Healthcare Improvement Scotland | ihub

A case study about reducing delayed discharge from hospital

Exploring how East Ayrshire Health and Social Care Partnership ensures that people are safely and legally discharged from hospital to home, or a homely setting, as soon as they are medically fit.

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Overview

Healthcare Improvement Scotland's Improvement Hub (ihub) supports health and social care organisations to redesign and continuously improve services.

The purpose of this case study is to share what East Ayrshire Health and Social Care Partnership (HSCP) did to reduce the total time patients spend delayed in hospital with no more need for hospital care, whilst also increasing the reliability of systems delivering safe, legal and person-centred discharge. It describes improvement initiatives the partnership took, and aspects of leadership and organisational culture enabling this progress and continued commitment to improvement.

It is Healthcare Improvement Scotland's hope that other HSCPs in Scotland will find this overview useful in further developing their own approaches to reducing both delayed discharge and the risks to patients from unnecessary time spent in hospital.

Summary

This case study reports on several initiatives undertaken by East Ayrshire HSCP to reduce hospital bed days and risks to patients associated with delays in discharge. Whilst the success of these initiatives – increasing early referral to social work, 'Discharge to Assess', a dedicated mental health officer, intermediate care and the Red Cross 'Home from Hospital' service – are considered key, it is important to understand they cannot be seen separately from one another nor from the whole organisation. Indeed a key finding of this case study is that East Ayrshire's whole system approach driven by strong consistent and caring leadership at all levels in the organisation, and with a relentless focus on person-centred outcomes, is central to the overall success.

Introduction

East Ayrshire Health and Social Care Partnership (HSCP) has had considerable success in reducing both the numbers and lengths of delayed discharges. A delayed discharge is defined by NHS Services Scotland as "a hospital inpatient who is clinically ready for discharge from inpatient hospital care and who continues to occupy a hospital bed beyond the ready for discharge date" (1). Since 2009, East Ayrshire has consistently met the national zero target for delayed discharge (2). More progress has been made in recent years to reduce both the length of delays and the number of bed days associated with delay, particularly for adults with incapacity (AWI).

This case study seeks to understand how East Ayrshire HSCP achieved this success, focussing mainly on the contribution of various changes made since 2015.

Approach

A mixed method approach was taken to build a rich picture of the success and how it was achieved. It was primarily a qualitative approach using semi-structured interviews and review of documentary sources (2–8), along with some observation of a hospital at work. A range of interviews were carried out with the chief officer, senior and middle managers, and front line workers. Several interviews took place during two site visits to University Hospital Crosshouse (UHC), one of the main acute hospitals in Ayrshire. Other interviews were conducted by telephone. Interviewees came from several organisations including HSCP management, NHS Ayrshire and Arran, and from the third sector. Some quantitative data was reviewed and is included, primarily to evidence and illustrate the successes achieved.

About East Ayrshire[a]

East Ayrshire is situated in southwest Scotland and has a mixture of urban, rural and isolated communities. Parts of the area are prosperous but inequalities continue to exist. Some key facts about East Ayrshire include that it:

- Covers an area of 490 square miles, from Lugton in the north to Loch Doon in the south.
- Has a population of 122,200 including 23,917 (19.6%) aged over 65 (Scotland has 18.5%).
- Has one urban area, Kilmarnock, with a population of 46,770 people.
- Has a relatively high share of the most deprived areas of Scotland with about a third of the area falling within the 20% most deprived areas in Scotland (see Figure 1).

[a] Population profile information from East Ayrshire Community Planning Partnership, Local outcomes improvement plan – area profile, March 2018. Deprivation information from SIMD16 council area profile for East Ayrshire available from https://www2.gov.scot/Topics/Statistics/SIMD/analysis/councils.

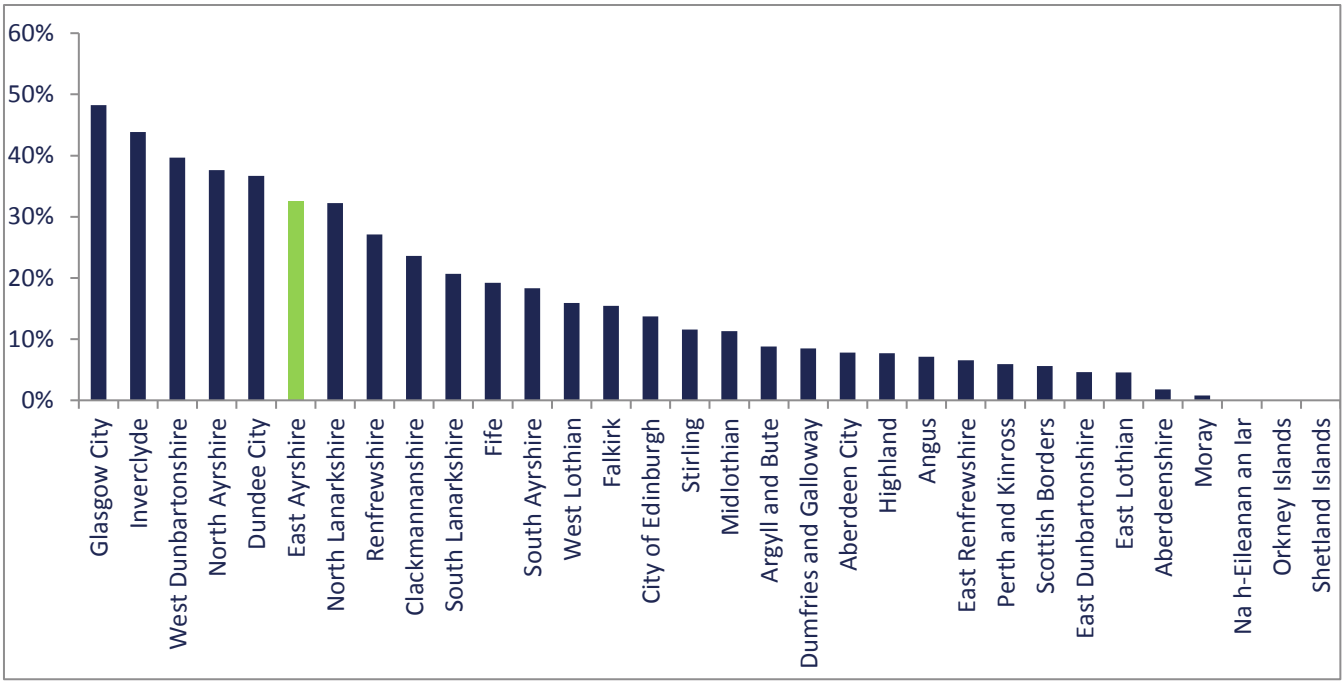

Figure 1: Percentage of council areas in the 20% most deprived areas in Scotland measured by data zones[b].

Why delayed discharge matters

Hospital is not always the safest place to be

Reducing delays in discharge from hospital matters for many reasons, but most importantly it is almost never an appropriate place for someone to be if they no longer need hospital care. Time spent in hospital when medically fit is an unnecessary risk to health and welfare, involving risks such as hospital acquired infection and loss of mobility. A delay extending into weeks can critically affect a person's chance of regaining independence, particularly for those with already complex health needs and those aged over 65 (9–12). Serious questions about a person's liberty are raised when delays extend to months, which is not uncommon in Scotland, where a person does not have the capacity to consent to life-changing decisions.

As well as being in a person's best interest in most instances, enabling timely discharge for someone to home, or a homely environment, brings with it other benefits in terms of more efficient use of hospital and community-based resources, reducing costs and increasing service capacity particularly when measured in saved hospital bed days.

[b] Data zones are the key geography for small area statistics in Scotland. They are designed to have roughly standard populations of 500 to 1,000 household residents, and so are large enough that statistics can be presented accurately without fear of disclosure and yet small enough that they can be used to represent communities. See https://data.gov.uk/dataset/ab9f1f20-3b7f-4efa-9bd2-239acf63b540/data-zone-boundaries-2011

Prompts for change in East Ayrshire

Changing the conversation: from numbers delayed to reducing bed days

In 2015, the wider conversation in Scotland about 'delayed discharge' shifted to focussing on the needs of the patient as a person. So, meeting the two-week maximum wait target was no longer considered, on its own, to indicate adequate performance. Attention was turned instead to reducing the overall time people spent delayed in hospital.

Although there are drivers related to finance and hospital capacity, this shift was driven by an increased recognition that being in hospital entails risks to patients' health and welfare, in particular for the elderly. As a result, East Ayrshire HSCP began to focus more on reducing total bed days occupied by those delayed in hospital, and not just the numbers of people delayed.

The integration agenda

Along with this changed conversation about delay, the Scottish Government's integration agenda including joint budgets, helped break down organizational boundaries between health and social care, as well as third sector services. This has facilitated better collaboration for improvement. It is also about cultural changes in the health and social care professions and is an ongoing process.

National Unscheduled Care Programme

Improving unscheduled care remains a key ministerial priority for the Scottish Government which, in May 2015 launched the '6 Essential Actions Improvement Programme' aiming to improve the timeliness and quality of care from arrival to discharge from the hospital and back into the community (13). Among other things, this programme encouraged a focus on the person, rather than bed management (Essential Action 3) and also on ensuring that people are cared for in their own homes or a homely environment (Essential Action 6). This thinking is clearly reflected in the drivers for the improvements made in East Ayrshire's approach to delayed discharge and its wider system.

The success in numbers

East Ayrshire HSCP has successfully reduced delayed discharge – the time people spend in hospital when they can be more appropriately cared for in another setting. This section presents some of the numerical measures which show this success. Most of the data was provided by the Information Services Division (ISD) of NHS National Services Scotland.

East Ayrshire HSCP has met national and local standards for delayed discharge since 2009[c]. Figure 2 shows the rate of over two-week delays by population, excluding delays associated with guardianship issues (recorded as complex, or "code 9", delays) since July 2016 (when how delays are measured changed). Figure 2 compares East Ayrshire and the whole of Scotland.

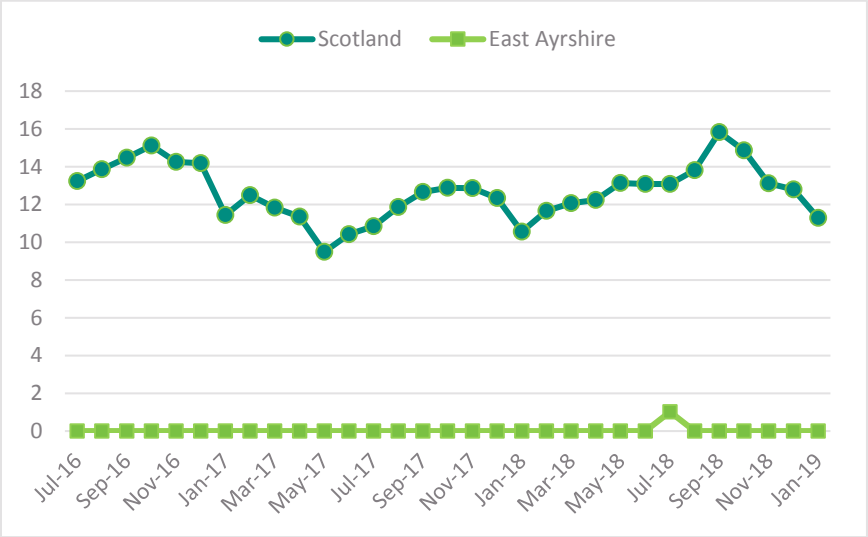

Figure 2: Number of delays of more than two weeks (excluding code 9). Rate per 100,000 population.

When including guardianship and other code 9 delays in the figures and exploring lengths of all delays, Figure 3 shows the steady reduction in proportion of those waiting over two weeks in hospital after being assessed as medically fit for discharge. (Note that this graph does not reflect overall delay levels).

[c] In July 2018, one person was delayed for over two weeks waiting for appropriate care outside the area of East Ayrshire. That aside, no one has waited more than two weeks in hospital once medically fit for discharge unless waiting for guardianship issues to be resolved.

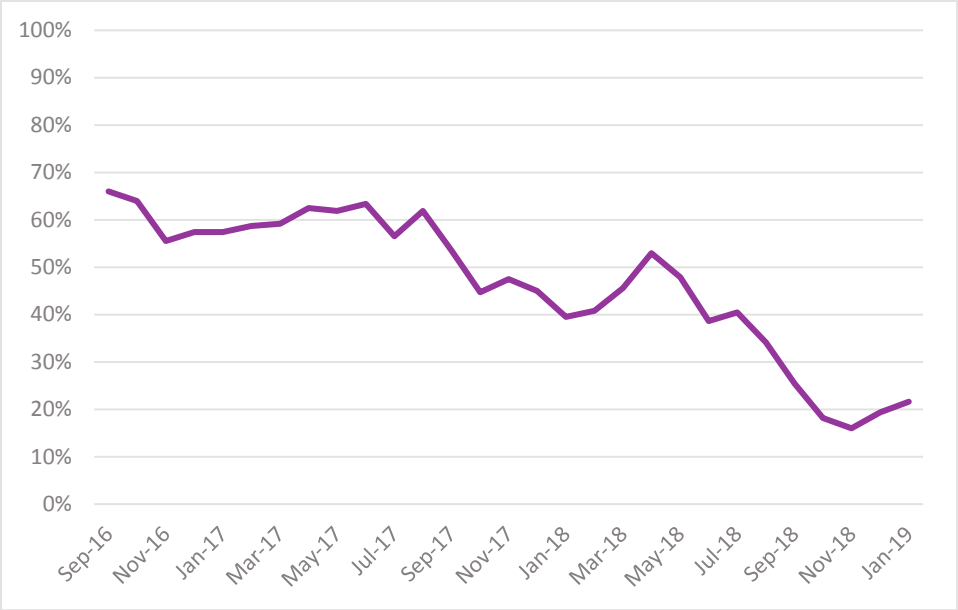

Figure 3: Over two-week delays as a percent of all delays (3 month rolling totals).

Figure 4 below shows delay in terms of associated bed days per 1,000 population and East Ayrshire's relative performance within Scotland. At around 5 bed days per 1,000 population, this measure is now well below the Scotland-wide average of around 10 bed days per 1,000 population.

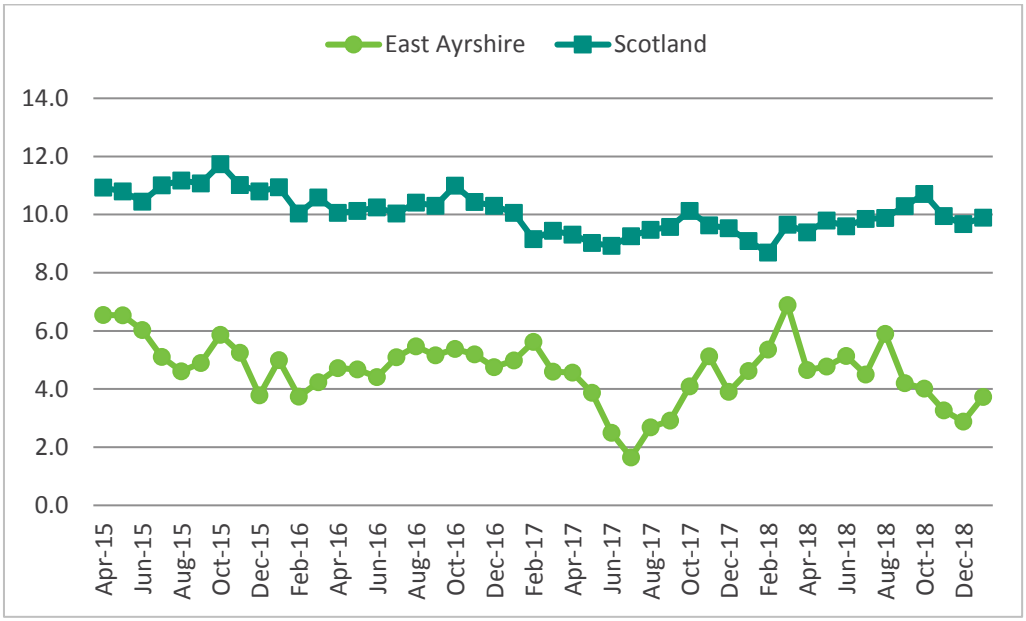

Figure 4: Delayed discharge bed day rate per 1,000 (all reasons).

Significant success latterly has been achieved in reducing delays due to guardianship issues for adults with incapacity (AWI). This is generally where people are awaiting court orders before major decisions about their care and circumstances can be made. Data on all code 9 type delays since July 2016 – shown in Figure 5 – confirms this downward trend in bed days associated with code 9 delay. There has been a sustained downward shift of around a third in the bed day rate per head of population since July 2016, and promising indications of a further shift down in the most recent data to February 2019.

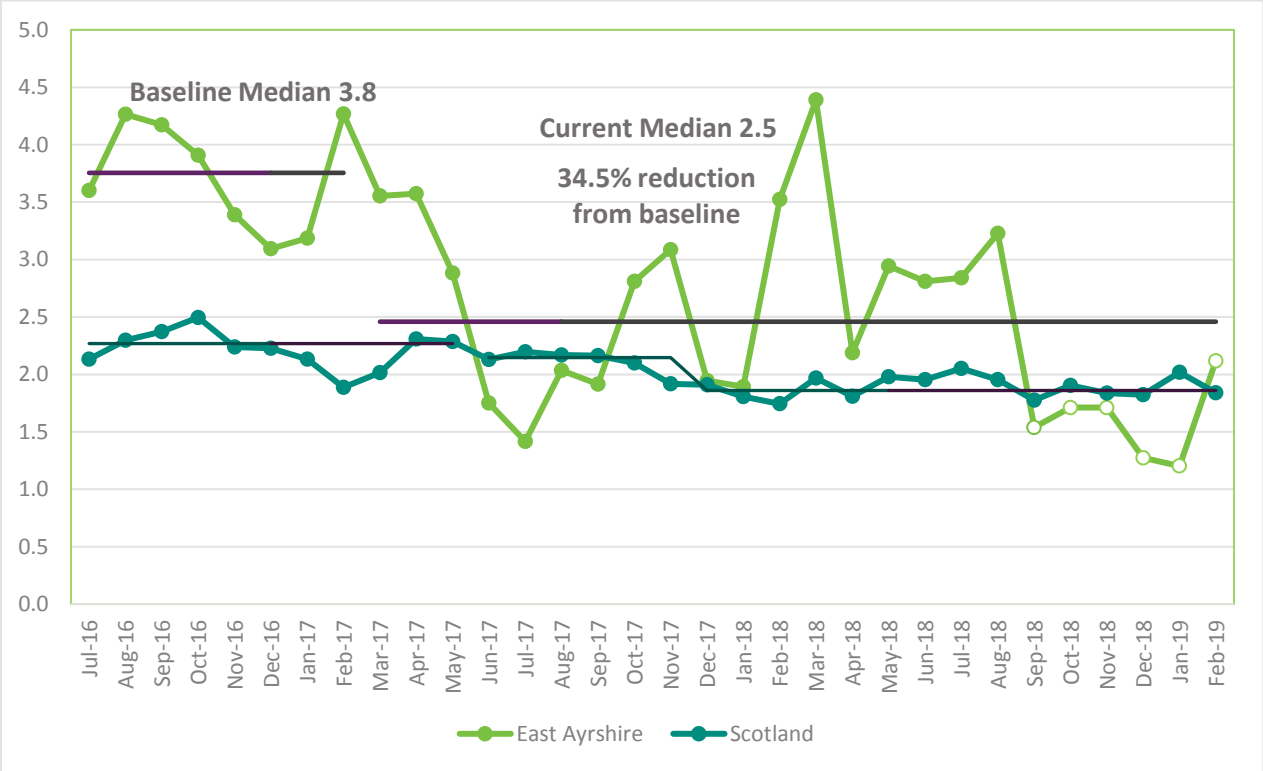

Figure 5: Monthly code 9 delayed discharge bed day rate per 1,000 population.

All of this has been achieved in tandem with a reduced need for care packages to support people living at home (reduced from 1,500 to 1,400 since 2015), reduced numbers needing care home accommodation (from 768 in late 2014 now down to 700), and maintaining steady readmission rates.

Figure 6 shows the steady reduction in monthly average number of care home placements. This has enabled more budget to be moved towards care services at home.

Figure 7 shows that the percentage of emergency readmissions within 28 days of discharge from April 2016 to January 2019 has been largely stable. Between September 2017 and March 2018 there was a small upward shift, however this was not sustained. (These figures were Age-Sex and Admission Type Standardised).

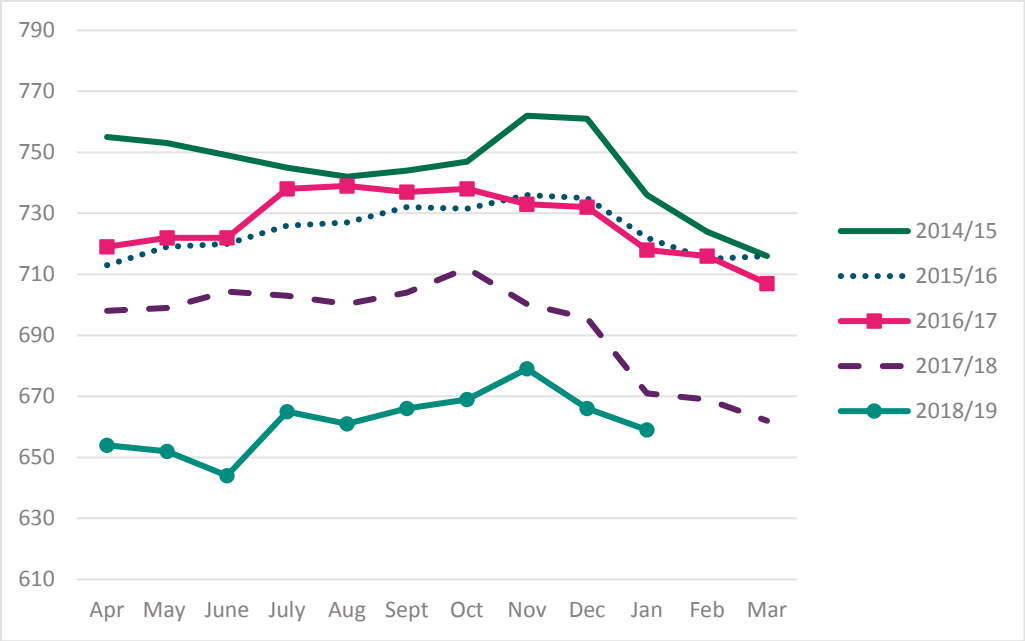

Figure 6: Monthly nursing/residential placements by year in East Ayrshire[d].

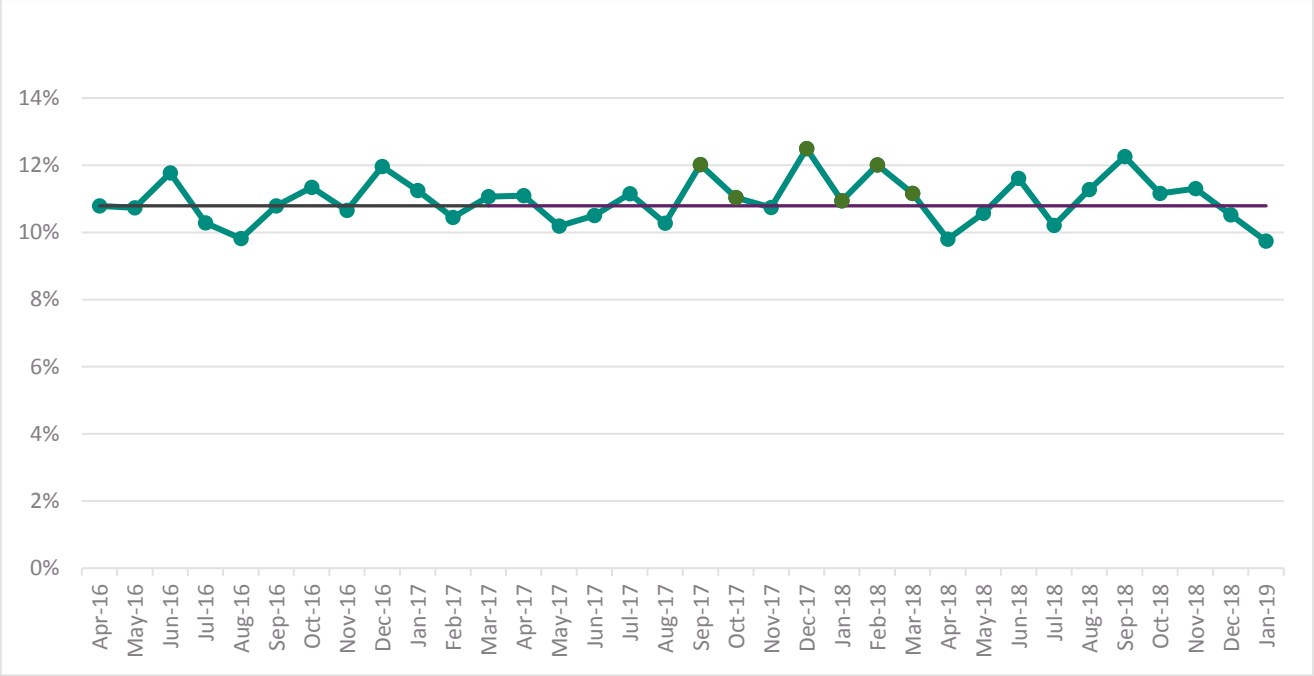

Figure 7: Percentage of emergency re-admissions within 28 days in East Ayrshire.

[d] Data provided by East Ayrshire HSCP by email on 15/3/2019.

In summary, East Ayrshire:

- **Consistently met the national zero delayed discharge target since 2009**
- **Achieved a bed-day rate associated with delays of 5 per 1,000 population compared with a Scotland-wide rate of 10 per 1,000**
- **Reduced the bed-day rate associated with code 9 delays by over a third since 2016**
- **Between 2014/15 and 2017/18:**
    - **Reduced care home placements from 768 to around 700**
    - **Reduced care packages at home from 1,500 to 1,400**

Improvement initiatives

Introduction

Whilst this study reports on several individual initiatives focused mainly on changes since 2015, it is important to understand they cannot be seen separately from one another, from the whole organisation nor from work prior to 2015.

Indeed, a key finding of this case study is that East Ayrshire's whole system approach, driven by strong consistent leadership at all levels in the organisation, and with a relentless focus on person-centred outcomes, is central to the success. Moreover, this is an evolving system and some of its foundations lie further back in time. For instance, there has been a long-term commitment in East Ayrshire council, going back to before integration, to shifting the balance from acute care to prevention. Also East Ayrshire's hospital-based social work team plays a key role in much of what is discussed here but, whilst a new team lead arrived in post in 2015, an East Ayrshire social work team has been based in UHC since the 1980s.

It is therefore important to remember this wider context when considering which aspects of this study can be successfully translated to different settings.

Early referral to social work and 'why NOT home?'

The problem

Discharge planning can be complex. Sometimes, patients may need to make major life-changing and emotionally difficult decisions, and their families and care givers will need to come to terms with this too. In crisis, in particular for the elderly, it is not possible, nor fair, to rush people into decisions.

Once key decisions are made a whole range of services may also need to be put in place and co-ordinated to transfer the person safely home or to another appropriate care environment. Services may include rehabilitation and assessment services from community-based teams, and then ongoing support once rehabilitation requirements have been met. This all takes time. In too many cases discharge planning did not begin until patients had been assessed as medically fit for discharge, leaving them vulnerable to the risks of extended hospital stays.

East Ayrshire's hospital-based social work team also found that healthcare staff, perhaps unaware of available community-based services, occasionally assumed a care home would be a patient's final destination. Sometimes patients, particularly the elderly, were persuaded by this assumption before referral to the social work team.

Addressing the problem

East Ayrshire HSCP decided they needed to find ways to identify and reach patients with complex discharge needs much earlier in their journey through the hospital. The intention was to begin the discharge planning process as early as possible with the starting assumption of a return home being possible. In particular, this would also allow more time for the social work team to build trusting

relationships with the patient, carers and significant others to really support their meaningful engagement in the discharge planning process. Early engagement with their healthcare team would also help maintain a person-centred approach, open to possibilities.

"Pulling behaviour"[e]

East Ayrshire's hospital-based social work team do not wait for referrals, rather they engage in "pulling behaviour" (as one interviewee described it). Since 2015 they made determined efforts, on multiple fronts, to identify East Ayrshire resident patients who are most likely to have complex discharge needs as early as possible. They do this both proactively themselves and by working through healthcare colleagues. Much was achieved by the social work team through close monitoring of patient data and through their work to be as visible and available as they can be to health colleagues.

Daily review of patient data

People already known to East Ayrshire social services can be identified by daily review of the hospital admissions list. Monitoring patient data can also identify those deemed medically fit (but not already referred to social work) and so enabling a proactive approach to the ward to find out if additional discharge support is needed.

Visibility of social work, and building trust with healthcare colleagues

Substantial gains however, came as a result of the work that the social work team, in particular the team leader, did to increase early referrals from healthcare colleagues. Their physical presence in and around the hospital is important to the success of this approach. The team constantly looked for, and took opportunities to be visible and to demonstrate to healthcare colleagues the value that social work and community services can offer to support people at home and maintain their independence, as well as improving patient flow. Sometimes this was made more explicit. A manager said:

> *"We're trying to get the message to doctors to not to say they are referring someone to social workers for a care home. For older people, what the doctor says is gospel and this makes it harder to discuss other options."*

The social workers saw a need to be on hand as much as possible so they can bring a holistic view of a person to bear in medical conversations where the need for this may not be recognised soon enough without prompting. They worked to build good links with nursing staff on key wards and made themselves available as much as possible, to respond immediately (often in person on the ward) to requests for advice, sometimes extending to patients not resident in East Ayrshire. Since the establishment of the hospital discharge hub[f], its staff are a key focus for collaboration with social workers. Discharge hub staff also maintain close links with the Combined Assessment Unit (CAU)

[e] Interviewee, service manager.

[f] The hospital discharge hub team case manages individuals with complex needs, facilitating multi-agency coordination for discharge as required. It was established in UHC in 2015/16.

which receives and makes admission decisions about most people arriving at the hospital for unscheduled care. They attend the daily CAU huddle and discuss all new admissions (and in a very recent innovation they are joined here by a member of the social work team).

A representative from the social work team also attends the main hospital huddle each morning and afternoon to report on delays in discharge, get early warning of emerging issues and also a sense of the overall strain the hospital is under. This is also an opportunity in the margins for ward representatives to discuss specific cases or issues around delay with the social work team.

All these measures to build close working relationships are particularly important in supporting healthcare staff who work with social work teams from three council areas (each with different processes) and rely on a patient information system which does not indicate in which area a person lives.

"We don't need the single shared assessment to start – just tell us the patient is there"[g]

As well as the work done to help change culture and improve mutual understanding, the social work team worked to improve the referral process.

A Single Shared Assessment (SSA) is a formal multi-disciplinary written assessment used where the healthcare team expect a person will require 24 hour residential/nursing care on discharge. They help indicate the complexity of a person's circumstances but take time and can delay social work involvement and discharge planning. A key change made by the East Ayrshire social work team is accepting, and indeed actively encouraging, these kind of referrals from health colleagues without a written SSA. Again this is made possible by the team's available capacity on site, and its commitment to engaging with patients as early as possible.

The result

Earlier referrals, earlier discussion of discharge to home

Interviewees report that there was earlier identification of patients likely to need additional support on discharge, both through monitoring patient data and through an increase in early referrals from healthcare colleagues. This included some referrals for patients made on their admission to hospital. The social work team leader also reported that since December 2017 they had not received any referrals using SSAs. This was likely to have been helped by a new IT system which supports simple electronic referral, but there was clearly an increased understanding among healthcare staff that the East Ayrshire social work team could and would act on early referrals, though there was still some way to go for this awareness to reach all staff.

So, East Ayrshire social workers could now begin much earlier in a person's journey through the hospital, to build relationships with them and their caregivers, and indeed their healthcare team. There was more time to build an understanding of their home and health situation, and their personal goals. Patients too had more time to gain confidence and trust in the social workers, and

[g] Interviewee, social work team.

more time to make difficult decisions. In particular the possibility of going home could be fully explored early with more time to address any of the patient's or family's anxieties. The close working relationship with discharge and ward staff also meant that social workers were aware of and could plan around medical estimates of discharge, even as they changed.

Mental health officer (MHO) to manage guardianship issues

The problem

East Ayrshire has a relatively high proportion of adults with incapacity (AWI) delayed in the acute hospital awaiting a court order for guardianship to enable life-changing decisions to be made on their behalf (included in so-called "Code 9" delays). This probably reflects East Ayrshire's relatively high rates of guardianship order applications (14)[h]. Legally the NHS has responsibility for the care of such a person and cannot discharge them without a guardianship order being in place. It was not uncommon for adults with incapacity to be delayed months, not only substantially increasing the risk of them falling ill again, but also raising serious questions about their liberty. Obtaining a court order for guardianship is often complex and takes time.

Addressing the problem

Appointing a dedicated mental health officer

To address this, East Ayrshire HSCP set up a pilot starting in June 2016 and appointed a mental health officer (initially on secondment) to work closely with the hospital-based social work team. The MHO's remit was to support social workers to manage the safe and legal discharge from hospital of people with guardianship issues. Whilst a dedicated resource for inpatient AWIs, the MHO also contributed to the wider MHO duty system.

Collaborative working to obtain urgent interim court orders

The MHO and social work team leader worked with several of the Consultant Psychiatrists to make highly credible applications to the courts for urgent interim orders to move AWIs out of hospital and into a care home. These applications were effective in communicating the urgent need to move people in light of the evidence of the risks to health and liberty from extended hospital stays. The narrowly defined and urgent nature of interim orders means they can be more quickly obtained whilst waiting for the full guardianship process to be completed.

Supporting families with guardianship applications

The MHO also worked to support families through the court processes, helping them make applications for full guardianship and to keep the process moving. Where there was no family, the MHO also worked with council lawyers to process guardianship order applications. It was thought that this work also reduced the time taken to secure guardianship orders.

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[h] East Ayrshire has rates of guardianship applications amongst the three highest in Scotland with 96.3 per 100,000 population compared with 68.6 per 100,000 for all Scotland (14)

Increasing visibility and awareness

The team has also included court milestones for AWI in their patient monitoring data. The social worker responsible for a case provides updates on progress and what should be expected by when, including for instance court dates and legal aid application submission, enabling case progress to be monitored more easily.

In common with the rest of the social work team, the MHO worked to increase visibility and awareness, including doing some "pop-up shops" giving information to healthcare staff about key aspects of the management of AWI.

The result

Reduced bed days associated with delays due to guardianship

The pilot was a success. An internal evaluation conservatively estimated that there was a reduction in length of stay in hospital of almost 40%, on average, for each person who obtained a guardianship order during the pilot. The MHO has been agreed as a permanent post, and filled by the originally recruited secondee.

Increased use of interim court orders

Those directly involved in the pilot identified the key change resulting from the MHO's appointment as the increased use of interim guardianship orders obtaining court permission to move someone to a more homely environment. The MHO said that being based in the hospital was critical to the success of the work because it helped challenge a widely held belief (including their own and possibly also court personnel) that if someone was in hospital they were safe.

The internal evaluation mentioned above reviewed the stays of 24 people who completed the whole process from interim to full guardianship during the first two years of the pilot. To estimate the number of bed days saved for each person, the evaluation used the time (in days) between gaining the interim order (enabling the person to be moved to a more homely environment) and the long-term guardianship order. **They calculated a total of 970 bed days saved amounting to £169,265 saved for these 24 people alone**.

This is a very partial view of the bed days saved by the pilot as a whole. It does not include those who were moved as a result of an interim order but did not then require a full guardianship order (for instance because of regaining capacity or perhaps dying). This figure also does not account for savings due to less illness arising from extended hospital stays, nor the likely reduction in time taken to obtain full guardianship as a result of the MHO's work supporting families.

Wider benefits

As well as these immediate cost savings and direct benefits to patients, there were wider benefits. The MHO's work also informed the early referral work and helped increase awareness of the need for early social worker and MHO involvement where there were questions about an adult's capacity to make life-changing decisions.

Discharge to assess

The problem

Many with complex health needs and those aged over 65 in crisis can easily become disorientated and confused in the hospital environment and risk loss of confidence and independence. These risks increase after 72 hours in hospital particularly for people aged over 75 (9–12) and an accurate and collaborative assessment with the person at this point is not likely to be possible. Disorientation can be alleviated by time in a more homely environment.

Addressing the problem

In April 2015 East Ayrshire HSCP introduced the Discharge to Assess (D2A) process, where the HSCP fully funded care home beds for the duration of assessments. This was a scheme for older people (aged 65+) in hospital, medically fit for discharge, and assessed as having complex needs and likely to need a care home placement. The D2A process, based on spot funding, allowed an individual to be placed in a care home of their choice where their assessment could be carried out in a more homely and less distressing environment. This was more conducive to engagement in the assessment by the individual, to a better understanding of their wishes and so, to an accurate assessment of their needs.

The result[i]

Increased in time spent in homely care settings, saved hospital bed days.

In piloting D2A, a person was typically funded for up to two weeks to allow the assessment to take place. In 2015/16 the average was 14 days per person, 10 days in 2016/17, and 14 days per person in 2017/18).

The total number of days that people were funded in a care home provides an approximation of the number of days they would have otherwise spent in hospital awaiting assessment. Various factors will affect the accuracy of this approximation[j]. However, with that caution in mind, the estimated number of bed days saved by D2A in 2015/16, 2016/17 and 2017/18 was reported to be: 1,541 days, 1,113 days and 1,169 days respectively.

Table 1 uses these as estimates of bed days saved each year and a figure of £174.50 as the cost of a hospital bed day to show an estimate of savings.

[i] This data in this section was provided by East Ayrshire HSCP by email on 15/3/2019.

[j] This figure may over or under-estimate bed days saved depending on whether regained capacity extends the assessment time or reduces it. It may underestimate the bed days saved as earlier discharge reduces the risk of a person falling ill again in hospital and needing further hospital treatment. It would possibly overestimate savings if social workers took longer to do the assessment (although note there is no evidence of this).

	£ spent care home beds	Acute £ avoided	Net £ saving to partnership
2015/16	£128,150	£268,905	**£140,755**
2016/17	£ 97,767	£194,219	**£ 96,452**
2017/18	£109,564	£203,990	**£ 94,426**
2018/19 (*partial*)	£ 88,153	£160,191	**£ 72,038**

Table 1: D2A saving (cost care home beds less avoided cost of hospital bed days).

A social return on investment analysis in 2018 estimated that D2A had avoided over 750 occupied bed days and produced a return of £170,000 in the previous year (6).

There were also non-monetary benefits. In a small proportion of cases, patients (originally thought likely to need residential care) did return home following D2A, showing a likely improvement in the accuracy of the assessment. Also where it was concluded that a care home was the appropriate destination identified in the assessment, people often chose to stay in the home where the D2A assessment had taken place. This shows the benefit of spot funding a care home bed according to an individual's choice and so reducing the likelihood of disruptive transfers.

Community rehabilitation team/intermediate care

The problem

The issue here was maintaining and improving an existing effective service. The Intermediate Care Team (ICT) had been in operation since late 2011 across Ayrshire and its purpose is to both facilitate discharge from and prevent admission to hospital. The team's approach was based on an integrated model of working bringing together and co-locating health and social care professionals. An evaluation was conducted during a six-month period in 2014 which found that the service was working well and should be further developed and improved.

Addressing the problem

Investment in intermediate care team

There was a high level of investment in ICTs with a focus on enablement. On discharge where rehabilitation potential had been identified, the intervention would comprise intensive individualised support from a multidisciplinary team for a short period of time. A personal outcome approach was taken moving away from the provision of standard packages of social care, installing a set number of hours per week for half a year, for instance.

Maximizing independence

The period of intervention was, and continues to be, based on need and lasts typically between four to six weeks. The focus is on supporting the individual to achieve their own goals, and maximise their independence through an enabling approach, making use of available personal and community assets. Where ongoing rehabilitation is required, this is delivered by community rehabilitation staff

within the HSCP. Where ongoing care needs are identified following a period of enablement, these would be provided by mainstream care at home services[k], using individual choice to guide provision.

The Integrated Care Fund was used in 2015/16 to boost service capacity in time for the winter surge in demand (5). This included additional assessment capacity, care at home provision and care home placements, along with resources such as winter equipment for care at home services, technology-enabled care and rehabilitation and enablement capacity.

The HSCP has also become more integrated in its management structure, and brought care at home services and ICT under the remit of a single senior manager to help align and co-ordinate the work of these two services.

The result

The saving for East Ayrshire due to the ICT in 2018 was estimated to be 3,036 bed days a month (8). Over 90% of these numbers were estimated to be due to earlier discharges being facilitated. This is an increase from a 2014 estimate of 1,100 bed days saved per month (4) but this is explained in part by improvements in reporting and data capture as well as by improvements in the use of ICT services including in facilitating early supported discharge. The HSCP chief officer's view is that the investment and results from this service have created positive feedback, helping build confidence in this mechanism amongst acute staff and the public, a likely factor in its increasing successful outcomes of getting people home.

The Red Cross 'Home from Hospital' service

The problem

Older and other socially vulnerable people sometimes find the transition back home from hospital difficult. They may have lost some confidence in their independence, possibly exacerbated by the interruption in family and community social contact and support. This meant, for some, increased risks to them at home from a range of issues, such as falls or social isolation for example.

Addressing the problem

Extending a proven service

The three Ayrshire HSCPs decided to commission the British Red Cross to extend its 'Home from Hospital' service which was already operating successfully getting vulnerable people home from emergency departments where they did not require hospital admission.

The service is available to people aged 65 and over and to younger people with particular vulnerabilities, who are deemed medically fit for discharge from hospital (or not requiring admission). Along with transport, additional services are provided to support people's transition from being a hospital patient to getting settled in back at home. These include: making sure basic food items and other provisions are in the house and that the person has a hot meal, carrying out

[k] Care at home services providing personal care and some practical support.

assessments of risks to the person in their home environment, such as falls or abuse risks, and, where needed, helping connect the person with community resources.

Focusing on a personal outcomes approach

A case worker is available for follow-up work if any issues need resolving (such as referral to a befriending service or community connectors). The service applies a 'Top 3 Goal' methodology in supporting people to identify the personal outcomes (goals) that they want to achieve and provides a level of support, information and/or resources appropriate to help them achieve those goals.

The Integrated Care Fund was used in 2015/16 to enhance the Red Cross 'Home from Hospital' service (5).

The result

Key benefits

In its first full year of operation, 2016-17, the service transported 1,947 individuals home from hospital. Of this total, 29% were transported to home addresses in East Ayrshire. An evaluation of the service found that it increased health service staff confidence in discharging medically fit but socially vulnerable people (7).

As a result, the service in East Ayrshire saved:

- 2,057 hospital bed days, 1,507 of which were due to earlier discharge(7)[l], and
- the equivalent of £359,975 in reduced cost of hospital bed days[m].

It also was found to have:

- prevented 253 breaches of the emergency department four-hour waiting time
- improved patient flow within hospital
- reduced health and welfare risks associated with hospital stays, and
- played a part in improving communication between agencies.

Given East Ayrshire's whole system approach, it is worth outlining the breadth of impact on the discharge process. The evaluation mentioned above also reported that, in 2016/17, the Red Cross 'Home from Hospital' service:

- completed 489 home checks
- made 241 follow up interventions
- successfully supported 47 applicants for attendance allowance, and
- secured £237,843 for service users through income maximization support and referrals (for instance for carer's allowance and welfare grants).

[l] Assuming one bed day is saved on average for each discharge, and 5 days for each admission prevented.

[m] Using the assumption (agreed with NHS Ayrshire and Arran) of an average daily hospital bed cost of £175.

Overall, the Red Cross 'Home from Hospital' service:

- produced an estimated (social) return on investment of £917,000 (6), and
- cost a total of £279,435 (or £93,145 per partnership).

Impact on service users

The evaluation of the service also examined the impact on users and found that the majority of service users identified goals/outcomes which centred on four key themes:

1. befriending/socialising
2. falls prevention/increased mobility
3. income maximisation, and
4. inappropriate housing/issues with disrepair.

In 2016/17 more than half of the individuals receiving higher levels of follow up support had fully achieved their Top 3 goals and almost 90% had made at least significant progress towards them.

The East Ayrshire HSCP annual report 2016/17 concludes: "The service provides people with supported transport to their home and re-settling, such as helping to prevent falls and reduce social isolation, which enables people to regain their confidence at home, and it organises telecare, which supports families and carers to continue to care."

Key enabling factors

Person-centred guiding ethos

"Do right by people and the money will look after itself"[n]

Every person interviewed, from senior manager to front line service delivery, described their work in terms of "doing right by people". There was also consistency in the belief that, whilst finance was very important, it was placed firmly behind people's needs in the organisation's priorities. The indications from interviews and documents was that this ethos runs throughout the partnership.

Crucially, the evidence was that this was not just an aspiration. **Although interviewees had some criticisms and ideas for improvement, in general they thought they were enabled to actually "*do right by people*" most of the time.** Whilst not explicitly discussed during interviews, comments indicated a passionate commitment to this aim and a great deal of satisfaction being part of a team delivering it. There seems little doubt that this commitment is a crucial factor in the success and something to be protected and developed.

"Delayed discharge? Not on my watch"[o]

There was also a sense of urgency and pride around discharging people safely, legally and without delay to an appropriate care environment, home if at all possible. It is a goal that is owned by everyone: **"*Delayed discharge? Not on my watch*" was the attitude evident in all interviewed.** This is seen as integral to a person-centred approach and came with a strong commitment to early and meaningful engagement of patients and their families in discharge planning.

Strong and caring leadership at all levels

All interviewees were clear about East Ayrshire's priorities. There was consistent evidence that senior managers are very visible throughout the organisation, were considered as approachable and took every opportunity to emphasise priorities.

The person-centred ethos is clearly driven by strong, caring leadership from the top and throughout the organisation. There were numerous examples of managers requiring and seeking assurance of a person-centred approach in practice. Communications and actions constantly and consistently repeat and reinforce the message that the organisation cares about people first. Specifically, managers make it clear that they place a high value on avoiding unnecessary hospital stays, and where inpatient treatment is needed, on "safe and legal" discharge as soon as they are medically fit.

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[n] Interviewee, HSCP manager.

[o] Interviewee, service manager (but sentiment widely expressed).

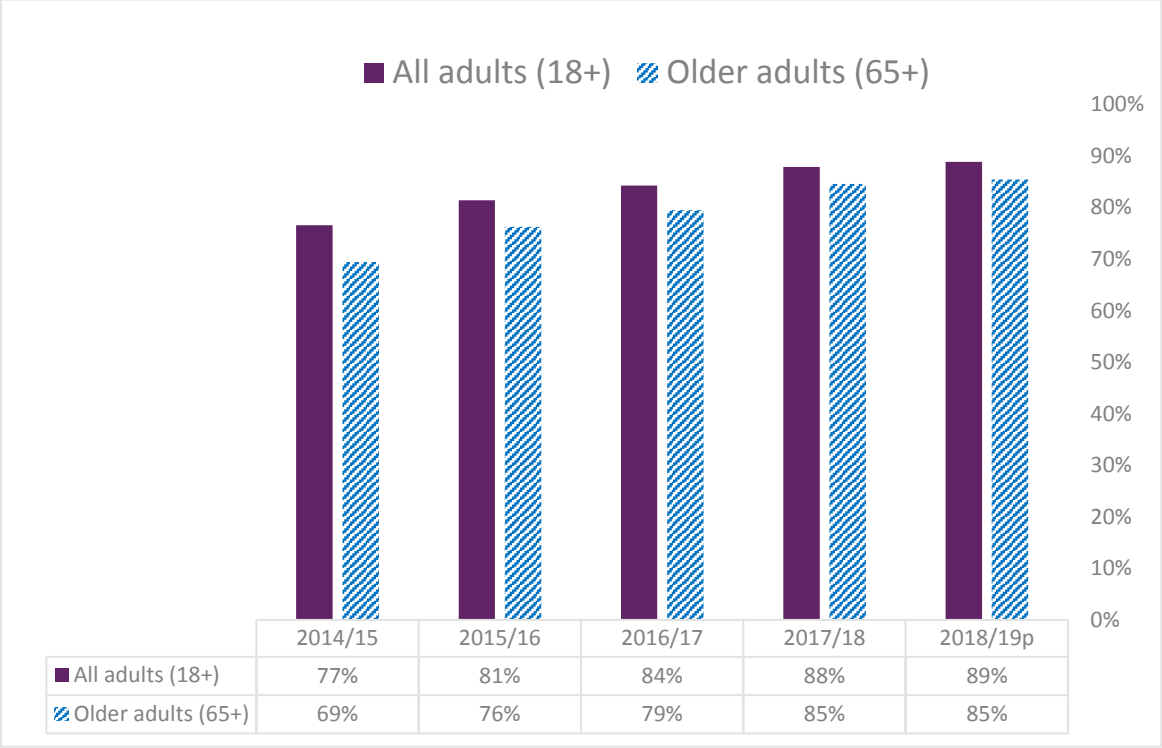
The person-first philosophy is not limited to service users – several staff interviewed described how their managers and senior leaders made clear that they valued and respected their work and opinions whilst also showing concern for welfare. Interviewees said that they felt both accountable and supported by those in leadership roles, including the most senior managers.

A whole system preventive approach

"A system in balance"[p]

One interviewee commented that East Ayrshire's system was "in balance", working on multiple fronts to maintain people's independence and prevent health crises. **There was a strong consensus among interviewees that no one initiative on its own can explain the success but rather they are all interlinked and interdependent.** "*It's like the snake eating its tail. It's all linked*" one interviewee commented, going on to explain that inadequate service provision in the community both stops patient flow out of hospital and leads to more admissions.

Some indication of East Ayrshire's wider success in improvement is shown in the increasing proportion of patients discharged within three days of admission for unscheduled care. See Figure 8 below.



	2014/15	2015/16	2016/17	2017/18	2018/19p
All adults (18+)	77%	81%	84%	88%	89%
Older adults (65+)	69%	76%	79%	85%	85%

Figure 8: Percentage of patients discharged within three days after admission for unscheduled care aged 18+ and 65+ (Source: ISD).

[p] Interviewee, HSCP manager.

This interviewee also noted how hard East Ayrshire HSCP colleagues work to maintain this balance. This was echoed by several in relation to discharge, stressing the need to "constantly keep on top of things". It is clear that considerable sustained effort is required to maintain the system in "balance" and indeed that pride is taken in doing so.

Shifting the balance to prevention

There has been a long-standing commitment in East Ayrshire to steadily **shift the emphasis in budget towards prevention and delivering more care at home and in the community.** If done well and in a way that supports person-centred care and enablement, this was considered by interviewees as not only good for finance, but good for people. East Ayrshire HSCP has maintained this strategic approach and recent additional funding through the Integration Joint Board has been committed to increasing capacity in care at home services.

Collaboration with third sector partners

Another long-standing enabler has been the **commitment by East Ayrshire council to supporting communities ("Vibrant Communities") which has formed a sound basis for much of the prevention and discharge work now undertaken.** The HSCP works closely with a range of third sector service providers as partners to help with both discharge and prevention of ill health, and is increasingly seeing the benefits of engaging more widely, including supporting community-led action plans[q]. An interviewee working at the third sector interface since 2016 and recently stepping into a management and HSCP liaison role, also described a long-standing collaborative relationship with the partnership.

Majority in-house care at home services enabling continuity

The HSCP has remained committed to in-house services which two interviewees identified as important when asked what accounted for the success of East Ayrshire in reducing delayed discharge. **They explained that it allows for much more flexibility making it easier to deliver continuity of care within a complex and changing system.** For instance if a service user needs to spend a short time in hospital an in-house service is more likely to be able to reinstate a known carer on their return home and, according to one interviewee: "*Where home carers know service users, they are less likely to escalate problems*". In contrast, private carers were thought less likely to know individuals and their needs well, and so less confident in managing problems arising themselves.

[q] An example given was funding a local bowling club roof repair in return for free access for people with learning disabilities.

An open, enabling culture - "Proceed until apprehended!"[r]

An open, enabling culture has been instilled by leaders encouraging new ideas for improvement from all parts of the partnership. One interviewee described this as "*Proceed until apprehended*" and another (manager) interviewee stated "*For 90% of the things I suggest, I'm given carte blanche*".

Ideas for improvement initiatives themselves arise from, and depend on, the system in place and the way it works. There are numerous examples of this. For instance, the idea for (and indeed impact of) the recently appointed hospital-based Mental Health Officer depended on the established hospital-based social work team and their close working relationship with hospital-based healthcare colleagues. The idea for the hospital discharge hub itself was shaped by a collaboration between the social work team lead and a hospital nursing manager, arising at least in part, from the active relationship-building approach by the social work team lead. In a recent innovation, someone from the social work team attends the daily combined assessment unit midday huddle and are included in all discussions about new patients. In an early example of positive impact, social work presence prevented what would have been an inappropriate discharge of an adult with incapacity without necessary legal decision-making frameworks. Also recently successfully piloted (with continued funding approved by the chief officer) is the commissioning of care home beds for adults with incapacity awaiting court orders. (For legal reasons this has to be funded from NHS budgets). And more recently, consideration is being given to a proposal to reduce guardianship delays by providing support, including legal costs, for power of attorney where this is likely to be needed (for instance, soon after a dementia diagnosis). And the idea for a recent successful pilot of a community connector based in an emergency department arose from a discussion between a third sector manager and a senior HSCP manager.

This range of ideas for improvement that are considered, piloted and ultimately adopted, depend, at least in part, on **the willingness of partnership managers to listen to all, and the confidence in that willingness that interviewees from health, social work and third sector backgrounds expressed.** One interviewee, and successor in post to the third sector manager mentioned above, commented:

> *"At any given time I can pick up the phone and talk to someone at the council in the partnership… And no question is a silly question. It's nice".*

And it is not only these ad hoc ideas which arise and are welcomed. The organisation also seeks out feedback and ideas, including by creating time and space to bring partners together regularly to plan and discuss services and how they are organised. Examples relevant to hospital discharge where the third sector are active participants include the Winter Planning group and Unscheduled Care Delivery planning group.

The evidence of genuine transparent engagement of all partners in both commissioning and improvement suggests an environment conducive to such new ideas emerging and their testing and implementation being supported.

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[r] Interviewee, HSCP manager.

Finance aligned to person-centred priorities

The HSCP finance department was seen as an enabler by all those interviewed. **There is confidence that finance colleagues share the person-centred ethos and the determination to work together to deliver in line with this for patients and other service users**. Exploring this further, a key aspect of this is the belief expressed by interviewees that finance staff respect and trust the professional judgment of their colleagues, in particular where applications are made by social workers for care placement funding. Also their work to flex budgets to priorities as much as possible is recognised and widely appreciated.

"Funding for care home beds has never been an issue"[s]

The lack of care home or care at home capacity has occasionally delayed a discharge, but not the availability of funds. A manager responsible for signing off assessments for care home funding said, "I have not been in a position here when funding for care home beds has been an issue". Interviewees described instances where managers were flexible with overstretched budgets to ensure 24 hour care was funded. One interviewee commented that it was sometimes difficult to "*hold the line*" on providing the care as soon as it is needed, but that it pays off in the long run.

An example given of flexibility in approach is placing a person in residential care on the understanding (with the care home) that payment for a nursing care placement would be backdated, if a four-week review proves nursing care is actually required. Another example was a woman, aged 59, requiring palliative care urgently being funded for a care home bed from the 60+ service budget because "*that was the right thing to do*".

Integrated working values

Culture shift

Another strongly emerging theme was the awareness of a shifting culture, with interviewees reporting **greater mutual understanding and shared goals, and ever more readiness to work collaboratively across disciplines and settings to achieve the best outcomes for the people in their care.** Whilst recognising the need for further progress, several described working relationships as now being more like equal and respectful partnerships, working with a common purpose (and less of a sense of being there to serve another group). This is both an enabler and a consequence of the initiatives described in this report.

The social work team's inclusion in hospital management processes, for example, is testament to the success of their efforts to build good working relationships with healthcare staff, but is also essential to healthcare colleagues consistently making early referrals to social work. Healthcare professionals are increasingly appreciative of the value of what social workers do, for both them and for patients, as well as increasing their understanding of how community-based services can support people with complex needs to be independent. Social workers too have increased their insight into the needs of

[s] Interviewee, service manager.

the hospital staff and into the risks to people of being delayed in hospital. The social work team has clearly developed a strong sense of the importance of what they do for both patients and hospital colleagues, and take their responsibility to deliver it very seriously.

HSCP and third sector partners

This shift in attitude of front line workers was also echoed from the third sector. There was a view that this had noticeably improved quite recently, perhaps due – at least in part – to the HSCP's long-established positive attitude to third sector participation:

> *"The third sector was seen [in 2016] as not as 'switched on' as the statutory organisations – we did have to force our way as community connectors a little. But looking at the top end it was a totally different picture – it's almost as if it hadn't filtered down."*

This interviewee, since 2018 acting in a third sector management capacity, also suggested that this increasing willingness, across the care sector, to see third sector service providers as partners, may help explain the increasing effectiveness of services like the Red Cross 'Home from Hospital' service.

Co-location can boost integration

Co-location of social, mental health and healthcare staff at the hospital has unquestionably helped build integrated working through growing mutual understanding of roles and pressures and so also trust between the professions. Social worker and healthcare worker interviewees, without prompting, identified the social worker team being based in the hospital as being crucial to building understanding of how to work together to best meet the needs of those in their care.

> *"There was talk of taking the [social work] team out of the hospital. We were very against that as you are immediately on hand if there is a difficulty… If someone knocks on the door you can just see them... we can go to whiteboard meetings and we can be visible".*

Constructive party politics

Senior managers interviewed noted that, in relation to health and social care, the political groupings in the council worked constructively together. This was felt to be an important enabler in being relatively free to explore, test and implement ideas for service change to bring about improvements. There was no sense of unrelated party politics distracting from important debates about public health and health services.

Conclusion

East Ayrshire's per capita rate of bed days associated with delay is approximately half that of Scotland as a whole and they have achieved considerable reductions in delays in recent years. A health and social care partnership is a hugely complex operation, and a case study of this scale can only begin to scratch the surface. Although this must be seen in its complex context, we draw out some concluding comments on the key success factors.

Early referral, home first and adults with incapacity

- Finding ways to identify patients likely to need social work assistance for discharge much earlier in their hospital journey (or even prior to non-emergency admission) through both constant patient data monitoring and collaborative work with healthcare colleagues.
- Finding ways to support healthcare staff to refer earlier to social work, including proactive presence of social workers on wards and at ward and hospital huddles, continuous education about the role of social work/mental health officer, and simplifying referral requirements.
- Achieving earlier referrals, enabling trusting relationships to be established earlier so allowing more time for patients and their families to make difficult decisions. This also allows more time for assessment and for planning (often complex) discharges collaboratively with patients, carers and ward healthcare teams.
- Starting with a presumption of working to get a person home ("why NOT home?"), and making use of care at home and other community-based services is thought to have increased the likelihood of some people continuing to live independently and safely.
- Directly addressing delays for adults with incapacity awaiting guardianship orders by appointing a dedicated mental health officer to obtain interim court orders for care home care and to support families through court proceedings. Latterly, running a successful pilot to commission care home beds on behalf of the NHS for those awaiting court orders.

Discharge to assess (D2A)

- Funding care home beds for those thought likely to require long term care home care but who need to be in a homely setting before an accurate assessment can be made. East Ayrshire HSCP has shown this investment has paid off in terms of hospital bed days saved and indeed report a small number of people assessed as able to return home following D2A.

Intermediate care

- Where rehabilitation is possible, a community-based service providing intensive short term support to promote independence and maximise quality of life, focussing on re-ablement aligned to personal goals and on minimising longer term support needs.

The Red Cross 'Home from Hospital' service

- Initially proving its success in preventing admissions via emergency departments, the subsequent improvement of discharges – both in timeliness and quality – delivered by the British Red Cross 'Home from Hospital' service has more than justified the investment in it by all three Ayrshire HSCPs. It has come to be widely respected and understood by health and social care staff.

Key enabling factors

- Strong, collaborative and enabling senior leadership, actively and very visibly working to build and continually reinforce shared values and common goals across organisations and disciplines. This approach supports and develops its leaders throughout the organisation to work with common purpose, and enables them to work collaboratively and responsively within the complexity of the operation.
- Transparent and open approach to commissioning and service (re)design, inviting – and hearing – a diverse range of voices from statutory, third sector and other services, as well as service users and wider community voices.
- A widespread and growing, cross disciplinary understanding throughout the partnership that timely discharge is an urgent health, welfare and rights matter. It is seen very much as a shared priority goal, extending to colleagues beyond the hospital to, for instance, those making home adaptations as well as to those overseeing budgets.
- Co-location of the social work team, including the mental health officer, in the main acute hospital (for East Ayrshire) is seen as crucial for the success. This is both for practical reasons (such as time spent parking, easier inclusion of patients' families) and also to further strengthen trust, respect and understanding between colleagues across different disciplines and sectors.
- Although not explored explicitly, the positive impact on job satisfaction and morale of consistently being enabled to "do the right thing by people" and to be respected and thanked for doing so, should not be underestimated.
- Senior managers felt an important enabler was the constructive working among elected council representatives around health and social care issues. This means there is a relative freedom from short term political pressures, perhaps allowing greater exploration and testing of ideas for service improvement.

Sharing good practice

It is Healthcare Improvement Scotland's intent with this case study to share some of the ideas that have worked for East Ayrshire HSCP and which are a result of their sustained hard work and commitment to continuous improvement.

We hope that the initiatives presented here, along with an exploration of key enabling factors, will provide enough information for other HSCPs to generate practical ideas for change in their organisation which reduce the time patients spend delayed in hospital once medically fit for discharge.

Acknowledgements

The successes described in this document are down to the hard work, ingenuity, compassion and commitment of everyone working in and with East Ayrshire Health and Social Care Partnership. It is their achievement and we thank everyone who contributed for the not inconsiderable time they took to patiently share their knowledge and so make this study possible.

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