Delayed Transfers of Care

Task Group

Final Report

June 2008

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Chairman’s Forward

“Delayed transfers of care”, known to most members of the public as “Bed-Blocking”, denies care to vulnerable members of our community.

Evidence presented to the task group has shown that “Delayed Transfer” is simply the most public symptom of issues that can arise in the complex processes; where different bodies must work together to ensure that a particular vulnerable person (perhaps someone known to us) gets the right care in the right place at the right time.

I would like to thank the members of the Task Group for their hard work, and for taking the reins when I was unable to attend meetings owing to my own work commitments.

I’d also like to thank the representatives of the NHS Trust’s and the County Council’s social care department for their honesty and willingness to help the Task Group get to grips with the issues.

We hope that the recommendations contained will form a blueprint for making further improvements and for maintaining the higher level of service achieved

Councillor Malcolm Hewson
Chairman of the Task Group

Summary

1. The Task Group has found evidence of a great deal of good work, since the introduction of the Shared Working Protocol late in 2006, and this has finally been borne out by a marked reduction in delayed transfers of care in the first months of 2008.

2. However, there are still changes that need to take place in all organisations, both culturally and with regard to investment in services, that will make the final difference to end the pattern of a build up of delays.

3. Equal attention needs to be given to prevention and rehabilitation. In the first instance to minimise hospital admissions and secondly to enable patients to move on from hospital in a timely manner following an episode of care, into a more appropriate supported setting, either at home or in an alternative suitable facility.

4. The Task Group is satisfied that the six partner organisations have been able to systematically work through the problems to eradicate many, and have identified and begun to address those that remain.

5. The conclusions and recommendations at the end of this report represent the culmination of the Task Group's work and the distillation of all the evidence gathered. The group has taken an unbiased approach and aims to present this evidence with the same attitude.

6. The Task Group did hear some conflicting evidence but, understanding this to be the natural side effect of partnership working, did not feel it affected the agreed aims of the partners in an unduly negative way. In fact, the different points of view held by the organisations allowed them to challenge each other and find resolutions to long standing problems. However, the group did feel that the spectres of past acrimony still had the potential, if not to skew the current climate of goodwill, then at least to colour it somewhat, and the members felt that all concerned should try to guard against this.

7. Having said that, the Task Group found much to praise in the new arrangements and agreed there is commitment at the highest level in all of the organisations to work together and provide integrated health and social care in Wiltshire, which is to be commended. In short, the Task Group was satisfied that the direction of travel is right, and that taking a measured approach will allow for sustainable long term solutions to be found and implemented.

Purpose

8. This report is a summary of the work undertaken by the Delayed Transfers of Care Task Group from July 2007 – June 2008.

Introduction

9. "Delayed transfers of care" is the term used by health and social care professionals to describe patients who, having been treated in an NHS setting, usually either an acute or community hospital, for a variety of reasons, cannot immediately return home or to another suitable place of care.

10. Delayed transfers are not new, there have always been people who stayed longer than necessary in hospital due to a lack of alternative care services. For a number of years they were widely referred to as "bed blockers".

11. There are many reasons why a patient may become delayed, and these will be discussed in more detail in the body of the report, but the impact of having a high number of delays is felt by the whole health and social care community.

12. However, the people who are most seriously affected by unnecessary delays are the patients themselves, some of whom will experience potentially disastrous and unwanted outcomes.

13. Nationally there is a drive to reduce delayed transfers and to find ways of delivering care that does not automatically resort to bed based provision. This requirement has been reiterated by the Strategic Health Authority in the South West region, which has identified Wiltshire as being a high priority for delayed transfers.

14. Wiltshire has a long history of higher than average delayed transfers of care, which has caused great concern in the NHS for a number of years. Delays have become unremarkable and, as a consequence, serious attempts to resolve the problem had not been made until recently.

15. When the County Council's social care budget came under significant pressure in 2005 & 2006, leading to a breakdown in joint working with the equally financially challenged Primary Care Trust, the Health Scrutiny Committee began to realise the extent of the problems associated with delayed transfers and received a number of briefings to help members understand this most complex of issues.

16. In July 2007, with work underway by health and social care partner organisations to find solutions, but achieving slow results, the Committee decided to look at the issue more closely and set up a Task Group to carry out more detailed investigation.

17. The Task Group was asked to "look into the issue of delayed transfers of care with a focus on a whole system approach from health and social care."

Task Group Terms of Reference

18. To identify the main reasons for hold ups and blockages in the current system of care.

19. To examine and monitor the targets in the joint working protocol against performance and, where targets are not being met, find out why.

20. To make recommendations to each of the agencies involved about how they could contribute to improvements to the system that would benefit patients and the system itself to improve services.

21. The task group would carry out the review over a three month period initially and would report back to the Committee at the November meeting.

The Task Group was made up of the following County and District Councillors:

Mike Hewitt, Salisbury District Council

Malcolm Hewson, Wiltshire County Council, Chair of the Task Group

Brian Mudge, West Wiltshire District Council

Judy Seager, Wiltshire County Council

Roy While, Wiltshire County Council

Programme of Meetings

15 August	**Scoping Meeting**
	with input from James Cawley, Wiltshire County Council Department of Community Services and Nicholas Gillard, Wiltshire Primary Care Trust
11 October	**Understanding the Care Pathway**
	Presentation from James Cawley and Nicholas Gillard Input from: Barbara Criddle, District Director for Community Services Nicola Gregson, Contracts Manager for Community Services
7 January	**Interviews with Witnesses**
	Mike Relfe, Assistant Chief Executive Julie Warner, Older Peoples' Lead both from Avon & Wiltshire Mental Health Partnership Trust
	Brigid Musselwhite, Deputy Chief Executive Diane Fuller, Director for Patient Care and Deliver both Royal United Hospital Bath NHS Trust
16 January	**Interviews with Witnesses**
	Peter Hill, Deputy Chief Executive, Salisbury Foundation Trust
	Donna Bosson, Operations Lead – Discharge Planning and Policies, Swindon & Marlborough NHS Trust
22 April	**Interviews with Witnesses**
	Jenny Barker, Managing Director, Wiltshire Community Health Services Madeleine Griffiths, Inpatient Manager and DTOC Lead, WCHS

Setting the Scene

22. The Task Group initially invited Nicholas Gillard of Wiltshire Primary Care Trust and James Cawley from the County Council's Department of Community Services, which provides social care, to the first scoping meeting to discuss the nature of the problem in detail.

23. Delayed transfers of care usually happen to older people who are often vulnerable and frail and can have a detrimental impact on the rest of their lives. The Task Group was keen to understand this and to be clear about the impact on the patients and their families as well as on health and social care providers.

24. The Task Group heard that Wiltshire has a long history of delayed transfers and is in the bottom quartile of similar sized councils. The reasons for this are spread across the health and social care community, but in the simplest terms the emphasis on and historical investment in bed based health and social care services has not allowed for the development of a wider variety of alternative services which would both help prevent hospital admissions and enable people to be discharged back to their own homes or other community settings more quickly.

25. In particular, the type of rehabilitation and community based solutions that would give older patients and their families an alternative to nursing or residential homes have not traditionally existed in Wiltshire. This lack of other services has meant that, for a significant number of people who have finished their treatment in hospital, a nursing or residential home is the only choice available to them, and so in a sense is no choice at all.

26. Historically, and despite being early pioneers of integrated services prior to 2006, health and social care in Wiltshire have not been close enough to be able to effectively tackle the issue of delayed transfers and the level of commitment required was not present in all the agencies involved.

27. There are six main organisations providing services at various stages in the care pathway for older people whose actions impact on the overall pattern of delayed transfers:

    Wiltshire County Council (WCC)
    Wiltshire Primary Care Trust (PCT)
    Avon & Wiltshire Mental Health Partnership Trust (AWP)
    Salisbury Foundation Trust (SFT)
    Royal United Hospital Bath NHS Trust (RUH)
    Swindon & Marlborough NHS Trust (running Great Western Hospital (GWH))

28. The acute hospital trusts had historically taken the stance that they were the victims of delayed transfers, which were caused by the inability of social services, and to a lesser degree community health services to provide the right level and range of care that would allow them to safely discharge patients into community or residential settings. In short, patients had to stay on wards in district general hospitals because there was no care package that would enable them to be discharged.

29. However, this lack of a joined up approach led to antagonism and did not foster a climate in which solutions could be found.

30. The national push to reduce delayed transfers of care brought about a system of fining that enabled acute hospital trusts to fine local authorities when a patient who was deemed ready for discharge could not be moved on because of a shortage of social care packages.

31. In Wiltshire the acute trusts initially agreed to waive the fine and to use the grant money issued by the Government to local authorities to pay the fines to put alternative services in place. However, as the problem was not resolved to a satisfactory level and budgets and services came under pressure some of the acute trusts decided to enforce the fines to try to bring the situation to a head. This in turn led to further breakdowns in communication between health and social care and a souring of relationships.

32. The acute hospital trusts all have targets for lengths of stay and timely discharge and it became clear they would continue to experience great difficulty in meeting these targets unless they became fully involved in finding the solution.

33. Finally it was accepted by all agencies that, in order to resolve the problem of delayed transfers once and for all, the whole system of care for older people would have to be overhauled.

34. So, the six agencies conceived a vision of care for elderly people which reflected the instructions set out in the Older Peoples' National Service Framework where bed based services would continue to be provided, but would be part of a richer pattern of care that aimed to help people to stay at home for as long as possible, and in which nursing homes would be seen as a last resort. The aim was to have enough alternative care provision to be able to reduce hospital admissions and ensure that patients, who were in hospital but ready for discharge, could be moved on quickly and appropriately.

The Picture for Wiltshire

35. The cost to the local authority for providing social care for older people is set to increase in Wiltshire no matter what services are put in place because the number of people needing care will continue to grow. Developing alternatives to nursing and residential home bed based care will help to manage the cost growth and provide a wide range of services, thus ensuring that the Council can continue to meet high demand.

36. If all the Council did was provide more of the same services that exist in the county now, the cost increase would be in the region of £3-£4 million per year, and this would be unsustainable leading to large holes in the Council's budget.

37. The NHS also has reason to be concerned about the growth in the elderly population as it can be reasonably expected that demand on health services will grow in a very similar way to that of social care. Therefore, the ideal scenario is for health and social care to plan how to meet demand jointly.

38. However, the Primary Care Trust had set out to remodel its services in 2005 to enable it to provide better, more affordable care to more people through Pathways for Change (later Reforming Community Services). The PCT had long since come to the conclusion that its existing services were ineffective and becoming more so, a conclusion which was borne out in part by the continued high number of delayed transfers across the county, both in acute and community hospital settings. If this trend continued the NHS feared it would see the urgent drive out the important cases.

39. Further facts compounded the need for radical change in the care pathway. By July 2007 £180 - £200k a week was being spent in Wiltshire keeping people in hospital who didn't need to be there because there was no viable alternative that would enable them to go home or to another care setting. This money could, and should, have been spent on improving care for people in the right place.

40. As well as the impact on the resources of health and social care providers in continuing with the hospital/residential/nursing home system prevalent in Wiltshire, the Task Group also heard about the impact on patients who can easily lose the ability to do things that enable them to live independently, if discharge is delayed.

41. Of course, for some patients the right type of care following an inpatient episode in hospital may be residential or nursing care, but both the PCT and social care are agreed there are a significant number of people who, with the right type of initial care and ongoing support may never have needed to go into hospital at all, or who could be discharged back to their home or original place of residence with added care and support to enable them to cope.

42. The Task Group agreed with the professionals that this was an unsatisfactory situation for the county to be in and decided to investigate the blockages in the care pathway.

43. The Task Group became aware early on of the concentrated effort being made by the health and social care community to reduce delayed transfers and began to receive the figures for the county on a weekly basis. Members were conscious that, between Task Group meetings things were moving quickly with professionals at the highest level in each organisation being involved to ensure the work was driven forward. The Task Group decided it must attempt to contribute positively to existing work, not try to come up with alternative solutions.

Evidence Gathering

44. Having spoken initially to representatives from the PCT and social care, the Task Group decided that, in order to get a full picture it would also need to take evidence from the three acute hospital trusts and the mental health trust.

45. The six partner organisations had, in late 2006, signed up to a shared working protocol which was designed to bring them together with a common aim to reduce delayed transfers and to facilitate a way of working jointly that would compel each to take responsibility for what happened in their own organisation and for the parts of the care pathway they could directly influence and shape. The protocol provided short and medium term solutions from November 2006 until March 2008, with a number of review periods built in.

46. The vision for the protocol was "for patients to receive the care they need in the best place for them, whether that is in a hospital, the community or at home. We want to provide care at home or closer to home when it is safe to do so. We believe that doing this will be better for patients since very few people want to be in hospital unless it is absolutely necessary. We also believe that we will be helping people to maintain an independent life for longer."

47. The Task Group was struck by the fact that the partner organisations needed to put such simple and basic aims into a formal agreement and took it as a measure of the difficulty experienced by all parties in trying to manage and reduce delayed transfers over a number of years while also having to focus on developing modern services suitable for future use.

48. However, analysis of the figures for delayed transfer across the county showed consistently high numbers in both acute and community beds. By the end of July, although the plan was for 91 delays across the health community, the actual figure was 160, 69 more than hoped for. The Task Group saw that, despite all partners stating their commitment to the aims of the protocol, it was not seeing the results they had hoped for.

2007/08 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY – (NHS and LA splits)

Data source		Wiltshire Acute and Non Acute								
SITREPs		NHS			WCC			Plan	Act	Diff
		Plan	Actual	Days	Plan	Actual	Days			
July	05/07/2007	18	**50**	344	79	**102**	707	97	153	56
	12/07/2007	18	**50**	312	77	**94**	656	95	148	53
	19/07/2007	18	**52**	321	75	**105**	680	93	161	68
	26/07/2007	18	**54**	351	73	**100**	673	91	160	69

Avon & Wiltshire Mental Health Partnership Trust (AWP)

Please note: the comments below are based on evidence provided to the Task Group at the time of evidence gathering exercise:

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49. The first trust to give evidence to the Task Group was Avon & Wiltshire Mental Health Partnership Trust. Mike Relfe, Assistant Chief Executive and Julie Warner, Older Peoples' Lead, attended a Task Group meeting and talked through the current situation, the problems experienced by the Trust, the protocol and future services.

50. The Task Group heard that AWP's wards operated at a consistently high level of delayed transfers which never fell below 19, but which was typically between 20 & 25. This was borne out by the figures up until the end of January 2008 (fig.2), when numbers finally started to reduce, although they had been as high as 55 during the summer of 2007.

51. NB Please see Addendum re Recording concerns

52. Prior to April 2007 AWP ward staff had not considered patients who had spent months, and even years, on the wards to be delayed, or requiring another form of care it was just taken for granted that they needed inpatient treatment. Consequently delayed transfers were counted by guesswork and were not properly or adequately analysed.

53. At the end of April 2007, when the PCT, WCC and AWP began to put greater emphasis on looking at delays, it was agreed the first priority was to move anyone who had been on a ward for more than 2 years and front line staff began to think in terms of finding appropriate care packages for patients after their initial period of assessment and treatment.

54. However, after an initial period of progress, decisions made as a result of Mainstreaming Mental Health and Pathways for Change to close inpatient wards at Chippenham community hospital, Savernake hospital and the older peoples' ward at Green Lane hospital were implemented, and progress in reducing delayed transfers slowed considerably while this work took precedence.

55. Despite this initial slow down, the culture on AWP wards has continued to change and staff now see patients as coming in for assessment and initial treatment before either returning to their original place of residence or moving on to a more suitable alternative. It is agreed by all that mental health wards are not places for patients to receive long term care.

56. AWP has historically experienced a high level of delays while patients wait for suitable EMI (elderly mentally ill) nursing or residential home placements, although a small number of adults of working age experience waits for more complex care packages.

57. The trust predicts there will continue to be a need for EMI residential and nursing home places and developments in community care may not significantly affect this. To address this WCC is working closely with the Order of St John to re-register some of its homes to enable them to take EMI patients.

58. However, despite moves to improve and re-register some care homes, there has been a reduction overall because legislation has made it more difficult for care homes to meet all the necessary criteria and a number have closed. AWP suspects this may have had some bearing on the build up of delayed transfers. Following this period of instability the care home sector has settled down and the Council has worked hard to ensure that existing homes are able to take the right mix of people, with the principle still being, for mental health clients as for everyone else, that residential care should be the last resort.

59. AWP is encouraged and optimistic about the renewed emphasis on joint working, especially between the Council and the PCT. For a trust whose services are commissioned by health and social care it is far easier to plan when the commissioners are working closely together and sharing a vision.

60. During the period of the first shared working protocol, and despite a long period where joint working improved but delayed transfers did not continue to significantly reduce, AWP felt that ways of working were established which can be carried forward into successful practices for the future. There has been a great deal of change on all sides, both in attitudes and practice. Social care had initially experienced problems working out who should take priority among long-standing delays when a placement became available. Now there is greater understanding and agreement about who takes priority and how to approach this.

61. The trust is also conscious that there is a fear among professionals about placing people who have been on a ward for a long time, back into a community setting. Some of the patients who are classed as delayed transfers today would have been institutionalised in a facility like Roundway Hospital years ago and understanding that these types of patients might have a different future involves a culture change across the whole organisation. However, the partners have been able to successfully place patients who had been hospitalised for ten years and enable them to live in supported settings. This “can do” attitude has to be carried forward.

62. The development of new dementia drugs may ultimately mean that fewer sufferers need residential placements, although this is far from certain and there will always be a need for residential nursing care. This will potentially lead to different sets of problems as dementia sufferers can often be physically very healthy and may live on for many years with their condition managed in residential settings, thus limiting the number of placements that become available.

63. Another set of as yet unknown or unplanned for problems may centre on what are thought of as lifestyle related problems, caused by drug and alcohol misuse, which will lead to different issues for service providers, although the long term effects are far from certain in many cases. As today’s generation of drug and alcohol users age they may require care and support that has not yet been planned for.

64. Older people with functional mental illness will possibly continue to need nursing as well as residential and community care. Better intermediate care services could help to reduce lengths of stay in inpatient facilities and help patients to stabilise more quickly. Good planning for future need should be carried out now to ensure services will be in place as required.

65. There is a model of care in Bristol, centred around a facility called Saffron House, which provides intermediate care to mental health sufferers who have finished treatment for physical complaints in acute settings, but who require a further level of support in order to get back on their feet. This approach has been successful in Bristol and Wiltshire could benefit from developing a similar model of care.

66. Significant problems will develop as carers' age. The growth in dementia sufferers is likely to be proportionate to the growth in the elderly population and, with more people expecting to stay at home or in the community improved carer support is a key factor in successfully enabling people to continue to manage their lives at home. Community psychiatric nurses and social workers often have to spend as much time supporting the carers as they do patients and, as people live longer into retirement and are physically fitter this is an issue that partners will have to address effectively.

67. AWP would expect investment to be needed in a range of areas, including intermediate care, extra care sheltered housing/supported housing, carer support and continued development of integrated health and social care services in order to ensure not only that delays will be reduced on a long term basis, but that the continued increase in demand can be met.

Royal United Hospital Bath (RUH)

Please note: the comments below are based on evidence provided to the Task Group at the time of evidence gathering exercise:

68. Brigid Musselwhite, Deputy Chief Executive and Diane Fuller, Director of Patient Care & Delivery met the Task Group to discuss the situation at the RUH.

69. The RUH has been concerned by the long red column of delayed transfers that did not significantly reduce for WCC delays from March until December 2007 (fig. 3). Social Care delays have come down, but NHS delays continue to be high. The trust is conscious that despite the introduction of the protocol the overall position remained poor for much of the period it covered and that national targets for reduction set by the Healthcare Commission of 3.5% were missed.

70. However, the trust accepts that the figures do not reflect the improved relationships between all the partners involved or the good working practices that are being established in order to address the problem.

71. The RUH has expressed concerns about the spot purchasing of residential and nursing home beds carried out by WCC towards the end of each financial year, which allows social care to move delayed patients and alleviate the problem in the short term, but without long term improvement processes having been put in place. The result is that, as soon as spot purchasing stops, the number of delayed transfers increases again.

72. The Trust has noted with interest the sustained improvement shown by Great Western Hospital and has invited the Care Services Improvement Partnership to come into the hospital to give advice in the hope of being able to learn from good practice elsewhere. The Trust agrees that a whole system action plan is the only way to solve the problem for good and provide better, more appropriate care.

73. In terms of improving its own systems, the RUH has been reviewing its lengths of stay and admission/discharge policies to see if steps can be taken internally to bring about improvements. Historically the trust has not performed well in the area of discharge planning but now aims for 100% of patients to be given an estimated date of discharge as soon as possible after admission.

74. Managers are seeking to improve performance by carrying out weekly audits and to look at overall bed occupancy which is also high. There are 650 beds at the hospital and the trust takes roughly 650 admissions a week, meaning that technically all the beds are turning over in the space of a week. This results in very little slack in the system and can make it difficult to admit patients for planned procedures.

75. Different routes into the hospital have been created to assist A & E in meeting its own target times. Now patients coming to the hospital for planned episodes of care can be admitted via the surgical wards and ambulatory care

has been extended to allow patients to walk straight in and out after assessment and treatment.

76. The RUH provides services to a very elderly population. 31% of admissions are for people over 75 whose needs tend to be significantly more complex than younger people. All the risks associated with being admitted to hospital in terms of infection and loss of mobility also come into play.

77. There have been some improvements in the way community hospitals work with the acute trusts as a result of Reforming Community Services, but the rate of change is slower than hoped. The pattern for the reduction of delays seems to be, while WCC delays in acute trusts have reduced, delays for patients waiting for social care in community hospitals have stayed high. This in turn has impacted on the community hospital's ability to take NHS delays out of the acute trusts.

78. Doctors agree that by the time people get to A & E and are admitted they tend not to be inappropriate admissions, but admissions that could often be avoided if other services were available in the community more quickly. The same services that help prevent admission can also be used to facilitate discharge.

79. Frustrating and avoidable delays occur in trying to get patients assessed for their post-discharge health and social care needs. However the RUH also falls down in this respect by failing to assess for physio and occupational therapy needs quickly enough. Families and carers may often compound the problem by refusing to accept the placement offered by social care and further delays occur.

80. The Trust would like social care assessments to happen more quickly, and feel Wiltshire social workers are hampered by an overly bureaucratic system which holds the process up. Sometimes consultants are asked so many times for a long term prognosis by the family while the patient is waiting to be assessed that they end up giving a view about where a patient should go after discharge because they feel under pressure to do so. Social care then feels this is inappropriate so there is a vicious cycle of cause and effect that impacts on patients and services.

Salisbury Foundation Trust (SFT)

Please note: the comments below are based on evidence provided to the Task Group at the time of evidence gathering exercise.

81. Peter Hill, Deputy Chief Executive of Salisbury Foundation Trust was next to attend a Task Group meeting. The OSC has previously given consideration to the problem of delays at Salisbury Hospital and members were keen to be updated about current circumstances.

82. The three health communities supporting RUH, GWH and SFT are very different, which is why there are different levels of delayed transfers and different practices in each area. The RUH has the most access to community hospital beds, the GWH has some and SFT has none.

83. To compound this problem the County Council recognises there is a shortage of nursing and residential home beds in Salisbury compared to the north of the county. As a consequence to this, nursing homes in Salisbury can charge more than the regional average, and this in turn makes it more difficult to move people out of hospital beds into the community.

84. SFT has found trying to drive down delayed transfer figures very frustrating over a long period of time (fig. 4). When figures do go down it is normally as a result of WCC spot purchasing, but this is a short term solution and an expensive remedy. Trying to get all the agencies galvanised into working effectively together has been testing, but now working practices are improving.

85. SFT would like to see alternative care put in place so that nursing and residential care becomes a last choice and to support people to settle back in their home environment as a matter of course. Nursing homes take independence away and peoples' own homes often have to be sold to pay for the care.

86. Some kind of night care or night sitting service would compliment the Neighbourhood Teams and enable more people to stay at home.

87. New criteria for assessing Continuing Healthcare (CHC) needs and responsibilities have been applied, recommending the removal of patients from acute settings to more appropriate forms of care either at home or in a nursing/residential setting. Applying a maximum six week assessment period will help to stop the culture of making quick decisions about a patient's future when in fact a more measured approach would result in better outcomes for the patient.

88. The Trust would like to see more health service providers in the community. When an acute bed is blocked in Salisbury it often means the PCT has to pay a charge for excess bed days and the County Council can be fined, so having more nursing and residential home beds in South Wiltshire would help to move people on more quickly. Assessments could then be carried out from these community settings and not an acute hospital bed.

89. SFT is trying to change the culture on the wards by persuading staff not to use the phrase “nursing home” too early in a patient’s episode of care because the aim is to get people back home. Sowing the seed too early in the patient’s and families minds can affect the outcome and prevent the patient from being able to return to their previous place of residence.

90. Since the shared working protocol was put in place the six partners have met monthly and had frank discussions. The acute trusts have tried to learn from each other, but they serve such different communities that it makes it difficult. There were initially differing levels of commitment to the protocol and prior to the introduction of the new CHC criteria the Trust was sceptical about its ability to effectively address the issue, but there have since been significant improvements and a renewed impetus.

91. Now the protocol is moving into a second version it is hoped it will be more meaningful. The partners have realised it’s alright to feel aggrieved and the partnership doesn’t have to be cosy. Relationships are still fragile, but further success gives everyone something to build on.

92. The national change in out of hours services has turned it into the weak link in the chain. Now patients are more likely to be sent straight to the hospital when accessing out of hour’s services because they don’t get to see or speak to their own GP who knows their history. This has, at times, led to inappropriate admissions.

Swindon & Marlborough Trust (Great Western Hospital GWH)

Please note: the comments below are based on evidence provided to the Task Group at the time of evidence gathering exercise.

93. The Task Group met with Donna Bosson, Operational Lead, Discharge and Planning Policy at Swindon & Marlborough Trust, who has a long history of working to reduce and manage delays.

94. GWH has a positive discharge management procedure which has enabled it to keep delayed transfers to a minimum. Figures at Great Western Hospital have been consistently lower than elsewhere (fig. 5) The hospital has a screening team who see all potential admissions and they begin to work out what level of care a patient is likely to need on discharge. If a patient is not deemed appropriate for admission there is an observation area next to A & E where doctors can continue to monitor a patient before deciding whether to send them home or admit them if their condition worsens.

95. If planning a patient's discharge and long term care starts early enough social care can more reasonably be expected to plan placements and care packages. Swindon Borough Council have pushed for early involvement and this has carried through into the Wiltshire team working at the hospital. At GWH there is complete co-operation between the agencies involved.

96. The staff at GWH work from a live delayed transfer list and discharge nurses go round to all the wards to make sure anyone who can be moved on is. The Neighbourhood Teams are beginning to carry out home assessments, and they liaise with Access to Care, so if a patient is not fit to return home or their home is unsuitable, they will go to a community hospital or a short stay placement. Patients entering a community hospital in Wiltshire are given a two week maximum stay and a clear discharge plan.

97. GWH opted out of the system of fining social services for delays from day one and so partnership working was able to grow in a positive and satisfactory way. The management team at the Trust is very pleased with the outcome of the joint working and feels the hospital contributed as much as it could to tackling the issues. The grant money that was ring fenced to pay fines was re-distributed to the development of services to stop delays building up.

98. The Trust is constantly trying to develop and improve its multi-disciplinary teams and sees good inter-agency relationships as key to this. Each week multi-disciplinary team members come together to validate the delayed transfer figures and this includes social workers from both councils. When social care staff from other areas cover shifts at GWH they are surprised by the close relationship between health and social care and the level of access they are given to the process for managing delays.

99. Good step up/step down care for Wiltshire could help to improve services for patients even further and the Trust would support any moves to develop services.

Wiltshire Community Health Services (WCHS) - (Provider arm of the PCT)

Please note: the comments below are based on evidence provided to the Task Group at the time of evidence gathering exercise.

100. Jenny Barker, Managing Director for WHCS and Madeleine Griffiths, Inpatient Manager & Delayed Transfer Lead met the Task Group to give an overview of the impact of delayed transfers on the community hospitals.

101. WCHS has developed two posts which are intended to make a positive impact on delayed transfers within the community hospitals: Neighbourhood Team Development Manager and Inpatient Development Manager.

102. The Care Services Improvement Partnership (CSIP) worked with all agencies involved to move the delayed transfer agenda forward, and delays did decrease, but then remained static.

103. The shared working protocol is monitored by the Strategic DTOC group, which has gone through a number of incarnations, but it is now agreed that due to the serious nature of the issue each organisation has to be represented at Director level and that commitment has to be taken seriously.

104. The nature of and reasons for delays varies across the patch, but in some instances mental health delays have been high and AWP has been the least consistently represented of all the trusts on the Strategic DTOC group.

105. Cluster groups are implementing the actions agreed by the Strategic group at local level and are looking for the blockages in each care pathway. The service provider directors meet before each Strategic DTOC group and discuss operational problems. The new CHC criteria have caused some problems and there are ongoing issues at the RUH, but there is confidence that this can be resolved.

106. Whilst numbers of delays in Community Hospital Delays have been high, they have been below plan for much of the year.

107. There is general agreement to increase collaborative working, and having Directors at the meetings helps in this. The blame culture is beginning to end.

108. There has been resistance in the past to moving patients on who have been stuck in hospital beds for long periods of time. However, recently two long term patients were moved on from a community hospital after 2 years and successfully placed together, in a nursing home. This has shown the health and social care professionals that it can be done and all parties are now agreed that cases like this must be resolved, although this will be a major cultural change and staff will need training.

109. There is a burgeoning re-ablement scheme which uses facilities at Bemerton Lodge and Camilla House to help prevent people who are in acute settings from becoming delayed transfers by taking them on a short term basis and helping them get back on their feet. Urgent care step up beds are being developed in Chippenham to try to prevent some acute hospital admissions.

110. The PCT tries to make sure that people are being made fit for discharge, so to a degree it does force the issue, and Access to Care screening means that admitting someone as an inpatient is always the last resort.

111. The PCT and social care try to identify as early as possible in an episode of care what services the patient will potentially need when they are discharged from hospital and the Neighbourhood Teams are picking up much of this work and gaining a reputation. However, the family of the patient often have firm ideas about what will happen and there needs to be a balance between their wishes, the wishes of the patient and the impact on the health and social care community.

112. There needs to be widespread understanding that the driver to reduce delayed transfers is not financial. It is clearly understood by the professionals that a hospital is not the right place for older people unless they are being treated for a medical condition which requires an inpatient stay.

113. The old integrated health and social care teams worked very well together on the ground and the PCT would like to return to this way of working, albeit with better management and financial controls.

114. The piloting of a 24 hour nursing service in West Wiltshire is ongoing and has benefitted a number of people. However it is becoming clear that some kind of night sitting service is needed to enable more people to remain at home.

Conclusions

115. The six partner organisations have recognised that the problem of delayed transfers of care is hindering the development of a balance of services and that the situation can not be resolved unless all parties commit to addressing it equally.

116. Robust planning to establish future need should be carried out now.

     There are a number of unknown quantities, particularly in the area of mental health conditions, which need to be investigated and planned for now in order for health and social care to be able to meet future needs.

117. Carers need more and better support.

     Carers are recognised as providing a vital service, complimenting and reinforcing both health and social care. However, many carers express concern about lack of support and stress, in particular a lack of respite care which allow them to take time off from their caring role. Everybody needs time off and it is unacceptable that carers should reach the point where they feel they cannot continue to care for loved ones due to lack of support from the statutory care providers.

118. Spot purchasing only solves short term problems and makes the acute trusts wary because they know the pattern of build up and action will recur the following year. (please also see addendum)

119. Older people lose independence when admitted into hospital.

     It is a widely accepted fact that older people need to use their skills or lose them. Even a short stay in hospital can lessen their chances for long term independence.

120. Some form of night care/night sitting service is needed to provide necessary care and reassurance to patients and professionals.

     The PCT's overnight nursing pilot scheme, which has been running in West Wiltshire, has not received a high number of calls, 63 from November to February, but it has benefitted those who have had call to use it. The PCT has committed to continue the pilot and to try out other systems to ensure a night service can run in Wiltshire, and this was a key benefit outlined in Pathways for Change. However, the night service needs to be cost effective and able to offer a balance of nursing and social care, to give reassurance to patients and families as well as to deliver good clinical care.

121. The new Continuing Healthcare criteria have solved some problems, and at the same time caused others.

     The Task Group has heard mixed reviews of the new criteria. However, they need to be made to work and the process must enable health and social care to be equally represented or further grievances will develop, leading to additional pressures.

122. Decisions about a patient's future should not be made in a rush in hospital.

    All the evidence suggests that a robust assessment where the professionals have time to investigate personal circumstances and agree on the required level of support. This is crucial when decisions about whether an individual may need to enter residential care or remain at home with support at being taken.

123. There is a lack of control over out of hour services, which seem to operate outside the framework of established acute and community health services, and is a source of frustration.

    In particular the acute trusts felt that A & E is having to deal with the fall out from out of hours doctors not knowing the full medical history of the patients they see, with more patients presenting at A & E as a result of precautions taken by the out of house services.

124. Most admissions are appropriate, but if interventions could be made earlier then these may be avoidable.

    GWH, in particular, has developed an attitude where, for a number of reasons a presentation by an elderly person, especially at night, may not necessarily be inappropriate because it may be symptomatic of a broader problem. A presentation at A & E at least allows for a period of observation, which can in turn lead to a support package being put in place provided the links between health and social care are good.

125. Social care needs early involvement in discharge planning.

    Unless social care staff are kept fully in the loop and up to date about what is happening with a patient, it can be impossible to ensure that the right care package is in place by the time a patient is ready for discharge.

126. Fining social care for delays creates bad feeling.

    Although fining took place when relationships were already under severe pressure, it does nothing to foster good will or good working relationships. Trust and commitment are needed to enable all partners to find solutions and shifting costs and blame does not help to improve services for the people of Wiltshire.

127. The blame culture is ending, although some organisations still harbour resentments.

    The Task Group accepts it is difficult to let go of historic feelings, especially if one party feels it has been wronged. However, in the same way that certain practices are unhelpful, holding onto bad feeling may prevent organisations from taking part in finding solutions with a truly open mind.

128. The culture of an organisation can be changed, but it is a challenge and requires commitment.

    However, it takes dedication from the organisation at the highest level and commitment to support staff who may have to do their job entirely differently in the future.

129. Patients who have been in hospital, inappropriately, for years can be placed in more suitable care settings.

AWP and the PCT have been able to move long-standing delayed patients, but it has required high level decision makers to take responsibility. Staff must be supported and empowered to implement decisions and to act confidently in challenging situations.

130. Family wishes and expectations can have a huge bearing on the outcome for patients.

Families can lengthen delays by being unhappy with the placements offered, opting to wait for something better on behalf of their loved ones. This can, understandably, cause frustration among the professionals.

131. The impact on families has to be balanced against what is best for patients.

Although professionals may at times see families as a barrier, they are often struggling to come to terms with a dramatic change in a loved one's circumstances. All families should be offered good support and advice by health and social care, whether they are self funders or not, to enable them to make responsible decisions and exert positive influence over the patient.

Recommendations

132. The PCT, WCC and the voluntary sector should work together to improve support for carers.
    - Carers should be involved in developing support services.
    - Services which are traditionally seen as being of benefit to carers, such as respite, should not be cut to make financial savings as the short term benefits are not worth the long term detrimental effects.

133. Long stay patients who could be appropriate placed elsewhere must be dealt with.
    - All agencies to work together to achieve this.

134. Planning for long term need should be started now with particular emphasis on the impact of new dementia drugs which may enable people to live longer, and on the potential effect of long term drug and alcohol misuse.

135. Investment should be made in a wide range of services that will help prevent hospital admission and allow for timely discharge.

136. All organisations need to forget the past and move forward positively without continuing to harbour resentments. A culture of honesty and openness needs to be fostered and maintained.

137. Family expectations need to be effectively and consistently managed.

138. Spot purchasing should be stopped and all efforts and resources put into finding long term solutions.

139. An effective and robust night care/night sitting service must be developed.

140. Out of hours services must be tightly managed and the concerns expressed by the acute trusts in terms of inappropriate admissions must be addressed.

141. A viability study should be carried out into whether a “Saffron House” model of intermediate care for mental health sufferers who need support following hospitalisation for physical needs would be a beneficial addition to care in Wiltshire.

142. Assessments for long term care needs should be carried out once, to look at health and social care requirements, in a timely manner, but without rushing and preferably not while the patient is in an acute hospital setting.

143. Discharge plans should be put in place early on in an episode of care to allow the professionals, families and patients to prepare for the point when other care services take over from acute hospital staff.

144. Residential and nursing home capacity in South Wiltshire must be extended.

Next Steps

145. This report will be submitted to the Health Overview & Scrutiny Committee on 17th July 2008 for endorsement. It will then be circulated to contributing stakeholders for comment and response. In anticipation that the recommendations will be approved a progress report on implementation in 12 months will be taken to the Health Overview & Scrutiny Committee (of the new Council)

APPENDIX A

Delayed Transfers of Care Monitoring Tables by Trust and Organisation - July2007 to June 2008.

Wiltshire Wide - Quarterly snapshot of DToC

The Following tables show the weekly number of Delayed Transfers of Care patients by organisation, as at the Thursday night snapshot, and delayed days throughout the week.

The Actual numbers are supplied weekly to the DoH by the Trusts, via the Unify2 NHS statutory reporting system.

The information has been sourced from the weekly monitoring report that is compiled and circulated by Wiltshire PCT.

SNAPSHOTS AT QUARTER END (NHS and LA splits)									
Data Source	**Wiltshire Acute and Non Acute**								
SITREPs	**NHS**			**WCC**			Plan	Act	Diff
Last wk of Qrt	Plan	Actual	Days	Plan	Actual	Days			
Jun 07	18	**61**	393	84	**104**	743	102	168	66
Sep 07	11	**35**	259	50	**81**	530	61	116	55
Dec 07	10	**28**	179	35	**44**	308	45	75	30
Mar 08	8	**55**	345	27	**35**	236	35	91	56
Jun 08	8	**43**	256	27	**18**	122	35	62	27

Red indicates 'above plan'

Fig 1: Wiltshire Wide - Quarterly snapshot of DToC

Avon and Wiltshire Mental Health Partnership (AWP) - Weekly DToC

2007/08 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Non-Acute					
	Data source	AWP (RVN)					
	SITREPs	NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
July	007	4	11	77	18	42	294
	12/07/2007	4	11	77	18	44	308
	19/07/2007	4	11	77	18	46	322
	26/07/2007	4	12	84	17	45	315
Aug	02/08/2007	4	9	63	16	43	301
	09/08/2007	4	9	63	16	45	315
	16/08/2007	4	9	63	16	45	315
	23/08/2007	3	11	77	16	39	273
	30/08/2007	3	9	63	16	30	210
Sept	06/09/2007	3	9	63	15	30	210
	13/09/2007	3	6	42	15	26	182
	20/09/2007	3	6	42	15	26	182
	27/09/2007	3	6	42	14	26	182
Oct	04/10/2007	3	3	21	14	23	161
	11/10/2007	3	3	21	13	23	161
	18/10/2007	3	4	28	13	22	154
	25/10/2007	3	4	28	12	22	154
Nov	01/11/2007	2	4	28	12	19	133
	08/11/2007	2	4	28	12	19	133
	15/11/2007	2	4	28	11	19	133
	22/11/2007	2	4	28	11	19	133
	29/11/2007	2	3	21	10	20	140
Dec	06/12/2007	2	3	21	10	20	140
	13/12/2007	2	3	21	9	20	140
	20/12/2007	2	3	21	9	20	140
	27/12/2007	2	3	21	8	20	140
Jan	03/01/2008	2	3	21	8	20	140
	10/01/2008	2	0	0	8	17	119
	17/01/2008	2	0	0	7	17	119
	24/01/2008	2	0	0	7	13	91
	31/01/2008	1	0	0	7	8	56
Feb	07/02/2008	1	0	0	7	8	56
	14/02/2008	1	1	7	6	7	49
	21/02/2008	1	1	7	6	8	56
	28/02/2008	1	4	28	6	7	49
March	06/03/2008	1	8	56	5	9	63
	13/03/2008	1	8	56	5	9	63
	20/03/2008	1	8	56	5	9	63
	27/03/2008	1	8	56	4	9	63

2008/09 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Non-Acute					
	Data source	AWP (RVN)					
	SITREPs	NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
April	03/04/2008	1	8	56	4	9	63
	10/04/2008	1	8	56	4	9	63
	17/04/2008	1	8	56	4	9	63
	24/04/2008	1	4	28	4	26	182
May	01/05/2008	1	4	28	4	25	175
	08/05/2008	1	6	42	4	23	161
	15/05/2008	1	6	42	4	21	147
	22/05/2008	1	2	14	4	15	105
	29/05/2008	1	12	84	4	3	21
June	05/06/2008	1	12	84	4	3	21
	12/06/2008	1	12	84	4	3	21
	19/06/2008	1	12	84	4	3	21
	26/06/2008	1	12	84	4	3	21

Red indicates 'above plan'
Green indicates 'at or below plan'

Fig 2: AWP – Weekly snapshot of DToC

Royal United Hospital - Weekly DToC

2007/08 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

Data source		Acute					
		RUH (RD1)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
July	05/07/2007	5	13	87	6	17	114
	12/07/2007	5	15	81	6	13	91
	19/07/2007	5	15	73	6	13	76
	26/07/2007	5	14	81	6	10	66
Aug	02/08/2007	4	15	74	5	10	65
	09/08/2007	4	12	67	5	12	70
	16/08/2007	4	10	54	5	11	77
	23/08/2007	4	11	61	5	7	39
	30/08/2007	4	8	38	5	8	50
Sept	06/09/2007	3	7	37	3	8	42
	13/09/2007	3	8	41	3	8	48
	20/09/2007	3	17	78	3	8	47
	27/09/2007	3	11	67	3	13	71
Oct	04/10/2007	3	10	42	3	9	53
	11/10/2007	3	7	30	3	12	72
	18/10/2007	3	17	63	3	12	78
	25/10/2007	3	12	70	3	15	99
Nov	01/11/2007	3	12	69	3	8	55
	08/11/2007	3	18	68	3	6	37
	15/11/2007	3	11	59	3	5	35
	22/11/2007	3	12	64	3	6	42
	29/11/2007	3	10	33	3	4	23
Dec	06/12/2007	3	12	63	3	8	56
	13/12/2007	3	16	84	3	9	55
	20/12/2007	3	15	83	3	2	14
	27/12/2007	3	8	38	3	1	7
Jan	03/01/2008	3	9	22	3	3	9
	10/01/2008	3	13	49	3	1	2
	17/01/2008	3	16	91	3	3	15
	24/01/2008	3	17	64	3	0	0
	31/01/2008	3	25	63	3	4	28
Feb	07/02/2008	3	22	98	3	4	17
	14/02/2008	3	23	119	3	10	57
	21/02/2008	3	17	103	3	11	72
	28/02/2008	3	25	94	3	7	48
March	06/03/2008	3	23	117	3	8	56
	13/03/2008	3	15	86	3	10	55
	20/03/2008	3	19	105	3	6	36
	27/03/2008	3	11	44	3	5	15

2008/09 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

Data source		Acute					
		RUH (RD1)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
April	03/04/2008	3	19	80	3	6	36
	10/04/2008	3	11	41	3	4	24
	17/04/2008	3	15	74	3	5	30
	24/04/2008	3	13	64	3	4	28
May	01/05/2008	3	13	57	3	5	34
	08/05/2008	3	16	78	3	8	50
	15/05/2008	3	14	58	3	9	53
	22/05/2008	3	17	93	3	9	52
	29/05/2008	3	19	102	3	7	48
June	05/06/2008	3	12	77	3	9	61
	12/06/2008	3	12	67	3	4	28
	19/06/2008	3	8	45	3	3	4
	26/06/2008	3	12	59	3	3	19

Red indicates 'above plan'
Green indicates 'at or below plan'

Fig 3: Royal United Hospital - Weekly snapshot of DToC

Salisbury Foundation Trust - Weekly DToC

2007/08 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Acute					
Data source		SFT (RNZ)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
July	05/07/2007	2	16	107	5	10	72
	12/07/2007	2	14	90	5	8	73
	19/07/2007	2	13	91	5	15	98
	26/07/2007	2	15	107	5	12	97
Aug	02/08/2007	2	14	103	4	15	102
	09/08/2007	2	13	84	4	14	126
	16/08/2007	2	13	95	4	14	98
	23/08/2007	2	9	77	4	12	90
	30/08/2007	2	10	65	4	11	73
Sept	06/09/2007	1	9	73	3	7	52
	13/09/2007	1	10	71	3	7	49
	20/09/2007	1	8	60	3	8	60
	27/09/2007	1	6	58	3	10	70
Oct	04/10/2007	1	9	71	3	12	87
	11/10/2007	1	13	97	3	13	91
	18/10/2007	1	13	88	3	12	91
	25/10/2007	1	8	57	3	16	103
Nov	01/11/2007	1	13	99	3	13	86
	08/11/2007	1	2	36	3	15	86
	15/11/2007	1	3	31	3	11	82
	22/11/2007	1	4	30	3	10	66
	29/11/2007	1	4	32	3	7	57
Dec	06/12/2007	1	9	58	3	6	42
	13/12/2007	1	6	48	3	7	46
	20/12/2007	1	6	44	3	4	35
	27/12/2007	1	7	50	3	2	14
Jan	03/01/2008	1	10	71	3	4	24
	10/01/2008	1	12	90	3	4	25
	17/01/2008	1	8	71	3	4	28
	24/01/2008	1	9	68	3	5	35
	31/01/2008	1	11	78	3	4	29
Feb	07/02/2008	1	12	79	3	3	18
	14/02/2008	1	10	71	3	1	13
	21/02/2008	1	9	46	3	1	17
	28/02/2008	1	6	40	3	6	48
March	06/03/2008	1	6	57	3	11	75
	13/03/2008	1	8	53	3	4	56
	20/03/2008	1	9	62	3	7	45
	27/03/2008	1	8	56	2	8	53

2008/09 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Acute					
Data source		SFT (RNZ)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
April	03/04/2008	1	2	34	2	7	54
	10/04/2008	1	2	14	2	4	32
	17/04/2008	1	3	22	2	2	14
	24/04/2008	1	4	29	2	8	48
May	01/05/2008	1	6	44	2	6	45
	08/05/2008	1	2	32	2	6	46
	15/05/2008	1	5	34	2	6	51
	22/05/2008	1	4	35	2	6	42
	29/05/2008	1	6	42	2	3	28
June	05/06/2008	1	7	48	2	3	26
	12/06/2008	1	6	48	2	3	28
	19/06/2008	1	4	41	2	5	36
	26/06/2008	1	4	41	2	5	36

Red indicates 'above plan'
Green indicates 'at or below plan'

Fig.4: Salisbury Foundation Trust - Weekly snapshot of DToC

Swindon & Marlborough Trust (GWH) Weekly DToC

2007/08 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Acute					
Data source		GWH (RN3)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
July	05/07/2007	3	0	9	2	2	15
	12/07/2007	3	0	0	2	3	13
	19/07/2007	3	0	0	2	1	5
	26/07/2007	3	2	8	2	3	11
Aug	02/08/2007	2	2	14	2	4	28
	09/08/2007	2	3	21	2	5	29
	16/08/2007	2	1	11	2	5	40
	23/08/2007	2	0	0	2	2	29
	30/08/2007	2	3	26	2	0	8
Sept	06/09/2007	1	3	23	1	1	7
	13/09/2007	1	3	17	1	1	11
	20/09/2007	1	6	43	1	1	6
	27/09/2007	1	4	36	1	0	0
Oct	04/10/2007	1	4	34	1	0	0
	11/10/2007	1	6	39	1	0	0
	18/10/2007	1	5	42	1	0	0
	25/10/2007	1	7	56	1	0	0
Nov	01/11/2007	1	10	48	1	2	14
	08/11/2007	1	7	59	1	3	19
	15/11/2007	1	10	65	1	2	14
	22/11/2007	1	5	30	1	3	15
	29/11/2007	1	2	36	1	1	13
Dec	06/12/2007	1	4	21	1	0	1
	13/12/2007	1	1	23	1	0	0
	20/12/2007	1	1	2	1	0	0
	27/12/2007	1	1	7	1	0	0
Jan	03/01/2008	1	2	16	1	0	0
	10/01/2008	1	1	9	1	0	0
	17/01/2008	1	1	20	1	0	0
	24/01/2008	1	1	4	1	0	0
	31/01/2008	1	1	4	1	0	0
Feb	07/02/2008	1	0	4	1	0	0
	14/02/2008	1	2	6	1	0	0
	21/02/2008	1	6	37	1	0	4
	28/02/2008	1	4	32	1	1	7
March	06/03/2008	1	11	78	1	0	0
	13/03/2008	1	8	56	1	0	0
	20/03/2008	1	8	70	1	1	5
	27/03/2008	1	12	70	1	1	7

2008/09 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Acute					
Data source		GWH (RN3)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
April	03/04/2008	1	11	87	1	2	10
	10/04/2008	1	10	91	1	2	12
	17/04/2008	1	11	80	1	1	7
	24/04/2008	1	9	75	1	0	4
May	01/05/2008	1	6	52	1	0	0
	08/05/2008	1	6	50	1	1	7
	15/05/2008	1	8	47	1	2	11
	22/05/2008	1	9	51	1	3	21
	29/05/2008	1	5	53	1	3	21
June	05/06/2008	1	5	43	1	2	18
	12/06/2008	1	2	26	1	2	21
	19/06/2008	1	4	26	1	1	8
	26/06/2008	1	7	37	1	0	5

Red indicates 'above plan'
Green indicates 'at or below plan'

Fig.5: Swindon & Marlborough Trust - Weekly snapshot of DToC

Wiltshire PCT - Weekly DToC

2007/08 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Acute					
Data source		Wilts PCT (5QK)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
July	05/07/2007	4	**10**	64	48	**31**	212
	12/07/2007	4	**10**	64	46	**26**	171
	19/07/2007	4	**13**	80	44	**30**	179
	26/07/2007	4	**11**	71	43	**30**	184
Aug	02/08/2007	4	**14**	92	42	**27**	189
	09/08/2007	4	**14**	93	41	**30**	190
	16/08/2007	4	**11**	77	39	**26**	169
	23/08/2007	4	**9**	53	37	**29**	189
	30/08/2007	4	**7**	32	36	**34**	225
Sept	06/09/2007	3	**6**	38	29	**32**	216
	13/09/2007	3	**6**	38	29	**27**	189
	20/09/2007	3	**8**	49	29	**30**	190
	27/09/2007	3	**8**	56	29	**32**	207
Oct	04/10/2007	3	**5**	35	29	**35**	222
	11/10/2007	3	**6**	38	28	**30**	194
	18/10/2007	3	**7**	30	27	**32**	205
	25/10/2007	3	**6**	42	26	**31**	205
Nov	01/11/2007	3	**9**	59	26	**28**	190
	08/11/2007	3	**9**	63	25	**25**	170
	15/11/2007	3	**10**	59	24	**19**	128
	22/11/2007	3	**8**	44	23	**22**	130
	29/11/2007	3	**5**	35	23	**24**	156
Dec	06/12/2007	3	**6**	36	23	**25**	175
	13/12/2007	3	**7**	43	22	**25**	158
	20/12/2007	3	**10**	56	21	**23**	149
	27/12/2007	3	**9**	63	20	**21**	147
Jan	03/01/2008	3	**12**	66	20	**18**	126
	10/01/2008	3	**13**	86	20	**19**	119
	17/01/2008	3	**11**	71	20	**17**	109
	24/01/2008	3	**14**	89	20	**13**	91
	31/01/2008	3	**15**	94	19	**14**	88
Feb	07/02/2008	3	**13**	91	19	**16**	79
	14/02/2008	3	**14**	89	19	**18**	107
	21/02/2008	3	**14**	87	19	**19**	128
	28/02/2008	3	**14**	94	18	**15**	105
March	06/03/2008	3	**13**	81	18	**14**	98
	13/03/2008	3	**10**	55	18	**14**	98
	20/03/2008	3	**11**	49	18	**10**	65
	27/03/2008	2	**10**	70	17	**11**	71

2008/09 WILTSHIRE DELAYED TRANSFER OF CARE SUMMARY - (NHS and LA splits)

		Acute					
Data source		Wilts PCT (5QK)					
SITREPs		NHS			WCC		
	Snapshot	Plan	Actual	Days	Plan	Actual	Days
April	03/04/2008	2	**15**	88	17	**11**	73
	10/04/2008	2	**8**	50	17	**11**	71
	17/04/2008	2	**8**	56	17	**10**	64
	24/04/2008	2	**10**	64	17	**9**	57
May	01/05/2008	2	**7**	44	17	**9**	59
	08/05/2008	2	**8**	46	17	**5**	35
	15/05/2008	2	**7**	49	17	**10**	46
	22/05/2008	2	**7**	49	17	**12**	78
	29/05/2008	2	**6**	35	17	**12**	84
June	05/06/2008	2	**7**	49	17	**10**	70
	12/06/2008	2	**5**	35	17	**8**	43
	19/06/2008	2	**4**	28	17	**9**	56
	26/06/2008	2	**8**	35	17	**7**	41

Red indicates 'above plan'
Green indicates 'at or below plan'

ADDENDUM

Delayed Transfers of Care, Task Group, Final Report June 2008.

The Delayed Transfer of Care Task Group met on 1st July 2008 to review the Final Report and to receive updates and comments from James Cawley (JC). James reinforced that the message that reconciling the DToC issues is not about blame, and also asked for the following comments to be recorded.

Para	Comments
50	**Avon & Wiltshire Mental Health Partnership (AWP)**: Following an unrealistic 'overnight' jump in AWP figures, there was found to be a recording problem. This has now been addressed and current reports show DToCs are down to single figures. Unfortunately, this cannot be untangled retrospectively, so the shared protocol was based on incorrect figures.
	Royal United Hospital (RUH)
71	**Spot Purchases (note also applies to SFT):** Clarity needed that DCS do not Spot Purchase just at year end. It is an ongoing activity through out the year, based on Individual cases e.g. If a patient lives in an area where we have no contract beds, a Spot Purchase is considered. This is about patient Choice, not any intention to massage figures.
80	All the Acute Trusts, not just the RUH, realise that Assessments need to be carried out earlier. RUH are currently learning from the Great Western.
Gen	Procedures are being amended to establish an 'Estimated Date of Discharge' early in the patient journey. However, it is slow to get underway.
	Salisbury Foundation Trust (SFT):
84	Reducing DToCs in Salisbury has been frustrating, but there has been a change in the last couple of months. The new acting CEO (Peter Hill) has contributed to this. See note for para 71 above re. Spot purchasing
89	Changing ward culture: A new concept of monthly 'Cluster Group' meetings is being introduced. The idea is to bring together the organisations within an area. Cluster Group DCS Acute Trust AWP Wilts PCT (Comm Hosp)

Para	Comments
92	Salisbury have started this Group, which is about the smooth running of the service and talking through how it works. SFT has 14 wards, and are looking at having multidisciplinary team meetings every week (including DCS). With new admissions they purposefully look at possible outcomes now, not later. If this proposal is successful then it will be considered by the other organisations There is no evidence to say that admissions have been inappropriate. However further work is required to ensure that people are supported in the right health / social care setting
99	**Swindon & Marlborough Trust** Update to step up /down care: Amesbury Care Home opens this week. It has 20 beds, 6 Health and 14 DCS.

Update information:

a) **Cluster Groups** (See above)

b) **Choice Protocol**: When a patient needs to be admitted to a Care Home, but there is no vacancy, the protocol states that the Patient must now accept a move to an interim home.

c) **Memorandum Of Understanding (MOU).**
This MOU is still in Draft form, but has been agreed in principle and is about to be signed. There is a shift in the ways of partnership working and the MOU is about performance as partners are more confident in working together.

d) **Target**:
There is a National guidance from the SHA to reduce DToCs to 1% of occupied (older people) beds by March 09, and this has been adopted by Wiltshire health and social care community. It is a very tight target, and it is recognised that it is probably not achievable. Wiltshire's aim is to maintain a downward trend.

The Acute Trusts, DCS, PCT, AWP all own this target, but DCS are the real drivers.

e) **Fining**
This has been taken out altogether.

f) **NHS and Social Care Night Service**.
West Wilts is running a NHS (only) pilot that is due to end in March 09.

DCS is now working towards extending this to a joint NHS and Social Care service pilot for both West Wilts and Devizes, running for 12 to 14 months. Following a review it would be hoped to extend this county wide. Telecare is to be introduced for all adults with Home Care in partnership with providers. Using the Telecare system a call goes straight through to Salisbury Control

Centre who can then respond by sending out an appropriate service / staff.

The budget for this scheme has already been set aside.

g) **Development Strategy**
As part of the overall Development Strategy, the Council and the Order of St Johns (OSJ) are looking at Extra Care and Nursing. Provision of EMI nursing facilities is also being considered.

h) **Care for the terminally ill**.
If a terminally ill patients needs medical intervention they need to be placed in NHS beds e.g. the ones at the new Malmesbury Care Home.

i) **Move On Beds**:
DCS will have ‘Move on Beds’ e.g. Bemerton Lodge in Salisbury.