

**ssia**

Social Services Improvement Agency  
Asiantaeth Gwella'r Gwasanaethau Cymdeithasol



Llywodraeth Cymru  
Welsh Government

# **DELAYED TRANSFERS OF CARE: INFORMAL REVIEW TO IDENTIFY GOOD PRACTICE**

September 2016

## Right care, right place, right time

*Independent Review of Delayed Transfers of Care in Wales  
February 2008*

Good flow across the system is key to creating and maintaining capacity.

If improving flow is to be assured on a sustainable basis a three stranded approach is needed:

- i. A preventative approach which identifies those at risk of being admitted to hospital and seeks to intervene to avoid this where it is appropriate to do so;
- ii. A proactive approach which identifies and manages those at risk of becoming delayed when in hospital;
- iii. Effective systems and processes to identify and manage those who experience a delay in their discharge or transfer to a more appropriate setting.

*Community Hospital Interface Group Report on  
Delayed Transfers of Care, 2013*

# Contents

1.	Executive Summary.....	4
2.	Introduction and Purpose.....	7
3.	Methodology.....	8
4.	The Evidence Base.....	8
5.	Findings.....	10
	Capacity.....	10
	Consistency.....	15
	Communication.....	19
	Culture.....	22
6.	Summary and Next Steps.....	24

# 1. Executive Summary

The content of this report is based upon conversations with operational staff from NHS and local authorities in Wales, as well as key documents provided both prior and during the discussions carried out in 2015.

In addition to national policy documents, there has been significant analysis of flow related problems, and delayed transfers of care specifically, over the past few years. There has been a range of guidance and good local practice in place for some time but the purpose of this report is to provide further insight in relation to additional areas that could be explored more widely across Wales. The findings have been grouped into four main themes:

- Capacity.
- Consistency.
- Communication.
- Culture.

Capacity was identified as the major factor impacting upon effective flow and contributing to delayed transfers of care. From an NHS perspective there has been a conscious move towards rebalancing provision towards primary and community led healthcare service. The move towards a more community driven NHS response has led to significant investments in community services, including the establishment of Community Resource Teams (CRTs). Local authorities have in partnership with Health Boards, developed the CRTs and have also provided a shared approach to Reablement, in addition to the longer term domiciliary care provision.

In relation to consistency, all Health Boards and partners described models in place linked to frailty and CRTs. These were universal and the services have been funded mainly through a limited reallocation of resources into the community and also by the use of the Intermediate Care Fund (ICF). Whilst the models were viewed positively, the reviewers did not find anywhere that has yet managed to put a system in place that operates 24/7. There is therefore currently an inconsistent response to frailty and Reablement/admission avoidance, dependant on the time of day, and day of the week, a person presents.

There were generally good working relationships between primary/community and social care services and an increased focus on partnership working. There is however more to do to improve the awareness of hospital based staff of the models of care and support in the community and how these resources are being utilised.

Despite the increasing drive towards integration, it is clear that in some areas both Health Boards and local authorities continue to operate their own systems, with few examples of truly integrated systems of working. Different drivers, targets and employment rights were recognised to pose challenges, and in those areas where it works it was felt this was down to local 'champions'. Despite the strategic intent to promote integration, there was concern that the only current joint performance measure is in relation to delayed transfers of care (DTC)

The Intermediate Care Fund has been developed to drive partnership working. The establishment of the statutory Regional Partnership Boards required under Part 9 of the Social Services and Well-being (Wales) act will have a key role to play in ensuring effective partnership working to meet the needs of people across Wales. Whilst the focus of this report has been in relation to health boards and local authorities, clearly the independent and third sectors have an important contribution to make.

The report also highlights a number of areas for consideration by Welsh Government/at a national level, these include:

- Setting out the expectation that health boards and partners will take forward the recommendations and actions from this and earlier reports.
- Ensuring there is a focus by health boards and partners on improvement as well as performance.
- Setting out the expectation that there should be a national forum (such as the previous national discharge forum/community of practice) for the identification and sharing of good practice to drive sustainable improvement, as well as national learning events (for example to look at discharge to assess models in Wales and rest of UK).
- Exploring the potential for a secure system for health and social care staff to share information (this could be delivered via the Welsh Community Care Information System (WCCIS) programme).

There was also reference to ensuring there is a strategic oversight group with specific responsibility for DToC, it has been agreed this will be the Unscheduled Care Programme Board.

The expectation is that the existing guidance and good practice will be implemented. Focus must continue to be given to care in the community, admission avoidance, early discharge, working with GP clusters, maximising resources and using people's skills effectively. Essentially, delivering services to the people of Wales in a timely way and in the right place – often as close to home as possible.

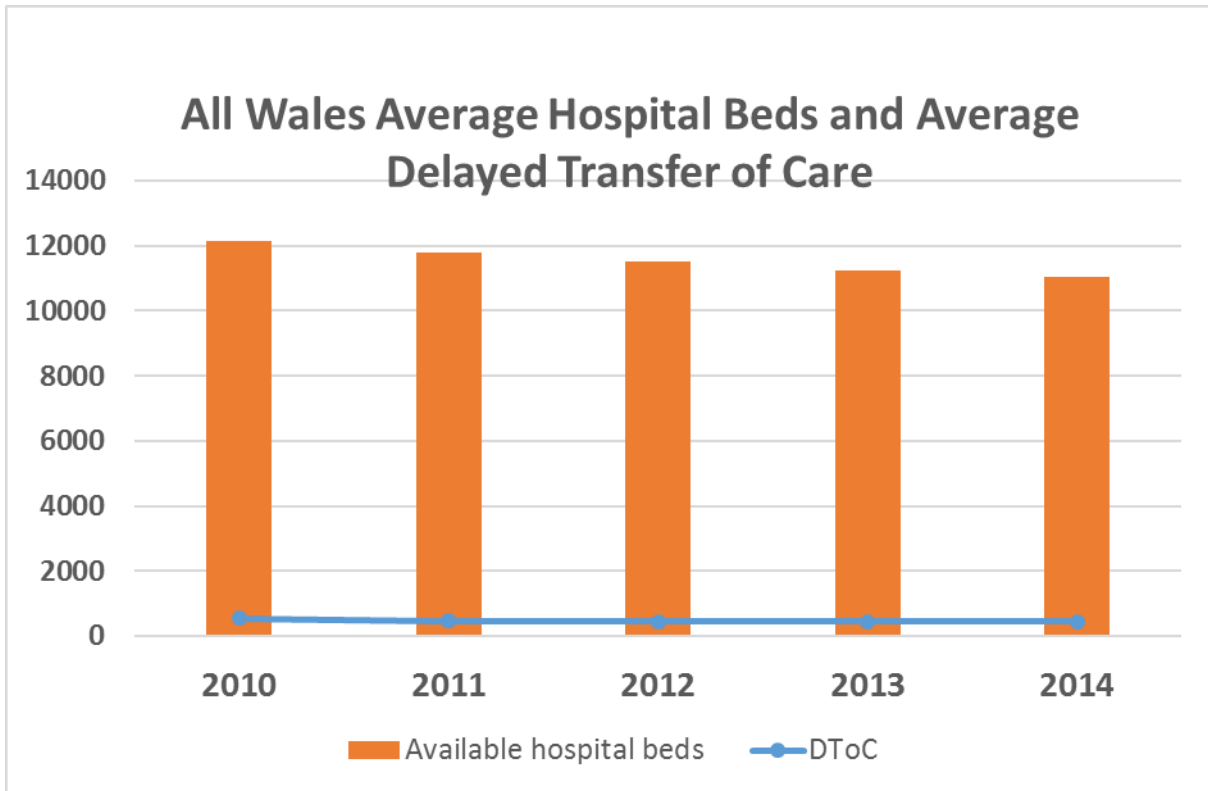
It is particularly important to ensure the best possible outcomes for individuals and their family/carer(s) in ensuring they are not in hospital longer than they need to be. Partnership working is essential to improve services, care and support for people and updates will need to be provided to Welsh Government, so Ministers can be briefed on progress.

It is important to note as outlined in the following chart, even with the average number of hospital beds decreasing over the years the number of DToC has fallen showing clear signs of the positive work that is taking place across Wales to address this challenge.

<sup>1</sup>

---

<sup>1</sup> Source Stats Wales - <https://statswales.gov.wales/Catalogue>



## **2. Introduction and Purpose**

The purpose of this report is not to replicate the analysis or recommendations identified in previous report, such as the Community and Health Interface (CHI) report. Instead, it seeks to provide an additional perspective on that work, one which reflects the views and opinions of health and social care practitioners who work with individuals at risk of losing independence and becoming increasingly dependent on a daily basis. Whilst reference will be made to a number of contemporary reports and programmes of work, the focus will be on services, schemes and models which have been shown to work, and how these can be further explored and disseminated.

This report has been designed to enable easy access to a summary of the work underway across Wales. Some of this work is applicable to all parts of Wales, other aspects may be of more local value in making service models more effective and efficient.

The reviewers would like to note the positive, open and welcoming approach that both health boards and local authorities have taken to this work. All partners have recognised the impacts of delays - both on a personal level for those delayed (often with poorer outcomes) and also the wider flow impacts for those people requiring care in an acute setting who experience delays in reaching the most appropriate setting – and have developed local plans to try to address these. A number of issues remain challenging to resolve and could benefit from nationally co-ordinated actions to support improved flow and better outcomes for those most frail and at risk of losing what can be quite fragile independent living.

## **3. Methodology**

In the summer of 2015, the Director of Social Services and Integration in Welsh Government wrote to all local authorities and health boards in Wales, recognising the significant work and improvement in the reduction in Delayed Transfers of Care (DToC) over the last decade, and seeking the support of both partners to maintain that momentum and address the more limited reductions achieved recently, with a worsening picture reported in some areas.

The proposed Programme of work was made up of three main components:

1. A review of the actual DToC monthly snapshot census process, seeking to ensure the process is fit for purpose in providing an accurate representation of delays at a given point in time each month;
2. A review of current practice, engaging with operational practitioners from across local authorities and health boards to obtain their views and perspectives and possible solutions;
3. A longer term consideration linked to the work programme of the Care Homes Steering Group established by WG in 2014, looking to ensure an appropriate

range of services are available from longer term care placements and shorter term interventions. This work will over time facilitate choice of accommodation decisions and support timely discharge from hospital.

This Report focuses on the second component, and was undertaken by an Associate of the Social Services Improvement Agency along with the NHS Wales National Director for Complex Care, working closely with both Welsh Government and WLGA officials. The work undertaken as part of the Report had the following key stages:

1. An initial contact with partners, setting out a timeline for the visits and meetings, and seeking initial basic documentation such as DToC action plans and local analysis;
2. Local 'fieldwork' involving site visits and meetings with a range of operational staff involved in flow and/or the discharge and transfer of people from hospitals to a more appropriate care setting and also services that help to prevent avoidable admissions to hospital;
3. The production of this Report summarising the findings from the Review and identifying opportunities for both national and local improvement actions, including existing recognised good practice and innovative/emerging ideas. The good practice from the review will be made available on the SSIA website ([www.ssiacymru.org.uk](http://www.ssiacymru.org.uk))

It is also important to note that alongside this work the NHS Delivery Unit also carried out a detailed review regarding hospital discharge and the then Deputy Minister for Health, Vaughan Gethin also carried out visits to each Health Board.

## **4. The Evidence Base**

In addition to national policy documents, there has been significant analysis of flow related problems, and delayed transfers of care specifically, over the past few years. This has resulted in a range of reports, recommendations and improvement activity across both local authorities and NHS Wales.

This report reflects the key issues and challenges identified by health and social care practitioners across Wales. It also makes reference to recommendations and solutions identified in previous reports that might be helpful, and also shares some of the developments and improvements designed and implemented locally by frontline staff that may be of value to others.

The vision set out in the Social Services and Well-being (Wales) Act is one where individuals are placed at the core of service design and development, with success measured in terms of improved outcomes for people. It places requirements on health boards and local authorities to work in partnership to create a seamless approach for those in need.

The recognition in the Act of the need to protect independence and ensure people retain control over their lives is also reflected in a number of earlier reports from improvement agencies, regulators and auditors. These reports remain relevant and pertinent and collectively provide significant opportunities for improvement and innovation.

The reports and documents that have helped to inform this work are listed below. The *Community Hospital Interface Group's Report on Delayed Transfers of Care* is a recent and very relevant report, and its findings are used throughout this document.

#### **Useful documents and information sources:**

- *Community Hospital Interface Group Report on Delayed Transfers of Care*
- *Passing the Baton*, issued in 2008 by the (then) National Leadership and Innovations Agency for Healthcare
- *10 High Impact Changes for Complex Care* issued in 2011 by the Continuing NHS Healthcare National Programme
- Delayed Transfers of Care analysis undertaken by the Wales Audit Office in 2007
- Flow and improvement related activity led by the 1000 Lives Plus Programme
- SSIA Reablement related improvement programmes and support
- Performance and improvement related work underway by the Delivery Unit
- Services being developed and implemented supported by the Intermediate Care Fund
- NICE Guideline Dec '15 - "Transition between in-patient hospital settings and community or care home settings for adults with social care needs"

## 5. The Findings

### Introduction

It should be stressed that the focus of this work has been on operational practice, systems and processes within local authority and health board partnerships. Clearly both the independent and third sectors also have an important contribution to make to this agenda. The third sector provide a wide range of services ranging from providing advice and information, helping individuals to find a suitable care home placement, hospital to home services, social support to isolated individuals post Reablement alongside many others. The independent sector similarly has a key role in providing longer term care and provides long term care home placements, step up and step down intermediate care facilities, long term home care support and many others. As providers, both sectors are a source of solutions and the review team would encourage partnerships to consolidate the mechanisms they have for engaging with these sectors to develop and commission an appropriate range of services to reflect the needs of the people in their area.

Whilst there have been local issues specific to each HB/partner LAs footprint that have been identified during the meetings held across Wales, in the main a number of themes have been raised consistently. These themes have been grouped in to four main themes:

- capacity,
- consistency,
- communication;
- culture

The findings are summarised in this section by these four themes. They are based upon conversations with operational staff across NHS Wales and local authorities and have been supported by a number of key documents shared with us either before or after discussions. Not all of the findings are supported by evidence, instead they represent the position as told by operational staff and senior managers during feedback sessions.

During the course of the visits, a number of documents exemplifying good practice have been shared, and it is proposed these be collated and made available online to allow ease of access.

#### a) Capacity

This was identified as the major factor impacting upon effective flow and contributing to Delayed Transfers of Care.

From an **NHS** perspective there has been a conscious move towards rebalancing provision of primary and community led healthcare service. The resulting reduced bed base has though made it even more essential that services exist to ensure

people can access care in the most appropriate location when they no longer require acute care and treatment; and where further rehabilitation is required prior to a long term solution being agreed and implemented.

There was a strong message that the reduced bed base has reduced the leeway that used to exist when HBs operated on an 85 – 90% capacity. Reviewers were told that HBs regularly operate now at near if not exceeding 100% occupancy, reducing the ability to accommodate day to day surges in demand within their operational bed base. Participants noted that current in patient capacity is, at times, insufficient to meet demand. The clear message from operational teams was that the increase in demand needs to be recognised and expectations managed.

The feedback was that the focus has been on those issues where there are more opportunities for resolution - i.e. the 'quick wins' but these have largely been exploited, leaving the more difficult and complex challenges to be fully resolved. Despite a range of Reports reflecting the need to address flow across the whole pathway, the focus of attention still appears to be at the 'front door', with actions still required to 'unlock the back door' and facilitate timely discharge for those with some level of ongoing needs continuing to prove difficult to resolve. Similar views were stated around step down capacity as opposed to additional core capacity for those with complex needs – they are frequently full and access to step down services – be they residential or community based – is limited, and waiting lists are developing.

The move towards a more community driven NHS response where that is appropriate has led to significant investments in community services, including the establishment of Community Resource Teams (CRTs) in most areas but the strong view expressed was that this investment has generally not matched demand for the services. A number of partners told us that there are now at times 'waiting lists' for Reablement meaning the service is not always available at the optimum time in a person's recovery. In response to this some partners have moved to a targeted model of Reablement in an attempt to focus the service on those most likely to benefit.

The role of GPs both operationally in supporting Reablement and other community provided care and support and in providing strategic advice to HBs differed across Wales. Some areas noted GPs as an essential core partner in delivering community services and as part of the CRT team, whilst others noted the input from GPs varied across the patch, based upon their personal interest and other factors such as whether additional resources were available to support their input – i.e. to support backfill arrangements that would allow them protected time to be released from practice duties.

Recruitment is an ongoing and major issue for the HBs – this is particularly around newly qualified/Band 5 RNs where there are vacancies due to insufficient supply despite aggressive and innovative recruitment drives. This can mean wards are operating at below their optimum RN establishment, limiting the time RNs have to oversee and drive timely discharge and transfer processes. Time for training in discharge planning was also identified as severely compromised. Significant vacancies were also reported in some HBs in respect of Care of the Elderly (CoTE) consultants and all reported they experience problems in recruiting therapists.

Current HR processes, developed to manage budget pressures, do not support HBs in rapid recruitment. Additional seasonal pressures/other short term funding is helpful and welcomed but as it can take up to two months to complete recruitment processes and get people into posts the impact is limited. Secondment arrangements are often explored as a way of recruiting staff more quickly for short term funded posts, but the limited core staffing reduces opportunities for secondment and where this does happen, there is a consequent knock on effect for the base staffing establishment.

The reviewers were told that short term increases in the bed base to manage demand can also have unanticipated impacts on core services – surge capacity is often staffed primarily through bank and agency staff, reducing the opportunity for wards to utilise bank/agency staff to bolster their core staffing levels.

HBs told us there were no difficulties in recruiting unqualified staff, due it was reported to the living wage. The concern now though is that the LA and care home sector may lose experienced carers to the NHS as there is a higher rate of pay.

**Local Authorities** report similar capacity challenges. They have also, in partnership with HBs, developed the CRTs and provide a shared approach to Reablement in addition to the longer term domiciliary care provision. Anecdotally, LAs report the need for high input packages of care is increasing – they are providing more double handed four times daily calls and these use up big chunks of the available resource. LAs limit the waste and make best use of their resource by the reallocation of domiciliary care slots when a person is admitted to hospital, but this can then lead to delays in restarting a package of care on discharge. A number of LAs told us they have to ‘juggle’ resources between Reablement and the longer term service on a regular basis to ensure responses are as timely as possible. There are some concerns that the introduction of the living wage may lead to staff viewing NHS as employer of choice over the LA.

In terms of care sector placements, LAs report that limited capacity and increasing fees are leading to additional resource pressures for them. The same issue is evident for domiciliary care services provided either directly or via a third party. Solutions have been explored in a number of areas, but capacity generally remains tight, leading to LAs having little choice but to identify the additional resources

Anecdotally<sup>2</sup>, the reviewers were told **Care Home Providers** report concerns the sector remains, in parts, fragile, and that that commissioning of services from both HBs and LAs could be improved, with requirements to implement the new minimum wage, along with new stakeholder pension contribution requirements, serving to exacerbate this situation. Across Wales it was a regular comment that few care homes accept individuals at the LA base rate, instead the majority require a top up to be in place. For those individuals who cannot provide resources for that top up their placement choices are very restricted and there are often long waiting lists for placement.

---

<sup>2</sup> The reviewers did not speak directly to care home or domiciliary care providers

The location and mix of care homes is not always aligned with demand – some areas have an overprovision whilst others have gaps for key provisions – EMI residential and nursing was the deficit most frequently referred to. Where there is capacity it isn't always in the right place or the right category – generally over provision of residential beds, very limited for EMI residential and nursing, with general nursing also limited in places. Homes will generally accept self funders first further reducing the places available to the HB or LA.

As with the other sectors, recruitment was reported to be a major challenge for the care home sector. The main difficulty is in recruiting registered nurses, though there are also concerns that the living wage now in place in the NHS in Wales may attract experienced care home carers.

All areas expressed concern at the likely impact on DToC next financial year, when LAs will have no choice but to action significant budget reductions. Not only will these impact on social care provision, but also other LA services which provide Wellbeing support, impacting therefore on the preventative opportunities.

Those people who were homeless or had housing related requirements on discharge were reported to be particularly challenging to resolve. Appropriate and timely discharge options for homeless people can be limited, with the danger that people are inappropriately having to move to residential care.

Joint equipment stores and access to equipment was generally felt to be efficient and effective. There was clearly a culture of shared working and of meeting need collectively. Telecare and telehealth was reported to be underutilised, with significant potential yet to be exploited, both for the more complex support packages of care and also for preventative impacts.

The development of an effective joint medication management protocol, was identified in almost all partnerships as a significant area for improvement. The engagement of community pharmacists in this action was noted by several as crucial.

## Capacity

### What we already know, from previous reports/analysis:

- 1) Proactive planning and access to services early in the day to enable morning discharges, via:
  - The early identification of likely complex discharges and proactive management from the point of admission;
  - Effective discharge planning processes, including ensuring take home medication and transport are arranged before the discharge day;
  - Aim for morning discharges to free up beds earlier in the day;
  - Utilise discharge lounges (where they exist) to free up beds early in the day.
- 2) Using alternative options to inpatient treatment, where that is appropriate, to help to protect independence, via:
  - Clinical and specialist nursing expertise into care homes to prevent avoidable admissions where that is appropriate
  - Making the best use of Telecare and telehealth opportunities
  - Ensuring an appropriate range of alternative options are developed including commissioning interim care sector placements and sufficient extra-care housing options.
- 3) Seek to ensure services are available outside of 'core hours', including:
  - Senior medical review
  - Access to therapies and diagnostics outside of core hours;
  - Access to urgent social worker input.

### New/emerging ideas being explored:

- 4) Providing additional input into care homes to maintain people in that setting where appropriate via:
  - Extending the community based role of CoTE consultant input into care homes;
  - Reablement teams inreach into care homes
  - Additional training and support to care homes along with access to expert/specialist nursing advice and input;
  - Develop market position statements as an initial step in joint and effective care sector commissioning;
  - Fully utilising Telecare and telehealth options, used in tandem with mobile response service to reduce ambulance call outs.
  - Falls treat at scene models.
  - Development of joint medication management protocols
- 5) Developing integrated health and social care responses, via:
  - Shared staff bank arrangements for community support services across the local authority and HB partners;
  - The inclusion of Housing Officer expertise as part of the CRT and MDT/discharge team;
  - Monitor, via the dashboard, the capacity of community reablement and intermediate care services to allocate support within given timescales.

## **b) Consistency**

All HBs and partners described models in place linked to frailty and Community Resource Teams. These were universally supported as effective and focused on those most likely to be at risk of losing their potential for independent living. The services have been funded mainly through a limited reallocation of resources into the community and also by the use of the Intermediate Care Fund (ICF). Whilst the models were viewed positively, the reviewers did not find anywhere that has yet managed to put a system in place that operates 24/7 and is supported by a 24/7 community nursing service, despite this being an aspiration stated many times. There is therefore currently an inconsistent response to frailty and Reablement/admission avoidance, dependant on the time of day, and day of the week, a person presents. Community escalation processes did not generally appear to exist – the default escalation process appeared to be admission to hospital, especially during those hours where CRTs did not operate.

Staff reported that care packages can at times be constructed using a number of providers for one individual, especially at the 'high end' where there is a need for several double handed calls per day. Whilst LAs and HBs recognised this is not ideal, the reality of an increased number of people requiring high levels of domiciliary care support, along with recruitment challenges, can at times mean an individual could experience a package of care delivered through a number of agencies. In addition to the risks of a less than seamless service for the person, the complexity of such arrangements adds additional challenges to case management, especially in ensuring that a co-ordinated, cohesive, and person centred package of care is in place.

The use of the choice policy is not consistent across Wales and is heavily dependant on the local service provision. In some areas where choice is extremely restricted because of capacity limitations the choice policy cannot operate as it is 'a purely academic exercise – no choice exists'. Other areas operate a brokerage system that appeared to limit choice to the care homes linked to cost. Even then the reviewers were told almost universally that a 'top up' arrangement is required for most of the 'choices'.

Top up arrangements were extremely common, with few care homes accepting residents at the LA rate. There were concerns that an individual without any personal resources/family support to meet the top up requirement gets little choice in where their care is provided (and therefore where they 'choose' to live). It was not clear whether the top ups were for additional/optional services or to supplement core service delivery.

Community based Reablement does not generally operate 24/7. Additionally, we were told that core community nursing services rarely operate 24/7 to provide support. Rapid response services were viewed to be very effective in preventing admission/early discharge but their potential is limited as they do not operate 24/7 and they are not available in all HB/LA areas. In one HB reviewers were given an example of a patient who required intravenous antibiotics three times daily. Whilst

the rapid response service could cover two of these it did not operate into late evening to administer the final injection of the day, meaning the person will spend three weeks in hospital when that could have been avoided.

There can also be inconsistent responses within HB boundaries – these are for services that have been developed over time on a locality basis with their LA partner – that are being reviewed with the aim of a more consistent response, but recognising the need also to shape services to reflect and meet local circumstances.

The variance in provision, both the models and access criteria can be confusing for hospital based staff, particularly for those acute hospitals with a number of LA partners or those which border other LAs and HBs, including those at the border with England-

Different models are in place regarding the way in which social workers work with ward staff. NHS staff were usually of the view that a social worker attached to a ward led to improved relationships and co-ordination, and in some cases, they believed, better outcomes (we were told for example that in one Hospital; there was a higher rate of discharge home for the wards with a social worker allocated to them, and conversely a higher rate of discharge to a care home for those wards with no attached social worker but no hard evidence was provided to support this view). Where there was no hospital based social work presence, this was because local authority staff did not necessarily see this as the best use of limited resources, considering that community based staff supported a more effective in-reach and “pull” model. We were also told of delays of several days in some areas for a social worker to be allocated, this was compounded at times by the need to screen out inappropriate referrals that used up time that could have been allocated to actively progressing cases where input was necessary.

The role and function of the discharge liaison team differs across Wales, with some focusing on training and developing ward staff, others focusing on the management of more complex discharges, and others expected to manage a more reactive model of work around DToCs reporting and validation. The teams that appeared the most effective were those that were integrated with local authority partners and had access to wider expertise including housing and mental health liaison.

Some areas, especially those who have CoTE consultants operating for part of the time in the community, have explored in-reach support into care homes as a way of maintaining frail people in their usual setting and preventing an avoidable admission to hospital. The success of this depended in part upon the interest and support of the care home team, but in those areas where care homes supported the in-reach model it was reported that additional treatments and services had been provided in that location with good outcomes.

The concept of discharge to assess appeared to differ across hospitals and HBs, the difficulties often stated to be due to limited capacity and appropriate options that could support this. The concept of discharge to assess also seemed to mean different things across the visits, with some viewing this purely as a requirement for CHC assessment and eligibility consideration rather than fundamental to optimising independent living potential.

Different systems are in place to quality assure CHC assessment and determination of eligibility processes. In some areas we were told this can take several weeks, with QA meetings often held only monthly and limited opportunity to process the CHC outcome outside of the formal 'panel' apart from fast track palliative care. There was some frustration that MDT assessment outcomes appear to be challenged and documentation returned several times for additional information before there is formal acceptance of the CHC determination to allow for placement. In those areas where this did not seem to be an issue the main difference seemed to be that those involved in the assessment process were also involved in the QA, meaning they could respond to queries immediately and prevent delays.

Another CHC related issue is the impact of CHC eligibility on direct payments. Several areas told us that a minority of individuals resist CHC assessment as eligibility would lead to the loss of Direct Payments (DPs) and a subsequent loss of a significant amount of control with regards to how their needs are met. HB staff note the loss of control as particularly significant for people with a learning disability where the loss of DPs risks moving the person more towards a medical model of care as opposed to the social model.<sup>3</sup> LA staff also reported the difficulties they face in continuing to support a person through DPs where it is likely they are no longer responsible for providing care (as the person is likely to be CHC eligible) and may therefore be operating ultra vires.

A further area creating delay concerns MCA and DOLs, where the need for such assessment involving additional staff was viewed to add a further layer of bureaucracy and impacts on the timeliness of discharge

---

<sup>3</sup> WG intend to undertake specific work on DToCs affecting those with a learning disability and those with adult mental health problems. The reviews have not therefore expanded any further on this matter in this report.

## Consistency

### What we already know, from previous reports/analysis:

**6)** In hospitals and in the community, develop and implement services that operate outside of core hours via:

- A community escalation model that challenges the default option of admission to hospital
- Map out the timing and frequency of admissions for the purpose of assessing the merits of extending community based services to provide 24/7 cover seven days per week;
- Ensure that the discharge model is consistent across hospital/locality boundaries and that clear protocols are in place to ensure appropriate referrals to social care teams. The policy should be clear about the role of the DLN and the interface with the responsibilities of the ward staff in delivering effective and efficient discharge planning systems;
- Ensure frailty based service models are in place, tailored to suit local circumstances, which include community based and front door rapid response as key components.

**7)** Health and local authority partners working together in their regional collaborative to develop consistent approaches across organisational and sectoral boundaries where appropriate.

### New/emerging ideas being explored:

**8)** Further development of community based treatment and care options, including:

- Extending the frailty model into care home settings, with CoTE inputs and access to nurse practitioner and therapies skills;
- Implement a consistent model of discharge to assess;
- Develop and implement systems to ensure appropriate inter agency referrals;
- The inclusion where appropriate of Housing Officer and Mental Health expertise in discharge liaison teams ;
- Seek to develop agreed processes across local authority boundaries.

**9)** HBs having systems in place to ensure the determination of eligibility and the subsequent QA processes do not lead to unnecessary delays. Including the care co-ordinator in the QA process has helped to reduce assessments being returned for further information.

– moved to national box on p25.

### c) Communication

A recurring view expressed during the meetings was that whilst there were generally good working relationships between primary/community and social care services, there is a disconnect between community and secondary care services in HBs. During many conversations we were told by hospital based staff that they had little understanding of how resources had been spent in the community/CRTs or of the overarching strategic model that was driving more community based care, support and treatment where that was appropriate - their perception was that community based investment had to date made little or no difference to the numbers presenting at hospital. Conversely, community based staff would present a very positive view of the impact of their services and the numbers of people who had been retained in their usual residence and their admission avoided.

There was recognition that there needs to be a shared language around Reablement and that cross sectoral teams were developing based on principles that support effective communication and mutual respect. The need to develop measures that can capture and demonstrate the impact of the CRTs was also identified frequently. Some individuals flagged the growing requirement for paperwork that can interfere in the time they have to undertake care and support. The requirements tend to have developed in each sector over time, and would benefit from a shared approach using a commonly understood technical language. IT remains poorly exploited in hospitals as a way of both capturing and sharing information – some LA and CRT/community staff for example can capture IA information via net books/other electronic options, but hospital staff still largely have to rely on paper based systems. It is of concern to note the ongoing use of faxes to share patient information as the ‘only option’.

Despite the increasing drive towards integration, it is clear that in some areas both HBs and LAs continue to operate their own systems, with few examples of truly integrated systems of working. Staff identified the need to operate a joined up service within the context of different operational and IT systems. Different drivers, targets and employment rights were recognised to pose challenges, and in those areas where it works it was felt this was down to local ‘champions’ have made it work despite the background systems rather than because of them. Many participants felt that ‘we desperately need fully joined up systems’, and the requirements in the SSWB Act were welcomed as a key way to drive that integration further.

There were many examples of HBs developing systems for capturing “live”/real time information and ensuring this is available to as many departments as possible— however, again these were mainly restricted to health staff and tended to focus on the ‘medically fit for discharge’ point rather than any wider indicators that could be of value to both partners.

The lack of access for LA staff to the DToC database<sup>4</sup> hinders their ability to work jointly on discharge and does not help to promote joint ownership of the issues or any confidence in the data.

---

<sup>4</sup> WG has undertaken a series of workshops across Wales focusing on the |DToC database and the census process so the reviewers have not focused in detail on this within this report.

Without fail, staff expressed concern that, despite the strategic intent of WG to promote integration, the only current joint PI is DToC - a measure which was felt to lead to blame and tension between partners. There is also no measure which recognises the impact of community interventions to address the increased complexity being managed throughout the system and which illustrates the trajectory of service demand being contained.

Hospital staff, in the main, cannot access community held IT based clinical and social information concerning their patients, although we were advised of ICF monies being used to fund LA staff who are based on the ward and can input information from their system into the patient's record.

Medication was mentioned on a number of occasions as a factor that can prevent timely discharge. Many patients take a number of long term medications, and ensuring their medication can be administered on discharge seems to be a growing issue. Where there is a package of care in place, carers will undertake a 'prompting' function, seeking to ensure the person is encouraged to take their medication and to note and alert others where compliance seems to be an issue. For people who do not require any supportive care other than medicines management this can be more problematic. Not all community pharmacies will participate in providing medicines in a suitable way – nomad boxes, blister packs etc – this seemed to depend on whether the HB has an enhanced service arrangement in place. Delays are not confined to community medicines refills though – we were told that take home medication in blister packs (or other alternatives) provided by hospital pharmacies can take a couple of days to make available, adding additional short term delays into the discharge process. Some wards have trialled systems where patients retain their medicines and self administer (with the medication kept in a locked bedside locker or alternative option), the aim being to maintain the routine in taking their medication they would have at home and to prevent any loss of confidence or ability to remember their regime. Whilst this had been reported to be a useful approach, the systems did not appear to have been sustainable for reasons that could have been overcome – for example we were told that on one ward it had ceased as 'they kept losing the keys to the lockers'.

One key initiative which does promote improved communication for staff and citizens is that of Single Point of Access (SPoA) and one staff member commented that 'SPoA could be transformational'.

Again there are significant variations in models and access criteria, sometimes within HBs, but the reviewers did see examples of good joint working e.g. one base being able to access both health and social services data.

## Communication

### What we already know, from previous reports/analysis:

**10)** Better integration and a shared understanding of the role of primary/community services and secondary care, via:

- Access to community nursing expertise in hospitals, including community nursing presence in the ED;
- Community led pull discharge models
- Clear agreed protocols in place between partners to manage simple discharges

**11)** Clear and effective protocols to support effective flow, including:

- Implement Board rounds that focus on progress and action planning
- Clear and agreed protocols to support accessing DToC information as a key information tool to manage flow;
- Providing discharge related information on, or as near as possible and appropriate to, admission in order to ensure any discharge related problems are identified early;
- Escalation mechanisms between Health Boards and Local Authorities to ensure timely discharge.

### New/emerging ideas being explored:

**12)** Proactive planning and strong leadership via:

- Utilising the 'what matters' conversation as an early identification of the person's expectations and preferred outcomes.
- Executive Directors/senior managers joining Board rounds to help unblock/problem solve issues that prevent discharge/moving on to a more appropriate location for care.
- Action based meetings to resolve DToC, operating across HBs and LAs. One example is for weekly locality based action planning meetings
- The use of Interactive Boards that store information and support progress chasing and action planning.
- Consider secondments or other arrangements to rotate staff between hospital and community settings or across sectoral boundaries (OTs were mentioned as a key group)

**13)** Arrangements in place to ensure that those individuals who fund their own care ('self funders') have the same access to information on the care and support options available as those funded by the public sector. This could be through Single Points of Access or on-line resources such as Dewis Cymru. This may avoid inappropriate admissions if individuals and their families understand all the options available. This includes support with the choice process to avoid preventable delays in the discharge process. Families are not always able to support the individual to choose a home.

## d) Culture

The shared approach to Reablement was seen to be a positive example of how teams are developing that respect different views and approaches. In this context of shared learning, the need to re-establish shared national fora e.g. for Discharge Liaison Nurses was noted.

We were told that expectations of patients/their families can be unrealistic and that more needs to be done nationally to educate the public on issues like timely hospital discharge, the impacts and implications of delays, expectations re choice and discharge options. LSBs and AMs were thought to be in a strong position to assist with driving this message to the general population.

The implications of the SSWB Act are also not felt to be broadly understood and work needs to be undertaken to address this, especially for many health staff.

HB staff felt strongly that there is a focus on performance rather than improvement and that their hard work is not recognised or appreciated. They are 'fed up with being criticised' and gave a strong message that external/political scrutiny will not in itself deliver a better outcome or create solutions.

The acuity in hospitals is now complex, with the majority of patients being very elderly with a number of long term conditions that need to be co-ordinated and managed. There are few mobile patients and demographic projections indicate this is likely to increase. DToC related issues are a consequence of this increasing complexity and the limited resources there are to develop services to meet growing demand.

The culture of care was raised on many occasions, with a view that secondary care staff can be overly risk averse – 'the cwtch culture' - and that rotation of hospital and community health care staff could help improve this situation. In those areas where a discharge liaison nurse with a community background was in place they were praised for managing discharges back into the community for people that other staff may not have felt appropriate. There appeared to be a lack of a culture that supported developing creative options, focusing on process and reporting instead of outcomes – 'we let patients down by being process led'.

Governance mechanisms were not always in place to support changing patterns of services or to support delivering services and care in a more flexible manner. This was also noted as an issue in debates with Regulators

Third sector support was rarely mentioned during the meetings with acute sector staff, although one HB did reference a contract with a third sector organisation to provide support to patients and their families through the Choice process. Within community settings, ICF funding has been used significantly to enhance 3rd sector involvement e.g. in preventative activity though placement within CRT and most notably having a 3rd sector broker based in or linked to the SPOA.

## Culture

**What we already know, from previous reports/analysis:**

**14) Respecting different perspectives and drivers whilst working together for the benefit of patients, via:**

- Co-located services, supported by inter agency protocols, including joint appointments where this is appropriate.
- Avoid risk averse behaviour, seeking to engage primary and community health and social care expert practitioners to ensure the default discharge option is home;
- Access to community based pull mechanisms;
- A focus on person centred outcomes that are realistic and seek to protect what can be fragile independent living wherever possible;
- Using the third sector to act as 'brokers' and support individuals and their families when selecting care home of choice.

**New/emerging ideas being explored:**

**15) Using new legislation and developing policy to ensure effective person centred services and care and support are the norm, via:**

- Implementing Integrated Assessment and the principles of the Social Services and Wellbeing (Wales) Act, focusing on the individual's strengths and the 'what matters' dialogue in constructing safe and effective support arrangements;
- Develop a meaningful set of performance measures that capture the impacts of reablement and other community interventions that prevent avoidable admissions to hospital;
- Ensure that all staff have access to training on the approach to assessment underpinning the Act and the 'what matters' approach to enable them to facilitate more effective outcomes for people in need of care and support. This is equally important for hospital staff.;
- Review the support offered to emergency departments and wards by specialist mental staff for the purposes of identifying individuals with mental health problems and providing appropriate interventions.

## 6. Summary and Next Steps

The introduction to this Report noted the wealth of information, analysis, evidence, improvement data and outcomes measures that exist that are relevant to the area of Delayed Transfers of Care. This Report has not sought to replicate that information, it is available and easily accessible to support health and social care teams in ensuring people receive the best outcomes possible from the services we provide.

The unique nature of this Report is that it has sought the views and opinions of frontline health and social care practitioners and clinicians. Those teams that work on a daily basis to ensure effective care and support is provided to those in need. They described difficult and challenging circumstances that they face on a daily basis, but despite recognising some differences in the way sectors respond and operate, the health and social care practitioners who participated in this work did not once mention 'blame'. There was a clear culture of mutual respect and of working together to problem solve.

The fieldwork undertaken has captured information about those issues that are difficult in ensuring that people receive the right care, in the right place, at the right time. It has also identified a range of emerging good practice that has been developed to address challenges. Some of this will be of value across Wales, other components may be of interest to some local partners, or may need some fine tuning to make them work in other areas.

In addition to the issues identified in this Report, the reviewers have identified a number of actions that it would be helpful to consider at a national level. These issues have been identified by frontline practitioners and need to be considered in tandem with the actions identified for partners.

Finally, there needs to be a clear process in place to ensure strategic oversight of delayed transfers of care and to take responsibility for taking the findings in this, and other, reports forward.

## **Key Issues for consideration at a national level**

- There has been much scrutiny and analysis of flow and delayed transfers of care over the past five years, and the findings and recommendations in these earlier reports remain relevant. There should be an expectation set that partners will ensure existing guidance and the good practice identified in this report is used and implemented to deliver sustainable improvements.
- Ensuring there is a focus by health boards and partners on improvement as well as performance.
- Ensure there is strategic oversight of delayed transfers of care and is positioned in the most appropriate group. This has been confirmed as the Unscheduled Care Programme Board. Regional Partnership Boards will have a key role to play at the regional level.
- Explore opportunities for the identification of best practice and improvement at a national level.
- Explore the potential for health and social services staff to use a secure system to share information.
- Require partners to have a clear model of care that has been agreed between them that has clear systems in place to capture capacity and demand.
- National review of choice policies to ensure appropriateness and consistency of policies
- Consider developing an integrated management information system that can measure the impact of services across the whole system for the purpose of informing appropriate actions and service developments.