Committee Name	**SERVICES SCRUTINY COMMITTEE**
Meeting Date	**4 June 2015**
Item Title	**SCRUTINY INVESTIGATION FROM HOSPITAL TO THE HOME PART 2**
Investigation Chairman	**Councillor Peter Read**
Investigation Chairman	**<u>Councillors</u> Selwyn Griffiths Linda Ann Wyn Jones Eryl Jones-Williams Ann Williams Eirwyn Williams**
Officers	**Gareth James Sioned Thomas Bethan Adams**
Purpose	**Present the Draft Final Report to the attention of the Services Scrutiny Committee Members for their comments**

We wish to acknowledge with thanks the valued contribution of the late Councillor Huw Edwards to the work of the Investigation

Contents

1 Investigation Background

The reason for this scrutiny investigation is the concern regarding arrangements for discharging and transferring patients from hospital. Members of the Services Scrutiny Committee had concerns regarding the suitability and effectiveness of these arrangements in Gwynedd.

This Investigation is based on the opinion of individuals interviewed and the observations are noted as Evidence under the headings of Main Findings and Main Recommendations in each section.

Members of the Investigation decided to follow this method in order to reflect the evidence fully and without prejudice.

2 Investigation Brief

The aim of the investigation was to consider the following matters:

- The suitability and effectiveness of discharge arrangements in terms of ensuring the best outcomes for older patients, by identifying and highlighting good practice and areas in need of improvement.
- The suitability and effectiveness of collaboration arrangements between the Local Health Board and the Council in terms of assessing, planning and providing integrated and appropriate care for older patients who are discharged from hospital.
- The role of the Third Sector organisations in terms of supporting older patients to return home or to live in the community.
- Identify examples of good practice from other areas and highlight the ones that could be adopted and put into practice in Gwynedd / North Wales.
- Draw up a series of improvement recommendations to be submitted to the Local Health Board, Gwynedd Council and Third Sector organisations to respond to the investigation's main findings and outcomes.

3 PART 1

The work of the investigation was divided into two parts. The PART 1 Report was submitted to the meeting of the Services Scrutiny Committee on 19 June 2014.

PART 1 focused on the arrangements from the perspective of the patient who was being prepared to leave the hospital. The Main Findings and Main Recommendations were based on the following information:

- Identifying Good Practices in other areas

- Observations from 14 Older People in meetings and forums

- Observations from 5 Betsi Cadwaladr University Health Board Officers

- Observations from 3 officers from the Council's Care, Health and Well-being Department

- Observations from 1 officer from the Third Sector.

The Recommendations were all received by the Cabinet Member for Care on 19 June 2014 and he agreed to draw up an Action Plan to implement the recommendations.

Members considered the Progress Report at their Preparatory Meeting in March 2015 and they asked for clarity on some points in the Action Plan.

4 PART 2

PART 2 has focused on the arrangements from the perspective of the patient after he/she returns to the Community or the Home. The Report along with the Main Findings and the Main Recommendations that are submitted are based on the following information:

- Performance Data
- Observations from 10 officers from the Third Sector
- Observations from 9 officers from the Council's Care, Health and Well-being Department
- Observations from 4 officers from the Health Board
- Observations from 1 from the Private Sector

1. Main Findings DRAFT 5

1.1 It is seen that on the whole, **Gwynedd is performing well** in terms of national comparison on the measure of Transferring Patients in a timely manner from Hospital to the Community.

1.2 It was seen that **the Brokerage Service was working effectively** on the whole with Service Users and internal and external Providers praising the service.

1.3 That patients are treated in Hospital for the period of their illness without a Care Plan and that this leads to rushing to create a **Care Plan** before they are discharged into the community, making it very difficult to prepare for planning care in the community.

1.4 There is a potential to increase the use of the services that are provided by the **Third Sector**, but there is a substantial lack of information regarding the services.

1.5 Despite an improvement in the arrangements in terms of discharging patients **at weekends**, there is room to improve this further.

1.6 There are no arrangements with Ceredigion County Council Social Workers in relation to patients that are discharged from **Ysbyty Bronglais** to South Gwynedd.

1.7 Despite examples of good quality arrangements which received wide recognition, the situation in **Meirionnydd** in general is a cause of concern, specifically because patients are referred to three Emergency Units in three different and distant locations in Aberystwyth, Bangor and Wrexham.

1.8 It was discovered that a **shortage of GPs and nurses** in some areas caused difficulties in terms of maintaining care in the community.

1.9 There was no evidence that the public and service users have had an opportunity to contribute to the process of creating Betsi Cadwaladr University Health Board's **Discharge Protocol**.

1.10 Examples of **bureaucracy** and a culture of completing forms were seen which sometimes undermined the main work of nurses and carers.

2. Main Recommendations DRAFT 5

The Report summarises the key issues that *Gwynedd Council* and *Betsi Cadwaladr University Health Board* need to consider further in the opinion of the Services Scrutiny Committee.

It is hoped that the points raised will help to ensure progress in this field.

The Cabinet Member for Care, Adults and Health and the **Chief Executive of Betsi Cadwaladr University Health Board** are asked to implement the following recommendations by creating an Action Plan by mid July 2015. The members will request a Progress Report in January 2016.

2.1 Support the **Third Sector** to co-ordinate preventative and support services in the community and ensure that they have adequate resources to satisfy this and to increase the frontline workers' knowledge and awareness of third sector services.

2.2 Assess the success of the *Intermediate Care Project* and ensure follow-up following the end of the grant to deal with any shortcomings which remain in terms of maintaining the service of the hospital discharge teams and the community teams in full **at weekends**.

2.3 Collaborate with Hywel Dda Health Board to agree on an arrangement with the **Ysbyty Bronglais** Discharge Team to discharge patients to South Meirionnydd.

2.4 Address some of the weaknesses of the patient transfer arrangements giving due focus where necessary to drawing up a new **Care Plan** soon after the patient arrives at Hospital.

2.5 It is understood that work is underway to improve the situation regarding the **shortage of doctors and nurses** and that the schemes need to be communicated clearly giving special attention to Dwyfor and Meirionnydd.

2.6 Review the **Discharge Protocol** by consulting with key stakeholders including the patients and the public in line with the Language Policies of Gwynedd Council and the Health Board.

2.7 Assess the success of the work that is underway on Lean/Vanguard at Ysbyty Alltwen to address the current bureaucratic arrangements to free staff's time to deal with their main duties of providing care and nursing.

3. **National Performance** **DRAFT 5**

Main Finding

It is seen that Gwynedd is performing well on the whole in terms of national comparison on the measure of Transferring Patients in a timely manner from the Hospital to the Community.

EVIDENCE

3.1 There is one main national indicator that measures the Council's performance in terms of delay while transferring from hospital due to social care reasons, namely: **SCA/001**- *The rate of delayed transfers while transferring social care per 1,000 of the population aged 75 or over.*

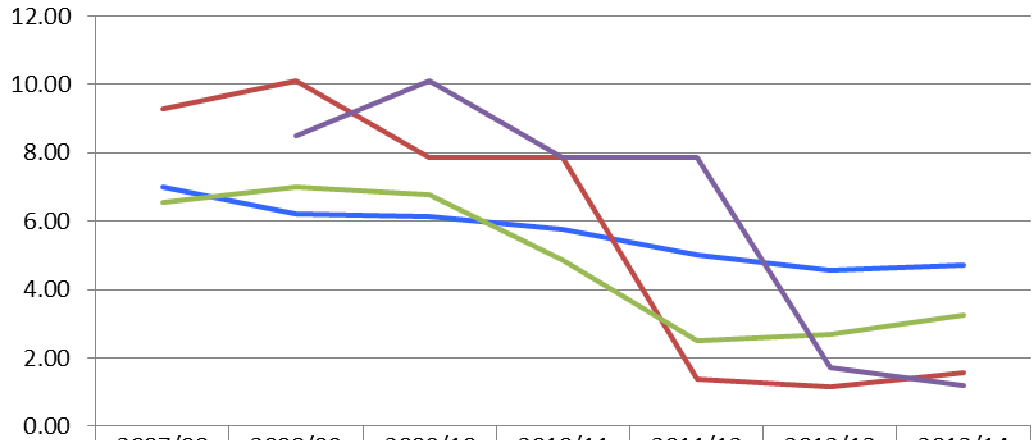
3.2 Delay in transferring care is something that an in-patient who is ready to move on to the next step of his/her care experiences, but is prevented from doing so. The 'next step of care' deals with all suitable placements within and outside the NHS i.e. those patients who cannot be discharged from NHS care, and also patients who cannot be transferred within the NHS to a more suitable bed.

3.3 The measure therefore seeks to discover the rate of delay in hospitals for patients due to social care issues only e.g. waiting to go to a residential home or arranging home care. Gwynedd performs well in this measure, and in 2013/14 Gwynedd was ranked sixth in Wales. There has been some slippage since last year, but Gwynedd has still performed well.

3.4 In 2013/14 a delay in transferring was noted on 19 occasions in the 12 months, in comparison to 14 occasions in 2012/13. Note that the same person could be counted twice if they continue to experience delays from one month to the next.

3.5 Please see the following graph on Gwynedd's performance in comparison to the whole of Wales. Gwynedd has worked hard in order to ensure that the rate of delay in transferring due to social

SCA/001- The rate of delayed transfers of care for social care reasons per 1,000 population aged 75 or over

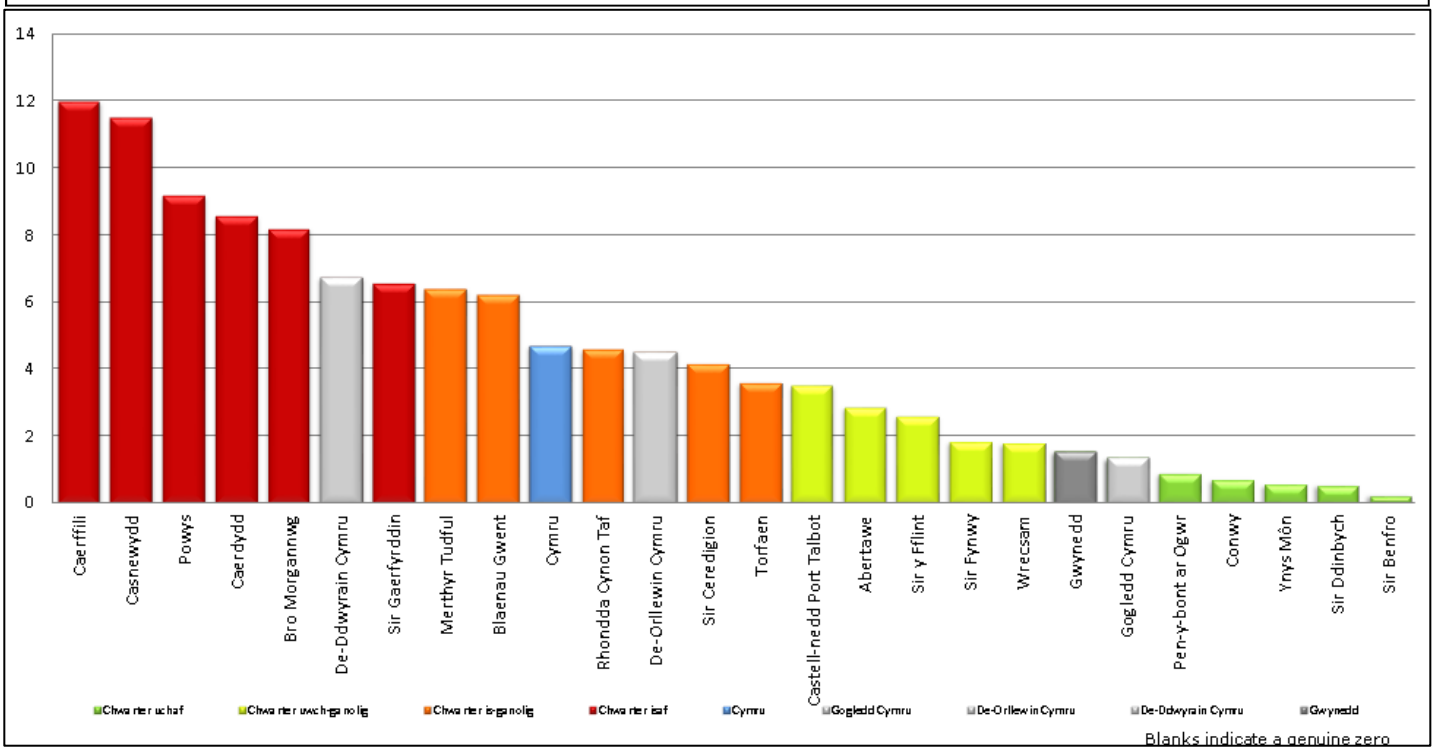


	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Cymru	7.01	6.21	6.13	5.76	5.03	4.57	4.70
Gwynedd	9.28	10.12	7.87	7.84	1.39	1.16	1.55
Teulu	6.55	7.00	6.76	4.87	2.5	2.69	3.24
Targed		8.48	10.12	7.87	7.87	1.70	1.20

care reasons has reduced, and as you see from the following graph the rate has reduced significantly since 2007/08.

3.6 As you see from the following table, in 2013-14 Gwynedd performed very favourably compared with the other Welsh authorities.

SCA/001- The rate of delayed transfers of care for social care reasons per 1,000 population aged 75 or over 2013-14



4. **Brokerage** **DRAFT 5**

Main Finding

It was seen that the Brokerage Service was working effectively on the whole with Service Users and internal and external Providers praising the service.

EVIDENCE

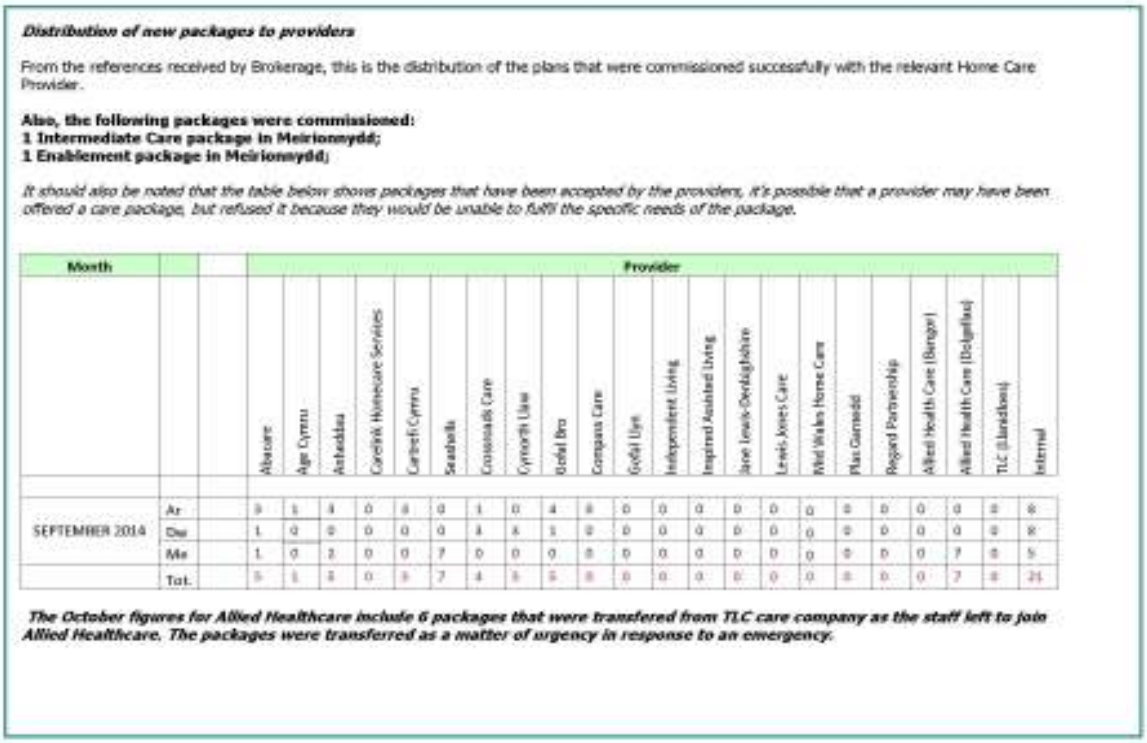
4.1 The brokerage service in Gwynedd has been greatly praised since its establishment in September 2010. The Brokerage Team is the first point of contact between social workers, older people who receive home care and home care providers. The team can respond more effectively to every request for home care and has released the time of social workers who previously arranged care packages.

4.2 In the Words into Action conference: **Welsh Language in Health, Social Services and Social Care Awards 2014**, the Gwynedd Council Brokerage Team won an award for ensuring that the language requirements of the service user are noted clearly. As far as we know, this is the only Brokerage Team in the home care sector which provides an entirely bilingual service and which takes very practical steps to ensure that Welsh-language provision is targeted where it is needed. Therefore, providers are increasingly aware of the fact that the Council will not accept any deviations from its contractual obligations, namely that providers must satisfy the requirements of *More than words*.

4.3 The brokerage service has also been an effective method of managing and developing the home care market and increasing the independent sector provision significantly since the establishment of the service.

4.4 The brokerage service has developed a monthly management report which assists them to monitor the service's performance. The report includes noting the new and existing referrals, the distribution of packages according to weekly hours and the distribution of new packages for providers.

4.5 The following table shows the distribution of new packages to providers in September 2014. The table shows that 21 new packages had been given to internal provision and 40 to external providers.



Distribution of new packages to providers

From the references received by Brokerage, this is the distribution of the plans that were commissioned successfully with the relevant Home Care Provider.

Also, the following packages were commissioned:
1 Intermediate Care package in Meirionnydd;
1 Enablement package in Meirionnydd;

It should also be noted that the table below shows packages that have been accepted by the providers, it's possible that a provider may have been offered a care package, but refused it because they would be unable to fulfil the specific needs of the package.

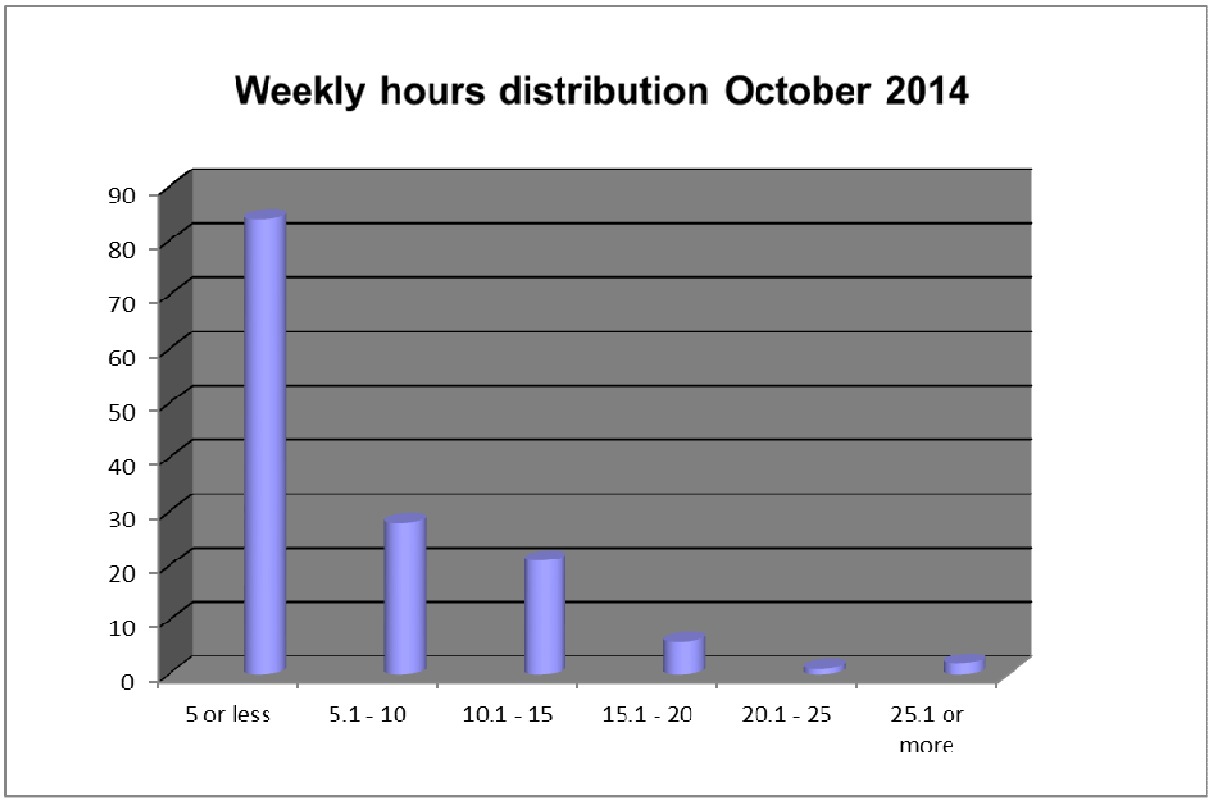
Month			Provider																				
			Abacare	Age Cymru	Anheddau	Careink Homecare Services	Carmel Cymru	Seabrella	Crossroads Care	Cymorth Uwch	Gofal Bro	Compass Care	Gofal Lyn	Independent Living	Inspired Assisted Living	Jane Lewis-Denbighshire	Lewis Jones Care	Mid Wales Home Care	Plas Garnedd	Regard Partnership	Allied Health Care (Bangor)	Allied Health Care (Dolgellau)	TLC (Llanidloes)	Internal
SEPTEMBER 2014	Ar		3	1	3	0	3	0	1	0	4	3	0	0	0	0	0	0	0	0	0	0	0	8
	Dw		1	0	0	0	0	0	3	1	1	0	0	0	0	0	0	0	0	0	0	0	0	8
	Me		1	0	2	0	0	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0	5
	Tot.		5	1	5	0	3	7	4	1	5	3	0	0	0	0	0	0	0	0	0	7	0	21

The October figures for Allied Healthcare include 6 packages that were transfered from TLC care company as the staff left to join Allied Healthcare. The packages were transferred as a matter of urgency in response to an emergency.

Intermediate and Enablement cases (provided by Internal Provider) are not included in these figures as these are not commissioned by Brokerage. However, the figures include the Intermediate and Enablement packages which have been commissioned by Brokerage to the private sector when there was lack of capacity to accept the packages by Internal Provider.

4.6 Of the referrals which came to the attention of Brokerage, this is the distribution of care plans according to the number of hours per week that were to be commissioned.

Month		Weekly Hours							Sleeping in packages
		5 or less	5.1 - 10	10.1 - 15	15.1 - 20	20.1 - 25	25.1 or more		
OCTOBER 2014		84	28	21	6	1	2		2


Weekly hours distribution October 2014
90
80
70
60
50
40
30
20
10
0
5 or less
5.1 - 10
10.1 - 15
15.1 - 20
20.1 - 25
25.1 or more

5. Care Plan DRAFT 5

Main Finding

That patients are treated at Hospital for the period of their sickness without a Care Plan and that this leads to rushing to create a Care Plan before they are discharged into the community, making it very difficult to prepare for planning care in the community.

Main Recommendation

Address some of the weaknesses of the patient transfer arrangements giving due focus where necessary to drawing up a new Care Plan soon after the patient arrives at Hospital.

EVIDENCE

5.1 One weakness in the "What's Important" Form, that is the integrated assessment form (the form to be used by Health and Social Services for referral) is that the expected discharge from hospital date is not noted on it.

5.2 There has been some misunderstanding about the intermediate service funding in Arfon this year. This has caused some difficulty in relation to Intermediate Care and Enablement. There is a breakdown in communication sometimes, mainly as the communication takes place through a virtual team. The nurses need to lead the work of sharing information.

5.3 Some difficulties arise sometimes with delays in providing suitable equipment for individuals.

5.4 In order to avoid any delay, a care plan and any necessary equipment need to be in place before the individual goes home. To enable this to happen the care plan must commence immediately when the person has reached hospital. Currently, this does not always happen immediately.

5.5 Sometimes, people do not realise the real effect of the stroke until they return home, as they have been receiving support at hospital from nurses, physiotherapists and occupational therapists. There is also a possibility that an individual is suffering from more than one condition, and it is necessary to identify the individual's greatest need.

5.6 In addition, difficulties arise because people do not identify third sector workers as professional people, and are therefore reluctant to share full information with the Association. This can cause difficulties because the entire information about a situation is needed and not just the core details.

5.7 The officers of the Red Cross expressed concern that although in the majority of cases the individuals' needs are met effectively by the various actions and services provided by the various establishments, there was no clear and integrated method.

5.8 Currently, the procedure is that the staff of the Advice and Assessment Team or Social Worker updates the information about the patient on an electronic system called RAISE.

The Single Point of Contact project considers how to develop the electronic data system that could be jointly-used by the health service also as a result of developing fully integrated work in the future. The objective is to do the best for the patient (considering health and care), without delay and to ensure early support to avoid an emergency and loss of independence to the individual.

5.9 When a problem arises or a complaint is received e.g. health sending an individual home late at night without putting arrangements in place, usually the charity's Advocacy Officer (Age Cymru) would deal with the matter, depending on the case.

5.10 One field that causes particular concern is the field of dementia. There is no sufficient and bespoke provision available in Gwynedd at present. Indeed, it is a crisis situation. One of the features of this is that patients remain in hospital for longer than is required and this contributes to the shortage of beds for acute treatment use. There is an insufficient provision of specialised nursing or residential beds.

5.11 Over the past few years, Heulwen Ward was closed in Ysbyty Gwynedd and this ward specialised in dementia work and now each dementia case is referred to Ysbyty Cefni, Llangefni. One of the wards in Ysbyty Cefni was also closed.

5.12 One element that contributes to the pressure is the lack of nurses specialising in dementia care.

5.13 The nature of some social workers and occupational therapists' part-time contracts means that coordinating the work can be difficult at times. Sometimes days or weeks pass without receiving a response.

5.14 Some problems can arise with complex care packages. For example, where the company is required to provide additional needs such as peg feeds and testing the blood of the person who is receiving the service. This can lead to additional costs for which there is no finance.

5.15 Occasionally, patients will state in Ysbyty Gwynedd that they do not require assistance to return home; however, once the reality of arriving home hits them, they, or a family member, realise that support is needed. Then, they would contact one of the area Teams and urgent arrangements will need to be made at that time.

5.16 In Ysbyty Alltwen, some difficulties have arisen due to the lack of communication between staff on the wards.

5.17 In general, a patient's stay in the community hospital tends to be for a longer period than a stay at Ysbyty Gwynedd and this means that more time is available to plan for discharge.

5.18 It was noted that Health staff had a lack of awareness of the new form. Some members of staff still fill in the old form as they are not aware that the form has been prepared jointly with Health.

5.19 Some Doctors and Nurses contacted the team to have a walking frame, although Health provides them.

5.20 It would be beneficial if Health staff had a better understanding of the services that are offered when they speak with individuals in the community hospitals before the individual returns home.

5.21 It was noted that it would be extremely valuable if the IT systems of the Council and Health talked to each other in order to facilitate access to information.

5.22 Although there is no capacity to increase the Red Cross' Convoy activity without additional resources, it is also concerning that there is so little awareness of the service amongst hospital staff and in general. The Health Board staff and the Council's Social Workers could extend this awareness.

5.23 Should the client's needs change substantially after a spell in hospital, the Social Worker will close the Care Package at Ysbyty Gwynedd, and a new Care Package will be opened for the client at Ysbyty Bryn Beryl.

5.24 This can cause difficulties and lack of clarity for the client and staff at Ysbyty Bryn Beryl. This can also mean that a new social worker will be creating the new Care Package. It would be better to continue with the same Care Package and the same Social Worker.

5.25 When a new Care Package is created, this can take up to a fortnight. This results in the client having to wait too long in the hospital before being transferred home.

5.26 It would be better to have one Social Worker dealing with Ysbyty Bryn Beryl.

6. Third Sector DRAFT 5

Main Findings

There is a potential to increase the use of the services that are provided by the Third Sector, but there is a substantial lack of information regarding the services.

Main Recommendation

Support the Third Sector to co-ordinate preventative and support services in the community and ensure that they have adequate resources to satisfy this and to increase the frontline workers' knowledge and awareness of third sector services.

EVIDENCE

6.1 There is a need to give detailed consideration jointly with a number of organisations, including local authorities, Ambulance Service, Third Sector organisations and others. There is a need to consider how best to provide transport services, home care and residential care services and care in people's homes. Clear and firm guidance on this matter is sought from the Health Board.

6.2 An integrated plan across north Wales should be formed and led by the Health Board to include providers of community transport.

6.3 It is important that the Health Board works with other establishments to plan and develop effective services across north Wales.

6.4 There is good contact between workers of the Stroke Society and the Health Board, especially with the stroke wards in Ysbyty Gwynedd, Ysbyty Maelor, Wrexham and Ysbyty Bronglais, Aberystwyth.

6.5 There is some input from the Council's Social Services with the Adults Team who make contact if an individual has had a stroke before they come into contact with them.

6.6 Often people become confused in terms of who they should contact or who they have been speaking with, as many people have an input to the patient's situation. This includes people in the hospital and the community.

6.7 Sometimes, people do not realise the real effect of the stroke until they return home, as they have been receiving support at hospital from nurses, physiotherapists and occupational therapists. There is also a possibility that an individual is suffering from more than one condition, and it is necessary to identify the individual's greatest need.

6.8 One of the biggest difficulties is the fact that there is only one available officer across Gwynedd and Anglesey. This officer is funded through BCUHB and Anglesey County Council, Gwynedd Council has not contributed to the service for around three years. There used to be an officer who serviced Anglesey and Arfon and another officer for Meirionnydd and

Dwyfor. The county's geographical situation can be difficult. The service's core hours is 25 hours per week across Gwynedd and Anglesey.

6.9 Transportation is a problem for people, due to the fact that after having a stroke people cannot drive for a month. As well as this, they must be assessed in an Assessment Centre in Glan Clwyd before they can drive a car. People are therefore dependent on public transport or family and friends which can be difficult.

6.10 The Association would like to undertake more preventative work for the future, like what is arranged jointly with the RCA in Bermo. This is an event that will raise people's awareness of stroke and the factors that affect people's risk of having a stroke and also taking people's blood pressure.

6.11 There is currently a lack of understanding amongst some Council officers of what a stroke is and the prominent effects that a stroke can have. Providing training on the effects of stroke and the service that the Stroke Association can offer would be beneficial.

6.12 In addition, difficulties arise because people do not identify third sector workers as professional people, and are therefore reluctant to share full information with the Association. This can cause difficulties because the entire information about a situation is needed and not just the core details.

6.13 The Red Cross - In Gwynedd, volunteers mainly work with older people in order to enable them to reclaim their independence following illness or to keep active.

6.14 Every local authority's funding arrangements across north Wales are very different. A joint-commission or commission is given by local authorities. In Gwynedd, Gwynedd Council does not commission work by the Red Cross. The Health Board is the only commissioner.

6.15 The officers expressed concern that although in the majority of cases the individuals' needs are met effectively by the various actions and services provided by the various establishments, there was no clear and integrated method.

6.16 It could work better should the functions and activities required by volunteers be identified and defined clearly in an integrated manner whichever establishment is involved with providing the service. This could be achieved by bringing establishments together in a consortia to provide the service. The key element is being able to collaborate effectively with other establishments. An example of this is the Gwynedd and Anglesey Befriending Network which is facilitated by *Cynllun Ffrindia*, Mantell Gwynedd.

6.17 There is an Engagement Group (Customer Care and Information Unit) which is chaired by the Senior Business Manager. It coordinates engagement matters relating to specific projects and ensures work programmes e.g. the field of learning disability

6.18 The Unit is responsible for leafleting. The current leaflets include:-

Direct Payments, Listening, Responding, Improving, Enablement Support, Dignity in Care, Paying for Non-residential Care Services (2014-15), How to get the Support you need.

6.19 The role of the Partnership in Care Transferring Manager in August 2014 was to lead the Single Point of Access work which is a scheme of integrated working between the public sector, the third sector and the independent sector in order to work closely to plan and provide services that support adults to look after themselves better, improve their well-being and assist them to remain as independent as possible and outside services for as long as possible. It also follows an assessment process to approve that those who require access to services receive these services as soon as possible.

6.20 The Officer worked as a Project Manager (on behalf of Gwynedd), to develop the local work and also on a regional level across north Wales. There is an element of delay with the local work at present as a fundamental change is taking place within the Department and the Senior Manager who was responsible for the project is away on a period of sickness. (It is understood that the Project Manager position has also been cut by now).

6.21 Some suggestions were made by those questioned that the third sector provision could not provide what the user required at the time they required it.

6.22 A brokerage system is implemented with public and private sector providers for care packages in the community. Establishing such a procedure for third sector providers would be useful. In the brokerage system, the Social Worker conducts an assessment of the user's needs and then asks the Broker which options are available that meets the needs of the user and then they are referred to the volunteer.

6.23 Historically, referrals for intermediate care were also referred directly to the internal Provider Service; however, due to the lack of capacity nowadays, more referrals are directed to Brokerage.

6.24 The two teams (Dwyfor Area) refer clients for assistance from the various organisations that offer a service, including a shopping service.

6.25 It would be beneficial if Health staff had a better understanding of the services that are offered when they speak with individuals in the community hospitals before the individual returns home. (The work underway through 'The Big Room' project at Ysbyty Gwynedd could be developed.)

6.26 It was noted that it would be extremely valuable if the IT systems of the Council and Health talked to each other in order to facilitate access to information.

6.27 The single point of contact would come into force soon, and hopefully this will make it easier for individuals to receive information.

6.28 It was extremely important that individuals are aware of the team's contact details.

6.29 Red Cross Transport - Although there is no capacity to increase activity without additional resources, it is also concerning that there is so little awareness of the service amongst hospital staff and in general. The Health Board staff and the Council's Social Workers could extend this awareness.

6.30 There is a need to consider procurement and service level arrangements carefully in order to make the best use of the service. Ultimately, maintaining people's independence is beneficial to the individual and to the health-care service in general.

6.31 Some were of the opinion that the Third Sector cannot offer many options because specialist care is mainly needed, such as providing personal care, manual handling of patients, etc. On the other hand, it was noted that the reality was that the Third Sector offers specialist care such as *Hospice at Home, nursing at Home, Day Care Hospice and Community Complementary Therapy* and numerous other providers.

6.32 It was noted that there was a need to strengthen the link between the Council and the Health Board by marketing the provision that is on offer at the Living Well Centres, in order to increase the attendance number. There is also a need to speak further with voluntary organisations in order to increase the support available.

6.33 It was noted that visits from social workers would strengthen the awareness of the services offered. This would facilitate referring individuals to the provision available in the *Living Well Centres*. Arrangements are underway to raise the awareness of local services teams.

6.34 It is essential that Carers receive support to assist them to cope with the demands of caring for their loved ones. Several Third Sector organisations play an important role to this end – e.g. an officer from *Carers' Outreach Service* at Ysbyty Gwynedd.

6.35 There is no provision for Palliative Care or residential provision (purpose-built building) in Gwynedd such as *St David's Hospice* in Llandudno.

6.36 There is a need to work closely with the Third Sector to ensure that the sector has adequate capacity to satisfy the needs.

6.37 The Third Sector has a key role in terms of providing community transport, and the provision needs to be co-ordinated better.

6.38 Third Sector organisations have expertise and knowledge of some specific conditions. It is essential that those who require it are referred to them for information and advice in a timely manner – e.g. *Alzheimer's Society, Parkinson's, Stroke Association* and organisations which work in the cancer field.

7. Weekends DRAFT 5

Main Finding

Despite an improvement in the arrangements in terms of discharging patients at weekends, there is room to improve this further.

Main Recommendation

Assess the success of the *Intermediate Care p*roject and ensure follow-up following the end of the grant to deal with any shortcomings which remain in terms of maintaining the service of the hospital discharge teams and the community teams in full at weekends.

EVIDENCE

7.1 One weakness in the "What's Important" Form, namely the integrated assessment form (the form to be used by health and social services for referral) is that the expected discharge from hospital date is not noted on it.

7.2 There has been some misunderstanding about the intermediate service funding in Arfon this year. This has caused some difficulty in relation to Intermediate Care and Enablement. There is a breakdown in communication sometimes, mainly as the communication takes place through a virtual team. The nurses need to lead the work of sharing information.

7.3 A full assessment should be undertaken of the proposals that address the needs of the Equality Act 2010 and go far beyond this in terms of considering the requirements of groups and communities across north Wales.

7.4 A pilot is being run at present with funding through the Intermediate Care Fund where a Care and Repair field officer provides assistance to individuals to move on to the Cae Garnedd Extra Care Housing in Bangor.

7.5 If the pilot is successful, being able to offer this service to more Gwynedd residents would be beneficial. The service will also look at other options i.e. a smaller house, a house closer to family, a house with a warden on site.

7.6 In addition to the Unit in Penygroes, through funding from the Intermediate Care Fund the service is opening three additional Units, two in Meirionnydd in the Llys Castan and Bryn Blodau homes and one in Dwyfor in the Plas y Don home.

7.7 Some difficulties arise sometimes with delays in providing suitable equipment for individuals.

7.8 In order to avoid any delay, a care plan and any necessary equipment need to be in place before the individual goes home. To enable this to happen the care plan must commence immediately when the person has reached hospital. Currently, this does not always happen immediately.

7.9 At present, people aged 65+ are receiving our enablement service. This will be extended to people aged 60+ in the future.

7.10 Stroke Cafés have been established in Arfon for some time in Bangor and Caernarfon. Volunteers run these now. The Association is currently establishing Stroke Cafes in Meirionnydd, Blaenau Ffestiniog and Dwyfor, Pwllheli with funding from the Intermediate Care Fund. This is temporary funding for a year, but it is hoped that it would be possible for volunteers to run these in the future once they have established.

7.11 When a problem arises or a complaint is received e.g. health sending an individual home late at night without putting arrangements in place, usually the charity's Advocacy Officer (Age Cymru) would deal with the matter, depending on the case.

7.12 Historically, referrals for intermediate care were also referred directly to the internal Provider Service; however, due to the lack of capacity nowadays, more referrals are directed to Brokerage.

7.13 In general, Brokerage deals with 4 or 5 referrals per month across the County in relation to intermediate care, and approximately 9 per month in relation to *enablement*. The numbers of referrals for this type of service have increased over the past 6 months (September 2014).

7.14 One difficulty is when applications are submitted on a Friday afternoon at short notice for patients to be discharged over the weekend. More notice is needed in order to conduct an assessment before discharging patients.

7.15 Another obstacle is that the Store room in the hospital is closed at weekends, therefore even after conducting an assessment, there is no means of obtaining the appropriate equipment for discharging the patient.

7.16 The nature of some social workers and occupational therapists' part-time contracts means that coordinating the work can be difficult at times. Sometimes days or weeks pass without receiving a response.

7.17 There is a possibility that the service will be extended in order to provide support for seven days a week. The current workforce is not very interested in working at weekends.

8. Ysbyty Bronglais **DRAFT 5**

Main Findings

There are no arrangements with Ceredigion County Council Social Workers in relation to patients being discharged from Ysbyty Bronglais to South Gwynedd. In addition, the fact the patients from Meirionnydd are referred to three different locations in Aberystwyth, Wrexham and Bangor can complicate the situation.

Main Recommendation

Collaborate with Hywel Dda Health Board to agree on an arrangement with the Ysbyty Bronglais Discharge Team to discharge patients to South Meirionnydd.

EVIDENCE

8.1 The rural nature of the Dolgellau area has an impact on several matters. One specific aspect which has become evident is the need to make the most of attending Consultants' Clinics in Dolgellau. There have been problems with the Health Board centrally referring patients to Wrexham and Ysbyty Gwynedd rather than to the clinic in Dolgellau.

8.2 Officers working in Wrexham or Bangor will book clients to attend clinics in Wrexham or Bangor even though there are more convenient clinics available locally for patients in Dolgellau.

8.3 The outcome is that patients have difficulty in attending appointments due to the distance and complexities of transport and care arrangements etc.

8.4 One easy way of resolving this would be for the officers in Wrexham and Bangor to look at the patient's postcode in order to arrange an appointment in the most convenient location.

8.5 Request the details of contracts with the Hywel Dda and Powys Health Boards and the Ambulance Service which ensure that patients from south Gwynedd are only referred to south Wales when the patient needs it.

8.6 A joint statement is needed with Ysbyty Bronglais with regards to access to services.

8.7 There is a need to revise the proposal for centralising X Ray services, and consider maintaining a service at Ysbyty Tywyn or Ysbyty Machynlleth.

8.8 It is important that the Health Board works with other establishments to plan and develop effective services across north Wales.

8.9 There aren't as many homes in Meirionnydd and this can cause problems with referrals not only coming from Ysbyty Gwynedd, but from Maelor Hospital, Wrexham and Ysbyty Bronglais, Aberystwyth.

8.10 Attracting volunteers in south Gwynedd is difficult. They have held several campaigns. It is possible that too many establishments are 'competing' for the same people to become volunteers.

8.11 It could work better should the functions and activities required by volunteers be identified and defined clearly in an integrated manner whichever establishment is involved with providing the service. This could be achieved by bringing establishments together in a consortia to provide the service. The key element is being able to collaborate effectively with other establishments. An example of this is the Gwynedd and Anglesey Befriending Network which is facilitated by *Cynllun Ffrindia*, Mantell Gwynedd.

8.12 That there are problems in relation to transport, especially in South Meirionnydd, with individuals failing to attend activities because there is no transport available to the locations. It was noted that the charity had mini-buses which are used for trips mostly due to the cost.

8.13 That the severe nature of individuals' condition means a time commitment and an increase in costs because the individual must be visited several times.

8.14 There is a lack of provision in some areas and in the Meirionnydd area in particular.

8.15 There is a tendency for each company to be operational in one area (Meirionnydd, Arfon or Dwyfor). A recent development took place where two companies were merged – Abacare (which operated mainly in the Meirionnydd area) and Caredig (which operated mainly in the Arfon area). The new company seems to be extending further into Powys also by now.

8.16 A service is provided to individuals across Gwynedd, but a shortage of provision in the Meirionnydd area can be an obstacle.

8.17 The service (Red Cross Transport) that is being run from Machynlleth provides transport to and from Ysbyty Gwynedd; however, no service is provided to and from the Community Hospitals.

8.18 Having made enquiries about the hospital to the home aspect at Tywyn Hospital, it was found that Gwynedd Social Services assessor did not assess clients from South Gwynedd at Ysbyty Bronglais, Aberystwyth until they are discharged from hospital and go home.

8.19 Consequently, the patients were transferred from Ysbyty Bronglais to Tywyn Hospital to be assessed, and only after having undertaken the assessments would the patients be sent home.

8.20 However, there are cases where friends and family members have travelled to Bronglais and beyond to Glangwili, Llwynhelyg and Morriston, Swansea Hospitals to take the patients home. This is when they fall through the net as it were, and no care plans have been implemented.

9. Shortage of Doctors and Nurses **DRAFT 5**

Main Finding

It was discovered that a shortage of GPs and nurses in some areas caused difficulties in terms of maintaining care in the community.

Main Recommendation

It is understood that work is underway to improve the situation regarding the shortage of doctors and nurses and that the schemes need to be communicated clearly giving special attention to Dwyfor and Meirionnydd.

EVIDENCE

9.1 The rural nature of the Dolgellau area has an impact on several matters. One specific aspect which has become evident is the need to make the most of attending Consultants' Clinics in Dolgellau. There have been problems with the Health Board centrally referring patients to Wrexham and Ysbyty Gwynedd rather than to the clinic in Dolgellau.

9.2 Often, local doctors will refer patients to clinics in Wrexham and Bangor as they are not aware of clinics being held in Dolgellau.

9.3 One field that causes particular concern is the field of dementia. There is no sufficient and bespoke provision available in Gwynedd at present. Indeed, it is a crisis situation. One of the features of this is that patients remain in hospital for longer than is required and this contributes to the shortage of beds for acute treatment use. There is an insufficient provision of specialised nursing or residential beds.

9.4 Over the past few years, Heulwen Ward was closed in Ysbyty Gwynedd and this ward specialised in dementia work and now each dementia case is referred to Ysbyty Cefni, Llangefni. One of the wards in Ysbyty Cefni was also closed.

9.5 One element that contributes to the pressure is the lack of nurses specialising in dementia care.

9.6 Good collaboration occurs between social workers and health officers in Plas Hedd. The fundamental needs to improve the situation are:

- More hospital beds
- Improve the skills of carers in dealing with dementia
- More Community Psychiatric Nurses (CPN)

10. Discharge Protocol DRAFT 5

Main Finding

There is no evidence that the public and service users have had an opportunity to contribute to the process of creating Betsi Cadwaladr University Health Board's Discharge Protocol.

Main Recommendation

Review the Discharge Protocol by consulting with key stakeholders including the patients and the public in line with the Language Policies of Gwynedd Council and the Health Board.

EVIDENCE

10.1 One weakness in the "What's Important" Form, namely the integrated assessment form (the form to be used by Health and Social Services to refer onwards) is that the date that the patient is expected to be discharged from hospital is not noted on it.

10.2 In order to be efficient, service providers must make time to speak with and listen to patients.

10.3 There is some inconsistency regarding the Discharge Protocol across north Wales.

10.4 It is important that the Health Board works with other establishments to plan and develop effective services across north Wales.

10.5 In order to avoid any delay, a care plan and any necessary equipment need to be in place before the individual goes home. To enable this to happen the care plan must commence immediately when the person has reached hospital. Currently, this does not always happen immediately.

10.6 At present, people aged 65+ are receiving our enablement service. This will be extended to people aged 60+ in the future.

10.7 In addition, difficulties arise because people do not identify third sector workers as professional people, and are therefore reluctant to share full information with the Association. This can cause difficulties because the entire information about a situation is needed and not just the core details.

10.8 One difficulty is when applications are submitted on a Friday afternoon at short notice for patients to be discharged over the weekend. More notice is needed in order to conduct an assessment before discharging patients.

10.9 Another obstacle is that the Store room in the hospital is closed at weekends, therefore even after conducting an assessment, there is no means of obtaining the appropriate equipment for discharging the patient.

10.10 The nature of some social workers and occupational therapists' part-time contracts means that coordinating the work can be difficult at times. Sometimes days or weeks pass without receiving a response.

10.11 In Ysbyty Alltwen, some difficulties have arisen due to the lack of communication between staff on the wards.

10.12 Care Plans are prepared in Welsh. Some care homes experience difficulties where there is no bilingual staff.

10.13 It was noted that Health staff had a lack of awareness of the new form. Some members of staff still fill in the old form as they are not aware that the form has been prepared jointly with Health.

10.14 Some Doctors and Nurses contacted the team to have a walking frame, although Health provides them.

10.15 It would be beneficial if Health staff had a better understanding of the services that are offered when they speak with individuals in the community hospitals before the individual returns home.

10.16 It was noted that it would be extremely valuable if the IT systems of the Council and Health talked to each other in order to facilitate access to information.

10.17 Although there is no capacity to increase activity without additional resources, it is also concerning that there is so little awareness of the service amongst hospital staff and in general. The Health Board staff and the Council's Social Workers could extend this awareness.

10.18 There is a need to consider procurement and service level arrangements carefully in order to make the best use of the service. Ultimately, maintaining people's independence is beneficial to the individual and to the health-care service in general.

10.19 Should a client have a Care Package before being admitted to hospital and their needs remain the same after being in hospital, the Care Package will be submitted to the Sister with minor changes.

10.20 Should the client's needs change substantially after a spell in hospital, the Social Worker will close the Care Package at Ysbyty Gwynedd, and a new Care Package will be opened for the client at Ysbyty Bryn Beryl.

10.21 This can cause difficulties and lack of clarity for the client and staff at Ysbyty Bryn Beryl. This can also mean that a new social worker will be creating the new Care Package. It would be better to continue with the same Care Package as the Social Worker.

10.22 When a new Care Package is created, this can take up to a fortnight. When a new Care Package is created, this can take up to a fortnight. The result of this is that a patient may stay too long in the hospital before transfer to home.

10.23 Newly introduced arrangements ask the Sister to fill forms with the client before they can be transferred to Ysbyty Bryn Beryl. Other forms also require time to complete them.

10.24 The Sister noted that she needed to communicate with the clients in order to understand their needs. Having to fill in the forms is an obstacle and a significant waste of time which detracts from caring for the client.

10.22 It would be better to have one Social Worker dealing with Ysbyty Bryn Beryl.

10.23 The substantial shortage of social workers means that some clients have to wait until they can be dealt with. The term ‘put in the basket’ is used to describe this delay.

10.24 To create a Care Package, the Sister needs to fill in two forms - the ‘Integrated Adult Health and Social Care Core Data Set’ and the 'Decision Support Tool for Continuing NHS Healthcare Section 1- Personal Details.'

11. Bureaucracy DRAFT 5

Main Finding

Examples of bureaucracy and a culture of completing forms were seen which sometimes undermined the main work of nurses and carers.

Main Recommendation

Assess the success of the work that is underway on Lean/Vanguard at Ysbyty Alltwen to address the current bureaucratic arrangements to free staff's time to deal with their main duties of providing care and nursing.

EVIDENCE

11.1 One weakness in the "What's Important" Form, that is the integrated assessment form (the form to be used by Health and Social Services to refer onwards) is that the date that the patient is expected to be discharged from hospital is not noted on it.

11.2 If the person being discharged from hospital is not open to either a social worker or an enablement officer, possibly because the case has been closed in its entirety to the department or is open under review, that is open/receiving a service from the Department but not open to a specific worker, the person who needs to be discharged from hospital will then be referred to the attention of Ysbyty Gwynedd's Social Work Team with the ward staff completing a 'What's Important' integrated assessment form with the patient.

11.3 There are cases that are already open to the Department, as a level of service is being provided, but that the case is stable and noted as open under review, and therefore is not known to any specific officer.

11.4 In order to be efficient, service providers must make time to speak with and listen to patients.

11.5 The Stroke Association provides a full assessment when the individual arrives home from the hospital. It is then possible to recognise the needs of the individual and to refer onwards to services which include support with benefits, NERS (Refer for Exercise Scheme), follow up with physiotherapy and occupational therapy or Care and Repair for support rails etc.Practical things are important to people, for example driving is a very important thing for people.

11.6 In addition, difficulties arise because people do not identify third sector workers as professional people, and are therefore reluctant to share full information with the Association. This can cause difficulties because the entire information about a situation is needed and not just the core details.

11.7 The Red Cross has recently been praised by external assessors – WIHSC – for developing the Change Wheel. This is a tool which considers the needs of an individual which results in clear Action Plans. The plan places the individual at the centre.

11.8 When a person returns from hospital to the home, following the first six weeks at home, an individual, family member, friend or social worker can contact the Red Cross and request an assessment by the Home from Hospital Team of their needs in order to allow them to continue to get better, or they can refer to the Befriending service.

11.9 If a person is referred to the Befriending service, an officer from the Red Cross will undertake an Assessment of their needs using the Change Wheel as a tool to plan and provide re-ablement services. This is separate from the Care Pack but the Care Pack will have been considered as part of the assessment.

11.10 The re-ablement service will run for a period of up to 12 weeks.

11.11 At the end of this period, a Closing Assessment will be undertaken.

11.12 Concern was noted that although in the majority of cases the individuals' needs are met effectively by the various actions and services provided by the various establishments, there was no clear and integrated method.

11.13 The fact that there are two separate complaints procedures by Health and Social Services and two separate timetables can cause difficulties and complexities.

11.14 Currently, the procedure is that the staff of the Advice and Assessment Team or Social Worker updates the information about the patient on an electronic system called RAISE. The Single Point of Contact project considers how to develop the electronic data system that could be jointly-used by the health service also as a result of developing fully integrated work in the future. The objective is to do the best for the patient (considering health and care), without delay and to ensure early support to avoid an emergency and loss of independence to the individual.

11.15 The Health Board's PIMMS system is used to arrange appointments for the Health Board's clients.

11.16 All clinic referrals are referred on the central electronic system which is used by all doctors and officers in the Health Board across north Wales.

11.17 Referrals for appointments with Specialists are noted on the system by administrative officers who work at Ysbyty Maelor Wrexham or Ysbyty Gwynedd Bangor.

11.18 Clinics are held in Wrexham, Bangor and Ysbyty Dolgellau.

11.19 Often, local doctors will refer patients to clinics in Wrexham and Bangor as they are not aware of clinics being held in Dolgellau.

11.20 Officers working in Wrexham or Bangor will book clients to attend clinics in Wrexham or Bangor even though there are more convenient clinics available locally for patients in Dolgellau.

11.21 The outcome is that patients have difficulty in attending appointments due to the distance and complexities of transport and care arrangements etc.

11.22 One easy way of resolving this would be for the officers in Wrexham and Bangor to look at the patient's postcode in order to arrange an appointment in the most convenient location.

11.23 After receiving an application from the Team in the hospital, an Officer or one of the Company's Regional Managers will conduct an assessment of the Care Package or the details of the application. Following the assessment the Officer or one of the Regional Managers will agree to implement the package or will redesign the package where necessary before agreeing to accept it.

11.24 A form has been drawn up jointly with Health, namely the 'North Wales Integrated Health and Social Care Core Data Set'. The objective of the form is that the first person who is in contact with the individual completes the form.

11.25 The joint form is an important step, with the expectation that doctors, nurses and Council officers use it.

11.26 It was noted that Health staff had a lack of awareness of the new form. Some members of staff still fill in the old form as they are not aware that the form has been prepared jointly with Health.

11.27 Some Doctors and Nurses contacted the team to have a walking frame, although Health provides them.

11.28 Now, the Red Cross in Gwynedd and Anglesey runs a Care and Support Service. The service is more convenient to users since it means that one person co-ordinates the needs of the individual when he/she leaves the hospital to go home. It includes transport, provision of a wheelchair, a packed lunch and settling the individual in the house.

11.29 The Scheme is implemented after a Social Worker or Ward Nurse completes a simple form that refers the Individual to the Red Cross noting his/her needs. The form is sent to the Officer in the hospital or it is faxed to another Officer. One of the Officers will process the application immediately either by using one of the organisation's vans or it is referred to a volunteer.

11.30 Newly introduced arrangements ask the Sister to fill forms with the client before they can be transferred to Ysbyty Bryn Beryl. Other forms also require time to complete them.

11.31 To create a Care Package, the Sister needs to fill in two forms - the 'Integrated Adult Health and Social Care Core Data Set' and the 'Decision Support Tool for Continuing NHS Healthcare Section 1- Personal Details.'