FINAL DRAFT

DELAYED DISCHARGE REVIEW FINAL REPORT

Report: Health Overview and Scrutiny Committee

Date: 23 June 2004

1. Introduction

This report was commissioned by the Health Overview and Scrutiny Committee at its meeting on 16 July 2003. The review was led by the Chairman, Councillor Douglas Orchard. The review was initially supported by Caroline Farrar; when she left the Policy Unit in October 2003 it was progressed to completion by Jeanette Phillips, Principal Policy Officer.

The Health Overview and Scrutiny Committee received an interim report on 25 February 2004 which outlined the progress which had been made on the review and the changes and improvements already introduced as a result of legislation and investment. The report also identified a number of areas which, although included in the original scope of the review, remained largely unexplored. The Committee decided that the report should be finalised on the basis of the evidence gathered to date, and that the areas that it had not been possible to explore fully - unnecessary admission and readmission and preventative services - could be considered for review at a later date. The Committee agreed that it remained important to gather evidence of the patient experience of the discharge process and Age Concern Richmond were commissioned to undertake this work in March 2004.

2. Aims and Objectives of the Review

The initial aim of the review was ***to examine the whole system around hospital admission and discharge to ensure measures and services are in place to avoid unnecessary admission and delay in hospital discharge for borough residents and to identify what further measures should be taken to achieve this objective.***

At the time the review was commissioned, the Department of Health estimated that, on any one day, there were over 4000 mainly older people occupying acute hospital beds even though they were ready to be discharged. Unnecessary admission and delays in discharge from hospital can undermine people's quality of life and increase dependence on institutional care. They are also costly to the NHS and interfere with attempts to improve patient care and meet stretching targets.

The review was established in the context of the Government's objective to end widespread delayed hospital discharge by 2004 and to maintain the rise in emergency admissions to less than 2%. To meet this challenging objective the Community Care (Delayed Discharges) Act introduced from January 2004 a system of 'fines' of £120 per

day per delayed discharge for local authorities which fail to provide the community care services needed to discharge patients safely from hospital. Known as 'reimbursement' this system is designed to provide incentives for local authorities to work more closely with the NHS and to invest in services to reduce delays. A 'shadow' reimbursement system was operational from October 2003 with the 'fines' becoming payable from January 2004 onwards. At the same time, local authorities received reimbursement grant from 2003 onwards to invest in a range of integrated services to improve the discharge process and prevent unnecessary delay.

3. Evidence Gathered

The Committee decided that it would gather evidence by interviews and visits to a wide range of professionals involved in the admission and discharge processes in Social Services, the PCT, local hospitals and other NHS services. A publicity campaign was undertaken to seek the views of the general public, particularly residents who had recently been discharged from hospital. An open meeting was also held with local voluntary organisations.

Following the February 2004 progress report, Age Concern were commissioned to carry out a survey to gather evidence of the patient experience of the discharge process via questionnaires and a limited number of face to face interviews. The survey commenced on 18 March 2004 with over 130 questionnaires being sent out to patients who had experienced a delayed discharge since January 2004 from the acute hospitals and patients who had been discharged from Teddington Memorial Hospital during the same period.

A schedule of the visits and interviews carried out is given below:

Social Services		
Ros Saunders (Manager, Enablement team)	9 September	Cllrs Parson/Dance, CF
Frances Swaine (Manager OT and Equipment adaptations service)	11 September	Margaret Dangoor, CF
Saby Apetroaie (Senior Care Manager, WM hospital team)	15 September	Cllr Carr, Mike Phelps, CF
Patricia Hibbitt (Principal Manager, Domiciliary and Day Care)	17 September	Cllr Coombs, Margaret Dangoor, CF
Lynn James (Senior Care Manager, Kingston Hospital Team)	29 September	Cllrs Parsons/Barnett, CF
Rachel Croft (formerly capacity planning officer)	6 October	Cllrs Carr/Coombs, CF
Nicky Bender (Locum Team Manager, Richmond Long Term Care Management team)	Ditto	Ditto
Meg Frost	22 October	No minutes
Jane Clark (Principal Manager, Adult Services)	11 February	Cllrs Head/Coombs/JP

R&TPCT		
Anne Stratton (Associate Director Adults and Older People)	23 September	Cllr Parsons, Mike Phelps, CF
Rohan Burke (Single Assessment Coordinator)	10 October	Cllr Carr, Margaret Dangoor
Judith Williams (Associate Director, Therapies and Rehabilitation)	13 October	Cllr Parsons/Carr, CF No minutes
Judith Kay (Intermediate Care Coordinator)	Ditto	Ditto No minutes
VOLUNTARY SECTOR		
Voluntary Sector (10 Organisations)	15 October	Cllrs Carr/Coombs/Parsons Margaret Dangoor, CF
Husband of delayed discharge patient identified by Voluntary Organisation	15 October	Cllr Carr, CF
HOSPITALS		
Kingston Hospital Trust	5 February	Cllr Carr/JP
Teddington Memorial Hospital	9 February	Linda Nazarko, Nurse Consultant for older people. Cllr Carr/Dance/JP
West Middlesex University Hospital Trust	12 February	Ranjit Koonar, EPR Project Manager /Cllr Parsons/JP

Evidence was also gathered from the working papers of the Capacity Planning Group.

What is delayed discharge?

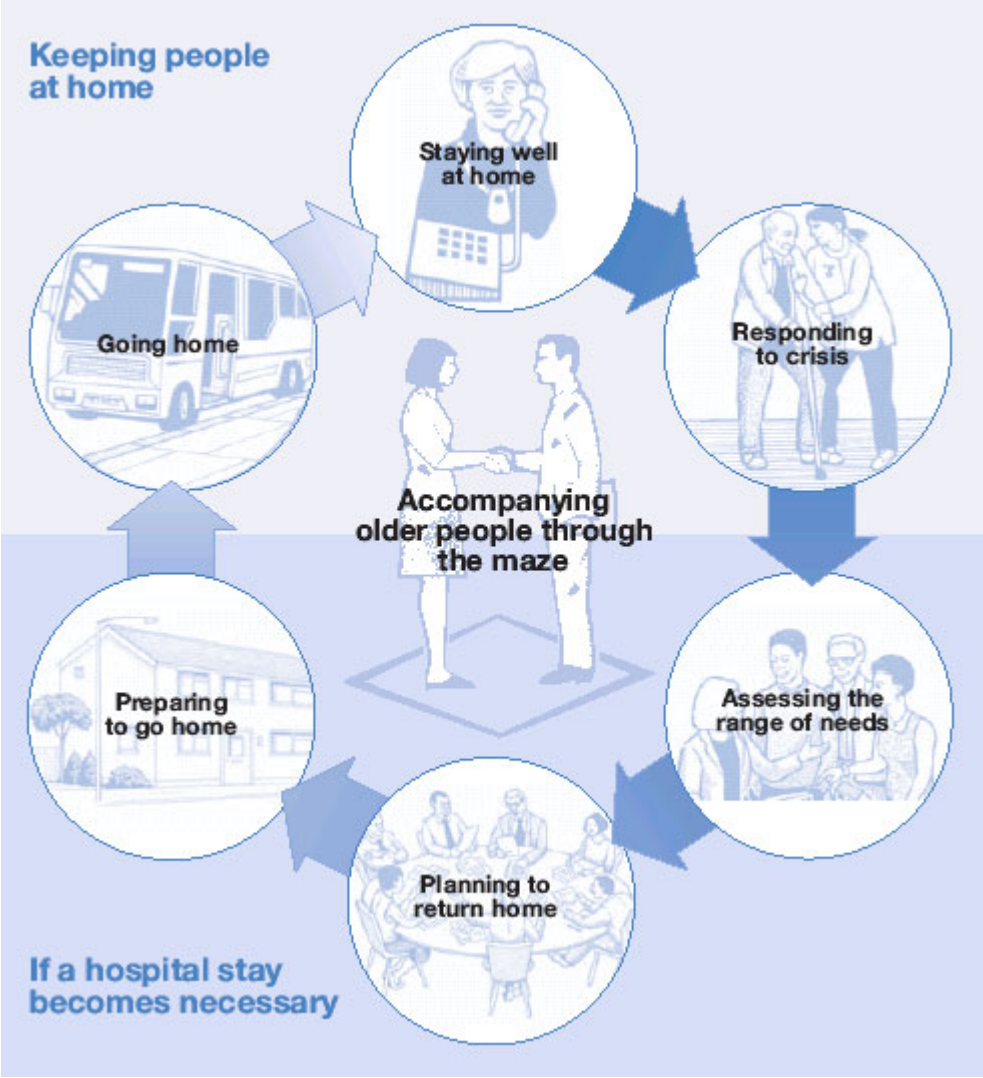
Delayed discharge occurs when someone is occupying an acute hospital bed even though they are ready to be discharged. This is sometimes referred to as 'bed-blocking'. The person may be waiting to be discharged to a residential or nursing home bed, a bed in the non-acute NHS, or their own home.

Delayed discharge is problematic for two main reasons – it is harmful to patients, and costly for the NHS. Even quite short unnecessary hospital stays mean the patient has more chance of contracting an infection, may become depressed and is likely to lose confidence and skills. Overall dependency increases, increasing the likelihood that institutional care will be needed and reducing the likelihood of the patient returning home. For the NHS, patients occupying beds unnecessarily wastes resources and increases waiting times for other patients in the system. However the focus of this review is not only on reducing delays in recognition of the costs and pressures they place upon

services, but about improving the quality of life of older people and improving the experience of the system for both patients and carers.

Reducing delayed discharge has been on the political agenda for a number of years now, and understanding of the problem and approaches to its solution have grown more sophisticated during that time. What began as planning for 'winter pressures' has become known as 'capacity planning', recognising that the issue is not only a winter phenomenon.

Delayed discharge is complex, less a single 'problem' than a symptom of various pressures on the health and social care system. Research and experience from all over the country has shown that it cannot be tackled effectively without looking at the system as a whole and delivering a full range of services. This is known as the 'whole system approach' or whole system working. The diagram below, from the Audit Commission report 'Integrated services for older people. Building a whole system approach in England', shows how a balanced whole system operates.

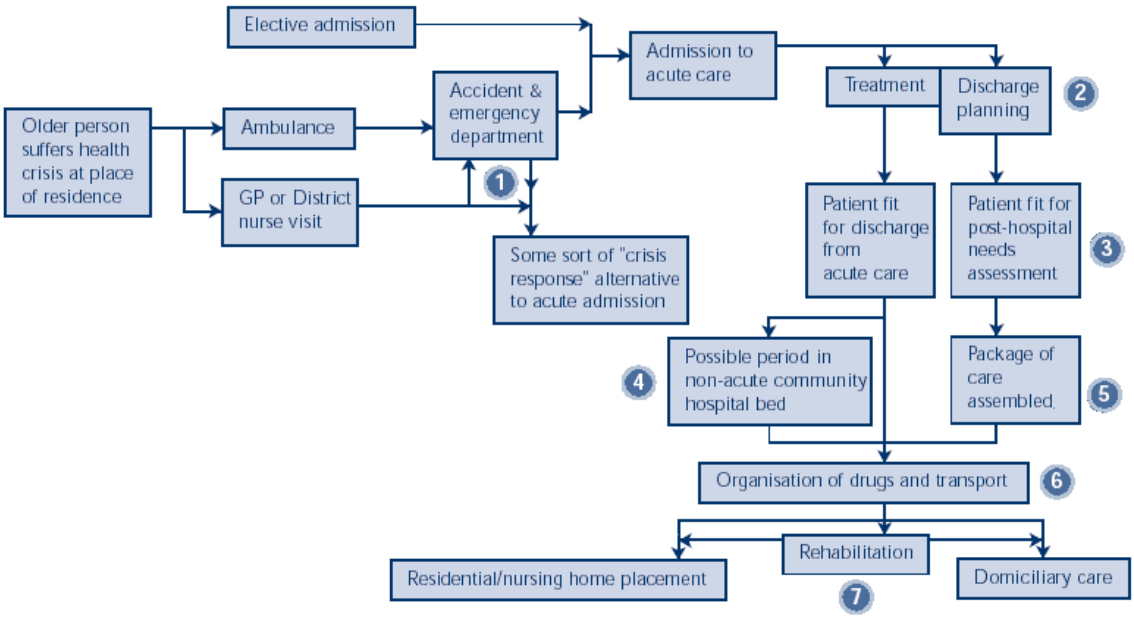


What causes delayed discharge?

The diagram below, from the National Audit Office report 'Ensuring the effective discharge of older patients from NHS acute hospitals', identifies some common factors contributing to delayed discharge through a representative care journey for an older person suffering a health crisis, or entering hospital for an operation or medical treatment.

These factors are set out with fuller explanation below.

1 A representative care journey for an older person suffering a health crisis, or entering hospital for an operation or medical treatment (elective admission)



What can contribute to delayed discharge?

1. Absence of alternatives to acute care.
2. Poorly co-ordinated or tardy discharge planning.
3. Delays in starting or completing needs assessments.
4. "Bottlenecks" in post-acute hospital care.
5. Delays in preparing packages of care due to funding and workforce constraints.
6. Poorly co-ordinated or tardy preparation for day of discharge.
7. Lack of capacity in post-acute care in all health, social services and independent sectors.

Source: NAO

(i) Absence of alternatives to acute care

Not all admissions to hospital are because of acute medical problems. A crisis can be generated by a breakdown in care and support systems or by short periods of poorer health or accidents when the older person needs additional support, but the response of services is not immediate enough. In these cases GPs and ambulance services may have little choice but to ensure an older person's safety by taking/sending them to Accident and Emergency, where a hospital admission becomes more likely.

Intermediate care services have been developed to provide community-based alternatives to acute hospital care, with the aims of promoting older people's independence and supporting them to stay at home, reducing unnecessary acute admissions and supporting timely discharge, and reducing admissions to residential and nursing homes. Intermediate care is usually short and fairly intensive in nature, and intended to provide a swift and responsive service. It can provide a range of support, usually from multidisciplinary teams, including domiciliary care, social work, rehabilitation and therapy and equipment and adaptations. Support can be provided instead of an emergency acute admission (i.e. beforehand) or following a planned or emergency acute admission.

(ii) Poorly coordinated or tardy discharge planning

Planning to discharge an older person from hospital can be complex, involving liaison with a wide range of professionals within the hospital as well as social services, the GP and primary care professionals, relatives and the patient themselves. Delays can therefore be caused if discharge planning is not properly coordinated or begins too late. For this reason good practice guidance recommends that discharge planning should be viewed as a process rather than an event.

Discharge planning should be coordinated by a designated person in the role of discharge coordinator and should start prior to admission for planned admissions, and as soon as possible after admission for emergency admissions (within first 24-48 hours). One of the aims of discharge planning should be to identify as early as possible those patients who are likely to need ongoing health and social care services following discharge, so that assessment and planning can begin.

(iii) Delays in starting or completing assessments

Again, assessments for those people who need continuing health and social care following discharge can be complex. Typically assessments are multidisciplinary and can involve between five and ten staff from hospital, community and social services. The professionals usually involved in assessments include ward staff, social workers/care managers, hospital therapists (occupational and physio), consultant geriatricians and other consultants, along with the hospital's discharge coordinator. Other professionals who may be involved include district nurses, community therapists, mental health specialists, voluntary organisations, housing and the GP.

Delays in starting and completing assessments are made more likely by shortages of specialist staff, as well as the difficulties inherent in coordinating such a large number of professionals in consultation with the patient and carer(s). Another factor in the assessment process has been the lack of a single agreed process for conducting them, although this has now been addressed.

(iv) Bottlenecks in post-acute hospital care

Some delays are due to blockages in other parts of the NHS, such as non-acute beds and mental health services.

(v) Delays in preparing packages of care due to funding and workforce constraints

This is largely self-explanatory. Once assessments are complete delays can be experienced in agreeing and implementing care packages. Funding constraints mean that packages of care usually have to be agreed before being implemented. Once agreed, arrangements have to be made with service providers to put them in place. However, the current system in the borough is that a care package that requires up to 28 hours of care per week can be sanctioned by a senior care manager before having to go before a panel for a funding decision prior to implementation. As few patients require more than 28 hours of care delays are not frequent.

(vi) Poorly coordinated or tardy preparation for day of discharge

Practical arrangements for the day of discharge need to be in place and run smoothly to avoid delays. Examples include ensuring that the patient's medication is available to take home; transport has been arranged; services and equipment are in place; the person has access to her/his home and the next of kin is present if needed.

(vii) Lack of capacity in post-acute care in all health, social services and independent sectors

This final point highlights the lack of capacity in all health and social care services, including residential and nursing homes in the independent and public sectors, domiciliary care, intermediate care, rehabilitation and therapy services, post-acute NHS services and primary care. Lack of capacity in all these sectors contributes to delays as the person cannot be discharged until their package of care or non-acute bed is available.

(viii) Staying well at home

A key area missing from the National Audit Office diagram and analysis above is preventative care. Keeping older people well at home for longer makes an important contribution to reducing delayed discharge, as a healthier older population puts less strain on the health and social care system. Preventative services could include: support and activities to keep older people healthy, fit and able to participate; identifying older people at risk and managing that risk; and provision of proactive support to enable people to remain at home with specific conditions that require specialist care, through more active case management and chronic disease management.

(ix) Summary

To have an impact on delayed discharge, we need to tackle all the areas contributing to delays.

Other relevant issues

This is a brief over-view of some of the other issues that are relevant to delayed discharge.

(i) Patient Choice

Patients must be given a choice about where they are placed if they are to be placed in a residential or nursing home upon discharge. Delays can occur because the placement of choice is not immediately available. Good practice guidance states that options for interim care should be available as well as information for patients from the point of admission about choice and how this is qualified by availability.

(ii) Joint working and integrated services

Providing many of the services outlined above in a way that is experienced as seamless by the people using them requires a more integrated approach between health and social services. In many areas teams of staff operate together across organisational boundaries. This can improve efficiency and reduce duplication of effort. This review looked at the arrangements for joint working and plans for integration between Social Services, the Primary Care Trust and the two main Acute Trusts in the area.

(iii) Single assessment process

Developing a single assessment process, agreed by all relevant organisations, is another area which can contribute to reducing delayed discharge. A single assessment process means that all organisations agree on the conduct and format of the assessment and therefore can have confidence in the outcome. Disagreement about the outcome of assessments can contribute to delays and differing assessment processes can lead to duplication of effort.

(iv) IT and administrative systems

Sharing information across organisational boundaries is challenging, requiring both paper-based and IT systems to become more aligned. However this can produce benefits in terms of providing better access to more comprehensive information for staff and by helping to reduce duplication of effort.

(v) Workforce planning/human resources

Many of the issues outlined above relate to the difficulties experienced across health and social care services in recruiting and retaining appropriately qualified staff. Shortages exist in many disciplines but particularly in social work, therapeutic and nursing staff.

4. Level of delayed discharges 2003/4

When the review was commissioned, information on the extent of delayed discharge and the reasons for it was somewhat unreliable. At the time of the September 2003 briefing report it was stated that a total of 136 patients had experienced a delayed discharge from l April to 28 August 2003. Of these, 40 patients experienced a delay of more than 28 days and the average length of delay was 47 days. In terms of reimbursement the total number of chargeable days (i.e. delays due to social services) was 1288 and would have cost £154,560 if reimbursement had been implemented**.** It was already becoming clear that there were both health and social service delays.

By the time of the February 2004 progress report it was clear that the focus on reducing delayed discharges and the various investments in capacity and services had resulted in improved statistical information and a slight downward trend in the number and length of delayed discharges. For the period September 2003 to end January 2004 the weekly average number of patients whose discharge was delayed was 16.42, with the weekly average length of delay being 88.78 days, of which 26.39 days were attributable to social services (approximately 30%) and the remaining 70% of the delays due to health delays. However there was a significant difference in the percentage of delays attributable to social services in the two main acute trust hospitals, with 25% at Kingston Hospital Trust and 45% at West Middlesex University Hospital.

The majority of delays were being experienced at Kingston Hospital, although it is now accepted that an element of over-reporting of delays attributable to health occurred when the new procedures were introduced. The performance at West Middlesex University Hospital had improved dramatically during this period reducing from 9 delayed discharges a week to one or two. The majority of delays were due to waiting assessment by acute staff (particularly psycho-geriatric consultants), awaiting non-acute NHS care, or a social services placement (particularly residential and nursing homes for the elderly mentally ill (EMI) and nursing homes generally).

The position at 1 April 2004 is given in detail in Appendix A. The statistics continue to show a steadily improving situation. The weekly average number of patients whose discharge was delayed has reduced to 13.8 per week with the actual number per week down as low as 5 on a number of occasions. The majority of delays are still being experienced at Kingston Hospital but the weekly number of delays there has steadily reduced since the beginning of December 2003 as a result of good joint working between the borough and the acute hospital trust. Similarly the weekly average length of delay has also reduced to 78.6 days with the number of days attributable to social services at 20.4, a reduction to approximately 25%. During this period delays remain attributable to awaiting assessment by Acute Staff, awaiting non-acute NHS care and awaiting placement. However, the position on awaiting assessment has improved dramatically since mid December 2003 with only one delay reported since. Similarly there has been a marked improvement in the number of delays attributable to waiting a placement since January this year, with only one a week on average.

The figures show that more recently there has been a slight increase in the number of self funders experiencing delays. Staff report that this may be due to self funders' reluctance

to leave hospital and meet the cost of nursing or residential placements. It is now made quite clear to patients that their best interests are served by leaving hospital when fit for discharge and that the bed is needed for more urgent acute cases. Patients in acute hospitals are now issued with choice letters which make the timetable for timely discharge clear and also contain arrangements for an interim placement if the patient is unable to be accommodated in their first choice straightaway.

5. Findings and Recommendations

The Committee recognised that whilst this review was taking place significant changes were being introduced in all agencies in order to achieve a reduction in both the number of patients experiencing a delayed discharge and the length of the delay. This has meant that many of the issues identified in the early round of visits have already been considered by the Capacity Planning Group and action aimed at improving services agreed and implemented in many cases. Where this is the case, the steps already taken have been identified in the findings of the review.

The findings and recommendations are set out under 5 broad categories with some areas of overlap inevitable:

- Overall position
- Investment in capacity
- Social Services/Primary Care Trust
- Local Hospitals
- Patient Experience

Overall Position

The statistics show that there has been a downward trend in the overall number of delayed discharges in the acute hospitals. The majority of delayed discharge cases are being experienced at Kingston Hospital Trust. West Middlesex University Hospital now has a consistently low level of delayed discharges. Similarly the length of delay has shortened. The majority of delays are attributable to Health (75%) with the main reasons being awaiting assessment by acute staff and awaiting non-acute NHS care. Delays attributable to social services (25%) are mainly due to waiting placement in EMI residential and nursing homes. Figures available from mid December 2003 onwards show a marked improvement in two of the three main reasons for delay (awaiting assessment and awaiting placement) and if this performance can be maintained there should be a significant decrease in the number and length of delayed discharges during 2004/5.

During the period September 2003 to end of March 2004, the Council would have incurred ‘fines’ of £76,080, less than half the amount of reimbursement grant paid to the Council.

This steady improvement would suggest that the Capacity Planning Group has been successful in its aim of identifying the reasons for delayed discharge and investing in a range of capacity building and service initiatives to reduce the number and length of delays.

Key Finding
There has been a welcome downward trend in the average number of people experiencing a delayed discharge and the length of time the delay lasts. On average, approximately 75% of the delayed discharges are due to the NHS and 25% to social services

Recommendation
That the Health Overview and Scrutiny Committee reviews the position on the number and length of delayed discharges in 6 months time to see if this improvement has been maintained.

Investment in Capacity

The Capacity Planning Group (CPG) was established early in 2003 to monitor delayed discharge performance, consider and agree investment in improved services and evaluate the effectiveness of the improvements introduced. The CPG consists of senior officers from the Council and the Primary Care Trust (PCT) and meets monthly. More recently, an operational capacity group has been established to monitor performance on a day-to-day basis and report through to the CPG. The CPG has utilised the reimbursement grant (£159,000 in 2003/4 and £312,000 in 2004/5) to invest in a range of new initiatives and services as detailed in **Appendix B**. Additional investment from the individual budgets of social services, PCT and acute hospital trusts has also taken place. The Committee noted the high degree of partnership working taking place between the officers of the Council, PCT and two main acute hospital Trusts.

Key Finding
Successful partnership working has resulted in a range of capacity building and service improving initiatives being introduced which have already reduced the number and length of delayed discharges and are expected to reduce them further in the future

The London Borough of Richmond upon Thames (LBRuT) does not have an acute hospital within its boundary. Residents are treated mainly at Kingston Hospital Trust (located in the Royal Borough of Kingston upon Thames) or West Middlesex University Hospital (located in the London Borough of Hounslow). During the visits to the hospitals, the Committee noted that both hospital trusts appeared to have stronger working relationships with the borough and PCT in which they are located. It was also noted that both LBRuT and PCT staff were over-stretched when trying to participate in necessary discussions around discharge procedures, patient choice, Single Assessment Process, etc. with two acute hospitals trusts, two neighbouring boroughs and two additional PCTs. The Committee felt that this had led to the Council and PCT having

less influence with the acute hospital trusts who had closer day to day working relationships with the host borough and PCT. The Committee felt that officers needed to consider the most effective way of maximising their input given that their limited resources were over-stretched.

Key Finding
The two acute hospitals used by borough residents have stronger working relationships with the Councils and PCTs in which they are located which results in the Council and Richmond and Twickenham PCT having less influence

Recommendation
That the Capacity Planning Group consider best practice on how to fully engage with acute hospital trusts located outside the borough

Social Services/Richmond and Twickenham Primary Care Trust (PCT)

Key staff in social services and the PCT were interviewed at an early stage in the review and many of the issues raised have already been considered by the Capacity Planning Group and action taken to improve the situation. For completeness, the main issues are documented below along with details of the steps already taken to improve the situation where appropriate.

The Committee noted that staff vacancy levels were high in social services, including many key posts such as Principal Manager and Team Managers. In addition many posts were being filled by locum workers, many on a long-term basis and at considerable expense. This contributed to inconsistency in service delivery and low morale. *During the course of the review the Committee noted that key management posts were now filled on a permanent basis and, where this was not possible, fixed term contracts for locum staff had been introduced. With more stable social work teams, efforts had begun to introduce performance management and staff development, particularly enabling care management staff to be more confident and influential in the assessment and decision making processes.*

Concerns were raised with the Committee about the capacity of the hospital teams, in particular whether there was sufficient capacity in the WMUH team to deal with patients at Teddington Memorial Hospital (TMH) and the small size and isolation of the KHT team, particularly when compared with the resources made available by Kingston social services. *During the course of the review, an additional care manager post has been allocated to the WMUH team to specifically work with transfers to and from TMH. However, TMH felt the position could be further improved by the care manager being permanently based at the hospital or by having a care manager responsible for patients at all community hospitals.*

The Committee also found an inconsistency of working patterns across the hospital and care management teams and as a result was concerned that residents should receive the same high standard of service, regardless of where they live in the borough and which hospital they were admitted to. In considering suggestions that the period of aftercare should be reduced from 6 weeks in order to free up capacity to deal with new referrals, the Committee found that the lower priority given to formally closing cases was contributing to the pressure felt by care managers. *During the course of the review, the appointment of two principal care managers and the filling of team manager vacancies has enabled management systems to be implemented which will ensure equality of treatment across the social work teams.*

Key Finding
That the improvement in filling key management posts and care management posts on a permanent basis had resulted in improved performance and consistency across the care management teams.

Recommendation
The capacity of the care management teams, particularly the hospital teams, should be closely monitored by the Capacity Planning Group and an increase in the staffing levels implemented if necessary.

The Committee was concerned about the consistency of care and the difficulty in brokering complex packages, a theme which emerged in a number of the interviews. A number of interviewees drew attention to the difficulty in recruiting and retaining low paid care workers in expensive areas of London. There were insufficient resources to research this in greater depth and the Committee felt that this was an area that needed further attention.

Key Finding
Consistency of care and difficulties in brokering complex packages of care remain a significant area of concern

Recommendation
That the CPG researches the scale of this problem and the impact on the quality of service patients and their carers receive.

The Committee found that whilst many interviewees valued the services provided by the enablement team, there was confusion and possible duplication with the role of the PCT's intermediate care team. *During the course of the review, the full integration of the intermediate care and enablement teams has been agreed and will take effect from 1 April 2004. Similarly a joint equipment service has been agreed and is in the process of being implemented.*

It became obvious to the Committee that successfully reducing the number and length of delayed discharges and the general move towards supporting older people to remain in

their own homes for longer, will increase the demand for a range of social and health care services. It was therefore important that the borough has a robust range of community services and sufficient capacity. The Committee noted the changes being implemented in the domiciliary care service and to day centres for the elderly which are designed to support people remaining in the community rather than entering hospital.

The Committee recognised the important contribution made by the local voluntary sector in supporting older people to remain in their own homes. The general meeting with the voluntary sector raised a number of useful issues, many of which have been echoed in other visits. In particular the voluntary sector was concerned that there should not be unrealistic expectations of the services they could provide within current resources. The Committee is aware that these services have been identified as a high priority area in the policy framework given to Grants Direct. The Committee would wish to encourage further development of services within the voluntary sector.

A number of interviewees suggested to the Committee that a number of procedures which have historically been provided in a hospital setting and the management of chronic conditions could be provided safely in the community if additional investment was made. The Committee found nursing representatives in the hospitals particularly keen that the range of nursing services provided in the community be considered more innovatively. The Committee felt it was important that the range of services to be provided by the new joint Intermediate Care Team should be kept under review and every effort should be made to expand the range of services available to patients at home wherever possible.

Key Finding
That the establishment of the joint Integrated Care Team will remove duplication and confusion for both patients and staff and should result in an improved service for patients

Recommendation
That the capacity and range of services provided by the new joint Intermediate Care Team be kept under review and expanded if necessary.
That consideration is given to increasing the range of nursing services which can be provided in the home, including considering whether initiatives currently being piloted elsewhere (e.g. Evercare Programme) might be appropriate for this Borough.

The Committee found that a significant cause of delayed discharges during 2004 was the lack of EMI residential and nursing home placements in the borough. The Committee was concerned that this need had not been foreseen at the time the contract with Care UK had been negotiated. The Committee was also concerned that patients had been placed out of borough, away from carers and relatives. At the meeting of the Health Overview and Scrutiny Committee in February 2004 when the progress report on the review was considered, officers outlined the steps that had recently been taken to increase capacity within the EMI residential and nursing home sector by renegotiating the Care UK contract to convert some existing capacity into EMI provision, as follows:

10 beds at Gifford Lodge
15 beds at Laurel Dene

In August 2004 the position will be further improved when a 20 bed unit within White Farm Lodge is opened.

Key Finding
That the lack of capacity in the EMI residential and nursing home sector was a major cause of delayed discharges until the end of 2003 when increased capacity was secured.

Recommendation
That the Capacity Planning Group keeps the need for EMI placements under close review and an EMI strategy developed as a matter of urgency (strategy to include mental health services provided in the three hospitals and by the Community Mental Health Teams).

Local Hospitals

In its visits to KHT, WMUH and TMH the Committee found staff fully aware of the need for timely discharge and committed to improving services for patients. Multidisciplinary working had been strengthened in both the acute hospitals. The Committee found no evidence that the introduction of the reimbursement scheme has produced a blame culture. Indeed, staff felt that the reimbursement scheme provided a necessary incentive to focus on the discharge process.

Whilst the majority of delays are still due to Health, significant improvement in reducing assessment delays had taken place since December 2003 and the Committee were hopeful that the problems in this area had been permanently overcome.

Key finding
Successful multidisciplinary working had been introduced in all hospitals with a resultant improvement in the management of the assessment and discharge procedures

The Committee was told that the majority of assessment delays in hospital were due to the availability of psycho-geriatricians who were not based in the hospitals. The Committee were also told that there was scope for improving the working relationships with the Community Mental Health Teams (CMHT). The Committee is concerned that patients with mental health needs may not receive the best possible service and would recommend that the EMI strategy suggested above covers the service received in hospitals and provided by the CMHTs.

The Committee found that the acute hospitals offered little active therapy on the wards and that vacancy levels for qualified OTs remained high. The acute trusts were piloting a range of initiatives involving less qualified staff and rapid response OT posts in order to

alleviate some of the problems. TMH have a reasonable number of therapy staff and supplement these with the use of therapy assistants which is successful.

Key Finding
There is difficulty in recruiting and retaining qualified OT staff and a lack of active therapy in acute hospitals

Recommendation
That all hospitals consider innovative ways in which the level of active therapy on the wards can be increased given the present shortages of qualified OT staff

The Committee also found that the acute hospitals had yet to gather evidence of the effect of the measures introduced to reduce delayed discharges on the patients and their carers/relatives. As the Committee was particularly concerned that the reduction in the number of delayed discharges should not be achieved at the expense of a reduced level of patient satisfaction with the service, this was an area where the Committee felt the hospitals should now be taking action. In particular, the Committee would be keen to learn if patients and their carers/relatives felt they were being pressurised into accepting hasty and/or inappropriate solutions to their care needs. Whilst the small survey being undertaken by Age Concern may give some insight into recent experiences, the Committee feel that it would now be appropriate for each hospital to assess the impact of the changes which have been implemented over the last 6 months so that if there has been an adverse effect on the patient experience this can be rectified.

Key Finding
Acute hospitals have no hard evidence of the patients' experience and level of satisfaction with the new procedures introduced to reduce delayed discharges.

Recommendation
That each acute hospital undertake as soon as possible a detailed survey of patient satisfaction with the newly introduced procedures to reduce delayed discharges. The hospitals should use the same methodology to determine patient views in order to produce comparable and valid data.

Written policies on patient choice were at an advanced stage in each of the acute hospitals at the time of the visit and have since been agreed. Up to date written information leaflets for patients on discharge were at an advanced stage in all three hospitals but had not yet printed and being distributed. The Committee felt it was important that good quality written information was available to patients. The written information should make it clear why it is in the patients' best interest to leave hospital as soon as it was safe to do so, the level and quality of service which patients could expect to receive and from whom, and the timetable and arrangements for an efficient discharge. The Committee believe it is good practice for this written information to be available as soon as possible upon entry to hospital so patients and their carers/relatives know what to

expect. The Committee also felt that upon discharge, patients should be given written information on services available in community that they might need.

Whilst the reduction in the number and length of delayed discharges is to be welcomed, the Committee needs to be assured that patients and carers have all the necessary information, at the right time, to make an informed choice about their discharge and continuing care. The survey by Age Concern will show that many patients lacked written information about the discharge process.

Key Finding
That up to date written information for patients on the arrangements for discharge was not available

Recommendation
That comprehensive written information is distributed consistently to all patients and their carers/relatives as soon as possible upon entry to hospital. That written information on appropriate services available in the community should be produced and given to all patients at the time of discharge.

The Committee was concerned that the improvement to the discharge process by early and appropriate referrals from the acute hospitals (step-down beds) to community hospitals (Teddington Memorial Hospital; Tolworth Hospital; Surbiton Hospital; Barnes Hospital; St Johns Hospital) could be jeopardised by bottlenecks developing in these hospitals. These hospitals are not yet covered by the reimbursement scheme although it is expected to be introduced from 1 April 2005 onwards. The Committee felt that many of the improvements introduced into the acute hospitals could usefully be employed in the community hospitals to ensure that patients' discharges are not unnecessarily delayed and that sufficient beds are available to assist the acute hospitals. The Committee could see no reason to wait until the reimbursement scheme was introduced and felt that effective monitoring systems should be introduced as soon as possible.

Key Finding
There is little hard evidence about the number and length of delayed discharges in community hospitals and this has the potential to create a bottleneck in the system. Community hospitals have yet to introduce systems designed to monitor and reduce the number and length of delayed discharges

Recommendation
That the community hospitals introduce discharge procedures and monitoring arrangements as soon as possible and report on a regular basis to the Capacity Planning Group on the number and length of delayed discharges and the main reasons contributing to the delays.

The Committee heard a number of concerns from the acute hospitals about progress with the introduction of the borough's Single Assessment Process and their view that the

implementation of the processes adopted by their host boroughs (Kingston and Hounslow) were more advanced. Both hospitals also pointed out that a more consistent approach would be achieved if the London Borough of Richmond implemented the same system as they had agreed with their host borough. However, as each acute hospital is currently adopting different systems, this would leave the borough with two different systems operating.

The Committee realises that the introduction of SAP is complex, particularly when the two acute hospitals are implementing different systems in negotiation with their respective boroughs, primary care trusts and strategic health authorities (which are different for each hospital). This echoes the Committee's earlier concern about the general difficulties encountered with the acute hospital trusts being located out of borough and having a stronger relationship with their host borough and PCT and, as a result, the Council possibly being in a less strong negotiating position.

The Committee was concerned that this might disadvantage patients from our borough who may not receive a smooth transition through the assessment and discharge process. The Committee was also concerned that delay in implementing SAP generally would place significant pressure on staff. The Committee feels that the progress of SAP implementation in line with the Government's timetable for full roll out by December 2004 should be closely monitored in order to achieve a solution which is beneficial for both patients and staff.

Key finding
That the introduction of the Single Assessment Process is complex and that the implementation of the systems agreed by each acute hospital with its host borough are more advanced.

Recommendation
That high priority be given to the implementation of the borough's Single Assessment Process so that the Government's timetable of achieving full roll out by December 2004 is achieved

6. Interviews with local hospitals

The overall findings and recommendations identified above materialised from the evidence gathered during the visits to individual local hospitals and summarised below.

Kingston Hospital Trust (KHT)

At KHT the Committee found that approximately 50% of the patients experiencing delayed discharge were from Richmond. When discussing the large number of delays due to awaiting assessment by acute NHS staff, it was felt that this was due to the reliance on psycho-geriatric consultants who were not based in the hospital. It was also felt that the high vacancy levels for Occupational Therapy staff delayed assessment. KHT had taken steps to reduce possible delays by employing OT support staff, less

qualified than OTs but able to carry out more simple activities with patients and thereby reduce the pressure on qualified OTs. *In recent months this category of delay has virtually disappeared following the appointment of an additional psycho-geriatric nurse based at the hospital.*

Staff in the acute hospitals also felt that bottlenecks were developing at the community hospitals which prevented them from discharging patients to them. It was felt that as the reimbursement scheme did not yet apply to non-acute hospitals, insufficient attention was being given to timely discharge in the community hospitals.

The Committee observed a stronger working relationship between KHT and Kingston social services staff and that Kingston was more advanced in the implementation of the single assessment process (SAP) and the installation of the necessary IT and training. The Committee was concerned that Richmond residents might be disadvantaged if the introduction of the borough's SAP was delayed. Whilst there were no plans for a fully integrated discharge team at KHT, staff could see the advantages in such a system, particularly where social services staff from both authorities are trying to secure the same placements. The Committee also noted that improvements in the working relationship with the Community Mental Health Team was needed, particularly their response time.

The Committee was provided with a copy of the agreed discharge policy. Advance drafts of the reimbursement policy and protocol for discharge to residential or nursing homes were also received and the Committee noted that KHT would be requiring patients to move to an interim placement if their preferred choice was not available. At the time of the visit no patients had been required to accept an interim placement but the Committee understands that a limited number of such letters have since been issued.

Information gathered from the Patient Advice and Liaison Service (PALS) service at KHT shows that in 2003/4, 66 concerns were raised on "generally unhappy with discharge", 38 concerns were raised on "lack of information available about discharge" and 15 concerns about "a delay in discharge".

The Royal Borough of Kingston upon Thames (RBKuT) has recently published its first Health Overview and Scrutiny review on Information for People on Discharge from Kingston Hospital. It found that KHT had a good record of providing appropriate information for patients on leaving hospital and generally patients are happy with the information they receive. The review made a number of recommendations, including the production of a comprehensive single pack of information on leaving hospital which would be consistent across all wards. Similar recommendations were made by the Commission of Health Improvement inspection which took place in June 2003. At the same time KHT is working towards achieving standards set by the Clinical Negligence Scheme for trusts which includes the need to have appropriate information available for patients.

West Middlesex University Hospital Trust (WMUH)

The Committee's visit to WMUH focused on the introduction of the Integrated Assessment Discharge and Rehabilitation Service (IADRS) on 1 April 2004. It was explained that the catalyst for the move to a fully integrated service was the acceptance that WMUH needed to dramatically improve its rehabilitation service. The new service will include Radiate, community rehabilitation and the inpatient assessment and care management team. A modernised rehabilitation ward has been provided offering 22 beds for longer-term rehabilitation.

The Committee questioned the reduction in the number of delayed discharges and found that a number of measures had been introduced to achieve this result, including a forecast discharge date on arrival, weekly multidisciplinary discharge team meetings and educating nursing staff on the need for timely discharge and supporting patients in regaining their independence.

As with KHT, where delays were occurring they were largely due to reliance on psycho-geriatricians from outside the hospital. WMUH had created a new Community Psychiatric Nurse post in the Radiate team which it was hoped would improve the situation. WMUH also acknowledged difficulties with OT vacancy levels which contributed to delayed assessments. A new post of rapid response OT had been created within the IADRS to remove any assessment blockages and the role of in-patient OT had been improved. WMUH felt that the fully integrated multidisciplinary team model would be attractive to potential employees and would aid recruitment and retention.

In common with KHT, WMUH had yet to evaluate the patient experience. Information leaflets were in draft form.

Teddington Memorial Hospital (TMH)

Although TMH is not an acute hospital and therefore currently outside the reimbursement arrangements, the Committee was keen to visit the hospital to gather evidence as it has an important role in supporting discharge from the two acute hospitals and in preventing unnecessary admission and re-admission.

The Committee found a number of physical and organisation improvements at TMH designed to improve the service to patients and its working relationship with the two acute trusts. TMH provides 50 beds, 30 for non-acute cases, 9 intermediate care, 7 continuing care and a further 4 beds which at the time of the visit were unfunded. Negotiations to use 2 of these beds for patients needing an interim placement while awaiting their first choice of nursing home were proceeding.

A new admissions policy has been introduced and the system of referrals from the acute hospitals was working well. A key senior nurse on each ward had now been given the responsibility for ensuring that accurate vacancy information is available to the acute hospitals. The Committee found that the hospital had not been able to meet demand

during January and referrals from the acute hospitals had been prioritised. The Committee felt that this confirmed the potential for a bottleneck to develop at the move on hospitals and that more emphasis needed to be given on the timely discharge of patients from move on hospitals.

The Committee learnt that the hospital was currently up dating its discharge policy. In common with the acute hospitals, TMH was beginning the discharge planning process upon the patient's arrival at the hospital. Primary nursing for each patient was being introduced which would mean that every patient would have an identified nurse and care assistant responsible for their care whilst in hospital.

At the time of the visit, staff were not able to provide statistical information and analysis on the extent of delayed discharges at the hospital. Staff estimated that at any one time around 10% of patients experienced a delayed discharge, largely due to delays in setting up a domiciliary care package and/or specialist equipment needed at home.

In some instances, patients identified as needing the services of the enablement team, had to accept an interim package of homecare due to lack of capacity within the enablement team. It was felt that this was counterproductive. *The Committee hopes that the creation of the new integrated Intermediate Care Team and close monitoring of its capacity will prevent this happening in future.*

The Committee felt that this replicated the position in the acute hospitals prior to the introduction of the reimbursement scheme, i.e. that patients were staying in hospital longer than necessary and there was a general assumption that this was due to the inability of social services to put an appropriate care package in place. Given the important role that move on hospitals such as TMH play in providing capacity for discharge from acute hospitals, the Committee feels that priority should be given to introducing appropriate systems, similar to those introduced in the acute hospitals, to define, monitor and eventually reduce, the number of patients whose discharge is delayed.

The Committee found staff at TMH keen to see an increase in physical and mental rehabilitative services to keep older people well in the community for longer. There was also concern that older people may be admitted to hospital unnecessarily when there was a breakdown in homecare and that additional training and support for homecare staff, particularly around when to call an ambulance for emergency admission, is necessary. Staff suggested that a scheme providing outreach specialist nurses for older people, which was currently being piloted across the country, might be appropriate for this borough.

Once again, appropriate written discharge information for patients was found to be in preparation but not yet available. Likewise evidence of the patient experience at the hospital had not yet been gathered although a questionnaire was in preparation.

7. Patient Experience of discharge process

As explained in paragraph 3, in February 2004 the Committee commissioned Age Concern Richmond to undertake a survey of the patient experience of the discharge process. The report makes a number of recommendations for all agencies involved in the discharge process and also identifies a number of outcomes from the survey which would usefully benefit from further investigation.

8. Evaluation and Monitoring

It is recommended that the Committee review this report early in 2005 to monitor progress on its recommendations.

9. References

The Community Care (Delayed Discharges) Act 2003
Audit Commission report 'Integrated services for older people, Building a whole system approach in England'
National Audit Office report 'Ensuring the effective discharge of older patients from NHS acute hospitals'
West Middlesex Hospital – Discharge policy; Joint protocol for delayed transfers of care from an acute bed and reimbursement; proposal for the development of an Integrated Assessment Discharge and Rehabilitation Service.
Kingston Hospital – Discharge policy; reimbursement policy; protocol for the timely discharge of patients to nursing and residential care home accommodation.
Teddington Memorial Hospital - Admissions policy
Evercare Programme – summary of pilot projects
Capacity Planning Group: notes of meetings and statistics
Social Services and Housing Overview and Scrutiny reports: Residential Care Services for older people October 2003
Cabinet report: Procurement strategy for residential care and nursing home beds for older people September 2003.
Notes of individual interviews and visits carried out September 2003 – February 2004