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Policies for reducing delayed discharge from hospital

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## Abstract

### Introduction

Delayed discharge from acute hospital has been a cause of concern for the last ten years. Older people with complex health needs are particularly vulnerable to delayed discharge with negative consequences for their health and wellbeing.

### Sources of data

Review of the literature on the impact of the Community Care (Delayed Discharge) Act (2003) and subsequent policy initiatives on delayed discharges.

### Areas of agreement

A number of cross institutional complexities contribute to delayed discharges. Policy measures have contributed positively to reducing delayed discharges. Investment in intermediate care services has provided a range of services to promote maximum independence for older people after acute hospital admission. Joint working between health and social services is necessary to prevent delayed discharges.

### Areas of controversy

Pressure to achieve rapid hospital throughput may be contributing to older people leaving hospital too soon and to recent increases in hospital re-admission rates. Policy measures are extending to older people with mental health problems.

### Areas timely for developing research

Patient and carer experiences of delayed or premature discharge. Quality and equity of access to intermediate care for older people.

## Introduction

### Definition

Delayed discharge (sometimes called delayed transfer or bed blocking) refers to the situation where a patient is deemed to be medically well enough for discharge but where they are unable to leave hospital because arrangements for continuing care have not been finalised <sup>1</sup>.

Delayed discharges are particularly associated with older people with complex needs. In 2000 the national Audit Office estimated that in 1998/99, 2.2 million bed days could be attributed to delays in discharge in this group, with a cost to the UK National Health Service (NHS) of about £170 million a year <sup>2</sup>. The House of Commons Health Committee concluded that delayed transfers affected 6% of all acute beds and cost the NHS £720million in 2001/2 <sup>3</sup>. There are also significant health reasons for preventing delayed transfer. Older people remaining in hospital are less likely to gain further independence and are more vulnerable to hospital borne infections <sup>4</sup>. The problem of delayed transfers is not confined to the UK and is recognised in countries such as Sweden, Norway, New Zealand and the USA <sup>5</sup>.

The problem of delayed discharges in the UK is identified as a system-level issue, leading to inefficiencies in acute bed usage. The problem is also frequently related to the need for a whole systems approach to avoid difficulties and disputes at the boundary between health and social care <sup>6</sup>.

This paper focuses on identifying the impact of policy measures on delayed discharge. Searches of all key medical databases were undertaken, and papers were then selected where evidence is specifically linked to the impact of policy on delayed discharges.

### Reasons for delayed discharge

Bryan *et al*<sup>1</sup> undertook a project to examine the causes of delayed discharges in 2001/2002 in one area of southern England. With the full co-operation of the Primary Health Care Trust and local Social Services departments, the researchers accessed jointly compiled weekly lists of the individuals who had been declared medically fit for discharge but who remain hospitalised pending agreement from all parties regarding their transfer. These records were analysed over a twelve month period. The analysis confirmed that delayed transfers were a continuing problem, but gave no information about the causes. Detailed data covering two separate weeks were therefore obtained from patient records and analysed in order to investigate the underlying factors. The first sample week was randomly selected amongst weeks with approximately average numbers of patients experiencing discharge delay. A second week was chosen from two that had unusually high levels of delay. Neither week coincided with the period when winter weather problems might be expected to affect hospitalisation. Data were extracted from patient files by an independent researcher and verified by a second researcher. Information was recorded on a specially prepared and piloted pro-forma that was structured around the stages in the discharge process.

The study area had a population of 289,200 at the time of the analysis, with 46,272 (16%) of residents over the age of 65. Data on hospital admissions over the twelve month study period showed that 8,645 people over the age of 65 (18.7%) had attended hospital; 39% for day care, 28% for elective surgery, 30% as emergency admissions, 24% for other reasons. An estimated 7-10% of people using hospital services were already receiving care from Social Services. Approximately 2% of older people died during their hospital stay. Of those discharged, 83% returned to their original place of residence, 3% moved to other NHS facilities, and 14% went elsewhere (intermediate care, relatives or long term residential care).

A total of 125 people across the two study weeks were experiencing delays in transfer from hospital. The number of people affected by delays at each of nine identified stages the discharge process (described below) and the total and mean number of days these individuals had already been waiting for discharge were computed. The data showed a similar pattern of delays across both the randomly selected “typical” week (Week 1) and the week with the unusually high number of delayed patients (Week 2). The overall mean length of delay already experienced by patients at the time of the investigation was over four weeks (29 days).

Discharge stages incurring the most serious delays were identified as those where three or more patients experienced delays of 21 or more days in either study week. Five stages met this criteria and together accounted for 3,170 of 4,029 (78.7%) of all days of delay across 97 of the 125 patients (77.6%). These stages and the number of people affected (mean number of days delayed) were:

- awaiting decision about social service funding, 37 people (40.7 days);
- seeking of care home placement: by Social Services, 14 people (37.4 days) or privately, 15 people (20.1 days);
- family delays, 14 people (27.8 days);
- domiciliary care unavailable, 8 people (29.3 days);
- no sub-acute NHS bed, 9 people (23.7 days).

Causes of delays in the discharge process involving fewer than three patients in either study week were at the stage of health assessment (of all types), care manager assessments and provision of home aids and adaptations. Small numbers of patients were also delayed due to disputes over care plans and legal proceedings. The numbers of people experiencing delays for a particular reason may not always be a good guide to the significance of that factor because, in some cases, the

average duration of delays could be lengthy; for example, patients who were in dispute about their care plans experienced mean delays of over 70 days.

The study showed that delayed transfers could occur at any stage in the discharge process, but that the main bottlenecks were associated with gaining approval for public financing of social care services, securing placements in residential care homes, resolving family disputes over possible arrangements and arranging both NHS sub-acute beds or domiciliary care assistance. The sheer complexity and bureaucracy involved in the discharge process was an overriding concern and an important contributory factor to delays that occur. Longer term issues such as workforce development to address systemic problems and capacity constraints were also evident. Similarly, capacity constraints in long-term residential care provision were evident and were associated with cost pressures and care home closures.

Delayed transfers exemplify many of the difficulties that arise from the separation of health and social care systems that have existed in the UK since 1948. In recent years the boundary between health and social care has shifted, with much of what would previously have been viewed as healthcare now categorised as social care <sup>7</sup>. Many people who would have been cared for previously by the NHS for free, now find that they must meet some or all of the costs of care themselves <sup>8</sup>.

Policy context for older people with complex conditions

Commitment to reducing delayed discharges was included in the NHS plan (2000) <sup>9</sup> including a £900 million package of new intermediate care services to allow older people to live more independent lives by 2004. The National Service Framework for Older People (2001) <sup>10</sup> also included a commitment to support early discharge and reduce or delay the need for long-term residential care.

The perception that many delays in transfer were caused by Social Services departments (SSDs) led to the Community Care [Delayed Discharge] Act (CCDDA) in 2003<sup>11</sup>. The Act gave NHS Hospitals in England the power to charge SSDs a daily tariff in the event of their failure to provide the required social care services within 48 hours of a person being declared fit to leave an NHS facility. The Act was fully implemented in England and Wales in 2004 but excluded children, and patients admitted for acute mental health services, maternity services and palliative care. In some parts of England and Wales health and social care Change Agent Teams were used to support local change where there were particular problems in tackling delayed discharges of older people from acute hospitals.

Measures to facilitate joint working across health and social care agencies were introduced by the DH's National Plan for Social Care for Adults in England in 2005<sup>12</sup>. This plan addressed organisational issues at the interface of health and social care in order to foster more co-ordinated service delivery for older people with complex needs.

In Scotland, Joint Action Planning was launched in 2002<sup>13</sup> to reduce delayed discharges of older people from hospital. Funding was provided by the Scottish Executive to support local authority and NHS partnership initiatives. In Scotland there was greater emphasis initially on reducing delays of more than six weeks<sup>6</sup>. In 2006, the Scottish Executive modified their policy<sup>14</sup> closer to that of England, although they established a distinction between 'short-stay' (acute) settings where the timescale for discharge was fixed at three days, and 'non-short stay specialities' where the time frame for discharge was specified as six weeks. There was also a greater emphasis on the multi-disciplinary nature of decision making in arriving at a date for discharge.



When the Community Care Act (CCDDA) was initially introduced, there were concerns that it would undermine co-operation between health and social services. Subsequently 'charging' was made optional, but SSDs were still required to measure delayed transfers as a key performance indicator and to provide information on the potential financial liability for SSDs. Delayed Discharge Grants were also made to all SSDs when the Act was implemented. This was worth £50 million in 2003/4 and £100 million in 2004/5 and in 2005/06 <sup>15</sup>. These grants were intended to support improvements in care services that would support the transfer of patients out of hospital, and could lead to joint investment plans between hospitals, SSDs and Primary Care Trusts (PCT). Substantial additional funding such as Intermediate Care Capital funding was also available up to 2006 to increase the capacity and quality of post hospital care.

Intermediate care, or 'step-down' facilities provide temporary assistance to patients to bridge the gap between hospital and long term placement in users' own homes, or in residential care. Nationally and locally there are examples of novel means to expedite transfers from hospital through hospital-at-home schemes, short term care home placements or dedicated multi-disciplinary community teams for particular groups of patients such as people who have suffered a stroke <sup>16</sup>. Such schemes can give patients and their families time to exercise informed choice about their future living arrangements.

#### Impact of the Community Care Act

McCoy *et al* (2007) <sup>17</sup> used a postal questionnaire and secondary data derived from DH quarterly bed-censuses from July 2001 – March 2006 and hospital episode statistics to examine the impact of the Community Care Act on delayed discharges. Data were obtained from 99 (out of 150) SSDs. 66% had arrangements with

hospitals who had not opted to charge the SSDs with whom they worked. 43% were charged but 28/62 involved incurred no charges because there were no delayed transfers. Two of the SSDs who were charged paid more than the value of their Delayed Discharge Grant in 2004/5.

The data showed a reduction in delayed transfers to 1.9 % of in-patient bed days in 2003/4, 1.6% of in-patient bed days admissions in 2003/4 and 1.6% of in-patient days in 2004/5 (excluding those patient groups exempt from the CCDDA) <sup>17</sup>. These reductions in delayed transfers resulted mainly from reduction in SSD delays (although these had started to decline before the CCDDA was implemented) but also reduction in NHS delays. Nearly all of the SSD delays were caused by delays in the provision of Social Services; the NHS delays were due to delays in the provision of specific services and included delays attributed to 'patient and family related reasons' (22% of the NHS delays).

By the middle of 2005, SSDs accounted for only a quarter of all delayed transfer bed days. However, delays attributed to the NHS included delays caused by patient and/or family reasons, disputes between statutory agencies and delays to patients who were not eligible for SSD-funded community provision, which are not necessarily the 'fault' of the NHS <sup>18</sup>. McCoy *et al* <sup>17</sup> suggest that the financial investment arising from the Delayed Discharge Grants which encouraged partnership working and longer term service planning were more effective than the delayed transfer charging.

Increase in re-admission rates

However, as delayed transfers reduced, two other significant patterns in hospital bed usage became apparent. These were shorter stay and increased hospital throughput. Between 2001/2 and 2004/5 in England, the average length of stay in hospital

reduced from 8.1 to 7.1 days and the number of admissions rose from 7.5 to 8.2 million per annum over the same time period. Therefore patients were being discharged earlier in their post-acute recovery phase and in greater numbers. The numbers of discharges delayed by patient and family issues might suggest that patients are experiencing discharge negatively. There is also some evidence to suggest that rapid discharge has some negative connotations for staff. A recent paper <sup>18</sup> used focus groups to examine staff perspectives on discharge processes in an acute hospital. The findings showed that staff felt very pressurised by the need to discharge patients rapidly. They reported being unhappy about patients being systematised and professionals feeling that they were losing their sense of professionalism due to lack of time for assessment and planning, overly complex discharge preparation paperwork and communication problems across and within services.

A further concern is the increase in the rate of re-admission to hospital. In England, in 2002/3 re-admission rates were 5.4% and in 2005/6 this had reached 6.7 % <sup>19</sup>. This may relate to increases in the age and complexity of hospital cases, but could reflect a lowering of thresholds for discharge <sup>17</sup>. The government has recently indicated that future policy will penalise hospitals if patients are re-admitted within thirty days of discharge so that the focus shifts to the outcome for patients (Lansley 2010) <sup>20</sup>.

#### Inappropriate discharge to residential care

A report by the Commission for Social Care Inspection (CSCI) in 2004 <sup>21</sup> noted that behind the encouraging data on the reduction in delayed transfers, there were some causes for concern. Large proportions of older people were found to be moving directly from hospital to permanent residential or nursing homes (up to a third in some SSDs). Concerns were raised about people being pressurised into making life-

changing decisions from a hospital bed. Where rehabilitation and intermediate care services were well developed, there was evidence of these being effective in facilitating discharge and in getting people back to their own homes<sup>21</sup>. However access to those services was found to be inconsistent.

The CSCI report did conclude that health and Social Services were working together as a result of the legislation and the capacity funding. A whole-systems approach to delayed transfers is clearly required to avoid ostensibly 'solving' the problem in one area, but in fact causing a problem in another area.

#### Patient perspectives on delayed transfers

A review of the literature on delayed discharges<sup>22</sup> concluded that one of the most substantial limitations of the delayed discharge literature is the failure to include the patient and carer perspective. A study of the patient experience of delayed discharge<sup>23</sup> from the perspective of fourteen older people who experienced a delayed discharge (including two in-depth case studies) showed that many patients had a negative experience. The features of this were:

- anxiety about a further move which did not appear to be appreciated by staff;
- being unaware of what was wrong with them;
- perceptions of living with pain;
- avoidance of friendship as they were aware that any friendship would be broken by the impending move.

There is very little research into carer perspectives but studies in 2001 suggested that carers were dissatisfied with the experience of discharge<sup>24, 25</sup>.

#### Intermediate care

The Department of Health published initial guidance on intermediate care in 2001<sup>26</sup>.

The guidance set out definitions of intermediate care, service models, responsibilities for provision and charges and planning. The British Geriatric Society defined intermediate care in 2006 as services that met the following criteria <sup>27</sup>:

- They are targeted at people who would otherwise face unnecessarily prolonged hospital stays or inappropriate admission to acute inpatient care, long term residential care or continuing NHS in-patient care.
- They are provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery.
- They have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home.
- They are time-limited, normally no longer than six weeks and frequently as little as one to two weeks or less.
- They involve cross-professional working, with a single assessment framework, single professional records and shared protocols.

A Cochrane review of the effectiveness of intermediate care in nursing-led inpatient units (Griffiths *et al* 2007) <sup>28</sup> found that patients stayed longer in intermediate care, but that discharge home was more likely with a lower rate of re-admission. The costs of care in intermediate care was increased (compared to usual care) but the patient functioning and well-being was higher.

The British Geriatric Society (BGS) have expressed concerns about variability in the quality and provision of intermediate care, particularly in terms of access to a consultant in care of older people and inadequate multi-disciplinary rehabilitation services. The BGS have also campaigned for intermediate care to extend to older people with mental health problems <sup>27</sup>. They have conducted surveys of intermediate care <sup>29</sup> and are currently discussing a national survey with the DH.

In 2009 the Department of Health guidance was updated to reflect a plethora of change in terms of policy, practice and organisational reconfiguration with a shift to more personalised services that address inequalities, and greater focus on prevention and early intervention.

The updated guidance<sup>30</sup> provides renewed clarification of intermediate care which should determine the way forward for the next few years. It builds on the 2001 guidance on intermediate care and adds the following:

- Inclusion of adults of all ages, such as young disabled people managing their transition to adulthood;
- Renewed emphasis on those at risk of admission to residential care;
- Inclusion of people with dementia or mental health needs;
- Flexibility over the length of the time-limited period;
- Integration with mainstream health and social care;
- Timely access to specialist support as needed;
- Joint commissioning of a wide range of integrated services to fulfill the intermediate care function, including social care re-ablement;
- Governance of the quality and performance of services<sup>30, p2</sup>.

The guidance is primarily aimed at Commissioners but is also of interest to practitioners, providers, service users and their carers. Further resources for commissioners were published in 2010 as part of a preventative package for older people which includes intermediate care (DH 2010)<sup>31</sup>.

#### Mental Health and delayed discharges

In England, the Community Care Act 2003<sup>11</sup> did not extend to psychiatric in-patients. A report by the CSCI in 2004 suggested that intermediate care provision should be available for people admitted to older age psychiatry wards. They showed that

delayed discharges from acute psychiatric wards were occurring and suggested that these patients could benefit from therapeutic and rehabilitative services offered by intermediate care <sup>21</sup>.

A review in 2007 <sup>32</sup> showed that numbers of older people admitted to general medical wards have increased but the number of delayed discharge numbers has decreased (from 1998/99 to 2005/06). However in older age psychiatry (OAP), admission numbers have dropped but length of stay has increased. This may be attributable to the fact that many OAP departments have not been involved in the development of intermediate care and many intermediate care services specifically exclude patients with mental health difficulties <sup>33</sup>. The Department of Health is currently consulting on extending the reimbursement legislation to mental health and non-acute settings in England and Wales but as yet there is no decision.

The 2009 intermediate care guidance clarifies that intermediate care should also be inclusive of older people with mental health needs, either as a primary or a secondary diagnosis, if there is a goal that could be addressed within a limited period of weeks. It is recognised that without specialist help, people with dementia are particularly likely to have a prolonged stay in hospital, due to difficulties in determining their longer term care needs, as they often recover their physical functioning more slowly. Also, their hospital experiences can be doubly traumatic, as the surroundings are disorientating and they are separated from familiar people and places. The guidance cites research that shows that appropriate rehabilitation therapies for people with dementia and physical health needs have been shown to be successful in enabling them to return home and to stay out of institutional care <sup>30</sup>. There is also potential to improve overall efficiency because of the numbers of people with mental health problems involved.

More recent emphasis on partnership working

The Our Health, Our Care, Our Say white paper (2006)<sup>34</sup> showed increasing commitment to partnership working and integrated services. In 2009 the Secretary for Health (England and Wales) issued the Delayed Discharges (Continuing Care) Directions 2009<sup>35</sup> requiring NHS Trusts to ensure that an assessment of eligibility for NHS continuing healthcare is made before notification of a patient's case is given to Social Services (as per the Community Care Act). NHS Continuing Healthcare refers to a package of care arranged and funded solely by the Health Service for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of illness. The Directions specify that the patient and carer should be consulted and specifies that the assessment must involve a multi-disciplinary team.

Assessment of needs should be used to complete the Decision Support Tool for NHS Continuing care<sup>35</sup>. Where a patient has a condition that is entering the terminal phase or a primary health need arising from a rapidly deteriorating condition, a Fast Track Pathway Tool is completed<sup>35</sup> and the relevant NHS body is required to grant NHS Continuing Healthcare.

Good practice in reducing delayed discharges

The review of delayed discharge literature in 2006<sup>22</sup> concluded that the vast majority of literature failed to identify possible solutions. Better access to rehabilitation services is often cited as a way to reduced discharge delays, but what this entails is not specified.

In 2002 the House of Commons Select committee report<sup>3</sup> advocated increased use of nurse-led discharge procedures, and multi-agency discharge protocols to improve multi-disciplinary working. The National Audit Office<sup>36</sup> promoted use of joint



assessment processes, communication protocols and joint care records to improve the flow of information between the NHS and local authorities.

Baumann *et al*<sup>37</sup> compared six 'high performing' English sites with low rates of delayed discharge. The evaluation included the NHS Trust, the local authority and the relevant Strategic Health Authority. The study aimed to identify factors that contributed to the avoidance of discharge delays. All sites considered that they had benefited from the government's reimbursement scheme. The results were primarily derived from interviews with a wide range of staff. Factors found to enhance discharge (found in at least three of the sites) were:

#### *Strategic prioritisation*

- senior level strategic prioritisation for reduction and monitoring of delayed discharges

#### *Hospital factors*

- General practice liaison nurses in A&E who could advise GPs on alternatives to acute hospital
- Medical assessment units that could conduct in-depth fast track assessment without admission to hospital if possible. Such units need systems in place to arrange community based services before discharge (if patients can be assessed and treated within a day thereby avoiding admission this has a great advantage in that Social Services are not stopped by the admission to hospital)
- Discharge co-ordinators or teams to support ward nurse led discharge planning and including:
  - monitoring patient's progress from admission to discharge

- assisting nurses to identify patients who might need need post discharge health or social care
- supporting nurses discharge planning, particularly with complex cases
- patient choice protocols
- agreed discharge protocols and inter-agency communication systems including early notification systems
- regular monitoring of discharge data and regular meetings between NHS and Social Services staff to meet the Community Care Act requirements.
- Hospital transport services that could meet the flow of discharged patients

*Intermediate care factors*

- A range of intermediate care services often involving stepped provision between acute care and home, each with their own eligibility criteria
- Intermediate care assessment teams who could assess patients for all intermediate care services whether they were at home, in hospital or in A&E.

*Social Services factors*

- Early notification systems for discharge
- Hospital based Social Services teams involved in care planning with budgets to purchase care, and placement 'officers' or brokers to support teams by identifying vacancies in residential and domiciliary care
- Regular meetings between team managers (Social Services) and care managers (NHS)
- A supply of social and other community based services (these were present in all areas except for patients with mental health problems)
- As well as availability of intermediate care (as above), availability of interim placements for patients requiring longer to make decisions about care or

waiting for particular care (though it was acknowledged that for some patients the additional moves involved could be detrimental)

A small number of factors that contributed negatively to delayed discharges were also noted. These were shortages of staff and services for patients with mental health problems and limited understanding of the Community Care Delayed Discharge Act notification system by nurses <sup>37</sup>.

## Conclusion

This review shows that delayed discharges have been a focus of policy initiatives for some time. In the main these policies have had a positive impact on reducing delayed discharge from hospital for older people. However, concerns about fast throughput leading to an increase in re-admission rates and inadequate consultation with patients and carers have been voiced. Intermediate care is now established as a layer of services necessary to allow older people to transfer successfully from acute care to home, and to ensure that older people are not opting for residential care before their full recovery is achieved. However, there remains a need to ensure that all intermediate care services offer a full range of provision to support older people who increasingly have complex needs. The provision of intermediate care to older people with mental health problems remains a contentious area. The debate around delayed discharges is now emerging as an issue relevant to the re-shaping of acute care where hospitals are becoming specialist centres providing assessment and highly technological treatment for patients with acute illness <sup>6</sup>.

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