

Independent Expert Review of Delayed Discharges

November 2018

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Chair's Foreword

1. Chair's Foreword

Patients whose discharge is delayed experience unnecessarily long stays in hospital, with consequential risks such as healthcare associated infections, general physical deconditioning and/or other adverse outcomes, such as falls. They reflect our inability to provide the right care, in the right place, at the right time - which would normally be the lowest complexity environment possible up to and including the patient's own home.

The output of the Working Group is that the system can significantly improve its performance in this area and we conclude that:

- The absence of a clear national policy and consistent approach regarding Delayed Discharges has resulted in significant under-reporting and has therefore inhibited the implementation of measures to manage this deficit;
- There is insufficient focus on the length of stay that patients spend in hospitals notwithstanding the risks that present the longer a patient is in hospital such as deconditioning and susceptibility to infection;
- There is significant variation in the reporting of Delayed Discharges and an insufficient capability in the health system to pro-actively manage patient flow;
- The HSE organisational structure militates against an integrated approach to patient flow and needs to adapt to address this deficit.

The cost of Delayed Discharges is not borne by the individual patient alone. Our hospitals have high occupancy levels that negatively impact on patient flow, increasing the time taken from presentation at the Emergency Department through to admission and eventual discharge, with associated disruption of elective admissions.

From an accountability, governance and leadership perspective, high level performance metrics such as those associated with Delayed Discharges should, as appropriate, act as a flag indicating the need for further investigation and analysis. For example, the national figures of patients delayed from going home, if accurate, would be indicative of a system operating at, or close to, optimum levels of performance. Instead there is a clear system-wide perception of a mismatch between discharge requirements and community capacity. The data appears to conflict with the narrative. It is surprising that this has apparently not been previously studied.

This ambiguity highlights a need to evaluate the policy and implementation factors underpinning Delayed Discharges. A definition is in place, namely - 'A patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged' - however our investigation revealed an absence of specific policies to guide the rigorous application of the definition, as well as the absence of policies to ensure the timely and robust management, recording and reporting of Delayed Discharges. This is despite The Emergency Department Taskforce report in early 2015 identifying a short-term action to "agree what is meant by a Delayed Discharge so that it can be appropriately measured and targeted at hospital and community level (HSE AHD (Acute Hospital Division), Social Care - Immediate)".

Field work was undertaken involving visits to/meetings with hospitals and Community Health Organisations (CHO's), including: Clinicians; Directors of Nursing; Bed Managers; Patient Flow Managers; Social Workers, Community Services Managers and Discharge Co-ordinators. This provided compelling evidence of varying practices regarding the interpretation of the definition, the making of the decision itself and the recording of same. The interviews also indicated significant under reporting. Additionally, differences in approach at organisational (Hospital Group/CHO) level were identified.

Whilst the development of a clear policy that is comprehensively and consistently rolled out is the central recommendation of this report, it must be recognised that even then there can still be variation (additionally, if the definition is too 'tight' there can be excessive exclusions). We therefore reviewed international measures of Delayed Discharges based on unexpectedly long lengths of stay. It is fair to say that as length of stay increases, the proportion of ill patients is likely to reduce and the incidence of delay is likely to increase. Whilst we are not suggesting that the gap is all due to unreported Delayed Discharges, scrutiny of length of stay can provide an objective indicator of possible under-reporting of delays, as well as identifying potential areas for performance improvement more generally, particularly given its comparative capabilities. The further development of such tools, alongside investment in analytical capacity would be of benefit as a complimentary measure.

From all the above, it is clear that the policy vacuum has enabled significant variation and under reporting across the system. The current weekly report, if intended to provide oversight of system performance regarding Delayed Discharges, is not fit for purpose. This is accentuated further by the current data collection points being limited to acute hospitals only, when we know there are also Delayed Discharges in other settings. It is imperative that control information such as Delayed Discharges be comparable, timely and appropriately accurate to enable effective organisational oversight and decision-making.

We are recommending that the Department of Health ensure the development of a policy, with national HSE responsible for ensuring its consistent implementation through accountability arrangements with delivery units. Its implementation should be subject to external audit. Moreover, we recommend a change in nomenclature from Delayed Discharges to delayed transfer of care. Through this, coupled with the support of a clear policy and supporting protocols/guidance, clinicians and organisations may be better incentivised to consistently report delays. Additionally, the key metric should move to occupied bed days. The current weekly reports give no insight as to the bed days 'lost' by theme or category. This information is important in terms of system performance and planning, different categories will have different average lengths of delay.

Local services are best placed to respond to local circumstances and should be empowered to take the initiative to do so. Joint hospital-community planning fora, with clear expectations set out nationally by HSE leadership, can help bridge the current organisational divisions. These fora should be assigned improvement targets and, in turn, they should set targets for the services they manage. This will drive service and process improvement. The development of an information system spanning hospital and community services, capturing data on need and supply, will highlight service gaps and thus identify development opportunities. This would also enable discussion on the contribution that lower cost community beds could make to improve patient flow as part of capacity enhancement. Through this approach - devolution of responsibility locally within the context of national policy - we should gather information that is of benefit both locally and nationally. It will be important to nurture and develop such fora, particularly through times of structural reorganisation.

We are at a key transformational point in the health system, with Sláintecare and the Capacity Review. Through improving our data reliability, we can help inform system planning, identifying opportunities for reform and investment that also release current capacity and that may not have long, capital intensive lead in times. Over time, it should also help to inform decisions regarding the additional capacity required in terms of the balance between in-patient and community services.

Finally, I would like to thank my colleagues on the Working Group for their commitment and contribution, the secretariat for their support and patience and to the reports authors who responded so positively within very tight timeframes to the feedback and comments from the group.

Graham Knowles
Chair



Executive Summary

2. Executive Summary

Background

The Minister for Mental Health and Older People, Mr. Jim Daly T.D., appointed Mr Graham Knowles, Chairperson of the University of Limerick Hospital Group to chair a Working Group to carry out an independent expert review of Delayed Discharges. The Working Group, through the Department of Health engaged external consultants to conduct the review and provide the Minister with its findings as outlined in this report. The aims of the Working Group and independent review included:

- Analysis of the factors which are causative of Delayed Discharges in the first instance and factors which then affect the final length of stay when a patient becomes classified as a Delayed Discharge. This includes the mapping of pathways of care and articulation of 'bottlenecks' in the system (see key findings below)
- Examination of current systems for the management of Delayed Discharges including performance monitoring and management with regard to Delayed Discharges. Each Wednesday, the HSE produces a twelve page National Report; this report illustrates the number of patients who have been discharged home, to long term care and to an alternative location. The Report also illustrates the number of Delayed Discharges recorded by Hospital and Hospital Group (see appendix 9.6)
- Analysis of the current data collection and reporting systems for Delayed Discharges and recommendations for improvements as appropriate (see key findings below)
- Identification of changes that can be made in the short term to inform planning for Winter 2018/2019 (see short term recommendations below)
- Identification of medium term changes to reduce the overall number of Delayed Discharges on an ongoing basis with reference to international best practice (see medium term recommendations below)
- Preparation of a costed implementation plan (see key findings below)

Approach

The work was undertaken from July to October 2018. This report sets out a summary of the approach and methodology employed, the findings identified, the short and medium term recommendations and the data and its analysis used to underpin these findings.

Several steps were taken to understand the current issues and challenges experienced when managing Delayed Discharges in the Irish Healthcare System. These include:

- Seeking written and oral submissions from key stakeholders and interested parties. A list of those who provided written submissions is available in Appendix 9.3.
- Collation of data from key sources, primarily the Delayed Discharge Dataset and the HIPE (Hospital In-Patient Enquiry) dataset.
- A comparative analysis of systems and approaches in other jurisdictions, including a review of approaches in the UK and other countries, with data from the Organisation for Economic Co-operation and Development (OECD).
- Site visits to a number of hospitals and community health organisations and discussions with key stakeholders to understand practices and processes in various locations.

- An analysis of the data and information gained in order to identify findings and recommendations for improvement.
- The initial observations were considered by the Working Group in August and September, feedback was sought and this Report was updated accordingly.

Key Findings of Review

- Delayed Discharges are caused by a multitude of factors, including (but certainly not limited to): the lack of availability of various forms of step down care, staff shortages, and administration systems. The limitations with the Delayed Discharge report and the uncertainty with regards to the information provided prevented the Working Group from assessing the relative significance of the factors cited.
- There is a commonly used definition for 'Delayed Discharge', which is known at individual site and CHO level. However this lacks a standard interpretation which results in variations in practice across the system, between hospitals and Community Health Organisations. In addition, as a result of the variations in practice, there are inconsistencies in the data recorded in the Delayed Discharges Dataset at hospital level.
- There is evidence that there are no issues with the core ICT (Delayed Discharges Dataset) underpinning the recording of Delayed Discharges. However, there is significant qualitative evidence that the definition of Delayed Discharges, at the clinician and administrator levels, is subject to material variation in interpretation. This is likely to lead to the information currently available from the Delayed Discharges Dataset not being reliable. Essentially, there is a lack of complete data to accurately quantify the scale or the precise causes of the challenges at all levels. The data limitations inhibit the ability to prioritise potential solutions and measure their impact.
- Until the scale of Delayed Discharges can be accurately quantified, it is not possible to complete a costed implementation plan, nor is it possible to accurately measure the success of same. A proposed implementation plan is included in the report. Recommendations regarding key performance metrics on this issue should be informed by a correct understanding of the scale and fully characterised nature of the issue.

The Review produced a number of recommendations as requested at the outset and these are outlined below.

Recommendations

Recommendations have been categorised as short term recommendations which should be implemented for the 2018/19 winter season and medium term recommendations which should be implemented within the next 18 months. It is important to note that the limitations with regard to accurate and robust information regarding the size and scale of the Delayed Discharge challenge means that it is not possible to make specific and measureable recommendations to improve the situation in the short term. While the recommendations (outlined below) are likely to improve the current situation, without an accurate understanding of the baseline with regards to the issue, it is not possible to estimate the specific extent of the improvements which will be delivered.

Short Term Recommendations

- *Policy Factors and Definition*- a national policy should be developed to provide an unambiguous definition and guide to categorising Delayed Discharges. This policy should include an agreed and consistent approach for the definition, recording, categorising, counting, and changing the status of Delayed Discharges. It should also incorporate the change in terminology from Delayed Discharges to Delayed Transfer of Care.

- *Accuracy and use of Data* - steps should be taken to improve data quality (to ensure all Delayed Discharges are captured on the Delayed Discharge dataset) and to extend the Delayed Discharge dataset to the non-acute healthcare setting. Consideration should also be given to including the number of bed days lost in the Delayed Discharges National Report (which is generated on a weekly basis).

Other methods to measure the number of Delayed Discharges should be reviewed and considered. This report outlines the approach taken in The Netherlands, England and Scotland, and presents how the Irish system would look if the Dutch model was applied. In this case, we can see that this alternative method highlights a potentially much higher number of Delayed Discharges.

In addition to the number of patients who experience a Delayed Discharge, the number of 'bed days lost' should also be reported. Calculating the number of bed days lost provides an additional measure as to the size and scale of the challenge facing the system. Any gains should be measured in terms of occupied bed days saved.

- *Joint Planning Forum* - the National HSE leadership team should emphasise the importance of hospitals and communities working together to optimise patient flow. This should help ensure there is equal emphasis on the community proactively 'pulling' the patient from the hospital and on the hospital planning to discharge the patient on a timely basis. The development of a shared view of demand, anticipating capacity and developing strategic responses to gaps in service should be encouraged. Furthermore, the HSE leadership team should ensure a Joint Planning Partnership Forum is established based on the population area of each Hospital Group.
- *Role and Responsibilities* - Roles and responsibilities should be reviewed to assess the support available to patients and their families regarding the NHSS (Fair Deal) process and discharges. It is recommended that each level 3 and level 4 hospital has a Discharge Coordinator and a resource allocation to the NHSS process. Level 1 and level 2 hospitals should have a joint resource which should be available as required. Furthermore, clarification should be provided to support accountability between various stakeholders responsible for managing Delayed Discharges.

Medium Term Recommendations

- *Audit* - An external audit should be undertaken to review quality compliance, address any issues, improve data quality and visibility and increase confidence in the data available.
Depending on the patient pathway, a complementary or alternative measure (such as the average length of stay +50%) should be considered.
- *Communication* - Establish a consistent approach and timed pathway for communicating with families (next of kin) to minimise any potential delays. A public health campaign should be undertaken to raise awareness that patients are better off being discharged rather than being kept unnecessarily in the acute healthcare setting.
- *Multi-Disciplinary Team* - Multi-disciplinary teams should conduct single discharge assessments. These teams should be supported by staff both in the acute healthcare setting and in the community. Input should be provided by the Discharge Coordinator at hospital level, and from several teams in the community. Intervention from all relevant stakeholders will help limit delays or uncertainty regarding post-discharge supports required.
- *Information Sharing* - Information sharing between Hospital Groups and CHOs, particularly in relation to bed availability and patients' status should be encouraged. The ICT system should adopt a whole system approach, capturing both supply and demand in both the acute and non-acute healthcare settings.
- *Early Discharge Pathway* - Establish early discharge pathways to prevent admissions in the first instance, which in turn will reduce the risk of Delayed Discharges. For example, the placement of Social Workers and other allied health professionals in the emergency department can reduce

the need for admissions. In addition, an early supported discharge pathway should also be considered to enable assessment of care needs in the patient's home, home like environment or transitional care unit, depending on the patient's care needs. Having been admitted, all patients should be categorised as requiring a 'Simple Discharge', a 'Supported Discharge' or requiring 'Continuing Care'. Categorising patients into these three categories allows the multi-disciplinary team to pro-actively plan the patients' discharge needs.

Conclusions

The Working Group requested suggestions for specific changes that could be made in the short term to inform planning for Winter 2018/2019 and in the medium term to reduce the number of Delayed Discharges. However, the absence of accurate data to quantify the full extent of the current challenge means that it is not possible to confidently identify measurable changes that can be implemented in the short term. Based on the analysis conducted, several 'Opportunities for Improvement' have been identified which will help address the current challenges. The first and most important step will be the establishment of a national policy to ensure Delayed Discharges (Delayed Transfers of Care) in both the acute and non-acute settings are reported accurately.

One of the implicit challenges in the development of the national policy is the possibility that this will result in the identification of a significantly higher number of Delayed Discharges than is currently reported. Once the data capture process is clarified and improved it is likely that the reported number of Delayed Discharges will increase. However, this increase in data capture will allow for a more robust root cause analysis of the issues and the development of more specific actions to support health service planning.



Introduction

3. Introduction

3.1 Terms of Reference

The Minister for Mental Health and Older People, Mr. Jim Daly T.D., appointed Mr Graham Knowles, Chairperson of the University of Limerick Hospital Group to chair an expert Working Group to carry out an independent expert review of Delayed Discharges. The Working Group engaged EY to conduct this independent review. The purpose of this review is to identify changes that can be made in the short term to inform planning for Winter 2018/2019 and in the medium term to reduce the overall number of Delayed Discharges. It was agreed that the scope of this review would be limited to the acute healthcare setting.

Delayed Discharges were assessed and examined from several perspectives which included examining several datasets, assessing patient pathways and subsequently identifying the factors which contribute to a patient being classified as a Delayed Discharge. Having completed this analysis, several recommendations have been made which will help alleviate the subjectivity and lack of transparency which currently exists in terms of recording Delayed Discharges. These recommendations should ensure the definition of 'Delayed Discharges' is applied in a more transparent and coherent manner.

A number of key components were considered as part of this review in order to understand the current situation with regards to Delayed Discharges, key roles and responsibilities and availability of data available to support recommendations for improvement. These areas are outlined below and were used as a basis for discussion during the stakeholder consultations.

Key Components Considered

1. **Accuracy and use of data**
Understand the current arrangements for monitoring Delayed Discharges, including:
 - Robustness of data and its use to improve practice/process
 - Current policy status, understanding and implementation
 - Definition of 'Delayed Discharge' and consistency of its application
 - Method for counting and monitoring Delayed Discharges at local, regional and national level
2. **Current Roles and responsibilities**
 - Understand the current management arrangements for Delayed Discharges
 - Processes for managing Delayed Discharges at local level
 - Ownership of Delayed Discharges at local level
 - Performance monitoring arrangements at local, regional and national level
 - Accountability arrangements at local, regional and national level
3. **Policy factors that influence management of Delayed Discharges**
 - Identify policy factors that influence the management of Delayed Discharges
 - Consider any perverse incentives or disincentives
 - Consider the impact of boundary or organisational structures
 - Consider any impact from funding flows
4. **Main causes and trends**
 - Identify the main factors that lead to Delayed Discharges
 - Understand typical patient profiles
 - Understand current care pathways
 - Understand existing decision-making processes

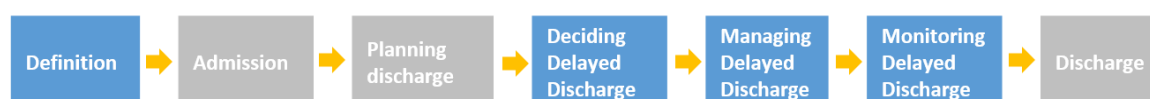
5. **Supply and demand**
Compare bed availability in Ireland to other jurisdictions for acute, community and nursing homes
6. **Improvement opportunities**
 - Draw on learning from international comparators and leading practice
 - Identify any policy or guidance improvements
 - Consider any system, process and practice changes
 - Identify the need for any realignment of resources or care pathways

3.2 Approach and Methodology

Delayed Discharges were examined from several perspectives and not through one lens. In order to ascertain why Delayed Discharges are occurring, which groups are most affected by Delayed Discharges and how accurate the reported figures are, the analyses followed a qualitative and quantitative approach. An assessment of the processes, practices and procedures in place for Delayed Discharges were reviewed by examining:

- The current strategic policy framework
- The organisational structure for the management of Delayed Discharges at national and local level
- Current practices and processes at local level within both Hospital Groups and Community Health Organisations (CHOs)

Key questions were compiled which allowed an examination of the current patient pathway. This review focuses on key areas along this map as highlighted in blue below:



This review's methodology comprised of the following four components:

1. **Meeting with a range of stakeholders:** Individual meetings were held with all members of the Working Group, representatives from several Hospital Groups and CHOs (Community Health Organisations). The meetings with each stakeholder followed a similar agenda (see 'Areas of Focus' - appendix 9.1) and each meeting lasted between 90 - 120 minutes. A site visit to several level four hospitals ensured this report could incorporate the views of various members of the MDT (multi-disciplinary team) including: Clinicians (directly involved in the care of older people), Directors of Nursing, Bed Managers, Patient Flow Managers, Community Services Managers, Discharge Co-Ordinators, Social workers etc.

The site visits provided an opportunity to view the 'White Board' (a communication tool used to document the care a patient requires which is typically located in the nurses' station). Typically, the white board should provide information such as a patient's EDD (expected date of discharge), diagnostics, the input required from various MDT members etc.

With an ageing population the demand for continued care following discharge from the acute healthcare setting is increasing. Discussions were held with several CHOs to gain an insight into the challenges they face in providing a patient with the level of care required post-discharge. While there were often similarities in the stakeholders' responses, there were some instances where factors contributing to a Delayed Discharge were more prevalent in certain geographical locations.

2. **Performing data analysis:** Data was obtained and analysed from the Delayed Discharge dataset and the HIPE dataset. The trends and analysis identified were contrasted to the data published by the OECD (Organisation for Economic Co-operation and Development).
 - The Delayed Discharge dataset is a live system used to track patients that are medically fit for discharge but remain in the healthcare setting. The data is collected at hospital level and a report is generated weekly. This report contributes to the National Performance Report which is available to the HSE and Department of Health. An example of the report is available at Section 9.6. As outlined in this report, the number of patients recorded on this dataset appears to be significantly understated.
 - The HIPE (Hospital In-patient Enquiry) dataset - The HIPE dataset is the principal source of national data on discharges from acute hospitals in Ireland. The data is collected from medical charts and coded by trained clinical coders prior to being entered into the HIPE Portal. HIPE does not contain the reason for Delayed Discharges nor does it intend to collect this information in the future. HIPE is not a live system and any reports generated can be up to three months in arrears.
3. **Submissions and Reports:** The Working Group sought submissions from a range of interested parties (see list of parties that provided written submissions in appendix 9.3). While the length of submissions received varied significantly, it should be noted that a wide cohort of interested parties provided a response. Each submission was reviewed and many of the points illustrated in the submissions have been incorporated into this report.

The submissions identified various factors contributing to and potential initiatives which could help reduce the number of patients experiencing a Delayed Discharge. A summary synopsis of the submissions is contained in section 7 of this Report.

The Special Delivery Unit (SDU) undertook a review of discharge processes and discharge pathways in four acute hospitals. Their review identified areas of good practice and areas for improvement. Although the final SDU report is not available, the SDU have provided the Working Group with a summary report. The findings of the summary report have been considered by the Working Group in the preparation of this report.

4. **Literature Review:** a limited literature review was undertaken to ensure conclusions reached reflected best practice. This literature review included (but was not limited to) reviewing the Health Service Capacity Review Plan 2018, The Sláintecare Report (2017) and the Sláintecare Implementation Strategy (published in August 2018). With regard to the impact of Sláintecare on the challenge of Delayed Discharges, it was noted that the implementation of this long term vision for the Irish healthcare system would be anticipated to have profound consequences for Delayed Discharges. However, the timeframes involved in its implementation will not impact on the short or medium term recommendations considered as part of this review. Once the data is robust, it will be used to support future planning decisions. This is an area that deserves further consideration at the point of publication of the 'Detailed Sláintecare Implementation Plan' expected in late 2018/ early 2019.

The initial observations were considered by the Working Group in August and September, feedback was sought and this Report updated accordingly.

3.3 Selected Hospitals

A number of hospitals and Community Health Organisations were selected for face-to-face meetings as part of this review. Those selected were aimed at providing a representative sample of organisations based on geographic considerations, scale and availability of key resources. All input received has been collated and combined and individual input or submissions have not been individually attributed.



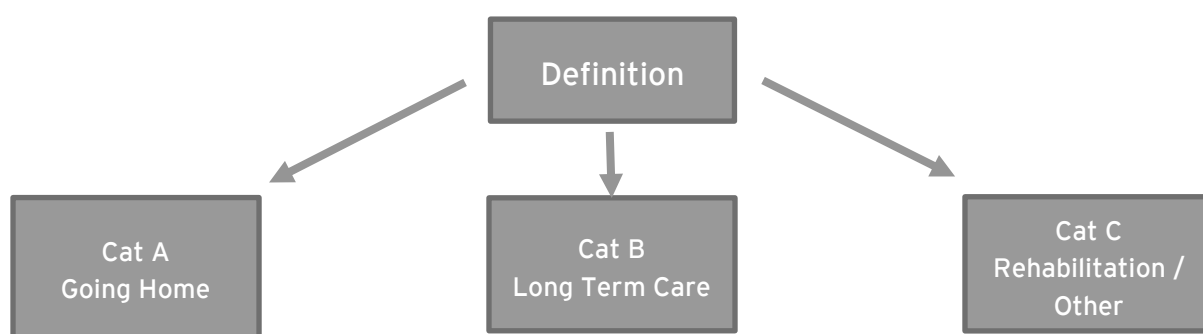
Analysis and Context

4. Analysis and Context

4.1 Definition of Delayed Discharge

It was noted that there is a clear definition provided by the HSE's Special Delivery Unit of what constitutes a Delayed Discharge - "A patient who remains in hospital after a senior doctor (consultant or registrar) has documented in the medical chart that the patient can be discharged".

It is understood that the definition was introduced to ensure senior clinical engagement in the decision-making processes. However, the Review was unable to ascertain any policy or guidance to Hospital Groups or to the CHOs in respect of the application of the definition. It was noted that a Quality and Patient Safety Audit was undertaken in late 2013 "to determine the level of compliance with consultant / registrar documentation that the patient can be discharged, before the patient can be categorised as a Delayed Discharge and the recording of categories of reasons for delay into three main areas:



The purpose of the audit included to "... confirm that there is a documented 'clinical' decision for discharge in the healthcare record at the time of the recording of a Delayed Discharge on the database..." The audit examined whether patients entered in the dataset met the definition. It did not examine the overall cohort of hospital in-patients, to determine if there were other patients who should have been included under the Delayed Discharges definition. The outcome of this audit confirmed that the decision to discharge was documented in 92% of the healthcare records reviewed and the reason for the delay was recorded in all but one hospital audited.

This audit was not designed to identify any delays in the period prior to the clinical decision being recorded on the Delayed Discharge dataset. Neither was it designed to determine the proportion of patients documented as Delayed Discharges (typically by virtue of being recorded as medically discharged) in the medical notes recorded in the Delayed Discharge dataset.

Due to the significant variation in the application of the Delayed Discharge definition used in Ireland (as outlined in section 4.2), the Irish definition and process was contrasted with the processes adopted in both Scotland and England for comparative purposes. In both Scotland and England there is a clear nationally agreed process for classifying a Delayed Discharge or Transfer of Care, as it is known in England.

For instance:

Scotland - Definition:

"A Delayed Discharge is a hospital in-patient who is clinically ready for discharge from in-patient hospital care and continues to occupy a hospital bed beyond the 'Ready for Discharge' date.

- ▶ *'Ready for Discharge' is the date on which a hospital in-patient is clinically ready to be discharged from in-patient hospital care.*
- ▶ *This is determined by the consultant/GP responsible for the in-patient medical care and where a multidisciplinary team, in consultation with all agencies involved, agrees that the individual's care needs can be further assessed or properly met outside of a hospital setting.*
- ▶ *Where the patient remains inappropriately in a hospital bed no longer receiving treatment but merely waiting for an appropriate place in the community then they should be classified as a Delayed Discharge.*
- ▶ *Patients on phased discharge involving trial periods of assessment and rehabilitation at home are not yet fully ready for discharge from hospital so should not be classified as a Delayed Discharge".*

England - Definition:

"The NHS England deems a patient being ready for transfer when:

- ▶ *A clinical decision has been made that the patient is ready for transfer, and*
- ▶ *A multi-disciplinary team has decided that the patient is ready for transfer, and*
- ▶ *The patient is safe to discharge/transfer*

As soon as a patient meets these three conditions and remains in a bed, the 'clock' starts and they are classified as 'a delayed transfer'."

While the wording of both the Scottish and English definitions differ, the principles applied to both definitions is similar. In comparison to the Irish definition, both definitions provide more detail and greater consistency in terms of the interpretation of the definition. In particular, both clarify the need for involvement of the multi-disciplinary team in the decision making process and both clearly specify when the Delayed Discharge begins.

The Emergency Department Task Force report outlined a range of short and medium term actions in order to reduce Delayed Discharges to a maximum level of 500 by the end of 2015. The first of the short term actions listed was to *"agree what is meant by a Delayed Discharge so that it can be appropriately measured and targeted at hospital and community level (HSE AHD, Social Care - Immediate)*. The latest information available on guidance to the system was issued by the Special Delivery Unit in May 2013.

4.2 Varying Practices

1. Interpretation of Definition

There appears to be significant variation in practice in terms of interpreting and implementing the Delayed Discharges definition. This finding is based on qualitative evidence (interviews with the clinical teams including: Consultants, Discharge Co-ordinators, Patient Flow Managers, Senior Nurses and Social Workers).

2. Decision

Having interviewed many clinicians, this review noted key discrepancies in deciding whether a patient is a Delayed Discharge. In some cases, this decision is made by the senior doctor,

while elsewhere, the decision will only be made following input from the multi-disciplinary team.

3. *Recording*

Variations were also noted in regards to the recording of Delayed Discharges. For example when a decision is made and it is documented in the medical chart, there is no standard process for the patient to be added to the Delayed Discharge dataset. In some cases, recording a patient as a Delayed Discharge on the dataset is completed by the Discharge Co-ordinators or Patient-Flow Managers.

Some patients are not identified as a Delayed Discharge and recorded on the dataset until the senior doctor and care team discuss the decision with the family, the social worker is engaged and the Common Summary Assessment Report (CSAR) is completed. In addition, some hospitals allow a 'grace' period (up to 10 days) before the delay is recorded. This time may be used to complete a community assessment of the patient's care needs. In some cases, the local practice is not to add the patient to the Delayed Discharge dataset until the community services have 'accepted' the patient.

4.3 Data Analysis

To determine whether these different practices impact on the number of patients who are recorded on the Delayed Discharge dataset, the following three primary data sources were examined:

1. Delayed Discharge Dataset - this is the primary 'real time' data source in Ireland for patient level tracking and monitoring the number of reported Delayed Discharges, where they actually went and how long they were waiting.
2. Hospital In-patient Enquiry (HIPE) Dataset - was used as an alternative source of data on the extent of Delayed Discharges among patients in acute hospitals.
3. Organisation for Economic Co-operation and Development (OECD) dataset² - this was primarily used to compare performance in Ireland with the rest of Europe in terms of length of stay, hospital and community bed numbers and availability of nursing home beds. Unless stated otherwise the data presented focuses on acute patients only (i.e. maternity is excluded).

Of significance, the data available was in respect of acute hospital beds only³. The issue with regard to Delayed Discharges is also highly relevant to the non-acute sector (e.g. NRH, other rehabilitation facilities, community hospitals). As outlined in the Recommendations section, this is a priority area to focus on in terms of short term data improvements.

Figure 1 on the next page, shows the distribution of Delayed Discharges by hospital group as recorded in the Delayed discharge dataset. While all acute hospitals (and the National Rehabilitation Hospital) record Delayed Discharges, the differing interpretation and processes mean that the data may not be comparable.

² The Ireland data on the OECD dataset is taken from the HIPE dataset

³ HIPE includes some non acute hospitals, Delayed Discharges dataset includes NRH

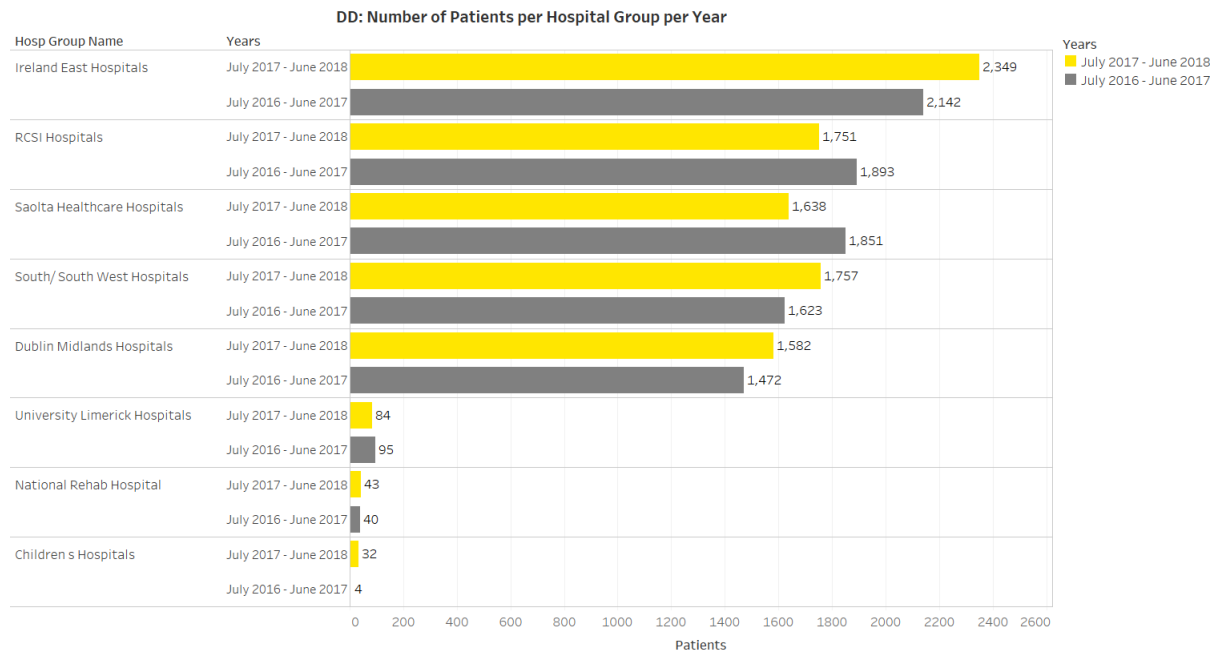


Figure 1: Number of Delayed Discharges - number of patients per hospital group per year

The Delayed Discharge dataset records a detailed reason for being added and removed as a Delayed Discharge. The most commonly occurring reasons for a delay are set out below in Figure 2.

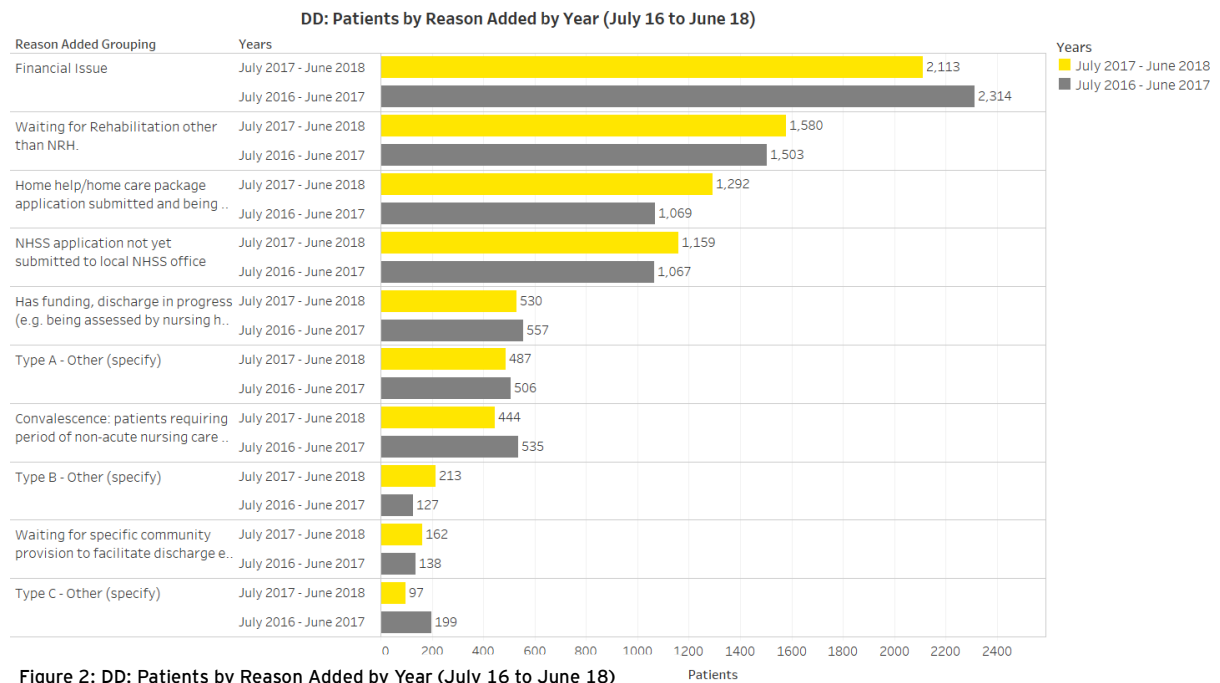


Figure 2: DD: Patients by Reason Added by Year (July 16 to June 18)

Figure 3, shows the top four reasons for delays in more detail. This analysis examines the number of days patients are delayed. Over 50% of those with financial issues were delayed 21 days or more, 80% of patients waiting on rehabilitation were delayed between 1 and 10 days and nearly 70% of those delayed due to administration issues were delayed between 1 and 20 days. The time a patient is delayed due to not yet submitting their NHSS application has increased year on year. The delay is with the patient gathering required information and not submitting it.

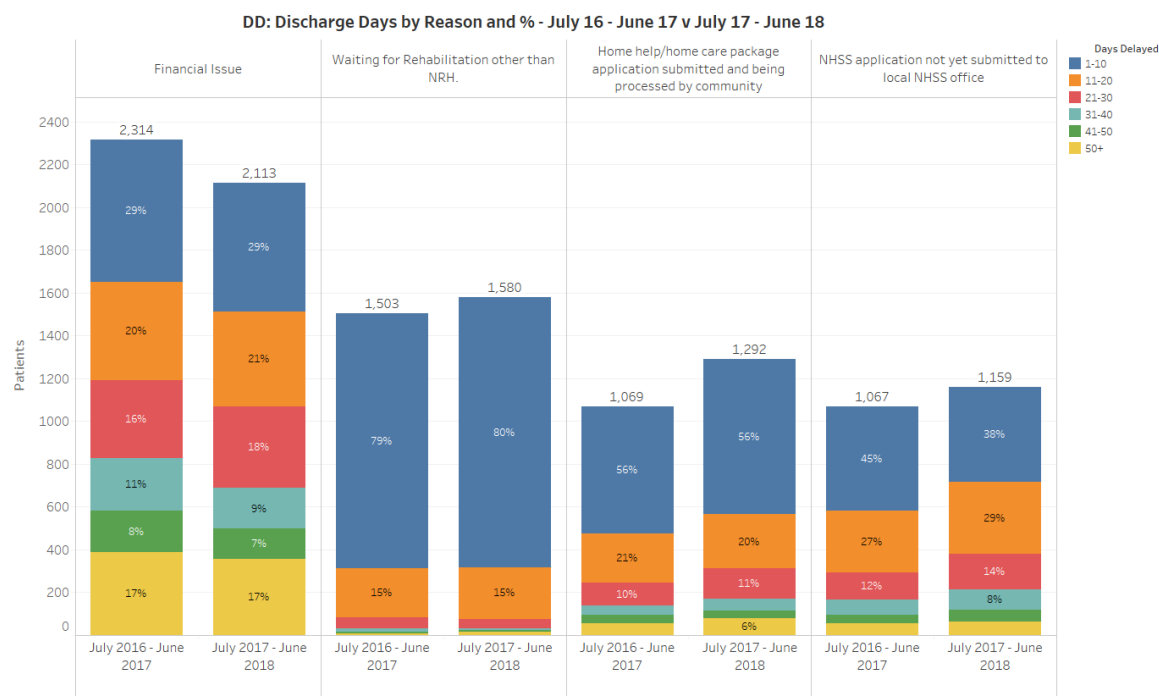


Figure 3: Number of Patients Delayed Discharge by Reason and %

4.4 Measuring Delayed Discharges

An examination of the reporting and counting methodologies for Delayed Discharges was also undertaken. The methodology and therefore reporting adopted in Ireland is a 'snapshot' of the number of patients on the Delayed Discharge dataset at midnight on any given day. This method of counting includes any patient that was added to the dataset on that day in the same way as a patient who had been on the dataset significantly longer.

The methodology for recording and counting in Scotland and in England is very specific:

Scotland - Recording:

Delayed Discharges are recorded as the total number of days patients spent delayed in hospital following their 'ready for discharge' date. The average daily number of beds occupied is calculated by dividing the total monthly number of Delayed Discharge bed days by the number of days in the calendar month to give the average daily number of beds that were occupied in that month by Delayed Discharge patients.

England - Recording:

“Delayed transfers of care are recorded as;

- 1. The total number of bed days taken up by all delayed patients across the whole calendar month, and*
- 2. The average daily number of delayed transfers across the month*

This measure is calculated by dividing the number of delayed days during the month by the number calendar days in the month”

While the wording of both the Scottish and the English count is different, the principles are essentially the same in that they provide a better view of the number of bed days lost to Delayed Discharges.

The ten most frequent reasons for Delayed Discharge recorded in Ireland versus those recorded under the English model were examined. It appears that the definitions in the English system are subject to less interpretation than the reasons provided by the Irish system. For example, ‘funding’ is listed as a reason for Delayed Discharges in half of the top ten reasons provided in Ireland whereas ‘funding’ is only referred to in one of the top ten reasons provided by England. While funding does impact on several factors which can contribute to a delayed discharge, the level of granularity provided by the England model does appear to provide a clearer rationale as to why the delay is occurring.

4.5 International Delayed Discharges Methods

Other countries (Australia, Netherlands, and Singapore) have adopted alternative approaches to measuring Delayed Discharges based on lengths of stay. In the Netherlands, discharges are considered to be delayed where the length of stay is 50% longer than the average length of stay for the general patient population in the previous calendar year. A similar approach is taken in Australia and Singapore where delays in discharge are considered to occur when a patient has stayed in hospital in excess of 21 and 35 days respectively.

Given concerns with the completeness of ‘Delayed Discharges’ data in the Irish healthcare setting, a notional application of the Dutch model to the HIPE dataset was completed to provide an estimate of possible “Delayed Discharges” in the Irish system.

This comparison is not intended as a way to calculate the Delayed Discharges or to supersede the current Delayed Discharge dataset but rather to provide an indicative estimate of the possible scale of the challenge. Neither is it suggested that Ireland’s current method should be replaced with this alternative method. However, the comparison may provide complementary estimates that could be useful in triangulating the improved Delayed Discharge data. It is also acknowledged that productivity and efficiency issues (or issues regarding access to key diagnostic tests) may well account for some of the differences. As length of stay increases, however the proportion of patients who require continued medical treatment is likely to reduce and the incidence of delayed transfer is likely to increase. Statistical review of samples of patients with long length of stay could provide valid indicators of the average proportions of each. The potential application of this approach should be systematically studied in the Irish context as a complimentary measure.

Using HIPE data on discharges of overnight inpatients (excluding maternity), an average length of

stay (ALOS) was calculated for each speciality⁴ and for three separate age groups. 50% was added to this length of stay; the number of patients where the length of stay was greater than or equal to that number was calculated. Applying this method to the Irish healthcare system, would have resulted in 67,149 patients being a Delayed Discharge in 2017 as opposed to the 8,817 patients which were actually recorded in the database.

There are many potential explanations for the difference between these two measures. The data presented is based on different sources with differing collection criteria. The HIPE data includes some of the non acute hospitals that are not currently included in the Delayed discharge dataset. The Delayed Discharge dataset only records Delayed Discharges from acute hospitals along with the National Rehab hospital. Patients in non-acute hospitals still contribute to demand for the long term care and home support schemes but are not currently captured in the Delayed Discharges data.

Patients who experience extended lengths of stay as captured in HIPE may still be acutely ill and in active treatment, no analysis has been carried out on the HIPE data to distinguish these patients from those patients not being actively treated for an acute illness. HIPE only records patients once they are discharged from the hospitals, so patients who have not been discharged will not be counted.

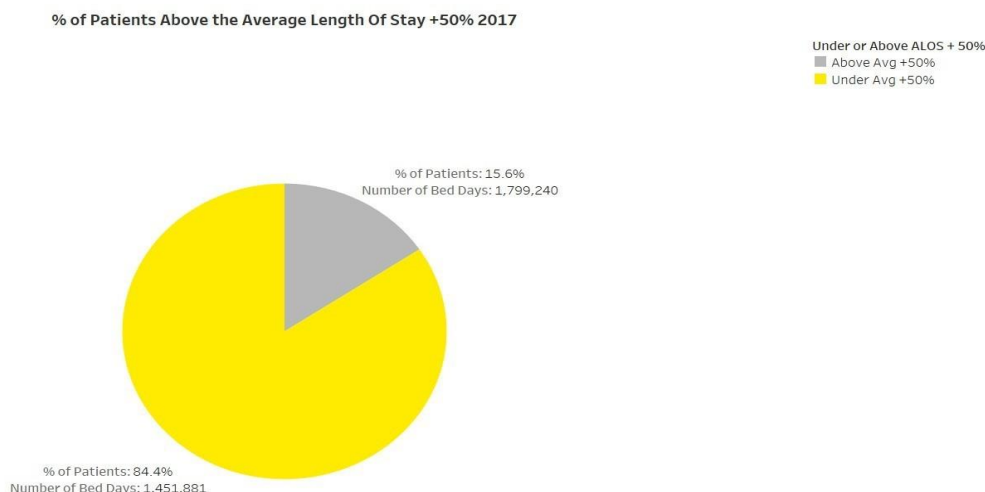


Figure 4: % of Patients Above The Average Length of Stay + 50%, 2017

Figure 5 below compares the actual number of bed days appropriate to the two methods per calendar month for 2017. For example under the ALOS +50% method (represented by the grey line), if ALOS +50% is assumed to be approximately 9 days and a patient has a stay of 20 days (per HIPE), the number of bed days lost will be 11 of the total for the month in question. The lower number of bed days lost per the Delayed Discharge dataset is captured based on the actual bed days lost for the Delayed Discharges recorded in the system per current methodologies. In this case the current data capture is 24% of the ALOS +50% method.

⁴ The speciality is defined as follows (reference HIPE data Dictionary- www.hpo.ie)

A speciality code is assigned to the record on the basis of the speciality assignment of the consultant associated with the principal diagnosis. The speciality of the consultant is the speciality in which s/he is formally recognised and contracted to work. A consultant may be formally recognised and contracted to work in more than one speciality; in these cases one speciality is recognised as the main one.

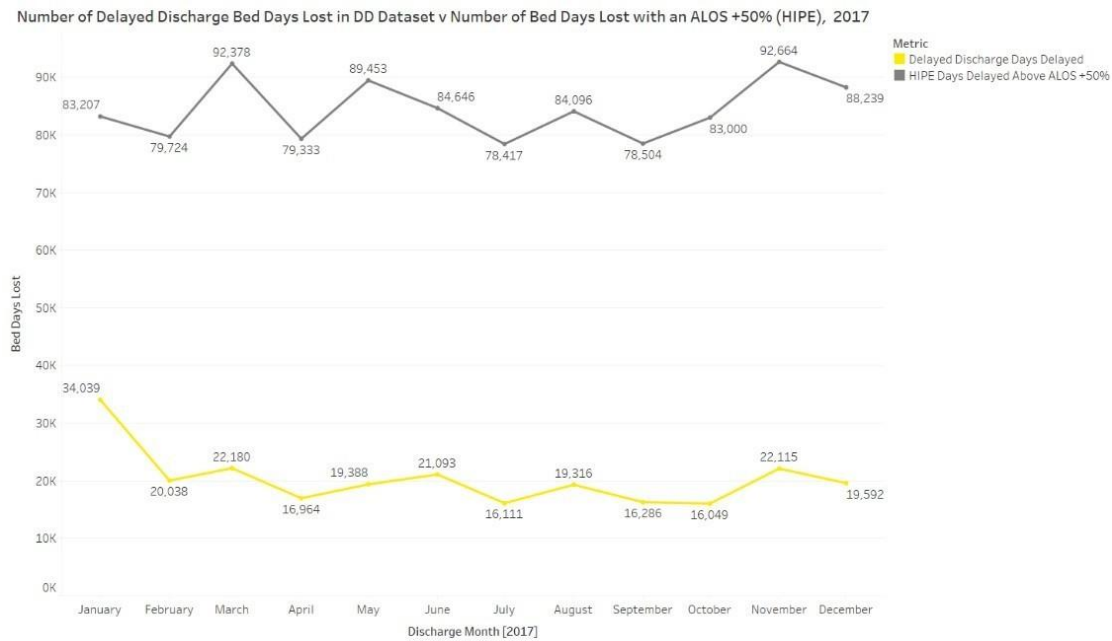


Figure 5: Number of Delayed Discharge Bed Days Lost in DD Dataset v Number of Bed Days Lost with an ALOS +50%, 2017

4.6 International Data Comparisons

Data from the OECD was used to analyse Delayed Discharges in Ireland when compared to other European countries in terms of hospital bed availability per 1,000 population, length of hospital stay and the availability of Nursing Home places per 1,000 population.

The following graphs provide further statistical analysis between the ALOS and the bed availability in Ireland versus other EU countries. It is important to note that these graphs have been included for comparative purposes only.

Figure 6 shows that Ireland has 3.0 beds per 1,000 population - 2.8 of these are acute beds. It is important to note that countries can have different definitions for acute and non-acute beds.

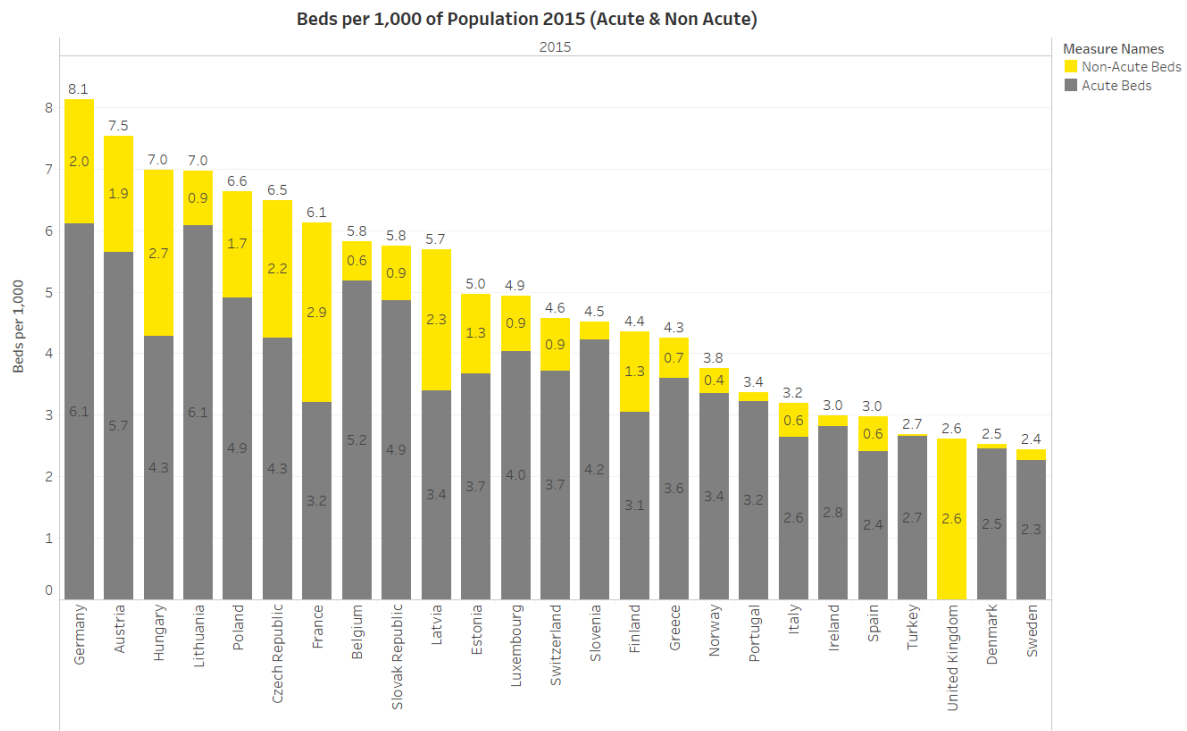


Figure 6: Number of Hospital Beds Acute and Non-Acute per 1,000 of the Population (2015)⁵

Ireland's LOS has reduced from 6.4 days in 2004 to 6.1 days in 2015 (figure 7).

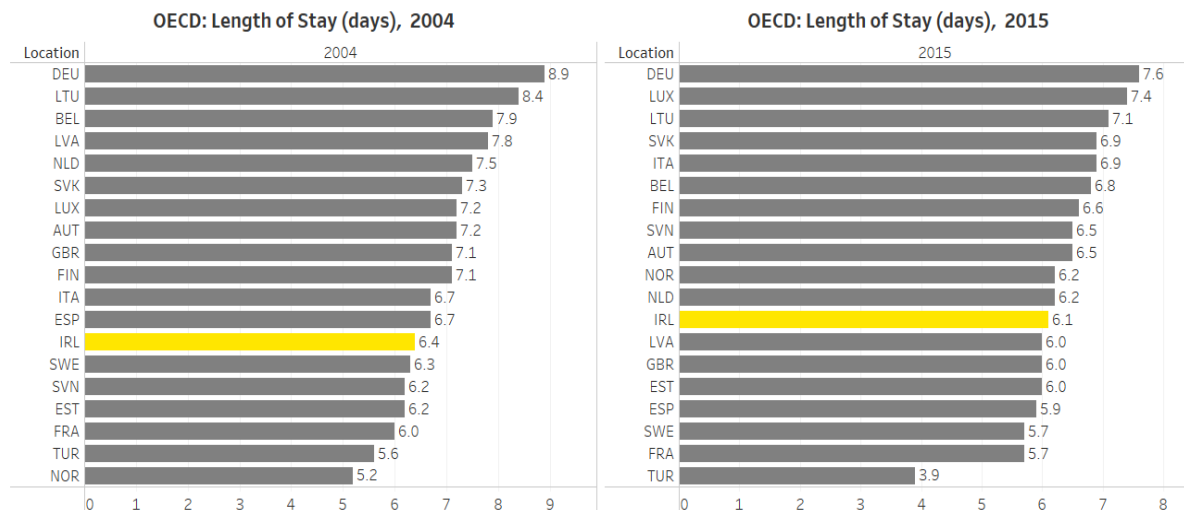


Figure 7: Average Length of Stay in EU 2004 & 2015 (Excluding Maternity)

⁵ UK - From the data submitted for the UK to the OECD it is not possible to separate long-term care beds, rehabilitation beds and other beds from curative care beds

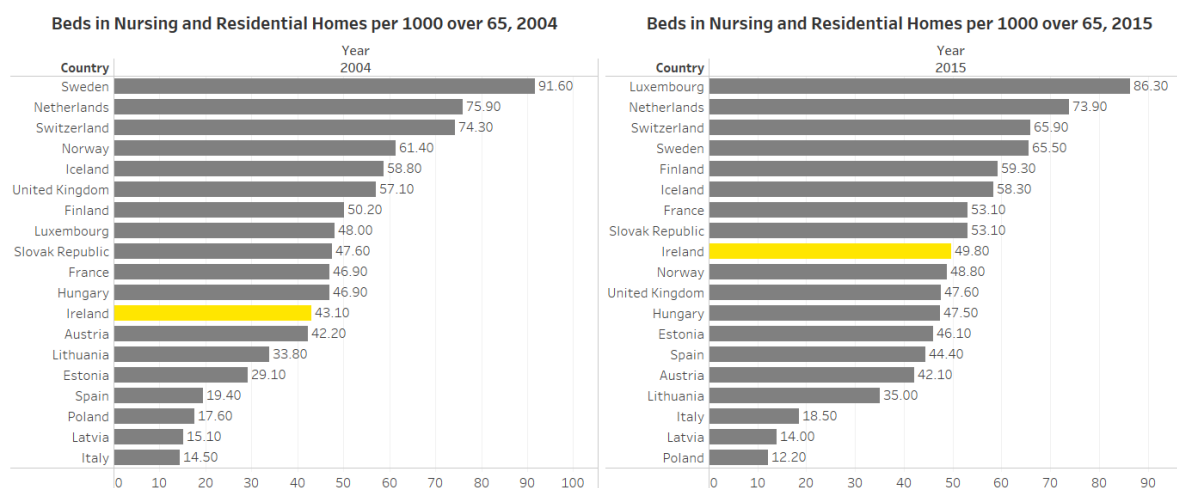


Figure 8: Number of Beds in Nursing/Residential Homes per 1,000 of the Population (2004 v 2015)

In 2017, The Lancet⁶ medical journal published the findings of its report on Healthcare Access and Quality Index based on mortality from causes amenable to personal health care in 195 countries. The countries with the best access to healthcare were: Andorra, Iceland, Switzerland and Sweden. In the comparative Figures above, Sweden has the least number of hospital beds (2.4 to Ireland's 3), has shorter length of stay (5.7 days to Ireland's 6.1) and significantly more Nursing Home beds (65 to Ireland's 49.80) all per 1,000 population.

4.7 The Ageing Population

According to the Central Statistics Office 2016 Census, Ireland has an ageing population. The number of people aged 65+ years has increased by 102,174 (19.1%) between the 2011 and the 2016 census. The National Service Plan 2018 states that each year the number of people aged 65 years+ increases by almost 20,000 and by 2,500 for those aged 85 years and older. The National Service Plan 2018 also states that it is estimated that between 2011 and 2020, the number of people aged >65 years will increase by up to 131,000 (21%).

An ageing population can significantly affect how health and social care services operate. While the elderly are living longer independent lives, as referred to in the Health Service Capacity Review they are the biggest users proportionately of acute in-patient services. As illustrated in Figure 9, those aged 65+ account for almost 90% of the patients recorded as a Delayed Discharge.

⁶ Healthcare Access and Quality Index based on mortality from causes amenable to personal healthcare in 195 countries and territories 1990 - 2015; a novel analysis from the global Burden of Diseases Study 2015 is published in the Lancet 2017, 390

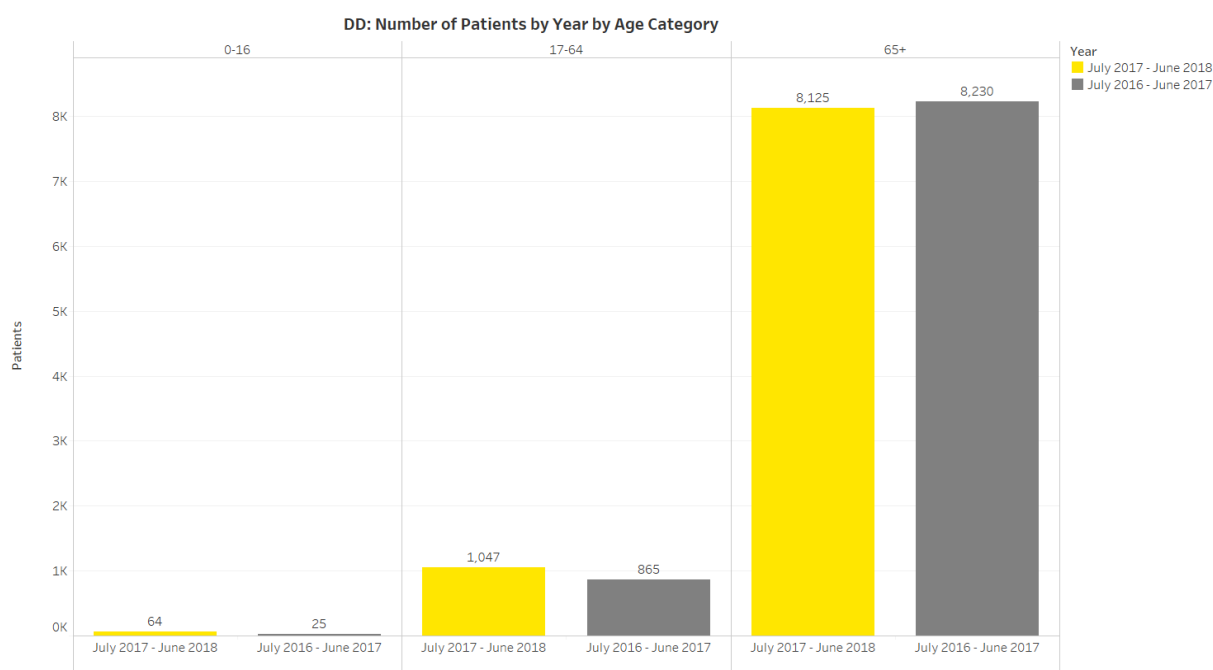


Figure 9 Number of Delayed Discharge patients by age - over 2 year obtained from the Delayed Discharges Dataset

“Older people increasingly present with geriatric syndromes such as frailty, complex co-morbidities, disability, delirium and/or dementia and complex psychosocial personal and/or family circumstance. In addition, older people often present with high acute illness severity, which in survivors is an independent risk factor of loss of functional capabilities. This complexity requires in-patient Comprehensive Geriatric Assessment (CGA) and multidisciplinary rehabilitation, discharge planning and support to return to their own homes as quickly as possible and less frequently to nursing home care” Irish Gerontology Society

4.8 The Clinical Risk

While a significant number of older people regain independent functional mobility after an acute admission to hospital, some do not. The longer a patient remains in hospital the more dependent they are likely to become and the more likely their discharge will be delayed. Unnecessary delays in hospital can have a detrimental effect on a patient’s health which can profoundly affect the patient socially. Being admitted for longer than necessary significantly increases the risk of a patient contracting a HAI (healthcare associated infection) and / or deconditioning. The patient may subsequently experience a significant decrease in their mobility and independence. If the patient significantly deconditions, they may require extensive care and thus may be referred to a nursing home or require a further level of community support services than might otherwise have been the case. These decisions can financially impact a patient. Furthermore, these stresses can cause detrimental mental and emotional outcomes for both the patient and their family.

Infection

The risk of acquiring a healthcare associated infection (HAI) is significant⁷ :

- 5% of inpatients will acquire a HAI
- One day in hospital increases the risk of acquiring a HAI by 1.37%
- Each HAI will result in an additional 9.3 days to length of stay

Deconditioning

The risk of 'Deconditioning*' in the 65+ age group is also very significant⁸

- 1-3% per day (variation depending on baseline)
- 10-20% per week (variation depending on baseline)

***Deconditioning** - muscle loss, mobility, continence, cardiovascular, respiratory

4.9 The Financial Costs

Longer unnecessary stays in an acute hospital are not only detrimental for the patient, they can have serious financial implications for an already overstretched health budget. The National Audit Office (NAO) in England reported in 2016 that the National Health Service (NHS) spends approximately £820 million a year treating older people who no longer need to be in hospital. Caring for those older people in other settings could result in an annual cost of approximately £180 million in other parts of the health and social care service.

“Without radical action to improve local practice and remove national barriers, this problem will get worse and add further strain on the financial sustainability of the NHS. Given the increase in delays and limited progress in reducing barriers to further improvements, performance does not represent value for money.” NAO

4.10 The Policy Framework

Following the establishment of the Working Group, the Chair of the Working Group wrote on a number of occasions to the Department of Health and the Health Service Executive (HSE) at both national and regional level, to ascertain the current policy framework within which Delayed Discharges are managed.

While several policy documents (including Sláintecare (published in May 2017), Sláintecare Implementation Strategy (published in August 2018) and The Health Service Capacity Review (2018) have been published in the past 18 months, there do not appear to be any specific policies to guide the definition, management and recording of Delayed Discharges. When meeting with the stakeholders, clarification was sought on this matter and while a number of documents were received in relation to the NHSS (Nursing Home Support Scheme) also known as the Fair Deal Scheme⁹, Discharge Planning, and the definition of a Delayed Discharge, no documents specifically related to the identification, recording or reporting of Delayed Discharges nor were any inclusion or exclusion criteria for reporting purposes obtained.

The *Integrated Care Guidance: A practical guide to discharge and transfer from hospital* - published in 2014 by the HSE identifies integration of care as “a single system of needs assessment, service planning and service provision using a whole systems approach”. It provides a 9 Step approach to discharge and transfer patients from hospital. Step 2 addresses whether a service user (patient) has simple or complex needs. It estimated that approximately 80% of patients will have 'simple needs' and 20% have 'complex needs'. The pathway outlined for patients with complex needs suggests “assess service user needs and send the required community based support services and

⁷ https://www.researchgate.net/publication/235314589_Hospital_Length_of_Stay_and_Probability_of_Acquiring_Infection

⁸ http://www.gphn.org.au/wp-content/uploads/2015/08/Deconditioning-in-hospitalised-older-patients_Alice-Lac.pdf

⁹ Fair Deal Scheme - The funding methodology for long-term care in Nursing Homes

multidisciplinary referral - arrange transport if required". The Guide makes no reference to Delayed Discharges.

An examination of policy factors which influence the number of Delayed Discharges in the acute sector of the Irish healthcare system was also undertaken. In the UK, Social Care sits within the Community whereas in Ireland Social Care services sits within the Health Service Executive. Many stakeholders regard having Social Care sitting within the HSE as a benefit to the Irish health and social care system and may be critical to the success of the initiatives to reduce Delayed Discharges.

4.11 Stakeholder Feedback

All stakeholders interviewed were very engaging and forthcoming and demonstrated a clear desire to ensure that all patients 'delayed' in hospital receive good care. Hospitals and CHOs focus resources on strategies related to managing Delayed Discharges, both within and across hospitals and community services. A number of initiatives identified include:

1. The introduction of 'Boards Rounds' in some acute hospitals to manage potential delays.
2. Acute hospitals (in some circumstances) resourcing transitional care beds in community hospitals.
3. The introduction of new pilot programmes of care such as the Integrated Care Programme and Frailty Intervention Therapy Teams.
4. Geriatricians working across the hospital and community boundaries to provide care in the patients' own home and other community settings, minimising delays and reassuring patients that the clinicians and geriatricians are caring for them holistically and in the right setting.

Many of the written submissions also referred to a number of initiatives that are reported as making a real difference in some areas and could be rolled-out across the country. These initiatives include:

1. Frailty Intervention Therapy Team (FITT)
2. Community Intervention Teams (CIT)
3. Home First Team (HFT)
4. Early Supported Discharge (ESD)

4.12 Accountability

As outlined below, the stakeholders interviewed have different opinions as to who is accountable for Delayed Discharges.

- Officials from *the Department of Health* indicated that hospitals are accountable.
- A representative from *the HSE* felt that hospitals are predominantly accountable but that the HSE is able to provide some support.
- *One Hospital Group* suggested that the CHOs should be accountable as the CHO will be responsible for providing the next step in the patients' care pathway.
- *The CHOs* have a variety of views, while it is accepted that accountability rests with the CHO, but it is also felt that the Department of Health and the HSE are accountable.
- Clinicians feel a sense of personal accountability for the care of patients but the overall accountability for Delayed Discharge rests with the HSE.

As part of the development of the policy, greater clarity regarding roles and responsibilities will need to be developed.



Summary Findings

5. Summary Findings

Having critically analysed the data available, interviewed a variety of stakeholders and reviewed the submissions received, this section outlines the findings noted under six key headings.

5.1 Accuracy and Use of Data

Following a review and analysis of the available data, its quality, accuracy and robustness, a number of findings were noted:

- There are many variations in practices between hospitals in the identification and recording of Delayed Discharges. Based on these variations, the current Delayed Discharge dataset is incomplete and lacks the accuracy required to complete a robust analysis.
- The interviews conducted and the qualitative evidence gathered suggests there is a significant under-reporting of Delayed Discharges.
- There appears to be an incomplete data record of reasons for delay and the length of delay incurred by patients (patient days lost). Without this data, opportunities for improvement cannot be confidently validated and prioritised.
- It was noted that there can be delays capturing Delayed Discharge decision data at ward and hospital level. These delays minimise the ability to implement early interventions to manage Delayed Discharges and have negative implications for hospital operations including patient flow, bed management and waiting list management.
- It appears that patients awaiting certain interventions are often excluded from the Delayed Discharge dataset. For example, there are a significant number of patients in the acute healthcare setting waiting for a bed in a rehabilitation centre, but who are not recorded as a Delayed Discharge.
- There may be a disincentive for public hospitals to include private patients on the Delayed Discharge dataset. For example private insurers often cease paying the (public) hospital once a private patient is classified as a Delayed Discharge. Furthermore, it is highly likely that there are patients in private hospitals who remain in hospital even if they are fit to be discharged.
- Only acute hospitals record Delayed Discharges on a dataset. Therefore, datasets do not record Delayed Discharges in the non-acute healthcare setting.

5.2 Roles and Responsibilities

Having considered the current roles and responsibilities to manage and monitor Delayed Discharges, the lack of standardisation including teams / approach / fora etc leads to:

- Variations with regard to the timing and recording of the Delayed Discharge decision. These variations appear to arise for a number of reasons:
 - The multi-disciplinary team may not be fully engaged with the decision making process due to local practice
 - There is often a delay between making the decision and recording the decision in the patient's chart file
 - There are delays in accessing discharge enablers such as assessments, forms and, family communications, for example:

- It appears that recording Delayed Discharges in the dataset is generally the role of the Bed Manager or the Discharge Co-Ordinator. There do not appear to be guidelines to provide consistency in terms of roles and responsibilities and thus practices vary from hospital to hospital.
- The HSE collates hospital data and provides a weekly Delayed Discharge National Report. This report is collated manually at hospital level and there is a lack of consistency in terms of responsibility for collating this data at local level.
- The management and monitoring of Delayed Discharges in hospitals and CHO's varies significantly. Input from both organisations is needed in order to effectively manage Delayed Discharges. There appears to be some duplication of effort where certain elements of discharges are managed and completed by both the community and the hospital.

5.3 Policy factors that influence management and monitoring of Delayed Discharges

Policy factors which impact and influence the management of Delayed Discharges were assessed and reviewed. Consideration was given to national and regional policies which may need to be addressed in order to improve the current situation as outlined below:

The HSE's Delayed Discharge National Report defines a Delayed Discharge as '*A patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged*' but it does not provide any guidance on the interpretation or application of the definition, or how it should be operationalised. The absence of a clear set of rules has led to many variations in practice.

- Confusion regarding the recording of Delayed Discharges was noted during the stakeholder engagements. In some cases, patients medically fit for discharge but awaiting support are recorded as delayed, and in some cases they are not.

5.4 Causes and Trends

The review considered the available data, and in particular feedback from stakeholder consultation and written submissions in order to better understand possible causes and trends affecting Delayed Discharges. While the available data is limited, a number of findings which provide some insight into the causes and trends in relation to discharges are outlined as follows:

- In 2017-18 it was noted that there were 8,125 Delayed Discharges on the Delayed Discharge dataset of whom 90% were 65 years and older.
- Based on the latest data available, the following reasons (which have been obtained from figure 3 on page 18) were recorded as the contributing factors for Delayed Discharges:
 - Financial issues are the largest contributing factor to Delayed Discharges. Financial issues contribute to almost one third of the top four most common reasons patients experience a delay in being discharged. The data suggests that 50% of patients with a financial issue were delayed between 1 and 10 days and that 39% were delayed between 11 and 30 days.
 - 80% of patients awaiting rehab (other than NRH), were delayed between 1 and 10 days.
 - Almost 80% of patients delayed due to a Home Care Package application process were delayed between 1 and 20 days.
 - While the total number of patients experiencing a delay in the NHSS process has marginally increased over the past 12 months, the number of patients experiencing a delay between 1 and 10 days has decreased. Subsequently there has been an increase in the number of patients delayed between 11-20 days and between 21-30 days.

- It was noted that the decisions required to address Delayed Discharges are often “life changing”. Patients and their families therefore need time to process these major decisions.
- The NHSS process can be complex and daunting and many families face significant challenges completing the Fair Deal processes particularly where there may be legal or financial complexities.
- Several staff in Community Health Organisations state that the inpatient clinical assessment process may refer patients for services which are not easily available. There also appears to be a mistrust in the current assessment processes, which can lead to duplicated assessments contributing to discharge delays.
- Delays in transferring patients to nursing homes and rehabilitation centres often occurs due to these facilities having restricted timeframes in which they are willing to accept patients. It appears the majority of nursing homes will not accept patients after 3pm on a Friday or at the weekend.
- There is a cultural perception that patients are ‘safer in hospitals’ and a willingness to allow patients to ‘stay another couple of days’ when requested by patients or families.

5.5 Supply and Demand

Having met with a variety of stakeholders, reviewed each submission and performed a limited literature review, a number of observations were made regarding supply and demand.

- There is a belief that there is a lack of resources for the range of initiatives and assessments needed to address the challenge. Many believe there is a lack of appropriate nursing home capacity, particularly for more complex patients and that staffing and recruitment challenges are limiting the ability to provide necessary packages of care. Nationally (and particularly in rural areas), there are significant challenges in recruiting and retaining community carers.
- Other workforce issues include the lack of senior decision makers and current work practices whereby certain resources are available Monday to Friday and typically 9am-5pm. The shortage of staff at weekends has been noted in both the acute and non-acute settings.
- There appears to be a particular challenge regarding the supply of care for palliative and rehabilitation patients, especially for patients with continuing care needs.
- In terms of service demand, there appears to be an increase in the number of patients presenting ‘in crisis’ to Emergency Departments requiring admission. The ageing population and the increasingly complex needs of patients, particularly the severe cognitively impaired are also placing greater demands on the healthcare service.
- Increasing numbers of complex cases including patients with acquired brain injuries, homelessness, those waiting for ward of court proceedings and those under 65 years old who are suffering from a sociological illness (such as dementia) are also contributing to the challenges being experienced.

5.6 Opportunities to Improve

Based on the information available (which incorporates both the quantitative and qualitative findings), there are several opportunities for improvement. The following is noted in this regard:

- A simple shift or reallocation of funding will not achieve the reforms required. For example, moving funding from hospital to community services will not be sufficient to recognise the integrated nature of health services and that opportunities to improve may sit at many points across the system.

- Prioritising the opportunities to improve should be agreed by various stakeholders at local, and national level and with a clear division of responsibility between the HSE and the Department of Health. This should also reflect the need for an agreed national policy and system rules, and the need for flexibility and autonomy to address specific local challenges.
- It appears that there is an opportunity to improve current needs assessments. The analysis carried out indicates these should be categorised to deal with three distinct categories of patients:
 1. Simple Discharge
 - Low Dependency - the patient will not require support following their discharge. They may however require GP or out-patient follow up.
 2. Supported Discharge
 - Medium Dependency - this cohort of patients are generally mobile. However, they may have some co-morbidities. Patients who meet the criteria for this category will often be discharged home with some level of support such as: early supported discharge or where appropriate the patient will be discharged to assess.
 - High Dependency - older patients who do not suffer from a cognitive impairment, or a patient suffering from a mild cognitive impairment will be discharged with a home care package or will attend a nursing home type arrangement prior to being discharged to their own home. Patients who qualify under this category may also be discharged to assess or will have an early supported discharge.
 3. Continuing Care
 - Complex Health and Social Care - patients who are typically <65 years who require continuing care. These patients may have suffered from an ABI, be post-neurosurgery, be vascular amputees, have motor neuron disease or could be homeless. These patients will require specialist rehabilitation and 're-ablement' including housing adaptations, specialist care packages or specialist placements.
 - Complex Health and Social Care - patients who are >65 years who have a severe cognitive impairment. These patients will require a nursing home which provides diversion therapies, mobility and continence care etc. This facility should also be equipped to provide end of life care.



Recommendations

6. Recommendations

6.1 Short Term Recommendations

The short term recommendations listed below should be implemented over the course of the next six months.

1. Policy Factors and Definition

The Department of Health should ensure that a national policy is established which will be supported by protocols / guidelines to ensure that the number of Delayed Discharges recorded (in both the acute and non-acute setting) is recorded consistently and accurately. The HSE should ensure the policy is implemented consistently across the healthcare system. Robust data will be crucial when monitoring bed availability and when setting 'target' corrective actions. The national policy should address the following issues:

- The current use of the term Delayed Discharge does not reflect the true nature of the issue and international practice suggests the term 'Delayed Transfer of Care' should be adopted.
- The Delayed Discharge policy should reflect good clinical practice. It could also refer to 'Average Length of Stay' approaches as a complimentary metric.
- Protocols for the recording, categorising and counting of Delayed Discharges to eliminate any unnecessary variation in the system of recording the data.
- Guidance on changing the status of a patient. For example, a patient should remain a 'Delayed Discharge' if they subsequently acquire a complication requiring further medical intervention. Furthermore, the fact of the development of the complication should be captured by the system as this is important data in assessing the patient cost of Delayed Discharges.
- The reporting of Delayed Discharges from non acute hospitals should be recorded.
- Patients and/or families may not always fully engage in the NHSS process and in choosing post-hospital care placement in a timely manner. This can contribute to delayed discharges and acute bed days lost. It is therefore recommended that guidance is provided to hospitals to ensure a consistent approach is adopted nationally for families who do not fully and seriously engage with the NHSS process and post-acute phase care in a timely manner.
- Clarification on the recording and reporting of those groups which are not currently recorded (such as non acute hospitals, patients waiting for rehab, palliative care etc). It is important to adopt a consistent approach when listing inpatients and those who are in medical facilities outside of the acute healthcare setting.

The Scottish and English definitions and recording methodologies appear to be well tried and tested. The adoption of a similar system in Ireland could significantly reduce the time taken to agree a national policy.

2. Accuracy and Use of Data

In the short term, measures should be taken to improve the quality and accuracy of the data captured regarding Delayed Discharges. Data should be captured to reflect both delayed patients and the associated number of bed days. The lack of data on bed days lost increases the risk that the full impact of complex long stay patients is not fully recognized. Specific actions should include:

- Following the issue of a national policy, responsibility for recording Delayed Discharges should be agreed and implemented so data is accurately recorded across the system.
- A review of the available data should be performed. For example, the Delayed Discharges National Report (which is generated on a weekly basis), could be strengthened if it included the number of bed days.
- Alternative methods to measure the number of Delayed Discharges should be assessed and considered. As outlined in this report, the approaches adopted by The Netherlands, England and

Scotland were examined. The Dutch model was applied to the Irish healthcare system. As outlined in this report, this alternative method highlights a much higher number in respect of Delayed Discharges.

- KPI's should be used to monitor the number of bed days saved.

3. Joint Planning Forum

The National HSE leadership team should lead and provide direction on the importance of hospital and community leadership working in unison to optimise patient flow. They should ensure that a Joint Planning Partnership Forum is established based on the population area of each Hospital Group.

The forum should map current services, develop a shared and simple view of current demand and anticipated capacity, developing strategic responses to gaps in service with a focus on:

- Strategic planning to ensure proactive management of individual patients to deliver care in the most appropriate setting. CHOs and HGs should meet regularly to review patients, anticipate demand and supply and actively manage cases to minimise, and where possible prevent Delayed Discharge.
- Encourage behaviours in which there is an equal emphasis on the community proactively 'pulling' patients from hospitals and on hospitals planning to discharge patients on a timely basis.
- A streamlined timed pathway for the assessment and transfer of patients from hospitals to Nursing Homes, especially over the weekend
- The supply, demand and location of complex care in the community enabling specific patients to be cared for in their own 'home' environment
- Plans that better support patients in the community and minimise demand on services
- Creative solutions to the development and resourcing of community packages of care
- Set and monitor local improvement targets that are classified as SMART objective (Specific, Measurable, Achievable, Realistic and Timely).

Any bidding process for additional funding should be conditional on joint planning and accountability through the Joint Planning Forum.

4. Roles and Responsibilities

From the qualitative analysis performed, it appears that the level of support and assistance provided to patients and their families regarding a patients' discharge can vary significantly. While some hospitals have a Discharge Coordinator and a resource to assist patients with their NHSS (Fair Deal) applications, other hospitals appear to have neither resource. It is therefore recommended that each hospital assesses whether the support provided is meeting the needs of their patients. Furthermore, level 3 and level 4 hospitals should consider the appointment of a resource to assist patients completing the NHSS application and one resource (Discharge Coordinator) to assist a patient and their family with the patient's discharge. Level 1 and level 2 hospitals should have a joint resource which should be available as required.

The Discharge Coordinator should have particular responsibility for the following:

- Providing support and information to the patient and their family when they are being discharged from hospital
- Implementing an agreed and consistent set of patient and family communications to set out options and expectations in terms of discharge
- Actively working with community and other services to arrange aids, appliances, home assessment etc.

In order to confirm the feasibility and viability of this recommendation consideration should be given to implementing this on a pilot basis. This should include reviewing existing resources available, how activities are currently allocated and trialling new ways of working. If pilot implementation is carried out, a post pilot review should be conducted so that lessons learned can be applied before the roll out to other sites.

6.2 Medium Term Recommendations

Medium term recommendations should be implemented within the next 18 months.

1. Audit

In the medium term it would be expected that a much higher percentage of Delayed Discharges are captured in the Delayed Discharge dataset. An assessment should be carried out to identify the reasons patients are being recorded as a Delayed Discharge and whether these reasons should be modified/updated.

An expected length of stay could be implemented depending on the patient pathway. This is another alternative measure of Delayed Discharges as well as ALOS +50% referred to previously.

An audit of the implementation of the new Delayed Discharge policy should be conducted in 2019 by an independent (external) body. The purpose of the audit would be to: monitor the implementation progress, provide visibility of progress and instil confidence in the data. It should specifically aim to assess:

- The compliance with implementation at system, hospital and department levels
- Improvement in the completeness and accuracy of data in the Delayed Discharge dataset

2. Communication

It is crucial a consistent approach is adopted when communicating information regarding Delayed Discharges to a patient, their family and their next of kin. All timelines should be communicated and agreed with the family which will ensure the patient and their family understand the timelines they and the clinical team are working towards.

A public health campaign should be undertaken to raise awareness that patients are better off being discharged rather than being kept unnecessarily in the acute healthcare setting.

3. Multi-Disciplinary Team

A key multi-disciplinary team should be established to conduct a single discharge assessment. These teams should be supported by a discharge coordinator at hospital level. Input should also be received from the community, health and social care professionals. Input from other relevant stakeholders may be required to limit delays or uncertainty regarding post discharge supports required.

4. Information Sharing

Information sharing facilities should be put in place to enhance the sharing of information between all parties involved with Delayed Discharges. This will ensure that each organisation is working towards the same strategic objective, as illustrated in the diagrams below.

Furthermore, measures should be taken to improve the following:

1. Implement an effective electronic live information sharing system between hospitals and community services whereby both services can view the 'one true list' of patients waiting at

the different stages on their pathway. The current system is paper-based and because patient situations regularly evolve it is difficult to maintain paper lists.

2. Develop a system to support the transparent sharing of step down bed availability in the community. This would allow discharge coordinators better visibility on options for patients.

5. Early Discharge Pathways

By introducing Early Discharge Pathways, some patients who present to the ED (emergency department) will not need to be admitted into the hospital and thus can receive the care they require in their home, home like environment or in a transitional care unit. To support this initiative, Social Workers and other allied health professionals should be available in the ED to assess the patient's needs.

Early Supported Discharge (ESD) for stroke patients, and Discharge to Assess for the more general patient population are available in some areas and consideration should be given to extending this service to a wider cohort of patients. The hospital's multi-disciplinary team should assess the patient against a criteria agreed between the hospital and the community services to determine whether a patients will be a:

- **Simple Discharge**
 - low dependency - will go straight home without support but may need GP or Out-patient follow-up
- **Supported Discharge**
 - medium dependency - relatively mobile, may have some co-morbidities, needing some home support discharged home with some level of support - multi-disciplinary team to decide the level in liaison with the community care team - early supported discharge or discharge to assess (where appropriate)
 - high dependency - older people without or with mild to moderate cognitive impairment - early supported discharge or discharge to assess (where appropriate) - home with care package or nursing home placement
- **Continuing care**
 - complex health and social care (ABI, post-neurosurgery, vascular amputees / motor neuron / chronic homeless) - specialist rehabilitation and re-ablement, housing adaptations, specialist care packages or specialist nursing home placements. Need to determine how many placements needed, at what cost, specialist planning and commissioning
 - complex health and social care (older people with severe cognitive impairment) will require nursing home placement which can provide re-ablement care, diversion therapies, mobility and continence care, will need goals of care assessment and end of life care planning. Need to determine how many placements needed, at what cost - Regional Partnership working.

Patients who are categorised as requiring "Supported Discharge" or "Continuing Care" will require bespoke ongoing care upon discharge. Having quantified the number of patients who fall into these categories, specialist planning and commissioning of tailored facilities will be vital to ensure these patients are discharged from the acute healthcare setting on a timely basis and cared for in a more appropriate setting.

While many patients' preference is to die at home or in a home like environment, patients requiring end of life care are often cared for in the acute healthcare setting. Subsequently patients are often encouraged to apply to the NHSS despite their families understanding their relative may not live long enough to be discharged to a nursing home. An integrated national approach to patients who are in the final stages of life, will ensure a number of community beds are designated to patients who are dying.

The ESD team must be multi-disciplinary involving doctors, nurses, physiotherapists, occupational therapists, speech and language therapists and dietitians to ensure the holistic needs of the patient are properly addressed and supported by healthcare and therapy assistants. The level of care needed for each patient would be assessed immediately in the patient's new environment and modified according to their progressing needs. A similar approach would be needed for the Discharge to Assess pathway with the extent of involvement of the multi-disciplinary team dependent on the patient specific care needs i.e. not all patients would require input from all members of the multi-disciplinary team.

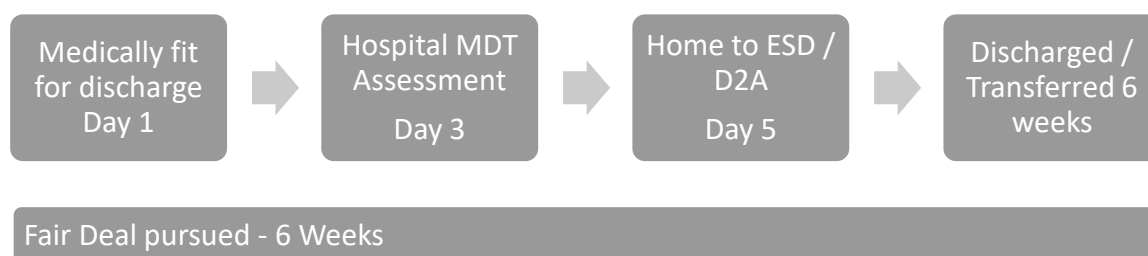
The length of stay / assessment period should not exceed six (6) weeks.¹³

The approach ensures the patient's on-going care needs are assessed in the most conducive environment, patients and families are supported to come to terms with life-changing decisions much more quickly when faced with the reality of the situation. Patients would be exposed for shorter periods to the hazards (HAI and deconditioning) of acute hospitals and, they would be in the most appropriate setting to properly assess their care needs and the continuity of care could be maintained through the supervision of hospital/community geriatricians.

This change in practice would mean that the role and function of the various community teams would need to be reviewed and streamlined in order to create sufficient flexibility and achieve effective and efficient use of resources.

Applications in respect of Fair Deal, where appropriate, would be pursued along the same timeframe.

The introduction of a new streamlined care pathway, particularly for the 'Supported Discharge' patients for example:



This change in service could be developed and rolled out progressively building on experience and growing confidence.

¹³ <https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf>



Stakeholders Viewpoint and Summary Submissions

7. Stakeholders Viewpoint and Summary Submissions

Meeting key personnel in the acute healthcare settings and obtaining submissions from a wide range of stakeholders was a key component of this Review. While each submission and discussion point has been reviewed and considered, it should be noted that no evidence has been sought to support the comments, observations and findings provided. The observations of the stakeholders have been summarised under the following headings:

- Long Term Care - Fair Deal Scheme / NHSS
- Long Term Care - Complex Needs
- Legal Proceedings - Ward of Court
- Home Care Packages
- Rehabilitation
- Palliative Patients
- Data
- Governance
- Recording of Delayed Discharges

1. Long Term Care - Fair Deal Scheme / NHSS

The submissions indicate that nursing homes directly and indirectly contribute to the backlog of Delayed Discharges. Nursing homes have a strict criteria whereby they will only accept patients within a certain timeframe. While the timeframe is not disclosed in the submissions, from conducting stakeholder interviews it appears that nursing homes will not accept patients before 12pm on a Monday or after 12pm on a Friday. The submissions propose the Department of Health and HSE need to liaise with HIQA/nursing homes and the community to ensure admissions can take place seven days a week. The submissions also recognise that not having managers, community services, social care, transport or therapists available at the weekend results in patients often being delayed during these periods.

Prior to admission many patients and their families may not have considered the patient requiring long term care. While some families wish to care for their relative at home, the level of support available for them is very limited and thus families are ultimately forced to transfer their loved one into a nursing home. Several of the submissions acknowledge that the NHSS process can take a considerable amount of time. While a patient may have deconditioned during their time in the acute hospital, it must be recognised that the acute hospital is the least appropriate place to assess a patient's care needs. It is also not an appropriate setting for the patient and their family to make the life changing decision as to which nursing home their relative will move to on discharge.

While the majority of patients will remain in hospital until a nursing home of their choice becomes available, the submissions suggest that some families do not cooperate with the NHSS process. Some may not provide the correct information, while others will refuse to send their relative to a number of nursing homes despite the patient having been accepted to the nursing home. The submissions received state a stricter process should be implemented to address families who are not cooperative with the NHSS (Fair Deal) scheme.

Other families may unintentionally cause a delay in the application being processed. For example if a family is not living close to the patient, logistically it may prove difficult to source all the documentation required within a short timeframe.

Some nursing homes charge families for certain services. If a patient is offered a place in one of these nursing homes, some families will refuse to accept the place.

2. Long term care - Complex needs

Over half the submissions received directly referenced the challenges faced in sourcing a bespoke care package for those requiring complex care. The submissions identify patients with complex needs as anyone who suffers from an ABI (acute brain injury), homelessness, dementia and those with a disability. Two submissions state that patients with complex needs can often reside in an acute hospital setting for over a year. The needs of these patients which often requires 24/7 care and a single room are particularly difficult to meet in an acute hospital setting.

The number of patients <65 years presenting with ABIs is increasing and at present, there is no long term facility to care for this cohort of patients. Several groups have stressed nursing homes are not equipped to care for patients with behavioural and psychological issues and as such, a patient with complex needs could pose risks to other residents. While the number of patients with an ABI is relatively small, the groups feel that they account for a large proportion of bed days lost to Delayed Discharges.

The submissions suggest an additional 500 rehab beds are required nationally for patients with trauma and non-trauma disability. One submission sought an immediate end to using one night only beds for homeless people being discharged from hospitals. This group believe the development of the "Step Up Step Down" transitional unit is urgently required ahead of Winter 2018/2019.

3. Legal proceedings - Ward of Court

A significant number of submissions referenced the prolonged delays experienced during legal proceedings. While some submissions stated this process can take up to 8 months in an acute site, others stated it can take more than a year. The delay is due to the onerous and complex nature of the legal process.

The submissions suggest immediate access to long term transitional beds for patients going through ward of court proceedings will alleviate the number of bed days lost in acute hospitals.

4. Home care packages

Home care packages often provide patients with optimal care in their own home and enable them to maintain their independence. A lack of resources (both financial and workforce) sometimes limits the ability of CHOs to provide home care packages. As a direct result, the number of patients in hospital awaiting a home care package is increasing. One hospital believes 20 of their patients could be discharged if the correct home care package could be provided.

As our population grows, and the life expectancy increases, it is not surprising to hear the number of patients applying for home care packages is also increasing. Some patients are applying for a home care package for the first time, others are requesting an increase to their existing home care package. This has resulted in the number of hours available not being able to meet the demand. As Ireland reaches full employment, it is becoming even more difficult to recruit carers, particularly carers with the necessary skillsets. Some of the submissions state there is a lack of trained homecare personnel to operate necessary equipment (such as hoists).

The submissions have identified a number of short and medium term actions which will help alleviate the number of Delayed Discharges. Short term actions include reversing the cuts made to the budget; this will allow more hours to be allocated to desperately needed home care packages, and it will provide patients with the equipment they require to stay in their home setting. Medium term actions involve recruiting staff to ensure that all patients requiring a small and medium home care package can have the package within 48 hours of applying for it. Another suggestion is to introduce a scheme similar to the Fair Deal scheme whereby patients can fund carers to attend to them in their home (as opposed to a nursing home).

5. Rehabilitation

The submissions state that rehabilitation beds are extremely limited and that there are inconsistencies when accessing rehab outside Dublin. The number of rehab beds for patients <65 years is extremely limited which results in patients often being forced to live in acute hospitals for years at a time as resourcing is not available close to their homes. The submissions recommend reviewing and standardising the criteria for accessing community rehab units.

A large number of submissions highlighted how valuable and effective the 'Early Supported Discharge' (ESD) scheme has been. The submissions comment that there are currently five sites operating with ESD teams which was to be extended to nine sites during 2018. The opening of these additional sites does not appear to have materialised. The submissions state ESD should be extended across the country and if a patient is suitable for ESD, funding should be put in place without delay nationally.

Other schemes / teams which the submissions said have enhanced the care being provided to patients and thus reduced the number of Delayed Discharges include:

- ▶ **FITT (Frailty Intervention Therapy Team)** - the FITT was 'set up to respond to the needs of frail patients attending the ED'.¹⁶ The submission identify FITT as being a best practice in the care of frail older people. They have requested FITT teams are rolled out to all hospitals.
- ▶ **Home First team** - this team has only been developed in very few hospitals in Ireland. Its aim is to discharge patients from hospital back home as soon as they are ready to be discharged. Any follow up care / support will be provided by the community.¹⁷
- ▶ **CIT (Community Intervention Teams)** - the HSE describe the CIT as a 'nurse led health professional team which provides a rapid and integrated response to a patient with an acute episode of illness who requires enhanced services / acute intervention for a defined short period of time'.¹⁸ The CIT usually operates between 8am to 10pm. CIT teams have been described in one submission as being 'invaluable' while other submissions have recognised how effective they are as they can provide antibiotic therapy etc. to patients in their own homes. One submission stated that at present there are only 10 CIT's available nationwide and these CIT's cover half the country. Several submissions request the CIT services to be provided/expanded to all acute hospitals. Another recommendation is to reverse the decision to remove the HCA (home care assistant) role from the CIT as HCA's are a vital support to acute hospitals.

6. Palliative patients

While only two submissions mentioned concerns in relation to palliative care, this contrasted significantly with the message received from the stakeholder interviews. The majority of the stakeholders interviewed believed that the care available for palliative patients is vastly under resourced to the extent that many patients aged 65+ years who, in their final months, are forced to apply for long term care through the Fair Deal scheme because there is no alternative setting to provide them with the care they need. A number of clinicians stated that these patients often die in hospital waiting for the Fair Deal process to be completed.

7. Data

Several of the submissions received, mentioned the need to address the accuracy of the Delayed Discharge data. Another submission has recommended that hospitals should become transparent.

¹⁶ <https://www.ijic.org/articles/abstract/10.5334/ijic.3739/>

¹⁷ <https://www.ekhufft.nhs.uk/patients-and-visitors/news/news-archive/news-archive-2017/home-first-gets-patients-home-from-hospital-safely-and-sooner/>

¹⁸ <https://www.hse.ie/eng/services/list/3/cits/>

This would involve each hospital providing the HSE with information detailing the length of time clinically discharged patients are waiting unnecessarily in hospitals. Furthermore, the submission recommends the HSE publishes a report stating the number of Delayed Discharges experienced on a monthly and quarterly basis.

8. Governance

A number of submissions recommended the merging of all hospital groups and CHOs within specific regions. Enhancing Information Technology systems and therefore ensuring an electronic discharge summary would improve efficiencies and save time on admission and discharge to hospitals. A different submission states that one of the key benefits of acute and community services working together in partnership is the joint appreciation of key issues across the acute and community settings. Other benefits include ensuring the provision of appropriate supports in the appropriate setting.

9. Recording of Delayed Discharges

Several stakeholders stated that certain cohorts of patients (such as palliative patients and patients awaiting rehab) are often excluded from the Delayed Discharge dataset.



Implementation Plan

8. Implementation Plan

Due to the lack of robust data, one cannot determine how many Delayed Discharges exist in Irish hospitals; it is therefore not possible to provide a costed implementation plan. As the extent of the issue cannot be quantified, several steps need to be taken over the coming 18 months to improve the robustness of the data.

In line with the recommendations made in this report, a short and medium term implementation plan has been devised.

1. Short Term Recommendations - 6 month implementation plan:

Short Term Recommendations - 6 month implementation plan					
Nov '18	Dec '18	Jan '19	Feb '19	March '19	April '19
Definition to be developed and finalised					
Policy and protocols to be developed					
		Joint Planning Fora to be established			
		Review of Roles and Responsibilities of parties involved in Delayed Discharges			
			Implementation of Definition in all healthcare settings which ensure data is recorded accurately		

2. Medium Term Recommendations - 18 month implementation plan:

Medium Term Recommendations - implementation plan for next 18 months														
May '19	June '19	July '19	Aug '19	Sept '19	Oct '19	Nov '19	Dec '19	Jan '20	Feb '20	Mar '20	Apr '20	May '20	Apr '20	May '20
Accuracy and use of Data														
<p style="text-align: center;">Communication</p> <ul style="list-style-type: none"> - Discharge timelines to be communicated to patient's family and next of kin - Public health initiative should be developed 														
<p style="text-align: center;">Multi - Disciplinary Team</p> <ul style="list-style-type: none"> - Introduction of single discharge assessments - Whole system approach to be adopted to ensure input from all parties involved with Delayed Discharges 														
<p style="text-align: center;">Early Discharge Pathway</p> <ul style="list-style-type: none"> - Introduction of Early Discharge Pathways - Early Supported Discharges should be extended to accommodate a wider cohort of patients. Patients should be assessed to determine if they will have a simple discharge, a supported discharge or whether the patients requires continuing care 														
<div style="border: 1px solid black; background-color: #90EE90; padding: 5px; display: inline-block; margin: 10px;">Audit of Data</div>														
<div style="border: 1px solid black; background-color: #90EE90; padding: 5px; display: inline-block; margin: 10px;">Audit Findings</div>														



Appendix

9. Appendix

9.1 Areas of Focus

The following were presented to and discussed with each stakeholder group:

Independent Expert Review of Delayed Discharges

1. Accuracy and use of data

Map of the current arrangements for monitoring Delayed Discharges, to include:

- ▶ Robustness of the Data and is it being used to improve practice/process
- ▶ Current Policy status
- ▶ Definition of 'Delayed Discharge' and consistency of its application
- ▶ How Delayed Discharges are counted/monitored at Local, Regional and National level

2. Current Roles and Responsibilities

- ▶ Clarify the current management arrangements for Delayed Discharges
- ▶ How are Delayed Discharges managed at Local level
- ▶ Who 'owns' Delayed Discharges at Local level
- ▶ Performance monitoring arrangements at Local, Regional and National Level
- ▶ Accountability arrangements at Local, Regional and National level

3. Policy factors that may unduly influence the management or monitoring of Delayed Discharges

- ▶ Identify any policy factors that may unduly influence the management or monitoring of Delayed Discharges
- ▶ Perverse incentives/disincentives
- ▶ Boundary issues
- ▶ Funding flows

4. Main causes/trends

- ▶ Identify the main factors that lead to Delayed Discharges
- ▶ Patient profiles
- ▶ Care pathways
- ▶ Decision-making

5. Supply and demand

- ▶ Clarify how Ireland compares on the availability of beds for its current population
- ▶ Acute
- ▶ Community
- ▶ Nursing Homes

6. Improvement opportunities

- ▶ Learning from international comparators / best practice
- ▶ Definition
- ▶ Policy
- ▶ Systems, processes and practices
- ▶ Alignment of resources / care pathways

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9.3 Submissions Received

The following Groups provided EY with a submission containing their views on Delayed Discharges. While the majority of Groups provided an in-depth analysis of the problem, others provided a brief synopsis. Each submission received has been reviewed and the points have been incorporated into this report.

Submissions Received:

1. Ireland East Hospital Group
2. South / South West Hospital Group
3. Irish Nurses and Midwives Organisation
4. Royal College of Surgeons Ireland Hospital Group
5. Irish Society of Chartered Physiotherapists
6. Irish Gerontological Society
7. Mid-West Community Healthcare
8. National Ambulance Service
9. Irish Hospital Consultants Association
10. Nursing Homes Ireland
11. Irish Association of Social Workers
12. Irish College of General Practitioners
13. Saolta University Health Care Group
14. Age Action Ireland
15. UL Hospital Group
16. University Hospital Kerry
17. CHO 1
18. CHO 2 - Community Healthcare West

9.4 Working Group Members

The following individuals were appointed to the Working Group:

1. Graham Knowles, Chair of University of Limerick Hospital Group
2. Mary Rose Burke, Chief Executive Officer, Dublin Chamber of Commerce
3. Dr Michelle Carr, Senior Lecturer BBS, MBS Research, University College Cork
4. Conor Leonard, Operations Manager, The Royal Hospital Donnybrook
5. Tony McNamara, Chief Executive Officer, Cork University Hospital
6. Prof. Dermot Power, Consultant Geriatrician, Mater Misericordiae University Hospital
7. Angela Fitzgerald, Deputy National Director of Acute Hospital Division, HSE
8. Grace Rothwell, Special Delivery Unit, Health Service Executive
9. Bernard Gloster, Chief Officer, HSE Mid-West Community Healthcare
10. Susan Scally, Scheduled and Unscheduled Care Performance Unit, Department of Health
11. Sheona Gilsenan, Statistics and Analytics Unit, Department of Health
12. Ciara Pidgeon, Principal Officer, Services for Older People, Department of Health - reassigned to a different area within the Department of Health during the Working Group review
13. Niall Redmond, Principal Officer, Services for Older People, Department of Health - was appointed after Ciara Pidgeon left the Working Group

9.5 Additional Graphs

Number of patients and average length of stay for overnight inpatients, 2017

Specialty Desc	Average LOS			Number of Patients		
	0-15	16-64	65+	0-15	16-64	65+
General Medicine	4	6	10	2,133	43,666	72,855
General Surgery	3	5	8	6,697	33,748	18,862
Orthopaedics	3	5	12	3,858	16,901	14,583
Geriatric Medicine	3	11	20	29	2,932	13,892
Cardiology	3	4	6	24	7,418	9,660
Respiratory Medicine	5	7	11	61	7,808	8,033
GastroEnterology	6	8	11	39	4,209	4,314
Urology	2	4	6	396	5,036	4,228
Endocrinology	4	7	13	158	2,806	4,187
Oncology	5	9	10	11	5,012	3,864
Nephrology	4	8	13	125	3,071	3,751
Vascular Surgery	4	12	13	16	1,426	2,687
Haematology	3	12	12	211	2,780	2,655
Rheumatology	6	7	13	79	1,485	2,157
Otolaryngology ENT	2	3	7	3,725	5,870	1,852
Gynaecology	2	3	5	178	8,095	1,759
CardioThoracic Surgery	11	12	15	257	1,617	1,634
Ophthalmology	2	3	3	250	1,799	1,351
GastroIntestinal Surgery	2	7	12	46	2,057	1,240
Neurology	14	10	16	222	3,092	1,081
Radiotherapy	26	20	22	3	991	1,076
Infectious Diseases	7	11	15	21	1,298	1,029
Plastic Surgery	3	4	6	900	2,918	1,013
Neurosurgery	8	10	10	361	2,588	948
Accident and Emergency	1	1	1	231	3,328	789
MaxilloFacial	2	3	7	209	1,170	266
Brest Surgery	3	3	3	2	496	244
Rehabilitation Medicine	10	65	53	102	377	223
HepatoBiliary Surgery	2	7	9	3	159	204
Palliative Medicine	4	19	18	1	134	200
GenitoUrinary medicine	2	8	10	2	345	130
ObstetricGynaecology	3	3	5	14	358	108
Psychiatry	6	27	42	41	422	63
Dermatology	5	7	9	69	88	60
Diabetes Mellitus	3	7	9	22	84	59
Oral Surgery	2	4	8	19	140	39
Radiology	1	1	1	2	123	37
Pain Relief	3	4	2	3	128	30
Renal Transplantation	8	8	10	1	157	23
Obstetrics	2	2	4	7	271	15
Anaesthetics	3	2	6	5	10	7
Neuroradiology		4	2		26	6
Clinical Immunology	6	6	16	14	13	4
Paediatric Orthopaedic Surgery	3	2	3	415	5	1
Dental Surgery	2	2	2	43	34	1
Clinical Neurophysiology	5	7	6	3	97	1
Substance Abuse		21			103	
Rehabilitation Psychiatry		1			1	
Paediatrics Development	4			182		
Paediatrics	3	9		37,691	71	
Paediatric Urology	4			58		
Paediatric Surgery	4	13		1,474	1	
Paediatric Respiratory Medici..	5	5		1,319	28	
Paediatric Radiology	2			2		
Paediatric Oncology	5	3		561	8	
Paediatric Neurosurgery	6	6		247	43	
Paediatric Neurology	6			344		
Paediatric Nephrology	5	2		389	4	
Paediatric Metabolic Medicine	4	1		105	2	
Paediatric Infectious Diseases	10			26		
Paediatric Haematology	6	7		758	15	
Paediatric Gastroenterology	9	3		281	8	
Paediatric Endocrinology	3	3		162	8	
Paediatric ENT	1			174		
Paediatric Dermatology	4			14		
Paediatric Cardiology	13	4		646	10	
Paediatric AE ED Medicine	1			140		
Neonatology	9			5,794		
Metabolic Medicine	3	2		145	9	
Intensive Care	16			1		
Immunology	15			10		
Childadolescent Psychiatry	8			37		
Grand Total	4	6	11	71,568	176,899	181,221

Table 1: Number of patients and average length of stay for overnight inpatients, excluding maternity 2017

Figure 10 shows the percentage of patients above the ALOS +50% at speciality level ¹⁹ (top 10, by volume only). In general all specialities behave in a similar fashion. Paediatric and ENT patients tend to experience fewer instances of delay.

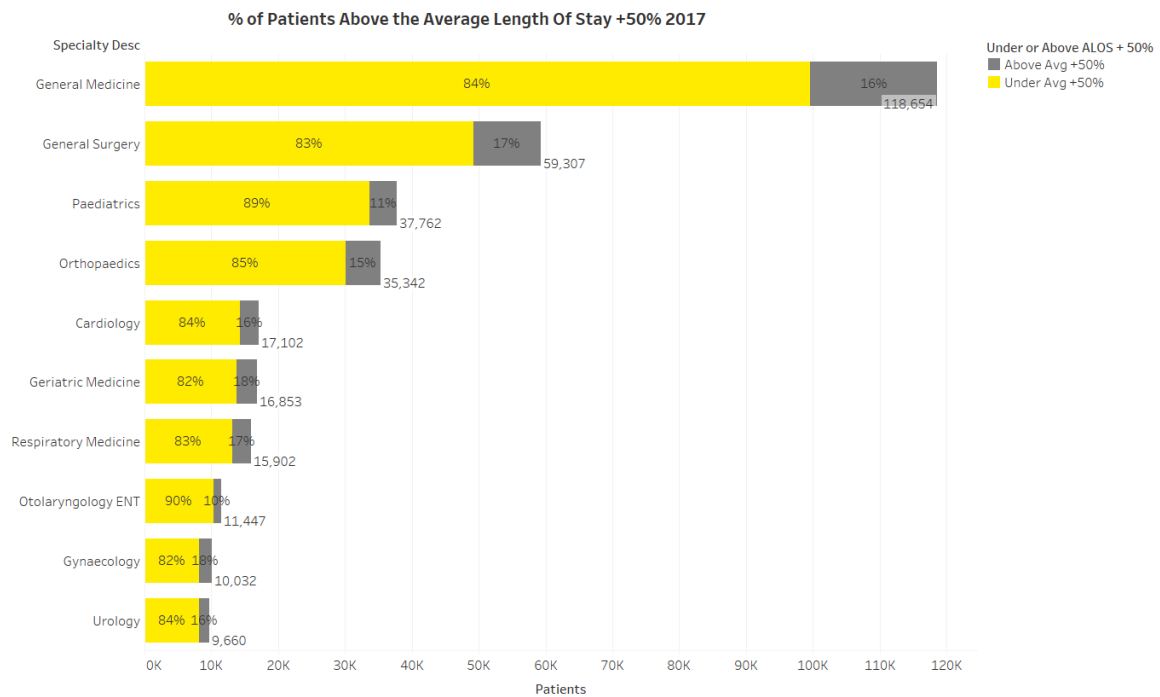


Figure 10: % of patients above the average length of stay + 50%, 2017

¹⁹ The specialty is defined as follows (reference HIPE data Dictionary- www.hpo.ie)

A specialty code is assigned to the record on the basis of the specialty assignment of the consultant associated with the principal diagnosis. The specialty of the consultant is the specialty in which s/he is formally recognised and contracted to work. A consultant may be formally recognised and contracted to work in more than one specialty; in these cases one specialty is recognised as the main one. The specialty is defined as follows (reference HIPE data Dictionary- www.hpo.ie)

Figure 11 shows the top 10 destinations patients are discharged to. It is interesting to note that 33% of patients going to a nursing home could be Delayed Discharge patients.

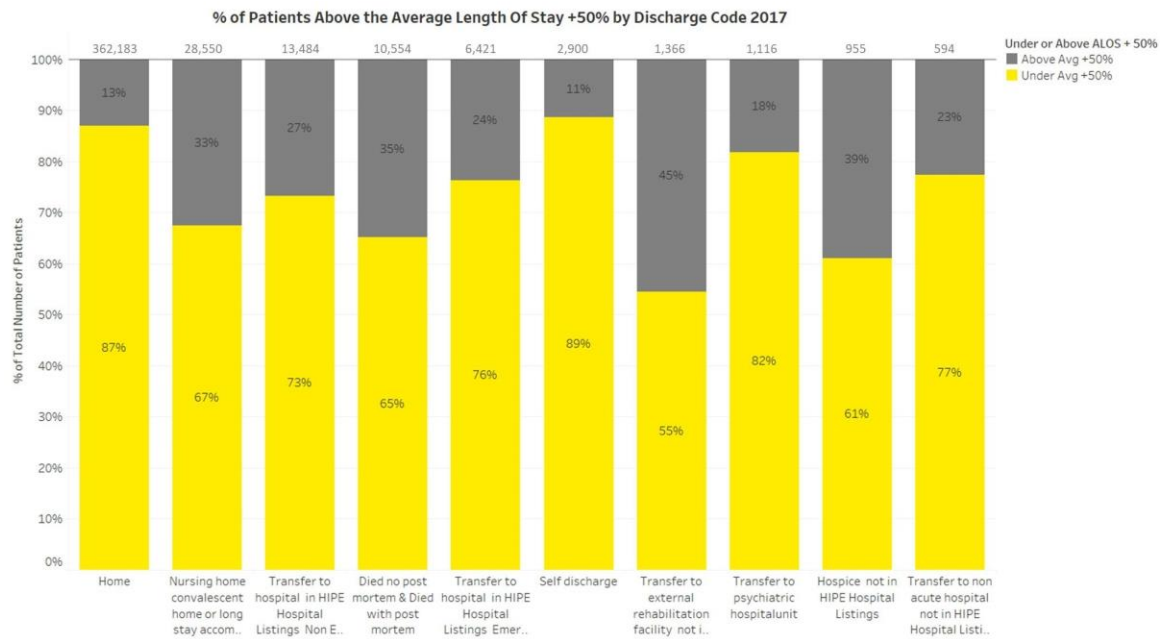


Figure 11: % of patients above the average length of stay +50% by discharge code, 2017

9.6 Example of a Weekly Delayed Discharges National Report

The Delayed Discharges National Report is generated on a weekly basis. The Working Group have critiqued the relevance and rigour of the report as a decision making tool for National HSE and Department of Health management.

One page from the 12 page report has been included in this report as outlined over the next two pages. These reports show that in June/July 2018 the average number of Delayed Discharges reported was 571 patients; the average number of Delayed Discharges recorded in August rose to 589 patients.

This report contributes to the National Performance Report and is available nationally to both the HSE and the Department of Health. This report is a key metric with a national target attached.

1. Definition of a delayed discharge

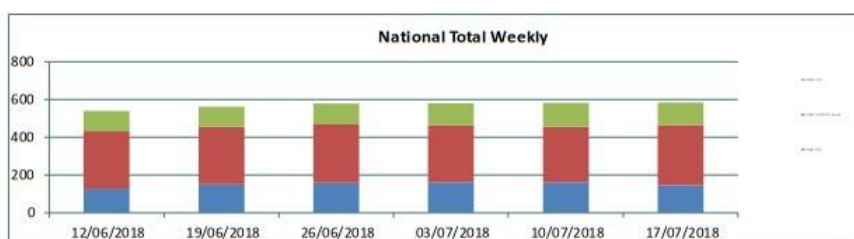
The operational definition of a delayed discharge in this monitoring system is:
 "A patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged."

2. Delayed discharges – Summary

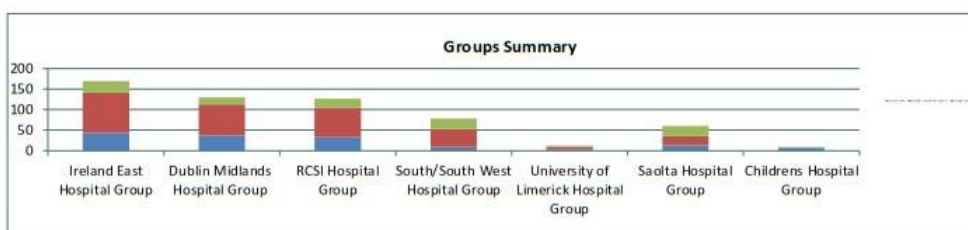
On the: 17/07/2018

The Number of Delayed Discharges Nationally was 584

Weekly published number of delayed discharges						
Type	12/06/2018	19/06/2018	26/06/2018	03/07/2018	10/07/2018	17/07/2018
Destination Home	126	150	158	161	162	145
Destination Long Term Nursing Care	304	306	311	304	294	319
Destination: other	110	106	109	116	126	120
Total	540	562	578	581	582	584



	Ireland East Hospital Group	Dublin Midlands Hospital Group	RCSI Hospital Group	South/South West Hospital Group	University of Limerick Hospital Group	Saolta Hospital Group	Childrens Hospital Group
17/07/2018							
Destination Home	43	37	33	9	3	13	7
Destination Long Term Nursing Care	98	76	72	44	7	22	0
Destination: other	28	17	21	25	2	25	2
Total	169	130	126	78	12	60	9



Average number of delayed discharges nationally each month

Monthly published average	Nationally	DATHs hospitals
Jun-18	553	225
May-18	581	231
Apr-18	587	234
Mar-18	582	235
Feb-18	560	218
Jan-18	501	172

The average number of delayed discharges for the month of June was 553
 Comparing this week's return of 584 to the average for June 553 shows an increase of 5.6%

Abstract from Report issued on 04/09/2018

1. Definition of a delayed discharge

The operational definition of a delayed discharge in this monitoring system is:
 "A patient who remains in hospital after a senior doctor (consultant or registrar grade) has documented in the medical chart that the patient can be discharged."

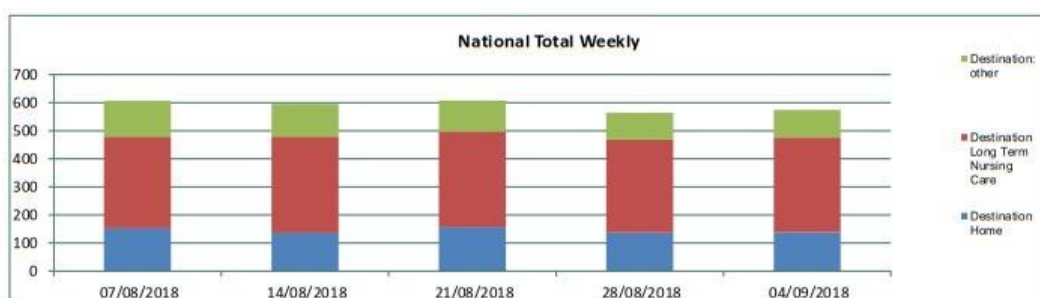
2. Delayed discharges – Summary

On the: 04/09/2018

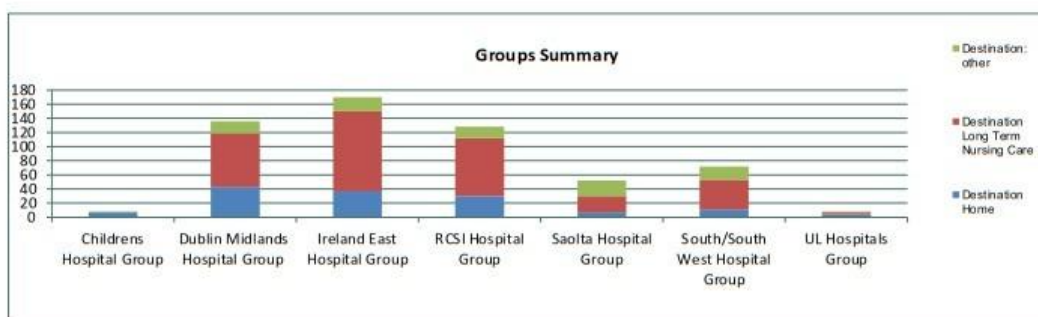
The Number of Delayed Discharges Nationally was 574

Weekly published number of delayed discharges

Type	07/08/2018	14/08/2018	21/08/2018	28/08/2018	04/09/2018
Destination Home	153	137	157	138	139
Destination Long Term Nursing Care	326	342	341	331	339
Destination: other	128	117	110	95	96
Total	607	596	608	564	574



	Childrens Hospital Group	Dublin Midlands Hospital Group	Ireland East Hospital Group	RCSI Hospital Group	Saoita Hospital Group	South/South West Hospital Group	UL Hospitals Group
04/09/2018							
Destination Home	7	43	37	30	7	11	4
Destination Long Term Nursing Care	0	76	113	82	23	42	3
Destination: other	1	17	20	16	22	19	1
Total	8	136	170	128	52	72	8



Average number of delayed discharges nationally each month

Monthly published average	Nationally	DATHs hospitals
Aug-18	594	260
Jul-18	592	246
Jun-18	553	225
May-18	581	231
Apr-18	587	234
Mar-18	582	235

The average number of delayed discharges for the month of August was 594
 Comparing this week's return of 574 to the average for previous month of 594 shows a decrease of -3.4%