Delayed Discharge: personal reflections on a one year service project

Gail Dearing
Head of Social Care
Social Care Directorate
Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust

Personal Reflection

‘Delayed Discharges disrupt the therapeutic potential of the ward, create dependence in service users and waste scarce resources’ (CSIP 2007: 3).

Introduction

A certain doctor in learning disability services influenced this article. We were sat contemplating the project before a review meeting, one of many I was welcomed to over the course of the project, when he suggested that an article in this journal would be a good idea - thank you very much!!

First of all, let me just clarify a few things: this is a personal account representing my views, as opposed to those of colleagues or of the Trust as an organisation; I will not be referring to specific case examples as there is a danger of breaching confidentiality, but to stress that my passion for this project has been driven by a wish to improve the experience of service users who come to stay in any of our Units; I will also not refer to individual workers or establishments (although you may know who you are!), instead talking about service areas (namely, People of Working Age (POWA), Services for People with a Learning Disability (SPLD), and Older Peoples' Mental Health Services (OPMH)).

This article will commence with an historical perspective, then focus upon the national context and origins of ‘Delayed Discharge’ within the national legislation and guidance, before considering local policy and the project itself – how it started, the key objectives, and the initial work that was carried out.

As an optimist, I will then reflect upon what I consider to have been the project highs, beginning with my favourite, statistics, and then moving onto some of the key challenges which remain ongoing. Finally, I’ll offer
some thoughts about future opportunities, which I hope will stimulate plenty of debate!!

**Historical Perspective**

I thought it important to start with some history, as we can easily forget the pace of change.

In 1954, there were 154,000 ‘psychiatric’ in-patient beds, amounting to 350 per 100,000 population. In 1961, Enoch Powell announced his vision for services which included a closure and re-provision programme for the ‘water tower hospitals’. In 1982, there were 151 beds per 100,000 population. In 1987, the beds had reduced further to 67,000, and in 2003-4 this was merely 32,400 (SCMH 2005: 37).

‘In 1985, someone looking for help with a mental health problem would expect to be treated in a psychiatric hospital. In 2005, someone with that same mental health problem could expect a very different approach to be offered by a range of Crisis Resolution and Home Treatment Teams (CRHTs), crisis houses, partial hospitalisation, Early Intervention Services (EI), Assertive Outreach Teams (AOTs), and multi-disciplinary Community Mental Health Teams (CMHTs) provided by a combination of health, social care and voluntary sector organisations’ (SCMH 2005: 37).

So my point here is that we have mainly institutionalised people with mental health problems until 20 years ago, perhaps explaining why we are taking some time to shift in our attitudes and ways of working. Alongside this, consider the continuing stigma surrounding mental ill health and the preoccupation with risk.

So how does this relate to delayed discharge? I think it explains why there is still a tendency to view admission as an outcome as opposed to part of a process in a service user’s journey.

It is also worth taking note of some research conducted by the Sainsburys Centre in 1998 across 38 hospital sites, which involved interviews with 112 service users. The findings were that 1 in 10 service users had been admitted for the wrong reasons, mainly relating to social factors or for respite. Nearly three quarters of these service users who were on the ward some two months later did not need to be there (SCMH 2005).
The question I would like to pose is this: *if you walked into your local acute unit today, how different would you find the picture to be for service users?* I suggest not dissimilar. The reduction in acute beds and rehabilitation placements has, I would argue, just exposed delays and prompted a need for early resolution due to the impact on admissions.

**National Context**

In 2003, the Department of Health published a policy document with the aim of improving ‘local hospital discharge policy and practice’ (DH 2003).

> ‘Discharge from hospital is not an isolated event. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individuals concerned and their carer(s) should be involved at all stages and kept fully informed by regular reviews and updates of the care plan’ (DH 2003: 2).

Doesn’t that sound simple and obvious? What the rest of the report goes on to unpick however, are the complexities of discharge planning, and particularly the interface between health and social care.

The Community Care (Delayed Discharges) Act came into force in October 2003. It brought in a process of reimbursement for hospitals by Social Services Departments when a delay was registered. Trusts providing mental health services, intermediate care or rehabilitation services were excluded from this financial process but were asked to prepare procedures.

In April 2006, Mental Health Trusts were required to start to complete weekly reports (called SITREP reports), which passed data onto the Department of Health: numbers of delayed discharges, their location and the cause of each delay.

There has been no further specific legislation around delayed discharge though its profile has grown due to related policy and guidance which has focused on recovery and social inclusion, moving even further away from institutional care. To mention just a few: the National Service Frameworks for Mental Health / Older people; Valuing People; Supporting People.
Acute care beds have been reduced nationwide with Crisis Resolution and Home Treatment Teams offering an alternative to hospital admission and facilitating early discharge. Rehabilitation projects have become recovery focused, offering short term programmes as opposed to the former ‘slow stream rehabilitation’ which had become, quite frankly for many service users, a stagnant pond.

Locally this translated, in 2006, into a 20% reduction in acute adult mental health beds, a 50% reduction in rehabilitation beds, 12 beds across two older peoples’ units, and fewer beds in the SPLD acute care.

**Local Context**
Within the Bedfordshire & Luton Partnership NHS Trust (BLPT), we are currently working to a Policy for the Management of Delayed Transfers of Care, dated 18th July 2007.

The purpose of the policy is: ‘To ensure that people who are medically / psychiatrically fit for transfer of care do not experience unnecessary delays. Where the delay exceeds an agreed acceptable period, the process will be actively managed to resolution by the Trust, Social Services and Health Commissioners.’

This policy offers a definition of a delay as: ‘A delayed transfer of care occurs when a patient is ready for transfer from an acute hospital bed, but occupying such a bed. A patient is ready for transfer when: a clinical decision has been made that a patient is ready for transfer AND a multi-disciplinary decision AND the patient is safe to discharge / transfer.’

A care pathway is set out for service users across service areas, which requires a treatment plan to be in place from admission, if not prior to admission. This care plan should be reviewed regularly, directly involving the service user and all relevant parties, including the advocate, carer and others, which should include discussing readiness for discharge. The Care Programme Approach is central to this, and particularly the role of the allocated Care Coordinator.

If a service user is transferring into another care setting, be it the one they were admitted from or a new one, then a delay will be recorded if the discharge is later than 3 days from the planned date. Otherwise, delay
begins when an agreed care plan for discharge has been completed and the planned date for discharge has passed.

As regards the reporting of delays, the policy requires this to happen weekly from Units / Projects, in accordance with Department of Health reporting guidelines. These cases should then be subject to weekly reviews with recorded action plans. The policy sets out plans for a fortnightly delayed discharge meeting to discuss cases and an escalation process for delayed cases which exceed 30 days through the Chief Executive.

Finally the policy sets out the key criteria for discharges being delayed:
1. **Completion of assessment**
2. **Public funding**
3. **Further non-acute NHS care (including rehabilitation)**
4. **Care home placement – residential or nursing**
5. **Care package in own home**
6. **Community equipment / adaptations**
7. **Service user / family choice**
8. **Disputes**
9. **Housing – service users not covered by NHS and Community Care Act**

**Establishing the Project**

The Delayed Discharge Project commenced in September 2007 and involved myself as Project Lead, a Line Manager, and we were lucky to have, even if only for one day a week for the first few months, a Discharge Coordinator from the Luton and Dunstable Hospital, who really helped with setting up systems and offering lots of ideas about addressing key causes of delays.

The project was launched widely using Trust communications, including Trust Today, Staff Matters, and the Team Brief, but also by meeting with all the Unit / Team Managers and Medical staff over the first month to introduce the project, gather information about positive practice and ongoing challenges. This led in many cases to invitations to team meetings and to provide some presentations.
Project Objectives
These were agreed as follows:
- To support multi-disciplinary teams to address delayed discharges, to include individual support for care coordinators / attending reviews;
- To work with teams in identifying the causes of delays and agreeing action plans;
- To collate statistics on a weekly basis for the DH, and then monthly for the Trust Board;
- To coordinate the delayed discharge meetings, providing summary reports of delayed cases for discussion and using this forum to highlight issues for the Trust and its partner organisations;
- To escalate cases where the delay exceeds 30 days and ensure the development of appropriate action plans;
- To focus initially on the process and management of delayed discharges, then moving to more proactive work around discharge planning in preventing delays.

Project Highs
Fortunately, the project has had many high points, although that is my opinion – let’s see if I can convince you.

Let’s start with numbers. When the project commenced, 24 service users were identified as delayed discharges for long periods of time, and some for several years. Of those cases, only two remained as delayed discharges by the end of the project: one in POWA and another in SPLD (the good news is that both service users have now moved on, as at January 2009).

I do need to clarify those Units / Projects that were included in this count. They included: all three POWA Acute Units; all four OPMH Acute Units; two adult rehabilitation projects; and, 2 SPLD Acute Units.

Between August 31st 2007 and August 31st 2008, there have been a further 106 delayed service users registered with the project and subsequently monitored, with support being offered to care teams and reported to the DH. As regards the service areas, of these 106 service users, 29 were in POWA; 4 in rehabilitation projects, 59 in OPMH, and 14 in SPLD.
The causes of delay have often been complex but for the purpose of statistical reporting, the key reason has to be recorded. It is also important to realise that the cause of delay can change a number of times during the delay process. I have therefore grouped *funding* and *placement* as a reason for delay, as the two tend to be inextricably linked.

In POWA, the reasons for delays were: housing = 11; placement / funding = 13; care package = 3; awaiting rehabilitation place = 2. In the rehabilitation projects: placement/ funding = 3; housing = 1. In OPMH: nearly all of the delays, some 58 of the 60, were the consequence of placements / funding and, of these, approximately one quarter involved issues of family choice at some point in the delay process; care package = 1; housing = 1. In SPLD: placement / funding = 9; care package = 4; housing = 1.

So what is significant about these figures? The number of service users being delayed has reduced considerably over the past 12 months. At the end of August 2007, 28 service users were delayed as compared to 14 in August 2008. More important, however, is the reduction in the length of delay for those service users (*as shown in Chart 1*). At the end of August 2007, some 1,158 bed days were attributable to delayed discharges, which breaks down to an average of 37.4 per day that month, as compared to 476 bed days at the end of August 2008, which breaks down to 15.3 per day that month.

So how did this relate to the national targets for delayed discharges? During the period of the project, Monitor (for Foundation Trusts) set a target of 7.5%. The Trust achieved 6.1% overall for the last financial year (2008-09), and as the project ended this was continuing to improve (*as shown in Chart 2*).

In April 2009, a new single set of 198 national indicators was launched for Local Authorities, following on from the comprehensive spending review in Oct 2007. N131 is the indicator for Delayed Transfers of Care, which has further heightened the profile of Delayed Discharge.
Chart 1: Trends in Delayed Discharges

Chart 2: Achieving Targets for Delayed Discharges
Changes & Improvements in Practice
So what made such a difference? Obviously I would like to say the project but, if I’m honest, that was merely a catalyst and what this was really about were changes / improvements in practice. Let’s consider some examples.

✓ In OPMH, I observed considerable improvements. Service user delays were generally promptly reported and lengths of delay reduced dramatically. Factors contributing to this included attention to the quality of funding applications, with the funding process becoming less complex in many cases, due mainly to good relationships with our partners in the Local Authority and Primary Care Trust (PCT) / Continuing Health Care Panels.

✓ One Acute Unit stood out particularly in that a discharge date was set, often within a week of admission, and attention to a delayed service user’s case, once registered, was reviewed regularly.

✓ Family choice often featured in the reason for delay in this service area, and mainly around placement in nursing / residential care, so I worked with the Trust solicitor who agreed a preferred choice letter which is now available for care coordinators to use as appropriate.

✓ In SPLD, I was struck by the quality of service user reviews that I attended, as a forum to address a service user’s delay. Service users were mainly fully involved in the review, usually with an advocate and good attendance by the whole multi-disciplinary team. I attended many reviews to facilitate the development of action plans to address the cause(s) of delay, setting realistic timescales and then maintaining the momentum through regular CPA reviews.

✓ Another development was the establishment of a local forum between SPLD, the PCT, Local Authority and BLPT which just focuses on delayed discharge. This has already had a positive impact on those service users delayed for a long period of time, including two service users having a house re-opened for them, with a specialist care team to meet their complex needs.

✓ In rehabilitation services, there were only a few reported cases, but I was actively involved in those cases and the impact was that staff started to realise the importance of long term planning with service users to prevent delay at the end of their six month stay. One success
to be highlighted has to be the offer of a flat to one service user in one day, following a meeting with housing that was facilitated by the project.

☑️ In **POWA**, progress was more gradual, though there was movement and examples of improvements in practice. I therefore spent more time during the project in this service area, both in terms of direct work with care teams and with proactive work that included training, audit, work around care pathways and housing.

☑️ To start with direct work, I called into the Acute Units regularly, meeting with care coordinators individually, attending reviews, offering support with funding applications, and assisting with finding suitable placements.

☑️ Listening to care teams, the funding application process to Local Authority Panels was felt to be hugely frustrating, and particularly in Luton. This led to the Project Manager developing a new form to ensure that all information was collated to avoid documentation simply moving back and forth. He then met the community teams with a representative from the Local Authority to discuss the funding process.

☑️ Housing / homelessness was the next area requiring a proactive approach. I had already been involved in setting up a protocol with housing services in Luton, and so I sought to re-activate this and the local mental health housing forum. Briefly, the process involves Unit staff referring a service user with any housing needs to the council upon admission, whether the reason is for homeless prevention or homelessness or a need to consider housing support. The housing forum then meets with care coordinators to see how identified housing needs can be met. This forum has continued to develop, with service users in the community now able to be referred, as addressing housing need can also prevent unnecessary hospital admission and hence delay.

☑️ In Bedford, I became a member of the Mental Health and Homelessness Task Group and, as part of that, carried out a pilot to launch a direct access form from the acute ward into housing options. In South / Mid Bedfordshire, work commenced and the new unitary Central Bedfordshire Authority should present as an opportunity to develop relationships further.
Care pathways in POWA have become more complex over the past few years, which was quickly evident when I started this project: with three strands of care (the Crisis Resolution and Home Treatment Teams, the Community Mental Health Teams, and the Acute Unit Teams) teams all trying to pull together, in addition to a functional model that separated in-patient care from community care – complications!! I therefore agreed to take part in some work focusing on care pathways in trying to focus on the need for joined up working. Key points included communication between all teams, prompt care coordinator allocation, and discharge planning from day one – all of these factors often contributed to the potential for delay.

Finally in POWA, I felt a need to undertake some work around service user reviews. Many I attended, as part of the project, lacked service user / carer involvement, nor involved any use of advocacy, showed poor preparation and were often rushed, resulting in confusion about the care plan and so compounding the cause of delay. I subsequently teamed up with the Nurse Consultant who had undertaken extensive work in this area, and we offered three educational sessions – one for each POWA Acute Unit, entitled ‘Meaningful Admissions’. These proved to be really fascinating, with each one proving to be very different. Briefly, the session consisted of role-playing a service user review and then using this as a basis to debate practice and identify key learning points. Attendance was multi-disciplinary and feedback was very positive. Highlights included an administrator role-playing a Consultant and loving every moment!!

Other highs that I have noted, have included: improved data collection, the setting up of a folder on the Trust’s computer hard drive (G drive) to ease access to all information about delayed discharge; launching a delayed discharge advice form to encourage early reporting and multi-disciplinary agreement; the escalation of cases involving delayed service users, which has brought about plenty of attention and interaction with relevant partner organisations.

Key Challenges
When talking about the project, above, I have already alluded to some of the challenges faced in addressing delayed discharges, though in a wider sense – for example: the culture of institutionalisation; the poor
streamlining of care pathways. Let’s now consider a few of these very real local issues that I have faced over the past 12 months.

- A lack of joint commissioning, such that there is no one point to direct deficiencies in service provision in seeking solutions.
- Finding suitable placements for some service users has been a particular challenge — *for example*, older people who present suicidality and or challenging behaviour; those with dual diagnosis (both with substance misuse / learning disability and mental health); those with early onset dementia; service users with a learning disability alongside dementia and physical health needs; adults in mental health services who require longer term detention under the Mental Health Act within a registered nursing setting.
- Geographical inequalities in service provision — South / Mid Bedfordshire has fewer Adult Mental Health Services, though the good news is that the Assertive Outreach Team has now arrived in South Bedfordshire (2009), in addition to a new supporting people provider.
- Age discrimination – service users in older peoples services are unable to access Crisis or Assertive Outreach Services.
- Section 117 – there is no local forum for discussing service users with complex needs. Continuing Health Care Panels are not the appropriate forum, but we have not created an alternative to resolve funding disputes.
- Rehabilitation services – there are a lack of vacancies locally and an inability to use some available resources.
- Supported housing – there is a need to look at increasing the range of provision. There is a glaring gap between having a tenancy with floating support and residential care, whereas some service users could benefit from a variation of this provision with housing / health and social care support being adjusted according to need.
- Social crisis house – there is as yet no local provision, though this could be a real alternative to admission for some service users.
- Care Pathways – to re-iterate some of the points made earlier: there is a lack of clarity about the purpose of admission; there is often a lack of involvement of the service user / carers; communication between Units / Projects and community teams is highly variable; there are delays in allocating a care coordinator; though service user reviews are so important, these are often ill prepared, rushed, and lack the full involvement of all parties.
There are intricacies in navigating funding application processes. The new Continuing Health Care Panels commenced in October 2007, as this project commenced. There has been new paperwork to negotiate and there is still the occasional dispute with the Local Authority, although I have observed less of this as workers have become more accustomed to the Decision Support Tool. The Local Authorities operate quite differently, with panels in Bedfordshire across all services but none in Luton, where, instead, the paperwork goes up for scrutiny, which can prolong decision making.

Linked to this, there is an ongoing issue about the quality of assessments, including risk assessment and care planning. This can complicate the funding process if the outcomes are unclear.

Future Opportunities
As usual, Mental Health Services and the rest of the public sector continue to be on the move. I thought it would be useful to finish by outlining some of the changes on the horizon which will impact further on delayed discharge.

- Delayed discharge is now a key performance indicator, and so will be subject to scrutiny both within the Trust and with our partner organisations. This will hopefully facilitate better partnership working, with regular forums being established, as has happened in SPLD, to focus on delays.
- Mental Health Act 2007 – Community Treatment Orders should limit the use of lengthy periods of Section 17 leave, and Independent Mental Health Advocates will support detained service users through their inpatient stay.
- Transforming Social Care – personalisation is coming and the hope is that it will lead to service users having greater choice and control of their care plans and more creative support plans being possible, contributing to less need for hospital admission and to earlier discharge.
- Mental Capacity Act 2005 / Deprivation of Liberty Safeguards – giving greater attention to capacity and human rights. This should ensure provisions are made so that the service user’s best interests are considered, including discharge planning, and ensure access to
Independent Mental Capacity Advocates to assist with residential placements.

- Housing – accommodation is moving up the agenda and will become a key performance indicator. We need to consider having a local housing strategy that involves all key agencies, including supporting people providers.

References
Sainsbury Centre for Mental Health (2005) Beyond the Water Towers. London: SCMH