Reducing delays in hospital transfers of care for older people

Key messages in planning and commissioning

Professor John Bolton

ipc
institute of public care

OXFORD BROOKES UNIVERSITY

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Report Summary

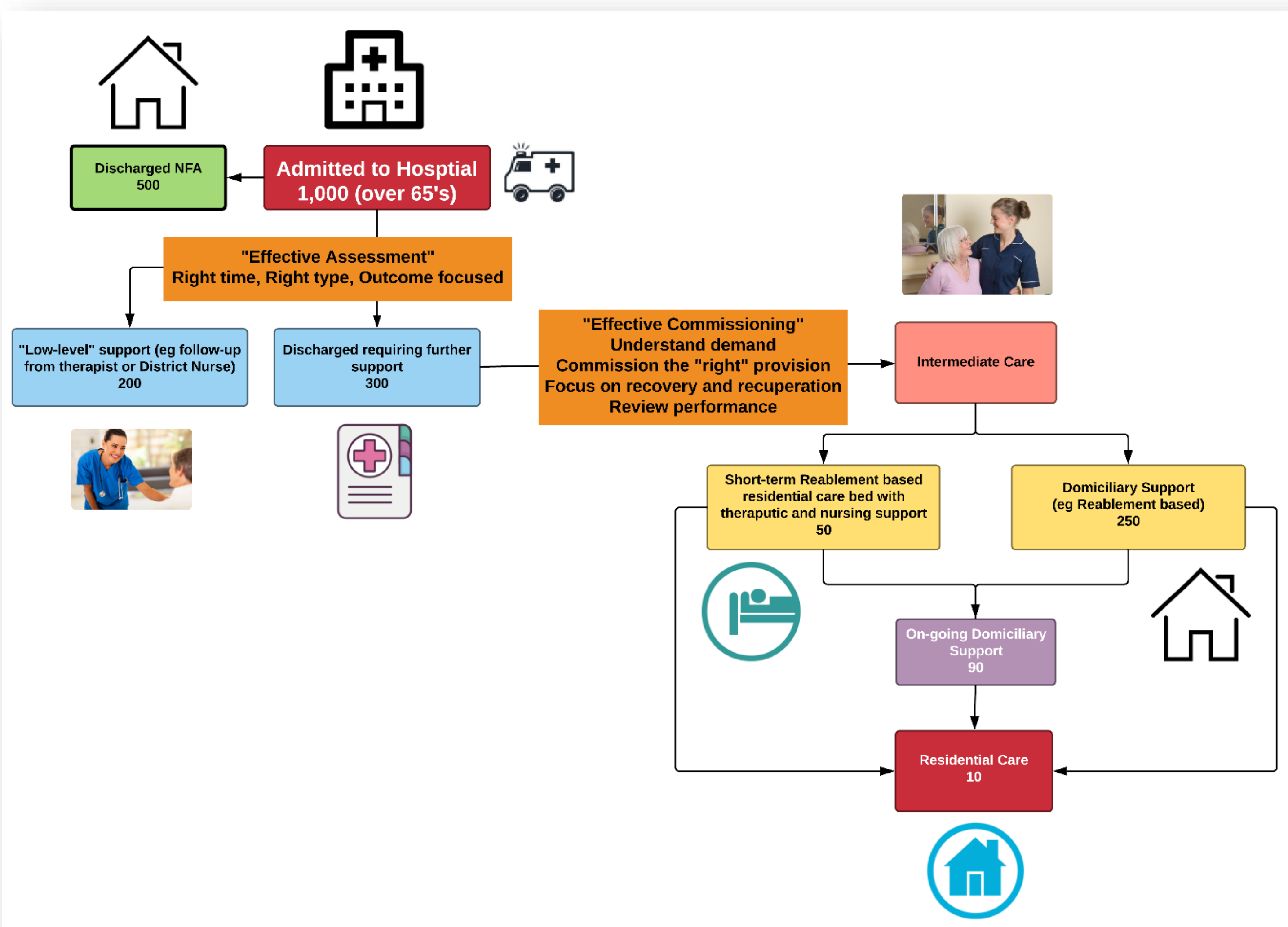
Delayed transfers of care for older people from acute hospitals can be reduced when:

1. There is less focus on assessment (for longer term care) at the point of discharge and more on recovery. Assessments take place after this help has been offered.
2. There is a specifically commissioned set of services to help people recover post hospital.
3. Commissioners understand the volumes of care that are likely to be required in the short-term.
4. There is a regular flow of people through the out of hospital care system with most not requiring longer term support (the system should not get “clogged up”).
5. Those not requiring care are let through the system quickly – providers are empowered to make the decision to end care where that is appropriate.
6. Therapists and others in the Multi-Disciplinary Teams write recovery plans for people at point of discharge (everyone should have a fully drafted discharge plan).
7. There must be a focus on how to assist people to manage their long-term condition(s).
8. It is not difficult to measure the outcomes of an out of hospital care system – whoever is the provider.

I have used the diagram below (Diagram 1) on several occasions to best describe the system that I think should be developed to assist in managing post hospital care.

The numbers in the diagram indicate what good practice might look like. Several local authorities have started using this chart to best capture current performance and to look to find areas where improvement might be made.

Diagram 1 – Managing the flow out of hospital



The diagram suggests that about one third of older people leaving hospital should need some care and support and most of those (around 85%) can be helped at home. The numbers ending up in residential or nursing care as a new admission on a permanent basis following a hospital episode should be very low (less than 4%).

The key message conveyed by the illustration and expanded in this paper, **is that each component of the model needs to understand the flow of patients, the outcomes achieved and the overall performance of the health and care system.**

Professor John Bolton
Institute of Public Care

Introduction

In the opinion of the author of this paper (Professor John Bolton) the main reason why delayed discharges from acute hospitals have dominated the health and care political landscape across the United Kingdom for the past three decades is because of the failure of both the health and social care commissioners/planners to design and procure the right services to support older people after a period in an acute hospital.

There has been much written on this topic and there has been guidance for Health and Care Professionals available since the 1990s. One of the best documents was – "Intermediate Care – Halfway Home - Updated Guidance for the NHS and Local Authorities" published by the Department of Health in 2009. Many of the messages of that guidance are repeated in this paper. However, this paper looks to make some stronger messages than much of the guidance which has not quite led to the transformation that the previous authors had expected.

The basic premise of this paper is that commissioners cannot expect providers of care (whether in-house or external provision) to be able to meet the demands and deliver the best outcomes for patients if they solely rely on services that were set up for a different purpose. Therefore, this paper **explores how local authority and health commissioners of "out of hospital care services" might determine the amount of care that is required to meet local demand and the services that should be commissioned**.

There are a further set of services that should be commissioned by health services to support discharged patients including a good supply of District Nurses, access to clinical support (especially GPs) and a clear line on the roles played by therapists; community hospitals (where they exist) and rapid response services whether they are employed or commissioned by health or social care. One of the current challenges to good out of hospital care is the shortage of district nurses (and community therapy). This needs to be discussed and explored by commissioners and decisions made about where paid carers can undertake some of the basic tasks (and who will pay for this). These matters are not explored further in this paper but are nonetheless important for consideration when designing an "out of hospital care system".

The assumptions are based on work I have undertaken in England, Scotland and Wales. Much of the model was built during early work on reducing permanent admissions to residential care from acute hospitals in Glasgow (working with both Local Authority and Health Board); work undertaken with the Borders Authorities (NHS, Social Care and Providers), work undertaken in Wales with Health Boards, Local Authorities and the Welsh Government and an examination of work undertaken by Newton (Europe) in Kent and their work for the LGA published as: "Why not home? Why not today"[1]. My more recent work (alongside case studies I have produced for the Local

[1] https://www.newtoneurope.com/content/sectors/NEW0164_DTOC_Brochure_Online_Spreads_1.0_1.pdf

Government Association[2]) with Nottinghamshire, Somerset and Pembrokeshire County Councils has affirmed my views. The emerging work in which I have participated on the Frailty Pathway in Wales has also contributed to the content.

From my work with these organisations across the UK there appear to be several key considerations when planning and designing services for discharges:

1. It is important to have **a good understanding of the patterns of demand** so that, at the point of discharge, a range and sufficient supply of the required services is readily available, including some residential intermediate care beds as well as support in the community.

2. Many delays are caused by patients waiting for an "assessment". Those planning discharges should always **consider whether an assessment in hospital is the best place** and whether many of the important aspects of an assessment could take place in a setting outside hospital – preferably at the person's own home.

3. As the needs of some people are frequently overestimated by some professionals at the point of discharge, a more timely and **systematic mechanism is needed that identifies people** who, when in the community, require less or no further support.

4. The services that should be available at the point of discharge should in most cases offer short-term **help that focuses on supporting recovery and recuperation**. These services must involve therapists, nurses and care workers, all of whom share the outcomes focus.

In addition, there is much work taking place with both Health and Social Care examining services that might be commissioned to reduce admissions to acute hospitals. These services are not discussed in this paper though there will be overlap between the proposals in this paper and the evidence emerging from this important work.

If health and care providers can agree that they want services that support discharge that can both respond in a speedy manner and deliver the best recovery for the patient, then there is a chance that they might be able to deliver a service that overall costs the system less, improves outcomes for older people and has much reduced delays within it.

This paper can be read alongside other papers produced by the author which are all located on the Institute of Public Care Website[3].

[2]https://www.local.gov.uk/care-and-health-improvement-programme-efficiency-project
[3]https://ipc.brookes.ac.uk/publications.html

As of way of exploring how local authority and health commissioners of “out of hospital care services” might determine the amount of care that is required to meet local demand and the services that should be commissioned (planned), I have structured my considerations using a basic commissioning cycle – “analyse, plan, do and review”. This approach reinforces the discipline of evidence-informed approach, and the importance of good performance management approaches.

1 Understand the probable numbers of older people requiring care and support (analyse)

The numbers of people who are likely to need support post hospital are fairly consistent week by week from particular hospitals (though they do vary significantly between hospitals). So those who will need support from domiciliary care each week; who may require bedded facilities (for a short period) or who need nursing support at home can be calculated and services commissioned accordingly. So, health and care commissioners should examine the patterns of discharge from a particular hospital and arrange for services accordingly. Commissioners may over time want to challenge those hospitals where patients require more care than others but in the first stage the local patterns should be considered.

Each acute hospital where I have considered the data shows variable performance in relation to the following factors:

- The percentage of older people who are discharged from hospital who are assessed as requiring formal care at the point of discharge.
- The percentage of older people who are discharged from care who are assessed as requiring bedded care at the point of discharge.

We can assume that there are a number of factors that will impact on who needs care (and who does not). There will be the activities and actions of the staff in the acute hospital: the risk averse nature of the assessments that take place; the work of therapists and others in helping people start their recovery whilst in hospital; the speed of discharge after surgical interventions; the way in which patients are encouraged to mobilise on wards; the use of catheterisation on hospital wards; and a whole host of variables around the lifestyles of patients and the availability of family (informal) carers. Suffice to say this paper does not provide answers to address these variables but it recognised that in each health and care system the commissioners should know what the likely performance is for their hospital and the likely impact that this may have on the demands on social care. It may be that the performance of the hospital can be improved over time once the features of a particular hospital are understood. There is really good work being undertaken by Professor Brian Dolan[4], Pete Gordon[5] and others under the heading of "End PJ Paralysis" which should assist in reducing the numbers who will need care post hospital.

Once we know the percentage figures it is relatively straight forward to predict the likely demands on the care system.

[4] The Last 1000 Days – Making Patients' time the most important currency. www.last1000days.

[5] The safer patient flow bundle

The following data will need to be collected:

- The numbers of older people (people over the age of 75) who are being discharged each week.
- The percentage of these who are deemed to require formal care and support.
- The percentage of these who require a bedded facility.

In my observations the numbers being discharged each week do not vary significantly (and is mostly determined by the size and type of work undertaken in the hospital). Again, the percentage of these who are assessed as requiring some formal care and support is fairly consistent week by week. The same applies to the likely percentage of these who are assessed as requiring bedded support.

Case Study

In a small general hospital (231 beds) there were 35 discharges a day of older people over a four-week study period in 2016.

Between 10 and 12 older people were assessed as requiring some formal care and support post discharge each day (about one third of those discharged). There were no specific services commissioned to support out of hospital care, but the care and support required was picked up by existing providers of care.

Each week there were about 20 older people who were delayed either because there were no bedded facilities for them or no available domiciliary care.

At any one time there were 126 older people in bedded facilities (including community hospitals) and their average length of stay was 28 days with a handful waiting much longer for a permanent placement.

From this hospital it was calculated that there needed to be 4,200 hours of reablement based domiciliary care available each 6 week period to support the demand on discharge.

The calculation was based on the assumption that 50 people per week would need some care at home of about 20 hours per week for two weeks (2,000 hours) reducing to 37 people needing 15 hours average for a further 4 weeks 2,220 hours).

It was expected that 25% of those referred to the service only required 2 weeks service; a further 60% required 6 weeks service with the remainder 15% requiring an on-going service of between 10 and 20 hours per person per week (an additional 110 hours per week for on-going care).

It was established that about one third of those admitted to residential care could have been discharged home if the above services had been available making significant long-term savings to the local authority.

From the calculations in the case study above it was estimated that each person who was discharged and assessed as requiring care and support were likely to need on average 100 hours per patient over a 6-week period. This is a slightly higher figure than seen elsewhere. This is probably because a relatively low percentage of older people being discharged were assessed as needing care therefore it was more likely that they had higher care needs.

For those places where higher percentages are assessed as having care needs post discharge it is likely that their care needs can be met with a lower average of hours per week. This requires a local calculation.

The main factor that could increase the number of care hours is where a person is immobilized in a way that at least initially they will need two carers to assist them in ambulation or transferring to a wheelchair. The number of people who will require these additional assistants can be reduced if occupational therapists and equipment stores prioritise their assessments to ensure that the right equipment (e.g. hoists) that can be installed as quickly as possible post discharge.

In summary for domiciliary care:

Calculate the numbers of people each week who are likely to be assessed as requiring care and support at the point of discharge by undertaking a sample over a 4 week period	**A**
Consider how many hours* of care they will require based on the principle that up to 40%* are likely to require no more than two weeks and the remainder between 6-10 weeks of care?**	**B**
Total hours (C) of domiciliary care needed	**A x B = C**

**Base the calculation on the average number of care hours/domiciliary care reablement that people will require e.g. 100 hours per person per episode of care in a 6-week period.*

***These percentages do vary from area to area according to the risk-averse nature of the assessments. Commissioners need to understand the requirement to meet the needs of their local populations.*

****Recognise that the care is delivered in a period of a six-week cycle and therefore carers should not be working with many patients for more than six weeks and many will be working with less. Therefore, carers should be taking on new people on a regular basis and assisting them to recover (under the guidance of a therapist).*

For bedded facilities a similar calculation is required. There are significant variations between acute hospitals as to whether a high or low percentage of older people require a bedded facility at the point of discharge. The number of people who are assessed as requiring a bedded care setting is unlikely to vary much week by week. If older people are placed in a bedded facility where there is both nursing and therapeutic support to the person and there is a focus on helping the person return to their home it is likely that 75% of these people will be able to return home within a six week period (thus freeing up the bed space for another customer). The calculation on the number of bedded facilities that should be specifically commissioned for the purpose of helping older people to return home can be made on this basis. Over time it may be possible to reduce the use of bedded facilities in some places.

2 Ensure the right range of care and support services are commissioned (Plan)

It is important that the NHS and Social Care work together to commission (procure) an "out of hospital care system that has its own set of (intermediate care) services and which focus on supporting the recovery of patients post-hospital. It will not work at its best if services are solely commissioned from existing services where they were not established for that purpose e.g. using standard home care agencies when they are not geared up to take a regular flow of new people. This applies to both residential care and to care at home.

The initial focus of all commissioned "out of hospital care" services should be on supporting recovery and recuperation. The evidence is clear to me that people are likely to make the best recovery in their own homes.

Domiciliary Care reablement is one of the main services that should be commissioned to support discharge and older people where the focus can be on their recovery (partial or whole). There is sometimes a view expressed by therapists and others that some older people are beyond help in relation to their recovery at the point of discharge. I am sure this may apply to a few people but my observation is that far more older people than we can predict will have some form of recovery. It is worth giving the majority of people this opportunity. We do know that the better domiciliary care reablement services (which are therapy led) can enable over 80% of older people to have a full or partial recovery after their hospital discharge. We also know that there are good reablement based domiciliary care services and some poor services.

The same style of services should be operated from bedded facilitates. The focus should still be on recovery and the main aim should be to help people return to their own homes. Programmes for older people should be commissioned from providers who have trained staff who can assist older people in their recovery, who are supported by therapists (and nurses where appropriate). There is evidence from some places that where the right services are commissioned over 80% of older people return home after a period in a residential care home. The phrase sometimes used to speed a hospital discharge is "discharge to assess". I absolutely agree that no one should be assessed from a hospital bed to determine their longer-term care and support requirements. This assessment should only take place after a period where therapy support has been offered to encourage the possibility of recovery (a minimum of six weeks). I prefer the phrase "discharge to support recovery – then to assess". There have been examples of older people who have ended up being "dumped" into residential care homes with no opportunity for recovery and within short periods of time they have been unnecessarily and prematurely admitted for long term care.

A piece of work I undertook in one large county in 2011 found that 1 in 3 of the older people who were admitted to residential care direct from hospital could have had their longer-term admission avoided if they had received the right support at the point of

discharge. These were older people who may well have required bedded care at the point of their discharge, but they were not given the opportunity to recover in their own time. The good quality care they received did support their recovery but by the time this was noted it was too late to reverse the permanent admission to the care home. These actions have two negative impacts – first for older people who generally want to return home if they possibly can but also to the discharge system as once a residential care bed is occupied by a permanent resident it is of course no longer available to support a new discharge. This clogs up the system and leads to more delays further down the line.

There is only so much supply of care in any community - bedded or community - making best use of the scarce resource (being mindful of the issues above) is one of the critical issues. Most areas can't increase bedded supply and can only influence care at home by around 5% of available supply.

There are risk averse cultures operating in health and care which have led to significant over prescribing of care at the point of discharge. This means that the capacity available is at risk of serious misuse at a cost to those who do need the services. The best way to overcome this is to allow providers to stop the service (without formal social work review) when they find someone does not require a service. The risk averse practice can also lead to a requirement for more "double-up" carer visits when these are either not required or where the use of simple equipment could reduce the numbers needed. Providers of domiciliary care should work with therapists to reduce the numbers of double-ups required. There is an excellent study undertaken by Cambridgeshire County Council and Prism Medical UK which demonstrates how this can be best achieved (and the consequent savings to budgets)[6].

Not enough help is given to people to assist them to manage their own conditions. If there was a greater focus on how to help people best manage their longer-term conditions so that patients could take some responsibility to reduce the impact of these on their lives demand on both health and social care services could be reduced.

There should be a separate service which focuses on assisting those who have a diagnosis of dementia (and their carers) to live with the disease. This should initially focus on helping people to remain in their homes. There should be wide use of assistive technology (including GPS technology and checking mechanisms and alert alarms). There should be opportunities for older people with dementia (and their informal carers) to experience relaxation massages, games to stimulate brain activity as well as exercise and outings (dementia cafes). There is much information on how best to live with dementia on the Alzheimer Society Web Site[7].

[6] Why wouldn't we do this Promoting Single Handed Care in Cambridgeshire May 2016 – Diana Mackay, Chris Marsh and Lesley Louden. The report can be obtained from diana.mackay@cambridgeshire.gov.uk
[7] https://www.alz.org/alzheimers-dementia/what-is-alzheimers

It has been noted that in some councils there has been a significant improvement in reducing delayed transfers of care, but this has led to a big increase in permanent admissions for older people to residential care. In 2009 a piece of unpublished work at the Department of Health showed quite a close correlation between the "best performing" councils in relation to delayed transfers of care and those councils with higher than expected (for the demographics of their populations) permanent admissions to residential care. This phenomenon can still be seen in some places today. Very much to their credit when Somerset County Council found that their improvements to reducing delays appeared to be linked to higher admissions to residential care they reviewed their front-line practice and in a relatively short period of time they sustained their reduction in delays whilst reducing permanent admissions to care. The key message here is that the role of social care is clearly to look to seek the best outcomes for an older person. A target to reduce delays should not be delivered at the expense of poorer outcomes for older people. The hypothesis developed in "Six Steps to Managing Demand"[8] and further developed in this paper is that one might expect 3% of those who are discharged from hospital to be assessed as requiring residential care (as a new placement).

Finally, there are a set of people who were admitted from residential and nursing care homes to the acute hospital. There can be delays for their return back to the home from which they were admitted when the staff at the home are uncertain as to whether they can cope with a person whose needs have increased (even if this is short-term). Some health services have increased their nursing support to both residential and nursing care homes in order to assist care providers with this. Others seek a period of assessment which should not happen within a hospital but in an intermediate care bedded facility (after a period for recovery). There should always be an expectation that people can return to the home from which they were admitted. In some cases, this might be written into the contracts between providers, commissioners and people requiring these services.

The range of care and support services that may be commissioned to support speedy discharges:

- Care at home provided by neighbours and volunteers.
- Care at home provided by care workers.
- Care at home provided by therapists supporting domiciliary care reablement-based workers.

[8] Six Steps to Managing Demand in Adult Social Care - https://ipc.brookes.ac.uk/publications.html

- Care in a bedded facility where therapists and nurses support people's recovery and recuperation through specialist care staff.
- Care at home supported by specialist dementia trained care staff.
- Care in a bedded facility supported by specialist trained dementia care staff
- Palliative care.

3 Ensure that only simple assessments are made at the point of discharge (Care Management Do)

There can be too much focus on "assessment" to meet people's longer-term care and support needs in hospital and not enough on supporting people to recover and recuperate. There is much evidence to suggest that a good percentage of assessments undertaken in hospital which determine a person's needs for longer term care can be overstated and inaccurate. Newton (Europe)[9] found that 1 in 5 assessments overstated older people's care needs. Acute Hospitals can be brilliant at interventions and surgery but can be poorer on recovery and rehabilitation.

There are eight different categories of older people who may require some care and support at the point of discharge[10]:

1. Those older people who require minimal and practical help to get home and start functioning successfully. These people may be supported by a family carer, volunteers/neighbours or a local scheme commissioned for that purpose.
2. Require support for a short time whilst they "find their feet" and work on the programme set by a therapist (need a little amount of care but emphasis on managing self-recovery). These people have often had some form of elective surgery and sometime require very minimal support (less than two weeks).
3. Require support through a re-ablement based package of care with a focus on a period of recovery which will vary according to the person and their condition.
4. Assessment is uncertain as to the individual's ability to manage (after a period of re-ablement).
5. Still have a serious condition where the prognosis is poor and need good quality nursing and care (including dementia care).
6. Require an assessment of their mental health (which is best not completed in an acute setting).
7. Require on-going nursing care and a "continuing care" health assessment.
8. Require palliative care.

For all of the help these people may require it is best not to make longer term plans before a period of opportunity for recovery (except of course those who are assessed as requiring palliative care). Even for those who may apparently need longer-term nursing care at the point of discharge a period of recuperation and support may allow some recovery which reduces the necessity of longer term care required.

The study undertaken by Newton[11] showed that there is an inconsistency in the decision-making process in acute hospitals related to the needs of patients at the point

[9] Report published by Local Government Association – Why not home? Why not today? 2018.
[10] Six Steps to Managing Demand in Adult Social Care - https://ipc.brookes.ac.uk/publications.html
[11] Report published by Local Government Association – Why not home? Why not today? 2018.

of discharge. Overall their evidence was that this leads to an overprescribing of care and support which the system can ill afford.

The best out-of-hospital care and support system I have observed only assessed patients in hospital as to whether they were fit for discharge and whether they would require any post hospital care and support. All of those who needed some care and support were referred to the "Intermediate Care Services" where they were then supported in the most appropriate way. This "assessment" for these services was made by nurses from the intermediate care service but who were based in the hospital(s). The recovery of the patient was the responsibility of therapists working with the Intermediate Care Services, which included bedded facilities and reablement-based domiciliary care. Social Workers carried out their "assessments" for long-term care at least four weeks after discharge and when people have had some opportunity to recover.

A percentage of people who are reported as delayed in a hospital bed are "waiting for an assessment". Invariably these people could be discharged and the assessment could be made at a later stage. A further group of people are assessed as requiring a longer-term care placement which is then not available for them. These people should be discharged to an intermediate care bedded facility where their potential for some kind of recovery can be assessed before seeking the best way of meeting their longer term care needs. No one should be admitted as a new person to a residential or nursing care home without experiencing a short-term programme for recovery. The simple message should be "Home First"!

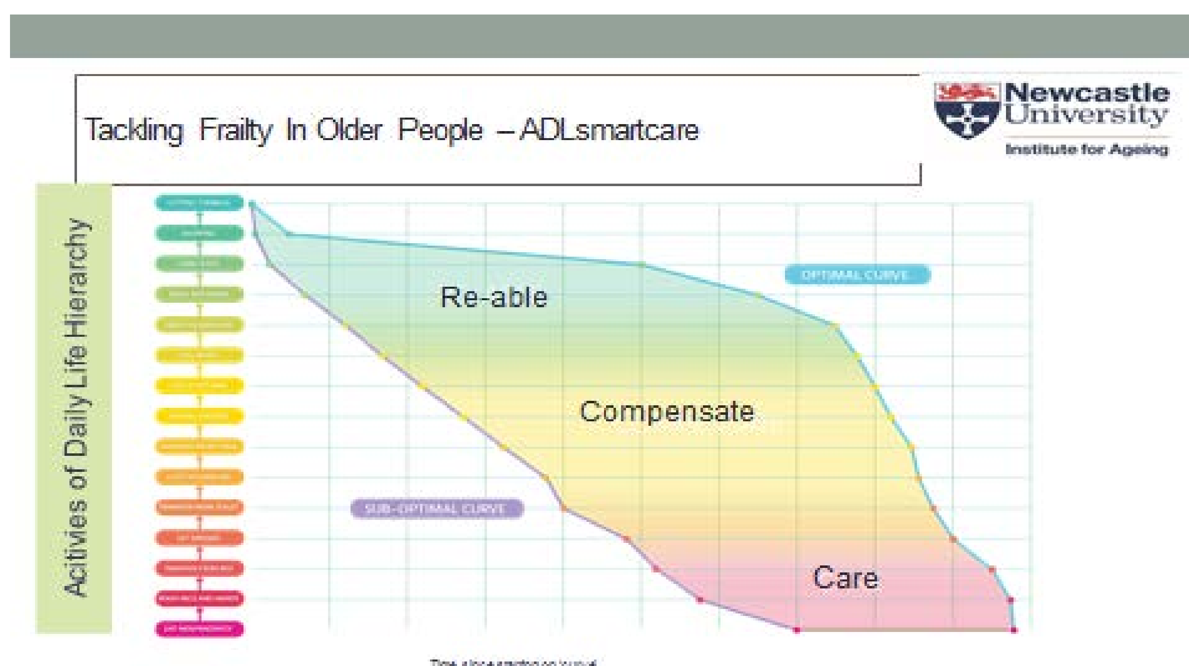
Some professionals in both health and care may pre-determine that a person will not benefit from a recovery-based service (but are not seen as requiring palliative care). Of course, this is a possibility, but my experience suggests that many more people will have some level of recovery beyond that which may be assessed when they are unwell in a hospital bed.

In addition, the work of Professor Peter Gore at Newcastle University Institute for Ageing has demonstrated that many older people can reduce their levels of frailty if they are offered the right help and encouragement. Professor Gore has even developed a software programme called ADL Smartcare[12] which helps to assess the best intervention that might assist in determining which forms of assistance might be most helpful. In their work the team at ADL Smartcare has suggested that most people could reduce their level of frailty. Diagram 2 lists the levels of help a person may need to help with their activities of daily living (ADLs) from cutting their toe nails; help with shopping; help using stairs or steps; help with walking 400 meters; help with heavy housework; help with cooking a meal; help with moving around; help to transfer from a chair; help with light homework; help to transfer from a toilet; help with getting dressed; help to get

[12] https://adlsmartcare.com/Home/LifeCurve

out of bed; help to wash hands and face; to help with eating independently. The list recognizes that anyone who is unable to undertake light housework (or any of the categories beyond that) is most likely to need some form of formal care and support. If a person can be helped in a way that enables them to undertake tasks that they previously could not do then the outcome is better for the older person.

Diagram 2



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Every person who is discharged from hospital should have a clear and concise discharge plan which they have read and understood. That plan should include a summary of the current and future treatment for the patient. It should include the best advice on opportunities to support the recovery of the patient (where appropriate); it should also include advice on assisting in managing any longer-term conditions; and it should include a contingency plan if things go wrong for the patient and what they might do. Many discharge plans that I have observed are inadequate and not fit for their purpose. Getting this right is an important part of an effective discharge planning process. The discharge plan may be reviewed by health and care professionals with the patient after a period focused on recovery and support.

This paper encourages all of those who are responsible for assessing older people for care and support needs to ensure that a period is allowed for recovery/recuperation before making longer term assessments. Of course, this is not a passive process but requires that the right help is offered to older people given their circumstances.

4 Ensure that providers of post hospital care are held to account for the outcomes they are expected to deliver (Service Provider Do)

Those who are providing these services should be held to account for the outcomes of their customers e.g. reduced hospital readmissions; low permanent admissions to residential/nursing care; high numbers not needing longer term care and support.

The following measures might be used for providers. The key message here is keep the measures simple and easy to collect the data:

Speed of response: Providers should be able to respond to a request for a discharge service within 48 hours (maximum).

Providers should be able to discharge people from their service as soon as they assess that the service is no longer required. (Sometimes providers have to wait for a period of time for the local authority staff to undertake or confirm the assessment which adds costs and unnecessary use of resources).

For those receiving reablement based domiciliary care the expectation might be that 65% of those receiving care at the point of discharge require no further on-going care and support within 6-8 weeks. (This is a figure that is regularly met by the providers in Coventry). This performance should be measured whether the service is provided in-house or commissioned from an external provider. If the performance does not meet the target this should be understood and shared between commissioners and providers. It may not always be the provider who is directly responsible for poorer performance in this area.

For those receiving bed based intermediate care the expectation might be that over 70% of the older people who have received a service are able to return to their own homes within 6-8 weeks. Where the performance is not reached this again should be understood by commissioners and providers.

5 Partners should consider a performance management system that supports best practice in relation to out of hospital care (Review)

In the paper – "Six Steps to Managing Demand in Adult Social Care[13]" the following objectives and measures were proposed. These might be considered:

Objective 1

The council working with NHS partners have in place a set of arrangements that allow for the speedy discharge of patients from hospital and achieves the best possible outcomes for those people.

Objective 2

There is timely, targeted and effective use of re-ablement and rehabilitation that has a focus on enabling independence and self-management and avoiding the over-prescription of care.

Objective 3

Health professionals managing medical conditions and delivering therapeutic help work closely with those offering re-ablement/rehabilitation to deliver the persons outcomes.

Objective 4

There are sufficient intermediate care type services available in the community to support discharge.

It is suggested that the evidence for the system working effectively is collected once a month and considered by the joint senior teams in order to better understand what is working well and what areas may require improvement. This data could be reported to the Health and Well-Being board once a quarter.

[13] https://ipc.brookes.ac.uk/publications.html

Performance Measures

For a council wanting to manage performance against these objectives we would suggest consideration of the following measures:

The % of patients who, at the point of discharge, have received an appropriate service within 48 hours. *This figure should be close to 100%.*

Key services are able to respond within 48 hours of being notified that their help is required. *This figure should be close to 100%*.

The proportion of people in any one week waiting for a service that has been agreed by the patient and the multi-disciplinary discharge team. *This figure should preferably be close to zero (with a record kept of reason).*

The proportion of people who are delayed from discharge when they are medically fit. *This figure should be close to zero.*

The proportion of patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery. *This figure should preferably be close to zero.*

The proportion of patients who return home after a short-term period (no more than six weeks) in a residential care bed. *This figure should be close to 75%.*

The proportion of people who receive long-term care after a period of short-term/re-ablement based care (this could be either a therapy led programme or domiciliary care based re-ablement). *This figure should preferably be close to 25%*

The proportion of older people who are discharged from hospital with no formal care services after two weeks/six weeks. *These figures should preferably be close to 40%/66%*

The proportion of people who receive long term support without being offered a period of recovery and recuperation. *This figure should be close to zero.*

6 Conclusion

It is not possible to eliminate all potential delays at the point of discharge. There are isolated situations that do require a complex assessment such as when it is considered that an older person may be being placed in or returned to an abusive situation or where a person's health needs are complex and require specialist attention. These should be marked out as the exceptions not the day to day activity. However, health and local authority commissioners should ensure that there is adequate supply of the right types of care and support at the point of discharge there should be fewer delays. Supply of care can be scarce as there are only so many care beds or hours of carer time available in any specific area and much of this resource is committed to people with longer term needs. The supply of care has to be well managed and providers should be held to account for the outcomes they produce for older people. This in turn both reduces the overall costs and delivers the best possible outcomes for older people.