Research Review on Tackling Delayed Discharge
A RESEARCH REVIEW ON TACKLING DELAYED DISCHARGE

By the Scottish School of Primary Care

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Scottish Executive Social Research
2004
ACKNOWLEDGEMENTS

This research review was commissioned by Community Care Division 1 of the Scottish Executive Health Department. However, the views expressed in the research review are those of the authors. Thanks to Rosemary Porteous, University of Edinburgh and Janice Reid, University of Glasgow for helping to conduct the literature search; Ailsa Stewart, Community Care Works, University of Glasgow who provided information about initiatives in Scotland to tackle delayed discharges and helped to conduct the telephone interviews; Steve Kendrick for providing ISD data; health and social care professionals in Scotland who provided information about initiatives to tackle delayed discharges.
## CONTENTS

### GLOSSARY

### SUMMARY 1

### CHAPTER 1 - INTRODUCTION 5

- Policy Development 5
- Aims and Objectives of the Research Review 8
- Methods 9
- Scope of the Research Review 12

### CHAPTER 2 – IDENTIFYING THE PROBLEM AND MATCHING SOLUTIONS 14

- What is a Delayed Discharge? 16
- Who is at Risk of Delayed Discharge? 17
- Are the Right People Being Targeted in Scotland? 19
- Are the Main Reasons for Delayed Discharge Being Addressed in Scotland? 21

### CHAPTER 3 – EVALUATING AND MONITORING IMPACT IN SCOTLAND 24

- Information Systems to Monitor Delayed Discharge 25
- Evaluating Impact of Initiatives 26

### CHAPTER 4 – EVIDENCE FROM THE LITERATURE OF WHAT WORKS 30

- Hospital at Home/Early Supported Discharge/Rapid Response Teams 32
- Discharge Planning and Assessment 33
- Improving Clinical Care in Hospital 36
- Equipment/Adaptations 36
- Step Up/Step Down Beds in Care Homes 36
- Joint Case Management 37
- Cross-Charging 37
- Care Homes Places 38
- Interim Care Home Beds 38
- Introducing a Range of Initiatives 38
- The Role of GPS 38
- The Role of Social Care Staff 39
- The Role of Nurses 39
- The Role of Allied Health Professionals 39
- The Role of Carers 40
- A Range of Perspectives 40

### CHAPTER 5 – INITIATIVES IN SCOTLAND 41

- Initiatives to Tackle Delayed Discharge 43
- Care Homes 45
- Step Up/Down Beds in Care Homes or Intermediate Care 46
- Rehabilitation 46
- Hospital at Home Rapid Response/Early Supported Discharge 46
- Assessment 48
- Out of Hours 48
- Care Managers 48
- Equipment and Adaptations 48
- Transport/Ready Rooms 48
- Day Care 48
CHAPTER 6 – CONCLUSIONS
DEVELOPING A WHOLE SYSTEM APPROACH TO TACKLE DELAYED DISCHARGES

ANNEX- RESOURCES SEARCHED

REFERENCES

TABLES
1: SUMMARY OF POLICY DEVELOPMENTS LIKELY TO IMPACT ON DELAYED DISCHARGE
2: VOLUME AND TYPE OF DOCUMENTS RELATING TO REASONS FOR DELAYED DISCHARGE
3: VOLUME AND TYPE OF DOCUMENTS RELATING TO SOLUTIONS FOR DELAYED DISCHARGE
4 - 6: INITIATIVES TO TACKLE DELAYED DISCHARGES IN SCOTLAND 2003/2004

DIAGRAMS
1: INTERSECTION OF PREDICTIVE INDICATORS OF RISK OF DELAYED DISCHARGE
2: A WHOLE SYSTEMS APPROACH TO TACKLE DELAYED DISCHARGE

GRAPHS
1: PREDICTED GROWTHS IN THE NUMBER OF OLDER PEOPLE IN LANARKSHIRE
2: DELAYED DISCHARGE BY REASON FOR DELAY JANUARY 2001 TO JULY 2003 IN BORDERS AND AYRSHIRE AND ARRAN
GLOSSARY

**Bed blocking** – this is a term used to describe a situation where people are occupying hospital beds when they no longer require the type of care provided in the acute setting. The need to avoid using the term bed blocking is increasingly recognised because it implies that it is the patient who is responsible for preventing others from using an acute bed rather than dysfunctions in the care system.

**Delayed discharge** – People are categorised as a ‘delayed discharge’ when they remain in a care setting (for example, acute hospital) when they no longer require the type of care provided in that particular setting.

**Partnerships** - these are multi-agency strategic level groups who are responsible for planning, monitoring and managing delayed discharges in each of the 15 Health Board regions in Scotland.

**Joint Action Plans** - all Scottish Partnerships have been asked to provide information on an annual basis about how they are tackling delayed discharges by filling out a form provided by the Scottish Executive Health Department. This is called the Joint Action Plan.

**Agencies** – health and social care organisations, for example general practice, hospital, social work department.

**Multidisciplinary teams** – teams involving different primary care, social care, and/or acute care professionals.

**Care system** – all primary care, social care and acute care agencies that are working within a particular Health Board.

**Whole system** – another word to describe a care system.

**Monitoring** – collecting and analysing data on delayed discharges to find out if the number of people having a delayed discharge has gone up or down.

**Evaluation** – an investigation of how initiatives have impacted on delayed discharges. An evaluation may also include an exploration of why initiatives have had an impact.

**Research review** - the term used to describe the work carried out for this document. This document is called the research review.

**Literature review** - the literature that was included in this research review.
SUMMARY

This research review draws on: UK and international literature; information produced by Information Statistics Division; a review of Scottish Joint Action Plans on delayed discharges; and a small number of snapshot interviews with Scottish health and social care professionals. These four sources of information were analysed both separately and in conjunction with each other to identify key areas that need to be addressed for delayed discharges to be tackled long term.

Policy developments
- Since 1999, a number of policy developments in Scotland have been introduced to tackle delayed discharges. These include the establishment of a learning network to disseminate ‘good practice,’ and annual funding streams to support the development of initiatives to tackle the problem. It is anticipated that other policy developments will impact on delayed discharge. Policies deemed likely to have a negative impact include the introduction of free personal care, Guardianship orders, and national care home standards. Policies deemed likely to have a positive impact include single shared assessment and choice of accommodation guidance. The impact of policy developments on delayed discharge therefore needs to be closely monitored.

Predictive indicators of risk of delayed discharge
- In 2000, the Scottish Executive issued a definition of delayed discharge from NHS care. However, publication of a definition of delayed discharge does not guarantee that clinicians and other professionals use the same criteria to decide who is ‘ready for discharge.’ It is not known if consultants and other health and social care professionals in Scotland use different criteria to determine if a patient is ‘ready for discharge’ and if they do, whether this has a significant impact on the numbers of people designated as a delayed discharge in different Partnerships. Further research around social and medical criteria for judging when a patient is ‘ready for discharge’ both within and between Partnerships would be useful. Due to lack of clarity about criteria for determining a delayed discharge it is difficult to accurately compare research findings reporting the number of delayed discharges and compare the number of delayed discharges in different Partnerships in Scotland.

- A combination of individual, medical and organisational factors interact to put people at risk of delayed discharge. The literature review identifies that older people, those with multiple pathology, and those with some specific clinical conditions (such as neurological deficit and stroke) are most at risk. Studies suggest that patients waiting for a place in their first choice of care home to become available, and patients who did not have a companion to escort them home, were also likely to be delayed.

- The literature review highlights that some medical conditions appear more likely to lead to a delayed discharge for all age groups and that this is often because there is a lack of alternative care facilities available for these particular people. In other words, it is not the clinical condition per se which causes the delay, but how organisations are managing services to care for these particular clinical groups. Problems within both health and social care organisations have been attributed with causing delayed discharges. Organisational factors associated with delay include: (i) lack of home support, (ii) unavailability of convalescent or rehabilitation facilities, (iii) waits for community care needs assessments or home care packages. Studies show that some people admitted as an emergency were more
likely to have a delayed discharge compared to elective admissions, and that people with severe mental illness admitted for planned short hospital stays were less likely to have a delayed discharge compared to those who were admitted as long hospital stays and in receipt of standard care.

- Whilst the Joint Action Plans of most Scottish Partnerships focussed on older people, they were not explicit about targeting particular groups of older people most at risk, nor about if, and which, high risk groups of the population, besides older people, were being targeted to tackle delayed discharges. This may be because Joint Action Plan forms did not specifically request this information. However, it would be useful to know whether Partnerships were targeting high risk groups and what initiatives they were developing to facilitate their discharge.

- Scottish Partnerships reported that the main causes of delayed discharge were insufficient care home places, lack of community-based care, and the slowness of assessment for community-based care. In other words, problems within social services were perceived as the main cause of delayed discharges.

- Most Partnerships did not make explicit the relationship between causes of delayed discharges and the initiatives that they were introducing to tackle delayed discharges. This may be because the design of the form did not explicitly request this information rather than reflecting a lack of planning on behalf of the Partnerships.

Monitoring and evaluation
- Examples of ‘good practice’ such as those described on the Scottish Executive ‘learning network,’ do not usually include evidence of effectiveness. However, without this information it is difficult to assess how and why initiatives have been successful.

- Partnerships did not make it clear if the initiatives that they were introducing to tackle delayed discharges were based upon external evidence of the effectiveness of similar initiatives elsewhere, or whether evidence of effectiveness of services was locally collected and available. This is likely to be because the Joint Action Plan form did not request this information. However, without this information it is difficult to know the extent to which initiatives are being introduced that are based on evidence of what works.

- There were several reasons that it was difficult to assess how Partnerships were monitoring delayed discharge. This was because Partnerships were not requested to explain on the Joint Action Plans: (i) what information systems they had in place to monitor delayed discharge, (ii) what data was being collected to monitor delayed discharge, (iii) what targets were being used to measure success, (iv) how people using services were being counted.

- Measures appropriate to maintaining a national overview of the situation such as the numbers of delayed discharges may be too broad for evaluating the impact of local initiatives. Instead, outcome measures that relate to the role of specific initiatives need to be identified. Evaluating the impact of an individual initiative and the combined impact of several initiatives is necessary for a whole systems perspective.

Initiatives to tackle delayed discharge: evidence from the literature
- ‘Hospital at Home’ schemes, sometimes called ‘Early Supported Discharge’ schemes have contributed towards tackling the problem of delayed discharges for some people.
Studies show increases in patient satisfaction, reductions in hospital lengths of stay, increases in the number of patients still at home 6 months after discharge, greater community reintegration, improvements in health-related quality of life, and reductions in costs per patient. On the other hand, these studies show that some of these schemes have led to lower carer satisfaction, no improvement on health outcomes or functional status, and increases in overall length of care. The studies reported in this research review thus show mixed results. Moreover, care at home for older people has been criticised because it may lead to age discrimination and to further marginalisation of some of Scotland’s most vulnerable people. This is because community-based care for older people may help to prevent an unnecessary period of hospitalisation but older people’s rights to equal treatment and equal access to services, including use of acute hospital beds, may be jeopardised if acute hospitals become perceived as no-go areas for this group of the population.

- Studies show that discharge planning can reduce the length of hospital stay, increase patient satisfaction, and reduce the number of patients experiencing a delay. However, further research in a range of contexts is required to clarify exactly what ingredients are necessary for effective discharge planning. In particular, it is not clear which professionals need to be involved in multidisciplinary teams, and which subgroup of patients would benefit most. How discharge planning impacts on for example, readmission rates, patient recovery time, and health care costs is also largely unknown.

- A number of studies found in the literature search provide evidence for encouraging Scottish Partnerships to include the improvement of clinical care as a component part of any strategy aiming to reduce delayed discharges.

- The literature search found limited evidence about the impact of equipment/home adaptations; step up(step down beds in care homes; joint case management, cross-charging, care home places and interim care home beds. A more thorough literature search, and/or research, is therefore required so that the effectiveness of these initiatives can be assessed.

- Other UK and international evaluative evidence suggests that a range of initiatives within a whole systems approach may be most effective overall in tackling the problem of delayed discharges.

- More research about GPs’ utilisation of community-based services and the impact that this has on hospital admissions and delayed discharges is necessary, particularly given that small changes in GP decision making has a disproportionate impact on the acute sector.

- Discharge managers such as liaison nurses can improve the discharge process. A danger however, of introducing a dedicated discharge manager is that other staff who have valuable knowledge about patients may abnegate responsibility for discharge. More research about discharge managers’ relationships with other staff and the impact that this has on the discharge process is required.

- A more thorough literature search, and/or research, is required about the role of allied health professionals in tackling delayed discharges.
• The views of a range of people are needed to gain a comprehensive understanding of the discharge process. In particular, the opinions of patients, carers and people from minority ethnic groups need to be included in discharge planning and also in evaluations about initiatives to tackle delayed discharges.

Initiatives to tackle delayed discharge in Scotland
• Care homes placement, hospital at home, rapid response and early supported discharge, rehabilitation, out of hours, assessment, equipment and adaptation, and the introduction of managers were the most common initiatives being introduced by Scottish Partnerships to tackle delayed discharge.

• A difficulty with comparing initiatives in Scotland was because Partnerships gave different names to similar services. For example, rapid response, early supported discharge and some types of home care services and rehabilitation may have a different name but operate in a similar way and with the same purpose. It would be useful therefore if Partnerships provided a brief description of the initiatives in future Joint Action Plans.

• This research review is unable to clarify whether initiatives being introduced in Scotland have evidence of effectiveness. This may be due to a number of reasons such as (i) the literature search for this review was not comprehensive, (ii) evidence exists but is not easily accessible, (iii) the evidence does not exist because evaluations are not being carried out. If it is the latter then more local evaluations of the impact of, for example, care homes, out of hours, assessment, equipment and adaptation, and the introduction of delayed discharge planning would be useful.

• Partnerships were not requested to provide a general strategic overview of how they were tackling delayed discharges in their Joint Action Plans. Instead, the focus was on initiatives being developed for the specific annual funding stream. This meant that it was difficult to understand how Partnerships were going to tackle the problem in the longer term.

The main conclusion from this research review
A whole systems approach that follows four key inter-connected stages may contribute towards tackling delayed discharges:
• Find out the main causes for delayed discharges in the local care system;
• Develop initiatives to tackle these causes;
• Evaluate the impact of these initiatives;
• Monitor the extent to which the delayed discharges are being successfully tackled.

This kind of approach can be supported if there is collaboration between local Partnerships on the one hand, and national strategic bodies on the other. Capacity building in terms of skills in whole system data collection, data handling and analysis is also likely to be required. Finally, organisational capacity to use a whole system approach systematically in service development and planning is also likely to be essential.
CHAPTER 1 - INTRODUCTION

POLICY DEVELOPMENTS TO TACKLE DELAYED DISCHARGES

1.1 Delayed discharge has been identified as a problem for the Welfare State since its birth and since then, there have been numerous policy responses (Glasby, 2003). In recent years, the Scottish Executive Health Department has taken steps to tackle the problem of delayed discharges and policy is currently under review. This research review, carried out by the Scottish School of Primary Care, was commissioned by Community Care Division 1 of the Scottish Executive Health Department to inform this policy review.

1.2 Since 1999, a number of policy initiatives designed to tackle delayed discharges have been introduced. For example, in 1999 a definition of delayed discharge from NHS care was issued by a multi agency working group involving representation from the Scottish Office, the NHS and local authorities (Scottish Executive, 1999).

1.3 In 2000, a number of policy developments were introduced to tackle delayed discharges. For instance,

- a learning network to share and disseminate ‘good practice’ was established (Scottish Executive, 2001a);
- a mandatory national data recording system for delayed discharge was introduced (Scottish Executive, 2000a);
- the first Information Statistics Division (ISD) census on delayed discharges was reported in September, and since then quarterly (ISD, 2004a).

1.4 In March 2002, a report from the Chief Executive of NHSScotland outlined the extent of delayed discharge in Scotland for 2001. The report highlighted key reasons for delayed discharge and showed that it was older people who were more likely to experience delay (Scottish Executive, 2002). The report presented five broad areas requiring attention if delays were to be prevented:

- emergency hospital admission;
- care packages to support hospital discharge;
- care home placements and choice;
- resources for appropriate care;
- organisation and management of health and social care.

1.5 In light of this report, in 2002 the Scottish Executive provided additional funding to Partnerships to reduce the number of delayed discharges and set targets for the reduction of delayed discharge (Scottish Executive, 2003a). Local Partnerships between health and social care organisations (referred to as ‘Partnerships’ in this research review) produced Joint Action Plans for the 2002/03 annual stream on how they would spend this funding. Following these, there was a decline in delayed discharges in Scotland. This has been followed however, by a recent rise in figures; the July 2003 ISD census shows an increase of 174 since April 2003 (ISD, 2003a).

1.6 In 2003, the Scottish Executive released 2003/04 funding to Partnerships to tackle delayed discharges and Partnerships drew up their annual Joint Action Plans on how they would spend this funding.

1.7 Other policy developments besides those listed above are also likely to impact on delayed discharge. Their anticipated impact however, remains largely speculative. Those
that were perceived by some of the Partnerships or the authors of this research review to have an impact on delayed discharges include:

**Adults with incapacity (Scotland) Act 2000** (HMSO, 2000)

1.8 The Adults with incapacity (Scotland) Act 2000 introduces Guardians for adults who no longer have capacity to make decisions about their own welfare. Some Partnerships believed that the awarding of Guardianship orders would delay patient transitions to other parts of the care system.


1.9 One policy development, which was the establishment of the Scottish Executive Joint Future Group, appears to have influenced what kind of initiatives were being introduced by Partnerships to tackle the problem of delayed discharge. The Joint Future Group was set up to provide more integrated community care services by developing joint working between local authorities, NHSScotland and other organisations. The Joint Future Group’s recommendations such as single shared assessment, intensive home support, rapid response service, and joint equipment and adaptations were being introduced by Partnerships to tackle delayed discharges.

**Guidance on single shared assessment for community care needs 2001** (Scottish Executive, 2001c)

1.10 Guidance on single shared assessment for community care needs was published following recommendations by the Joint Future Group. A single professional will carry out an assessment, with other specialist involvement where appropriate, and this assessment will be acceptable to all professionals in health, social care and housing. This information will be shared and accessed by these organisations. A key aim of single shared assessment is to speed up the delivery of services, which may prevent a hospital admission, facilitate timely or early discharge and/or prevent a readmission. It is anticipated therefore that single shared assessment will have a positive impact on delayed discharge.

**Regulation of Care (Scotland) Act 2001** (HMSO, 2001)

1.11 All new care homes in Scotland are being built to comply with the national care home standards specified in the Regulation of Care (Scotland) Act 2001. Existing care homes have until 2007 to comply with the standards (Scottish Executive, 2001d). Most Partnerships suggested that lack of care home placements was one of the main causes of delay from hospital and this regulation may exacerbate the problem further. Lothian Partnership, for example, believed that some care homes would close rather than up-grade, thus putting increasing pressure on care home capacity.

**The Community Care and Health (Scotland) Act 2002** (HMSO, 2002)

1.12 The Community Care and Health (Scotland) Act introduced free personal and/or nursing care (Scottish Executive, 2001e). Lothian Partnership believed that this would lead to self-funders moving to more expensive care homes, which in turn, would lead to smaller and older care homes closing down. Again, this may compound the problem of lack of care home placements for people waiting to be discharged from hospital to a care home.

**Partnership for Care Scotland’s Health White Paper 2003** (Scottish Executive 2003b)

1.13 The Partnership for Care Scotland’s Health White Paper re-confirmed the need for partnerships with social care and for integrated healthcare. In particular, Community Health Partnerships (CHPs) will be established that are NHS bodies designed to take responsibility
for the ‘system of care’ within a defined area. CHPs will have the planning, co-ordination and development role for health but not local authority services. However, they will ideally, be coterminous with local authority boundaries and have representation from the local authority and voluntary sector in management structures. CHPs are likely to play a key role in tackling the problem of delayed discharges in the future.

*Choice of accommodation – discharge from Hospital guidance 2004* (Scottish Executive, 2003c).

1.14 The choice of accommodation – discharge from hospital circular was designed to facilitate discharge from hospital for those people awaiting a care home place. The circular outlines how local authority and NHS boards should manage choice of care homes for people moving from hospital. Patients will be asked to make a choice of care homes and interim accommodation will be secured if none of these choices became available within the discharge planning period. This should facilitate discharge from hospital because people will be placed in interim care homes as opposed to waiting in hospital.

*Implementing the new GMS contract in Scotland* (Scottish Executive, 2004).

1.15 The General Medical Services (GMS) contract is being introduced in Scotland in 2004. The contract will affect the provision of out of hours services because people who require this service may not necessarily see a GP, but will instead be seen by, for example, an allied health professional. The impact that this will have on the rate of emergency admissions and readmissions remains unclear.
Table 1: Summary of policy developments likely to impact on delayed discharge

<table>
<thead>
<tr>
<th>Year</th>
<th>Policy Developments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>• Definition of delayed discharge from NHS care.</td>
</tr>
</tbody>
</table>
| 2000 | • Learning network to share and disseminate ‘good practice.’  
      • Mandatory national data recording system for delayed discharge.  
      • ISD census on delayed discharge.  
      • Adults with Incapacity (Scotland) Act. |
| 2001 | • Guidance on single shared assessment for community care needs.  
      • Regulation of Care (Scotland) Act - national care home standards. |
| 2002 | • Report from the Chief Executive of NHSScotland.  
      • Release of 2002/03 funding.  
      • 2002/03 Joint Action Plans.  
      • Community Care and Health (Scotland) Act - free personal care. |
| 2003 | • Release of 2003/04 funding.  
      • 2003/04 Joint Action Plans.  
      • White Paper ‘Partnership for Care.’ |
| 2004 | • Choice of accommodation – discharge from hospital guidance.  
      • Implementing the new GMS contract in Scotland  
      • Policy review and commission of research review. |

AIMS AND OBJECTIVES OF THE RESEARCH REVIEW

1.16 The Scottish School of Primary Care was commissioned by the Scottish Executive Health Department to conduct this research review to inform the current review of policy on delayed discharge. The main aims of the research review were to:

- review delayed discharge Joint Action Plans and any other information to identify initiatives to tackle delayed discharges in Scotland;
- set the information on action on delayed discharges in Scotland in the context of current policy and existing evidence on the nature and extent of the problem and on ‘good practice’ in tackling delayed discharge.
1.17 The specific objectives of the research review were to:

- review current delayed discharge Joint Action Plans from the 15 Partnerships in terms of the initiatives being developed and what is known about their effectiveness;
- review any further information on delayed discharge to identify as far as possible the full range of action to tackle this issue in Scotland;
- review existing research literature on delayed discharge;
- examine the evidence in terms of the following key themes:
  - preventing emergency admissions;
  - the assessment process;
  - the availability of care home places;
  - care at home;
- describe the scope of the existing research and identify significant gaps;
- outline the nature and extent of the problem of delayed discharge in Scotland at the local and national level (and in comparison with other countries as appropriate);
- outline what is known from the literature about ‘good practice’ in tackling delayed discharge;
- consider the extent to which existing Joint Action Plans reflect ‘good practice’ and are likely to achieve a longer term reduction in delayed discharge;
- in light of the research review, outline the implications for policy on delayed discharge and any changes in practice and further actions which could be taken to reduce delayed discharge.

METHOD OF RESEARCH REVIEW
1.18 This research review was carried out in eight weeks and draws on four different sets of information in order to identify key areas that need to be addressed for delayed discharges to be tackled long term:

- UK and international literature;
- ISD data;
- Scottish Joint Action Plans on delayed discharges; and
- a small number of snapshot interviews with Scottish health and social care professionals.

Literature review
1.19 The main purpose of the literature review was to find evidence on the nature and extent of delayed discharges, and on ‘good practice’ in tackling delayed discharges. A number of health and social care databases were searched (Annex 1). Most of the papers included in this research review relate to delayed discharges in the UK, with a minority of papers reporting the findings of studies conducted in Australia, North America and Scandinavia. Papers that had ‘delayed discharge’ or ‘bed blocking’ in the title or abstract were searched for because the focus of the review was on initiatives that impacted on delayed discharge. In addition, papers that were already known to the research team for example, a review of ‘hospital at home’ schemes and references to intermediate care were included. It is likely that more relevant information would have been found if the search terms had been widened to include for instance, papers on specific initiatives to tackle delayed discharges such as the role of liaison nurses and intermediate care. Unfortunately, extending the search terms was not possible in the time given to conduct the research review.
1.20 The criteria for inclusion in this research review were original data or discussion papers relating to reasons and solutions for delayed discharges that had been published between 1984 and 2004. All documents were read by one of the authors of this research review and summarised using a similar pro forma to that adopted by Glasby et al. (2004). The pro forma included the following details:

- Author(s)
- Data of publication
- Publisher
- Brief summary if appropriate
- Main findings (causes of, and/or solutions for delayed discharge).

If the paper was reporting original data the following information was also included:

- Research question
- Design
- Setting
- Population/participants
- Methods
- Outcomes

1.21 In order to provide an understanding of the type of literature included in this research review documents were catalogued using a typology set out in a recent review of literature on delayed discharges of older people by Glasby et al. (2004:10) and previously outlined in the National Service Framework for Older People (Department of Health 2001a):

- **Type A Evidence:**
  - (A1) Systematic reviews which include at least one Randomised Control Trial (RCT).
  - (A2) Other systematic and high quality reviews which synthesise references.

- **Type B Evidence:**
  - (B1) Individual RCTs.
  - (B2) Individual non-randomised, experimental/intervention studies.
  - (B3) Individual well-designed non-experimental studies.

- **Type C Evidence:**
  - (C1) Descriptive and other research or evaluation not in B.
  - (C2) Case studies and examples of good practice.

- **Other:**
  - (D) Summary review articles and discussions of relevant literature and conference proceedings not otherwise classified.
  - (P) Professional opinion based on clinical evidence or reports of committees.
  - (U) User opinion.
  - (C) Carer opinion. ’

1.22 Chapters 2 and 3 include tables that show both the volume and type of documents that were used to draw conclusions about tackling delayed discharges.

**Scottish Joint Action Plans**

1.23 The main purpose of analysing Scottish Joint Action Plans for 2003/04 was to find out how Partnerships were tackling the problem of delayed discharge. Since 2002, Joint Action Plans to tackle delayed discharges have been presented annually to the Scottish Executive
Health Department by the 15 local authority and Health Board Partnerships. Grampian Partnership also provided Joint Action Plans for Aberdeen City, Aberdeenshire and Moray and these have also been included. Thus 18 Joint Action Plans in total were included for this research review.

1.24 The Joint Action Plan was a pro forma developed by the Scottish Executive Health Department. Partnerships were requested to provide information on delayed discharge numbers and on the following:
1. ‘Current extent and nature of the problem or delayed discharges in your area – brief overview.
2. Key constraints, over the next 12 months, to maintaining and improving this position and plans for dealing with these.
3. Range of measures planned to reduce delayed discharge.
5. When will these measures be implemented and by whom?
6. What impact will your plan have on overall delayed discharge numbers and on number in acute sector and waiting over a year?
7. What plans do you have to provide additional convalescent care services?
8. Will any of these measures affect NHS capacity and if so, how? Do you intend to buy more care homes places?
9. What do you think is a realistic set of targets for your Partnership to achieve for delayed discharge?
10. How do you intend to monitor the implementation of the Action Plan?
11. What progress have you made with capacity planning and whole systems work in your Partnership area?’

1.25 They were also requested to complete a summary table outlining which initiatives they were going to introduce or develop to tackle delayed discharges using money from the 2003/04 annual funding stream. A handful of Partnerships supplemented their Joint Action Plan with additional information. Joint Action Plans and additional information were compared and analysed by the authors of this research review using the following framework:
• Reasons for delayed discharges.
• Responsibility for planning, managing and monitoring delayed discharges.
• Types of initiatives to prevent delayed discharges.
• Initiatives to increase residential care home capacity.
• Impact of initiatives on tackling delayed discharges.
• Targeted groups of the population to tackle delayed discharges.

Snapshot telephone interviews
1.26 The main purpose of carrying out snapshot interviews with health and social care professionals responsible for some of the initiatives being introduced to tackle delayed discharge in Scotland was to find out about these initiatives in more detail. Staff at Community Care Works, University of Glasgow carried out five interviews. Examples of initiatives that had tackled delayed discharge were identified from the Community Care Works Database of Good Practice. Examples on this database have been scrutinised by a good practice panel comprising representatives from health, social work, housing, supporting people, the voluntary sector, users and carers. These examples were examined to identify if they had any element of evaluation or clear evidence of effectiveness. Where this was the case, the named contacts were telephoned for interview for the purposes of this research review. The focus of these interviews was to establish the current status of the initiatives,
what, if any, methods of evaluation were currently being used and to identify how and if
reductions in delayed discharge numbers could be directly attributed to the initiative under
discussion. In addition, the interviews attempted to establish whether the delayed discharge
initiatives took a whole systems approach to the issue and how this was achieved. In
addition, three telephone snapshot interviews were carried out by the authors of this research
review, who randomly contacted named professionals listed on some of the Joint Action
Plans responsible for specific initiatives to tackle the problem of the delayed discharge in
their region. The following framework was used during the telephone interview:
• Organisation (for example, social work, primary care, acute care).
• Title of initiative.
• Contact details.
• Short description of the initiative.
• Impact on delayed discharge if known.
• Evidence (for example, external or in-house evaluation, anecdotal).
• Initiative’s link to the whole system of care.

1.27 Unfortunately, because of the time scale of this research review it was not possible to
carry out more interviews and gather all of the published information discussed during the
interview. However, these interviews suggest that evidence of impact, at least for some
initiatives, has been collected at local level. This evidence could be usefully shared between
Partnerships with a view to improving ways of tackling delayed discharges.

ISD information
1.28 The main purpose of including ISD information was to briefly outline the extent of
the problem of delayed discharge in Scotland. ISD information for this research review
included a working paper on preventing emergency admissions (Kendrick & Conway, 2003).
This paper sets out existing evidence on the nature and extent of the problem of rising
emergency hospital admissions in Scotland and is summarised in chapter 2. Rising
emergency admissions may impact on delayed discharge because it means that more people
are entering the care system thus increasing demand on services. At the time of conducting
this research review, ISD were also analysing the relationship between admission diagnosis,
previous history of hospital admission and the probability of experiencing delayed discharge,
and a summary of their findings has also been included (ISD, 2004b). ISD also publishes key
reasons for delayed discharges in different Health Boards and the graphs included in chapter
2 show that these reasons vary. A detailed discussion of census data was not included in this
research review because it has already been reported elsewhere (ISD, 2004a).

SCOPE OF THE RESEARCH REVIEW
1.29 Information on the numbers of people experiencing a delayed discharge and lists of
initiatives to tackle the problem has been published (ISD, 2004a; National Audit Office,
2003; Epstein et al. 2001; Koffman et al., 1996). The main aim of this research review is to
identify initiatives that have evidence of impacting on delayed discharge. To do this the
research review takes an overview of:
• how the problem has been identified and solutions attempted;
• how impact has been monitored and evaluated;
• evidence of initiatives to tackle delayed discharges;
1.30 The final conclusions suggest that there is no ‘quick fix’ to the intractable problems of delayed discharge. However, some approaches offer promise. These approaches are likely to:
- target those most at risk of either emergency admission or delayed discharge;
- plan flexible, integrated services to both reduce emergency admissions and delayed discharge; and
- use monitoring information about the impact of services, and evaluations of initiatives to effect further quality improvement.

1.31 This research review can inform Scottish Executive guidance to multi-agency Partnerships regarding the systems that may be useful to put in place to ensure sustainable and long-term strategies to tackle the problem.
SUMMARY OF KEY POINTS

• It is not known if consultants and other health and social care professionals in Scotland use different criteria to determine if a patient is ‘ready for discharge’ and if they do, whether this has a significant impact on the numbers of people designated as a delayed discharge in different Partnerships. Further research around social and medical criteria for judging when a patient is ‘ready for discharge’ both within and between Partnerships would be useful. Due to the lack of clarity about criteria for determining a delayed discharge it is difficult to accurately compare research findings reporting the numbers of delayed discharges and compare the number of delayed discharges in different Partnerships in Scotland.

• A combination of individual, medical and organisational factors interact to put people at risk of delayed discharge. The literature review identifies that older people, those with multiple pathology, and those with some specific conditions (such as neurological deficit and stroke) are most at risk. Studies suggest that patients waiting for a place in their first choice of care home to become available, and patients who did not have a companion to escort them home were also likely to be delayed.

• The literature review highlights that some medical conditions appear more likely to lead to a delayed discharge for all age groups and that this is often because there is a lack of alternative care facilities available for these particular people. In other words, it is not the clinical condition per se, which causes the delay, but how organisations are managing services to care for these particular clinical groups. Problems within both health and social care organisations have been attributed with causing delayed discharges. Organisational factors associated with delay include: (i) lack of home support, (ii) unavailability of convalescent or rehabilitation facilities, (iii) waits for community care needs assessments or home care packages. Studies show that some patients admitted as an emergency were more likely to have a delayed discharge compared to elective admissions, and that people with severe mental illness admitted for planned short hospital stays were less likely to have a delayed discharge compared to those who were admitted as long hospital stays and in receipt of standard care.

• Whilst the Joint Action Plans of most Scottish Partnerships focussed on older people, they were not explicit about targeting particular groups of older people most at risk, nor about if, and which high risk groups of the population, besides older people, were being targeted to tackle delayed discharges. This may be because Joint Action Plans did not specifically request this information. However, it would be useful to know whether Partnerships were targeting high risk groups and what initiatives they were developing to facilitate their discharge.

• Scottish Partnerships reported that the main causes of delayed discharge were insufficient care home places, lack of community-based care, and the slowness of assessment for community-based care. In other words, problems within social services were perceived as the main cause of delayed discharges.
Most Partnerships did not make explicit the relationship between causes of delayed discharges and the initiatives that they were introducing to tackle delayed discharges. This may be because the design of the form did not explicitly request this information rather than reflect a lack of planning on behalf of the Partnerships.

2.1 This chapter draws on information provided in Joint Action Plans, ISD data and documents found through the literature search to identify reasons for delayed discharges. Table 2 shows the volume and type of document (outlined in the introduction) upon which recommendations for identifying the problem of delayed discharges and matching solutions are based. Thirty-two documents, the majority of which report original research findings have been included.

Table 2: Volume and type of documents relating to reasons for delayed discharges

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2.2 Analyses of a recently published working paper by Steve Kendrick and Mags Conway of ISD in relation to emergency admissions may shed light on recent increases in delayed discharges in Scotland (Kendrick & Conway, 2003). The working paper is part of the ‘Whole Systems Project’ managed by ISD (ISD, 2003b), which focuses on how health and social care functions as a whole system and aims to examine for example, how changes in society or in one part of the care system impacts on other parts. This approach is in line with current policy, which aims to place ‘greater emphasis on systems of care’ (Scottish Executive, 2003b).

2.3 The paper shows that there have been steadily rising numbers of people aged 80 years old and over admitted to hospital as an emergency and that those who were admitted 3 or more times in a single year made a disproportionate contribution to the overall increase in the use of inpatient beds. The diagnosis that is increasingly common amongst this group upon admission is very broad and coded ‘signs and symptoms.’ The ‘signs & symptoms’ codes can be summarised using the World Health Organization's International Classification of Diseases 10th Revision and includes cardiac murmur, cough, chest pain, abdominal pain, difficulty walking, dizziness, confusion, malaise and fatigue, syncope and collapse (World Health Organisation, 1992).

2.4 Kendrick and Conway suggest that demographic, social and organisational factors contribute towards explaining the problem. They point out that there are rising numbers of people aged 80 years old and over in Scotland, many of whom live alone without the support of an informal carer. They also suggest that organisational changes such as a decline in NHS long-stay beds and lack of care home places means that increasing numbers of older people are living at home, although the decline in long-stay beds preceded recent increases in emergency admissions. They hypothesise that primary care and social care may not have the capacity to care for these older people at home, which is why there has been an increase in the number of emergency admissions for this group of the population. The authors conclude their report by recommending a whole systems approach where all health and social care agencies collaborate to provide seamless care on a continuing and preventative basis.
2.5 Thus, like emergency admission, the problem of delayed discharge is likely to have arisen from the interaction of a number of factors, some of which are not well understood or for which poor evidence exists. Demographic and social changes as well as organisational features of care systems are likely to be important. This research review adopts a broad view of the possible reasons for, and response to, delayed discharges in order to support Scottish Partnerships in their consideration of policies and services to address the problems. The research review cannot identify all key factors and their impact on delayed discharges. As will become evident, this information is simply not available. Rather, this chapter highlights what kinds of information are useful for identifying some of the main causes of delayed discharges in order to tackle the problem.

**WHAT IS A DELAYED DISCHARGE?**

2.6 ISD presented the following definition of delayed discharge that was mandatory for NHSScotland:

“where a patient remains in hospital after his/her clinical readiness for discharge has been determined by the lead clinician in consultation with all agencies involved in planning that patient’s next stage of care. The date on which the patient is judged clinically ready for discharge is the *ready for discharge* date” (ISD, 2000).

2.7 However, establishing a clear definition is only the first step towards reaching an agreed and common measurement of the number of delayed discharges. Issuing a definition does not guarantee that it will be used; the National Audit Office for England and Wales found that only 27% of Trusts were following a national definition of what constitutes a delayed discharge in 2002 (National Audit Office, 2003). In addition, some researchers have suggested that deciding when a patient is ‘ready for discharge’ is an inherently subjective judgement and lead clinicians and agencies may use different criteria for making that decision (Glasby et al. 2004; Styrborn and Thorsland, 1993a,b; Vetter, 2003). Others have pointed to a discrepancy, which is that discharge planning is often a nursing function; yet medical staff determine when a patient is ready for discharge (Armitage and Kavanagh, 1996). The authors point out that ‘medical readiness for discharge may not necessarily coincide with nursing readiness for discharge’ (p.220). It is not known if consultants and other health and social care professionals in Scotland use different criteria to determine if a patient is ‘ready for discharge’ and if they do, whether this has a significant impact on the numbers of people designated as a delayed discharge in different Partnerships. Further research around criteria for judging when a patient is ‘ready for discharge’ both within and between Partnerships would be useful. Due to lack clarity about criteria for determining a delayed discharge it is difficult to accurately compare research findings reporting the numbers of delayed discharges and compare the number of delayed discharges in different Partnerships in Scotland.
WHO IS AT RISK OF DELAYED DISCHARGE AND WHY?

Diagram 1: Intersection of predictive indicators of risk of delayed discharge

2.8 There is no conclusive evidence to demonstrate that a deficit in one part of the care system, for example, within social care or the acute sector is causing delayed discharges. This is why recent research has tended to highlight a combination of contributory factors. For example, an editorial in the British Medical Journal suggests that individual, medical and organisational factors are likely to cause delayed discharges (Black and Pearson, 2002). A study of delayed discharges of people aged 75 years old and over in three hospitals in England shows that ‘individual’ and ‘organisational/administrative’ factors were associated with delayed discharge (Victor et al., 2000). The individual factor was whether or not the older person had a family carer to support them after their discharge from hospital. Those that did not have a family carer available were more likely to have a delayed discharge. Two ‘organisational/administrative’ factors were associated with delayed discharge. Firstly, delays in assessment procedures and waiting lists for care homes was associated with delayed discharge, which meant that people who were going to be transferred to a care home were more likely to have a delay. Secondly, the composition of the discharge assessment team also influenced whether or not a person would have a delayed discharge. People managed by nurse-led teams experienced the longest delay.

Individual factors associated with a delayed discharge

2.9 Individual factors associated with a delayed discharge are broad ranging and include personal choice, age, emotional disposition and personal support from family and friends.

2.10 A pilot of a data collection form in Birmingham concludes that the greatest number of reasons for delayed discharge fall into the categories outside the responsibility of the hospital or social services (Roberts and Houghton, 1996) for example, patients and/or relatives refusing to accept temporary alternatives to their first choice of care home. Through exercising choice patients remain in hospital until their first choice of care home becomes available thus delaying their discharge.

2.11 The literature indicates that age is the strongest predictor of delayed discharge. It is widely accepted that older people are most at risk of delayed discharge, but a UK study suggests that those with multiple pathology, physical disability, stroke, incontinence and dementia were more likely to experience delayed discharge than other older people (Victor et al., 2000). Recent Australian research shows that the average length of stay (not necessarily inappropriate) was four times greater for people aged 65 years old and over with dementia than for all other people (McCormack, 2002), whilst in New Zealand, a prospective study of all patients who were 15 years old and over admitted to acute medical beds found that people over 75, living alone and who were admitted with a ‘cerebrovascular problem’ (associated
with stroke) were more likely to have a prolonged length of inappropriate stay (Lewis and Purdie, 1988). A study of people aged 64 years old and over in Sweden suggests that this group of the population are more likely to experience new medical problems requiring treatment after they have already been declared ready for discharge, thus further exacerbating and complicating their discharge from hospital (Styrborn and Thorsland, 1993a).

2.12 In Scotland, preliminary analyses undertaken by ISD to investigate relationships between admission diagnosis, previous history of hospital admission and the probability of experiencing delayed discharge broadly confirm this picture for Scotland (ISD, 2004b). The study suggests a strong relationship between age and the likelihood of experiencing delayed discharge (1.3% of patients aged 65 to 69 experienced delays compared with 9.5% of those aged 90 years old and over). Women were more likely to experience delayed discharge than men especially in the older age groups. The rate of delayed discharge was strongly associated with diagnosis. In terms of broad groups of diagnosis the rate was highest among those diagnosed with ‘other circulatory disorders’ (mainly stroke) and ‘mental disorders and diseases of the nervous system.’

2.13 Other individual factors that have been found to influence whether a person will experience a delayed discharge is the patient’s and their carer’s emotional disposition and if the patient has a companion to escort them home once they are ready for discharge. There is very limited evidence that a person’s emotional disposition may influence whether or not a delayed discharge is likely. For example, a study of factors associated with delayed discharge in school-aged children undergoing minor day-case surgery found that older children and those who had operations later in the day were most likely to experience a delayed discharge. The study also found that children who were less happy about going to school and those who were worried about having the operation beforehand were also more likely to have a delayed discharge; although these factors were not as significant for predicting which children were likely to experience a delayed discharge as age and time of the operation (Glazebrook and Sheard, 1994). A study of factors that delay discharge after home readiness criteria are satisfied after ambulatory surgery found that just over 50% of people were delayed because their companions were not immediately available to take them home (Chung, 1995).

Medical and organisational factors associated with delayed discharge

2.14 The literature highlights that medical and organisational factors are likely to cause delay. In other words, it is often not the clinical condition per se that causes the delay but how organisations are managing services to care for these particular clinical groups. Problems within both health and social care organisations have been attributed with causing delayed discharges. For example, a recent review of studies on the rate and causes of delayed discharges for older people in the UK concludes that a key issue was related to internal hospital factors as opposed to shortfalls within social care, although these shortfalls accounted for some (Glasby et al., 2004).

2.15 Organisational factors associated with delay include:
- lack of home support,
- unavailability of convalescent, nursing or rehabilitation facilities,
- waits for community care needs assessments or home care packages.

2.16 A Canadian prospective observational cohort study of 130 patients who had undergone an elective thoracic surgical procedure found that the three most frequent medical
complications that prevented discharge were persistent air leaks, pulmonary infections and atrial fibrillation. The study also found that lack of home support and the unavailability of convalescent facilities prolonged hospital stay. The researchers concluded that medical and non-medical factors significantly delay discharge (Irshad et al., 2002). An Oxford-based three month prospective analysis of patients deemed to have a delayed discharge found that the majority of people between the ages of 18 and 70 whose discharge was delayed had a cognitive impairment and/or neurological disability and that this was mainly because there was no suitable accommodation available for these people (Carter and Wade, 2002). A retrospective cohort study of 2232 people admitted for acute stroke in 13 hospitals in Canada found that the majority of stroke patients remained in hospital after meeting criteria for medical discharge and that the main reason for this was lack of alternative care, including nursing facilities and rehabilitation centres (Mayo et al., 1997). Several English studies highlight that the main reasons for delayed discharges were waits for social services assessment or home care packages (Vaughan and Withers, 2002), lack of rehabilitative facilities (Koffman et al., 1996) and waiting for a place in a residential home (Moore, 2002).

2.17 The literature review also highlights a small number of studies suggesting that other organisational factors, for example, if people are an emergency or elective admission and if they are a planned short stay admission or a long stay admission, may influence whether or not people are likely to have a delayed discharge. A prospective audit of delays on a surgical unit for instance, shows that people who were admitted to hospital as an emergency admission experienced greater delays than elective admissions. This led to the introduction of a new rota whereby surgical teams put elective commitments to one side for the week they are on call to manage emergency admissions (Schwanhaeuser et al., 2002). The cost effectiveness and impact of this new rota on delayed discharges however, was not reported. A systematic review of all randomised controlled trials comparing planned short hospital stay with long hospital stay or standard care for people with serious mental illness showed that people allocated to planned short hospital stays had no more readmissions and more successful discharge on time (Johnstone and Zolese, 1999).

2.18 Thus a combination of ‘individual’ factors, most notably age and ‘medical’ factors such as the presence of multiple pathology, and ‘organisational’ factors, most notably lack of alternative forms of care facilities, put people at risk of delayed discharge. Although the categories ‘individual,’ ‘medical’ and ‘organisational’ may be interpreted in different ways, they are concepts that help to distinguish between factors that are primarily associated with a person’s personal and social situation, medical procedures and clinical conditions, and the ways in which health and social care organisations’ function. A challenge for Partnerships in Scotland is to find out the extent to which these factors cause delayed discharges in their local care systems.

ARE THE RIGHT PEOPLE BEING TARGETED IN SCOTLAND?

2.19 Joint Action Plan forms did not explicitly request information about whether Partnerships were targeting specific groups of the population to tackle delayed discharges. A review of Joint Action Plans, however, shows that many Partnerships had specifically identified older people as at risk of delayed discharge although it was not always specified who came under this category. Lanarkshire, Orkney and Borders Partnerships placed the problem of delayed discharge in a demographic context by highlighting significant increases in the older population in their region. Borders Partnership, for example, claimed the highest rate of over 75s in the UK; Orkney Partnership claimed that their population of ‘frail older people’ was increasing more rapidly than any other Health Board area. In addition, the
Ayrshire and Arran, Lanarkshire and Lothian Partnerships noted that older people were the biggest group of the population that experienced delays. At a Lanarkshire presentation on ‘Delayed Discharge and Integrated Services,’ graphs showing predicted growths in the number of people aged over 75 in three localities between 1998 and 2011 were used to highlight the importance of targeting older people to tackle delayed discharges (ISD 2003c). These figures are presented in the graph below.

Graph 1: predicted growths in the number of older people in Lanarkshire

2.20 Some Partnerships either directly or indirectly involved older people’s planning groups to tackle delayed discharge. For example, Greater Glasgow’s whole system approach to planning, managing, and monitoring delayed discharges was the responsibility of the Greater Glasgow North/South Elderly Planning Group who was also responsible for presenting the Joint Action Plan. Finally, some Joint Action Plans were not explicit about identifying older people as at risk, but the initiatives listed to tackle delayed discharges were specifically designed for older people. For example, in all three Grampian areas (Aberdeen City, Aberdeenshire and Moray) a Community Geriatrician was being appointed to carry out Geriatric Assessment in the community as opposed to within hospital.

2.21 A minority of Partnerships was targeting particular groups of the population besides older people. Lothian Partnership’s Joint Action Plan described the introduction of initiatives for people with brain injury, mental illness and/or learning disabilities who were waiting to be discharged for more than one year. Lothian suggested that the main reason for delay for these people was lack of appropriate facilities in community settings. A Specialist Unit to facilitate intensive rehabilitation and discharge planning for people with mental health difficulties was being introduced. Ayrshire and Arran Partnership were introducing a deep vein thrombosis pilot that was being managed by the hospital trust with a view to preventing hospital admission and reducing delayed discharge. Dumfries and Galloway and Highlands Partnerships were developing community support services for mental health. Orkney and Shetland Partnerships were specifically targeting people with dementia.
ARE THE MAIN REASONS FOR DELAYED DISCHARGE BEING ADDRESSED IN SCOTLAND?

2.22 An important step towards tackling delayed discharge is to identify factors that cause a delay (Mitchell et al., 1993). The main reasons for delayed discharges are likely to vary between different regions in Scotland (ISD, 2004a) and health professionals may have different explanations for why delays occur (Minichiello et al., 2001). Expressed reasons for delay suggest variation by Health Board areas and that reasons may vary over time. This is illustrated by a comparison between expressed reasons for delayed discharges between Ayrshire and Arran and Borders between January 2001 and July 2003 (ISD, 2003c). Reasons are presented in the graphs below.

Graph 2: delayed discharge by reason for delay January 2001 to July 2003 in Borders and Ayrshire and Arran
2.23 All Scottish Partnerships reported what they believed were the main causes for delay in their Joint Action Plans. However, it was not clear what evidence they were using to identify causes for delay, or how robust and relevant the information was. All key reasons for delay identified by Partnerships related to gaps in care provided in community settings. In other words, problems within social services were identified as mainly responsible for delayed discharges. These reasons fell into three main categories:

- **All Partnerships believed that insufficient care home places were a major reason for delay.** Some Partnerships also mentioned that people were being delayed in hospital as they awaited their first choice of placement in a care home to become available. However, recently issued guidance may help to alleviate this problem in the future because people will be expected to identify three care homes that they will be willing to move to, and also wait in an interim care home until a place becomes vacant rather than in hospital (Scottish Executive, 2003c). Decision-making about moving to a care home needs to be conducted sensitively, particularly since some people may not have had the opportunity to find out about care homes before they entered hospital to enable them to make a choice.

- **Many Partnerships highlighted problems with delivering community-based care which compounded pressures on the acute sector.** Community-based care was unable to meet demand because of, for example, budgetary constraints for providing care at home, lack of community geriatrician support, problems with recruiting and retaining staff, and problems with housing and equipment. Some Partnerships also mentioned that there was no intermediate/step down facility or community hospital, which meant that people remained in the acute sector because there was nowhere else for them to be transferred to.

- **6 Partnerships felt that assessment for community care needs was too slow.**
2.24 Other reasons identified by Partnerships included the following:
- Adults with Incapacity (Scotland) Act - awarding of Guardianship orders was slow and thus delayed patient transitions to other parts of the care system;
- rising admission rates to acute hospitals - explicitly expressed as a main cause for delayed discharges by Grampian – Aberdeen city, although many Partnerships were introducing initiatives to prevent hospital admissions;
- general lack of finances - for example, according to Grampian – Aberdeenshire, uptake of free personal care from self-funders had significantly cut into the Care Management Budget.

2.25 Perhaps because of the design of the Joint Action Plan form it was difficult to tell from the majority of Joint Action Plans whether Partnerships were developing initiatives to tackle what they perceived as the main reasons for delayed discharges. On the other hand, some Partnerships were attempting to clarify how they were going to address the problem of delayed discharges by explaining the purpose of each initiative or the initiatives as a whole, as shown below;

- Ayrshire and Arran Joint Action Plan described whether initiatives were designed to reduce hospital admission, facilitate hospital discharge and/or prevent re-admission. For example, the purpose of North Ayr Speedy Action Consolidation was to prevent hospital admission and facilitate hospital discharge;
- Grampian – Aberdeen City Joint Action Plan described how initiatives would impact on discharge. For example, they anticipated that rehabilitation facilities would prevent admission to hospital and ease early discharge from hospital;
- Greater Glasgow Joint Action Plan focussed on two key drivers: rising hospital admissions and weaknesses in the discharge process. All initiatives listed in their Joint Action Plan related specifically to either preventing hospital admissions and/or providing timely discharge.
- Lothian Joint Action Plan prioritised action for tackling delayed discharges. Their first priority was to increase the supply of care home places; second, to ‘target therapeutic services on individuals for whom a better clinical outcome could be achieved;’ third, to make more effective use of community care capacity; fourth, to develop schemes that have already been ‘tried and tested.’ However, it was not always possible to categorise their listed initiatives within one of more of these priorities.

2.26 It was not clear from the majority of Joint Action Plans whether initiatives listed by Partnerships were being introduced and/or developed to tackle what were perceived as the main causes of delayed discharge. As suggested, this may be because of the design of the form rather than because local Partnerships have not acted logically in the design of their services. However, it would be useful if more Partnerships made more explicit their rationale for introducing and developing each initiative or group of initiatives and related these to causes of delayed discharges that they had already identified. For example, were Partnerships that identified lack of step down community facilities as a main reason for delay, introducing step down facilities and what impact did they foresee on delayed discharges by developing the initiative? This approach to planning may help Partnerships to identify goals and to focus on how these goals were going to be achieved.
CHAPTER 3 – EVALUATING AND MONITORING IMPACT IN SCOTLAND

SUMMARY OF KEY POINTS

- Examples of ‘good practice’ such as those described in the Scottish Executive ‘learning network’ do not usually include evidence of effectiveness. However, without this information it is difficult to assess how and why initiatives have been successful.

- Partnerships did not make it clear if the initiatives that they were introducing to tackle delayed discharge were based upon external evidence of the effectiveness of similar initiatives elsewhere, or whether evidence of effectiveness of initiatives was locally collected and available. This is likely to be because the Joint Action Plan form did not request this information. However, without this information it is difficult to know the extent to which initiatives are being introduced that already have evidence of effectiveness.

- There were several reasons why it was difficult to assess how Partnerships were monitoring delayed discharge. This was because Partnerships were not requested to explain on the Joint Action Plan: (i) what information systems they had in place to monitor delayed discharge, (ii) what data was being collected to monitor delayed discharge, (iii) what targets were being used to measure success, (iv) how people using services were being counted.

- Measures appropriate to maintaining a national overview of the situation such as the numbers of delayed discharges may be too broad for evaluating the impact of local initiatives. Instead, outcome measures that relate to the role of specific initiatives need to be identified. Evaluating the impact of an initiative and the combined impact of initiatives is necessary for a whole systems perspective.

3.1 This chapter discusses the extent to which initiatives to tackle delayed discharges were being monitored and evaluated in Scotland. For the purpose of this research review, monitoring impact is defined as a process whereby data on delayed discharges is analysed in order to find out if, and by how much, the number of people having a delayed discharge has gone up or down. ISD carries out a quarterly census of delayed discharges so that figures are monitored on a regular basis in Scotland (ISD, 2004a). An evaluation is defined as an investigation that aims to find out how initiatives have impacted on delayed discharges and may also include an exploration of why initiatives have had an impact. Both monitoring and evaluation are useful for developing strategies to plan, manage and deliver initiatives to tackle delayed discharges in the long term and should ideally be carried out as a matter of course.

3.2 The English Department of Health (2003), National Audit Office (2003) and Scottish Executive (2001a) provide a rich and comprehensive range of practical initiatives to tackle the problem of delayed discharges. However, actual evidence of the impact of these initiatives is often missing, which makes it difficult to understand how and why they have been successful.
INFORMATION SYSTEMS TO MONITOR DELAYED DISCHARGE

3.3 All Joint Action Plans outlined which agency was responsible for monitoring the impact of initiatives on delayed discharge. The strategic level multi-agency Partnership was usually designated with responsibility with support from local partnership groups. Some Partnerships were also creating specific posts to provide information. Forth Valley Partnership for example, had created a new post. One of the responsibilities of the ‘delayed discharge nurse’ was to find and provide information about people who were delayed which would be reported to the strategic Partnership group.

3.4 However, assessing how effective Partnerships were in monitoring delayed discharges was problematic for several reasons. This was because Partnerships were not requested to explain in the Joint Action Plans:
- what information systems they had in place to monitor delayed discharge;
- what data was being collected to monitor delayed discharge;
- what targets were being used to measure success;
- how people using services were being counted.

3.5 Partnerships were not explicit about what information systems they had in place to monitor delayed discharges and it may be the case that some information systems were more robust than others (Vetter, 2003). Tayside Partnership, for example had electronic management systems that tracked delayed discharges and enabled them to monitor delayed discharge daily. Reports using these data were disseminated monthly to the strategic level multi-agency group. This kind of daily delayed discharge tracking may have provided more detailed information and thus given real-time insight into where most bottlenecks were arising, which in theory would enable Tayside Partnership to target particular parts of the care system and specific groups of people more accurately and quickly.

3.6 Another reason it was difficult to assess how well Partnerships were monitoring delayed discharges was because it was not clear what data Partnerships were collecting and using. A Scottish pilot study for instance, noted information deficits for evaluating the role of community hospitals (Urquhart et al., 2002) and there may be similar information deficits in relation to tackling delayed discharge. For example, primary care and social care services are likely to be key to preventing hospital admission and to enabling people to experience an early or timely discharge. It seems sensible therefore, to include information about these community-based services and track patient utilisation of services across agency boundaries so that an overview of the whole care system is used to tackle delayed discharges. However, it was not possible from the Joint Action Plans to comment on whether, and the extent to which, Partnerships used data from a range of sources to monitor delayed discharges.

3.7 Thirdly, it was not clear what targets Partnerships were using to measure success. Greater Glasgow Partnership for example, considered several different ways of setting targets, for example:

1. ‘high level – by selecting a level for target improvement e.g. 10%;’
2. ‘plan based – assess the likely impact of each individual component of the new Joint Action Plan and aggregate to provide the new target;’
3. finance driven – by selecting a level for target improvement based on estimated cost of tackling the problem;
4. ‘hospital/Trust derived – based on closer analysis of the performance across individual hospitals or Trusts with differential specific targets sets accumulating to the GGNHS overall target;’

5. ‘reason for delay analysis – over 60% are for reasons associated with access to care homes. 14% due to issue with assessment and 10% for housing reasons. Target is calculated on basis of estimated plan impact on specific reasons.’

3.8 Fourthly, it was not clear how people using services were being counted. Different Partnerships may count the number of people using an initiative in different ways. For instance, a Lanarkshire rapid response team only counted a person if their assessment led to providing a service whereas other rapid response teams counted all people seen by the team irrespective of whether or not a service was then provided. If success was measured by the number of people seen by a team then the latter would be perceived as the most successful. Moreover, the interviewee who made this point also believed that it was difficult to compare initiatives because Scottish Partnerships used different names for almost identical initiatives, for example ‘it may be called a rapid response team here but an early supported discharge team elsewhere.’

3.9 A report in the literature search highlights that some areas in Scotland were effective in using monitoring data to improve care. West Lothian Healthcare NHS Trust and West Lothian Council had joint community planning and a shared data set that summarised the reasons for delay and the bed days lost (Gabbitas, 2002). This data set was reviewed every month at a meeting that included the Chief Executive of the Healthcare Trust, Director of Housing and Social Work, key clinicians and frontline staff. According to the Chief Executive of the Healthcare Trust, this enabled four key areas for minimising delayed discharge to be identified which were: (1) developing alternatives to hospital admission, (2) reducing hospital admissions, (3) managing admissions and discharges (4) care home placements. This monitoring information was then translated into service developments including: investment in smart home technology, introduction of discharge co-ordinators, and interim care home placements. According to the Chief Executive, the result of these initiatives was a general decline and stabilisation in the volume of delayed discharges. Likewise, the Elderly Persons Integrated Care System in South Buckinghamshire stressed the importance of information systems to undergird service development and delivery (Foote and Stanners, 2002). For instance, older people most ‘at risk’ of needing care could be identified, which was a useful way of prioritising the time and resources of the teams when an older person required help to avert or manage a crisis.

EVALUATING IMPACT OF INITIATIVES

3.10 Joint Action Plans were not specifically designed to inform about whether or not initiatives listed to tackle delayed discharge were either based upon external evidence of effectiveness of similar initiatives elsewhere, or whether evidence of effectiveness of services was locally collected and available. However, the Joint Action Plan form did ask for an estimate of anticipated impact of initiatives on delayed discharge and some of the Scottish Partnerships provided this information. For example, all of Lanarkshire initiatives had an estimated impact figure whereas none of the initiatives for Tayside and Forth Valley Partnerships specified impact. This suggests that it may be difficult to estimate the impact of individual initiatives and also that indicators for assessing effectiveness have not been identified.
3.11 Snapshot interviews with a small number of named individuals about the evaluation of initiatives for which they were responsible illuminates difficulties in relation to evaluating the impact the initiatives. Three key points are discernable. Firstly, identifying appropriate outcome measures is problematic. At the moment, measures such as the delayed discharges and reasons for delay censuses are used to monitor national and local trends in delayed discharges. Regular returns specifying 'bed days saved' are required from individual services funded by delayed discharge monies. Measures appropriate to maintaining a national overview of the situation, such as the number of delayed discharges, however, may be too broad for local evaluations to capture the role that initiatives play in tackling the problem. For example, one specific aim of a 'delayed discharge' initiative in the Borders was described as being to 'change the culture' so that professionals are all working towards caring for people in their own homes. A social care professional interviewed for this research review suggested that evaluating the impact of this initiative presented problems because the measure of 'number of delayed discharges' was too narrow to capture the long term and systemic changes they were aiming to put in place.

3.12 Secondly, it is difficult to establish if a particular intervention or project causes a measured change in delayed discharge patterns, or if some other intervening variables, or a particular constellation of variables, are the main cause. However, attempting to establish such a relationship between an intervention and observed outcome should be the aim of evaluation. One way around this difficulty is to use evaluation designs based on comparisons between an intervention group on the one hand, with, on the other hand, a control group similar to the intervention group apart from the fact that they do not receive the intervention. For example, provision of an additional 10 medical beds in Forth Valley for people who were medically stable but not well enough to be cared for at home or to return home from hospital had recently been evaluated. The evaluation shows that people's functional ability and nutritional scores were better compared with a control group. Average length of stay was also reduced for these people compared to the control group.

3.13 Randomised controlled trial designs in areas such as discharge management do, however, present some problems. They can be expensive to design and to run, and are sometimes not felt to be appropriate to organisational evaluation. In some cases, however, control groups occur 'naturally' in a setting. For example, an evaluation of an augmented discharge scheme in Edinburgh was able to use as 'controls' patients from wards, which as a rule did not refer to the scheme (Huby and Mcleod, 1998). Comparing between areas: one where the intervention is being introduced, and a similar area where no similar intervention exists, is another way around this. However, as Partnership areas are very different in terms of service systems and population demographics it will be difficult to establish relevant controls. Nevertheless, evaluation and research designs using some form of control, however imperfect, are useful in establishing the effect of individual initiatives.

3.14 Thirdly, it is important to attempt to evaluate the combined effect of individual services on delayed discharges. Increasingly, 'whole systems' thinking leads to a focus on the combined effects of a range of services on delayed discharges. For example, Greater Glasgow Partnership's Joint Action Plan reported plans for a 'whole systems’ evaluation of their approaches to tackling delayed discharges. They were proposing an independent evaluation of their whole system approach to managing delayed discharges during 2003/04. They anticipate that the introduction of shared information systems and the development of comprehensive performance indicators will improve monitoring. This Partnership was, however, the only one to explicitly state plans for a whole system evaluation.
3.15 A social care manager interviewed said that there was no specific evidence of impact on delayed discharges relating to an early supported discharge for rehabilitation at home initiative in Dundee. This was because the initiative was an integral part of the discharge planning process and linked with the other delayed discharge and supported discharge schemes in Dundee (there were seven separate teams working on different initiatives in relation to early discharge and preventing delayed discharge). Thus she felt it best to evaluate the impact of all seven initiatives and was pleased to report that Dundee had recorded a decrease in delayed discharges although there was no clear evidence to indicate that this was a direct result of one or all of these initiatives. For effective management of the whole system of care, however, a way of establishing the contribution of an individual service to the whole is necessary so that service planners and developers know where to intervene to adjust the system for maximum impact.

Self evaluation in Rapid Response Teams
3.16 An example of the issues facing Partnerships in evaluating initiatives to tackle delayed discharges, together with ways of addressing them, is provided by a project concerned with self evaluation in rapid response teams in 3 Scottish Partnerships areas. This project is part of a Scotland-wide R&D initiative (Research-based service development in primary care, 2004). In this example, the emphasis is on establishing the contribution of individual services to the whole system of care.

3.17 The rapid response teams are integrated teams consisting of health and social work practitioners. The aim of all teams is to ensure early supported discharge or prevention of admission of older people. These teams accessed some ring fenced funds and used team resources and outside local contacts to react quickly to users’ needs. The teams felt this way of working was successful in providing a high quality service that also reduced inappropriate pressure on acute care resources. However, they felt somewhat isolated and unsupported and lacked an awareness of where the service ‘sat’ in the larger system of services. They faced two issues in demonstrating the effectiveness of the service. One was the lack of appropriate measures to capture the impact of this particular service, and the other was the lack of organisational infrastructure and capacity to use information collected by the teams in strategic development of a care system.

3.18 Teams in two of the areas were funded by a combination of social work and Winter Bed monies. At the start of the project, ‘saved bed days’ estimates were the main measure used to judge the effectiveness of the service. These were regularly returned to local managers, who forwarded them to the central funders. However, figures were not reviewed and the services’ overall impact on acute service use was not evaluated. A programme of evaluation by the teams was developed which aimed to increase understanding of the service among main stakeholders and thus contribute to improved support and strategic direction for the teams.

3.19 A ‘pathway’ approach to evaluation was adopted. This was a framework for data collection and analysis, which gave routine quantitative data meaning in the context of everyday conditions of the teams’ work. It helped to specify relationships between care process and outcomes. Teams collected data on critical points in the pathway, which they believed impacted on care outcomes, so that they could improve practice at critical points and monitor the effects of changes. They used a combination of quantitative and qualitative methods: routine quantitative data to acquire an overview of the service, and qualitative audit to investigate in greater detail key points in the care process.
3.20 A workshop was held to explore the use of teams’ data in the context of ISD national data on patterns of discharge and emergency admissions. Emerging findings from the ISD Whole Systems Linkage project suggest relationships between admission diagnosis and previous history of hospital admission on the one hand, and on the other, the probability of experiencing delayed discharge (ISD 2004b). Comparing teams’ data with preliminary ISD linkage data suggested that services like rapid response could have little impact on the care of people who were most likely to end up as long term delayed discharges as picked up by the census. These were very frail older people suffering from, for example, dementia or the effects of stroke. It was felt that rapid response teams in isolation did not have the resource to manage these people. Rather, the teams believed that they contributed to the overall turnover of beds by helping the ‘middle range’ severity patients to leave hospital one or two weeks earlier than would otherwise have been the case.

3.21 The approach explored in the workshop has a number of implications, for example:
- Number of ‘delayed discharges’ may be inappropriate as a measure of the teams’ impact. True, some of the patients picked up by the teams might have contracted complications from a prolonged stay in hospital and their early discharge may have prevented institutionalisation and a long term delayed discharge. However, this cannot usefully be measured. Instead, measures of bed turnover within each acute setting from where teams receive their referrals may be more appropriate to establish impact on local use of acute beds.
- Issues were raised in the workshop around the local capacity for evaluation, and managerial and organisational infrastructure to make use of it. First of all, appropriate methods of individual service evaluation may need to be put in place and training provided. Secondly, mechanisms of decision-making and planning are required to collate evaluation results and act on them in terms of strategic local planning of service systems to tackle delayed discharges.

3.22 The challenge for the majority of Scottish Partnerships is therefore to:
- establish realistic goals for individual services and groups of initiatives;
- identify appropriate outcome measures to allow for meaningful evaluation;
- develop a system of monitoring in order to identify weaknesses in the care system and to respond quickly.

3.23 This approach to monitoring and evaluation would enable Partnerships to compare the kinds of initiatives that are most effective and the kinds of combination of initiatives necessary to have an impact.
SUMMARY OF KEY POINTS

• ‘Hospital at Home’ schemes, sometimes called ‘Early Supported Discharge’ schemes have contributed towards tackling the problem of delayed discharges for some people. Studies show increases in patient satisfaction, reductions in hospital lengths of stay, increases in the number of patients still at home 6 months after discharge, greater community reintegration, improvements in health-related quality of life and reductions in costs per patient. On the other hand, these studies show that some of these schemes have led to lower carer satisfaction, no improvement in health outcomes or functional status and increases in overall length of care. The studies reported in this research review thus show mixed results. Moreover, care at home for older people has been criticised because it may lead to age discrimination and to further marginalisation of some of Scotland’s most vulnerable groups of people. This is because community-based care for older people may help to prevent an unnecessary period of hospitalisation but older people’s rights to equal treatment and equal access to services, including use of acute hospital beds, may be jeopardised if acute hospitals become perceived as no-go areas for this group of the population.

• Studies show that discharge planning can reduce the length of hospital stay, increase patient satisfaction, and reduce the number of patients experiencing a delay. However, further research in a range of contexts is required to clarify exactly what ingredients are necessary for effective discharge planning. In particular, it is not clear which professionals need to be involved in multidisciplinary teams, and which subgroup of patients would benefit most. How discharge planning impacts on, for example, readmission rates, patient recovery time, and health care costs is also largely unknown.

• A number of studies found in the literature search provide evidence for encouraging Scottish Partnerships to include the improvement of clinical care as a component part of any strategy aiming to reduce delayed discharges.

• The literature search found limited evidence about the impact of equipment/home adaptations; step up/step down beds in care homes; joint case management, cross-charging, care home places and interim care home beds. A more thorough literature search, and/or research, is therefore required about these initiatives in order to judge their effectiveness in tackling delayed discharges.

• Other UK and international evaluative evidence suggests that a range of initiatives within a whole systems approach may be most effective overall in tackling the problem of delayed discharges.

• More research about GPs’ utilisation of community-based services and the impact that this has on hospital admissions and delayed discharges is necessary, particularly given that small changes in GP decision making has a disproportionate impact on the acute sector.
• Discharge managers such as liaison nurses can improve the discharge process. A danger however, of introducing a dedicated discharge manager is that other staff who have valuable knowledge about patients may abnegate responsibility for discharge. More research about discharge managers’ relationships with other staff and the impact that this has on the discharge process is required.

• A more thorough literature search, and/or research, is required about the role of allied health professionals in tackling delayed discharges.

• The views of a range of people are needed to gain a comprehensive understanding of the discharge process. In particular, the opinions of patients, carers and people from minority ethnic groups need to be included in discharge planning and also in evaluations about initiatives to tackle delayed discharges.

4.1 Reasons for delayed discharge in the UK are well known and have remained generally consistent, at least, since the early 1990s (Namdaran et al., 1992; Simpson and Marnoch, 1999). As discussed in chapter 2, one of the main reasons for delay is related to organisational factors and the overwhelming majority of initiatives to improve discharge from care facilities have tended to focus on service reorganisation. This chapter describes a number of initiatives found through the literature search that have been introduced to tackle delayed discharges and reports on their effectiveness.

4.2 The majority of the initiatives described here have only been evaluated in specific and local contexts, which means that it is not possible to verify whether they will effectively reduce delayed discharges if introduced in other care settings. However, some initiatives have been evaluated in a number of different care systems, which suggests that they are likely to be successful if introduced elsewhere. Table 3 (below) shows both the volume and type of document (outlined in the introduction to this research review) found through the literature search and thus gives some indication of the scope of the literature upon which recommendations proposed in this research review to tackle delayed discharges are founded. Sixty papers in total are included in this chapter, the majority of which report original research findings.
Table 3: Volume and type of documents relating to solutions for delayed discharges

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**HOSPITAL AT HOME/EARLY SUPPORTED DISCHARGE AND RAPID RESPONSE TEAMS**

4.3 ‘Hospital at Home’ schemes, sometimes called ‘Early Supported Discharge’ schemes have contributed towards tackling the problem of delayed discharges for some people. Studies show increases in patient satisfaction, reductions in hospital lengths of stay, increases in the number of patients still at home 6 months after discharge, greater community reintegration, improvements in health-related quality of life, and reductions in costs per patient. On the other hand, these studies show that some of these schemes have led to lower carer satisfaction, no improvement on health outcomes or functional status and increases in overall length of care.

4.4 A review of 16 randomised controlled trials of hospital at home schemes (3 for admission avoidance, 13 for early discharge from hospital) found no difference in health outcomes, greater patient satisfaction, but lower carer satisfaction with hospital at home schemes (Shepperd and Illiffe, 2002). The review found that hospital at home schemes were associated with a reduction in hospital lengths of stay, but greater overall length of care. The review concluded that early discharge schemes for patients recovering from elective surgery and elderly patients with a medical condition may have a place in reducing the pressure on acute hospital beds, providing the views of the carers are taken into account.

4.5 Early supported discharge from hospital to home schemes for some older people have been found to be effective. A review of a number of research trials indicates that community rehabilitation schemes for older people can facilitate earlier discharge from hospital (Heseltine, 2001). A systematic review of studies that have investigated the effects of
supported discharge on older people after an acute admission found that the proportion of those at home 6-12 months after admission is greater with supported discharge (Hyde et al., 2000). However, there was no research data on functional status or patient and carer satisfaction. A survey of patients’, carers’ and community staffs’ views of an early supported discharge scheme for elderly trauma patients in an Edinburgh hospital concluded that the scheme was efficient and effective (Closs et al., 1995).

4.6 Hospital at home schemes have been found to be appropriate for specific clinical groups including people who have had a stroke, people with exacerbations of chronic obstructive pulmonary disease and those who have undergone hip and knee replacement surgery. A Cochrane review of outcome data of 4 randomised controlled trials compared the costs and effects of early supported discharge, defined as early discharge with rehabilitation at home, with conventional services for people who have had a stroke. The review found that early supported discharge can significantly reduce length of stay, but the relative risks and benefits and overall costs of such services remain unclear (Early Supported Discharge Trialists, 2002). Early discharge to home rehabilitation for stroke patients in Montreal, Canada was also found to be successful. In particular, health-related quality of life and community reintegration was improved compared to those people who received routine provision (Mayo et al., 2000). In an Edinburgh hospital, a randomised controlled trial of supported discharge in patients with exacerbations of chronic obstructive pulmonary disease found that home supported discharge is a safe and economic alternative to hospital admission. The median time to discharge was 7 days for the home support group and 5 days for the control group and the mean total health service cost per patient was estimated as £877 for the home support group and £1753 for the control group (Swarzka et al., 2000). An evaluation of an orthopaedic early discharge scheme found that prior to the scheme average length of stay for patients was approximately 12 days (Black, 1997). After the scheme’s introduction patients undergoing unilateral total hip and knee replacements returned home as planned, 5 days post surgery, and the 2 patients having bilateral knee replacements returned home after 8 days.

4.7 The reviews of hospital at home and early supported discharge services show mixed results and do not provide sufficient information about how the services themselves were configured, and how they interfaced with mainstream health and social care services to allow confident ‘roll out’ in Scotland. Moreover, care at home for older people has been criticised because it may lead to age discrimination and to further marginalisation of some of Scotland’s most vulnerable groups of people (Department of Health, 2001a; Crouch, 1997). Community-based care for older people may help to prevent an unnecessary period of hospitalisation, but older people’s rights to equal treatment and equal access to services, including use of acute hospital beds, may be jeopardised if acute hospitals become perceived as no-go areas for this group of the population. On the other hand, hospital at home schemes have been identified as very flexible intermediate care services in that they are appropriate for a range of conditions and age groups, and can be used in conjunction with other services to either prevent emergency admission or to facilitate early discharge.

DISCHARGE PLANNING AND ASSESSMENT

4.8 Although discharge planning schemes vary, what they all have in common is a system whereby discharge is planned for an individual patient prior to leaving hospital for home or to another care setting. Previous research suggests that effective discharge planning requires (McKenna et al. 2000; Taraborrelli et al. 1998; Tierney et al. 1994; Van Emden et al. 1999):  
- adequate notice of discharge to all concerned parties;
consultation with patients and carers throughout the discharge process;
- a system of information collection and dissemination between hospital and community;
- co-ordination by a named professional;
- multidisciplinary approach involving different health and social care professionals;
- early and coordinated assessment of patient’s needs and home circumstances;
- early planning of the needs for further care;
- effective communication between hospital and community.

4.9 Studies show that discharge planning can reduce the length of hospital stay, increase patient satisfaction, and reduce the number of patients experiencing a delay. However, further research in a range of contexts is required to clarify exactly what ingredients are necessary for effective discharge planning. In particular, it is not clear which professionals need to be involved in multidisciplinary teams, and which subgroup of patients would benefit most. How discharge planning impacts on, for example, readmission rates, patient recovery time and health care costs is also largely unknown.

4.10 A Cochrane review of 8 randomised controlled trials and controlled trails compared discharge planning, defined as an individualised discharge plan for the patient prior to leaving hospital for home, with routine discharge. The effects of discharge planning on readmission rates were mixed. There was some evidence that discharge planning reduced the length of hospital stay for older patients and increased patient satisfaction for some patients but there was no evidence that discharge planning reduced health care costs although few studies conducted a formal economic analysis (Parkes and Shepperd, 2003).

4.11 Several studies highlight the positive role of a dedicated discharge planner. A full-time discharge planner worked with three GP practices in Oldbury and Smethwick, taking referrals from hospitals of people admitted as emergencies and planning discharges for elective admissions. The Nuffield Institute who evaluated the scheme indicated that GPs and community-based staff became more involved in planning for discharges and that people and carers enjoyed the fact that the discharge planner was with them throughout the period of the discharge process, thus providing a degree of continuity of care. The Nuffield Institute also recommended improvements, such as focusing on the most complex cases that are the most time consuming, and improving inter-agency communications so that the discharge planner is quickly informed about emergency admissions (Combes, 2002). A care-coordinator was appointed in Barts and the London Trust to ensure that the patient’s discharge from hospital was not delayed. The coordinator identified people likely to benefit from their input; considered the patient for occupational therapy and social work services; gathered information about the patient’s living situation and clinical problems; liaised with the patient, families and carers and advocated on behalf of the patient. The Trust believes that the care coordinator made a significant contribution in reducing the number of delayed discharges. For example, the average length of stay had been reduced from 8.5 to 5.9 days over two years. However, they point out that more evaluation is necessary in order to determine the post’s unique contributions (Bridges et al., 1999). An intervention study evaluating the effectiveness of the role of a discharge coordinator on three medical wards in a London hospital found that the discharge coordinator improved the discharge process (Houghton et al., 1996). For example, patients were more likely to be discharged on the date specified for discharge, and problems experienced by patients after discharge were reduced. However, there was no evidence that the discharge coordinator led to more timely or effective provision of community services or that appropriateness of efficiency of bed use was improved in the hospital.
4.12 Alongside a dedicated discharge planner other health professionals working as part of a multidisciplinary team have also been found to play a positive role in discharge planning. A National Audit Office report (2003) briefly highlights examples where discharge planning has reduced the delayed discharge rate. Delayed discharges were reduced in one London acute trust when junior doctors’ working practices were re-organised so that they attended multidisciplinary team meetings to discuss discharge. A detailed discharge planning protocol at St Mary’s Hospital Trust, which adopted an integrated team approach and empowered ward staff, reduced levels of delay from about 50-60 patients per week in the mid 1990s to between 10-15 in early 2000. An intervention study in an acute hospital in Sweden found that older people (above the age of 75) whose discharge was planned by a team consisting of a geriatrician and a district nurse had shorter total hospitalisation time and were more engaged in their own discharge planning compared to the control groups (Styrborn, 1995). A prospective randomised controlled trial of GP input into discharge planning for frail older people in Sydney, Australia found no significant difference with regard to length of stay, readmission rates or time to first readmission (McInnes et al., 1999). However, GP input did lead to more patients being recommended for community services at discharge and to patients reporting that their return home was well prepared. Some professionals tend to be excluded from discharge planning. A study of discharge planning in Scotland for instance, found that representatives from housing and the voluntary sector tended to be left out of discharge decision making processes (Taraborrelli et al., 1998).

4.13 An important aspect of discharge planning is communication between health and social care professionals and patients. Sandwell Hospital established a Discharge Communications Centre that was notified by ward staff of all people requiring discharge planning. The IT system in the Centre logged all admissions and notified the appropriate social services team that began assessment and care planning. Discharge trackers chased up all notified cases and supported ward staff for those people with complex needs. Ward staff had access to the social service IT system so that they could see people’s existing packages of care and they alerted occupational therapy and physiotherapy of expected assessments. Preliminary data indicates that the Centre had cut the average length of stay in hospital by half for those people whose discharge was delayed for more than 60 days (Combes, 2002). Verbal and non-verbal information is likely to be required during discharge planning. A systematic review of randomised controlled trials found that the provision of verbal and written information for patients and/or significant others about their discharge significantly increased knowledge and satisfaction scores (Johnson et al., 2004). According to a review of literature on the effectiveness of the transfer of patient information between hospital and community for older people with physical illness there was little evidence that a key worker (discharge coordinator, liaison practitioner, liaison nurse, link nurse) decreased readmission rates although they did improve patient and carer satisfaction and patient concordance with offered services (Payne et al., 2002). The review also highlights that even when formal documentation such as discharge plans and discharge summaries were used, some information was either missing or inadequate. Despite a lack of empirical evidence, the reviewers conclude that the appointment of a key worker can facilitate information transfer across professional, organisational and geographical boundaries.

4.14 An integral part of discharge planning is assessment. A systematic review of the effectiveness of pre-discharge home assessment visits for people 65 years old and over, found no randomised controlled trials even though home visits to smooth the transition from hospital to home are being introduced in the UK (Patterson and Mulley, 1999). On the other hand, anecdotal evidence and small scale studies show that assessment can be improved using
a multidisciplinary team. A local systems review in North Essex led to a number of initiatives that contributed towards reducing the rates of delayed discharge. The review, for example, highlights that the assessment process was slow and to resolve this problem, three nurses were trained by social services to work with social workers to carry out assessments. This dramatically cut the time it took to complete an assessment (Pascoe, 2001).

**IMPROVING CLINICAL CARE IN HOSPITAL**

4.15 A number of studies found in the literature search provide evidence for encouraging Scottish Partnerships to include the improvement of clinical care as a component part of any strategy aiming to reduce delayed discharges. Some research, for example, has demonstrated the role of clinical guidelines for tackling delayed discharge:

- A controlled intervention trial of a guideline to reduce hospital length of stay for people admitted with chest pain shows that adhering to guidelines is a useful complement but not a substitute for physician judgement (Ellrodt et al., 1995).
- ‘Rapid recovery guidelines,’ which include patient and family education and post-operative early extubation, improved discharge rates and reduced the occurrence of pneumonia and wound infection for people undergoing heart surgery (Dunstan and Riddle, 1997).
- A US study concluded that a lobectomy patient care pathway reduced length of stay (Wright et al., 1997).

4.16 Other research has shown that:

- Greater emotional support and information to parents and children prior to admission may prevent an overnight admission in school aged children undergoing minor day surgery, although this kind of provision has not been evaluated (Glazebrook and Sheard, 1994).
- Postoperative pain is a common reason for delayed discharge and emergency hospital admission, and various ways of preventing postoperative pain by anaesthesiologists have been proposed (Chung et al. 1997; Pavlin et al., 2002). A study of 500 patients in a Canadian hospital, for example, found that the main reasons why people after ambulatory surgery experienced a delayed discharge were because of the unavailability of someone to escort them home and the reoccurrence of pain (Chung, 1995).

**EQUIPMENT/ADAPTATIONS**

4.17 The literature search highlights limited evidence of the impact that equipment and home adaptations have on tackling delayed discharges. A snapshot study of a Home from Hospital project in Gloucestershire suggests that a dedicated case worker responsible for identifying problems in people’s homes, which may cause a hospital admission or a discharge delay if not rectified, and an in-house ‘handyman’ to make the necessary home adaptations had a positive impact (Williams, 2003).

**STEP UP/STEP DOWN BEDS IN CARE HOMES**

4.18 Anecdotal evidence from an initiative in England suggests that step up/step down beds in care homes may contribute towards tackling delayed discharges. Oldbury and Smethwick Primary Care Trust, for example, contracted nursing homes to provide step up and step down beds. Admissions to step up beds were made by community nurses, social workers and GPs, and admissions to step down beds were made by hospital consultants. A local GP practice was responsible for medical provision for people in these beds. Progress in using beds was slow, for example, it took over a year and a half for all GP practices to refer people to the step up beds. According to the author describing this initiative, people who would have remained in hospital had been discharged into this service (Combes, 2002).
4.19 The use of nursing home beds for providing this type of care, however, has its critics. A survey of nursing home owners, managers and matrons of 570 homes found that there were major shortfalls in the provision of NHS services to nursing homes which hinders the rehabilitation potential of intermediate care placements in nursing homes. The study concludes that unless these kinds of problems are sorted out, ‘these placements will serve only to shunt the problem of bed-blocking into the independent sector and will not restore the functional independence of older people as intended’ (Jacobs and Rummery, 2002).

JOINT CASE MANAGEMENT

4.20 Evidence from an initiative in England suggests that Joint Case Management may contribute towards tackling delayed discharges. In Runcorn, a General Practice adopted a joint case management approach with social services for older people. A general practice-based social worker and a nominated district nurse collaborated by targeting older people at risk of hospital admission, organised proactive discharge planning and referred to other services if appropriate. The result of the scheme was that the number of hospital admissions among older people at the General Practice fell by 15%, the average length of hospital stay was reduced by 31% (from 6.2 to 4.3 days), and the total number of hospital bed days was cut by 41% (Christie, 2002). More evidence of the effectiveness of joint case management in different contexts is however, needed to be able to recommend this type of initiative for tackling delayed discharges with confidence.

CROSS-CHARGING

4.21 One possible solution to improving discharge from hospital is cross-charging. In England and Wales, new funding arrangements have been legislated for so that the costs of a patient’s continued stay in hospital can be borne by the local authority where they have been notified by the NHS of both the patient’s likely need of community-based care on discharge and their proposed day of discharge. A rationale for introducing cross-charging is that it will provide an incentive to local authorities to support people ready for discharge in the community, thus reducing the numbers of delayed discharges. Evidence from Sweden and Denmark was used as a rationale for introducing cross-charging in England and Wales. A study in Sweden for instance, concluded that, ‘financial liability for bed-blocking patients would appear to be the most powerful factor working for a reduction in numbers of bed-blockers’ (Styrborn and Thorsland, 1993b). However, the authors point out that access to alternative institutional beds and other forms of care also contributed.

4.22 Cross-charging has only just been implemented so its impact is unclear. However, several reservations about the inadvertent consequences of cross-charging have already been voiced (Christie, 2002; Glasby, 2002; Moore, 2003; Nuffield Institute for Health, 2002). These include:

• Financial penalties may distort social service development priorities because there will be a financial incentive to focus on reducing delayed discharge at the expense of other services.
• Social services may focus on the immediate issue of facilitating discharge from hospital at the expense of implementing strategies that prevent hospital admission in the first place.
• There is a danger that social services will take people too early, which could trigger a readmission.
• Charging jeopardises the development of inter-agency working, which is essential to securing long-term solutions to the problem of delayed discharge since it encourages one agency to blame another for whole care system problems.
CARE HOMES PLACES
4.23 Demand for care home places is greater than supply (Joseph Rowntree Foundation, 2002) and one of the most popular reasons for delayed discharges given by Partnerships in the Joint Action Plans was that there were insufficient care home places available. This problem was also found in Sweden where there was a correlation between the availability of alternative institutional beds, such as beds in care homes, and the number of delayed discharges (Styrborn and Thorslund, 1993b). The literature search found no evidence of the ways in which increasing care home capacity had been used successfully to tackle delayed discharge.

INTERIM CARE HOME BEDS
4.24 Interim care beds may help to tackle delayed discharge. A recent study in North Essex, for example, shows that interim care home facilities contributed towards a sharp reduction in the numbers of people waiting for discharge in North Essex (Pascoe, 2001).

INTRODUCING A RANGE OF INITIATIVES
4.25 Where evidence does exist in the literature, it supports an approach that uses a range of initiatives to improve integrated or continuity of care to reduce use of hospital based services. For example, in Queensland, Australia, an integrated package of initiatives was put in place that together successfully reduced lengths of hospital stay, reduced readmission, and cut the costs of treating people in the community. Service gaps and reasons for delayed discharge were identified. Hospitals were allocated funds to pay for a range of community-based services and hospital/community liaison nurses consulted with people, families, GP and service providers etc. to plan the smooth transfer of the patient from hospital to home (Mitchell et al., 1993). Similarly, evidence from an evaluation of total purchasing pilots in the UK in the 1990’s shows that those total purchasers who managed to reduce emergency activity in acute hospitals did so by putting in place a range of community-based services such as increased use of community hospitals, or hospital at home services, discharge liaison nurses and community rehabilitation teams. Others focussed on their relationship with their local social service departments and transferred funds to pay for services that were traditionally in the remit of social care (McLeod and Rafferty, 2001).

THE ROLE OF GPs
4.26 The section on discharge planning above highlights the positive role of GPs. There is also speculation that GPs may play a key role in tackling delayed discharges through preventing a hospital admission. Many emergency hospital admissions in Scotland arise as a referral by a GP, and a local audit carried out by consultants and GPs in West Lothian Healthcare NHS Trust highlights that the overwhelming majority of referrals were appropriate. On the other hand, anecdotal evidence and small scale studies suggest that some GPs possess little knowledge of community-based services or do not have full confidence in the quality and effectiveness of these services, which means that they may refer people to hospital as opposed to using community-based alternatives (Hubbard and Themessl-Huber, 2003). A social care manager in the Borders, who was interviewed for this research review, said that she wanted to develop community services so that GPs and hospital consultants have full confidence in these services so that they will refer people knowing that they are in receipt of quality care. A question therefore arises which is, if GPs are aware of, and have confidence in community-based services, will they be willing to refer people to these services which in turn, will prevent, or at least defer until a later date, a hospital admission? More research about GPs’ utilisation of community-based services and the impact that this has on hospital admissions and delayed discharges is necessary, particularly given that small
changes in GP decision making has a disproportionate impact on the acute sector (Kendrick and Conway, 2003).

**THE ROLE OF SOCIAL CARE STAFF**

4.27 Social care staff play an important role in providing community-based care. One paper was found in the literature search which concluded that although there was still no conclusive evidence, small scale studies and cumulative circumstantial evidence indicate that social workers attached to emergency departments and working as part of a multi-professional team can prevent unnecessary hospital admission, reduce discharge delay and reduce readmission (Bywaters and McLeod, 2003).

**THE ROLE OF NURSES**

4.28 Several Scottish Partnerships were introducing discharge managers, some of which were nurses. These are called ‘liaison nurses’ in other countries and previous research suggests that they play a positive role in the discharge process. A nation-wide survey of the role of the discharge liaison nurse in the Netherlands suggests that there are three types of liaison nurses (Van Emden et al., 1999). The overwhelming majority of liaison nurses in the Netherlands have an ‘ organisational’ function where they organise the discharge process. A small minority have an ‘advisory’ function where they advise other professionals on matters concerning discharge and a small minority have a ‘policy-making’ role where they consult with a range of professionals and formulate guidelines and provide information about discharge planning. The survey found that only 20% of schemes had been evaluated and that no results were given on efficiency aspects. An evaluation of the role of liaison nurses for stroke patients carried out in two hospitals in the Netherlands found that after the introduction of a liaison nurse more patients stated that their post-discharge needs had been discussed not later than 48 hours prior to discharge and their after care had been discussed with community nurses (Arts et al., 2000). The evaluation found no significant difference in the duration of hospital stay. A prospective evaluation of the effect of a liaison nurse in a Netherlands hospital found that the number of patients where the quality criteria for the discharge planning process were met improved following the arrival of the liaison nurse (Peters et al., 1997). The evaluation found no significant difference in relation to continuity of care, such as if the community nurse or home help visited the patient upon discharge. Research carried out in Sydney, Australia, found that discharge liaison nurses were perceived by other nurses as effective at providing informal and formal advice and guidance to staff about discharge, and facilitating communication between hospital and community (Armitage and Kavanagh, 1996). However, the authors stress that other nurses should not abnegate responsibility for discharge because, ‘it is the nurse at the bedside who is in the best position to identify and plan for patient aftercare needs’ (p.219).

**THE ROLE OF ALLIED HEALTH PROFESSIONALS**

4.29 Whilst the literature search found no evidence of the role of allied health professionals in tackling delayed discharges, one of the snapshot telephone interviews carried out for this research review did. A hospital in the Scottish Borders has introduced an initiative that located occupational therapists, who assessed whether or not a person could be cared for at home as opposed to being admitted to a ward, within an Accident and Emergency department. A health manager said that a local audit had shown that this initiative had reduced the number of hospital admissions.
THE ROLE OF CARERS
4.30 As far back as 1993, the Scottish Office emphasised the importance of consultation with, and involvement of, patients and carers in discharge planning (Scottish Office Home and Health Department 1993). In a recent UK survey of 2215 carers, 45% of carers said that their concerns and ideas were not taken into account when planning for hospital discharge and 43% said that they had not been given sufficient help to care for the person (Holzhausen, 2001). Carers from minority ethnic groups in particular said that they were not involved in the discharge planning process. The survey suggests that more needs to be done to improve discharge from the perspective of carers.

A RANGE OF PERSPECTIVES
4.31 The literature search highlights the importance of eliciting a range of perspectives in order to gain a comprehensive understanding of the discharge process. This is because different people have different experiences and opinions. A survey of patients’, carers’ and community staffs’ views of an early supported discharge scheme for elderly trauma patients in an Edinburgh hospital found that 73% of patients but only 44% of carers said that discharge arrangements had been discussed with them, and that community nurses compared to GPs were the least satisfied with the information that they received from the hospital (Closs et al., 1995). Another survey of patients’ and carers’ experiences of discharge carried out in a hospital in Edinburgh also shows differences of opinion (Tierney et al., 1994). For example, 16.1% of patients and 30.8% of carers said that they would have preferred more notice of the discharge date. A survey of the quality of discharge arrangements in a hospital in Chester and Ellesmere Port found that 80% of patients felt they had been adequately consulted about arrangements for their discharge but 69% of professionals felt that patients and staff did not receive necessary information or advice prior to discharge (Fairhurst, et al., 1996).
CHAPTER 5 – INITIATIVES IN SCOTLAND

SUMMARY OF KEY POINTS

- Care homes placement, hospital at home, rapid response and early supported discharge, rehabilitation, out of hours, assessment, equipment and adaptation, and the introduction of managers were the most popular initiatives being introduced by Scottish Partnerships to tackle delayed discharge.

- Partnerships were not requested to provide a general strategic overview of how they were tackling delayed discharges in their Joint Action Plans. Instead, the focus was on initiatives being developed for the specific annual funding stream. This meant that it was difficult to understand how Partnerships were going to tackle the problem in the longer term.

- A difficulty with comparing initiatives in Scotland was because Partnerships gave different names to similar services. For example, rapid response, early supported discharge and some types of home care services and rehabilitation may all have a similar function. It would be useful therefore if Partnerships provided a brief description of the initiatives in future Joint Action Plans.

5.1 The Learning Network for tackling delayed discharges that is managed by the Scottish Executive has over thirty ‘good practice’ examples that are described in detail (Scottish Executive, 2001a). Not all initiatives to tackle the problem of delayed discharges are represented on the learning network and others have been listed on the Joint Action Plans.

5.2 Evidence presented in this chapter is mainly from the Joint Action Plans and is supplemented with information from the snapshot telephone interviews. Many Scottish Partnerships were tackling delayed discharges by developing initiatives that aimed to:
- prevent hospital admission,
- facilitate timely or early discharge from hospital, and/or
- prevent readmission.

Lothian Partnership for instance, acknowledged that it would be, ‘counterproductive to focus simply on delayed discharge numbers, only to see emergency admission and lengths of stay increase.’ This problem was also highlighted in a survey of 2215 carers in the UK (Holzhausen, 2001). According to the survey, there has been a steep rise in the number of people who had to go back into hospital within 2 months of being discharged. Readmission was more likely for people from minority ethnic groups and people aged between 26 and 35 years. Forty-five per cent of carers believed that this was due to the discharge being too early. Research carried out in an Edinburgh hospital shows that over one quarter of patients were readmitted to hospital during the 3 months post-discharge and 74% of those were on an emergency basis (Tierney et al., 1994).

5.3 Tables 4-6 show the range of initiatives listed in the Joint Action Plans to tackle the problem of delayed discharges. However, the main difficulty in analysing which initiatives Partnerships were developing to tackle delayed discharges is that different Partnerships may use different names for very similar services. It would be useful therefore if Partnerships
provided a brief description of initiatives. For example, it would have been helpful to know if hospital at home schemes included rehabilitation.

5.4 Another difficulty is that some of the Partnerships only mentioned those initiatives that were being funded by the 2003/04 financial stream. This meant that it was not possible to use Joint Action Plans to gain a general overview of how the Partnerships were tackling delayed discharges. Some Partnerships, however, did appear to provide this overview by supplementing Joint Action Forms with additional information. For example, Greater Glasgow, Grampian and Lothian Partnerships presented additional information, which meant that their direction of travel and general approach to tackling delayed discharges in the longer term was evident. It would be helpful therefore if Partnerships provided a general strategic overview of the ways in which delayed discharges were being tackled, for example, it would be useful to know if their overall priority was to develop hospital at home and rehabilitation facilities in the community. This strategic overview would provide a context for understanding the role of specific initiatives that were being introduced and/or developed for each annual funding stream.
### INITIATIVES TO TACKLE DELAYED DISCHARGES IN SCOTLAND

#### Table 4: Initiatives to tackle delayed discharges in Scotland 2003/2004

<table>
<thead>
<tr>
<th>Care homes places</th>
<th>Interim care homes</th>
<th>Step up/down beds in care homes or intermediate care</th>
<th>Rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aberdeen city</td>
<td>Lothian</td>
<td>Ayrshire &amp; Arran – <em>intermediate care beds in residential care homes</em></td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>Aberdeenshire</td>
<td>Shetland – <em>interim supported housing options</em></td>
<td>Fife – <em>intermediate beds in care homes</em></td>
<td>Aberdeen city – in sheltered housing; beds in hospital; across the whole care system</td>
</tr>
<tr>
<td>Argyll &amp; Clyde</td>
<td></td>
<td>Highlands – <em>step down beds in community hospitals</em></td>
<td>Grampian – facilities in hospital</td>
</tr>
<tr>
<td>Fife</td>
<td></td>
<td>Lothian – <em>interim care wards in hospital</em></td>
<td>Fife – in community hospitals</td>
</tr>
<tr>
<td>Forth Valley</td>
<td></td>
<td>Tayside – <em>step down beds in care homes</em></td>
<td>Forth Valley</td>
</tr>
<tr>
<td>Greater Glasgow</td>
<td></td>
<td></td>
<td>Greater Glasgow – hospital &amp; community</td>
</tr>
<tr>
<td>Highlands</td>
<td></td>
<td></td>
<td>Highlands – integrated health &amp; social care rehab services</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td></td>
<td></td>
<td>Lanarkshire – beds and rehab service</td>
</tr>
<tr>
<td>Lothian - 'resource finding team' for care places</td>
<td></td>
<td></td>
<td>Moray</td>
</tr>
<tr>
<td>Moray</td>
<td></td>
<td></td>
<td>Orkney – at home</td>
</tr>
</tbody>
</table>
| Orkney            |                    |                                                      | />
| Shetland – review of admission and discharge practices for care places | | | />

*Note: *Interim care homes, Step up/down beds in care homes or intermediate care, Rehabilitation*
Table 5: Initiatives to tackle delayed discharges in Scotland 2003/2004

<table>
<thead>
<tr>
<th>Hospital at home</th>
<th>Rapid response &amp; early supported discharge</th>
<th>Assessment</th>
<th>Out of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran – home from hospital</td>
<td>Aberdeen city – rapid response</td>
<td>Ayrshire &amp; Arran – in A&amp;E for community care</td>
<td>Ayrshire &amp; Arran – day centres evening &amp; weekend; evening nursing service; out of hours integrated care</td>
</tr>
<tr>
<td>Borders – home based care</td>
<td>Dumfries &amp; Galloway</td>
<td>Aberdeen city – community geriatrician; social work &amp; OT home assessment</td>
<td>Aberdeenshire</td>
</tr>
<tr>
<td>Greater Glasgow – home care &amp; intensive home care</td>
<td>Forth Valley – rapid response</td>
<td>Aberdeen - community geriatrician</td>
<td>Fife</td>
</tr>
<tr>
<td>Highlands – evaluating hospital at home service</td>
<td>Grampian – early discharge planning &amp; information gathering</td>
<td>Borders</td>
<td>Forth Valley</td>
</tr>
<tr>
<td>Lothian – care at home</td>
<td>Greater Glasgow – rapid response</td>
<td>Dumfries &amp; Galloway - allied health professions to improve assessment</td>
<td>Greater Glasgow – overnight care</td>
</tr>
<tr>
<td>Orkney – home from hospital</td>
<td>Highlands</td>
<td>Highlands – single shared assessment; increase pace of assessment for community care</td>
<td>Lothian – weekend OT; emergency social work and physiotherapy</td>
</tr>
<tr>
<td>Western Isles - enhanced care</td>
<td>Moray</td>
<td>Lothian – care managers; out of hours for community care assessment; GPs in assessment unit</td>
<td>Moray</td>
</tr>
</tbody>
</table>

| | | | Western Isles – mobile overnight support scheme |
Table 6: Initiatives to tackle delayed discharges in Scotland 2003/2004

<table>
<thead>
<tr>
<th>Managers</th>
<th>Equipment &amp; adaptations</th>
<th>Transport &amp; ready rooms</th>
<th>Day care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forth Valley – delayed discharge support nurse</td>
<td>Aberdeen city – extra equipment purchase</td>
<td>Forth Valley - driver</td>
<td>Lanarkshire</td>
</tr>
<tr>
<td>Highlands – delayed discharge facilitator</td>
<td>Aberdeenshire</td>
<td>Lothian – paramedical staff; delayed discharge transport</td>
<td>Shetland – day care review</td>
</tr>
<tr>
<td>Lanarkshire – joint discharge management</td>
<td>Fife</td>
<td>Moray</td>
<td></td>
</tr>
<tr>
<td>Lothian – joint programme manager; delayed discharge co-ordinator; social work care manager</td>
<td>Forth Valley</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moray – early supported discharge nurse; care organiser; lead nurse; delayed discharge development officer</td>
<td>Greater Glasgow</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tayside – managed care network project manager</td>
<td>Lothian</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Western Isles – practical home safety initiative</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CARE HOMES

5.5 Most Partnerships indicated in their Joint Action Plans that they were increasing care home capacity. However, Ayrshire and Arran, Western Isles, Borders, Tayside, Dumfries and Galloway and Grampian were not increasing capacity or developing systems to improve placement.

5.6 Lothian Partnership believed that increases in care home places during 2002/03 had contributed towards a reduction in delayed discharges although they were concerned that further care home closures would compound delayed discharge problems. Argyll and Clyde Partnership were planning to improve care home placements by identifying care home beds as soon as they became available as well as by purchasing additional care home places. Most Scottish Partnerships measured the impact of providing additional care home places on delayed discharges by counting the number of additional care home beds being introduced into the care system.

5.7 Several Scottish Partnerships noted that some older people remained in hospital despite being ready for discharge until a bed in their first choice of care home became
available. One solution being tried in Lothian and Great Glasgow Partnerships was the introduction of **interim care homes**. This is a waiting facility where older people who have been assessed as ready for discharge are moved out of hospital and to an interim care home where they live until a bed in their first choice of care home becomes available.

5.8 However, providing more care home placements for older people may facilitate discharge from hospital and help to meet targets but it may not offer people the right care, in the right place. People may prefer an intensive home care package so that they can live independently in their own home rather than moving to a care home. This was one of the reasons why not all Partnerships were increasing care home capacity to tackle delayed discharges. Ayrshire and Arran Partnership for example, were not introducing additional care home places even though they had identified lack of care home capacity as the main reason for delayed discharge. Similarly, other Partnerships, for example, Grampian, were aiming to reduce local authority care home capacity with a view to investing resources in sustaining and developing community-based initiatives. Borders Partnership had a clear aim for 2003/04, which was to provide alternatives to care home placements. They were focusing on speeding up discharge by developing provision at home including **augmented home care**. More detail about how and why these Partnerships believed that they could tackle delayed discharges **without** increasing care home capacity, which was one of the main reasons for delay, would be useful information for all parties interested in finding ways of tackling the problem.

**STEP UP/DOWN BEDS IN CARE HOMES OR INTERMEDIATE CARE**

5.9 A minority of Partnerships indicated in their Joint Action Plans that they were introducing and/or developing step up/down beds in care homes or intermediate care.

5.10 Intermediate care, which lies between primary and secondary care, may play a role in tackling delayed discharge. It is a term that is more widely used in England and Wales although some Scottish Partnerships have also adopted the term to describe some initiatives to tackle delayed discharge in their Joint Action Plans. The Department of Health has applied the concept of intermediate care to services in a patient’s own home, care home, community hospital, day hospital or day centre that aim to prevent hospital admission and/or facilitate early discharge (Department of Health 2001b; Petch, 2003). However, the Scottish Executive has rejected the usage of this term and others are also cautious of adopting it because it has been used to re-label and reinvent existing services, for example, rehabilitation facilities. Clarification about the nature and purpose of intermediate care being introduced by some of the Partnerships to tackle delayed discharges would therefore be useful.

**REHABILITATION**

5.11 Rehabilitation facilities delivered in hospital and/or the community were being developed and/or introduced by most Partnerships. Joint Action Plans did not make it clear exactly what type of rehabilitation services were being introduced and it may be the case that other Partnerships were introducing and/or developing rehabilitation services within other initiatives such as hospital at home or rapid response teams.

**HOSPITAL AT HOME RAPID RESPONSE/ EARLY SUPPORTED DISCHARGE**

5.12 Many Partnerships had hospital or community-based teams that assessed and if necessary referred people to community-based care services so that they did not have to be admitted to hospital or to facilitate a timely discharge. Greater Glasgow Partnership called their teams **integrated hospital discharge teams**; Moray called their teams **rapid response teams** and early supported discharge teams.
5.13 Providing home care, particularly for people recently discharged from hospital was also being introduced by a number of Partnerships. This initiative was called different things, for example, Lothian Partnership had care at home, Greater Glasgow homecare, and Ayrshire and Arran and Orkney Partnership had home from hospital.

5.14 Snapshot telephone interviews suggest that these types of initiatives have been successful. A social care manager, who was interviewed for this research review, claimed that in the first six months of introducing the ‘rural integrated outreach’ service in Argyll and Bute nine people had been supported to remain at home as opposed to being admitted to hospital. Argyll and Clyde Health Board and Argyll and Bute Council jointly funded this initiative. The aim of the service was to prevent unnecessary admissions to hospital or residential and nursing home care by providing ‘enhanced personal care’ to vulnerable adults. This support included a 48 hour crisis response. Monthly management meetings were held between the district nurse and home help organiser. The district nurses undertook Carenap E assessments and home help staff provided enhanced personal care. The home helps involved in the service had received additional training along with support workers employed in the Oban based outreach service. A small in-house evaluation of the service had been undertaken and a further one was planned; unfortunately further details about these evaluations were not obtained for this research review.

5.15 Many Partnerships were also introducing or developing early supported discharge teams and evidence of success has been claimed. For example, three early supported discharge teams in Lanarkshire were aligned to the catchment areas of the three acute hospitals. Multidisciplinary health and social care teams, single shared assessment, common protocols, shared information, patient held record and evaluation were key characteristics of the teams. Between May and October 2001 the teams had 439 referrals. In-house audit shows that functional ability and mobility scores were favourable for people who used the service though it was not possible to indicate direct impact on the extent to which the team had contributed towards tackling delayed discharges (ISD, 2003c).

5.16 Some Partnerships were introducing rapid response teams that played a similar role to early supported discharge teams. For example, a rapid response team in the City of Aberdeen was a multidisciplinary crisis intervention team set up through a joint venture between Grampian University Hospital Trust, Grampian Primary Care Trust and Aberdeen City Social Work Department. The team had been built on three main foundations: the co-location of multidisciplinary staff, use of a common assessment form and a pooled budget. The aims of the team were to prevent unnecessary admission to hospital, to arrange early discharge from hospital, and to have services in place within 24 hours of referral. The team worked with all the community care client groups. According to the professional who was interviewed for this research review, the pooled budget had allowed financial decision making to be devolved to team level. In her opinion, this had prevented debates between agencies over financial responsibility from holding up the delivery of urgently needed service provision to service users and carers. It had allowed essential, intensive, high cost, care packages to be put in place speedily without the need to obtain prior authorisation. At the end of June 2000, 401 referrals had been made from GPs, community nurses, social workers and social care managers, hospital liaison nurses and occupational therapists. Thus, according to the professional interviewed, the rapid response team facilitated discharges from hospital although there was no clear evidence to show the direct impact that the team had on tackling the problem.
ASSESSMENT
5.17 Many Partnerships indicated that they were improving assessment using a range of approaches. Lothian Joint Action Plan for example, were improving assessment by introducing GPs into an assessment unit, creating Care Managers and introducing out of hours services for community care assessments.

OUT OF HOURS
5.18 Most Partnerships were introducing new working practices for social workers, allied health professionals and/or nurses in order to care for people in the community outwith normal working hours and/or to speed up the assessment process. Ayrshire and Arran Partnership, for example, were opening day centres during evening and weekends, developing an evening nursing service and introducing ‘out of hours integrated care.’ Other Partnerships were developing out of hours services though they did not explain how this would improve the discharge process.

CARE MANAGERS
5.19 Many Partnerships were introducing or developing discharge planning in hospital to tackle delayed discharges. Particular posts responsible for managing discharge were being created. In Forth Valley for example, a ‘delayed discharge nurse’ was responsible for targeting people who had been delayed the longest. An individual action plan to facilitate their discharge was drawn up. A health care manager, who was interviewed for this research review, said that preliminary data held by Forth Valley Partnership shows that this initiative had resulted in a reduction in the number of ‘longest waiters.’

5.20 A number of other Partnerships were creating management posts to co-ordinate and/or manage delayed discharges. Moray Partnership, for example, was introducing an early supported discharge nurse, care organiser, lead nurse, and delayed discharge development officer.

EQUIPMENT AND ADAPTATIONS
5.21 The majority of Partnerships were introducing equipment stores and home adaptation initiatives.

TRANSPORT/READY ROOMS
5.22 A handful of Partnerships had introduced bespoke vehicles to take people home who had been discharged so that they did not have to wait in a hospital bed until someone could take them home. Orkney Partnership had a ready room for those ready and waiting to go home so that they did not have to wait in the hospital bed.

DAY CARE
5.23 A minority of Partnerships indicated on their Joint Action Plans that they were focussing on day care with a view to tackling delayed discharges. A social care manager who was interviewed for this research review reported that Borders Partnership had introduced an initiative in which social care and allied health professionals were jointly providing day services. They intended to evaluate this integrated approach by finding out if it prevented a hospital admission and/or facilitated discharge.
CHAPTER 6: CONCLUSIONS
DEVELOPING A WHOLE SYSTEM APPROACH TO TACKLE DELAYED DISCHARGES

6.1 This research review offers no conclusive evidence of the causes of delayed discharge or ways of solving the problem. Instead, it has highlighted that individual, medical and organisational factors are related to delayed discharge. Examples of initiatives that have evidence of effectiveness in tackling delayed discharges, both from the literature, Joint Action Plans, and from snapshot telephone interviews have been presented including hospital at home schemes, discharge planning and clinical routines.

6.2 This research review is unable to clarify whether a number of initiatives being introduced in Scotland have evidence of effectiveness. This may be due to a number of reasons such as (i) the literature search for this review was not comprehensive; (ii) evidence exists but is not easily accessible; (iii) the evidence does not exist because evaluations are not being carried out. If it is the latter then more local evaluations of the impact of, for example, care homes, out of hours, assessment, equipment and adaptation, and the introduction of delayed discharge planning would be useful. This research review also similarly suggests that further evaluations of the role of different health and social care professionals would add to understandings of how to effectively tackle the problem of delayed discharges.

6.3 Additional information should be requested on Joint Action Plan forms. For example, there is no requirement for Partnerships to specify in their Joint Action Plans if groups of the local population are being targeted and if so, how. The majority of Partnerships identified older people as the biggest group in the population at risk of experiencing a delay. However, it was not clear how most Partnerships were developing strategies for specific groups of older people, such as those with dementia or if, and how, they were targeting other high risk groups of the population. Secondly, it would be useful if Partnerships specified if there is a relationship between local causes for delay and initiatives being introduced and developed to tackle the problem. Thirdly, it is not clear if Partnerships are drawing on evidence of ‘good practice’ to introduce and/or develop initiatives. This evidence could be drawn from elsewhere for example, from the Scottish Executive ‘learning network’, or from local evaluations. Fourthly, it is not possible to derive from the Joint Action Plans if initiatives listed were being evaluated. Finally, it would be useful if Partnerships described how they were monitoring delayed discharges and what information systems they were using, and in particular if they were using data across the care system that included primary care and social care data.

6.4 The authors of this research review, like others (Foote and Stanners, 2002; Glasby et al. 2004; Kendrick and Conway, 2003; Reed et al., 2002) recommend a whole systems approach to tackle delayed discharges because it is an approach which draws attention to the importance of assessing the impact on delayed discharges of individual initiatives, and combinations of initiatives, in the context of local needs and local resources and service configurations. It is an approach that is “based on the principles that any meaningful changes or solutions involve whole systems rather than separate organizations or sectors, and so any development work needs to encompass as much of the system as possible” (Reed et al., 2002, p.37). Scottish Partnerships are moving towards developing a whole systems approach. For example, most Partnerships recognised the need to tackle emergency unscheduled admissions and delayed discharges simultaneously. A whole systems approach, that looks at the ways in which one part of the care system impacts on another part, is likely
to be important in view of imminent health service changes such as the new out-of-hours arrangements in the new GMS contract.

6.5 A further demonstration of the move towards a whole systems approach in Scotland is that all Partnerships are composed of multi-agency strategic level groups. In this sense, an overview of the whole local care system is potentially being used to tackle delayed discharges. However, the research review suggests that a whole systems approach still largely remains an aspiration for the majority of Scottish Partnerships in relation to evaluating how initiatives function as distinct services but also how they inter-relate and operate as a component part of a range of initiatives tackling delayed discharges.

Diagram 2: A whole systems approach to tackle delayed discharges can be captured diagrammatically
6.6 There are four key inter-connected steps when using a whole systems approach to tackle delayed discharges:

**Reasons for delayed discharges**
6.7 This research review highlights the need to find out which people in the local care system are most at risk of experiencing a delayed discharge, and why. It also suggests that particular parts of the care system, for example, waiting lists for care home places or deficits in discharge planning are likely to require specific attention because of the impact that it has on delayed discharges. At the same time, the research review suggests that causes for delay are likely to be a consequence of how the care system as a whole functions.

**Initiatives to tackle delayed discharges**
6.8 A wide range of initiatives in different parts of the local care system are likely to be required to tackle delayed discharges. An understanding of relationships between initiatives and the impact that they have on each other is necessary so that the system as a whole functions effectively to tackle the problem.

**Monitoring**
6.9 Monitoring the impact of initiatives nationally and locally with well-designed information systems will inform the design and development of care systems to tackle delayed discharge. Measures need to be used consistently both within and across different regions to allow for meaningful comparisons in Scotland.

**Evaluation**
6.10 Evaluations need to assess the impact of individual initiatives, as well as the combined impact of a range of initiatives to identify what aspects of services are really making a difference. The following areas were identified as useful for service development purposes to tackle delayed discharges:

- many outcome measures commonly used to assess the effect of initiatives on delayed discharges, for example the number of delayed discharges as defined by the census, may be unsuitable for local evaluations because they are too broad to capture how some initiatives are impacting on delayed discharge;
- measures need to structure local action towards long term systemic change, as well as helping to assess the effects of short term action to combat delayed discharges;
- evaluations need to capture the impact of individual initiatives, as well as the combined effects of a range of initiatives, on delayed discharges;

6.11 This kind of approach can be supported if there is collaboration between local Partnerships on the one hand, and national strategic bodies on the other. Capacity building in terms of skills in whole system data collection, data handling and analysis is also likely to be required. Finally, organisational capacity to use a whole system approach systematically in service development and planning is essential.
Annex 1

LITERATURE SEARCH
Search terms
Delayed discharge
Bed blocking
Dates 1984 - 2004

Table: Databases searched and number of documents

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