

Managing hospital admissions and discharges



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The Accounts Commission is a statutory, independent body which, through the audit process, assists local authorities and the health service in Scotland to achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The Commission has five main responsibilities:

- securing the external audit
- following up issues of concern identified through the audit, to ensure satisfactory resolutions
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in local government and the NHS
- issuing an annual direction to local authorities which sets out the range of performance information which they are required to publish.

The Commission secures the audit of 32 councils, 36 joint boards (including police and fire services), 15 health boards, 47 NHS trusts and five other NHS bodies. In total, these organisations spend public funds worth around £12 billion a year.

Executive summary

Background

The need to manage hospital beds and other resources effectively has never been more important. Hospital admissions have been rising for years. Increasing numbers of emergency admissions have put pressure on hospitals, leading to waits in A&E, cancelled operations and longer waiting lists. At the same time, lengths of stay have been getting shorter and numbers of beds falling, as new ways of treating patients more quickly and in different settings are developed.

The active management of admission and discharge is therefore vital to ensure that:

- beds are available for emergency admissions
- beds are available for elective patients, so that waiting lists are kept down
- the quality of care is high
- patients get the care they need when they are discharged from hospital
- beds are used efficiently.

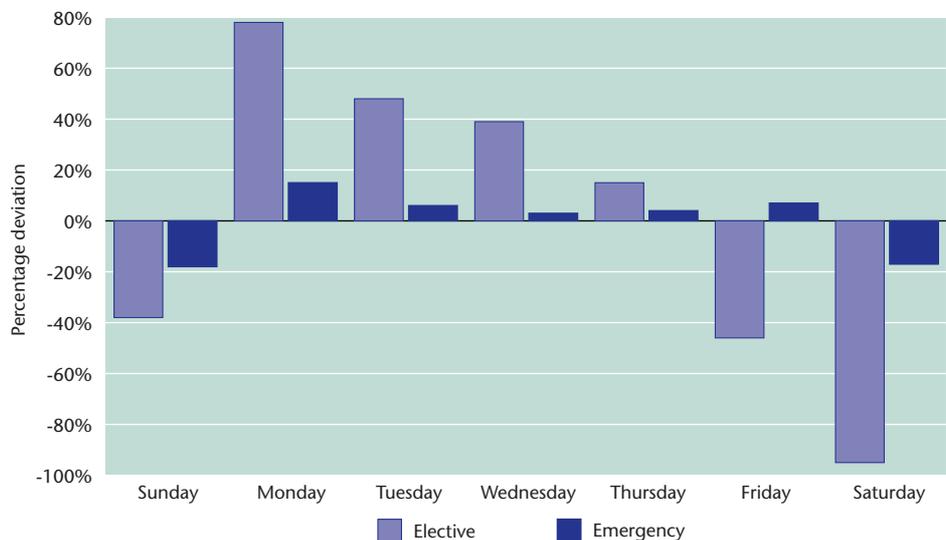
The Accounts Commission has reviewed the management of emergency admissions and discharges over the past two years, covering most acute trusts in Scotland. Each trust has received its own reports, with indicators of the quality of their management arrangements and recommendations to address any shortcomings. The purpose of this report is to highlight the main findings from these local reviews.

Main findings

All trusts have taken steps to improve their management of admissions and discharges. A number of trusts have made considerable efforts to improve both the quality of care and the efficient use of resources. Our findings show that there is room for further improvement, but they should be read in the light of the good work that has already been undertaken by most trusts.

- The way in which beds are managed varies considerably between trusts. Some manage beds across the whole trust, while others manage by specialty, with nurses and doctors responsible for bed management outwith office hours. Beds need to be seen as a resource available to the whole hospital if full flexibility is to be achieved.

Exhibit 1: Daily deviation from weekly average admissions (emergency and electives)



Source ISD data, Accounts Commission analysis.

- Trusts could improve their management of elective admissions, which represent the admissions over which they have control. Elective admissions are significantly higher at the start of the week and fall towards the end (mainly due to surgical admissions), while emergencies are slightly higher at the start of the week (exhibit 1). The current pattern of admissions is not efficient, but to make a serious impact on bed use hospitals would have to move towards working methods which use resources more evenly seven days a week.
- Trusts should examine the possibility of varying their elective workload, to maximise day case and short stay procedures during the busiest periods. This is rare at the moment. However, a number of trusts do review in detail whether non-urgent elective cases should be cancelled at periods of high pressure.
- Few trusts try to predict or obtain early warning of rises in emergency admissions, although almost all trusts had contingency plans to cope with peaks in emergency admissions in the winter of 1996-97. However, some of these plans were not detailed enough.
- The availability of diagnostic services has a significant effect on the emergency admission process, and a number of trusts are experimenting with the introduction of fast diagnostic facilities to improve admission and care.
- Most hospitals now have admissions wards, but some are too small. This can stop the ward from fulfilling its function, since patients have to be admitted directly onto general wards. The effect is to increase the number of admission points, which in turn makes clearing beds in the admissions ward even more difficult. It also adds to the problem of how to provide fast diagnostic facilities, as these facilities need to be readily available to a larger number of locations.
- Few trusts have formal policies on which beds should be used for 'boarding out' patients when wards are full. This can lead to doctors' and nurses' time being wasted in trying to locate available beds, rather than caring for patients. While boarding out is to be avoided if possible, where this is not possible the problems associated with boarding out can be reduced by use of a formal policy and procedures.
- Monitoring discharge delays is crucial if the causes are to be identified and tackled. All trusts monitor delays due to social services, and most share definitions and information with their social work colleagues. However, the quality of monitoring is variable, with only about half the trusts studied monitoring the number of bed days which are lost in waiting for discharge as well as the number of patients affected. About half identify whether the cause of the delay lies within the trust, with other NHS services, or with social work. Very few trusts monitor 'same day' delays, such as transport or the issue of prescriptions. A multi agency working group on delayed discharge is currently working towards an agreed definition of delayed discharge.
- Fewer than half of trusts monitor the quality of discharge, although some include patients' views of discharge as part of more general patient surveys.

Acute hospital admissions

Introduction

The number of emergency admissions has been increasing steadily since at least the early 1980s. The effect of these increases has been to put pressure on hospitals, leading to waits in A&E, cancelled operations and longer waiting lists. At the extreme, hospitals may close to new admissions, affecting the quality of patient care directly. More commonly, patients may be 'boarded out' to wards serving other specialties. This can be awkward for patients and staff, and can lead to additional difficulties in planning care and discharge.

This study focused on what action can be taken to improve the management of acute hospital admissions. The objectives were to:

- determine how trusts ensure that all hospital resources are used flexibly to accommodate fluctuations in workload
- assess the quality of management information, and how effectively this information is used
- determine what contingency plans trusts have in place to deal with particularly high levels of admissions
- review the effectiveness of the assessment, admission and placement process.

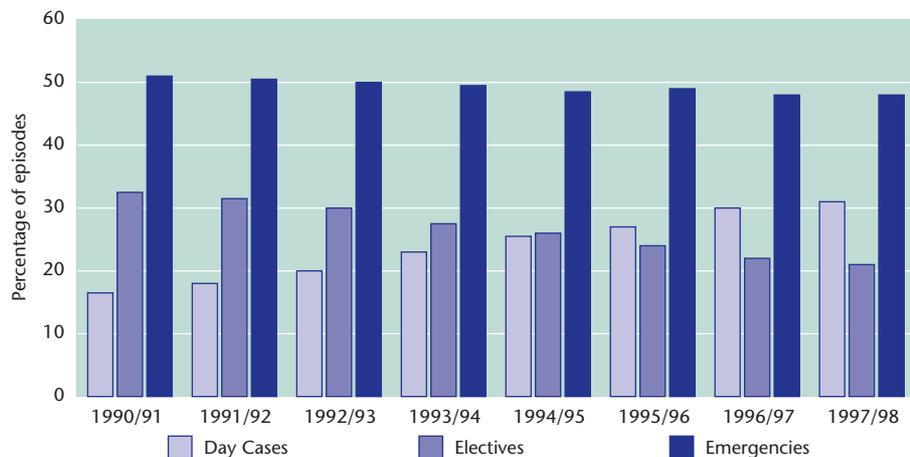
The study was designed to complement other work in this area. In particular, ISD¹ have looked at the reasons underlying the increase in emergency admissions, while Donaghy² has analysed the needs of patients in order to examine possible alternatives to emergency admission. In addition a number of recent reports^{3,4,5} have looked at these and other aspects of emergency admissions.

Patterns of emergency admission

In spite of the concern over increasing emergency admissions, they are actually rising more slowly than elective admissions when day cases are included in the equation. Exhibits 2 and 3 show that emergency admissions are decreasing as a percentage of all admissions.

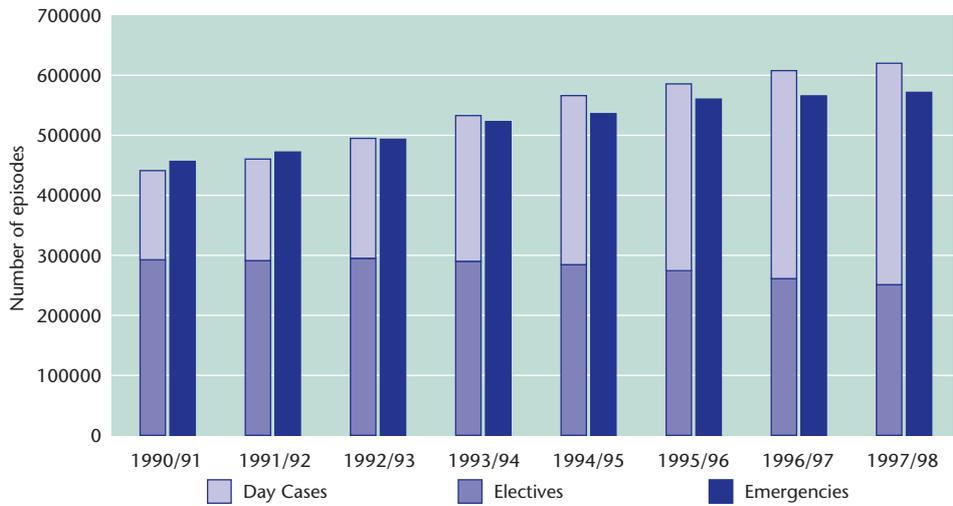
Exhibit 2: Day & inpatient percentages by episode type

The percentage of emergency admissions has fallen slightly over the period as a proportion of all admissions. This is due to the large increase in day cases.



Source: ISD data, Accounts Commission analysis.

Exhibit 3: Although elective inpatient numbers are falling this is more than offset by the increase in day cases

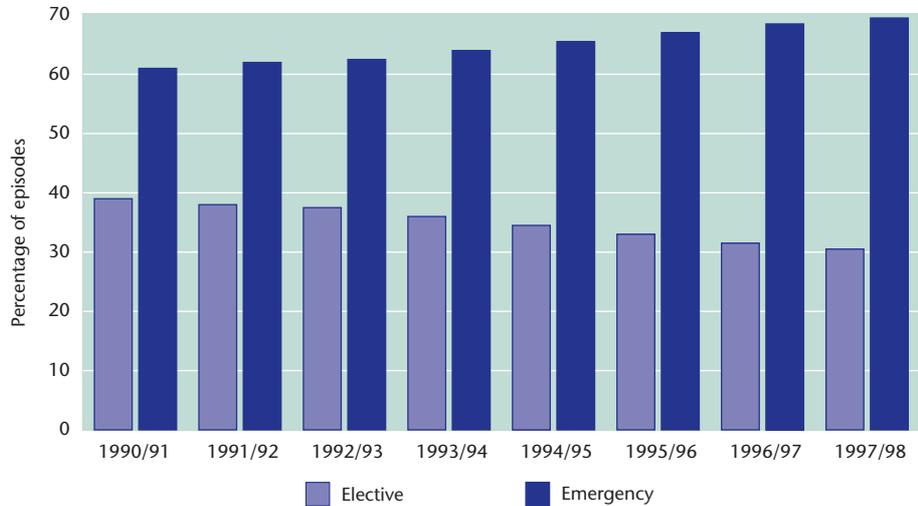


Source: ISD data, Accounts Commission analysis

When day cases are excluded and only inpatients are compared, there has been a rise in the percentage of emergency admissions (exhibit 4).

Exhibit 4: Inpatient Admissions - Percentage by episode type

When day cases are excluded, the pattern is of increasing emergency admissions and falling inpatient elective admissions



Source: ISD data.

At the same time as emergency admissions have been rising, lengths of stay and bed numbers have been falling. This has increased the difficulties of managing emergency admissions. Under this pressure, all trusts have taken steps to improve their management of admissions in general, and emergency admissions in particular. Different trusts face different levels of difficulty; for example some have greater access to rehabilitation and long stay beds. The impact also varies between specialties, with general medicine usually facing the most severe problems. However, there are many common problems, and much scope for trusts to learn from one another.

Variation & unpredictability

The rising number of emergency admissions is only one of the sources of difficulty for trusts; more problematic is the variation in the number of patients seeking admission over time, and the unpredictability of this variation. This makes the management of admissions extremely complex, and means that resources are likely to be stretched to the limit from time to time.

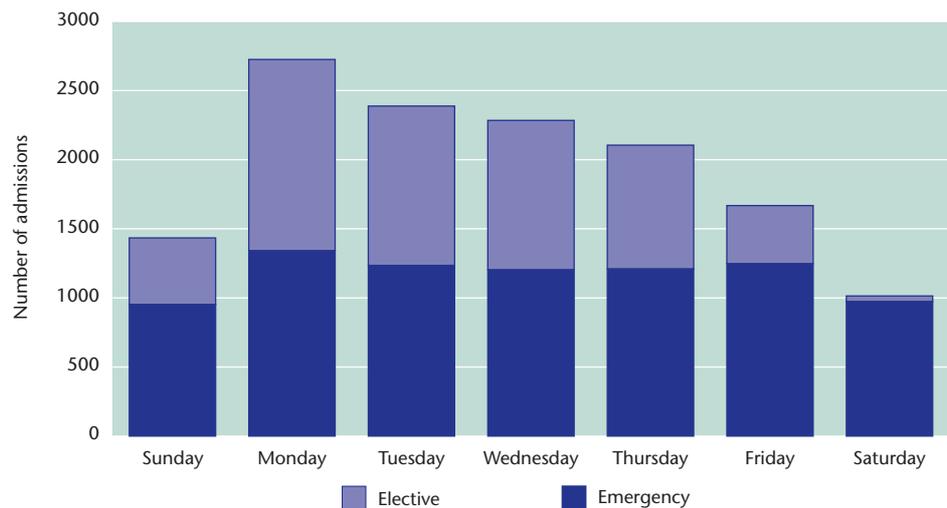
Variation

Emergency admissions vary in a number of ways:

- the number of admissions varies according to the time of day
- it also varies from day to day; for example at one large trust the daily number of emergency admissions varies from 30 to 120
- in addition there are seasonal fluctuations, but these do not occur at exactly the same time every year, nor are the fluctuations of uniform size

Emergency admissions vary comparatively little by day of the week, in contrast to elective admissions which are much more variable (exhibit 5).

Exhibit 5: Admissions by day of the week



Source: ISD data, Accounts Commission analysis.

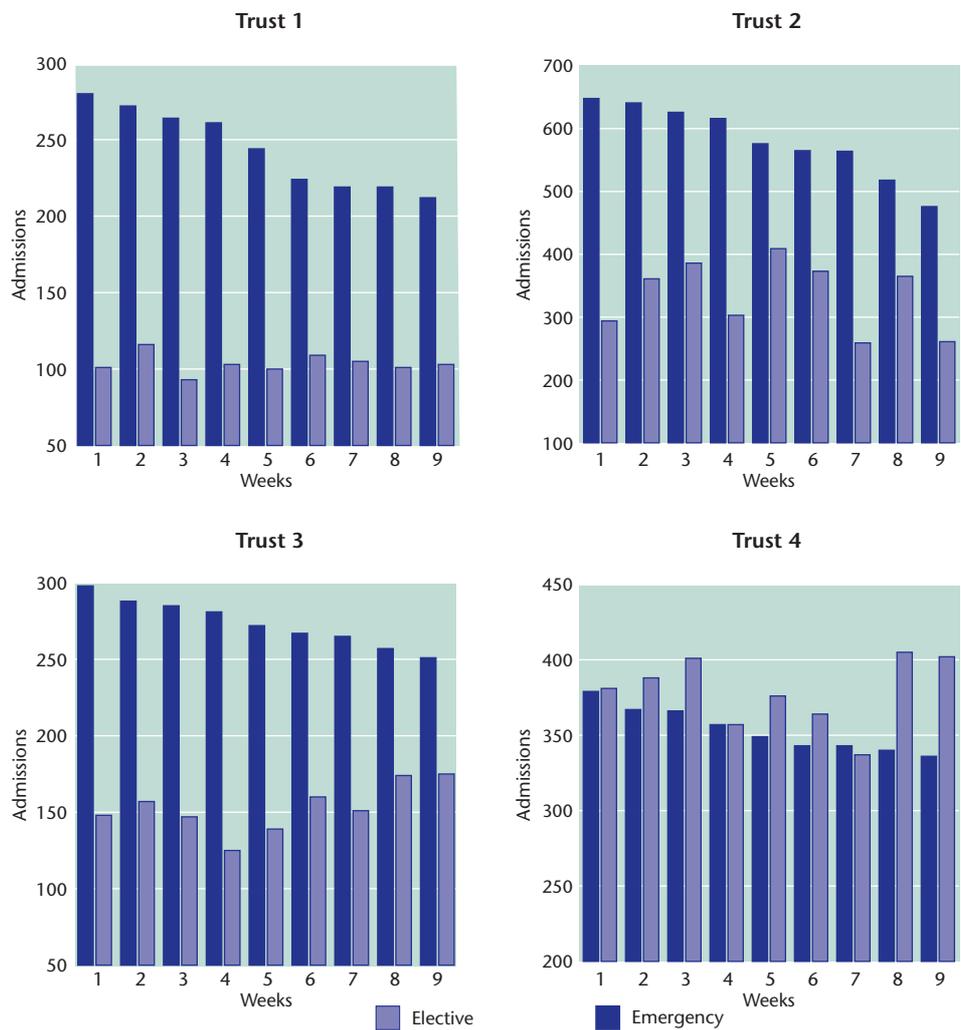
The differing patterns of emergency and elective admissions offer some scope for managing hospital resources overall, since trusts have some control over the scheduling of elective admissions. If elective admissions can be managed so that they are higher when emergency admissions are likely to be lower and vice versa, then the overall pressure will be reduced. At present, however, elective admissions have the effect of increasing the overall variation.

It could be argued that this increased variation is to be expected, since emergency admissions take place throughout the week while there is only a very small number of elective admissions at weekends. However, even when weekdays only are compared, the addition of elective admissions still increases the variation. This shows that the management of elective admissions adds considerably to the unavoidable variation in emergency admissions, rather than being used as a means of alleviating this variation.

In addition to this day-to-day variation, emergency admissions also vary seasonally. Pressure on beds is higher in winter than in summer, due to increased emergency admissions and longer lengths of stay. However, with the exception of the Christmas period, the number of elective admissions does not fall significantly in the winter months. This seems surprising, since some trusts cancel elective admissions when bed availability is very tight, but the number of cancellations is small in relation to the total number of admissions.

We compared admissions for 9 random weeks throughout the year at a sample of 4 trusts, to see whether elective admissions fell as emergency admissions rose (exhibit 6).

Exhibit 6: Comparison of emergency and elective admissions on different weeks throughout the year for 4 trusts



Source: ISD data, Accounts Commission analysis.

It is clear that elective admissions do not reduce as emergencies rise, or increase as emergencies fall. The only exception is when extreme pressure on beds means that trusts have to cancel elective admissions.

There are several reasons why trusts do not plan and co-ordinate bed use across hospitals:

- if planned admissions and emergency admissions can be accommodated, then trusts may not see it as necessary to even out elective admissions
- beds are seldom seen as a trust resource; instead they are managed by specialties or by clinical directorates
- each speciality has limited understanding of the problems facing other specialties
- specialties with a high elective workload do not usually schedule surgery on Saturdays or Sundays; this contributes strongly to a high level of admissions at the start of the week, with very few on Fridays or at weekends. To change these patterns of elective surgery would require significant shifts in working patterns, with attendant cost implications
- few trusts try to predict emergency admissions systematically.

Recommendations

- *Beds should be treated as a trust resource, rather than being managed by individual specialties or clinical directorates.*
 - *Specialties should be encouraged to increase their cross-specialty co-operation and understanding.*
 - *The pattern of elective admissions should be managed to reduce the overall variation in admissions. This may require changes in the pattern of working. Any changes in working patterns may have significant cost implications and therefore cost benefit analysis would be required at a local level as both costs and benefits will vary with local circumstances.*
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Predictability

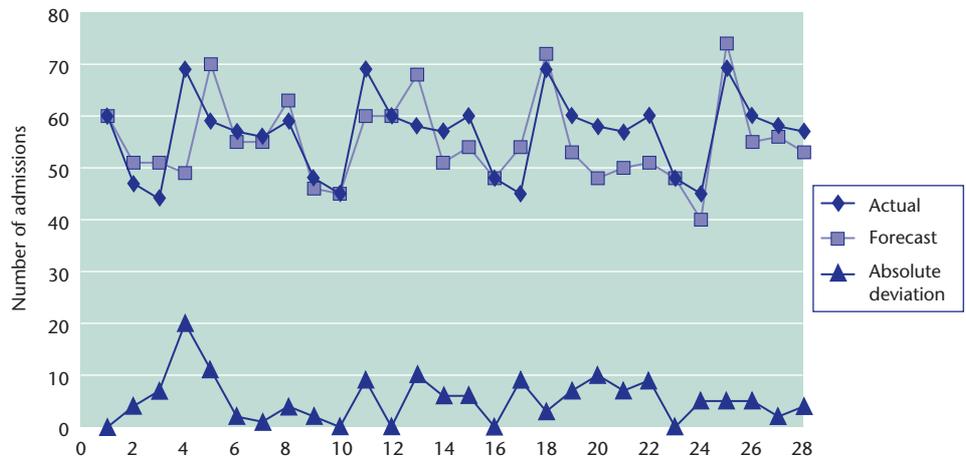
Managing the elective admissions which can be controlled by the trust is the first step in improving the admissions process overall. The next stage is to examine emergency admissions more closely. Traditionally, emergency admissions have been viewed as unpredictable, and the most important source of information has been the estimates of those with experience of managing beds.

The expertise of a bed manager and other members of staff is certainly essential in predicting the demand for emergency admission. However, there are ways in which this experience can be augmented to provide a more reliable forecast.

The simplest method is to get early warning of those events which are known to lead to increased emergency admissions, such as spells of cold weather and significant increases in colds, flu and other respiratory infections. Long and short range weather forecasts should not be neglected as potentially useful sources of information. Even more valuable is the use of GP 'spotter' practices to provide information as soon as the number of patients with respiratory infections starts to rise. This information can also help to indicate when the peak of admissions had been reached and demand is likely to fall.

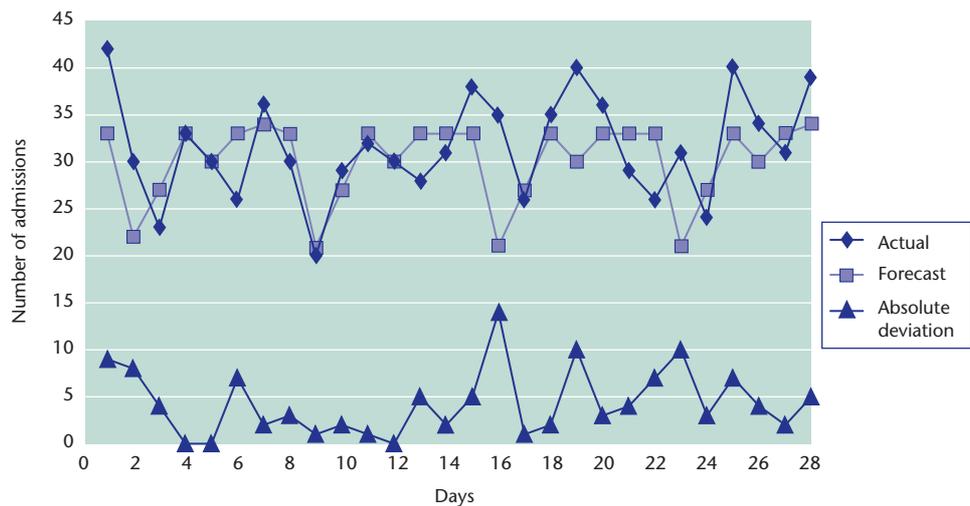
Another option is the use of a forecasting model to assist in predicting daily demand for emergency admission. The Accounts Commission developed such a model for this study and, as the exhibits below show, the results were encouraging. It uses information about past admissions patterns (over the past 56 days) to predict the future.

Exhibit 7: 28 day forecast for Trust A



Source: Accounts Commission forecasting model.

Exhibit 8: 28 day forecast for Trust B



Source: Accounts Commission forecasting model.

These methods are concerned with relatively short term forecasting but the use of weather forecasts and GP spotter practices could provide some advance warning of large seasonal variations. Very few trusts currently use predictive methods similar to these to improve their ability to predict and manage peaks in emergency admissions. However, following local audits a number of pilots are now underway.

Recommendation

- *Trusts should develop their forecasting methods and test them against actual levels of admissions. This may be done by working together with other trusts to pilot different combinations of methods to establish the most successful. If admissions can be forecast and variation reduced, the bed management problems discussed later in the report would be greatly reduced.*

Bed management

Contingency plans

All trusts had some form of contingency plan to cope with periods of high demand. The most common options were:

- bring an extra ward on stream to increase total capacity
- use a 'swing' ward to transfer capacity from surgery to medicine (which is most subject to peaks in demand).

To a large extent, the contingency plans depend on practical issues, such as whether the trust has a 'spare' ward which can be held in reserve and brought into operation when required, and whether the configuration of the hospital makes a 'swing' ward feasible.

Contingency plans varied significantly in their level of detail. Some trusts had only high level plans, identifying for example which ward would be brought into operation, the level of staffing, the specialty it would serve, and how long it could be financed. These plans did not, however, cover operational issues.

Other trusts had detailed plans. For example, in addition to the above information they identify a designated member of staff responsible for deciding when the extra ward should be opened. The sister who will be responsible for managing the ward knows the type of patient the ward will receive, and is charged with developing detailed plans for its operation. Issues such as portering and supplies as well as medical cover have all been detailed, and the staffing plans take account of likely high levels of sickness absence and the high demand for agency staff. Staff have been asked to indicate if they are willing to do overtime if the additional ward becomes necessary. This degree of planning allows trusts to be clear about the likely numbers and experience of staff who will be available and to plan accordingly.

Recommendation

- *Trusts should develop comprehensive contingency plans, taking account of likely levels of sickness and availability of agency staff.*
-

Admitting patients

Patients requiring emergency admission may either refer themselves to hospital, or they may be referred by their GP. There are two broad routes for patients into hospital, either through the Accident & Emergency (A&E) Department or directly to the inpatient ward. In general, patients who refer themselves are admitted through A&E, while those who are referred by their GP may go either through A&E or straight to the ward.

A number of factors determine the route used by a hospital for admitting GP referrals, including:

- the location of wards in relation to A&E, radiology etc.
- the ability of specialties to cope with admissions at two points
- the ability to complete administrative admission procedures at more than one location
- the disruption to A&E caused by the admission of large numbers of GP referrals
- the relationship and understanding between hospital receiving staff and GPs
- the level (real or perceived) of inappropriate GP referrals.

A number of trusts work closely with GPs to encourage good communication and high standards of referral. Minimum standards for referral letters are agreed, and dedicated help lines for GPs are provided. At other trusts, however, the hospital is dissatisfied with the standard of referral, but there has been little contact with GPs to discuss how improvements could be achieved.

A Scottish Intercollegiate Guidelines Network (SIGN) guideline on GP referral letters was issued during November 1998. This guideline provides an ideal vehicle to address any short comings in GP referral letters and so improve the communication between GPs and hospitals.

In most cases patients go through A&E. While this may be a fast, seamless service, there are often delays between entering the A&E department and being admitted to the ward. Our study found that the most important reasons for delay were:

- the length of time taken by specialty doctors to assess the patient for admission. This may be due to:
 - junior doctors waiting for a second opinion after completing the initial investigation
 - staff undertaking other duties while on call, and therefore unavailable to respond immediately to A&E calls
 - too few doctors on the receiving team to cope with the number of emergency admissions
- the lack of availability of portering staff to take patients from A&E to the ward
- delays in registering the patient by reception staff, caused by general pressure of work within the A&E department
- delays in carrying out initial diagnostic tests such as CT scanning.

Doctors at some trusts raised the problem of admissions which are perceived as inappropriate. One of the main reasons cited was the reliance on junior house officers attending A&E on their own. These staff do not have the authority to discharge a patient from A&E, but do have the authority to admit. Although they are able to seek a second opinion, many doctors believe that it would be possible for some patients to be safely discharged from A&E if they were examined by more senior staff, although doctors disagree on the possible number.

Another suggested reason for delay was the lack of availability of comprehensive diagnostic investigations early in the process. Many clinicians believe that if a high quality, comprehensive and timely diagnostic service could be provided then the number of unnecessary admissions would fall, as would the time spent in hospital by some patients who need to be admitted.

Fast tracking

A number of trusts have introduced or are considering 'fast tracking' - methods of speeding up the admission process for specific groups of patients. Two main methods of fast tracking are used:

- patients referred by their GP are admitted direct to the ward
- certain categories of patient are identified in A&E and transferred directly to a receiving ward.

For many patients this system works well, but there are some potential problems. Successful fast tracking requires:

- close working between A&E and the receiving wards. There must be a clear understanding of which patients are to be fast tracked.

- affected specialties able to cope with patients being admitted at two points
- diagnostic services available close to both the A&E department and receiving wards.

Fast diagnostic investigations

The lack of fast diagnostic facilities is one of the main reasons for both unnecessary admissions and slow admission processes. This finding is supported by the Donaghy study² which found that the lack of diagnostic facilities at primary care level and fast track diagnostic facilities in secondary care causes unnecessary admissions to acute beds. A number of trusts believe that their management of admissions has been improved by the provision of faster diagnostic services, and others are examining how to provide a high level of diagnostic services as soon as possible when a patient arrives at the hospital. This is in line with the recommendation of the Acute Services Review.

The Royal Infirmary of Edinburgh, for example, is experimenting with assessment areas, with the aim of offering immediate round-the-clock access to a wide range of diagnostic services and specialist opinion without the necessity of admission. This approach is part of a much larger programme aimed at enabling patients who would otherwise be admitted to be treated while staying at home, and those who need to be admitted to be discharged sooner.

An important feature of this type of approach is a clear understanding between all those involved of their respective responsibilities and how services will interact. The use of protocols can prove a valuable aid in achieving the close working required.

Recommendations

- *Where there is concern about the appropriateness of GP referrals, the level of inappropriate referrals should be monitored. This would identify whether any GPs are referring inappropriately and the type of patients involved; and it would allow action to be taken to reduce these inappropriate referrals by better communication between the hospital and GPs and by providing alternative services where necessary.*
 - *Trusts and GPs should work together to plan an integrated service by agreeing minimum referral information and providing easy access to second opinions. This should take full account of the SIGN guideline on GP referral.*
 - *The time taken to move patients from A&E to the ward should be kept under review, along with the causes of any delays (such as lack of portering staff, slow response by receiving teams, or delays in diagnostic tests).*
 - *Trusts should ensure that timely backup is available to junior house officers in A&E.*
 - *Trusts should establish thresholds for emergency admissions which trigger the release of on-call staff from other duties.*
 - *Trusts should review how comprehensive diagnostic investigations could be provided sooner and more speedily.*
-

Admission wards

The majority of acute trusts now have admission or assessment units, with the objective of grouping all the functions associated with admitting patients into a single location. There is almost universal agreement that these wards offer a great improvement over the old system of admitting directly to general wards on a rota basis. In particular they allow the ward to be organised around admissions; disturbance on other wards is greatly reduced; and subsequent placement of patients on wards can be better managed.

However, some admission wards appear to be too small, either because of physical constraints in the hospital, or because the trust is concerned that increasing the size of the admission ward would reduce the number of beds remaining on general wards to too low a level. Lack of capacity can mean that the admission ward fails to fulfil its function and patients have to be admitted directly on to general wards. The effect is to increase the number of points of admission, which in turn makes clearing beds in the admission ward even more difficult. In addition, the increase in admission points also increases the problem of providing fast diagnostic facilities.

Recommendations

- *Those few trusts without an admissions ward should assess the costs and benefits of developing one.*
 - *Trusts should review regularly the size of the admission ward and the time patients spend on the ward.*
-

Boarding out

Traditionally, when the level of admissions means that a specialty runs out of beds, patients are 'boarded out' into wards belonging to other specialties. While it should be avoided if possible, the reality is that boarding out happens in most hospitals, but formal policies setting out how the process should be managed are rare.

While informal arrangements can work well, they may also be a sign of poor planning leading to urgent searches for an available bed. The situation is worse in winter, as there are higher numbers of patients needing admission together with higher levels of sickness among staff. This can result in medical and nursing staff working on unfamiliar wards, or with unfamiliar patients.

Trusts should therefore have boarding out policies in place to guide this process, covering:

- to which specialties and wards patients can be boarded out
- the criteria to be applied to determine if a patient is suitable for boarding out
- how often a patient can be boarded out
- whether and when boarded-out patients should be returned to their original wards
- who is responsible for the patient's care while they are boarded out
- who is responsible for arranging discharge. This is important, as it is often patients who are close to discharge who are boarded out, and this can interfere with their discharge planning. Delayed discharges make an already difficult bed position worse, and the quality of patient care may suffer.

Recommendations

- *Trusts should develop comprehensive boarding out policies which are effectively communicated to medical, nursing and PAM staff.*
-

Discharge management

Introduction

As with admissions, the standard of discharge management impacts on both hospital efficiency and the quality of patient care. If discharge is delayed or mismanaged, this can reduce the quality of care of patients awaiting discharge and prevent the admission of another patient.

Good discharge management is therefore vital to ensure that:

- beds are available for emergency admissions
- beds are efficiently used for elective patients, so minimising waiting times
- the quality of patient care is high
- patients receive the care they need when they are discharged.

The study of discharge management was carried out at 20 trusts, and looked at 4 specialties:

- care of the elderly
- general medicine
- orthopaedics
- general surgery.

The objectives were to review:

- the discharge process
- discharge monitoring
- the implementation of policies and joint agreements in practice.

Trusts have worked hard to improve the management of discharges, and significant advances have been made. The following sections concentrate on those areas where there is potential for further improvement, but this should not devalue the improvements which have already been achieved.

Screening patients

In order to identify which patients are likely to require careful discharge planning to return home quickly and safely, all patients should be screened as soon as possible after admission. Many trusts require that patients should be screened within 24 hours, unless their condition makes this impossible.

Comprehensive, speedy diagnosis has already been discussed in this report. Some trusts are also providing an enhanced screening service to aid the treatment and discharge of patients. A few trusts have introduced additional physiotherapy or occupational therapy staff (often referred to as Professionals Allied to Medicine, or PAMs) to their assessment wards and A&E to ensure that all patients are properly screened. This approach has enabled the early identification of patients needing full assessment, allowing those patients to be assessed and therapy started within 48 hours of admission. These initiatives have not only speeded up treatment and discharge, but also improved communication and the quality of discharge planning.

For elective patients who are admitted for planned treatment, it is possible to start assessing their discharge requirements before they come into hospital. Pre-admission screening clinics have proved effective in many trusts, providing an opportunity to screen for operative fitness as well as for discharge requirements, and there seems to be scope for their wider use.

Recommendations

- *Trusts should consider making greater use of PAM staff in receiving wards and A&E on a pilot basis, to determine if faster functional assessment can be made and whether discharge planning can be enhanced*
 - *Trusts should continue to develop pre-screening clinics.*
-

Multi-disciplinary working

Patients with complex discharge needs often require the involvement of professionals from several different specialties or disciplines if their care is to be of the highest quality. For example, an elderly woman with a broken hip will require acute care from orthopaedic surgeons and nurses to repair the fracture; rehabilitation care from specialists in care of the elderly to help the process of recovery and tackle any other health problems; and occupational and physiotherapy to get her back on her feet. However, it can be a real challenge to get all these different professionals working together in a co-ordinated way for the same patient outcomes.

All specialties claim to practice multi-disciplinary working, although those (such as care of the elderly) with the highest number of patients requiring multi-disciplinary care tend to be the most integrated. In the majority of hospitals general surgery was viewed as the specialty which was least developed in its approach to multi-disciplinary working. A number of specialties highlighted the production of integrated care pathways as one of the significant steps in achieving good multi-disciplinary working.

The term 'multi-disciplinary working' is interpreted in various ways. For example, some specialties have weekly multi-disciplinary meetings, and there is agreement on how the different professionals and specialties work together. At the other extreme, some specialties only call a multi-disciplinary meeting when one is thought to be required by the consultant; in these circumstances medical staff may believe that multi-disciplinary working is operating satisfactorily, but other staff often consider there is substantial room for improvement. This approach cannot be considered truly multi-disciplinary.

The range of staff involved in multi-disciplinary teams varies, but they most commonly include hospital-based medical, nursing and PAM staff, together with social work and possibly a community liaison nurse (who may also be hospital-based). The most common concerns within multi-disciplinary groups were the failure of medical staff to attend the weekly meetings regularly, or the attendance only of junior doctors.

There is little agreement on the extent to which multi-disciplinary working should involve community staff and GPs. Most hospital staff were in favour of working closely with community colleagues, but there was concern about how this could be achieved in practice. The cost in time and money, and the practical difficulties of bringing together all the relevant staff, mean that this approach is only used for those patients with the most complex needs.

Recommendations

- *Trusts should establish if all those who should be involved in multi-disciplinary working believe that they are appropriately involved; whether all staff believe that multi-disciplinary working is effective; and canvass their views on how improvements could be made.*
 - *Trusts should ensure that staff in all specialties and wards are clear about who is responsible for communicating with the various community professionals who need to be involved in the discharge and after-care of individual patients.*
-

Discharge documentation

The documentation used to plan a patient's discharge is not purely an administrative issue. It is the main vehicle by which all the different individuals and professionals can communicate what plans have been made and how they are progressing, so that the care provided is co-ordinated and managed. However, patients records are often fragmented, with each of the different professional groups, such as doctors, nurses and therapists, maintaining their own records which are not accessible to the others.

Some of those using separate documentation argue that combined documentation may mean the creation of an additional set of records, with duplication and overlap, or that it causes access problems when more than one member of staff requires access at the same time. These problems will be resolved as trusts move towards the use of integrated electronic patient records, but in the meantime they can be minimised by ensuring that the combined documentation is well-designed and tested in practice. Trusts which have adopted this approach believe that it provides a better information source which aids multi-disciplinary working.

A few trusts leave the management of discharge planning to individual wards. This may be acceptable if it reflects a conscious decision that differences between the types of patients cared for on different wards require different approaches to planning, but this does not seem to be the case in practice. We found wards in the same hospital with similar patients sometimes have different documentation. This can only add to the problems of discharge planning, particularly as many professionals work across a number of different wards. The aim should be to have a single discharge planning process across the trust, so that everyone is clear what their responsibilities are and how they communicate with the other professionals involved.

Recommendation

Trusts should review their discharge documentation to ensure that it captures and disseminates the information required and aids high quality multi-disciplinary discharge management.

Delayed discharge

There is no routinely available information on the level and causes of discharge delays across Scotland, since trusts do not consistently measure delays nor use the same definitions. The multi agency working group on delayed discharge is currently working towards an agreed definition of delayed discharge and it is expected that a definition will be agreed prior to April 1999.

A small number of trusts do not believe that they have a problem with delayed discharges; these are non-teaching trusts with good access to community hospital beds. However, all teaching trusts and most non teaching trusts consider delayed discharge to be a significant problem. Figures vary depending on the time of year and how a delayed discharge is defined, but on any given day the average number of beds occupied by patients whose discharge is delayed is over 20 in each trust, with larger trusts often reporting double that number.

We also carried out 'snapshot' surveys at trusts, looking at the number of patients awaiting discharge at a single point of time for any reason, including delays due to prescriptions, transport and other services within the hospital. Using this definition the number of patients awaiting discharge rises to 80 or more. It is inevitable that some patients will be waiting to be discharged at any point in the day, but this information can help to identify the source of problems within the hospital which exacerbate the overall pressure on beds and may reduce the quality of patients' experience of discharge.

Monitoring

Good monitoring can identify patterns of delayed discharge which clarify what type of remedial action is necessary, and where. Equally, monitoring can be used to ensure that the quality of care is high for individual patients all the way through to discharge.

A few trusts do not monitor discharge delays on a regular basis because they do not believe they have a discharge problem. Apart from this small number of trusts, all monitor delays for patients waiting for care to be arranged by social work departments, which they perceive to be the most important in terms of the length of delays they account for.

For good reasons, delays while waiting for care to be arranged by social work departments tend to be longer than those due to other causes. People are taking decisions which may affect where they spend their lives, and funding is often scarce. However, a range of other problems can also lead to delays, and the way in which they are monitored is very variable. Only around half of trusts identify whether the reason for the delay is caused by the trust itself, by other NHS services or, by social work services.

All trusts either have already or are in the process of reaching agreements with their local social work departments, covering:

- a common understanding of what constitutes a delay
- information sharing on delays
- agreed times for assessments to be completed.

A few trusts and social work departments jointly monitor social work delays in greater detail, breaking down the process into the following stages:

- assessment process
- funding approval awaited
- awaiting funding
- awaiting appropriate placement.

This information is important in understanding what is causing delays and how problems can be tackled. Only half of trusts monitor the number of bed days 'lost' as well as the number of patients; this information would allow clinicians and managers to identify which patients are facing particular difficulties, and to target them for extra attention.

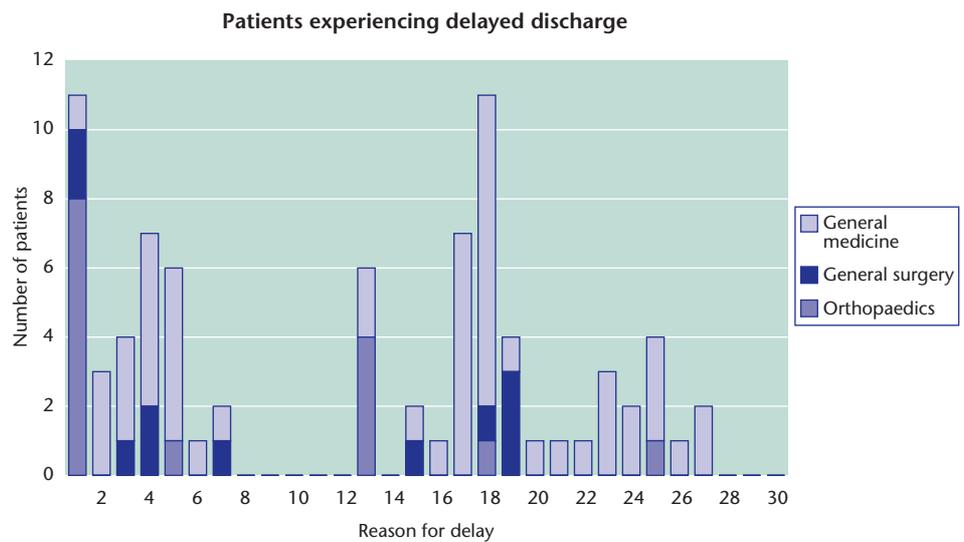
The lack of analysis of the cause of delay and information on days 'lost' leaves many trust monitoring systems unable to provide the information which would be of real use in identifying and agreeing problems, causes and action required to achieve improvements. Many trusts recognise the need for improvement.

Information on shorter delays tends to be even worse. Very few trusts monitor delays which do not lead to an additional overnight stay, often referred to as ‘same day delays’, and several do not see this as worth doing even on an ad hoc basis. Short delays of this type are often due to waits for take home drugs to be dispensed, and for transport to be arranged. They do not result in the loss of many bed days, but they do affect the patient’s experience of discharge. They cause worry and inconvenience to patients and their families, and they can also prevent a smooth transition from hospital care to community services.

Exhibits 9 to 11 show the results of a survey undertaken at one trust as part of this study. The survey identified all patients clinically fit for discharge at a single point in time. The reasons for delay were recorded for each patient, using 30 categories shown at Appendix 1. These categories fall into 4 broad areas of responsibility:

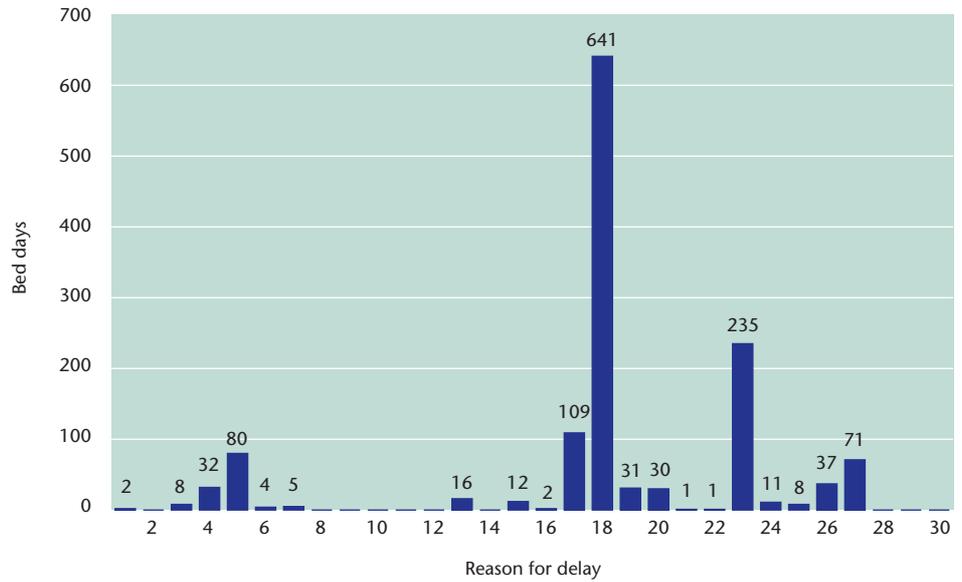
- 1 - 10 are caused within the trust
- 11 - 16 are caused by health services outwith the trust
- 17 - 24 are connected with social work
- 25 - 30 are other, miscellaneous reasons.

Exhibit 9: Reasons for delayed discharge



Source: delayed discharge survey.

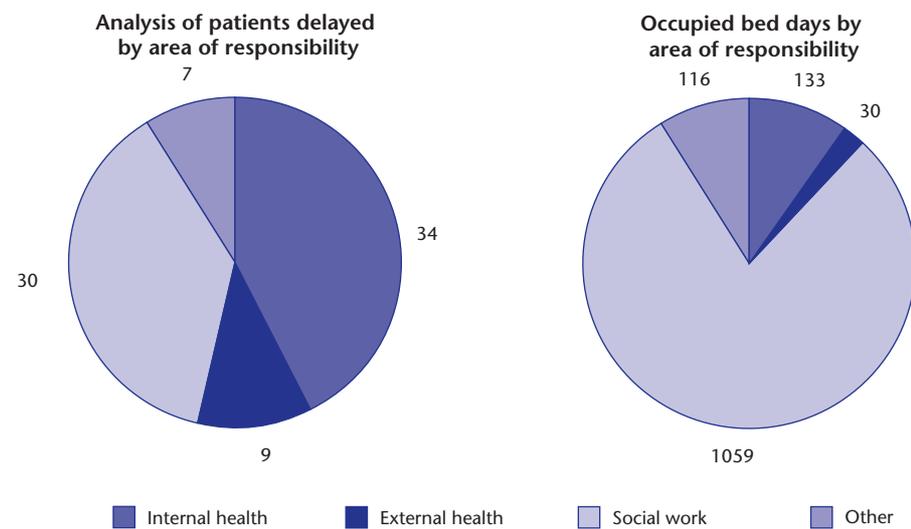
Exhibit 10: Occupied bed days lost due to delayed discharge



Source: delayed discharge survey.

At this trust, 80 patients were experiencing discharge delays at the date of the survey, accounting for a total of 1338 lost bed days. These can be broken down over the 4 broad areas of responsibility (exhibit 11).

Exhibit 11: Responsibility for delayed discharge



Source: delayed discharge survey.

The largest group of patients is affected by delays caused within the trust itself, but these delays account for only 10% of the associated bed days. In contrast, 37% of patients experienced delays associated with social work services, but this accounts for 70% of bed days. It should be noted that reasons for delay were collected by trust staff, which may introduce an element of bias into the figures. On-going monitoring would allow patterns of delay to be established and underlying reasons to be investigated.

Further, it is unlikely that all of the delays associated with social work services are due to social work failing to respond. In addition to the factors outlined above which can lead to unavoidable delays, social workers must be informed early enough to allow an assessment to be completed and any necessary services arranged before the patient is medically fit for discharge. If this does not happen, then they are not the cause of the delay. The trust's failure to notify social work at the earliest stage is the real source of the problem.

In occasional cases, it will not be possible to start the assessment process until the patient is very close to being fit for discharge. In these cases it may be impossible to complete an assessment and provide appropriate services by the time the patient is medically fit for discharge, and some 'delay' is inevitable. If this type of delay is monitored, the trust can assess whether it would be worthwhile to introduce additional services to meet the needs of this group of patients, perhaps a less acute setting staffed mainly with nurses and PAMs.

Detailed information on the reasons for delayed discharge, and the impact on the trust's management of its beds, can help to inform both internal decision-making and joint planning with services outwith the trust. It enables resource utilisation to be measured throughout the discharge process, which may help to stimulate the development of services to resolve specific problems.

Less than half of trusts monitor the quality of discharge in its own right, although some cover discharge as part of wider surveys of patients' views. Most trusts rely on complaints. However, this is likely to significantly underestimate the number of patients who experience problems, and means that an important source of information is lost.

Staff are also an important source of information on how discharge planning is working in practice. Simply because there are so many different groups of staff involved, their views on what is and is not working should be collected as part of the monitoring process.

Recommendations

- *Trusts should monitor delays by specialty and by reason. Reasons should be split in a way which will help identify where action is required (for example within the trust, other health services, social work or elsewhere).*
- *Within the broad groupings, specific problem areas should be monitored*
- *Trusts should agree definitions of delays and target times for assessment and placement with their local social work departments if they have not already done so. Definitions should be brought into line with national standard definitions once they are available.*
- *Data on delays should be agreed and shared with social work so that discussion can concentrate on solving the problems.*
- *'Same day delays' such as transport and prescriptions should be monitored on at least a periodic basis. Monitoring should include the views of patients, carers and staff.*
- *Monitoring information should be used to identify where service development would be worthwhile to resolve particular problems.*
- *The views of patients and staff on the quality of the discharge process should be collected at least periodically as part of the monitoring process.*

Discharge information for GPs and Nurses

GPs need to know when their patients have been discharged from hospital, so that they can provide the appropriate care if necessary. This is normally achieved by means of a discharge letter from the hospital. In order to improve the quality of this information, a national SIGN guideline has been produced setting out a recommended minimum dataset in the form of 'the immediate discharge document'.

We compared the letters produced by trusts with the guideline. Few trusts complied completely, but most were either introducing a revised immediate discharge document or already had a document which complied with most of the guideline. Nurses may be the first contact with a patient on discharge from hospital. It is therefore important that district and practice nurses receive timely information regarding patients' discharge.

Recommendation

- *Trusts should ensure that all immediate discharge documents comply with the SIGN guideline and that there are adequate arrangements in place to ensure district and practice nurses receive appropriate timely information regarding patients' discharge.*
-

Providing information to patients and carers

Patients and their carers also require clear and comprehensive information about follow-up treatment and services to be provided on discharge. However, the standard of information provided to patients varied between trusts and between specialties within trusts. In general, staff considered that verbal communication with patients was good, although they often expressed concern that patients might receive inconsistent messages from medical, nursing and PAM staff where multi-disciplinary working was less developed.

Information should also be provided in writing, so that patients can refer to it in their own time. The written information examined often omitted basic information, such as a specific, named contact for any queries the patient might have after discharge.

Recommendations

- *Trusts should ensure that all patients receive clear and comprehensive written information before they are discharged from hospital.*
-

Trust discharge policy and inter-agency agreements and arrangements

Joint discharge agreements are one of the fundamental ways of establishing a clear understanding of how agencies and their staff should work together to provide a seamless service to patients as they move from acute care to the community. These agreements, together with more detailed joint protocols, provide the opportunity to establish what information is to be shared, and how duplication in the assessment process can be avoided.

Hospital discharge arrangements are governed by a Management Executive Letter (MEL(1996)22), which makes it clear that much of the responsibility for joint agreements rests with health boards and local authorities. Nevertheless, trusts have to implement these agreements, and they should therefore be involved in their production, monitoring implementation and agreeing remedial action where necessary.

Joint arrangements must provide a clear understanding of the responsibilities of different groups of staff. It should be clear how the agencies will monitor the delivery of their agreed aims, and the quality of the discharge process from the patient's perspective. This should be stated in terms of both the process, and the targets and standards which will be used as measures. Finally, the agreement should set out what action will be taken to rectify any problems with standards of care or delays.

Joint discharge arrangements and protocols should include:

- criteria for referring patients to social work for assessment
- definitions of simple and complex assessments, and triggers for each
- agreement on timescales within which assessments should begin and be completed
- agreement on maximum time between completion of assessment and placement
- estimates of the number of patients who will need assessment
- identification of those authorised to commit expenditure
- responsibility for co-ordinating the discharge process
- inter-agency disputes procedures
- patients' complaints procedure
- arrangements for joint monitoring of discharge.

None of the trusts we reviewed had agreements and protocols covering all of these issues.

Agreements and protocols can be backed up by:

- joint training for social work and trust staff
- a single set of documentation for all professionals
- jointly funded assessment posts
- the attendance of social workers at case conferences for their own clients, rather than working through liaison staff
- social work cover for admissions wards, so that the discharge planning process can be started immediately for elderly patients, and the most complex cases can be spotted early.

These examples of good practice are already routine in some trusts, but many trusts have yet to consider them.

Recommendations

- *Trusts should ensure that their joint agreements and protocols cover the points listed above.*
 - *Trusts should explore with social work whether the good practice examples would help to solve their own particular problems .*
-

Discharge policies

In addition to the high-level agreements and protocols discussed above, developed and agreed with social work, trusts need to have their own operational policies for managing discharge. Staff need to be involved in developing them, and the policies need to be reviewed regularly.

A discharge policy should be based on the following principles:

- discharge planning should start as early as practical, if possible before admission
- the health and social needs of the patient must be considered, along with other factors which might affect recovery, when assessing discharge requirements
- consideration of referrals to other professions should be an integral part of consultant ward rounds
- referrals should be made early to allow the other professionals time to carry out an assessment before the patient is ready for discharge
- the consultant should involve all professionals involved in providing care on the ward or planning to meet the needs of the patient after discharge
- a minimum discharge planning process (specified in the policy document) should be applied to all patients
- patients with continuing care needs or needing short term packages of care in the community will receive a more detailed discharge planning process (specified in the policy document).

In addition, the policy should:

- require training for new and existing staff involved in discharge planning
- define the patients to whom the policy applies
- describe the discharge planning process
- clarify the responsibilities of the various staff involved in the discharge process
- set agreed timescales for action
- specify how the quality and effectiveness of discharge planning will be monitored and maintained.

Most trusts do have a discharge policy; however some are only in draft, and others lack the necessary level of detail to act as practical working documents.

Recommendation

- *Trusts should review their discharge policies to ensure that they cover the essential areas and are detailed enough to assist staff managing patient discharge on a daily basis.*
-

Summary of recommendations

Bed availability

- Beds should be managed on a corporate basis, rather than at the specialty or directorate level.
- Specialties should be encouraged to increase their cross-specialty co-ordination and understanding.
- Trusts should examine the potential to change the pattern of elective admissions to see if the variation in all admissions can be reduced. This is likely to require consideration of seven-day working for some services. Any changes in patterns of working may have significant cost implications and therefore cost benefit analysis would be required at a local level as both costs and benefits will vary with local circumstances.

Predicting admissions

- Trusts should develop their use of forecasting methods, including links with GPs, weather forecasts, and data modelling.
- Trusts should consider working together to pilot different combinations of methods to establish the most successful combination.

Contingency planning

- Trusts should develop detailed contingency plans, covering: wards to be used; staffing levels and skills required (taking account of likely levels of sickness absence and availability of agency staff); finance; ward management responsibilities; and the types of patients for whom the ward will be used.

Admitting patients

- Where inappropriate referrals are thought to be a problem, levels should be monitored to identify problem areas. This will allow action to be taken to reduce inappropriate referrals or provide alternative services as necessary.
- Trusts and GPs should agree minimum referrals information and establish a robust system for providing second opinions. This should take full account of the SIGN guideline on GP referral.
- Trusts should monitor the time taken to move patients from the A&E department to the ward, together with the causes of any delays. This will allow persistent problems to be addressed.
- Admitting specialties should ensure that junior house officers working in A&E have timely back up available.
- Admitting specialties should set thresholds for the level of admission at which staff on call are relieved of other duties.
- Trusts should consider the practicality and cost-effectiveness of providing comprehensive diagnostic services early in the admissions process. This is likely to have wider implications for the number of admissions and lengths of stay.

Admissions wards

- Trusts should monitor the operation of their admissions ward routinely, looking particularly at the availability of beds and the time taken for transfer to a standard ward.

Boarding out

- Boarding out policies should be developed and understood by medical, nursing and PAM staff. The policies should cover:
- the specialties and wards to which patients can be boarded out
- the criteria to be applied to determine which patients are suitable for boarding out
- how often a patient can be boarded out
- whether and when boarded out patients should be returned to their original wards
- who is responsible for patients' medical, nursing and PAM care while they are boarded out
- who is responsible for arranging discharge.

Screening

- Trusts should continue to develop pre-admission screening clinics.
- Trusts should consider making greater use of PAM staff in A&E and receiving wards on a pilot basis, to determine whether faster assessment can enhance discharge planning.

Multi-disciplinary working

- Trusts should establish whether staff believe that multi-disciplinary working is effective, and what improvements they suggest.
- Trusts should ensure that all specialties and wards are clear who is responsible for communicating with the various community professionals who need to be involved in the discharge and after-care of individual patients.

Discharge documentation

- Trusts should review their discharge documentation and its dissemination to ensure it provides the information required and supports effective, multi-disciplinary discharge management.

Monitoring

- Trusts should monitor discharge delays by specialty and by reason. Reasons should be split in a way which will help to identify broad areas where action is required (for example within the trust, other health services, social work and elsewhere).
- Within these broad groupings, more detailed analysis should be undertaken to identify specific problem areas. Appendix 1 shows an example of the type of analysis that might be adopted.
- Where trusts have not already agreed with social work departments definitions of delays, and target times to assessment and placement, they should do so.
- Data on delays should be agreed and shared with social work so that discussion can concentrate on solving the problems.
- 'Same day delays' such as those due to transport or prescriptions should be monitored at least periodically. This monitoring should involve the views of patients, carers and staff.

- Monitoring information should be used to identify where service development would be worthwhile to resolve particular problems.
- The views of patients and staff on the quality of the discharge process should be collected at least periodically as part of the monitoring process.

Immediate discharge documents

- Trusts should ensure that their immediate discharge documents comply with the SIGN guideline and that there are adequate arrangements in place to ensure district and practice nurses receive appropriate timely information regarding patients' discharge.

Providing information to patients and carers

- Trusts should ensure that all patients receive clear and comprehensive written information before they are discharged from hospital.

Trust discharge policy and inter-agency agreements and arrangements

- Trusts should ensure that their joint agreements and protocols include:
 - criteria for referring patients to social work services for assessment
 - definitions of simple and complex assessment, and triggers for each
 - agreement on timescales within which assessments should begin and be completed
 - agreement on maximum time between completion of assessment and placement
 - estimates of the number of patients who will need assessment
 - identification of those authorised to commit expenditure
 - responsibility for co-ordinating the discharge process
 - inter-agency disputes procedure
 - patients' complaints procedure
 - arrangements for joint monitoring
- Trusts should explore with social work:
 - joint training for staff
 - a single set of documents for all professions to use in discharge planning
 - a jointly funded assessment post
 - social workers' attendance at case conferences for their own clients
 - basing social workers in admissions wards.

Trust discharge policies

- Trusts should review their policies to ensure that they:
 - clearly state the underlying principles
 - set agreed timescales for action
 - specify how the quality and efficiency of discharge planning will be monitored and maintained.

Appendix 1

Survey of delayed discharge

Code	Reason - within trust
1	Delayed transport
2	Delayed prescription
3	Awaiting a bed in same hospital (eg rehab)
4	Awaiting opinion of another consultant
5	Awaiting continuing care bed
6	Decision for continuing care eligibility under review
7	OT assessment
8	OT home visit
9	Awaiting assessment by discharge liaison
10	MRSA delay
	Reason - other NHS
11	Community physiotherapy
12	Community psychiatric, district or Macmillan nurse
13	Awaiting transfer to an NHS non-acute hospital
14	Awaiting a place in a day hospital
15	Awaiting health funding or vacancy for a continuing care bed
16	Awaiting elderly mentally ill bed or hospice in another trust
	Social work
17	Awaiting completion of assessment
18	Assessment completed, awaiting funding authorisation
19	Awaiting domiciliary care package
20	Awaiting nursing home placement
21	Awaiting residential care placement
22	No appropriate placement available
23	Funding not available for nursing home, residential care or intensive home care package
24	Awaiting home adaptations/equipment
	Other
25	Family/carer decision (eg choice or financial refusal)
26	Awaiting multi-agency decision
27	Re-housing (LA responsibility) sheltered accommodation
28	Re-housing (LA responsibility) mainstream accommodation
29	Dispute between trust & HB over eligibility for NHS funded continuing care
30	Dispute between health & social work over responsibility to meet need

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Responsibility for the contents and conclusions rests solely with the Accounts Commission.

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