

Moving on?

An overview of delayed discharges in Scotland

Prepared for the Auditor General for Scotland and the Accounts Commission

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Acknowledgements

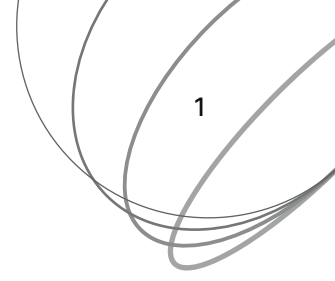
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Key messages summary



Solving the problem of delayed discharges needs action across all parts of the health and community care system.

“No one in Scotland should have to remain in a hospital bed because of a lack of appropriate care in the community. It is equally not acceptable that people who need hospital beds should be deprived of them through no fault of their own... we are talking about people’s quality of life. We must deliver on this issue because patients, older people and their families expect us to.”

Deputy Minister for Health and Community Care, March 2004

Background

1. Most patients in Scotland’s hospitals are discharged promptly, with arrangements for any ongoing support and care put in place in time for them leaving hospital. However, a patient may have to stay longer in hospital than necessary if these arrangements are not ready. This situation is often called a delayed discharge.

2. Delayed discharges occur for a number of reasons, including delays with:

- assessing a patient’s ongoing care needs
- putting in place community services, such as home care
- arranging funding for a care home place.

3. As well as affecting delayed patients and their families, delays in discharging patients can increase the length of time other patients wait for hospital treatment. They can also lead to cancelled operations because of a lack of available beds.

4. At any one time, about 8% of all hospital beds are occupied by patients who are ready for discharge.¹ Most patients delayed in hospital are aged 75 and over.² With an expected increase in Scotland’s older population over the next 20 years, the number of delayed discharges is likely to increase unless further action is taken to plan and coordinate services more effectively.

5. Working together to reduce delayed discharges involves much more than local health and community care colleagues meeting to discuss discharge planning and agree priorities for spending the additional funding from the Scottish Executive Health Department (SEHD). Delayed discharges are only one element of a complex health and community care system, and cannot be seen in isolation from other mainstream capacity planning issues such as hospital bed management.

6. Tackling delayed discharges is a high priority for the SEHD and the 15 delayed discharge partnerships across Scotland.³ The SEHD has targeted £30 million a year until 2007/08 to help partnerships reduce delayed discharges. This is in addition to the resources from their existing budgets that partnerships already use to tackle this problem. This makes it difficult to identify the total amount of money being spent on reducing delayed discharges.

Our study

7. There were two elements of our study:

- whole systems modelling in the Tayside Partnership
- an overview of delayed discharges across Scotland.

Whole systems modelling in the Tayside Partnership

8. Health, social care and housing support services cannot operate in isolation. Taking a whole systems approach requires a shared understanding of how changes in one of these areas can affect other parts of the same system.⁴ This understanding helps partners plan how to deliver services and use resources to ensure that people get the services they need, delivered to a high quality and in a sustainable way. This is reflected in the findings from our modelling work in Tayside ([Exhibit 1 overleaf](#)).

9. During 2004 we led a project with the Tayside Partnership and ISD to build an interactive whole systems model for Tayside which looked at ways to reduce the number of delayed discharges for older people.^{5 6} This involved testing out various strategies that could be adopted in different parts of Tayside’s local care system. Key findings from the Tayside model can be found in [Part 3 \(page 19\)](#).

10. More detail about the methodology and findings from our work with the Tayside Partnership are reported in a separate handbook;⁷ and the computer model can be viewed online at www.audit-scotland.gov.uk/publications/ddischarges.htm

¹ ISD census, January 2005.

² ISD census, January 2005.

³ Local delayed discharge partnerships are made up of representatives from NHS boards and councils. These partnerships are based on NHS board areas.

⁴ www.thewholesystem.co.uk

⁵ The Tayside Partnership comprises NHS Tayside and Angus, Dundee City and Perth & Kinross Councils.

⁶ Information Services Division of NHS National Services Scotland (ISD).

⁷ *Moving on? A handbook on modelling the whole system for delayed discharges in Tayside*, Audit Scotland, 2005.

Exhibit 1

Characteristics of effective whole systems working

Services are responsive to the needs of the individual patient, client or carer.

All stakeholders accept their interdependency and the fact that the action of any one of them may have an impact on the whole system.

There is agreement between stakeholders about the vision of the service, priorities, roles and responsibilities, resources, risks and review mechanisms.

Those using the system do not experience any gaps or duplication in provision.

Relationships and partnerships are enhanced.

Source: *Discharge from hospital: pathway, process and practice*, Department of Health, 2003

Findings from whole system modelling in Tayside

Testing a number of strategies to reduce delayed discharges over a five-year period in Tayside highlighted that:

- the older population is growing, meaning that, without further action, the number of delayed discharges is also likely to rise
- reliance on purchasing extra care home places, in isolation, produces the poorest performance overall
- shortening the assessment time in hospital appears to sustain longer-term reductions in delayed discharges compared to any other single strategy
- no strategy, adopted on its own, can sustain continued progress in reducing delayed discharges beyond 2005/06
- strategies pursued in isolation result in significantly poorer performance than adopting all the strategies
- short-term reductions may be achieved by implementing a chronic disease management programme, or providing more home care, or increasing specialist housing. Long-term reductions may only be achieved by implementing all of these strategies.

Source: Audit Scotland

Overview of delayed discharges across Scotland

11. This report focuses on the work carried out as part of our overview of delayed discharges, which ran alongside our whole systems modelling work in Tayside. It was a high-level review involving the analysis of national data, and interviews with delayed discharge managers and teams in partnerships, and with the SEHD. Audit Scotland may do further work in this area at a later date, which would include surveying views from patients, service users and carers.

12. The overview's findings and recommendations are reinforced by our whole systems modelling work in Tayside. Both elements of our study provide information about ways to tackle delayed discharges.

13. The main findings from this overview report are outlined below, and are further developed in the main body of this report. [Part 1 \(page 6\)](#) provides analysis of national delayed discharge data; [Part 2 \(page 11\)](#) looks at national measures to tackle delayed discharges; and [Part 3 \(page 19\)](#) focuses on local measures undertaken by partnerships, and how taking a whole systems approach would help.

Key findings

14. The number of patients delayed in hospital has reduced over the past few years, although it remains a problem.

- The total number of people delayed in hospital has fallen by 40% over the period September 2000 to January 2005 (from 3,021 to 1,785). The number of patients delayed for longer than six weeks has fallen by 45% over the same period (from 1,944 to 1,056) ([Page 8, paragraphs 27-28](#)).

- Three out of every four people delayed in hospital are waiting for community care assessments to be completed or community care arrangements to be put in place ([Page 8, paragraphs 29-31](#)).

- The length of time patients wait to be discharged once they are fit to leave hospital has fallen since the first census in 2000. The mean length of delay has reduced from 149 days in January 2001 to 102 days in January 2005. The median length of delay has fallen from 79 days to 57 over the same period, indicating that the more serious delays are being dealt with more quickly ([Page 8, paragraph 32](#)).

15. Tackling delayed discharges is a high priority for the SEHD. It has established networks to share good practice, which partnerships find helpful ([Page 11, paragraph 34](#) and [page 18, paragraphs 54-55](#)).

16. The current national target is for a 20% reduction in delayed discharges on an annual basis. But the way in which this target is set:

- potentially penalises partnerships that are performing well
- acts as a deterrent to doing better than the target
- leads to a less challenging target for those partnerships that do not hit their annual target ([Page 12, paragraphs 36-39](#)).

17. Setting a uniform national target does not necessarily recognise the complexity of the issue, nor does it reflect local circumstances. The challenges facing partnerships in reducing delays vary ([Pages 12-16, paragraphs 40-42](#)).

18. The SEHD needs to take a more coherent approach to target-setting. At the same time as the national target for delayed discharges is in place, the SEHD has also introduced a Local Improvement Target for delayed discharges which must equate to the national target. We are unclear of the added operational value of a Local Improvement Target in the context of a national target ([Page 16, paragraphs 43-46](#)).

19. Local partnerships use a range of initiatives to reduce delayed discharges in their area. But these need better evaluation to assess their success and whether they deliver value for money ([Page 16, paragraphs 50-51](#) and [page 20, paragraphs 60-62](#)).

20. Delayed discharges are a symptom of wider systemic problems in the delivery of health, social care and housing services, as our detailed work in Tayside demonstrates. Therefore, partnerships must:

- consider all aspects of their system when developing strategies to reduce delays, and integrate these strategies into mainstream capacity planning
- develop a shared, in-depth understanding of the way in which local health and social care services interact
- undertake detailed, long-term planning to take account of the projected growth in the older population ([Pages 20-23, paragraphs 63-73](#)).

Part 1. Setting the scene



Key messages

The number of patients delayed in hospital has reduced over the past few years, although it remains a problem. The total number of people delayed in hospital has fallen by 40% over the period from September 2000 to January 2005 (from 3,021 to 1,785). The number of patients delayed for longer than six weeks has fallen by 45% over the same period (from 1,944 to 1,056).

Three out of every four people delayed in hospital are waiting for community care assessments to be completed or community care arrangements to be put in place.

The length of time patients wait to be discharged once they are fit to leave hospital has fallen by nearly

a third since January 2001 (from 149 days to 102 days in January 2005). There is evidence that the more serious delays are being dealt with more quickly.

Most patients are discharged from hospital promptly but some experience a delay

*'A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, to purchase a care home place, for example.'*⁸

21. Most patients in Scotland's hospitals are discharged promptly, though at any one time about 8% of all hospital beds are occupied by patients who are ready for discharge.

22. The main source of national data on delayed discharges is a quarterly census where data are collected by each partnership and reported to ISD. This represents a snapshot of delayed discharges in every local partnership area on a given date at the end of every three-month period. The census covers the:

- total number of patients delayed
- total number of patients delayed for more than six weeks
- main reason for delay
- mean and median length of delay.⁹

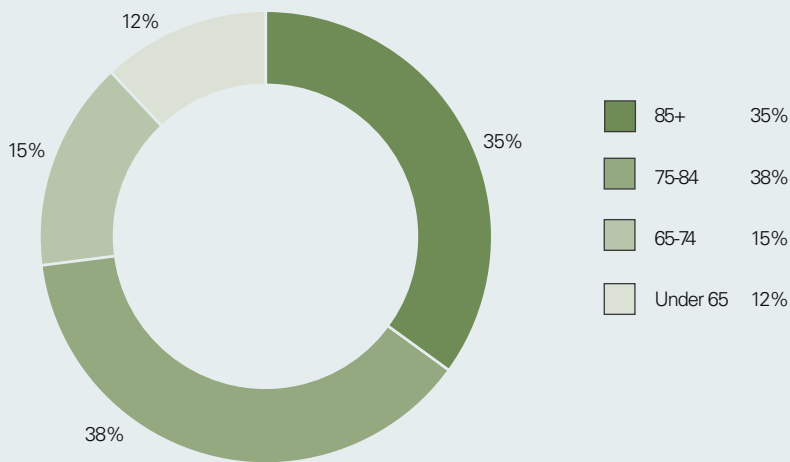
⁸ <http://www.isdscotland.org/isd/files/Oct04pub.pdf>

⁹ The mean duration is the average of all delays, while the median is the number in the middle of the sequence of all delays when they are listed in order. The median is a useful additional measurement as the mean will be affected by a relatively small number of very long or short delays which will skew the average.

Exhibit 2

Patients experiencing delayed discharge, by age

Most patients delayed in hospital are aged 75 and over.



Source: ISD census data, January 2005

23. There are two measures for delayed discharges; those delayed for up to six weeks and those delayed for longer than six weeks. Local partnerships and the Scottish Executive agreed that a reasonable period to plan and implement a patient's discharge is six weeks.¹⁰ Our whole systems modelling work with the Tayside Partnership found that reducing this assessment period may have an impact on tackling delayed discharges, both in terms of the number of patients delayed and how long patients wait to leave hospital (Part 3, page 19).

Delayed discharges have wide-ranging effects

24. The effects of delayed discharges are wide-ranging and can lead to:

- distress for patients and family concern that patients become

more dependent on care when staying in hospital for a longer time than is necessary

- increases in the time other patients wait for treatment
- cancelled operations.

Older people are most likely to be delayed in hospital

25. Almost three-quarters of people delayed in hospital are aged 75 and over (Exhibit 2).¹¹

26. The people most likely to be delayed are those admitted to hospital as an emergency or psychiatric admission, highlighting the need to plan services for people with specialist care needs.^{12 13} Delays in discharge following emergency or psychiatric admission are most likely to occur among:¹⁴

- older patients – 4.5% of patients aged 65 and over will experience a delay
- women rather than men in the older age groups – 5.2% of female patients aged 65 and over experience a delay compared to 3.6% of male patients in the same age group
- patients whose main or secondary diagnosis is a mental or nervous system disorder, such as dementia – 14.7% of these patients will experience a delay
- patients whose main diagnosis is 'other circulatory disorder', mainly a stroke – 8.7% of these patients will experience a delay.

¹⁰ *Delayed discharges in Scotland. Report to the Minister for Health and Community Care*, Trevor Jones, Head of the SEHD and Chief Executive NHSScotland, 2002.

¹¹ *ISD census*, January 2005.

¹² *Factors associated with delayed discharge following emergency and psychiatric inpatient admission of patients aged 65 and over, Scotland and NHS Argyll & Clyde 2001*, ISD, May 2004.

¹³ *Commissioning community care services for older people*, Audit Scotland, 2004.

¹⁴ *Factors associated with delayed discharge following emergency and psychiatric inpatient admission of patients aged 65 and over, Scotland and NHS Argyll & Clyde 2001*, ISD, May 2004.

The number of people delayed in hospital has fallen

27. There has been a reduction in the total number of people delayed in hospital and the number of people delayed for longer than six weeks since the first census in 2000 (Exhibit 3).

28. The total number of delays and the number of delays of longer than six weeks both peaked at the October 2001 census – at 3,138 and 2,191 respectively. The numbers currently stand at 1,785 and 1,056. These peaks occurred prior to the publication of the Delayed Discharge Action Plan in 2002 and the release of additional ring-fenced money to help tackle the problem (Part 2, page 11).¹⁵

Community care assessments or arrangements are the main reasons for delay

29. The most recent census shows that the main reasons for delay are:

- Community care arrangements or assessments, which account for three-quarters of delays. The biggest single reason within this category is where a patient is waiting for a place in a non-NHS funded care home (22% of the total number of delays).
- Healthcare arrangements or assessments, which account for 9% of delays. The largest single reason within this category is where a patient is waiting for a bed in another NHS hospital or facility (7% of the total number of delays).
- Eight per cent of delays are due to patients exercising their statutory right of choice, often over the destination of their ongoing care. For example, a patient may want to go to a particular care home but is not able to do so because it has no spare places.
- Legal and financial reasons account for 7% of all delays.

30. Community care assessments or arrangements have consistently been the main reason for delay. An increasing proportion of people are delayed because they are exercising their right of choice, or because of legal factors such as arranging guardianship (Exhibit 4).

31. Our detailed work in Tayside reflects these national findings.

Length of delay is falling

32. The length of time patients wait to be discharged once they are fit to leave hospital has fallen since 2001 (Exhibit 5, page 10). The mean length of delay has reduced from 149 days in January 2001 to 102 days in January 2005. The median length of delay has fallen from 79 days to 57 over the same period, indicating that the more serious delays are being dealt with more quickly.

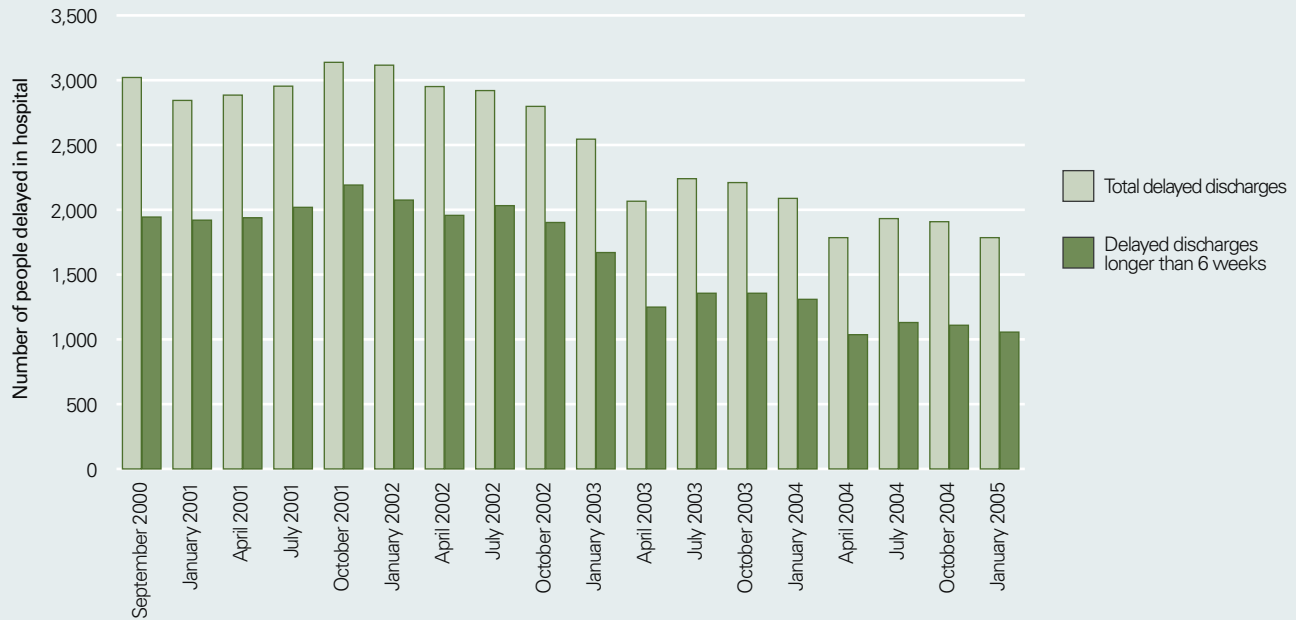
33. People delayed in hospital are now generally waiting for shorter periods before they are discharged, but there are some people who are still waiting for a long time (Exhibit 6, page 10). Just over a third (37%) of patients in January 2005 were delayed for more than three months compared to half of patients in January 2001.

¹⁵ *Delayed discharges in Scotland. Report to the Minister for Health and Community Care, Trevor Jones, Head of the SEHD and Chief Executive NHSScotland, 2002.*

Exhibit 3

Number of delayed discharges, September 2000 to January 2005

The total number of people delayed in hospital and the number delayed for more than six weeks have fallen since a peak in October 2001.

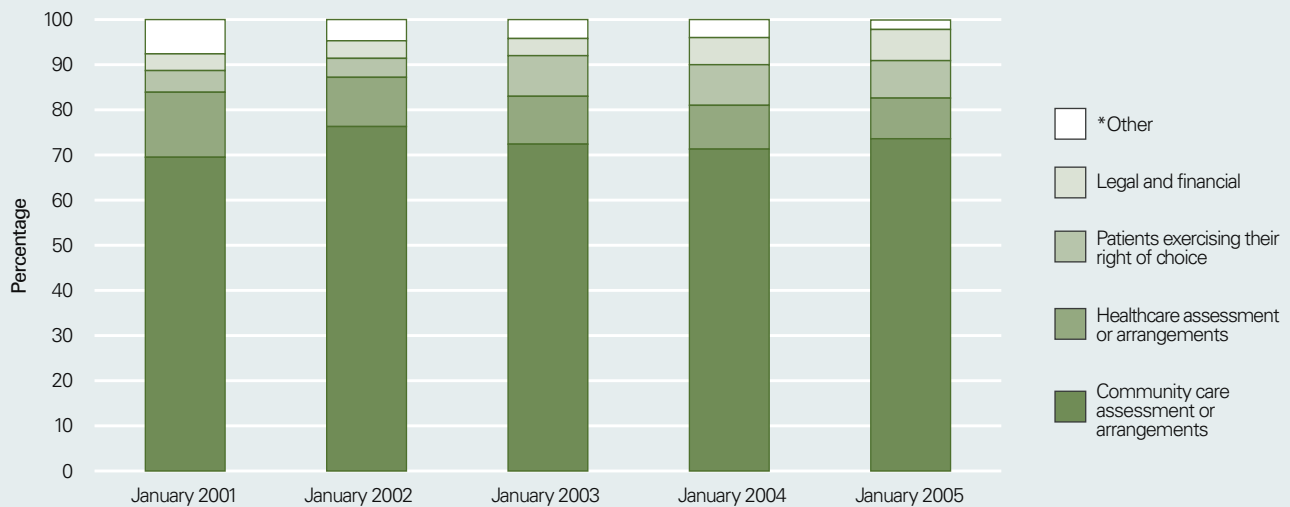


Source: ISD census data

Exhibit 4

Main reasons for delay, January 2001 to January 2005

Community care assessments or arrangements continue to account for about three out of every four delays.



Note: *Other includes disputes between patient/carer and the health or social services.

Source: ISD census data

Exhibit 5

Average length of delay, January 2001 to January 2005

The length of delay has been falling over the last five years.

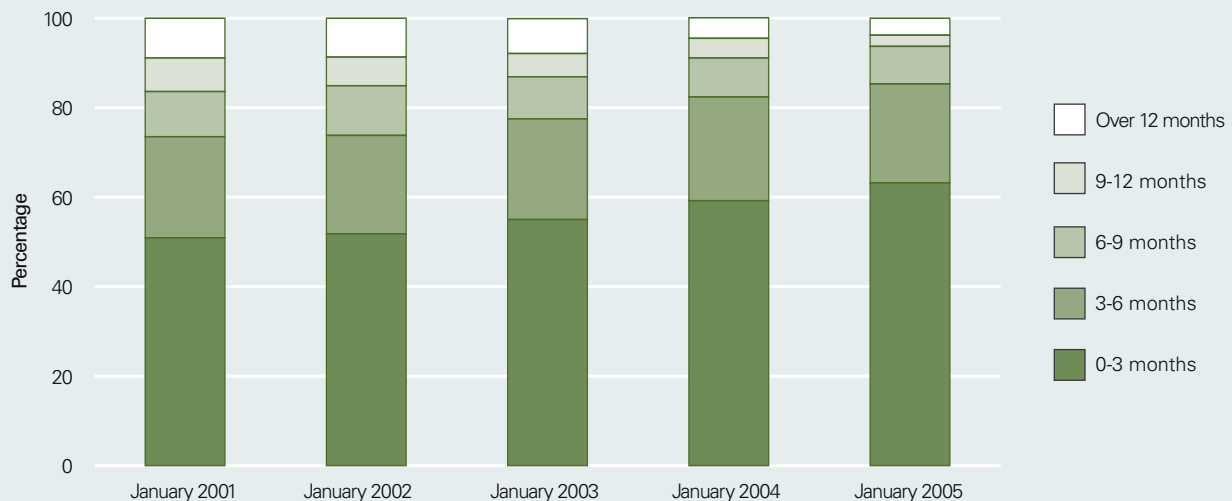
	Median duration (days)	Mean duration (days)
January 2001	79	149
January 2002	78	146
January 2003	72	136
January 2004	63	113
January 2005	57	102

Source: ISD census data

Exhibit 6

Length of delays, January 2001 to January 2005

Just over a third of patients in January 2005 were delayed for more than three months, compared to half of patients in January 2001.



Source: ISD census data

Part 2. National measures to reduce delayed discharges



Key messages

Tackling delayed discharges is a high priority for the SEHD. It has established networks to share good practice, which partnerships find helpful.

The current national target is for a 20% reduction in delayed discharges on an annual basis. But the way in which this target is set:

- potentially penalises partnerships that are performing well
- acts as a deterrent to doing better than the target
- leads to a less challenging target for those partnerships that do not hit their annual target.

Setting a uniform national target does not recognise the complexity of the issue nor is it sufficiently sensitive to local circumstances. The challenges facing partnerships in reducing delays vary.

The SEHD needs to take a more coherent approach to target setting. At the same time as the national target for delayed discharges is in place, the SEHD has also introduced a Local Improvement Target for delayed discharges.

Tackling delayed discharges is a high priority

34. Both the SEHD and local partnerships have prioritised reducing the number of people who are delayed in hospital. National policy on delayed discharges is based on the findings of the Delayed Discharge Action Plan. Specifically, the SEHD has:

- set targets for reducing delayed discharges
- provided ring-fenced money for specific initiatives
- monitored the performance of partnerships through local action plans
- issued guidance on joint discharge protocols and choice of accommodation
- established a learning and support network to share good practice.

Exhibit 7

Setting of national targets

Each year the SEHD has changed the way it sets national targets.

2002	A target was set to reduce delays by 1,000 patients across Scotland.
2003	Partnerships set their own targets.
2004	The SEHD thought that some partnerships set targets in 2003 that were not sufficiently challenging. Therefore, in 2004, all partnerships were set a target of reducing the total number of delays by 20%. This target was based on the numbers they had achieved in 2003.

Source: SEHD

Targets have changed three times over the past four years

35. Since 2002, the SEHD has made three changes to the way it sets national targets for reducing the number of people delayed in hospital (Exhibit 7).

The way the current national target is set is not helpful

36. National targets can be an effective way of focusing attention on key areas for improvement. But the way in which the current 20% annual target is set:

- potentially penalises partnerships that are performing well
- acts as a deterrent to doing better than the target
- leads to a less challenging target for those partnerships that do not hit their annual target.

37. This is because the national target for each partnership is based on actual reductions in delayed discharges in the preceding year rather than the target figure (Exhibit 8 opposite and examples 1 and 2, page 14).

38. There is no financial incentive to hit the targets. Currently, ring-fenced money for delayed discharges is not linked to achieving targets, though the SEHD retains this as an option.

39. Focusing the target on the number of people delayed carries a risk that the length of time patients wait can be overlooked. The time that people spend in hospital, when ready for discharge, is reducing steadily. But for some this can still be unacceptably long. As well as looking at the number of people delayed in hospital (which is the national target), a good local performance management system needs to be in place. This should include quality measures which examine patients'

experiences, and efficiency indicators such as throughput in a hospital or the proportion of occupied bed days used by people ready for discharge.¹⁶

An annual national target for reducing delayed discharges may not be sufficiently sensitive to local circumstances

40. There are variations in local performance in tackling delayed discharges. Exhibit 9 (page 15) shows that, apart from Shetland where there are rarely any delayed discharges, the number of delayed discharges has fallen in each partnership area since 2002, but that the scale of reduction varies among partnerships.

41. As a consequence of this variation in the number of people delayed, the percentage of all occupied beds used by patients ready for discharge also varies. Eight partnerships exceed the Scottish average of 8% (Argyll & Clyde, Ayrshire & Arran, Borders, Fife,


16 A new 'whole systems' indicator is being developed as part of the Joint Performance Information and Assessment Framework. This includes the number of delayed discharges within each of the 32 joint future partnerships. More information can be found at www.scotland.gov.uk/health/jointfutureunit

Exhibit 8

Local achievements against the national 20% target

The national target penalises partnerships that do better than their target by setting them a more challenging target for the following year. This contrasts with partnerships that fail to meet the national target, which are subsequently given a less challenging target.

	A	B	C	D	E
	Total number of delayed discharges at April 2003 census	Target number of delayed discharges for April 2004 This target was set by the partnerships	Total number of delayed discharges at April 2004 census These are the figures that partnerships actually achieved	Scottish Executive target for April 2005 This is a 20% reduction on the figures which partnerships achieved (column C)	If the 20% reduction had been based on the targets which partnerships had set (column B), the target for April 2005 census would be...
Argyll & Clyde	277	233	218	174	186
Ayrshire & Arran	190	169	143	114	135
Borders	45	40	38	30	32
Dumfries & Galloway	8	8	8	6	6
Fife	96	90	121	97	72
Forth Valley	105	100	98	78	80
Grampian	230	228	221	177	182
Greater Glasgow	339	230	293	234	184
Highland	61	54	54	43	43
Lanarkshire	138	123	122	98	98
Lothian	401	345	321	257	276
Orkney	11	7	3	2	6
Shetland	2	2	-	-	2
Tayside	147	150	134	107	120
Western Isles	16	9	11	9	7

 Achieved better than the target

Source: Audit Scotland

Example 1

Argyll & Clyde

Partnerships that exceed their 20% target reduction in numbers of delayed discharges in one year have a more challenging target reduction to make the following year.

1. Argyll & Clyde's target for April 2004 was to reduce the number of people delayed in hospital to 233.
2. It did better than this target, achieving a figure of 218 people delayed.
3. The SEHD then set Argyll & Clyde a target of 174 for April 2005, representing a 20% reduction on its achieved total of 218, rather than 186 (20% of its target for 2004).
4. This means that, because Argyll & Clyde outperformed its target in 2004, the SEHD set it a more challenging target in 2005.

Example 2

Fife

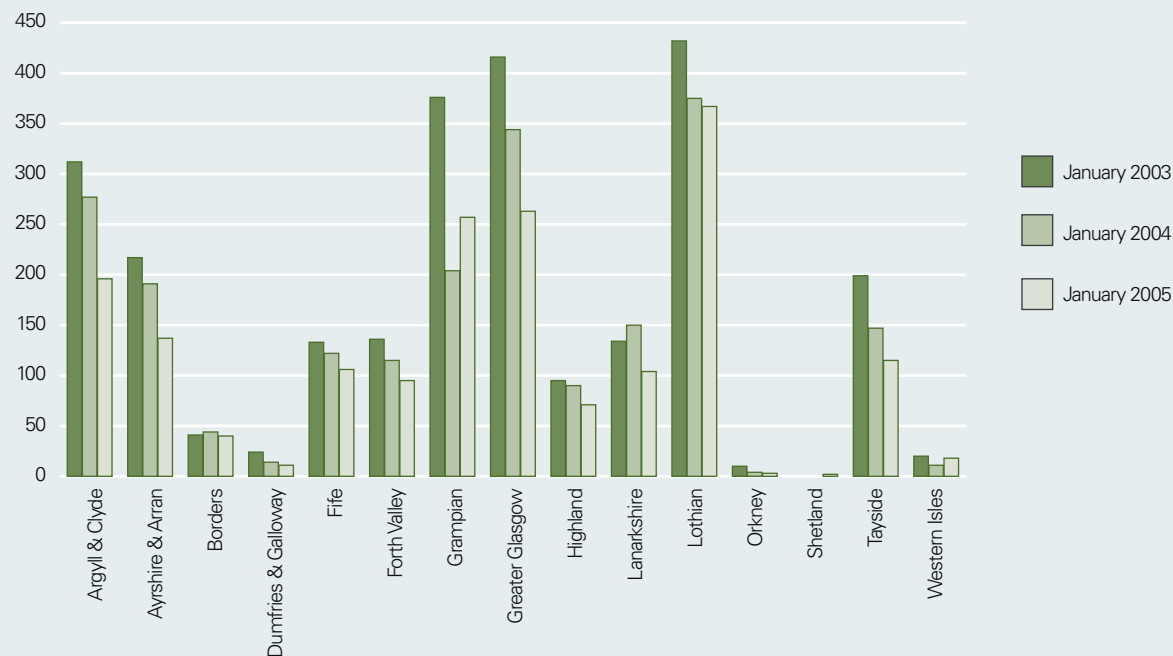
Partnerships that fail to meet their 20% target reduction in numbers of delayed discharges in one year have a less challenging target reduction to make the following year. Their target for the next year is based on the number of reductions they actually achieve rather than what they should have achieved.

1. Fife's target for April 2004 was to reduce its number of people delayed in hospital to 90.
2. It failed to meet this target, achieving a figure of 121 people delayed.
3. The SEHD then set Fife a target of 97 for April 2005, representing a 20% reduction on its achieved total of 121, rather than 72 (20% of its target for 2004).
4. This means that, because Fife underperformed against its target in 2004, the SEHD set it a less challenging target in 2005.

Exhibit 9

Total number of delays by NHS board area of treatment, January 2003 to January 2005

All partnerships, apart from Shetland, had fewer people delayed in hospital in January 2005 than in January 2003.



Source: ISD census data

Forth Valley, Grampian, Lothian and Western Isles). The range is from 2.5% in Dumfries & Galloway through to 15% of beds in the Western Isles.

42. While annual national targets have been used to address inefficiencies in local care systems, they are less good at reflecting local circumstances which are more complex and need long-term strategic planning to solve. For example, care home capacity varies across the Tayside Partnership where Dundee and Angus Councils face bigger challenges in providing these services compared with Perth & Kinross Council.

The SEHD needs to take a more coherent approach to target setting

43. The Deputy Minister for Health and Community Care set up a tripartite working group in December 2003 to look at the barriers to prompt hospital discharge. The group recommended that annual target setting be devolved to local partnerships, and local targets scrutinised by the Scottish Executive.¹⁷ The report is currently being considered by the Minister.

44. At the same time as the national target for the 15 delayed discharge partnerships (based on NHS Board areas) is being reviewed, the SEHD's Joint Future Unit has issued guidance to the 32 joint future partnerships (based on the 32 council areas) to develop a Local Improvement Target for delayed discharges of longer than six weeks.

45. The Local Improvement Target must reflect the national target, meaning that the overall target remains a 20% reduction at

NHS Board level. The joint future partnerships, which set their own Local Improvement Targets, must ensure that the sum of the local targets is at least 20% at NHS Board level. There is flexibility around how the share of the total 20% is divided between the joint future partnerships in each board area.

46. This seems to place an unnecessary burden on joint future partnerships, particularly those which are not coterminous with NHS board areas. In such cases, the negotiations about sharing the burden of the 20% reduction have to be made with two NHS boards. We are unclear about the added operational value of a Local Improvement Target in the context of a national target.

Monitoring ring-fenced funding and local performance is difficult

47. Following publication of the Delayed Discharge Action Plan, the SEHD provided £20 million to partnerships in 2002/03 and in 2003/04 as ring-fenced funding to reduce delayed discharges. The money was distributed according to the Arbutnott formula and distributed to partnerships via NHS boards.¹⁸

48. In 2004/05, the annual funding was increased to £30 million, with a commitment from the SEHD to provide this level of ring-fenced funding up to and including 2007/08. *Exhibit 10* shows the annual allocation to partnerships for 2004/05.

49. This is not the only source of funding to help reduce delayed discharges. Partnerships also use funding from general allocations to NHS boards and councils, and may

use non-recurring winter funding. This makes it difficult to identify the total amount of money being spent on reducing delayed discharges.

A lack of evidence on cost and effectiveness makes it difficult for the SEHD to monitor performance

50. Each partnership prepares an annual delayed discharge action plan. These set out planned actions and allocated resources to achieve the target reduction in the number of people delayed in hospital. The SEHD uses these action plans and regular progress reports to monitor the performance of each partnership.

51. The use of ring-fenced money has coincided with a reduction in delayed discharges across Scotland although, because partnerships may use additional funds, it is difficult to isolate the effect of the specific ring-fenced element. It is also difficult for partnerships to quantify the impact of individual initiatives, and few are fully costed. This means that neither the SEHD nor partnerships can fully assess which initiatives are successful, or whether the ring-fenced money could be better spent and achieve more for the same amount. (Part 3, page 19).

Implementation of national guidance on discharge protocols and choice of accommodation is patchy

52. In January 2004 the SEHD issued guidance to partnerships on joint discharge arrangements and choice of accommodation for patients leaving hospital.¹⁹

¹⁷ *Report of the tripartite working group on delayed discharges*, Scottish Executive, 2005.

¹⁸ The Arbutnott formula is used to allocate funds to local NHS systems. It aims to be needs-based, take account of remote areas and deprivation issues, and address Scotland's inequalities in health.

¹⁹ *Choice of accommodation – discharge from hospital*, SEHD, January 2004; and *Framework for the production of joint hospital discharge protocols*, SEHD, January 2004.

Exhibit 10

Annual ring-fenced allocation to partnerships to tackle delayed discharges, 2004/05

Partnership	Annual ring-fenced allocation 2004/05 £000
Argyll & Clyde	2,553
Ayrshire & Arran	2,292
Borders	665
Dumfries & Galloway	957
Fife	1,982
Forth Valley	1,559
Grampian	2,679
Greater Glasgow	5,455
Highland	1,367
Lanarkshire	3,152
Lothian	3,986
Orkney	124
Shetland	134
Tayside	2,361
Western Isles	234
Total	29,500²⁰

Source: SEHD

²⁰ The remaining £0.5 million was retained by the SEHD to fund central projects such as the Joint Improvement Team and the Learning and Sharing Events. This has risen to £1 million of the allocation in 2005/06.

- Joint discharge protocols are meant to cover issues such as staff roles and responsibilities; timescales for discharge; specific procedures for different client groups; and how to resolve disputes among partners.
- Some patients are delayed in hospital because a place in their preferred care home is not available. The national guidance aims to strike a balance between supporting patient choice and making the most efficient use of hospital beds. It recommends that a patient should be asked to make three choices, and that reasonable efforts should be made to meet a patient's stated preferences.

53. Our discussions with partnerships found that the implementation of both sets of guidance is patchy. The tripartite working group has also expressed concern about the implementation of the choice of accommodation guidance. It has recently recommended that the Scottish Executive reviews the implementation of this guidance, and examines in more detail why patients are being delayed where their choice of care home is not available.

The SEHD supports partnerships through helping to share good practice

54. The SEHD supports partnerships in reducing delayed discharges in two main ways:

- arranging learning and sharing events. These aim to provide a forum for wider discussion and an opportunity to share good practice
- maintaining a 'learning and sharing network'.²¹ This is a web-based facility which shares information about good practice.

55. This is useful support and partnerships are positive about the learning and sharing events, but it could be strengthened by more robust evidence of cost-effective good practice (Part 3).

Recommendations

56. The SEHD should:

- review the way in which the national target is set if it decides to continue with an overarching national target
- ensure that targets are as sensitive to local circumstances as possible
- take a more joined-up approach to target setting and ensure that partnerships are not subject to too many targets aimed at tackling delayed discharges
- review the implementation of guidance on joint discharge protocols and choice of accommodation.

Part 3. Local measures to reduce delayed discharges

Key messages

Local partnerships use a range of initiatives to reduce delayed discharges in their areas. But these need better evaluation to assess their success and whether they deliver value for money.

Delayed discharges are a symptom of wider systemic problems in the delivery of health, social care and housing services, as our detailed work in Tayside demonstrates. Therefore, partnerships must:

- consider all aspects of their system when developing strategies to reduce delays, and integrate these strategies into mainstream capacity planning

- develop a shared, in-depth understanding of the way in which local health and social care services interact
- undertake detailed, long-term planning to take account of the projected growth in the older population.

Strategies for reducing delayed discharges are targeted at different stages in the patient journey

57. Exhibit 11 (overleaf) shows the key stages for a patient from home, to treatment and assessment in hospital, through to discharge. Planning a patient's discharge should start as early as possible in the patient journey, if possible before admission.²²

58. Partnerships have developed a range of initiatives for tackling delayed discharges and Exhibit 11 (overleaf) illustrates that these are targeted at all stages in the patient journey.

A selection of these initiatives is described in the [case studies section](#) (page 24). They include preventing unnecessary admission to hospital through:

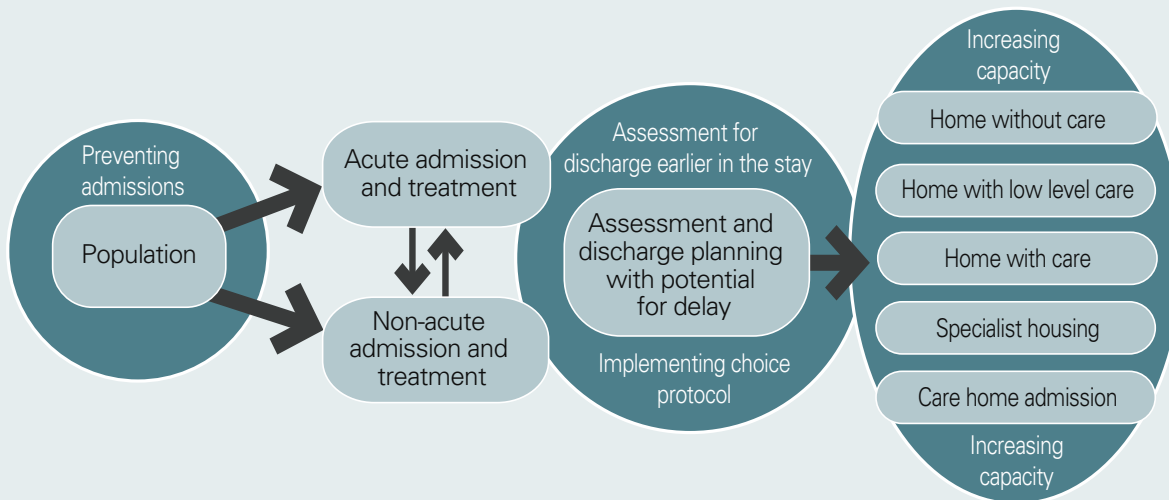
- admission prevention programmes, such as chronic disease nurses and rapid response teams, working in the community
- initiatives aimed at speeding up assessment in hospital, such as the employment of delayed discharge co-ordinators in hospitals
- developing better community services which enable people to live as independently as possible, such as extending home care hours and more specialist housing.

Partnerships have a lot to consider as they develop different initiatives

59. Partnership working is not easy, but it is essential to delivering joined-up services for older people and their carers. Exhibit 12 (page 21) highlights

Exhibit 11

The patient journey



Source: Audit Scotland

the main actions partnerships need to take when developing delayed discharge initiatives.

Better evaluation of local initiatives is needed to assess what difference they make and whether they deliver value for money

60. Local partnerships need to understand the costs, quality and effectiveness of services in order to manage services well. They also need this information to assess the impact of initiatives in reducing hospital admissions and preventing delayed discharges.

61. During our visits to partnerships, we examined the way in which partnerships are evaluating 'what works' in reducing delayed discharges. Although a reduction in delayed discharges against the national target is a high level measure of success, this does not provide any analysis of the extent

to which services are sustainable or identify which initiatives have the most cost-effective results.

62. Evaluation is patchy across partnerships, and most have yet to develop robust evaluative methods. A more consistent approach to evaluation would enable benchmarking among partnerships, and provide the SEHD with better evidence of what works. The SEHD could usefully support partnerships by developing a good practice guide to evaluation which covers all the features of an effective evaluation programme (Exhibit 13).

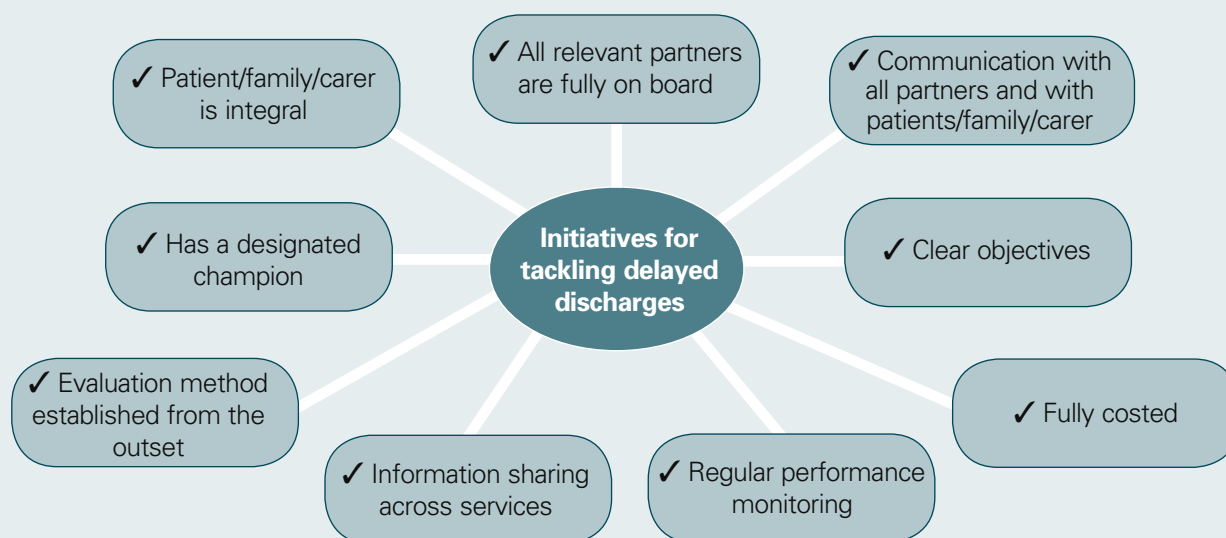
Joint working to reduce delayed discharges needs good local understanding of the whole care system

63. Partnerships need an in-depth understanding of their local health and social care system if they are to achieve a sustained reduction in delayed discharges.

64. We worked with the Tayside Partnership to build an interactive computer model that helped us examine a whole care system and test out a range of strategies for reducing delays among older people. Although our findings are specific to Tayside, as they are based on the local system and local data, other partnerships may find the approach useful in their own planning. The main findings from this work are outlined in the rest of this chapter. More detail about the process of building the Tayside model can be found in the handbook which accompanies this report; and a description of the work and a link to the model can be viewed at www.audit-scotland.gov.uk/publications/ddischarges.htm

Exhibit 12

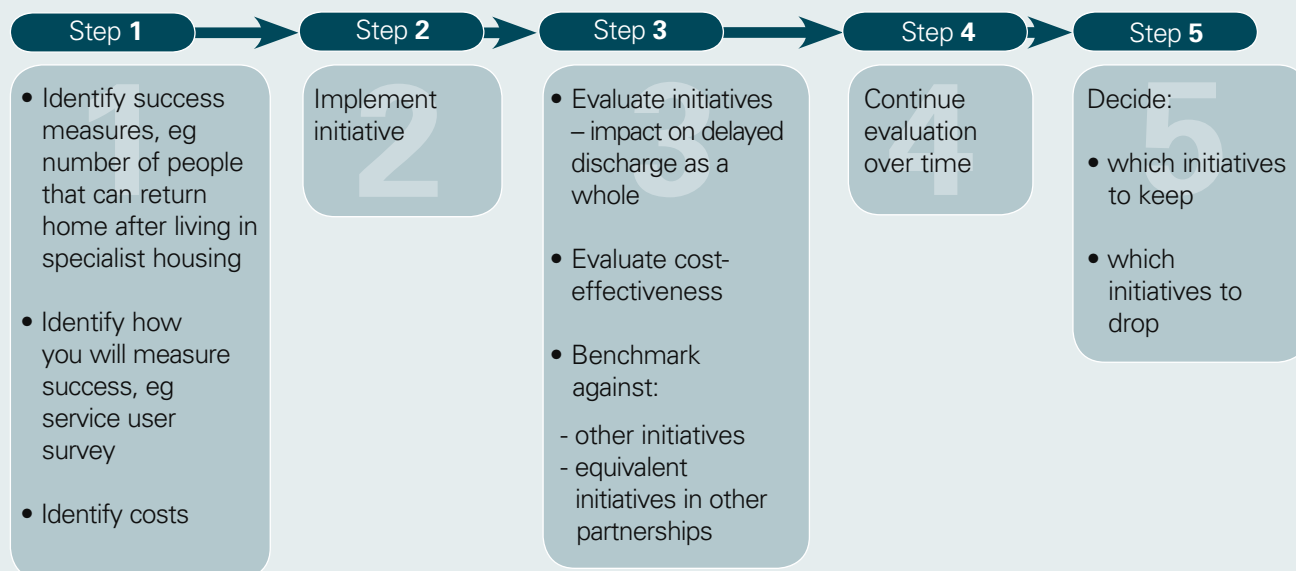
Working together to reduce delayed discharges



Source: Audit Scotland

Exhibit 13

Five key steps to effective evaluation



Source: Audit Scotland

65. The local work in Tayside involved:

- Bringing together staff from across the partnership to develop a picture of Tayside's whole health and social care system.
- Building the computerised model using local data which needed to be as comprehensive as possible. These data were mainly provided by Tayside's EMPTAYDD system, which provides real time information updated on wards by trained staff.²³
- Sharing assumptions about how different parts of the whole system interact.

66. The Tayside model is interactive and can demonstrate what may happen in different parts of the partnership when various strategies are adopted, such as investing in more care home capacity or introducing a chronic disease management programme.

Providing for a growing older population requires a range of strategies

67. If the Tayside Partnership continues with its current delayed discharges strategies then the expected growth in the older population would lead to a steady increase in the number of older people admitted to Tayside's hospitals. This is likely to lead to more delays for patients being discharged from hospital. This means that the 'status quo' is not an option. The effect of a growing older population on existing provision will be of relevance to all partnerships in Scotland forecasting a growth in their older population.²⁴

A combination of approaches is likely to lead to the most sustainable reduction in delayed discharges

68. We used the model to test a range of strategies aimed at reducing delayed discharges over a five-year period. These were:

- introducing a chronic disease management programme aimed at helping people manage their disease at home rather than being treated in hospital
- speeding up the assessment process in hospital
- increasing the number of care home places
- increasing the number of specialist housing places
- providing more complex packages of home care.

69. The model showed the need to introduce a range of strategies and the necessity to redesign existing services, such as reducing the length of the assessment period in hospital, as well as increasing service capacity in the community (Exhibit 14). Although based on Tayside's own information and local systems, this finding is likely to be applicable to all partnerships.

Joint working on delayed discharges involves more than agreeing how to spend the additional money

70. Working together to reduce delayed discharges involves much more than local health and social care colleagues meeting to discuss

discharge planning and to agree priorities for spending the additional funding from the SEHD. It is about ensuring that there is a shared understanding across the partnership of how the local system works; what the complexities and inter-relationships are; and how staff and services can influence what happens. Feedback from the Tayside Partnership showed that the whole systems approach we used enabled genuine joint working, where staff from across the four organisations in the partnership and a variety of professions came together to discuss a common issue.

71. Service providers from across the local health and social care system must be involved in planning how services can be better delivered and have an impact on delayed discharges. Engaging with independent sector providers can strengthen a partnership's understanding and influence the way services are developed. It is also important to include patient, service user and carer perspectives.

72. Robust data are also needed to support joint planning and performance management. Despite Tayside's data being amongst the most comprehensive in Scotland, we still found that data about community care services, and their costs in particular, could be better. Audit Scotland has highlighted this in previous reports on community care.²⁵ Partnerships should review the data needed to support good joint planning and performance management to ensure that it is fit for purpose.

23 Electronic Management of Patients in TAYSIDE Delayed Discharge system (EMPTAYDD). This is a web-based facility that provides secure access for NHS Tayside and Tayside's three councils to a patient specific database, with real time reporting.

24 *Commissioning community care services for older people*, Audit Scotland, 2004.

25 For example, *Homing in on care*, Audit Scotland, 2001; *Commissioning community care services for older people*, Audit Scotland, 2004; and *Adapting to the future: Management of community equipment and adaptations. A baseline report*, Audit Scotland, 2004.

Exhibit 14

Findings from testing a number of strategies for reducing delayed discharges over a five-year period using the Tayside model²⁶

Reliance on purchasing extra care home places, in isolation, produces the poorest performance overall.

Shortening the assessment time in hospital appears to sustain reductions in delayed discharges for longer than any other single strategy.

No strategy, adopted on its own, can sustain continued progress in reducing delayed discharges beyond 2005/06.

Strategies pursued in isolation result in significantly poorer performance than adopting all of the strategies.

Short-term reductions may be achieved by implementing a chronic disease management programme, or increasing home care provision or increasing specialist housing. Long-term reductions may only be achieved by implementing all of these strategies.

Source: Audit Scotland

73. Delayed discharges are a symptom of a wider, systemic problem and cannot be treated as a stand-alone issue. Decisions made about services aimed at reducing delayed discharges may also have unintended consequences for other parts of the wider health and social care system. Delayed discharge planning therefore needs to be integrated with mainstream capacity planning and decision-making about projects and funding across partnerships.

Recommendations

74. Local partnerships should:

- include cost, quality and success measures when evaluating services and initiatives aimed at reducing delayed discharges
- consider a range of strategies to reduce delayed discharges, including those aimed at redesigning services as well as increasing capacity in the community
- take a whole systems approach to developing a shared understanding of the interdependence of services
- ensure that all key stakeholders are involved in developing an understanding of the whole system

- link delayed discharge planning with mainstream capacity planning
- improve information on the cost, quality and provision of community care services.

75. The SEHD should:

- work with local partnerships to develop a consistent approach to evaluating local initiatives. This can be achieved by supporting benchmarking through the learning and sharing network, and providing partnerships with systematic and consistent evaluation tools.

²⁶ These findings are examined in more detail in the accompanying handbook.

Case studies

Local initiatives aimed at reducing delayed discharges

The following case studies illustrate the variety of local initiatives in place. They demonstrate that initiatives are happening at all stages of the patient journey. The first case study looks at an admission prevention scheme in Dumfries & Galloway; the second highlights a scheme from Greater Glasgow which speeds up the process while the person is still in hospital; the third looks at a scheme aimed at improving care after discharge in Lothian; and case study four looks at how Ayrshire & Arran is evaluating one of its initiatives.

Case study 1

Crisis assessment and treatment service (CATS) in the Dumfries & Galloway Partnership

CATS has been developed to enhance community mental health and inpatient services that already exist across Dumfries & Galloway. This service has been in place since February 2004 and operates seven days a week. It aims to provide intensive health and social care assessments and interventions in a community setting for people with mental ill health. Where appropriate, the team aims to offer clients who have been referred to the service a viable alternative to hospital admission. It also provides support for people discharged from acute inpatient care, but who may still need a period of intensive support. It is a good example of joint working as it is provided by health and social care within Dumfries & Galloway.

The CATS team also works with community mental health teams to enable clients to move between primary care, mental health specialist care and intensive care outside hospital, according to their needs.

Source: Dumfries & Galloway Partnership

Case study 2

Direct ordering of home care from hospital in the Greater Glasgow Partnership

Greater Glasgow Partnership has developed a system that enables nursing staff in Glasgow hospitals to order home care services for patients before they are due to be discharged. The system is a good example of joint working as it is provided by both Glasgow City Council and NHS Greater Glasgow.

The service is based on an assessment of need. Before a patient is discharged from hospital, nursing staff and hospital social work staff make an assessment of any needs a patient requires when they get home. The services are ordered and arranged before the patient is discharged so that they are available when the patient arrives home. Shortly after the patient is discharged home, a social worker visits them to carry out a detailed needs assessment in order to confirm or adjust the level of home care being provided.

Source: Greater Glasgow Partnership

Case study 3

The Belhaven Project in Lothian

Belhaven Hospital was used to establish the first nursing home in Scotland to be operated by the NHS when it opened in June 2004. The project is a joint venture between East Lothian Council and NHS Lothian.

The idea behind the project was to use spare capacity at Belhaven Hospital to try and address the lack of care home places across Lothian. This lack of care home places had contributed to a growing number of delayed discharges, particularly in East Lothian.

East Lothian LHCC brought ward one at Belhaven up to standards required by the Care Commission, and East Lothian Council registered it as a care home. The home currently houses 11 older people from East Lothian.

Source: Lothian Partnership

Case study 4

Evaluating initiatives in the Ayrshire & Arran Partnership

The Ayrshire & Arran Discharge Capacity Group sets standards for each new initiative to enable evaluation later on:

- There is a checklist against good practice which includes the need to objectively assess the impact of an initiative.
- Evaluation methods are agreed before the initiative begins.
- One person in the group takes responsibility for measuring impact.
- Evaluation results are brought back to the group which then decides whether or not to continue with the initiative.

For example, success measures for its rapid response team are the number of:

- referrals made to the service and the source of those referrals
- patients maintained in the community as a result of the rapid response service
- bed days saved as a result of the service.

Source: Ayrshire & Arran Partnership

Appendix 1. Study advisory group

Members sat in a personal capacity

Ian Aitken	NHS Forth Valley
Chris Bruce	NHS Lothian
Bruce Dickie	Fleming Nuffield Unit, Newcastle upon Tyne (formerly with NHS Tayside)
Ken Emmerson	NHS Ayrshire & Arran
Harry Garland	Orkney Islands Council and Association of Directors of Social Work
George Hunter	East Renfrewshire Council and Association of Directors of Social Work
Steve Kendrick	ISD Scotland
Peter Knight	ISD Scotland
Allan McKeown	Convention of Scottish Local Authorities
Margery Naylor	Social Work Services Inspectorate (to March 2005)
Adam Redpath	ISD Scotland
Grant Ross	City of Edinburgh Council
Andrew Sim	Age Concern Scotland
Ros Watkinson	NHS Grampian

Observers from the Scottish Executive Health Department

Shaun Eales	Older People's Division (from April 2005)
Jinny Hutchison	Older People's Division (to December 2004)
David Orr	Analytical Services Division
Douglas Phillips	Joint Future Unit (from April 2005)
Brian Slater	Older People's Division (from April 2005)

Accounts Commission project sponsors

Owen Clarke
Alyson Leslie

Moving on?

An overview of delayed discharges in Scotland



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Audit Scotland
110 George Street
Edinburgh EH2 4LH

Telephone
0131 477 1234
Fax
0131 477 4567