House of Commons

Committee of Public Accounts

Ensuring the effective discharge of older patients from NHS acute hospitals

Thirty-third Report of Session 2002–03

HC 459

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Report, together with formal minutes, oral and written evidence

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The Committee of Public Accounts

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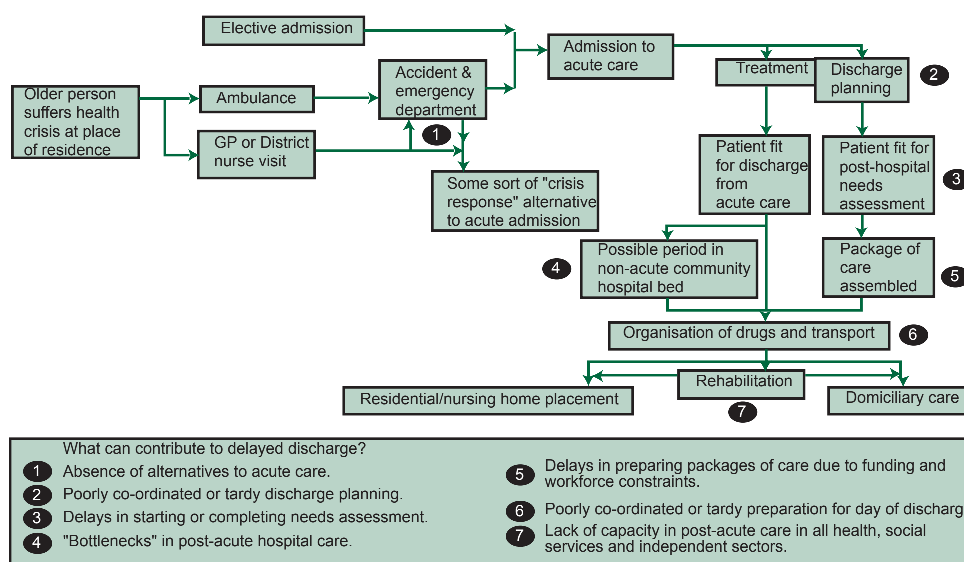
Summary

On any given day, some 3,500 older patients remain in National Health Service (NHS) acute hospitals after medical staff have declared them fit and safe to be discharged, because arrangements are not complete for them to move on. Many delays are for a few days, but about one-third are for more than 28 days. The Department of Health estimate that delayed discharges cost the National Health Service around £170 million a year (or around £0.5 million for every day of the year), and account for 1.7 million lost bed days annually.[1] Reducing delays has become a Government priority, and was the subject of legislation during the winter of 2002–03.

Delayed discharge is as much about the availability of services in the community as what happens in hospital. While hospitals can do much to move patients efficiently through the system, they have to retain them longer than is medically necessary if patients cannot be discharged safely to a more appropriate place. Delays can occur at a number of points (**Figure 1**), and the most common causes are patients awaiting a care home placement or assessment of needs, problems with transfers to further NHS care, or delays in the availability of public funding. To tackle the problem, successful co-ordination is needed between NHS acute Trusts, Primary Care Trusts, local authority social services departments, and independent sector providers and others.[2]

Figure 1: Points in the care process where delayed discharges commonly occur



Source: National Audit Office

On the basis of a Report by the Comptroller and Auditor General,[3] we examined the action taken by the Department and the National Health Service, on their own and with local

1 C&AG's Report, *Ensuring the effective discharge of older patients from NHS acute hospitals* (HC 392, Session 2002–03) para 1.5; Qq 28–30; Ev 19–20 (Q 28)

2 C&AG's Report, Figure 5

3 C&AG's Report, *Ensuring the effective discharge of older patients from NHS acute hospitals* (HC 392, Session 2002–03)

authorities and the private sector, to tackle the problem of delayed discharges. In the light of our examination, we draw the following main conclusions:

- **The Department and the NHS have reduced levels of delayed discharge significantly since 1997, but some acute hospitals are still not implementing best practice for discharging patients, and there are still too many older people waiting longer in hospital than is necessary, including many for a month or more.** The Government aims to end widespread delayed discharge by 2004, and is committed to reducing levels to around 3,000 by the end of 2004, and between 2,000–2,500 by the end of 2005. The Department does not expect that further reductions will be possible due to inherent delays in the system, but should review this assumption once the new cross-charging system has bedded in.

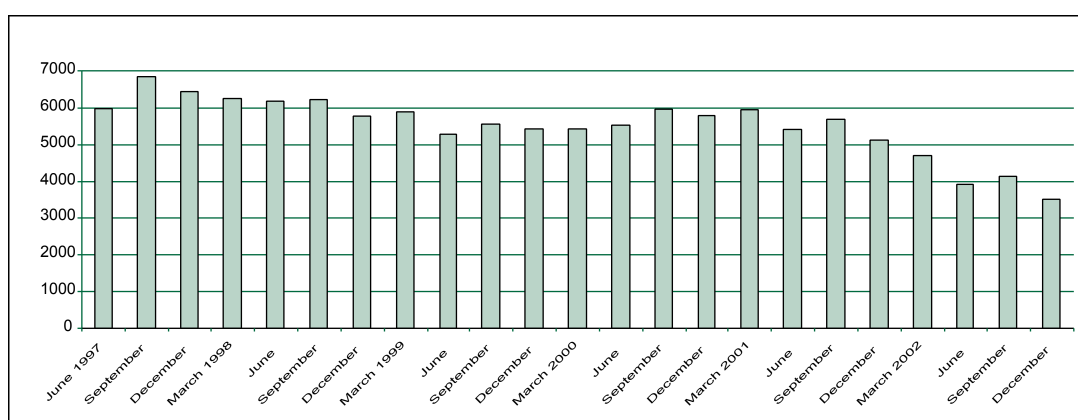
- **Involving patients and their relatives and carers in discharge decisions is crucial for timely and appropriate discharge** and is expected under the NHS Plan and the Health and Social Care Act 2001. Although almost all acute trusts consider they do involve patients, relatives and carers, many of these people do not see it that way. All Trusts should ensure that their current practices meet reasonable expectations, with discussions including full information on options available and the provision of a discharge plan. This may require them to survey patients to confirm satisfaction levels.

- **A long term solution to delayed discharges will only be achieved through private and public sector partners working together**. The Department aims to expand capacity in a variety of care provision. In developing and reviewing local delivery plans, Strategic Health Authorities and Primary Care Trusts need to have a clear picture of current provision across health and social care in their local areas, consulting with independent sector providers when planning provision. In particular, they need to tackle the significant regional variations in the availability of intermediate care.

1 Reducing levels of delayed discharges in the future

1. Older people occupy around two-thirds of general and acute beds and are three times as likely to be admitted to hospital than the population as a whole. Once in hospital, older people are likely on average to remain there much longer. Those over 75 represent around 77% of all people whose discharge has been delayed. This reflects the fact that many older people have complex needs and may be making major decisions about where they spend the remainder of their lives.[4]

Figure 2: Levels of delayed discharge for patients 75 and over



Source: Department of Health

2. The number of patients over 75 whose discharge is delayed has halved since 1997, but is still high (**Figure 2**). In December 2002 (the latest figures available), the number of delays for all ages on any given day fell to 4,600 (5,400 in September) and for people over 75 to 3,500 (4,100 in September).[5] Within these overall figures, there is significant regional variation. London and the South are particularly affected, whereas the problem is generally less pronounced in the north of England. The Department's progress reflects the importance it has accorded to this issue in the last two years. In particular, the NHS Plan, the National Service Framework for Older People and the Building Care Capacity Grant have each been designed to help reduce levels of delayed discharge.[6]

3. The Department interprets its commitment to end "widespread" delayed discharge by the end of 2004 to mean a reduction to "about 3,000" delays of all ages, with a further reduction to 2,000 to 2,500 by the end of 2005. The Department sees this as a minimum level below which further improvement is not practicable, because it believes there will always be some patients awaiting a suitable placement and delays in the system. Patients also have the right to be involved in the decision as to where they are to move.[7]

4 C&AG's Report, paras 1.3, 1.13, 2.22

5 Q 1

6 C&AG's Report, para 1.18 and Appendix B

7 Qq 3–6

4. Despite the reduction in delays, there remain a significant proportion of those affected who remain in hospital for a long period; nearly one-third for more than a month after they are fit and safe to be discharged,[8] although this proportion has fallen. The Department agrees that tackling long waits is important, but does not collect data in a way that allows a more detailed national analysis of the longest delays. These people usually have the most complex problems, often with more than one condition, and the Department acknowledges that they will probably require the most expensive packages of care. This is likely to make it harder to reduce delays, and there is a danger that some of these people will remain in hospital, as priority is given to discharging large numbers of simpler cases. The Department has now asked its Health and Social Care Change Agent Team to examine delays over 28 days as part of its future work programme.[9]

5. More widespread data problems mean that the Department does not have a full picture of discharge delays. It warned about the accuracy of data for the first two quarters of 2002–03, as a result of initial collection problems following the transfer of functions from health authorities to Strategic Health Authorities. The current figures do not cover non-acute, mental health and community beds, even though delays also occur there.[10] Moreover, the National Audit Office found that (in August 2002) only 27% of trusts were following the national definition of what constitutes a 'delayed discharge'. The Department has since contacted the acute trusts identified as not following any part of the definition and has assured the Committee that all have confirmed that correct procedures are now being followed.[11] Moreover, the implementation of the 'cross charging' arrangements under the Community Care (Delayed Discharge etc) Act 2003 should ensure that different interpretations of 'delayed discharge' no longer occur.[12]

6. One sign of possible premature discharge is levels of readmission. The number of emergency hospital re-admissions for people over 75 increased from 22,000 to 34,000 a quarter between 1997 and 2002. The Department is unclear why this is happening and is examining the evidence, but rising re-admission rates may signal problems with discharge, which makes it important that those rates are monitored and the causes understood. The National Audit Office found that only one-fifth of trusts did so.[13]

8 C&AG's Report, para 1.5
9 Qq 7, 18–22, 25; Ev 19 (Q 18)
10 C&AG's Report, para 1.8
11 Q 80; C&AG's Report, para 1.6–1.9
12 Qq 80, 140
13 C&AG's Report, paras 2.26–2.27

2 Working together to plan effective arrangements

7. Patients' needs are often varied and complex, but there is much about their treatment that is predictable, so that prompt and well co-ordinated planning in advance of discharge is often possible. The Department of Health provides advice and guidance to the NHS on good practice in patient discharge (**Figure 3**).

Figure 3: Good practice in patient discharge

- **A clear discharge policy**: setting out good practice in patient care that will be applied to all patients discharged. This should be produced in consultation with, and circulated to, those involved in discharge inside and outside the hospital so that all are clear of what is expected of them and, for outside agencies, what they can expect of the hospital.
- **Early planning**: wherever possible, planning for discharge should start before the patient arrives for a planned admission, and on admission for an emergency. Setting target dates for discharge helps staff to focus on discharge in the face of other demands.
- **Early assessment**: patients must be assessed before they can be discharged. Given that best practice is to undertake multi-disciplinary assessments which may involve several specialists from hospital, community and social services, the process should begin early.
- **Discharge co-ordinators**: a specified person, often a nurse, who has the responsibility for ensuring the effective discharge of patients, and in doing so, overcoming barriers to that discharge.
- **Mapping patient pathways to identify blockages**: reviewing the pathway that patients take through the hospital is a valuable diagnostic aid to identifying bottlenecks and potential problems which may obstruct discharge.

Source: C&AG's Report, Part 2

8. The Department's Health and Social Care Change Agent Team, made up of professionals from a variety of backgrounds, is an important element of driving up performance. The Team works with those who have the biggest problems, and also seeks to spread best practice through conferences and guidance. To date, feedback from those receiving advice has been positive. In January 2003, the Department issued *Discharge from hospital: pathway, process and practice*, which provides good practice guidance on these and other issues.[14]

14 C&AG's Report, paras 3.18–3.20; Q 89

9. Inefficiencies in the preparation of patients for discharge can arise from poor communication between hospital wards, transport departments and pharmacies. Hospitals have traditionally struggled with inter-departmental issues such as these, although the NHS Modernisation Agency has been focusing on ensuring a more co-ordinated approach. Delays can also occur due to problems installing inexpensive equipment such as hand rails, so that people can return home. This underlines the importance of well planned assessment processes involving decision makers from both health and social services. The Department is encouraging local authority and health services to set up joint occupational therapy and equipment services so that those identifying needs can work closely with those able to resolve them.[15] Discharge into domiciliary care is also affected by the availability of community equipment to enable the frail to live at home. The National Audit Office reported that 40% of Primary Care Trusts considered shortages hindered discharge, and the Audit Commission have expressed concerns in two reports about the lack of priority given to this area. The Department is making available £105 million of additional funding over three years from 2001–02 and expects to provide up to half a million pieces of equipment free at the point of delivery by 2005.[16]

10. Before a patient can be discharged, an assessment must be made of their medical, functional, social and psychological needs. Awaiting completion of assessments accounts for nearly one-fifth of all delays. The National Audit Office found that more Trusts were starting assessments promptly for emergency cases than in 1999, but for planned admissions, three out of every ten Trusts did not begin until some time during the patient's stay. As part of its inspections, the Department examine whether people have been assessed properly and placed in an appropriate care setting. Currently, these examinations find that the matching process is not always undertaken well, and as a result many older people are placed in the first available home.[17] To co-ordinate and standardise the assessment better, the National Service Framework for Older People required a Single Assessment Process to be introduced, initially from April 2002 but now by April 2004.[18]

11. Improvements are also needed in the way patients and carers are involved in the discharge decision. While almost all Trusts state that they do consult patients and carers, many carers considered they had little information or involvement prior to discharge. Many felt poorly informed about the availability of care services after the patient left hospital, and only one-fifth received a copy of the discharge plan.[19]

12. Occupational therapists and physiotherapists are an important influence on prompt discharge at several points in the care pathway. However, shortages of therapists exist and vacancies are increasing despite increased recruitment effort and more resources made available for training. As a result, more than half of Primary Care Trusts considered shortages of these professionals affected discharge in their areas. The gradual integration of therapy services in all local health and social care communities is an important step in tackling these shortfalls.[20] Our 2002 Report on *Educating and training the future health*

15 Qq 83, 143

16 C&AG's Report, para 4.8

17 *ibid*, paras 2.9–2.11; Qq 90–91

18 C&AG's Report, paras 2.13–2.17

19 *ibid*, paras 2.22–2.25

20 *ibid*, paras 2.18–2.21; Q 125

professional workforce in England made recommendations for meeting the demand for nurses and other health professionals envisaged by the NHS Plan.[21]

13. The level of communication and co-operation between local health and social care bodies has improved and there is joint working of various kinds under way (**Figure 4**). Most NHS acute trusts consider their contacts with social services and Primary Care Trusts helpful in addressing delayed discharge, and the majority of social services departments consulted by the National Audit Office were positive about their relationships with the NHS. Nevertheless, there are still examples of poor communication and co-operation in individual localities.[22] The main barriers include staff and funding shortages, pressure of time, incompatible administrative systems and a lack of shared boundaries between Primary Care Trusts and local authorities.[23]

Figure 4: Forms of joint working

- Pooling of funds between health and social care organisations as a means of using funds efficiently
- Delegating functions, allowing one organisation to be lead commissioner of overlapping or related services on behalf of others
- Integrating services into a single provider organisation through the creation of Care Trusts under the Health and Social Care Act 2001. Such Trusts can provide services for older people in a more co-ordinated way from hospital admission to sustained care at home
- Development of co-ordinated administrative systems, for example, through a system of joint patient records
- Joint appointments, for example, whereby senior officials of health agencies are also in senior positions within social services departments
- Health and Social care collaboratives established by combining teams of frontline staff from across health and social care agencies to focus on providing efficient and co-ordinated front-line services for older people

Source: C&AG's Report, Part 3

14. Developing shared boundaries for health and social care bodies is difficult in the short term, but one currently under-used approach is joint appointments to Primary Care Trusts and social services departments. These are valuable in bringing different agencies together, and overcoming suspicions and some of the barriers. The Department noted that there are three Primary Care Trust chief executives who are still directors of social services, and most Primary Care Trusts have some kind of joint appointments. In Knowsley, where this is the case, delayed discharge levels are low, and a plan has been developed to look at how all

21 20th Report 2001–02 from the Committee of Public Accounts, *Educating and training the future health professional workforce in England* (HC 609, Session 2001–02)

22 C&AG's Report, 3.7–3.8; Q 53

23 C&AG's Report, Figure 16

services might be integrated through a system of joint appointments. The Department is seeking to learn lessons from a range of current examples of partnership working, including Care Trusts, and does not consider that there is a 'one size fits all' solution.[24]

15. The Community Care (Delayed Discharges) Act received Royal Assent in April 2003. It provides that NHS bodies will notify local authorities as soon as they are aware that a patient requires community care services after discharge. The local authority will then have a number of days (a minimum of two days excluding Sundays and public holidays) to put together a discharge plan in consultation with the relevant NHS bodies and determine which services are required. Thereafter, the local authority is required to make payment to the NHS body where it does not put together a discharge plan within a specified number of days or where discharge is delayed specifically because the local authority is not able to provide services to the patient or their carer at the specified time of discharge, whichever of these is the later. These provisions are due to come into force in October 2003, with charging starting in January 2004.[25]

16. There is potential for the proposed scheme to have a positive impact in reducing delayed discharge. It is designed to encourage local authorities to take responsibility for developing capacity of all kinds.[26] The Department believes there will be incentives on local authorities to invest to avoid larger payments, although there is a danger that this might not be the case for the more complex cases.[27] The Department also wants to remove the incentive to rely on health service funding for even a short 'breathing space' when a person no longer needs to be in hospital and is legally the responsibility of the local authority.[28]

24 Qq 100–102, 105–108

25 Details of the Community Care (Delayed Discharges etc) Act 2003

26 Qq 12, 113–114

27 Q 24

28 Q 47

3 Addressing the shortfall in capacity and developing measures to promote independent living

17. Rather than simply increase the numbers of nursing home places, the Department is looking for capacity to be developed through care homes, intermediate care schemes, and support for people in their own homes. In July 2002, the Secretary of State announced an additional £1 billion for older people's services over the period 2003–06. In 2001–02 and 2002–03 the Department provided £300 million (the Building Care Capacity Grant), mainly to local authorities, specifically to reduce delayed discharges. Although it had the desired effect, the Department's own review acknowledged the inherent tension between the need to reduce the number of delays as quickly as possible, and wider objectives of diversifying service provision. Much of the funding was used to buy care home places, and much less went into supporting people in the community or on preventive services. In April 2003, the Government introduced a funding framework—the Supporting People initiative—for housing-related services for vulnerable people, including older people, to enable them to either remain independent or gain independence in their own home.[29]

18. Other sources of funding have also been used. For example, a small number of projects under the Invest to Save Budget will have an impact on levels of delayed discharges, in particular through the development of intermediate care services.[30] In addition, funds from the National Lottery are being used to establish a network of Healthy Living Centres, some targeted at older people, which should help reduce hospital admissions.[31] The Department is concerned about how effectively all forms of funding are being used, and in its view, many local authorities still need to develop better commissioning strategies for their services.[32]

19. The National Audit Office reported that in some parts of the country there are severe capacity problems in residential and nursing care leading to delays in patient discharge. The Independent Healthcare Association told us that there had been a gross loss of 50,000 independent care home beds since 1996–97, with closures taking place in a haphazard and unplanned way.[33] The problem has been building up for some years.[34] One in every four older people whose discharge is delayed is awaiting a nursing or residential care placement, and a further 10% await a placement in a home of their choice. Under-supply of affordable beds is particularly acute in London and the South East of England.

20. A major cause of the fall in capacity has been fee levels. The Independent Healthcare Association said that local authority prices often did not cover costs and there was a widespread assumption that they would not in future. The Department has prepared a

29 C&AG's Report, paras 1.18, 4.21–4.25, 4.30–4.32

30 Qq 37–46; Ev 20 (Q 39)

31 C&AG's Report, Figure 29

32 Qq 31–36

33 C&AG's Report, paras 4.2–4.5; Ev 1

34 Qq 53–76

framework for local authorities to use in their discussions with independent care providers.[35] Fee levels vary considerably across the country but in the past year additional funding has increased fees by 3–10%. The Department believes that higher fees seem to helping to sustain levels of nursing care at the moment.

21. Another issue influencing capacity has been concerns about the cost implications of proposed new care standards. These were introduced under the Care Standards Act 2000, making specific requirements for the physical environment of home occupants to be implemented by 2007. Subsequently, concern was expressed about the implications for the profitability of care homes, and after consulting on the proposals, the Department has changed the rules so that those registered before April 2002 do not have to meet some of the physical standards.[36]

22. A departmental priority for expanding capacity is to develop intermediate care—short term provision to allow people to receive care without the need for admission to acute facilities, provide rehabilitation in a non-acute setting, and ultimately reduce the need for some people to be admitted to a nursing home. The NHS Plan set targets for 5,000 extra beds by 2004 and 1,700 extra supported non-residential intermediate care places, and the Department is investing over £800 million between 2001–02 and 2003–04. Provision is currently unevenly spread around the country and is not linked to levels of delayed discharges, nor to the numbers of older people in hospital. The National Audit Office also reported some uncertainty amongst those making referrals as to the existence of intermediate care facilities, including those outside the NHS. Each Strategic Health Authority has been preparing three year plans which will include intermediate care provision, and the Department will need to satisfy itself that gaps in provision are being addressed, given the incomplete picture of current provision in parts of the country.[37]

23. Many older people would prefer to be supported in their own home, and while there are examples of good provision, building up appropriate support to provide intensive domiciliary care in the community is one of the main issues facing local authorities.[38] The proportion of home care which is a substitute for admission to care homes is increasing, although the proportion of people supported in their own home has remained steady in recent years. The Department would like to see intensive home care capacity increase considerably.[39]

35 Qq 93–94; Ev 2, para 8

36 C&AG's Report, para 4.27; Qq 14–15

37 C&AG's Report, paras 4.15–4.20; Q 16

38 Q 25

39 C&AG's Report, para 4.6; Q 94

Conclusions and recommendations

Reducing levels of delayed discharge in the future

1. While there has been a fall in the number of patients whose discharge has been delayed, there is a risk that in seeking to reduce the total further the main focus will be on those cases easiest to resolve. Around one-third of delays are for a month or more, and often involve those with complex and multiple needs, who are harder and more costly to place, but the Department does not collect data which allows it to analyse this figure further. The Department should now investigate the extent and causes of long term delays and devise strategies to discharge the people involved.

2. The Department's central monitoring covers only acute and general beds in NHS acute trusts. Its analysis should extend to the level of delayed discharge in 50,000 non-acute, mental health and community beds. Delays also occur in these settings, and waiting for other forms of NHS provision is a regular cause of delayed discharge from acute care.

Working together to plan effective arrangements

3. Many NHS Trusts are following best discharge practice, and performance in several areas has improved since the Comptroller and Auditor General last examined this issue in 1999.[40] For example, most NHS Trusts now have discharge co-ordinators to help overcome internal obstacles to discharge, and almost all have developed discharge policies. Nevertheless, there is still scope for more NHS Trusts to:

- circulate their discharge policies more widely within and outside the Trust, for example, to hospital pharmacies and local general practitioners;
- begin earlier their discharge planning and assessment of patient needs;
- map older patients' pathways through hospital as an aid to identifying bottlenecks within the system; and
- involve key groups such as hospital pharmacies and transport departments more routinely in decisions about discharge.

4. The Health Act 1999 and the Health and Social Care Act 2001 allow health and social care organisations to form a range of partnerships, including setting up Care Trusts to commission and provide both health and social care services, and sharing budgets. The Department should stimulate the take up of co-ordinated initiatives, for example, by promoting joint appointments at local level (such as Primary Care Trust Chief Executives remaining as Directors of Social Services), and using initiatives such as the Integrated Care Network to publicise the benefits of joint approaches.

40 C&AG's Report, *Inpatient admissions and bed management in NHS acute hospitals* (HC 254, Session 1999–2000)

5. The Department is committed to developing domiciliary care, allowing people to be looked after in their own home. Despite this, and two critical reports by the Audit Commission, the availability of community equipment to enable the frail to live at home remains an issue. By 2005, given the promised injection of ring fenced funding for up to half a million pieces of equipment, the Department should be able to report significant progress in reducing delays caused by equipment shortages.

6. Physiotherapists and occupational therapists play a key role in the assessment process prior to decisions being made about patient discharge, and in the development of intermediate care. Shortages of these professionals are a cause of discharge delays in many areas, and the Department should focus further on ways of overcoming them, taking account of our previous recommendations in this area.[41] For example, they should set recruitment targets which reflect increased activity levels, and promote combined therapy services and more integrated working between therapists.

Addressing the shortfall in capacity and developing measures to promote independent living

7. The independent sector provides most of the care homes and home care services, and without their full participation, the NHS is unlikely to reduce delayed discharges significantly. Providers nevertheless remain concerned about the adequacy of fee levels paid by local authorities, about the risks of investment in new capacity and about difficulties in collaborating with some health bodies. NHS Trusts and Primary Care Trusts should involve independent providers more in the planning and development of older people's services to ensure they stay in the sector.

8. Provision of intermediate care across the country varies and there is some uncertainty amongst local commissioners as to what is available. Primary Care Trusts and Strategic Health Authorities should obtain a clear picture of intermediate care provision in their area, and publicise its availability.

41 20th Report from the Committee of Public Accounts, *Educating and training the future health professional workforce in England* (HC 609, Session 2001–02)

Formal minutes

Monday 23 June 2003

Members present:

Mr Edward Leigh, in the Chair

Mr Richard Bacon
Geraint Davies
Mr Frank Field
Mr Nick Gibb
Mr George Howarth
Mr Brian Jenkins
Mr Gerry Steinberg
Jon Trickett
Mr Alan Williams

The Committee deliberated.

Draft Report (Ensuring the effective discharge of older patients from NHS acute hospitals), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 23 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Thirty-third Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (Reports)) be applied to the Report.

Adjourned until Monday 30 June at 4.30 pm

Witnesses

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Sir Nigel Crisp, KCB, Department of Health, and **Ms Denise Platt CBE,** Social Services Inspectorate Ev 4

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The reference number of the Treasury Minute to each Report is printed in brackets after the HC printing number