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Commissioning Out of Hospital Care Services to Reduce Delays

Discussion Paper

March 2020

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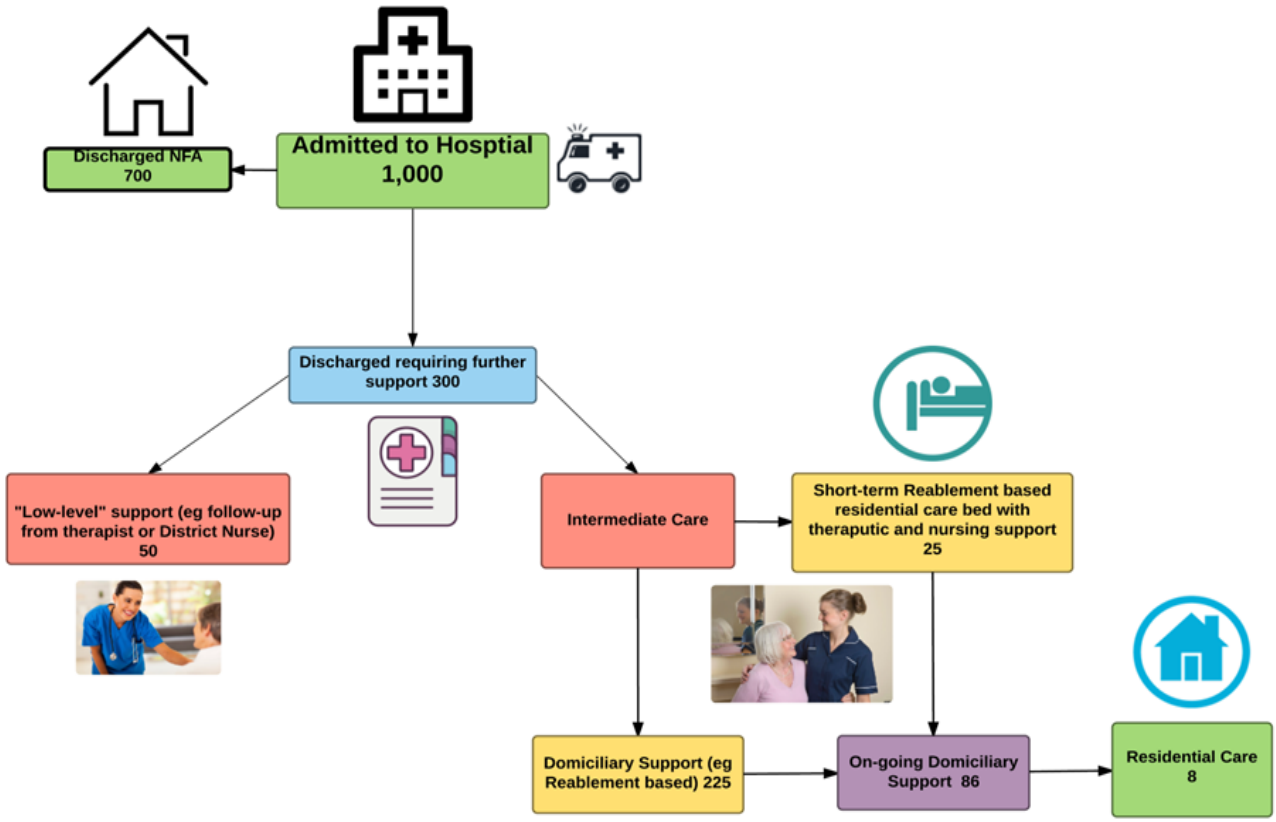
Forward

Across the United Kingdom, the NHS and local authorities are looking to work with their partners to find solutions to the increasing challenges presented by the numbers of older people who need on-going or additional care and support at the point of discharge from an acute hospital.

Professor John Bolton has spent much of his time during the last few years looking at this issue and making suggestions as to how it might be best addressed. In September 2018 he wrote a paper based on his 'original model' shown in Diagram 1 below that made several recommendations as to how both health and social care could work together in order to help meet these challenges. (Institute of Public Care, 2016)

More recently, Professor Bolton has drawn on the work he developed in partnership with the NHS Wales Delivery Unit (DU), where they used his 'original model' to track as many older patients discharged from hospital across Wales as possible in 2018 and sought to understand the outcomes achieved from the different arrangements in place to sustain post hospital care and support[1].

Diagram 1 - The 'original' model



This and other work have provided Professor Bolton with a further understanding of what may need to change for health and social care systems across the UK to be better prepared for the demands presented from out of hospital care and to support people to

[1] Similar approaches have also been adopted to help the Nottingham and Nottinghamshire Care and Health Partnerships as well as in Falkirk in Scotland.

achieve positive outcomes. This paper sets out a two-year process to develop a strategy and a set of services that will support out of hospital care and at the same time reduce delays in the system.

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March 2020

Institute of Public Care

Commissioning Out of Hospital Care Services to Reduce Delays

Discussion Paper

Purpose of this paper

The aim of this paper is to offer health and social care organisations a coherent rationale for developing integrated strategies that can guide effective performance management, commissioning and day-to-day service delivery. At its core is the underlying principle that by focusing on achieving the right outcomes for people, tangible improvements in the effective use of resources should be seen. The paper, offers the following:

1. Considerations for health and social care partnerships on the behaviours that underpin integrated strategic demand management thinking.
2. Considerations for data collection to better understand supply, demand and outcome focused performance of current and future service models.
3. A 'model' for describing the service elements that make up intermediate care services.
4. Considering what a 'good' intermediate care system should achieve.

Throughout the paper the term 'out of hospital care system' refers to all the services that support older people when they leave hospital – right across health, social care and wellbeing support. The term 'intermediate care services' refers to all those services that offer special care and support to older people post hospital whose aim is to assist in delivering care and to support their recovery and rehabilitation.

The Institute of Public Care and Professor Bolton wish to give special thanks to the NHS Delivery Unit in Wales with whom Professor Bolton worked for much of last year (and some of this) in learning and developing our understanding of out of hospital care. Their analysis, their challenge and their support has contributed significantly to this paper.

1 Considerations for health and social care partnerships on the behaviours that underpin integrated strategic demand management thinking

Our starting assumption is that is it necessary for the health and social care system to provide a coherent direction and a set of values and behaviours that are implicit to the effective functioning of the model.

The first consideration is whether health and social care are willing and able to work collaboratively to jointly design, monitor and performance manage a whole system of shared out of hospital care and support service (called intermediate care services).

While some health and social care systems may report acceptable performance in this area, generally, our experience is that most places don't have sufficient clarity on the services they have commissioned / planned for out of hospital care which compromises the effectiveness of these resources. Typically, there is a reliance on other services that were previously commissioned for a different purpose to fill the gaps in out of hospital care.

Therefore, consider how to ensure that Health Boards / Clinical Commissioning Groups / Local Authorities / Partnership Boards are making joint plans to commission a set of unique services (intermediate care services) that are responsible for delivering out of hospital care for older people.

Second, the aim of these services should be to assist older people with their recovery after an episode in an acute hospital (or to avoid an admission to an acute hospital). These services should consider why the patient was admitted to a hospital and should work on both a recovery plan to encourage recuperation and rehabilitation as well as a long term plan to look at how the person's long term condition(s) are being managed so that more attention can be paid to these for the longer run.

Consideration of diet, exercise, compliance with prescribed drugs and the general well-being of the person are all important aspects of these services. Programmes such as falls prevention and other effective reablement-based services should feature highly within the arrangements. Important community-based services such as 'support to live at home with dementia' are essential for out of hospital services to work effectively.

Therefore, consider how to ensure that intermediate care services are systematically focused on recovery, recuperation and living with long term conditions, including dementia.

Services should be based in the person's own home as this is the place where they are most likely to recover quickest; in their own familiar surroundings. Where bed-based services are seen as essential, their aim must be to get people back home. This is particularly the case for community hospitals and other short-term residential care beds where there should be therapists and nurses who are committed to working with older people to help them get back home. Placing someone in a bedded facility without a recovery plan is paramount to placing them in a bedded facility for the rest of their lives.

Therefore, consider how to ensure you can promote the mantra that the purpose of the bedded intermediate care services (community hospitals and short-term residential care beds) should be to get the person back home.

There is little value in undertaking an assessment for longer term services when a patient is in a hospital bed. The decision in hospital is about the right type of help a person needs to either help their recovery or to live as well as they can with their long-term condition. A focus on long term plans is not helpful and can accelerate unnecessary care and support. There is a phrase used across the United Kingdom "discharge to assess" to describe this. The new version of this phrase that is now used across Wales "discharge to support recovery and then assess" is a much more pertinent way of describing what should happen to an older person leaving hospital (NHS Wales Delivery Unit, awaiting publication).

Therefore, consider how to promote and ensure that you don't assess a person for long term care from a hospital bed. Help them to get back home, support their recovery as best as possible then start the assessment process. Discharge for recovery then assess.

There is of course the question of the over-prescribing of care to which the evidence points (Better Care Support Programme, 2017). Research by Newton Europe looking at arrangements at fourteen English acute hospitals found that two out of every five patients that were being discharged from hospital were over-prescribed more care than they needed. This puts an unreasonable strain on the out of hospital care services.

Some intermediate care services (e.g. domiciliary care reablement) offer some time-limited initial help and then review after an agreed period in order to eliminate those who don't require further support. In other places, greater use of volunteers is made to help people settle back at home which reduces the pressure on the formal care and support services. If either more voluntary sector services are used or shorter-term help is offered there is likely to be more capacity available for the next set of people needing support.

Therefore, be mindful of over prescribing care and support post discharge. Ensure there are mechanisms in place to reduce or stop care and support when it is no longer required. Treat the community-based services as precious resources. Develop support schemes for older people with the community and voluntary sector that can assist people in settling back in their own homes and thus reduce the pressures on the formal care services.

Section 2 and 3 of this paper describes the purpose, focus and methodology for constructing a systematic review of out of hospital systems.

2 Considerations for data collection to better understand supply, demand and outcome focused performance of current and future service models.

2.1 A focus for understanding demand, supply and impact

There are a number of key challenges that need to be met in order to best understand what is happening in any particular out of hospital care and support system. These are the main questions that require attention:

1. Can we count the numbers of discharged patients in such a way that we might be able to better predict who is going to require care and support post discharge?
2. Can we identify the range of services (intermediate care) that they will require?
3. Can we reduce the need to make assessments for people's longer-term care in hospital? That is, can we develop a set of services that will support speedy discharge and then to help recovery before an assessment is made?
4. Can we collectively understand the care pathways that each of the services support and ensure that better decision-making takes place at the point of discharge?
5. Can we distinguish between those people who need time for recovery and those who don't?
6. Can we measure the outcomes of the various services that we use to support older people in post hospital care?
7. Can we see the flow of patients out of the hospital and ensure that a good supply of these services is always available for the next set of patients?

Most health and care systems use an approach to discharges that can be paraphrased below:

- Pathway Zero – People are discharged home to the community with follow up from their GP and minimal formal support.
- Pathway One – People are discharged home to their community with further support to assist in their recovery and rehabilitation.
- Pathway Two – People are discharged to a bedded facility to offer further support to assist their recovery and rehabilitation.
- Pathway Three – People are discharged to a place where an assessment can be made for their longer-term needs.

This is shown in Diagram 3, section 3.2 below.

2.2 Constructing a demand, supply and impact data set

The first task for organisations commissioning out of hospital care is to understand the numbers of patients who are likely to be flowing through the care and health system at any time. The task is to collect the data that will inform the following:

- In any week, how many older people who are being discharged from hospital are assessed as requiring additional care and support (to facilitate their discharge on Pathways One, Two or Three)?

- What proportions of these older people are assessed as requiring bedded facilities and what proportion can be helped in their own homes? (Pathways One versus Pathways Two and Three)
- Are there clear care pathways to support people's needs that are understood by those making arrangements for discharge?
- Can the outcomes be measured for the older people who are discharged into these services (Pathways One, Two and Three)?
- Do the commissioners and planners understand the outcomes that each of these services delivered and which achieve acceptable outcomes and which don't?

In more advanced systems they will identify the flow of older people out of hospital into a wider range of services, including understanding the demands on the community and voluntary sector; demands on primary care and demands on community health services. In addition, one health and care system in Pembrokeshire looked to understand what services had been used by older people who were successfully supported to avoid an admission to hospital.

The demand for each of these services does vary between different hospitals and for different local authorities. However, the patterns of demand that each setting creates tend to be similar week by week. Once the patterns of demand are understood by commissioners and planners it is possible to better ensure that the right services in the right quantities are available. It is important to first understand the local patterns of demand before exploring how they might be changed over time. For example, many more people are assessed as requiring bedded support than is probably necessary. Both how that bedded support works (the outcomes for their patients) and how the admission to that bedded facility might be avoided need to be tackled over time.

In the Institute of Public Care paper (2018) Professor Bolton suggested that there was a "best practice" approach which would expect 30% of older people to require additional support and most of these could be managed in the older person's own home. In fact, there are very few examples of this best practice (Institute of Public Care, 2018)[2]. Although there are some good examples from Rhondda Cynon Taf, Bridgend and Somerset which have demonstrated that these approaches can help. NHS England also report good outcomes from South Warwickshire. However, far more places are struggling with reducing the need for bedded care and getting the right capacity in the community. This is probably the biggest challenge for intermediate care services.

As is stated above, it is important to know and understand the patterns of demand for a specific acute hospital and to plan for intermediate care services accordingly. There are a number of reasons why the percentages of older people who require care and support being discharged from one hospital will be different from another, including:

- The failure of the hospital to assist people in becoming mobile whilst they are in hospital (known as 'pyjama paralysis').
- The decision to catheterise patients to reduce pressures on nursing staff to take older patients to the hospital.
- Risk averse practise in the multi-disciplinary team.

[2] The Government Guidance in England "COVID-18 Hospital Discharge Service Requirements" restated this model to demonstrate what good practice might achieve

- The availability of some services and the lack of availability of others.

Generally, we see a range of 20%-30% of older people who are being discharged are likely to be assessed as requiring additional care and support. This means that the numbers can vary significantly from one place to another.

It is really important to know how your system operates and what its figures are.

We suggest the following three stages to understand this requirement:

2.3 Stage 1: Constructing the data set, identifying your demographic

Stage 1 requires a focus on the following activities:

- Count all the older patients who are being discharged each week. Keep a record of each older person (over 65) who is discharged and keep an account of their destination e.g. home, nursing home, residential care home or community hospital. Consider this data over a 12-week period. Generally, one will find a pattern of demand emerges over this period which is fairly consistent.
- Keep a record of what additional care and support was arranged at the point of discharge for those people who were assessed as requiring additional help. In the best systems this might include either additional help from nursing/health services or from services commissioned by social care. In particular, note the numbers who are assessed as being able to go home with additional support and compare those with older people who are assessed as requiring a bedded facility to support their discharge (include all bedded facilities from community hospitals to short-term residential care or nursing care beds). In the earlier work (based on evidence in Scotland) this was suggested to be just over 8% of those assessed as needing additional care and support. In the new sites that have been visited not only does the figure vary widely but most places the proportion is much closer to half of those requiring support. This still feels very high, and anecdotal evidence suggests that many of these do not really require a bedded facility and would have done better if they had been discharged home with the right support.
- Pay particular attention to those older people who are starting a new long-term service as assessed in hospital. The general view expressed in many papers[3] is that no one should be assessed in a hospital bed for long term permanent residential care without an opportunity for recovery and rehabilitation. In most hospitals it has been found that significant numbers of older people are moved on to a permanent residential care or nursing care bed despite the wisdom above. This needs to be noted.
- In addition, people may of course return to the place from which they were admitted including a residential care or nursing care bed and many older people who were receiving domiciliary care prior to admission to hospital will have their service restarted at the point of discharge. For many this may be the right decision, for others it may be that they would benefit from some domiciliary care reablement at this time or at least a review of their lifestyle to ensure they are taking prescribed medications and maximising the way in which they manage their long-term

[3] For example, the intermediate care guidance Department of Health, '*Halfway Home*' (2009)

condition(s). The routes to the different services should be tracked using the boxes in Diagram 2.

3 A 'model' for intermediate care services

In this section, we describe how to determine which out of hospital services from health and social care should form part of the intermediate care services model and the focus for integrated performance monitoring.

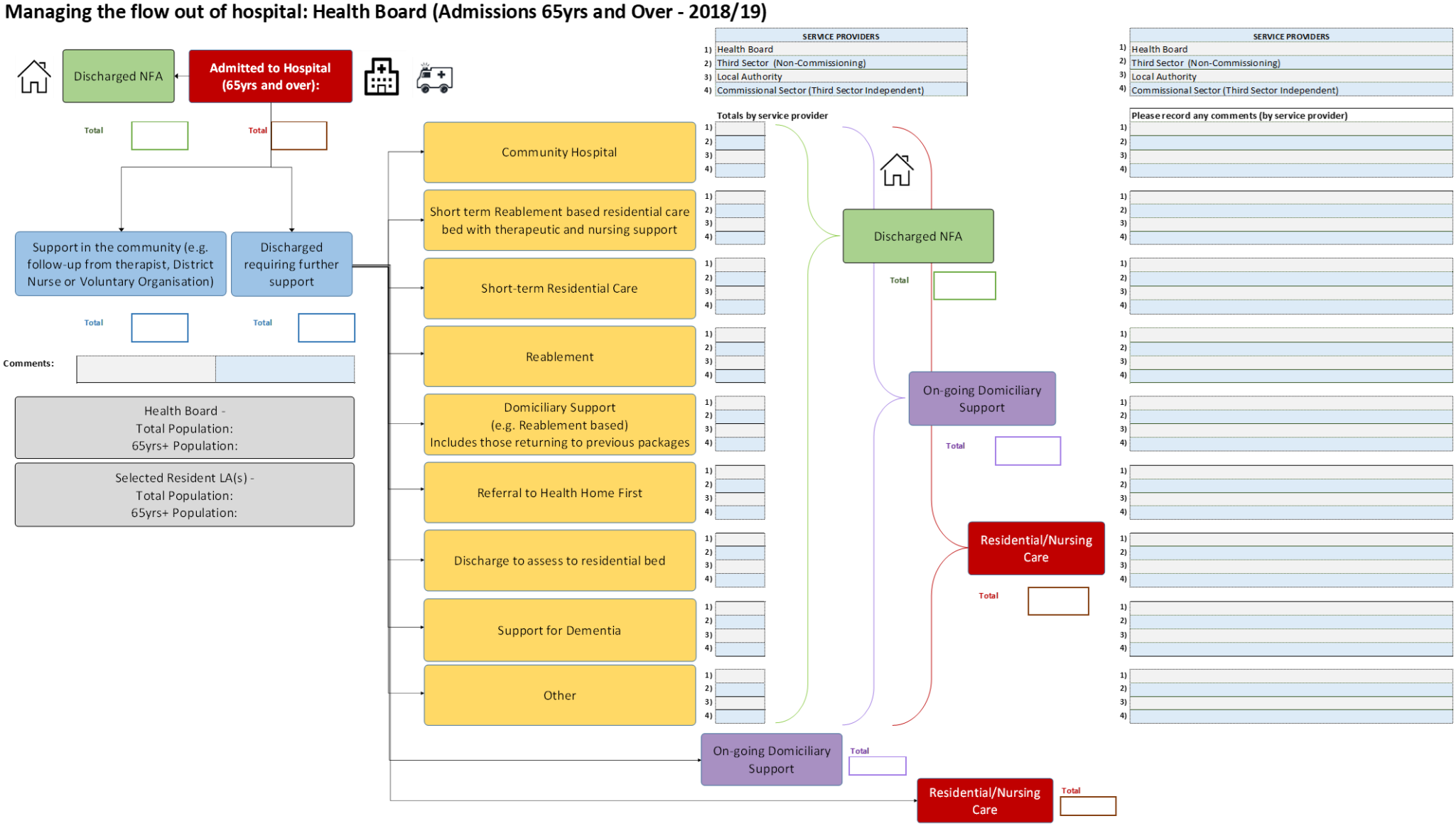
3.1 Stage 2: Consider each of the services that have been used to support older people being discharged from hospital

In Wales (NHS Wales Delivery Unit, awaiting publication), the template reproduced below was used to help staff to understand the range of services into which people might be placed as part of their discharge arrangements. One of the problems that emerged during the project is that the names given for these services vary from one place to another as well as the existence of services that again vary significantly.

Care and health systems were invited to list the services that they had as part of their intermediate care in their place in the yellow boxes.

There are a wide range of services that will need to be commissioned to support older people to assist with their recovery at the point of discharge. It is important for each health and social care partnership to decide what is required for their community from their understanding of the needs that have been presented in the past. The numbers needed for a specific service can be determined by tracking past requirements. Stage Two of the approach asks health and social care to work together to calculate the numbers of staff to support each of the subgroups that are identified. **It is only if the demand for specific services is known that the right services can be available for patients at the point of discharge**.

Diagram 2 – Data collection template



These services can be summarised in the following way:

Services that help older people to recover at home

- Volunteer or neighbour support for older people in their own homes
- Wellbeing services to support older people in their own homes
- Therapy support for older people in their own homes
- Reablement-based domiciliary care for older people in their own homes (best if this is therapy led)
- Nursing support to older people in their own homes
- Ancillary nursing support to older people in their own homes
- Dementia care specialist support to older people in their own homes
- All of the above in supported accommodation e.g. extra care housing
- Support for stroke pathway for older people in their own homes
- Telecare or equipment to help people in their own homes
- Direct payments for older people in their own homes
- Domiciliary care support for older people in their own homes
- Clinical support for older people in their own homes
- Nutrition, dietetics, and other allied health professionals supporting older people in their own homes

Bedded services that support older people to recover

- Care in a nursing home (short term)
- Care in a residential care home (short term)
- Care in a community hospital (short term)

In whatever place an older person is put to support their recovery, there must be an expectation that that is what the staff working in the resource are being supported to achieve. For some groups of older people, it is relatively straight forward to predict the numbers of staff required. For example:

On average, an older person receiving six weeks of domiciliary care reablement will require between 100-120 hours of care. A good proportion of older people (about half) are unlikely to need more than two weeks care. If it is understood how many people are being referred for their recovery-based support in any given period at home, it is possible to calculate the total number of hours required and therefore the number of staff needed to deliver those hours. This is then the service that should be commissioned (or delivered in house).

There would of course need to be additional staffing to deal with admission avoidance support or for direct referrals from the community. As a bare minimum the number of staff required to support an out of hospital care system should be calculated. It is rare to find that places have done this.

3.2 Considerations for the 'model'

The proportion of older people leaving hospital who are assessed as needing care and support varies from place to place. On average our experience shows that the range is between 20% and 30% assessed as requiring additional support (though both higher and lower figures have been reported). Our understanding from all of the places where we have worked is that it was consistently reported by community-based staff that many older people were overprescribed the care and support they need at the point of discharge from hospital. It is important that any care and health system understands the demand that their acute hospital is generating for them (as in Stage 1 above).

In some places more of those people who are assessed as requiring care and support are likely to be placed in a bedded facility than good practice might expect. This can be the case in some places because of the way in which the community hospital is used, in others it is because of the lack of supply of alternative provision in the community. Again, there are significant variations in what happens in different parts of the country. The range from the sites where we have worked was 90% of people being placed in a bedded facility to 5%. The average is in the region of 30%, which still appears high.

Of those who enter bedded facilities after an episode in an acute hospital the percentage varies as to whether they return home or not. In our earlier paper (Institute of Public Care, 2018) it is suggested that over 75% of older people who have been in an acute bed should return home even after a further period in a bedded facility. Not all of the short-term bedded facilities (including community hospitals) had the therapy and nursing support that focused on their recovery and helping them to get home. Most places did get over 80% of older people home after a spell in a short-term bedded facility.

For those who receive support in the community, including domiciliary care reablement they are likely to experience a positive recovery which for many includes not needing further formal care or support. There is of course the question of the over prescribing of care to which the evidence points (Better Care Support Programme, 2017). Local authorities and health providers need to be mindful of this so that episodes of care can be reduced or stopped as soon as it is appropriate. There is a question as to whether enough domiciliary care or reablement based health care is made available to older patients to support their recovery. In most places those who were offered domiciliary care based reablement had a positive experience and over 66% experienced a full recovery (Institute of Public Care, 2018) that required no further formal care or support.

Quite a number of people end up having the domiciliary care service they had earlier received reinstated. For some this is very important, but for others they might benefit from a period of reablement to assist in reviewing their lifestyle in order to see if some changes may be advised in order to reduce the risk of a further episode of acute care.

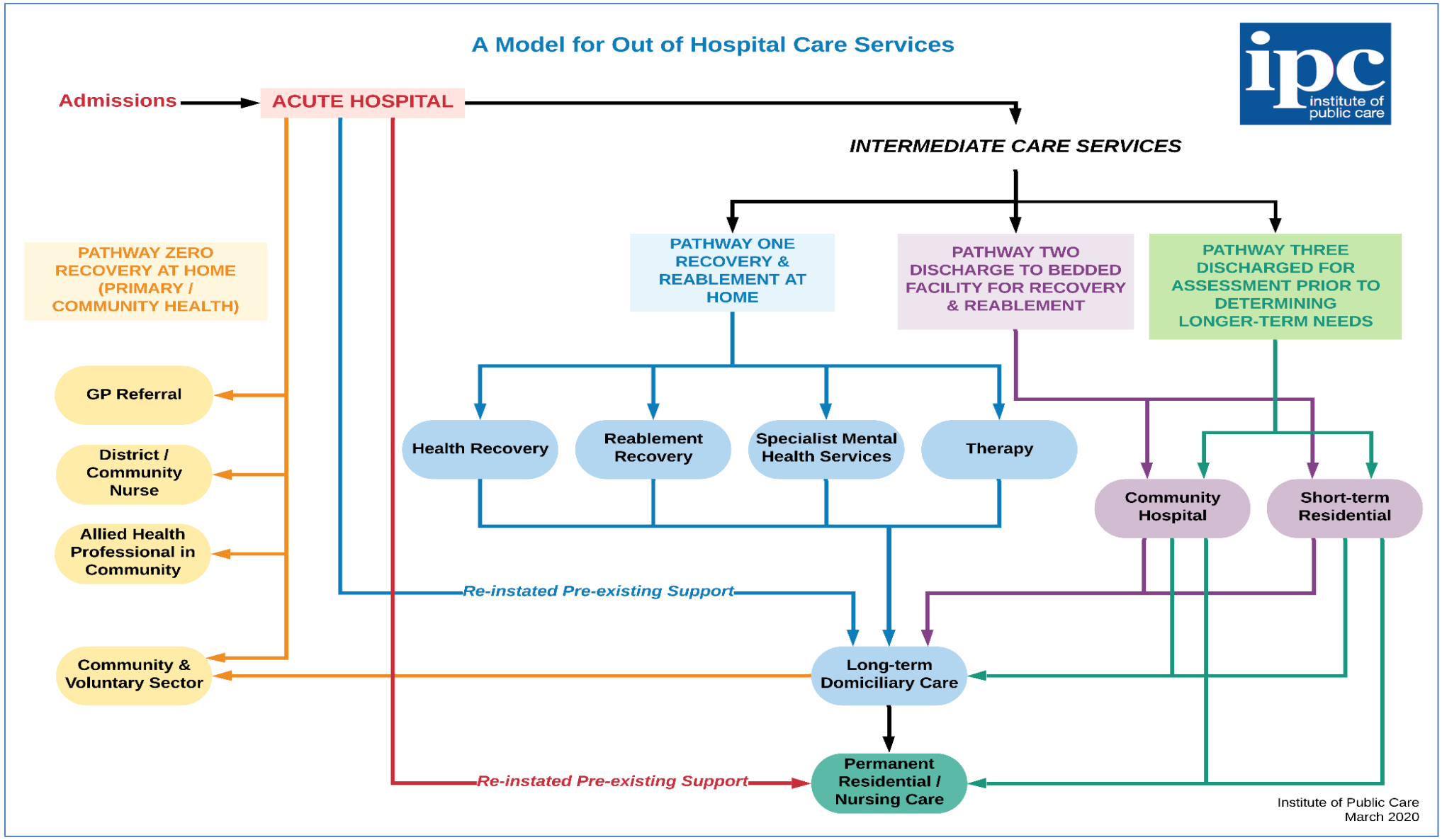
The role of the role of the voluntary sector and of family or community support is also an important consideration. There are examples across the UK of voluntary organisations using volunteers to help people manage their discharge from hospital, ensuring that they can settle back into their homes, get access to the things they need and to help give people confidence to go back to the things they have always been able to do without the need for any formal service. Where these services do exist, the reported outcomes are very positive. In some cases, it could be seen that the use of volunteers

could free up the valuable reablement-based domiciliary care support services. To summarise, the places in our work where transfers of care were seen to be working well had all or most of the following features:

- A well-integrated set of intermediate care services (Community Resource Teams) where health and care worked in partnership to support the process and a focus on getting the best possible outcomes for the customer.
- A clarity that most people can make a full or partial recovery and that should be at the heart of the help people receive.
- A focus on 'home first' with the right resources available to help people get back home, including mental health community support (Community Dementia Services).
- An Acute Health Team in the community available to support people with serious health conditions who did not necessarily require a hospital bed.
- A common access point to address hospital-based requests for help.
- Short term reablement teams who were therapy led, had flexibility in their responses and could change (or stop) care packages without referring to anyone else.
- An integrated community equipment store with easy access for professionals.
- A sensory team to support people with newly acquired disabilities to gain independence as soon as possible.
- Clarity for those who were providing services (whoever the provider is) on what was expected of them and the outcomes that were required.
- A clear understanding of what services were working well, and which needed improvement to support effective discharges.
- A focus on the flow of patients coming through the system and an ability to monitor that flow and to focus on the areas that get clogged up.

These elements can be seen in the following updated model for out of hospital services (Diagram 3) developed with Regional Partnership Boards in Wales.

Diagram 3 – A revised model for out of hospital care services



4 Defining the outcomes for intermediate care services

4.1 Stage 3: Specify the outcomes

When services are commissioned to support the numbers of people with the range of needs that have been identified in Stage Two then the outcomes from each of the services should be clearly specified. The outcomes can be defined in relatively simple terms:

- The person requires further help either in their own home or in a bedded facility (permanent admission).
- The person still requires some help, but this can be reduced from the intensive help offered by the service.
- The person requires no further formal help at this time.

Based on our previous work (Institute of Public Care, 2018) the following working assumptions might be made:

- The percentage of older people who will require no further help after a period of care and support at home, e.g. domiciliary care reablement, should be over 66%.
- The percentage of older people who are placed in a bedded facility who can then return to their own home should be over 70%.

These are outcomes that commissioners should expect from services they have procured (or are being delivered in-house). All services (including community hospitals) need to aspire to meet these targets in order to have an out of hospital care system that has low levels of delay.

The same report identified a number of other performance measures that could be used to help in understanding if the intermediate care services are operating effectively. These are reproduced in the appendix.

4.2 Long stayers or stranded patients

It is clear that in many hospitals there are older people (and others) where it has not been easy to identify the right resource to assist them at the point of discharge. Most of these are people who have been assessed as requiring a bedded facility which is either not available or the person (or their relatives) want to select a place of their choice. These are people who are most likely to require formal care for the long run. They can contribute to a high number of additional days spent in hospital. This is usually because the best possible services are either not available or there are no current vacancies.

This paper has already pointed out that one of the main shortages is of the ‘right type of services’ to support older people with different levels of dementia (more specifically those services that could support an older person in their own home). Intermediate care services can still play a vital role for many of these ‘stranded’ people. Though one may want to minimise the disruption that moving from one placement to another might cause an older person there is still a role for bedded facilities that can both help to get the best

possible assessment of the person's needs as well as being a safe haven for them whilst they are awaiting a longer term placement.

Though the numbers of older people who are stranded in hospital may be low, they can account for a large numbers of lost bed days. These delays can be reduced if the right range of intermediate care services is commissioned using the approach shown in this paper.

5 Conclusions

Our health and social care systems are not currently set up to systematically collect the data required to inform the integrated commissioning of community services. We think that this gap in information and intelligence contributes to a shortage of services to support older people at the point of discharge. This is a challenge for commissioners though often it is those who are delivering the services who are expected to 'carry the can' for any shortfall.

There is still plenty of opportunity to maximise personal outcomes and system efficiency through getting the right people onto the right 'discharge to recover then assess' pathway. Significant savings would accrue to both health and social care if the right resources were made available to support hospital discharge. Hospital readmissions and admissions to residential and nursing homes would reduce.

In some areas also, the risk aversion of acute hospital multi-disciplinary teams (MDT) and clinicians continues to lead to over-referral to intermediate or direct long-term care pathways, where short-term, low-level support could be a safe and sufficient option. This is both costly and misuses scarce resources. The use of the voluntary sector to support discharges is often not sufficiently developed. A routine review after one or two weeks in an intermediate care service could help release scare capacity and allow more people to access the right pathways in a timely manner.

Where the services identified in this report are in place in the right quantity they are, on the whole, effective and achieve good outcomes for people. Rather than creating new initiatives, there is evidence (Institute of Public Care, 2018) to support up-scaling what works.

As a result of lack of capacity for support for people at home (and possibly traditional bed management practices) too many people requiring ongoing support following admission to our acute hospitals are defaulting to bedded intermediate care facilities. Many areas use community hospitals for this purpose, with smaller numbers commissioned from care homes. There is variation in the reablement approach in both environments, and consequently there is variation in the outcomes for people on this pathway.

Excellent examples were found in our work of bedded facilities that helped get high numbers back home, but these were a minority of places. Too often older people were left to their own devices waiting for an assessment, which led to their unnecessary permanent admission to a residential or nursing home. There is clear evidence from our work to suggest that individuals can be admitted prematurely to care home placement as well as those who are over prescribed care in the community. In other words, we are creating additional 'failure demand' in an already stretched system. People with mental

health co-morbidities (dementia), are often excluded from intermediate care services and pathways to return home. We did find some areas, such as Bridgend in Wales, where they have developed specialist services to support this client group and appear to be achieving good outcomes.

6 Recommendations

In summary, we suggest the following key actions for health and social care partners to explore together:

1. Managing out of hospital care can be best achieved through a partnership between health and adult social care services. Both parties need to commission the right arrangements with dedicated intermediate care services to support their desired outcomes. The current governance arrangements in all four home countries can enable this to happen.
2. Health and social care together should make a decision if it is worth their while pursuing this approach to assist them in better planning for transfers of care. For those who use the suggested data collection template, they will need to make a decision on how frequently it is collected and shared as part of the performance management arrangements for the services. If a system can count the demands for care and support, it can better meet those demands.
3. Health and care partnerships, as a minimum, might use the list of services identified in this paper (section 3.1) to review their current provision and to make plans to develop those services that are required. The partnerships should focus on which services deliver the best outcomes. They should measure the outcomes from the services they arrange or commission.
4. The role and purpose of community hospitals (where they exist) needs to be considered. Ensuring the right resources are available to these hospitals is also important. This equally applies to short-term residential and nursing care. In particular, support from a range of allied health professionals can be very beneficial.
5. The need for community dementia teams to support older people back at home after an episode in hospital is an important part of the out of hospital care system.
6. Partnerships should look at the workforce that is required to deliver these services and develop a shared approach to support recruitment and retention of a workforce to support people in their own homes.

Professor John Bolton
Institute of Public Care
March 2020

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8 Appendix: Performance measures for out of hospital care

For a local authority wanting to manage performance against these objectives we would suggest consideration of the following measures (Institute of Public Care, 2018):

- The percentage of patients who, at the point of discharge, have received an appropriate service within 48 hours. This figure should be close to 100%.
- Key services are able to respond within 48 hours of being notified that their help is required. This figure should be close to 100%.
- The proportion of people in any one week waiting for a service that has been agreed by the patient and the multi-disciplinary discharge team. This figure should preferably be close to zero (with a record kept of reason).
- The proportion of people who are delayed from discharge when they are medically fit. This figure should be close to zero.
- The proportion of patients who are discharged to a permanent residential care bed without any opportunity for short-term recovery. This figure should preferably be close to zero.
- The proportion of patients who return home after a short-term period (no more than six weeks) in a residential care bed. This figure should be close to 75%.
- The proportion of people who receive long-term care after a period of short-term/reablement based care (this could be either a therapy led programme or domiciliary care based re-ablement). This figure should preferably be close to 25%.
- The proportion of people who receive long term support without being offered a period of recovery and recuperation. This figure should be close to zero.