

Delayed Discharges from Hospital Executive Summary

Jane Hughes, David Challis, Chengqiu Xie and
Janette Bateson

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PERSONAL SOCIAL SERVICES RESEARCH UNIT

The University of Manchester

Dover Street Building
University of Manchester
Oxford Road
Manchester M13 9PL
Tel: 0161 275 5250

The University of Kent at Canterbury

Cornwallis Building
University of Kent at Canterbury
Canterbury
Kent CT2 7NF
Tel: 01227 823963/823862

London School of Economics

London School of Economics
Houghton Street
London
WC2A 2AE
Tel: 020 7955 6238

DELAYED DISCHARGES FROM HOSPITAL

EXECUTIVE SUMMARY

The Community Care (Delayed Discharges) Act of 2003 placed new duties upon both councils with social services responsibilities and the NHS in respect of communication between health and social care agencies about the discharge of patients and the involvement of patients and carers in this process. In particular it sought to strengthen joint working and encourage clear and timely communication between the NHS and councils; improve assessment and the provision of community care for patients on discharge from hospital; and encourage the development of new services to facilitate this process, prevent unnecessary admission and promote the independence of patients/users. This study was designed to inform managers in the Adult Social Care sector of the Adults and Communities Directorate of Stockport Metropolitan Borough, Stockport NHS Foundation Trust and Stockport Primary Care Trust of the characteristics and circumstances of those patients who come within the parameters of the new legislation in order that they can amend and improve the assessment of their needs prior to discharge from hospital and commission appropriate services to facilitate this process.

Method

Although the legislative framework applied only to patients receiving acute inpatient medical care at the outset, a decision was made to include patients from both sectors within the hospital in the study. Data was collected retrospectively on a sample of Stockport residents discharged from hospitals within the Stockport NHS Foundation Trust whose discharge from hospital was subject to delay (186 patients) and those whose discharge was not subject to delay (231 patients) from both the acute wards and the non-acute wards within the Stockport NHS Foundation Trust between July 2004 and January 2005. It comprised information relating to patient/user characteristics, demographic information and service receipt details and was extracted from patient/user records in both the NHS and the Adult Social Care sector of the local authority (known as the social services department at the time data collection began). These data were analysed to identify the most salient factors in both the characteristics and circumstances of patients/users which impede arrangements for their safe and effective discharge from hospital.

Findings

- Length of stay in hospital was significantly associated with cognitive impairment, high dependency as measured by the Katz activities of daily living score and the provision of a care package on discharge from hospital.
- Admission to a care home was the most significant predictor of delayed discharge from acute inpatient care. Thirty eight per cent of the study sample was discharged to a care home for either long-term or interim care. Thirty per cent of patients admitted to hospital from their own home were discharged to a care home.

- Rehabilitation as an inpatient was a significant predictor of delayed discharge from hospital. Thirty nine per cent of patients were referred for rehabilitation assessment by a geriatrician and these patients were significantly more likely to have a delayed discharge. Twelve per cent of patients were moved to a rehabilitation facility and were also significantly more likely to be delayed.
- The requirement for home care was a significant predictor of delay on discharge from hospital. When service receipt prior to admission to hospital was compared with that on discharge, the proportion in receipt of home care doubled (26% to 52%) and the biggest change was within the group whose discharge from hospital was delayed. Arrangements for the provision of the community meals service on discharge from hospital were also significantly associated with a delay in the process.
- Patients with cognitive impairment were almost twice as likely to experience a delay in their discharge from hospital as those who were cognitively intact. They were also significantly more likely to receive a publicly funded care package including home care, the community meals service and day care and, unsurprisingly, the community psychiatric nursing service on discharge from hospital than those who were cognitively intact. Furthermore, patients admitted to hospital from home and discharged to a care home were significantly more likely to be cognitively impaired than those discharged to their own homes.
- Eighty three per cent of the patients admitted to hospital from their own or a relative's home had a main carer, 35 per cent of whom lived with them. These figures were almost the same in respect of patients whose discharge from hospital was subject to delay and those whose discharge was not delayed. Patients aged less than 65 years on admission without a carer were significantly more likely to experience a delay in their discharge from hospital than those with a carer.
- The social work team at the hospital received referrals about older people with a wide range of abilities. Whilst about just over 40 per cent of the study had short-term memory problems about half of the study sample did not have short-term memory problems prior to their admission to hospital. In terms of capacity to perform activities of daily living under a quarter were categorised as of high dependency and half of the patients in the study sample were classified as of low dependency.

Conclusions

In the period between the beginning of the study and its completion existing services within the locality principally concerned with the discharge of patients from acute care have changed and will continue to evolve and alongside them new services have developed and will continue to do so. The value of the study in this dynamic arena is that provides an evidence based benchmark by which to judge progress to date and signpost areas for future development. The components of this are summarised below. As such this research performs the traditional role of an evaluation study which seeks both to describe progress to date and the current state of service provision and identify areas for future development.

- Multidisciplinary teams will be required to provide rehabilitation services within the intermediate care sector in the community for people discharged from acute inpatient care.
- To provide care for vulnerable older people with complex needs at home in the immediate post discharge period requires continued assessment at home and that specific therapeutic and supportive services can be commissioned to support both the older person and their carer by discharge coordinators who have control of a budget for this purpose.
- The development of a service employing generic rehabilitation assistants will provide the additional assistance which carers require in the period immediately after the person they care for is discharged from hospital and be a tangible expression of the concept of 'supported discharge'.
- An adequate supply of interim care home placements within the intermediate care sector is required in order to facilitate the timely discharge from hospital of older people and avoid precipitate decisions about long term care arrangements.
- Attention must be paid to the interface between acute services and old age psychiatry services to ensure working practices and protocols promote appropriate inpatient care which in turn will influence the process of discharge planning for older people with mental health problems.
- To provide a service for the co-ordination of hospital discharge arrangements for patients with a range of needs requires an approach which discriminates between those with complex needs and those with less complex needs in terms of service response in order that procedures are in place which promote the timely and safe discharge of both groups.

