard et al. (2004) review UK and international literature 1984-2004 identifying key areas that need to be addressed for delayed discharges to be tackled long term; [4] Fisher et al. (2006) seek to improve discharge practices through a synthesis of evidence on older people’s experiences; most recently, [5] Coffey (2006) review the literature on older people’s discharge from hospital to home to identify areas for further research. Glasby et al. (2004) make the important summation that the existing evidence base concerning delayed discharges and older people is extremely weak and that this is especially the case as regards what works to prevent them. It is further recognised that one of the most substantial limitations of the delayed discharge literature is the failure to systematically include a service user and carer perspective.

1.3 The policy response to delayed discharge in England and Scotland

1.3.1 National context

The divergence of healthcare policy across the NHS in the devolved countries of the United Kingdom has led to some notable differences between England and Scotland, though many similarities remain. Both countries have in recent years worked towards refocusing acute care, reducing the number of acute hospital beds, and providing more care and treatment closer to home and in community based settings. Two key features are significant in respect of this study. Firstly, the number of available hospital beds per head of population has declined in both countries, but Scotland still has a higher bed base than England. There has also been a shift in both countries towards a higher proportion of acute compared to all hospital beds (Alvarez- Rosete 2005). The pattern of change from 2000/1 is shown in Figure 1.

¹ The findings of the systematic literature reviews are summarised in Appendix 1.
England and Scotland differ in the extent and nature of community based care. In England, there has been substantial national investment in intermediate care and recently, in admission avoidance schemes. This was the government response to the Royal Commission on Long-term Care (Secretary of State for Health, 2000) as an alternative to the recommendation of free personal care which was adopted by the Scottish Executive. Scottish national policy is not to invest in intermediate care per se, although some services which in England come within the ambit of intermediate care have been established (i.e. time-limited, transitional services providing a bridge between hospital and home or between illness and a resumption of daily routines). It is difficult to obtain directly comparable data on care home provision and use. The number of older people who are supported in care homes in England declined by 3.4% from 2002 to 2006. In Scotland, the number of care homes has decreased by 2.8% from 2000 to 2006.\(^2\) These trends are in line with policies in both countries about facilitating older people to live in their own homes. This presents both

\(^2\) In England in 2002 there were 206,950 residents in all types of accommodation aged 65 years and over and 200,005 in 2006. (http://www.ic.nhs.uk/webfiles/publications/ccs06suppres/CommunityCareStatistics). In Scotland the number of care home places decreased by 2.8% between March 2000 and 2006. (http://www.scotland.gov.uk/Resource/Doc/171984/0048134.pdf)
opportunities and challenges for social and primary care services to support an increasing number of older people living at home.

Across both countries, although the numbers of people delayed has significantly fallen, delayed discharge remains a significant “policy problem” (Black, 2006). However, there are important differences in the approaches to tackling it.

### 1.3.2 Reimbursement in England

In England, the NHS Plan (Secretary of State for Health, 2000) set targets for a year on year reduction in the number of delayed discharges. In 2002, arguably without sufficient preparation or consultation (Henwood, 2006) the government announced its intention to introduce a system of reimbursement similar to that implemented in Scandinavia (Department of Health, 2002b). In Sweden and Denmark, financial incentives are a key mechanism for addressing delayed discharge (Styrborn and Thorsland, 1993; Andersson and Karlberg, 2000):

> ‘In Denmark, the counties administer and finance the hospitals, while the municipalities administer and finance the measures concerning the elderly discharged from hospitals. The municipalities thus have an economic incentive to prolong the stay of elderly citizens at the hospital. One of the solutions has been to make the municipalities pay per day for patients waiting for admission to a nursing home. Thus, since 1993 there has been a decrease in the amount of elderly somatic patients at hospitals waiting for a place in nursing homes.’
>

Reimbursement was enshrined in the Community Care (Delayed Discharges) Act of 2003 and was implemented in England and Wales in shadow form from October 2003 with full charging taking effect from the 5th January 2004. In England, social services\(^3\) can be held liable to charges of £100 per day (£120 in London) if a patient is found to be occupying an NHS acute hospital bed for the sole reason that they are waiting for a community care assessment or the delivery of community care services. Guidance supporting the Act emphasises that reimbursement is about incentivising service improvement and partnership development across the whole system. Its stated purpose is to strengthen joint working and encourage timely communication with new statutory duties on the NHS and social services; and to improve assessment and provision of community care services for people in hospital.

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\(^3\) This refers to local council adult social services.
A carrot and stick approach was adopted to effect these changes. The ‘stick’ of fines was mitigated by the ‘carrot’ of financial incentives. Additional resources in the form of the Delayed Discharge Grant (£50 million in 2003/4 and £100 million in 2004/5 and 2005/6 was allocated by the Department of Health to Local Authority social services departments. This was intended to encourage the development of new service capacity and to facilitate patient transfers to community settings (Department of Health, 2003b).

Figure 2 summarises the key features of the English reimbursement process (Department of Health, 2003b).

**Figure 2 - Summary of the Reimbursement Process**

- NHS bodies have a statutory duty to notify social services of a patient’s likely need for community care services (referred to as an ‘assessment notification’ or Section 2 notification). Section 2 notifications should only be made after patients’ eligibility for continuing NHS care has been assessed. Where possible, assessment notifications should include an estimated date of discharge.

- There is a defined timescale – a minimum interval of two days for social services to complete the individual assessment and provide appropriate social care services.

- A second notification (Discharge Notification or Section 5 notification) follows completion of a multi-disciplinary assessment and gives notice of the proposed day on which discharge will take place (minimum 24 hours notice).

- A reimbursement charge is paid by social services to the acute trust if the fact of social services not having met their obligations – that is to assess the patient (and carer if appropriate) and provide social care services within the set time – is the sole reason for the delay in discharge from hospital. If any element of the delay is related to NHS areas of responsibility then reimbursement does not apply.

- NHS bodies have to make both notifications to social services if a claim for reimbursement is to be triggered. The charge applies from 11am on the day after the proposed discharge date identified by the NHS in the discharge notification, or three days after social services have been given an assessment notification of a patient’s likely need for community care services, whichever is later. If services are not in place after 11am, the full daily charge will apply from that day onward.

The assumption underpinning the introduction of the reimbursement policy in England was that most delays in discharge were caused by social services departments (McCoy et al. 2007). As Booth and Mead (2007) point out, “The intention is not that social services should
make payments to the NHS, but that they should avoid doing so by providing services to their residents more rapidly”.

Initially, there was much opposition to the policy (Rowland and Pollack, 2004; House of Commons Select Committee, 2002). Commentators pointed to the considerable evidence to suggest that the causes of delayed discharge were complex and multi-layered, and often out of the hands of social services (Henwood, 2006). There were concerns that the policy was not sufficiently evidence based (Paley, 2004) and that circumstances in Scandinavia were very different to those in England (Glendinning, 2002; Millard, 2004). Other concerns were that (Nuffield Institute for Health, 2002; Moore, 2002; Glasby 2002, 2004):

- Financial penalties may distort social service development priorities because there will be a financial incentive to focus on reducing delayed discharge at the expense of other services;
- Social services may focus on the immediate issue of facilitating discharge from hospital at the expense of implementing strategies that prevent hospital admission in the first place;
- There is a danger that social services will take people too early, which could trigger a readmission;
- Charging jeopardises the development of inter-agency working, essential to securing long-term solutions to the problem of delayed discharge, since it encourages one agency to blame another for whole care system problems.

To support implementation, a small ‘reimbursement group’ was established within the Department of Health’s service improvement vehicle, the ‘Change Agent Team’ (http://www.changeagentteam.org.uk/). The involvement of the Change Agent Team is said to have marked a critical turning point both in acceptance of the policy and in the operation of the arrangements in practice (Henwood, 2006).

1.3.3 Joint Action Plans in Scotland

In Scotland, Executive Ministers launched the Delayed Discharge Action Plan in March 2002, recognising both the “scale of the problem” and the need for immediate action to reduce the unacceptably high number of older people whose discharge from hospital was being delayed and who were being cared for in “inappropriate settings”. This introduced clear guidelines which stated that all Health Boards and local authorities in Health Board areas (fifteen at the time) should co-operate to agree Joint Action Plans to reduce the number of delayed discharges. Additional year on year funding of £20 million was granted by the Scottish
Executive to joint local authority/NHS partnerships, through NHS Boards “ring-fenced for delayed discharges only and targeted as first priority to freeing up beds in the acute sector” (SEHD, 2002, p14). Each local partnership was required to bring forward an innovative solution to develop community care capacity, improve assessments and develop stronger liaison between social work and NHS emergency services for older people to head off avoidable hospital admissions and develop and employ rehabilitation earlier. The underpinning rationale for the approach was that each area will have its own unique problems depending on the local demography and level of organisational development (Namdaran and Sherval, 1995).

In 2004, Hubbard et al. (2004) were commissioned by the Scottish Executive to review the delayed discharge Joint Action Plans that the 15 Partnerships NHS Boards had with Scotland’s 32 Local Authorities in terms of the initiatives being developed and what is known about their effectiveness. All Scottish Partnerships reported what they believed were the main causes of delay in their Joint Action Plans. The reasons fell into three main categories: insufficient care home places; problems delivering community-based care; and slow delivery of community assessments. The most popular initiatives being introduced in the Joint Action Plans were: care home placements; hospital at home; rapid response and early supported discharge; rehabilitation; out of hours; assessment; equipment and adaptations; and the introduction of managers.

To further tackle the issue of delayed discharges, a Tripartite Working Group of senior representatives of the Scottish Executive, health boards and Local Authorities was established in December 2003 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 the Group’s efforts to reduce the numbers of people delayed in what was termed “inappropriate” hospital settings. The Tripartite Group was asked to consider the issue of reimbursable payments and financial incentives in light of the policy adopted by the Department of Health in England. It concluded that reductions in delayed discharges had already been incentivised in Scotland through the injection of new funds paid to NHS board areas but only released by the Executive following approval of agreed Joint Action Plans. Consequently, it would, they stated, be “counterproductive” to adopt the system operating in England and did not recommend its introduction in Scotland.

Until recently, a distinctive feature of discharge planning in Scotland was the “reasonable discharge period” which gave staff six weeks “breathing space” (Glasby et al. 2004) to arrange on-going care once the patient had been identified as medically fit for discharge.
However, in May 2006, a number of significant changes were made to policy on delayed discharge. First, the terms short stay and non-short stay specialities were introduced into the lexicon of delayed discharges. Second, the Executive stipulated that a reasonable timescale to facilitate a patient’s discharge from a short-stay (acute) setting was three working days (SEHD, 2006). Short-stay was used to describe the most needed acute beds (35 listed specialities); the term ‘acute’ was not used because it is interpreted differently across Scotland and there is no universal description. For non-short stay specialities the “reasonable discharge period” remains fixed at six weeks. Current targets for reducing delayed discharge in Scotland are as follows:

- For 2006-07, to reduce all delays over six weeks by 50%;
- For 2006-07, to free up 50% of all beds occupied by delayed patients in short-stay beds;
- For 2007-08, to reduce to zero those patients delayed over six weeks; and
- For 2007-08, to reduce to zero those patients delayed in short-stay beds.

### 1.4 Monitoring systems

As touched upon earlier, comparing the ways in which different care systems tackle delayed discharge is challenging because of different performance monitoring systems. In England, delayed discharge data are collected for patients deemed medically fit and safe to leave an acute bed; delays elsewhere in the health system are unreported. Scottish data are collected for all delays in whatever type of bed, but there is a particular policy focus in the Joint Action Plans on people delayed over six weeks and outcomes for these patients are reported. Furthermore, local arrangements about reimbursement affect what and how data is collected and defined. Although the policies of reimbursement and Joint Action Plans advocate a whole system approach to dealing with the issue of delayed discharge, their prime focus is at the point of move from acute healthcare out into the wider system. In England especially, concern about the effects of patients’ delay on the efficiency of the acute system is reflected in the data published regionally and nationally. Here, attention is directed at the numbers of delays, bed days lost and the agency to whom responsibility for the delay can be attributed. Neither the cause nor length of delay for individual patients is reported. Moreover, policy and service development is primarily focused on the entry and exit points of the acute hospital rather than on community provision further upstream.

In Scotland, early efforts were concentrated on patients experiencing the longest delays so its planners do have patient focused data routinely available to them. However, recent
differentiation between acute and non-acute settings reflects a movement towards balancing attention to both shorter acute and longer non-acute delays.

Capturing something of the complexity, Figure 3 below summarises some of the other key differences and similarities in the way delayed discharge is managed across England and Scotland.

**Figure 3 - Delayed Discharge in Scotland and England: A Comparison.**

<table>
<thead>
<tr>
<th>Definitions &amp; Guidance</th>
<th>Scotland</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is a delayed discharge/delayed transfer of care?</strong></td>
<td>‘A delayed discharge is experienced by a hospital inpatient who is clinically ready to move to their next stage of care but is prevented from doing so for various reasons’. (Ref: 1 [p5]). *Note this definition covers all hospital specialities and significant facilities</td>
<td>‘A delayed transfer of care occurs when a patient is ready for transfer from acute care, but is still occupying a bed designated for such care.’ (Ref: 2 [p16]).</td>
</tr>
<tr>
<td><strong>Notifying social services</strong></td>
<td>Early referral to social work for community care assessment is emphasised in the good practice guidance. (Ref: 1 [p5])</td>
<td>Under Section 2 of the Community care (Delayed Discharges etc,) Act 2003 the NHS has a statutory duty to notify councils of any patient’s likely need for community care services. (Ref 3: [p21])</td>
</tr>
<tr>
<td><strong>Ready for discharge / Safe to discharge</strong></td>
<td>Ready for discharge date is determined by the consultant/GP responsible for inpatient care in consultation with all agencies involved in planning the patients discharge, both NHS and non-NHS (Ref: 1 [p5]).</td>
<td>Safe to discharge is determined by (Ref 4 [p1]): (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. Under Section 5 of the Act, the NHS has a statutory duty to notify the local council of the confirmed date of discharge. (Ref 3 [p31])</td>
</tr>
<tr>
<td><strong>Arrangements for Counting Delayed Discharges</strong></td>
<td>Monthly Census (published quarterly): ISD will comprehensively report data only for those patients who have been clinically ready for discharge for more than six weeks, irrespective of cause of delay (Ref 1: [p6])</td>
<td>Weekly Census: SITREP (Situation Reports) count the number of ‘acute beds’ where a delay is occurring — the section on length of delays has been removed (Ref 2 [p15]). <em>(SITREP and reimbursement definitions of acute care are consistent apart from the fact that one refers to beds and the other to patients. Reimbursement applies to delays affecting those patients admitted for, and who have been receiving acute...</em></td>
</tr>
</tbody>
</table>
In the understanding that acute care is not always provided from an acute bed, the focus of reimbursement stresses the type of care the patient has received at the hospital, not the bed she has been allocated to (Ref 2 [p15]).

| Time Limits for Monitoring and Managing Delays | Zero Delay: [short stay] is defined as a patient whose ready-for-discharge date is within three working days from the census date (see recording below). This is considered an acceptable period of time for making arrangements to move patients to their next stage of care. A patient whose delay is of three working days or less should be excluded from monthly and quarterly census data returns (Ref:1[p6]) | Minimum interval for assessment: (Ref 3 p23). The minimum period provided for a council to assess a patient and arrange services is set at two days. The regulations also provide that charging does not start until 11am on the day following the proposed day of discharge. It is recognised in the guidance that there are actually very few patients for whom a payment would be liable immediately after the minimum interval, since the majority of patients likely to need community services are older people and will remain in hospital for longer than three working days. Once the NHS has notified social services of the confirmed date of discharge, social services have 24 hours to make the necessary arrangements before charging commences. Reimbursement does not currently apply to non-acute care. |
| Recognised Causes of Delay for Reporting Purposes. | Principal Reason Group Codes: (Ref: 1 [p12]) 1 = Community Care Assessment. 2 = Community Care Arrangements. 3 = Health Care Assessment. 4= Healthcare Arrangements. 5 = Legal/financial. 6 = Disagreements. 7 = Other patient/carer/family related reasons. 8 = Principal Reason not Agreed. | Reasons for Delayed Transfer of Care: (Ref: 2 [p.17]). A = Awaiting completion of assessment B = Awaiting Public funding C= Awaiting further (non acute) NHS Care (including intermediate care, rehabilitation services etc,) D(i) = Awaiting residential home placement or availability D(ii) = Awaiting nursing home placement or availability E = Awaiting care package in own home F = Awaiting community equipment and adaptations G = Patient or family choice H = Disputes I = Housing – patients not covered by NHS and Community Care Act. |
1.5 Summary

This section introduced the policy background surrounding delayed discharge, presenting an overview of the key differences between England and Scotland. The broad thrust of policy on delayed discharge is similar in both countries to the extent that measures are to be taken collaboratively across the whole system albeit focused mainly on the acute hospital sector. Both are accompanied by additional funding to enable service development. But there are also key differences of content and philosophy:

- In Scotland, there are no immediate financial penalties if an individual's delay exceeds either the three day or six week time limit. In England, social services can be held liable to charges if a patient is found to be occupying an NHS acute hospital bed for the sole reason that they are awaiting a community care assessment and the delivery of community care services.

- In Scotland, the length of delay for an individual patient is recorded and routinely published every quarter. In England, the length of delay of individuals is not recorded; instead, the focus is on the number of bed days lost in relation to a delayed patient.

- In England, no distinctions are made between short stay and non-short stay specialities. However, measures to tackle delayed discharge have been targeted exclusively at acute medical care. In preparation for the implementation of reimbursement in 2003, local health services were advised to agree which of their beds were ‘acute’ and which were 'non-acute'. There are no defined time scales for facilitating discharge from the non acute sector though other policy guidance in England advises a six week time limit for intermediate care services (DH, 2001b).

- The English system has imposed statutory duties around what is expected of different parties in the hospital discharge process (i.e. minimum timescales for completing...
assessments). It also broadens out the decision making on fitness and safety for discharge beyond medical personnel to include the wider multidisciplinary team. In Scotland, following the new targets set in May 2006, the Executive modified the definition of what constitutes a patient’s ‘ready for discharge date’. Now it also places emphasis on the multi-disciplinary nature of decision-making in arriving at a date for discharge: “in consultation with all agencies involved in planning the patient’s discharge, both NHS and non-NHS” (SE, Definitions and Recording Manual, May 2006).

- The system of reimbursement in England focuses attention on costs relating to individual delays and which service is responsible for that delay. There is a potential penal element in the Scottish system also, but this threatens to impose financial penalties on the local partnership (no individual partner is singled out) by denying access to future delayed discharge funding where a Joint Action Plan fails to deliver its targeted reductions in the number of delayed discharges or fails to develop sufficiently robust Joint Action Plans: “The Scottish Executive will monitor performance closely, and where partnerships fail to deliver will not release further funds until the Support Team has helped the partnership resolve their difficulties”. (Delayed Discharges in Scotland: Report to First Minister, 2002 p.15).

- These differences in content reflect different approaches to change management. In Scotland, whilst the policy outcomes to be achieved are clearly stipulated as well as the targets by which success will be measured, the delivery mechanisms are to be locally determined through partnership agreements. In England, there was explicit attention in national policy not only on the outcomes and targets but on the precise mechanisms to effect change in relation to delays.
2 National Trends and Early Evidence

2.1 Overview
In this chapter we explore national trends in delayed discharge across England and Scotland and the wider literature to assess what is already known about the effectiveness of reimbursement and Joint Action Planning.

2.2 National Trends
Patterns of delay, as described by national statistics in England and Scotland, have fallen dramatically since 2001 (see Figure 4 and Figure 5). In England, most commentators agree that it is very difficult to ascertain the extent to which the Community Care Act (and in particular the option for hospitals to charge social services) contributed to the decline because of the concurrent impact of the Delayed Discharge Grant and other measures\(^4\) (Henwood, 2006; Young and Stevenson, 2006; McCoy et al, 2007). The steep decline between the 3\(^{rd}\) quarter of 2001 and the 1\(^{st}\) quarter of 2003 (approximately 40% decline) suggests that the implementation of intermediate care in particular is likely a major contributor here. The national evaluations of intermediate care (Barton et al. 2006; Godfrey et al. 2005) concluded that the extent to which it is impacting on delayed discharge was uncertain. However, the fieldwork for both studies was carried out at the point where intermediate care services were only being developed and had not matured.

\(^4\) Access and Systems Capacity Grants, Building Care Capacity Grants and Intermediate Care Capital Funding between 2001 and 2006 worth hundreds of millions pounds were also provided in addition to the Delayed Discharges Grant (McCoy et al. 2007 p2).
Paley (2004) makes a similar point as regards the lack of evaluation of effectiveness of many of the initiatives which have been introduced locally under the auspices of the Delayed
Discharges Grant. It is noted that the Department of Health Change Agent Team on their website suggest that there is no “ultimate formula” for tackling delayed discharges, only a “pick and mix, look and learn” approach. Baumann et al. (2007) take a different view based on their investigation of discharge practice and organisation of services in six sites with consistently low rates of delayed discharge. They suggest that all six high performing sites in their study had addressed, albeit in different ways, the three underlying issues recognised in the literature as key causal factors in delayed discharge (i.e. capacity, internal hospital efficiencies and inter-agency efficiencies). With implications for Joint Action Planning in Scotland, they tentatively conclude that the essence of the solution lies in addressing these core elements, rather than requiring entirely localised solutions.

Figure 6 shows the main reasons for delayed discharges in England. These data indicate that the proportion of people waiting for particular reasons has remained fairly consistent over the three years during which reimbursement has been operational, although the number of delays has reduced overall. The main cause of delay in numerical terms is people awaiting further NHS care, often intermediate care, which is attributable to health and not social services. Completion of assessment is the second highest category, though in only a minority of cases is the responsibility for delay solely attributable to social care. Patient choice has remained an issue for many and has not reduced in the past two years.

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Delayed transfer of care data from SITREP, averaged over Q1. Data show numbers of patients.

Figure 7 indicates the proportion of reimbursable delays, i.e. those regarded as solely the responsibility of social care authorities. They are shown to be declining slightly faster than the general reduction of delays, from around one third of all delays in Q3 2003-4 to about one quarter in the same quarter two years later.
In Scotland, there has been a marked reduction in delays dating from January 2003 (following the introduction of Joint Action Plans in April 2002) and this decline has been sustained at a steady pace to nearly a quarter of its 2000 level up to April 2006 (Figure 5 above). At the April 2007 census, the number of six weeks and more delays had fallen from 1826 in April 2002 to 233 in April 2007, an 87% reduction.

As Figure 8 shows, for these Scottish patients there has been a quite consistent reduction in most areas of delay and significant inroads have been made into waits for community care assessments and for funding. Waiting for a care home place continues to be the main cause of delays of six week or more.
Patients ready for discharge who are outwith the six week discharge planning period by principal reason for delay: Scotland; September 2000 to April 2007

Other includes Disagreements; Other patient/carer/family related reasons excluding patient exercising statutory right of choice; Community Care Arrangements (no additional detail); awaiting completion of social care arrangements (no additional detail); Principal reason not agreed; and Principal reason not recorded.

The reason codes 24DX, 24EX and 42X (awaiting place or bed availability where no appropriate facilities exist) now act as secondary codes to Complex Needs [See introduction to this report and appendix 5]. Prior to the April 2003 census these codes were included under codes 24D, 24E and 42 (awaiting place or bed availability). Therefore cannot be taken out of the census totals prior to April 2003 census.

The reason code 51X (Adults with Incapacity Act) now acts as a secondary code to Complex Needs [See introduction to the July 2006 report and appendix 5]. Prior to the July 2004 census these codes were included under code 51 (legal issues). Therefore cannot be taken out of the census totals prior to July 2004 census.
Currently, it is not possible to discern which initiatives or which bundles of initiatives contained within the Joint Action Plans have been most effective in reducing delayed discharges. Hubbard et al. (2004) make the point that the Joint Action Plans they reviewed did not make it clear if the initiatives introduced to tackle delayed discharges were based on evidence of effectiveness of similar initiatives elsewhere, or whether evidence of effectiveness of services is locally collected. In order to achieve a whole system perspective it becomes necessary to evaluate the impact of an individual initiative and the combined impact of several initiatives. It is concluded that there is a need for capacity building in terms of skills in whole systems data collection if this is to be achieved.

Across both countries, concerns have already been expressed about the sustainability of these successes in reducing delays (McCoy, 2007). Moore (2007) suggests that there is some evidence that the ‘easy wins’ which came from sorting out social care delays in England may have been delivered fairly quickly (partly due to reimbursement) and more problematic elements of delays now remain.

The Scottish figures apply to those people whose delay exceeded six weeks, wherever they were located. Individual patient’s length of delay is not collected in England but the general view in our study sites was that delays of six weeks or more are rare; the combined result of greater emphasis on moving patients from acute beds through the reimbursement process and investment in intermediate care and rehabilitation services. In one of our fieldwork sites, a detailed audit of delays in 2005 showed that while the majority concerned older people awaiting home care or admission to intermediate care, these were often of short duration (Tulloch, 2005). Lengthy and more problematic delays concerned people of all ages with serious medical conditions, notably neurological problems, who needed complex packages of care and often specialist housing adaptations. There were also lengthy delays for older people who needed more specialised long term care such as those with mental health problems awaiting EMI nursing care. In this respect, it seems that, although not clearly identified in the official statistics, problems in enabling some patients with complex needs to leave hospital in a timely way are similar in both countries.

Prior to implementation there were concerns that the reimbursement policy might lead social services to focus on the immediate issue of facilitating discharge from hospital at the expense of implementing strategies that prevent hospital admission in the first place. It was also feared that social services might discharge people too early, which could trigger readmission to hospital. In England there has been a steady rise in readmissions to hospital of older people within 28 days of discharge (Figure 9). Scottish statistics do not offer this
indicator but instead record multiple (more than two emergency admissions in one year). Here the Scottish national trend is upwards, though not consistently.

**Figure 9 - Emergency Readmissions Within 28 days of Discharge (all ages) in England**

An analysis of Scottish data confirmed that over 90% of people who became a delayed discharge were initially admitted to hospital as a medical emergency (Kendrick and Conway, 2003). They suggest in relation to delayed discharges that demographic, social and organisational factors contribute towards explaining the problem. They point out that there are rising numbers of people aged 80 years old and over in Scotland, many of whom live alone without the support of an informal carer. They also suggest that organisational changes such as a decline in NHS long-stay beds and lack of care home places means that increasing numbers of older people are living at home, although the decline in long-stay beds preceded recent increases in emergency admissions. They hypothesise that primary care and social care may not have the capacity to care for these older people at home, which is why there has been an increase in the number of emergency admissions for this group of the population. The authors conclude their report by recommending a whole systems approach where all health and social care agencies collaborate to provide seamless care on a continuing and preventative basis. Data from both countries indicates that emergency admissions to hospital have continued to rise, and that they are treated in a decreasing number of days. This has resulted in a reduced length of stay for the population as a whole, and for the oldest old in both countries, as shown in Figure 10 below.
One of the first studies to report on the impact of the reimbursement policy on older people’s experiences was carried out by the Commission for Social Care Inspection (CSCI 2004, 2005). This examined the experiences of 70 older people, in seven localities across England who were discharged from hospital in March 2004, conducting a follow-up study nine months later (twelve months after the implementation of reimbursement). The study concluded that reimbursement had helped to accelerate a downtrend in the number of delayed hospital discharges, but that behind the very promising statistics lay a much more mixed picture in terms of the quality of the person’s experience. The study did not find gross risk as a result of premature discharge but there was marked variation in readmission rates at the first point of follow-up, rates varied between 8% and 50%. By the time of the second follow-up study one third had been in hospital again (some more than once) and often as a consequence of a crises that might have been potentially avoided. There was also evidence of large proportions of older people moving into care homes on a permanent basis. In the follow-up study, there remained peaks and troughs in discharge delays in some councils but overall the localities that had more problems at the time of the original study had learned from the more successful places and were introducing new initiatives to better facilitate the transition home. In all councils visited, the reimbursement scheme had brought councils together rather than pulling them apart.
This last finding was supported by Baumann et al.’s (2007) aforementioned study. They conclude that reimbursement appears to have been largely helpful, prompting efficiency driven changes to the organisation of services and discharge systems. In particular, factors contributing to this were the requirement to further prioritise tackling delayed discharges, develop more robust communication systems, and monitor and report delays more rigorously. Significantly, “far from creating a blame culture in these already high performing sites, it has added some clarity about responsibility that allows sites to get to the heart of the problem and find appropriate solutions” (Baumann et al. 2007, p304).

According to Lymberry and Millward (2004) reimbursement is inadequately theorised in that it focuses only on acute beds, not the sub-acute hospital beds which are also critical to the care of older people. However, the reimbursement legislation is framed in a way that will allow regulations to “gradually extend the reimbursement mechanism through the whole system, where this would be appropriate and beneficial to do so” (Department of Health 2002b).

A survey carried out by the NHS Confederation (Lewis and Glasby, 2006) of 35 mental health providers, found that staff supported the extension of reimbursement, but concluded that this may actually be motivated by a desire to try anything that might reduce delays rather than by commitment to this particular policy. Thus, it was concluded that most people seemingly in favour of extending reimbursement might be better described as 'anti-delayed discharges' rather than necessarily ‘pro-reimbursement’.


‘The initial focus of the introduction of reimbursement to the acute sector was on one part of the whole system, social care, but the successful use of reimbursement money has depended on understanding that the reason for delays was much wider than social care assessment shortfalls…Fines did not galvanise Local Authorities. The key to successful management of delayed transfers was the provision of £100 million a year, for three years, from the NHS budget which have helped to bring about whole systems planning and integrated solutions’.

There are at present no plans to extend reimbursement to mental health or community hospital beds (Change Agent Team, 2007). This may suggest that the policy of
reimbursement has already fallen out of favour in England. Lewis and Glasby (2006) conclude that it is far too early to consider national extension of reimbursement based on the evidence currently available.

2.3 Summary
This chapter considered national trends in delayed discharge across England and Scotland and the wider literature to assess what is already known about the effectiveness of reimbursement and Joint Action Planning:

- It is difficult to make direct comparisons between England and Scotland in terms of the effectiveness of the different policy solutions to tackling delayed discharges because of the variation in the way the data is collected.

- There has been a significant decline in delays in both England and Scotland. Most commentators agree that it is very difficult to ascertain the extent to which the Community Care Act (and in particular “cross charging”) contributed to the decline in England because of the concurrent impact of the Delayed Discharge Grant and other measures such as intermediate care.

- Scottish achievements in reducing delayed discharges appear to be more closely linked with Joint Action Plans and the accompanying resource investment. However, it is not possible to discern which initiatives or which bundles of initiatives contained within the Joint Action Plans have been most effective. In Scotland, strategic planners at NHS Board and local authority level believed that partnership working between the NHS and social services working around delayed discharge had improved since 2002 and was a factor in the reduction of the number of people delayed in hospital.

- Statistical evidence suggests that there is a link between the number of emergency medical admissions and the number of delayed discharges. The national picture suggests that both countries are managing increased emergency admissions at the same time as a reduction in the number of delayed discharges. In England there has been a steady rise in readmissions to hospital of older people within 28 days of discharge at the same time as a reduction in delayed discharges.

- It is conceivable that the apparent success in increasing hospital throughput, shortening length of stay and reducing delays in discharge has been accompanied by deterioration in the overall quality of care (McCoy et al. 2007). While an early audit report on
reimbursement (CSCI 2004, 2005) did not find that older people were being placed at undue risk, there are broader questions as to the extent to which current policies designed to tackle delayed discharge are supportive of quality improvements in discharge planning more generally.

- To date, there is very little evidence on the impact of reimbursement and Joint Action Planning on the practices of front line health and social care professionals and managers.

- It appears that despite considerable success in reducing delays, health and social care systems in both countries are still challenged by lengthy delays especially in some complex cases. This is a central theme in respect of service user experience and outcomes described later in the study.
3 Strategic Approaches and Implementation

3.1 Overview
This chapter examines strategic approaches to the management of delayed discharge within the five sites. In particular, we highlight key areas of difference, uncertainty and some challenging aspects of translating policy into implementation strategies.

3.2 Site selection and fieldwork
The case study sites were selected through a combination of: (i) analysing national data trends; (ii) discussions with key stakeholders at national level and; (iii) discussions within the project team based on our research aims. Because data collection often yielded sensitive information, a decision was taken not to name the sites within the context of this report. Sites 1 and 2 are located in Scotland and sites 3, 4, and 5 are in England.\(^6\) Scottish sites are similar to those in England in respect of key factors such as rurality and organisational complexity. Sites 2 and 3 are of similar population size, having around three quarters of a million residents. Both of them have large acute teaching hospitals that also offer regional specialties. Sites 4 and 5 are also broadly alike in population terms, with around 200,000 populations and lying close to large conurbations, one in the north of England and one in Outer London. Site 1 has a population in the region of 400,000 and serves urban and rural localities. The sites embrace different rates of delayed discharge as detailed in Figures 11 and 12\(^7\) overleaf.

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\(^6\) An additional site was included for England as the research team had the opportunity to build on earlier work linked to one fieldwork site which had been included in the national evaluation of intermediate care (Godfrey et al. 2005).

Figure 12 illustrates the pattern of delayed discharges in the main provider hospitals relating to each English site. Originally we decided to use data from provider hospitals as the basis for this chart, in order to get a single picture of change over a six year period, which was not possible for Local Authorities or for health commissioners (PCTs). The pattern shown in these hospitals does reflect the data from Local Authorities and PCTs where this is available. However, since there are doubts about the robustness of data collated prior to October 2003, these have not been included in the published graph.
Figure 11 - Patients Ready for Discharge Who are Outwith the Six Week Discharge Planning Period: Scottish Sites and Scotland; September 2000 to April 2007

Source – ISD
(NB different axis values for Scotland)

Figure 12 - Delayed discharges in our three English study sites and in England October 2003- April 2007

(NB Note different axis values for England) Based on SITREP data for the main provider hospital in each study site obtained from DH statistics

Fieldwork in the five case study sites was carried out between the spring and autumn months of 2006. The first stage involved the collection of documentary data in each of the sites to
compare local policies and procedures relating to delayed discharge (partnership protocols, local implementation plans, procedures for implementing reimbursement). This was followed by interviews with strategic and operational managers in health and social care agencies (n=56); with patients (n=68); operational staff directly responsible for their care/discharge planning (n=132), and informal carers (n=40). Patients were selected for interview from among those who had been referred for social care input. Using the systems in place for identifying such individuals in each site during a specified period, we approached for interview individuals whose discharge was delayed for whatever reason. Our rationale was that this would allow us to explore whether reimbursement might have had the consequence of exporting the ‘problem’ of delays elsewhere in the system. In Scotland, we selected patients from among those who were delayed for six weeks or more. A follow-up interview was conducted with patients and carers between four and six months subsequently. The researchers immersed themselves in the localities and whenever possible observed practices and relevant meetings (discharge planning groups, acute bed forums). More detailed information about the research methodology can be found in Appendix 2. This includes a detailed profile of the cases tracked in this study.

The chart below (Figure 13), derived from SITREP data indicates the considerable variation between sites not only in recorded delays but also in the proportion of reimbursable delays. Understanding what this actually means is complicated because we found considerable diversity in investment in the intelligence and data gathering systems designed to performance manage delayed discharge across sites. Furthermore partnership agreements relating to reimbursement had clear effects on what was and what was not counted as a reimbursable delay as we discuss later.

**Figure 13 - Rates of reimbursable delays in English sites 2006-7**

<table>
<thead>
<tr>
<th></th>
<th>Total number of bed delays</th>
<th>Total number of reimbursable days</th>
<th>Proportion of reimbursable bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 3</td>
<td>12364</td>
<td>3434</td>
<td>27.8%</td>
</tr>
<tr>
<td>Site 4</td>
<td>1618</td>
<td>32</td>
<td>2%</td>
</tr>
<tr>
<td>Site 5</td>
<td>1321</td>
<td>111</td>
<td>8.4%</td>
</tr>
<tr>
<td>England</td>
<td>785093</td>
<td>185,868</td>
<td>23.7%</td>
</tr>
</tbody>
</table>

Source of data: SITREP- allocated to local authority codes.
3.3 What is meant by ‘delayed discharge’?

From the outset, the meaning of ‘delayed discharge’ and its determination in practice has been widely contested. Indeed, a major difficulty in undertaking a comparative study on this topic is the different definition of ‘delayed discharge’ in England and Scotland.

The diverse processes and criteria by which decisions are arrived at to determine a delay mean that different local factors will operate in both countries to construct the pattern of delays. In England, the involvement of the multi-disciplinary team in the decision-making process and the broadening of the criteria of ‘fitness for discharge’ open up the process to negotiation between partners at local level. In Scotland, the determining role of the ‘responsible clinician’ (at the time of the research) was also likely to give rise to local variation – both between clinicians within as well as across hospitals/units.

Some respondents, in all sites and at various levels within different agencies, point to the constructed and negotiated nature of ‘delayed discharge’:

‘Technically if everyone obeyed the same rules and interpreted them the same way the definition of what constitutes a delay would be standard…In practice, I very much doubt it. It represents a bureaucratic attempt to put firm lines round fuzzy concepts in uncertain systems involving the frail elderly. So, if someone tells me that an old lady became a delayed discharge at twenty past three on Tuesday 13th of June I would wonder why it had happened just like that. It’s a necessary artefact in a vague and troubled system’.

Hospital Consultant StHc2 (7)

The “fuzziness” in part pertains to the difficulty in practice of assessing ‘medical fitness’ in respect of older people particularly with multiple health and functional problems. A senior social services manager in Site 5 argued that ‘medical fitness’ in the sense of ‘no need for acute care/in a position to care for oneself’ will vary not only with the setting where people are intended to go – whether home or long-term care – but the person’s rehabilitation potential and the services available to enable that.

Within our two Scottish sites, the determination of ‘fitness’ for discharge reveal important differences in emphasis between professionals within health and social care agencies. For medical and nursing professionals, the emphasis is on ‘medical’ or ‘clinical’ fitness; for social care professionals, it is “well enough to go home either with assisted support” or “well enough to go to a care home with the assisted support provided”. Moreover, therapists and
social care staff generally consider that the decision-making about readiness for discharge is driven by medical conceptions and dominated by doctors/consultants. Even so, it is argued that the partnership initiatives around discharge planning have effected some change and there are more opportunities for therapists and social workers to contribute to decision-making within the multi-disciplinary team.

In the English sites, there is acknowledgement that reimbursement has directed attention at ‘reimbursable delays’, the perceived impact of which tends to vary depending on where the respondent is located in the system. Health staff in particular voice concern that reimbursement has concentrated attention on reimbursable delays to the detriment of shared responsibility for joint action on all sources of delay:

‘...the whole focus has been on reporting reimbursable discharges...the problem is considerably wider than that...it is overall bed usage...and because so many beds are occupied by people who are ready to move on means that people are being delayed unnecessarily in getting in’.

Senior Hospital Manager StHc 5 (5)

And,

‘The physicians on our elderly beds unit will tell you that they have huge problems with delayed discharges and that we have lots and lots of them and that half the patients they see on their ward rounds are delayed. But if you ask Social Services we don’t have any and they are actually talking about two different things. There’s a big difference in people’s understanding and we are trying at the moment to bridge that so we are all talking about the same thing.’

Senior Hospital Manager StScHc4 (3)

We now turn to explore in more detail how sites approached the issue of implementing policy on delayed discharge. In the next chapter, we return to the question of negotiating ‘delays’ at patient level.

3.4 From policy to implementation: Joint Action Planning

Within the two Scottish sites, there was agreement among strategic managers in health and social services that delayed discharge not only is of key policy interest but is a top strategic priority within the local health and social care economy. Whilst both sites mirrored the national picture in respect of a reduction in delayed discharges from 2001/2 onwards, the numbers of older people delayed in hospital for six weeks or more were still high in light of the target of zero delays by April 2008. In each case, the Joint Action Planning process
established a framework for shared responsibility between the health and social care partners to review progress made, identify problems and initiate service developments to reduce the numbers of older people experiencing a delay.

In both sites, the main contributory factors in delayed discharges are identified as lack of capacity in community care services, particularly care home places and home care support, both to facilitate discharge of people with complex needs and prevent unnecessary emergency medical admissions. These factors could be exacerbated during periods when funding for such places was not available.

Systems are in place in both sites to routinely monitor individual patients (quarterly census), track length of stay and agree funding (jointly managed funding panels). The service development response in Site 1 focuses primarily on initiatives at the hospital/community interface: short term supported discharge schemes or intensive support in the home on a time limited basis to either prevent admission or facilitate discharge. In Site 2, the emphasis is on expanding long term care capacity, enhancing therapy input in acute and rehabilitation wards and increasing home care resources. Whilst some of these initiatives were either in development or only beginning to come on stream in the course of the study (expansion in care home places in Site 2), others were operational (early discharge schemes in Site 1 and additional funding for home care in Site 2). Even so, as we consider later, the main reason for delays of patients interviewed in the study are that they were waiting for a place in a care home (related to capacity and not choice) or for a home care package.

In Scotland, Joint Action Planning between Health Boards and local authorities encourages the development of locally based practice initiatives to prevent/reduce delays but does not necessarily involve the implementation of specific procedures laid down by the Executive. In the drive to prevent and reduce delays, Partnerships are encouraged to develop practice initiatives that take into account local circumstances. There are policy guidelines from the Executive, for example, early referral to social services is recommended as ‘good practice’ (SEHD, 2006), but unlike the reimbursement policy there are no specific mandatory timescales.

Instead, each Partnership is annually evaluated by the Executive in the form of the Joint Performance Information and Assessment Framework (JPIAF). The Executive invites each Partnership to submit details of how they plan to deliver the next steps on outcomes for delayed discharges. The Partnerships are assessed on a number of performance indicators related to whole systems performance and local improvement targets. For example the
JPIAF for 2005-06 consisted of four Performance Indicators (PIs): Whole Systems working; Local Improvement Targets (e.g. reducing emergency admissions, developing intensive home care & rapid response and better support for carers); Single Shared Assessments; and Access to Resources across agency boundaries. For each of these PIs, partnership performance is also measured. Thus, partnership in the context of Whole Systems Working is assessed at three levels: (i) relative performance vis-à-vis the average; (ii) demonstrable holistic working and local cause/effect processes; and (iii) translation of the above into medium term strategic action and annual local improvement targets (i.e. what the problems are and what they intend to do about it over the next year). Any indicator in which a partnership scores, “improvement required’ is followed up by the Executive’s Joint Future Unit. Where a partnership’s overall performance is deemed “improvement required’, the Joint Future Unit or the Joint Improvement Team becomes involved as appropriate. In 2007 the Scottish Executive became the Scottish Government following the Scottish Parliamentary elections in May. In October 2007 the National Outcomes Framework was introduced in place of the JPIAF to demonstrate how joint working between local authorities and their NHS partners is improving community care services. The National Outcomes Framework includes four national outcomes and 16 performance measures. National targets are also currently being developed as part of the Framework.

In Scotland therefore, whilst the implication is that local partnerships will review their own front line practices and procedures and make any improvements necessary to meet their targets for reducing delayed discharges, these processes are strongly monitored by the Executive. This applies both to the annual assessments and the quarterly census figures. In the 14 Health Board Area Partnerships in Scotland, when the census figures show areas falling short of targets, not just senior delayed discharge staff but senior Health Board and local authority staff (including chief executives) are asked to account to the Executive for their particular area’s performance.

Among strategic planners in Scotland there was broad support for Joint Action Planning as an approach to tackling the problem of delayed discharge. As a result, the process of policy and practice implementation was not perceived as contentious among those interviewed. There were, however, comments from both sides of the partnerships which recognised each other’s financial pressures and its impact on what could be achieved.

‘There are issues about the amount of funding the Local Authorities put into their older peoples’ programmes in terms of GAE analysis. I think there are issues about whether they’re below the Scottish average so I think one could
pick particular Local Authorities... The contribution they make to the older peoples’ programme is less than one would hope for if one is to prioritise these patients. Undoubtedly you can argue that with everything...health has been subject to that in the past few years with the new contracts (following the introduction of free personal care) which have cost majorly more than the Executive has funded so there are continual pressure on both sides’.

Strategic Health Manager StHc2(6)

A number of strategic planners also expressed concerns that the monies for delayed discharges allocated by the Executive since 2003-4 had, in their opinion, not kept pace with health and community care inflation costs and that to sustain the reduction in delays and achieve and maintain the zero targets, the Executive would need to provide additional funding, especially with the growth of complex cases involving very frail older people. This applied particularly to the provision of intensive home care support and care home places, the inadequacy of which contributed to delays. Concerns about monies for delayed discharges should be placed in a context where local authorities are mandated to deliver on a range of policies each of which has financial implications, and where budgetary control is a perennial challenge. Whilst free personal care policy was not cited as a major issue by managers, it represents an expenditure that local authorities were faced with at the time of the study. Free personal care policy, which was introduced in 2002 means that older people who are assessed as needing personal and/or nursing care will not be charged for it. Between 2002 and 2005 there was a ten per cent increase in the overall number of local authority home care clients. Within this group, the number receiving personal care increased by 62 per cent. Although £712 million was allocated for its delivery some local authorities have remained within budget, but others have overspent and report that free personal care has been a significant cause (Bell et al. 2007).

In Scotland, therefore, there are checks and balances built into the delayed discharges system and whilst the levers that can be pulled are not as potentially penalising and punitive as in England, they do exist.

As a senior strategic planner in one of the Scottish sites stated;

‘You have to find ways of making partnership stick and the only way I can think of, that works, is a disincentive which is that nobody likes to be publicly humiliated. So I think publishing data regularly, naming and shaming who it is and has failed to deliver and holding individuals to account rather than just
3.5 Reimbursement: framework for local implementation

In order to develop systems to cope with delays in the context of reimbursement, guidance required local statutory agencies to work in partnership, to determine that there was sufficient appropriate service capacity in their locality, to agree the processes and pathways through which patients’ discharges could be organised and how the system of fines would work locally.

The ‘stick’ of fines was mitigated by the ‘carrot’ of additional resources in the form of the Delayed Discharge Grant, (£100 million nationally) allocated to local authority Social Services Departments to develop this partnership work (see Box 3:1).

<table>
<thead>
<tr>
<th></th>
<th>2003-4 £000</th>
<th>2004-5 £000</th>
<th>2005-6 £000</th>
<th>2006-7 £000</th>
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<td>Site 5</td>
<td>200</td>
<td>409</td>
<td>404</td>
<td>393</td>
<td>383</td>
</tr>
</tbody>
</table>

3.6 Policy implementation at local level

Within the three English sites, whilst it might be anticipated that the more formal and prescriptive policy context set by reimbursement would lead to greater consistency in strategic approach and policy implementation, this proves not to be the case in practice. In part, this reflects the perceived significance of the delayed discharge problem in the system; in part it reflects features of the local context (historical patterns of services, inter and intra-agency relationships and vested interests).

In the English sites, there was recognition of significant improvement in dealing with delays from the position five years previously. Success in reducing delays was attributed to measures such as increased capacity, particularly around intermediate care provision, service redesign and effective management of multidisciplinary working. In Site 4 the impact of reimbursement in achieving the intended outcomes was perceived by senior social care managers as minimal compared to these initiatives. In Sites 3 and 5, on the other hand, the
consensus emerging from documentary data and interviews with strategic managers in health and social care is that delayed discharge - for whatever reason – remains a major issue for strategic managers, that initiatives to manage it preceded the introduction of reimbursement but that reimbursement has provided specific incentives or drivers in the system in the following ways:

- In both sites, it has raised the profile of delayed discharge and has led to the establishment of joint mechanisms for the systematic collection of data around delays, for negotiating between agencies about the reasons for delays and for reporting them externally;
- It has acted as a spur to create routine multidisciplinary forums to review pathways of individual patients and facilitate their move out of acute care;
- It has directed attention and resources at assessment and discharge planning for those particularly with complex health and social care needs. This complements action within acute trusts to reduce average length of stay and increase admissions in the context of a reduction in acute beds in a new PFI hospital (Site 5) or addressing the 4-hour wait target in A&E (Site 3).

Each site adopted a somewhat different approach to partnership working in developing their strategy to manage delays. Within Site 5, the formal partnership is based on the following principles: joint agreement on prioritising expenditure; transparency of finance and resources in the system; and investment of all new monies including the Delayed Discharge Grant in enhancing capacity. This is most clearly evident in respect of the acute trust within the borough boundary where capacity development is targeted at the entry and exit points of the acute hospital. There has been an expansion of the scope and multi-disciplinary composition of the Intermediate Care Rapid Response Team operating from a base in Accident and Emergency to prevent unnecessary acute admissions and facilitate early discharge through in-reach into the Medical Assessment Unit. There has also been the organisational integration of hospital social work, continuing care assessment and discharge planning. In addition, a Notifications Team comprising social workers employed by the local authority has the dual remit: to monitor assessment and discharge planning for patients on a Section 2; and provide an assessment and discharge planning role in respect of patients in acute trusts outside the borough boundary. The team manager also acts as a single point of access for all notifications and for negotiating and agreeing delayed transfer of care returns. The rationale underpinning this approach is that investment in service development would both reduce reimbursable delays and be called off against any fines incurred. From a local authority perspective, the strategy has meant substantial investment in services within/at the
boundary of the acute hospital, resulting in minimal reimbursable delays and a reduction in all delays. Whilst acknowledging the investment, senior managers in the main acute trust are preoccupied with increasing throughput, reducing length of stay and addressing all delays. Indeed, in response to this, there was, in the autumn of 2005, a broadening out of the weekly multi-disciplinary forum from a focus on patients whose discharge was delayed to include all patients with lengthy acute episodes (defined as stays of more than 20 days).

In Site 3 there is substantial inter-agency partnership working on strategies to shift resources towards more community based services; initially relating to older people’s services and then to redesign of care pathways for all acute services. Significant investment has been agreed within these city-wide strategies on intermediate care, hospital based rapid response and joint care management and more recently to community rapid response and admission avoidance services. These joint strategies are implemented by individual agencies, without any formal pooling of budgets. In this site, the Delayed Discharge grant is not part of the joint protocol. A small part of it has been used to fund additional discharge co-ordinators but the bulk is being retained and deployed by the local authority as one senior manager explained, to “increase the amount of care purchased...home care and residential care”.

In respect of reimbursement, a more literal interpretation of national guidance was pursued in Site 3 from 2003, set out in the Joint Protocol that agreed principles, systems and operational processes. It was established that the local authority would pay any fines to the acute trust to be then passed on to the primary care trusts to spend on community services. The agreement was short lived in the context of considerable financial and performance challenges. From the perspective of the acute trust, additional costs relating to the management of older people in acute care and meeting its own performance targets gave legitimacy to retaining ‘fines’. For the local authority, subject to its own financial pressures, action by the acute trust was responded to by a refusal to hand over fines until new arrangements were negotiated. From mid 2005 a new agreement has been brokered. In 2006, £400K per annum (the estimated costs of fines) has been invested in a Discharge Task Force (DTF) to promote joint working on delays and to facilitate timely discharges; a budget available to the DTF is primarily being used to spot purchase home or interim care. Thus, an initial attempt to divert reimbursement money towards community infrastructure shifted to a more pragmatic approach to dealing with delays on a short-term basis.

In Site 4, the ‘problem’ of delayed discharge as reflected in statistical returns was small, even prior to reimbursement. This position has been sustained over time. The Commission for Social Care Inspection (CSCI) Performance Review Report for Adult Social Care 2005/2006,
reported that there were no delayed transfers of care for which the local authority was responsible all year and in this respect it is one of the highest performing authorities in the country in tackling delayed discharge. For the same period there was only one delay reported for the ‘acute beds’. This context then, provides the backdrop to the initiatives put in place to implement reimbursement: the re-organisation of hospital based social work teams (attaching social workers to individual wards) with responsibility for all community care assessment and discharge planning for patients in hospital; and the use of the Delayed Discharge grant by the local authority to commission five ‘nurse led’ assessment beds from the acute trust to provide assessment and rehabilitation, thereby expanding intermediate care capacity. The emphasis here then is on streamlining community care assessment and involvement in discharge planning; in extending the intermediate care repertoire; and providing transitional support to those who do not need acute care but whose long term needs require further assessment to determine. The joint protocol on reimbursement agreed between social services and the acute trust is directed primarily at operational aspects of implementing the notification system rather than on strategic issues. Thus, the mechanism for the systematic collection of data around delays, for negotiating between agencies about the reasons for delays and for reporting them externally is a weekly meeting between senior managers in the acute trust and social services. However, the delayed discharge intelligence and data gathering systems within the acute hospital trust were under review at the time of the fieldwork, and among staff there was much disagreement as to whether the figures officially reported accurately reflected the true nature and extent of delayed discharges. This is examined in more detail in the next chapter.

3.7 Managing delays: intended and unintended consequences

The time lapse between negotiations around reimbursement and interviews with strategic managers means we could explore their views of policy implementation from the vantage point of some 30 months experience. If the general consensus among those involved at strategic level at the outset is that reimbursement provided a kick to the system, the verdict now is generally more muted and ambiguous, despite the fact that formally there has been a reduction in both reimbursable and all delays. In part, this reflects the interests of different agencies vis-à-vis the delayed discharge ‘problem’. In part it relates to agencies and professionals’ assessment of the extent to which reimbursement is managing the ‘problem’ as they now perceive it. Firstly, we examine the views of reimbursement articulated by strategic managers under the broad themes: success in reducing delays, patient choice, and joint working. Secondly, we look at shifting perceptions of the delayed discharge ‘problem’.
3.7.1 Success of policy in reducing delays

In Sites 3 and 4, there is a clear divergence between health and social services managers in their assessment of reimbursement.

In Site 3, whereas acute trust managers and clinicians view reimbursement positively as contributing to speedier response times for assessment and care planning and better patient care and would see it extended across the board in mental health and rehabilitation, their counterparts in social services and the primary care trust (PCT) are more ambivalent. A senior social services manager makes the point that reimbursement has created a bureaucracy of considerable proportions:

‘The thing that reimbursement has done is added another rich layer of complexity onto the process because now... we argue about who is paying for what, whose responsibility the delayed discharge is – is it a health delay, is it a social delay or is it in fact the bed occupant’s own fault because they want to go somewhere where there isn’t a vacancy and they are refusing to move from there? We have created a whole industry around delayed discharge... If anybody was to sit down and work out how much it costs us to have these discussions, to come to a view about how we settle up on delayed discharges, how we account for delayed discharges, it must cost the system hundreds and thousands if not millions of pounds a year’.

Senior Social Services Manager StSc3 (10)

Others consider that whilst it has created a more efficient patient processing mechanism so that the “discharge carousel spins faster and faster”, they question whether the consequences of this are helpful to patients (see Chapter 5 for a discussion of the experiences of patients). A senior manager in the PCT argues that it has not proved effective in enhancing community based services and should be replaced with shared targets around all delays and joint investment plans to create services.

In Site 4, some senior social services managers articulate a more positive view of reimbursement as compared with their colleagues in health agencies. It is viewed as having clarified roles and responsibilities, especially in the ‘grey’ areas around patient choice:

‘For Social Services, reimbursement has in some respects been a godsend’.

Senior Social Services Manager StSc4 (1)
From the perspective of senior managers in the acute trust however, the focus on reimbursable delays has meant there is a lack of shared responsibility among all the partners to respond to all sources of delay. And although, as noted earlier, there are few recorded delays of any kind reported in Site 4, there was a strongly expressed view among senior clinicians that the problem of delayed discharge has been relocated to the rehabilitation wards.

In Site 5, the verdict on reimbursement of senior managers across the agencies was generally more positive, but then “we had a very big nut to crack”. At the same time, there was the perception that it was the approach adopted by the local authority – transparency in the flow of money and joint agreement on investment decisions that contributed to shared understanding, trust and commitment to work toward finding solutions to address all causes of delays, and not just reimbursable delays.

It is difficult to draw any clear conclusions about the role played by the ‘stick’ of reimbursement i.e. fines imposed on the local authority for reimbursable delays. With the exception of Site 3, little or no money has changed hands in ‘fines’. Only Site 3 has maintained a consistent mechanism of invoicing. Here, Social Services received invoices as follows: no charge in 2003-4 when reimbursement became operational from 5th January 2004, £216k in 2004/5 and £422k in 2005/6. In Site 4, no charges have been imposed. In Site 5, by agreement, the main local provider has not issued invoices, since any fines were to be called off against investment in service development. In 2005/6, a small sum, just under £3K was paid to other hospitals outside the borough boundary, the bulk to one acute trust that had refused to engage in the partnership agreement – a significantly smaller sum than had been initially offered by the local authority as investment in capacity.

However, in each of the English sites, there was a view that the reimbursement ‘stick’ – whether wielded or not – is creating certain imbalances or inequities in accessing resources. The re-location of the problem of delays to rehabilitation wards as expressed in Site 4, found echo also in Site 3. In Site 3 as well, PCT managers expressed concern that the siting up of intermediate care could be attributed in part to the difficulties staff experienced in securing timely access to home care packages – since priority is given to those being discharged from acute care. Blockages in intermediate care could also impact on decision-making about who was accepted into the services, as illustrated in a patient’s experience in Chapter 4. Social services managers and staff expressed concerns about community-based individuals who were waiting for long periods for homecare, because priority was given to patients who were discharged from hospital, especially if that person was reimbursable.
3.7.2 Patient choice

In two of the English sites (Sites 3 and 4) ‘patient choice’ is a particularly contentious area around which tensions are played out and partnerships tested. Under the rules of reimbursement, where once an offer of a specific placement or bed has been made and refused, the patient’s delay becomes non-reimbursable, which it is suggested, gives rise to ‘gaming’ in times of resource constraint.

In Site 4, patient choice is cited by the acute trust as a significant cause of delay, particularly in respect of those waiting for long term care. It is also viewed as a problem for which the local authority can divest itself of responsibility and a key factor in the sense of mistrust felt by health staff in the way holding beds are sold to patients and families:

‘…most of our hold-ups would be about waiting for financial details from people, waiting for homes, patients who are offered holding beds and refused and the way that those holding beds have been sold to them…For the patients where it is quite straight forward and where they do fit the category of being reimbursable, Social Services will turn those around very, very quickly.’

Senior Hospital Manager StHc4 (3)

Similar views were expressed by senior managers in Site 3:

‘… If the resources are not in the system or the solutions are not being sought from within existing resources then you will find ways of manipulating the system… I wouldn’t say every patient in the choice category is there because of manipulation of the system, but no doubt in our mind it’s a high percentage of them are [as a result of] professionals offering them an inappropriate choice knowing they are going to turn it down’.

Senior Hospital Manager StHc3 (13)

In Site 5, patient choice is viewed less as an arena of conflict between health and social care and more about disputes between families and the multi-agency placement panel over continuing care, particularly in respect of people who were above the financial threshold for paying for their own care. Here also, some senior acute staff articulated that ‘choice’ is not just a social services responsibility:

‘It’s not always social services that causes the delay…many times it could be the patient themselves, or the family…it’s about communicating and liaising with
family …conveying to them: “its an acute hospital – we need the beds to treat sick patients, we’ve given you options; we want to support you in making decisions now - you have to make choices”…It’s a big cultural change’.

Senior Hospital Manager 5 (4)

Whilst this particular dimension of the ‘choice’ debate was evident in the other sites also, it was this facet that was of most concern to managers here.

In Scotland, patients have the statutory right of choice in deciding which care home they wish to go into and can wait for their preferred choice to become available. *Guidance on Choice of Accommodation – Discharge from Hospital*, which was issued in January 2004 does, however, encourage patients to identify at least three care homes that are acceptable as future residences and if the preferred choice of care home is not available an interim place will be found within the six week planning period. Figure 8 in Chapter 2 shows that patient choice was a reason for some of the delays recorded from September 2000 to April 2007. The picture, however, is uneven across the country. Census data for one local authority in Site 1 for instance, suggests that the exercise of choice is not a contributory factor for delays. In 2005, one person exercised their statutory right of choice out of a recorded 103 delays for the year, representing 1 per cent; and in 2006 ‘patient exercising statutory right of choice’ was not recorded once as a reason for the older person being delayed 6 weeks or more.

3.7.3 Partnership

In their approach to implementing the legislation and guidance on reimbursement, Sites 3 and 5 exhibited high level commitment of energy and resources in partnership working, reflecting an appreciation at strategic level of the scale and priority attached to the problem of delayed discharge. Even so, as described above, in Site 3, lack of transparency on the deployment of monies, coupled with a failure to agree priorities for action at a time of significant financial pressures contributed to a period of mistrust in relationships and early disruption of the protocol agreements. Some senior social services managers in Site 3 made the point that the legislation was itself divisive and counter-productive to the creation of good partnerships in its conception of ‘blame’ directed at one of the partners. But simultaneously many managers and staff in this site noted that regular working together and detailed investigation of issues of delay had in fact improved working relationships and brought shared understanding and ownership. At the time of the fieldwork, strategic planning relationships were regarded as more positive, but it was acknowledged that partnership waxed and waned:
‘I’d say it’s been pretty consistent that way (good partnership working) since about last summer, so, and we’ve have periods in the past where we’ve had consistency, but, the system has lost its momentum every now and again. Of course I think a lot of that has been down to how we interpret policy and procedure on reimbursement, and sometimes in the past, we’ve got into difficulties with social services where we’ve had different interpretations. It’s almost like everybody tends to go back into their own camps, because of their own financial pressures, and the whole system approach sort of disintegrates’.

Senior Hospital Manager StHc3 (13)

As indicated above, in Site 5, partners placed great store on the jointness of investment decisions and the sense of shared responsibility this engendered for identifying and tackling all sources of delay. The approach was perceived as facilitating a common framework for joint working:

‘…what’s probably rolled on here is the partnership agenda …we were lucky in the way it was embraced by the acute trust and by the local authority…the way the local authority handled it was very, very positive…It was ‘let’s not get into fines, guys. Let’s invest the money…it was a real partnership.’

PCT Manager StHc 5 (1)

It was evident here also that despite quite often difficult negotiations relating to individual cases, there existed considerable mutual trust between individuals across agencies responsible for managing the process of notification and reporting. Even so, in final interviews with senior managers there were expressed portents of trouble on the horizon linked with financial difficulties in each of the agencies.

In Site 4, the scale of the ‘problem’ to be dealt with at the outset was viewed as small, although partners appeared to differ on this. Here, reimbursement was seen as having created a particularly defensive climate where there was (quite understandably) a strong desire on the part of social services to maintain their untarnished record as regards never having had a reimbursable delay. However, this caused tensions with health staff and hospital managers that saw this as a denial of their service capacity issues:

‘I don’t know whether I agree with reimbursement or not, but the thing that would be most helpful to me, and the thing that I am striving towards is a better working relationship with Social Services. I don’t actually think reimbursement
would help that in any way because it would just become whether or not the patient is reimbursable. Whenever we come across a problem everything comes to halt and Social Services say well it doesn't matter they are not reimbursable and we say well it does - they are in our bed and we just don't get anywhere’.

Senior Hospital Manager StHc4 (3)

What comes across clearly from the foregoing, is that partnerships do not denote a fixed set of relationships but are subject to tension and faltering, reflecting different interests and different pressures operating on each of the partners at varied points in time.

In part this relates to the fact that reimbursement is only one mechanism in securing a general shift in the re-focusing of acute care that is not necessarily viewed in the same terms by each of the agency partners. This is articulated by a senior acute hospital manager in one site, but mirrored in others:

‘My overriding concern is that we make maximum use of each acute bed – that is what drives my concern about people waiting in acute beds when they should not be there…We have made enormous strides here over the last two years…having lost 60 beds when the new hospital opened…but through a number of interventions we have managed to reduce our in–patient stay for emergency admissions by more than half…From my point of view the issue is not just about discharge. It is about establishing clearer patient pathways and decision making processes for people with complex needs…for the SSD it is about discharge planning’.

Senior Hospital Manager StHc 5 (2)

Moreover, in England, the primary focus of reimbursement is on delays relating to assessment and service provision by the local authority. Not only is this seen as but one of many reasons for delay, but the apparent singling out of one partner for the ‘stick’ was a source of resentment, particularly in Site 3:

‘[Reimbursement] is a huge problem - with no more money in the system it causes resentment’.

PCT Strategic Manager StHc3 (1)
In Scotland, at strategic level, the Joint Action Plan process, alongside a working culture that had embraced joint working between NHS and social services for some time, facilitated a positive view of partnership working and joint planning around tackling delayed discharge. Staff described how the ownership of the problem was shared equally between organisations:

‘Transparancy, co-terminosity and a unified Trust mean that we have a vision of where we want to be in four or five years time and how we are going to get there’

Director Community Health & Care Partnership StSc2 (1)

However, as becomes clear in the following chapter, partnership working between health and social care practitioners at patient level was not without its challenges.

3.8 Shifting nature of acute care: reimbursement as an adequate solution?
Reimbursement and JAP are policies designed to facilitate more effective flows through acute care by means of action directed primarily at the entry and exit points of the acute hospital. Although they advocate a whole system approach to this, their primary concern is on the effects of patients’ delay on the efficiency of the acute system. Paradoxically, whilst such policies have facilitated quicker throughput, they have also thrown the spotlight on those individuals with complex needs, solutions to which require resources in intermediate or community based provision.

Community based health managers and commissioners in Site 3 expressed concern about delays in intermediate care, where patients had lower priority for follow-on home care services. They viewed reimbursement as shifting delays away from the acute hospital but backing up in another part of the system. As a short term measure here, the PCTs had invested in interim home care so as to be able to discharge patients from intermediate care and disputes occurred with social services in relation to funding such provision. The bottleneck tended to influence staff assessments of eligibility for their services.

‘In the past we would have been more likely to take some of the border-line people on than we are now because the hospitals have the priority for social services because of reimbursement. We struggle to get social services in when we finish...We’ve become more of a bottle neck now with certain patients’:

PCT Operational Manager (PrHc3 (11)
Health service managers and clinicians in Site 4 also expressed concerns about the numbers of older people who were delayed in non-acute or rehabilitation wards, not only in terms of patients’ well-being but also in misuse of those resources.

‘I understand it only applies to the acute beds and the majority of vulnerable patients are listed for the rehabilitation wards. In the real world the main problems are within the rehab beds so that is a frustration’

Consultant Geriatrician PrHc4 (4)

These issues were not unique to the English sites. In all sites, individuals with multiple physical and mental health problems were a particular focus of interest. Among this heterogeneous group, it was commented that lengthy delays were experienced in putting together complex packages of care that often also included specialist housing adaptations or re-housing. Additionally, lengthy delays for older people needing more specialised long term care such as those with mental health problems were viewed as a significant problem that had not been addressed by reimbursement.

There was increasing awareness then from strategic managers not only in England but in Scotland also that the speeding up of acute care required not only investment to facilitate throughput, but resources directed further upstream to support individuals with complex needs in the community. This view is encapsulated in the following quote, which although expressed by one of our interviewees in Scotland, conveys sentiments that were articulated by respondents across all the sites:

‘To the acute sector, like the man with the hammer, every problem looks like a nail. We’re the acute sector, we admit. Delayed discharge has a kind of totemic importance which some would say is the acute sector saying it must remain acute and others would say it is systems failure of which acute sector dominance is a major contributor. We admit in haste, mismanage at leisure, latently you’re a “bed blocker” and that’s why delayed discharge is important. And the best way of avoiding delayed discharge is way up stream with provision for the avoidance, for the identification and support of the frail elderly and appropriate admission avoidance of the frail elderly when they get acute or chronic pathologies… There’s a lot of nonsense around delayed discharge as
the problem, when in fact the problem is a systemic problem about the less than adequate care for frail older people’.

Consultant Geriatrician StHC2 (7)

3.9 Summary

- The experience of ‘Joint Action Planning’ in Scotland points to the significance of a policy that promotes, encourages and incentivises shared responsibility for the problem of delayed discharges – whatever their nature and source. At the same time, whilst it was generally agreed that JAP had contributed to partnership working, there were some tensions between partners around finance. As respondents here argued, the Scottish policy was not without its ‘sticks’ as well as ‘carrots’. However, the ‘stick’ in Scotland, namely, ‘naming and shaming’ and the threatened loss of funding (contained in the original 2002 report on delayed discharges to the Minister for Health in Scotland) meant JAP was directed at the partnership as a whole and not at one of the members. Whilst it might be argued that in England, reimbursement per se set partners against each other, the experience of Site 5 suggests that such a conclusion is too simplistic and the approach to implementation adopted could be critical in developing shared responsibility for the problem of delays.

- Overall, in our English sites, we found different implementation styles of reimbursement at a strategic and operational level. Moreover, partnership working is fluid with shifts and changes arising in light of for instance, financial imperatives and resource constraints.

- Among strategic planners in Scotland there is broad support for Joint Action Planning as an approach to tackling delayed discharge, although some believe that to achieve and sustain the Executive target’s, additional expenditure will be required. There are few contentious issues as regard the process of strategically developing, monitoring and implementing Joint Action Plans, although as in England, questions are being posed as to whether the focus on delayed discharge in and of itself is sufficient.

- In England, there was general agreement that reimbursement has been a spur to focus on the problem of delayed discharge and to bring partners to the table. However, there was much less consistency about the overall benefits of reimbursement and some concerns about unintended consequences in the wider system.
Running through the accounts at strategic level, a more fundamental question was being posed, namely the shifting nature of acute care. Indeed, whilst a major critique of reimbursement was that it contributed to the speeding up of patient throughput in acute care, it is arguable that this process reflects wider changes in the use of acute care – focus on high technology acute care, shorter lengths of inpatient stay and the diversification of less complex treatments and care to other settings. The issue then is the extent to which it is sufficient to locate solutions to this speeding up solely at the entry and exist points of the acute hospital as opposed to more investment in resources for rehabilitation and community based provision. This was equally an issue for strategic managers in Scotland as it was in England.
4 Facilitating Discharge: System Constraints and Patient-Centred Care

4.1 Overview

In this chapter we consider how reimbursement and Joint Action Planning have been implemented in practice in our sites and the perceived impact on inter-agency relationships, negotiation and decision-making around assessment and discharge planning for individual patients. We also begin to tease out some of the implications for individual patients of the implementation of reimbursement and more generally, the consequences of a re-direction of policy emphasising a shift in care from the acute hospital to community-based care that has been taking place in England and Scotland.

One aim of reimbursement and JAP is to facilitate the flow of patients through acute hospital in a timely and appropriate way. The Community Care Act 2003 emphasises the benefits of ‘flow mechanisms’, pointing to increased dependency, infection and loss of social networks as risks incurred in prolonged stays in hospital. JAP cites both the impact of delayed discharges on the capacity of the NHS to treat acutely ill people and an acute hospital as being a ‘wholly inappropriate environment in which to maintain people who need long term care’. Whilst the focus of our study is reimbursement and JAP, these sit alongside other mechanisms that are designed to effect discharge planning, traditionally a site of conflict between agencies (health and social care) and sectors (acute and community), for example: multi-disciplinary assessment and discharge planning, discharge co-ordination and allocation panels. It is well to note at the outset then, that while the ‘flow mechanisms’ linked to JAP or reimbursement tackle a specific facet of discharge, namely the problem of delays, a recurrent theme across all our sites is the speeding up of patient journeys as part of the refocusing of acute care. Yet, many of the patients included in our study were in hospital for lengthy periods of time. It is this duality that shapes the views and experiences of staff in respect of reimbursement and JAP as we see in the following pages.

4.2 Reimbursement: co-ordination mechanisms

Two different types of mechanisms are considered here: those designed to secure co-ordination between assessment and discharge planning; and those aimed at timely notification of need for assessment and readiness for discharge.

All sites in both countries established discharge coordination teams, which were perceived to have progressed joint working. In Sites 3 and 5, where delayed discharges were seen as a major problem, a significant factor in their reduction has been the development of
mechanisms for co-ordinating assessment and discharge planning. In Site 3, a discharge task force (DTF) was established in 2006, linked into both strategic and operational structures, with a dual remit: to facilitate the discharge of patients at risk of, or experiencing a delay; and to deliver a work programme aimed at reducing the barriers to timely discharge. It also acts as the first stage in strengthened escalation procedures whereby individual disputes or very lengthy delays are resolved. In essence, then, it has both a facilitation and enforcement role. The former role is widely welcomed; the latter is at times a source of tension with front-line care managers:

‘I was a bit annoyed really with the Task Force. The daughter was really helpful in keeping me in touch with what was going on. They were ringing the nursing home but it does cause confusion. When I rang the nursing home on Monday, the manager said “How many of you are there?” She had had calls from two of the Task Force. She said she was feeling harassed – she agreed that really she should be ringing the social worker and did not mean to sound cross. I rang the discharge advisor and told her that I would not be ringing the home anymore because they were being bombarded’.

Hospital Social Worker PrSc3 (11)

In Site 5, integration within the acute hospital of assessment (community and continuing care), discharge planning and rapid response under a single organisational umbrella (IARDS) was viewed by health and social care practitioners as contributing to more effective discharge processes and enhanced joint working:

‘I’ve worked here for nearly 20 years…and with IARDS the hospital has really gone intensely to look into the social side. It has massively improved’.

Health Care Practitioner HCP 3 (5)

4.3 Notifications system under reimbursement

4.3.1 Section 2

In England, under reimbursement, the trigger for a community care assessment to plan for discharge is a Section 2 notice. Formally, a Section 2 provides a minimum of three working days for the completion of a social care assessment and the mobilisation of services to meet identified needs. However guidance suggests that good practice will include an informal early alert of the likelihood that someone may need support. All English sites had formally agreed protocols and procedures relating to notifications, and the practice everywhere is for wards to issue Section 2s to a central point from which they are allocated to designated care
managers. In Site 3, the referral points are based in the PCT, in Site 4, in the hospital social work team, and in Site 5, in a dedicated Notifications Team of social workers, established as part of reimbursement. All sites had invested in staff training on the wards on the new systems in place, reckoned in Site 5 to have contributed to the effective implementation of Section 2s, although discharge staff in Sites 3 and 4 commented on the difficulties of getting consistency across all the wards.

The point at which a Section 2 is issued is very variable. In Site 5, for example, the Section 2 tends to be issued within days of admission in respect of patients who are deemed likely to require multi-disciplinary support to facilitate discharge. Here, hospital based social workers are only engaged in assessment and care planning in respect of people for whom a Section 2 has been sent – this provides the justification for social work involvement. Where it is simply the resumption of an existing care package, or a request for assistance or an intervention by a single agency (for example, for a district nurse to dress a wound), this will be organised at ward level. The case study in Box 1 from Site 5 is both illustrative of the practice of early notification and the complexity of need that requires time to achieve a user-centred response.
Box 1

Mrs Marsh (99 years) collapsed at home with complete heart block and was admitted to the coronary care unit in a critical condition. Following insertion of a pacemaker, she became disorientated and confused – prior to her admission she had been mentally alert although physically frail.

Within ten days of admission when her condition had stabilised a little, although she was still confused, a Section 2 was sent to the ward and she was allocated to a social worker for assessment for a care home. Basically ...she was in bed and couldn't do anything for herself at the time because of her health problems...but...this lady...she'd been independent with living on her own. She had a carer three times a day previously to help with personal care and meals.

The social worker with the therapists initially worked on getting Mrs Marsh to sit out on a chair on her own. Three weeks later, she was more alert, initial progress in sitting up was put back on account of an infection and medical and ward staff were of the view that she needed a continuing care assessment for long term care. Mrs Marsh at this point was indicating she wished to go home, supported by her family.

The social worker supported her in this; attempted to get her admitted to the rehabilitation ward but was refused because she was deemed ‘not to have rehabilitation potential’ and then sought increased therapy input on the ward to facilitate her sitting out. The rationale was that even with four times daily home care, she would be alone for several hours during the day and needed to be able to at least transfer from bed to commode: ‘I can't put in twenty four hour care it's just purely you know I can only put in maximum four times a day for you know probably half hour slots and that's pushing it because you need two people each time. So anyway, so she was prepared to take the risk. She said "I don't care what happens I'm going to live and die in my own home, I don't want to go into a home" and her family were prepared to back her up So I said “right I'll do my very best to achieve that”.

With some therapy input, Mrs Marsh was able to sit in a chair for several hours, an application to panel secured an extensive care package (four times daily home care with two carers; a range of assistive devices, including a special mattress) and 64 days after the Section 2 returned to her own home and spoke of her delight to be home. Four months later, she was still at home, although not well enough to be interviewed. For medical and nursing staff a key issue was that Mrs Marsh could have left hospital earlier if she went to a nursing home where 24 hour care would be available; to go home, however, required that she was fit enough to spend long periods on her own.

SU 5 (6)

In Site 3, a census undertaken for our study in June 2006, found that for over a fifth of the 351 patients with section 2s in that month, these were issued more than 8 days prior to issue of the Section 5. Front-line staff also referred to informal early alerts from wards where they had built up good working relationships about individuals with complex needs:
‘I think that maybe we are more sympathetic in our communications with the social services department and try and give them a bit of warning or we try and do professional ‘guestimates’ of what will be the expectations so that they know that they’re looking for something expensive so they could already start thinking about it’.

Therapists PrHc3 (22)

In Site 4, views expressed indicate that there are concerns about the speed of some assessments, especially where complex issues are being considered:

‘If they have come into hospital from their own home and then they need to go to a nursing home or residential home it is quite difficult…These are complex discharges and we need to make sure that people are going out to the right places. You need to take time over the process to make sure you have got everything right for them. Three days for getting an assessment done isn’t very long’.

Senior Hospital Manager StHc4 (3)

Across all the sites, medical and nursing staff especially noted that the Section 2 contributed to speedier response times for assessment and care planning.

4.3.2 Section 5

If the Section 2 is generally perceived as a helpful trigger, the Section 5 is more variably used across Sites. It is also a potent symbol of systemic tensions in the discharge process whose weight is perceived as falling inequitably on social work practitioners.

From a system perspective, Sites 3 and 5 are at opposite ends of the spectrum in respect of their approach to Section 5s, with Site 4 between these extremes.

In Site 3, the Section 5 is a formal, routine element of the system for avoiding delays. Senior social services managers pointed to its value as an audit tool to establish the point of shared recognition that a patient is near readiness for discharge. In practice, informal relationships and rules of engagement involving operational staff introduced an element of variability into the system that could either allow for flexibility in responding to the needs of individual patients or reflect the different pressures on practitioners variously located within the system:
‘I work on two wards which have very different cultures. Both of them are medicine for the elderly wards; one has a well-developed multidisciplinary attitude to care planning, all professionals are included on the ward meeting. If I can’t attend a ward meeting there are regular phone calls. When the S5 is to be issued I am notified so that I can argue the case. On the other ward, they often send the S2 and S5s together which I know is a legal loophole but it means that the accepted day of triggering the assessment is three days rather than four days. It is a coercive method, rather than being inclusive. The social services department is seen as being outside of the decision-making with decisions made by the ward’.

Hospital Social Worker PrSc3 (3)

Where good informal relationships existed between care managers and ward staff agreements are reached about the timing of Section 5s:

‘From the reimbursement point of view, the ward was faultless. By delaying the S5 for 12 days, it was actually hidden from the reimbursement system that these negotiations were ongoing between SSD and the private sector’.

Hospital Social Worker PrSc3 (4)

For social care practitioners in this site, however, there is a strongly held view that the Section 5 is deployed as a tool by nursing staff to speed up the discharge process:

‘I believe that most social workers are able to prioritise their work without being given threats which is the way Section 5s can be used on the wards. I have sat at the hospital listening to sisters talking and saying “Send them a Section 5, that will gee them up”. It can be very negative’.

Hospital Social Worker PrSc3 (3)

No-one wanted a delayed reimbursable patient with a Section 5 amongst their clients. Care managers saw this as an adverse reflection on their own professionalism and the impact on them was twofold: firstly, to subject them to close monitoring and progress chasing; and secondly to inject additional pressure to prioritise action on those for whom a Section 5 is issued:

‘Yes, because every day they are asked about a person, every day they chase. Usually for our teams there are probably only three names on the list so it is not
huge numbers but everyday having to account for what progress they have made, whether the situation is the same. It may be that they haven’t had contact with the ward that day, legitimately but the same questions are asked, is the code still the same, what is the plan for discharge, when is that person leaving, so it is just that always on your back sort of thing’.

PCT Operational Manager StHc3 (8)

And,

‘Getting an S5 is the most de-motivating thing for me. I prefer to plan my own work and make decisions about priorities, so that I can do my best for my clients. That planning and the quality of work is not improved by my managers, discharge advisors, wards etc phoning me to ask if I have done this and done that. The time taken in these phone calls chasing up absorbs time that I could have spent on other referrals. Once the S5 comes into play we are under real pressure’.

Hospital Social Worker PrSc3 (11)

Part of the frustration related precisely to the fact that in the struggle for priority, it was clear that reimbursable Section 5s carried most external weight in obtaining services. Where a service was not immediately available, efforts would be made to move the patient into a transitional bed to wait until it could be provided.

In Site 4, Section 5s are not issued routinely for all patients who are subject to a Section 2. Here, discharge co-ordinators play a key role in generating Section 5s from the wards. Where the discharge is perceived to be timely and straightforward then a Section 5 is not usually issued. There is also scope for some negotiation particularly if it is perceived to be in the patient’s interest to remain in hospital for an extra few days. However, informal agreements may not be sustained where there is pressure on beds, as illustrated in the following quotation:

‘A Section 5 had been issued but we were powerless to move the patient as there was a two day wait for the residential home. I negotiated with the hospital manager not to issue the Section 5 on the grounds that it was not in the patient’s interest to move them to a holding bed for just two days. The hospital manager agreed and the Section 5 was withdrawn. However, the hospital went on Red Alert and the patient did go to the holding bed for a day’.

Social Services Senior Manager StSc4 (1)
As in Site 3, a Section 5 is perceived as adding to the pressure on social work practitioners:

‘As soon as a Section 5 comes in the pressure is on...I remember when they first introduced it, when you heard Section 5, it was panic throughout the office.’

Social Services Reablement Team PrSc4 (12)

There was acknowledgement among acute staff too that a Section 5 is used punitively in some circumstances:

‘You may find that we never have to do a Section 5 because the patient goes somewhere appropriate quickly... Unfortunately there seems to be a need for a stick at the moment...’

Consultant Geriatrician PrHc4 (4)

Within Site 5, Section 5s are only issued where the multi-disciplinary team agrees that this should occur and the social worker is perceived as dragging his/her feet. Where the process is underway to achieve discharge, for example, a plan of action has been negotiated and agreed with the patients/relative and a decision is awaited from the multi-agency panel to which all requests for intensive care packages or long term care must be made, Section 5s tend not to be issued. During the period of fieldwork, a Section 5 was issued for an average of 6% of all Section 2 notifications – with the bulk of these being sent by hospitals outside of the borough. From the perspective of ward staff, “we don’t do a Section 5 that often because things do move in time”.

Whilst the use of Section 5 is a major focus of social workers’ negativity about reimbursement, particularly in Sites 3 and 4 and a reflection of the weight of responsibility on them personally for ‘delays’, social workers in Site 5 also articulated a keen awareness of the ‘stick’ of reimbursement looming over them and of being held personally responsible for delays:

‘I haven’t had any delays against my name at all, which is quite something, but it does put no end of extra pressure on us because you just feel like you’re just getting so much more flak from everyone’.

Hospital Social Worker PrSc5 (5)
The consequences of these experiences of the notification systems are not positive. Where it is perceived that a Section 5 has been issued punitively or unreasonably then the temptation is for social services to ‘start playing things by the book’. Reimbursement is said to fuel this type of low level negativity and to have taken a lot of the good will out of the system.

The formal timescales of the processes also laid ward staff open to accusations that they had not completed the documentation properly. Such measures are regularly used by care managers and social workers to rescind the Section 5 which nursing staff in turn found demoralising. A senior nurse manager who believed that the Act had brought benefits to patients by enabling them to move out of hospital more quickly commented that when she had spoken to her ward sisters, they saw things differently:

‘The ward staff did not really have the same view; they thought they (Section 5s) could be rescinded and that they struggle to get people to accept the referral sometimes’.

Hospital Nurse Manager StHc3 (16)

On the ground, there is strong consensus across the sites that the rules and nuances of the reimbursement process are very difficult to grasp especially where there may be a high turn over of staff: There is continuous attention given to training in processes, especially because there is acknowledged variability between wards and specialties within sites:

‘We know that [ward staff] don’t understand the whole process of the MDA [multi-disciplinary assessment], Section 2 and Section 5… And that is another reason for delay. We [the Acute Trust] will submit the paperwork and there will be something in it that is wrong and Social Services have to send it back, and we have to pick it up and correct it and then it goes back. In the meantime the patient [moves] ward and we have to do all the paperwork again, and it just goes around and around. So I think there is a lot of work we could do in the Trust to smooth that out and make it much quicker for patients’.

Senior Hospital Manager StHc4 (3)

And,

‘We always say when we do our little slot lectures to ward staff, that discharge starts from admission. It doesn’t really…We get the patient ready for discharge, and only then will the nurse think to phone the family and say: “your Mum’s
“ready for discharge”. That’s when all the problems come forward and you might be [another] three weeks down the line before it all gets sorted’.

Discharge Co-ordinator PrHc4(6)

4.4 Multi-disciplinary decision-making

If the Section 2 and Section 5 are the procedural elements to pursue discharge, the practice of making it happen occurs through a multi-disciplinary approach. Good practice in both health and social care services requires that decisions about complex discharges are located in multi-disciplinary team working. This is generally felt to have progressed over the past five years but it is also evident that discharge planning remains an arena where tensions emerge.

Practitioners in the English sites, especially social workers and therapists cite the emphasis in the reimbursement guidance on multi-disciplinary decision-making around medical stability and the patient being safe to go home. As a senior nurse in Site 5 explained:

‘We are all involved in the decision on discharge now…and where before…the consultant or the doctor would say “okay, discharge this patient, discharge them home”, now we need to be sure they can manage so they go through all these assessments’.

Ward Sister PrHc5(6)

Whilst emphasis in reimbursement on multi-disciplinary planning appears to contribute to a positive shift in practice, there is a simultaneous view that practitioners have to be constantly vigilant and to stand their ground in order to have their voices heard. Moreover, it is perceived that practitioners have to work through deep-seated cultural differences and differing pressures on a day-to-day basis:

‘On the level, we all understand where we’re all coming from, because we’ve got all the pressures from the above saying... we need to keep these targets and figures....but, yet we need to stand our own ground as well and look after our own, and maintain our own rules, so even though we’ve all got an understanding, we do put pressure on each other and you can tell there’s a little bit of - not tension - but there’s something there. Although we’re all singing from the same hymn sheet there are different ways of doing it’.

Therapist PrHc3 (8)
Although often stereotyped in terms of medical and psycho-social models of care, with respective foci on disease and wider determinants of health, these tensions can be seen to reflect differing conceptions of risk from clinicians and practitioners depending in part on where they are sitting in the system. Thus many medical and nursing staff on all sites expressed concerns about the risks faced by older people of prolonged stays in hospital and feel that social workers don’t understand these fully:

‘Today’s urgency is different to two different people and again I think social work believe that a person in hospital is safe whereas a person in crisis in the community needs to be the priority. What they don’t understand is the clinical risk associated with being in hospital. Not only MRSA and things like that but also actually taking away your independence because we institutionalise you very quickly and you may never get back out again’.

Senior Health Manager StHc2(6)

‘From my point of view when I’ve got people that are on the ward that are Section 5 you get them to the optimum level on a specific day and you want to get them out because if you don’t they’re just sat about they get fed up, they get depressed, there’s risk of infection, there’s risk of being in a hospital bed that they don’t need to be using. And then of course with resources, if that patient’s sat in the bed and you’ve got somebody that needs the bed it just causes a problem for everybody’.

Ward Sister PrHc3 (2)

A social services manager put the reverse argument as did a group of therapists. However, community based nursing staff themselves were seen by a consultant who worked both in the hospital and the community as being risk-averse.

In Scotland where the processes for managing delays are less clearly outlined by legislation, similar tensions and feelings arose around the timing of assessments, as we examine below.

4.5 Impact of Joint Action Planning on practice

In the Scottish sites, while it was considered that great strides had been made at a strategic planning level in tackling the problem of delayed discharge, significant problems were seen to persist at the level of front line practice:
‘In terms of the system working smoothly and everybody knowing everybody else’s job I don’t think it’s systematised yet as far as I’m aware. What we need to do is develop a system, a process that will happen and that is not a person dependent process’.

Consultant in Medicine for Elderly PrHc1 (2)

There were comments in the Scottish sites about the capacity within social work teams, which inevitably impacted on speed of response to assessments, as we discuss later. In particular, the advent of free personal care meant social services teams had seen their workloads dramatically increase. Although there was multi-disciplinary decision making in every patient case in both sites, in terms of ‘actioning’ a patient’s discharge, sometimes it was a different social worker to the one who attended the multi-disciplinary meeting. Some social workers countered these criticisms of it taking time to organise discharge by highlighting the very large caseloads most social workers have:

‘The other issue is around the resourcing of assessment and care management after the introduction of free personal care. Along with free personal care came a lot of people who now need assessment to get their free personal care which has increased and the resourcing for that was never put in so it is quite demanding on our assessment care management services… that's one of the biggest pressures because within that period of time from when somebody is in hospital and you're going in to do an assessment they need to make that life changing decision, there's a lot of work that goes on not only with that individual but with their family as well as setting up the packages and that's very intensive. And if you haven't got the resources or you can't recruit to those posts you've got a problem’.

Head of LA Community Services StSc2 (2)

Some health care practitioners argued the need for more hospital based social workers. A clinician in Site 1 commented:

‘In terms of practical coal face issues, the one change that could be done to improve the process would be the employment of more coal face social workers on the hospital sites. Here we have a significant problem with the work that we are asking our coal face social workers to do…[they are] totally, totally stretched
and maybe partnership working needs to look at that. I mean we’ve tried in the last few months to really highlight this to the appropriate authorities’.

Hospital Consultant PrHc1(16)

Unlike in the English sites where it is acknowledged that reimbursement processes have resulted in speedier assessments, there are many complaints from health staff that it takes social services far too long to respond. In this respect, although most people are opposed to the idea of reimbursement because they consider that it might erode partnership working, some health professionals believe that it would have a beneficial effect:

‘I’ve been in this job 15 years and we’re still having the same problem as we had 15 years ago. Trying to discharge patients! And it’s still the same things that are coming up. Like - you put a referral into social work that can take anything up to a week for it to be actioned. Once you’ve contacted a social worker from the hospital to come and see them they’ll allocate them the care manager and it could be eight weeks before they’re allocated a care manager and in that eight weeks nothing happens’.

Senior Charge Nurse PHc1 (9)

And,

‘[Social Services] will not take on anybody else beyond their case load and my understanding is that is so they can give good attention to the ones they’ve got on their books. Now I do find it an intriguing concept as somebody who works in the health service that you can say I’m sorry we’re full…’

Hospital Consultant PHc2 (8)

As we described above, in English sites persistent and continuous monitoring of delayed discharges and the threat of cross charging has given the set timescales for assessment and arranging care some ‘bite’, which is experienced as a personal threat by front-line social workers and care managers. It is interesting to note that there exists powerful pressure at the front-line to discharge patients in Scotland, though this is felt more intermittently. The ‘bite’ comes in the run up to the census when the delayed discharge figures are sent to ISD and the Scottish Executive Health Minister, and then published. There are daily phone calls from the Chief Executive downwards causing a chain reaction throughout the system, to the extent some practitioner staff described themselves as feeling ‘under the cosh’.
It is evident that although Joint Action Planning emphasises partnership, some front-line social workers experience a feeling that they are being held personally responsible for delays in their day-to-day work and experience ‘pointing the finger at social work’:

‘The nurses can be extremely negative about maybe a particular social worker that hasn’t managed to get a patient moved. But if its because there is no money or no places in a care home or you have to wait to get approval for a complex home care package, what can we do?...But its still seen as being held up by social work. I mean we get frustrated as well because we’ve done everything’.

Social Worker PrSc1 (10)

This is variable across hospitals. Another social worker spoke of the bad old days when it felt as if we were being beaten on the head by a whole lot of different people, which she felt had now improved with more regular meetings to sort out issues.

In Scottish sites too there is a strong perception of medically dominated decisions to discharge patients:

‘...the acute ward obviously I think quite often have a very sort of particular threshold about when the treatment’s finished ....but I think sometimes there’s a very basic approach to someone being medically fit for discharge...by and large it’s a medical definition and by and large we have to accept it....You know it’s within the discretion of the consultant and he’s got issues to deal with about capacity and bed capacity and so forth’.

Senior Social Services ManagerStSc1 (3)

Looking across both countries, the key differences made by reimbursement appear to be in clarifying processes for assessment and care management and creating auditable systems to facilitate these. As we have shown above, however, clarification does not mean that processes are immune from interpretation, challenge and dispute. What is also evident is that in both countries social workers feel personally blamed where they were not able to progress a discharge speedily. In England, this is compounded with a sense of professional affront linked to the Section 5, with the implication that they cannot prioritise their own workload.
4.6 Perceptions of delayed discharge systems in England and Scotland

In England there are strongly expressed views among some practitioners that reimbursement is about the needs of the system rather than of the individual:

‘We will soon be working with bar codes rather than people’.

Social Work Practitioner PrSc4 (4)

And,

‘We are required simply to activate the conveyor belt of care. I always thought care pathways were about negotiation and empowerment but these are designed by people interested in numbers and a quantitative approach to discharge management’.

Care Manager PrSC3 (4)

There is a sense across both countries from many clinicians and practitioners that they feel disempowered in trying to achieve the best outcomes for their delayed patients in the pressures and constraints of the systems. Some practitioners in England spoke in general terms about the speed of decision-making which is required in organising discharge from acute hospitals.

‘You want people to go to the right place and you want to give people the time to make the decisions but you don’t really want them taking too long making those decisions because you have to keep the flow going’.

Discharge Co-ordinator PrHc4 (6)

However, with regard to specific patients – as reflected in the experiences of people interviewed – what emerges is a rather different picture, namely one where the discharge planning process is lengthy and prolonged. In part the discrepancy can be explained by practitioners’ perceptions of the availability and quality of options available to individuals waiting for their designated package of care. These relate in particular to funding and to the use of ‘holding’ or interim beds.

4.6.1 Funding to move on

In Chapters 2 and 3 we outlined the main causes of delay. All sites use allocation panels, often jointly run, to agree funding for packages of care. There appears to be a difference between England and Scotland in relation to delays in waiting for funding from these panels. All the English sites had quite slick systems for panels to agree packages of care, usually
within a week. There were few cases where funding was said to be unavailable, though there was evidence of panels scrutinising the level of care requested in Site 3, seen by many as a way of rationing services because of financial constraints. An English health manager recalled the bad old days prior to reimbursement when:

‘It went in surges, relating to money, often relating to the fact that SSD would come up with an amount of money and clear a backlog of people waiting for care. So a whole lot would be taken off the delayed discharge list – traditionally end of February and March – that always happened. There was always an amount of money given to clear a lot of delayed discharges. What I think is better and fairer now is that people are progressed immediately they become a delay and some of those tactical games don’t exist now. I think there is a more concerted effort to move people through’.

PCT Operational Manager StHc3 (8)

In Scotland, many of our interviewees commented on the lottery around funding for individuals within the panel allocation system:

‘We’ve all sat around waiting for things to happen. Every two weeks there is a meeting looking at availability of places in nursing and care homes within Site 1b [1 of the 3 Local Authorities in Site 1] and that is matched against need and against availability of funds and this patient sat at the top of the list for quite a wee while and because its residential care that she’s waiting for there are so few, few places come up in residential care that the poor woman’s still waiting ten months down the line…But even resourcing it…there’s still a problem because of no availability in the community’.

Senior Charge Nurse PrHc1 (6)

And,

‘I think there is an issue of equality of access here. The figures state that there are no hold ups due to lack of funding but that’s not true. Yes there are delays due to financial constraints if people haven’t got significant savings, if people don’t have property or don’t have any financial back up, don’t have the capacity to pay top ups which most of the units are asking for now. If families aren’t in a
position to pay then it delays even longer. How is that not down to lack of funding?'

Social Worker PrSc2 (5)

4.6.2 ‘Holding’ or interim beds

Whatever the cause of delay, there was an issue for practitioners in England and Scotland that the options available for those who are waiting are limited and sometimes of questionable therapeutic value. In both Scottish sites, wards widely known as ‘holding wards’ operate, but these evoke negative comments from some staff:

‘With the type of patient that we have with a high dementia rate...the noise factor, as far as I’m concerned I certainly don’t think that this is a suitable environment to bring patients who are waiting for discharge, I really don’t. I feel quite strongly about that actually. Having worked in it now for quite some considerable time I think it creates distress...They’re not used to a hospital environment in the first place and to come in and have to deal with a dementia situation and patients, people wandering, a mixed ward to some extent because of the cross over and the lack of privacy. Nobody is denying that coming into hospital your privacy is compromised to a certain extent, but one tries to maintain as much dignity as possible. I think their dignity is not maintained as well as it ought to be, that’s just my personal view’.

Hospital Nurse PrHc2 (14)

In the English sites, there are also ‘non-acute’ or ‘rehabilitation’ beds. Assessment and care planning continue in these, although practitioners in Sites 3 and 4 in particular commented that these beds tend to be used for patients who are awaiting long-term care, particularly EMI care, for whom active rehabilitation many has ceased. Nursing staff express concerns about the lack of opportunity to use the wards as intended for patients who need rehabilitation. By default, some of the English non-acute beds have taken on the role of ‘warehousing’ patients until their care package becomes available.

In Site 3, the local authority purchases interim and transitional care beds in local nursing and residential homes. At strategic level, some senior managers have a vision of transitional care as rehabilitative and recuperative; this was not evident operationally at the point of the fieldwork. In practice at the time of the study, most delayed patients, including those in non-acute beds, were offered such a placement so as to free up an acute bed. Care managers and social workers were very ambivalent about use of these beds, since in practice, they are
required to offer any available bed anywhere in the city that provides an appropriate level of care – a practice that cause difficulties for families. At the same time, means tested charging applies for use of this facility after two weeks:

‘…there is a cost for people – they are charged for the bed. People don’t see that coming. If you think of my husband thinking about his mother, if she was taken ill and in hospital and they said to him: “She’s medically fit to go – we are going to move her to a bed at X and by the way, it will cost you £350 per week”. He simply would not understand it – he would be shocked because to him she is old and ill and frail and in hospital and now they want to charge him as well as sending her out’.

PCT Strategic Manager StHc3 (19)

For some staff, also there are professional concerns about offering second-best choices which did not actually meet the patient’s needs and may lead to loss of independence:

‘It has enabled us to look at different options although I sometimes think the disadvantage of that is that the options are not necessarily the first choice or the right options for the individual so that person may have to go into step down because there isn’t the home care. So maybe that is what we would request when actually, if the home care were available, there is no reason why they should not go straight home’.

PCT Operational Manager 3(8)

Mr Jones’ story (see Box 2) illustrates this situation

**Box 2:**

Prior to his stroke Mr Jones lived with his wife and daughter. He was a proud man, head of the family, active in his community and respected in the neighbourhood where he had lived for 40 years. A severe stroke resulting in loss of function on his left side meant that he was wheelchair bound and doubly incontinent.

Initially, staff believed that nursing home care was the only option for Mr Jones but he and his family were adamant that he should return home. To do this he needed a full care package and adaptation to the house. The main problem was incontinence since night care could not be provided and his wife and daughter could not lift him with a hoist to change him at night.

A physiotherapist on the rehabilitation ward devised a plan of frequent day time toileting to avoid the need for night care. Achievement of this goal meant that he could return home.
An extensive care package was agreed by panel but could not be provided by the local services. His care manager then had to offer him a transitional bed, to await the care package. She was concerned about this and fully supported his refusal. *We offer a transitional bed. Mr Jones had to have a long rehabilitation because he hated nursing homes, he didn’t want to go to a nursing home... So now offering a transitional bed was saying: “Go to that nursing home you don’t want to go to, really”. But anyway he refused, he said “No I told you I don’t want to go to a nursing home and I’m not going to, don’t want to be in hospital but I’m not going to go to a nursing home”. If he had accepted the transitional bed, he would still be stuck in the transitional bed now. At follow-up, Mr Jones was at home cared for by his family and transitional home care services.*

Mr Jones’ delay of 35 days was briefly reimbursable (4 days) until he refused transitional care, when it was recoded as patient choice.

SU 3 (15)

4.6.3 Intermediate care

A highly valued way of moving people on was into intermediate care or rehabilitative services. This is variably available. In Scottish sites there was no investment in intermediate care per se, and it appeared that some of the patients who were moved into holding wards there may have experienced intermediate care in England. Similarly there were variations in the levels of investment in intermediate care in the English sites, particularly for older people with mental health needs. Additionally, a key issue is the eligibility criteria for entry into intermediate care, which can exclude some individuals whose case is deemed to be borderline. Both gaps are illustrated through Mrs Forrest’s experience (Box 3).

**Box 3**

Mrs Forrest was 91 years old; she had arthritis, mild dementia and a chronic mental health problem (bipolar disorder) for which she received specialist community services. She was sociable, chatty and managing at home with family and home care support.

Mrs Forrest was taken to A&E with significant loss of mobility and pain in her hip, which was treated with pain relief and physiotherapy. She did not fare well in hospital. She became disoriented and found it difficult to learn to walk again. A multidisciplinary team meeting, including her CPN, agreed that she would benefit from intermediate care in a community bed, especially since Mrs Forrest was adamant that she wanted to go back to her own home. However, the intermediate care team refused to take her because her needs were deemed to be ‘too complex’ and she had to stay in the acute orthopaedic ward.

The following week a full care planning meeting was held at which Mrs Forrest reluctantly agreed to go into residential care. Thereafter, Mrs Forrest developed three different ‘hospital acquired infections’ and a very bad bed sore, which weakened her enormously. Her family put great efforts into finding a suitable home into which she moved three weeks later. By this time, she was physically quite unwell and very depressed. At follow-up she was critically ill in the home, having had a number of strokes and she died around 5...
months after leaving hospital. Her daughter said that “she just went downhill after she moved here”.

Mrs Forrest’s consultant regretted the decision to refuse intermediate care, because “I think the benefits of it were that she would have had a trial of rehabilitation and yes if it did not work, she would have been more accepting then that she had tried her best and the therapists had tried their best to get her back home. If it didn’t work it would not have been so stressful her going directly to a residential home. But in the end she was in hospital, acquiring infections and then going to a nursing home. She was having ongoing therapy obviously while she was on the ward but once the decision had been made that she was going into long-term placement, she developed this sort of inevitability about things and what is the point of trying now because I’m not going to go back home. I was quite sorry actually that she missed an opportunity”.

When the ward conducted a clinical review of her case, they concluded that she should never have been admitted to hospital but moved from A&E directly to a community intermediate care bed, because “they would have taken her at that point”. Mrs Forrest’s delay of 31 days was non-reimbursable, being coded as patient choice and later medically unfit.

SU 3(5)

4.6.4 Lodging out

One unfortunate consequence of being delayed is that the patient becomes vulnerable to moves within the hospital, when there were pressures on beds. This was a negative experience of several of our patients across England and Scotland, causing them to feel upset and isolated. It was also an element of the system which staff disliked because they considered it eroded dignity and quality of care (see Box 4).

Box 4

Mrs Varley was a lady in her 70s who had collapsed at home after being discharged from hospital, following surgery. She had decided to move into residential care and was waiting for a place in a home to become available. Her bed on the acute ward was required urgently so she was moved to a bed on the maternity ward.

As she said: “I’m in my seventies for god’s sake! You should have seen the look on the young women’s faces when I was getting pushed in on the wheelchair, I didn’t know whether to laugh or cry. I’m laughing about it now but it really wasn’t funny at the time”.

She felt unhappy about it; cut off from the other patients, because of her age and the nature of the ward. The staff nurse who had to move her also commented: “What I object to is having to tell that woman she is getting moved and put on a smiley face when telling her though I know it is disruptive to them and they are apprehensive about it. They want out, they don’t want moved around the hospital”.

SU 2 (3)
4.7 Emergency readmissions to hospital in England

We asked managers and staff in England about their perception of a relationship between emergency readmission to hospital and the policy of reimbursement. In England, hospital professionals felt strongly that although they were under considerable pressure to speed up of assessments and discharge people quickly, this was never at the expense of the older person’s safety. This view was not always supported by those working outside of the hospital in the community. Their perception was that since the advent of reimbursement older people are being sent home a lot ‘sicker’ and that this places a significant extra burden on community staff. Nevertheless, front line care workers saw themselves as playing a vital and successful role in preventing emergency hospital readmissions:

‘It’s almost a case of within hospital we’re just quickly patching them up and then the agencies and the community agencies really work on that within their own home, whereas when I first started it was very much like we’ll get them well and then we’ll give them a little bit of a chance to get going again and then they can go home with some support, but now its like…right, they’re ready, right OK, just solve that problem and they’ll sort it out later at home, which in a sense is better that they are in their own home, their own environment…there’s less chance of them picking up infections whilst they’re in hospital, but you know, being on your own all day at home…’

Therapist PrHc3 (6/8)

Few people in the English sites considered that readmissions were directly associated with those patients who were delayed, since most of these receive packages of support on return home. Practitioners in the study suggested rather several possible causes. Firstly many older patients, and often those who are delayed, have high levels of medical and social needs and stability is difficult to predict precisely. It seemed possible that increased investment in community geriatricians, intermediate tier services and/or community matrons meant that issues could be picked up quickly but could result in readmission where they were best dealt with in hospital. Some people argued that lack of on-going community social care may be a contributing factor. Nurses and therapists remarked that some older people are reluctant to accept help and say that they are managing independently, while therapists did believe that a period of waiting in an interim bed for a home care package led some older people to lose the skills and confidence learnt on the wards and thus be more vulnerable when they finally go home.
Within our sample of patients, there were nine experiences of emergency readmissions which shed some light on this issue. Six of these appear to relate to the inherent medical instability of some of these older patients. For example, one patient was readmitted after nine days as a result of another ‘funny turn’, another after a fall and a third with a serious chest infection. Another case reveals the complex interplay between medical and social factors which is rarely described fully in hospital notes, since it is usually only the medical reason for the readmission that is recorded. Mrs Kenny was readmitted on the day of discharge on the grounds of ‘shortness of breath’. In fact, she had not wanted to go home, because her carer, on whom she depended greatly, was still in hospital. Two people were taken back to A&E by their relatives within 24 hours of discharge. Neither had a care package arranged – they were ‘independent discharges’: people deemed not to require additional support from formal services, who comprise around 80% of hospital discharges (Change Agents Team, 2007). A number of people (including local older peoples’ groups) made the links with those patients who are not assessed as needing help from services in order to leave hospital (independent discharge) as one of the PCT managers explained:

‘But they feel that people are being shoved through so that they don’t ever get on to the delayed discharges list. They (the nurses) may ask an individual, “Are you all right to manage at home- do you have any difficulties?” “No. I’m fine Thank you.” – to prevent a referral to somewhere – social services… who might identify difficulties which might result in a delay. There was almost a ‘Get them out of the door and nobody will notice’ so it is seen as a side effect of reimbursement. But I think it used to happen before reimbursement. I think there have always been poor discharges and for me it is much more of a clinical governance issue’.

PCT Operational Manager PrHc3 (8)

‘I suppose there is a discrepancy between what the hospital say, “Do they need to be in hospital? No they don’t. Are they able to manage well at home”? Well they haven’t reached that point, so there is a gap in between isn’t there. So you might legitimately say they don’t need to be in hospital but if you say,” can they manage at home”, well actually they are going to struggle to manage at home for a while because they have not really recovered from whatever it was brought then in’.

Social Services Manager StSc3 (12)
With currently high levels of eligibility for home care, people with quite significant needs are likely to be included in this group. Mr Wood’s story illustrates a number of these points; medical instability, reluctance to accept help, not being identified as needing support (Box 5).

**Box 5**

At the age of 98, Mr Joseph Wood was reasonably well and fit. Twice a week he walked out half a mile to the village for his newspaper, although when he got back, he was a bit jaded. He was supported to live in his sheltered accommodation by his daughter (71) who had been doing his shopping, cleaning, laundry and some meals for about 10 years.

Mr Wood was admitted to hospital after collapsing at the luncheon club and stayed there for a week. His daughter was amazed when a nurse told her they were sending her father home next day – no-one had spoken to her or him about what help he needed and she thought he looked very unwell. Discharged home on Friday, his daughter was appalled by how tired and ill he was. On Saturday she rang the out-of-hours doctor who eventually decided to send him back to hospital where he was admitted. On this second admission, an S2 was sent and the occupational therapist assessed him in the kitchen and discussed the possibility of some support. He reluctantly agreed to have some help with meals from homecare. A ward meeting agreed he was ready to go home but ward staff became concerned about the level of his confusion and it was decided that a psychiatric referral should be made. The S5 was rescinded while Mr Wood awaited his assessment. This was completed five days later and he was discharged the next day, when home care started. He was still at home four months later, though he had had another recent collapse and had spent a week in hospital..

SU 3(8)

The reimbursement guidance advised of the balance needed to ensure that only those patients who are likely to need community care services are referred to social services, while at the same time recognising that there are risks to patients’ health if they are discharged without a thorough assessment of their needs and are subsequently unable to cope when they return home.

Whilst reimbursement has tended to target those likely to need multi-disciplinary support, it has also meant that those whose needs are less complex or who only require transitional support may not be identified, a process that is likely to be exacerbated by the speeding up the system as a whole and by the emphasis on community care provision for the highest levels of need. Listening and responding to the needs of carers and family members is key here.
4.8 Summary

- From a practitioner perspective in English sites, a helpful facet of reimbursement was the Section 2 or notification of need for assessment and provision of support on discharge. This was seen as allowing for proper identification of the patient's needs and multi-disciplinary input to facilitate safe discharge – although the formal timescales were generally agreed as unworkable in respect of the more complex discharges that increasingly are the purview of most hospital social work teams. By contrast, the Section 5 was a potent source of tensions between operational staff, and symbolic of the way in which reimbursement has, from the social work perspective, cast them as being personally responsible for delays.

- This sense of blame among social services staff shaped relationships between them and health practitioners in the acute hospital at a general level, although for individual patients, there was evidence of good multi-disciplinary working. There was simultaneous understanding of the respective pressures under which different professionals worked. Even so, whilst formally reimbursement required the discharge decision to be made within the multi-disciplinary team, therapists and social workers felt the need to continually reinforce this as an aspect of practice.

- In the Scottish sites, although JAP was viewed as promoting partnership working at strategic level, practitioners were more ambivalent. The decision on discharge was often the site of cultural and professional disputes linked with a continued dominance of medical professionals in the decision-making process. These professionals were perceived by social work staff as not being fully cognisant of the psycho-social needs of older people. Such needs questioned the concept of an individual being 'medically fit' for discharge.

- Staff (and carers) were concerned about the impact on patient dignity and care of non-purposive patient moves in hospitals in response to bed pressures.

- In the context of a speeding up of the discharge process, reflected in the metaphor of the carousel spinning faster, non-acute beds of all types (holding beds, intermediate care beds, rehabilitation beds, interim and transitional care beds) are perceived to be used more frequently. For those older people who are waiting for appropriate assessed services, the move from acute hospital care may proceed through an interim solution of little therapeutic value as a facet of the strategy toward making more effective use of acute beds. It is here that the tension between system led and
user centred approaches to discharge planning assume its most acute form. Practitioners saw the benefit to patients of these facilities and welcomed their use if the patient received, for example, rehabilitation, further assessment or convalescence but not if they were used simply as a place to put patients whilst they waited for a care home placement or a home care package.
5 The Perspectives of Older People and their Families

5.1 Overview

In this chapter the understanding and experience of delayed discharge from the perspectives of older people and their families are explored. It is important to stress that because of the focus on delayed discharge, the views presented here are not representative of the wider hospital discharge experience in either England or Scotland. The majority of the cases described are termed ‘complex discharges’. These are challenging and require that staff have developed highly sophisticated skills (Wade 2006).

In the interviews with older people and their families we talked through their story about how and why they were admitted to acute care; their experience in hospital, aspirations for the future and their knowledge and understanding of the process of discharge planning. We also followed up each older person to see how they were doing around four to six months post discharge. Targeting complex cases over a period of time affords an insight into the views of the ‘oldest’ old, many of whom were extremely frail and sometimes approaching the end of their life. Nine of our participants died during the research study period. Whilst these are the core users of the NHS whose needs must be met by the system, they are a group that tend to be neglected in research.

Ascertaining the full story was important because few participants in the research were explicitly aware of how their case had been progressed through the ‘system’ leading to their identification as a ‘delayed discharge.’ In England, very few older people had heard of the reimbursement process, though some family carers knew about it.

Across the five sites, 68 older people whose discharge from hospital was delayed and 40 family members were interviewed. Critical points and times in the trajectory regarding each case are presented in Appendix 2; as are diagrammatic patient pathways from one site. Names and any identifying features have been changed to protect the anonymity of the participants. Our sample of patients is broadly representative in age, gender and reason for delays of delayed patients recorded in local site data.
5.2 ‘Windows of opportunity’ and negotiated outcomes

During their varied journeys through care, there were particular points which were critical for patients’ outcomes and in reducing or extending delays: we called these windows of opportunity. In Chapter 4 we considered how service capacity and funding might close the window of opportunity and lead to longer delays. In Mrs Forrest’s traumatic experience (Box 3, Chapter 4) there were two clear windows of opportunity, one at admission when she might have been diverted from the acute hospital and the second when she was referred to intermediate care. It is clear, however, that service capacity is not the only determinant of the pathway and that many decisions are affected by personal preferences, needs and desires of patients and carers and by differing practitioner perceptions of the best way to meet these needs. The complex and often protracted negotiations and decision-making around moving into long-term care offer a point at which to view this interplay and its outcomes. It is important to note that while reimbursement provides a context within which these happen, in the narrow sense of cross-charging, it is largely irrelevant because many of these patients are not reimbursable as they are deemed to be exercising choice or in dispute or for a host of other reasons.

All the staff we spoke to saw themselves as patient-focused, trying to achieve the best for their patients within their professional sphere. As we indicated earlier, not all staff saw the same outcome as desirable, which led sometimes to different alliances between patients and members of staff. These alliances did not simply reflect a health/social care dichotomy of need or risk, as Mrs Patton’s experience set out in Box 6 below attests.

Box 6: Mrs Lily Patton, 88 years

Mrs Patton was admitted to hospital after a fall and two broken ankles while in respite care. She was previously living in supported housing but had become increasingly immobile on account of rheumatoid arthritis. This was her third acute admission in seven months. The first related to a long standing medical problem; the second admission resulted from an excessive nose bleed due to polyps and then a heart attack whilst being treated in A&E. Following this last admission, Mrs Patton’s package of care increased from three times a week to three times a day (organised by the hospital social worker).

Mrs Patton stated from the outset that she wanted to move into residential care, because she could not cope alone anymore. Her son was supportive of her decision.

There was some disagreement within the MDT. The consultant considered that given the progress she had made with rehabilitation, she could manage physically at home with her existing package of care, and should return there. Nurses, therapists and the social worker were in agreement that she had lost the confidence to remain on her own and would not cope physically or psychologically at home: they supported her decision to apply for residential care. Mrs Patton’s social worker explained that “she couldn’t even get
down to the communal lounge to take part in activities, and ...feeling very lonely and isolated and depressed, and she has subsequently been diagnosed with depression and on anti-depressants.”

The MDT assessment and recommendation to panel was for residential care, which was subsequently agreed. A place was secured within a short time in a home locally. However, her move was delayed for a month because she contracted an MRSA infection. Her length of stay was 172 days. Four months later, she had settled in the home and felt better in herself.

SU 5(6)

On other occasions, families and patients felt that they had to battle to get the outcome they wanted (Box 7).

Box 7: Mrs Carey, 93 years

Mrs Carey lived at home with her son, who had given up his job to care for his mother. In general they managed well. Mrs Carey had short-term memory loss but did not have any strange things going on. She was admitted to hospital after a collapse at home. Her son said he was appalled when, a short time later, he was informed by the hospital that they had assessed her and felt that she needed to go into a care home. He considered that this decision had been made without involving him, or the community social worker who had supported the family prior to admission, because the case had been transferred to hospital social work. He felt that it was based erroneously on the degree of confusion shown by his mother on the ward, which in his view was probably linked to medication given to her there. At his request, a care planning meeting was held to discuss the case; he went accompanied by his sister and niece and successfully argued for his mother’s return home with some nursing support.

Mrs Carey's hospital stay was 65 days. Technically, her delay was for 6 days awaiting delivery of a pressure relieving mattress. She was living contentedly at home four months later

SU 4 (6)

There were also times when the outcome depended on the willingness of family carers to continue providing care at a high level. In some cases, they were able to accept this given some support; in others admission to care homes became the only option, even though it was hard for them to accept and was not desired by the patient (Box 8).
Box 8: Mr Alcott, 83 years

Mrs Alcott had been caring for her husband who had dementia for several years, without any formal service help. Mr Alcott’s daughter felt that her mother could no longer manage to care for her father at home and felt that the time had come to consider a care home. She suspected that the real reason why Mr Alcott had been admitted was because her mother was suffering from a bad cold and could not cope as she normally did: *When the paramedics suggested they were going to admit him my mother didn't argue and just said “yes”. She didn't go to see him for ten days. She had had enough...”*

Within a few days of admission, Mr Alcott’s daughter was informed that her father was medically fit for discharge and reacted angrily *He may be fit for discharge but he is not coming home...It was at that point that they went to find a social worker. She saw the social worker who gave her a list of homes and she and her mother started to look around for a home they liked at a price which could be afforded. This took around 10 days, but after they had completed this process, the ward was hit by an outbreak of D&V and her father was not allowed off the ward. He was subsequently in hospital for 109 days. In the extended stay on the ward, the nurses began to get more insight into the scale of his problems. Nevertheless, his daughter felt that the only thing that anybody seemed bothered about was when we chose the next home there was a top up thing, £16 top up. My mother had to go in and sign forms and she came away and she said to me “I have signed some forms but I don’t know what they are about”.*

When Mr Alcott was finally discharged to the care home, a delay of 4 days was recorded in the notes and was put down to “family choosing care home”, although his daughter said they had not felt under any pressure to make the choice. Unfortunately, things did not work out for Mr Alcott in the care home. His needs were more far complex than the assessments had suggested and, at the six weeks review, the home manager suggested to the family that they might want to find a different home. Shortly after this, Mr Alcott was readmitted to hospital with a heart attack and died.

SU 4(1)

Financial matters of all kinds also complicated decision-making. These could be seen in disputes about the level of care home required and about contribution to fees. Top-up fees were an issue both in England and in Scotland, while disputes over continuing care could extend delays considerably in England (Box 9).

Box 9: Mrs Beatrice Ovens, 80 years

Mrs Beatrice Ovens was admitted to hospital with a severe stroke the beginning of June. Two weeks following admission to the specialist stroke unit, a Section 2 referral was made. The social worker commented that there was a debate within the MDT at this point as to whether she was appropriate for further rehabilitation as progress was very limited on the ward. The decision was made, however that she should be offered further rehabilitation in a specialist rehabilitation facility.

She made no progress, suffered a couple of unresponsive episodes and returned to the
acute ward when a further Section 2 referral was made. However, a continuing care assessment was deemed necessary and this was completed by the continuing care team, although the social worker continued to see Mrs Ovens and her family.

Her case was taken to the panel for decision within a week of the second S2 and a nursing home placement was agreed (Mrs Ovens was self-funding). The family disputed the decision not to award NHS continuing care funding and involved a solicitor. At this point the social worker explained: “Although I was told I should have no further involvement pending the legal outcome, I would get calls, sometimes two or three a day from the doctors, from the ward and the discharge co-ordinator asking what I was doing. It was an utter nightmare”.

During the following weeks whilst the family and the hospital were in dispute, Mrs Ovens’ condition deteriorated and a further continuing care assessment was completed and went to panel: This time the panel agreed continuing care funding and a placement, which was acceptable to the family, was found immediately. She moved to a nursing home within less than a week following the panel. The duration of hospital stay was 146 days, with delay in discharge calculated at 31 days, although this was not reimbursable.

The examples above are of interest in light of the principle that older people should not be discharged straight into a care home from an acute hospital bed (Change Agents, 2007). Fifteen of our 38 older people in England and 16 of our 30 Scottish participants were admitted directly into care homes from hospital, with a small number directly from the acute wards. Concerns have been raised by the British Geriatrics Society (Morris 2005) that ‘short termism’ is leading to longer term problems:

‘The important recent concentration on the acute aspects of care in hospital can lead to decreased opportunities for frail older people to receive beneficial rehabilitation (see compendium) and comprehensive assessment. Short-term benefits may result in expensive institutionalisation with older people losing control over their lives, over their function and over their environment.’

There are three specific issues from our study relevant to this debate. First, for some individuals (such as Mrs Ovens) the illness that precipitated acute admission resulted in a catastrophic change from their prior situation and left them with substantial support needs. Others, with multiple health problems, experienced deterioration in their condition whilst in hospital, that increased their need for support. Access to rehabilitation in both scenarios is key to assessing and maximising potential but we found that sites varied both in the extent of
rehabilitation that was offered to individuals and the level of risk of poor outcomes that professionals were prepared to consider.

Second (Mrs Forrest's case is illustrative), for individuals with complex needs, there are windows of opportunity that open and shut quickly at different points of the acute episode. Recognition of, and being able to access appropriate resources to meet the complexity of need when the window is open is critical if patients are to have the opportunity to return to their previous home routines.

Third, for some individuals, their current acute admission is but one episode in a sequence that has over time undermined their confidence and contributed to their decision to go into residential care (for example, Mrs Patton). Understanding and responding earlier to not only medical and physical needs but psychological and social needs is necessary to delay or avoid admission to long term care.

5.3 Patients’ experience of acute hospital

The reimbursement guidance is well sighted on the effects of delay in hospital for older people, especially those who are frail and vulnerable. It stresses that unnecessary stays on acute wards are inappropriate; dangerous, in terms of infections and unhelpful in potentially leading to loss of independence and skills and breakdown of support networks in the community. Across the sites in England and Scotland, many of the patients who were interviewed fully agreed with this view. The acute wards were seen as busy, hectic places; as Mr Forder explained when he praised the way in which nursing staff on the acute ward coped with a constantly changing, complex and very poorly clientele:

‘It’s like a sausage machine in the sense that you get someone being transferred back to a nursing home who is very ill, and someone else coming in even worse into that bed the same day’.

SU3 (9)

Many older people across all five sites in England and Scotland spoke highly of the friendly, reassuring attitude of the nurses and clinical staff. However, they also commented that on occasions, they had to wait for attention or help. Some carers expressed concerns about how far their relatives, especially those who were very frail, were seen as individuals:

[Researcher: ‘Do you think the Hospital did enough to get to know your Mum as a person?] No. I wouldn’t say they got to know her a great deal really. We had
to keep on reminding them because they kept on calling her Annie. That is her first name but she’s never been known as Annie. She has a second name, Milly which is what everyone has always called her. So we mentioned that to the hospital: “please call her Milly because that is what she responds to”. Then we would go in again and they were still calling her Annie…She was unconscious and they are calling her by the wrong name and with no hearing aid in. You are not going to get much of a response are you?’

CA4 (10)

And,

‘To me it felt in that hospital as though all the staff could see was a hip. That’s what it felt like. One of the other things that did delay my mum’s discharge was she had two urinary tract infections. The second one was nearly fatal. Now they did jump and they did deal with that well you know kept her alive, but as regards anything else, as regards treating her as a valued human being or somebody with a bi-polar disorder or somebody who was frail and would easily get bed sores I just think there was not enough resource there to deal with that’.

CA3 (5)

Within this context, the meaning of being delayed was affected by a number of factors, including the nature and length of delay, choices and outcomes in respect of discharge destination and where the person was located.

5.4 Experience of ‘a delayed discharge’: the patient perspective

Whether older people knew that their hospital discharge was delayed seemed to depend on a number of factors. People waiting for an assessment (e.g. psychiatric assessment) or for intermediate care had no sense that their discharge was delayed - they were simply waiting for the next step in their acute episode. People whose delay was attributable to an external cause such as waiting for a home care package usually knew that they could go home if and when that was available. Ward staff made people aware that they were waiting for help from elsewhere and this indication of delay was often reinforced by changes in ward routines; such as the doctor no longer coming to see them, cessation of therapy inputs or of active nursing care:

‘They sort of hinted I’d be going next week… I asked one of the doctors like, when will I be going home? He said, “It’s not up to us. It’s up to the people who
have to arrange everything”. While I was in there for the last week I had nothing to do with the doctors. Before that they used to come and see me everyday…”

SU4 (6)

Whilst some patients were aware that they were waiting for post-discharge service, they did not draw from their interactions with staff that they themselves were the ‘problem’. One of the younger patients with disabilities did however preface his follow-up interview with the greeting, “this is me, the spare part, the square peg in a round hole”, describing the way staff spoke about him:

‘You know, Tim over there, he’s in bed 4, leave him, he doesn’t need any medication, any medical help, if he wants anything he’ll ask for it or whatever just leave him”…You were just left. I heard them say many a time that Tim should not be in hospital. Tim is medically fit, which I was medically fit, or whatever I went in for I’d been cured of. I was just there, waiting. I didn’t take offence at it because there was no offence intended. It was just a situation’.

SU3 (14)

Those who had a real personal sense of delay were the people waiting for a prolonged period. Participants in Scotland were purposively sampled because their delays exceeded six weeks, so this was a particularly marked aspect of their experience. While delays of such length were much less common in English sites, they did occur within our samples, especially in relation to waits for EMI care and specialist housing, or where the outcomes were disputed. For all these older people, their accounts of delayed discharge were characterised by an overwhelming sense of tedium. Our study confirms earlier findings as to the negative and enduring impact such long delays cause to older people’s independence and well-being. This was especially the case for those older people who had recovered physically and who were effectively being ‘warehoused’ without further treatment or active therapy until their social care became available. Thus people spoke of “being built into the woodwork here”.

In England and Scotland, many of the people who experienced a lengthy delay were moved from acute wards into wards with a variety of designations - non-acute or rehabilitation wards within the same location, community hospitals, or holding wards (although this varied between sites). Here, while a quiet and gentler pace of life suited some patients, others commented on the lack of active intervention or activities:
'This [ward] is a recuperating place and there it was all operations. They did not have room for picnickers. Some picnic!! …Now I must admit they talk to you more here than the acute hospital. I have found out more here than all the time I was there'.

SU3 (10)

'[At the hospital] they did blood tests and they said it wasn’t a stroke. Once she was [on the ward] no one bothered, she had her tablets on time and… I was there night and day and it was just “Oh yes your mum is fine.” I don’t think they bothered at all...You know I mean they care for them but they didn’t have anything interactive… She was in for rest really’.

CA4 (3)

In Scotland where holding wards had been established, many of the activities once provided to bring a little cheer to older people delayed in hospital had disappeared. Not only did patients talk about lack of stimulation and purpose, but they complained bitterly about the presence of ‘others’, ‘not their kind’ with whom they shared:

‘I tried talking to the guy next to me but he wasn’t all there I asked him a question and he must have talked for 20 minutes to answer it, he made no sense whatsoever. There’s quite a few people on this ward like that. I’m no criticising them, they can’t help it, but it doesn’t make it any easier on me, which is a terrible thing to say, but it’s the truth’.

SU2 (10)

And,

‘I wasn’t really prepared for how noisy the place would be here. When I was in hospital before for the operation I was telling you about it was like a monastery, you could hear a pin drop, it can be like the High Street on a Friday night when the pubs shut.....I’m exaggerating of course but you know what I mean, that woman that was shouting at you for a cigarette and to be allowed out, I have to here that all day’.

SU2 (3)

Whilst there is, correctly, a great deal of attention given to the risks to physical health of being delayed in hospital, for example, catching a hospital acquired infection, the emotional consequences of being delayed excessively tend to be under-reported. A number of patients spoke about having nothing to do and being bored, having no mental stimulation and how
this made them ‘fed up’ or ‘down’. Loss of independence was a common theme and there were clear indications that long delays had enduring consequences:

‘I came in with a fall and I was walking with the aid of two sticks and now… I can walk a wee bit but not much….And I’ve lost an awful lot of weight because I’ve been in hospital. Lost all confidence…because it’s just one thing happened after another. I caught a bug, diarrhoea, sickness which I wasn’t bothered with before then; that was clearing up and I caught another bug. So it hasn’t helped. Anyway who wants to be in hospital?’

SU 2 (2)

‘I used to like a laugh but it’s slowly wearing away I just lost some of my spark. I felt so left out in the hospital. I thought I was never getting out. There was no one to talk to. It’s a lot better in [the care home. I’m still on my own most of the time but I’ve got a TV in my room, a DVD player. I can use the phone whenever I want, my friends get up and it’s quieter’.

SU1 (9)

‘I fulfilled all my goals that we set and so I’m hardly getting any therapy anymore and that has been the case for a number of weeks now…They say that for me, walking around the ward is dangerous because of the obstacles. [Leaving hospital] is essential for mental health as well. They don’t seem to concentrate very much on the mental side of being here. So you can imagine the rest of my day is very long. I’m very angry that I’m not in control and I’m liking it less and less’.

SU3 (9)

Despite awareness among staff of the adverse consequences for patients of delayed discharge, there were few examples of any action being taken to mitigate the risks beyond securing the actual discharge itself. A rare exception in Site 3 led to a younger disabled man, awaiting specialist housing adaptations, being allocated a counsellor by the ward.

5.5 Discharge planning

Guidance in relation to reimbursement stresses the importance of rooting it within best practice in multi-disciplinary discharge planning, using single assessment procedures and improving communication both between professionals and with patients and their carers.
The patients’ experience of discharge planning was variable between wards within hospitals in the same site, as well as across sites. Many, especially the oldest old, had little awareness of the process, other than knowing that somebody had spoken to them and was making arrangements. There were, however, many examples of good trusting relationships built up between patients and staff, as they named individuals who were the ‘helper with it’, ‘on our side’. One patient spoke of how her care manager had all the relevant notes from the ward prior to her assessment:

‘She’s lovely. She gets on well with our Mary – they are the same kind, practical, straight to the point, not fiddling’.

SU 3 (1)

Some of the younger patients were critical of the discharge planning processes, seeing them as overly procedural and disjointed.

‘It seems to me to be very territorial, this is my province, this is their province and once you have passed it on, you then go to the next one. There does seem to be a lack of – now then to accuse everybody of being uncaring perhaps is not fair—but professionally, it seems to me that their minds have been switched to acting in a ‘Right that’s another one out of the way, another piece of paper that can be filed in…’

SU3 (9)

Significantly, in Scotland, having a more relaxed time frame for assessment and care management in non-short stay settings did not appear to translate at the level of patient experience, perhaps reflecting deeper rooted and long standing problems with assessment and care management practices per se (Postle 2000).

5.6 Information sharing and involvement in decision-making

In both England and Scotland, health and social care staff are committed to the principle of involving older people and their families in all aspects of their care including discharge planning:

‘Around discharge planning [patients] are involved every step of the way. We do nothing until they have consented, they are consulted every step of the way...Everything is explained to them they are given sheets to explain what has
been ordered equipment wise. If there are case conferences they will have notes from that’.

Senior Primary Care Trust Manager (Hospital Based) StHc4 (5)

Practice as described by patients and their carers revealed a more nuanced and mixed picture. Mrs Marsh’s daughter described communication between the ward and the family as:

‘…very good…and there was eight of us in family…I have more to do with Mum so I was designated to be the person that spoke to them…But the social worker went to see my mum first to find out what she wanted…and when she said she’d like to go back to her bungalow…that’s what they’ve done….The actual discharge was being planned for a couple of weeks, there was so much to organise…the district nurse to arrange a bed and hoist…and the social worker had to arrange the care package…and put it to panel…Mum wanted it [to go home] and we were happy if they could arrange it’.

CA5 (7)

For others, there was little sense of discharge planning being an active and engaging process of assessment and care co-ordination and several commented that they did not feel involved or well informed about many aspects of their hospital care and treatment, extending to discharge planning. This pattern of variation applied equally to England and Scotland:

‘I don’t think I’ve been told half as much as I should have been. Okay, maybe they don’t like giving me bad news because I don’t take it well and no news is as bad as not getting out of here I had to get one of my family to find out from social work what was happening… none of the nurses knew. She just pestered them everyday and then she got me the booklets about the homes’.

SU1 (11)

‘I know that it can be difficult for the nursing staff because they don’t know what’s going on outside the hospital. But I was waiting for three weeks to speak to a social care manager about getting discharged. They didn’t know, I asked them why and they says we don’t have the spaces. Now even if things don’t change, which they didn’t I still wanted to know but I kept on having to ask and I felt I was being a pest but I was really desperate to know’.

SU2 (8)
'We are all in [hospital] with the worry of what’s the matter with us, [the other patients] are worried, I am worried…The [nurses and doctors] are in the passageway…They talk about you and you are left wondering. Lots of older people have ear trouble like me. I just need care and attention instead of being ignored…someone to listen to you.’

SU4 (3)

Even patients like Mr Logan who demanded and received full descriptions of the ‘system’ spoke of it all as very woolly. Mr Logan considered that not being ‘kept in the loop’ was a major quality issue in his discharge. Asked about his involvement in discharge planning, (which in his case included health, social care and housing personnel) he said ‘It sucks’:

‘Communication across the full spectrum – letter, phone, face-to-face, email and in not letting me know and letting other people know that state of play. There are no regular updates, they are non-existent – it is a very poor show. This is their job, it is what they are meant to do, this is virtually the top priority for them - otherwise they might as well go and sweep roads’.

SU3 (14)

Carers too spoke of the need to be proactive on the wards and having to seek out nurses or doctors to find out how their parents were or what was going. Several carers knew the system through work or through family informants. Even so, they also expressed frustration that, despite their own knowledge, they could not achieve the outcomes they wanted for their relatives or railed against their own sense of impotence in the system.

5.6.1 Care planning meetings
Some of the complexities of decision-making about future care are reflected in patient stories: families faced with difficult decisions about the future as a result of a sudden onset chronic disability (e.g. stroke) where the person was previously fit and active; older people and/or their relatives coming to terms with physical or mental deterioration and their continuing ability to manage independently. It is not surprising that for some carers and older people, their accounts of not being involved in decision-making are at odds with professionals’ accounts of seeking to involve older people and relatives in decision-making. Mrs Ovens (Box 9), when interviewed, a month following the first panel meeting that agreed nursing home care, expressed her hope of returning home and commented that no-one had spoken to her about what she wanted. Her social worker considered that Mrs Ovens “sometimes would understand what was said to her and sometimes not. I’m not sure how
much she did…and how much she remembered.” In such difficult cases, care planning meetings could be the locus of anxieties and distress, as well as a daunting experience. For several carers, the meetings felt less like discussions than ratifications of decisions already made:

‘But the meeting wasn’t a meeting. When I went with my sister and her daughter to try and sort things out, they didn’t ask me what I needed or anything like that. They were just telling me more or less, that she had to go in a home. I was amazed at that, I didn’t think it was legal that sort of thing’.

CA4 (5)

And,

‘If there’d been a bit more proper conversation between us all like saying to me: “What would you like Mr. Monroe? Could you suggest a better way of caring for your wife or something like that”? You see, more or less from the start she had to have 24 hour care. If you can’t supply it, it’ll have to be in a nursing home because we can’t do it here, and that was more or less that was the way it was going’.

CA3 (10)

This resulted in some carers indicating they felt they were being pressurised into a decision with which they were not comfortable and which they considered they had to resist. However, it is interesting to note that despite this feeling of pressure, having indicated they were not in agreement, other options were considered with them and often the outcome was what the carers and their relatives had sought. Mr Carey, for example, was able to take his mother home with the care package he felt was necessary, Mr Jones was given additional rehabilitation and similarly enabled to return home with a care package. The issues were both about the feeling of powerlessness and of having to be assertive. This led carers to express concerns about those who were not as strong or well-informed as themselves or people alone and about whether they would be pushed into inappropriate decisions. Some carers, who were involved in these decision-making meetings, eventually reluctantly agreed that they could not manage to provide the high level of care needed, because of their own disability, frailty or other commitments.

5.6.2 Lack of information

In Scottish sites, some communication difficulties stemmed from the fact that staff couldn’t provide the information older people and their families wanted – quite simply because they didn’t know the answers themselves. This was especially the case where ward staff and
social workers were waiting for decisions about when funding would become available for a care home placement. The sharing of information and degree of involvement in decision-making between patient and staff tended to be at its worst during a funding crisis or when there was an availability problem with care home spaces or home care packages:

‘Well, [hospital staff] don’t know. I don’t think they can give me any more information because they don’t have it…They have a meeting every week and I think every week they send in or they phone in about things…The doctor says she phones (about getting funding for discharge from hospital) but she said “I won’t give you a date because probably it wouldn’t materialise and you would be disappointed”’.

SU1(2)

Similarly in England, staff commented sometimes that they had not been in touch with carers or patients, because they had been unable to make any progress. From the patients’ perspective, however, this could mean that they felt out of the loop. It resulted in the paradox that after days or weeks of delay, several patients and carers expressed huge surprise when the actual date of discharge arrived:

‘To tell you the truth I was shocked. At the time I was livid…I sat on the train coming home from work, the phone rang and they said: “Your mum is coming home tomorrow morning”. With the situation as it was – Dad was in the same hospital – he had had a stroke and since then he is now in a home. So Mum was going back to an empty house, no partner there’.

CA3 (12)

These comments reflect the unblocking in the system of whatever was causing the delay in respect of formal services, at which point it was all systems go. Families, however, were juggling other commitments and felt the decision was suddenly thrust upon them.

5.7 Understanding the context of delayed discharge

Managers and staff commented about the need for public education to ensure that patients and carers understood that people awaiting discharge who had completed their acute medical treatment did not have the right to wait indefinitely in acute medical beds. Many hospital staff were also very aware of pressures on beds, with new patients waiting to be admitted. However, there was a widespread perception that older people, and particularly their
families, have their own priorities around discharge and moving on and that this has the potential to cause considerable tension between staff and carers.

‘[Researcher: And do you find mostly people are understanding about the issue of the beds?] No. Well some are I would say. All the others don't understand. They are very selfish. They are blinkered. They just see their own relative and they don't care that other people need their bed…’

Discharge Co-ordinator PrHc4 (7)

In Site 4, at the time of the fieldwork there were no leaflets available which explained about the discharge process. A working group had been set up to look at the issue. In terms of what information should be given, there was agreement among most staff that older people and their families did not need to know about reimbursement because it was thought to be either too complicated, not relevant or potentially distressing:

‘I think that’s a difficult one…It depends really if they are told things on admission as to what is the norm… We treat your medical condition and you wait in a holding bed before you go. Then that becomes the expectation… I think in all honesty most of them are not aware of it…’

Discharge Co-ordinator PrHc4 (7)

In Site 3, discharge procedures required that a letter be handed to patients on arrival on the ward, informing them that when they are assessed as medically fit, they will be required to move to another location. In fact, no-one remembered seeing this but several people spoke about the pressures on beds within the hospital:

‘I were in longer than I should have been I think. And it isn’t fair. I mean the hospital wants them beds, don’t they?’

SU3 (6)

Asked directly whether people had said anything to them that made them feel as if they were causing a delay, most said that this had not been the case. However, Mrs Monroe worried that the problems in finding new housing ‘is taking time and they are saying that we are taking too much time over it’. Asked who said this she did not know but somebody is. Her husband described a pincer movement, on the ward and from the care manager to effect Mrs Monroe’s move into nursing care:
‘The charge nurse says look we really want this bed, if she stays in till October or after this is when all the poorly people are coming in with different diseases and different infections and different things and if Eileen is still here then she’s going to pick something else up, so it’s best if you can get her out somewhere. The care manager seemed very good to start off with, until we started to want discharge like to come out somewhere, all the pressure started’.

CA3 (10)

Mrs Jones and her daughter similarly recognised pressure from the ward on their care manager but felt she was on their side:

‘They wanted the bed and that’s all because that’s why they were pushing the care manager, you see they were on her. She didn’t tell us this but the way she was saying it, coming to us and saying about homes and trying to get us some information about different homes, and I know they were pushing her, you know, and so we didn’t want that But the care manager was good, she never pushed the home on to us, she wasn’t saying that’s what you should do. She was quite honest and upfront about what the situation is, and to think about it, you know is it best for him, things like that, what does he want’.

CA3 (15)

On Site 3 there was a clearly defined escalation procedure for prolonged delays. Mr Williams’ daughter described a process of negotiation and attrition; firstly she was telephoned by someone nagging about beds all over the place. However, when she finally met the Discharge Task Force, she was impressed by their helpful, practical approach. She felt that ward staff wanted to move her father on because of bed pressures.

‘I know this is all about government policy – getting people out of hospital beds. It is difficult because people start in-fighting. They are under pressure to have the bed for others to come in. I think if you are not strong, you might have ended up anywhere…because they are desperate to move them on. We were told that he has been in the bed too long. But on the other side, it was unhelpful for dad to stay there. He wasn’t so well in hospital. If things are in place, they should move’.

CA3 (11)
Eventually, when offered an interim placement close enough for her mother to visit daily, she agreed to the move. She felt that the interim home provided good care, but that her father was more confused when he actually went into his permanent care home. Sadly he died two months later.

This carer’s sense of being caught on the horns of a dilemma was reiterated by others. They were aware of systems and of the harmful effects of lengthy stays in hospital for their relatives but they needed reasonable and viable alternatives to consider. Their duty, as they saw it, was to look out for the welfare of their relative and this determined their actions.

5.8 Transitions and follow-up

Although the time gap between the first and the follow-up interview was relatively short - between four and six months - nine had died, reflecting the degree of frailty of many in our study.

28 people went home directly, mostly with home care support and two returned with or after intermediate care. At follow-up, two had died, two had moved into care homes, six were not interviewed and eighteen older people (64%) were still living at home. They and their families were mostly positive about their current overall situation. For most of them, the relief of being at home was enormous. Mr Smith’s wife was delighted with the support from home care:

‘[Discussing the home care ‘girls’] They’re marvellous, they come in the morning and wash and dress him, I make his breakfast, because he likes me to do it, anyway, and then come in at dinner time, and if I have to go shopping they will give him his lunch, because he wears continence pads so they change his pads, and then they come in, in the evening and wash him and put him to bed. I’ve never known girls like them, they’re fantastic’.

CA3 (3)

The most important factor was a return of a degree of independence in their lives, and a re-connection with their wider group of friends.

One Scottish patient spoke about the benefits of being discharged back to her own home with a package of care that involved being dressed morning and undressed in the evening and bathed twice a week:
‘Because I’m back home I can do things when I want to do them not when someone is telling me when I have to do them. I also see my friends, they stay locally and couldn’t get up to the hospital and I missed them. Most importantly I have my privacy which is the most important thing…I can also sleep at night now! Before in the hospital I’d get woken up at all hours by a poor soul singing or shouting, it was awful’.

SU1 (2)

Her carer reiterated the benefits of being at home:

‘There’s a smile on her face which I hardly ever saw when I visited her and I did that nearly every week for three months. She’s a bit more confident as well and she’s actually talking more. She’s still not very mobile because of her arthritis but up top she’s more active and that’s where it really matters because when she was in that hospital there wasn’t a lot going on at that level’.

CA1 (2)

Another patient was very succinct about the benefits of being discharged from hospital. After being delayed for over two months following a stroke and awaiting new specialist adapted housing he said about being discharged:

‘Total relief, that more than anything else…I would gladly have gone back to my (old) own home even though I’m in a wheelchair and wouldn’t have been able to move out of one room…To be in a new house with my wife is such a difference…the most important thing is I can do what I want (well up to a point) when I want. I’ve got some of my own life back’.

SU2 (10)

Many of the older people and their relatives were facing significant new disability and had to adjust to a new way of life. There was a sense that it was not easy getting to this point and that the first few weeks home could be a critical time. Mr Jones and his family had to adapt to a completely new life after his massive stroke. They were still in the process of dealing with the rigours of high-level care but found the support of carers four times a day together with the district nurse and physiotherapist helpful. The care package worked fairly smoothly and they had got to know many of the care workers and knew who to expect. Miss Jones, who had given up her job because she was becoming so stressed, spoke about the process.
‘Well it’s been really difficult adjusting to it. We’re just starting to adjust now, but at first it was a total shock to the system, because we didn’t have a routine because either you have to be getting up quite early, well we do anyway dad being diabetic we have to give him something before they come, so you have to adjust your time when you get up and have your shower and get something to eat for yourself and I have to take his blood sugar, and then you’ve got to work round their schedule as well as dad’s schedule, so it’s very difficult, very difficult adjusting, sometimes I wouldn’t even get into the shower until 11 12, one o’clock…Yeah at first, you know when you’re thrown in to this situation you don’t know, I mean there was the care manager there, especially when dad was in hospital, but when he first came out you’re kind of a little bit left on your own really, different numbers you had to ring, and sorting out prescriptions or things like arriving on time, catheters, you know, all sorts of little bits and bats. I wasn’t sure “do I ask the nurse about that or do I ring the people myself”.’

CA3 (15)

In making adjustments to their new situation, access to reliable and trusted information was crucial that for some was not easily accessible. For example, Mrs Hancock started to experience problems during the night getting her husband to the toilet and the resulting accidents led to considerable extra washing. She phoned the care agency that provided her helpers to ask if she could possibly get a ‘night nurse’. The care agency told her that there was no possibility at all of such a service; but she was not made aware either of the availability of continence services so she continued to struggle alone:

‘Some of its wrong…Well that bed was a mistake and they have ideas like that pillow but it didn’t go on the mattress…Lots of gadgets that don’t work really. Still it is a very good system these helpers. I am getting a bit exhausted. They say things like well you must take care and look after yourself, but I don’t know quite how.’

CA4 (8)

Emotional adjustment to newly acquired disability or ill-health posed significant difficulties, as Mr and Mrs Hancock related:

Researcher: And what is it like now you have to live downstairs?
Mr Hancock: Well I don’t feel that I am a free person really, I wake up, my wife brings me my breakfast in bed and then carers come
and get me out of bed, put me in this chair, then two others come just before lunch, put me on the commode.

Mrs Hancock: That’s not their fault. We are stuck with you being sort of immobile. I did ask today if they could possibly open the front doors and get him into the front garden so he can see my hydrangea. But they only got him to the door as there is a step. I would have to get a ramp to take him outside. I have opened the door once or twice so that he could see out’.

SU4 & CA4 (8)

Mrs Marsh, although desperate to go home, was described by her daughters four months post discharge as being very depressed, her expectation of returning to her previous routines not having been met.

‘I mean my mum was always so independent always doing everything for herself, and to be in a bed and have everyone to look after her is not her way of life. She gets very low to think that she has to be asking, you know everything she wants’.

CA5 (7)

In the English sites, 12 of 38 patients were admitted to long term nursing home care following their discharge from hospital and one other died whilst awaiting a nursing home place; four others were admitted to residential care (three directly from hospital, and one via home and a subsequent acute admission). Thus, nearly half the patients in the sample within the English sites were assessed as needing or were admitted to long term care. At the follow-up interview, eight of the 12 admitted to nursing home care had died. Of the remainder, not all had settled by the follow-up interview. Mr Monroe spoke of his wife’s daily plea to be taken home and the distress this caused him:

‘Well I go to keep her company because she gets so down and depressed and “where’ve you been all this time like, I thought you’d be here earlier”. And then when it’s time to come home [she says] “come on let’s go home”. And you’ve got to really feel rotten and say, “Sorry I can’t take you like”, “oh why am I staying then… I don’t want to say here”. What do you say to them like? You know because you’re feeling rotten yourself having to say, “I can’t take you home, you know”.

CA3 (10)
Generally, those admitted to residential care described themselves as content. Mrs Patton, who had made a positive choice to go into a residential care home felt more confident and was able to go out more frequently whereas previously she had been unable to get out on her own:

‘I haven’t been too bad you know. I have a laugh… with all of them, you know. I’m getting to know them. They’re all very nice. I went from hospital to here, and I think by doing that I didn’t miss going back to the flat. If I’d have come from there to here it would have probably been a different story. But I’ve been in hospital all that time, I forgot all about it, you know, it wasn’t there…Yeah I go down to lunch with that [wheelchair] now. I didn’t at first, I, wheel meself, But I think we’re getting better at it and when I go out I go in the wheelchair, you know, cause it, they always send an escort with you from here, you don’t go on your own’.

SU7 (5)

5.9 Summary

- Patients in our sample represent core NHS service users. Many were very old and had chronic health conditions, many were frail and often in the last years of their lives. This is a very important group of service users whose voices are not often heard. However, as they were sampled because they were delayed, and in Scotland because they were experiencing lengthy delays of six weeks or more, they are unlikely to be typical of NHS patients generally being discharged from hospital.

- What is evident in many patients’ stories is that decisions are affected by an interplay of factors - personal preferences, needs and desires of users and carers, that may also conflict and different professional perceptions about how best to meet needs - which are played out in the context of the system pressures, capacity and processes outlined in Chapter 4. The conception of ‘patient-centred care’ and ‘choice’ needs to be developed to take account of this complexity with the focus on addressing the system and capacity constraints that make such rhetoric appear hollow.

- The concept of ‘patient choice’ as a cause of delayed discharge is often used pejoratively by staff to indicate reluctance to move from the hospital and to assume responsibility for care costs. From the accounts of older people and their families, it has a range of different meanings. Especially when a care home is an option, it is
wrong only to see the awkward consumer when the reality is that many older people and their families will be facing an extremely tough and distressing time which requires a more supportive response. Where needs are very complex and the prospect of a care home is on the horizon, both time frames for assessment need to be relaxed and time to seek appropriate accommodation to be available.

- There is considerable variation in patients’ discharge experiences. We heard stories of close and trusting relationships with discharge staff coexisting with narratives of poor communication, lack of information and involvement in discharge processes in both Scotland and England.

- Few older people and carers knew about policies on delayed discharge and reimbursement. Many of them were aware of pressures on acute beds and the need to move on, so that other people could be admitted.

- It was clear that all our patients agreed with the basic underlying premise of reimbursement and Joint Action Plans that acute hospitals were not the place for older people to stay once their treatment had been completed. However, frequently suitable alternative support or accommodation was simply not available, either in the community or in the hospitals while awaiting a permanent place.

- People who were most likely to be aware of being delayed were those whose delay related to an external agency (such as social services or housing and/or those who experienced lengthy delays. Those waiting for very long periods (strongly articulated by our Scottish sample of over six-week waiters), experienced low mood, loss of control, frustration, anger, reduced skills and confidence.

- Moves within the hospital and between wards are commonplace and often distressing, particularly where they are not seen as purposeful by patients (for example, ‘holding beds’). Patients commented on having to get to know a new set of nurses and carers, on reduced social contact and sometimes acute embarrassment.

- For family carers, the process was often very stressful and at points they felt a sense both of powerlessness and of having to fight to achieve what they felt would be best for their relatives. These areas of conflict arose particularly in care planning meetings, over finances and levels of care and around moves into interim care.
6 Conclusions

6.1 Implementation and impact of reimbursement

The broad policy context in which ‘delayed discharge’ is played out in England and Scotland is the re-focusing of acute care – the designation of hospitals as settings in which specialist diagnosis and high technology treatment is provided to patients with acute illness – and the proliferation of alternatives closer to home to offer support and care in the transition between “illness” and “wellness” (for example, rehabilitation and recuperation). This shift is of particular significance for older people, since they are more likely to experience multiple health problems that complicate and extend recovery from acute illness; they are also susceptible to sudden onset conditions, like hip fracture that affect functional abilities and resumption of the routines of daily life. The problem of delayed discharge – however defined (and we return to this below) - is a key policy concern in both England and Scotland from both a patient and a system perspective: prolonged, stays in hospital for patients increase risk of infection and contribute to reduced independence; they also represent an inefficient use of costly and valuable resources.

In this final chapter we start by briefly addressing the questions (focused on reimbursement) that were set out in the proposal for the study. We then compare and contrast the process and impact of reimbursement in England with JAP in Scotland to highlight both the positive and negative features of the reimbursement policy as implemented in our study sites. Finally, we draw out some policy implications that flow from our findings and conclusions.

6.1.1 How is the reimbursement scheme being implemented?

Although our study was located in only three sites in England, the findings indicate considerable diversity in the approach to implementation. Despite the prescriptive nature of the legislation and guidance on reimbursement, we found different modalities of implementation, in part reflecting how significant the ‘discharge problem’ was seen to be in the system, in part reflecting features of the local context (different historical patterns of services, inter- and intra- organisational relationships and vested interests). This diversity operates both at the strategic level – the approach adopted by health and social care agencies in translating policy into structures and protocols; as well as in day-to-day implementation.

In the two sites where delayed discharge was regarded as a ‘big nut to crack’, one of them adopted a strict procedural approach in respect of notifications and cross charging
simultaneously with little transparency about the use of the delayed discharge grant. This shifted over time to a more collaborative approach. The other started from the premise that additional resources should be pooled and deployed through a joint investment plan, linked with an open and transparent process for agreeing priorities and the flow of money to fund them. Any fines incurred were to be called off against this investment, removing the need for ‘cross charging’. In the third site, ‘delayed discharge’ had not been viewed as a major problem requiring radical solutions – although it emerged in the course of the research that this may have reflected its export to other parts of the system (this site had a community hospital which closed part way through the study).

At the operational level, there were aspects of the policy that were generally perceived as contributing to good practice by staff in all agencies, as for example the Section 2 notification of need for assessment and provision of support on discharge. By contrast, the Section 5 was a source of tensions between operational staff, and symbolic of the way that reimbursement has, from the social work perspective, cast them as being personally responsible for delays. Indeed, the issuing and withdrawal of Section 5 notifications was subject to considerable negotiation. Its flexible use in some situations was a product of the strength of informal relationships between practitioners and their joint quest toward achieving the most appropriate solution for individual patients. But ultimately, at the grassroots it was seen as a punitive weapon directed against one partner that often resulted in negative organisational behaviour and contributed to a blame culture that undermined partnership relationships (see below).

6.1.2 How much money is changing hands?
The amount of money changing hands as a consequence of reimbursement varied yearly within sites and between sites (see Box 3.1, page 39) and this confirms the findings of Pollock’s (2007) recent study that fines and cross charging are only being adopted in a minority of English localities. However, it is not possible to read from this the number of actual delays occurring within a site. This is because there is considerable variation between sites in agreements reached between NHS Trusts and local authorities relating to how reimbursement is implemented, whether money will be exchanged as a consequence of reimbursement and if so, how this will be spent. Moreover, formal agreements are contested and reworked, as priorities and pressures impact on strategic decisions.

6.1.3 In what way, if any, has reimbursement contributed to a reduction in delayed discharges?
Prior to our study, most commentators were in agreement about the difficulty of specifying
the extent to which the Community Care Act contributed to the decline in delayed discharges in England. This was because of the other prior and concurrent measures such as intermediate care and admission avoidance schemes. Even so, whilst the statistical trends suggest that the decline in delayed discharges preceded reimbursement, there was a further fall in the pattern of delays at the point at which reimbursement was introduced in shadow form. Moreover, the reason for delays has also shifted with reimbursable delays contributing a smaller proportion of all delays.

The evidence from our study sites is that all of them have achieved reductions of their delays – both reimbursable and all delays, although with some fluctuations in one site. In all sites too, there was a generally held view among strategic and operational staff that reimbursement had contributed to this, although depending on their position within the system, they were more or less pre-occupied with the unintended consequences of the policy (see below). It is important to note, however, that this reduction is in the context of ongoing negotiations about what is and is not a ‘reimbursable delay’. What was recorded as a delay generally and a reimbursable delay specifically varied between sites due to a range of factors, such as investment in data-gathering systems, degree of transparency about delays and the nature of the partnership agreements.

At the same time, whilst it was acknowledged that the policy profile on reimbursement and the systems established to monitor and progress the flow of patients had highlighted one facet of the problem of delayed discharges, they were insufficient to address all of them. In consequence, sites had introduced, or were in process of developing, other approaches (for example, the use of discharge co-ordinators to support ward staff in managing the routine discharge of patients whose needs did not warrant a Section 2 notification, the extension of the multi-disciplinary team forum to consider all patients who were experiencing lengthy in-patient stays and not only those identified as ‘delays’, community discharge matron to support early identification of patients for discharge).

Whilst there is no clear, definitive answer to this question, our study suggests that a range of policies, of which reimbursement is one, is contributing towards reducing delayed transfers of care from acute beds.

6.1.4 What has been the impact of reimbursement on readmissions and emergency admissions?

We are unable to provide a definitive answer to this question from our data. Whilst national statistical trends suggest that there is a relationship between emergency admissions and
delayed discharges, attributing causality is more problematic. It is possible that both trends reflect the speeding up of acute care, reflected in increased admissions and reduced length of the acute episode. These trends are likely to be more pronounced for older people because of the complexities of later life illness/disability.

Within our English sites there was a variation in emergency readmission rates. Staff, managers and older people’s representatives in the sites (especially in Site 3 where this was an issue) attributed these readmissions variously to the inherent instability of frail older people’s health, to increased follow-up in the community which picked up problems more frequently and to readmissions of those patients who had been deemed to be ‘independent discharges’ and had been discharged home without a package of care. In this last scenario, reimbursement, as one of the policies that had contributed to a general speeding up of the discharge process, was identified as a factor that had possibly accelerated difficulties for older people.

6.1.5 What has been the impact of reimbursement on partnership working between health and social care?

The impact of reimbursement on partnership working between health and social care agencies in England is inconsistent. In some respects, relations between health and social care since reimbursement are still vested with characteristics that existed before its implementation. In other respects, there was agreement at strategic level that the problem of delayed discharge had brought partners to the table. In the one site which had pursued a joint investment strategy to improve partnership working, this had achieved the desired outcome.

In each of the sites reimbursement has been perceived as a spur to specific incentives or drivers in the system in three main ways. It has raised the profile of delayed discharge, establishing joint mechanisms for the systematic collection of data around delays, for negotiating between agencies about the reasons for delays and for reporting them externally. It has provided the impetus for creating routine multi-disciplinary forums to review pathways of individual patients and facilitate their move out of acute care. It has directed attention and resources at assessment and discharge planning for those particularly with complex health and social care needs, complementing action within the acute trusts to reduce average length of stay and increase capacity.

In characterising partnership working around reimbursement, it is more accurate to view partnership as an emergent quality of relationships than a fixed and immutable characteristic.
Across all the sites, alongside a commitment to joint working there were tensions and strains resulting from financial pressures that disrupted the equilibrium which then had to be re-forged on a new basis.

Inconsistency was also a feature of inter-professional relationships at the operational level. On the one hand, there was evidence of multi-disciplinary team working in respect of individual patients. On the other, among social workers in particular, there was a strong sense of being held personally responsible for delays that shaped relationships with other professionals.

6.1.6 What is the impact of reimbursement on people using services?

There are two aspects of this question that we review here. First, there are the intended and unintended consequences for patients from the perspective of managers and staff. Second, there is the impact on patient experiences and outcomes.

The impact of reimbursement on patients is perceived differently by the various stakeholders, depending on their position in the system. Many hospital staff and clinicians saw benefits to patients individually, in reducing their delays in hospital and collectively, in enabling better patient flow. Some strategic managers in the local authority, and social workers in particular, considered that reimbursement was a ‘system-focused’ policy and that it contributed to the general speeding up of acute care to the detriment of patients. Often, operational staff struggled to reconcile the pressures on the hospital system with their professional ideals around person-centred care. Concerns were expressed about time limits for assessment especially where patients had complex needs, and the difficulty in finding appropriate care packages, especially long-term care placements, in time.

The perception of the speeding up of the system at first sight appeared at odds with the experience of patients in our sample, most of whom had spent a lengthy period in hospital. We sought explanation for this puzzle in the wider system context.

Firstly, whilst reimbursement has directed attention on those individuals requiring multi-disciplinary input because of complex needs, a parallel development has been the narrowing of eligibility criteria for community care provision to those with critical and substantial needs. The impact of both has been to exclude the majority of people entering acute hospital from reimbursement processes with discharge planning being organized at ward level. It was the adequacy of discharge planning at this level that was an explicit focus of concern among some managers as it was for older people’s organizations.
Secondly, it was related to concerns about non-purposive moves of patients from acute beds into ‘transitional’ or ‘holding’ beds as they waited for services to be available. Whilst placing them at risk of being made ‘invisible’ in monitoring systems designed to measure delays in acute beds, such moves were also seen as detrimental to people’s physical and mental health as well as loss of skills and confidence.

Thirdly, it reflected staffs’ perception that priority was given to ‘reimbursable’ patients in the allocation of community based and long-term care whilst patients elsewhere in the system experienced lengthy delays – in mental health beds, in non-acute wards and in intermediate care which were not recorded in official statistics.

With regard to patient experiences, older people and their relatives agreed that the acute hospital was not the place to be, once their treatment was completed. Although few of them knew about policies on delayed discharge, they were aware of pressures on acute beds and the need to move on, so that others could be admitted. Most of them appeared unaware – or at least did not express it – of being perceived as a ‘problem’ or a ‘bed-blocker’ through their day-to day interactions with staff. The exceptions were two younger men with disabilities.

We have emphasised that the patients in our sample were selected because they were experiencing delays/lengthy in-patient episodes. Whilst they represent core NHS users – being in advanced older age, with chronic or multiple health problems – they are not typical of the wider hospital discharge experiences of NHS patients. For our respondents, what emerged from the stories related by the different narrators (patient, relative, health and social care practitioner) was that their experiences and outcomes reflected an interplay of factors: the nature of the illness, their personal wishes and preferences, availability of informal support and willingness of relatives/carers to continue to provide care, different professionals views of people’s needs and how best they should be met, and the resources available in the system. These factors were played out in the context of system pressures, service capacity and discharge processes. Three fundamental issues emerged from their experiences that the reimbursement policy alone does not address (and in some circumstances appeared to exacerbate) and which highlight system level constraints on achieving user centred practice.

Firstly, for individuals with complex needs, there are windows of opportunity that open and shut quickly at different points of the acute episode. Recognition of, and being able to access appropriate resources in timely fashion to meet the complexity of need, when the window is open, is critical if patients have the opportunity to return to their previous home routines. This could take the form of specialist advice and intervention for people with mental and physical
health needs. It could also involve enabling rehabilitation input to maximise skills even when the eventual discharge destination is uncertain. Critical to this is the involvement of the multi-disciplinary team, including social workers, early in the acute episode, to assess, plan for, and respond to changing needs and wishes.

Secondly, for those older people who are waiting for assessed services, the move from acute care may proceed through temporary or interim solutions of little therapeutic value as part of the process of making acute care more effective but to the detriment of individuals. It is important that solutions to making acute care more efficient should not just be focused at the entry and exit points of the hospital but that there should more investment in resources for rehabilitation and community based provision.

Thirdly, the concept of ‘patient choice’ in the context of delayed discharge and reimbursement has diverse connotations and meanings. It can be viewed simply by staff as indicating patients’ reluctance to leave hospital and to assume responsibility for care costs. For patients and their families, it has a hollow and distressing edge to it, occurring at a major point of transition, where the decisions to be made often require sensitive and difficult negotiations between irreconcilable needs and wishes.

6.2 Verdict on reimbursement through comparison with Scotland

The comparative focus of this study, namely to examine the process and outcomes of different approaches to managing the problem of delayed discharge in England and Scotland, highlights questions and issues that would not have been posed in a study located only in one country.

In both England and Scotland, ‘delayed discharge’ is viewed as a major policy ‘problem’. In both countries too, the ‘problem’ is located in the wider context of a re-shaping of acute care, albeit they exhibit differences as well as similarities in their respective health and social care economies and policies.

In the policy response to delayed discharge, not only does each country differ on the details (which we summarise below), but these grow out of fundamentally different change management approaches. These different management approaches are in turn reflective of the different health policy approaches that exist between Scotland and England in general. Scotland adopting a more ‘collectivist’ approach in health policy with England opting for competition and contestability (Hudson, 2007; BMA Health Policy Unit, 2007). In Scotland,
whilst the policy outcomes to be achieved are clearly stipulated as well as the targets by which success will be measured, the delivery mechanisms are to be locally determined through partnership agreements. In England, there is explicit attention in national policy not only on the outcomes and targets but on the precise mechanisms to effect change, many of which are focused on the ‘flow’ of patients through the system (notification systems, weekly monitoring, and processes for defining ‘reimbursable’ delays and for financial arrangements arising from reimbursement policy).

Even so, there are important features of similarity as well as difference in the policies. Both countries have adopted a ‘carrot’ and ‘stick’ approach to achieve change. The ‘stick’ wielded by Joint Action Planning (JAP) in Scotland is two-pronged: the publication of quarterly figures on delayed discharges for every Scottish NHS Board and their corresponding Local Authority partners) means the ‘naming and shaming’ of partners that are failing to achieve the targeted reductions (likely to be a powerful sanction in the context of the size of the country and the network ties between senior managers within and across agencies and with government) and the threatened withholding of funding to each NHS Board and local authority partner until the Scottish Executive agrees the details of the JAP. The difference between them is that JAP both encourages and incentivises shared responsibility for the solutions to managing the problem of delayed discharges, whatever their nature and source, and sanctions are directed at the partnership as a whole. In England, reimbursement formally places responsibility for delays on the local authority. But this is not the whole story. The legislation and guidance relating to reimbursement points in two directions simultaneously: on the one hand emphasising partnership working and on the other the threat of sanctions against one of the partners. Whilst this offers the potential for divergent approaches to local implementation as revealed in our study sites, in essence it has the effect of contributing to a ‘blame’ culture.

There was general agreement among strategic planners in Scotland that the process of strategically developing, monitoring and implementing Joint Action Plans helped towards cementing partnership working between NHS and local authority social services. In England, although there was acknowledgement that reimbursement had been a spur to focus on the problem of delayed discharge and to bring partners to the table, it was also a source of tensions between partners; there was much less consistency about the overall benefits of reimbursement and some concerns about unintended consequences in the wider system.

At operational level, the experience of implementation of JAP and reimbursement was more nuanced and complex. One significant feature of reimbursement was the attention given to the negotiated nature of ‘readiness for discharge’ and in particular, the participation of the
members of the multidisciplinary team – including social workers and therapists in the decision making around ‘readiness’ and the extension of its meaning to include ‘safe to go home’. This allowed the insertion of different professional perspectives into the decision-making process, although this was not without difficulty. In Scotland, the decision on discharge was often the site of cultural and professional disputes linked with a continued dominance of medical professionals and it was this that shaped practitioners ambivalence about JAP. This was especially the case in acute settings when facing pressures on bed availability.

Despite the differences in the approach to change management, we did not find that patients’ experiences were qualitatively different in England and Scotland. In both countries the costs of delays to patients interviewed were felt in terms of boredom, low mood, reduced functional abilities as well as risks to physical health. It did appear to us that some of the patients delayed more than six weeks in Scotland were similar to people in England that would have received intermediate care. In hindsight it would have been useful to have collected systematic information on functional abilities to ascertain whether the samples were the same in respect of need and resources.

The value of a comparative approach between England and Scotland is not only revealed in policy divergence and statistical data but in grassroots experiences. It has thus highlighted which groups of people are liable to be subject to delay by creating a sensitive picture of their specific needs – albeit the focus of diverse policy solutions.

6.3 Reimbursement: is this the last piece in the Jigsaw?

From the findings and conclusions of our study, it is evident that reimbursement has acted as a spur to direct attention on the issue of delayed discharges, to encourage shared responsibility of the problem and the forging of solutions to tackle it. These solutions have primarily focused on, and contributed to, the development of flow mechanisms to facilitate patient journeys through and out of hospital. In this respect it has located those pieces of the puzzle that build up the picture on the organisation of acute and follow-on care at the boundary of the hospital. But in doing so, it has also highlighted the fact that this picture is only part of a broader and changing landscape that also requires filling in.

Moreover, since reimbursement was introduced in England in 2003, the landscape of health and social care policy has changed and reimbursement in the specific sense of ‘cross charging’ does not fit well into it in two important ways. In the context of Joint Commissioning Frameworks and whole-system reconfiguration of care, it is conceptually uncomfortable and
divisive in emphasising delays relating to social care only. Its exclusive focus on delays in acute beds is at odds both with new financial processes such as payment by results and with concepts of holistic patient-centred care around long-term conditions and personalised care.

The implications of our study for policy then are two-fold: in terms of the wider system within which reimbursement is located; and in respect of approaches to manage the problem of delays.

6.3.1 The wider system
A key conclusion from our study – applicable to the situation in England and Scotland – is that the solutions put forward to tackle delayed discharges in themselves are insufficient to address the wider system changes resulting from the re-focusing of acute care. What is needed is more investment in resources beyond the entry and exit points of the acute hospital to develop a broader range of rehabilitation, intermediate and transitional care provision as well as long term community infrastructure. This will require whole system working and joint investments, which encompass not only the marginal additional growth money but also shared decision-making around mainstream budgets.

6.3.2 Managing delayed discharge
Our findings suggest that reimbursement is a policy that has had its day – or at least significant features of it. Whilst it is important not to divert organizational gaze from ‘delays’, the factors contributing to them and solutions to address them, the focus needs to be on systems and processes that contribute to, and flow from, a sense of joint ownership and responsibility of the problem at strategic and operational levels. Neither reimbursement nor JAP has been entirely successful in overcoming a ‘blame culture’ at both these levels. Specifically, we consider that the following require addressing:

- The engagement of members of the multi-disciplinary team, including social workers, at an early stage in the patient episode to identify needs, wishes, support and interventions to optimise options for recovery and discharge;
- Prioritising and maintaining emphasis on multidisciplinary decision-making around the process and timing of discharge;
- Building on systems which have grown up to monitor and respond to delays to include wider aspects of patient flow such as discharge coordination, multi-agency review of all patients who are delayed across the system, information gathering on the causes, length and types of delays which follow the patient through the system;
• Reviewing the reimbursement notifications procedures to ensure that timescales are sufficiently flexible around assessments of the most complex cases;

• Reviewing the purpose and use of interim care with a special focus on the needs of the people with complex needs; notably older people with mental health problems, younger people with high-level physical disabilities and the older old toward the end of their life;

• Considering how the policy of dignity in care could be extended from its current emphasis on staff/patient interaction to include strategic pathways planning which ensure that the context designed for care is one where dignity can be maintained;

• Exploring the relationship between emergency re-admissions to acute hospital, ‘independent discharges’ and the raising of the eligibility criteria for home care.

In conclusion then, we would argue that – to continue the jigsaw metaphor – the reimbursement piece is somewhat ragged around the edges and does not quite fit the puzzle. Further, this study, by highlighting both its intended and unintended consequences on different stakeholders, including older people who experience its impact, suggests that the puzzle to complete is considerably larger than this piece was intended to fill.
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Department of Health (2002a) *Delivering the NHS Plan*. Cm 5504. London: HMSO.


http://www.adass.org.uk


Reimbursement Implementation Team (2003) Whole system finance and investment update: Offsetting reimbursement liability against new investment – what is permissible?
http://www.dh.gov.uk/assetRoot/04/06/22/32/04062232.pdf


Schimmel EM (1964) The hazards of hospitalization, Annals of Internal Medicine 60, 100-110


Appendix 1: Synthesis of the Literature on Hospital Discharge and Delayed Discharge.

<table>
<thead>
<tr>
<th>Name of Report</th>
<th>Author(s)</th>
<th>Publication Date</th>
<th>Focus</th>
<th>Number of Studies Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharging Older People from Hospital to Home: What do we Know?</td>
<td>A Coffey</td>
<td>2006</td>
<td>The aim of this literature review was to examine empirical research to date on hospital discharge and illuminate areas in need of further exploration.</td>
<td>Using a seven step approach a keyword database search was conducted which revealed 44 studies.</td>
</tr>
<tr>
<td>Using Qualitative Research in Systematic Reviews: Older People’s Views of Hospital Discharge</td>
<td>M Fisher H Qureshi W Hardyman J Homewood</td>
<td>2006</td>
<td>Older people’s experiences of hospital discharge, and how they are influenced by staff views and behaviours.</td>
<td>15 (104 identified)</td>
</tr>
<tr>
<td>Show Me the Way to go Home: Delayed Hospital Discharges and Older People</td>
<td>J Glasby R Littlechild K Pryce</td>
<td>2004</td>
<td>Studies published since 1993 which focus on rate and cause of delayed discharges for older people in the UK</td>
<td>21</td>
</tr>
<tr>
<td>Research Review on Tackling Delayed Discharge</td>
<td>G Hubbard G Huby S Wyke T Themessl-Huber</td>
<td>2004</td>
<td>UK and international literature 1984-2004 identifying key areas that need to be addressed for delayed discharges to be tackled long term. Includes information produced by the Information Statistics Division (Scottish Executive) and a review of Scottish Joint Action Plans on Delayed Discharge plus a small number of interviews.</td>
<td>105</td>
</tr>
<tr>
<td>A Systematic Review of Discharge Arrangements for Older People</td>
<td>SG Parker SM Peet A McPherson AM Cannaby K Adams R Baker A Wilson</td>
<td>2002</td>
<td>Clinical trials relating to interventions to improve the discharge of older people from inpatient hospital care</td>
<td>Synthesis comprising 71 articles representing 54 RCTs, 10 of which were from the UK. (6972 articles identified)</td>
</tr>
</tbody>
</table>
Interpretative Framework

| Delayed discharge does not feature in studies which explore older people’s views of hospital discharge. According to the authors, ‘The synthesis points to a completely different kind of understanding of the discharge process than that which underpins the traditional view’ (p.47). The synthesis suggests that older people view discharge as an integral part of the process of coming to terms with the impact of illness on life planning. Experiencing illness, being treated in hospital and leaving hospital is therefore a major event or process that threatens self-sufficiency and control over one’s life, particularly if complete physical recovery is not expected longer term. |
| Fisher et al. |
| Points to the complexity of delayed discharge and the need for a ‘whole systems’ approach. Stresses the importance of local contexts and history. Suggests that delayed discharge can be understood in terms of three areas: (I) Individual factors (O) Organisational factors (S) Factors associated with wider social policy and the structure of current services |
| Glasby et al. |
| Suggests that delayed discharge can be understood in terms of the interaction between, individual, medical and organisational factors. It is further suggested that organisational capacity to use a whole system approach systematically in service development and planning is essential given that tackling delayed discharge depends on: o Finding out the main causes for delayed discharge in the local care system o Developing initiative to tackle these causes o Evaluating the impact of these initiatives o Monitoring the extent to which delayed discharges are being successfully tackled |
| Hubbard et al. |
| Professionals in health and social care use agreed protocols to help ensure proper quality standards of discharge processes for vulnerable elderly people. These were systematically reviewed to test if some interventions were more effective than others. The interventions considered were: discharge planning; comprehensive geriatric assessment; discharge support and educational interventions. The interventions were not mutually exclusive. The outcomes considered were mortality, length of hospital stay and readmission rates. |
| Parker et al. |

Rates of Delayed Discharge

| None reported |
| Fisher et al. |

Studies reported rates of between 8-66%. It was highlighted that studies tend to adopt very different definition of delayed discharge which make comparisons between different studies and locations impossible.

| It is argued that it is difficult to accurately compare research findings reporting the number of delayed discharges because it is not clear if |
| Hubbard et al. |
consultants and other health and social care professionals use the same criteria when determining if a patient is ‘ready for discharge’.

**Causes of Delayed Discharge**

None reported  
Fisher et al.

A key aspect of a number of the studies reviewed is the high number of delayed discharges associated with internal hospital factors. It is noted that given the widespread assumption that delayed discharges are caused by shortfalls within social care this is a key finding.

Problems with both health and social organisations are identified. Organisational factors associated with delay include (i) lack of home support (ii) unavailability of convalescent or rehabilitation facilities, (iii) waits for community care assessment or home care packages. Within Scottish Partnerships, problems with social services were perceived as the main causes of delayed discharges.

Who is most likely to experience a delay? (risk)

Not reported  
Fisher et al.

Older people and those with multiple pathologies are most at risk of delay. Some medical conditions (such as neurological deficit and stroke) appear more likely to lead to delayed discharge for all age groups and that this is often because there is a lack of alternative care facilities available for these particular people. Patients waiting for a place in their first choice of care home to become available, and patients who did not have a companion to escort them home, were also likely to be delayed. People admitted as an emergency were more likely to have a delayed discharge compared to elective admissions, and people with severe mental illness admitted for planned short hospital stays were less likely to have a delayed discharge compared to those who were admitted as long hospital stays and in receipt of standard care. A key finding was that the Scottish Partnerships were not explicit about targeting particular groups of people identified as at risk of delayed discharge.

Practice Issues in Hospital Discharge

When arranging hospital discharge staff need to adopt a ‘life planning framework’. Staff currently focus on safety and risk in the short term – seeing the discharge date as the end of their involvement. In contrast older people had a primary focus on the longer term.

Older people experience anxieties about their impending discharge from hospital. This relates to safety (particularly fear of falling), how they will manage or cope: being a burden to others. For some, there may be an anxiety and uncertainty about whether they will be “allowed home”.

Older people and carers receive inadequate information on discharge
and not knowing who to ask for help. Uncertainty was identified as the fundamental factor in problems experienced by older people in the short term after discharge. This highlights importance of continuity of staff between hospital and home.

A key concern is the low participation among older people in planning for discharge. This was linked to,
- Differences in power and status – with doctors perceived to be in charge and older people deferring to professionals
- Hospital organisation, atmosphere and staff behaviour
- Older people did not feel it was their right to express their views – often waiting for staff to initiate discussion.
- Older people not at their most assertive because they are weak or ill
- Being aware of pressure on beds. In one study, older people were told directly by nurses that they had to move on to make room for other

- Poor communication between hospital and community
- Lack of assessment and planning for discharge
- Inadequate notice of discharge
- Inadequate consultation with patients and their carers
- Over-reliance on informal support
- Inattention to the special needs of vulnerable groups such as frail older people

- If acute hospitals become perceived as no go areas, community based ‘Hospital at Home’ and ‘Early Supported Discharge’ schemes may jeopardise older people’s rights to equal treatment and equal access to services.
- Improving clinical care needs to be a component part of any strategy aimed at reducing delayed discharges.
- Discharge managers such as liaison nurses can improve the discharge process. However, this may result in other staff abnegating responsibility for discharge.

None reported

**Reducing Delayed Discharge - What works?**

None reported

Many studies identified the need for additional rehabilitation – a finding which would appear to support the emphasis placed in England on developing intermediate care services.

Suggests that given the importance of local contexts, an initiative like the Change Agent Team would seem to be a useful way of working with local health and social communities to resolve the difficulties associated with delayed discharges.

There is no ‘quick fix’ to the intractable problem of delayed discharge. Some approaches offer promise. These are likely to:
- target those most at risk of either emergency admission or delayed discharge;
- plan flexible, integrated services to both reduce emergency admissions and delayed discharge; and
- use monitoring information about the impact of services, and
evaluations of initiatives to effect further quality improvement.

Specific approaches offering promise include,

- Discharge planning. This can reduce the length of hospital stay, increase patient satisfaction, and reduce the number of patients experiencing a delay. However, it is not clear from existing studies what ingredients are necessary for effective discharge planning (e.g. which professionals should be involved in multi-disciplinary teams).

- Hospital at Home schemes (sometimes called Early Supported Discharge schemes). These have contributed toward tackling the problem of delayed discharges for some people. Studies show these schemes to:
  - Increase patient satisfaction
  - Reduce hospital lengths of stay
  - Increase the number of patients still at home at 6 months after discharge
  - Lead to greater community reintegration
  - Improve health related quality of life
  - Reduce costs per patient
  - Lower carer satisfaction
  - Do not improve health outcomes or functional status
  - Increase overall length of care

There is limited evidence about the impact of equipment/home adaptations: step-up/step down beds in care homes: joint case management, cross charging, care home places and interim care home beds. In summary, a range of initiatives within a whole system approach may be most effective overall in tackling the problem of delayed discharges.

The evidence from the trials does not suggest that discharge arrangements have effects on mortality or length of hospital stay. This review supports the concept that arrangements for discharging older people from hospital can have beneficial effects on subsequent readmission rates. Interventions provided across the hospital-community interface, both in hospital and in the patients home showed the largest effect.

None of the four intervention types (discharge planning; comprehensive geriatric assessment; discharge support and educational interventions) were shown to have major effects on mortality or length of stay. Only educational interventions had an effect on readmission risk ration, however, the trials were limited in focus so may not be generalisable outside selected patient sub-groups.

The overall conclusion was that evidence from RCTs is not available to support the general adoption of discharge planning protocols, geriatric assessment processes or discharge support schemes as a means of improving discharge outcomes.
<table>
<thead>
<tr>
<th>Limitations of current studies/need for further research</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>This review uncovers aspects of the discharge process that are in need of further research, and particularly suggests more rigour in the measurement of hospital discharge outcomes.</td>
<td>Coffey</td>
<td></td>
</tr>
<tr>
<td>Concludes that existing evidence base is extremely weak. ‘Research into the rate and causes of delay is characterised by a series of methodological limitations which raise significant questions about the extent to which recent policy changes can be said to be evidence based’ (piv)</td>
<td>Glasby et al.</td>
<td></td>
</tr>
<tr>
<td>Suggestions for further research include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Focus on the patient perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Problem solving rather than problem seeking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Needs of minority groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Ways in which hospitals can address internal causes of delayed discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Longitudinal research which not only diagnoses the problem but which also explores delayed discharge over time in order to examine whether proposed solutions are actually successful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Wider issues such as premature discharge, admission avoidance, the risk of inappropriate placements and delays in accessing community services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Points to uncertainties around how local initiatives to tackle delayed discharge are being monitored and evaluated. A key observation is that capacity building in terms of the skills in whole system data collection, data handling and analysis is required.</td>
<td>Hubbard et al.</td>
<td></td>
</tr>
<tr>
<td>Notes that many studies do not include opinions of patients, carers and people from minority ethnic groups.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies need for further research in the following areas:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Medical and social criteria for judging when a patient is ready for discharge (for example, a comparative study of practices across different Scottish partnerships).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o GPs’ utilisation of community-based services and the impact this has on hospital admissions and delayed discharges, particularly given that small changes in GP decision making has a disproportionate impact on the acute sector.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Discharge managers’ relationships with other staff and the impact this has on the discharge process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o The role of allied health professionals in tackling delayed discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>More research is needed particularly in the UK. Models that provide intervention across the hospital-community interface and /or education are worthy of consideration. Patient health outcomes, patient and carer satisfaction and costs should be measured. Future studies should ensure that mortality, index length of stay and readmission rates are recorded. Trails should be conducted to agreed standards with harmonisation of outcome measures to facilitate pooling of data.</td>
<td>Parker et al.</td>
<td></td>
</tr>
<tr>
<td>Further research to explore the issue of cross-national comparability of studies between different healthcare systems would be worthwhile.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Updating the Literature for the Jigsaw Project
As part of this study we updated the literature search used by Hubbard et al. (2004) rerunning the search to cover the period 2004-2007. We included the additional search term 'reimbursement and delayed discharge'. This resulted in the retrieval of a further 25 full text articles (with 2 relevant to reimbursement).
Appendix 2: Methodology and Profile of Patients Interviewed

The research methodology comprised four interlocking stages:

**Stage 1 - Mapping patterns of delayed discharge**

The initial stage of the work drew upon the quarterly returns to the DH in England and ISD census data in Scotland to monitor and compare the emerging patterns of delayed discharges across England and Scotland. In both countries, contact was made at national level with stakeholders and organisations involved in delayed discharges. In England, this was Department of Health delayed discharge staff, DH Statistics Division, Change Agent Team (CAT). In Scotland, it was Scottish Executive staff with national responsibility for delayed discharges, Information and Statistics Division of NHS Scotland (ISD), Centre for Change & Innovation (CCI), Scottish Executive Joint Improvement Team (JIT). Stage 1 also focused on government policy developments around older people and delayed discharge in both countries. Meeting people working on delayed discharges at a national level was important for five reasons:

1) It would provide us with a more detailed insight into national data on delayed discharges and allow us to ask specific questions about the data;
2) It would be an important supplement to the data provided in the literature and reports;
3) We would, hopefully, become aware of new or forthcoming policy initiatives;
4) Contact with national stakeholders could help facilitate access at regional/local level;
5) It could help with site selection.

**Stage Two: Service responses to delayed discharge and reimbursement**

This stage focused on the process of local implementation and service responses to national policy on delayed discharge. It involved the collection of documentary data relating to delayed discharge and reimbursement policies and practices (partnership protocols, local implementation plans, procedures for implementing reimbursement), interviews with strategic and operational managers in health and social care agencies (n=56); and observation of relevant meetings (discharge planning groups, acute bed forums).
**Stage Three: Impact of delayed discharge and reimbursement on service users**

The final stage of the study ran in parallel with stage two and examined user experiences and ‘journey’ through interviews with service users (n=68), operational staff directly responsible for their care/discharge planning (n=132), and informal carers (n=40) (see Figure I below).

**Figure I: Total number of interviews in each of five study sites**

<table>
<thead>
<tr>
<th>Site</th>
<th>Patient</th>
<th>Family</th>
<th>Managers and clinicians about the system</th>
<th>Practitioners and clinicians about individual patients</th>
<th>Total number of completed interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>15 (5)</td>
<td>8 (4)</td>
<td>10</td>
<td></td>
<td>39</td>
</tr>
<tr>
<td>Site 2</td>
<td>15 (5)</td>
<td>8 (4)</td>
<td>12</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Site 3</td>
<td>15 (8)</td>
<td>10 (3)</td>
<td>22</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Site 4</td>
<td>13 (2)</td>
<td>7 (7)</td>
<td>16</td>
<td></td>
<td>24</td>
</tr>
<tr>
<td>Site 5</td>
<td>10 (1)</td>
<td>7 (6)</td>
<td>9</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>68 (89)</strong></td>
<td><strong>40 (64)</strong></td>
<td><strong>67</strong></td>
<td></td>
<td><strong>132</strong></td>
</tr>
</tbody>
</table>

(n) = number of follow-up interviews 4-6 months post discharge

In approaching patients for interview we identified mainly older people with complex needs who required social care input and whose discharge was actively being planned during a specified period. From these, we purposively selected individuals for interview whose discharge was delayed for whatever reason or who had experienced lengthy in-patient stays. We considered that if we only concentrated on reimbursable delays, not only would we find it difficult to locate an adequate sample in some sites, but we would not then be able to explore how the problem of delay might have been exported elsewhere in the system. It should be noted that when the fieldwork commenced in Scotland, the definition of a ‘reasonable discharge period’ meant that the term delayed discharge was only usually applied to those patients whose stay in hospital had already exceeded six weeks. For this reason, participants in the Scottish sample have a length of stay almost invariably longer than six weeks while in England, length of stay tended to be shorter.

An element of purposive sampling to include ethnic diversity was introduced. However, because the numbers were small (n=2), a separate focus group was held in Site 3 to hear the views of older people from Afro-Caribbean and South Asian backgrounds (this explored hospital discharge more generally).
Older people likely to be involved in delayed discharge and reimbursement are a particularly vulnerable group of the population. Finding out if they are willing to be involved in research requires particular sensitivity. We worked on the basis of ongoing consent for the study and this approach was approved by the ethics committee. First, the discharge co-ordinator or care manager determined which patients met the inclusion criteria for the study and also decided who was able to give informed consent to participate. Only those deemed capable of giving informed consent were approached. The care manager or co-ordinator briefly explained to each of the potential interviewees what the study was about and then asked them if they were willing to be approached by a researcher who would clarify the purpose of the study in more detail. Older people who agreed to be approached were given an information sheet and consent form by the researcher. They were reassured that participation was voluntary and that declining to take part would not be detrimental to the care provided. Consent was monitored throughout the interviews so that the older person had an opportunity to terminate their participation at any point. The researcher also paid attention to non-verbal cues such as the older person showing signs of tiredness or anxiety. Quite a high number of the older people we approached did decline to participate usually because they were feeling too tired or unwell. Nine participants died during the research study period.

Patients (and carers) who agreed to take part were interviewed in hospital at first interview (or shortly after discharge) and then re-interviewed four to six months later. Longitudinal information about patients is very rare within the health and social care economy so these stories offer a valuable insight into their experiences. This is especially the case as regards the involvement of the ‘oldest’ older people whose voices are seldom heard. The particular interest of the DH in ‘revolving door’ patients is acknowledged in the study. A key rationale for tracking the sample of individual patients over six months was to determine the extent to which there are readmissions. In addition the intention was, with the consent of patients, to gather retrospective data for a maximum of six months from patient records and from key workers. The national data for both countries was also scrutinized to identify patterns of recurrent and emergency admissions.

Figure II below shows the reason for admission to hospital and the average age of participants included in the study. Full background information as regards each individual case is presented in Figure III (which appears at the end of this Appendix). Names and any identifying features have been changed to protect the anonymity of the participants. Our patient sample is not representative, nor is it intended to be. Furthermore, it should be
stressed that because of the focus on delayed discharge the views presented in this report are not representative of the wider hospital discharge experience in either England or Scotland. The majority of the cases could be termed ‘complex discharges’ (Wade 2006) and the varied experiences of participants in the study highlight critical decision-making points or ‘windows of opportunity’ opened and closed that are relevant to this specific patient group.

Figure II: Reasons for admission to hospital and average age of participants experiencing a delayed discharge

<table>
<thead>
<tr>
<th>Reason for Admission</th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
<th>Site 4</th>
<th>Site 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Overdose</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol Problems</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaemia</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breathing Problems</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Collapse</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Confusion/Depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Diabetic Ulcers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Fall</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Fracture Neck of Femur</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Heart/Vascular Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Kidney Infection/UTI</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Painful Hip</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pneumonia/Chest Infection</td>
<td>4</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>2</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Skin Infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Average Age</strong></td>
<td><strong>79 Years</strong></td>
<td><strong>78 Years</strong></td>
<td><strong>80 Years</strong></td>
<td><strong>81 Years</strong></td>
<td><strong>84 Years</strong></td>
</tr>
</tbody>
</table>

For each individual patient within the tracking sample the following data was collected with their permission:

- Retrospective hospital data on admission, moves within the hospital and the sequence of decision-making to discharge;
- Experience of the decision-making process in relation to discharge, experience of discharge (if it has occurred) and of the immediate period post discharge – what was
missing and what was good, their aspirations/expectations for the future;\(^8\)

- (In England) knowledge or awareness on the part of the older person of the reimbursement process;
- (At second interview) the intervening experiences, including any readmission, experience of care (whether at home or in a care home), and their reflections on their discharge and post-discharge experiences to date (respondents may have had multiple readmissions in the intervening six months).

Interviews with practitioners were linked to the case tracking sample above and addressed two broad topics: firstly, discussion of the individual’s care pathway and critical points in the journey; secondly, a more general exploration of the perspective of front-line professionals on the operationalisation of Joint Action Planning and reimbursement.

Two elements of the project design were changed during the course of fieldwork. First, we made a decision to curtail mid-point telephone tracking with older people as many of the older people were too poorly to communicate by telephone. By necessity, most of the face to face follow-up interviews were with family members and carers. Second, older people were not asked to complete the Philadelphia Geriatric Center Morale Scale (PGCMS – Lawton, 1975) because this was not appropriate in the context of the interviews, many of which lasted a long time and were at risk of tiring the older people. The researchers felt uncomfortable attempting to carry out these assessments since professionals had often asked the older people concerned numerous questions of a similar type.

**Stage 4: Data analysis**

Apart from the statistics on delayed discharge and reimbursement at stage one, the majority of the data gathered during the study was qualitative in nature, field notes from observations or from interviews, both with professionals and with older people and carers. Interviews were tape-recorded and transcribed. The researchers framed the analysis within a policy context and drew broadly on the disciplines of social anthropology and medical sociology. Team members read and re-read transcripts carried out within individual sites. Discussion within the team and further exploration of the interviews generated a framework of thematic categories which was applied to the data drawn from the observations and interviews within

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\(^8\) The project advisory group sought the participation of older people with a particular interest in the topic of delayed discharge. An advertisement was placed in Help the Aged’s ‘Policy Update’ newsletter and two older people were recruited as a result. In the planning phase, one of the researchers worked with one of the older advisory group members to host a seminar event with members of a local older people’s forum. Forum members gave their views on the interview schedules and other materials and also reflected on the likely issues to emerge from older people’s perspectives.
individual sites. We employed the constant comparative method to explore similarities and differences between stakeholders and sought to locate these in the local organizational and national context through use of documentary data and observation of decision-making forums at different levels. Further discussion within the team focusing on inter- and intra-site variation identified a further set of thematic categories that were applied across the data as a whole. Again the use of the constant comparative method was used to examine patterns of variation within and between sites and countries. The emerging findings from the study were presented and their relevance and validity ‘checked’ initially in local groups in each case study area (e.g. National Service Framework Local Implementation Teams) prior to the preparation of this final report.
Appendix 2/Figure III: Profile of Interview Participants Experiencing a Delayed Discharge

**Notes on comparative interpretation of following tables:**
Delays are calculated as commencing on the day after a Section 5 (confirmed date of discharge) has been issued. Where Section 5s are not issued, lengths of delay are deduced form the patient records and interview data.

**Site 1 (Scotland)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Age</th>
<th>Gen</th>
<th>EO</th>
<th>Date of Admission</th>
<th>Reason for Admission to Hospital</th>
<th>Section 2</th>
<th>Section 5</th>
<th>Date of Discharge (Length of Stay)</th>
<th>Length &amp; Cause of Delay, Discharge Destination &amp; @ 4-6 month Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU1 (1)</td>
<td>75yrs</td>
<td>F</td>
<td>WS</td>
<td>08/06/06</td>
<td>Pneumonia, then on admission found out fracture in back after falling at home. Previous admission for stroke.</td>
<td>N/A</td>
<td>N/A</td>
<td>06/10/06 (120 days)</td>
<td>Delay: 84 days. Awaiting care home placement. @ 6 months: Living in care home. Still feeling very down at second interview, doesn’t like care home but happier than when in hospital</td>
</tr>
<tr>
<td>SU1 (2)</td>
<td>76yrs</td>
<td>F</td>
<td>WS</td>
<td>23/03/06</td>
<td>Had reaction to new arthritis drug, made her fall getting out of bed.</td>
<td>N/A</td>
<td>N/A</td>
<td>27/07/06 (198 days)</td>
<td>Delay: 63 days. Awaiting home care package. @ 6 months: Discharged home with care package. Coping much better at home.</td>
</tr>
<tr>
<td>SU1 (3)</td>
<td>76yrs</td>
<td>M</td>
<td>WS</td>
<td>1/05/06</td>
<td>Breathing problems and black outs</td>
<td>N/A</td>
<td>N/A</td>
<td>06/10/06 (158 days)</td>
<td>Delay: 98 days. Awaiting specialist housing @ 4 months: Still in hospital at second interview – very frustrated</td>
</tr>
<tr>
<td>SU1 (4)</td>
<td>79yrs</td>
<td>M</td>
<td>WB</td>
<td>01/06/06</td>
<td>Fell at home, unable to walk without assistance.</td>
<td>N/A</td>
<td>N/A</td>
<td>31/10/06 (152 days)</td>
<td>Delay: 84 days. Awaiting care home placement @ 6 months: living in a care home and much happier to be there than hospital.</td>
</tr>
<tr>
<td>SU1 (5)</td>
<td>81yrs</td>
<td>F</td>
<td>WS</td>
<td>12/05/06</td>
<td>Accidental overdose of prescribed medicine for chronic condition.</td>
<td>N/A</td>
<td>N/A</td>
<td>29/10/06 (170 days)</td>
<td>Delay: 70 days. Awaiting care home placement @ 6 months: no second interview. Discharged to care home</td>
</tr>
<tr>
<td>SU1 (6)</td>
<td>86yrs</td>
<td>M</td>
<td>WS</td>
<td>08/08/06</td>
<td>Fell out of bed, damaged shoulder</td>
<td>N/A</td>
<td>N/A</td>
<td>25/10/06 (78 days)</td>
<td>Delay: 70 days. Awaiting care home placement @ 6 months: living in a care home. Much happier</td>
</tr>
<tr>
<td>SU1 (7)</td>
<td>80yrs</td>
<td>F</td>
<td>WS</td>
<td>22/05/06</td>
<td>Collapsed at in bedroom found on floor by sheltered housing staff</td>
<td>N/A</td>
<td>N/A</td>
<td>14/11/06 (176 days)</td>
<td>Delay: 112 days. Awaiting care home placement @ 6 months: living in a care home. Much happier.</td>
</tr>
<tr>
<td>SU1 (8)</td>
<td>72yrs</td>
<td>F</td>
<td>WS</td>
<td>27/08/06</td>
<td>Stroke</td>
<td>N/A</td>
<td>N/A</td>
<td>10/01/07 (136 days)</td>
<td>Delay: 91 days. Awaiting home care package. Discharged home with home care package. No 2nd interview.</td>
</tr>
<tr>
<td>SU1 (9)</td>
<td>77yrs</td>
<td>M</td>
<td>WS</td>
<td>12/07/06</td>
<td>Kidney Infection</td>
<td>N/A</td>
<td>N/A</td>
<td>20/10/06 (80 days)</td>
<td>Delay: 49 days. Awaiting care home placement. No second interview. Discharged home with home care package.</td>
</tr>
<tr>
<td>SU1 (10)</td>
<td>90 yrs</td>
<td>M</td>
<td>WS</td>
<td>12/07/06</td>
<td>Pneumonia</td>
<td>N/A</td>
<td>N/A</td>
<td>01/09/06 (59 days)</td>
<td>Delay: 49 days. Awaiting home care package @ 6 months: discharged home with care package. Much happier to be in own home.</td>
</tr>
<tr>
<td>SU1 (11)</td>
<td>83yrs</td>
<td>F</td>
<td>WS</td>
<td>09/08/06</td>
<td>Fell at home, chronic illness (COPD)</td>
<td>N/A</td>
<td>N/A</td>
<td>25/09/06 (47 days)</td>
<td>Delay: 35 days. Awaiting home care package. No 2nd interview. Discharged home with care package.</td>
</tr>
<tr>
<td>SU1 (12)</td>
<td>81yrs</td>
<td>F</td>
<td>WS</td>
<td>01/09/06</td>
<td>Chest Infection</td>
<td>N/A</td>
<td>N/A</td>
<td>22/11/06 (82 days)</td>
<td>Delay: 49 days. Awaiting care home placement @ 6 months: Discharged home with care package. Far happier.</td>
</tr>
<tr>
<td>SU1 (13)</td>
<td>78yrs</td>
<td>F</td>
<td>WS</td>
<td>5/09/06</td>
<td>Fell at home</td>
<td>N/A</td>
<td>N/A</td>
<td>28/11/06 (84 days)</td>
<td>Delay: 63 days. Awaiting home care package. No second interview. Living at home with care package.</td>
</tr>
<tr>
<td>Code (14)</td>
<td>Age</td>
<td>Gen</td>
<td>EO</td>
<td>Date of Admission</td>
<td>Reason for Admission to Hospital</td>
<td>Section 2</td>
<td>Section 5</td>
<td>Date of Discharge (LOS)</td>
<td>Length &amp; Cause of Delay, Discharge Destination &amp; @ 4-6 months</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>SU1</td>
<td>74</td>
<td>F</td>
<td>WS</td>
<td>03/07/06</td>
<td>Chest Infection</td>
<td>N/A</td>
<td>N/A</td>
<td>23/09/06 (88 days)</td>
<td>Delay: 49 days. Awaiting care home placement. Discharged to Care home. No second interview.</td>
</tr>
<tr>
<td>SU1</td>
<td>72</td>
<td>M</td>
<td>WS</td>
<td>04/08/06</td>
<td>Stroke</td>
<td>N/A</td>
<td>N/A</td>
<td>22/10/06 (79 days)</td>
<td>Delay: 42 days. Awaiting care home placement. Discharged home with care package. No second interview</td>
</tr>
</tbody>
</table>

**Site 2 (Scotland)**

<table>
<thead>
<tr>
<th>Code (1)</th>
<th>Age</th>
<th>Gen</th>
<th>EO</th>
<th>Date of Admission</th>
<th>Reason for Admission to Hospital</th>
<th>Section 2</th>
<th>Section 5</th>
<th>Date of Discharge (LOS)</th>
<th>Length &amp; Cause of Delay, Discharge Destination &amp; @ 4-6 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU2</td>
<td>82</td>
<td>F</td>
<td>WS</td>
<td>02/06/06</td>
<td>Breathing problems (COPD) Unsteady on feet</td>
<td>N/A</td>
<td>N/A</td>
<td>20/07/06 (48 days)</td>
<td>Delay: 49 days. Awaiting a package of supported care in own home. Discharged to own home with care package. No second interview</td>
</tr>
<tr>
<td>SU2</td>
<td>76</td>
<td>M</td>
<td>WS</td>
<td>25/04/06</td>
<td>Urinary tract infection</td>
<td>N/A</td>
<td>N/A</td>
<td>10/08/06 (107 days)</td>
<td>Delay: 56 days. Awaiting community care assessment. Discharged to own home. No second interview</td>
</tr>
<tr>
<td>SU2</td>
<td>79</td>
<td>M</td>
<td>WS</td>
<td>03/04/06</td>
<td>Skin infection and infected foot</td>
<td>N/A</td>
<td>N/A</td>
<td>21/08/06 (140 days)</td>
<td>Delay: 42 days. Waiting for community care package in own home. Discharged home with package of care. @ 6 month: Happier at home.</td>
</tr>
<tr>
<td>SU2</td>
<td>72</td>
<td>M</td>
<td>WS</td>
<td>06/06/06</td>
<td>Collapsed at home, unsteady on feet.</td>
<td>N/A</td>
<td>N/A</td>
<td>31/08/06 (86 days)</td>
<td>Delay: 49 days. Waiting for alterations to home. Discharged home with a package of care. @ 6 month: Very happy to</td>
</tr>
<tr>
<td>SU2 (5)</td>
<td>76</td>
<td>F</td>
<td>WS</td>
<td>22/06/06 Stroke</td>
<td>N/A</td>
<td>N/A</td>
<td>29/09/06 (98 days)</td>
<td>Delay: 77 days. Waiting for a care home place. Discharged to care home. @ 6 month: Prefers care home to hospital but rather be in own home.</td>
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</tr>
<tr>
<td>SU2 (6)</td>
<td>77</td>
<td>F</td>
<td>WS</td>
<td>12/06/06 Collapsed at home after being discharged from hospital after surgery. Severe arthritis</td>
<td>N/A</td>
<td>N/A</td>
<td>20/09/06 (100 days)</td>
<td>Delay: 56 days Waiting for a place in a care home. Discharged to care home. No second interview</td>
<td></td>
</tr>
<tr>
<td>SU2 (7)</td>
<td>81</td>
<td>F</td>
<td>WS</td>
<td>09/02/06 Collapsed at home, damaged legs, confusion.</td>
<td>N/A</td>
<td>N/A</td>
<td>02/09/06 (205 days)</td>
<td>Delay: 98 days. Waiting for a place in a care home Discharged to care home. @ 6 month: More content in care home.</td>
<td></td>
</tr>
<tr>
<td>SU2 (8)</td>
<td>86</td>
<td>M</td>
<td>WS</td>
<td>17/04/06 Stroke</td>
<td>N/A</td>
<td>N/A</td>
<td>13/09/06 (149 days)</td>
<td>Delay: 49 days. Waiting for a place in a care home. Discharged to care home. @ 6 month: Relieved to be discharged from hospital but rather be in own home.</td>
<td></td>
</tr>
<tr>
<td>SU2 (9)</td>
<td>78</td>
<td>F</td>
<td>WS</td>
<td>14/09/06 Collapsed at home unsteady on legs, cannot walk.</td>
<td>N/A</td>
<td>N/A</td>
<td>23/01/07 (131 days)</td>
<td>Delay: 98 days. Waiting for a place in a care home Discharged to care home. @ 6 month: Unhappy in care home and feels could be in own home.</td>
<td></td>
</tr>
<tr>
<td>SU2 (10)</td>
<td>75</td>
<td>M</td>
<td>WS</td>
<td>11/04/06 Stroke</td>
<td>N/A</td>
<td>N/A</td>
<td>14/12/06 (245 days)</td>
<td>Delay: 91 days. Waiting for specialist housing Discharged to specialist housing. @ 6 month: Relieved to be discharged from hospital and back in own home.</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Age</td>
<td>Sex</td>
<td>Admission Date</td>
<td>Diagnosis</td>
<td>Discharge Date</td>
<td>Days in Hospital</td>
<td>Delay Days</td>
<td>After Discharge Details</td>
<td></td>
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<td>---------</td>
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</tr>
<tr>
<td>SU2 (11)</td>
<td>75</td>
<td>M</td>
<td>04/09/06</td>
<td>Alcohol related liver problems</td>
<td>N/A</td>
<td>N/A</td>
<td>20/02/07 (162 days)</td>
<td>Delay: 91 days. Awaiting place in a care home. Discharged home. No 2nd interview.</td>
<td></td>
</tr>
<tr>
<td>SU2 (12)</td>
<td>78</td>
<td>F</td>
<td>12/08/06</td>
<td>Pneumonia</td>
<td>N/A</td>
<td>N/A</td>
<td>18/12/06 (121 days)</td>
<td>Delay: 49 days. Awaiting place in a care home. Discharged home with care package. No 2nd interview.</td>
<td></td>
</tr>
<tr>
<td>SU2 (13)</td>
<td>77</td>
<td>F</td>
<td>12/05/06</td>
<td>Stroke</td>
<td>N/A</td>
<td>N/A</td>
<td>19/09/06 (130 days)</td>
<td>Delay: 63 days. Awaiting place in a care home. Discharged to care home. No 2nd interview.</td>
<td></td>
</tr>
<tr>
<td>SU2 (14)</td>
<td>79</td>
<td>F</td>
<td>13/07/06</td>
<td>Stroke</td>
<td>N/A</td>
<td>N/A</td>
<td>20/10/06 (99 days)</td>
<td>Delay: 77 days. Awaiting place in a care home. Discharged to care home. No 2nd interview.</td>
<td></td>
</tr>
<tr>
<td>Code</td>
<td>Age</td>
<td>Gen</td>
<td>EO</td>
<td>Date of Admission</td>
<td>Reason for Admission to Hospital</td>
<td>Section 2</td>
<td>Section 5</td>
<td>Date of Discharge (LOS)</td>
<td>Length and Cause of Delay, Discharge Destination &amp; @ 6 month Update</td>
</tr>
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</tr>
<tr>
<td>SU2 (15)</td>
<td>76</td>
<td>M</td>
<td>WS</td>
<td>18/07/06</td>
<td>Pneumonia</td>
<td>N/A</td>
<td>N/A</td>
<td>20/09/06 (64 days)</td>
<td>Delay: 56 days. Awaiting place in a care home Discharged home with care package. No second interview.</td>
</tr>
<tr>
<td>SU3 (1)</td>
<td>78</td>
<td>F</td>
<td>WB</td>
<td>26.5.06</td>
<td>Confusion, TIA</td>
<td>29.5.06</td>
<td>7.6.06</td>
<td>16.6.06 (21 days)</td>
<td>Delay: 9 days. Awaiting residential care (reimbursable) Admitted to residential home from hospital Settled in home at 4 months</td>
</tr>
<tr>
<td>SU3 (2)</td>
<td>84</td>
<td>F</td>
<td>WB</td>
<td>17.6.06</td>
<td>End stage COPD, acopia</td>
<td>19.6.06</td>
<td>25.6.06</td>
<td>21.7.07 (34 days)</td>
<td>Delay: 17 days. Awaiting continuing care (non-reimbursable) Admitted to nursing home Deceased 6 weeks later.</td>
</tr>
<tr>
<td>SU3 (3)</td>
<td>85</td>
<td>M</td>
<td>WB</td>
<td>23.6.06</td>
<td>Collapse, hypoglaecemia</td>
<td>26.6.06</td>
<td>3.7.06</td>
<td>18.7.06 (25 days)</td>
<td>Delay: 8 days. Awaiting home care (reimbursable) Discharged to interim bed. Return to own home with existing care package At home at 4 months</td>
</tr>
<tr>
<td>SU3 (4)</td>
<td>91</td>
<td>F</td>
<td>WB</td>
<td>15.6.06</td>
<td>Fall one week ago, subdural haemorrhage</td>
<td>28.06.06</td>
<td>10.7.06</td>
<td>14.7.06 (29 days)</td>
<td>Delay: 4 days. Awaiting EMI nursing care (reimbursable) Admitted to nursing home (previously residential) Comfortable in home at 4 months.</td>
</tr>
<tr>
<td>SU3 (5)</td>
<td>91</td>
<td>F</td>
<td>WB</td>
<td>22.5.06</td>
<td>Painful right hip, immobile</td>
<td>1.6.06</td>
<td>15.6.06</td>
<td>6.7.06 (55 days)</td>
<td>Delay: 21 days. Awaiting EMI nursing care (non-reimbursable – patient choice) Admitted to nursing home (self funding) Deceased at 4 months</td>
</tr>
<tr>
<td>SU3 (6)</td>
<td>87</td>
<td>F</td>
<td>WB</td>
<td>8.7.06</td>
<td>Fall at home, on floor overnight. Previously arthritis</td>
<td>11.7.06</td>
<td>18.7.06</td>
<td>22.7.06 (14 days)</td>
<td>Delay: 4 days. Awaiting home care (reimbursable) Return home to await care package of 2X daily home care started one week later Admission to intermediate care bed at 3 months; at home at 4 months-</td>
</tr>
<tr>
<td>SU3 (7)</td>
<td>93</td>
<td>F</td>
<td>WB</td>
<td>23.3.06</td>
<td>Painful cold feet, chronic peripheral vascular disease</td>
<td>13.4.06</td>
<td>14.5.06</td>
<td>8.7.06 (106 days)</td>
<td>Delay: 55 days. Dispute about level of care (non-reimbursable) Upgrade from residential to nursing home. Deceased 6 weeks later.</td>
</tr>
<tr>
<td>SU3 (8)</td>
<td>98</td>
<td>M</td>
<td>WB</td>
<td>1.7.06</td>
<td>Unwell after failed discharge. Previously collapse/dizziness</td>
<td>13.7.06</td>
<td>19.7.06 rescinded 20.7.06</td>
<td>27.7.06 (26 days)</td>
<td>Delay: 8 days. Waiting for psychiatric assessment/home care package (non-reimbursable) Home with care package At home 4 months later Emergency admission for one week at three months post discharge.</td>
</tr>
<tr>
<td>SU3 (9)</td>
<td>52</td>
<td>M</td>
<td>WB</td>
<td>17.3.06</td>
<td>Multiple falls and UTI. Blind from birth and cerebral palsy</td>
<td>22.3.06</td>
<td>24.05.06</td>
<td>13.09.06 (180 days)</td>
<td>Delay: 112 days. (non-reimbursable – in rehabilitation ward) Admitted to transitional residential to await home adaptations and then nursing care. Mobility significantly reduced at 4 months –future home location uncertain.</td>
</tr>
<tr>
<td>SU3 (10)</td>
<td>71</td>
<td>F</td>
<td>WB</td>
<td>29.12.05</td>
<td>Amputation left leg, diabetic ulcers</td>
<td>19.4.06</td>
<td>10.8.06</td>
<td>13.10.06 (274 days)</td>
<td>Delay: 64 days. (non-reimbursable- in non-acute ward) Waiting or re-housing/complex package of care Admitted to nursing home Still there at 4 months</td>
</tr>
</tbody>
</table>
| SU3 (11) | 79  | M  | WB  | 22.5.06 | Falls/crisis. Carer breakdown. Vascular dementia | 1.6.06 | 12.6.06 | 14.9.06 (115 days) | Delay: 94 days. Awaiting EMI nursing care (non-reimbursable- in non-acute ward)
Admitted to transitional care and then EMI nursing care three weeks later. Deceased at 4 months |
|----------|-----|----|-----|---------|------------------------------------------------|-------|--------|------------------|----------------------------------------------------------------------------------------------------------------------------------|
| SU3 (12) | 75  | F  | WB  | 21.8.06 | Fall, #NOF | 25.8.06 | 28.8.06 | 1.9.06 (11 days) | Delay: 4 days. Waiting for intermediate care (non-reimbursable)
Home with ICT support. Now at home with home care |
| SU3 (13) | 84  | F  | WB  | 8.8.06 | Collapsed in house | 23.08.06 | 27.08.06 | 2.9.06 (25 days) | Delay: 6 days. Awaiting intermediate care bed (non-reimbursable)
Admitted to CIC bed for one month and then readmitted to hospital
Deceased 7 weeks later |
| SU3 (14) | 53  | M  | WB  | 30.6.06 | MRSA in diabetic ulcers, osteomyelitis, amputation of leg. Blind since 2001 | 3.7.06 | 30.08.06NHS Cont care | 14.11.06 (147 days) | Delay: 76 days. (non-reimbursable) Admitted to transitional care awaiting re-housing. Housing still awaited 4 months later but likely to be available in next month |
SU3 (15)  76  M  BC  5.04.06  Collapse at home, CVA  1.07.06  18.08.06  22.09.06 (170 days)  Delay: 35 days. Waiting for complex package of home care (non-reimbursable because patient refused transitional care) Discharged back home with home care 3X daily and with regular physiotherapy. At home 4 months later

Site 4 (England)

<table>
<thead>
<tr>
<th>Code</th>
<th>Age</th>
<th>Gen</th>
<th>EO</th>
<th>Date of Admission</th>
<th>Reason for Admission to Hospital</th>
<th>Section 2</th>
<th>Section 5</th>
<th>Date of Discharge (LOS)</th>
<th>Length and Cause of Delay, Discharge Destination &amp; @ 4-6 month Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU4 (1)  83  M  WB  5.3.06  UTI Increased Confusion and falls  ID  22.06.06 (109 days)  Delay: 4 days “Family looking for nursing home”. Admitted to nursing home from own home Died 23.8.06</td>
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<tr>
<td>SU4 (2)  77  F  WB  26.5.06  Fall (fracture right neck of femur).  CDD  27.6.06  5.7.07 (41 days)  Delay: 8 days “Awaiting POC” Return to own home. @ 4 months: At home and happy with situation – some outstanding issues</td>
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</tr>
<tr>
<td>SU4 (3)</td>
<td>85</td>
<td>F</td>
<td>WB</td>
<td>7.6.06</td>
<td>Falls. Reduced mobility</td>
<td>7.6.06</td>
<td>ID 26.6.06</td>
<td>30.6.06 (23 days)</td>
<td>Delay: 4 days due to “Awaiting POC”. Discharged to Intermediate Care (30.6.06) then home (3.7.06) with increased POC. @ 6 months: At home and happy with situation – some outstanding issues</td>
</tr>
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</tr>
<tr>
<td>SU4 (4)</td>
<td>71</td>
<td>F</td>
<td>WB</td>
<td>20.6.06</td>
<td>Atrial Flutter/SOB</td>
<td>21.06.06</td>
<td>CDD 3.7.06</td>
<td>3.7.06 (13 days)</td>
<td>Delay: none recorded but was waiting for a few days for previous care package to be increased. Once Section 5 issued discharge was within the 24 hour time period. Discharged home. Readmitted to hospital 12.7.06 -16.7.06 @ 6mths: At home and happy with situation</td>
</tr>
<tr>
<td>SU4 (5)</td>
<td>93</td>
<td>F</td>
<td>WB</td>
<td>2.5.06</td>
<td>Collapse/fall</td>
<td>9.5.06</td>
<td>ID 29.6.06</td>
<td>5.7.06 (65 days)</td>
<td>Delay: 6 days “Waiting pressure relieving mattress” Discharged home with carers @ 4 Mths : At home and happy with situation.</td>
</tr>
<tr>
<td>SU4 (6)</td>
<td>81</td>
<td>M</td>
<td>WB</td>
<td>26.5.06</td>
<td>Anemia</td>
<td>30.5.06</td>
<td>CDD 13.7.06</td>
<td>17.7.06 (52 days)</td>
<td>Delay: 4 days. “Package available – awaiting equipment and further medical tests” Return home with care package. @ 6mths: At home and happy with situation.</td>
</tr>
<tr>
<td>SU4 (7)</td>
<td>75</td>
<td>M</td>
<td>WB</td>
<td>25.6.06</td>
<td>Investigation on prostrate</td>
<td>28.6.06</td>
<td>CDD 25.7.06</td>
<td>27.7.06 (32 days)</td>
<td>Delay: 2 days due to “hoist” and waiting for other equipment and alterations to equipment.</td>
</tr>
<tr>
<td>SU4 (8)</td>
<td>85</td>
<td>M</td>
<td>WB</td>
<td>14.6.06</td>
<td>Fall, fracture right neck of femur</td>
<td>14.6.6</td>
<td>None</td>
<td>2.8.06 (49 days)</td>
<td>Discharge home with increased care package. @ 6 mths: At home and happy with situation. Extended stay due to chest infection. Proposed discharge date was 12.7.06. Discharge home with care package. @ 6 mths: At home and happy with situation.</td>
</tr>
<tr>
<td>SU4 (9)</td>
<td>80</td>
<td>F</td>
<td>WB</td>
<td>13.07.06</td>
<td>Depression, Confusion, felt unwell</td>
<td>15.7.06</td>
<td>ID 24.7.06</td>
<td>11.8.06 (30 days)</td>
<td>Delay: 19 days “Awaiting POC/MDA not completed. OT/Macmillan needed to complete” Discharged Home with reablement. Readmitted 16.8.06 Died in hospital 19.8.06.</td>
</tr>
<tr>
<td>SU4 (10)</td>
<td>87</td>
<td>F</td>
<td>WB</td>
<td>11.5.06</td>
<td>Intracranial Bleed/Stroke causing a fall</td>
<td>26.5.06</td>
<td>CDD 28.06.06</td>
<td>14.8.06 (80 days)</td>
<td>Delay: 47 days “Awaiting financial forms from the family”. Discharged to a nursing home. @ 6 mths: Still living in the nursing home and overall situation unchanged.</td>
</tr>
<tr>
<td>SU4 (11)</td>
<td>80</td>
<td>F</td>
<td>WB</td>
<td>4.5.06</td>
<td>Increased SOB</td>
<td>23.5.06</td>
<td>ID 12.6.06</td>
<td>29.6.06 (57 days)</td>
<td>Delay: 18 days “No Section2” then awaiting POC. Readmitted with SOB 29.6.06 and then admitted to residential care in Aug 06. Follow-up not appropriate.</td>
</tr>
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</tr>
<tr>
<td>SU4 (12)</td>
<td>?</td>
<td>F</td>
<td>WB</td>
<td>4.5.06</td>
<td>COPD</td>
<td>?</td>
<td>?</td>
<td>8.8.06 (96 days)</td>
<td>Admitted to nursing home 8.8.06 Died 8.8.06 SU4 (12) was a close relative of SU4 (11). However, SU4 (12) was under a different social services department and therefore it was not possible to ascertain all details.</td>
</tr>
<tr>
<td>SU4 (13)</td>
<td>76</td>
<td>F</td>
<td>WE</td>
<td>10.8.06</td>
<td>Fall (fracture left proximal humorous). Dementia/Wandering</td>
<td>11.8.06</td>
<td>None</td>
<td>14.9.06 (36 days)</td>
<td>No delay, but pressure on SW to arrange discharge Admitted to residential care Follow-up not appropriate.</td>
</tr>
</tbody>
</table>
## Site 5: (England)

<table>
<thead>
<tr>
<th>Code</th>
<th>Age</th>
<th>Gen</th>
<th>EO</th>
<th>Date of Admission</th>
<th>Reason for Admission to Hospital</th>
<th>Section 2</th>
<th>Section 5</th>
<th>Date of Discharge (LOS)</th>
<th>Length of Delay, Discharge Destination &amp; @ 6 month Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU5 (1)</td>
<td>80 years</td>
<td>Female</td>
<td>WB</td>
<td>2.6.06</td>
<td>Severe stroke</td>
<td>(1&lt;sup&gt;st&lt;/sup&gt;) 15.6.06; (2&lt;sup&gt;nd&lt;/sup&gt;) 23.8.06</td>
<td>No Section 5 was issued</td>
<td>8.11.06. (146 days)</td>
<td>Delay: 31 days Cause of delay: Family disputed continuing care panel decision. Destination: Continuing Care Nursing Home. @ 6 months: Not appropriate for follow-up and family refused.</td>
</tr>
<tr>
<td>SU5 (2)</td>
<td>67 years</td>
<td>Male</td>
<td>WB</td>
<td>20.6.06</td>
<td>Emergency admission – collapse at home. DVT in legs leading to sepsis and necrosis –likely on floor for a week, resulting in bilateral amputation (long term mental health problems)</td>
<td>28.6.06</td>
<td>As above</td>
<td>Not yet discharged. Transferred to rehab hospital on 2 February 07 with possibility of long term care subsequently.</td>
<td>General consensus that combination of complex physical and mental health problems contributed to long stay.</td>
</tr>
<tr>
<td>SU5 (3)</td>
<td>90 years</td>
<td>Male</td>
<td>WB</td>
<td>8.7.06</td>
<td>UTI and dehydration in severe dementia. Multiple health problems: COPD, cancer of prostate</td>
<td>31.7.06 (to assess for move to EMI unit)</td>
<td>As above</td>
<td>Died on 5.11.06 whilst still in hospital (LOS 120)</td>
<td>Fall in hospital and #NOF; C.difficile. Had been awarded continuing care funding for EMI nursing home.</td>
</tr>
<tr>
<td>SU5 (5)</td>
<td>87 years</td>
<td>Male</td>
<td>Asian Indian</td>
<td>19.8.06 (Previous admission: 2 May – early June)</td>
<td>Falls, dizziness, hyperventilation, anxiety, renal impairment, pains in left arm [numerous previous admissions for dizziness and falls]</td>
<td>21.8.06</td>
<td>As above</td>
<td>21.11.06 (LOS 94 days).</td>
<td>Discharged home –no formal care provided: “patient refuses to contribute to care so no services planned”. Daughters provide informal support.</td>
</tr>
<tr>
<td>SU5 (6)</td>
<td>88</td>
<td>Female</td>
<td>White</td>
<td>26.6.06</td>
<td>Fall and # both ankles (whilst</td>
<td>29.6.06</td>
<td>As above</td>
<td>15</td>
<td>Discharged to long term</td>
</tr>
<tr>
<td>Years</td>
<td>Irish</td>
<td>Date of Admission</td>
<td>Reason</td>
<td>Date of Discharge</td>
<td>Notes</td>
<td></td>
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<tr>
<td>99</td>
<td>Female</td>
<td>21.07.06</td>
<td>Complete heart blockage and UTI</td>
<td>2.08.06</td>
<td>Discharged home with extensive package of care (4 times daily). @ 6 months: still at home but depressed at inability to get out of bed and unable to do anything for herself.</td>
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<tr>
<td>76</td>
<td>Male</td>
<td>10.08.06</td>
<td>Renal failure [multiple health problems: CVA, late stage Parkinsons, heart problems].</td>
<td>16.8.06, 19.9.06</td>
<td>Discharged to private nursing home @6 months: Was admitted to acute hospital again for 2 weeks and discharged back to nursing home</td>
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<tr>
<td>83</td>
<td>Female</td>
<td>21.06.06</td>
<td>UTI, dehydration and acute confusion (delirium) (chronic disability: severe rheumatoid arthritis, recent loss of sight in one eye (bleed) when had another acute admission</td>
<td>22.9.06</td>
<td>Discharged to nursing home</td>
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</tr>
<tr>
<td>89</td>
<td>Male</td>
<td>19.04.06</td>
<td>Diarrhoea, c.difficile; not eating or drinking</td>
<td>27.04.07</td>
<td>Discharged to nursing home and died there on 13 days later. Medical staff were unhappy with discharge as regarded him as medically unstable but consultant acceded to family’s wishes.</td>
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</tr>
</tbody>
</table>
Appendix 3: Patients’ Journeys in one English Site

To develop a better understanding of patients’ experiences in hospital and beyond, the charts below map diagrammatically the care journeys for study participants in one English site (3), which has a well developed infrastructure for the management of delayed discharge and of ‘movement options’ with a range of intermediate, community and interim care services. The diagrams show the length of time taken within the discharge planning process and the subsequent delays, the moves undertaken by patients (although moves between acute wards have not been recorded) and outcomes.

The journeys provide some insight into the frailty of many of these older people. One third of them died within four months of their discharge and of the remainder, three had further acute crises. In the month prior to admission, five had had a health emergency; two of these were being supported by rapid response teams before they were admitted. Seven people who had previously had no formal service support started to receive this and two got additional home care support. Five moved to a higher tariff of care: i.e. from home or residential care to nursing care.

SU 1 – Age 78, awaiting residential care

SU 2 – Age 84, awaiting continuing care/nursing care
SU 3 – Age 85, awaiting home care

SU 4 – Age 91, awaiting EMI nursing care

SU 5 – Age 91, awaiting EMI nursing care

SU 6 – Age 87, awaiting home care

SU 7 – Age 93, awaiting nursing care / family dispute
SU 8 – Age 98, awaiting psychiatric assessment / home care

SU 9 – Age 52, awaiting housing adaptations

SU 10 – Age 71, awaiting housing and home care

SU 11 – Age 79, awaiting EMI nursing care

SU 12 – Age 75, awaiting intermediate care
SU 13 – Age 84, awaiting intermediate care bed

SU 14 – Age 53, awaiting rehousing

SU 15 – Age 76, awaiting home care
Appendix 4: Comparative Data for the Five Case Study Sites

A4.1 Data construction
As we noted in the main report, it is difficult to draw direct comparisons between the two countries. This applies both to the construction of the discharge data and to the broader context of health care systems.

When we looked at our sites, in Scotland we have used aggregated data for Health Boards which offer a consistent set of data. The Boards include more than one hospital and local authority in each site, and there is considerable variation within each site. In England, acquisition of consistent data over a six year period for local health commissioners is complicated because of changes in 2002 and 2006 and because two of our sites have more than one PCT. Some of the data we sought is not available by local authority, which did remain stable. We have, therefore, used either data from the local authority or from the provider hospital in each site, depending on where those performance data were collected. In all sites the Local Authorities relate to one main hospital, but they are not precisely coterminous. Furthermore, local arrangements about reimbursement affect what and how data is collected and defined in our study sites. Because of these factors, these data should be treated very cautiously – they are here to provide an indication of similarities and differences on each site, rather than for in-depth analysis.

A4.2 The local context: similarities and differences in acute hospital usage
As we indicate above, the local health and social care context is relevant to consideration of delayed discharges. The Scottish sites have more available beds than those in England. However, Site 3 is notable in achieving a considerable decline in beds within a five year period while all the other sites produced a rather less dramatic change. (Appendix 4 Chart 1) Sites 2, 3 and 5 also coped with substantially more medical emergency admissions, albeit in a declining number of bed days in Sites 2, 3 and 4 (Appendix 4, Charts 2 and 3).

Bed availability across our five sites does not simply reflect population size. In our Scottish and English sites with similar populations (Sites 1 and 3 respectively), bed availability is lower in Site 3. Bed availability in the two English sites with similar populations (Sites 4 and 5) is broadly the same; but the second Scottish site (Site 2) has triple bed availability for double the population.
Finished emergency admission episodes also vary between sites but the pattern of variation does not reveal a simple Scottish/English divide. Thus, site 3 in England and sites 1 and 2 in Scotland show an increase in the number of episodes following an emergency admission over 5 years. Site 4 and 5 remained fairly stable, with the exception of an increase in 2005-6 in Site 5.
In sites 3 and 4 there has been a steep decline in bed days relating to emergency admission, while Site 5’s bed days have remained fairly stable overall in the period. In Scotland, the decline in bed days has been more gradual.
The chart below shows length of stay relating to finished emergency admissions calculated by dividing bed days by numbers of admissions. It illustrates that English lengths of stay have dropped more steeply that those in Scotland, though from a higher starting point. Lengths of stay in all the English sites have dropped, especially in relation to over 85s. Site 4 started out with much higher lengths of stay than all other sites, especially for over 85s, and though still high, has made significant reductions. (Site 4 has no reimbursable delays and few delayed discharges overall.) Our two Scottish sites have not followed the national trend of reduction but show slight increases of lengths of stay for over 85s.

**Chart 4 - Average length of stay relating to emergency hospital admissions**

From Hospital Episodes Statistics- emergency admissions and bed days relating to emergency admissions

In respect of emergency re-admissions of older people, the pattern varies between our English sites (Appendix 4, Chart 5). Site 3 has an above average rate of emergency re-admissions, which reduced in 2003-4; whilst site 4, which remains just below the national average has moved steadily upwards from a very low base in 2001/2. Scottish statistics do not offer this indicator but instead record multiple (more than two emergency admissions in one year). Here the Scottish national trend is upwards, though not consistently. Site 2’s re-admissions were variable, but Site 1 has made reductions in re-admissions. (Appendix 4, Chart 6). Insert here
**A4.3 Community based services**

The variation in community based services is also marked across sites. It is clear that the planners and practitioners in each site are working within very different contexts, which may both create conditions for delays and affect the ways in which these may be tackled. Once again as noted in the report, data are collected around different indicators in England and Scotland and are not directly comparable.

For older people supported in care homes of all types in England (Chart 7 below), there has been a decline in numbers nationally over the period 2002 to 2006. This is broadly reflected in Sites 3 and 5, although Site 3 started from a slightly higher than average bed base. Site 4 also started from a high bed base but, with fluctuations, has retained this level over the period.

**Chart 7 - Local authority supported residents aged over 65 in permanent residential and nursing care in England 2002-2006 (rate per 100,000 population aged 65+)**

![Chart 7](chart7.png)

Source – Community care statistics, Department of Health

In Scotland, Site 2 followed the national trend of a reduction in the number of care home places over the period 2002-2006. Site 1 however, remained almost constant in its care home places.
In respect of households in receipt of home care, (Chart 9) Sites 3 and 4 display similar trends in reductions over the period 2002-6, though both started above the national average (dramatically, so in the case of Site 3). Site 5, however, had a lower rate than average and overall retained similar number of households. All sites show an increase in the rate of hours per household, with Site 4 above the national average and Site 3 well below it. In Scotland, while the number of clients in receipt of home care nationally has risen considerably over the period 2002-2005, in Sites 1 and 2, there have been slight fluctuations downwards.
Chart 9 - Households in receipt of home help or home care services (rate per 10,000 households) in England 2002-2006

Source: Community Care Statistics, Department of Health

Chart 10 - Hours of home help and home care In England 2002-2005 (Rate per 10,000 households)

Source: Community Care Statistics, Department of Health
Chart 11 - Number of clients aged over 65 receiving home care in Scotland 2002-2005

Source: ISD Home care statistics