





## **ACKNOWLEDGEMENTS**

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The team would like to record its thanks for the unstinting cooperation it has been afforded over the course of this Review. Particular thanks go to all the staff from the NHS and local government in Wales, from the voluntary sector and from the Welsh Assembly Government, and colleagues in Scotland, who provided the team with all the documents and other information requested, and who made themselves available for interview. The WIHSC team cooperated closely with the Wales Audit Office, who conducted a linked study in Gwent, Cardiff, the Vale of Glamorgan and Carmarthenshire, and our particular thanks go to Gill Lewis, Rob Powell and Martin Gibson. Finally, the project benefited greatly from the cooperation and support throughout of Welsh Assembly Government officials, notably Jonathan Isaac, Carol Harris, Helen Jones, Julie Sinfield and Gaynor Williams.

Responsibility for the contents of the Review, of course, rests with the WIHSC team.

## **THE REVIEW TEAM**

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The Review was conducted, and this report written by Marcus Longley, Tony Beddow, Andrew Bellamy, Michelle Davies, Glyn Griffiths, Julia Magill, Andrew Scowcroft, Carolyn Wallace and Morton Warner, all from the University of Glamorgan. The team has considerable experience in conducting reviews and evaluations of many aspects of health and social care policy and service delivery, and individual members bring particular expertise in social work, clinical practice, provider and commissioner management, and strategy development.

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## CHAPTER 1

# BACKGROUND, TERMS OF REFERENCE AND APPROACH

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## A. BACKGROUND

### What are Delayed Transfers of Care?

- 1.1 Delayed transfers of care (DToC) have been acknowledged as a major cause of concern in health and social care for some time. In the context of this Review, they arise when hospital patients no longer need to remain where they are, but cannot leave because either
- there is as yet no agreement about where they should go, or
  - there is agreement, but a more appropriate care setting is not available.
- They are measured in terms of the numbers of patients delayed, and by the number of hospital bed days which they occupy.
- 1.2 A national database to monitor the extent of delayed transfers was introduced in Wales in April 2002, and continues (with modifications) to the present. Based on a monthly snap-shot census, it was designed to become a real-time reporting system to support local action to reduce delays, while also providing a reliable and consistent national picture of the problem. It also identifies the principal reasons for each delay, and is a key component in the overall performance management of both health and social services.

### Why They Matter

- 1.3 The NHS in Wales discharges about 500,000 people from hospital each year, of whom fewer than 10,000 (about 2%) are deemed to be 'delayed transfers of care'. However, such delays are a significant problem, for three main reasons:
- *Patient well-being*  
Patients who are ready to move elsewhere but are being delayed in hospital are likely to suffer adverse consequences as a result. These can range from anxiety and discomfort – both for the patient and their family – to more serious and longer-lasting physical and psychological harm, and even the potential that their capacity for independent living may be significantly reduced.
  - *Depriving others of care*  
Their occupancy of a hospital bed may deprive someone in greater need of that facility, with the potential for harm that this entails. In some parts of Wales, the level of delayed transfers has adversely affected NHS ability to deal with elective and emergency cases, and has imposed

considerable burdens on both NHS and social services staff as they endeavour to hasten patients' transfer to a more appropriate setting.

- *Inappropriate financial burden*  
Delayed transfers of care may lead to the agency caring for the delayed patient bearing the financial consequences of the delay, when the responsibility should lie elsewhere (for example, with social services or the patient themselves).

## **Where They Occur**

### *District General Hospitals – non-mental health*

- 1.4 DToC can occupy the acute beds of one of Wales' District General Hospitals, and in the majority of cases the patients concerned will be older people brought into the hospital as emergency or urgent medical admissions. Older patients who become DToC will usually occupy medical beds or beds assigned for the care of the elderly and, often, will need complex packages of care because of their medical and social needs. A small number of DToC arise in patients admitted for planned surgical care and requiring a period of recuperation which the patient and family could not, by themselves, manage at home. These may occupy beds intended to provide either for elective or emergency surgery cases. A few DToC will relate to younger patients needing specialist, post-District General Hospital care – for example trauma patients recovering from serious head injuries requiring ongoing specialist rehabilitation or care.

### *Mental Health and Learning Disabilities*

- 1.5 Patients with mental illness or learning disabilities can also be delayed in a setting for which they no longer have a need. They can occupy acute or assessment psychiatric hospital capacity, or learning disabilities settings, again denying these facilities to others and possibly receiving sub-optimal care.

### *Community Hospitals*

- 1.6 NHS Wales currently operates a number of Community Hospitals that support their local District General Hospitals in providing acute care. These vary in size and capability across Wales but across the piece they offer, either explicitly or implicitly, some or all of the following services:
- rehabilitation following injury or physical illness initially treated in a General Hospital;
  - admitting/assessment capability for General Practitioners cases where low level short term medical/nursing care is indicated;
  - continuing care;
  - end of life care;
  - social care.

*Earlier Work*

1.7 Over the years, considerable effort has been devoted to identifying and implementing good practice in relation to delayed transfers. For example, in 2004 a Circular - WHC (2004) 066/NAFWWC 46/2004 Guidance on the National Assistance Act 1948 (Choice of Accommodation Directions) - defined key principles on choice of accommodation at the time of discharge:

- that people should not go from acute care to a permanent placement in a care home, but instead there should be a period of rehabilitation;
- that permanent placement should not be rushed, and the needs of individual patients and carers should be properly considered;
- that where a move from an acute hospital to care home is essential, those moved should not be placed at a disadvantage;
- and that local policy on choice should be embedded in transfer of care procedures and should be made available to patients on admission.

1.8 Another Welsh Health Circular in 2005 (WHC (2005) 035) provides guidance on hospital discharge procedures. This identifies Unified Assessment – a common system to be used by all professionals involved in a patient's care – as the main way of ensuring that patients' needs are identified, agreed and acted upon in a timely manner. It recommends that discharge arrangements should be:

- covered by multi-agency policies;
- planned on or before admission by all relevant people;
- an ongoing process;
- patient centred;
- co-ordinated by a named person;
- look across all parts of the system;
- ensure all equipment and transport is in place on the day of discharge;
- delivered by trained staff.

The Circular requires that local protocols are in place covering

- agreed time standards;
- information sharing;
- information for GPs;
- carers' assessments;
- nursing assessments;
- assessments for homeless or inappropriately housed people;
- people with learning disabilities;
- helping vulnerable people;
- discharges taken against medical advice; and

- refusal to be discharged.

Commissioners were required to ensure services met identified needs.

- 1.9 Also in 2005, a Welsh Assembly Government *Report of the Interface between Health and Social Care for Wales in the 21st Century* examined issues of infrastructure. It called for the different information and communications technology systems of health and social services to be integrated as soon as possible, for the independent sector to be fully engaged in joint strategic service planning and commissioning, and for local partners (NHS and local government) to ensure that sufficient services were available to each locality, 24 hours a day 7 days a week, to meet the anticipated care needs of local residents.

### **Recent Work**

- 1.10 The summary above indicates something of the range of activity which has sought to address the problem of delayed transfers in recent years. During the course of this Review, two other important pieces of work were completed, the findings and recommendations of which form an important part of our review. In each case we have sought to ensure that we did not duplicate their work; rather the intention was to build on, and complement it.
- 1.11 The first was the work of the National Leadership and Innovation Agency for Healthcare Wales (NLIAH), which produced a report in July 2007 entitled *Six Steps from DToC to EToC* ('EToC' stands for effective transfers of care). This summarises the findings of a national self-assessment of discharge planning in Wales, and outlines areas for further attention. It provides a particularly timely and useful focus on the many operational and procedural aspects of the work of service providers and commissioners, and identifies areas of good practice. The Agency's work on this continues.
- 1.12 The second was the study of delayed transfers of care in Gwent, Cardiff, the Vale of Glamorgan and Carmarthenshire, carried out by the Wales Audit Office and published in November 2007. The Review Team worked closely with Audit Office staff to ensure that as far as possible the two pieces of work complemented each other, and that their findings on most of South East Wales and Carmarthenshire could be compared with our own on the rest of Wales.

### **Problems Posed, and Problems Revealed**

- 1.13 It has been frequently observed that delayed transfers of care are both a problem in their own right, and also a consequence of other problems. In other words, they both pose problems, and reveal them.

- 1.14 The problems they cause have been summarised above, and will be explored in more detail in this report. The problems they reveal are of two sorts. First, *inefficiencies* in the way people are supported, assessed, cared for, and discharged following stays in hospital. Second, inadequacies in the *supply* of the full spectrum of services and care settings which are needed to support people with varying degrees of vulnerability. Both are considered in the Review.
- 1.15 Tackling delayed transfers is therefore an important task. It requires input from a wide range of agencies – NHS, Social Services and Housing; from the professions, commissioners and suppliers, and the statutory, independent and third sectors. It also requires action to tackle some of the root causes which high levels of delay reveal – in terms of efficiency, and the adequacy of supply of appropriate services and care settings.
- 1.16 Delayed transfers are, of course, only a part of the wider problem of care in inappropriate settings – the objective is to provide the ‘right care, in the right place, at the right time, delivered by the right person’. Perhaps the most obvious other example is the admission to hospital when domiciliary or other care (if it had been available) could have prevented such admission. Inappropriate care is at least as serious as those caused by delays, but it is not the focus of this review.

### **Where Next?**

- 1.17 The terms of reference of this study are set out below. They should be seen in the context of where we now stand. The studies mentioned above, and many others, comprehensively describe most of the generic causes of delayed transfers. Our task, in a nutshell, was to capture the current position in Wales, with its various geographical and other variations, and to answer two related questions:
- If we know so much about what causes delayed transfers, why are they still such a big problem?
  - What should we do differently?

## **B. THIS REVIEW**

### **Terms of Reference**

- 1.18 This study was commissioned by the Welsh Assembly Government in June 2007, but has its origins in a debate and subsequent motion (NDM3295) passed by the National Assembly for Wales in November 2006. This instructed the Welsh Assembly Government to commission an independent review of delayed transfers of care which would make recommendations for both health service and social care settings to examine:

- (a) The ways in which acute hospital beds may be used more effectively.
- (b) How the wellbeing of patients ready for discharge can be promoted.
- (c) The development of joint or pooled budgets for healthcare and social services to improve co-ordination between local health boards and local authorities.
- (d) Whether there are sufficient social care places and appropriately trained staff available.

It also suggested that 'the review should consider whether it is necessary for the Welsh Assembly Government to compel local authorities and local health boards to pool budgets'.

1.19 This was translated into the following terms of reference by the Welsh Assembly Government as follows:

- To review the effectiveness of Assembly Government policies relating to delayed transfer of care through assessing practice within the NHS and local authorities, and to make recommendations, by considering:
  - The development of pooled budgets and other forms of partnerships for health care and social services to help to reduce delays and improve co-ordination between the NHS, and local authorities, and other partnerships; and whether the Assembly Government should compel the use of such arrangement;
  - What would be an appropriate data set, information collection and reporting system that adequately reflects the complexity of delayed transfers of care and supports collective ownership and response to the issues?
  - The context of delayed transfers, considering the adequacy of capacity within the system including:
    - the ways in which acute hospital beds, community and social care services may be used more effectively
    - and whether there are sufficient care places, domiciliary care packages, and appropriately trained staff available;
  - How the well being of patients ready for discharge can be promoted including the effectiveness of discharge review procedure;
  - The implications of choice.

The terms of reference were further condensed into four 'Lots', representing the main foci of the Review.

- 1.20 In June 2007 the Welsh Assembly Government commissioned the Welsh Institute for Health and Social Care (WIHSC) at the University of Glamorgan, to conduct the Review. This is the report of that review.

### **Issues of Methodology**

- 1.21 This section describes the approach adopted by the team, and explores the relevant methodological considerations.

### **Overall approach**

- 1.22 The Terms of Reference, and the detailed 'Lots' contained therein, provided a clear framework for the Review. In order to meet them, we synthesised the already published work on the causes of delayed transfers and approaches to their reduction, and then explored in Wales the extent, nature and causes of such delays, and how they might be further reduced. In broad terms, therefore, the approach combined a review of selected literature with data collection (from the multiple sources described below) and a more reflexive process with key informants, developing and testing different solutions as the Review progressed.
- 1.23 As the literature abundantly demonstrates (in Chapter 4), DToC result from a combination of factors specific to the assessment, care and discharge procedures for individual patients, together with a variety of wider structural, operational and cultural factors. This complexity presents several methodological challenges. In addition to the usual issues associated with gathering valid and reliable data, the Review had to ensure that the multiple factors were properly explored, and that the different perspectives on particular issues were understood and tested against all the evidence available.
- 1.24 In general, the Review proceeded according to plan, and the team was able to gather all of the data which had been required at the outset.

### **Data collection**

- 1.25 The data which inform this Review were gathered from a number of principal sources.

#### *Review of published literature on delayed transfers*

- 1.26 A review of the published and other literature on key aspects of the approach to delayed transfers of care in the rest of the UK, and in selected other countries was conducted. Our review concentrated on identifying recently published papers (2005-2007) on developments in the UK and a range of countries who are within the Organisation for Economic Co-operation and Development, known as OECD countries.

1.27 We used the following main sources:

- Policy documents produced by, or on behalf of, governments and statutory bodies;
- Policy documents published by organisations with an established record in the health and social policy field (for example the King's Fund);
- Press reports; and
- Academic journals.

1.28 As well as our own literature review, we also drew on a number of others previously undertaken on delayed transfers of care by researchers. We refer to these in more detail in Chapter 4. These earlier reviews provided material to comment on the theory and policy concerning delayed transfers of care prior to 2005.

1.29 In terms of the quality of the academic literature, we have referred to papers from peer-reviewed journals. The process of peer-review involves academics anonymously reviewing research submitted for publication to ensure that only articles of a sufficiently high standard are published in terms of the evidence presented and the conclusions drawn. The references provide an indication of the sources used.

1.30 In considering the strength of the evidence from which we draw conclusions and make recommendations, Chapter 4 indicates where evidence from the literature is robust and where the conclusions that can be drawn have to be more tentative.

#### *Review of statistical evidence in Wales*

1.31 The data derived from the Welsh monthly census of delayed transfers of care were subject to detailed analysis, and considered in conjunction with published data on relevant 'inputs' (e.g. levels of related expenditure) derived from the Local Government Data Unit, the Care and Social Services Inspectorate Wales (on the availability of care home beds), Wales Audit Office and other published sources as indicated in the text.

#### *Field work in selected localities in Wales*

1.32 The team conducted interviews with approximately 200 people in selected localities in Wales in October and November 2007. These were semi-structured, open ended, face-to-face interviews with key informants, derived from a common sampling frame (see Appendix 2), generally based around NHS Trusts and their associated LHB and local authority partners.

1.33 Because the Wales Audit Office was already conducting a study in Gwent, Cardiff, the Vale of Glamorgan and Carmarthenshire (see below), we agreed with the Welsh Assembly Government and Wales Audit Office that our two studies would be coordinated, and that WIHSC's fieldwork would be



concentrated in those parts of Wales not considered in detail by the work already done by the Wales Audit Office. We reviewed documentary evidence and conducted our own interviews in the other parts of Wales, as follows:

<b>Local Health Boards/ Local Authorities</b>	<b>NHS Trusts</b>
<p>Anglesey Bridgend Ceredigion Conwy Denbighshire Flint Gwynedd Merthyr Tydfil Neath and Port Talbot Pembrokeshire Powys Rhondda Cynon Taff* Swansea Wrexham</p>	<p>Bro Morgannwg Ceredigion Conwy and Denbighshire North Glamorgan North West Wales Pembrokeshire and Derwen Pontypridd and Rhondda* Swansea Wrexham</p>

*\*Limited fieldwork was conducted in these localities, and only to supplement work on similar projects that WIHSC had recently undertaken.*

- 1.34 Particular individuals corresponding to the sampling frame were identified locally by senior staff and, following discussion with the Review team, a final list of interviewees was agreed in each locality. Appendix 3 contains the full list of those who were interviewed or personally contributed to other aspects of the study. Interviews typically lasted from 45 minutes to two hours, were generally audio-recorded, and were a mix of either one to one discussions, and occasionally discussions with either two or three interviewees, depending on the individuals concerned and a variety of practical constraints. All interviewees were provided in advance with details of the Review’s terms of reference and approach, and an outline of the issues which we wished to explore. Written consent was obtained from all interviewees prior to the interviews. They were assured that the interviews would remain confidential to the team, and that all data would be fully anonymised.
- 1.35 The areas for exploration in the interviews, and the specific questions within them, were derived from our analysis of the published and grey literature, the local policy and other documentation (see below), and the analysis of the published statistics relating to that locality. A copy of the outline interview schedules is contained in Appendix 4; these were adapted for each individual interview to match the particular areas of expertise of each interviewee, whilst maintaining a common core set of questions to ensure comparability.

- 1.36 The interviewees provided the team with a rich account of the policy, practice and consequences of delayed transfers from their multiple perspectives, and also explored with the team some of the causal factors, and the ways in which further progress could be made in tackling such delays. They were thus both respondents and key informants.

*Review of documentary evidence from selected localities in Wales*

- 1.37 Key documentary evidence from the selected localities in Wales was also requested and reviewed. This focused on key aspects of service provision and management arrangements relevant to delayed transfers of care. The documentation provided a common dataset for each of the localities, to address each of the Review's terms of reference. This provided a useful source of data in their own right, and is reflected in the analysis contained in this report, and also informed the interview schedules for field work. Appendix 1 sets out the documents initially sought.

*Interviews with other stakeholders*

- 1.38 The fieldwork was supplemented by interviews with approximately 20 other 'key informants' (see Appendix 3), including relevant policy leads from the Welsh Assembly Government, and others with an all-Wales perspective on relevant aspects of delayed transfers of care and related matters (such as the Welsh Local Government Association and representatives of the voluntary and commercial sectors).

*Wales Audit Office study*

- 1.39 The similar study by the Wales Audit Office, referred to above, provided a set of data – quantitative and qualitative – which complemented that collected by the WIHSC team, to provide an all-Wales perspective. The methodological issues which this raised are discussed below.

*Field work in Scotland*

- 1.40 The team visited Scotland for three days in December 2007 to explore in more detail how policy on delayed discharges had been developed and implemented in that country. The Scottish experience was particularly relevant because of the substantial progress made there in reducing delayed transfers in recent years, and because the health and social care contexts in Wales and Scotland are broadly comparable – for example in terms of size, relationships between national government and local agencies, and attitude towards 'market'-based approaches in public policy. In addition to interviews with relevant Scottish Executive officials, the team visited five contrasting localities (Aberdeen, Dundee, Forth Valley, Edinburgh and West Lothian) to explore with local stakeholders how progress had been made locally, and to contrast experience with that found previously in the Welsh fieldwork.

### *Workshop*

- 1.41 A one-day workshop was held in January 2008 with 12 selected key informants, from social work, medical, nursing, voluntary and private sector backgrounds, facilitated by WIHSC, with whom emerging conclusions and recommendations were tested.

### **Analysis**

- 1.42 The data collected from the fieldwork in Wales and Scotland was subject to three levels of analysis. The first two were concerned primarily with assuring the quality of the fieldwork data; the third was used to generate hypotheses for further testing.
- 1.43 First, the content of each interview was reviewed immediately following the locality visit by the team of three which had conducted those interviews, using the audio recordings and their contemporaneous notes. This was to allow the team to test each others perceptions and to identify the emerging issues, to confirm consistencies and inconsistencies, and to identify any gaps (which were addressed subsequently by supplementary interviews). Each member of the visiting team was involved to ensure the reliability of the process. Second, the whole team reviewed the interviews as they progressed, in order to explore the emerging themes and to refine the interview schedules and selection of interviewees for subsequent fieldwork.
- 1.44 Finally, the team met regularly to explore possible hypotheses about causation and solution. This process was iterative. It typically began by considering the fieldwork data collected in the preceding period – which included the views of informants on how delays could be reduced – triangulating this with the published literature on approaches elsewhere, and other evidence (for example, the statistical data on levels of delayed transfer in particular localities, and the causes attributed by the data coding system). The team then explored the possible relevance and applicability of the different emerging approaches to reducing delayed transfers. Finally, the emerging understanding was shared, explored and further refined as the additional fieldwork was conducted. The final workshop provided a forum for exploring these emerging conclusions with a wider 'reference' group of professional staff involved in service delivery, and for considering their relative importance and possible inter-relationships.

## **Other methodological considerations**

### *Collaboration with the Wales Audit Office*

- 1.45 For the reasons set out above, the Review worked closely with the Wales Audit Office who had already begun a similar project examining delayed transfers of care in parts of South East Wales and Carmarthenshire. The terms of reference and the detailed methods of the two studies were not identical. The Audit Office study arose from its risk assessment in local government and NHS bodies in Cardiff, the Vale of Glamorgan and Gwent, coupled with the need to follow-up an earlier project in Carmarthenshire. They also considered the interaction of local factors with the Welsh Assembly Government's role in establishing the framework for local management of delayed transfers and the whole system. So the Wales Audit Office, for example, focused on a detailed consideration of progress in reducing delayed transfers in their selected localities, in the context of the risks posed to the NHS and local authorities concerned, whereas the WIHSC Review also looked at a variety of national and policy issues relevant to delayed transfers. WIHSC's Review was conducted as 'research', whereas WAO operated under the remit of 'audit'.
- 1.46 Both studies, though, were designed to explore the nature, extent and impact of delayed transfers, the adequacy of data collection systems and the data available, and the role that factors such as commissioning, operational and clinical management, and organisational and boundary issues could play in the reduction of delays. The result was that both studies explored a similar set of issues, a few months apart, using very similar approaches.
- 1.47 In terms of the detailed planning of the WIHSC approach, the team had access to the detailed results of the Wales Audit Office fieldwork throughout, and to their statistical analyses. These were considered in the context of the particular methods used by the Audit Office team, and the detailed focus of their audit, and provided a data set for our Review. The two approaches were very similar and both used a combination of statistical analysis and extensive fieldwork, involving similar stakeholders. In addition, the WIHSC team met with the Wales Audit Office team at the outset, to align approaches where appropriate; and they then met approximately monthly to explore and compare the emerging issues from the two studies, and to test the hypotheses emerging from the two sets of data in a process similar to the third stage of the Review's own analysis, as described above.

### *Fieldwork*

- 1.48 The conduct of fieldwork on this scale, and in such a constrained timescale (October and November 2007), inevitably poses challenges, which the team had to address. For example:

- Availability of interviewees – in many of the localities, it was not possible to ensure that all of the identified interviewees were available on the days the team visited. Subsequent interviews or telephone discussions were arranged where possible;
- Conduct of interviews – important issues of cultural sensitivity and effective interviewing technique are common in most work of this sort. All of the staff on the team had considerable experience of interviewing in the context of public service delivery, and well understood the cultural conventions which apply in such settings;
- Interviewer effect – in order to minimise the risk of individual interviewers having such an effect as to make data incapable of comparison, the quality assurance measures identified above were employed;
- Interviewee effect – many of those interviewed had particular interests in the outcome of the review: they were both informant and stakeholder. This was both a strength and a weakness, in that their first-hand knowledge of the issues was clearly of great help, but their vested interests might result in selective presentation of the evidence. The team addressed this during the interviews by various processes of test and challenge, and after interviews through the process of team review described in 1.43 and 1.44;
- Iteration – the fieldwork was designed both to elicit data on the extent and nature of the problem of delayed transfers, and to identify and test solutions. This carries the risk that the two roles will be confused, resulting in contamination of one or the other. The team was alert to this issue, and so conducted and structured the interviews to reduce the risk.

### *Ethics and Governance*

- 1.49 The research proposal was submitted to the Multi-Centre Research Ethics Committee for Wales, and was implemented in accordance with the terms of their approval. R&D approval was also sought and obtained from each of the NHS bodies which participated in the research.

### **Structure of this Report**

- 1.50 The remainder of this report is structured as follows:
- Chapter 2 reviews the statistical data on delayed transfers in Wales, looking at trends, geographical and sectoral variations, and compares this with the data on key aspects of the 'balance of care' required for timely transfers;
  - Chapter 3 reviews current policy on DToC and associated issues in Wales.
  - Chapter 4 reviews the problems associated with delayed transfers of care across OECD and in the rest of the UK;
  - Chapter 5 reports the evidence gathered during the course of this study on the impact of delayed transfers on patient well-being, on the

sufficiency of capacity in Wales to care for people in differing circumstances, and the extent to which patient transfers are managed efficiently;

- Chapter 6 considers the evidence gathered on the impact of joint working between the different statutory agencies and providers, and with the independent and third sectors, and on the role which linked financial and other mechanisms could play in improving it;
- Chapter 7 considers how information is collected and used to improve the transfer processes, how assessment processes are being managed, and the extent to which staff are equipped and supported in their various roles;
- Chapter 8 draws on the evidence and discussion of the preceding chapters to highlight areas for improvement and further development, and makes specific recommendations.

1.51 Case studies are included in the report to illustrate interesting examples of local developments which, in their different ways, seek to address aspects of the DToC problem.

## CHAPTER 2

# AN OVERVIEW OF DELAYED TRANSFERS OF CARE IN WALES

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### A. INTRODUCTION

2.1 This Chapter describes the scale of the problem of delayed transfers of care in Wales and explores the reasons behind these delays. Using data from the Welsh Assembly Government, the Wales Audit Office, the National Leadership and Innovation Agency for Healthcare, (NLIAH) and the WIHSC team's own research, we look at trends in the number of people experiencing delays and the length of time that they are delayed, at a national, regional and local level. Using information concerning the reasons for delays we consider whether there is a consistent picture across the whole of Wales, or whether different issues are affecting different locations. In this chapter, we indicate where available capacity in health, social care and independent settings may be helping to reduce delays, or may be contributing to causing them. In Chapter 5 we go on to look at capacity issues in more detail by commenting on supply and demand in relation to:

- support for people at home;
- supported housing (for example sheltered housing);
- residential and nursing home places; and
- the workforce.

2.2 As we will demonstrate in later chapters of this review, fundamental to achieving smooth transitions for people between different kinds of health and social care is that there is effective partnership working between all of those involved. This includes people who have health or social care needs, their carers and families, and local authorities, LHBs, NHS Trusts, and voluntary and private sector organisations. The characteristics of partnerships that work well across the whole system are considered in more detail in Chapters 4 and 6. Consideration of issues concerning the well-being of patients faced with transitions between care settings and the effect of the choices that patients, carers and families make are explored in Chapter 5. In this chapter we refer both to the effectiveness or otherwise of partnership working and issues around patient choice where they have an impact on the number of, or length of, delays.

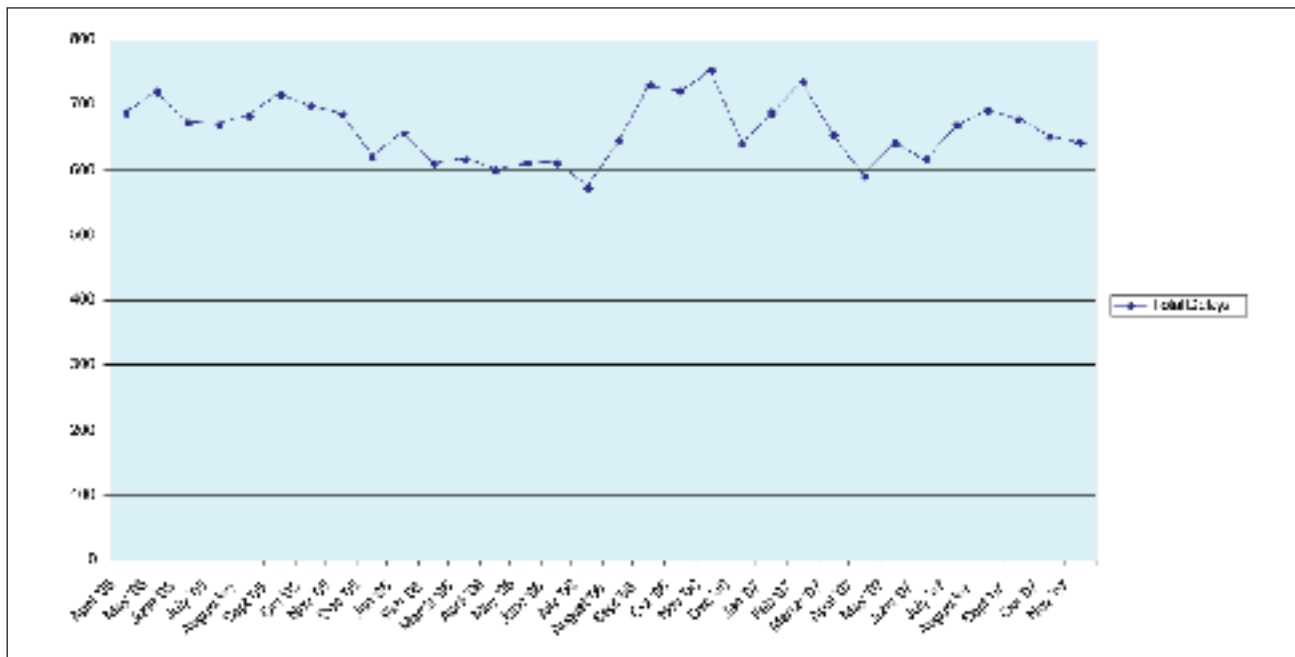
## B. TRENDS IN DELAYED TRANSFERS OF CARE

### National Trends

#### The number of delayed transfers

2.3 The overall pattern of the number of people experiencing delayed transfers of care in Wales between April 2005 and November 2007 is shown in the graph in Figure 2.1.<sup>1</sup>

**Figure 2.1: Trend – Number of Delayed Transfers of Care in Wales from April 2005 to November 2007**



Source: WIHSC analysis of Welsh Assembly Government data

2.4 In a Wales Audit Office (2007) report about tackling delayed transfers of care published in November 2007, it was noted that there had been a substantial decrease in the number of delayed transfers of care in Wales from 1116 in September 2003 to 642 in May 2007, (a fall of 42%).

2.5 Data available since the Wales Audit Office carried out their analysis shows that between May and November 2007, after an increase to 692 delays in August 2007, the trend was once more downwards. By November the number of delays was 643. The latest available figures at the time of writing are for December 2007 (Welsh Assembly Government 2008). These show a further decline to a total of 621.

#### The number of days of delay

2.6 At the time of the Wales Audit Office report, although the total number of people delayed had declined, the overall number of days spent in hospital by people subject to delayed transfers in care appeared to be increasing. This is

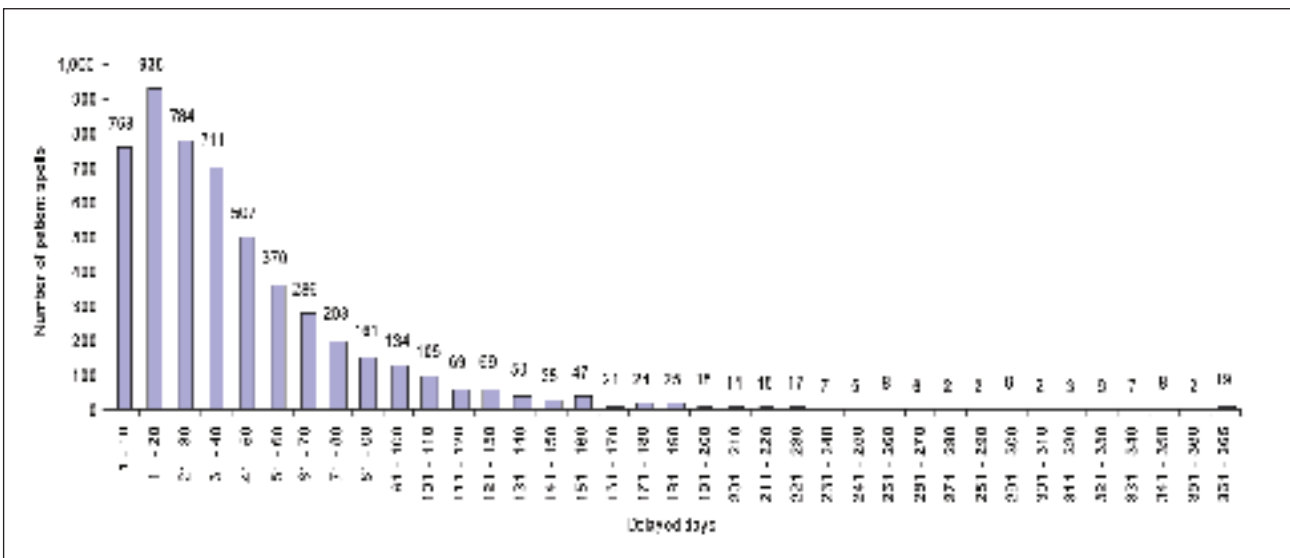
<sup>1</sup> Data excludes Welsh residents in English Hospitals, non Welsh residents in Welsh Hospitals, those of no fixed abode, and those for whom there is no postcode.



measured by the number of ‘bed days’ associated with each patient who is being delayed. The Wales Audit Office reported that the number of bed days attributed to delayed transfers of care had gone up by 2% when comparing 2005-2006 with 2006-2007.

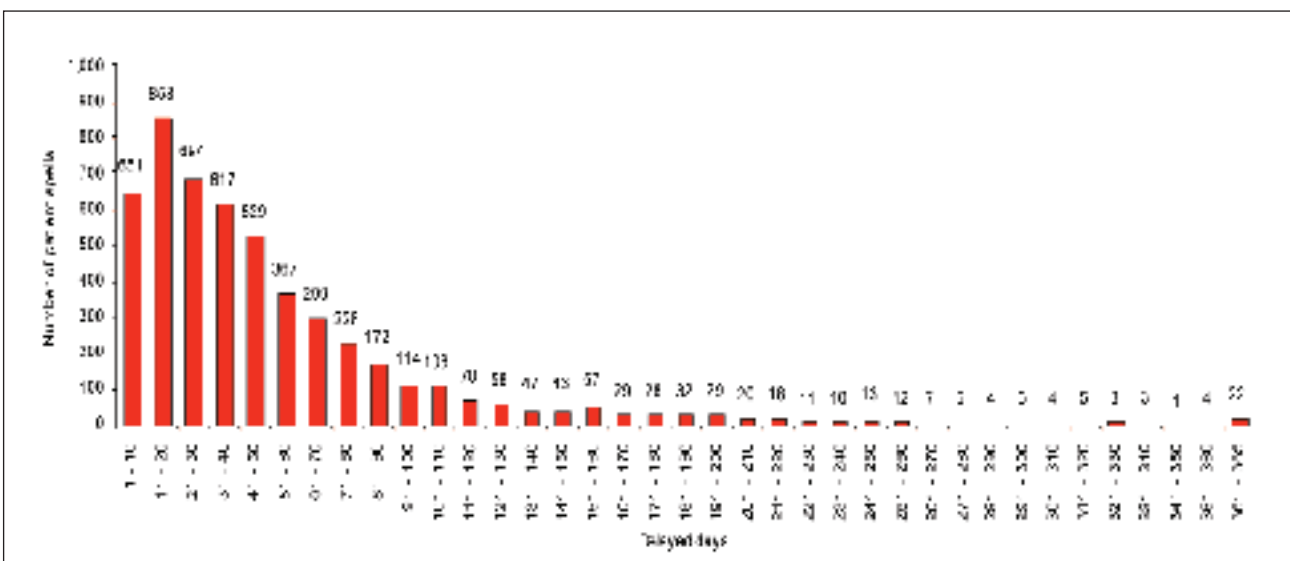
2.7 The number of bed days as a measure does not fully convey the impact of delays for individual patients; for example five days delay could represent five patients waiting one day or one patient waiting five days. Figures 2.2 and 2.3 use patient spells to demonstrate how long patients were in hospital unnecessarily in 2005-2006 and 2006-2007.

**Figure 2.2: Number Of Patient Spells In 2005-2006 That Experienced A Delayed Transfer Of Care**



Source: Wales Audit Office

**Figure 2.3: Number Of Patient Spells In 2006-2007 That Experienced A Delayed Transfer Of Care**



Source: Wales Audit Office

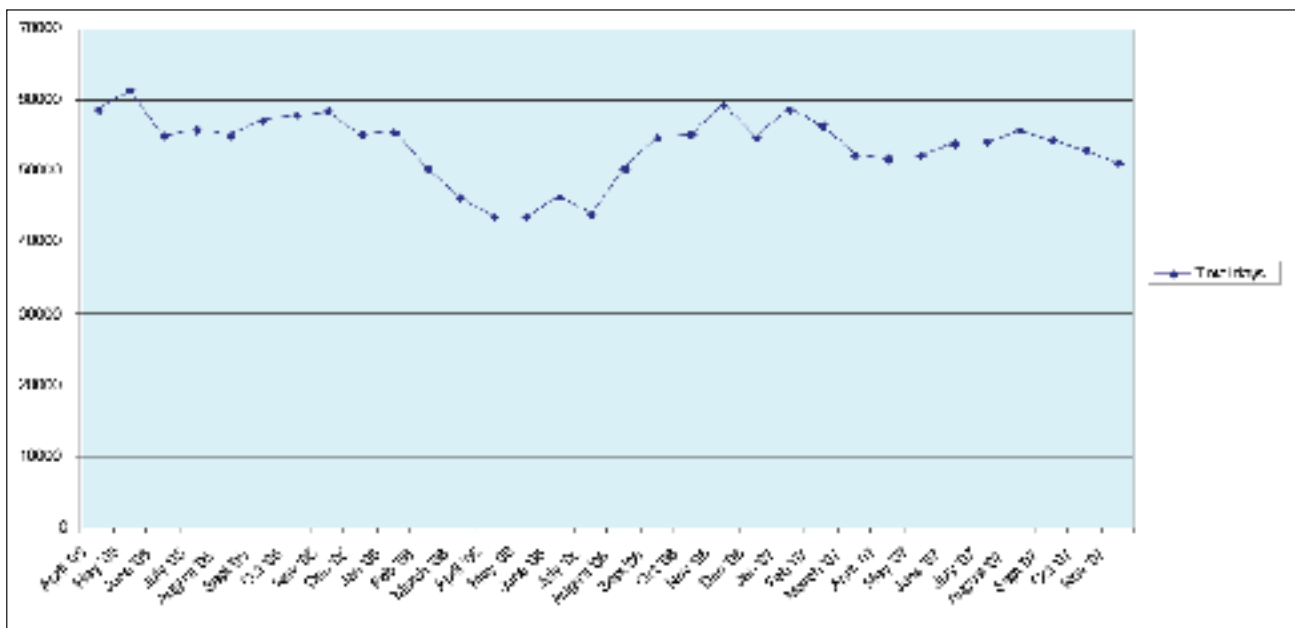
2.8 Figures 2.2 and 2.3 show that there were significant numbers of delayed days that were affecting a small number of patients.

2.9 In Figure 2.3 the following emerges:

- 57.4% of those delayed were delayed for more than 1 month;
- 28.2% of those delayed were delayed for more than 2 months;
- 14.7% of those delayed were delayed for more than 3 months;
- 214 of the delayed patients had been in hospital beds unnecessarily for more than 6 months.

2.10 More recent data suggests that the upward trend in the bed days taken up by delayed transfers reported by the Wales Audit Office has passed and that as with the number of delayed transfers, the trend in the number of bed days is also heading downwards, as shown in Figure 2.4.

**Figure 2.4: National Trend – Number Of Bed Days Occupied Because Of Delayed Transfers Of Care In Wales – April 2005 To November 2007**



Source: WIHSC analysis of Welsh Assembly Government data

2.11 Nonetheless, as discussed in Chapter 5, there are potentially adverse consequences for patients experiencing delays, so 57.4% of those patients experiencing delays being delayed for more than a month, gives cause for concern.

2.12 The upward trend in the number of delayed transfers and the number of bed days occupied because of delayed transfers in Wales during part of 2007 was in the context of an increase in the number of delayed transfers also being experienced elsewhere in the UK. There was a slight increase in Scotland with 425 delays being recorded in October 2007 compared with 423 in July 2007. (ISD 2007b, ISD 2007c). In England the number of bed days associated

with delayed transfers had gone up by 30% when comparing 2005-2006 with 2006-2007 (Gainsbury 2007). By contrast, the trend in Wales since September 2007 has been of decreasing numbers of patients delayed and a decrease in the number of bed days being identified each month as associated with delays.

- 2.13 Despite the targeting that has been directed towards delayed transfers, the overall picture, however, is that after a steep initial fall of 38.2% in the number of delayed transfers of care from September 2003 to April 2005, between April 2005 and November 2007, whilst the numbers have fluctuated, the national trend is essentially a straight line.
- 2.14 In other words Wales is overall doing no better or worse by the end of 2007 than it was in 2005.

### **The reasons for delays – a national picture**

- 2.15 The Review team commissioned a statistical analysis of the data to establish whether there were statistically significant links between delayed transfers of care and other variables.
- 2.16 Some correlations that might have been expected intuitively, for example, between the number of delayed transfers and the rate of medical admissions, could not be established statistically at the national level.
- 2.17 In only two instances was some correlation found between delayed transfers and particular variables. These were:
- Total personal social services expenditure/1000 population aged 65 and over; and
  - Rate of older people (aged 65 and over) helped to live at home per 1000 population aged 65 and over.
- 2.18 However, further analysis could not establish that even these correlations were significant enough to have statistical value. Consequently, no statistically significant correlations were found that linked delayed transfers with particular issues that could be said to apply throughout Wales.
- 2.19 This does not imply that variables including:
- Referral rates;
  - Elective and emergency admission rates ;
  - Capacity in social care settings;
  - Capacity in NHS Trusts;
  - Financial resources.

are not important at the local level. What we cannot say from the data is that any single variable, or set of variables are equally important in all areas across Wales.

- 2.20 As we will discuss in Chapter 4, evidence from the rest of the UK, and elsewhere in the world is that there are many factors that play a part in creating delays. The issues affecting delays in one community will not necessarily be the same as those affecting delays in another community. Differences in capacity, for example, the availability of residential and nursing home places, varies from place to place (see Figures 2.15-2.19 later in this chapter).
- 2.21 The national picture, therefore, is best understood as a collection of local issues.

### **Local trends**

- 2.22 Overall responsibility for commissioning health and social care services in Wales that meet the needs of local communities rests with local health boards and local authorities. Services should be commissioned so that the transitions between health and social care settings and services are managed in a way that minimises delay, as part of the whole system of health and social care locally. We have, therefore, looked at local trends principally from the perspective of local authority/ local health board areas. Whilst delayed transfers are recorded in hospital settings, patients are on the whole admitted to hospitals from the local community and return to that community.
- 2.23 Nonetheless, NHS Trusts are adversely affected by delayed transfers of care. The effect of delays is to limit their capacity to provide care for patients needing acute hospital care because of other patients who no longer need acute care being delayed.
- 2.24 Table 2.1 represents a mixed picture, but one which indicates that in the month for which we have the latest figures, about 1 out of every 25 beds was being occupied at any one time by a patient who no longer requires hospital care. In Powys, 33 delays recorded in November 2007 meant that 1 out of every 10 beds was affected that month. The relatively small number of beds in Powys (327), however, means that relatively small changes in the total number of people delayed has a big effect on overall availability. For example, in July 2006 20 delays were recorded in Powys with an overall percentage of beds affected of 4.9%. (Source: Statswales 2007)

**Table 2.1: NHS beds Occupied By DToC Patients In November 2007, As Percentage Of Total Available Beds**

	Nov 2007
<b>All Trusts</b>	<b>4.1</b>
<b>Mid and West Wales</b>	<b>4.9</b>
Bro Morgannwg	5.5
Carmarthenshire Trust	6.8
Ceredigion and Mid Wales	2.3
Pembrokeshire & Derwen	0.3
Powys Healthcare	10.0
Swansea Trust	4.2
North Wales	2.1
Conwy & Denbighshire	1.2
North East Wales	2.7
North West Wales	2.3
South-East Wales	4.6
Cardiff & Vale	4.3
Gwent Healthcare	5.3
North Glamorgan	5.6
Pontypridd & Rhondda	2.9
Velindre	0.0

Source: STATSWALES

<http://www.statswales.wales.gov.uk/TableViewer/tableView.aspx>

2.25 Table 2.2 gives an indication of the impact of delays on different kinds of care. The highest totals for acute services are found in Cardiff, with Swansea not far behind. Despite the relatively high number of overall delays in Gwent, the effects on acute services there are amongst the lowest in Wales. This can be partly attributed to the relatively higher availability of community beds than in other areas. By comparison, the availability of community beds in Cardiff is lower and so there is less flexibility in managing the flow of transition between one type of care and another. Cardiff also has an evident problem with delayed transfers in mental health services and rehabilitation.

Table 2.2: Summary Of Delayed Days In Welsh NHS Trusts By Care Category For 2006/2007

<b>NHS Trust</b>	<b>Acute</b>	<b>Community</b>	<b>Mental Health</b>	<b>Other</b>	<b>Rehab</b>	<b>Total</b>
Bro Morgannwg	6,203	6,540	3,318	133	0	16,194
Cardiff & Vale	18,631	2,691	27,203	9,228	19,760	77,513
Carmarthenshire	6,785	334	121 *	0	8,513	15,753
Ceredigion & Mid Wales	344	2,267	24	0	0	2,635
Conwy & Denbigh	857	2,352	1,392	0	0	4,601
Gwent Healthcare	924	27,511	9,803	0	6,218	44,456
North East Wales	4,496	2,366	2587	0	6197	15,646
North Glamorgan	5,136	4,653	4,560	482	0	14,831
North West Wales	1,814	3,707	3,855	0	2,067	11,443
Pembs & Derwen	1,899	738	6,241	0	866	9,744
Pontypridd & Rhondda	846	6,504	6,872	0	0	14,222
Powys	2,091	3,190	2,626	1,737	327	9,971
Swansea	10,387	6,092	5,080	67	9,509	31,135
Velindre	0	0	0	336	11	347
<b>Total</b>	<b>60,413</b>	<b>68,945</b>	<b>73,682</b>	<b>11,983</b>	<b>53,468</b>	<b>268,491</b>

Source: WIHSC adaptation of Wales Audit Office analysis

\* Carmarthenshire Trust has no designated mental health beds but the figure included here, derived from a Wales Audit Office analysis, apparently refers to patients in non mental health beds who are awaiting placement in a care home with the capacity to accept patients with dementia.

2.26 Looking at data on delayed days in NHS Trusts by care category from 2003-2004 to 2006-2007, the causes of delays have proportionately changed little over the last 4 years. Patient/carer/family reasons continue to be the cause of almost half of the total number of delays. The number of delays categorised as being caused by “disagreements” has risen steadily, with patient/carer/family choice still being the largest contributor to the number of delays.

2.27 It should be noted that overall the largest total number of bed days associated with delays occurs in mental health services. The interviews conducted throughout Wales certainly confirmed that transferring people with mental health problems from hospital into other care settings was one of the most difficult components of managing delays. Both the literature review (Chapter 4) and the results of our field work (Chapters 5, 6 and 7) suggest that there may be significant under-reporting of delays, and that this may be a particular problem in relation to mental health services. If a safe service offering an alternative to hospital care is not in place, then those with mental health problems, (or those with learning disabilities) are not necessarily recorded as being delayed.

2.28 Whilst NHS Trusts have an important role to play through the effective and efficient management of the aspects of delay for which they have responsibility (we discuss their role in relation to discharge planning and management in more detail in Chapter 5) they are only one part of a complex jigsaw.

## **Local authority/local health board areas**

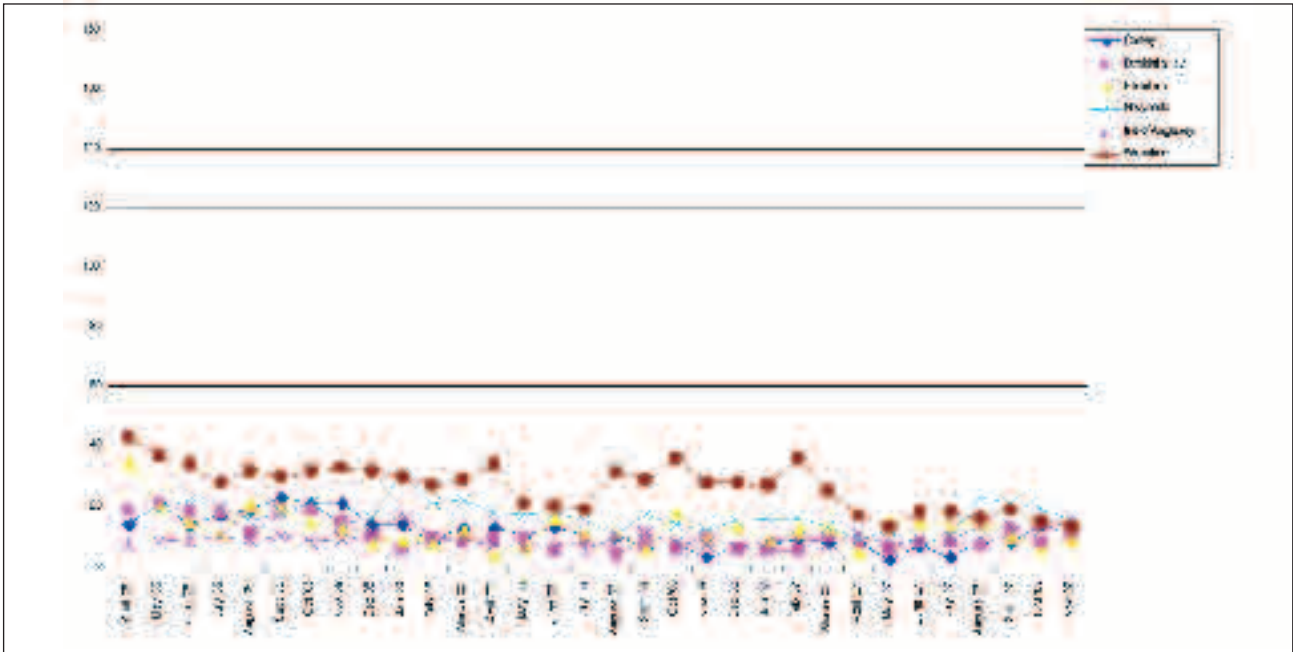
2.29 In analysing the trends affecting local authority/ local health board areas, the following four graphs for North Wales (Figure 2.5) South West, Mid and West Wales (Figure 2.6) Gwent (Figure 2.7) and South East Wales (Figure 2.8) show that the trends in delayed transfers of care regionally and for each local authority/local health board area are not uniform. We have divided the local authority/ local health board areas into geographical groups, partly to explore whether there are regional differences and partly so that the trend for each individual local authority/ local health board area is legible. So that the trend in each area is directly comparable with all other areas, a scale of 0 - 180 has been used for the vertical axis of each of the graphs. In order to begin to explain the regional and local differences we comment from three different perspectives:

- analysis of the quantitative data;
- drawing on our qualitative research through which local conditions have been explored, (referred to as fieldwork and discussed more fully in Chapter 5); and
- referring to issues and themes from our review of the literature (Chapter 4).

## **North Wales**

2.30 The trend in North Wales (Figure 2.5) is quite different from the national trend shown in Figure 2.1. The trend in the North has been downwards and appears to be flattening out with relatively low numbers of delays, (less than 20 in each area per month) being recorded by all local authority/local health board areas in North Wales by November 2007. Having had higher numbers of delays for much of the period shown in Figure 2.5, the trend in Wrexham is now aligned with the other areas of North Wales. The availability of high quality residential and nursing homes (identified in our field work and the relatively high number of residential and nursing home places for people over 65 in North Wales (see Figure 2.18) appear to be important factors.

**Figure 2.5: North Wales: DToC – April 2005 To November 2007, Number Of Patients**

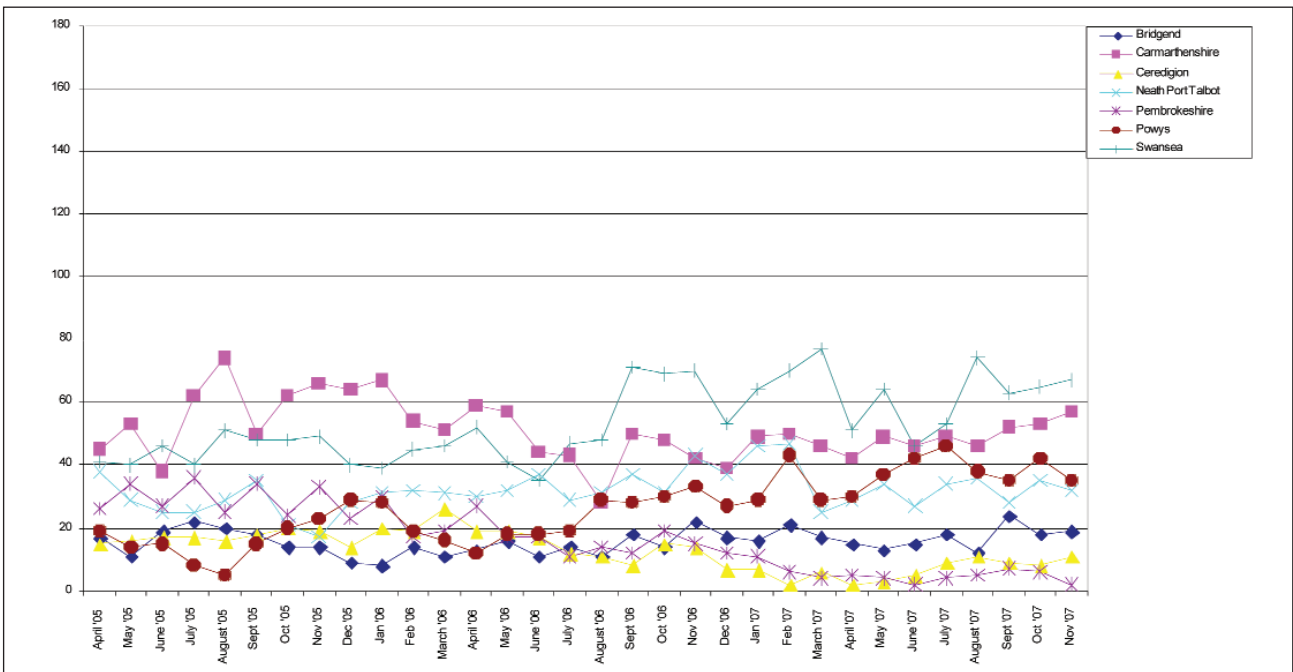


Source: WIHSC analysis of Welsh Assembly Government data

South West, Mid and West Wales

2.31 The position in South West, Mid and West Wales (Figure 2.6) is more mixed with Bridgend, Ceredigion, and Pembrokeshire being broadly comparable with the picture in North Wales, but Swansea and Carmarthenshire going against the national trend with an upturn in the number of delays towards the end of 2007.

**Figure 2.6: South West, Mid And West Wales DToC – April 2005 To November 2007, Number Of Patients**



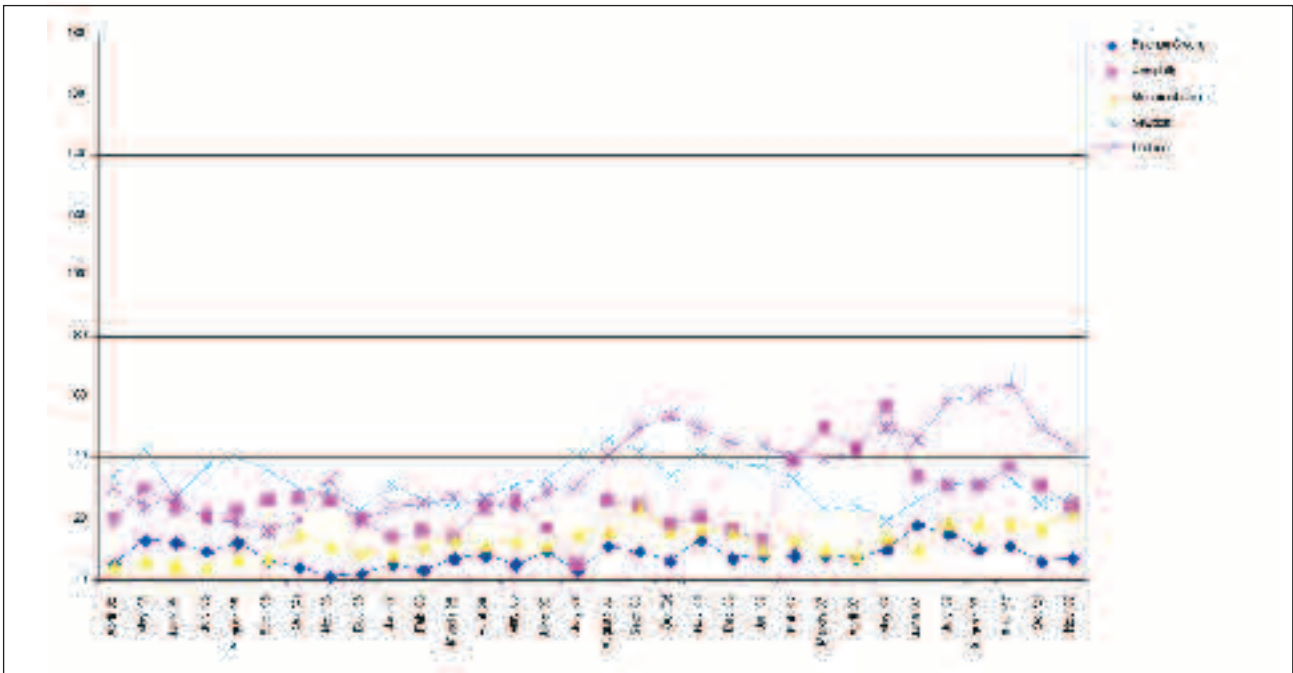
Source: WIHSC analysis of Welsh Assembly Government data



## Gwent

2.32 In Gwent (Figure 2.7) the trend in Blaenau Gwent and Monmouthshire is similar to that in North Wales, but Newport, Caerphilly and Torfaen have all experienced peaks at various points over the period shown. Monmouth and Newport are showing indications of going against the national downward trend towards the end of 2007.

**Figure 2.7: Gwent DToC – April 2005 To November 2007, Number Of Patients**

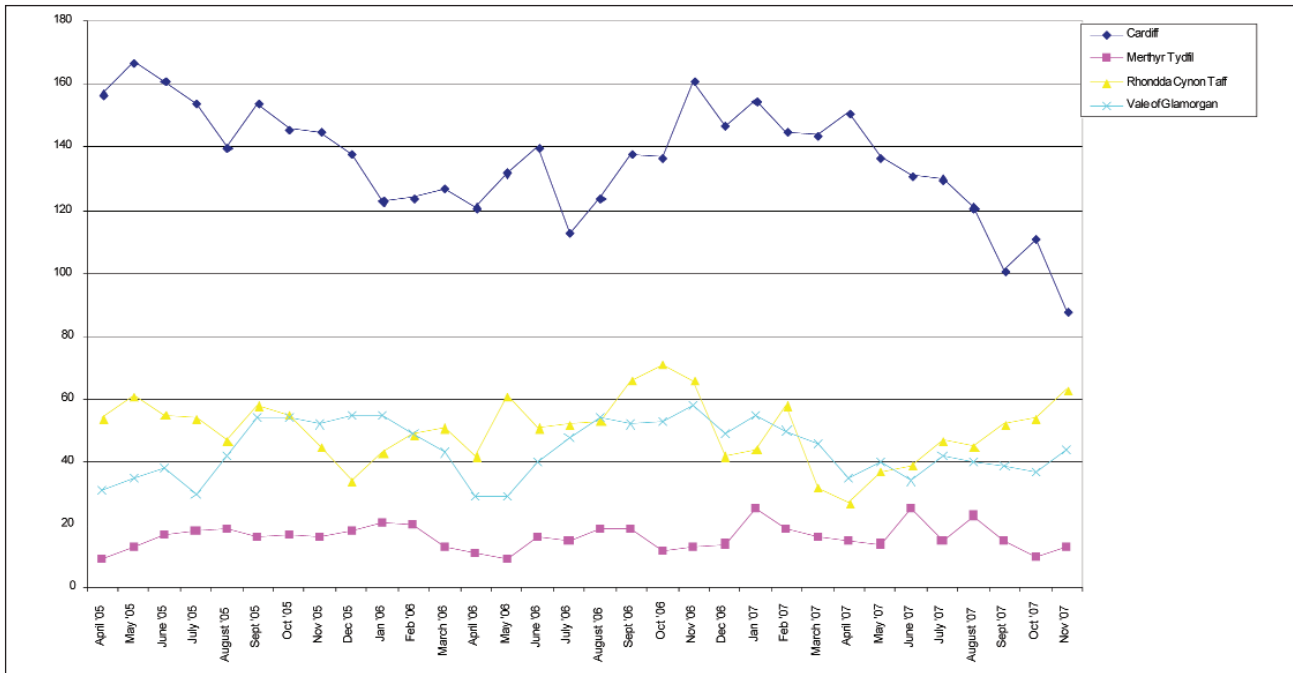


Source: WIHSC analysis of Welsh Assembly Government data

## South East Wales

2.33 In the South East (Figure 2.8), the trend in Merthyr Tydfil is closest to that of the North Wales authorities. The trend in Rhondda Cynon Taff is upwards from March 2007 onwards and is against the downturn in the national trend at the end of the year. Having peaked in November 2006, the trend improved in the Vale of Glamorgan but from October 2007 looks as though it may be heading upwards again. The trend in Cardiff most closely mirrors the national trend, but given the relative size of the Cardiff population it is unsurprising that the Cardiff position was influencing the overall trend nationally.

**Figure 2.8: South East Wales DToC – April 2005 To November 2007, Number Of Patients**



Source: WIHSC analysis of Welsh Assembly Government data

**Relative performance in relation to population size**

2.34 In Figure 2.9 we have taken account of the population size of each of the local authority/local health board areas in Wales to look at the performance of each locality relative to its total population size. The local authority/local health board areas are shown in Figure 2.9 numbered in alphabetical order as follows.

1= Blaenau Gwent	7= Conwy	13 = Momouthshire	19 = Swansea
2= Bridgend	8= Denbighshire	14 = Neath Port Talbot	20 = Torfaen
3= Caerphilly	9= Flintshire	15 = Newport	21 = Vale of Glamorgan
4= Cardiff	10= Gwynedd	16 = Pembrokeshire	22 = Wrexham
5= Carmarthenshire	11= Isle of Anglesey	17 = Powys	
6= Ceredigion	12= Merthyr Tydfil	18 = Rhondda Cynon Taff	

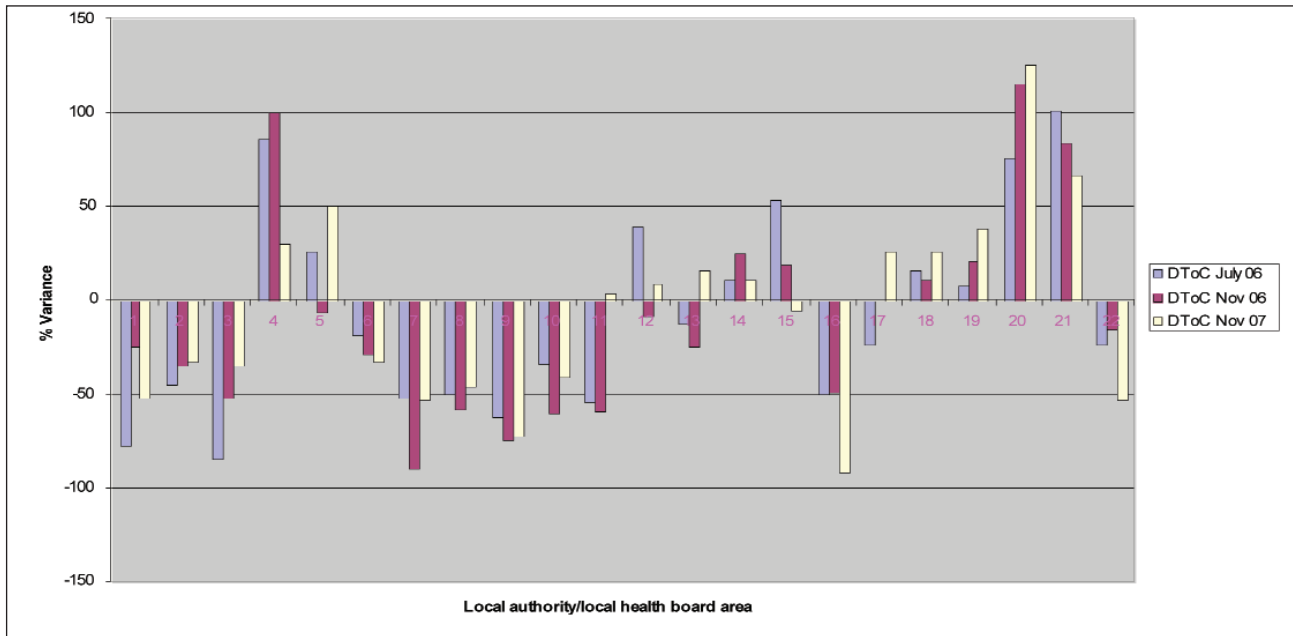
2.35 We have contrasted performance for:

- July 2006, (the month with the lowest number of delays between April 2005 and November 2007 on national trends);
- November 2006, (the month with the highest number of delays between April 2005 and November 2007 on national trends); and
- November 2007 (the most recent month for which we had data at the time of this analysis).

2.36 For each of the three months we took the total number of delays for that month. We then took the actual number of delays each local authority/ local health board area had experienced and compared this with the number of delays within the total for Wales that would have been in proportion to their

relative population size. Figure 2.9 shows how far in percentage terms their actual performance varied from the number of delays that would have been anticipated, taking into account population size.

**Figure 2.9: Performance On Number Of DToC Proportionate To Total Population Size**



2.37 Looking at the figures from this perspective indicates that the North Wales local authority/local health board areas all perform relatively better than 'expected' whereas there are relatively more problems with the number of delayed transfers in Cardiff, Torfaen and the Vale of Glamorgan than in other areas.

2.38 This way of looking at the data reflects the actual number of delayed transfers recorded in July 2006, November 2006 and November 2007, respectively. It should be considered as illustrative of how areas are tending to over or under perform, rather than any inference being drawn that any area already has delayed transfers of care down to an irreducible minimum; for example, despite better than average performance, there were still 74 delayed transfers recorded in North Wales in November 2007.

2.39 Given the fairly consistent differences in relative performance shown in Figure 9, we now explore the different reasons for delay to see if this could start to explain these differences and to suggest how delays might best be tackled.

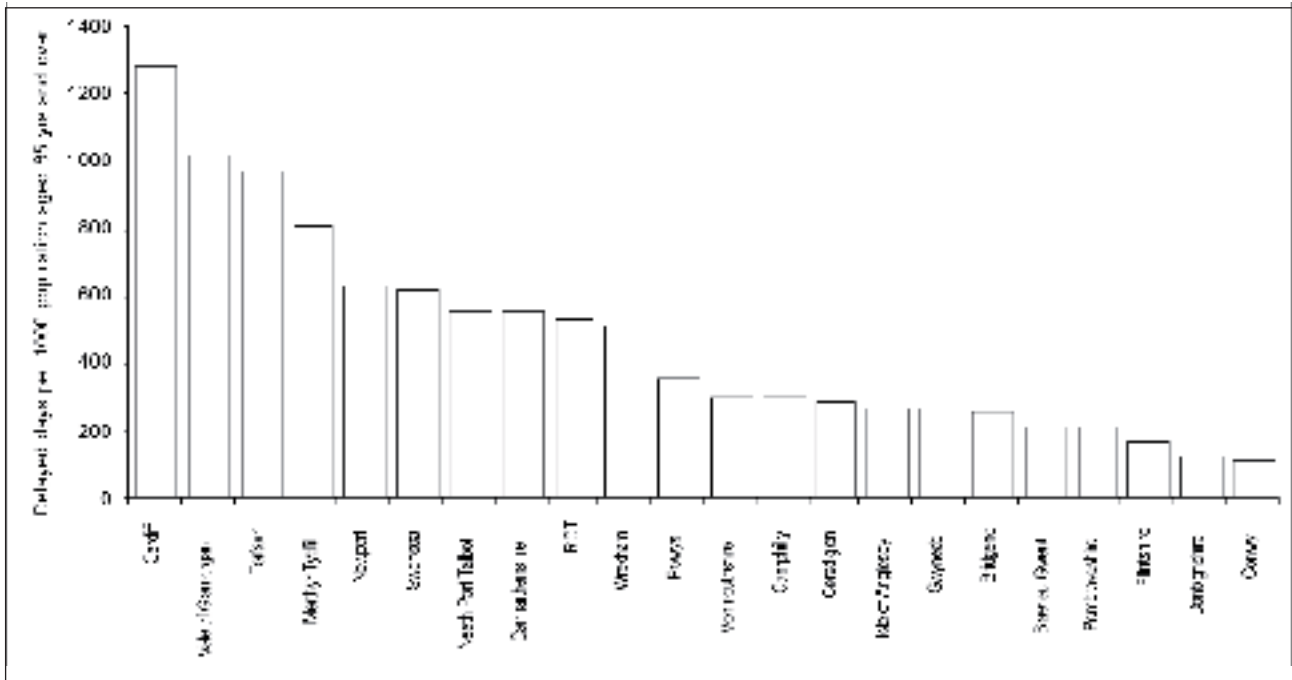
**The reasons for delayed transfers of care at the local level.**

2.40 Data submitted to the Welsh Assembly on delayed transfers of care is coded to indicate the reason for the delay. These codes are grouped and presented as graphs, (Figures 2.10, 2.11, 2.12 and 2.13) showing the three broad categories of reasons for delay:

- social care reasons;
- healthcare reasons; and
- patient/family/carer related reasons.

- 2.41 Because these graphs record the reasons for delay as a rate (delayed days per 1000 population aged 65 and over) they take into account the varying size of authorities and therefore show the relative performance in each local authority/ local health board area.
- 2.42 The overall picture by local authority/ local health board area for 2006/07 is as shown in Figure 2.10.

**Figure 2.10: Delayed Days For Local Authority/Local Health Board Residents In 2006/2007 For All Reasons Per 1,000 Population 65 And Over**

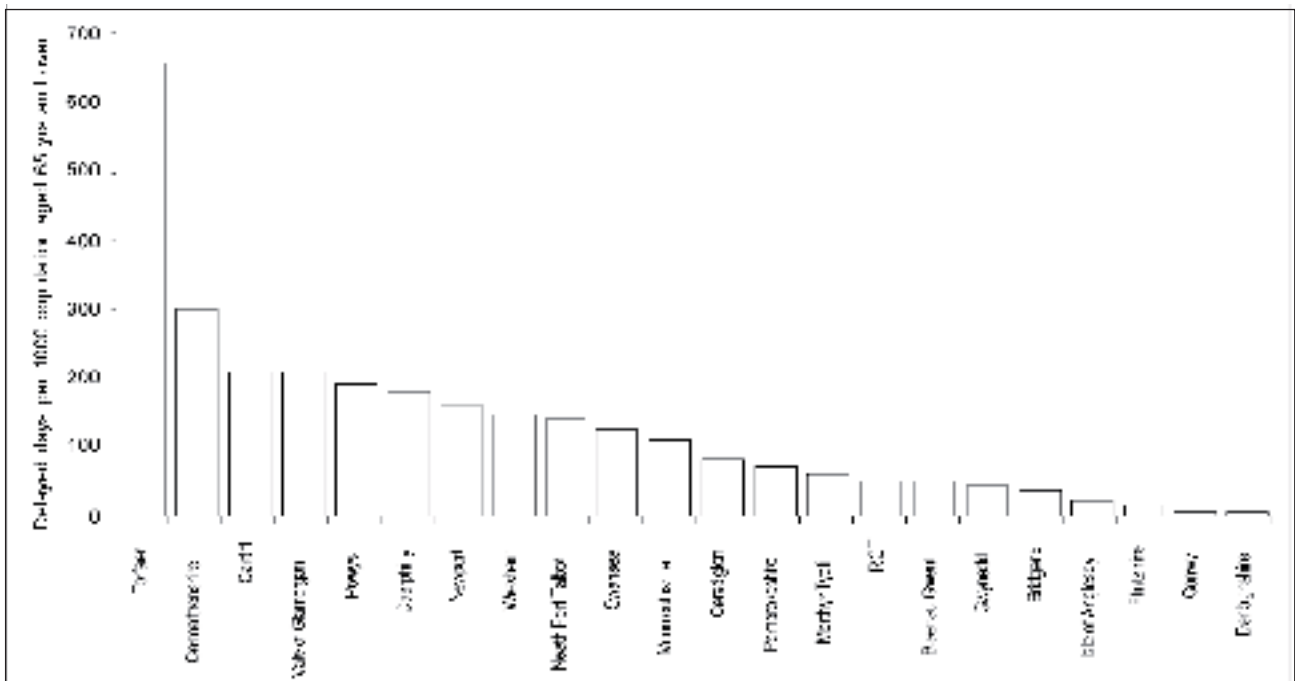


Data: Health Solutions Wales 2007 Analysis; Wales Audit Office

- 2.43 Figure 2.10 is based on data from the beginning of April 2006 to the end of March 2007 and shows the days delayed per 1000 of the population aged over 65 in each area. Figure 2.9 is based on the number of delays in relation to the size of the total population in each area and includes later data from November 2007. This means that Figures 2.9 and 2.10 are not directly comparable. It is interesting to note, however, that in terms of absolute numbers of delays (Figures 2.6, 2.7 and 2.8) and relative performance (Figure 2.9), for two out of three of the months shown in Figure 2.9, Carmarthenshire, Newport, Rhondda Cynon Taff and Swansea all fared worse than Merthyr Tydfil. Figure 2.10, would suggest, however, that Merthyr Tydfil's problems with delays are relatively worse than those in Carmarthenshire, Newport, Rhondda Cynon Taff and Swansea. Caution is therefore needed in identifying which areas are faced with the most significant problems with delayed transfers.

- 2.44 Figures 2.11 – 2.13 demonstrate that there are different reasons for delays arising with differing frequency in different areas.
- 2.45 Figure 2.11 illustrates the very significant problems in Torfaen related to the provision of social care to support people in a way that prevents or minimises them being delayed in hospital. For the period shown, Torfaen was recording more than twice the rate of delayed days per 1000 population 65 and over of any other area in Wales.

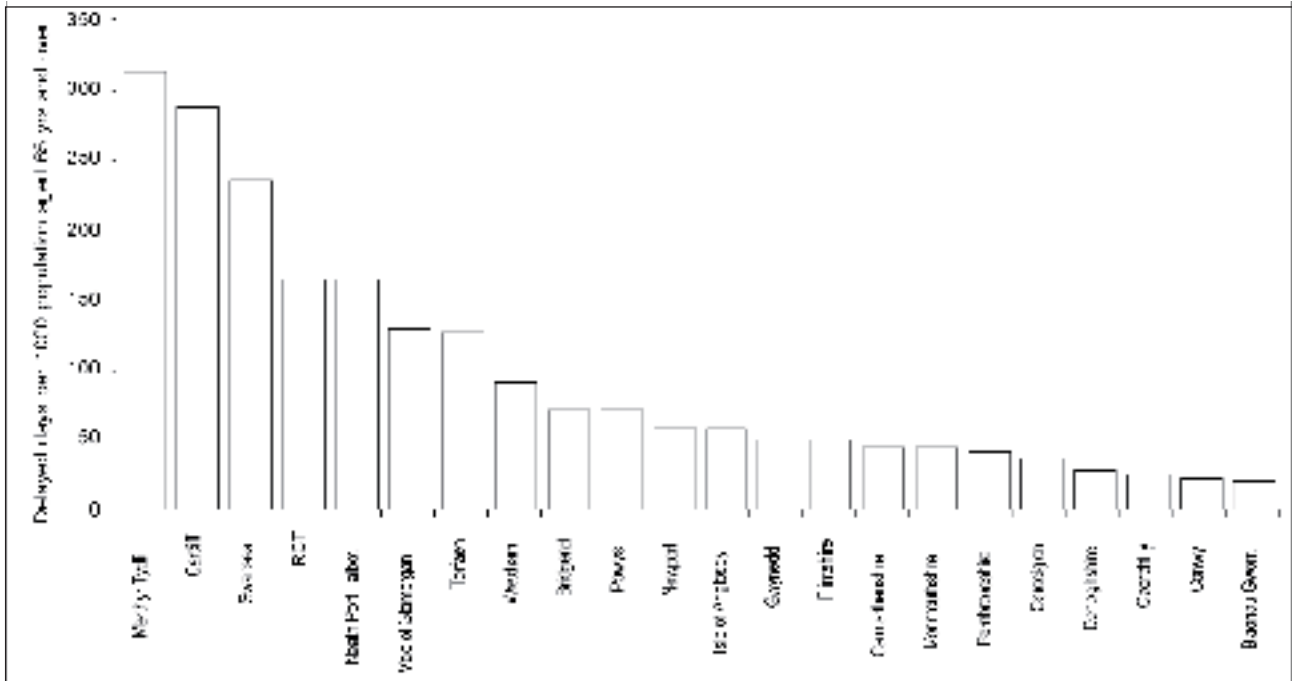
**Figure 2.11: Delayed Days For Local Authority/Local Health Board Residents In 2006/2007 For SOCIAL CARE Reasons Per 1,000 Population 65 And Over**



Data: Health Solutions Wales 2007 Analysis; Wales Audit Office

- 2.46 Figure 2.11 also shows that the four areas ranked highest according to the rate of delayed days per 1000 population 65 and over associated with the assessment and provision of social care services are, Torfaen, Carmarthenshire, Cardiff and the Vale of Glamorgan. However, Figure 2.12 shows that the four areas experiencing the highest rates of delayed days per 1000 population 65 and over because of healthcare issues, (for example limited availability of community hospitals where patients can be referred after they no longer need acute care) are Merthyr Tydfil, Cardiff, Swansea and Rhondda Cynon Taff.

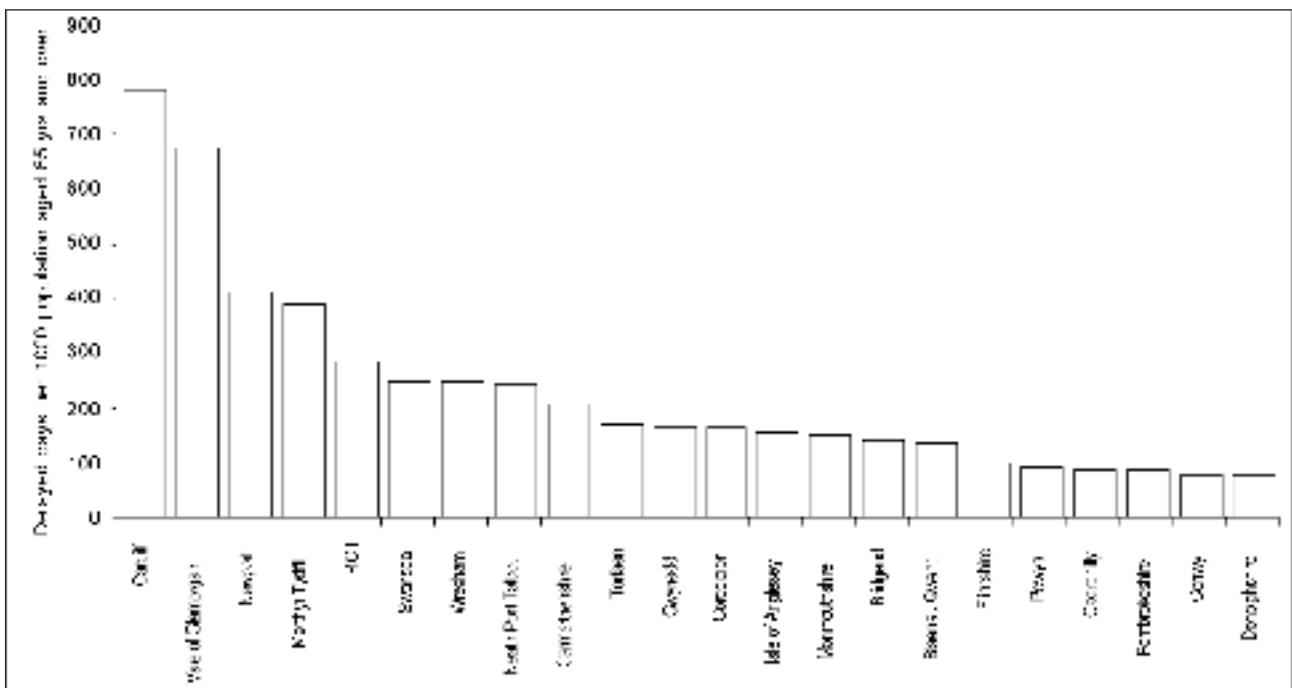
**Figure 2.12: Delayed Days For Local Authority/Local Health Board Residents In 2006/2007 For HEALTHCARE REASONS Per 1,000 Population 65 And Over**



Data: Health Solutions Wales 2007 Analysis; Wales Audit Office

2.47 Figure 2.13 indicates that the four areas experiencing the most issues related to patient/family/carer choice (where, for example, a patient may want to wait until a place in a particular residential or nursing home becomes available) are Cardiff, the Vale of Glamorgan, Newport and Merthyr.

**Figure 2.13: Delayed Days For Local Authority/Local Health Board Residents In 2006/2007 For PATIENT/FAMILY/CARER RELATED Reasons Per 1,000 Population 65 And Over**



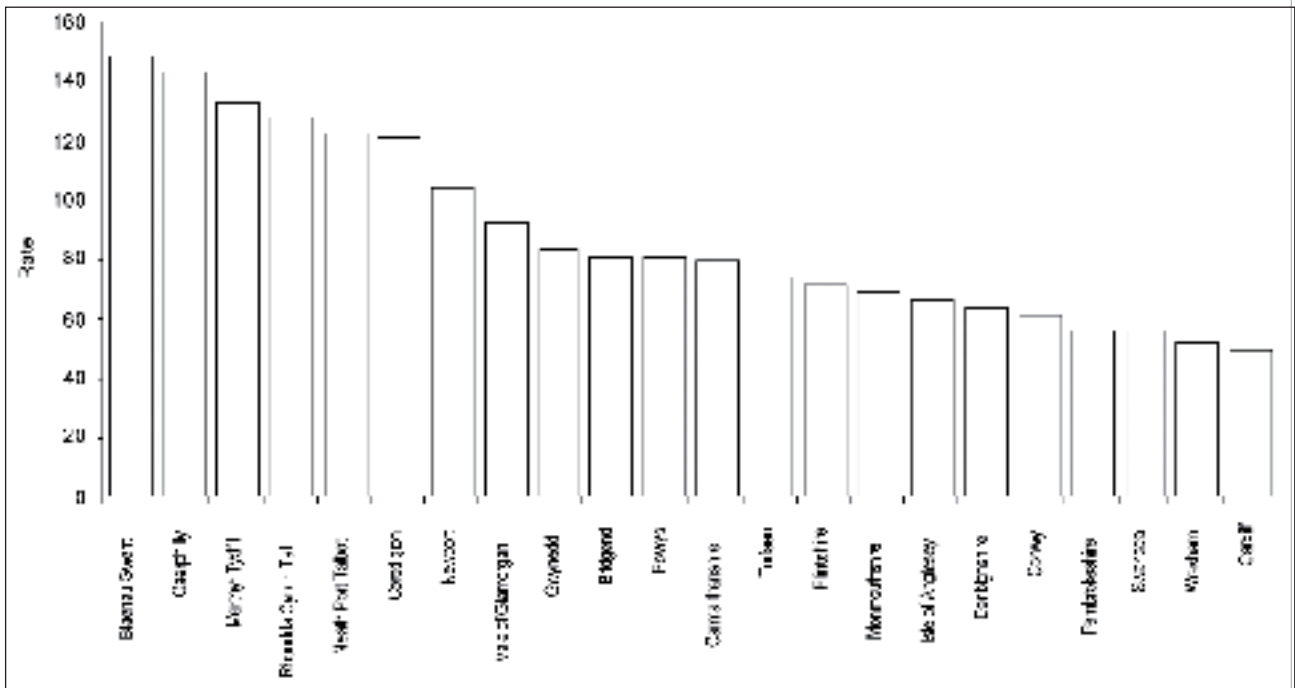
Data: Health Solutions Wales 2007 Analysis; Wales Audit Office

- 2.48 This variation in the issues being faced and in the degree to which they are faced in different local authority/ local health board areas helps to explain the lack of any statistically significant issues being identified that would apply throughout Wales.
- 2.49 In the following sections on the supply of care and expenditure on social care and continuing healthcare, we consider the possible impact of these factors on delayed transfers of care at the local level.

### **C. THE SUPPLY OF CARE**

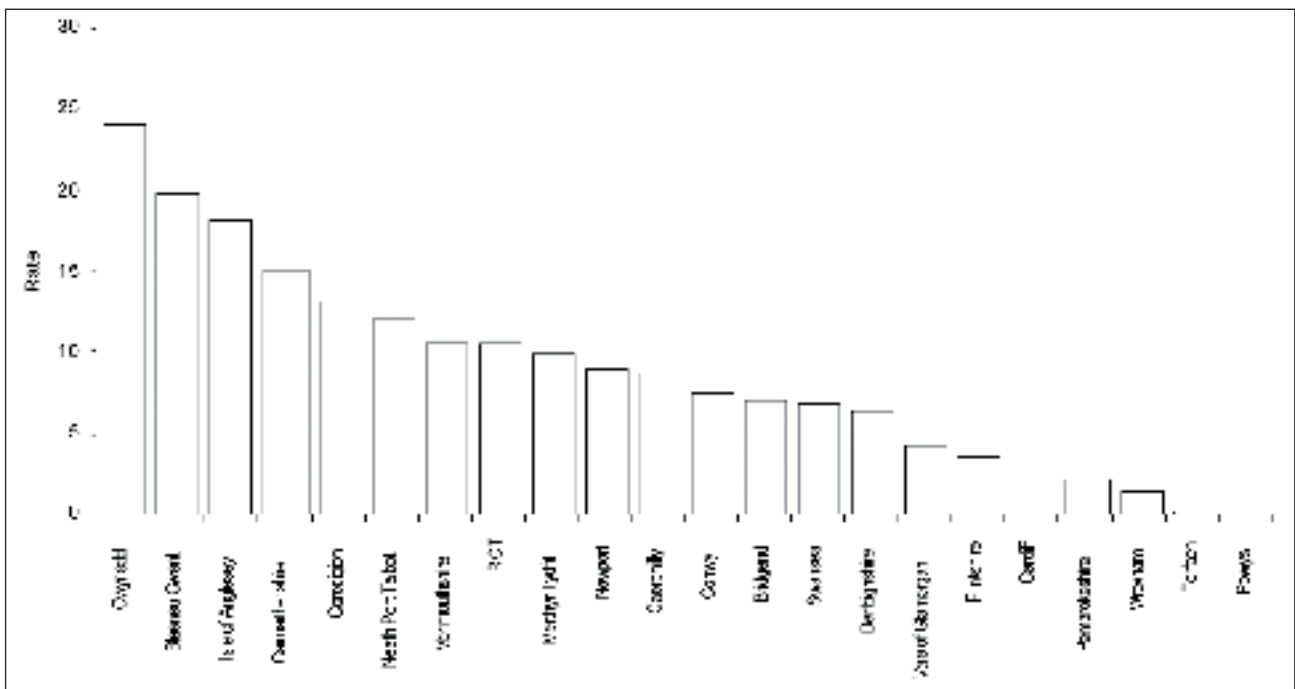
- 2.50 The data considered in this chapter set alongside the findings from our literature review (Chapter 4) and our fieldwork (Chapters 5, 6 and 7) all suggest that the range and balance of care options available in each locality is critical to the management of delayed transfers of care. Broadly the options required to minimise delayed transfers in acute hospital settings would be for patients to be able to:
- return home with a package of care to support them;
  - move to a new home with an environment offering more support;
  - move to a local authority residential home;
  - move to an independent sector residential home;
  - move to a suitable nursing home.
- 2.51 The following Figures 2.14 – 2.19 show the range and balance of care options available by local authority/ local health boards areas throughout Wales. Figure 2.19 includes the total number of “cared for” elderly people; that is the total of all those helped to live at home, plus those in local authority or independent residential homes, plus those in nursing homes. Because Figures 2.14 – 2.19 record types of care expressed as a rate, (for example ‘the rate of older people helped to live at home per 1000 population 65 or over - Figure 2.14) they take into account the varying size of authorities and therefore show the relative performance in each local authority/ local health board area. This allows broad comparisons across localities.

**Figure 2.14: The Rate Of Older People Helped To Live At Home Per 1,000 Population 65 And Over In 2005/2006**



Source: SCA/002a (NS2) (PA10)

**Figure 2.15: Older People Receiving LOCAL AUTHORITY Residential Care Per 1,000 Population 65 And Over In 2005/2006**



Source: Social Services Statistics 2005/6 (2.2)





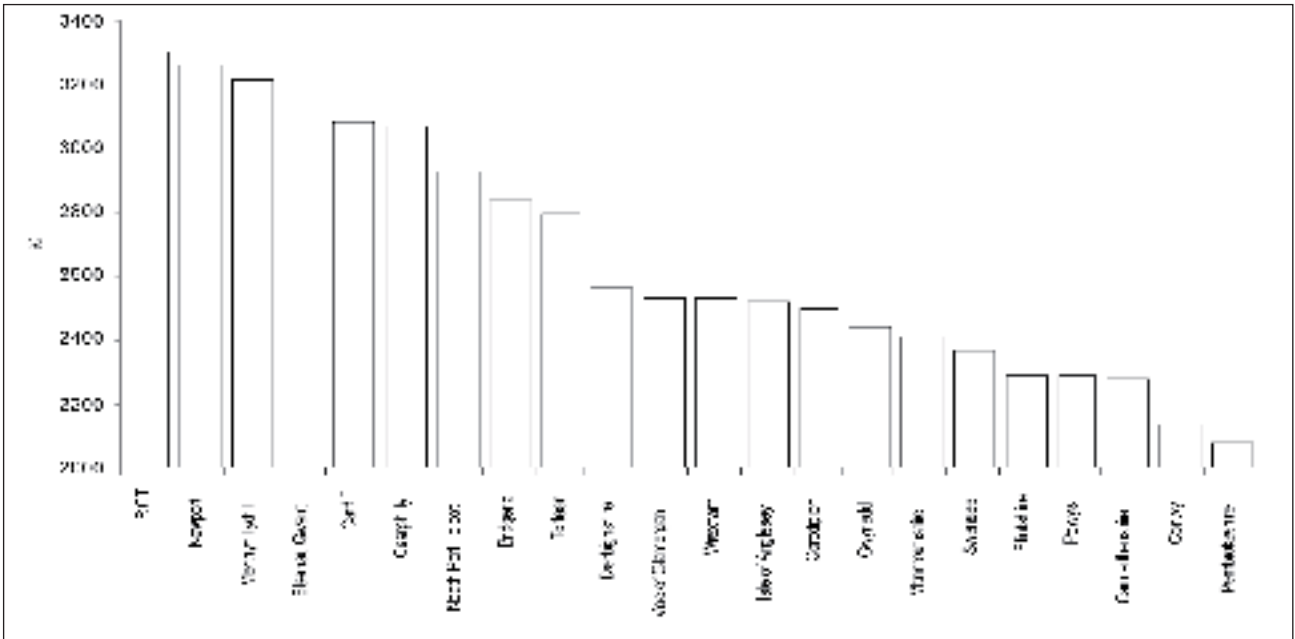


- 2.52 The variation in the overall number of places available (Figure 2.18), and wide variation in the proportion of over residents over 65 years of age in each area who are being cared for (Figure 2.19) is striking.
- 2.53 Figure 2.18 shows the relatively high number of places available in care settings in 5 of the 6 local authority/local health board areas in North Wales. The importance of the availability of such places was emphasised in several of our fieldwork interviews locally. Local authorities in North Wales had worked in partnership with local care providers, to maintain and finance a vibrant independent care sector.
- 2.54 Figures 2.15 and 2.16 suggest a relationship between the availability of independent sector places and provision by local authorities in some parts of Wales. Blaenau Gwent, for example, has a relatively low level of independent care sector placements but a higher rate of local authority provision than all other areas in Wales apart from Gwynedd.
- 2.55 By contrast, Cardiff has the following proportions per 1000 people over the age of 65: 51 being supported to live at home, 22 receiving independent care sector residential placements, fewer than 5 with a local authority residential care place, and 16 in nursing home care. A total of 89 people per 1000 65+ in Cardiff were being supported across the range of care settings in 2005/2006 compared with 202 per 1000 65+ in Blaenau Gwent.

## **D. SOCIAL SERVICES AND CONTINUING HEALTHCARE EXPENDITURE**

- 2.56 Figures 2.20 - 2.22 and Table 2.3 shows total expenditure on personal social services per 1000 population of all ages compared with expenditure per 1,000 population aged 65 and over. Expenditure on continuing healthcare for the over 65 population is shown in Figure 2.22.

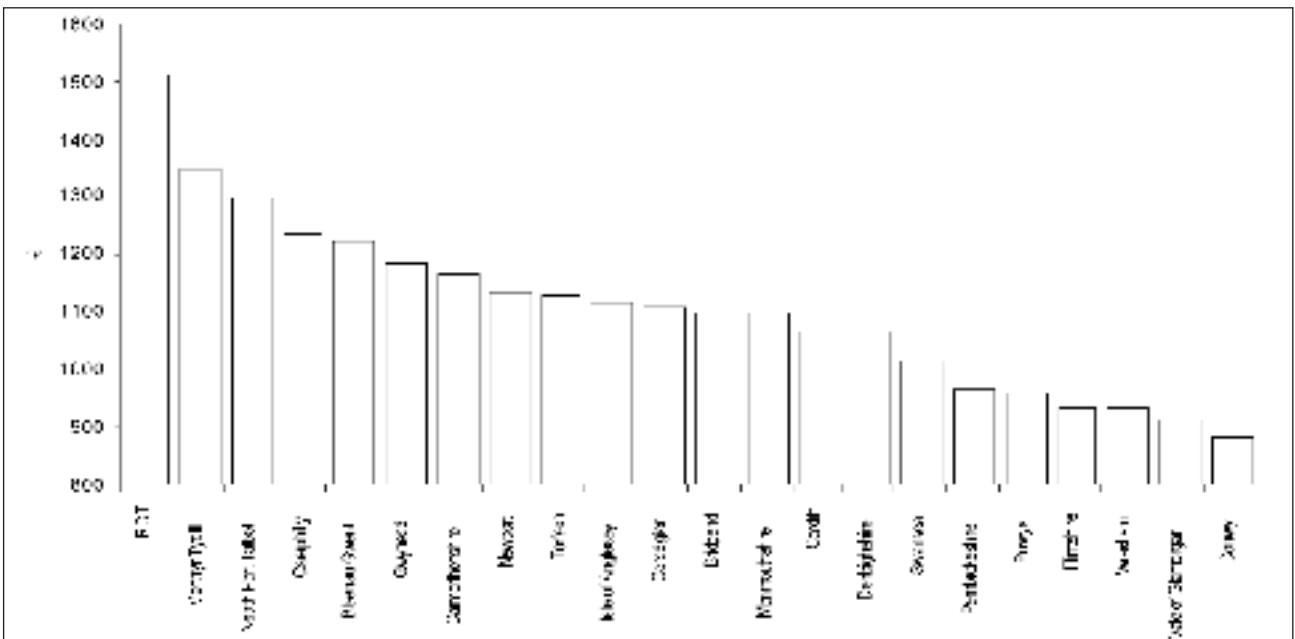
**Figure 2.20: Personal Social Services Gross Expenditure Per 1,000 Population In 2005/2006**



Source: Local Authority Revenue Out turn Wales National Assembly for Wales

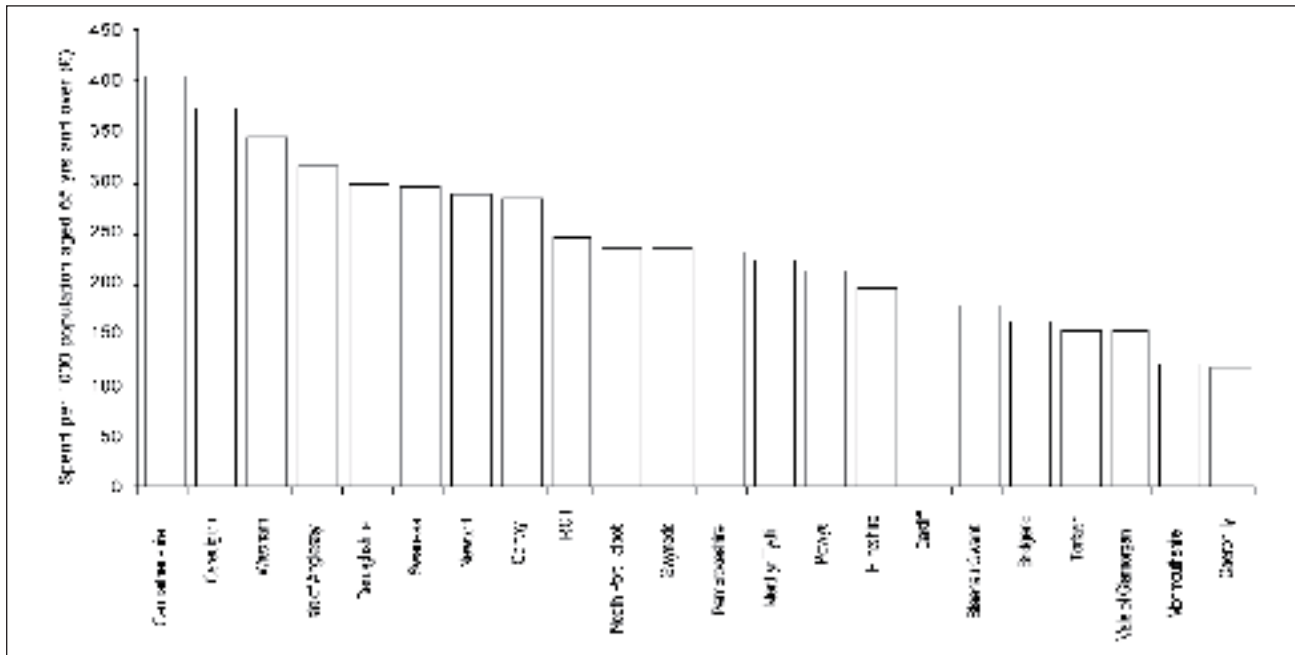
2.57 Throughout the fieldwork enquiries the problems of increasing continuing healthcare expenditure were highlighted in every locality; but, in relative terms, this currently represents a lower rate of spend by local health boards than that on older people by social services departments (see Figures 2.21 and 2.22). It should be noted, however, that the local health board expenditure shown in Figure 2.22, only reflects additional local health board spending on continuing healthcare over and above the continuing healthcare elements built into long term agreements.

**Figure 2.21: Personal Social Services Gross Expenditure Per 1,000 Population 65 And Over In 2005/2006**



Source: Local Authority Revenue Out turn Wales National Assembly for Wales

**Figure 2.22: Continuing Healthcare Expenditure 2006/2007 Per 1,000 Population 65 And Over**



Source: Wales Audit Office 2007

2.58 The picture across Wales comparing social services spend with the number of care places supported by social services is shown in Table 2.3

**Table 2.3: Expenditure On Personal Social Services Related To The Total Number Of Care Placements Funded In Each Locality**

Local authority/local health board area	Total personal social services gross exp. per 1000 aged 65 and over in 2005/06	Total number of care placements supported per 1,000 population aged 65 and over in 2005/06
Rhondda Cynon Taff	1519	169.4
Merthyr Tydfil	1350	168.1
Neath Port Talbot	1301	160.6
Caerphilly	1242	182.3
Blaenau Gwent	1225	201.7
Gwynedd	1190	141.3
Carmarthenshire	1169	117.5
Newport	1139	148.8
Torfaen	1133	117
Isle of Anglesey	1120	124.1
Ceredigion	1114	151.5
Bridgend	1103	125.6
Monmouthshire	1101	105.4
Cardiff	1072	88.6
Denbighshire	1072	107.2
Swansea	1019	92.2
Pembrokeshire	966	86.6
Powys	962	110.7
Flintshire	937	109
Wrexham	935	85.1
Vale of Glamorgan	916	119.6
Conwy	888	110.3

Source: WIHSC analysis of Local Authority Revenue Outturn Wales Welsh Assembly Government

2.59 It may not be surprising to see little correlation between overall local authority spend on social services (which includes services for all age groups) and delayed transfers of care; but what is perhaps noteworthy is the comparison in Table 2.3 of expenditure on older people compared with provision of support at home and residential and nursing home places (Figure 2.19). Cardiff, the fifth highest spending local authority when it comes to total social services spend, appears to be purchasing the fourth lowest rate of care for its population of older people. Perhaps not surprisingly, the cost of care appears to be higher for Cardiff in relation to the number of places provided compared with some other authorities. For example, Pembrokeshire secures the same rate of provision as Cardiff with expenditure of £966 per thousand over 65, compared with expenditure of £1072 per thousand over 65 in Cardiff. Denbighshire spends at the same rate as Cardiff but secures 107.2 places per 1000 population over 65 whereas Cardiff has a rate of 88.6 places per 1000 aged 65 and over.

## **E. THE FINANCIAL CONSEQUENCES OF DELAYED TRANSFERS**

2.60 Data provided by the Wales Audit Office (Tables 2.4, 2.5 and 2.6) examines the financial effects of delayed transfers of care on the NHS in Wales. The overall cost to NHS Trusts in Wales in 2006/2007 is estimated at £69.2m, (see Table 2.6) of which the largest proportion is in mental health services, at £21.4m. The costs for acute and community services are £16.3m and £17.2m respectively. It should be noted that the cost of delayed days for community services has increased by 17% since 2005.

**Table 2.4: Summary Of The Financial Costs Of Delayed Transfers For NHS Trusts For 2005/2006 And 2006/2007**

	2005/2006			2006/2007			Change			Percentage Change		
	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Bro Morgannwg	13,948	230.00	3,208,040	16,194	246.00	3,983,724	2,246	16.00	775,684	16.1%	7.0%	24.2%
Cardiff & Vale	72,787	229.00	16,668,223	77,513	239.87	18,603,120	4,726	10.87	1,934,897	6.5%	4.7%	11.6%
Cardiff & Vale	15,344	234.00	3,590,496	15,753	239.00	3,764,967	409	5.00	174,471	2.7%	2.1%	4.9%
Ceredigion & Mid Wales	3,661	258.00	944,538	2,635	267.00	703,545	-1,026	9.00	-240,993	-28.0%	3.5%	-25.5%
Conwy & Denbighshire	7,963	254.00	2,022,602	4,601	263.00	1,210,063	-3,362	9.00	-812,539	-42.2%	3.5%	-40.2%
Gwent Healthcare	33,829	238.00	8,051,302	44,456	248.00	11,025,088	10,627	10.00	2,973,786	31.4%	4.2%	36.9%
North East Wales	18,673	264.00	4,929,672	15,646	272.00	4,255,712	-3,027	8.00	-673,960	-16.2%	3.0%	-13.7%
North Glamorgan	14,318	304.00	4,352,672	14,831	307.00	4,553,117	513	3.00	200,445	3.6%	1.0%	4.6%
North West Wales	16,818	273.00	4,591,314	11,443	285.00	3,261,255	-5,375	12.00	-1,330,059	-32.0%	4.4%	-29.0%
Pembrokeshire & Derwen	20,592	313.00	6,445,296	9,744	327.00	3,186,288	-10,848	14.00	-3,259,008	-52.7%	4.5%	-50.6%
Pontypridd & Rhondda	14,284	234.00	3,342,456	14,222	272.00	3,868,384	-62	38.00	525,928	-0.4%	16.2%	15.7%
Powys Health Care	6,582	322.00	2,119,404	9,971	347.00	3,459,937	3,389	25.00	1,340,533	51.5%	7.8%	63.3%
Swansea	23,271	222.00	5,166,162	31,135	232.00	7,223,320	7,864	10.00	2,057,158	33.8%	4.5%	39.8%
Velindre	525	123.00	64,575	347	128.00	44,416	-178	5.00	-20,159	-33.9%	4.1%	-31.2%
<b>Totals</b>	<b>262,595</b>	<b>250.00</b>	<b>65,496,752</b>	<b>268,491</b>	<b>258.00</b>	<b>69,142,936</b>	<b>5,896</b>		<b>3,646,184</b>	<b>2.2%</b>		<b>5.6%</b>

Source: Wales Audit Office

**Table 2.5: Financial Costs Of Delayed Transfers For 2005/2006 And 2006/2007 By Reason For Delay**

	2005/2006				2006/2007				Change				Percentage Change			
	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	
Healthcare reasons	56,992		14,102,079	57,018		14,690,237	26		588,158	0.0%					4.2%	
Patient reasons	133,222		33,195,322	135,128		34,604,901	1,906		1,409,579	1.4%					4.2%	
Not agreed	3,868		955,989	3,085		849,895	-783		-106,094	-20.2%					-11.1%	
Social reasons	68,513		17,243,362	73,260		18,997,903	4,747		1,754,541	6.9%					10.2%	
Totals	262,595	250.00	65,496,752	268,491	258.00	69,142,936	5,896		3,646,184	2.2%					5.6%	

Source: Wales Audit Office

**Table 2.6: Financial Costs Of Delayed Transfers For 2005/2006 And 2006/2007 By Care Category**

	2005/2006				2006/2007				Change				Percentage Change			
	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	
Acute	58,816		15,528,720	60,413		16,348,713	1,597		819,993	2.7%					5.3%	
Community	63,539		14,721,006	68,945		17,233,431	5,406		2,512,425	8.5%					17.1%	
Mental Health	84,222		23,643,889	73,682		21,422,294	-10,540		-2,221,595	-12.5%					-9.4%	
Other	11,734		2,856,050	11,983		3,065,719	249		209,669	2.1%					7.3%	
Rehabilitation	44,284		8,856,571	53,468		11,125,102	9,184		2,268,531	20.7%					25.6%	
Totals	262,595	250.00	65,606,236	268,491	258.00	69,195,259	5,896		3,589,023	2.2%					5.5%	

Source: Wales Audit Office



- 2.61 It would be wrong to give the impression that £69.2m shown in Table 2.6 as the cost of delay related to care categories could all be released from NHS Trusts and reinvested. The services used to accommodate delayed transfers are part of a complex service configuration. However, for 2006/2007, by converting the total number of bed days from Table 2.2 into the number of beds these would represent we can say that the equivalent of 165 acute hospital beds were being occupied by delayed transfers, with 50 of them in Cardiff. If people were not delayed after their need for acute hospital care ended there would be the opportunity to improve efficiency within NHS trusts in a number of ways, including the scope to further reduce waiting times, and to avoid cancelling operations. There would also be the opportunity for local authority/ local health boards to consider the overall capacity required in acute hospital settings and to consider re-deploying resources (in terms of staff and equipment, not just financial resources) so that more aspects of acute care pathways could be provided in community-based settings.
- 2.62 Given that the largest cost relating to a single category of care is for mental health, the reconfiguration of these services and reinvestment of some proportion of the £21.4m associated with delays faced by people with mental health problems should be an important focus of attention for local authority/local health board commissioners.
- 2.63 The largest proportion of community hospital beds used to house delayed transfers is in Gwent, where 75 community hospital beds are being inappropriately used at any one time (Table 2.2). There may be some opportunity for rationalisation of these beds if significant reductions in delays can be achieved.
- 2.64 In most cases though, the number of beds freed by the elimination of all delayed transfers would only allow for marginal costs to be released from hospital settings in the short term. Other non financial benefits that could be realised in the short term might include more appropriate utilisation of hospital services and better integration and co-ordination of hospital, primary, community and social care.
- 2.65 One final factor may affect this financial analysis: interviewees throughout Wales indicated that there was under-reporting of DToC. This, combined with the unreported figures masked by local agreements, could mean that the preceding cost figures are conservative. Reasons for under-reporting are discussed further in Chapter 6.

## **F. SUMMARY: WHAT THE DATA TELL US**

- 2.66 The main issues emerging from our analysis of the data on delayed transfers of care are:
- After an initial fall of 38% from 2003-2005, the number of delays, despite some fluctuation has essentially plateaued between 2005 and 2007;
  - The national trend is significantly influenced by the position in Cardiff and masks considerable local variation;
  - There is no single variable, or group of variables that explain the level of delayed transfers across the whole of Wales;
  - Different local areas face differing reasons for delays to differing degrees;
  - The causes of delays have proportionately changed little over the last 4 years. Patient/Carer/family reasons continue to be the cause of almost half of the total number of delays. The number of delays categorised as being caused by “disagreements” has risen steadily and choice is still the largest contributor to the number of delays.
- 2.67 The over-arching implication of our analysis of data for this review is that delayed transfers of care are multi-factorial and are dependent on the situation locally. There is no simple ‘one size fits all quick fix’ that can impact across the whole of Wales.
- 2.68 Looking at the data from the national perspective is important in understanding relative performance so that effort can be targeted towards those localities facing the most significant problems.
- 2.69 This local variability, combined with complexity, clearly suggest that delayed transfers must be tackled at the local level. This has important consequences for national policy, and for the way that issues impacting on delay are commissioned and provided locally, and this in turn, informs the approach that we have taken in the remaining chapters of this review.

## CHAPTER 3

# WELSH ASSEMBLY GOVERNMENT POLICY, STRATEGY, AND GUIDANCE IMPACTING ON DToC

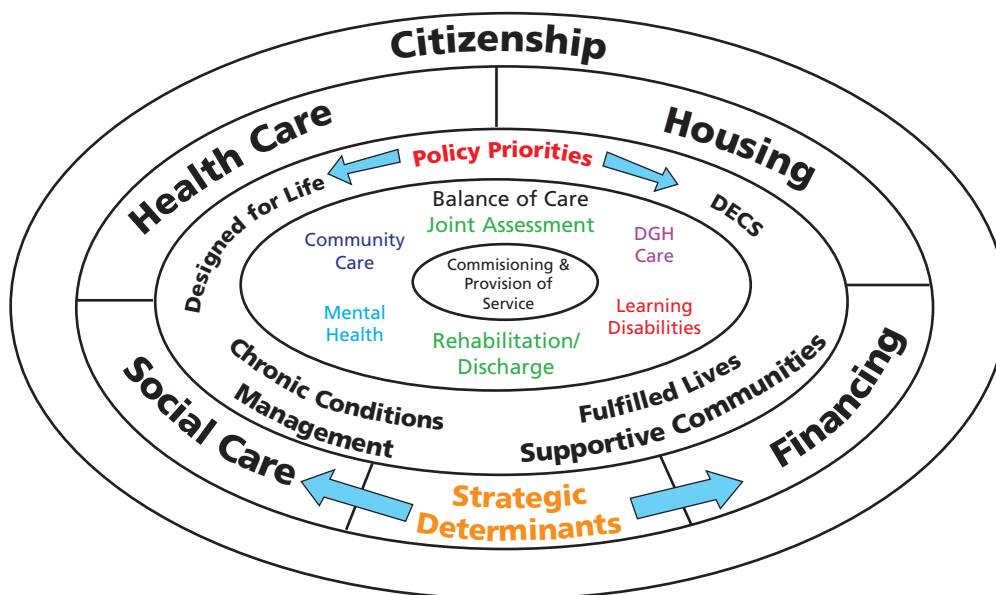
## A. INTRODUCTION

3.1 The Welsh Assembly Government has, since 2003, been the source of a number of documents which address the issue of delayed transfers of care. This chapter:

- Identifies the main documents which create the complex policy environment which needs to be understood;
- Sets out relevant specific strategy documents; and
- Summarises current legal issues which have become important to the management of DToC.

3.2 The policy territory is set out in Figure 3.1 and is explored further in this chapter. The associated strategy and guidance documents that support each element of the model are identified and outlined, and the inter-relationships described. Any deficiencies found by the research that require remedial action are identified later in the report, following the presentation of the current DToC situation and proposals for action.

**Figure 3.1: The Policy Map Within Which Delayed Transfers Of Care Sit**



3.3 Increasingly, health and social care policy in Wales is viewed in the context of *citizenship* following the publication of the Beecham Report, Making the Connections in 2006). Care arrangements must identify which services the

public should expect or have a right to, their standard, and how they might be accessed. But citizens also have responsibilities. Part of the emerging social contract between people and government in Wales is the expectation that citizens will take care of their own health wherever possible, and also engage with statutory bodies in developing plans and services.

- 3.4 The model contains four determinants which have a bearing on the DToC issue – *health care, social care, housing and financing*. These must be seen in context. For example, suitable housing which is affordable and adapted to meet the needs of at risk citizens requires financial support to both home owners and landlords. The range of health services provided in a community needs to be linked to the delivery of social care services to prevent confusing and inefficient duplication, and to facilitate early discharge. Targeted social care services, primary care-based monitoring, and integrated home maintenance and repair services can, when brought together, prevent unnecessary admissions, and remove the possibility of delayed discharge at its source.
- 3.5 Sitting within these determinants is a range of key policies developed by Welsh Assembly Government:
- Designed for Life;
  - Fulfilled Lives, Supportive Communities;
  - Designed to Improve Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action;
  - The Delivering Emergency Care Strategy (DECS) programme.
- 3.6 Each has an important contribution to make to the way services might be better developed and coordinated to avoid DToC. Better management of chronic conditions in the community will reduce the need for admission and also prevent delays in returning to the home environment. The avoidance of unnecessary admissions will allow other health and social care resources to be directed at supporting the early discharge of those who do require hospital services. One major challenge contained in the '*Fulfilled Lives*' and '*Designed to Improve*' strategy is the development of collaborative services which actively prevent loss of independence. Finally the DECS programme is looking to coordinate the work of all agencies involved in responding to unscheduled and emergency requests for assistance, with the aim of ensuring that care is provided as close to the patient's home as possible.
- 3.7 The penultimate area of the model contains the key territories or the filter through which the four determinants and key policies must be passed if DToC are to be addressed satisfactorily at the commissioning and provision levels. Also their presence here reminds us that whilst the health and social care services are delivered by separate agencies, they must connect, particularly at the assessment and rehabilitation/discharge planning stages. The closeness of

these connections will greatly influence the incidence and severity of delayed transfers; and the *commissioning* process needs to promote a strengthening of these vital 'local points' of *provision* across the public, independent, private and voluntary sectors.

- 3.8 What follows is a brief summary of the general themes of the documentation, together with the specific references or connections with DToC in each.

## **B. STRATEGIC CONTEXT**

### **Can Health Care and Social Care Work Together More Closely?**

- 3.9 The Wanless Review of Health and Social Care in Wales (2003) called for closer integration of health, social care and other agencies. It made clear to the NHS that it was not acute bed capacity that was the major issue, but how beds and other resources were used; and that delays led to patients remaining unnecessarily in an inappropriate setting. The report also highlighted that social care funding and organisation made the initial construction of a care package, and the reinstatement of that package following admission to hospital, unacceptably cumbersome. No less than fifteen separate references to the subject of DToC left readers in no doubt that this was a central issue for the NHS and its partners to address.
- 3.10 In calling for delayed transfers to be addressed as a priority, the Review noted that there was no direct correlation between the costs of care, the *per capita* spend by local authorities, and the incidence of delays, suggesting that the problem was systemic. There was also concern about the different targets set for local authorities, social services and the NHS, suggesting that policy lacked the very cohesiveness and integration being called for at the local level.
- 3.11 It is significant that much of the guidance issued since has linked DToC with the reduction of avoidable admissions and providing care closer to home.
- 3.12 The Mental Health Strategy (2001) and the Strategy for Older People in Wales (2003) both promoted the fundamental concept of citizenship and full engagement in the community. They call for non-hospital settings to be the default location for care, with only appropriate and necessary transfers into other care settings, and timely discharge. Both strategies have been subject to revised National Service Frameworks (2005 and 2006 respectively), and both National Service Frameworks stress the importance of normal daily life as a contributor to good health and well being. The NSF for Older People, in particular, sets a gold standard for intermediate care, involving an integrated system of health and actions which promote effective rehabilitation and a return to independence.

### **What Effect Does Housing Have on Delayed Transfers of Care?**

- 3.13 Two significant initiatives can be highlighted here in potentially reducing delayed transfers of care. First, there is the Assembly's announcement under RSL 03/06 of the Social Housing Grant Programme payable to registered social landlords to pay for making housing association dwellings suitable for disabled tenants. This arrangement creates an additional and potentially speedier route for disabled tenants to obtain the same benefits arising under the Disabled Facilities Grant. The guidance envisages that local authorities would continue to be responsible for providing equipment that can be installed and removed with little or no structural modification. Social housing grants would, therefore, normally be limited to major items such as stair lifts.
- 3.14 The second initiative is a product of the Strategy for Older People in Wales. The creation of a Rapid Response and Adaptations Project created funding to support minor repair and adaptations in the homes of older and disabled homeowners or private sector tenants. Care and Repair Cymru carry out many of the adaptations in Wales and evaluated the scheme in 2006. They found the average cost of a Rapid Response and Adaptations Policy job is less than 50% of the cost of one hospital bed day. There was also some tentative data to suggest that the activities reduced the chances of a readmission due to making home environments safer. Overall, the evaluation reports a positive impact on self confidence and engagement with communities.

### **What Financial Support is already in Place?**

- 3.15 The Welsh Assembly Government has a history of providing a range of capital and revenue grants which facilitate strategy implementation and which particularly encourage the joint working that underpins much of current Assembly policy. Four documents are of particular relevance to 'avoiding preventable admissions' and 'delaying transfers of care'.
- 3.16 Under the provisions of Section 33 of the NHS Wales Act 2006, there are three main levers of change available, of which the most significant is the ability for health and social care agencies to bring their resources together into a pooled budget. This is designed to create economies of scale and allows the resultant integrated commissioning plans to promote a more systemic change than might have been possible with multiple smaller service agreements. Until now, this provision has not been extensively used in Wales.
- 3.17 Section 33 also allows Social Care and NHS commissioners to identify from between them a lead agency to carry out commissioning for specific services on behalf of the others. This provides clarity and integration of commissioning plans, leading in turn to service agreements that promote integrated service provision. The last option takes this further by allowing statutory health and social care providers to deliver services on behalf of

others, and either second or transfer the employment of appropriate staff into a single management structure and therefore really integrate the care for service users.

- 3.18 The second key document is the guidance on Telecare Revenue Grants (NAFC 09/2007). Telecare is a central part of the Assembly's strategic direction and this reinforces:
- The messages in the Wanless Review about prevention and early intervention;
  - The acknowledgement in *Designed for Life* that greater technology will reduce the need for hospital visits;
  - The NSF for Older People, where a connection is made between telecare and the management of chronic conditions in the home environment; and
  - *Fulfilled lives, Supportive Communities* which emphasises the importance of continuing independence.
- 3.19 The grants are made with the expectation that local authorities work together with their partners in health and the voluntary sector to maximise the potential of the telecare, telehealth and other assistive technologies to allow timely support to be provided to the patient or client in their home. Some criticism has been made at the delivery level that the revenue consequences have been insufficiently appreciated.
- 3.20 A third funding support scheme is the revenue grant for the integration and modernisation of community equipment services (NAFW 07/2007). As with the telecare grants, this is intended to promote a service that responds quickly to the needs of people of all ages with limited mobility or other difficulties associated with maintaining independence, so that they can remain in their home or be quickly discharged when other forms of care are no longer required.
- 3.21 The last funding initiative is for the Rapid Response and Adaptations Project outlined earlier. The original three year central funding has now finished, but local authorities are expected to support the local repair and maintenance service infrastructure to ensure that the benefits of the original scheme continue. Some local authorities are considering the integration of these services within their community equipment infrastructure.

### **Is There Guidance in Relation to Commissioning and Provision?**

- 3.22 Those responsible for the commissioning and provision of services can call upon a significant amount of guidance and direction. The documents relating to older people and mental health contain a mixture of action plans, targets, and evidence of current good practice upon which new local arrangements can be based.

- 3.23 In 2004 the first set of Health Social Care and Well Being Strategies was developed jointly by local health boards and local authorities, and these set out ways to achieve closer working relationships between the statutory bodies and their independent and voluntary sector partners. The publication of WHC (2005) 035 provided health organisations with updated guidance on planning discharge from hospital, and stressed the need for agencies to develop joint plans rather than just bring together two or more existing separate plans.
- 3.24 Action 21 of *The Strategy for Older People in Wales* (2003) focused on ways of avoiding unnecessary hospital admissions and prolonged hospital stays. The Older Persons' NSF (2006) set a standard of timely discharge to more appropriate care settings. Broadening the target group, Health Inspectorate Wales published a Review of Specialist Learning Disability Services in 2007 which was concerned that in some areas service users for which NHS facilities were no longer appropriate, occupied 90% of learning disability beds.
- 3.25 The Wales Audit Office DToC Review (2007) has been the subject of extensive analysis by the Assembly's Audit Committee. Major concerns were expressed in the report about the under-reporting of DToC, the challenge of the increasing complexity of cases, the lack of joint action in some areas, and the relative infancy of the commissioning process.

### **Is There Appropriate Guidance on Funding Arrangements?**

- 3.26 One of the significant factors to be taken into account when considering a transfer from one care location to another (particularly admission to a nursing home) is agreement on the funding of that care. In the past there have been disputes as to which agency should fund aspects of the care package and these have contributed to delays. It is well known that NHS Care is free at the point of use and therefore not usually subject to charges, whereas some or all of social care costs can be covered by local authorities or passed on to the recipient via means testing. Because of these two different funding arrangements it is important for health and social care agencies, as well as the users of their services, to be clear on who will be able to provide what before care packages are finalised and agreed by all concerned.
- 3.27 Two significant legal judgements, accompanied by revised guidance, have attempted to clarify the development and application of criteria. Since 1996, the NHS has been required to have in place eligibility criteria to determine who is entitled to fully-funded NHS care. In 1999 a Court of Appeal ruling in the case of Miss P Coughlan formed a test for deciding when the NHS should be responsible for funding a care package in a nursing home. It stated that where a person's reason for the placement in a nursing home was *primarily a health need*, the NHS was responsible for funding the whole care package. The judgement indicated that local authorities can only be legally responsible for nursing care which is '*merely incidental or ancillary to the provision of accommodation*'.



- 3.28 In 2001 a three level banding system was introduced in England (low, medium and high) for the input of registered nursing care when carried out by employees of nursing homes. In Northern Ireland and Wales a single band was adopted. Known as the Registered Nurse Care Contribution, it involved the NHS making a financial contribution to the overall cost of a care package based on the level of registered nursing input. From October 2007 the three levels of banding in England have been incorporated into a single band. Despite assurances that the nurse care contribution scheme and the Coughlan test were complementary, there was concern that applying the nursing care criteria within the scheme would produce only a small contribution from the NHS (even at the highest band of care), whereas using the Coughlan test on the same person could result in eligibility for fully funded NHS care.
- 3.29 In 2006 the case of *Grogan vs. Bexley Care Trust* revealed the potential for these two systems of assessment to conflict. By 2002 Mrs Grogan had a number of serious medical and mobility problems requiring significant carer assistance. After the death of her husband she suffered further deteriorations in her health and a number of falls. Following admission to hospital in November 2002 she was assessed as being unable to live independently, and in February 2003 was transferred to a care home providing nursing care. Subsequent assessments concluded that Mrs Grogan did not qualify for fully funded NHS care (but was eligible for medium and high banded care\* under the Registered Nurse Care Contribution scheme).
- 3.30 Mrs Grogan argued that the decision to deny fully-funded NHS care was unlawful as the criteria in place were contrary to Coughlan and that the medium and high bands of nursing care were consistent with a primary need for health care. The Court concluded that the criteria used in Bexley contained no guidance as to the test to be used when assessing health needs. The judge also criticised Department of Health guidance for its lack of clarity, stating that this could lead to confusion and inconsistency. Both the NHS and Social Services were urged to look at the totality of a person's needs when determining either a primary health need or the legal ability of a local authority to take on the whole care package.
- 3.31 In recent months the term 'Grogan Gap' has been coined to identify those cases where a patient is assessed as *not* having a primary health need but still requires nursing services that are above the *incidental* or *ancillary* threshold (and so beyond the legal scope of a local authority to provide under the 1948 National Assistance Act). The 'Grogan Gap' is therefore one which describes the legislative potential for a gap between what the patient can receive from the NHS and what the local authority is allowed to provide.

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\* Later, a single band was introduced.

3.32 The publication in Wales of WHC (2006) 46, NAFW 32/2006 gives further guidance to NHS and local authorities on Continuing Health Care, and *inter alia* aims to close any potential 'gap'. The updated guidance calls for:

- joint NHS/Local Authority reviews of local implementation plans and criteria to ensure that current practice is in line with the Grogan judgement;
- consideration of the interaction between NHS continuing care arrangements and NHS funded Nursing Care procedures;
- guidance and training for those involved in assessments; and
- consideration of reassessing eligibility in cases where there is the potential for a different outcome if the amended criteria were to be applied retrospectively.

As yet, however, LHBs and NHS Trusts have no certainty as to the funding for undertaking increased continuing healthcare.

3.33 In 2007 the Association of Directors of Social Services and the All Wales Adult Service Heads (AWASH) published a document for local authority staff, developed with legal advice, containing an assessment tool. The tool is aimed at giving greater consistency in the continuing health care assessment approach across the 22 local authorities. However, as will be seen later in this Review, although the tool has not been endorsed by the Welsh Assembly Government, it does appear to have been introduced by some authorities.

## **C. WHAT WELSH ASSEMBLY GOVERNMENT PROCESSES ARE RELEVANT TO DELAYED TRANSFERS?**

3.34 The terms of reference of the review did not require an in-depth analysis of the role of the Welsh Assembly Government in health and social care provision in Wales; but clearly some understanding of two aspects of Government - the creation of policy and oversight of performance management - is necessary. The following summarises key aspects of the strengths and weaknesses of current arrangements in these regards.

### **How is Policy Coordinated?**

3.35 At ministerial level three ministers have a role in the relevant policy aspects of health and social care, housing, and the funding and performance of local government. The policy creation process has been described to us as having at least two significant features: first it is iterative, in that Government engages with key players within Wales in order to devise and refine policy; and, second, within Government there are a variety of mechanisms or arenas within which attention to policy development can be given.

- 3.36 Key elements of this are:
- The Minister for Health and Social Services and her Deputy who, with her Chief Executive, NHS Wales and Head of Department for Health and Social Services, has a clear responsibility for developing coherent policies across the health and social care field for Wales;
  - The existence of the policy gateway process which ensures that significant proposals receive wide attention and scrutiny across Government before final decisions are taken;
  - The Management Board of the Department;
  - The availability of a number of cross-disciplinary officer groups, such as the Joint Officials Group, established by the then Minister for Social Justice and Regeneration, which seeks to bring together related aspects of health, housing and social care policy;
  - The existence of the DToC Strategy Group, which brings together finance, performance and delivery, and other strategy in areas directly relevant to the better management of DToC;
  - Performance Management of the DToC related policies by NHS Regional Offices.
- 3.37 The strengths of this approach are that the Minister for Health and Social Services and her officials have a clear lead for integrating policy development in these two areas. The Assembly Government continues to adjust aspects of the internal machinery to try to ensure a coherent approach to policy, with both health and social services actively engaged. In housing policy, too, there is a consistency of approach with maintaining 'independence', one of the three themes within 'Supporting People'.
- 3.38 Weaknesses remain, however, in terms of the extent to which housing policy is engaged if, for example, novel housing solutions are required which retain independent living whilst also providing greater levels of personalised support. We understand that the Joint Officials Group – which is an arena in which housing and health interests are blended – reported to the Minister for Social Justice when it was created; but the reporting line now is unclear, and the group functions to facilitate mutual support and advice amongst officials.
- 3.39 The Review also heard some reservations about the extent to which social services interests – both in the field and within Government - are fully able to engage in timely policy development.

### **How is Performance Management Coordinated?**

- 3.40 Performance management in the NHS is relatively well defined via a number of processes, including those deliverables required through the Annual Operating Framework arrangements; and the Regional Offices of the Assembly have a key role in overseeing this. However in September 2007, WHC (2007) 069 was issued outlining 'An Incentives and Sanctions Framework for NHS Wales 2007/2008' which did not specifically include the achievement

of DToC targets as part of the incentives programme. Essentially, though, performance management is a local matter, with accountability ultimately to WAG.

- 3.41 Accountability arrangements for local government are very different, reflecting the local democratic imperatives and a different process for accounting for the use of national taxpayers' funding. In general terms, performance agreements are negotiated between national and local government to reflect a balance between the national and local contexts.
- 3.42 DToC indicators for local government were negotiated individually with each local authority from 2004-2007, but this practice is not expected to be revived.. Now, even though DToC is not a specific item of accountability, it remains a consideration amidst numerous operational objectives, the progress on which is monitored and supported by WAG following prioritisation by local authorities.
- 3.43 There is now a strong policy drive in Wales – supported by national and local government – to effect significant improvements in the ways in which public services work together. The recent establishment of Local Service Boards, for example, provides one mechanism for facilitating joint working, and some of these Boards have already decided to focus on DToC as a key issue. There is also a clear intention – for example in *Fulfilled Lives, Supportive Communities* - to develop agreed levels of performance and service delivery which will apply to *all* local authorities. In these ways, it should be possible to achieve a more consistent and integrated framework for managing the input of multiple agencies to shared problems such as delayed transfers of care. However, it is likely that the different types of accountability, remit, funding arrangements and culture of local government and the NHS will continue to present significant challenges to joint working.
- 3.44 In respect of housing services, the performance management framework sits within 'Supporting People'. Local Authorities remain key commissioners but provision is in the hands of private developers and, for more specialised forms, housing associations. Policy intent is delivered through a number of specific grants - for social housing, supporting people, extra care schemes, telecare and community alarms. However, the Review has not been able to establish whether there exists a clear picture centrally of the intended extent of provision at a future date that would be consistent with the range of housing services that would be necessary to ensure that people might remain at home for as long as possible.

## **D. CONCLUSION**

3.45 In summary, and referring back to the policy map, the general direction of strategic travel in the area of DToC is clear. The key points which emerge include:

- The subject is well covered in the major reviews and strategy documents produced in recent years;
- The documentation recognises that DToC is not a problem simply associated with acute healthcare services and social care provision;
- Housing policies take into account the importance of the need to support peoples' ability to live in their own homes;
- Flexibilities under Section 33 of the NHS Wales Act 2006 already provide agencies with a range of opportunities for working together to address the problem;
- Current guidance places a requirement on public sector agencies to work together to produce their plans;
- Guidance on 'responsibilities' has been the subject of recent legal challenges which have created some concerns;
- Mechanisms exist at an all Wales level for inclusive policy development for public sector agencies;
- Performance management arrangements do exist but are aligned separately to different agencies.

3.46 Finally, there is no shortage of advice, guidance and evidence relating to specific aspects of the problem of DToC in Wales. Nevertheless, the problem has yet to be solved. The next chapter considers how experience from outside Wales might inform the approach to be adopted here.

## CHAPTER 4

# DELAYED TRANSFERS OF CARE: THE EVIDENCE BASE AND POLICY BACKGROUND FROM THE OECD AND HOME COUNTRIES

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### A. INTRODUCTION

4.1 Chapter 4 begins by defining what is meant by ‘delayed transfers of care’ before considering the policy background in Scotland, Northern Ireland, and England. It then looks at a number of themes that emerge both from policy on delayed transfers across the home countries and a literature review that have a bearing on delayed transfers. These include:

- good practice;
- characteristics of localities with high performance in tackling delayed discharges;
- performance management;
- NHS continuing care;
- capacity;
- mental health;
- unintended consequences; and
- incentives and sanctions.

What follows is a consideration of whether developments in Europe, Canada and the United States may offer insights into how we might tackle the root causes of DToC in Wales.

4.2 In the UK, Europe and the wider world concerns about DToC from hospital settings have a long history in various guises - as ‘bed-blocking’, ‘delayed discharges’ and ‘delayed transfers of care’. Various literature reviews: Hudson (1998); Glasby (2003); Scottish School of Primary Care (2004); Social Care Institute for Excellence (2006); and The Cochrane Collaboration (2007) attest to policy initiatives and academic studies dating back over thirty years.

4.3 As Glasby (2003) has pointed out, research findings relating to DToC have been remarkably consistent over the last three decades. These have been summarised as:

- Poor service co-ordination;
- Lack of clarity over respective responsibilities;
- Lack of information-sharing;
- An inappropriate range of service models;
- Inadequate assessment and planning for discharge;
- Inadequate consultation with patients and their carers;

- Lack of notice of discharge; and
- Over-reliance on the contribution of family carers.  
(Henwood 2006)

- 4.4 Yet Lim et al (2006) were identifying similar issues delaying the discharge of patients in Singapore in 2006 to those identified by Lewis and Purdie (1988) in New Zealand almost two decades earlier. This is, then, an intractable problem that is by no means found only in Wales.
- 4.5 The question arises as to whether recent policy development around the UK, Europe and beyond can offer useful insights in the Welsh context? How might it be possible to go beyond scoping the problem and identifying its characteristics, to offering policy-makers and practitioners a strategy that would address the fundamental issues that have proved so difficult to resolve, in order to ensure that DToC are at an irreducible minimum?
- 4.6 In looking at the evidence base on DToC the approach we have taken has been to: draw on literature reviews undertaken prior to 2005; undertake a further limited review to identify recently published papers (2005-2007) and consider developments in the UK and a range of OECD (Organisation for Economic Co-operation and Development) countries. (Chapter 1 discusses the methodology for the literature review in more detail).

## **B. DEFINING 'DELAYED TRANSFERS OF CARE'**

- 4.7 A fundamental starting point is to define the terms to be used in the enquiry. The variation in the terms used to describe the phenomenon described in current Welsh policy as DToC has emerged an important issue in its own right. There are two strands in relation to definitional issues, both of which illustrate important themes in the literature and policy review, and in the field work associated with this report. The first relates to scoping the size of the problem in terms of data on DToC, and the second to cultural change.

## **C. SCOPING ISSUES**

- 4.8 After a multi-agency consultation in 2000, the Information Services Division (ISD) of NHS Scotland issued the following mandatory definition of 'delayed discharge':

*"Where a patient remains in hospital after his/her clinical readiness for discharge has been determined by the lead clinician in consultation with all agencies involved in planning that patient's next stage of care. The date on which the patient is judged clinically ready for discharge is the ready for discharge date."*

(ISD 2000)

- 4.9 The data definition in England in guidance issued in 2002 by the Department of Health (see National Audit Office 2003) was as follows:

*“A delayed transfer occurs when a patient is ready for transfer from a general and acute hospital but is still occupying a bed. A patient is ready for transfer when: a clinical decision is made that the patient is ready for transfer; a multi-disciplinary team decision has been made that the patient is ready for transfer; and the patient is safe to discharge/transfer.”*

- 4.10 The definition set out in guidance (Department of Health 2003) on the implementation of the Community Services (Delayed Discharges etc) Act 2003 on reimbursement is that the Act applies to:

*“Delays in discharging adults who have been receiving acute medical care and who qualify for community care services under the National Health Service and Community Care Act 1990 ... to those patients who are safe to be discharged subject to being provided with community care services and who are now delayed awaiting provision of those services ...”*

- 4.11 The Community Services (Delayed Discharges etc) Act 2003 also defines ‘acute medical care’ as:

*“Intensive medical treatment provided by or under the supervision of a consultant which is for a limited time after which the patient no longer benefits from that treatment.”*

- 4.12 The Statistical Directorate of the Welsh Assembly Government (2007) gives the following definition of DToC:

*“A delayed transfer of care is experienced by an inpatient in a hospital who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons.”*

- 4.13 The 2002 English definition related only to those due to transfer ‘from’ a general and acute hospital. The Scottish and Welsh definitions, however, refer to ‘the next stage of care’, which could encompass a wider range of services, including delays relating to other NHS services. Guidance published in England (Department of Health 2003) relating to ‘reimbursement’ enabled NHS Trusts in England to seek reimbursement from local authorities where delays are attributable to delays in assessment for, or provision of, social care services. These provisions were limited to patients entitled to packages of care under the NHS and Community Care Act 1990, and also tightened the definition of ‘acute medical care’. By contrast, the Welsh definition refers to ‘inpatients’. These definitional differences mean that comparisons in looking at trends relating to DToC have to take into account that like for like comparisons across the UK cannot be assumed. For example, more patients



are likely to fall within the broader definition applying in Wales than would be expected to fall within the definitions applying in England.

- 4.14 As well as differences in the definitions themselves, there are also differences because of differing interpretations. The National Audit Office (2003) reported that “only 27% [of NHS Trusts in England] were following the official definition in full.”
- 4.15 The Wales Audit Office have very recently (2007) highlighted similar issues around data collection in Wales that tends to understate the scope of the problem. This includes the widespread use of ‘local agreements’ between health and social services about when the DToC clock should start ticking. Our fieldwork has also found uncertainty about defining and recording delayed transfers at the local level.
- 4.16 The extent to which DToC informs commissioning is hindered by a form of ‘self-censorship’. Where services in appropriate settings are in short supply, particularly in relation to mental health, the tendency seems to be not to record patients as delayed. Consequently, commissioners may not be aware of the full extent of the problem. In the English context, research indicates (Lewis and Glasby, 2006; Glasby and Lester 2004; and Beer et al 2005) that this kind of under-reporting affects forensic and acute adult mental health, and learning disabilities, as well as older people with mental health problems. It may well be that the number of delays attributed to these groups in Wales are similarly understated.
- 4.17 In addition to this evidence from England, our fieldwork in Wales would also suggest that particular caution is needed in interpreting data concerning mental health. That ‘the patient’ is safe to discharge seems to have been translated into a ‘safe setting’ being available. If there is limited or no capacity in the community mental health service, inpatients who could be transferred if such a service existed are not necessarily being recorded as having a delayed transfer.
- 4.18 Scoping the problem will remain problematic unless definitional and measurement issues are addressed that allow for a consistent approach across the whole system – an issue that will be explored further later in this chapter. The measurement of delayed transfers per se, (however defined) may not be getting to the root of the problem of how best to manage transitions between acute care and other settings. Also, the focus on DToC may result in some unintended consequences that do more harm than good.

## D. CULTURAL ISSUES

- 4.19 The glossary of the *Research Review on Tackling Delayed Discharge* (Scottish School of Primary Care 2004) says of the term 'bed-blocking':
- "The need to avoid using the term bed-blocking is increasingly recognised because it implies that it is the patient who is responsible for preventing others from using an acute bed, rather than dysfunctions in the care system".*
- 4.20 Recent press reports, however, suggest that this term still has an emotive currency. Recent articles in the *Health service Journal* (Moore 2007) and *Public Finance* (2006) suggest that once DToC become a political issue, the term quickly re-emerges. After some years of significant decline – in England from 3220 cases in December 2003 to 2190 in December 2006 (a drop of 32%) (Source: Moore 2007), and in Wales from 1116 cases in September 2003 to 642 in May 2007 (a drop of 42%) (Source: Wales Audit Office 2007) - delayed transfers appear to be once more on an upward trend. This has led to a number of articles appearing in the press referring to 'bed-blocking' such as *Why bed-blocking is making an unwelcome comeback* (Moore 2007) and *NHS Debt fuels bed-blocking surge* (Public Finance 2006). Generally speaking, health and social care professionals in the UK context would not refer to bed-blocking, or bed-blockers.
- 4.21 The use of 'delayed discharge' does not have the same connotation of implying that the person 'blocking' a bed is in some way responsible, but could arguably imply that the person concerned no longer needs on-going care – they can be 'discharged'. In favouring the term 'delayed transfer of care' Wales is in line with the World Health Organisation European Observatory which has identified (2004) that for many countries, including, for example: Greece, Germany, Spain, Sweden and Finland, it is the co-ordination of transitions throughout health and social care systems that create particular challenges.
- 4.22 These subtle, but significant shifts in the use of language are important in assessing recent policy developments in a number of European countries, and in the USA and Canada 'Bed-blocking' was identified as a problem in Sweden in the 1990s (Styrborn and Thorslund 1993), but by 2007 the issues had been re-framed. Issues of transition in Sweden are now more likely to be discussed in the context of whole systems and 'chains of care' (Ahgren and Axelsson 2007).
- 4.23 Before looking at developments in the wider world that may have lessons for Wales, consideration is given as to how policy has developed in recent years and its implications in Scotland, Northern Ireland and England.

## **E. POLICY DEVELOPMENT IN SCOTLAND, NORTHERN IRELAND AND ENGLAND**

### **Scotland**

4.24 Post-devolution Scotland placed an early emphasis on delayed discharges. In 2000 a learning network was established to share and disseminate good practice. In 2004, the Scottish Executive published research commissioned from the Scottish School of Primary Care which undertook a review of policy on discharge. The resulting report (2004) concluded that the evidence base suggested that the issues contributing to delay were contextual, and that each of the Scottish Partnerships within each of the Health Board areas should take steps to understand the particular drivers impacting locally. Some evidence was available that the following may all have a part to play:

- Hospital at home / early supported discharge;
- Rapid response teams;
- Care home placements;
- Discharge planning;
- Identifying those at highest risk of delays;
- Better clinical care;
- Discharge managers / liaison nurses;
- Home adaptations;
- Emphasizing the role of professions allied to medicine;
- Rehabilitation;
- Engaging with patients and carers.

There was concern that the evidence of effectiveness for these types of initiatives had not generally been tested through evaluation. The conclusions were, therefore, tentatively that a range of initiatives relevant to the local context was the best approach to adopt. For the future, a 'whole systems approach', tackling unplanned emergency admissions as well as delayed discharges, was proposed.

4.25 Data on delayed discharges has been collected nationally in Scotland since 2000, based on the mandatory definition set out in paragraph 4.6. It should be noted that after a patient is defined as being ready for discharge, there is an accepted period beyond the 'ready for discharge date' during which all assessments and follow-on arrangements are put in place. For most local authority partners in Scotland this 'accepted period' is 6 weeks. Since April 2004, the figures for Scotland have focused on those patients who, at the time of the census, have been ready for discharge for more than six weeks.

4.26 As in England, the number of delayed discharges in Scotland showed a slight upturn during 2007 with 425 delays identified in the October 2007 Census (ISD 2007b) compared with 423 in the July Census (ISD 2007c). In this context, guidance issued in September 2007 advocated an approach based on lean management theory to improve patient flow in planned care, including

identifying systemic bottlenecks impacting on discharge and length of stay (NHS Scotland 2007). This approach bears many similarities to initiatives already implemented in Wales in guides to good practice (Cumming 2005 ; NLIAH 2005).

#### *National Rate for Care Homes in Scotland*

- 4.27. In 2003, prompted by a reduction in the number of available care home places in some parts of Scotland, the Scottish Executive took action to stabilise the situation. The Executive led discussions with health boards and the independent sector, including private sector providers, to establish agreed fees rates. A package of nearly £80 million for the care home sector, offered by the Scottish Executive and the Convention of Scottish Local Authorities, was accepted by Scottish Care, representing private sector care homes in Scotland. The package had already been accepted by leading voluntary sector providers.
- 4.28 The deal allowed average fees in homes without nursing care to rise from £260 a week in 2001 to £346 in 2003 - an increase of 33%. In homes with nursing care the fees were set to rise from £336 to £406 - nearly 21%. The aim was to stabilise the care home sector and to avoid separate negotiations having to be undertaken within each local authority area.
- 4.29 Bell and Bowes (2006) identified an overall increase in fees of 38% in independent sector nursing homes in Scotland by 2004, and noted that the variation in the distribution of homes and variation in fee structures was in fact greater in Scotland than England and Wales. Their analysis was that a range of policy initiatives, including those on free personal care and the £239 million made available through the Delayed Discharge Action Plan in 2002 for the period 2004 – 2008, had all had a bearing in putting upward pressure on prices. The overall number of care home places remained more or less static.
- 4.30 At the time of our fieldwork in Scotland in 2007, problems of supply were still being experienced in Edinburgh. The Health Board had decided that directly (public sector) provided and managed care home services would be created to ensure the supply of places.

#### *Free Personal Care*

- 4.31 The provision of 'free' personal care in Scotland has proved to be a popular policy. The funding arrangements are, however, complex. The cost of 'board and lodgings' – typically half the cost of residential care - is not covered and is still means tested. Payments of £145 per week for personal care and an additional sum of £65 per week for nursing care, do, however, represent a substantial contribution. Even so, the full cost of care may not be covered, depending on individual homes' charges and may have to be 'topped up' from a resident's own resources.

- 4.32 The public sector cost differentials between Scotland and England have been found in a comprehensive study by Stirling University for the Joseph Roundtree Foundation not to be nearly as great as has been popularly assumed (Bell and Bowes 2006). An important factor is that those in residential care in Scotland lose entitlement to Attendance Allowance, unlike those in the rest of the UK. Also the payment for nursing care is fixed at a much lower rate than in England, (£65 in Scotland compared with £130 in England in 2006).
- 4.33 The Local Healthcare Bill, currently out to consultation in Scotland (January 2008), envisages direct elections to Health Boards in Scotland. It might be anticipated that the issues of transitions between acute hospital and other settings would be a matter of keen interest, should this come to pass, to those elected to Health Boards.

#### *Choice*

- 4.34 In the course of our fieldwork we were advised that legal proceedings were in the process of clarifying what powers Scottish Health Boards have when patients are ready for discharge, but do not want to leave hospital.

#### *Governance*

- 4.35 In Chapter 6 the arrangements through which services that have a bearing on delayed transfers might best be organised and managed, are discussed. The governance arrangements in Scotland since devolution have involved Health Boards that bring together commissioning and provider functions in one statutory body. This arrangement has been further developed in West Lothian, where there is unified management structure reporting to the Health Boards and their local government partners with responsibility for the primary health, community health and social care resources of health and local government. An Executive Board of senior Health Board and local government officials act for the partners to oversee the joint development of services. A jointly appointed senior manager reports to the executive board on both planning and service delivery. It is understood that this approach is being introduced in other parts of Scotland where the maturity of existing partnerships allows.

#### *Integrated services*

- 4.36 In West Lothian technology (telecare/telemedicine) is being provided in purpose built, residential facilities. Residents (mainly older people with care needs) receive broadly based packages of care to support a high level of independent living. Jointly planned and operated facilities provide both health and social care from the same premises, with residents moving freely between health and social care as their needs change.

## Northern Ireland

- 4.37 Given the moves internationally towards whole systems approaches with an emphasis on integration and co-ordination, it is perhaps surprising that there has been relatively little analysis of the arrangements in Northern Ireland. According to McCoy (1993), Northern Ireland has one of the most structurally integrated and comprehensive models of health and personal social services in Europe.
- 4.38 Heenan and Birrell (2006) argue that experience from Northern Ireland has been too readily dismissed, based on an over-reliance on the part of subsequent researchers on a brief report by the Northern Ireland Social Services Inspectorate (SSI 2000 ) written over a three week period in 2000 looking at delayed discharges in relation to winter pressures. Whilst integration is not in itself a panacea, and structural integration does not necessarily lead to integration in practice, there are some aspects of experience in Northern Ireland that have not, perhaps, had sufficient profile.
- 4.39 An efficient and timely system of hospital discharge is seen as a major benefit of integration, facilitating a strategic approach. For example, hundreds of people with learning disabilities have transferred into community settings without the need to set up bespoke management arrangements. There is a view that the unified assessment process and integrated budget prevents 'buck-passing' and ensures that resources are focused on facilitating transitions rather than being expended on managing the system. There are policy-into-practice issues in that integration in practice is still somewhat patchy, and there is some evidence that where integration is not working as it should resources have been diverted from social care into acute care, exacerbating problems with delayed transfers. However, Heenan and Birrell conclude that:

*"the most distinctive features of integration are that all professionals are employed by the same organization, have the same source of funding, share the same goals and objectives and work alongside each other ... positive outcomes include:*

- *integrated planning and commissioning*
- *professionals working together*
- *integrated management*

*[to deliver] client-based programmes of care."*

- 4.40 Their research describes the views of those working in health and social care in Northern Ireland that the programmes of care are 'the jewel in the crown', 'the best bit' and 'the central feature of the system. These are programmes for:

Acute services  
Maternity and child health  
Family and child care  
Elder care  
Mental health  
Learning disability  
Physical and sensory disability  
Health promotion  
Primary and adult community

- 4.41 Programmes of care operate on an interdisciplinary basis across social care, primary, community and secondary healthcare, fostering a co-ordinated approach. An approach to performance management, aimed at supporting whole programmes, has the potential to avoid the issues that have arisen in Wales, whereby targets for health and social services have not always been aligned and different parts of the health and social care system are responding to financial and service pressures from differing perspectives. The creation of such integrated programmes does not necessarily depend on integrating services along the lines of the model in Northern Ireland as is illustrated later in this chapter with experience from Europe.

## England

- 4.42 In England, an emphasis on the effective management of the processes involved in discharging patients from hospital has been in evidence for more than a decade. The Department of Health produced the *Hospital Discharge Workbook* in 1994; and *The NHS Plan* (2000) and the *National Service Framework for Older People* (2001) both included targets for reducing the number of delayed discharges. A further significant policy development concerning delayed discharge resulted from an observation in the Wanless Report (2002) that the Government:

*“should ‘examine the merits’ of financial incentives (such as employed in Sweden) to help reduce the problems of delayed discharges”.*

As Henwood (2006) describes, rather than ‘examining the merits’ the Government chose to head straight into implementation in *Delivering the NHS Plan* (Department of Health 2002).

- 4.43 A proposed system of incentives and sanctions proved to be highly controversial. The Local Government Association published A whole in one (LGA 2003) in which they advocated a whole system approach to managing delayed discharge and a concentration on partnership working. They warned that the system in Sweden was not readily transferable to the English context. The BBC reported (2003) the opposition of the British Medical Association on the grounds that fining overstretched local authorities would make things worse and that further developing partnership working was a preferable approach.

- 4.44 The furore led to a delay of a year in implementation but the subsequent legislation and supporting guidance in the Community Care (Delayed Discharges etc) Act 2003 (CCDDA) put reimbursement, (often - pejoratively – reported as ‘fining’) onto a statutory footing. Where a patient is entitled to a care package under the NHS and Community Care Act 1990 and delays are attributable to delay in assessment for, or provision, of social care services, it is open to NHS trusts in England to seek reimbursement from the local authority responsible of £120 per day.
- 4.45 Alongside the implementation of the CCDDA there were: a Delayed Discharges Grant of £100 million per annum; a £546 million Access and Systems Capacity Grant (to fund home improvement services, purchase community equipment and improve home care); and the establishment of a Change Agent Team also put in place. As discussed in the section on incentives and sanctions later in this chapter, recent research has indicated that it was these support mechanisms, implemented alongside the system of reimbursement, that were more important in addressing delayed discharges than the sanction of reimbursement proved to be in practice.

### **Transforming Adult Social Care in England**

- 4.46 The publication of *Putting People First* (HM Government 2007) offers a shared vision and commitment on the part of national and local government, the NHS and the independent care home sector to create personalised social care with personal budgets for adults needing social care and greater availability of direct payments. Capital investment will be targeted to provide a better integrated approach health and wellbeing in every community. This move towards co-production (compare it with the Beecham Report 2006 in Wales) may have implications in terms of (quite rightly) raising expectations and consequently impacting on people’s willingness to co-operate with issues relating to delayed discharge, in the absence of being offered choices that they and their family find acceptable.
- 4.47 The policy direction for health and social care in England towards co-production and greater choice has been underlined in a speech by the Prime Minister in January 2008:

*“Our ambition must be to give everyone a choice - and we can expect this will mean more and more people choosing to be cared for at home.*

*This will depend on a new flexibility and responsiveness in primary care, and new partnerships with the voluntary and private sectors where they can contribute and innovate.*

*And it means a more seamless integration of services between acute and primary care, and between health and social care -- reflecting far better the needs and wishes of patients and of their carers.”*

(Gordon Brown 2008)



## F. HOME COUNTRY ISSUES

4.48 Next is a consideration of a number of themes, emerging from the review of policy in the home countries and the review of the literature that have a bearing on delayed transfers of care in the UK context.

### Good Practice

4.49 As in Wales with the development of the Welsh Change Agent Team as part of NLIAH, the development in England of a Change Agent Team in 2002, followed by the introduction of the Community Services Improvement Partnership (CSIP) in 2005, seems to have been very important in fostering partnership working, innovation and sharing good practice in relation to delayed discharge, affecting not only older people, but other groups too, including those with mental health problems. A very wide range of projects and initiatives illustrating good practice are available through The Change Agent Team and Community Services Improvement Partnership websites. The extracts that follow about projects in Hackney, Bedfordshire, Rotherham, Darlington and Durham are taken from the 'Bright Ideas' area of The Change Agent Team website:  
<http://www.changeagentteam.org.uk/index.cfm?pid=19&sectorID=11>.

***Making available temporary housing whilst adaptations are put in place (Hackney)***

**Issue:** To minimise delayed discharges from hospital for Hackney residents where housing issues like the need to fit equipment are the sole cause of delay.

**Action:** Service users identified on the ward as possible discharges are referred to the scheme by hospital social workers, who submit a community care assessment and care plan to help determine the level of support necessary. The project manager liaises with the housing department, housing association and occupational therapy service to provide users with accommodation for up to six weeks while their own home is being adapted. Help with personal care, food preparation and domestic support is offered, although the aim is to maximise independence.

**Outcome:** Fewer people enter residential care directly from hospital, and the number of delayed discharges has been reduced.

Users have an opportunity to re-equip themselves with the skills they need to live independently and breathing space to make decisions about their future care and accommodation needs. Around half have moved back to their previous accommodation after adaptation work has been carried out.

**Organisations Involved:** Hackney social services, Homerton University Hospital, City & Hackney PCT

***Providing rehabilitation beds in care homes to prepare for returning home (Bedfordshire)***

**Issue:** To reduce hospital admissions, or delayed discharge, for older people who need a period of rehabilitation.

**Action:** Social services has agreed a block contract for a unit of six single rooms in a private residential home for people over 65 who are either medically fit to be discharged from hospital, but need rehabilitation, or who are not ill enough to need to go to hospital, but need rehabilitation in a residential setting before they can return home.

These beds are supported by social workers, the intermediate care team, occupational therapists and physiotherapists, and care home staff. There are areas where patients can practice their self-care, kitchen and mobility skills. A key worker is assigned to each case to ensure continuity of care and single assessment paperwork is used, including patient-held records.

**Outcome:** Hospital admissions have been avoided because patients are admitted to the rehab beds direct from the community, via their GP, or by social work/therapy assessments in A&E. Delayed discharges have been prevented by timely identification of suitable and willing candidates for the rehab beds.

**Organisations Involved:** Bedfordshire County Council social services

**Appointing a discharge co-ordinator specifically for people with dementia (Rotherham)**

**Issue:** A new discharge co-ordinator role helping to facilitate discharge plans for all people with dementia, regardless of age.

**Action:** The Mental Health Discharge Coordinator for Older People and Younger People with Dementia has now been in post since June 2004. The main focus of the post is to work across partner organisations to fundamentally refocus the approach to the provision of services for older people with both physical and mental health problems and younger people with dementia on acute wards at Rotherham District General Hospital. The partnership working aims to improve the experience for older people with mental health problems and younger people with dementia admitted to the acute wards by ensuring timely access to services to meet individual needs which ultimately leads to timely and appropriate discharge.

**Outcome:** Through advising consulting and training with the general hospital staff the Mental Health Discharge Coordinator aims to reduce lengths of stay for older people with mental health problems on the acute wards. Close involvement in discharge planning enables more accurate placement of patients post discharge, reducing costly revisions of care packages, which in turn improves the patient and carer experience. Coordination of communication across the partner organisations has prevented any delayed discharges and facilitated early diagnosis and treatment of mental health problems in older people and younger people with dementia. Work has also included changes to ward environment to improve the experience for older people with mental health problems. Examples of this have included visual signs and a nutritional screening tool for people with dementia to assist staff in establishing the level of supervision required during meal times.

As a result of the training and education a breakfast club has now been developed to promote independence and one care of the elderly ward is looking to facilitate a reminiscence area in their day room. An integrated care pathway is also being piloted to facilitate transfer of patients between the acute trust and the mental health inpatient wards to improve communication and information sharing about the patient. The post has also been on the authoring group of an NHS live project to develop an information diary for people with dementia during their stay in hospital in an attempt to transfer the care they receive at home into hospital.

**Evaluation:** The service receives on average 60 referrals a month and referrals are received from all members of the multi disciplinary team including close working and liaising with the Older Peoples Mental Health Team. The post provides a proactive service with a physical presence on the wards to assist and support staff when caring for older people with mental health problems. The post has recently reached the finals of the South Yorkshire PROUD Awards and received the Doncaster and South Humber Healthcare NHS Trust Chairman's Award for Outstanding Achievement in Older Peoples Mental Health.

**Organisations Involved:** Doncaster and South Humber NHS Trust, Rotherham General Hospital

**Intensive specialist mental health support including daily visits for the first fortnight post discharge (Durham and Darlington)**

**Issue:** It is generally recognised that approximately two thirds of acute hospital beds are occupied by people aged over 65 years of age (Department of Health 2001) and that within this group there is a high psychiatric morbidity. The co-existence of physical and mental health problems results in longer hospital stays and premature admission into 24 hour care, due to lack of home support. Discharging older people with mental health problems is considered to be of a complex nature that requires special attention and a range of options (Health & Social Care Change Agent Team 2003). In response to this challenge a 6 month nurse led pilot was funded from the local Delayed Discharges Grant. The aim of the initiative is to enable early and safe discharge of older people with mental health problems

by providing intensive specialist mental health support following acute hospital admission. Specific objectives are to facilitate discharge of older people who have had an acute hospital admission, and also have a mental health problem. To prevent premature transfer to residential/nursing care. To reduce failed discharges and prevent readmission to hospital.

**Action:** Initially funding was agreed for a period of six months and a further six months funding has been identified. In September, a business case for substantive funding is to be presented via the Local delivery Planning process. If successful we hope to extend the service to the two other general hospitals within our community.

We investigated services offered in other parts of the country and have been unable to identify any service that matches the intense level of support we are able to provide. Some teams offer limited support in the first two weeks post discharge, some offer only a weekday service. We could not identify one that operates for extended hours (8am-8pm) and also operates on a weekend. The support offered is individually planned with the patient, carer and any other professional involved. Interventions include continuing assessment within the home environment, supervision and monitoring, advice and education to carers, social support, identification of risk and action to reduce this, provision of optimum care package and identification of deterioration in health.

The older person would generally receive daily visits for the first two weeks post discharge. Initially visits are made at different times of the day to establish the assessment covering the 12 hour period (8am-8pm). Visits normally last for up to 4 hours. Over the next 6-8 weeks visits are reduced in length and frequency until it is envisaged that the older person can manage without the team.

**Outcome:** We have produced information posters and leaflets, which are displayed in the acute wards, in an attempt to make the service as accessible as possible. The team coordinator publicised the service through attending Social Services team meetings, daily discussions with ward staff and the Discharge Management Team. Referrals are accepted from any source. We are currently receiving more referrals than we can accommodate. The team has strived to provide excellent communication to all involved in the older persons care. We have developed a self carbonating communication sheet which is left in the older person's home, and which the support workers, other carers, the older person and their family and friends can write updates or messages to each other. This has been very well received by all concerned. The team co-ordinator provides fortnightly updates regarding each older person to social workers and written reports to GPs.

**Evaluation:** Evaluation of the team is a continuous process and includes:

- Quantitative data collection
- Anonymised patient details
- Length of hospital stay
- Follow up six weeks post discharge from the team

Qualitative data collection:

Capturing the experience of patients, carers and partners involved in the service

**Organisations Involved:** A proposal was developed and submitted to the multi-agency Modernisation Group Who Supported and funded the project. The team is led by a group who supported and funded the project. The team is led by a registered mental health nurse, and includes 4.2 whole time equivalent support workers.

### **Therapists working with architects to design supportive environment (Bedfordshire)**

**Issue:** To reduce delayed discharges from acute services and inappropriate admission to residential or nursing homes, and give older people a safe environment in which to regain their independence after an acute episode of care.

**Action:** Six short-stay flats are being built within an existing sheltered accommodation complex. Therapists have been involved with the architects throughout, so that the units are designed to support people in their final assessment before discharge to their own home. The intermediate care team of therapists will continue rehabilitation - there will be a purpose-built treatment room - and rehabilitation assistants will be employed by the PCT on a rota to act as housekeeper during the day, with support from the onsite warden. At night residents can call on the out-of-hours nursing/social care service.

**Outcome:** *The facility is due to open in December 2003. Average length of stay will be around two weeks. The scheme is expected to give clients with complex needs a chance to participate in their short and long-term care planning to help them maintain a level of independence.*

**Organisations Involved:** *Bedfordshire Heartlands PCT, Aragon Housing Association*

- 4.50 As well as the projects described in 'Bright Ideas', there is also specific practical advice and numerous examples of good practice as a toolkit to improve discharge from inpatient mental health care in *A Positive Outlook* (CSIP 2007).
- 4.51 The Wales Audit Office (2007) also drew attention to some of the initiatives highlighted by the Change Agent Team and CSIP and particularly commended the 'virtual ward model' developed in Croydon. In line with the Scottish perspective that a range of initiatives tailored to local circumstances are required, there is the opportunity in Wales not to have to reinvent the wheel, but to make sure that there is a nationally-led approach, through NLI AH, to disseminating innovation and good practice and to providing active support to local health and social care communities in drawing on initiatives material to local conditions.
- 4.52 Examples of existing good practice in Wales are given in the form of case studies in subsequent chapters of this review and through reference to NLI AH's (2007) work in this area which is discussed in Chapter 5.

### **Characteristics of localities with high performance in tackling delayed discharges**

- 4.53 Whilst ideas suggesting good practice in relation to delayed transfers may be helpful, the Change Agent Team makes clear that it only offers the projects it highlights as 'ideas', not as evidence-based good practice. Indeed, a note of caution concerning over-reliance on a series of initiatives has been sounded by Baumaan et al (2007). This research into the characteristics of sites with low levels of delayed discharge found that there are 'core' elements present. They argue that these core aspects should be in place irrespective of whether other locally-based initiatives are tried, as follows:

#### **All Agencies**

- Interagency commitment to open, constructive communication about causes and solutions for delays;
- Make tackling delayed discharges a strategic priority;
- Develop good information systems for monitoring delays;
- Analyse whole system and commission services where gaps exist;

- Monitor delays and causes robustly and target action at causes;
- Take action to improve performance;
- Regularly review progress.

### ***Hospitals***

- Establish resources and teams (Medical Assessment Unit, GP Liaison Nurses, intermediate care assessment team in A&E) to prevent avoidable admissions;
- Establish early discharge teams to support nurses' discharge planning;
- Develop systems for close monitoring and communicating individual patients' progress;
- Develop and apply robust patient choice protocols;
- Ensure availability of responsive transportation and discharge lounges.

### ***Hospital and Community Services Staff***

- Develop interagency discharge protocol;
- Develop simple and efficient early notification systems incorporating Estimated Discharge Date;
- Jointly monitor progress of individual discharges and agree weekly delay figures.

### ***Community Services Commissioners/Managers***

- Ensure a good range of social services are available;
- Ensure Social Services Department staff have good access to services: own budgets, placement staff/brokers;
- Social services department team managers closely monitor care managers progress with individual patients' discharge;
- Ensure a good range of intermediate care services are available and teams to facilitate access;
- Use interim placements for patients waiting for vacancies or who need more time to choose;

- Social Services Department teams based in hospital and care managers attached to specific wards to aid multi-disciplinary team relationships;
- To this might be added the need to underpin such arrangements with a commonly shared set of values across both organisational and professional settings that value the promotion of independence and accept the desirability of community based forms of care.

### **Performance Management**

- 4.54 Throughout the UK, commissioners have been set targets of one kind or another specifically focusing on reducing delayed transfers of care.
- 4.55 In Scotland, the Delayed Discharge Action Plan's aspiration in 2002 to reduce the total number of discharges by 20% per annum was, by 2006, seen to be unrealistic and modified targets were set, with delayed discharges being monitored on the basis of a quarterly census. The targets were to be reflected in Local Improvement Targets, agreed by the NHS and local authorities at the local level and performance managed as part of an annual Joint Performance Information and Assessment Framework.
- 4.56 In England, a new performance management regime is being put in place to better align the targets set for, and performance management of, health and local government. Delayed transfers of care are identified within a National Indicator Set as one of the areas to be targeted jointly by health and local authorities in partnership with other local stakeholders in Local Strategic Partnerships (Department of Health 2007). Based on a Joint Strategic Needs Assessment, Local Area Agreements will be put in place incorporating a range of local targets, a proportion of which will be drawn from the National Indicator Set. Government Offices will have a key role in performance managing these agreements working with bodies such as Regional Improvement and Efficiency Bodies, Special Health Authorities and Regulators.
- 4.57 The Independent Review of Health and Social Care Services in Northern Ireland (Appleby 2005) identified that the performance management arrangements then in place lacked appropriate performance structures, information and clear and effective incentives. Nonetheless, when in 2006 a target of all patients being discharged from hospital within 72 hours of being declared fit by March 2008, it was to be left to Area Health Boards and Trusts to decide how the target should be met.
- 4.58 As policy in this area develops in Northern Ireland and elsewhere in the UK, it is to be hoped that the possibility of exploring measures of performance across 'bundles' of care, programmes of care and care pathways will be pursued. The organisation of health and social care in Northern Ireland may well give a head start in adopting this kind of approach. Although better alignment of health and social care in relation to delayed transfers is very

much on the agenda across the UK, it may be that the focus needs to shift to the whole system, rather than a potentially distorting over-emphasis on DToC.

### **NHS Continuing Care**

- 4.59 One of the assumptions that led to the implementation of the policy on reimbursement in England appears to have been that delays in assessment and service provision on the part of Social Services were generating most of the delay associated with DToC. However, from 2003-2005, it transpired that 67.6% of delays in England were attributable to the NHS with 27.1% attributable to Social Services (McCoy et al 2007). One aspect of NHS-related delays has been addressed through the Delayed Discharges (Continuing Care) Directions 2007. These regulations reflect recent decisions of the Courts concerning the continuing care responsibilities of the NHS. The application of a statute-based decision support tool to determine whether a patient is entitled to free NHS care rather than means-tested social care will impact on an issue that has been a source of conflict between the NHS, social services departments and families. Similar non-statutory guidelines are being followed in many parts of Wales (AWASH 2007).
- 4.60 The application of this decision-support tool is not unproblematic and there are significant financial implications for the NHS if, as seems likely, there is a shift towards more patients being identified as having continuing healthcare needs. Not only is there the potential for more delays being attributed to the NHS, but barriers to integration and co-ordination between health and social care services may be reinforced, with powerful incentives for social services and families to identify as many patients with continuing health care needs as possible.

### **Capacity**

- 4.61 As in Wales there are significant issues in England around the perception of capacity in the care home sector, with limited resources available via social services funding, leading to some homes struggling to provide high quality care and some going out of business (Bryan et al 2006). In the English policy environment where plurality in service provision has been important, Wade et al (2006) and Woodin and Wade (2007) clearly identify securing services through active market management as a key activity for commissioners. The Wales Audit Office (2007) has argued for commissioners to move away from spot contracts to block contracts to help stabilise the care home sector.
- 4.62 Whether commissioners should be encouraging this type of provision is, however, another matter. Glasby and Henwood (2007) have recently called into question how appropriate care homes are for many older people, and whether there has been an over-emphasis on this type of provision precisely because of pressure to tackle delayed discharge.

## **Mental Health**

- 4.63 There do seem to be particular issues with capacity in mental health services in both England and Wales. Lewis and Glasby's (2006) survey of mental health services in England suggested that where no service provision in a more appropriate setting was available, patients were not being flagged as being delayed. They noted that, whilst it appeared delays may have been under-reported for those with functional mental health problems, EMI and learning disabilities, the absence of any patients in medium or low security being identified as delayed suggested that they had not been counted at all. Beer et al (2005) found that around a third of inpatients in secure units were at a level of security incommensurate with their needs, with most requiring a lower level of security. The characteristics of those at the wrong level of security were 'being female' and 'not being a risk to others' for the mental health cohort and 'being younger' and 'being admitted on an informal basis' for those who have learning disabilities.
- 4.64 Paton et al (2004) in their case study in Camberwell found that 46% of older mental health inpatients were delayed of whom 53% had dementia, 26% affective disorder and 21% schizophrenia.

## **Unintended Consequences**

- 4.65 The Commission for Social Care Inspection (CSCI, 2004 and 2005) highlighted some potential unintended consequences arising from the policy focus on delayed discharge. Concern was expressed that:
- Older people may not have sufficient access to rehabilitation and scope to maximise improvement if too much emphasis was on freeing-up their bed.
  - Re-admissions had in the year since the CCDDA was implemented gone up by between 8% and 50% in the local authority areas reviewed by the CSCI.
  - Older people may feel pressurised into making long term decisions about their future care without sufficient time to explore all the options – militating towards residential care / nursing home options.
  - Early discharge home may result in unfair pressure being placed on carers who are often themselves older people.
  - Attention may be diverted from other vital outcomes to maximise health and well-being.

## **G. INCENTIVES AND SANCTIONS: FROM MARKET BASED INCENTIVES TO INTEGRATION AND NETWORKS**

- 4.66 To date, the reimbursement (fining) policy applied in England under the Community Services (Delayed Discharges etc) Act 2003 (CCDDA) has not been



adopted in Wales. As part of this review, the question arises as to what the literature review and experience elsewhere tells us about the effectiveness of the application of incentives and sanctions in the context of delayed transfers of care?

- 4.67 McCoy et al (2007) in a study funded by the Economic and Social Research Council under its Public Services Programme emphasised that it was the incentives, the 'carrots', in terms of: the financial investment available through a Delayed Discharges Grant of £100 million per annum; the £546 million Access and Systems Capacity Grant (to fund home improvement services, purchase community equipment and improve home care); and establishment of The Change Agent Team, that made a difference in England in improving performance in relation to delayed discharge rather than the stick of reimbursement.
- 4.68 They found that the 'stick' in terms of the provision for local authorities to be charged £120 per day per patient for those delayed for reasons within the purview of local authorities had, for the most part, not been wielded. In 2004/05 only 18% of Trusts charged Social Services Departments and retained the money, 14% had arrangements to charge and retain in place but had never used them, 66% elected not to charge at all or to reinvest all of the money into community-based services.
- 4.69 There has been some support for the policy. Baumann et al (2007) report in their study on the organisation and features of hospital, intermediate care and social services with low rates of delayed discharge that interviewees were mainly positive about the CCDDA. They acknowledged, however, that this was not a topic they explored in any depth.
- 4.70 On implementation in 2004, the reimbursement policy did not apply to a number of services, including services for children, maternity services, palliative care, learning disabilities and mental health. In a study on delayed discharge in mental health services, (Lewis and Glasby 2006) there was some support for the extension of the reimbursement policy to mental health, not because the possibility of reimbursement was thought to be beneficial in itself, but because of the perceived focus of attention it had generated. It was felt that delayed discharges in mental health services were being ignored in favour of services where reimbursement applied. The Change Agent Team itself acknowledged that the reimbursement aspect of the CCDDA had had the effect of concentrating minds rather than necessarily being extensively applied. As McCoy et al (2007) found, where partnerships were already mature and had opted for pooled budgets and joint commissioning, to apply the reimbursement policy would have required the partnership to fine itself!
- 4.71 Interestingly, given that the approach of applying financial incentives and sanctions drew on policy developed in Sweden, similar issues have arisen there and, for that matter, in Denmark (Colmorten, Clausen et al. 2004). The potentially detrimental effect on partnership working and a greater emphasis

on whole systems has meant that fines have not, for the most part, been imposed between partners. In Sweden it is thought that changes introduced by the national government, deteriorating funding conditions together with new technology have had more far-reaching effects than reforms affecting local government. (Anell 2005).

- 4.72 As in England, there is evidence to suggest (Annell 1996) that the trend in delayed discharge was already downwards when reimbursement was introduced in Sweden so that cause and effect is not clear. The emphasis in Sweden seems to have moved in favour of integrated working and partnership and a focus on care pathways and networks of care, rather than on bed-blocking and fining. (Ahgren and Axelsson 2007).

### **Aligning incentives and sanctions with governance arrangements**

- 4.73 The three main forms through which organisations are structured and managed are markets, hierarchies and networks.

- 4.74 The incentives and sanctions appropriate to markets, like the reimbursement policy, are not readily transferable to other forms of governance, such as networks. In *Making the Connections* (Welsh Assembly Government 2004) collaborative models are favoured over competition:

*“By using co-ordination rather than competition, users and producers of public services are ... on the same side ... the best outcomes are obtained when those who use and those who provide services work together in collaboration.”*

- 4.75 As we describe in Chapter 6, the most effective way of supporting this type of collaboration is through the development of multi-agency networks. Opinion in some quarters in England is also beginning to head in this direction. In *Clinically integrated systems: the next step in English health reform*, Ham (2007) argues that the balance between competition (contestability) and collaboration in England now needs to move in the direction of collaboration. He draws on the HMO model in the USA (the HMO model is described in paragraph 4.96 below, on the USA) in concluding that a network-based approach is needed:
- *“The increasing prevalence of chronic disease will require ... clinical integration between primary and secondary care and the development of clinical networks*
  - *The levers and incentives to promote clinical integration and networks are underdeveloped and ... this needs to be addressed*
  - *Practice based commissioning [should be used] as a mechanism for developing multi-specialty based commissioning*

- *In the longer term ... reform ... might support patient choice between integrated systems in which clinicians lead the quest for improvement.*

(Ham 2007)

- 4.76 This broadly accords with the desire of UK healthcare professions for a focus on co-ordination, integration and clinical leadership, notably in commissioning.
- 4.77 BMA Cymru Wales (2006) has argued for better integration of services and for team working opportunities across primary, secondary and tertiary care to be investigated.
- 4.78 The College of Occupational Therapists (2007) has also stressed the need in Wales for more effective and integrated health and social care services to reduce the need for long-term community-based support and expensive secondary and tertiary services.
- 4.79 In England, the Joint Medical Consultative Council and NHS Confederation (2007) argue for:
- breaking down the primary/secondary care divide;
  - introducing pathways, guidelines and bundles of care;
  - not using inappropriate (market based) incentives.
- 4.80 The BMA (2006) has argued for collaboration between professionals across local health economies – including primary and secondary care and for commissioning to be clinically led.
- 4.81 The Royal College of Nursing has stressed the role of nurses in working in co-ordinated partnerships, including partnership with older people themselves (2004).
- 4.82 The under-development of incentives and sanctions in relation to chronic disease management is also explored by Dixon (2007). In her view, however, better incentives are the key to improving the management of chronic illness, including the transitions between different care settings. She advocates that:

*“... for example, allowing primary and secondary care providers to integrate ... and manage year-long capitated budgets ... could significantly incentivize hospitals to seek ways to reduce the risk of admission for patients ... localities should be allowed the autonomy to experiment with new incentives.”*

- 4.83 Networks bring together organizations of different types. A network with responsibility for delayed transfers of care would ideally include public, voluntary and private sector partners. The command and control form of governance associated with hierarchies cannot apply in the context of such organisational diversity. Market based incentives and sanctions are effective in the context of competition more than collaboration (Ham 2007). The most fruitful approach would appear to be to develop locally based incentives and sanctions to support a limited number of national targets, (including on DToC) and a range of demanding, but achievable local plans and targets. The effective application of incentives and sanctions would be assured through a combination of:
- peer pressure based on long term relationships established within the network;
  - development support, (for example through NLIAH); and
  - oversight and inspection by health and social care regulatory bodies.
- 4.84 We have argued in Chapter 2 that the assessment of the extent and the development of solutions to the problem of DToC should be developed at the local level. It is also our view that the mechanisms through which change is achieved should also primarily be developed at the local level.

## H. EUROPEAN ISSUES

- 4.85 As we have already commented, WHO recognises that the management of transitions and co-ordination of health and social care are a challenge to many countries. *Patients' Experiences with Hospital Care in Five Countries (Germany, Sweden, Switzerland, UK and US)* (Coulter and Cleary 2001) drew on a World Health Organisation survey of OECD countries. Problems with co-ordination around admission and discharge were identified for up to a fifth of hospital patients surveyed.
- 4.86 The varying organisation of, and funding arrangements for, health and social care inevitably means that different issues arise in different countries. Generally, we have found that specific transitions such as discharge from acute hospital settings are not considered as a separate issue from the broader agenda around co-ordinating transitions through integrated care for older people and for those with long term conditions.
- 4.87 **Finland** has faced some difficulties (Haakinen 2005). Funding arrangements whereby outpatient services are financed through national health insurance, whereas hospital services and nursing homes are paid by municipalities, has built in perverse incentives tending to the over-use of hospital care at the expense of community based services.
- 4.88 **Sweden and Denmark** have both experimented with enabling acute

hospitals to charge local authorities in relation to delayed discharges. There has been concern about the impact on partnership-working leading to a reluctance to use the available sanctions. There has also been scepticism about the impact of charging given the pre-existing downward trend in delayed discharges. (Styborn and Thorslund 1993) The emphasis in Sweden has moved away from conceptualising the management of transitions as the problem of 'bed-blocking' towards seeking integration through the development of networks, - referred to locally as 'chains of care' (Ahgren and Axelsson) - and pooled budgets, (Hultberg et al 2005).

- 4.89 Reforms in **Germany** initially built in perverse incentives by giving choice of insurance providers (commissioners) to its citizens, without making special arrangements for those with long term health problems. Subsequently, an approach based on 'risk pools' was established and financial incentives are now offered for the development by insurance providers of networks of integrated care (Stock et al 2007, Saltman et al 2006).
- 4.90 **France** has tended to take one of the least market-oriented approaches to the reform of its health system and has a strong tradition of top-down (national) public administration (Bellanger and Mosse 2005). Dating back to the 1960s, the French have, however, developed regional community-based specialties for people with long term conditions. For example, Stuart and Weinrich's (2004) study relating to COPD illustrates how the development of physician-led networks, including patient co-produced, community, intermediate and acute services, provided sustainable alternatives to institutional care for people with COPD. Transitions into and out of acute hospitals are managed from within the network.
- 4.91 There is evidence in the **Netherlands** of integrated networks operating across the public and private sectors in health, social care and community development for over 30 years. The Dutch take the perspective that:
- "Growing and more complex clinical needs ... as a result of ageing and changes in the values of both care givers and those cared for will require health and social care systems to develop and strengthen integrated care arrangements beyond the boundaries of public and private institutions, long-term and short-term care, purchasers and providers and beyond health and social care."
- (Mur-Veeman et al, 2003)
- 4.92 Plochg et al (2006) note that in the Netherlands, as with most governments, there is a failure to embed population health considerations into their health systems and incentive structures. Whilst partnerships with network-based governance can successfully operate across health social care and public private boundaries, incentive structures and population-based performance measures need to be developed to foster community-based integrated care.
- 4.93 The operation of networks across not only health and social care boundaries

but also across public and private sector organisations offers an alternative approach to integration from the structural integration of services in Northern Ireland.

## I. NORTH AMERICAN ISSUES

### Canada

- 4.94 McWilliam and Ward-Griffin (2006) record the move from the centralized allocation and control of resources typical of publicly funded home care programmes in Canada, to empowerment and partnership between health, social care staff and carers in, for example, Ontario.
- 4.95 The degree of co-ordination or fragmentation across public/ private sector boundaries and the existence of policy networks around these boundaries is seen as the key to understanding the difficulties of translating policy into practice and policy drift in the Canadian health sector (Gildiner 2007).

### USA

- 4.96 There has already been considerable interest in Wales (and England) in the models of integrated care found in Health Management Organisations (HMOs) in the USA such as Kaiser Permanente (KP). KP is a not-for-profit HMO that contracts with individuals and groups, (for example of employers on behalf of employees) to arrange comprehensive medical services for them. As in Europe, issues around discharge arrangements between acute and community care are within the context of an integrated approach to the management of care.
- 4.97 In considering the transferability of the KP model into the Welsh context, (as in *Designed to Improve Health and the Management of Chronic Conditions in Wales*, Welsh Assembly Government 2007) much of the emphasis has been on the proactive and planned management of the care of people with chronic conditions through four escalating levels of care. There has been less emphasis, perhaps, on the transferability of governance aspects of the model that might also play an important part in managing transitions well.
- 4.98 In *From the Rockies to the Rhondda* (Welsh NHS Confederation 2005) it was pointed out that in the KP arrangements, the average length of stay in an acute hospital for a broad case mix, including orthopaedic trauma and stroke, was 3-4 days. This was feasible because KP has invested in, and had sub-contracts for: facilities for rehabilitation, skilled nursing, assistive technology, supported housing, and continuing care. Patient management remains the responsibility of a KP internist (physician) even when other specialist services are required. Integrated care enables patients to move easily between hospitals and the community. Medical specialists and generalists work

together in multi-specialty medical groups that are decoupled from the hospital setting and focus on providing care in the most appropriate setting.

## **J. THE EVIDENCE BASE AND POLICY DEVELOPMENT: OBSERVATIONS**

4.99 In considering evidence and experience from elsewhere in the UK, Europe and North America we would draw the following conclusions:

- The emphasis in Wales should be on creating integrated systems as a whole – not just the transitions between acute hospital care and other aspects of the care system.
- Policy on delayed transfers of care should be fully integrated with policy on chronic conditions and emergency care.
- Measuring DToC is a useful signal for local partnerships about how effectively they are managing transitions between various health and social care settings, but an over-emphasis on DToC can have harmful unintended consequences.
- Currencies, incentives and performance management based on ‘care bundles’ should be developed in Wales, drawing on the positive aspects of developments elsewhere; for example: care pathways as in Sweden, integrated programmes of care, like those in Northern Ireland and public health based incentives as in the Netherlands.
- Commissioners in Wales should actively manage the market to ensure sufficient capacity in terms of supporting people at home, and in terms of care home options.
- We should be thinking beyond a move to block contracts from spot-purchasing in the domiciliary and care home sectors, to creating integrated networks, based on Local Service Boards, that include private sector partners akin to networks in the Netherlands.
- The integration of primary and secondary care clinicians into multi-specialty community-based teams who commission acute care as part of an integrated network along the lines of the American HMO model should be pursued. It is envisaged that this could be achieved through networked forms of governance (see Chapter 6) that do not impact on employment status; for example GPs who are independent contractors would remain independent contractors.
- Older people, carers and those with long term conditions should have the opportunity to be co-producers of care, as in the French regional networks in which clients chose to pool their benefits to fund locally

based services. Involving patients, clients and carers as co-producers of care accords with the recommendations of the Beecham Report.

- If network-based approaches are developed along the lines we describe in Chapter 6 and recommend in Chapter 8, then incentives and sanctions appropriate to network forms of governance (Warner et al 2005), rather than market forms of governance need to be developed. This could include greater direct involvement of the community in the work of LSBs (compare with direct election to Health Boards being consulted upon in the Local Healthcare Bill in Scotland).

4.100 Addressing these issues from a whole systems perspective focused at the local level would offer the opportunity to go beyond the symptoms behind the problems of transition in Wales to address their root causes. Their implications are reflected in the overall conclusions and recommendations set out in Chapter 8 of this Review.



## **CHAPTER 5**

### **PATIENT WELL-BEING, SYSTEM CAPACITY, AND EFFICIENCY**

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#### **A. INTRODUCTION**

5.1 This chapter covers:

- The impact of delays, on the well-being of those patients whose transfer has been delayed;
- The availability of sufficient capacity – of all types - to meet the needs of patients who are delayed, or who are liable to delay if such provision is not available;
- Workforce issues;
- The efficiency of discharge processes.

#### **B. HOW TO SAFEGUARD THE WELL-BEING OF DELAYED PATIENTS**

5.2 Delayed transfers of care are, by definition, examples of unsatisfactory care. In most cases they expose patients to unnecessary dangers, prolong periods of uncertainty about the future, impose burdens on patients' families, and may reduce patients' long-term chances of recovering their independence and full health. Hence, the NHS and its partners must do all that they can to preserve the patient's well-being during any period of delay. The most obvious way to achieve this is by reducing the delay itself. This section, however, focuses on those other aspects of the way in which services are provided during any period of delay that might have significantly adverse effects on patients' well-being.

5.3 This is often a very sensitive time for both patients and their families. Delayed discharge is often associated with one or more physical moves, including long-term into a new care setting. Where such a change is occurring the patient faces having to leave behind the home and way of life with which they are familiar, moving to circumstances which are largely unknown. Relatives are living through this transition too. And at the same time they are having to come to terms with the fact that their relative is entering a changed – and possibly final – phase of their life, and that their capacities may be greatly reduced. Relatives may feel guilty that this change somehow reflects their own 'failure' to support their loved one adequately; they may be dealing with feelings akin to bereavement.

5.4 At the same time, important decisions have to be made, not just about the location of a new home, but about its type, a new set of carers and neighbours, and about the financial arrangement. For many, this will be a

once-and-for-all decision about the final phase of someone's life. All of this occurs largely unplanned, in circumstances of no-one's choosing, and knowing that the time in which to make a decision is severely limited.

- 5.5 Our discussion with patients and carer representatives, advocates, and a wide variety of staff involved in providing services highlights several aspects of the care and support provided at this time which sometimes adversely affects patients' and families' well-being. This is reflected in the literature on the topic. While it is undoubtedly the case that many patients delayed in hospital make the change to the next phase of their life in a wholly satisfactory and appropriate manner, we received evidence of sufficient cases where this did not happen to suggest that services still need to pay more attention to these aspects of care.
- 5.6 The following areas all merit attention, as being aspects of service provision which may not always work well, and which can then have a significant impact on people's well-being.

### **Are Patients and Their Relatives Given Enough Information?**

- 5.7 Patients and their families need quite a lot of understandable information to enable them to make a decision about the next stage of care. This includes needing to understand:
- the varieties of new care setting available locally, and
  - how to choose between them;
  - the complexities of the different types of statutory funding of different sorts of care;
  - the process for 'means testing';
  - the different sorts of financial help available;
  - how patients are assessed to decide on the type of care they need;
  - how to appeal.
- 5.8 There is a lot of information available, from a variety of reputable sources, covering most of what is needed, and generally it would appear that most patients and their families are provided with it. However, for some there is too much information, and a lack of explanation. In other words, relatives are provided with a range of leaflets and other advice, but sometimes find it difficult to have time to talk with staff in order to understand it, and apply it to their own circumstances. The Review was informed of examples where patients and families were unaware of key aspects of the system designed to ease this very period of transition – for example, the alternatives to selling the family home, or the 'grace period' where patients are able to decide whether their new care setting is appropriate.
- 5.9 It is impossible to quantify precisely the extent of this problem, but there are certainly good grounds, based on interviews with frontline staff, for supposing that there is a problem in practice. Clearly, the needs of different

families will vary, with many quite content to deal with the system themselves using the information available; others may struggle because they feel particularly vulnerable in the circumstances in which they find themselves, and therefore require much more support. Relatives who do not live near the delayed patient face particular problems. NHS and Social Services staff need to regularly audit their performance in this respect, perhaps using independent third parties to provide feedback on the success of their efforts to inform people.

### **Are Patients' Families Involved Enough in Making Decisions?**

- 5.10 One of the complications of discharge is the need in many cases to involve a variety of relatives in considering and planning for the discharge. There are logistical challenges to overcome – agreeing mutually convenient meeting arrangements, sometimes involving people travelling long distances. There is also concern that in some cases professional staff seem reluctant to involve family members as equal partners in making these important decisions. This was highlighted by a number of interviewees as a difficult task; and there may be concerns about conflicts of interest, around financial circumstances or family relationships which properly should be taken into account.
- 5.11 It would appear that such problems are relatively rare, but their existence highlights the need for staff training and support, and regular audit of families' - as well as patients' – experience of the service.

### **Should Independent Help Be Available?**

- 5.12 In those cases where – for whatever reason – the decisions about discharge are difficult and could cause delay, advocates who can independently support people can play an important role. This might simply involve improving communications between the patient and professionals; or it might involve setting up discussions which allow the patient to make a free and informed choice. Sometimes this role can be performed by a social worker, nurse or other employee; but on other occasions, third party advocacy can be more appropriate.
- 5.13 The value of such a role is generally accepted by the organisations we visited, but the arrangements for ensuring that such advocacy is easily available vary considerably. In some cases, voluntary sector agencies are paid to provide such a service, and are well used; in others, special arrangements have to be made *ad hoc*, with the result that advocates are rarely used.
- 5.14 Where advocacy appears to work best, skilled advocates are available as part of a dedicated service, with sustained funding. Ideally, they are located close to the nurses and social workers with whom they will work, and there is good mutual understanding of each other's role and how advocates can help all concerned. In such cases, referrals by social workers and nurses are common, before problems have arisen. However, even where advocacy

services exist, there are still some examples of social workers and nurses who are reluctant to involve an advocate, seeing it as an impediment to the process – perhaps ‘raising false hopes’ for the patient, or pointlessly ‘delaying the inevitable’.

### **Does Discharge Planning Start Too Late?**

- 5.15 For some time there has been a general acceptance that planning for discharge should begin almost immediately following admission (and, where feasible, even *before* admission), with continuing re-appraisal of the plans as the patient’s care progresses. It is often possible to identify on admission those patients whose eventual transfer is most likely to be delayed, and to anticipate and address the problems from the start of their stay in hospital. This was accepted as good practice by all of the organisations we visited, and it was incorporated in their formal procedures. It would appear that, in practice, most of the discharge needs of most patients are in fact approached this way. However, feedback to us from patient and carer representatives in particular would suggest that in a minority of cases such early planning is not always carried out very effectively. Examples were reported where, for instance, the social worker did not become involved at the earliest stage, or where the patient and family were not fully involved until the date of discharge was imminent. Sometimes these delays were caused by operational difficulties – for example, admission to wards not intended for the patient’s specialty, or lack of availability of key staff. In other cases, it would appear that some staff were reluctant to engage with the family because of the difficult decisions required, or because the outcome was likely to be contentious.
- 5.16 Generally, such delays have an adverse impact on patients’ well-being. In addition to the delays they cause, they can result in patients having to make very difficult decisions late in the process when the time constraints are most acute.
- 5.17 However, some interviewees described an emerging view that leaving such planning until just before, or immediately after hospital admission is, in fact, too late. For as the population ages, acute episodes of hospital care become ever more likely for older people – either for routine attention to physical illnesses or for unplanned attention to failing minds and bodies. Primary care teams are well placed – as part of their care of older people – to encourage their patients to contemplate when it might be sensible to contemplate lifestyle changes or prepare their home for increased dependence.

### **Are We Recognising Cultural Differences?**

- 5.18 Patients who have particular cultural or religious requirements of their new home following discharge can experience additional stress in trying to locate suitable accommodation. Many NHS Trusts and Social Services departments recognise this, and have arrangements in place to offer appropriate

information, advice and support. It would appear that this often works well. However, the situation varies across Wales, misconceptions still exist about the inappropriateness of particular homes or settings for people from different groups, and continuing effort is required to highlight and resolve them.

- 5.19 In many parts of Wales the availability of services and care offered in Welsh is an important factor, and should be taken into account when assessing the adequacy of total provision for such communities.

**Does Personal Financial Responsibility for Continuing Care result in delayed transfers?**

- 5.20 The arrangements for determining the financial responsibility for care following discharge are complex, and particularly confusing for patients and relatives who will often not have had to think about such issues before. For example, the Review met senior councillors with long experience of social services matters who were unaware of the arrangements in force. The possibility of unreasonable behaviour and avoidance by relatives anxious to protect either 'their financial inheritance' or simply wishing to retain a family home that symbolises 'family' in less tangible ways are well rehearsed.
- 5.21 This matter was raised by interviewees on so many occasions during the team's programme of interviews that it was decided to commission a limited survey of the number of patients who were felt to be using either financial reasons or 'choice' to delay their placement in a new setting. This work should not be considered to be definitive. Instead it is simply an attempt to gauge the extent, on a sample basis, of the size of a problem which was raised in every locality the Review team visited.
- 5.22 The survey was undertaken on the January 2008 DToC census day in three NHS Trusts. The team of professionals involved in coordinating care for delayed patients was asked to use its judgement to determine whether the patient or their relatives were seeking to delay the placement process for financial reasons. This covered two basic issues. First, whether the patient or their relative were openly challenging placements on financial grounds; and second whether the team undertaking the survey considered that the way in which choice was being exercised was in some way designed to delay the placement. This of course means that there would be no direct relation between the codes allocated to the patients represented in the table below and the census submission for the month of January for the three NHS Trusts who participated in this exercise.
- 5.23 The results below in Table 5.1 demonstrate that the numbers of patients judged to be delaying the process for these reasons is relatively small. However, the census team were also asked to annotate the survey and the notations are illuminating in the way that they describe the very real problems being experienced by frontline staff in this area. They included:

- family stated ‘they did not feel their mother should pay for her long term care’;
- family member with power of attorney ‘will not engage with the Trust despite recorded mail being sent’;
- ‘family refuse to discuss discharge’ .

**Table 5.1: Patient Delay: Choices Exercised**

Trust	Average number of DTOCs per month Oct – Dec 2007	No of patients judged to be delaying transfer for financial reasons?	If ‘patient choice’ is the recorded reason for delay, is this caused by:-		
			Trying to find accommodation in right locality	Trying to find services of the right quality	Other
A	40	2	1	4	
B	26		7		1
C	76	5	3	3	3

Source: WIHSC Survey

- 5.24 The table shows that, in the NHS Trusts surveyed, about 5% of patients or relatives were judged to be delaying the discharge from hospital for financial reasons, and 8% because of the location of accommodation. The 5% of patients or relatives who were considered to be delaying for quality reasons had sometimes indicated that there were no homes at all which offered services of the right quality.
- 5.25 Where the assessment was made that the delay was related to choice, the most commonly reported reason was that the family would only consider a placement to one specific setting and would not nominate any other choices.
- 5.26 No major conclusions can be drawn from this limited exercise. But, on the basis of this evidence, it would appear that the numbers of patients ‘perversely’ delaying their transfer is small, although they require a disproportionate investment of staff time to resolve the issue.
- 5.27 There is often considerable anxiety caused for patients and relatives around discussions which they may perceive to be designed primarily to shift the cost burden between different statutory agencies, or on to themselves. Further, among older people in particular, there is some sense of unfairness that healthcare they think should be covered by the National Insurance contributions they have paid to the State all their lives has now to be paid for again if savings or assets are available. There may also be a mis-match between people’s view of what is ‘fair’ and what the law prescribes. For more knowledgeable relatives and patients this is sometimes made worse by the differences around funding which now exist in different parts of the United Kingdom. There is also evidence of growing concern that the law is not being properly applied, and patients are increasingly considering taking legal action. Such legal challenges are likely to increase, at least in the short term.

- 5.28 Given this background, it is important that patients and their relatives understand the processes involved and have confidence in their impartiality and effectiveness. Statutory agencies need to ensure that procedures are always followed; they also need to communicate their decisions – and the reasons for them – effectively. During our programme of visits, we found little evidence of organisations routinely auditing this aspect of their performance.

### **Do Patients Really Have a Choice About Their Care?**

- 5.29 The notion of patient choice is said to be central to all discharge planning. Provisions to ensure ‘choice’ are enshrined in the procedures of all the organisations we examined. Guidance such as WHC(2004)54 and HSG(95)8/LAC(95)5 state that when a patient has been assessed as needing nursing or residential placement, the patient has the right to choose, within their assessed needs, which home he or she moves to, so long as it does not cost more than the NHS and the Local Authority Social Services would normally pay for such accommodation and care.
- 5.30 There is reason to believe that such free choice is not universal. There were many examples of parts of Wales where local provision did not allow for choice between alternatives, because the level of provision locally (because of vacancy rates, location, or perceived suitability) was such that patients and their relatives did not have a ‘real’ choice to make. This appears to be particularly true for people with dementia.
- 5.31 There were also examples of patients having to accept a care setting which was far from the ideal because, in their view, the alternatives were worse. There are also examples of the assessment process being affected by knowledge about the likelihood of available services. For example, where facilities for the elderly mentally ill were some distance away – and for that reason were likely to be strongly resisted by relatives – assessments were sometimes adjusted to enable patients to be admitted to local homes that were not registered for this category. The guidance acknowledges that, where a place in the chosen home is unavailable and is unlikely to be available in the near future, it may be necessary for the patient to transfer to another home until a place is available. The guidance also comments that where patients have been assessed as not needing NHS inpatient care, they do not have the right indefinitely to occupy an NHS bed.
- 5.32 One way of dealing with this problem is to allow patients to ‘try out’ a new care setting to see if they like it, before permanently moving in. Whilst this option may be available in most localities in theory, we were told that in practice patients did not believe that they were really ‘trying it out’, because they knew either that there was nowhere else to go, or that the process of settling in and then moving back to hospital if they did not like it was too difficult to contemplate. Some professional staff also noted that, at times of

pressure, patients still in hospital would have priority for nursing home places over those now temporarily placed in settings that were not their first choice.

- 5.33 Similarly, there appeared to be a reluctance on occasion to encourage the patient to try to manage in their own homes with a care package to see if they could cope. This may have been based on a realistic assessment of the patient's capability; but it has also been described as due to reluctance by staff to accept the risks involved, or to the fact that such approaches were not common. The take-up of 'direct payments' in Wales – another way of facilitating choice and independent living - is variable, but often relatively low in comparison with other parts of the UK. The provision of intensive and free home support for a period of up to six weeks, followed by assessment of continuing needs, is yet another way of addressing this issue, but appears only to be readily available in some parts of Wales.

### **Case Study 5.1**

#### **BRO MORGANNWG**

##### **Developing a Choice of Accommodation Policy across the Bro Morgannwg Health and Social Care Community**

A Choice of Accommodation Policy has been developed and agreed by partner agencies across the Bro Morgannwg Health and Social Care Community. The organisations involved in the development and agreement of the policy are:

Bro Morgannwg NHS Trust  
Neath Port Talbot LHB  
Neath Port Talbot County Borough Council  
Bridgend LHB  
Bridgend County Borough Council  
Vale of Glamorgan LHB

The Policy has been ratified by the organisations listed above and was introduced in December 2007. There will be a review of the policy and its use after 3 months to determine if it is being accessed easily, if the content needs to be revised, what the early indications are of its effectiveness in reducing delayed transfers of care.

The aim of the policy is to recognise the right of the patient to be cared for in a setting which is most appropriate to meet their assessed needs and which takes into reasonable account their preferred choice of accommodation in a manner which recognises the rights of the individual patient under the National Assistance Act 1948 (Choice of Accommodation) Directions 1993 and the right for every individual to be treated in accordance with the Human Rights Act and the Articles of the Human Rights Convention. The overall aim of the policy will be to reduce the length of time a patient has to wait in an acute hospital bed prior to transferring to a more appropriate environment. Following the outcome of the multidisciplinary assessment, where it is indicated that care in a nursing or residential home is the most appropriate place for the patient, the patients and carers will be assisted and supported to choose a suitable and available home of their choice. However, where a bed in the home of choice is not available within a reasonable timescale, transitional arrangements may need to be put in place to meet the patients needs on a temporary basis.



**Key Steps in process**

The policy sets out a process with clear timescales to support the multi disciplinary team in planning an appropriate and timely discharge to the home of choice, or transfer to a transitional placement in a care home that can meet the patient's needs whilst waiting for the home of choice to become available

**Evidence of impact**

It is too early to identify what the impact will be, but the number delays due to choice issues since from April 2007 to January 2008 was 117. The policy will be used in all similar situations.

**Lessons Learned**

It would not have been possible to have got the policy developed and agreed without the prior establishment of a Strategic Discharge Planning Group consisting of Directors and Heads of Service across all agencies. The forum gave a focus for the development of the policy and for robust debate about use of language and intent.

Source: Bro Morgannwg NHS Trust

**What Happens if Disputes Occur?**

- 5.34 Each of the Trusts we visited reported growing levels of dissatisfaction by patients and families about the assessment of need, and the effect that this can have on who pays for continuing care. This has become a difficult area, as the consequences of the Grogan judgement (described in Chapter 3) require a re-examination of decision-making processes, and as aggrieved patients and families increasingly resort to litigation.
- 5.35 The legal situation is currently somewhat unclear, and several test cases now being prepared may clarify the position. The 1998 Human Rights Act establishes certain key principles, and the 2005 Mental Capacity Act provides a legal framework for people who lack capacity to make decisions for themselves. But a major point of difficulty described during almost all of our visits is the way in which assessments are made for Continuing NHS Healthcare.
- 5.36 The starting point for avoiding disputes is to have in place a clear policy and procedures relating to discharge and choice of future accommodation, with explicit timelines and a clear pathway. These must then be understood and followed by all professional staff. There is much that can be done to minimise the number of disputes. NLIAM has identified seven 'Essentials' underpinning good practice in this area, which constitute a practical guide to those staff directly involved:
- acknowledge that no-one wants to end up 'in dispute';
  - remember the person at the centre of the dispute;
  - communicate, communicate, communicate;
  - understand and adhere to agreed discharge policies and processes;
  - don't prejudge outcomes;
  - manage expectations from the beginning;
  - document and communicate individual and rational decisions.

- 5.37 In most cases, such good advice will avoid a dispute arising, but ensuring all staff follow the advice is a major development exercise for NHS Trusts and Social Services. We found many examples of variability in practice (see below) which would suggest that significant numbers of staff are not fully aware of their own procedures, or are not confident in following them.
- 5.38 However, where disputes still occur, we found a considerable degree of ambivalence about how to proceed if the patient ultimately refuses to leave hospital. It was clear that everyone concerned would do all they could to avoid moving a patient against their will; and many also acknowledged that they felt powerless to deal with a patient who refused to move. All of the procedures we reviewed were silent on this ultimate problem, referring instead in rather vague terms to seeking legal advice.

### **Should 'Holding Wards' Continue To Be Used?**

- 5.39 In some NHS Trusts – especially in mental health services – patients whose discharge is delayed for some time are transferred to non-acute wards or community hospitals while an appropriate discharge is arranged. This is often a part of a planned process of rehabilitation, and is therefore entirely appropriate. In some instances, however, patients are placed on wards, often away from the DGH site, with others whose conditions are far worse, because there is nowhere more appropriate available at the time – a so-called 'holding ward'. This can be distressing and adversely affect the patient's well-being, and can further delay the patient's transfer - patients can become a lesser priority for the system once they are no longer occupying an 'acute' bed. The use of 'holding wards' in this context is clearly unacceptable.

### **Do Patients' Experiences Vary?**

- 5.40 NHS, Social Services and other professional staff have a key role in balancing the needs of their individual clients with the overall need to maximise the efficiency of their services for the benefit of all. Most seem to meet both of these objectives successfully. However, there would appear to be an unacceptable level of variation between professionals here. We were informed of instances where, for example, staff were unduly anxious to get the patient and family to make a quick decision about future care, and behaved in a way which seemed to apply undue pressure to meet an arbitrary deadline, possibly at the patient's expense.
- 5.41 Such variability can give rise to patients' concerns that they are not being treated equitably. We found examples of relatives of different patients comparing their experiences, sometimes at second hand, and becoming convinced that they had suffered as a result of inequitable treatment. In the context of a complicated and at times opaque system, such grievances can easily inflame relations with the hospital or Social Services, leading to further disagreement and delay.

## C. IS CURRENT SERVICE PROVISION ADEQUATE?

### The Ideal

- 5.42 In broad terms, delays in transferring patients to more appropriate settings can have two causes: an inappropriate range of service provision; and inefficient use of that provision. This section considers the evidence relating to the former.
- 5.43 It was clear from our research in all localities, and the recent WAO and other studies confirm this, that it is important to consider the capacity of the totality of service provision in relation to delayed transfers. This embraces all those services which are designed to support people with health problems, whoever provides them. This provision will be complex and diverse, designed to meet the changing needs of individuals, and reflecting their locality and the unpredictability of many illnesses for older people. But, in general terms, the ideal range of provision in any locality would include an appropriate supply of all of the following, up to and including admission to hospital:

**Figure 5.1: The Balance of Care**

Acceptable health status			Crisis intervention				Hospital inpatient
1	2	3	4	5	6	7	8
Population health promotion	Targeted health promotion for those at known higher risk	Monitoring and timely intervention for those at higher risk	Crisis intervention: multi-agency support at home	Specialist assessment by primary/secondary care: no admission	Intensive support at home	Specialist assessment: hospital admission	Hospital diagnosis, treatment and rehabilitation

Source: WIHSC

- 5.44 The overall strategic aim should be to ensure that as many people as possible are supported for as long as possible towards the left of the spectrum (numbers 1 to 3) represented in Figure 5.1. However, it is also important that everyone who needs the more intensive interventions, 4 and above, receive them in a timely fashion.
- 5.45 Following hospital discharge - or indeed for anyone in the community of increased need - all of the following should also be available in each locality (or easily accessible), in sufficient quantity and of sufficient quality to meet need:

**Figure 5.2: The Balance of Support**

Increasing levels of dependency...				
1	2	3	4	5
Short and ongoing domiciliary support for those living in own homes (and for carers), inc access to 'day care' facilities	Supported housing, of various types including extended care	Residential homes	Nursing homes	Specialised care facilities including community hospital settings

Source: WIHSC

5.46 The responsibility for the provision of the various elements in Figure 5.2 will typically be shared between:

- the NHS (secondary, community and primary care);
- Social Services;
- Statutory and voluntary sector housing organisations;
- Other voluntary sector providers;
- The commercial sector.

5.47 Typically though, the majority of support will come from family and friends. Services will generally be supported by a mixture of direct provision by statutory agencies, contracted-for provision by third parties, private-payer provision, and voluntary services.

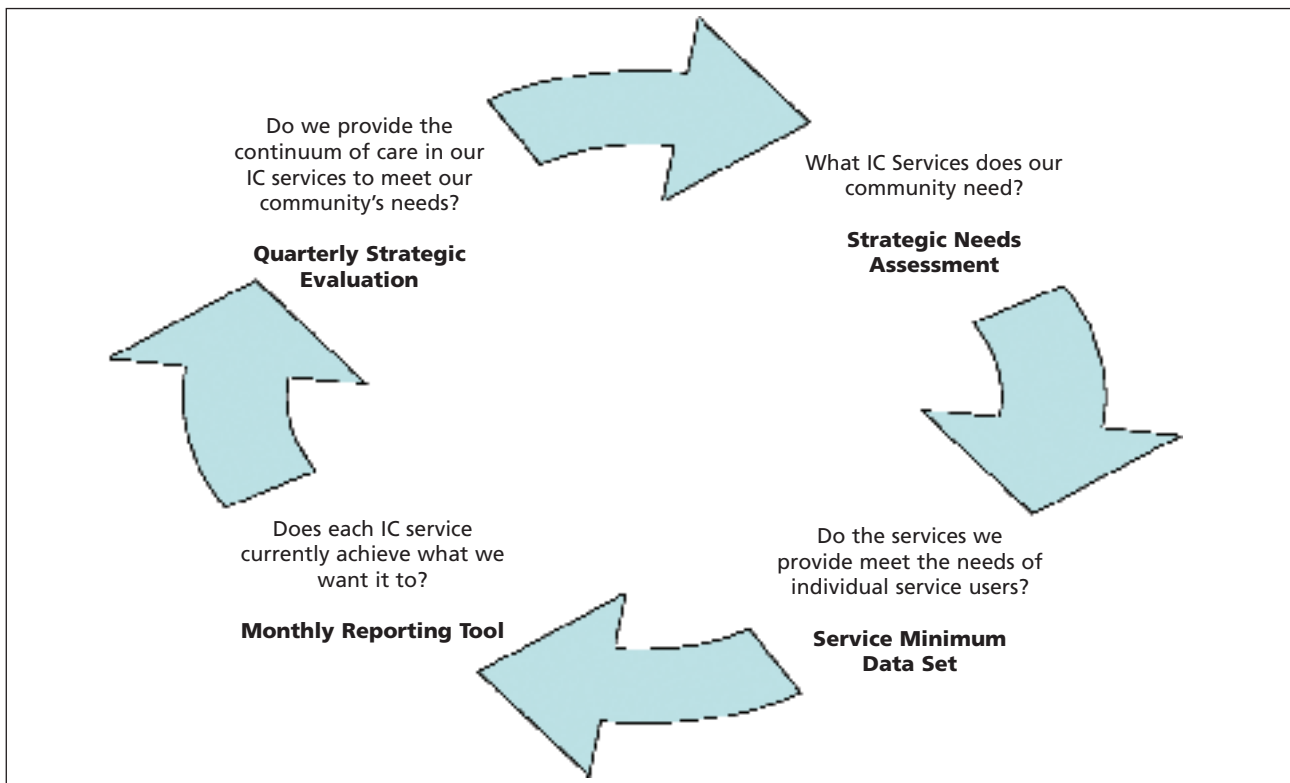
5.48 The consequences of 'unbalanced' provision across this spectrum will be seen in increasing numbers of people not being supported appropriately, for example in admission to a hospital instead of crisis support at home, or in admission to long-term residential or nursing homes instead of staying at home with an appropriate package of care. The lack of balance is also likely to be reflected in increased numbers of patients with delayed transfers of care, since a disproportionate number of delayed patients were first admitted as emergencies with all the disruption to often fragile domestic support which this can entail.

### **Achieving The Ideal**

5.49 This 'blueprint' requires local adaptation to meet local needs. In particular, it requires an informed assessment, and continuing re-assessment, of the quantity, quality and location of the various types of provision, and it may require early action by the relevant statutory agencies to ensure that sufficient the provision is available. This may take the form of direct control (e.g. through NHS or social services direct provision), or it may require the use of various 'contractual' levers, the use of the regulatory system, or other forms of facilitation.

- 5.50 Each locality, therefore, should have a shared view amongst all the stakeholders on:
- the key elements of the Balance of Care and Balance of Support which is optimal for that locality, both now and for the foreseeable future;
  - the volume and location of provision;
  - the optimal range of providers – including the place for directly managed provision where the market, however well managed, is unlikely to deliver adequate and sustainable services ;
  - the desired levels of quality;
  - clear policies and procedures for its successful operation;
  - the responsibilities for its realisation, and the methods available;
  - the timescale for formally reviewing the balance of care/support model.
- 5.51 The process which should underpin this is similar to that summarised in Figure 5.3. This relates particularly to intermediate care, but is capable of wider application:

**Figure 5.3: Achieving the Optimum Balance of Care**



Source: NLIAH Development and Implementation of a National Intermediate Care Services Evaluation Tool

- 5.52 We looked in particular for evidence that this was in place, reviewing the relevant documentation from each locality which we visited, and reviewing the findings of the Wales Audit Office study.

- 5.53 We were unable to find a locality in Wales which had a fully developed local agreement on all seven of these elements, although most had some in place. For example, quality issues (d. above) were addressed everywhere through a variety of national and local standards, and procedures were in place for their monitoring; assessment and referral protocols (e. above) were being used in each locality, with varying degrees of success (see discussion later).
- 5.54 In relation to items a. to c., most localities had a shared understanding about the (in)adequacy of certain key elements of provision, and were taking steps to address them. In many places, for example, the range of support for older people with mental health problems was imbalanced, and attempts were being made to rectify this. Many locations had also identified a lack of domiciliary support and crisis intervention services, and these were also being addressed. Where such needs were apparent, the responsibilities for addressing them (f. above) had generally been determined.
- 5.55 But much of this response was essentially *ad hoc*, responding to isolated elements of the totality or to difficulties which had become apparent, rather than anticipating, and therefore avoiding them. In other parts of Wales, there was very little evidence of any proactive efforts to shape the level and type of care available, especially that from non-statutory sector providers. Many interviewees in these localities shared a belief that little could actually be done to shape private sector provision anyway, and therefore there was little point in trying. There was little evidence in these cases of working in partnership with private and voluntary sector providers, on either the commissioning or provision of services (see also Chapter 6).

## Case Study 5.2

### PEMBROKESHIRE & DERWEN

#### South Pembrokeshire Health and Social Care Resource Centre

##### History

Following a Community Health Council review of community services in Pembrokeshire, it was agreed that health and social care services for adults and older people should have a fully integrated approach, provided by local statutory and non-statutory agencies.

The service is jointly resourced between Pembrokeshire and Derwen NHS Trust and Pembrokeshire Social Care and Housing Directorate. Partners include, Pembrokeshire Association of Voluntary Services, Pembrokeshire Local Health Board, local General Practitioners, and the Community Health Council.

South Pembrokeshire Hospital Health and Social care Resource Centre opened in March 2007.

##### Objectives

The primary objective in modernising community services in this way was to ensure effective use of NHS, local government and voluntary sector resources through more effective commissioning, use of professional skills and removing duplication and overlap between services. The delivery of integrated services to patients, customers and carers in this modern clinical and social care environment includes:

- A Day Care Unit with capacity for 70 places delivering rehabilitation and reablement care both to those people living in the community and those who require in-patient care.
- 40 in-patient beds, 35 for health care, rehabilitation, wound management, palliative care and 5 beds for re-ablement support for community clients.
- Voluntary Groups
- Full range of Allied Health Professional services.
- Social Care Teams on site
- District Nurse Evening Service
- Macmillan Nurse
- Minor Injury Department
- Care on Call
- Radiology
- Outpatient department

#### **Evidence of impact**

Work is in progress to measure patient/client outcomes as a result of accessing the Resource Centre. However, an initial review has revealed evidence of effective joint working:

- By December 2007 within the Acute and Community Division, DToC had reduced to zero.
- Improved co-ordination of services and joint working has led to a reduced length of stay. During the same period in 2006, average length of stay was 39.9 days, it has been reduced to 39 days.

#### **Lessons learned**

A joint appointment of a Resource Centre Manager has been in place for 10 months, but there are still issues to be resolved in delegating accountability for matters such as information sharing, etc. A decision matrix is being agreed to clearly define accountability in decision making relating to services run from the Resource Centre, but which are not jointly provided.

Source: Pembrokeshire & Derwen NHS Trust

5.56 The Swansea case study (5.3) illustrates another of the many initiatives in Wales to redress some of the imbalance in the current provision of care. It also, however, shows the difficulty of establishing a causal link between such developments and reductions in delayed transfers of care, since the level of delayed transfers in Swansea has remained fairly constant during the period that this new service has been introduced. This lack of simple cause and effect is not surprising – it reflects the multiple causes of delay – and points to the need to address simultaneously all of the factors involved.

### **Case Study 5.3**

#### **SWANSEA**

##### **Swansea Chronic Conditions Management Service**

The Swansea Chronic Conditions Management Service is a Swansea-wide health care service based within primary care. The nurses, known as case managers, are employed by Swansea LHB, but work seamlessly across health, social and voluntary organisations. The involvement of the Medicines Management team is key to the success of the scheme.

##### **History and Objectives**

Following a pilot study in 2005/06, the Chronic Conditions Management service was rolled out across the Swansea locality. Living with a chronic condition can have a significant impact on a person's

quality of life. Individuals are more likely to visit the GP, be admitted to hospital and be an inpatient for longer following admission. Good chronic conditions management offers real opportunities for improvements in patient care, service quality and reduction in costs. People can be helped to prevent crisis or deterioration and be enabled to improve their quality of life.

The aim of the Chronic Conditions Management Service is to: -

- help people with complex chronic conditions manage their conditions more effectively and stay healthier for longer
- reduce avoidable or over-long stays in hospital
- provide accessible and prompt support for individuals in their own homes
- maximise or maintain the independence and quality of life of people with complex long term conditions, their families and carers.

### **Evidence of Impact**

The latest emergency medical admission data for the 2007/08 period demonstrates a 13.5% reduction compared to the same period in 2006/07. This equates to approximately 100 admissions less per month since the schemes introduction.

### **Lessons learned**

- Involve key stakeholders as early as possible
- Work tirelessly to raise profile of service and educate others on the service remit
- Be prepared for change and evolution of new service to fit with the needs of the community
- Establish links with specialist regional services for timely and effective co-working and communication
- The importance of effective medicines management should not be underestimated.

Source: Swansea Local Health Board

## **Is There Enough Overall Provision of Care for the Older Population?**

- 5.57 The balance between supply and demand varies considerably across Wales. There are certain types of provision which appear inadequate in most parts of the country; there are some which are more problematic in rural areas; and some whose actuality is barely realised anywhere. In all cases, the task of balancing supply and demand is hampered by the lack of active long-term planning across the spectrum of services identified above.
- 5.58 The best approximations on the relationship between the supply of, and the demand for support services for older people are based on proxies and assumptions about demand. There is little independent evidence of the need for different types of service and support, because 'need' is generally only assessed when patients present with a problem. There is no reliable estimate, for example, of the number of people living in any community whose levels of support are inadequate, but who do not present as a 'case' for health or social services. Similarly, there is little direct evidence on the number of patients transferred to a care setting which they regard as sub-optimal, or on 'inappropriate' discharges generally. As a result, conclusions about overall demand must be tentative.
- 5.59 The relationship between supply and demand in respect of the support for older people and the reported level of delayed transfers of care is also



problematic. As Chapter 2 has shown, many of the relationships which would appear – intuitively – to be reasonable, such as that between DToC and the level of social services spending on older people do not appear statistically significant. In essence, this is because the cause and effect relationships are multi-factorial, and highly geographically specific. They also probably reflect various (largely unquantified) factors, such as the varying costs of service provision, level of private financing of long-term care, and public expectations.

- 5.60 This complexity argues strongly for the need for all stakeholders in each locality to develop a shared understanding of their own demand and supply-side factors. The evidence presented here from the fieldwork – and also Chapter 2 – illustrates the various issues which affect demand and supply in different parts of the country; but this requires calibration to local circumstances.

### **Demand**

- 5.61 Certain broad conclusions are reasonable, however. The background demand for care from people with increasing dependency is rising. Although initiatives to improve health in older age may have some impact on the level of dependency, the rising numbers of older people seem set to increase overall demand. In 2001, there were 59,000 people aged 85 and over in Wales; this had increased to 67,000 by 2006; and by 2010 it is projected to have increased by 28.8% to 76,000 [Government Actuaries Department, 2007]. The Wales Care Strategy Group examined the impact of these demographic pressures on the demand for services in their report published in April 2003 which examined the Care Needs of Older People in Wales [Wales Care Strategy Group, 2003].
- 5.62 A study from the Personal Social Services Research Unit, (Wittenberg *et al*, 2006), projects a doubling in the number of disabled older people in England between 2002 and 2041. However, it points out that the service and cost implications of this vary considerably according to the assumptions made about:
- future disability rates;
  - changes in unit costs;
  - the availability of informal care;
  - support for carers; and
  - the threshold levels for state support.
- 5.63 Important, too, are the assumptions made about the best balance of care between, for example, residential and domiciliary care.

## Domiciliary Care

- 5.64 In the first weeks after discharge and for longer periods thereafter, all stakeholders acknowledged domiciliary care to be a core element of the ideal overall balance of support (Level 1 in the balance of care). It was generally recognised to be the preferred option for many patients, allowing people to remain in their own home, family and community, and being capable of escalating support to meet changing needs.
- 5.65 There are substantial variations across Wales in the amount and type of domiciliary care provided. Evidence from the Local Government Data Unit suggests that the total number of people supported at home with domiciliary care has changed little over the past few years. However, the total volume of such care increased by 29% between 2001/2 and 2005/6, as the level of input per person has increased by almost a third, suggesting greater levels of dependency for individual clients.

**Table 5.2: Trends In Local Authority Funded Services Provided In House And By The Independent Sector**

Sample week in year	Total clients 65+ receiving homecare	Total hours home care per week clients 65+	Average home care hours per client
2001-2002	20,459	126,410	6.18
2002-2003	21,863	155,976	7.13
2003-2004	21,962	169,921	7.73
2004-2005	20,094	159,410	7.93
2005-2006	20,198	163,314	8.08

Source: Local Government Data Unit – Wales Adult Homecare Service Intensity Analysis

- 5.66 This Review found few localities that had conducted a thorough assessment of how much care at home was needed, where, and of what types, and how this could be expected to change over the near future. However, there was general recognition that more care at home was needed – now and for the future – and that development in this part of the spectrum of support was a priority. Key constraints on further development were:
- Finance – although this was a priority area, limited additional funding was available, and there were felt to be very few areas for dis-investment from existing provision;
  - Staff availability – many of the more rural areas of Wales reported difficulty in attracting sufficient staff to provide domiciliary care for all those who wanted it. This was in part a product of sparsity since the greater traveling distances involved required more per capita carer time, and in part because of a shortage of people interested in taking up such posts. Elsewhere, alternative employment was available that was more attractive in terms of income and stress. Also, the increasing level of demand on community nursing services, and the level of dependency of their patients, was described in several localities, and is already stimulating a re-appraisal of such services. Workforce factors are discussed in more detail below;

- Suitability of patients – the increase in the average level of support provided to people in recent years supports the evidence quoted to us of increasing thresholds for care at home.
- 5.67 Some parts of Wales are routinely offering up to 6 weeks of intensive domiciliary support for patients discharged from hospital (see Case Study 5.4). They argue that such support, based on purposive rehabilitation, followed by assessment in the home at the end of the 6 weeks, often reduces the patient's longer-term dependency levels, and results in more people being able to be supported in their own homes. Although this approach has been endorsed by the Welsh Assembly Government, not all localities appear to provide a comprehensive service at present.

### **Case Study 5.4**

#### **MERTHYR TYDFIL**

##### **Initial Response Service**

Funding became available from the Welsh Assembly Government for the provision of 6 weeks free home care to people discharged from hospital and receiving services for the first time. This was part of an initiative to reduce delayed transfers of care and ensure that individuals received support on discharge from hospital. Merthyr saw this as an opportunity to combine the additional funding with existing funding to develop an enabling service. As the effectiveness of the service in enabling customers was proven over a 2 year period, it was decided to extend this service to encompass all new referrals for personal care services.

'This is a community-based domiciliary care service. It started in May 2003, originally to support people in their home for a fixed period following discharge from hospital. All initial requests for home care are assessed quickly and the team can respond promptly to the needs outlined in care plans. It works to maximise the individual's independence and to identify the longer term support needs of customers. Because the team monitors the numbers of people not requiring a service after 6 weeks or requiring a reduced service, they have been able to demonstrate a positive effect on reducing the need for longer-term support' – Joint Review

##### **Reablement**

The Reablement Team in Merthyr was originally set up as a 3-bedded step-down intermediate care scheme that was to focus on supporting people discharged from hospital following a stroke. The evidence for developing this service was provided by the Trust and suggested that there was a gap in service provision for people with stroke. Once the service became operational it was soon evident from the number of referrals that this service would be under-utilised and the service was revised over a 6 month period into the service that continues today.

The funding for this service is through the Joint Working Special Grant previously known as Flexibilities which was provided by the Assembly to promote innovative joint working between partner agencies such as Local Authorities and trusts.

The Initial Response Service provides packages of personal care to all customers who are receiving support for the first time following an assessment under the Unified Assessment Process. Staff work in partnership with customers to increase their confidence and encourage them to consider alternative ways to meet their needs and maximise their independence. The level of support provided in the first instance is dependent on the assessment, the level of support is then refined as the service progresses. The team is made up of 14 support staff and one manager. The Reablement Team predominantly takes referrals from hospital-based occupational therapists and physiotherapists as part

of the discharge arrangements and provides time-limited therapeutic interventions. The team is made up of 1 physiotherapist, 1 occupational therapist, 1 speech/language therapist and 2 support staff.

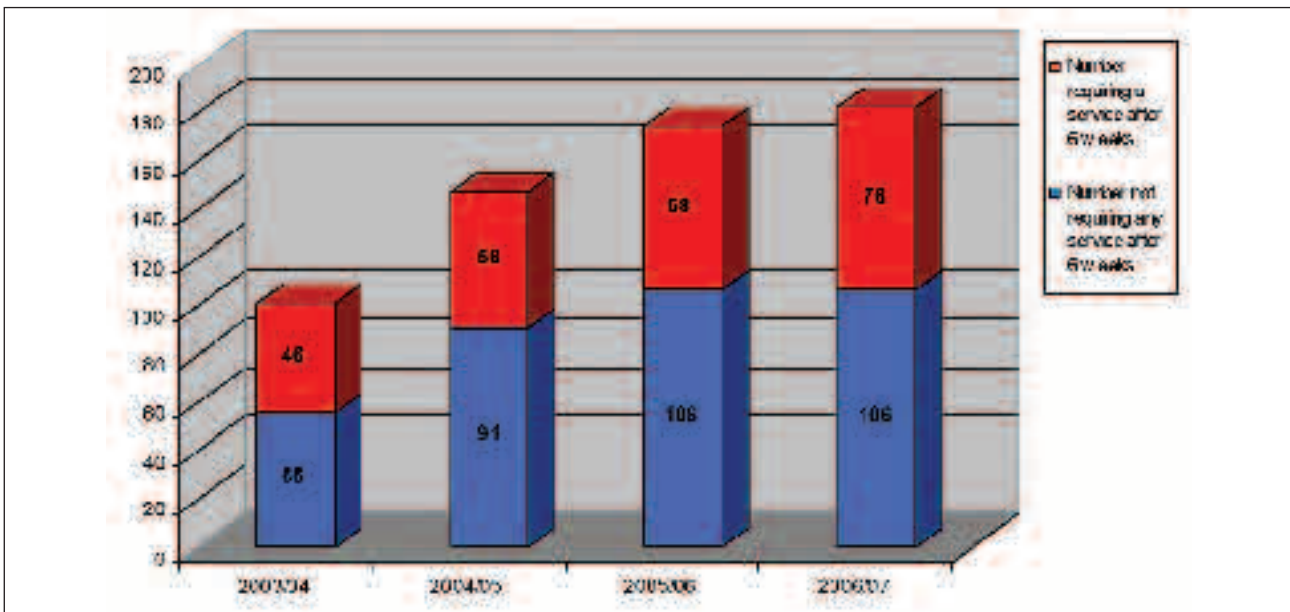
Customers may receive services from one or both of the services to ensure that the service they receive is tailored to meet their individual needs. Where a customer receives support from both teams, liaison takes place to ensure that the customer is provided with consistent support that enables them to be as independent as possible.

**Evidence on Impact**

**Why does the service work?**

- Customers really buy in to it
- Exceptional relationship with care management
- Strong relationship with continuing home care service
- Staff with the right skills, knowledge and attitudes
- Senior management and elected members' commitment
- Commitment to change across the Directorate
- Incremental service growth/development

There is considerable statistical evidence from a three year period to demonstrate the impact the service has in enabling customers to be self-managing. Approximately 50% of customers receiving support from Initial Response have benefited from the service either by ending any service provision or reducing the level of support they require.



The following people achieved greater independence:

- 2003/04 81 people – 80% of referrals
- 2004/05 123 people – 83% of referrals
- 2005/06 134 people – 77% of referrals
- 2006/07 182 people – 60% of referrals

Source: Merthyr Tydfil County Borough Council

5.68 A significant amount of various types of domiciliary care is provided by the voluntary sector, often funded by Social Services. Relationships between the statutory and voluntary sectors in this area have improved over the past few years as partners recognise the potential of greater collaboration. The *Assembly's Building Strong Bridges* initiative has also helped in this regard. Further progress is still possible, however, in areas such as joint planning,

greater mutual understanding, willingness to support innovation, greater security and longevity of funding, and more cooperation within the voluntary sector to deliver greater efficiency gains. Issues related to joint working are explored in Chapter 6.

## Telecare

- 5.69 The potential for telecare – remote monitoring and response services which allow timely support to be provided, wherever the person lives - to effect a speedier discharge, and support people living in their own homes, has been well-recognised. In Scotland, for example, the Review saw how packages of telecare in West Lothian were supporting large numbers of older people at home, and was a part of a balance of care and support which had assisted the authority to eliminate all delayed transfers of care. There are also examples of the effective use of telecare in Wales, often supported by the Welsh Assembly Government. However, the full potential of this range of technologies has yet to be exploited.
- 5.70 For example, one study for the English Department of Health - focusing on a Powys population which had been assessed by Social Services as requiring some form of institutionalised care - found a full 91% would not have required such care if total homecare packages had been put in place. Further, 81% of those in Community Hospitals following District General Hospital care could have gone straight home with an adequate care package in place. [WIHSC, 2004]. Further details are provided in Appendix 6, along with descriptions of the care packages that would be required for a range of chronic conditions, and the comparative cost in providing these as opposed to institutional care.
- 5.71 This study – and other work – suggests a variety of factors which would support the effective and sustainable introduction of telecare more widely:
- High uptake of unified assessment; together with the interpretation of the data in an objective way, and one which is linked to supply-side possibilities (i.e. the range of technologies). This would also unify the training requirements across different professionals;
  - Review of supply logistics, which are generally poor and serendipitous, and the development of a well-ordered 'just in time' system. An information infrastructure will be required to support this;
  - Equipment maintenance must be undertaken in such a way as to diminish down-time;
  - The provision of capital 'pump priming' and extra resources for start-up costs. The NHS should enter into a partnership with local authorities and the voluntary sector to manage the processes;
  - Flexibilities in provision will be required to accommodate the constantly changing physical and mental state of clients;

- Carer training and support is essential<sup>1</sup> if maximum advantage is to accrue from a new and increased provision of home based technologies;
- Local authorities will need to reconsider housing and community regeneration policies and programmes to include smart home adaptations of vacant properties;
- GP practices and community health centres will need to develop services for frail older people at home more proactively, monitoring changes in function that might require new service provision and technologies.

5.72 The complexity of these requirements, and the need for responses to be orchestrated at both local and national level, will be clear. But only if this occurs will the potential to impact on DToC, both through better support and preventive activities, and home-based rehabilitation, be realised.

### **Supported Housing**

5.73 Level 2 support in the balance of care embraces a wide variety of housing in which people generally have the status of tenant, but are offered a spectrum of support to maintain their independence. This ranges from the availability of site-based staff, through to provision of a wide range of personal care and support throughout the day and night. Sometimes such housing is located alongside nursing home-type accommodation to enable couples to continue to live close to one another.

5.74 Again, the importance of this element of the balance of support is well-recognised, and forms part of most local plans for the future. There are many innovative examples of such developments – both in the private (owner occupier) and public sectors. In the latter there are short-falls in provision in most localities, which local partners are trying to address, and some areas have clear plans for future expansion. The same constraints exist here as do for domiciliary care (described above). However, there are perhaps more options available for funding such developments, and the availability of staff appears to be less of an obstacle.

### **Private Nursing and Residential Home Provision**

5.75 During the past 10 years, there has been a substantial (26%) reduction in the number of nursing homes in Wales, and a 14% reduction in the number of residential care homes. During the past 3 years, the level of provision appears to have stabilised somewhat both in terms of number of homes and also number of places. From 2004 to 2007, there was a 4% reduction in the number of nursing homes, a 17% reduction in the number of residential care homes, and a 4% reduction in places.

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<sup>1</sup> A £7.5m fund is now in place, but is heavily oriented towards equipment, and emphasises insufficiently the 'soft' technologies associated with care staff.

**Table 5.3: Nursing Home Places, Wales, 1997-2007**

Date	Number of Nursing Homes	Number of Care Homes	Number of Places
March 1997	410	1,401*	
March 2004	317	1,409	27,745
March 2005	313	1,265	27,103
March 2006	307	1,218	26,679
March 2007	304	1,205	26,660

\*Smaller care homes and numbers of places are not included in this data

Source: CSIW

- 5.76 As highlighted earlier, it is difficult to assess the significance of this change in relation to need, given the lack of work to define the level of provision required. It was reported to us that the decrease in numbers of homes has been accompanied by an increase in levels of dependency of people admitted in recent years. The variation in provision across Wales suggests that more planning is required to ensure that an adequate supply of care home places is available throughout Wales. This should draw on professional assessments of unmet need, and patients' and relatives' perceptions of the acceptability of current provision in the context of possible alternatives.
- 5.77 Relationships between the statutory and private homes sectors also pose some difficulties. Again, there is considerable variation across the country, but some encouraging examples of improved understanding and communication. However, several localities reported to us a variety of problems:
- lack of understanding by health and social care professionals of the private sector provision locally including mistaken assumptions about the levels of dependency which individual homes would accept;
  - concerns about quality of care which did not, as yet, trigger regulatory intervention, including concerns that particular homes, perhaps because of recent high staff turnover, were struggling to meet acceptable standards;
  - failure to involve the private sector fully in discussions about future provision – this appears to stem from the somewhat ambiguous relationship between the two sectors, which struggles to reconcile a desire to think about 'whole systems', with a suspicion that there is an inherent conflict of interest between statutory commissioners paying for profit-making providers. Case study 5.5 illustrates one example of an approach to overcome this problem.

## Case Study 5.5

### SWANSEA

#### **The Development of a Care Homes & Commissioning Alliance**

The establishment of the Alliance resulted from an agreement to meet regularly between Social Services, the Local Health Board and Independent Sector Care Homes in the City and County of Swansea. The purpose of the group is to provide a regular opportunity for commissioners and providers to discuss and address strategic issues, policy developments and matters related to current working agreements that impact on the provision of residential and nursing home care locally.

From the early part of the 1990s the only contact between Care Homes and the Statutory Authorities was by way of quarterly meetings with Social Services Departments entitled The Independent Sector Forum. For many years the Forum proved to be a very useful vehicle where both parties were able to discuss the problems that were faced at that time. These meetings were organised and chaired by a senior member of the Social Services Department and were open to Care Homes across the area.

Following the introduction of Care in the Community and the setting up of twenty two Local Health Boards the effectiveness of the Forum was brought into question as the context within which Care Homes were now operating was changing and the Independent Sector now faced different pressures.

Initiated by the Registered Nursing Home Association and following a series of meetings with both Social Services and the Local Health Board it was suggested that some form of tripartite grouping should replace the Forum: the Swansea Care Homes & Care Commissioning Alliance was established. It was agreed:-

- that a Steering Committee be set up comprising of eight representatives from each of the participating agencies.
- that there should be quarterly meetings
- that the question of chairmanship be raised
- the question of Sub Groups to the main Steering Group

The result was that the Steering group resolved that each of the quarterly meetings would be chaired in turn by each of the three parties on a revolving basis with each chair preparing the agenda after discussions with the other two groups. This was to ensure that each takes ownership of that particular event and makes for a more open and meaningful discussion. It was also agreed that a number of Sub Groups be set up to discuss and work on specific items such as fees, training and human resources.

During 2007 the Alliance met on six occasions, including a very successful Business Development Day attended by a large number of Care Homes, representatives of Social Services, Local Health Board, Care and Social Services Inspectorate for Wales and the South Wales Fire Service. Sub Groups also met with Social Services and the Local Health Board regarding issues of patient care and funding. 2008 commenced with the first meeting of the Alliance chaired by the Independent Sector with reports received from the Sub Groups and ongoing discussions regarding this years Business Development Day.

It is difficult to quantify the impact of the Alliance as it is still in the first phase of its development but during the meeting in October 2007, chaired by the Local Health Board, the question of Delayed Transfers of Care was the main topic on the agenda and was debated in full.

The Alliance has proved that it is a platform on which to debate all issues regarding the care of the elderly.

Source: Registered Nursing Home Association



- 5.78 Another common source of disagreement is the level of fee payments to the private homes sector. They argue that this issue should have been resolved through the local application of the guidance on fees issued by the Assembly Government in 2003 (under Section 7 of the 1970 Health and Social Services Act), which calls for providers' reasonable costs to be taken into account when fees levels are set. Fee rates appear to vary considerably across Wales, and the private sector argues that many local authorities are not recognising the real costs of provision. Some flexibilities may be appropriate, for example, to reflect variations in property values, or to recognise the difficulty of recruiting and retaining staff in rural areas. However, there is little evidence of an attempt to quantify real variations and reflect them in the payments made.

### **Is There Enough Mental Health and Specialised Care Available?**

- 5.79 Two areas where there was general agreement that provision was inadequate were: housing and care for older people with mental health problems (primarily dementia); and highly specialised care for the small numbers of people with more specialised mental health and learning disability needs. Many parts of Wales reported a shortage of this provision.
- 5.80 In some localities, new provision for dementia support was planned and imminent, although there was some doubt about whether it would be sufficient to meet the latent demand already in the local community. This uncertainty appeared to be a result of the lack of detailed consideration about future need for the totality of provision.
- 5.81 Additional provision for highly specialised care was inherently more difficult to predict and to plan for, given the small numbers of people involved.

### **Are Patients' Perceptions Affecting Their Choice of Homes?**

- 5.82 Patient perceptions of the quality of private sector provision are another key element in determining how much provision is needed. A variety of factors appear to influence patients' and relatives' perceptions, including the location of homes, local reputation, impression when visiting, and the variety of information from inspections and other sources. In many of the localities visited by the team, the absolute number of places appeared to be broadly sufficient to meet demand, and yet patients were still delayed in hospital because there was no 'suitable' place available to them. It is not surprising that professionals' and patients'/families' perceptions of what is 'suitable' should vary given the essentially subjective factors which come into play.

## **D. IS THE CURRENT WORKFORCE ADEQUATE?**

- 5.83 Clearly there are many facets of broader workforce development in social, primary, and secondary care and in the independent sector that have a bearing upon how these services are managed and staffed more generally, but these are beyond the scope of this review. It bears repeating that the workforce most closely involved with services that address DToC comprises both key professions (medical, nursing and social work), and a broader more vocationally trained staff, all of whom work for a wide range of employing bodies. Some homes are large, but the majority are privately owned and managed and relatively small-scale. Workforce development therefore will fall to a variety of bodies with varying abilities to lead, or respond to, change.
- 5.84 This section addresses those aspects of workforce planning and development that are clearly signalled as arising directly from the examination of DToC. They fall into two broad areas: first shortfalls in the availability of labour; and second the potential for further improvements in the attributes of key parts of the workforce.

### **Are there any Shortfalls?**

- 5.85 The review has found shortfalls in the availability of three aspects of services. One is the provision of domiciliary care in more rural parts of Wales. The second is the provision of nursing home care for older people with dementia or similar conditions. The third is the provision of specialist services for people with, in the main, psychiatric problems.

#### *Domiciliary care*

- 5.86 Commissioners have regularly experienced difficulty in finding reliable providers of services because, in turn, would-be providers face difficulties in maintaining a suitably trained workforce able to cover the territory involved. The fieldwork suggests that this comes from a mix of impediments: the comparative levels of take-home pay and overall benefits that current funding streams support; the availability of a suitable workforce in rural localities where the average age of the population tends to be higher; and the availability of alternative employment that is perceived as offering better overall employment conditions. Domiciliary care workers in many areas are often required to work at the beginning and end of the day to meet clients' needs for continuity of care, have to travel some distance between clients often using their own vehicles, and undertake tasks which not all workers find easy.
- 5.87 The challenge for commissioners is to work with local private sector providers to identify ways in which these jobs can be made more attractive to new applicants and to those already in the sector. Family-friendly arrangements, assistance with transport costs, pension provision, and career opportunities

are examples of ways that this might be achieved. Some local authorities have chosen to serve hard-to-reach populations by a directly employed workforce where the facilities available to a relatively large employer can be utilised to enhance the attractiveness of jobs.

*Nursing Homes caring for older people with mental illness*

5.88 Here the review has noted a recurring issue of the lack of such provision. However, the shortfall is not clearly a direct result of shortfalls in available labour, but rather the lack of wider incentives to possible providers to enter what is regarded as the more demanding and expensive part of the nursing home sector. However, were these issues to be addressed by the other recommendations made in this review, it is likely that an expansion of nursing home capacity would highlight some shortages in the supply of appropriately skilled nursing and other care staff able to work effectively for this client group.

*Specialist services for people with psychiatric illness*

5.89 As with nursing home capacity, the absence of services in this part of the care system does not appear to be directly related to a scarcity of staff. Rather their highly specialised nature and relatively low numbers of service users results in the commissioning of such services being highly fragmented and heavily reliant upon contracts for individuals.

**Do any aspects of the Workforce require further Development?**

5.90 The review has highlighted a number of areas where the workforce can be helped to perform better, and here a wide view is taken of the workforce to include clients and carers themselves. Key aspects are briefly outlined below.

*Primary care teams*

5.91 Primary care teams (doctors, social workers, nurses and support staff) have a key role in providing good anticipatory care for, in particular, older people with chronic diseases, and assisting them to make choices about future lifestyle. The review has highlighted the need for older people to anticipate the possible gradual loss of independence and make (and possibly implement) plans to enable them to cope - for example with the loss of a partner, with reduced mobility, with impaired memory – before a crisis suddenly erupts. A multi-disciplinary primary care team offers an appropriate setting from which such support can be opportunistically offered.

*Patients and carers*

5.92 Patients and carers, armed with the advice of professional staff, should be increasingly seen as co-producers of their own health and well-being.

*Partnership skills*

- 5.93 A recurring theme of the literature review and field work is the importance of knowledge and skills of partnership working for staff of commissioning organisations (see chapters 4 and 6). Programmes that bring together staff of health and local government bodies to understand the pre-requisites of partnership working, and to create the social and organisational bonds that underpin good partnerships, should be built into Welsh management development programmes. The development of staff able to move between health and social care settings, and between statutory and independent sector providers, should be encouraged.

*Professional and inter-professional matters*

- 5.94 Four particular issues arise from the fieldwork for professional matters, where further development is indicated.
- 5.95 First, the challenges posed by patient assessment for all professional staff involved are considerable. These are discussed in more detail in Chapter 7.
- 5.96 Second, attitudes to the management of 'risk' when assessing the ability of patients to cope on discharge from hospital appear to differ between nursing and social work colleagues, in part derived from the different training, socialisation and values that underpin both professions. Professionals that collaborate in the assessment of patients would benefit from opportunities away from front-line practice to enable them to explore in more depth the reasons why approaches differ and whether current practice is too conservative.
- 5.97 Third, the Review has raised the issue of the extent to which generic workers – provided with both nursing and social work skills - should increasingly be developed and deployed in key points of the care delivery processes, for example in offering anticipatory care for older people prior to any need for hospital care, and in providing ongoing care both in nursing homes and own-home settings. It is understood that at least one education and training provider has made some progress in developing courses that might support such an approach.
- 5.98 Finally, the review proposes that the precise services to be offered in particular localities by Community Hospitals should be more closely defined and then staffed accordingly. Depending upon the mix of services being looked for from these, there will be particular challenges posed for their medical oversight, their nursing leadership, and their paramedical support, especially where rehabilitation skills are required. The overall practice governance of such units – as a key component of services designed to counter DToC – will require specific attention especially where such hospitals set out to offer a wider range of clinical skills.

## **E. ARE EFFECTIVE DISCHARGE ARRANGEMENTS IN PLACE?**

5.99 The efficiency with which the NHS and Social Services manage the care of patients throughout their stay in hospital, and particularly all the arrangements associated with discharge obviously influences the extent of delayed transfers. We found without exception that staff responsible for the various aspects of the discharge process understood where most of the 'process efficiency' problems lay, and were seeking to address them. All had jointly agreed discharge policies and procedures, and most localities brought together the relevant staff from the NHS Trust and Social Services to monitor and review individual delayed patients on a weekly basis in line with these policies, with senior staff conducting a joint review each month. Many also monitored patients *approaching* their discharge date in order to anticipate any likely problems, and try to avoid them.

### **Is There Local Variation in Discharge Planning Procedures?**

5.100 Three areas of practice were viewed as problematic, however. The first was the extent to which all front-line staff understood and followed the agreed processes, which they often said were extremely complex. There were several examples of individual wards staff who, for example:

- did not appear to have a sound understanding of the processes to be followed prior to discharge;
- were reluctant to discuss discharge options with patients and families at an early stage in the patient's stay;
- lacked detailed knowledge about the range and nature of suitable provision available on discharge;
- appeared to have different perceptions of what were 'acceptable' levels of risk for patients being discharged – it was reported that in some multi-disciplinary teams, there were frequent disagreements about whether it was 'safe' to discharge patients to their home, rather than to a care home.

5.101 Such variation is perhaps not surprising, given the wide variety of wards and other settings involved, and the large numbers of staff and levels of turnover. It indicates a continuing agenda for managers and professional leaders, especially in NHS Trusts and Social Services Departments.

## Case Study 5.6

### MONMOUTHSHIRE

#### Joint Nurse/Social Worker Discharge Team

Began in 1998. Partners included Monmouthshire County Council, Gwent Healthcare NHS Trust and the Local Health Board

#### Aims

- To reduce DToC.
- To provide people with a speedy and effective service that aims to reduce re-admission and help them settle successfully after an episode in a District General Hospital.
- To develop joint working and understanding between health and social care professionals, including shared utilisation of resources.

#### Description

- An experienced nurse was seconded from the Gwent Healthcare Trust to pair up with a local authority social worker in the LA Community Care Team covering the South of the County. They used an agreed joint assessment protocol as the scheme started before unified assessment implementation. The staff member went in to locate patients from Monmouthshire who were at that time dispersed in up to 31 different wards in the Royal Gwent Hospital and were ready for discharge.
- A speedy and effective discharge was arranged which included
  - Ensuring that GPs and district nurses were alerted and ready to provide care after hospital.
  - Using the Council's Community Care arrangements and funds to arrange care packages as needed. Nurses therefore accessed the Social Services budget. The nurse was managed by the Social Services Team Manager who was the budget holder.
  - Close liaison to ensure transfer to Community Hospitals.

In 2001 the scheme was expanded to cover the North of the County which another 2 person 'team' of nurse and social worker put in place.

#### Outcomes

- Consistently good performance on managing low levels of DToC in the County despite absence of development funds.
- Positive feedback from individuals and carers on the effectiveness of their discharge arrangements and the quality of the service provided.
- Strong foundation of partnership and joint work across health and social care in Monmouthshire which has assisted further development.
- Effective budget management at the local level.

#### Lessons

- The importance of locating successful discharge outside of hospital to ensure that services are ready to receive older people and understand their needs.
- How well nurses and social workers can work together while still needing firm arrangements to make sure that happened.
- The complexity of acute hospital systems and the needs of older people don't always fit well together. A simple clear straightforward approach that focussed on the person and their services outside the acute sector worked well.

Source: Monmouthshire County Council

### **Are Decisions About Continuing Healthcare Being Made Appropriately?**

5.102 The second problem area relates to the process efficiency of the decision-making required to determine eligibility for continuing healthcare. Decisions on this matter clearly have a profound impact on the patient's future well-being; they also have substantial financial implications for the Local Health Board and for social services and the patient. There were many examples where the decision-making process seemed unreasonably protracted:

- In many localities, the team making the decision only met monthly, thereby building in an initial delay;
- There were many examples of paperwork not being completed, thereby requiring referral back to the service provider, and further delay;
- In some instances, these delays were so protracted that the patient's condition had materially changed and then required further assessment.

### **Can Patient Management Initiatives Help to Reduce Delays?**

5.103 The care required by many delayed patients with complex problems requires input from several professionals and agencies. This often means very proactive management of the patient's stay in hospital, constant evaluation and revision of the patient's progress targets, and coordination of the input required. It should also be based on an assessment of the patient's risk of being delayed, which is frequently linked to a common set of factors:

- age (typically 75+);
- living alone or with a frail partner;
- receiving a long-term package of care at home before admission, or not being known to care services despite being frail;
- previous unplanned admissions, often with non-specific diagnoses; and
- a history of falls.

5.104 Difficult assessment issues requiring multi-professional input can, of themselves, lead to delays related to difficulties in coordination and communication. In some instances, Trusts employed a proactive process of case management, with a key member of staff empowered to manage the complex care so as to minimise any delays. The Review found good examples of this focus on the expeditious management of the patient's care throughout their stay in hospital, rather than waiting for delay to become imminent before intervention. However, such practice was not universal.

## Are There Any Planned Initiatives Which Will Help?

- 5.105 In 2006/7 the National Leadership and Innovation Agency for Healthcare carried out an examination of the specific factors within discharge planning that can contribute to, or reduce, DToC. For each factor, they developed a set of best practices which should be followed by the relevant agencies [NLIAH, 2007]. This forms a useful benchmark for health and social care staff.

The key factors include the following:

### Discharge Policy and Protocols

- o Appropriate multi-agency discharge policy
- o Patient/carer involvement
- o Communication
- o Information
- o Vulnerable Groups
- o Early Planning
- o Avoiding re-admission
- o Local agreements and protocols
- o Assessment
- o Discharge from A&E
- o Discharge to Care Homes
- o Care Options
- o Senior Management Support
- o Accessible discharge protocols

### Discharge Processes

- o Early assessment
- o Use of integrated care pathways
- o Patient/carer involvement
- o Focused approach
- o Multi-disciplinary assessment
- o Care Options
- o Provision of equipment and adaptations
- o Coordination of 'to take home' medication
- o Transport arrangements
- o Seven days a week discharge
- o Escalation processes
- o Follow up

### Commissioning and Partnership Working

- o Access to diagnostic and therapeutic procedures
- o Joint/integrated equipment stores
- o Partnership in practice
- o Commissioning
- o Relationships with the voluntary and independent sectors
- o Staff training

### Audit and Review

- o Understanding and Ownership
- o Working to achieve continuing service improvement

Source: NLIAH (2007)

- 5.106 NLIAH produced an Effective Discharge Planning Self-Assessment Audit Tool to enable local agencies to assess their own performance against these parameters, and the results of the first audit were reported in July 2007 in their publication, *From DToC to EToC*. This is the most recent attempt to provide a comprehensive assessment of these aspects of discharge planning across Wales.
- 5.107 Clearly this is a *self*-assessment tool, and therefore subject to the usual problems: trend data is not yet available. However, the results are useful, and correlate closely with our own. They reveal a generally high level of understanding of what is needed to improve the efficiency of discharge planning, and where many of the problems lie. However, consistent front-line implementation remains a problem in many localities, and the Agency



concluded:

*'In general communities across Wales do know exactly what needs to be done to effect safe and timely discharge. Most communities have up to date multi-agency policies that reflect this position and ... are... aware of the areas they need to improve upon. Problems arise however in the actual implementation of accepted good practice, using improvement methodologies to respond to audit evidence...'*

- 5.108 Clearly there is much work needed to embed good practice into everyday working, and the audit suggests that departmental culture, leadership and management, and inter-agency cooperation are all key to this.
- 5.109 NLIAM concludes that six practical steps are now necessary to effect the transition from delayed to effective transfers of care:
- Use and monitoring of care pathways;
  - Further use of nurse-led discharge;
  - Facilitation of seven-day a week discharge;
  - Multi-agency training;
  - Jointly commissioned services that are responsive, seven days a week;
  - Creative care across the continuum of care, with network management and a single point of access.
- 5.110 The Agency will be continuing to work with local partners to implement these recommendations over the coming year. Our discussions with staff who had been involved with the early stages of this project revealed a real enthusiasm for the work; and it would seem that this will be one of the major elements of activity which could produce short term improvements in the level of delayed transfers.

## **F. CONCLUSIONS**

- 5.111 The provision of a balance of care and support approach which meets local needs is central to reducing the number and length of delayed transfers of care. Although the position varies substantially across Wales, and even within the boundaries of individual LHBs, there are many examples where provision is not sufficient to allow patients reasonable choice of setting on discharge, and where there is prime *facie* evidence that patients are being admitted to hospital where alternative provision might have allowed them to be cared for at home. The Review found little evidence of this 'balance' being described and calibrated across Wales, through full involvement by all the local stakeholders. Such a task requires full participation by health, social care and housing agencies, and by the voluntary and commercial sectors, informed by a good understanding of local need and patients'/ families' perceptions.

- 5.112 In addition to re-balancing for the future, there is a substantial and continuing need to improve the efficiency of existing services, including addressing some workforce issues. In general, research and development work across the NHS and social care has identified 'good practice' for most of these issues but considerable commitment is still needed to ensure that it is embedded in the way services are provided. This, in turn, requires commitment by the local stakeholders – from all sectors – facilitated by external agencies such as NLI AH, the Inspectorates, and the Welsh Assembly Government.
- 5.113 Finally, the existing system could do more to safeguard the well-being of patients. It is inevitable that patients will continue to be delayed, albeit hopefully in smaller numbers and for shorter periods. Provision of better information and support, proactive and timely management of patients' progress, and regular monitoring of patients' and carers' perception of the quality of their care, can do much to minimise the harm which delays can cause.

## CHAPTER 6

### THE DEPLOYMENT OF PARTNERSHIPS AND NETWORKS

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#### A. INTRODUCTION – TERMS & MEANINGS

- 6.1 This chapter:
- provides an overview of partnership and network arrangements for commissioning and delivery; and
  - lays the groundwork, through a review of current arrangements, for suggestions in Chapter 8 on new, better governed organisational approaches to both.
- 6.2 Chapter 4 has outlined the three broad forms of governance that underpin the delivery of publicly provided services: bureaucracies, markets and networks. Both the literature review and the fieldwork emphasise that, in order to better manage the issues arising from the real levels of DToC occurring in Wales, improvements are needed in planning, specification, and commissioning to achieve all-embracing service provision, and in the way that the delivery components of health, social care and housing come together.
- 6.3 The multi-agency and multi-professional nature of both the commissioning and provider activities required are such that hierarchical or bureaucratic forms of governance are not appropriate. Equally, heavy reliance upon market mechanisms alone to regulate relationships and behaviours sits uneasily with the declared intention in Wales to proceed by strengthening the partnership arrangements that operate both between the main commissioners and the service providers to which they relate, and between providers themselves. For these reasons partnerships are required in order to plan and commission services to resolve the issues arising from DToC, and networks would be the most advantageous approach to the delivery of high quality and integrated programmes of care<sup>1</sup>.
- 6.4 The literature also suggests that formally constructed networks are a superior form for the delivery of services when the care requirements are complex and the organisations to be involved are fragmented. Throughout this report it will be seen that this is the situation that pertains in relation to DToC; and indeed it is, particularly, the complex cases that the services are failing to deal with effectively.

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<sup>1</sup> For the evidence base on the use of networks to achieve better integration of care, see Warner et al ( 2005).

- 6.5 At the outset it is useful to be clear on the differences between the two terms, but also to understand how they are related. Figure 6.1 provides a summary based on an extensive review of the literature.

**Figure 6.1: Partnerships and Networks: What is the difference?**

Both partnerships and networks use social contracts to contain or direct people's behaviour. Contracts provide a form of 'governance'.

Traditional partnerships may be completely governed by contract. But it is difficult to see a large network being governed by a single legal contract – multiple legal contracts, maybe, but even this begins to strain accepted definitions of 'organisational network'.

So, in summary:-

- All partnerships can be considered as networks. But the reverse is not true.
- Partnerships can be thought of as special sorts of networks.
- Networks and Partnerships are both entities. We can point to actual examples in the world.
- Networks and Modern Partnerships share a common approach to organisation in that they rely on trust, commitment and mutual respect (social contract).
- Traditional Partnerships have their basis in a legal contract.
- Ideally, networks have their basis in social contracts.
- Partnerships have a small number of people or organisations at their core.
- A network may involve dozens of organisations.
- Networks have a distinctive form of analysis. This can be used to study partnerships.
- Partnerships do not have a distinctive form of analysis.

Source: Gould N, Warner M and Magill J, (2005)

**B. WHO ARE THE KEY PLAYERS AND WHAT ARE THEIR ROLES?**

- 6.6 In terms of DToC, the Review sees the commissioning agencies (LHBs and local authorities) as key members of the partnerships (or sometimes, more correctly, 'claimed partnerships'), whereas the various services that provide care operate largely as networks although they would not necessarily think of themselves as being in a network as such. A number of clinical networks have been developed, but apart from these, the service delivery and commissioning networks that have developed are not planned as networks. Local authorities are commissioners of domiciliary and residential care services but also act as providers of key functions – including the social services contribution to the assessment and care brokerage functions and varying levels of directly managed domiciliary and residential care. To this extent they engage in both partnerships and networks. LHBs also operate as commissioners (for primary, community and secondary care), as well as being direct providers of some primary and community health services, for example through supporting the management of chronic diseases in primary care settings. Powys LHB, uniquely in Wales, operates fully as both.
- 6.7 A third player is the local NHS Trust which, in most parts of Wales, provides acute secondary, mental health, learning disability, and community health services. Selected NHS Trusts have other functions, notably the tertiary care offered by Cardiff and the Vale, Velindre, Swansea, and Bro Morgannwg. Trust staff are also heavily engaged in the assessment processes which

patients ready to leave hospital undergo although such assessments are conducted, in effect, on behalf of funding / commissioning bodies.

- 6.8 The review has shown that each NHS Trust approaches these aspects of its care responsibilities in its own way. However, in common, most NHS Trusts govern the planning and delivery of mental health services separately from acute services. This Review has shown that the position of NHS Trusts in partnerships varies, with perhaps only two (Powys excepted) being engaged fully in tripartite partnership arrangements; in other parts of Wales NHS Trusts operate as junior or partial players, predominantly only working with their main commissioner. A number of small NHS Trusts sit uncomfortably at the edge of partnerships.
- 6.9 The place of NHS Trusts in provider networks is more uniform; they each have largely similar relationships with other significant components of the care system – they are partly engaged with GPs, social care teams, and local authority provided services, though less directly connected to independent sector provided domiciliary and residential care.
- 6.10 General Practitioner services, which predominantly operate as independent primary care contractors to the NHS, have responsibility for three important care processes relevant to DToC: first, the proactive management of chronic diseases which, in older people, are often associated with admission to hospital; second, decisions about when to refer patients to hospital for further diagnosis or treatment; third, assisting in the arrangements for caring for patients returning from inpatient care, either to their own homes or to other residential settings covered by general practice. Arrangements vary in different parts of Wales for engaging general practice collectively as commissioning partners or service providers; where GPs provide, for example, the medical cover of community hospitals, collective engagement is increased. In the main, however, individual practices retain considerable freedom, within the nationally agreed contract, to operate as they wish within the care system.
- 6.11 Independent sector providers of residential care vary from large organisations present in many parts of the UK and often with individual premises of considerable size, to providers operating just one small unit in their locality in Wales. This sector has both commercial and not-for-profit organisations operating within it. In two areas of Wales the sector is being viewed increasingly as an important partner in creating the right mix of care, and is included in planning. For most of Wales, however, the sector interacts with statutory bodies mainly where it is proposing developments following its own market analysis. There are a number of independent sector providers of domiciliary care services (both commercial and not-for-profit) and while these vary in size many tend to serve defined and largely urban localities.

- 6.12 Finally, there is a number of not-for-profit support services including, for example, those provided by Age Concern and British Red Cross offering assistance to patients on their return home, along with Care and Repair schemes that address aspects of housing. The Review suggests that these services play an important role in discharge arrangements, but have been involved in only a limited way in both commissioning partnerships and provider networks.

### **Case Study 6.1**

#### **POWYS**

##### **Health & Social Care in Builth Wells & Community – Engaging the Public**

###### **Background**

The small essentially rural community of Builth Wells (population 7688) has a population older than the Wales average and a high population growth rate; almost entirely due to people of retirement age moving into the area.

At the same time and for reasons of clinical governance, changes to the General Practitioner contract and clinical staffing shortages, the use of the local much loved community hospital had markedly declined, whilst demand for social and nursing home care had continued to increase.

Given this background of changing needs and patterns of care, a joint health and social care project was established during 2007 to plan for the future of services for the local population. The project was established at a time when the local community had set up a pressure group, "Builth Against Hospital Closure" (BACH) with the sole aim of protecting and retaining the local hospital.

###### **Project Aim**

The brief for the project gradually developed out of discussion with the general practice and with a large number of groups representing the public. The aim of the project was to establish a 'One stop shop' enabling the public to access all local health and social care services. This was to be delivered within a process fully involving the public and all service providers, whether statutory or voluntary.

###### **Process**

A project Board was established under the joint chairmanship of the County Councillor portfolio holder for social care and a non officer member of the Local Health Board. Membership of the Board comprised representatives from General Practice, the Voluntary Sector, County Councillors, Community Health Council, Local Health Board and Social Services etc.

The community generally and special interest groups (80) were invited to take part in a set of stakeholders' events, with the aim of defining what services were needed locally and what could best be provided elsewhere. The outcome from this process has been a clearly defined specification for local services which incidentally, does not include a hospital, although General Practitioner beds will be provided within the proposed Nursing Home.

Whilst BACH has stood outside the redesign process, maintaining independence, representatives have taken part in public debate and have voiced approval for the process and proposals.

###### **Lessons learned**

Do not underestimate the time and effort needed to engage with the public and to help them become truly informed.

Pressure groups have value in modernising services since they act as a locus for opposition to change and a point where debate can take place.

Social Services and LHB's have differing approval processes and timetables; these have to be brought together under joint chairmanship so that for example single press releases are issued.

Source: Powys Local Health Board

## C. THE COMPLEXITY OF ARRANGEMENTS

- 6.13 Wales has varying numbers of statutory organisations forming the core of the key commissioning and providing relationships. Where the field is crowded, planning to counter DToC can be complex. Powys has the lowest number of statutory bodies involved, with just two organisations - the Local Health Board and Powys County Council. This contrasts with three such bodies in Anglesey and Swansea, and five or more for Neath Port Talbot and Caerphilly where patient flows move in several directions. However, observations made in the Review suggest that even small partnerships are not, by dint of that factor alone, guaranteed to operate smoothly and achieve low numbers of DToC.
- 6.14 Many NHS Trusts in particular have to engage in a number of tripartite relationships with each of the LHBs and the local authorities whose population they serve. The remit of the Trusts tends to determine the extent of the local health economy, and presently change is underway through Trust re-structuring. The tripartite relationships are, theoretically, dominated by the relationship with the LHB as funder. Local authorities, whether in their own right or as joint commissioners, are rarely seen in the role of commissioner of those services offered by the Trust. Rather, they are seen as commissioners of services upon which the Trust relies in order to speed its patients through the hospital system and into other care settings. In most partnerships the Review concludes that Trusts and Local Authorities do not engage actively or directly with each other in helping to shape the services needed. This function, where it happens, is carried out through a principal role exercised by the LHB; and this places a particular load upon the LHB.
- 6.15 For a few NHS Trusts that link to a number of commissioners, the separate tripartite relationships are both broadly balanced and compatible. For most Trusts however, one relationship is, because of the volume of patients involved, more dominant than others. Where NHS Trusts have a number of such relationships these pose a challenge to Trust staff to engage in different arenas. For a small number of LHB and local authorities their size and location is such that they are not a significant player with any NHS Trust.
- 6.16 Neighbouring LHB and local authorities, the Review concludes, vary in the extent to which they collaborate with each other. In part this is a function of geography, and the extent to which they share common NHS Trust providers; but in at least one part of Wales the relationship between neighbouring pairs of authorities with some common NHS Trust linkages has been described by key players as 'distant'.

## **D. VARIABILITY IN PARTNERSHIP AND NETWORK ARRANGEMENTS**

- 6.17 Variabilities result from the wider economic and geographic context within which partnerships and networks are required to operate. These particularly include:
- largely rural areas, where labour shortages exist, distances between fixed service locations (for example hospitals and nursing homes) are long, and where public transport is poor;
  - locations which look to English providers of hospital care;
  - in cities, with particular challenges of volume, and of land and housing costs, which determine the supply of labour and capital assets;
  - environments where higher levels of deprivation shape some aspects of the care environment, for example the quality of housing within which home care can operate, and levels of disposable income.
- 6.18 The Review has found that the quality and nature of commissioning partnership arrangements operating across Wales is variable. Broadly, partnerships in North Wales and parts of South West Wales have demonstrated reasonably good partnership working; but central and South East Wales, for a variety of reasons, have deficiencies when set against the constructs set out in Figure 6.2 at the end of this chapter.
- 6.19 Finally, in terms of provider arrangements, there is the need for a wider range of key players to come together in networks to include primary care, NHS Trusts, local authorities and a range of independent sector providers of, in particular, domiciliary and nursing care. The Review has found that the provider networks are, in most parts of Wales, more 'assumed' than 'real', or are still immature, and connections between the NHS Trusts and the independent sector are indirect. Care planning arrangements that ensure the efficient and safe transfer of patients at critical stages are an essential practice and governance tool, and cannot currently be guaranteed.

## **E. WHAT PARTNERSHIP MACHINERY EXISTS IN WALES?**

- 6.20 The tripartite relationships (local authority, LHB, and NHS Trusts) sit, in the main, within the Health Social Care and Well Being Partnerships operating at local authority level. Reports indicate that even with these arrangements in place DToC *per se* is rarely addressed.
- 6.21 Performance management arrangements for DToC within partnerships are most usually set within the broader performance management scrutiny processes that apply to each partner, and are usually viewed in this way. Local authorities, LHBs and NHS Trusts all appear to report their total key performance indicators to their appropriate senior forum. For local authorities this can be in a number of scrutiny committees, and for LHBs this is usually at the Board level. The Review found that unless DToC figures greatly exceed those expected, the subject will tend to be overshadowed by



other areas of concern. Thus at the most senior and strategic level the problems of which DToC are a symptom tend not to be anticipated. Instead, the point at which the statutory bodies (and providers) come together is largely at the operational level where the information derived from DToC reporting systems is assessed. However, it is less often taken into the planning and commissioning processes.

6.22 The Review has found few examples where pan-health economy planning machinery has been operating over the longer term. However, there are examples where individual organisations within the Partnerships have introduced new services. For example:

- changes in the balance between residential care and domiciliary care provision have been effected in two parts of Wales as part of wider and longer term plans to decrease the former and increase the latter in particular locations;
- jointly used beds allowing for patients to be moved from the district general hospitals and to have their assessment processes completed elsewhere have been created, in different forms, in two parts of Wales;
- in two areas of Wales plans have been negotiated with the private sector to create nursing home capacity to serve particular locations – with funding guarantees given to provide some certainty for investors;
- in two parts of Wales interagency machinery has been created to begin to design a system of care to serve the locality along the lines of the Balance of Care Model described in Chapter 5.

6.23 It is also important to remember that the public should be seen as partners in some areas of this work. In particular where new services are being developed which will result in disinvestments elsewhere.

### **Case Study 6.2**

#### **PEMBROKESHIRE & DERWEN**

##### **Joint Working Between Pembrokeshire and Derwen NHS Trust, Pembrokeshire LHB and Park House Nursing Home.**

##### **History**

Following public and political debate and a tender exercise in recent years, a partnership initiative was progressed to reach agreement to re-provide the 10 NHS beds at Tenby Cottage Hospital within the private sector at Park House Court Nursing Home. A contract was agreed between Pembrokeshire LHB, Pembrokeshire and Derwen NHS Trust and Park House Court Nursing Home for the LHB to fund the 10 beds. The beds are registered under the Care and Social Services Inspectorate for Wales (CSSIW).

Tenby Cottage Ward at Park House Court Nursing Home opened in September 2007. It is anticipated that length of stay will generally not exceed 6 weeks.

### **Objectives**

The objective was for Park House Court Nursing Home to provide packages of care for eligible NHS patients who need:

- An intermediate care service
- Palliative care Assessment and Symptom Control Service
- Emergency Respite care to alleviate crisis situations when alternative facilities or arrangements are not available.

The 10 NHS beds are nurse led, supported by Tenby GPs and the Tenby Rehabilitation Team Co-ordinator. There is access to multidisciplinary services to support patients in their care pathway. The beds are fully staffed by the independent sector nursing and care staff, supported by the Tenby Rehabilitation Team Co-ordinator.

### **Evidence of impact**

Analysis of the service is currently being undertaken to understand the impact it has had on transferring patients from acute beds and in preventing admission to them. However, an early review has revealed that bed occupancy is higher in the new Tenby Cottage Ward, and this will only improve as criteria to access the beds are developed alongside the organisation's Rehabilitation Strategy.

The Chronic Condition Nurse Practitioners have successfully utilised the beds for a small number of patients to prevent acute admission and re-able them to return to their own homes. The Rehabilitation Team is developing a tool to measure patient outcomes in terms of progress against individual care management plans.

### **Lessons Learned**

Park House Court Nursing Home is to work within the Trust's clinical governance framework and hence a training programme was put in place to support the independent sector nursing and care team in working within Trust policies. However, the operational support required has been higher than anticipated.

Future training needs and delivery requires further development and the level of administration required has been higher than anticipated by Park House Court Nursing Home.

The focus on promoting and maintaining patient independence with the aim of going home also requires further support. To that end, a patient Discharge Group is being established to develop and embed this ethos with the team and with patients.

Source: Pembrokeshire & Derwen NHS Trust

## **F. WHAT FACTORS SUPPORT OR INDICATE GOOD PARTNERSHIP WORKING?**

6.24 The Review has found a number of factors that can be associated with successful partnerships where success is currently good if assessed in terms of low levels of DToC. This re-enforces the message of Chapter 4 concerning the importance of good partnership working. These include:

- A shared value base between the three statutory partners that underpins their approach to service planning. For example, in some parts of Wales partners were clear that they were seeking to promote independence and that this required a strategy based upon proactive prevention programmes and care to be offered outside hospital settings.

- The crafting of shared plans for service development directly derived from the value base. For example, some parts of Wales could demonstrate investments and disinvestments that were already altering service components.
- An ability to manage consistently the routine tasks that ensure success. For example, in the case of DToC, ensuring that the day-to-day operational procedures to assess and put in place care packages for patients are consistently carried out.
- Competence across the defined range of tasks for which each organisation is responsible; strong partnerships require self-confident organisations that resist self-defensive activities and actions.
- Partners that, because of their competence, are able to control much of the environment in which they operate so, for example, recurring financial or service pressures do not regularly divert attention away from maintaining partnership working. Or, if pressures are experienced, shared attempts are made to manage them.
- A cadre of senior staff who are respected across organisational and professional boundaries. Often these have been in the locality for a number of years, either in their present post or some other, and have built up good personal relationships across the partnership.
- The presence of what are sometimes called 'boundary spanners', key staff who work outside the normally recognised 'span' covered by their own organisation to cross organisational or professional boundaries. Typically, these individuals operate in a number of different areas of the partnership machinery and supply the 'organisational glue' which links different organisations together to deliver coherent services.
- The innovative use of aligned financial planning and other joint mechanisms to plan and support new services – for example, the use of Section 33 agreements to create joint equipment services.

### **Case Study 6.3**

#### **CEREDIGION**

##### **Ceredigion Delayed Transfers of Care Working Group and Ceredigion Delayed Transfers of Care Review Group**

###### **Partners**

Ceredigion Local Health Board, Ceredigion Social Services Department, Ceredigion & Mid Wales NHS Trust and Pembrokeshire & Derwen NHS Trust

###### **History & Objectives**

Following the Welsh Assembly Government allocation of funding to address Delayed Transfers of Care in the summer of 2004, a number of bids were submitted collaboratively from the Ceredigion health community. Funding was awarded for a number of initiatives to facilitate the reduction of delays within the county.

A multi-agency operational group was developed to pro-actively address the issues and break down barriers thus reducing delays and ensuring more timely discharge processes. This working group meets weekly and focuses not only on the validated delays, but also explores any potential problems

which may lead to delays at a later date. The group also works to reduce the number of bed days lost as well as the number of actual delays.

The DToC Review Group provides a multi-agency (senior level) mechanism for strategically directing the reduction of delayed transfers of care. The group also works to ensure compliance with Social Services DToC Performance Indicators and the LHB DToC targets as well as strategically reviewing local and national DToC priorities and directing implementation locally where appropriate. This group also provides a link between the DToC agenda and the Health, Social Care & Well Being Strategy.

### **Evidence of Impact**

Delays in Ceredigion have reduced considerably since the development of the above groups. Taking into account inevitable seasonal fluctuations, delays have been consistently lower.

### **Lessons learned**

A multi agency approach which embraces a no blame culture but which collaboratively explores, discusses and seeks solutions to delays has consistently demonstrated success.

Source: Ceredigion Local Health Board

## **G. WHAT FACTORS INDICATE IMMATURE PARTNERSHIP WORKING?**

6.25 The Review has observed events which have indicated poor partnership working. These include:

- Unilateral action by one partner to suddenly reduce services or budgets. For example, there are instances where organisation-wide financial pressures resulted in service capacity or eligibility criteria being changed at short notice.
- Unilateral action by one partner to introduce new assessment or care management processes. For example in one part of Wales social services staff began to use the guidance developed by the All Wales Adult Service Heads and the Directors of Social Services cited in Chapter 3 without the agreement of health colleagues.
- Financial pressures upon one or more partners which can quickly corrode relationships where these result in actual or threatened service cutbacks.
- Uncoordinated changes in enhancing service patterns or service capability, for example where different partners encourage service development that, in the round, results in excess capacity.
- Largely reactive responses to external proposals for service developments, for example the proposed creation of new residential facilities by the private sector, rather than the proactive pursuit of new service profiles.
- Lack of clarity about responsibilities for leading specific initiatives, for example in responding to recurring shortages of capacity in defined locations or service.
- A failure of the partnership to respond to market signals, for example where providers forecast a reduction in capacity because income levels are insufficient or uncertain or because labour shortages are being experienced, and yet the partnership fails either to avert the pressures or prepare for the service reduction.

- Uncertain political leadership within local government related to plans for service change, especially where these are opposed by individual elected members.

## **H. LEVELS OF TRUST BETWEEN PARTNERS**

6.26 In most parts of Wales, the Review asked informants to give their assessment of the levels of trust that existed between their own and other organisations at the time of the field work. Broadly, these were reported as being above a score of 6 (10 indicates a high level of trust). In several locations, though, one or more partners registered quite low scores, suggesting that this partner was less trusted than other members. Scores for NHS Trusts were, on the whole, slightly lower than scores registered by LHBs and local authorities. Generally, DToC numbers are low where NHS Trusts have rated the relationship between LHBs and local authority partners at 8 or above.

## **I. HOW DO FUNDING ARRANGEMENTS WITHIN PARTNERSHIPS WORK?**

6.27 The Review examined the extent to which the various forms of joint working sanctioned in Section 33 of the NHS Wales Act 2006 were being used, or felt to be useful in relation to delayed transfers of care.

6.28 Joint funding occurs in a number of locations, and examples of activities include:

- shared guarantees of levels of income to independent sector operators in order to encourage new provision;
- jointly funded staff posts to serve several organisations;
- equipment services;
- the creation of new facilities to offer free post District General Hospital ongoing assessment beds for a limited period;
- the funding of ongoing care on a 50:50 basis where it had otherwise been difficult to agree precise service classification.

Across the board the funding came from within existing resources.

6.29 However, it is also the case that in most of these examples, local partners saw the best arrangements as being the ones where the different partners had 'aligned' their budgets, i.e. they had co-ordinated their financial plans so that the necessary funds were available from each partner when required by the plans in question. This carried forward the emphasis of retaining control of the sums set aside which, for many partners, was felt to be necessary.

6.30 This was one issue where the Review team did find some note of dissonance between front-line professionals and senior managers. A number of nursing staff and social workers had discussed initiatives which were, in their view,

good candidates for a 'pooled budget' approach, but had met resistance from finance staff and others who sometimes saw pooled budgets as 'ring fenced budgets'. In other words they would become budget areas for which they would be accountable, but which would no longer be under their full control. The evolution of 'aligned budgets' appears to be a locally developed solution designed to overcome this.

- 6.31 Where real 'pooled budgets' can be identified, these have been created using new money – for example that coming to localities through Wanless funding – and used to create the additional services which partners agreed had priority.
- 6.32 Informants' views on the utility of pooled budgets were sought. Where these were to be created from existing funds, the majority view was that pooled budgets, if imposed from outside, would be unlikely to assist. For partnerships already working well, the approaches using aligned budgeting were considered more practicable: any arrangements that implied a forced reduction in spending power - or control over it - would engender opposition. For partnerships already experiencing some difficulty, external requirements to pool budgets would merely add to tensions that already exist.
- 6.33 Imposing financial penalties within partnerships that are expected to work together to improve services have often been seen to be somewhat divisive when imposed in England. The review of literature in Chapter 4 has already cited examples where partnerships refused to impose fines on partner organisations. Two thirds of local partnerships in 2004/5 had not charged Social Services Departments the £120 per day fines for delayed transfers which were allowed at the time. Slightly less than one in five English NHS Trusts imposed fines and retained the money.
- 6.34 Any initiatives which impose sanctions on partnerships need to be carefully crafted if they are to be used at all. The system of 'fines' in England only applied to patients in particular types of beds – mental illness beds were excluded. Chapter 2 has already identified that ignoring those patients would leave a substantial proportion of the DToC problem outside such sanctions.
- 6.35 Also, the utilisation of performance incentives needs to be developed further if it is to have any benefit for all partners working on reducing DToC levels in Wales. The recent publication of the incentives and sanctions framework for NHS Wales does not include DToC targets as part of the framework. To do so would mean that some rethinking is needed on how such a framework could operate across organisational boundaries, and perhaps even include private sector providers.

- 6.36 In respect of new money (for example to cover the running costs of new services whilst old ones are modified), where service changes were agreed locally, the use of pooled budgets would be less controversial. However, in these circumstances, it would also normally be the case that the respective partners would have agreed the funding requirements for the proposed changes and would be clear as to which agency should bear the responsibility for meeting ongoing costs. With these provisos, allocating new money directly to agencies would also be possible. However, one reason for requiring a pooled budget to occur would be if some aspect of the plan was still to be determined and a jointly held contingency sum was felt to be appropriate.

## **J. DEVELOPMENT AND GOVERNANCE OF NETWORKS TO TACKLE DELAYED TRANSFERS OF CARE**

- 6.37 The evidence tells us that networks are the most promising organisational form through which to tackle issues where there is high complexity and many stakeholders are involved. Delayed transfers of care have both of these characteristics. For the future, the various initiatives which are part of the 'Making the Connections' policy – notably the recent advent of local service boards – are an important part of the equation in ensuring that further progress is made in tackling delayed transfers of care, and that good practice is shared.
- 6.38 In terms of planning and commissioning the range of services that will support further reductions in delays, networks at the local level should be planned to build on the approach underpinning the development of local service boards to bring together:
- local authorities;
  - local health boards;
  - primary care;
  - secondary care clinicians ;
  - NHS Trusts;
  - the voluntary sector; and
  - the private sector.
- 6.39 From the evidence of this review, particularly drawing on international experience, we would recommend that voluntary and commercial providers should be directly involved in local networks. Long term relationships, that are the hallmark of networked forms of governance, are, we believe, key. All partners should be directly involved in the planning and delivery of services, sharing an approach to designing a pattern of services that will address a range of complex issues, and co-ordinate and integrate a number of key policies at the local level including:

- developing care ‘bundles’ and care pathways that build in a focus on minimising delayed transfers of care in transitions between all settings, (not just concentrating on the transition out of acute hospitals);
- services for people with chronic conditions; and
- emergency care.

6.40 Building on the development of local service boards would avoid creating specific mechanisms just to deal with delayed transfers and would be the basis for addressing other issues that, like delayed transfers of care, have the characteristics of multiple stakeholders and high complexity.

### **Clinical leadership**

6.41 Clinical leadership is clearly a key element in the arrangements considered here. There would be merit in exploring whether, within the kind of multi-agency network we have described, primary and secondary care clinicians could work jointly in community settings. This would be a step in the right direction in meeting the aspirations of clinicians to work in a more co-ordinated and integrated way. It would ensure clinical leadership in developing care bundles and care pathways through which patient care is managed into and out of healthcare settings, drawing on acute hospital care, domiciliary and residential care in partnership not only with the organisations who make up the local networks, but also with patients and their families as co-producers of care. As networks can be made up of organisations of various forms, this way of working would not impact on the employment status of clinical staff, including the independent contractor status of general practitioners.

### **Incentives and sanctions**

6.42 As set out in Chapter 4, the incentives and sanctions developed as part of a performance management regime need to be aligned with the form of governance that is in place. As the form of governance most suited to tackling the root causes of delays in transfers of care in the Welsh context is the network form, rather than hierarchies, or markets, the incentives and sanctions applicable to networks we propose would be performance managed through:

- Peer pressure based on long term relationships established within the network;
- Development support through NLIAM and the Social Services Improvement Agency; and
- Oversight, inspection and reporting by health and social care inspection and regulatory bodies.

6.43 In this context we would recommend that, as with the assessment of the extent and the development of solutions to the problem of delayed transfers being developed at the local level, the mechanisms through which to achieve



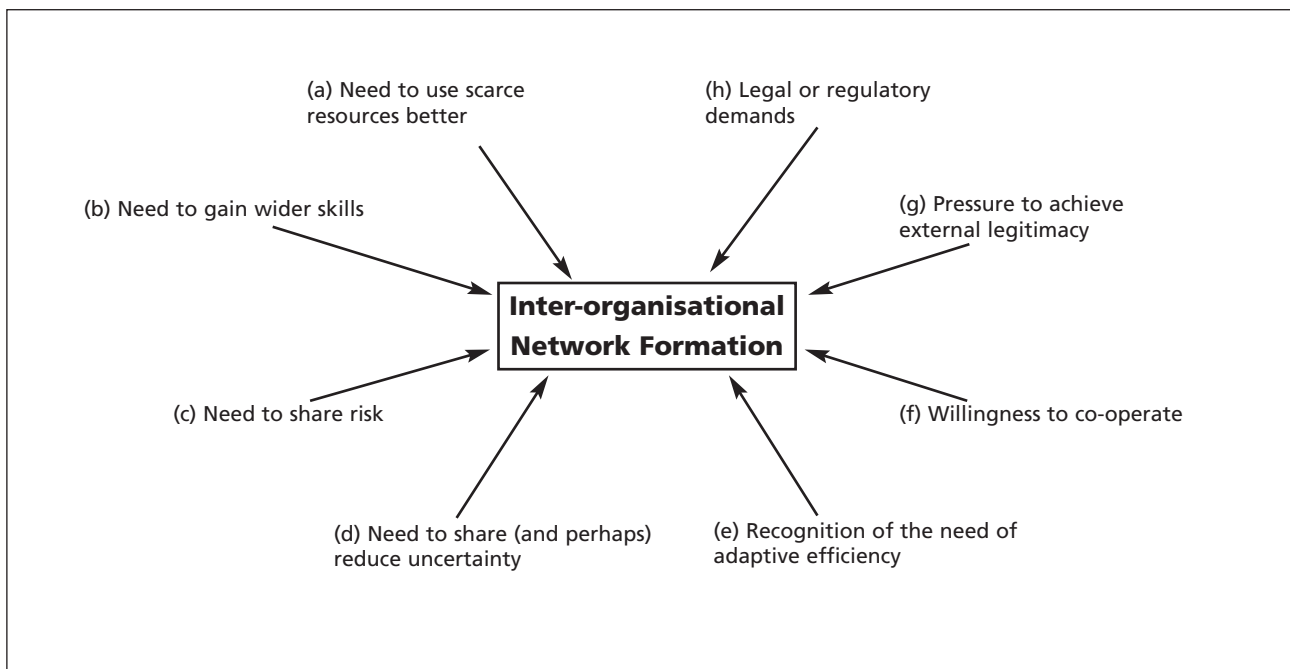
change should also primarily be developed at the local level. This would include the extent to which pooled budgets, joint commissioning and integrated care would play a part.

- 6.44 We have referred to some of the adverse consequences that can flow from an overemphasis on delayed transfers of care as a performance management issue (Chapters 4 and 5). Targets to reduce delayed transfers of care have a role to play, but should be performance managed in a way that is proportionate to the seriousness of the problem. Decisions on how to plan, commission and deliver services that will address the factors affecting delay; establish targets and milestones towards developing such services; and measuring progress towards those targets and milestones should be made locally.

## K. SUMMARY AND CONCLUSIONS

- 6.45 Throughout, reference has been made to the immature level of development of partnerships and networks currently in respect of service planning and delivery. It is also unclear the degree to which network formation is recognised as an imperative (because of the complexity of cases and the current fragmented effort) in the DToC arena, and how much the factors influencing network formation have come into play. Figure 6.2 sets these out:

**Figure 6.2: Factors Influencing Network Formation and Operation**



Source: Warner M. et al (2005)

- 6.46 If these factors were recognised more explicitly and became an integral part of the considerations and actions of professional colleagues and managers,

care per se would improve through better integration, and so too would managerial efficiency and partnerships.

- 6.47 There are a number of partnership assessment toolkits and frameworks available to support local partnerships in their evaluation of the maturity and effectiveness of local arrangements for collaborative working. Local partnerships could identify a tool which best reflects local needs and circumstances, undertake an assessment and develop an action plan (including their local development needs) to implement the findings of the assessment.

## CHAPTER 7

### OPERATIONAL ISSUES: DEFINITIONS, DATA AND ASSESSMENT

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#### A. INTRODUCTION – TERMS & MEANINGS

7.1 This chapter discusses:

- current definitions for DToC, reporting and data reliability;
- the use of data for commissioning;
- unified assessment, the assessment pathway and nursing elements;
- information and communication technology; and
- staff training and developments.

It offers examples of national and international examples of best practice and concludes by summarising the variety of problems and gaps evidenced within the chapter. These include problems with:

- operational definitions and coding of DToC;
- Unified Assessment and nursing assessment;
- Commissioning information and its use;
- Lack of supporting ICT; and
- Gaps in training an education to support the whole system.

#### B. DToC DEFINITIONS, REPORTING AND DATA RELIABILITY

7.2 Current definitions for delayed transfers of care are set out in the Welsh Assembly Government publications: 'Health Statistics Wales 2007' and the 'Delayed Transfer of Care Database Implementation & Process: Guidance Notes Version 2' (August 2005). However, the Review found uncertainty at operational and executive levels as to:

- Who makes the decision to transfer a patient?
- Who decides when a patient is actually a delayed transfer?
- Whether relocation was actually a transfer; and which code is applied at a local level for delays?

It appears that this uncertainty derives from a patchy understanding and implementation of the definitions, and results in potentially unreliable data in respect of number counting and verification, and a lack of clarity about who is responsible for decision-making and the actions that are necessary to discharge patients.

### **Current definitions – Who Makes the Decision?**

- 7.3 A DToC is defined in 'Health Statistics Wales 2007' as being experienced by an inpatient who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons.
- 7.4 This definition is reflected within much of the local discharge planning guidance submitted to the Review. A particular example of good practice can be seen in Conwy and Denbighshire where their 'Policy for Discharge and Transfer from Adult General Wards' is supplemented by a 'Toolkit for Transfer and Discharge'. This includes the current definition of DToC and its codes in addition to role responsibilities, timescales, and procedures for referral to other inpatient and outpatient services, all in accordance with the Unified Assessment Process.
- 7.5 The Welsh Assembly Government (2005) 'Delayed Transfer of Care Database Implementation & Process: Guidance Notes Version 2' are currently used by staff who input the data into the All Wales database. This is encouraged to be a 'live' arrangement with appropriate staff (supported by nurses who coordinate complex discharge) being required to input the appropriate data. They, however, rely heavily on colleagues to provide them with current information to ensure that the data is accurate. The definition used here is consistent with the 2007 publication:
- 'A delayed transfer of care is experienced by an inpatient occupying a speciality/significant facility bed in a hospital, who is ready to move on to the next stage of care but is prevented from doing so by one or more reasons for delay in transfer of care. This will include a delay in discharge. The "next stage of care" includes all appropriate destinations within and out of the NHS (further inpatient episode, patient's home, nursing home etc).'*
- 7.6 The Welsh Assembly Government (2005) Guidance Notes states that 'the date on which the patient is ready to move on to the next stage of care is the ready- for- transfer of care date' and this is determined by
- 'the clinician responsible for inpatient care, in consultation with colleagues in the hospital multi-disciplinary health care team and all agencies involved in planning the patient's transfer of care (both NHS and non-NHS).'*
- 7.7 The Welsh Assembly Government's (2005) WHC: 035 Discharge Planning Guidance currently in use does not include a definition of DToC nor does it ask practitioners to consider it within daily discharge planning and its 'Checklist of Key Requirements' for discharge planning. It does mention the reporting mechanism of a monthly snapshot for capturing delayed transfers of care, the usefulness of the information captured, the role of the Regional Offices and the link to the Service and Financial Framework in paragraphs

27-29. Therefore, within the policy guidance, practitioners may not perceive a delayed transfer of care as a negative element of the discharge planning process, but something that happens in isolation. However, practitioners are referred to a 'Good Practice Guidance' which was published in 2004 by Innovations in Care where operational staff should be able to find detailed information on the guidance and codes and links discharge and delay processes.

- 7.8 The 'clinician responsible for inpatient care' is traditionally determined as the consultant physician or surgeon. Interviews during the fieldwork for the Review highlighted that the term 'medically fit for discharge' was not used in all localities; and, on occasion within some localities there was a combination of either 'fit as determined by the multidisciplinary team', or 'medically fit by the consultant'. Other definitions used were 'fit and healthy and ready for discharge' or 'clinically fit for discharge' or 'no longer needs a hospital bed or care setting', 'ready to move on to the next stage of care following an acute episode', 'being in for an unnecessary day or week' or inappropriately placed in a hospital setting, not getting appropriate care'. Only a fifth of those localities where interviews took place were clear that the responsibility lay with the clinician to define whether a person was a delayed transfer of care. The Welsh Assembly Government definition cannot be said to be applied in a standardised way and operational across Wales. This raises caution in the interpretation of the trends as the data collected cannot be said to be entirely reliable and consistent across Wales.
- 7.9 In some areas the individuals interviewed felt it was more appropriate that the multi-disciplinary team (MDT) determined fitness for discharge in order to avoid readmission, and to promote independence and wellbeing. The clinician may have determined that an individual is fit for discharge from a medical or surgical perspective, but if assessments and treatments appropriately determined by other professionals within the MDT have not been completed, the patient will not be discharged successfully. People with complex needs, co-existing problems and who are very frail, experiencing deterioration in their physical function or mental health were seen to be of particular concern.
- 7.10 The discharge planning guidance WHC (2005) 035 is set in the context of the Unified Assessment and Care Management guidance (and Care Programme Approach). People with complex needs require comprehensive assessment which comprises a number of specialist assessments determined by individual need. The role of the consultant is that of a specialist assessor, with the coordination of the overall assessment undertaken by the care coordinator. In the health setting this is undertaken by a nurse, usually the discharge 'expert', or sometimes the ward sister. In addition the 'six practical steps' advocated by the National Leadership and Innovations Agency for Healthcare in their 2007 report promotes the further use of nurse-led discharge.

### **Case Study 7.1**

#### **BRO MORGANNWG**

##### **Work of the Trust on improving discharge practices**

A discharge project has been established within the Trust which has established a number of work-streams to take forward the improvement of discharge practices. Representatives from all key directorates are involved in the project and it has dedicated project management.

One key area of work was the development of a transitional care ward. It had been identified that the assessment documentation was taking nursing staff up to 5 weeks to complete. Further delays were then caused when the LHB sent the assessment back requiring amendments to be made. This was often due to the assessment having been completed in a fragmented manner with several nurses completing the paperwork in between care delivery and the general running of the ward.

The timescale for completion of the initial paperwork is 10 working days and it was felt that this could be met through a Plan/Do/Study/Act (PDSA) cycle.

Twelve beds on a ward were dedicated to patients requiring assessments for NHS funded or continuing healthcare placements. This 'transitional care' area was staffed by dedicated nurses and was clinically led by a consultant physician. Wherever possible the nursing staff were allocated dedicated protected time to complete the assessment paperwork and each assessment was owned by an individual registered nurse.

##### **Outcomes**

Prior to the PDSA cycle the average assessment time was 33 days. During the PDSA cycle this was reduced to 19 days.

##### **Conclusion**

The PDSA cycle was successful in achieving the expected outcomes and proved that a dedicated transitional care area could expedite the process for completing the assessment documentation for a nursing home placement.

Source: Bro Morgannwg NHS Trust

- 7.11 As a result of this shift towards nurse led discharge planning, the Welsh Assembly Government may wish to consider a review of the definition of the 'next stage of care'. The aim of which would be to reflect the context of current assessment, whole system's thinking and the way in which organisations are expected to manage the discharge of patients with complex needs and whose fitness for discharge is now frequently determined by the whole MDT. A definition of 'ready-for-transfer' is offered for consideration:

*'The ready for transfer date of the patient with complex needs is determined by the discharge 'expert' or care coordinator in consultation with all named members of the designated Multidisciplinary Team (and relatives or carers) who have been involved in planning the patient transfer of care'*

The definition of complex within the WHC (2004) 54 'NHS Responsibilities for Meeting Continuing NHS Health Care Needs: Guidance 2004' is

*'when the patient's needs are complicated due to interactions of multiple factors that require frequent assessment'*

In accordance with WHC (2006) 046 'Further Advice to the NHS and Local Authorities on Continuing NHS Health Care' complexity must also be considered in terms of both quantity and quality required by the patient and explored by the multi-disciplinary team. Therefore a definition of complexity is offered for consideration as:

*'when the patient's needs are complicated due to interactions of multiple factors in terms of both quantity and quality that require frequent assessment by appropriate members of the multi-disciplinary team'*

### **How are DToC Reported?**

- 7.12 The Welsh Assembly Government gathers DToC data through a monthly census system. It provides a picture of the number of delayed patients within NHS beds on that day, and the number of bed days lost. Welsh Assembly Government guidance (2007) states:

*'It is essential that local procedures are developed and agreed by trusts and local authorities to ensure that data entered onto the database is accurate and where necessary validated with local authority colleagues. This will ensure that the method applied is best suited to local circumstances.'*

- 7.13 In this Review the documentation showed that all localities have developed locally agreed procedures. However, of the staff interviewed for this Review, approximately a third were not always clear as to the reporting process within their own organisations. This disrupts wards and senior staff as they scramble to meet the census day target. The local ways in which the process is managed vary, with DToC meetings being held monthly, weekly and more frequently where the locality perceived a potential or real problem with targets being achieved. The Wales Audit Office (2007) report found that general wards and mental health services had different processes for gathering information and verifying the data. In addition, the Review found that health and social care services occasionally reported different figures, although social care staff did have an opportunity to challenge the data. However, DToC numbers were also seen as an artificial - and not particularly informative - measurement at a point of time, and staff had to invest considerably more effort to understand the reasons for the delays. The Welsh Assembly Government should work with discharge experts to review current codes and develop methods which as useful in understanding reasons for the delays.

- 7.14 The process of coding varies across localities, some undertaking a pre-census process (not always multi-agency). Approximately 40% of locations where the Review conducted fieldwork admitted there were instances when certain patients were regularly not included in the census numbers. This was particularly in respect of those people who were longer term patients (the longest was 5 years) in mental health directorates who had nowhere else to go, and those who were detained under mental health legislation.
- 7.15 Whether reporting of DToC should be quarterly rather than monthly as practiced in Scotland is for debate. However, the reality is that DToC measurement is a snapshot in time of data, the definition of which should be rigorously determined for the whole of Wales including coding standards, and a required joint process which reflects the reality of the current situation as perceived and understood by all staff. This would assist in accurate benchmarking across Wales. Maintaining a monthly reporting requirement where delay levels are low takes clinical staff away from patient centred activities.
- 7.16 The Review has found that the database within Wales poses some problems for DToC entries as they are often delayed due to information technology problems within NHS Trusts as reported by practitioners. Thus the proposed 'live' management of discharges is impossible, especially at weekends, despite the fact that the system should be available seven days a week. Practitioners reported inaccessibility and lack of familiarity with national computerised information which resulted in localities not regularly benchmarking themselves. The Review team met individuals responsible for delayed transfers who reported that they did not often look at the all-Wales data for comparative performance purposes.

### **Who does the counting and when does it start?**

- 7.17 The Review found staff were often unclear as to when counting began for a person who had been defined as a delayed transfer. For some locations ward staff determined this, and in others it was the senior nurse or the multidisciplinary team. 'Local agreements' of varying length (some as long as 14 or 15 days) were in place, during which period patients were not counted as being delayed, in order to allow staff to make the necessary arrangements for their discharge. The evidence from the interviews suggests that the local agreements clouded the present recording systems and the numbers of people being cared for in hospital settings (which they no longer needed) were de facto under-reported.
- 7.18 Ascertaining the number precise number of delayed transfers is therefore very difficult, as under-reporting occurs for a variety of reasons: the patient might have been delayed prior to the monthly census; delayed and waiting for assessment within the local agreement time limits; or awaiting tribunal; or were (in some cases) not counted as DToC as they had been transferred to a community hospital.



- 7.19 The use of local agreements is clearly problematic. They were often introduced to reflect the 'unavoidable' time taken to make complex arrangements, and to avoid a 'blame culture' where social services were likely to be criticised for *any* delay. However, their effect is to compromise the reliability of the data, as different periods are used in different localities. Removing these local agreements must not be seen as a mechanism for one organisation to 'blame' another for delays. It is clearly not possible for complex packages of care to be constructed overnight. Nor is it possible for a placement in a residential or nursing home to be arranged instantaneously. At present though, the very fact that local agreements vary from one location to another adds confusion to any assessment of the real position in relation to how long patients are being delayed in hospital.
- 7.20 Counting should commence on the date that the discharge 'expert' or care coordinator determines the patient as 'ready for transfer', having consulted with the multidisciplinary team and the relatives or carers. The appropriate code should then be allocated immediately by the discharge 'expert'.
- 7.21 The discharge 'expert' or care coordinator is a collective term for those roles such as discharge liaison nurse, discharge coordinator etc. It is a role which should incorporate all the principles expressed within the NLIAM document 'Passing the Baton'. This Practical Guide to Effective Discharge Planning will offer (when published) a common sense guide to the principles, which they acknowledge as communication, coordination, collaboration, consideration, creativity and integrity. Please see Appendix 7 for a suggested description of the role of the discharge 'expert'. It is suggested that this role should be considered in the context of Skills for Health Career Framework Level 8 with appropriate skills competence and educational attainment at a minimum of Masters level education.
- 7.22 The Review interviews found that the coding of delayed transfers of care often relied on individual nurses who were knowledgeable and experienced in coding and undertook the coding in isolation. This was found to be occurring in over half of localities visited. However, sometimes the process relied on individuals who depended on others within the multi-disciplinary team to participate in the coding process. Senior staff were aware that very often their staff did not understand the codes and that ward staff regularly attempted to upwardly delegate this role to those nurses designated as 'discharge' experts. Those who were confident in their coding abilities had established long term relationships across and within agencies and fully understood each others' roles and working constraints. Discharge teams often spent time trying to empower ward staff in their reluctant role of defining and reporting a delayed transfer of care. Social workers challenged codes where they felt it was necessary. However, there was a clear desire to have an All-Wales integrated health and social care reporting of delayed transfers of care codes which reflect the reality of the episode of care.

- 7.23 The Review learned from its interviews that difficulties in coding had arisen through individuals within agencies having difficulty interpreting what they perceived as 'rather vague' definitions of delay codes and delay specialities which they saw as open to interpretation or did not have codes at all - such as, homelessness, unmet need, sectioned and substance misuse. Following from this, professionals interpreted them as they perceived correct, in accordance with their differing philosophies or models of care, learning from each other's individual interpretation and on occasion imposing these upon another agency.
- 7.24 The general lack of ability to define whether someone was regarded as a delayed transfer of care, and then defining the type of delay or speciality code, led to ward staff not being able to identify a delay or a potential delay early enough. This, in turn, meant that more senior staff did not get reliable data. Four in ten of localities felt there were too many codes, or the codes were not useful. Some areas had created a list of 'secondary delayed transfers of care' where people had transferred from a district general hospital to a community hospital and became delayed within them.
- 7.25 The informants within this Review suggest that work is needed to review the current codes and develop a list which reflects current patient and service experience. Although the codes are not intended to be client group specific, operational and executive staff suggested that a review may increase their usefulness to both practitioners and commissioners. Attention is required to be given to frequently used codes and those that have been identified in the Wales Audit Office (2007) report and this study as 'missing' - including learning disabilities, substance misuse, mental health, homeless and unmet needs.

## **B. USE MADE OF DATA IN WALES FOR COMMISSIONING PURPOSES**

- 7.26 The NHS Commissioning Guidance (WHC (2007) 023) states:

*'commissioning must drive improvements in quality and performance...', 'commissioners must be able to provide a rationale for all services contracted for' ... 'rooted in strategic objectives' informed by the community, service users, professionals and clinicians, 'respond to changing needs'... and underpinned by good clinical, management and financial information'.*

- 7.27 The DToC codes provided by the Welsh Assembly Government (2005) document, however, do not provide enough detail for the LHB and local authority to accurately commission the services required by people with complex needs. The role of the LHB is to commission services with the local authorities across the whole of the patient pathway, which in itself should be linked into the Unified Assessment and the minimum dataset of information.

In the future this should provide the foundation for commissioning and benchmarking service information. This review suggests that the Welsh Assembly Government with commissioners and members of the unified assessment Community of Practice discuss and decide in partnership what they perceive as the total information dataset that they require for commissioning purposes.

- 7.28 Providers, such as the NHS Trusts, are accountable for what they have been commissioned to provide. The Fair Access to Care Services document, which determines a person's eligibility for community care services, is linked to the Unified Assessment; and therefore, effective people centred services should be achieved in partnership with commissioners, providers and service users. The Unified Assessment Minimum Dataset (2006) is the key to commissioning services across localities as it is designed to gather individual information which collectively can be used for commissioning. But unfortunately this has only just been embedded into the new local authority data systems.
- 7.29 Commissioning should take a long term view of supply and demand to provide evidence based services which meet the population needs today and in the future. Good practice checklists such as 'Commissioning and the Independent Sector' (Department of Health, 2003) advocate that it should be based upon demographic and other data to estimate the type and quantity of services required. Evidence gathered within this Review (including interviews and planning documents), shows that has been happening within localities through the compilation of locality needs assessments and Health and Social Care Well Being Strategies.
- 7.30 Some commissioners have information in respect of service gaps and delays in service and have used this to jointly commission posts (e.g. discharge 'experts') and services which promote independence and avoid hospital admission such as intermediate care services. Documents clearly stated the intention to work in partnership, and many cited joint commissioning as crucial for the future, although in interviews there was an occasional expression of reluctance by some partners to participate.
- 7.31 Social services, through their commissioning strategies, have set out their intentions within national and local contexts. In some areas a view was expressed that a shift in demand towards further nursing home care had been seen, an acknowledgment that falls in the home were common and there was a need to reduce preventable falls.
- 7.32 Unfortunately, a fifth of Local Health Board staff indicated that commissioning was not based on evidenced need. In many cases staff either did not know whether evidence was used to commission services or understand how services such as care home beds were commissioned. Further comments were made that the independent sector was determining its own requirements in terms of provision and location. In addition, some

NHS Trust staff interviewed viewed Local Health Boards as too small to commission effectively. Frustration was often seen in respect of commissioning of restricted 'office hours' health and social care services, with no weekend and holiday cover. Also there was a lack of decommissioning in order to redesign service provision. The Wales Audit Office (2007) reported that the assessment of unmet need was not well informed:

'DToC are an outcome of other failures and it is important to have information and activity to evaluate and support new patterns and models of care'.

- 7.33 The Review noted that localities were considering future needs through the development of joint groups and joint commissioning posts. This was evident in the interviews and through documentation. However, commissioners were aware of gaps in information available to them - many times first choices could not be met, and assessment was tailored more to the services available than to the person's needs. This was especially so in respect of elderly mentally ill services. However, there was acknowledgment that the unified assessment minimum dataset could provide this information if it was operational through a joint information technology system. This standardised dataset would provide the comprehensive information required to jointly commission services for those assessed.

## Case Study 7.2

### CONWY & DENBIGHSHIRE

#### Organisations involved

Conwy Local Health Board, Conwy Local Authority, Conwy & Denbighshire NHS Trust, and Denbighshire LHB

#### History and Objectives

Conwy LHB partners were struggling to meet their DToC targets. Meetings were held with relevant stakeholders in attempts to address the problem. It became evident that our efforts should be directed proactively prior to census days, to ensure maximum effect on facilitating patient flow through improved planning and discharge arrangements.

#### Objectives:

##### First and foremost:

- To ensure patients discharge arrangements were timely and appropriate with any continuing care needs being identified and planned well in advance.

##### Secondly

- To meet our DToC targets
- Highlight operational issues
- Problem solve by sharing ideas, solutions and new ways of working
- Identify service gaps to inform commissioning

#### Evidence of Impact

- Weekly information is received by the LHB enabling individual patient tracking and discharge planning.
- Pre-census meetings are held with Partners to consider each patient on the list and take agreed action.

- The LHB nurse reviewers know day to day where care home vacancies exist and link directly to wards where patients are awaiting transfer.
- Patients are referred to the strengthened Conwy Intermediate Care Service as appropriate to facilitate more rapid discharge of those requiring short term intensive support.
- Gwynedd and Mon also joined the meetings to learn from our experiences. They now hold similar meetings.
- Fewer problematic DToCs.
- Better co-ordination of complex discharges.
- DToC targets are being met.

**Lessons Learned**

- Communication is key across both organisational and professional boundaries.
- Greater understanding of team members' contribution and organisational roles, responsibilities, and resources.
- Procedures and processes support the management of complex cases.
- DToC is a shared responsibility.

Source: Conwy Local Health Board

## **C. UNIFIED ASSESSMENT, THE ASSESSMENT PATHWAY AND NURSING ELEMENTS: AN APPRAISAL OF REQUIREMENTS**

### **Background**

- 7.34 Creating a Unified and Fair System for assessing and managing care was published in 2002 by the Welsh Assembly Government with the view that eligibility criteria for all adults requiring social care services would be implemented in that year, with the eventual implementation of the Unified Assessment Process commencing in April 2005. Its purpose was to promote proportionality in a holistic and whole systems approach to assessing people with complex needs and to enable professionals to share relevant assessment and care management information within a standardised assessment framework. This should lead to more effective, appropriate shared working and speedier assessments which are more focused and provide depths of assessment which are proportionate to individual need. This, in turn, would result in professionals undertaking focusing their skills and expertise where it is most required. This is particularly relevant to those people awaiting multiple in-depth assessments and an effective co-ordination of their 'discharge' process. Unfortunately, the cultural differences that exist between health and social care are such that health services and their practitioners seem to have been reluctant to accept that local authorities have to assess eligibility for services, especially in respect of their statutory functions and responsibilities.
- 7.35 The main guidance was issued under section 7(1) of the Local Authority Social Services Act 1970 and is integrated and core to Fair Access to Care. Its principles are to:

- promote independence and avoid risks to independence;
- ensure assessment is person-centred and proportionate to need;
- use an outcomes approach;
- minimise duplication, co-ordinate services and integrate assessment at all levels and across health and social care;
- ensure that the eligibility criteria for service provision are fair and standardised across Wales.

### What is the Unified Assessment Process?

7.36 This process of assessment has five sections within it, but is not linear (see Table 7.1). The responsibility for implementation lay initially with Social Services Departments. Unfortunately, in reality, project managers were initially often working in isolation within their own agencies without the support of a project team to deliver this cultural change. The size of this change was often underestimated as project managers struggled to engage with different working processes, different working languages and working practices which occur in the two agencies. There was often a lack of awareness of the benefits of Unified Assessment.

**Table 7.1: The Unified Assessment Process**

<b>Enquiry</b>	<b>Contact</b>	<b>Overview</b>	<b>In-depth</b>	<b>Comprehensive</b>
<ul style="list-style-type: none"> <li>• For information</li> <li>• Service request</li> <li>• Leading to contact assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Basic Personal information</li> <li>• 7 key issues</li> <li>• 2 domains</li> </ul>	<ul style="list-style-type: none"> <li>• User’s perspective</li> <li>• Disease prevention</li> <li>• Personal care/physical well-being</li> <li>• Senses</li> <li>• Mental Health</li> <li>• Safety</li> <li>• Instrumental activities of daily living</li> <li>• Carer’s perspective/ assessment</li> <li>• Clinical background</li> <li>• Activities of Daily Living</li> <li>• Relationships</li> <li>• Immediate environment and resources risk assessment</li> </ul>	<p>This is undertaken by an appropriately qualified and experienced professional using models and scales of assessment as indicated by their professional judgment. This type of assessment should be provided when distinctive triggers for assessment are recognized.</p>	<p>This is not an additional assessment but an overview of the whole. The care coordinator draws all assessments together and gains an overall picture as to what exactly is happening with the patient, in order to inform decision making and develop appropriate plans.</p>
<b>Completed by unqualified but trained staff</b>	<b>Completed by unqualified but trained staff</b>	<b>Completed by professionally registered staff</b>	<b>Completed by professionally registered staff</b>	<b>Care coordinator</b>

7.37 In order to implement the process the Welsh Assembly Government published ‘The Unified Assessment Process Implementation Toolkit’ in 2006 which sought to explain how implementation could be achieved by professional groups. This included a checklist which advised professionals to map their assessment information needs across to the framework and the patient’s

journey in order that the information flowed from ward to ward etc. It also asked the professional to question:

- whether they could achieve assessments which were proportionate to individual need?
- what referral information they supplied to others?
- whether assessments had been dovetailed into the framework to avoid duplication?
- whether terminology had been agreed with other professionals and agencies?

### **How Does Nursing Assessment Fit In?**

- 7.38 Assessments such as the NHS Funded Nursing Care and Continuing NHS Health Care are seen as in-depth assessments within this more general framework. The former includes in-depth nursing assessments only, which determines whether or not a person is eligible for NHS Funded Nursing Care. The latter has a collection of professional assessments which are proportionate to the individual's needs and determine whether a person has a health care need which may give rise to eligibility for Continuing NHS Healthcare. The decision whether a patient has a nursing need or not, or may require further assessment in regard to a health need, is made by nurses and requires clear documentation within the Unified Assessment Summary Record. This is the minimum amount of information which is required by professionals and agencies to share. This information is crucial to the 'care co-ordinator' or discharge 'expert' as they manage individual discharges, engage with professionals and agencies to avoid re-admission. (See Chapter 5 for a discussion on choice).
- 7.39 The Welsh Assembly Government launched the Nursing Needs Assessment Decision Record, workbook and training pack early in 2007. Its purpose (in response to the 'Grogan judgment') was to support nurses who make decisions on whether an individual has a nursing need, requires Multidisciplinary Team referral for Continuing NHS health care and/or eligibility for NHS Funded Nursing Care. Its implementation has not been embraced across Wales, some LHBs deciding not to use it, some nurses having difficulty with identifying a nursing need (which in some cases is compounded by use of unified assessment as their nursing assessment, rather than an assessment based on a nursing model). The increasing demand for assessment due to the AWASH document (see Chapter 3) has added further friction in some parts of Wales. This is especially so when a decision as to whether a patient has a nursing need cannot be identified and documented correctly, clearly distinguishing it from a social need. The use of the Nursing Needs Assessment Decision Record tool would support the nurse in clearly identifying a nursing need. This would address some of the friction encountered by staff and patients when trying to determine whether an individual has a nursing or social need.

## How Has the Unified Assessment Process Been Implemented?

- 7.40 The fieldwork for this Review demonstrated a considerable measure of support for the principles of unified assessment (WAG, 2002), as this standardised framework improves the assessment of individual need, outcome based care and the practice of sharing information. However, its attempted implementation has been erratic throughout Wales with some areas and/or agencies experiencing more success than others. The fieldwork found that two thirds of the localities visited were using Unified Assessment, and a fifth admitted that they were not. One senior manager, when interviewed, stated that the Trust had withdrawn from its use. However, when practitioners were interviewed the document was still in use and was seen as very useful when assessing patients with complex needs. There are still many barriers to using unified assessment, including the size of the documentation and the unified assessment's relationship with the Care Programme Approach employed in mental health. Whether the Care Programme Approach is viewed as an assessment or a process is still debated between mental health practitioners, and it is often used outside the unified assessment framework. However, the Welsh Assembly Government is quite clear in its guidance that it forms an in-depth or specialist assessment within the Unified Assessment Process.
- 7.41 Unified assessment continues to be a paper-based exercise in health agencies and has not progressed to what was generally felt by the informants within the Review to be a much needed IT-based system. Social Services have progressed, through their consortia, to deliver improved information technology systems which have embedded within them the Unified Assessment National Minimum dataset (2006), most of which have either 'gone live' or will do so within 2008. In 2006 Informing Healthcare and the Welsh Assembly Government described how they intended to develop a joint interface between health and social care. The momentum for this appears now to have been lost. The Community of Practice (developed in 2006) December 2007 meetings notes state, *'There will be **no** joint health and social care IT system'* (page 2 of 4). This view is in direct contrast to those expressed by informants within this Review, where information technology development supporting integrated assessment was seen as an essential tool within the modernisation agenda, not just for assessment purposes but for gathering the essential information required for commissioning individual services which would be proportionate to need. Furthermore, examples of best practice in Scotland (Dumfries and Galloway) and England (Cambridge) show how staff from health and social care are enabled to gather assessment information electronically to determine an individual's care needs in a single visit. Referrals to other services can also be made electronically from this assessment.
- 7.42 Whether or not unified assessment is utilised in health or social care, the process of assessment more generally is currently perceived as slow. Referrals to other professionals can take time due to continuing vacancies and



incomplete documentation. Responses to referrals to social services are often interpreted by health staff as delaying discharge, practitioners responding to the Review team stating that they waited 3-14 days for simple to complex social care assessments. Often this time period does not include the construction of a package of care. Social services staff stated that the referrals did not give enough information. In some areas, social workers who are linked to wards endeavour to speed up that process by making initial contacts prior to initial assessment. However, the speed of assessment is hindered as social workers have to input their assessments as soon as they return to the office.

### **Is Unified Assessment Working Well in Hospitals?**

- 7.43 The Wales Audit Office (2007) report has recommended that the Welsh Assembly Government publishes updated guidance setting out a standard shorter form and process for unified assessment in acute hospitals. This should be developed jointly between health and social care agencies in addition to reflecting the views of the recently developed Unified Assessment Community of Practice. Where unified assessment has been successful, agencies have worked together whilst mapping their assessment information in detail giving them an understanding as to how their individual assessments map onto the unified assessment pathway and the patient's journey through health and social care services.
- 7.44 Acute services are complex and require multiple 'specialist' or 'in-depth' assessments undertaken by the professional groups that work within them. 'Specialist' or in-depth assessors share common sets of information which are reflected in the 'enquiry' and 'contact' assessments of the standardised framework. The task here is in identifying need in relation to the 12 domains (and sub domains) within the 'overview' assessment and its relevance to health services. This cumbersome element of the framework is required only as part of a 'comprehensive' assessment when referring patients to social services. They use this information to help determine eligibility for social care services. It is often the responsibility of nursing staff to complete, which they often do reluctantly, to the potential detriment of their nursing assessment, and so fail to determine the patient's nursing needs. The completion of the overview by nursing staff may lead to social needs not being fully and properly assessed. The time taken for nurses to complete the overview detracts from the time spent caring for patients and managing patient discharge.
- 7.45 The Welsh Assembly Government might consider altering the Unified Assessment Process for use in health services in Wales. A shortened version of enquiry, contact, in-depth and comprehensive assessments is suggested in Table 7.2. The overview assessment would be completed by a registered social care worker to assess social care eligibility: this would necessitate the collocation of social workers within acute and community hospitals.

**Table 7.2: Unified Assessment Process Healthcare Shortened Version**

<b>Enquiry</b>	<b>Contact</b>	<b>In-depth</b>	<b>Comprehensive</b>
<ul style="list-style-type: none"> <li>• For information</li> <li>• Service request</li> <li>• Leading to contact assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Basic Personal information</li> <li>• 7 key issues</li> <li>• 2 domains</li> </ul>	<p>This is undertaken by an appropriately qualified and experienced professional using models and scales of assessment as indicated by their professional judgment. This type of assessment should be provided when distinctive triggers for assessment are recognized. Examples: Consultant, Nurse, Occupational Therapist, Allied Health Professional.</p>	<p>This is not an additional assessment but an overview of the whole. The care coordinator draws all assessments together and gains an overall picture as to what exactly is happening with the patient, in order to inform decision making and develop appropriate plans.</p>
<b>Completed by unqualified but trained staff</b>	<b>Completed by unqualified but trained staff</b>	<b>Completed by professionally registered health staff</b>	<b>Care coordinator</b>

7.46 The development of a joint working system in Dumfries and Galloway has led to increasing trust in assessment information, speed of the assessments undertaken (older people do not wait for an assessment), the preservation of nursing assessment, the identification of eligibility for services (domains) and quality of assessment. The Bluesky (Council) and Generic Clinical System (nursing) systems access the Joint Working System through a firewall, which ensures that each system can only access the joint system. Most recently this approach is being further developed for use by occupational therapists and physiotherapists. It has also led to the development of joint contracting and commissioning of local services. They have also developed the role of a joint service broker who constructs packages on behalf of either the district nurse or the social worker, whoever is recognised as the lead assessor. The original fear of professionals being too 'generous' and 'unrealistic' in their care packages has not materialised.

**Does the Quality of Nursing Assessment Affect DToc?**

7.47 During the Review the quality of nursing knowledge and assessment was criticised, not only by the nursing profession itself but by other professions within and across agencies. The Wales Audit Office (2007) has also reported problems with assessing need and eligibility for NHS Funded Nursing Care and Continuing NHS Health Care.

7.48 The Review found all staff were very supportive of nurses and acknowledged the speed at which they had to work on the wards. Nursing assessment itself was seen as inadequate with a loss of expertise having occurred in this area. Many did not adhere to discharge planning guidance, especially those newly graduating, who are ill-equipped to assess effectively. It was acknowledged that nurses do not have mandatory and regular assessment skills training updates throughout their careers.

- 7.49 One NHS Trust commented that they had introduced a foundation programme to increase nursing knowledge in respect of chronic care and complex needs. In over half the localities visited by the Review team, staff expressed that in complex cases where NHS Funded Nursing Care or Continuing NHS healthcare was being determined, nursing assessment was seen as giving cause for concern. This was demonstrated through:
- incorrectly completed documentation;
  - sporadic completion;
  - social work assessment providing more nursing information than the nursing assessment itself;
  - loss of confidence in assessing patients with complex needs;
  - not promoting independence;
  - 'very cautious risk takers'.
- 7.50 The Review discovered some examples where the provision of incomplete documentation to the LHB resulted in the Board referring the case back to the Trust. This has led on occasion to mutual criticism, with Trust staff concerned that LHBs may apply unnecessarily rigorous standards to the paperwork in order to 'save money', and LHB staff frustrated by what they regard as 'sloppy' paperwork. In any event, such delays are clearly unfortunate and preventable, and should be rigorously audited locally.
- 7.51 Discharge planning has increasingly become nurse-led, carried out by staff external to the ward, whilst staff working on the wards have lost assessment and planning skills. In order to rectify this, NHS Wales will need to ensure that nursing assessment, and the assessment of frail people with complex needs, are at the centre of adult higher educational and NHS Trust training programmes. Both nurses newly qualifying and those in practice must be sufficiently skilled and motivated to use Unified Assessment Process and have assessment and planning skills that are fit for purpose. It was the opinion of the informants within this review that it would also benefit the patient and the services if the Welsh Assembly Government worked with leaders in continuing NHS healthcare and NHS funded nursing care to develop all Wales assessment documentation.

### **What is the Assessment Pathway?**

- 7.52 The assessment process is generally seen as long and cumbersome, due to the number of professionals involved and the time needed to complete all assessments. It is accepted that it is not a single measurement at a point in time, but a comprehensive understanding of the person's complex needs. It requires an understanding of effect of function, cognition, disease process etc. The difficulty arises when there is a wide ranging view of an individual's risk. Practitioners are aware that assessment provides knowledge upon which decisions of care provision and desirable living arrangements are made which may be challenged by law. Funding mechanisms require a differentiation between what is perceived as a social need and a health or nursing need,

when often they are intertwined. Families are often insufficiently engaged in the discussions and decision making at the important early stages of this process.

- 7.53 Promoting independence and the transparency of process are principles of the Unified Assessment process. The Review identified integrated care pathways as a possible vehicle that would enable both health and social care organisations, in partnership with those who have complex needs and their families, to understand the process and reduce the conflict that arises through communication and information errors. One of the findings that the Wales Audit Office (2007) also reported on were process weaknesses which they said compromised the efficient flow of patients through the system. Gwent Healthcare NHS Trust with Cardiff University have also been actively undertaking work in process flows utilising Lean Thinking.
- 7.54 The speed of a person's journey through hospital is hindered through care packages being frozen or stopped when a person is admitted to hospital. The rationale for this is the possible need to alter a care package following an acute or functional crisis in order to avoid re-admission. In addition an older person admitted to hospital in Gwent will experience a pattern of care which moves older people from acute to community hospitals 'with very long stays when their transfer has been delayed'. The informants interviewed within this review also discussed similar patterns of care. Research published in 2007 suggests that functional status on admission changes very little, if at all, from that at discharge. Therefore, initiating a discharge plan based on a functional status on admission would seem reasonable (Nsameluh et al, 2007). Unless an individual's functional status has changed on admission then the package should remain the same.
- 7.55 In the Trento region of Italy they have developed an evidenced based care pathway which commences within the local district general hospital outwards to the community services. Patients are identified as simple or complex discharges within 48 hours of admission by nursing staff. This is entered onto their integrated medical and nursing notes. There is a discharge coordinator identified to support staff in decision making and managing the patient's journey along a pathway which is closely linked to the Multidimensional Needs Assessment.
- 7.56 In the context of the UK standardised frameworks (unified assessment, single assessment and single shared assessment) this would be viewed as a specialist integrated assessment for older people. The assessment is medically led but also includes nursing and social work assessment. The result is in numerical form and is used to denote three levels of need which are attached to a care package i.e. basic nursing care, integrated domiciliary care and 'nursing home' care. Patients requiring nursing home care are entered onto a dynamic list which alters continuously based on need, i.e. the score depicts

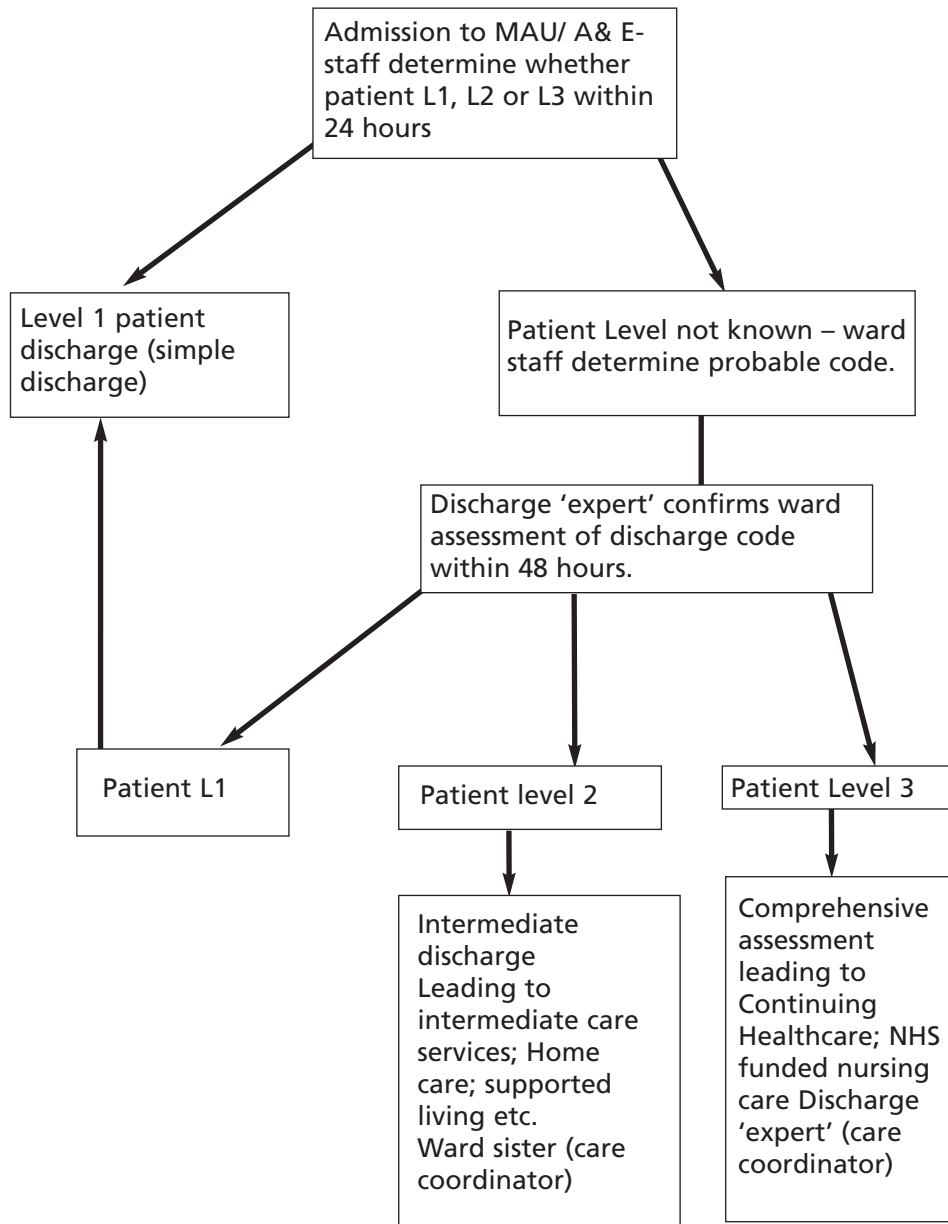
the position of the person on the waiting list. This pathway was developed by professional staff using integrated documentation and the Joint Commission International (JCI) Accreditation Standards for Hospitals (2nd Edition).

7.57 The district general hospital in Trento which serves a population of approximately 500,000 people has achieved Joint Commission International Accreditation. Five sets of integrated patient notes are audited on every ward once a month by a doctor and a nurse, annual feedback is given to all staff by the quality department. The Joint Commission International Accreditation Standards for Hospitals (2007) has been updated to a 3rd edition to include inter-professional working and the use of new technologies and are effective from January 2008. The standards include:

- assessment of care;
- care of patients;
- access to care and continuity of care;
- patient and family rights;
- management of communication and information;
- governance;
- leadership and direction.

7.58 The flow of patient assessment and discharge planning throughout the hospitals in Wales would benefit from such a pathway especially if it were developed in the context of 'Designed for Life' (WAG, 2005) and the chronic care publications. The discharge 'expert' team would manage the pathway ensuring that all time limits were met. The pathway would ensure that discharge planning started on admission and that programmes of assessment were commenced as soon as possible. A suggested outline of a pathway is given in Figure 7.1.

**Figure 7.1: Discharge Pathway Outline**



7.59 Level 1 is where a patient is capable of independent living, cognitively orientated with a family/support network, able to manage medicines, and a carer able to support independent living. This is aligned with the Welsh Assembly Government (2007) document ‘Designed to improve health and the management of chronic conditions in Wales’ level 1 (primary prevention and health promotion) and level 2 (population management chronic care management programme).

7.60 Level 2 within the outline pathway is where a patient, whose cognition isn’t clear, has limited autonomy, problems with managing medicines, and has nursing and some functional needs. This patient requires intermediate,

reablement, home care or district nursing services to promote independence. This level is aligned to the Level 3 (high risk management: network based chronic care management services).

- 7.61 Level 3 within the outline pathway is where a patient requires comprehensive Multidisciplinary Team assessment based on the Unified Assessment principles. This patient will require assessment for continuing NHS healthcare and NHS funded nursing care with consideration of case managed complex package of care at home or within a care facility. This level is aligned to the level 4 (Case Managed Services) within the Welsh Assembly Document (2007). The responsibilities of the liaison nurse or discharge expert are outlined in Appendix 8.
- 7.62 One example of good practice was seen in Pembrokeshire where medical wards in the district general hospital had implemented Multidisciplinary Team meetings on a Monday, Wednesday and Friday every week. The purpose was to discuss all patients present on the ward and to ensure that discharge planning had commenced and was actively managed. During that meeting the individual patient's past and current needs were discussed even if they are not medically fit for discharge. Appropriate referrals were made to other professionals. This has led to well planned and uneventful discharges. The problems of waiting for assessments (which they had experienced) do not generally happen now. In-depth assessors are now aware of the urgency of the assessment in relation to others, and the ward staff have contact names for individual case workers.
- 7.63 This type of ward level activity could aid a well developed discharge pathway and ensure that nurses engage with the process effectively at all levels; and it would enhance the assessment and management of individual patient need. However, the quality of future assessment and discharge planning cannot be achieved unless the NHS in Wales realises the need to develop much further its information technology capability for practitioners, and engage in developing a shared working system with its social service colleagues.

## **D. INFORMATION AND COMMUNICATION TECHNOLOGY**

- 7.64 An estimated £46 million is spent in Health on Information management and technology every year in Wales, of which approximately half is spent through Informing Healthcare (PERA, 2006). In 2003 the Welsh Assembly Government launched Informing Healthcare and published 'Informing healthcare: transforming healthcare using information and IT'. It stated that the health service had 'not invested adequately in information support for healthcare delivery'. It attributed this to:
- lack of resources;
  - focus on management information rather than clinical information;
  - risk aversion;

- the separation of information and IT from core healthcare delivery;
- a failure to integrate new technology with modern ways of working.

It made a financial commitment of £88 million over a three year period commencing 2004-5.

- 7.65 One of its five 'key benefit areas' was to develop the single patient record with the eventual goal of developing 'a fully integrated approach to health and social care records' with 'all steps' taken to ensure that developments in healthcare records and social care records were 'strategically convergent'. Another key benefit was that of service improvement. It argued that:

*'the introduction of technology without changed working practices will have little impact. Changed working practices without new technology will be harder to sustain in the long term and may miss important effectiveness and efficiency gains.'*

- 7.66 In 2005 the Welsh Assembly Government created a new department called the Information Systems Division to develop primary care systems. The individual health record, My Health Online and primary care systems working with GPs and pharmacy systems is the initial focus, while an all-Wales individual health record for chronic conditions is expected to be delivered only within the next four years.
- 7.67 The development of information and communications technology systems for health practitioners to use during the assessment process does not appear to be a priority. Informing Healthcare, at the meeting of the Unified Assessment Community of Practice in 2007 stated that they were not supporting and did not have plans to support nurses in developing a nursing minimum dataset and assessment data system in the future. This in addition to the indication that there will be no joint information technology system to support unified assessment, makes any service and professional changes difficult to sustain and the opportunities to commission and decommission in relation to need very difficult indeed.
- 7.68 The importance of developing such a system is such that it will give accuracy to the translation of individual and proportionate assessment of need and measured outcomes into commissioning data for health services, which, in turn, will lead to more effective and person centred services for patients. This could be achieved through a quantifiable understanding of the individual patient's needs throughout the acute and community health journey. Currently, information and technology developments are not integral to healthcare and Multidisciplinary Team practitioner developments in delivering modernised assessment, treatment and care. This is particularly problematic for professionals experiencing increasing pressures to effectively coordinate the assessment and care of people with complex needs and who require multiple in-depth assessments.



- 7.69 The dysfunction in information and communication technology provision can be seen in practice where social workers use computers to write their assessments and care plans which have been developed by their consortia, whilst nurses and other professional groups generally continue to use paper documents. Sharing information across professional groups and agencies is difficult when one uses a computerised system and the other a paper system for assessment.
- 7.70 Avoiding duplication and maintaining confidentiality is even harder. The Wales Audit Office (2007) report professionals have to fax 40 pages of an assessment document to another agency. In addition, social workers are required to complete the ICDL (International Computer Driving Licence) before graduation and registration, whilst nurses are not required to do so. This inequity in professional skills development leads to nurses not having the confidence and ability to use computers effectively. Also some practitioners continue to want to maintain duplicate paper and electronic assessments.
- 7.71 The closer the organisations work together, the greater the need for standardisation of skills and tools. This includes the development of information sharing protocols and practices. However, the Review is unable to verify whether agencies have embraced the four tiers for sharing personal information which are advocated within the Wales Accord on Sharing of Personal Information published in 2006.
- 7.72 By contrast, in Dumfries and Galloway, district nurses developed in 2001 a Generic Clinical System using Microsoft Access. This includes:
- the basic patient information first form;
  - Activities of Daily Living;
  - the MUST tool;
  - Waterlow;
  - Care planning;
  - caseload waiting;
  - grade of nursing required;
  - Read codes;
  - prioritisation of caseload.
- 7.73 It was built initially locally with local expertise and is now used in the community hospitals and geriatric ward in the local District General Hospital. It is now undergoing an upgrade supported by the Scottish Government with a view to other parts of Scotland adopting this system. The project team was chaired by the Trust Chief Executive and managed by a social worker.

## E. STAFF TRAINING AND DEVELOPMENT

- 7.74 A programme of sustained staff training and development would help to resolve many of the problems encountered by both the Wales Audit Office (2007) and this review. The Review found in its interviews with staff that within some of the localities staff training and development in the context of discharge planning had been inconsistent. The main barrier to discharge training was the inability of staff to be released from the wards. In some areas, however, there has been training which had focussed for example, on the funding processes, or provided a foundation programme to supplement the degree based pre registration programme.
- 7.75 The Review heard from many informants that 'nurses don't see discharge as their role'. It was argued that, where complex discharges occur, nurses appear risk averse, and are reluctant to cope with conflict, whether that derived from patients, carers or other staff. In contrast, nurses on the wards were also seen as the natural coordinators of care, who should act as advocate and negotiator between families, services and professionals. Lack of knowledge of process, policy, local services and the limited availability of the 'discharge' expert compounds this increasing problem and often leads to fragmented or failed discharges. The Review was not able, in the time available, to substantiate the extent of these problems, but the level of concern expressed by a variety of informants, in different parts of Wales, makes a compelling *prime facie* case for further investigation of this issue.
- 7.76 Multi-professional and multi-agency working and learning where it occurred, has been seen as valuable. However, staff stated that they felt that there was a significant lack of regular inter-professional discharge planning training for all members of the multi-agency team. This compounds the problem of a shared vision of a delayed transfer of care, the unified assessment process, continuing NHS health care/NHS funded nursing care and staff's ability to collate and process reliable data and speedily initiate their problem solving skills. It is clear that to participate and manage discharge planning effectively staff need to develop the relationships and understanding of each other's roles. In order to do that effectively multi-agency and multi professional learning must be adopted through training. The work being undertaken by the National Leadership and Innovations Agency for Healthcare (Passing the Baton) is acknowledged and the three levels here suggested for staff working with the discharge process in Wales should be integrated within it. They are:
- Level 1-staff interagency training on managing simple discharge awareness of how and who manages complex discharges, and service availability for level 1 discharges within the discharge pathway.
  - Level 2- staff interagency training on managing level 2 (intermediate) discharges and awareness of how and who manages complex discharges, service availability for level 2 discharges within the discharge pathway.

- Level 3- staff interagency training on Managing level 3 (complex discharges), managing the discharge pathway and care coordination versus care management.

- 7.77 The Review finds that the development of the role of the discharge liaison nurse has not been uniform across Wales; in some areas they manage all complex discharges, and in others they are not responsible for managing discharges at all, but act only as an advisor. Most often they work office hours, Monday to Friday, without holiday and sickness cover, which makes cover somewhat sporadic. Where they act as an advisor they work proactively ensuring that staff who manage the discharges on the wards are aware of the current procedures, policies and service availability in their localities. They often chair census and multidisciplinary meetings but this reduces their availability on the wards.
- 7.78 The Wales Audit Office Report recommended that the Assembly Government should develop clinical capacity and career pathways for nurses working with older people to meet demographic demands with targeted intervention. This should be expanded to include a 7 day week cover for discharge planning throughout the year. The additional responsibilities identified in this chapter should be adopted, and training and education provided for this challenging role at Higher Education level 7 (Masters programme level).
- 7.79 Wales Audit Office also reported there was evidence that nursing staff saw patients with complex needs as requiring institutional care rather than returning to their own homes via intermediate care services. They advocate education, training and understanding of roles. In light of the view that accurate assessment forms the basis of the treatment and care that services deliver, this should be expanded to a recognition that a higher priority should be given in pre- and post-registration education to the nursing assessment and care of people who have complex needs, including those older people who are frail. The Welsh Assembly Government should suggest a mandatory requirement for nursing staff to update their assessment skills on an annual basis. Although it is recognised that mandatory training is burdensome, accurate nursing assessment holds the key to successful discharge planning. In addition, the acquisition of local knowledge and experience of community services across health and social care should be advocated, with emphasis on inter-professional learning at pre- and post-registration where appropriate. Nurses working within acute and community services (including mental health and learning disability) should be required to undertake rotational experiences of working in both to enhance their knowledge and understanding of the patient journey. The role of the practice facilitator should be reviewed to aid this development.

7.80 The development of a new generic health and social care workers as associate practitioners within the workplace will inevitably impact on the role of nursing as they become more confident in the speciality. The Review found that localities had started to consider the role, especially in the development of community and intermediate care services. The education of such a support worker needs special consideration to ensure that they benefit from both NVQ and higher education. There should be an emphasis on inter-professional learning to ensure that the key principles of working across health and social care are adopted - reduction of a silo mentality, and enhanced role flexibility.

## **F. CONCLUSIONS**

7.81 This chapter has presented evidence on:

- a variety of problems relating to the operational definitions of delayed transfers, and to the ways they are reported, which require the current DToC dataset to be treated with some caution;
- little use being made for commissioning purposes of information on the immediate and underlying causes of delayed transfers;
- significant problems with patient assessment processes, which on occasion lead to delays and to sub-optimal assessment;
- a lack of supporting information and communication technology; and
- gaps in staff training and development.

7.82 These contribute in their various ways to a lack of clarity about the real causes of delays, and to an inability of the care system to deal with some of the challenges inevitably posed by patients with more complex needs.

## CHAPTER 8

### ACHIEVING A BALANCE OF CARE AND SUPPORT *Tackling the Root Causes*

#### Conclusions and Recommendations

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##### INTRODUCTION

- 8.1 This chapter summarises the main conclusions to be drawn from the evidence presented throughout this Review. The conclusions and recommendations fall into two main categories:
- Whole system issues – achieving a proper balance of care and support in each locality;
  - Operational issues – making the existing system work better.
- 8.2 Tackling the root causes of delayed transfers of care will require new ways of working, involving managed networks of health, social care, housing and the voluntary and private sectors – in other words, the whole system of health and social care. Our recommendations include an indication of the timescale required to achieve systems change; but the complexity of the issues involved mean that their implementation will be in the medium to long term rather than the immediate short term.
- 8.3 In the meantime, we make a number of recommendations about the operational (day-to-day) management of delayed transfers. Whilst we do not believe that managing delayed transfers more effectively without addressing the whole system issues will be enough to deal with the fundamentals of the problem, we do think that translating good practice into action at the local level will improve the management of transitions between different health and social care settings and ameliorate the worst effects of delayed transfers of care.
- 8.4 It is clear from this Review that many factors affect the level of delayed transfers of care, and that those factors vary significantly from area to area. Detailed implementation plans should therefore be developed for each area by all the local stakeholders working together, and should address both the whole systems and the operational issues.

## THE NATURE OF THE PROBLEM

- 8.5 Delayed transfers of care are clearly a significant problem for those patients who are being delayed, and for health and social care generally in Wales. For patients and their families, they cause unnecessary anxiety and discomfort, and may have long-lasting consequences for people's health and well-being. For the care system, they represent wasted resources, patients denied treatment, and inappropriate expenditure.
- 8.6 The number of delayed transfers should be considered in context. The vast majority of hospital inpatients are discharged without significant delay; each year, there are more than 500,000 discharges from NHS Wales hospitals, and fewer than 10,000<sup>1</sup> (about 2%) of these would be classified as 'Delayed'. The number of delayed transfers has fluctuated, month by month, over the past two years, but there is no discernible downward trend at the all-Wales level, despite the significant investment of managerial and professional time on the problem. At the local level, however, there is substantial variability in the level of DToC, and in trends.
- 8.7 Delayed transfers, then, appear to be a stubborn problem, which still resists the best efforts of many in the NHS, local government and the Welsh Assembly Government. Memorably described as a 'great octopus of a problem' by one AM on the National Assembly Audit Committee, it is the quintessential example of a 'whole system' problem – one whose causes are to be found within the remit of various agencies and sectors, where causes are often deep-rooted and multi-faceted, and where responsibility for the solution needs to be shared but is not always fully recognised. The time has now come for an approach which matches the nature and scale of the problem.
- 8.8 The evidence indicates that the level and causes of DToC vary across Wales, but also that present reporting systems understate the extent of the problem. No simple set of factors explains the levels of DToC in particular localities. The highest numbers of DToC relative to population are currently being experienced in Cardiff, the Vale of Glamorgan, Torfaen and Merthyr Tydfil (approximately 800 – 1300 delayed days per 1000 population aged 65+), with Conwy, Denbighshire, Flintshire Pembrokeshire and Blaenau Gwent having much lower levels (under 200 days per 1000 population aged 65+). Some localities – for example Cardiff, Pembrokeshire, Newport, Vale of Glamorgan and Wrexham – have made substantial progress in reducing their level of DToC in the past year; in others – such as Caerphilly, Anglesey and Torfaen – progress has proved more difficult.
- 8.9 The rates of emergency admissions to hospital for people over 65 years vary between local authority areas; the highest rate being double the lowest. It has not been possible to establish to what extent this variance arises from the propensity to refer, or the propensity to admit.

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<sup>1</sup>In fact, because the number of delayed transfers is counted as a monthly census, it is not possible to determine how many individual patients have been delayed over the course of a year. The number is almost certainly less than 10,000, and may actually be may be less than 8,000.

- 8.10 In terms of the availability of alternative care settings, North Wales authorities have better access to a range of private sector residential care settings than have some authorities in South East Wales. Most authorities report some difficulties in providing domiciliary care in rural parts of Wales. Most authorities also report difficulties in accessing suitable residential accommodation for patients with specific mental health needs. In a few authorities accessing health care, usually community hospitals, has proved occasionally difficult.
- 8.11 The deliberate refusal of patients to move from hospital to other settings has been reported fairly evenly across Wales and while the numbers of patients so delayed appears small, they probably account for a higher, but occasionally significant, percentage of the total number of lost bed days caused by DToC.
- 8.12 Recurring inefficiencies in assessment and care brokerage processes have been discovered in some health and care partnerships.

### **Main causes of delayed transfers**

- 8.13 In summary the evidence presented in this Review, from statistical returns (Chapter 2), from a review of the relevant literature (chapters 3 and 4), and from the field work (chapters 5 -7), identifies five main drivers of delayed transfers of care. They are:
1. the propensity of a given location to generate referrals to hospital – either from key professionals, or from individuals who refer themselves. This is largely a function of the adequacy of the full range of community provision, including health, social care and other support, and the way in which patients at known higher risk (e.g. those with long term conditions) are supported in the preservation of their own health;
  2. the extent to which hospitals receiving such referrals are able
    - to identify only those patients who need admission, either to acute general, acute psychiatric, or community hospitals, and
    - to access easily other, more appropriate forms of care for those not needing hospital admission;
  3. for patients who no longer need the care provided by a particular hospital, the availability of next-stage care in another hospital, in another residential care setting, or at home, which is acceptable to the patient and relatives;
  4. the extent to which patients or their relatives deliberately refuse to cooperate with forms of care following hospital treatment, for example residential care where costs would fall upon the patient or family; and
  5. inefficiency in the management of assessment, care planning, care brokerage and discharge processes.
- 8.14 These are the immediate drivers. But they beg the question ‘why?’ – why should these drivers be operating in such a way as to delay patients’ transfer, and why is there such variation between localities? For example: why should

some localities have a greater propensity to refer people to hospital? why do most localities have gaps in the provision of the full spectrum of care and support that they need? why are some localities more successful than others in addressing some of the efficiency issues?

8.15 The answers to these questions are not simple: not surprisingly, any problem which has defied the collective attention of capable managers and professionals for so long is not susceptible to simple cure. We conclude, from the evidence presented here, that the five drivers described above are in various ways connected with two sets of complex, underlying factors:

1. difficulties in working across professional, organisational and sectoral boundaries;
2. lack of a coherent set of effective incentives to encourage local agencies to tackle difficult problems.

These two are, of course, inter-related.

### **The way forward**

8.16 When considering those localities which appear to be achieving most in relation to DToC, the fieldwork and other evidence has suggested that they tend to be characterised by some or all of the following:

- good historical levels of investment in the full spectrum of care and support, including alternatives to hospital admission;
- a determination to understand the underlying causes of delays locally – e.g. the causes of inappropriate admission, structural delays in handling patient transitions;
- good relationships between senior staff and other stakeholders in different agencies, based on a willingness to cooperate in tackling ‘each other’s’ problems;
- an acceptance of the responsibility to work with others to achieve a balance of care across sectors (e.g. involving the private and voluntary sectors as full partners);
- a recognition that DToC is a serious problem that has to be addressed;
- obvious personal interest in DToC by the most senior staff;
- lack of serious financial or other strains on the partner agencies;
- a critical mass of staff committed to developing new service models and ways of working; and
- a number of easy wins in terms of efficiency which have not previously been realised, but whose achievement now supports a sense of local ability to go on and address other issues.

8.17 The least effective tend to be characterised by some or all of the following:

- a poor service base, with substantial gaps in elements of the balance of care and support;

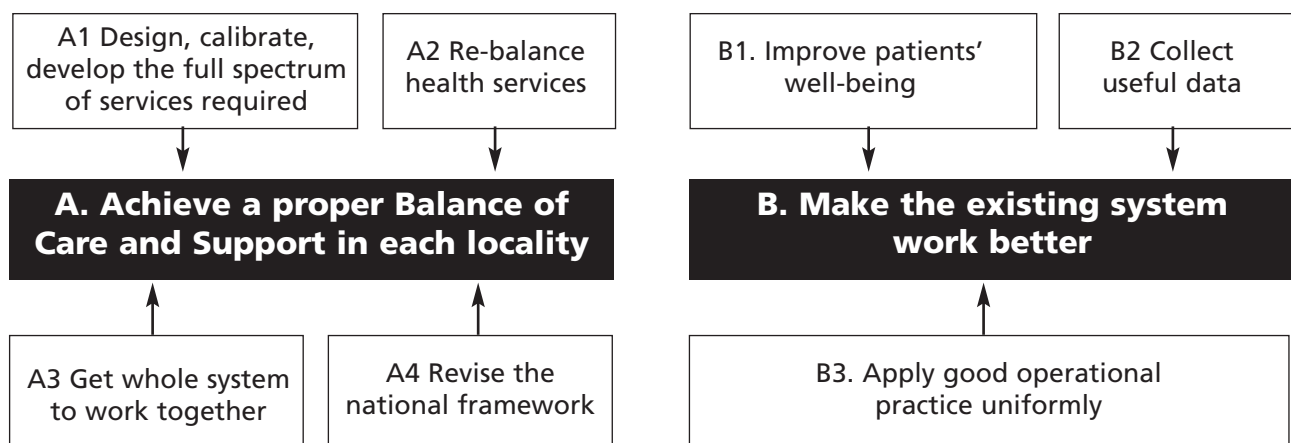


- a focus on the presenting causes of DToC (e.g. taking the DToC codes at face value), rather than what might lie behind them;
- senior staff and others who find it difficult to work together, and who are not willing to commit their organisation to solving a problem which they regard as not being their own;
- a parochial focus on what their own agency provides, rather than on shaping a multiplicity of providers;
- a belief amongst some partners that DToC is less important than other issues;
- a belief in the organisation that the senior management is not really engaged in the problem;
- serious financial and other problems which prevent partners from devoting sufficient time and resources to resolving DToC; and
- a conservative group of staff at key points in the organisation who are unwilling to develop new approaches.

8.18 Two conclusions follow from this. First some further impact upon the numbers of DToC is possible by more work on the better micro-management of existing processes. Second, to make a significant impact upon the numbers of people delayed and the hospital capacity so used, but more importantly upon the quality of care received from the care system as a whole, improvements are required in planning/commissioning processes and in the management of care pathways for key client groups across the diverse organisations involved in providing care. These factors go to the heart of the problem.

### An Agenda for Action

8.19 This discussion and recommendations are grouped under seven headings:



8.20 **Part A** addresses the underlying problems:

- A1. designing a local **balance of care and support services** which prevents unnecessary hospital admission, and offers patients on discharge from hospital an appropriate range of places to live, well located, and with levels of support to match their individual needs (Recommendation 1);

- A2. **achieving** that balance across Wales within health services:
- Community Hospitals (Recommendations 2-5);
  - Deflect unnecessary admissions (Recommendations 6-8).
- A3. improving **collaborative working** between the various bodies who together hold the key to reducing delayed transfers:
- Improve partnership working (Recommendations 9-18);
  - Financing (Recommendations 19-21);
  - Information Communication Technology (Recommendation 22).
- A4. setting the most supportive **national policy** framework:
- Financial responsibility for long term care (Recommendations 23-25);
  - National coordination (Recommendation 26);
  - Performance management (Recommendations 27-30);
  - Pooling and alignment of budgets (Recommendation 31);
  - Apportionment of the costs of DToC (Recommendation 32);
  - Personal planning (Recommendation 33).

8.21 **Part B** addresses the more immediate problems:

- B1. providing a service which actually enhances **patients' well-being** when transfers of care are necessary:
- Patient assessment (Recommendations 34-36);
  - Choice (Recommendations 37-38);
  - Advocacy (Recommendation 39);
  - Impact on patients (Recommendation 40).
- B2. collecting **data** which improves our understanding of the problem of delays (Recommendation 41-44).
- B3. improving the **efficiency** of the current systems affecting transfers of care (Recommendation 45-46).

### Timescales

8.22 The two sets of recommendations – A1-4 and B1-3 – should be implemented in parallel, starting immediately. Each local area, and the Welsh Assembly Government, should agree their own timetables for implementation, within the context set out below.

8.23 Key to the success of all the recommendations in Section A is Recommendation 1: agreeing on, designing, and developing a local action plan for balancing local provision of care and support services relevant to local needs. This recommendation sets out its own timetable:

- a. By September 2008, to agree the process to be adopted locally;
- b. By September 2009, conduct a joint review of local needs;

- c. By September 2009, agree the local balance of care and support and a year on year financial and service plan for its achievement by 2012.

All of the other recommendations in Section A should fit with this overall timetable.

- 8.24 Significant progress has already been achieved in relation to many of the recommendations in Section B, and this work is on-going. Because of the nature of the recommendation in Section B, observable progress here can be expected within the next 12 months, at which point further action should be considered.

## PART A ADDRESSING THE UNDERLYING PROBLEMS

### **A.1. Designing the local Balance of Care and Balance of Support *Right care, in the right place, at the right time, by the right person***

#### *The need for a balance of provision*

- 8.25 This review has clearly demonstrated that delayed transfers of care must be seen in the context of the provision of support for people living in the community. Lack of such provision will delay transfer, or result in people moving to locations which are unsatisfactory; a lack of the sufficient range of accommodation and support is also likely to result in unnecessary hospital admission, which itself will lead to more patients who are likely to be delayed.
- 8.26 The provision must comprise two broad types - the notion of the 'balance of care' and the 'balance of support' discussed in Chapter 5. The balance of care refers to the range of services designed to preserve the good health of older people (for the whole ageing population, and those at known higher risk), and those services which are designed to respond appropriately to an increasingly severe range of 'crises' which may occur (Figure 8.1).

**Figure 8.1: The Balance Of Care**

Acceptable health status			Crisis intervention				Hospital inpatient
1	2	3	4	5	6	7	8
Population health promotion	Targeted health promotion for those at known higher risk	Monitoring and timely intervention for those at higher risk	Crisis intervention: multi-agency support at home	Specialist assessment by primary/secondary care: no admission	Intensive support at home	Specialist assessment: hospital admission	Hospital diagnosis, treatment and rehabilitation

Source: WHSC

- 8.27 The over-riding aim of all these services should be (as far as possible) to support people living where they choose – which will often be in their own home. However, if their level of dependency increases, their 'own home' may no longer be suitable. For these people, a range of increasing support, and

different types of accommodation will often be required (Figure 8.2). The key is to ensure that there is enough of each type to meet anticipated demand, in the right location and designed to meet people’s reasonable wishes. The assessment of what is ‘reasonable’ will, of course, have to take account of local circumstances and the opportunity costs of maintaining unused services.

**Figure 8.2: The Balance Of Support**

Increasing levels of dependency...				
1	2	3	4	5
Short and ongoing domiciliary support for those living in own homes (and for carers), inc access to ‘day care’ facilities	Supported housing, of various types including extended care	Residential homes	Nursing homes	Specialised care facilities including community hospital settings

Source: WHSC

- 8.28 For acute hospital services especially, it is clear from this Review that the absence of a well-designed and linked system of care within which the District General Hospital sits, severely inhibits the ability of the NHS and its partners both to avoid admissions of patients to District General Hospitals and then speed discharge from them. Although some localities had developed some components of a comprehensive model of care, few had sought to identify totally the intended and calibrated components of the local care system and the linkages between them, and then to plan systematically to put these elements in place.
- 8.29 The absence of such a system is linked to weaknesses at both the local partnership level and at the all-Wales level, and in particular to a clear lack of an organisational focus for the leadership and delivery of such a system. It is further hindered by the absence of clear patient pathways in each locality which address the main ‘handover’ stages of the patient journey. Each of these elements is considered later in this chapter.
- 8.30 At local level, most localities accepted that the responsibility for designing the local balance of care and support rested with commissioners rather than service providers. However, commissioners varied in their willingness to drive service redesign. Some took the view that their ability to ‘manage the market’ in provision was limited, whereas the evidence from our literature review underlines that this is an important role in effective commissioning. Many also identified various financial factors which stood in their way. These too are considered below.
- 8.31 In almost every part of Wales studied by the team it was noticeable that there was no shared vision across partnerships of the intended components

of the care system which could guide all partners towards shared investment and disinvestment decisions. Further, in some parts of Wales, there was a reluctance to take positive action to ensure that required services were made available. For example, if the private sector was not offering needed nursing home capacity in certain areas, this was seen as a 'given' and therefore not really amenable to change. Partners with responsibility for the provision of supportive housing were often not fully involved in the discussions on delayed transfers, with the result that their element of the spectrum of support – and how it should be altered - was not fully considered.

- 8.32 One part of Wales was able to describe a shared value base that underpinned its approach to shaping the care system and was also able to describe many of the components of the system of care which partners required, with some notion of their scale and capacity. Further, the partnership was able to show how it was moving towards its intended balance of components – for example by reducing the number of residential homes it was commissioning and increasing the amount of domiciliary, extended care and nursing home support offered.

#### *Good Design Principles*

- 8.33 It is important that the partners in each locality – including LHB, NHS Trust, Social Services, housing agencies, the voluntary sector and the private sector – develop their own vision of the right balance for their locality, fully informed of patient opinions and future levels of need, in the context of governance arrangements including an approach to incentives and sanctions that support working in multi-agency networks operating in issues of high complexity. Only in this way will the shared vision reflect local circumstances, and such engagement is probably necessary to ensure commitment to achieve it.
- 8.34 However, local partnerships should consider certain universal 'good design principles' in their work. From our consideration of the evidence, and from our discussions with the stakeholders, these should include:
- The clearer separation of the roles of the District General Hospital into assessment, treatment, rehabilitation and discharge which is already emerging in many parts of Wales and follows on from *Designed for Life*, with assessment and discharge more clearly seen conceptually as being an outreach of primary/community care;
  - Good links, at the point of assessment, between the hospital-based assessment function and a range of alternative care settings which the assessment unit commands and into which patients can be safely and properly transferred, either for the assessment to be completed or where an agreed care plan can be put into effect and re-assessed/reviewed as appropriate;
  - The components of the care system that surround the District General Hospital, so that reliance upon the hospital for assessment and treatment can be minimised.

8.35 In broad terms, the components of the care system could be expected to include the following:

- Good primary care medical, nursing and social services which proactively manage, in particular, elderly people with chronic illnesses and thus seek to reduce referrals to hospital;
- Good secondary care assessment services (e.g. medical assessment units) which offer speedy diagnosis and care planning and which have immediate access to a range of care services where patients needs can be met without admission to the District General Hospital for treatment;
- Where hospital admission for treatment is indicated, good District General Hospital discharge processes, including intensive support for rehabilitation first in hospital and then at home;
- Domiciliary support and telecare services able to support people in their own home on leaving either the assessment or treatment capability of the District General, or community, hospitals;
- Community hospitals geared to undertake a range of care including palliative care, rehabilitation, continuing health care (and possibly social care where locally agreed), respite care and G.P. admissions; and
- Various forms of supported living, including sheltered housing, extended care and nursing home settings.

Many of these design principles are shown diagrammatically in Appendix 5.

8.36 The model assumes that the assessment process will be undertaken swiftly and often without formal 'admission' to hospital; admission will only occur when the full panoply of District General Hospital treatment services is required to ensure ongoing safe care. The model also assumes that, increasingly, the care deemed necessary as a result of a good assessment can be provided outside the hospital setting.

**Recommendation 1: Designing the Balance of Care and Support for Patients and their Carers**

Health and social care partnerships – statutory, voluntary and private - at all levels should be required by Welsh Assembly Government to:

- a. Outline by September 2008 the process which the partnership will use to design and calibrate its own version of the balance of care and support needed to meet the projected needs of the localities it serves.
- b. Conduct their own joint review of the local and regional need for the various elements of the balance of care and support, reflecting the different circumstances and likely 'pathways' of the different categories of patient. The following groups are suggested as ones deserving of attention, but this list should be tested and further refined:
  - Patients expected to be nearing the end of their life but not in need of complex pain control.

- Patients needing complex end-of-life care.
  - Patients with enduring multiple and complex physical needs.
  - Patients with impaired mental ability.
- c. Provide, by September 2009, their final version of the balance of care and support, showing the range, location and volume of care and accommodation needed by 2012 (including independent living) and the year on year financial and service plan for moving to that model from the present range of services. This should be explicit about which elements are to be provided by which partners. The plan should be explicit about the intended timing and broad total of the finances intended to move between services and agencies.

It is important that this work (which is fully compatible with the approach outlined in *Designed for Life*) is set within the context of other on-going planning and service development initiatives – it should not replicate or cut across them. It is likely, for example, that the forthcoming Health, Social Care and Well-Being strategies will address some of these issues, while others will be taken up in the development of services for chronic conditions and for intermediate care. Local agencies, with the support of the Welsh Assembly Government, should ensure that existing initiatives and planning mechanisms are appropriately adapted to incorporate the work set out in this Recommendation.



## **A.2. Achieving the Balance within Health Services**

### ***Creating services which match needs***

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8.37 It will take some time to effect the changes to current levels of provision required by Recommendation 1. Part of this process will require changes to major aspects of health service provision and ways of working. These are considered here; areas which are more about partnership working are considered in the next section.

### **Community Hospitals**

8.38 NHS Wales currently operates a number of community hospitals that to a great extent support local District General Hospitals in their provision of acute care. These vary in size and capability across Wales, but have a crucial role to play in the overall balance of care. They offer, either explicitly or implicitly, some or all of the following services:

- rehabilitation following an injury or physical illness initially treated in a DGH;
- assessment/admitting capability for General Practitioners;
- admitting capacity for DGH assessment units to access where further simple assessment or medical/nursing care commensurate with the resources available and the care plan created by the DGH is indicated;
- continuing care for the elderly;
- end of life care;
- social care (where provided in agreement with partners); and
- short term care whilst assessments are completed and arrangements for the next stage of care are completed.

8.39 In some locations community hospital sites are becoming the base for a shared care resource straddling health and social care partners, able to offer flexible care to patients/clients whose needs move between these two services. Such a development has much to commend it.

8.40 The different functions carried out by community (care) hospitals should be carried out by staff, and in ward environments, specifically able to meet these different needs, and it might be expected that the commissioning arrangements that govern community hospital services would recognise this. However, this Review has found that the services offered by community hospitals are rarely well specified. This would suggest that the clinical services offered in each hospital are not always deliberately designed and supported to ensure maximum care; neither is social care always properly keyed into emerging arrangements. In some cases, the use made of hospitals seems to owe more to 'custom and practice' than it does to a well-thought-out strategy. For example, this Review found cases where patients who had little clinical need for a community hospital bed were transferred there anyway. And there were instances where patients who were too frail to get up to the toilet independently at night after an operation were transferred

to a community hospital, whereas the same patients in other parts of Wales would go home with re-ablement and a 24 hour night sitting service.

- 8.41 Existing guidance recommends that patients whose discharge requires careful planning – especially if the patient is no longer able to return to the home from which they were admitted – should not normally be discharged to a new care setting direct from the acute wards of the District General Hospital. Community hospitals are well placed to allow for the proper assessment of need to be undertaken and to provide a more paced planning of the discharge process.
- 8.42 Many delays arise in smaller community hospitals where active rehabilitation has been offered, or where complex discharge planning can be effected. Two main forms of delayed transfer have been discovered in community hospitals. First, patients occupying community hospital beds beyond their planned stay for rehabilitation may prevent others from accessing scarce rehabilitation resources. Second, patients who inappropriately occupy community hospital beds designed to provide ongoing NHS care make these beds unavailable for others and this also means that the NHS may be funding care which should, under present rules, be funded by either local government or citizens directly.

### **Recommendations 2 – 5: Reducing Delayed Transfers from Community Hospitals**

2. The roles to be played by community hospitals in each local care system should be more clearly described (for example some or all of the seven functions outlined above) so that funding, clinical/practice governance and admitting arrangements can be more deliberately shaped. The resources invested in these services should be seen as ones available to the partnership as a whole - where appropriate offering care that straddles primary and secondary, and health and social, boundaries.
3. Both commissioners and providers should be much clearer about the precise clinical tasks and capacities which they require of their community hospitals (including hospital provision for older people with mental health problems). Thus they should describe in broadly quantifiable terms the types of services each hospital is intended to provide and the broad numbers of patients/service users in each category that are expected to be cared for during any given period. This should help ensure that the clinical and other skills available are commensurate with the tasks given, but should also enable the community hospital component of the total system of care available locally to be better understood both by the hospital staff concerned and by other parts of the care system.
4. The costs of care available from community hospitals should be assessed in terms of cost effectiveness with other local services to ensure that where services are provided by community hospitals the opportunity costs borne by the hospital service are appropriate in the light of any alternatives.
5. Social worker support should increasingly be rooted in community hospital settings.

### ***Deflecting Acute Hospital Admissions***

- 8.43 Previous studies have shown that a number of admissions to District General Hospitals arise not because the hospital is the preferred care setting, but because the social or other needs of the patient cannot be met in other settings at the time when the patient presents. Many of these patients go on to become delayed transfers of care. Thus, as noted above, a key strategic issue is to so engineer the total system of care that:
- unnecessary referrals to hospital are avoided; and
  - unnecessary admissions to hospital are prevented.
- 8.44 The first requires improved and proactive management in primary care of those conditions likely, if not so managed, to lead to patients being taken to hospital. Throughout Wales better management of chronic conditions is being given increased attention. It is too soon, however, to assess the extent to which these new approaches will stem the rate of urgent GP and emergency referrals to hospital A& E/Medical Assessment Units. In any event, GPs will continue to need the support of hospital diagnostic services and consultant colleagues where their patients become unexpectedly ill.
- 8.45 Assessment processes at receiving District General Hospitals should be designed to ensure that:
- the causes of illness are identified as quickly as possible;
  - an appropriate care plan is devised; and
  - treatment is carried in the most appropriate care setting.
- 8.46 For some patients, treatment is best delivered within the District General Hospital, and admission to their treatment facilities is appropriate. For others, however, once the uncertainty of the nature of the illness has been reduced by good diagnosis, care could be offered at home or in a community hospital or other supported care setting.
- 8.47 This Review has found that District General Hospital assessment processes are not always fully designed as part of a wider system of care and, further, they vary from location to location. In some hospitals referrals may be routed through an A&E department and, if the condition is not immediately obvious and capable of being diagnosed within the 4 hour window allowed for in A&E performance targets, admission to a hospital bed will almost certainly follow. Admission then inevitably, after a period, requires a planned discharge.
- 8.48 Increasingly in Wales, however, patients are brought to medical assessment units often covered by senior medical and nursing staff and supported by responsive pathology, radiology and other diagnostic services – all of which allow for swift diagnosis, and safe transfer to other competent settings where indicated. (Immediate social work advice is not however routinely

available throughout the 24-hour period and at weekends). The immediate availability to the assessment unit of such settings is not presently designed into local care systems and thus the potential for deflecting admissions at this stage is not maximised.

**Recommendations 6 – 8: Deflecting Unnecessary Acute Hospital Admissions**

6. As part of their work to define an appropriate balance of care in their localities, local partnerships should review the range of services available in primary care, and in support of primary care (1-7 in the Balance of Care figure), to ensure that urgent referrals to secondary care do not occur simply because other services are not available locally.
7. For those patients whose not needs cannot appropriately be met by out-of-hospital services, Commissioners and NHS Trusts should review the capability of medical assessment services, so that all patients have immediate access to comprehensive diagnostic services, 24 hours a day, seven days a week.
8. Medical Assessment Units should have unfettered access to a range of care options in addition to that of DGH admission as indicated in the balance of care model, and the availability of social work support to assessment units should be increased.

### **A.3. Working across boundaries**

#### ***Getting the whole system to work for the patient***

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##### ***Improving Collaborative Working***

- 8.49 Whilst circumstances vary considerably around Wales, it is apparent from this Review that the success at tackling delayed transfers of care has been in part a function of the quality of the key tri-partite statutory sector partnerships operating at local level - that between the local health board(s), the NHS Trust(s) and the local authority(ies). It is clear that different locations in Wales are currently served by partnerships of very different types and complexities. For example in Powys there is an apparently simple partnership of two bodies; NHS commissioning activity normally carried out by a Local Health Board is carried out alongside considerable provider activity within one health organisation which in turn relates to one Local Authority. This is contrasted with Gwent where eleven partners - one NHS Trust, five local authorities, and five local health boards, seek to relate to one another.
- 8.50 This Review has sought to discover whether there are any partnership factors which aid or impede good partnership working. The number of bodies comprising the partnership is one factor to take into account. Were these to be based around the emerging NHS Trusts then the number of partnerships would be about 10, with most involving between 5 and 11 bodies. If partnerships were to cluster around the regions then 3 partnerships with a greater number of players in each partnership would be created; likewise if grouped around the 22 LHBs/local authorities then a smaller number per partnership would emerge. This number will be affected by the result of the current discussion on the future roles and relationships of NHS bodies in Wales, and such a debate lies outside the terms of reference of this Review. But as a guiding principle, and all else being equal, it will generally be the case that the fewer bodies involved, the easier it will be to address the operational and strategic barriers to reducing delayed transfers of care.
- 8.51 All parts of Wales have made substantial progress in forging productive relationships between the key partners, especially within the statutory sector. One very practical development that appears promising, especially in regard to delayed transfers, is the creation of a small number of joint posts between health and social services aimed at bringing much closer together the community health and social services provision in particular localities.
- 8.52 The Review found some dissatisfaction with the level of partnership working between the statutory and voluntary sectors. This relationship does appear to be improving, and is the subject of on-going work by the Assembly Government. Relations between the statutory and private sector were also difficult in many localities. We found three areas of concern:

- Strategically, the private sector did not appear to be fully engaged with discussions about the range of provision needed in the future;
- Operationally, professional staff in both the statutory and private sectors often had limited understanding of each others' roles, aims and limitations;
- Financially, there appeared to be an unnecessary level of arbitrariness and variation between the rates paid by commissioners, particularly for residential and care home provision.

- 8.53 We have noted the proactive approach adopted by the Scottish Executive in shaping the debate in Scotland about appropriate fee levels for care home providers and all that flows from such discussions when key players come together.
- 8.54 Underlying these issues in Wales were elements of mistrust, concerns about uncontrolled cost inflation exceeding budgets, and a desire on the part of commissioners to ensure that residential and care home provision did not expand at the expense of alternatives such as domiciliary care. The process of creating a shared vision of the future balance of care and support (Recommendation 1) should do much to resolve the causes of misunderstanding, and should establish a basis upon which everyone can contribute to a more secure balance of provision, with less reliance on 'spot purchasing'. In the meantime, the level of payments to the private sector need to be based on a robust process of cost assessment, as set out by the Welsh Assembly Government.
- 8.55 Any delay in deciding about patients' eligibility for continuing healthcare can cause considerable anxiety and distress for those involved. The Review found some examples of cases where such delays appeared excessive – where the case was referred back from the LHB to the Trust for more information, and was then followed by further delays. It would appear that the staff and agencies involved in such cases did not always have a shared understanding of precisely what information was required in order to enable a decision to be made. It is vital that all such delays are audited locally, and the lessons learned.
- 8.56 The Review found significant fragmentation of the provider network which appeared to cause difficulties in some locations within commissioner partnerships. Not all locations have taken the opportunities presented by service developments or changes in policy or practice, to communicate these deliberately through a multi-disciplinary and multi-agency learning process. In order to participate and manage discharge planning effectively staff need to develop the relationships and understanding of each other's roles. They should be routinely afforded opportunities for multi-agency and multi-professional training.

- 8.57 For the future, the various initiatives which are part of the Making the Connections policy – notably the recent advent of Local Service Boards – are an important part of the equation in ensuring that further progress is made, and that good practice is shared. In terms of planning and commissioning the range of services that will support further reductions in delays, networks at the local level need to build on the approach underpinning the development of local service boards to bring together:
- local authorities;
  - local health boards;
  - primary care;
  - secondary care clinicians;
  - NHS Trusts;
  - the voluntary sector; and
  - the private sector.
- 8.58 From the evidence of this review, particularly drawing on international experience, we would recommend that voluntary sector and private providers should be directly involved in local networks. Long term relationships, that are the hallmark of networked forms of governance, are, we believe, key. All partners should be directly involved in the planning and delivery of services, sharing an approach to designing a pattern of services that will address a range of complex issues, and co-ordinate and integrate a number of key policies at the local level including:
- developing care ‘bundles’ and care pathways that build in a focus on minimising delayed transfers of care in transitions between all settings, not just focusing on the transition out of acute hospitals;
  - services for people with chronic conditions; and
  - emergency care.
- 8.59 Building on the development of local service boards would avoid creating specific mechanisms just to deal with delayed transfers and would be the basis for addressing other issues that, like delayed transfers of care, have the characteristics of multiple stakeholders and high complexity.
- 8.60 Consideration should be given to helping primary and secondary care clinicians to work jointly in community settings to develop care bundles and care pathways through which patient care is managed into and out of the community, drawing on acute hospital care, domiciliary and residential care in partnership, not only with the organisations who make up the local networks, but also with patients and their families as co-producers of care.

### **Recommendations 9 – 18: Improving Partnership Working to Achieve Integrated Care**

9. There are a number of partnership assessment toolkits and frameworks available to help local partnerships to evaluate the maturity and effectiveness of local arrangements for collaborative working, and securing improvements to service delivery. Welsh Assembly Government should require local partnerships to identify a tool which best reflects local needs and circumstances, undertake an assessment and develop an action plan (including their local development needs) to implement the findings of the assessment.
10. Performance management processes should require health communities to formally review their inter-agency machinery on a bi-annual basis and report improvements identified to their governing bodies.
11. Using the results, the Welsh Assembly Government should, in the broader context of discussion on structural change within the NHS, seek to establish a view on the number of such partnerships that are capable of being sustained in Wales and how they should work, taking account of the issues identified in this Review.
12. NHS Trusts, Local Health Boards and Local Government in Wales should consider adopting as one criterion for the short-listing of candidates for chief officer posts and those immediately below them clear evidence that applicants have at least two years of effective partnership working.
13. Local partnerships should explore the merits of a small number of joint appointments whose role would be to bring more closely together community health and social care provision.
14. The costs of private sector nursing home provision should move as quickly as possible to be determined on the basis already suggested by the Welsh Assembly Government. This process should be facilitated by the Government. Commissioners should report the fee levels being paid locally to both residential and nursing home operators. This level of fees should, in turn, be used to benchmark the costs of equivalent provision offered by the statutory sector and also help determine the levels of domiciliary care that should be funded as an alternative to residential forms of care.
15. All LHBs should review their arrangement for assessing the need for continuing healthcare. They should consider having machinery in place which determines requests for continuing healthcare support on at least a weekly basis. Further, LHBs should report the number of assessments which have not been accepted, the source of those assessments, and the main reasons why submissions were felt to be deficient.
16. Consideration should be given to ensuring that pre- and post-registration education focuses more on the assessment and care of people who have complex needs including those older people who are frail, and to greater provision of inter-professional learning where appropriate. Staff working within acute and community services (including mental health and learning disability) should be encouraged to undertake rotational experiences of working in both to enhance their knowledge and understanding of the patient journey. The role of the practice facilitator should be reviewed to aid this development.



17. In the longer term networks should be established, based on local service boards, that bring together
  - local authorities
  - local health boards
  - primary care
  - secondary care clinicians
  - NHS Trusts
  - the voluntary sector and
  - the private sector.
18. Consideration should be given to facilitating primary and secondary care clinicians to work jointly in community settings to develop care bundles and care pathways through which patient care is managed into and out of the community, with patients and their families as co-producers of care.

### **Overall Funding Issues**

- 8.61 Current funding arrangements may serve to impede strategic progress in tackling delayed transfers. Two key issues need to be addressed:
  - the need to ensure that the care system across Wales is fairly resourced to support the demands placed upon it and that the funds flowing through both LHB and Local Authority channels are considered together; and
  - the need to ensure that funds are available to enable changes in service provision to be made.
- 8.62 The limited information available on the costs of delayed transfers of care, and the alternative uses to which that money could be put, have been summarised in Chapter 2; but these figures are beset with various limitations as a planning tool. We are not aware of any recent work which models, in Wales, the likely financial impact upon public funds of the services that will be needed to support patients needing to leave hospital settings. While many of these will be older people leaving acute hospitals and needing ongoing care, a number will be younger patients leaving both acute and mental health services and requiring individually tailored and expensive forms of care.
- 8.63 The Balance of Care and Support referred to above assumes changes in financial flows will be required to support the development of the model. For example, District General Hospital bed numbers should decrease over time as the demand – for hospital *treatment*, but especially care whilst awaiting discharge - is reduced, with the revenue associated with these re-deployed to other settings. Second, more of the funds currently deployed to supporting residential home care should be invested in services supporting people living in their own homes or needing specialised forms of nursing care. The costs of creating new services while running down old style services have not been fully identified in many localities.

- 8.64 It is clear that the availability of funding across local partnerships is a significant factor in shaping their performance; this Review has found that severely restricted finance in one part of a partnership affects the ability of all partners to manage discharges appropriately. The funding set aside within local government particularly affects the number of home care packages that can be provided to those wishing to remain at, or return to, home and it is a significant factor in shaping the capacity and quality of nursing home and residential home provision.
- 8.65 Where partnerships consist of a number of health and local government bodies – as will increasingly be the case if partnerships in the future are to be grouped around enlarged NHS Trusts – piecing together investments over several financial years in order to create a new balance of care across the areas served will prove challenging.
- 8.66 Difficulties in the NHS commissioning process also appear to be an impediment. The Review found many examples where LHBs were unable to ensure that resources were diverted from existing service provision to support alternatives. To a large extent this was due to the difficulty of identifying a sufficient element of service to be able to release resources – a clear case for pump-priming. But where this was not the case, there was also some evidence of LHBs being unable to ensure that NHS Trusts responded to their wishes. This was for a variety of reasons, such as the LHB’s lack of detailed knowledge about current provision, the lack of effective means of ensuring that NHS Trusts complied with commissioners’ objectives, and NHS Trusts’ ability to develop new services without the LHB’s sanction. The future of commissioning in NHS Wales is the subject of active consideration, and goes beyond our terms of reference, but is clearly an important element in the context of the future reduction of delayed transfers.
- 8.67 However we note the arrangements operating in some parts of Scotland where, with health boards responsible for both planning and providing healthcare, new management arrangements are emerging by agreement between those Boards and local government that, without structural change, appear to allow for a better integration of health and social care provision. These developments would inform any consideration of further changes to health and social care in Wales.

**Recommendations 19 - 21: Financing the Rebalancing of Patient Care**

19. The Welsh Assembly Government should test the plans provided for intended balances of care and support in each locality to ensure that they have been both realistically costed and demonstrate the release of resources from District General (and community) hospital care, and from any community forms of provision no longer needed in the quantities currently offered.
20. Where additional short term funding is needed to provide bridging funds to allow new services to be developed whilst old services are wound down, and where such plans have clearly emerged from a robust planning process owned by

the partnership, pooled funds should be made available by the Welsh Assembly Government. This would provide a certainty of funding across several financial years and minimise the need to co-ordinate funding from within a number of health and local government allocations.

21. Two changes to financial flows are indicated. First, there is a need to unlock resources from District General Hospital beds that are used for patients whose treatment has ended, but are still undergoing the assessments needed to plan the next stage of care; these should be transferred to other parts of the spectrum of care. Second, there is a need to unlock resources from residential home provision so that these can be added to those freed from the general hospital and used to increase support/care in the home, and more intensive forms of nursing care.

### ***Use of joint information and computer technology***

- 8.68 The matters referred to immediately above arise in part from an incoherence in the information systems being used to capture data and report it. The unified assessment process remains a paper-driven process almost everywhere in Wales where it is in use in the acute hospital service. The difficulties inherent in the unified assessment process are addressed below, but the absence of an easy facility to transfer data electronically between agencies and professionals clearly is a major inhibitor to its full use.
- 8.69 Mental health services operate to an extent outside the unified assessment process, preferring instead the Care Programme Approach, but again the use of electronic data gathering systems is limited. Social services employ computer based systems to hold data and track progress with delivering care packages but in only a few locations have efficient data sharing arrangements been put in place. The Review found only one location that was fully aware of the Wales Accord on the Sharing of Personal Information and had signed up to its requirements, but others had it under consideration.

### **Recommendation 22: Shared ICT to Support Shared Care**

Consideration should be given to the accelerated development of a Wales-wide robust information communications and technology environment able to support an inter-agency and inter-professional approach to the assessment of patients needs and the acquisition of the care packages.

#### **A.4. National policy**

##### ***Setting the right framework***

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##### ***Financial responsibilities for long-term care***

- 8.70 There is quite a complex set of responsibilities for the continuing care of vulnerable people. For patients experiencing a delay in transfer, who are moving to a setting that requires more support than is available from family and friends, the responsibility for their continuing needs can be borne by one (or more) sources, depending upon the nature of their needs and their own means. The time taken to determine responsibility – and the significant financial consequences of getting it wrong – is an important contributor to the overall level of delayed transfers.
- 8.71 Long term care, as presently conceived, comprises three levels of need, and various financial responsibilities are linked to each, but the arrangements are complex.
- 8.72 The least dependent level is that where the patient has a range of social needs – for example assistance is required with washing, dressing, shopping – and these may be met either in the client’s own home or in a residential care setting. Service users are frequently required to contribute towards the costs of social care and where the person needing care has assets in excess of £21,500, he/she may be liable to fund the total cost of, for example, residential care provision.
- 8.73 Where the client has nursing needs in addition to social needs, the costs of these will be met by the NHS at no charge to the client. Nurses may visit the patient at home, or the NHS may pay for nursing care to augment the social care provided in residential settings such as nursing homes. Clients however remain responsible for any social care costs they have to bear.
- 8.74 The determination of ‘health’ and ‘social’ needs by health and social care professionals is not always clear cut and the precise boundaries of the responsibilities held by local government social care and NHS nursing bodies remains contentious, with further guidance imminent. Further, it has been noted by informants that the current assessment process is subject to influence depending upon the range of services actually available and, further, is as much about determining financial responsibility for care as it is about defining the true care needs of the individual.
- 8.75 Where clients are deemed to have continuing health care needs then the total costs of care fall to the NHS and are no longer means tested.
- 8.76 To the extent therefore that patients with only social care needs remain in an NHS facility, the NHS meets costs that should fall either to the local authority or to the patient. There is evidence that some protracted delays in

discharging patients from NHS facilities arise because patients and their families wish to remain in care settings that are free, although the small-scale survey conducted for this Review would suggest that the numbers are relatively small. This requires further exploration. The Review learnt that a pilot study has been undertaken in one part of Wales to assess the impact of offering free personal care, and understands that although there was an additional cost for providing this, the extent of extra funds needed was not deemed to be unattainable.

- 8.77 There is also evidence that local authorities in Wales – partly arising from the recently issued guidance from the Heads of Adult Social Care for Wales - are increasingly challenging the numbers of patients for whom social care, with or without accompanying nursing care, is deemed appropriate. Instead local authorities, relying upon advice offered by social work staff, have re-asserted the need for continuing health care to be positively ruled out by a full multi-disciplinary assessment process before social care options are considered.
- 8.78 This Review has found evidence to suggest that there remains a gap between those services provided by the NHS (continuous health care needs) and those provided by local government, and in many parts of Wales this gap has been managed by Health Boards and local authorities each meeting half of the costs involved in providing the packages of care needed.

### **Recommendations 23 - 25: Financial Responsibility for Long-term Care**

23. A review of present charging policies should be undertaken to establish the extent to which attempts by families to retain the home of family members being considered for means tested care impede the accessing of such care, and the total cost to the public purse if using this element of an individual's wealth were to be ignored or limited.
24. The Welsh Assembly Government should monitor the extent to which the assessment processes in health and social care ensure that all needs are captured as one shared and standardised process. This should include the effectiveness and timeliness of the local response in cases where patients appear to 'fall into the gap' between agencies' responsibilities
25. As the changes to the balance of care set out here are realised, and as the financial implications of this become clear, the Welsh Assembly Government should consider whether some or all of the costs of personal care could in future be met from the resources so released. One option might include making free personal care available to all for a fixed period post discharge, for example 6 months. They should take account of the relevant recent experience of Scotland in this area.

***Coordination of policy and performance management at the national level***

- 8.79 Three parts of the Welsh Assembly Government are particularly involved in addressing delayed transfers of care: health and social care, local government, and housing. The Minister for Health and Social Services and the Director of the Department for Health and Social Services are both seen as having the pivotal role for synthesising health and social care *policy*, but the remit of the Minister and the accounting officer in respect of social services *performance* appears limited. For example, the extent to which the accounting officer oversees spending upon social services is limited to defined and relatively small programmes of expenditure. The discussion of local government performance, and its subsequent monitoring, (in relation to DToC and other matters) resides elsewhere within the Welsh Assembly Government.
- 8.80 The implementation of policy and performance management insofar as the *system* of care is concerned therefore appears to be diffused across a number of Assembly functions – although we note that this has been recognised and plans currently exist to further integrate thinking and policy development. Currently however the arrangements whereby the Assembly Government oversees the work of local government appear to dilute the Assembly Government’s ability to ensure that actions of local government and health bodies are co-ordinated; for example the different expectations of performance on delayed transfers agreed with health and local government bodies are not mutually reinforcing. Housing policy, at the all Wales level appears to have a limited influence and involvement in the wider shaping of the care system which does not do justice to its growing importance.
- 8.81 Although the Review did identify some mechanisms within the Assembly Government that sought to address some of these challenges of coordinating policy development and implementation, significant ambiguities of role and responsibility remained, and different parts of the Welsh Assembly Government appeared to have significantly different perspectives on the importance of DToC in relation to other priorities.

**Recommendation 26: National Co-ordination**

26. The Welsh Assembly Government should review its present arrangements for integrating the development and implementation of housing, social care, and health policy so that the main actions needed to ensure good interlocking systems of care are developed in all parts of Wales. Greater clarity is needed in terms of:

- ministerial portfolios relating to health, social care, housing, and local government financial, service and partnership performance;
- the arenas within which senior officials operate to refine funding approaches, guidance to key stakeholders, and performance management.

### **Performance management**

- 8.82 Present performance management arrangements for the NHS require it to drive down the number of both patients experiencing a delayed transfer and also the number of bed days accounted for by such patients. However, the equivalent processes for local government assess performance on a different basis which is not derived from, or related to, other partners' objectives.
- 8.83 The current performance management systems take little account of the variation in levels of delayed transfers across Wales, which results in areas with low numbers bearing a disproportionate administrative burden. It is probably not realistic – or proportionate, taking account of opportunity costs – to expect localities to devote their energies to eradicating all delayed transfers - even where well developed care systems exist, some delays will still occur because of unavoidable, minor inefficiencies, and because some patients will require longer to make decisions about their future. There are also likely to be a very small number of patients who, because of exceptional needs or circumstances, cannot be transferred for some time. They can account for a significant number of 'delayed days'.
- 8.84 The data gathering processes that report DToC are based on a monthly sampling process which in some parts of Wales probably under-reports the true numbers of both. Recommendations on the data collection processes are given in B2 below.

### **Recommendations 27 – 30: Performance Management**

27. Agreed levels of performance for co-terminous local authorities and LHBs should be aligned, and the performance of the partnership should be monitored in a coherent way by the Welsh Assembly Government.
28. Where (a) adequate management arrangements for managing DTOC are in place, and (b) numbers of DTOC are low<sup>2</sup>, or delayed beds days relate to a few known patients who are proving difficult to place because they have specialised needs that are taking time to meet, present monthly reporting arrangements should end. Instead the agencies concerned should report their experiences on a six monthly basis, for as long as their low levels continue.
29. For all localities Annual Operating Framework (SaFF previously) targets should include to a much greater extent, reference to locally specific service changes and partnership development issues which arise from the plans for creating a new balance of care model outlined above.
30. In areas where delays remain high present reporting arrangements should continue and each agency should have targets for delivery which sum to the total placed upon the partnership as a whole.

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<sup>2</sup>If measured at LHB level daily patients numbers below 10 would be judged low.

## **Governance**

8.85 As set out in Chapter 4, the incentives and sanctions developed as part of a performance management regime need to be aligned with the form of governance that is in place. The form of governance most suited to tackling the root causes of delays in transfers of care in Wales is the network form, rather than hierarchies, or markets. The incentives and sanctions applicable to networks we propose would be performance managed through:

- Peer pressure based on long term relationships established within the network;
- Development support through National Leadership and Innovation Agency for Healthcare and the Social Services Improvement Agency; and
- Oversight by health and social care inspection and regulatory bodies.

8.86 In this context we would recommend that, as with the assessment of the extent and the development of solutions to the problem of delayed transfers being developed at the local level, the mechanisms through which to achieve change should also primarily be developed at the local level. This would include the extent to which pooled budgets, joint commissioning and integrated care would play a part.

## ***Pooling and alignment of budgets***

8.87 Health and local authorities have had the power to 'pool' budgets - and in other ways share or apportion their responsibilities for issues of mutual concern - since 1999. This new power was intended to represent a major breakthrough in joint working, by removing what was thought to be an unhelpful legal restriction on who could pay for what. Eight years on, the use of this freedom is low.

8.88 This Review found relatively few examples of pooled budgets which were reducing delayed transfers. This was despite many examples of separate funding streams apparently preventing the development of services which actually would reduce delays. There was also little enthusiasm for their greater use, particularly among senior management and finance staff. While front-line staff were often frustrated by financial impediments to joint working, others argued that, while pooled budgets were a superficially attractive solution to this problem, they would actually create a new set of problems. These might include:

- Unhelpful rigidities associated with any substantial 'ring-fencing' of resources, in the context of changing and significant alternative calls on resource;
- Reluctance to accept a future share in the financial responsibility for certain aspects of provision;
- The setting of an inadequate budget, as authorities seek to protect themselves from future increases in demand for the 'pooled' service.



- 8.89 Some argued for alternative mechanisms which might achieve similar outcomes. We found promising examples of statutory bodies working together to 'align' their budgets, in such a way that their respective staff could access sufficient resources to provide a properly coordinated service, without the need to create a formally pooled budget. We also found local agreements to 'split the difference' where it was reasonable to assume that, in aggregate, the needs of a group of patients would fall equally on the two partners. This avoided the need of time-consuming individual apportionment of costs in every case.
- 8.90 Pooled budgets are clearly a useful mechanism in some circumstances. Their principal advantage over 'alignment' and other less formal mechanisms is that they provide clarity and certainty about the governance of joint service provision. They tend to be adopted where partnership working is already effective; it is difficult to conceive circumstances where pooled budgets would be helpful if those relationships were not already good, since the strains of establishing the budget might prove too great. We did not find a strong case for enforcing their use, and recommend that attention should be devoted to improving the underlying relationships, rather than compelling the use of this particular financial mechanism.

### **Recommendation 31: Pooling and Alignment of Budgets**

The extent of the funds to be released by disinvestment in each care economy will be identified through the plans for the balance of care aimed for in 2012, as should the plans for investment.

- a) The financial resources released by such disinvestments should be used to create shared budgets that would be available on a care economy-wide basis to allow new services to be planned and created.
- b) The Welsh Assembly Government should identify localities or schemes where external-short term funding might be useful – for example to meet dual running costs of new and reducing services while the latter are run down, or to support pilot schemes likely to be of benefit to Wales – and add such funds to the emerging pooled/shared budgets.
- c) As part of the plans for describing the intended balance of care, partners should be encouraged to further align or pool existing budgets to enable the maximum levels of service to be accessed.
- d) With the exception of funds released from the disinvestments described in the balance of care model, pooled budgets (or other mechanism under Section 33) should not be imposed upon partnerships. However, if partnerships choose not to adopt such approaches, they should explain why to the Welsh Assembly Government.

*Apportionment of the costs of delayed transfers*

- 8.91 In England, arrangements have been put in place to ensure that the financial consequences of delays caused by Social Services are borne by the Social Services department concerned. Commonly referred to as 'fining' Social Services for their inability to perform, this approach has been evaluated, with mixed results (see Chapter 4). It has been argued that the threat of a fine may be sufficient to ensure that Social Services departments take the issue sufficiently seriously, but such 'fines' have rarely been implemented, reflecting in part the difficulty of attributing blame for such complex issues, and in part the fact that such a regime may well hinder joint working, resulting in one partner penalising another.
- 8.92 The Review found very little support in Wales for the introduction of such a regime, for the reasons given above. It was also felt to be incompatible with the *Making the Connections* approach, which stresses collaboration and joint working.
- 8.93 The contrary argument is that such a measure might be useful as a reserve power, to be deployed with discretion, if the recommendations on developing a new balance of care and support – and the major disinvestment and reinvestment that that entails – are not implemented, as a result of one partner failing to make the issue a sufficient priority. So much of the current system of incentives relies upon rewards – praise, additional specific funding, professional satisfaction - rather than sanctions, that it may be argued that an element of punitive intervention, held in reserve, could contribute to a more balanced portfolio of performance management measures.
- 8.94 We have concluded that, on balance, such a measure would not be helpful in Wales. The approach set out in *Making the Connections* is very clearly one of partnership working, and the recommendations set out in this Review also emphasise the need to develop those local partnerships well beyond the point they have reached so far. It would contradict all of this for one partner to seek to 'fine' another. Instead, those partnerships – embracing statutory as well as voluntary and commercial partners - must be made to work to resolve the problem of delayed transfers, and all the other local priorities. If such an approach ultimately proves to be disappointing, then - as the Beecham report suggests – an entirely new way of tackling joint working must be considered.
- 8.95 The NHS will shortly adopt a new system of internal 'financial flow', which will present NHS Trust Boards and others with 'real' financial information, including data on the costs (in terms of forgone income) of DToC. This will provide the NHS with an equivalent incentive to the 'fining' approach in social service to further reduce their level of delays.

**Recommendation 32: Apportionment of Costs**

The Welsh Assembly Government should not adopt measures to allow for the apportionment of NHS costs of delayed transfers to Social Services.

***Personal planning for life-changing events***

8.96 It is clear that for many people the need to make life changing decisions is precipitated by the, for them, unexpected event of a hospital admission. Yet everyone reaching retirement age could be encouraged, as part of their long term planning, to consider how and where they would wish to live in their older age, especially if having to live without supporting close family. This might be part of employer-led retirement planning schemes, or incorporated opportunistically into existing health care processes such as primary care or hospital consultations. Such forward planning is already a key theme within the Older People's Strategy, and it features as part of other initiatives targeted at particular groups, such as the chronic conditions management framework. To reach all of the people potentially affected will require a substantial sustained and coordinated effort.

**Recommendation 33: Personal planning**

The Welsh Assembly Government and partners should review existing arrangements for encouraging middle aged people to anticipate the, often inevitable, decreasing levels of independence which accompany lengthier lives.

## **PART B**

### **ADDRESSING THE IMMEDIATE PROBLEMS**

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#### **B.1. Patient well-being** ***Putting the patient at the centre***

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##### ***Patient assessment***

- 8.97 Assessment of patients' needs, from multi-disciplinary perspectives, with a full awareness of the patient's wishes and circumstances, and frequent re-assessment, is a key element in ensuring as brief a stay in hospital as possible, and the most satisfactory outcome for the patient. The assessment process should impose as light a burden as possible on the patient, and consume as little staff time as possible.
- 8.98 All of this is what Unified Assessment is designed to achieve. The slow introduction of the process across Wales has been well rehearsed elsewhere, but its link to delayed discharges should not be forgotten.
- 8.99 This Review has also highlighted other features of the assessment process which are relevant to the well-being of delayed patients. First, it would appear that in some cases social services and health professionals approach patient/client assessment with a different attitude towards risk. It is very difficult, of course, to generalise about such matters, but there would appear to be a tendency for social workers to be more willing to accede to patients wishes, even if 'risky', than nursing staff; on the other hand, to a social worker a ward is a relative 'place of safety' compared with the circumstances facing others of their clients. It can be difficult for staff with such different perspectives to reach common assessments in some cases.
- 8.100 Second, when applied to older patients, the assessment process in some parts of Wales appears to be unduly concerned with matching patients to the best, easily available provision, rather than necessarily to provision which might be better, but more difficult to obtain. The Review was told of examples where assessments have been changed in order that scarce or distant care options are avoided in favour of those that are more immediately accessible. Whilst this may be done in the best interests of the patient – i.e. to minimise their length of stay – there is a real danger that their longer-term well-being may be compromised by sub-optimal care.
- 8.101 Third, assessments that identify needs which are not quickly or fully met are not usually brought together so that:
- gaps in the availability of services can be identified, and
  - steps taken to create new, additional or more local services.

The Review did not find clear processes that fully link operational assessments to the broader service planning processes to ensure that services are commissioned which meet previously unmet needs.

### **Recommendations 34 - 36: Patient Assessment**

34. The Welsh Assembly Government should consider altering the Unified Assessment Process for use in health services in Wales. The shortened version of enquiry, contact, in-depth and comprehensive assessments is suggested, with the overview assessment completed by a registered social care worker to assess social care eligibility. This would necessitate the co-location of social workers and health staff within acute and community hospitals.
35. The Welsh Assembly Government should consider amending the assessment process for delayed patients so that it operates in three distinct parts:-
  - an assessment that the patient 'no longer needs this NHS care setting' – and confine this assessment to the clinical team;
  - an assessment that provides a 'prescription' of care for each patient based upon what the patient should receive in an appropriately balanced care system, unconstrained by current service gaps; and
  - a 'brokerage' system that performs two functions: it obtains the best care that is available in the care system, taking into account the compromises that the family, client and professionals are prepared to make; and it quantifies the extent to which the system fails to meet the prescription, so that this can inform future commissioning.
36. Discharge pathways should be developed for each hospital in Wales, consistently implemented, and regularly reviewed. These should take full account of the principles enunciated earlier in this Review, and in *Designed for Life*, the work on chronic conditions management, and elsewhere.

### ***The choice agenda***

8.102 Current guidance lays stress upon patient choice as an important part of the overall assessment process. However, having reviewed the documentation used and the processes that statutory bodies employ regarding patient choice, it is clear that the emphasis of the guidance is not exclusively geared to ensuring that the care system strives to meet the choices made by patients or their relatives. Rather it is also designed to ensure that:

- patients are made aware early in the treatment process of the need in due course to make a choice of care setting and thus their expectations are managed;
- where that setting is likely to be a nursing or residential home, patients are clear that their preference for a particular setting will not be met initially if that setting is not immediately available.

- 8.103 It might be considered from the use of the language of choice that one aim of service planners and commissioners would be to meet as many of the first choices of patients as possible. This would mean allowing patients who wished to return home - with support - so to do. It would also require commissioners to ensure that an adequate range of quality services (especially nursing homes) was available so that an adequate range of places was supplied. Neither of these outcomes is currently a service target.

#### **Recommendations 37 - 38: Choice**

37. Using the approach outlined in Patient Assessment above, the extent to which it proves impossible to meet the patient's choice of setting (either immediately or ever) should be routinely recorded and used to inform future commissioning.
38. The extent to which patient choice of setting is not met should be considered as a performance indicator for the local partnership.

#### ***Patient Advocacy***

- 8.104 The Review has noted the numbers of individuals who pass through the health care system in Wales each year for whom some post discharge arrangements are necessary (these of course far exceed the number of patients actually delayed) and also appreciates the complexity of the assessment processes that are involved. Coupled with the often significant choices that patients and their relatives are called upon to make, these factors bring to the fore the need for good advocacy services to be available. Frequently the role played by social work staff delivers good advocacy; however for some patients social work support may arrive late in the assessment process or alternatively be viewed by some as having a pre-determined agenda. The Review found good evidence to suggest that a significant number of delays occasioned by 'patient choice' could have been reduced if patients had better understood the necessary processes prior to discharge, and patient advocates can have play a useful process in fostering such understanding. Such advocacy must be easily available to all patients who would benefit from it, whether by referral from professionals or through self-referral.

#### **Recommendation 39: Patient Advocacy**

All patients faced with making decisions about their long term support and care prior to transfer of care should have easy access to independent advocacy services.

### ***Impact of Delayed Transfers on Patients***

8.105 Although there was universal agreement that delayed transfers were potentially harmful to patients' well-being, the Review found little evidence of any systematic measurement of the extent to which the quality of care is compromised by patients remaining in inappropriate care settings. Given that delayed transfers are not going to be eliminated immediately – and indeed, some are likely always to occur – it would be useful to categorise and measure them, at least on a sample basis. This would allow agencies to aim to reduce harm, and to measure their progress in so doing.

8.106 The following were all identified as potential harms:

- dying in inappropriate settings;
- reduced independence;
- contracting hospital-borne infections;
- loss of confidence;
- reduced contact with family and friends (for example where the hospital is some distance from family members or poorly served by public transport).

8.107 The new social services data systems have embedded the Unified Assessment Process Minimum Dataset (2006) and so data on individual needs could be gathered. The issue is whether harm (or disability) occurs due to delays in rehabilitation. The data would need to be gathered from health assessments and through increased dependency, frailty or vitality. This could be collected in a standardised continuing healthcare assessment.

#### **Recommendation 40: Impact on patients**

Data on key aspects of the patient's experience of delayed transfers – including the five types of harm outlined above – should be routinely gathered and used as a key component in improving both operational/clinical management and service planning and development. The data gathered should reflect patients' and carers' own perceptions of what constitutes a 'quality' service.

## **B.2. Useful data**

### ***Getting a measure of the real problems***

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8.108 It is clearly important that the data on delayed transfers should be both a valid and reliable measure of the problem, to enable policy makers to assess its overall extent, whether progress is being made, and which factors or locations are experiencing particular problems. Whilst the national data collection system has improved significantly since its inception, a number of problems remain.

#### *Local Agreements*

8.109 The use of 'local agreements' makes comparison difficult. The local agreement specifies the time that may elapse between the patient being medically fit for transfer and actually being deemed to be 'delayed'. This period is intended to allow Social Services in particular to carry out whatever work is necessary to identify appropriate accommodation and services for the patient, and also to allow the patient reasonable time to assess the alternatives. Although such agreements only affect a proportion of the total number of delayed patients, their impact is significant. As the Wales Audit Office noted, and as this Review has confirmed, local agreements currently allow different lengths of time for social services to assess patients. By comparison, Scotland has a standard period of six weeks for all localities.

8.110 Local agreements concentrate upon the processes that seek to meet the needs of the patient after discharge, rather than the narrower assessment that, medically, the patient no longer needs the hospital facility then occupied, and to this extent they also understate the number of patients inappropriately remaining in particular hospital settings. It may be possible to determine that the patient no longer needs the care setting occupied sooner than it is possible to determine what the best future care setting should be.

8.111 However, local agreements have the significant merit that they do allow Social Services time to carry out their functions without attracting the 'blame' for delay which might unreasonably accrue without them. The principle underlying local agreements is therefore a reasonable one; the drawbacks with their current use are that they vary across Wales, making comparison difficult, and the basis upon which they are determined is not clear. A more satisfactory approach would be to adopt a standard period for Wales, based on what should be achievable everywhere.

#### *Defining a 'delayed discharge'*

8.112 The issue is further complicated by the lack of precision about which patients are counted as delayed transfers by the bodies undertaking the recording.



Most authorities operate a definition of delayed transfers which have a number of components including:

- a multi-disciplinary assessment has to have been completed;
- the clinical team must be satisfied that the patient is ready for discharge; and
- it must be safe to transfer the patient to the next care setting.

- 8.113 The Review has ascertained that these are subject to different approaches locally. Indeed informants offered a variety of subtly different definitions of DToC to which they were working. Some stressed the centrality of the clinical team in determining only that the patient no longer needed their current care setting for a DToC to be declared. Others stressed the need to ensure that a safe transfer to another setting was possible before a DToC could be recorded.
- 8.114 Further, the machinery able to determine DToC varied. For example, in some localities if one member of the multi-disciplinary team felt that the patient's condition was not sufficiently stable then an assessment would not be completed and a DToC could not be declared. Different professionals will feel more or less confident about resisting pressures to assess prematurely, more senior practitioners being more likely to wait.
- 8.115 Data is only gathered for patients cared for in Welsh hospitals; Welsh patients cared for in English hospitals who experience delays in discharge are not reported by present performance management arrangements. Yet the numbers involved are significant.
- 8.116 The Review also identified some inadequacies in the coding system for the cause of delays. In particular, there were some elements which did not appear to be easily recorded, notably patients with a 'physical' condition who also had requirements associated with learning disabilities, substance misuse, mental health problems, homelessness and unmet needs. These are all factors which may have an impact on the patient's needs, and which should be quantified to inform the commissioning process for a more appropriate balance of care and support. It was also argued that there was some redundancy in the codes currently available.
- 8.117 Finally, the system is not routinely measuring inappropriate discharges and the data gathering system should address this dimension too. Further work is required to develop a practical approach to this.

**Recommendations 41 - 44: Data**

41. 'Local agreements' should now be replaced with a nationally agreed period between the patient being 'medically fit' for discharge and being deemed a 'delayed transfer of care', based on an assessment of the minimum time required to carry out the necessary functions.
42. The Welsh Assembly Government should work with the discharge experts to review the current codes and develop a list which reflects current patient and service experience. They should include the most frequently used and those that have been identified by the Wales Audit Office and this study as not easily recorded.
43. Data on all Welsh patients experiencing delays should be captured and reported, including those treated in English hospitals.
44. Data on both numbers of patients, and numbers of days, should continue to be reported, since both sets of data are needed to understand the impact on both individual patients and the care system as a whole. Mental health and non-mental health delays should be reported separately, and this reporting system should consistently take account of patients' needs rather than simply where they happen to be located (e.g. patients with mental health needs who are being nursed on general medical wards may be more appropriately regarded as 'mental health' patients).

### **B.3. Improving efficiency**

#### ***Getting existing systems to work better***

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- 8.118 In addition to the major re-design of the components of the system of care indicated above, much can be done in the meantime to manage better the present arrangements for assessing patients and accessing care for them. An important element in this is the pro-active management of patients' care throughout their stay in hospital – and not just from the point where they are about to become a 'delayed transfer' (Chapter 5). Useful work has already been done – identified by the Wales Audit Office study and in the literature (see Chapter 4) - to identify the characteristics of a significant proportion of patients who go on to be delayed, and who therefore should receive early additional input in hospital to address the problems they may encounter on discharge. These characteristics include a variety of factors which can easily be established on admission – such as age (typically 75+); living alone or with a frail partner; receiving a long-term package of care at home before admission, or not being known to care services despite being frail; having previous unplanned admissions, often with non-specific diagnoses; and having a history of falls.
- 8.119 There is a substantial agenda of other operational issues which also require attention. These include:
- having quick processes for the timely engagement of social work teams with the clinical team;
  - considering whether generic workers could be used to undertake some nursing and social work functions;
  - having standing arrangements for the fast determination of patients being considered for continuing health care;
  - having 'on tap' the services often needed on discharge – for example domiciliary care support for the first 6 weeks after discharge;
  - rapid escalation processes where disagreement between professionals or agencies is encountered;
  - simplifying discharge processes and ensuring that all staff are aware of, and can apply them; and
  - addressing difficulties in the supply of discharge medication.
- 8.120 There is still progress to be made on all of these issues, while the more fundamental re-design described earlier is being addressed. The National Leadership and Innovation Agency for Healthcare has already carried out significant work in this area (see Chapter 5), and the Social Services Improvement Agency also has an important role to play. This work has developed from a thorough analysis of the common immediate causes of delayed transfer across Wales, carried out in close collaboration with the relevant agencies and professions. The National Leadership and Innovation Agency for Healthcare is currently developing a forward programme - 'Passing the Baton' - to address the issues that have been identified.

**Recommendations 45 - 46: Improving Efficiency**

45. The 'Passing the Baton' initiative being prepared by The National Leadership and Innovation Agency for Healthcare should be fully supported and implemented across all the agencies and sectors involved in patient transfers, and this implementation should be audited. Particular attention should be given to ensuring that patients most at risk of being delayed receive help from the beginning of their hospital stay to address any factors which might lead to their transfer being delayed.
46. All local agencies should continue to review actual and anticipated delayed transfers frequently, with active leadership and engagement from senior staff, to identify and remove the remaining barriers to more efficient working. Delayed transfers are a corporate responsibility, and ultimate accountability should be clear held at the most senior level in the organisation.

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## **APPENDIX 1**

### **DOCUMENTS REQUESTED FROM LOCAL HEALTH BOARDS**

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1. LHB Local Agreement(s) regarding data capture as required by DToC: Database Implementation and Process Guidance Notes.
2. Local protocol(s) regarding discharge procedures as per WHC 2005 (035) – i.e. covering agreed time standards, information sharing, carers assessment etc.
3. Most recent report to Board advising Board of levels of DToC and actions being taken to reduce or better manage them.
4. Extract(s) from current commissioning plan which directly addresses action needed to either maintain present levels of DToC (if judged satisfactory) or reduce them.
5. Most recent document(s) which sets out the LHBs partnership arrangements/from which addresses multi agency action to address DToC.
6. Monthly snapshot census data for all matters in 2007.
7. Duty documents describing status of linkage of interagency IT systems.
8. Statement for citizens of national standards as recommended by “Making the Connections”.
9. Most recent documents describing work of Local Action Teams as set out in “Guide to Good Practice” Emergency Care, 2004 Innovations in Care.
10. Document describing LHB response to most recent situations when a patient’s preferred accommodation was not available (as recommended in WHV (2004) 066/NAFWWC 46/2004, Guidance on National Assistance Act).

#### **Documents requested from Local Authorities**

1. Number of homes registered with the Authority to provide residential and/or nursing care as at latest date which data is available showing numbers of beds registered, category of bed (residential or nursing), and type of bed (e.g. general nursing, EMI etc).
2. Same data as in 1 above but for April 2006 and April 2005 (or nearest month for which data is available).

3. Number of residential and nursing home placements supported by local authority funds irrespective of where cared for:
  - *currently;*
  - *as at April 2006;*
  - *as at April 2005.*
4. Data held by the Authority on vacancy rates in locally registered care homes:
  - *latest position;*
  - *as at April 2006 or nearest date;*
  - *as at April 2005 or nearest date.*
5. Number of clients in receipt of domiciliary care funded by local authorities.
6. Current waiting list data for clients assessed as needing domiciliary support.
7. Summary social care budgets and outturn for 2005/6 and 2006/7.

(For Adult Services Only)

8. January, March and May 2007 monthly signed off delayed transfer reports.
9. Most recent report considered at Cabinet level or above that reported status of delayed transfers of care, actions being proposed or problems being encountered.
10. Most recent report considered at Chief Officer level that reported status of delayed transfers of care, actions being proposed or problems being encountered.
11. Most recent document setting out LA policy on recognising carers needs (as per "Fulfilled Lives – Supportive Communities").
12. Latest report to Cabinet/Council describing the multi agency arena in which LA participates re DToC as suggested in WHC 2005 (035) Hospital Discharge Planning Guidance.
13. Latest document describing any joint commissioning process/machinery involving LA relating to delayed transfers of care as recommended in "Making Connections".
14. Copies of local protocols regarding discharges (time standards, information sharing, carer assessments etc.) as recommended in WHC 2005 (035) Hospital Discharge Planning Guidance.
15. Document describing what social services are available.

### **Documents requested from Trusts**

1. Local Agreement(s) regarding data capture as required by DToC: database implementation and process guidance notes.
2. Trust Discharge Procedure as required by AHC 2005 (035).
3. Local protocol regarding discharge procedure as per WHC 2005 (035) e.g. covering agreed time standards, information sharing, carers assessment etc.
4. Trust policy regarding the exercise of "choice" by patients needing to move to residential or nursing care as required by WHC (2004) 066 NAFWWC 46/2004 Guidance on the National Assistance Act 1948.
5. Most recent report to NHS Trust Board on number of DToC and action being taken to address them.
6. Most recent report to Trust Management Executive Group on number of DToC and action to be or being taken to address them.
7. Most recent report to Division/Directorate level on number of DToC and action to be or being taken to address them.
8. Most recent Trust documents that describes the partnership arrangements/partnership forum that oversees other agency working relating to DToC (its remit, membership, and last action taken to improve management of DToC) as per WHC 2005 (035).
9. Trust documents that give clear statements of national standards for key services, as per "Making the Connections".
10. Latest bed statistics for Trusts giving numbers available, numbers occupied, classification, and hospital location/description.

## **APPENDIX 2**

### **LIST OF POST HOLDERS WITH WHOM WIHSC REQUESTED INTERVIEWS:-**

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#### **Local Health Board**

1. Chair and Directors (including acting staff).
2. Information / analyst staff responsible for studying and interpreting data on DToC.
3. Non Board level staff responsible for commissioning secondary care acute and mental health services.
4. Named individuals responsible for liaison and coordination on DToC as per DToC database implementation guidance.

#### **Trust**

1. Trust officer(s) responsible for liaison and coordination of DToC under Guidance Notes on database implementation and process (DToC).
2. Trust Officer responsible for co-ordinating discharge (as per WHC 2005 (035)).
3. Trust Officer responsible for overseeing working of clarified assessment process.
4. Directorate Managers covering medical (and care of elderly) services and mental health services.
5. Trust Chair, Chief Executive, Medical Director, Director of Finance, Nursing Director.

#### **Local Authority**

1. Director of Social Services.
2. Cabinet Member with responsibility for Social Services.
3. The named individual responsible for liaison and coordination on behalf of Authority covering DToC – as per Delayed Transfer of Care.
4. Senior Social Worker (hospital based) engaged in discharge planning.

## APPENDIX 3

### LIST OF DTOC INTERVIEWEES

First Name	Surname	Organisation
Deb	Gould	Age Concern
Sarah	Perry	Age Concern
Richard	Ellison	Allied Health Professionals
Lorraine	Hughes	Anglesey Local Health Board
Elizabeth	Powell	Anglesey Local Health Board
Ann	Williams	Anglesey Social Services
Carmel	Donovan	Bridgend County Borough Council
Gordon	Jones	Bridgend County Borough Council
Catherine	Poulter	Bridgend County Borough Council
Rosemary	Fletcher	Bridgend Local Health Board
Zoe	Wallace	Bridgend Local Health Board
Ed	Wilkins	British Geriatric Society
Firdaus	Adenwalla	Bro Morgannwg NHS Trust
Carol	Cleary	Bro Morgannwg NHS Trust
Hilary	Dover	Bro Morgannwg NHS Trust
Mandy	Edwards	Bro Morgannwg NHS Trust
Louise	Panes	Bro Morgannwg NHS Trust
Paul	Williams	Bro Morgannwg NHS Trust
Sue	Hutton	Cardiff Carers
Simon	Jones	Cardiff and Vale NHS Trust
Helen	Herbert	Ceredigion & Mid Wales NHS Trust
Linda	Hughes	Ceredigion & Mid Wales NHS Trust
Eiri	Jones	Ceredigion & Mid Wales NHS Trust
Judith	Williams	Ceredigion & Mid Wales NHS Trust
Janet	Hawes	Ceredigion Local Health Board
Sue	Hurds	Ceredigion Local Health Board
Ceri	Lewis	Ceredigion Local Health Board
Kay	Morgan	Ceredigion Local Health Board
Sam	Small	Ceredigion Local Health Board
Helen	Williams	Ceredigion Local Health Board
David	Harries	Ceredigion Social Services
Mair	Morris	Ceredigion Social Services
Gaby	Staite	Ceredigion Social Services
Wendy	Fitzgerald	City & County of Swansea
Ffion	Larsen	City & County of Swansea
Chris	Maggs	City & County of Swansea
Gareth	Powell	City & County of Swansea
Jack	Straw	City & County of Swansea
Mark	Andrews	Conwy & Denbighshire NHS Trust
Janet	Davies	Conwy & Denbighshire NHS Trust

Independent Review of Delayed Transfers of Care in Wales

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Mary	McGirr	Conwy & Denbighshire NHS Trust
Nigel	Morris	Conwy & Denbighshire NHS Trust
Claire	Owens	Conwy & Denbighshire NHS Trust
N	Ramessur	Conwy & Denbighshire NHS Trust
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Pat	Mowll	Conwy Local Health Board
Sue	Owen	Conwy Local Health Board
Lynn	Prior	Conwy Local Health Board
David	Scott	Conwy Local Health Board
Karen	Williams	Conwy Local Health Board
Joanna	Griffiths	Conwy Social Services
Claire	Harding	Conwy Social Services
June	Roberts	Conwy Social Services
Helen	Thomas	Conwy Social Services
Neil	Ayling	Denbighshire County Council
Yvonne	Hughes	Denbighshire County Council
Ellen	Greer	Denbighshire Local Health Board
Jane	Jones	Denbighshire Local Health Board
Jane	Trowman	Denbighshire Local Health Board
Mike	Williams	Denbighshire Local Health Board
Mike	Williams	Denbighshire Local Health Board
Lin	Hawtin	Flintshire County Borough Council
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Nesta	Rees	Flintshire Local Health Board
Sue	Catherall	Flintshire Social Services
Tim	Holt	Gwent Healthcare NHS Trust
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Eleri	Hugheston-Roberts	Gwynedd Local Health Board
Peter	Liptrot	Gwynedd Local Health Board
Glenda	Lloyd-Evans	Gwynedd Social Services
Ann	Lloyd-Jones	Gwynedd Social Services
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Roger	Laidlaw	Merthyr Tydfil County Borough Council
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Kim	Davies	Merthyr Tydfil Local Health Board
Dave	Bamforth	Merthyr Tydfil Social Services
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## Independent Review of Delayed Transfers of Care in Wales

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Wendy	Chaloner	North East Wales NHS Trust
Lesley	Cooil	North East Wales NHS Trust
John	Falcus	North East Wales NHS Trust
Nia	Jones	North East Wales NHS Trust
Nia	Owen Jones	North East Wales NHS Trust
Heather	Piggott	North East Wales NHS Trust
Judith	Rees	North East Wales NHS Trust
Andrea	Gristock	North Glamorgan NHS Trust
Deborah	Harris	North Glamorgan NHS Trust
Jonathan	Haxton	North Glamorgan NHS Trust
Lynne	Roberts	North Glamorgan NHS Trust
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Paul	Birch	North West Wales NHS Trust
Jacqui	Ehlen	North West Wales NHS Trust
Kate	Elis-Williams	North West Wales NHS Trust
Christina	Griffith	North West Wales NHS Trust
Angela	Hopkins	North West Wales NHS Trust
Mandy	Jones	North West Wales NHS Trust
Sandra	Jones	North West Wales NHS Trust
Ann	Lloyd-Williams	North West Wales NHS Trust
Ann	McIntosh	North West Wales NHS Trust
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Gina	Hughes	Pembrokeshire & Derwen NHS Trust
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Hassen	Joomraty	Pembrokeshire & Derwen NHS Trust
Charles	Merrill	Pembrokeshire & Derwen NHS Trust
Caroline	Oakley	Pembrokeshire & Derwen NHS Trust
Christine	Phillips	Pembrokeshire & Derwen NHS Trust
Dai	Pick	Pembrokeshire & Derwen NHS Trust
Chris	Small	Pembrokeshire & Derwen NHS Trust
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Jon	Skone	Pembrokeshire County Council
David	Wildman	Pembrokeshire County Council
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Alison	Kedward	Pembrokeshire Local Health Board
Sue	Lewis	Pembrokeshire Local Health Board
Karen	Miles	Pembrokeshire Local Health Board
Mary	Owens	Pembrokeshire Local Health Board

## Independent Review of Delayed Transfers of Care in Wales

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Rosemarie	Harris	Powys County Council
Phil	Robson	Powys County Council
Nygaire	Bevan	Powys County Council
Catherine	Davies	Powys Local Health Board
Beverly	Evans	Powys Local Health Board
David	Evans	Powys Local Health Board
Yvonne	Jones	Powys Local Health Board
Paul	Labourne	Powys Local Health Board
Meryl	Lloyd	Powys Local Health Board
Lorna	Luter	Powys Local Health Board
Christopher	Mann	Powys Local Health Board
Peter	Meredith-Smith	Powys Local Health Board
Noreen	O'Connor	Powys Local Health Board
Judith	Paget	Powys Local Health Board
Graham	Powell	Powys Local Health Board
Margaret	Pratt	Powys Local Health Board
Mike	Thomas	Powys Local Health Board
Gillian	Todd	Powys Local Health Board
Paul	Worthington	Powys Local Health Board
Emlyn	Davies	Private nursing home provider
Mike	Kemp	Private nursing home provider
Jeff	Collins	Red Cross
Dorothy	Edwards	Swansea Local Health Board
Sue	Heatherington	Swansea Local Health Board
Catherine	Roberts	Swansea Local Health Board
Stephen	Wilson	Swansea Local Health Board
Jan	Worthing	Swansea Local Health Board
John	Calvert	Swansea NHS Trust
Joanne	Davies	Swansea NHS Trust
Mandy	Davies	Swansea NHS Trust
Janet	Fisher	Swansea NHS Trust
Liz	Guthrie	Swansea NHS Trust
Chris	Jones	Swansea NHS Trust
Jill	Luckwell	Swansea NHS Trust
Lee	Morgan	Swansea NHS Trust
Liz	Rix	Swansea NHS Trust
Jan	Thomas	Swansea NHS Trust
Jeff	Buggle	Welsh Assembly Government
Simon	Dean	Welsh Assembly Government
Hugh	Gardner	Welsh Assembly Government
Tony	Hurrell	Welsh Assembly Government
Ann	Lloyd	Welsh Assembly Government
Paula	Martyn	Welsh Assembly Government
Steve	Milsom	Welsh Assembly Government

## Independent Review of Delayed Transfers of Care in Wales

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Chris	Riley	Welsh Assembly Government
Emyr	Roberts	Welsh Assembly Government
Eleanor	Sanders	Welsh Assembly Government
Paul	Webb	Welsh Assembly Government
Chris	Davies	WLGA
Beverley	Frowan	WLGA
Stephen	Jenkins	Wrexham County Borough Council
Alwyn	Jones	Wrexham County Borough Council
Sheila	Wentworth	Wrexham County Borough Council
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Denise	Griffiths	Wrexham Local Health Board
Richard	Owen	Wrexham Local Health Board
Andrew	Figiel	Wrexham Social Services

## **APPENDIX 4**

### **DToC STUDY**

#### **INTERVIEW SCHEDULE**

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##### **Local Health Board**

###### *Chief Executive*

1. Which types of DToCs can the NHS family itself prevent/improve and which do the NHS need others to help with - by rough proportion?
2. What aspect of DToCs does the LHB Board itself a) take an interest in b) intervene with.
3. In terms of 2b what types of intervention does the Board make? When was the last time – and describe.
4. What is the joint arena in which the Board, Trust and the Local Authority agree the strategic nature of the DToC problem and agree the local plan for DToCs –i.e. changing the processes, agreeing investments and using problems to inform action. Where has this a) worked well b) not made much progress.
5. What three changes would reduce the present numbers of DToCs or DToC days in your locality? Why these three? Do these figure in an agreed plan?
6. What problems do you think DToCs actually cause? What is it we are trying to avoid / make better? How are these quantified?
7. How do you see the level/nature of DToC changing in the next 2 years? What does your planning assume – for example in terms of changes in the availability of domiciliary or residential forms of care, or improved management of individual cases?
8. How would you describe the level of trust you have with: a) the Local Authority b) your main NHS Trust(s) on a scale of 1-10 where 1 is low and 10 high.
9. Questions arising from the documentation.
10. Have you signed up to WASPI? (The Wales Accord on the Sharing of Personal Information).
11. What processes are in place to ensure that the DToC codes are allocated?

12. Who decides which DToC code to apply to a patient?
13. How is this information processed through the organisation for reporting purposes?
14. What issues do you encounter when allocating and agreeing DToC codes?
15. Who manages the DToC information within the organisation?

*Director of Finance*

1. What informs your advice to the Board about investments to reducing DToCs?
2. What 3 things would reduce the number of DToCs or DToC days in your locality? Why these 3?
3. In which areas of activity do you and your LA and Trust finance counterparts come together to agree the scope of the DToC problem and then plan / agree what advice you each give to your Boards? How does this work?
4. Have you jointly costed an alternative “balance of care” model in this locality – if so what is its cost impact?
5. How would you describe a better and different balance of investments between the LHB, Trust and LA that might reduce DToC?
6. What problems do you think DToCs actually cause? What is it we are trying to avoid / make better? How are these presently quantified?
7. How would you describe the level of trust you have with: a) the Local Authority b) the NHS Trust(s) on a scale of 1-10 where 1 is low and 10 is high.
8. Questions from the documentation .

*Nurse Director*

1. What part do nursing staff and processes play in ensuring a proper discharge for patients? Is the present level of engagement of nurses in these processes appropriate?
2. How adequate is the present assessment process that determines what services are needed by patients leaving acute general and rehabilitation hospitals?
3. How adequate is the present assessment process that determines what services are needed by patients leaving psychiatric general hospitals?

4. What is the assessment REALLY seeking to determine:
  - *Describe the needs of the patient so that others can find services to meet them*
  - *Assess which of the present range of services the patient needs;*
  - Determine who should pay for care?
5. How frequent are disagreements about what services patients need? Why do these differences arise? How adequate and fast is the machinery for resolving these?
6. What 3 things would reduce the number of DToCs in your area?
7. Questions from the documentation.

#### *Commissioning Officer*

1. How do you see the commissioning of services designed to address DToC?
2. Is how you currently commission a) acute DGH assessment and admitting services and b) long term care for people with physical or mental care needs conducive to avoiding DToCs.
3. To what extent is commissioning for these a shared operation with the Local Authority? How does this work?
4. What different "balance of care components" are needed in your view to reduce DToC in this area OR Why do you think your level of DToC is low?
5. Would pooled budgets assist for buying selected services – which ones would be best suited for this approach?

#### *Chair*

1. What do you understand to be your "standing instructions" regarding DToC?
2. What do you believe to be the problems that DToC cause?
3. Have you discussed DToC with the Chair of the Trust / Leader or Chief Executive of the Local Authority? When was the last time? What was the result?
4. What four changes in practice, service delivery would ensure that DToCs became insignificant?
5. Questions from the documentation.

## **NHS Trusts**

### *Chief Executive*

1. How do you see the DToCs that the NHS family itself can do better with and those that the NHS needs help with by rough proportion?
2. What aspects of DToCs does the Board itself a) take an interest in b) intervene with?
3. In terms of 2b what types of intervention does the Board make? When was the last occasion and what happened?
4. How would you describe the level of trust you have with: a) your Local Authority (ies) b) your LHB(s) (s) on a scale of 1-10 where 1 is low and 10 is high.
5. Has the Trust identified the "pattern" of acute admissions that feed through into DToC – e.g. the practices/localities from which referrals come, patient characteristics, the time of day/week? How has this informed local plans to reduce DToC by the better management of referrals?
6. How would you summarise the challenges posed by managing DToCs from MH facilities?
7. How does the Trust seek to deflect unnecessary acute admissions?
8. In terms of planning discharges, how satisfied are you with the assessment and placing machinery operating within the Trust?
9. Which Local Authorities work well and which not so well?
10. What assumptions are you working to regarding future trends in DToCs?
11. Questions on the documentation.

### *Medical Directorate*

1. What processes exist to assess medical referrals and then transfer selected patients to care settings other than the DGH before admission?
2. What care settings other than DGH admission are intended to be available 24/7 to the assessment unit to access? What settings are actually available? What alternative service is least available?
3. What proportion of DGH admissions are made for social reasons?

4. What proportion of DGH admissions are made because of the non availability of alternative care when the initial assessment is completed?
5. What proportion of admissions are necessary because required diagnostic facilities are not available when patients attend.
6. Of your total DGH medical admissions about what proportion need the treatment capacity of the DGH?
7. Of your total medical admissions to non DGH hospitals, what proportion need the care capacity of those hospitals?

*Discharge Nurses: acute and mental health*

1. When does the discharge planning process begin and who is involved?
2. Do you use the "estimated day of discharge" approach – if so, how helpful is it?
3. If you do not use 'estimated day of discharge' - why not?
4. What is your view of the top 3 factors that lead to DToC?
5. How often, and for what reasons, are there professional disagreements about the patient's needs?
6. How often, and for what reasons does the patient disagree with the professional assessment made?
7. How often, and for what reason, does the family disagree with the professional assessment made?
8. How well does the machinery work to resolve inter-professional disagreements?
9. How well does the machinery work that addresses professional and family disagreements?
10. Is it possible to measure the harm caused to patients by being delayed? How would you describe / estimate it?



*Mental Health Directorate*

1. How well does the machinery intended to assess patient needs for post hospital care work?
2. What are the main causes of disagreement about the patient's needs?
3. What are the main reasons why the barriers to discharge cannot be overcome?
4. Are there any problems with using Unified Assessment and other care planning approaches?
5. How would you assess the impact of DToCs in this field?

**Local Authority**

*Director of Social Services*

1. What proportion of DToC a) do you see the NHS family itself doing better with and b) what for what proportion does the NHS need your help?
2. For 1b) what more a) can you do and b) are you going to do?
3. What aspects of DToC do you report to the cabinet member for social services? How, and how frequently, is this done?
4. What aspects of DToC do you discuss, and agree action, with the cabinet member for social services? How often is this done?
5. What care settings other than DGH admission are intended to be available 24/7 to the assessment unit/ GPs to access? What settings are actually available? What alternative service is least available?
6. How do you determine your strategy for commissioning domiciliary care and long term residential care?
7. How would you describe the LA approach to shaping the provision of residential care<sup>1</sup>?

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<sup>1</sup> Here we are looking at the balance of in-house and privately provided capacity; how the LA decides what level of spending is needed to bring enough quality provision into the locality / prevent existing quality provision leaving the sector.

8. What does your planning process suggest should be your intended balance of care for your >75years population e.g. in terms of those:
  - *Living independently (and able to secure any help needed);*
  - *Living independently but with help from LA services;*
  - *Living in supported housing / extended care of some kind;*
  - *Living in a care setting similar to residential/nursing home setting;*
  - *Cared for in a NHS facility*
9. What would be the implication of pooled budgets?
10. What would be the implication of the costs of care falling to whoever is given the responsibility under the legislation – irrespective of where the client sits?
11. How does the LA financial strategy seek to meet the needs of people over 75 needing LA care? How does this relate to your statutory duties of partnership and providing care?
12. Describe the inputs that shape the budget setting process for adult social services.
13. Do you compare the costs of different blends of care for older people:
  - *within the LA;*
  - *with LHB and other partners;*
  - *Is your present blend that which you intend?*
14. Have you costed what it would take to reduce the level of DToC to match the best in Wales?

#### *Cabinet Member*

1. How is the budget for social services determined?
2. Within that budget, how do you decide what should be spent on children's services, adult services etc?
3. Does the LA have a political view about its responsibility towards DToC? If so, please describe.
4. Are you satisfied with the present level of DToC in your locality?
5. If not, what should the LA be doing to reduce those levels?
6. What should others be doing to reduce those levels?
7. What would be your view on pooled budgets for adult care?

8. What would be your view on allowing a professional assessment to determine patient need and then automatically requiring whoever is responsible under the law to meet and pay for that need?
9. Is the present balance of services for older people needing help about right e.g. independent living: support at home: supported housing: residential/nursing home care: hospital care. If not, how should it change?

*Hospital-based social worker involved in discharge planning*

1. When does the discharge planning process begin and who is involved?
2. What processes determine the time taken to complete an assessment?
3. Do you use the "estimated day of discharge" approach – if so, how helpful is it?
4. If you do not use 'estimated day of discharge', why not?
5. What is your view of the top 3 factors that lead to DToC?
6. How often, and for what reasons, are there professional disagreements about the patient's needs?
7. How often, and for what reasons does the patient disagree with the professional assessment made?
8. How often, and for what reason, does the family disagree with the professional assessment made?
9. How well does the machinery work to resolve inter-professional disagreements?
10. How well does the machinery work that addresses professional and family disagreements?
11. How do discharges from acute hospitals differ from those from mental health units?
12. Is it possible to measure the harm caused to patients by being delayed? How would you describe / estimate it?

*Social worker*

1. When are you usually requested to undertake the financial assessment?
2. Do you encounter any issues with regard to completing the service user's financial assessment?
3. How often do service users move to a care home that wasn't on their choice list?
4. How often do you encounter a service user transferring between care homes once discharged from hospital?
5. What reasons for transferring are given?
6. What issues do you perceive that the carer/patients have with respect to choosing a care home?
7. Do the social work team use the patient Unified Assessment document on the ward?
8. Are there any issues relating to information sharing across agencies that you have witnessed?
9. Do you encounter any issues whilst identifying /installing domiciliary care services for patients with complex packages of care in the community?
10. What processes are in place to ensure that the DToC codes are allocated?
11. Who decides which DToC code to apply to a patient?
12. How is this information processed through the organisation for reporting purposes?
13. What issues do you encounter when allocating and agreeing DToC codes?
14. Who manages the DToC information within the organisation?
15. Is there a register of unmet need with regard to discharge planning?

*Acute hospital either discharge nurse or staff nurse on the ward*

1. Once a patient has been admitted to a ward and immediate crisis over, what criteria are used to identify the appropriate care setting for the patient's subsequent care?
2. Who initiates the decision making regarding a move to a more appropriate care setting?
3. Who makes the final decision and what factors influence that decision?
4. When is the patient/ carer informed of the detail of the discharge process?
5. When is the patient/carer informed of the choice protocol in respect of care home provision?
6. Who discusses the discharge process and choice protocol with the patient / carer?
7. What written and verbal methods of communication are used regarding the patient discharge process in the ward setting?
8. Where and by whom is the unified assessment summary document initiated?
9. Which members of the Multi Disciplinary Team use the document?
10. What happens to the Unified Assessment document upon patient discharge from hospital?
11. Do you encounter any difficulties in ensuring the patient has a multidisciplinary/comprehensive assessment?
12. Who decides when a patient is to be discharged?
13. Does the decision lead to any disagreements between professionals?
14. Who generally undertakes the role of the care coordinator on the ward?
15. Are there any issues when determining who is the care coordinator?
16. When discharging a patient with complex needs, have you ever contacted the patient after discharge?
17. If you do so, what do you discuss? Do you ever identify any issues the patient may have post discharge?
18. What arrangements have been made to ensure that staff have the skills to undertake the role of the care coordinator?

19. How often are you aware of any conflict between patient and next of kin or carer when planning discharge?
20. What sort of issues do you encounter?
21. Who assesses whether a patient is eligible for NHS funded nursing care and continuing NHS Health Care?
22. Do you encounter any professional disagreements with regard to whether a patient has been refused NHS funded Nursing Care or continuing NHS health care?
23. What arrangements are there to ensure that staff have the skills to assess for NHS funded nursing care and continuing NHS Health Care?
24. Where do you get your information about what services are available for the patient upon discharge?
25. What services do you generally use when discharging a patient with moderate to complex needs?
26. What everyday factors delay the assessment process?
27. Do you encounter any border issues (England/Wales etc) when managing patient's discharge with complex needs?
28. Do you encounter any issues whilst identifying /installing domiciliary care services for patients with complex packages of care in the community?
29. What processes are in place to ensure that the DToC codes are allocated?
30. Who decides which DToC code to apply to a patient?
31. How is this information processed through the organisation for reporting purposes?
32. What issues do you encounter when allocating and agreeing DToC codes?
33. Who manages the DToC information within the organisation?
34. Is there a register of unmet need with regard to discharge planning?
35. How often do service users move to a care home that wasn't on their choice list?

## **APPENDIX 5**

### **BRIEF OUTLINE OF THE BALANCE OF CARE MODEL**

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The model presented describes the care services context within which delayed transfers of care occur.

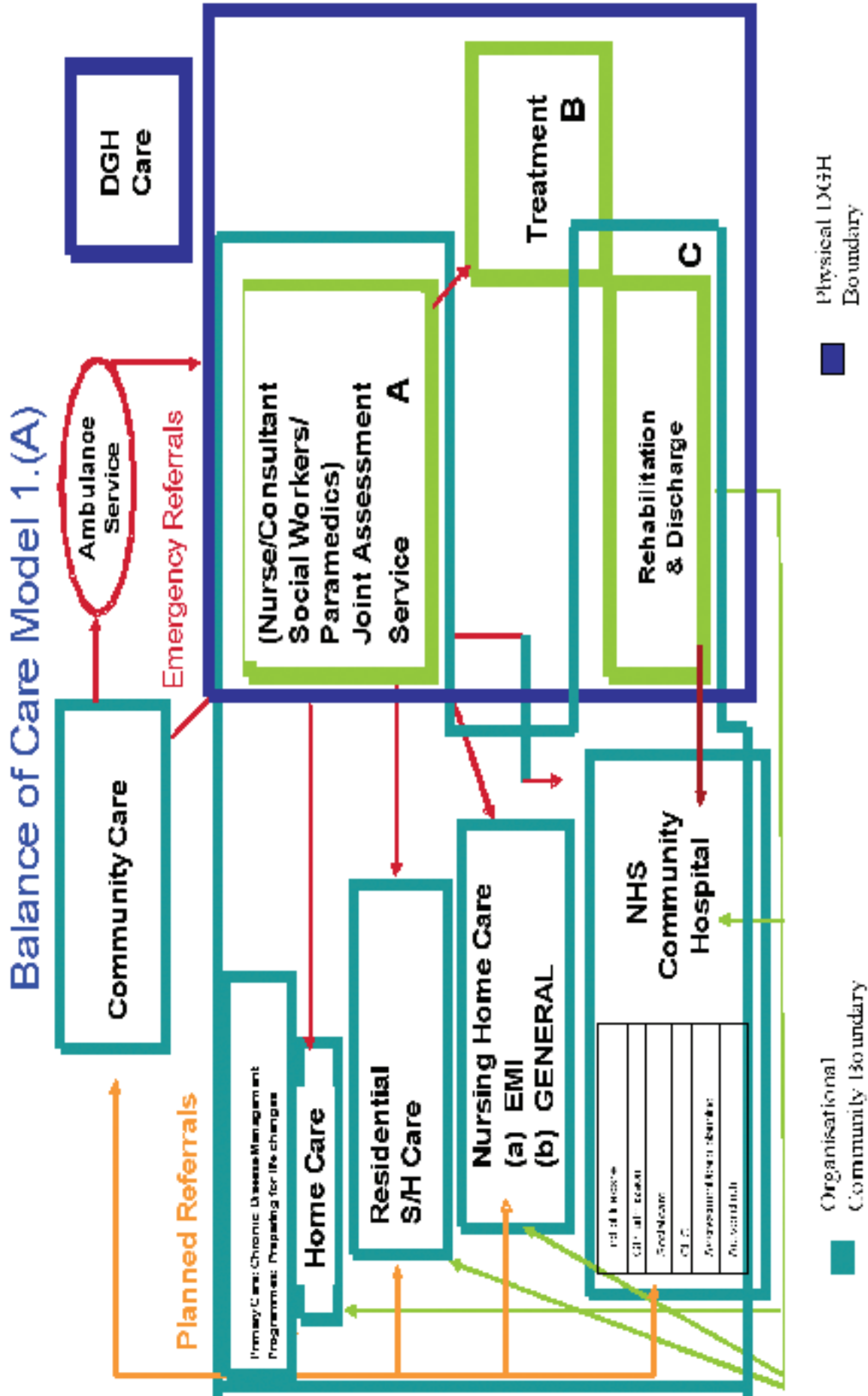
In model 1 (A) three green blocks are set within the dark blue boundary now seen as District general Hospital (DGH) care: block A is the joint assessment function typically carried out in medical assessment units, A & E departments or day units and indicates the skills that contribute to good assessment based on timely diagnostic services; block B relates to treatment services, typically admission to medical trauma or psychiatric wards where these are operated by DGHs; block C relates to post treatment processes of rehabilitation and discharge planning.

Within the light blue community care boundary are a number of key services that both prevent referrals to hospital and speed safe discharge where admission and treatment are indicated. Key services include those that support people needing help to live independently at home and those provided in community hospitals and nursing homes for people needed high levels of care.

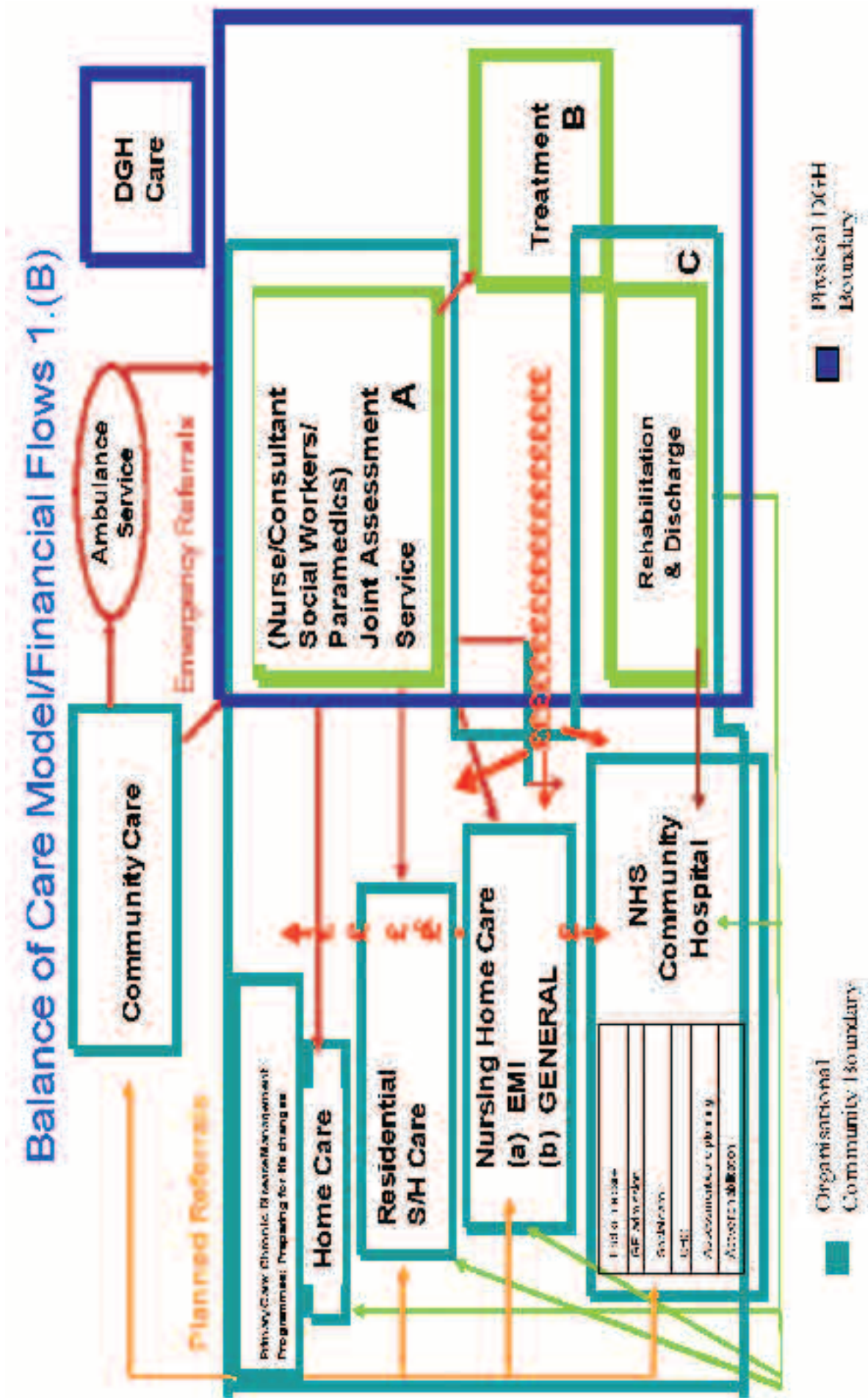
Community hospitals can offer a range of services and many are indicated in the model. The model assumes that the:

- three functions of DGH need specific governance arrangements and clinical and managerial support;
- assessment and rehabilitation functions should be seen as engaging more closely with primary and community care skills;
- assessment function can, as part of its role, deploy a range of community care services for patients referred to it whose assessed needs do not require admission to the full panoply of DGH treatment services.

Model 1(B) indicates the financial flows that are predicted if community care services are developed as set out in the model. DGH beds now used for discharge planning and rehabilitation could be reduced and resources moved to support these functions in community care settings. Resources currently directed towards residential care could be redeployed to support home based and nursing home/ community hospital care.







## APPENDIX 6

### TAKING A SYSTEMATIC APPROACH TO DToC - AN EVIDENCE BASED PROPOSAL FOR THE FRAIL ELDERLY

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#### A. INTRODUCTION

1. In her evidence to the WAG Health and Social Care Committee the NHS Director, Mrs Ann Lloyd, indicated a need for a systematic approach to solving the DToC problem. Elsewhere in this report it has been emphasised that DToC should be viewed a symptom, not a cause of the failure to provide high quality integrated care for the frail elderly. In this regard, there is general agreement of the need to develop home based services and to avoid unnecessary institutionalisation or prolonged stays in hospital.
2. What follows is the summary of an extensive piece of research carried out in Wales by WIHSC between 2001 and 2003. Funded by NHS Estates R & D, and later sponsored by them in policy formulation by the Department of Health on technology support at home for the elderly, the report of this research broke new ground by operationalising a 'substitution' model (involving technology, workforce and location), later to be recommended for use by the UK Health Foresight Panel.
3. Two terms which are now in relatively common usage were introduced in the research. The first is the recognition of the need to provide a 'balance of care'. The second is the use of 'bundles' of technologies, or care arrangements involving, critically, both soft (human resources) and the hard (equipment) technologies being brought together.

#### B. PROJECT SHIFT – A SUMMARY\*

4. Project SHIFT followed a number of lines of enquiry which, in total, enable some conclusions to be reached about: developing a new approach to home care, and the balancing of care more generally; and applying existing and yet to mature technologies to maintain frail older people at home.
5. Older people, then, are the major group to form the basis of this research. And, in substitution terms, technologies form the starting point. In respect of frail older people two general questions are posed:
  - (a) If currently existing home-based technologies were fully utilised (which they are not), to what extent would the demand for community hospital and various forms of other institutional care be reduced?
  - (b) If these technologies were in place, could the number of patients who currently return home from DGH care via community hospitals be reduced?

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\*Warner, M. et al. *Can Home Be Possible for the Frail Elderly? Substitution of Hospital and other Institutional - Focussed Technologies*. Pontypridd: NHS Estates/WIHSC, January 2003

6. Clinically qualified project personnel undertook an extensive review of the various areas of dysfunction that affect older people suffering from major disabling conditions (Disability Adjusted Life Year groups). These were: ischaemic heart disease; cerebrovascular disease; trachea, bronchus and lung cancers; unipolar major disorders; and dementia and other degenerative and hereditary CNS disorders. The dysfunctions were grouped under four major headings of deficit: functional, knowledge, communication, and environmental communication.
7. Through a National Expert Panel technology possibilities were identified that might be employed to reduce the deficits, and which could be applied in home settings. Three bundles of technology were identified: the first is applicable to all older people; the second to all six DALY item sufferers; and the third to specific DALY items. These were later refined into minimum rather than maximum sized bundles (to represent the reality of public policy approaches to spending), and the items defined more specifically to enable costing (see Section 4).
8. Function and form have been brought together in a piece of empirical research to answer the questions set in 2.2. This took place in the Powys Health Care NHS Trust. Here, acute and specialist services are mainly obtained outside the county boundaries. The Trust estate does, however, contain 10 community hospitals.
9. The most readily identifiable older people for whom the introduction of the technology bundles hypothetically might have made a difference were:  
  
*Cohort 1* – those at home, but on waiting lists for residential or nursing home care, and individuals recently admitted to either type of care;  
  
*Cohort 2* – patients recently discharged from a DGH to a community hospital.  
  
In total this provided 266 individuals to become the study population, with 127 and 139 in the respective groups.
10. For all patients dysfunction was assessed from existing social service or community hospital records, and algorithms applied to determine if benefit could be obtained from the bundles. If it could, home based care was determined to be a real option over institutional care. Comparative costings are calculated for the different settings.

## C. THE TECHNOLOGIES

11. Bundle 1 (Table 1) is aimed at healthy older people who, by definition, are able to live at home. The focus is on soft technologies - human resources - and, in the main, does not involve hard home-based technologies.

**Table 1: Bundle 1: Actions and technologies for healthy older people**

Actions	Bundle 1
1. Comprehensive General Assessment <ul style="list-style-type: none"> <li>- general health promotion plus specific initiatives as required to:</li> <li>- increase exercise</li> <li>- increase up-take of flu vaccine</li> <li>- reduce smoking</li> <li>- increase use of osteoporosis drugs</li> <li>- reduce alcohol intake</li> <li>- increase weight and diet awareness</li> <li>- deal with bereavement</li> </ul> 2. Reduce social isolation 3. Reduce risk of hypothermia	1. Multidisciplinary team working alongside the GP comprising occupational therapist, dietician, physiotherapist, nurse, optician (0.2), community dentist (0.1) 2. Bereavement counselling 3. Social interaction initiatives such as: <ul style="list-style-type: none"> <li>- Elderly People Clubs</li> <li>- Age Concern Initiatives</li> </ul> 4. Home computers with Internet link 5. Financial assistance with home heating

12. All individuals would receive a Comprehensive Geriatric Assessment (CGA) in a GP surgery from a multidisciplinary professional team as shown in Table 2. Given most older people consult their GP at least once per year (Rowlands and Moser 2002), opportunistic assessment will reach most older people regularly.

**Table 2: Composition and Costs of Comprehensive Assessment Teams**

Health Professional	% WTE	Gross Employment Cost
<b>Bundle 1</b>		
Nurse (G grade)	100	31,602
Occupational therapist	100	22,050
Physiotherapist	100	22,050
Dietician	100	22,050
Orthoptist	20	4,410
Community dentist	10	4,267
<b>Add for Bundle 2</b>		
Geriatrician (Specialist Registrar)	100	34,605
Chiropodist	50	8,888
Social worker	50	15,332
Technician	100	16,800
<b>Add for Bundle 3</b>		
Psychiatric nurse (G grade)	100	31,062
Oncology nurse (G grade)	100	31,062
Mental handicap nurse (G grade)	100	31,062
Speech therapist	100	22,050
<b>Other costs include</b>		
- <b>Bundle 1 overheads (£2,007)</b>		
- <b>Bundles 2/3 travel (£400) per team</b>		

13. Beyond this, each individual would receive other components of Bundle 1 according to need. General health promotion and other specific initiatives would be provided by the assessment team. For those facing social isolation, the bundle also provides: increased access to social clubs where the focus is on activities to engage older people in society; and/or internet-linked home computers for socialising in virtual neighbourhoods, gaining access to information and performing activities such as shopping or banking. Both would be useful to retain cognitive ability. Although computer use may currently appeal to only a limited number of older people, it is anticipated to become increasingly commonplace. Finally, Bundle 1 could provide bereavement counselling, and financial assistance with home heating.

**Table 3: Bundle 2: Actions and bundle technology needed for frail older people across all conditions**

Actions	Minimal Bundle 2
<ul style="list-style-type: none"> <li>• Enhanced comprehensive geriatric assessment</li> <li>• Care plan, including follow-up</li> <li>• Rehabilitation</li>   <li>• Define follow-up strategies</li>   <li>• Home hazard assessment</li> <li>• Installation of assistive devices</li> </ul>	<ul style="list-style-type: none"> <li>• Expanded multidisciplinary team of technicians, geriatrician, podiatrist, social worker</li> <li>• Carer training</li> <li>• Assistive devices to match patient’s needs in the areas of mobility aids; home environment; informal personal care/household/finance; care home technologies (mainly passive systems)</li> <li>• Exercise, immunisations, dietary intervention, secondary prevention</li> </ul>

14. Bundle 2 is designed for all the frail elderly within the study as a general service response to their dysfunctions, and is set out in Table 3. It involves an extended multi-disciplinary team (see Table 2); and CGA now takes place in the home and involves re-assessment, rehabilitation and follow-up as well as scanning of the home environment. Individuals are provided with whatever additional home-based soft and hard technologies they need - examples are shown in Table 4. Included are unobtrusive technologies which maintain passive monitoring; but their use will vary with the level of informal support available from family and friends beyond that available through state provision.

**Table 4: Bundle 2: Examples of technologies from which assessment team can choose**

<b>Home environment and devices</b>	<b>Unit Costs (range)</b>
Additional heating	£285 (£96 - £3274)
Concrete ramp	£428 (£44 - £1834)
Electrical modifications	£291 (£38 - £2531)
Entry phone	£238 (£142 - £2024)
Grab rail	£62 (£2 - £280)
Individual alarm system	£252 (£140 -£635)
Low level bath	£352 (238-£967)
Relocation of bath or shower	£702 (£120 -£7081)
Community alarm	£96 (£33 - £159)
Sticks, crutches, walking frames	£15 (£9 -£205)
Wheelchairs (self or attendant propelled)	£225
Wheelchairs (active user)	£562 (£166-£883)
Self test kits (blood pressure monitor)	£65 - £82
Self test kits (cholesterol)	£11 - £13
Drugs dispenser/Advanced drug delivery	£166 - £666
<b>Professional and non-professional services</b>	
Informal carer	£14/hour
Laundry service	£14/hour
Finance assistance	£23/hour
Gardening	£14/hour
Meals on wheels	£2.45/meal
Respite care in the home	£12/hour
Community nurse	£21/hour
GP home visits	£59/home visit
Chiropodist	£19/hour
Physiotherapist	£21/hour
Occupational therapist	£21/hour
Counselling	£28/hour
Hospital at home	£2515
Community memory teams	£261
<b>Care Home Devices</b>	
Personal emergency response system	£152 - 215
Wireless home security system	£184 - 380
Motion detector alarm	£68 -70
Patient monitoring system	£183 - 2000
Motorised water valve	£71
Video phones/webcams	£16 - 316
Medication compliance system	£3 - 570
Home automation – timer/heating control	£12 – 439
Occupancy sensor	£26 - £40
Door/window sensor	£21 - 30

15. Bundle 3 technologies refer to groupings of items specific to each of the six conditions. The broad description of this bundle is shown in Table 5; and the list of condition specific additional home-based technologies from which to choose are shown in Table 6.

**Table 5: Bundle 3: Actions and bundles of technology needed for frail older people for specific conditions**

Actions	Minimal Bundle 3
<ul style="list-style-type: none"> <li>• Improve effectiveness of informal carer</li> <li>• Aggressive blood pressure assessment</li> <li>• Patient education programmes</li> <li>• Patient rehabilitation</li> <li>• Aggressive blood pressure management</li> <li>• Cognitive behaviour therapy</li> <li>• Palliative care</li> </ul>	<ul style="list-style-type: none"> <li>• To bundle two team add psychiatric nurse, speech therapist, oncology nurse, mental health nurse</li> <li>• Specific carer training</li> <li>• Enhanced respite care in nursing home setting</li> <li>• Specialist community palliative care team</li> <li>• Specific smart home technologies (mainly active systems)</li> </ul>

**Table 6: Bundle 3: Examples of technologies from which assessment team can choose**

Technologies		
Graduated floor shower	£1589 (£857-£4468)	A,B,C,F
Hoist	£3000 (£620-£5390)	A,B,C,F
New bath/shower room	£5157 (£2538-£22845)	E
Complex redesigned kitchen	£1906 (£465-£4442)	B,E,F
Stair lift	£1732 (£1523-£4882)	A.B.C.F
Biofeedback systems	£2887 (£1109 - £4666)	A,B,C,F
Wheelchair (powered)	£1123 (£938-£1656)	A,B,C,F
Telemedicine	£3956	A,B,C,D
Scooters	£1395 - £3332	A,B,C,F
McMillan nurse	£21/hr	C
Community palliative care team	££619/year	C
Speech therapy	£21/hr	B,C,E
Smart home technologies		
Automatic self-locking door operating system	£301-£366	D,E
Locator watch	£253	D,E
Smart cane/Smart walker	£3163	F
Remote video monitoring	£1046 - £2699	B,D,E

(\*) A = Ischemic Heart Disease, B = Cerebrovascular Disease, C= Cancer - Lung, trachea, bronchus, D = Unipolar Disorders, E = Dementia, F = Osteoarthritis

## D. RESULTS

### *Relocation of Care Provision*

16. Table 7 provides the summary.

**Table 7: Ability to stay at home with technology bundles available, with and without existing informal carer**

		Care at home with Bundle 2 only	Care at home with Bundle 3 in addition	Institutional care required	Total
Cohort 1 (awaiting or very recently admitted to institutional care)	Carer exists	54	39	6	99
	Carer does not exist	15	12	1	28
	Total	69	51	7	127
Cohort 2 (discharged from DGH to Community hospital)	Carer exists	41	16	24	81
	Carer does not exist	54	2	2	58
	Total	95	18	26	139

17. For Cohort 1, totalling 127 people, 69 (54%) could be cared for at home if Bundle 2 were to be available, and a further 51 (40%) if Bundle 3 were provided in addition. The majority (93 or 73%) have an informal carer at their home or nearby.
18. For Cohort 2, totalling 139 people, 95 (68%) could be cared for at home if Bundle 2 were available, and a further 18 (13%) if Bundle 3 were provided in addition. That the first figure is correspondingly higher than that for Cohort 1 is not surprising: this group is younger on average.
19. However, for Cohort 2 there is a considerably higher representation in the 70-84 year old age group than for Cohort 1 (59% v 34%) and this is reversed for the 85+ group (33% v 61%). This indicates a greater propensity to provide treatment earlier on in life, even though ultimately dysfunction would dictate that many more will still not be able to remain at home (18.7% for Cohort 2 v 55% for Cohort 1), even though there is a similar level of carer availability (92% v 83%).
20. Overall, the figures are interesting and also in some ways surprising. In total, only 33 of 266 people would require institutional care (although more may choose it of course). The presence of a carer is critical, one reason for including them in the Bundles in various guises. For Cohort 1 the issue may be the involvement of carer support, but for Cohort 2 it is the provision per se.
21. Expediency, as well as organisational failure, may account for the comparatively large number in Cohort 2 that could be at home just with the availability of Bundle 2. But without good discharge planning and organisation by health centres and GPs, and good co-ordination with social services to ensure carer services are available at the right moment, little else can change the current picture.



*Cost of Provision – Cohort 1*

22. Given the provision of Bundle 2 technologies would allow 69 of the 127 in Cohort 1 (54%) to remain at home; and the assumption that the alternative for 1/3 of these would be a low dependency residential home, for 1/3 a high dependency residential home and for 1/3 a nursing home, then the saving from avoided residential/nursing home care is  $(23 \times \text{£}14,040) + (23 \times \text{£}14,820) + (23 \times \text{£}19,292) = \text{£}1,108,416$  per year.
23. With the provision of Bundle 3 technologies for the 58 people who still required a move to institutional care despite Bundle 2 being available, a further 51 (40% of the initial sample) were shown to now to be capable of remaining at home. On the assumption that in the absence of Bundle 3, 1/3 of these would go to a low dependency residential home, 1/3 to high dependency and 1/3 to a nursing home then the saving from avoided residential/nursing home care is  $(17 \times \text{£}14,040) + (17 \times \text{£}14,820) + (17 \times \text{£}19,292) = \text{£}818,548$ .
24. If these 51 share lower dependency characteristics, then the cost of providing them with Bundle 3 technologies will be £508,572 in first year and £297,738 in each subsequent year, assuming no deterioration in their functioning. If they share high dependency characteristics then the cost of providing them with Bundle 3 technologies will be £1,982,931 in the first year and £1,423,818 in each subsequent year - again assuming no deterioration in functioning.
25. The comparative costs of care provision, employing the technology bundles at home versus institutional care are given in Tables 8 and 9.

**Table 8: Costs / 1000 older people / year (initial year): Home v Residential and Nursing Home Care**

		LOW (£)	MID (£)	HIGH (£)
NO BUNDLE	1000 MOVE	14,040,000	14,820,000	19,292,000
BUNDLE 2	543 HOME	2,110,641	5,404,479	8,697,774
	457 MOVE	6,416,280	6,772,740	8,816,444
	TOTAL 1000	8,526,921	12,177,219	17,514,218
BUNDLE 3	543 HOME (BUNDLE 2)	2,110,641	5,404,479	8,697,774
	402 HOME (BUNDLE 3)	4,008,744	9,819,654	15,630,162
	55 MOVE	772,200	815,100	1,061,060
	TOTAL 1000	6,891,585	16,039,233	25,388,996

**Table 9: Costs / 1000 older people / year (subsequent years): Home v Residential and Nursing Home Care**

		LOW (£)	MID (£)	HIGH (£)
NO BUNDLE	1000 MOVE	14,040,000	14,820,000	19,292,000
BUNDLE 2	543 HOME	992,604	4,578,033	4,578,033
	457 MOVE	6,416,280	6,772,740	8,816,444
	TOTAL 1000	7,408,884	11,350,773	16,979,363
BUNDLE 3	543 HOME (BUNDLE 2)	992,604	4,578,033	8,165,091
	402 HOME (BUNDLE 3)	2,346,876	6,784,554	11,223,036
	55 MOVE	772,200	815,100	1,061,060
	TOTAL 1000	4,111,680	12,177,687	20,447,015

26. In each case the institution costs used are based on Powys rates. For home costs, the low and high estimates are for the lowest and highest cost examples of Bundles 2 and 3. It should be stressed that these are just illustrations; and in particular the high cost should not be interpreted as an absolute 'maximum'. These could only be imposed by the relevant public body.

#### *Costs of Provision – Cohort 2*

27. The Powys cohort was made up of 139 people for whom a stay in a community hospital was required between discharge from a DGH and return to their own home. The algorithms were applied to determine how many of these could go directly home with provision of Bundle 2 (95 individuals = 68% of sample) and how many of the remainder could go directly home with provision of Bundle 3 (18 individuals = an additional 40% of those who would not go directly home with Bundle 2). The 36 remaining (19%) would require a stay in a community hospital regardless of bundle provision.
28. The algorithms show that provision of Bundle 2 could avoid 95 admissions (1596 days) which, on the basis of a cost per patient day of £231, would save £368,676. Provision of Bundle 3 avoids a further 18 admissions (302 days) or £69,762. Provision of both bundles thus has the potential to free 1898 days valued at £438,438.
29. Table 10, below, shows the economic implications of a cohort of 1000 older people being discharged from a DGH who, without the provision of Bundles 2 or 3, would require a stay in a community hospital before being permitted to return to their own homes. The proportions affected are based on those in the above exercise with the cohort of 139 older people in Powys.

30. The mid-cost estimate for a stay in community hospital is based on the average length of stay in Powys of older people admitted there directly from a DGH (ALOS 16.8 days) during the sample period described above. The low cost estimates which are used in Table 10 assume 50% shorter and 50% longer lengths of stay respectively.

**Table 10: Costs / 1000 older people / year: Community Hospital v Direct Return to Home following stay in District General Hospital**

		LOW (£)	MID (£)	HIGH (£)
NO BUNDLE	1000 to community hospital	1,940,000	3,880,000	5,820,000
BUNDLE 2	683 directly home	2,654,821	6,797,899	10,940,294
	317 to community hospital	614,980	1,229,960	1,844,940
	Total = 1000	3,269,801	8,027,859	12,785,234
BUNDLE 3	683 directly home (bundle 2)	2,654,821	6,797,899	10,940,294
	130 directly home (bundle 3)	1,296,360	3,175,510	5,054,530
	187 to community hospital	362,780	725,560	1,088,340
	Total = 1000	4,313,961	10,698,969	17,083,164

31. The figures in Table 10 need to be treated cautiously, and it would be misleading to interpret them in the same way as the data in Tables 8 and 9 above. In those earlier cases the cost of a long term commitment to providing care in the home was set against saving from a long term stay in residential care. For Table 10, however, the cost of a long term commitment to provide care in the home is set against the saving from a short spell in a community hospital - the cost of the bundle can include the cost of major home improvements and the installation of various hard technologies in the home while the only specified saving is from the avoidance of 2 or 3 weeks in a community hospital. Clearly, the cost of the bundle will be significantly more than the resulting savings and this is reflected in the figures. Avoidance of community hospital costs would make a difference if the early discharge programme was applied not only to the DGH. If this was the case the NHS would be expected to transfer some of their savings to social services.

## **E. THE REQUIREMENTS IF THE LEVELS OF HOME CARE ARE TO BE SUCCESSFULLY INCREASED**

32. The research concludes that for the potentially large increase in the number of frail older people who might be looked after at home:
- (a) High uptake of the developing unified assessment (called single assessment in England) is of major importance; but more so is the interpretation of the data in an objective way, and one which is linked to supply side possibilities (ie the range of technologies). This will also unify the training requirements across different professionals;
  - (b) To match need on a timely basis supply logistics must be scrutinised as to their current state, which is generally poor and serendipitous, and a well-ordered 'just in time' systems developed. An information infrastructure will be required;
  - (c) Equipment maintenance must be undertaken in such a way as to diminish down time;
  - (d) The provision of a capital thrust fund will be essential\*, and so, too, will extra monies be needed for start-up costs. The NHS should enter into a partnership with local authorities and the voluntary sector to manage the processes;
  - (e) Flexibilities in provision will be required to accommodate the constantly changing physical and mental state of frail elderly people;
  - (f) Carer training and support is essential if maximum advantage is to accrue from a new and increased provision of home based technologies;
  - (g) Local authorities will need to reconsider housing and community regeneration policies and programmes to include smart home adaptations of vacant properties;
  - (h) GP practices and community health centres will need to develop services for frail older people at home more proactively, monitoring changes in function that might require new service provision and technologies.
33. The complexity of these requirements, and the need for responses to be orchestrated at both local and national level will be clear. But only if this occurs will the potential to impact on DToC, both through better support and preventive activities, and home-based rehabilitation, be realised. The approaches that can be proposed as a result of the SHIFT work should have a positive impact on both acute hospital demand management and early discharge.

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\* A £7.5m fund is now in place, but is heavily oriented towards equipment, and emphasises insufficiently the 'soft' technologies associated with care staff.

## **APPENDIX 7**

### **THE ROLE OF THE DISCHARGE LIAISON NURSE OR DISCHARGE 'EXPERT'**

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The responsibilities of the discharge 'expert':

- Provide advice and guidance regarding complex Level 3 discharge cases.
- To lead the coordination of the multidisciplinary team regarding discharge issues of complex cases.
- To confirm the identification of Level 1, Level 2 & Level 3 discharges within the All Wales discharge pathway within the allotted timescales.
- To confirm the estimated date of discharge of Level 3 patients.
- To empower the ward sister to confirm the estimated date of discharge of Level 1 & Level 2 discharge cases.
- To supervise the identification and assessment of patients who may be eligible for NHS Funded Nursing care and continuing health care.
- To liaise with Local Health Boards in order to secure appropriate funding for patients being transferred to Care homes with nursing or who may require continuing care at home.
- To participate in the planning and delivery of training/education sessions regarding discharge and continuing care, for the multidisciplinary team including voluntary organisations and social work members.
- To empower staff to plan discharges at Level 1 & Level 2 effectively.
- To promote interagency and inter-professional working.
- To monitor discharge patterns and complaints through the All Wales Discharge Pathway.
- To participate in Welsh Assembly government discharge planning initiatives.
- To lead the multidisciplinary team in the decision as to whether and when a patient becomes a DToC.
- To collect and monitor DToC statistics as required by Welsh Assembly Government within its most recent published guidance.
- To undertake audit and feedback to the Trust via local reporting arrangements.
- To receive referrals from the multidisciplinary team for patients who require expert discharge planning skills i.e. those defined as level 3 complex case management such as continuing health care and NHS funded nursing care.
- To ensure that discharge processes are immediately explained and transparent to relatives or carer of patients who have been identified as Level 3 discharge case. Ensuring that they understand their role in the discharge process.
- In partnership with the ward sister ensure that all Level 3 documentation is accurate and effectively processed.
- To participate in appropriate research projects.

## APPENDIX 8

### A COMPARISON OF THE RECOMMENDATIONS OF THE WIHSC REVIEW AND THE WALES AUDIT OFFICE REPORT ON DToC

This table lists the issues and related recommendation numbers in the Review and relates those to the work done by the Wales Audit office in their 2007 report.

<b>WIHSC Review</b>		<b>Related Wales Audit Office Recommendation No.</b>
<b>Issue</b>	<b>Recommendation No</b>	
Designing the balance of care	1	9
Reducing delayed transfers from Community Hospitals	2	9
	3	11
	4	10
	5	9
Deflecting unnecessary acute hospital admissions	6	16
	7	16
	8	9
Improving partnership working to achieve integrated care	9	21
	10	23
	11	23
	12	22
	13	22
	14	15
	15	20
	16	18
	17	14
	18	9
Financing the rebalancing of patient care	19	11
	20	11
	21	11
Shared ICT to support shared care	22	17
Financial responsibility for long term care	23	15
	24	17
	25	No specific match
National co-ordination	26	No specific match
Performance management	27	23
	28	No specific match
	29	23
	30	23
Pooling and alignment of budgets	31	19
Apportionment of costs	32	No specific match
Personal planning	33	No specific match

## Independent Review of Delayed Transfers of Care in Wales

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Patient assessment	34	17
	35	17
	36	17
Choice	37	15
	38	15
Patient advocacy	39	13
Impact on patients	40	No specific match
Data	41	5
	42	6
	43	5
	44	5
Improving efficiency	45	No specific match
	46	7

Note – The above table illustrates the close working relationship developed during the preparation of this Review and the convergent nature of the WIHSC Review and the Wales Audit Office Report. Where recommendations are shown to relate it does not infer that they are in fact the same. Instead it indicates that both organisations made a recommendation which covers the same issue.

## **APPENDIX 9**

# **INDEPENDENT REVIEW OF DELAYED TRANSFERS OF CARE IN WALES**

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### **Participant Information Sheet**

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish.

This information sheet is intended to provide you with the answers to some questions you might have about the study. If there is anything that is not clear, or you would like more information, please ask.

#### **What is the purpose of the study?**

Delayed transfers of care are a significant problem. For patients, they often mean sub-optimal care; for the NHS, Social Services and others, they constitute an inefficient use of resources. The causes of such delays are often complex, resulting from a variety of different factors affecting several parts of the 'care system'. The aim of this study is to explore, in a variety of locations across Wales, and in an international context

- Best practice in preventing delayed transfers
- How structures, capacity and performance can best be aligned to reduce delayed transfers
- How partnership arrangements can work most effectively
- How data systems can best support the above.

#### **Why have I been chosen?**

You have been chosen as someone with significant and relevant expertise in one or more of the above areas.

#### **Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

#### **What will happen if I take part?**

If you decide to take part, you will be interviewed by the researchers in an interview of about one and a half hours. It will take place at your normal place of work. You will be free to leave at any time, without needing to give a reason. The interview will be tape recorded (with your permission) so that the researcher will have an accurate record of what is said. The consent form asks you to give specific permission for this. Both the transcripts and the tapes will be anonymised, and kept securely locked away. No-one, apart from the researchers, will know what you have said. However, we might wish to publish direct quotes from you and others; if we do so they will be completely anonymised. The consent form asks for your separate consent to this as well.



**What are the possible benefits of taking part?**

There are unlikely to be any personal benefits for you, beyond the satisfaction of knowing that you will have contributed to the study.

**What are the possible disadvantages and risks of taking part?**

We do not foresee that any disadvantages or risks will follow from taking part in the study. If at any time you would like to make a complaint, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, you should contact Professor Marcus Longley, contact details are provided below.

**Will my taking part in the study be kept confidential?**

All information which is collected about you during the course of the research will be kept strictly confidential. Your name will not be published in any documents or publications written as a result of this research. Tapes will be destroyed after transcription, and transcripts and consent forms will be kept securely and then destroyed five years after the research, in keeping with recommended research guidelines.

**What will happen to the results of this study?**

The findings of this study will be written up and submitted to the Welsh Assembly Government. The report will be in the public domain.

**Who is funding the research?**

This research is funded by a grant from the Welsh Assembly Government.

**Who has reviewed this study?**

This study has been reviewed and approved by the University of Glamorgan Faculty of Health, Sports and Science Ethics committee and the appropriate NHS Research Ethics Committee.

**What now?**

You may keep this information sheet. If you decide to take part in this study, you need to sign the consent form.

Thank you very much for taking the time and trouble to read this information sheet. We hope that you will be able to participate in this study.

If you have any questions or require any further information about this study, you can contact **Professor Marcus Longley, Welsh Institute of Health and Social Care, School of Care Sciences, University of Glamorgan, Pontypridd, CF37 1DL**. Tel: **01443-483070**. E-mail: **mlongley@glam.ac.uk**

## Consent Form

Please initial box

I confirm that I have read and understood the information sheet for this study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.

I agree to take part in the above study.

I agree to the audio-recording of the interview in which I participate.

I agree to the publication of my anonymised quotes

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### Participant

Signature .....

Date.....

Name (BLOCK LETTERS).....

Address.....

.....

.....

Telephone.....

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### Researcher

Signature .....

Date.....

Name (BLOCK LETTERS).....

Address.....

.....

.....

Telephone.....

---

Participant Identifier Number:



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