LONDON BOROUGH OF HILLINGDON

HEALTH AND SOCIAL CARE
OVERVIEW AND SCRUTINY COMMITTEE

2003/4

Minority Report

REVIEW OF HILLINGDON'S PERFORMANCE: DELAYED DISCHARGE

Members of the Committee

Cllr Catherine Dann (Chairman)
Cllr Janet Gardner
Cllr Lee Griffin
Cllr Shirley Harper O'Neill
Cllr John Major
Cllr Mary O'Connor (Vice Chairman)
Cllr Jill Rhodes







FOREWORD TO MINORITY REPORT

Regrettably, two members of the Health and Social Care Overview and Scrutiny Committee feel obliged to exercise their right to publish the accompanying amended minority report following a meeting of that Committee on 18th September 2003. We voted against the Committee's report not because we disagree with anything contained in it. Our concern is with what it omits.

In our view much of the report is factual and positive in charting a way forward dealing with this difficult problem. We are pleased that it includes the vast majority of the proposals we put forward. However the final report, regrettably in our view, omits a number of important matters of detail, key points and the fundamental issue of the failure to involve front-line staff in the scrutiny exercise. We will leave it to the reader to decide whether or not the report is enhanced by the added prose and whether it is a better reflection of the evidence heard by the committee.

Cllr JOHN MAJOR & Cllr LEE GRIFFIN
19th September 2003

REVIEW OF HILLINGDON'S PERFORMANCE : DELAYED DISCHARGE

SUMMARY

The Social Services, Health and Housing Overview and Scrutiny Committee began this review in June 2002 having identified it as a priority issue for review.

The key outcomes identified were :

- To identify the issues leading to delayed transfers of care
- To develop recommendations on actions needed to reduce delayed transfers of care

As part of the review a wide variety of witnesses attended meetings, whose contributions are reflected in the conclusions of the Committee. In addition the Committee considered written representations and reports of officers. Running parallel to this review was an intensive push from all service providers to resolve the problems, which has significantly informed the review.

RECOMMENDATIONS ARISING FROM THE REVIEW

1. Local service providers must continue to work together in pursuit of the aims we have set out in our conclusions.

2. The Cabinet Member for Social Services and Health should receive weekly monitoring reports on progress in implementing the Hillingdon Health Economy Delayed Discharges Action Plan.

3. The Cabinet must receive urgent reports of any serious problems identified in implementing the Action Plan with recommendations on how to address them, and the Committee be made aware of any actions taken.

4. That lessons be learned from the Best Value Review of Accommodation and Residential Care for Adults with Learning Disabilities with respect to the use of sites for combined purposes (e.g. intermediate care, sheltered accommodation and other facilities offering a higher level of care).

5. That early next year, when full reimbursement under the Community Care Act will have commenced, the Committee review the Delayed Discharges Action Plan in operation and that frontline staff be called to give evidence to the Committee.

BACKGROUND

1. In 2002 Alan Milburn announced that the Department would "penalise councils that fail to tackle 'bed-blocking' (delayed discharges)". This raised the profile of an acknowledged problem: that of elderly patients who once admitted to hospital were not discharged to other care environments when their medical condition would have made that appropriate.

2. According to the Department of Health website (Feb 2003) :
    - Two-thirds of general and acute beds were occupied by people over the age of 65 years
    - People over 65 accounted for more than half the recent growth in emergency admissions
    - In 2000/2001 the average admission period in hospital was 9 nights. However for those aged over 75 this was 16 nights

3. The Department of Health's definition (April 2001) of delayed discharge was :

    "A delayed transfer occurs when a patient is ready for transfer from a general and acute hospital bed, but is still occupying such a bed. A patient is ready for transfer when :
        - A clinical decision has been made that the patient in ready for transfer
        - A multi-disciplinary team decision has been made that the patient is ready for transfer
        - The patient is safe to discharge / transfer"

4. The situation reflects interrelationships between the health and social care systems as well as the predominately private sector providers of older person care homes. Accordingly the Committee needed to look not just at what the Council could do, but at how this would affect the other partners within the health economy.

CURRENT POSITION

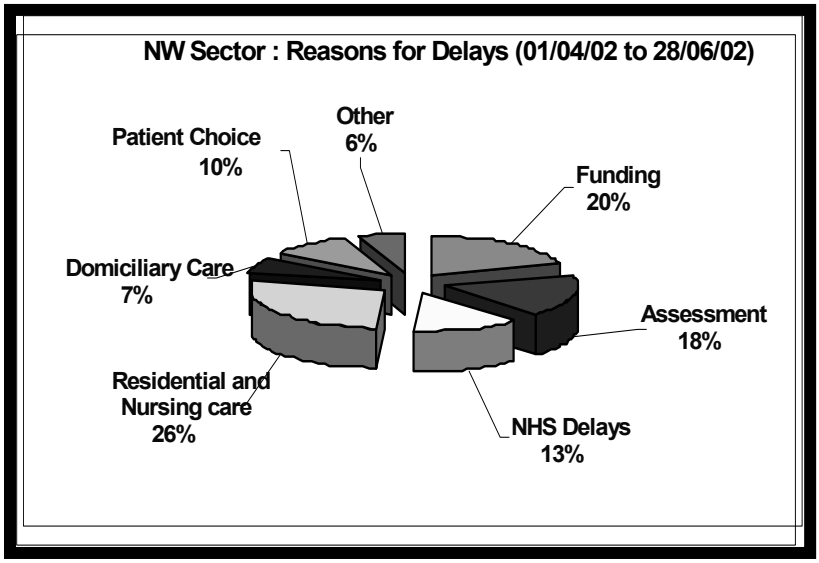
5. On 29th August 2002 the Committee received information on the local situation regarding delayed discharge, in particular from a one week survey of 42 patients aged 65 or over in hospital waiting for alternative accommodation, the results of which are set out in Table 1.

Table 1 : Performance In Hillingdon

	Total	Percentage
	42	100%
Reason for delay		
Waiting for assessment and identifying appropriate care setting	12	29%
Awaiting funding from social services	6	14%
Awaiting further NHS Care	0	0%
Awaiting nursing home placement	20	48%
Awaiting domiciliary package, inc equipment and adaptations.	0	0%
Patient and/or carer exercising right to chose.	2	5%
Other reasons	2	5%

6. Looking over the local region the following reasons were identified as causing delays in discharging patients across the North West London Sector (including Hillingdon)

Reason for Delays – North West London Sector



7. The Committee was also informed of another review, of inpatient stay, which found that 3 out of 11 patients could have been diverted from hospital admission - 2

by better medical intervention and 1 by combined medical or psychiatric and social care.

STEPS ALREADY BEING TAKEN

8. On 6th March 2003 the Committee reviewed actions already taken by officers to address the issue of delayed discharge, including the 'Hillingdon Health Economy Delayed Discharge Action Plan' which is attached at Appendix 2 to this report. The Action Plan was developed by Dorian Leatham (Chief Executive of the London Borough of Hillingdon), Graeme Betts (Chief Executive of the Hillingdon Primary Care Trust), David McVittie (Chief Executive of Hillingdon NHS Trust) and Jim Wilson (Interim Director of Social Services).

9. The Committee following consideration of the Action Plan agreed to welcome the information received, expressed concern at the spiralling cost of placements, welcomed the move towards sheltered accommodation in the Borough and recommended that there should be learning from the Best Value Review of Accommodation and Residential Care for Adults with Learning Disabilities in respect to the use of sites for combined purposes (e.g. sheltered accommodation and facilities offering a higher level of care).

10. As of 6th March 2003 the Committee heard from Jim Wilson that a range of measures had already been implemented :

- Extra funding for older people's service to increase the purchase of residential and nursing home provision – several beds purchased on a block contract in Feltham and Rickmansworth
- Development of community based service so that people can return from hospital to their own home, with appropriate domiciliary care
- Increase the amount paid to purchase beds in order to maintain LB Hillingdon's place in a competitive market
- Social Services would be giving £95,000 to the Hillingdon PCT to open beds in Northwood and Pinner Community Hospital
- Discussions with Housing Services about development of suitable units for sheltered beds
- 31 residential nursing beds due at Franklin House when the project comes on line (2004)
- 21 intermediate care beds at Franklin House (2004)
- build up Home Care capacity
- a prevention of admission scheme in partnership with GPs.

Other potential ideas that might help alleviate delayed discharges problems:

- more rehabilitation facilities created
- figures seem to indicate that 50% - 80% of discharges go back home after intermediate care. The alternative is residential care at much greater cost
- home care to review the way it operates in order to make the best use of resources

- housing to develop a support strategy for older people that will improve choice and quality as well as working in partnership with other agencies to ensure homes are warm and safe
- ensure that all services are promoting independence
- ensure that older people have access to good quality specialist information and receive free practical support
- careline offered free for up to six weeks after discharge
- full training for frontline staff. Too often conflicting or inaccurate information is given.

COMMON THEMES

11. In addition to the written evidence presented to the Committee it received evidence from a range of the organisations directly involved in resolving the delayed discharge issue, as well as from groups representing users, listed at Appendix 3.

12. Common themes that the Committee identified as coming from the presentations were :

- the need for more support in the community to avoid unnecessary admissions and to enable people to return to their own home, with appropriate care, following a stay in hospital
- the need for the earliest possible planning around discharge
- difficulties with the recruitment and retention of front line staff (e.g. Occupational Therapists, District Nurses) exacerbate the problem of delayed discharge
- the importance of liaison between the services to ensure a coherent 'whole systems' / partnership approach

Possible Additional Support

- more investment in preventative services (bathing, cleaning, escort shopping, home care/day care)
- better access to respite care
- affordable day care at weekends
- post discharge hot line service to assist or advise on any matter which might present problems coping at home.

Some of statements forthcoming from witnesses were:

- "lack of choice of residential placements"
- "discharge arrangements only considered once discharge has been decided upon"
- "need for some kind of transitional care after discharge, but before final decisions and choices are made"
- "need for collective information sharing between agencies and departments"
- "inconsistent availability of full information"

Some of the contributing factors either collectively or in isolation that witnesses thought were contributing to the problems were:

- high numbers of people who enter hospital in crisis;
- shortage of rehabilitation facilities;
- cost of nursing care beds;
- discharge not considered on admission to hospital;
- no discharge pack given to (and explained in detail) on admission to hospital;
- GPs are all informed of patient discharge; while some provide excellent backup, some do not follow this up with appropriate, or any support;
- in some cases there is a delay in organising simple but very necessary pieces of equipment for short term use;
- home care packages are not being arranged quickly enough, mainly due to a shortage of assessors;
- there is a York University study, which shows that nationally 40% of older people in residential homes do not need to be there;
- need to work with neighbouring boroughs rather than get involved in a bidding war for residential placements;
- costs now rising (for residential placements) so that it is difficult to budget with confidence.

WHOLE SYSTEMS APPROACH

Members of the Committee received an LGA written report entitled 'A Whole in One', which offered a whole systems alternative to the Community Care (Delayed Discharges) Bill, in which models of best practice, including Medway Council, were highlighted. The Committee agreed to invite a representative from Medway Council. That this did not prove possible was regrettable, for a valuable opportunity to hear first hand about best practice elsewhere was lost. The Committee did however receive a written submission from Medway that provided comprehensive information about the Council's Integrated Services initiatives.

INTERMEDIATE CARE

13. Intermediate care seems to be a key provision in solving the Delayed Discharges conundrum. It can act as a buffer between full residential care home care. But crucially it gives time for difficult, life changing decisions to be made in a careful and balanced way. It is vital that patients and their relatives are given the necessary information to make informed decisions about their care.

OUR CONCLUSIONS

1. Delayed discharge from hospital is a serious problem for all concerned – patients and their relatives – and medical, care and other service providers. We believe that the aim should be for a whole systems approach that achieves the following

- prevent unnecessary admission to hospital
- facilitate early but planned discharge from hospital
- provide a fast effective response to referrals

- give service users a breathing-space period in an enabling, non-acute setting (intermediate care)
- prevent long term admission into residential or nursing home where not appropriate
- more sheltered accommodation (homes for life) built for low dependency service users
- assistance to carers in making the right choices for their loved ones and also for themselves
- involving service users and their families fully in choice of care home or package of home care.

2. It is essential that the Hillingdon Health Economy Delayed Discharges Action Plan works. If it does not, there will be severe consequences

- for patients themselves and their relatives through the distress caused
- for other local services if the Department of Health's financial penalties are triggered.

Final comments:

It is in all agencies' best interests to ensure that Hillingdon's delayed discharge problems are resolved. Not least because under the Community Care (Delayed Discharges) Act new financial arrangements will operate in shadow form (i.e. without payment) from 1st October 2003. Full reimbursement will commence from 1st January 2004 at the rate of £120 per user per day.

It is also crucial to remedy these problems because of the cost in human terms.

Hillingdon Hospital has around 430 acute beds. If at any one time just 10% of these beds are inappropriately occupied, that means 43 patients are kept waiting.

It is crucial that all agencies continue to improve collective working; including very crucial links with GPs.