EMERGENCY PRESSURES PLANNING GUIDANCE

2002 - 03
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A Framework for Emergency Pressures Care Delivery

Emergency care services can be seen as consisting of a number of overlapping elements, such as:

- prevention, including chronic disease management;
- immediate crisis support;
- hospital admission avoidance;
- hospital assessment, diagnosis and admission/discharge;
- inpatient care;
- discharge;
- post hospital care and support.

The providers who work in this very complex health and social care system include:

- primary care services – GPs, pharmacists and others;
- voluntary services – including organisations and carers who look after individuals;
- acute care services – such as hospitals;
- community services – such as community nursing;
- the independent sector – especially the home care and care home providers;
- local authority social services.

The better these work together, the more effective the overall support to patients will be.

Emergency pressures are felt everywhere across this system. They grow and diminish through the year, sometimes in ways that cannot be easily explained or controlled. There is a danger that if one element in the system tries to solve its own problems, the pressure will merely be pushed elsewhere in the system. Whole system planning and management is, therefore, essential.

Guidance such as this cannot dictate local efforts. It can support them. This revision is intended to update, support and supplement earlier guidance, not replace it.

The guidance has been designed to:

- promote a consistent all-Wales approach to emergency pressures, though allowing for local variations in service provision;
- give brief but authoritative information to everyone involved;
- provide examples of good practice, that people can copy;
- offer the basis for self-assessment, in terms of what should be provided;
- prompt services in each part of Wales to set objectives on each of the elements cited above.

It aims above all to promote co-operative working across the whole system, based on the following principles:

- within the system as a whole, services should be patient-centred, and patient-focused;
- throughout the care pathway, patients should receive the care needed, at the time it is needed, where it is needed;
- improvements recommended and implemented should be evidence based and effective;
- resources allocated should be used efficiently and care pathways should be equitable;
- emergency pressures need to be managed as a year-round phenomenon.
EMERGENCY PRESSURES

1.1 INTRODUCTION

New elements

This revised guidance will apply in a period of transition, as Health Authorities give place to Local Health Boards, and as discussions continue on new contractual arrangements for doctors in the NHS. While continuity of service must be protected at all costs during this period, the opportunity must not be lost to consolidate and build on previous good practice.

In this guidance, therefore, special emphasis is placed on:

- further strengthening joint working;
- assessing strengths and weaknesses throughout the patient pathway (and correcting the latter);
- forward-estimating activity.

As a result, the Welsh Assembly Government is aiming to promote:

- realistic, measurable, sustainable and achievable objectives set locally for each of the elements of emergency care outlined on the first page;
- much more rigorous analysis of trends and variances, with profiles of expected performance agreed, differences examined and the lessons learned;
- assessment by Health Authorities, Local Health Groups and Trusts, of the seasonal pattern of activity expected in their area, with allowance for expected and unexpected fluctuations in demand;
- a ‘whole systems’ approach that will continue to develop when organisational change is complete in 2003.

This guidance offers a basic framework for care delivery across Wales. Each player within the system must play its part, and at 4 levels:

1. At a Welsh national level, the Welsh Assembly Government:

- has led development of this updated guidance, to support self-assessment and offer examples of good practice;
- has appointed a lead individual, for each major topic area, to monitor current practice and develop and implement a strategy for the development and dissemination of best practice. These individuals are named at the head of each of the guidance sections;
- will redouble its efforts to ensure that it adopts a co-ordinated approach to the management of emergency pressures, to maximise the benefits and simplify channels of communication with colleagues in the field;
- will, especially through the lead individuals, work closely with agencies across Wales to assist in problem analysis, targeted practice improvement, plan implementation, monitoring information flows, disseminating good practice and reporting on increases in pressure;
- will lead on developing integrated forward-planning arrangements.
2. **At a regional level, Trusts, Local Authorities and Partners, with help from the NHS Wales Department:**

- will join together to tackle known problems and plan more effectively on a regional basis ahead of pressures developing;
- will act together to ensure that each local body works closely with others to manage pressures across organisational boundaries and over a wide geographical area, to maximise use of resources;
- will begin to develop closer working relationships, using SITREPS data, to manage pressures across boundaries and organisations. Detailed planning has yet to be finalised.

3. **At a local level, Trusts, Local Authorities and Partners:**

- will be expected to monitor and evaluate, in terms of success, sustainability and transferability, existing local practice innovations, both to inform their own investment decisions (especially in defending valuable schemes threatened by resource shortages) and to assist others considering similar approaches;
- will, in the light of evidence suggesting the need to improve specific management arrangements and escalation procedures, work to tighten up in those areas to ensure a robust system is in place to manage periods of increased pressure;
- should assess themselves against examples of good practice included in this guidance;
- should participate fully in work to plan activity and manage priorities through capacity mapping.

4. **At a patient pathway level, all agencies:**

- should critically examine local processes, using external assistance where appropriate;
- should draw on the work of the Innovations in Care team, the Social Services Inspectorate for Wales and others to:
  - identify best practice;
  - assess themselves against best practice;
  - develop tools, techniques and skills within the organisations to achieve best practice;
  - develop best practice;
  - create a change programme to achieve best practice;
  - communicate best practice.

**Notes**

- This guidance can be found on the HOWIS Intranet by clicking [here >>](#).
- As the work develops, additional information, best practice examples and development projects to improve patient care will be included.
Background

As part of emergency pressures planning, the Welsh Assembly Government is planning to repeat the successful “Keep Well This Winter” (KWTW) campaign. This aims to provide information and support to people aged 65 and over to help them to keep well during the winter months. The 2002-03 campaign will be the third KWTW campaign.

The new campaign will adopt the partnership approach that has worked well in previous years. It will draw together a number of initiatives in a systematic approach and focus the expertise and resources of a number of statutory and voluntary organisations in a co-ordinated campaign.

In addition to delivering high quality health care services, the NHS has a key role to play in promoting people’s health and well-being. Health authorities have a statutory responsibility to meet the needs of local communities, and promoting good health is a priority action for Local Health Groups. NHS trusts are close to their communities and therefore in a good position to develop initiatives to promote health and well-being.

Primary care services are particularly well placed to make a very valuable contribution to getting the message across to some of the most vulnerable people in our communities.

Campaign Partners

- Care Forum Wales
- Age Concern Cymru *
- Care & Repair Cymru *
- Energy Saving Trust
- Food Standards Agency Wazles
- NHS Direct Wales
- National Association of Citizens’ Advice Bureaux *
- National Energy Action (Wales) *
- NHS Wales
- Royal National Institute for the Blind *
- Wales Youth Agency *
- Wales Council for the Blind

* Voluntary organisations involved in the Keep Well This Winter Campaign

Contribution of Voluntary Organisations to Keep Well This Winter 2000-01

The five-month campaign, launched in October 2000, combined the efforts, expertise and resources of a number of statutory and voluntary organisations towards the common goal of enabling older people to maintain good health in winter.

Evaluation of the 2001-02 Campaign

- There was a substantial increase in the uptake of ‘flu vaccination this winter, from 53% in 2000-01 to 61% in 2001-02. Uptake of ‘flu vaccination since the KWTW campaign started two years ago has increased greatly;

- Almost 2,000 homes in Wales have had new heating systems installed through the Home Energy Efficiency Scheme, and a further 8,468 homes have received new insulation;

- The campaign partnership approach is recognised by partners as providing “added value” to the campaign. All have expressed a wish to be involved in a 2002-03 campaign;

- More than 80 community events were held in 2001-02, covering such issues as nutrition and home safety. A formal evaluation is being undertaken;

- Campaign materials were made available in ethnic minority languages and in large print for the visually impaired. They were also available as ‘Talking Newspapers’;

- Twice as much press coverage was gained as in the previous year, with a series of articles for weekly newspapers by the Chief Medical Officer proving particularly successful.
The Keep Well This Winter Campaign 2002-03

The campaign will run from October 2002 until February 2003. It will focus on three key themes:

1. **Keep Well** – encouraging people in the 65 and over age group to have a ‘flu vaccination, to eat nutritious food and to take appropriate exercise.

2. **Keep Warm** – promoting uptake of the Home Energy Efficiency Scheme grants and energy efficiency generally, and raising awareness of the importance of adequate heating in winter.

3. **Keep Safe** – addressing issues such as falls in the home, electric blanket safety and promoting a befriending scheme.

The campaign will, through a combination of community action, media relations work and public information materials, seek to engage the target audience in the main messages of the campaign. In 2002-03 a Keep Well This Winter Roadshow is visiting all 22 local authority areas in Wales to help engage the target audience.

The main messages are:

- **Get ready for winter** - how to find help and advice to help stay well during the winter.
- **Flu can be serious** - ‘flu vaccination will prevent many cases of ‘flu. Talk to your GP.
- **Keep your home warm** – help may be available.
- **Keep yourself warm** - promotes wearing extra layers of clothing and wrapping up warm when going out.
- **Eat well** – advice on what to eat during the cold days and taking appropriate exercise.
- **Make sure your home is safe.** Simple changes: better lighting, making sure rugs won’t slip, fitting “grab rails”, for example – can make the home safer.

To help promote the campaign, organisations should:

- nominate a campaign co-ordinator to take the campaign forward;
- develop local activity to support and enhance the national campaign;
- brand local activity as part of the national campaign so that the impact of all efforts is maximised;
- follow the campaign themes and messages;
- ensure that public information materials are disseminated effectively;
- identify opportunities to promote the campaign messages to the target group as part of routine work.

Working with visually impaired people

Four out of five people with impaired vision are over retirement age, and among the over 75s one person in six is blind or partially sighted.

The Royal National Institute for the Blind (RNIB) works to help visually impaired people lead as normal a life as possible. As a Keep Well This Winter partner, it is effective in conveying campaign messages to its particular audience.

During the 2001-02 campaign, the RNIB:

- published and distributed four monthly Keep Well This Winter newsletters between October 2001 and February 2002 in large print and on audio tape;
- held 20 Community Information Sessions, providing advice to more than 400 people with severe sight loss in Wales;
- helped more than 500 people with severe sight loss to gain grants under the Home Energy Efficiency Scheme.
Background

- Every winter, ‘flu causes acute respiratory illness affecting people of all ages. Among the elderly and those with certain medical conditions, ‘flu carries an increased risk of serious illness - often resulting in admission to hospital. Pressures are put on health, social and other care services - usually at an already busy time.

- In deciding how best to meet the needs of the people in Wales, the Welsh Assembly Government takes expert medical advice from the Welsh Immunisation & Vaccination Sub-Group (of the Committee for the Control of Communicable Disease) and the UK Joint Committee on Vaccination & Immunisation.

Objective

The continuing aim of the ‘flu immunisation programme is to reduce serious illness and deaths to those most vulnerable. This guidance sets out the arrangements for the 2002-03 programme in support of the management of emergency pressures across all organisations in Wales.

Immunisation Policy

The ‘flu vaccine is effective in preventing ‘flu and, in UK studies, has been shown to reduce complications and hospital admissions by as much as 60% and mortality by about 40% compared with match controls. The aim is to immunise people who are most likely to suffer complications or die from ‘flu.

Thanks to the efforts of all the health professionals and support staff involved in reaching those people who should be vaccinated, the immunisation rate has almost doubled over the past two years (see the table below for regional achievements).

<table>
<thead>
<tr>
<th>HEALTH AUTHORITY</th>
<th>NO. OF PATIENTS REGISTERED</th>
<th>NO. IMMUNISED</th>
<th>% IMMUNISED</th>
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<tr>
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<td>61,635</td>
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<td>Dyfed Powys</td>
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<td>60,358</td>
<td>60.54</td>
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<td>Morgannwg</td>
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<td>75,882</td>
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</tr>
<tr>
<td>WALES</td>
<td>508,002</td>
<td>309,576</td>
<td>60.94</td>
</tr>
</tbody>
</table>

Note: The figures above report those immunisations carried out between October and December 2001. They do not reflect immunisations undertaken later.

For the third year running, immunisation is available free of charge to all people over 65 years old and those younger people who are in specified ‘at-risk’ groups. As part of the settlement with GPs in 2000-01, practices were required to establish an ‘At-risk’ Register so that they could ensure that immunisation was offered to the vulnerable patients on their lists.
Primary care services through GP practices must provide an effective immunisation programme.

- GP practices are primarily responsible for making all reasonable efforts to immunise their vulnerable patients. For the first time, the Welsh Assembly Government is setting a national up-take rate of 70% for immunisation of those people aged 65 years or over - as has been done in the rest of the UK. Health Authority Immunisation Co-ordinators will continue to monitor immunisation levels and report progress regularly to the Assembly. They will also again be available to offer advice and support to GP practices.

- To achieve an effective immunisation programme, GP practices must look at innovative ways to reach vulnerable patients and not rely on them coming to the practice. Further details are contained in the 12 August 2002 Welsh Health Circular – WHC (2002) 094.

- Immunisation Co-ordinators will be responsible for ensuring that GP practices provide information in a timely manner and will work closely with those practices where early indications are that the national immunisation rate for people over 65 years is unlikely to be met.

- GP practices must ensure that patients' records are updated in a consistent way with the following information:
  - vaccine given including the batch number;
  - person giving the injection;
  - site of the injection if more than one vaccine given during visit; and
  - 'At-risk' group(s) that entitles them to immunisation when younger than 65 years old.

- A system for reporting adverse reactions should also be in place.

- Those targeted for immunisation:
  - All people over 65 years;
  - Those living in long-stay homes; and
  - Younger people in the following groups:
    - chronic heart disease;
    - chronic respiratory disease;
    - chronic renal disease;
    - Diabetes; and
    - Immuno-suppression.
Health, Social & Care Staff may also need to be included in this programme.

- Immunisation of healthcare staff may reduce staff absenteeism and disruption of services at a time when demand of those services is likely to be increased. It may also reduce the transmission of 'flu to vulnerable patients - some of whom may have impaired immunity and therefore reduced protection from immunisation themselves.

- As previously, responsibility for immunisation rests with employers.

- The NHS Wales Department strongly recommends that employers fund a programme that:
  - offers immunisation to all employees directly involved with patient care;
  - maintain records of those immunised; and
  - monitors the effectiveness of the programme.

Healthcare staff should not be asked to go to their own GP unless they fall into one of the 'At-risk' groups or GPs have been contracted to provide this service.

Monitoring of ‘flu and ‘flu-like illness is provided by:

Communicable Disease Surveillance Centre (CDSC)
The CDSC obtains, analyses and distributes information on influenza activity, including laboratory data, mortality data from the Office for National Statistics, morbidity data from the Royal College of General Practitioners (RCGP) and other sources in the UK as well as data from other European countries and the World Health Organisation (WHO).

The Public Health Laboratory Services (PHLS)
The principal roles of the PHLS are to provide virological and epidemiological data upon which national decisions, such as the choice and deployment of vaccine or the use of antiviral agents are based, and to provide viral and other diagnostic services.

The Royal College of General Practitioners Research Unit and the CDSC (Wales) Spotter Practice Scheme
Through the sentinel practice scheme, the RCGP and CDSC (Wales) monitor new GP consultations for 'flu like illness and other respiratory infections in England and Wales. Reports are aggregated by region. Sentinel schemes for 'flu are also run by Scottish Centre for Infection and Environmental Health.

Gwent ‘flu alert
This aims to provide a timely summary and interpretation of influenza activity in Gwent and to help predict trends in hospital admissions for influenza and influenza-like illness. It is proposed to use this method to rollout on an all-Wales basis.
Assembly contacts

The Assembly’s Public Health Protection Division is responsible for the ‘flu immunisation programme. Leaflets or other information can be obtained by writing to:

Public Health Protection Division 2
Welsh Assembly Government
Cathays Park
Cardiff  CF10 3NQ
Tel:  029 2082 3395 or 029 2080 1232

E-mail correspondence can be addressed to:

Jenny.Thorne@wales.gsi.gov.uk
or
Richard.Norman@wales.gsi.gov.uk
EMERGENCY PRESSURES
2.3 PRIMARY CARE

Lead: Trevor Neatherway

Background

- Primary care is an essential component of the healthcare system, and acts as one of the main providers of emergency care, as well as a gateway to secondary care.

- This guidance is to support Health Authorities (HAs) and, increasingly, Local Health Groups (LHGs) in the management of emergency pressures in primary care, and across the primary care/secondary care interface. It recognises that pressure is felt across the whole healthcare system, often at the same time, and that action is needed to assist primary care providers in managing this pressure, and thus minimising the knock-on effect on secondary care. It also marks a move to a greater emphasis on the quality of service provision.

- HAs and LHGs should use this guidance to test the current level of services. Some areas of good practice have been identified in this guidance.

- Within primary care, different services are available in-hours and out-of-hours. Outside “normal” working hours, a number of arrangements from out-of-hours GP co-operatives to commercial deputising services to individual practice rotas are in place.

- This guidance covers both GP services and the other primary care services – for example, pharmacies, dentists, community nursing and NHS Direct Wales. It recognises that the availability of a range of responses is helpful in managing emergency pressures.

Performance Management and Monitoring

Work has started on developing a continuous improvement approach. The status of GPs and other contractor professions as independent contractors means that seeking information on services provided will need to be handled sensitively. The new arrangements will, nevertheless, need to look more closely at the set up, capacity and performance of primary care and link into an overall view of emergencies. Separate guidance on this is being issued.

LHGs should ensure that:

- Planning processes recognise the key contribution made by all primary care professionals – not just GPs, but also their practice staff, pharmacists, dentists and optometrists. HAs and LHGs should ensure that such groups are fully engaged in the planning process;
- Planning for emergency pressures should recognise that emergency pressures happen in primary care as well as the secondary care sector, and usually at the same times. HAs and LHGs should develop processes for supporting primary care to avoid a knock-on impact on secondary care;
- Examples of good practice in primary care are continually identified and are shared not only across the primary care system, but also with HAs and other LHGs.
Primary care – in-hours

LHGs should ensure that:

- mechanisms to support practices in-hours are developed, especially those which are professionally isolated, and those least able to cope with surges in demand;
- the contribution that community pharmacists can make in tackling workload pressures is mapped, for example, by developing the role of providing advice to customers;
- a number of “Spotter” practices are identified to provide early warning of increases in the incidence of certain illnesses.

Primary care – out-of-hours

LHGs should ensure that:

- a comprehensive, responsive and quality out-of-hours service for local residents is developed. This should be achieved in partnership with GPs, out-of-hours providers, NHS Direct and other primary care/community services professionals. Further guidance on this will be issued in November 2002;
- all out-of-hours providers are monitored to assess their effectiveness in managing patients appropriately and their impact on secondary care services through referrals to A&E. Further guidance on this will be issued in November 2002;
- they are working with out-of-hours providers to review call handling services, to monitor their performance in meeting patient demand;
- they are working with NHS Direct to identify opportunities for closer working out-of-hours;
- opportunities for developing out-of-hours services to provide a wider range of service responses are identified, e.g. community nursing, mental health teams, social care teams, dentistry and pharmacy;
- information is available to the public on the availability and scope of out-of-hours services and that the standard of service that can be expected is improved;
- they are working with Local Pharmaceutical Committees to review the formal pharmacy out-of-hours and additional services rotas and that arrangements are in place to meet periods of anticipated high demand;
- the issuing of emergency drug kits to GP out-of-hours services is considered for use during extended holiday periods, in addition to standard provision;
- a review is conducted of the need for an out-of-hours formulary as part of the developing formulary arrangements;
- arrangements are in place for out-of-hours providers and NHS Direct to provide LHGs with early warning of increases in the incidence of certain illnesses.

Cynon Valley Primary Care Support Unit has been set up to support local GPs to improve existing primary care services, develop a wider range of services and access training and personal development opportunities.

Taff Ely Emergency Medical Service (TEEMS) provides out-of-hours services to 107,000 patients based at a treatment centre adjacent to the A&E department of the Royal Glamorgan Hospital. 16,000 consultations were carried out in 2001, with only 5% requiring a home visit. Other patients were either offered a phone consultation or visited the treatment centre.

Meddygon Menai Doctors Co-operative provides services to 96,000 patients and is piloting joint working between out-of-hours services and NHS Direct, resulting in a reduced time commitment by doctors and a reduction in home visit rates.
EMERGENCY PRESSURES
2.3 PRIMARY CARE

Lead: Trevor Neatherway

Links with intermediate care
LHGs should ensure that:

- appropriate use is made of intermediate care facilities to avoid unnecessary admission to hospital;

- they are working with local GPs to develop the range of services available locally in community hospitals;

- local multi-disciplinary teams are developed to provide appropriate support to patients in nursing and residential care homes as well as in their own homes, to allow earlier discharge from hospital where possible. This may be a role for the support teams described earlier.

Links with secondary care
LHGs should ensure that:

- direct access by GPs to hospital services such as X-ray and pathology is developed and monitored;

- consideration is given to introducing a primary care presence in secondary care settings, particularly out-of-hours services in A&E, to ease pressure resulting from patients visiting a hospital who may require a primary care response;

- referral patterns from primary to secondary care are monitored;

- they are working with trusts to renew the arrangements relating to the quantity of drugs supplied to patients on discharge from hospital.

Chronic Disease Management
LHGs should ensure that:

- systems are developed and maintained in primary care to identify patients at risk of or suffering from key chronic conditions such as coronary heart disease and diabetes;

- prevention as well as robust disease management is in place to avoid referral to secondary care;

- where referral is required, integrated care pathways are in place which identify all stages of care and treatment.
Background

- In this context the term 'Emergency Pressures' does not denote an extraordinary event such as a major incident. Instead it refers to those periods of heavy demand for health and social care services which occur once or more each year, often in the winter, and often related to viruses or bad weather conditions.
- Emergency Pressures are therefore normal and the flexibility to deal with periods of increased demand has to be built into the regular systems and processes of both health and social care agencies.
- The circumstances that lead to increased demand for services are also likely to affect the health of staff. So agencies may be faced with increased demand at the same time as having staff shortages because of sickness.
- Peaks in demand need to be managed jointly by health and social care agencies to ensure that individuals are not prematurely discharged from NHS care, and that they have appropriate treatment and support to enable them to make full recovery and avoid readmission to hospital or unnecessary long-term social care.
- Discharges should continue to be safe and appropriate.

Good practice in planning and commissioning should include:

- participation in HA / LHB planning arrangements;
- reviewing service planning and commissioning arrangements to build in flexibility to help cope with peak demand periods;
- reviewing arrangements for flexibility in increasing staffing hours during periods of peak demand, e.g. by ensuring that sufficient numbers of domiciliary care/agency staff are appropriately trained to deal with the more common “special” demands such as moving and handling clients;
- making appropriate use of Health Act Flexibilities for supporting rehabilitation and intermediate care services and enhanced domiciliary care;
- planning joint processes and mechanisms to respond to peaks in demand, e.g. agreed revised priorities and criteria for care;
- involvement of housing agencies;
- reviews of local arrangements for commissioning care with health authorities (especially from the voluntary and independent sectors), to ensure that all services provided are fully integrated with those provided by the statutory sector.

Good practice in service provision should include:

- agreed joint arrangements for minimising unnecessary hospital admissions and promoting timely discharge;
- learning from monitoring information on delayed transfers of care for future practice;
- local protocols between Social Services (SS) and, for example, GPs to enable appropriate community care services to be directly purchased for limited time periods and within eligibility criteria;
- collaboration and protocols in place between SSDs wherever possible to enable a hospital-based social services team to undertake basic level community care assessments for neighbouring authorities;
- involvement of SSDs prior to admission for elective surgery and day cases so that likely needs on discharge can be assessed and preliminary discharge arrangements made wherever possible;
- identification by GPs and pre-admission clinics of those patients who are likely to require social and/or primary care on discharge from hospital so that early referral, preliminary assessment and planning for discharge can be undertaken.
Most local authorities and health authorities are anxious to develop community services that can act as an alternative to hospital, nursing home and residential care admissions and facilitate more effective hospital discharge. Although the role of social services is most obvious, wider local authority involvement is required from Environmental Health Services and Housing, particularly for achieving preventative strategies.

Care and Repair Agencies can assist the preventative health and social care strategies by:
- making the homes of older people safe;
- enabling people to remain at their home;
- creating safer homes for carers and statutory providers, making it easier to attend to the needs of clients; and
- enabling independence, reducing the need for domiciliary care and assisting carers in accessing additional resources.

Sub-standard and deteriorating housing leads to a loss of self-respect and motivation. Unsuitable housing leads to a loss of independence. The consequence of this can be social isolation, depression and other mental and physical health problems. These are the challenges for strategies that are concerned with addressing quality of life issues and preventative health measures.

Care & Repair agencies have been working for a number of years in partnerships with health and social services to provide a range of services designated to maintain the independence of older and disabled people in the community.

- **Handy Person Services** have been developed in various counties in Wales to provide assistance with small repairs and adaptations and are recognised as a valuable service for older people. Research conducted by the Joseph Rowntree Foundation (JRF Findings 179) has found that ‘Handy Person Services’ provides a valuable service with beneficial effects for the health, safety and well being of older people and other vulnerable groups.

- **Dementia Services** use social services, health, housing and private funding to install innovative ‘smart’ technology and adaptations in older persons’ homes to assist them in maintaining independence through increased security. The project also assists carers of people with dementia to make their homes safer and give increased peace of mind.

- **Safety at Home Services**, funded by social services and health authorities, provide small adaptations and repair services which aim to prevent accidental injury at home to ensure that the client lives in as safe an environment as possible. They are designed to help facilitate effective discharge from hospital by ensuring a safe home environment and avoid possible re-admittance to hospital by improving the safety of the home environment for those older people who have been identified at risk from accidental injury.

**The Rapid Response Adaptations Programme**
A new Welsh Assembly Government initiative is intended to provide a small rapid response adaptation and repair service. This is an Assembly funded programme and referrals will come from a range of statutory and health sector organisations. The aim is to ensure that older and disabled people are able to remain in their own home by:
- reducing long delays in waiting for home adaptation prior to discharge;
- avoiding admission through addressing problems of housing;
- preventing accidents within the home;
- developing existing arrangements between all agencies involved.
Some evidence of good practice:

**Carmarthenshire County Council, Carmarthenshire LHG and Carmarthenshire NHS Trust**

In 2001 a multidisciplinary **Community Intermediate Care Team** was established in the Ammanford area. The team’s function is to address the health and social care needs of clients who have experienced a functional decline as a result of injury or illness. The team comprises a Physiotherapist, Occupational Therapist, District Nurse, Community Psychiatric Nurse, Social Worker, Team Leader and support staff.

Clients can be referred to the team by their GP, other health care professionals and social work assessment staff. After the multidisciplinary assessment, care packages will be provided for up to 6 weeks either in the client’s own home or through the use of day hospital or intermediate care beds. The service aims to reduce the number of emergency admissions to hospital and support clients upon discharge.

It is recognised that this service is part of a network of both intermediate care and other services. The team will work collaboratively with other service providers to create a sequence of events that demonstrates a single continuous process to the provision of care.

The service is to be expanded to cover the Llandeilo and Llandovery areas during 2002.

**Monmouthshire CC, Monmouthshire LHG and Gwent Healthcare NHS Trust**

The Monmouthshire Joint Pathway and Discharge Scheme was developed to improve the process of managing discharge for Monmouthshire residents who were receiving care in the Royal Gwent Hospital. The scheme comprises a small team of a social worker and a nurse, that receives referrals early, usually on admission, which allows them time to plan for an effective discharge while the patient receives medical treatment.

The scheme is highly valued by service users and a similar scheme is being introduced into Nevill Hall Hospital, to serve those residents from the north of Monmouthshire.
Local Authority – Housing

If housing issues are not addressed as part of the community care package, there are financial costs:

- health problems and accidents caused by poor housing result in extra health costs to primary and community health services, in prescription costs, and hospital admissions;
- unsafe or unsuitable housing can also result in patients being retained in hospital beds or being readmitted prematurely;
- illness and accidents involve extra costs for social services departments, through occupational therapy services, rehabilitation services, day and respite care and transport costs.

It is essential that Local Government fulfils its broader community role (together with Health Authority partners) through:

- securing broader community support and action across the range of the local authority’s responsibilities in the following areas;
- adaptations, care and repair and special housing provision;
- communities first: securing partnership with voluntary and other sectors to support disadvantaged groups;
- using Health Alliances to develop joint approaches to improve health and well being of the population.
Among the projects designed to address the specific needs of sections of the older and disabled population of Wales are:

- handyperson services;
- dementia services;
- safety at home services;
- technical advisory services;
- Local Exchange and Trading System (LETS) feasibility work;
- caseworker based in GP practices;
- Home Maintenance Schemes and Healthy Home Checks;
- Tool Hire or Loan Schemes;
- Local Advice Surgeries and Outreach Services Advice Packs.

Supporting People

Supporting People is a policy initiative designed to consolidate the funding frameworks for supported housing and will replace existing arrangements from April 2003. The Welsh Assembly Government and local government will administer funding for supported housing within the Supporting People framework. Supporting People will include sheltered provision for older people.

Supported Housing provides practical and emotional support to vulnerable people to assist them to maintain their own home and to prevent homelessness. In Wales, the Welsh Assembly Government currently funds nearly 3,000 bed spaces of supported housing for a variety of needs, including:

- people with mental health problems;
- people suffering from an alcohol dependency;
- people suffering from a drug dependency;
- people with a chronic illness, including AIDS-related conditions or HIV positivity.

In addition, it supports a number of other vulnerable people (such as homeless people) whose health is affected by lifestyle.

It is, therefore, able to support preventative health services by:

- maintaining individuals in a setting that reduces the harmful environmental factors associated with insecure housing and street homelessness;

- enabling individuals to engage with primary and preventative health care services prior to a crisis stage by 'normalising’ what are frequently chaotic lifestyles;

- assisting people through education, emotional support and stabilising lifestyles, to reduce or cease patterns of behaviour that have negative health impacts, e.g. drug-taking;

- assisting people through education, emotional support and stabilising lifestyles, to increase patterns of behaviour that have positive health impacts, e.g. healthy diet.
Background

This document gives information about the capacity and the ability of the independent sector to support the management of emergency pressures across all organisations.

Services provided by the independent sector support and work in co-operation with health and social services and may consequently come under pressure at the same time.

The independent sector is a major contributor to both health and social care in Wales; it provides a vast array of complementary roles. Recent data suggests there are some 7,000 different care providers across residential, day and domiciliary care.

Care at home

In Wales, there are over 200 independent providers of domiciliary care, including private, not-for-profit, co-operatives and voluntary organisations:

- each is highly individual but collectively they offer a wealth of supply and experience of providing flexible and responsive services both directly with clients and families and under contracting arrangements with public sector agencies and charitable organisations;
- most employ a mix of care assistants and qualified nurses;
- during times of increased pressure on hospital beds, the independent sector is an integral part of providing additional support services to families at home. For instance, immediate respite care during the illness of or following an accident to a carer reduces the likelihood of hospital admission of both the carer and the person cared for.

Step-up / Step-down Care North East Wales

Following the success of the initial ‘step-down care’ pilot between North East Wales NHS Trust, Wrexham Social Services Department and a local nursing home in Wrexham, it has been decided that a step-up by GPs and rapid response as well as the ‘step-down’ would be piloted.

‘Step-up’ offers patients rehabilitation and physiotherapy without having to be admitted to hospital, and ‘step-down’ offers early discharge when hospital treatment is no longer required.

Services provided by the independent sector for the prevention of hospital admission and the enabling of early hospital discharge should be considered all the year round and based on the needs of individuals requiring care. It is possible to prevent some of the pressures on acute services by making earlier use of step-up and step-down care provided by the independent sector:

- Intermittent respite care in a care home may be a valuable preventive measure in avoiding the breakdown of care arrangements at home for family and friends who provide long term care.
- Providing short-term step-up care to assist individuals to regain abilities that have declined and enable them to return to their own home.
- Providing step-down care can promote early hospital discharge whilst providing re-abling care to achieve a return home.
These types of care can be provided in nursing and residential homes according to the assessed care needs for each individual. These types of care can also enable family carers to maintain contact and to be involved actively in learning about and managing the re-ablement process and a return home at the optimum time.

Key features of working with the independent sector in managing emergency pressures are:

- information - about resources and capacity;
- imagination - about alternative means of meeting individual care needs;
- flexibility - in considering the best use of all resources including short-term funding geared to specific targets or time periods.

Given the Health Act “Increased Flexibilities” provisions and local purchasing arrangements now possible, hospital trusts can seek other solutions through innovative purchasing of care or block contracts to meet specific needs.

The Role of Carers

The essential role that carers play in supporting family members, partners and friends within the community is recognised by the Welsh Assemby Governemtn in its Carers Strategy and other key policy statements.

Emergency pressures on the health service cannot be seen in isolation from the knock-on effect that these pressures have on the carers who look after their family members and friends. The report by the Carers National Association, “You Can Take Him Home Now”, details the problems for carers surrounding hospital discharge, with many carers feeling that their loved-ones had been transferred home from hospital too early.

Carers’ needs must be assessed as early as possible in the process, to ensure that:

- they have a choice about whether they wish to care or continue to care;
- they are able to continue to care, in terms of their own health, age, etc;
- they have all the training and support necessary to enable them to take part in the continuing care plans;
- all necessary aids and adaptations to the home are completed as soon as is practicable, and ideally before the patient comes home;
- they know which agency is taking the lead role, so that they are not left while agencies discuss budgets and responsibility;
- they are offered services under the Carers and Disabled Children Act 2000, should they choose to continue caring.

Carers supply the major part of community care and do it willingly, given sufficient support. They should be partners in the caring process so that the emergency pressures on hospitals are not transferred to them.
Background

- Services provided by the voluntary sector support, and sometimes even sustain, many health and social services, and consequently come under pressure when health and social services do. There is a need for a co-ordinated approach to services and it is essential that the voluntary sector is included in multi-agency planning to tackle emergency pressures, to enable effective and seamless joint working.

- The voluntary sector is able to advise on and provide alternative models of service delivery and innovative health initiatives. It should be viewed as an integral part of providing additional support services to families at home, during times of increased pressure on hospital beds. The voluntary sector has a role to play in enabling effective hospital discharge, as well as helping to avoid admission in the first instance.

- A change in the role and responsibilities of the voluntary sector is emerging in the light of devolution in Wales. Section 114 of the Government of Wales Act 1998 requires the Assembly to develop a scheme setting out how it proposes to promote the interests of relevant voluntary sector organisations in the exercise of its function. This scheme must set out how the Assembly proposes to assist voluntary organisations through grants and loans, etc. and how it will monitor the use of this assistance.

- Developing an effective partnership with the voluntary sector requires a new approach to consultation and involvement. Sound protocols need to be established, which are clearly agreed and which operate in a transparent way.

To assist the NHS and its partner agencies in planning for emergencies, the voluntary sector should:

- work with all partner agencies through the appropriate emergency pressures planning group;
- work with LHGs to minimise the risk of inappropriate hospital admissions;
- work with partner agencies to ensure timely and appropriate discharge from hospital;
- recognise that it has an important role to play in helping to facilitate timely discharge from hospital, as well as preventing hospital admissions by providing support for people and carers in the community;
- continue to develop innovative and flexible services to support more people at home;
- develop enhanced services for carers and be able to respond to increased demand for services (particularly at peak times during the winter) to avoid a breaking down of the situation where the carer becomes incapacitated.

PATH – Age Concern Gwent

- Age Concern Gwent operate a P.A.T.H. service (Prevention of Admission to Hospital).
- This aims to reduce the number of inappropriate "social admissions" of older people to hospital by providing a fast response time-limited service that will support the client in their own home.
- Individuals are referred by GPs and other medical staff and are given an assessment, care plan and trained carer allocation for 1 week.
- If the client is still receiving support after 4 days, a case review is then undertaken and if long term support is required then a referral is made to statutory authorities.

Crossroads

- In the Vale of Glamorgan, additional support is provided for the elderly mentally ill and their carers. When carers are ill, Crossroads steps in to provide support, enabling elderly relatives to stay at home and avoiding emergency admissions to hospital.
- In Blaenau Gwent, Crossroads have extended their night care arrangements sitting.
Background

The timely transportation of patients through the acute and primary health care sectors is essential in ensuring that an appropriate level of care is delivered in the most timely manner. There is a significant effect when either the acute or primary care sectors are unable to accept patients, and so release ambulances to be re-deployed. Nationally agreed performance standards will illustrate how efficiently patients are transferred between sectors.

The elapsed time relating to each incident consists of:

- time taken to receive a call and to take the appropriate details to pinpoint the chief complaint of the patient;
- time taken from identifying the chief complaint to a resource being allocated;
- time in which it takes the allocated resource to become mobile to the incident/address;
- time taken for the vehicle to travel to the incident/address;
- time spent treating the patient at the incident/address;
- time taken to remove the patient from the incident to the receiving unit (acute/primary care); and
- time taken for the crew to hand over duty of care to the receiving unit and it becoming available to respond to the next incident.

These elements are dependent upon each other and the ability of the acute/primary healthcare sector in admitting or receiving the patient into their care. An ambulance is not available to respond to any other calls until the duty of care of the patient is transferred from the ambulance service to the receiving unit.

The ambulance service provides two systems working at different levels:

- Non-emergency patient transport system, which takes patients whose dependency/medical care needs are low, from an incident/address to receive treatment. This includes patients that require either day surgery or admission for surgery within a 24 or 48 hour period. This system operates predominantly Monday to Friday, from 8am to 6pm.

- Emergency paramedic service which responds to all 999 calls, doctors’ urgent admissions and acute sector emergency/urgent transfers. In addition, depending on their dependency, patients could well be transferred on an emergency vehicle because this is the only service that is provided 24 hours a day, seven days a week.
To ensure that the service provides the best care for patients, the Ambulance Service needs to:

**manage patient transport and treatment by increasing flexibility and responsiveness to the acute and primary health care sectors. This requires:**

- greater flexibility in the type of staffing of ambulances, so that the ambulance service can meet the expectations of the acute and primary healthcare sectors in the admission of patients, or their transfer between health care facilities and sectors;
- that the ambulance service is able to achieve a timely response to the primary health care sector, for the rapid assessment of a patient requiring services to transport them to an appropriate care facility;
- the promotion of relationships between the ambulance service, acute care service providers and the primary healthcare providers;
- the inclusion of the Ambulance Trust in the Local Emergency Planning Teams.

**develop a more flexible approach with all organisations, to meet peaks in demand in the admission and treatment of patients in a more timely manner. This requires:**

- the development of protocols which allow for direct admission to wards for suitable patients;
- the development of systems that genuinely remove boundaries;
- that the ambulance service works with the secondary/acute sector in the provision of support in assessing, prioritising and maintaining appropriate patients in the community thereby delaying admissions to meet the capacity of the acute unit without detriment to the patient;
- that relationships are developed with community rapid response teams to extend the role of paramedics. They will work with the communities with these rapid response teams as a fast response unit who will then, through criteria and protocols, determine whether or not a patient needs to be admitted, or whether they can be cared for in the community.

**Developmental opportunities**

- The development of an intermediate care service, funded by health authorities and supported by grade three patient transport staff, is planned. The staff are dedicated to the admission, transfer and discharge of patients to relieve pressure on Emergency Medical Services which will subsequently assist both secondary and primary care facilities.
- NHS Wales Department is reviewing emergency capacity systems in use in parts of the UK. Many of these provide real-time situation reports on bed availability for the specially required in secondary and primary care. Consultation with health and social care providers will be on-going and the Welsh Ambulance Service could provide an intermediary role between secondary and primary care.
- Extending the hours of operation of the non-emergency and high dependency type transport systems. If appropriate, a 24-hour, 7-day a week service could be considered.
- Information systems that are linked to A&E/Assessment units to identify the number of patients being conveyed to each unit. This information could be used at times of extreme pressure.
Background

Following fact-finding Trust visits, completed by the Innovations in Care Emergency Pressures Programme Manager during November and December 2001, it became apparent that the patient experience and care received within an Assessment Unit or Admission Ward needed to be improved. The main findings included:

- bottlenecks in the admission process, including delays in diagnostic tests, accessing an inpatient bed, or waiting for senior medical review for discharge;
- wide variation in practice across Wales. No uniform policies and guidelines to inform patient expectation;
- lack of admission alternatives once a patient's assessment is complete but admission into secondary care is not needed;
- staff attitude to the assessment process. There is a marked difference in approach to patient assessment in an Assessment Unit compared to that provided on an Admission ward. It would seem that staff who work on an Admission Ward do not see their main role as that of assessment with a view to discharge, whereas A&E based staff do.

Objective

The patient receives the appropriate care in the appropriate place at the appropriate time and experiences a seamless service.

To ensure optimum patient care, trusts should:

- provide assessment to all emergency admission patients that includes:
  - diagnostic testing;
  - senior medical review;
  - transfer to an appropriate facility that meets the patient need.

- make a decision to admit or discharge based on need not availability of services;

- ensure that appropriate Nurse Managers take part in the Innovations in Care learning network whose aims are:
  - to both improve the system for the patient and also understand why the improvements have worked in this context;
  - to create measures up front, so that progress towards the aim can be monitored;
  - to move forward using cycles of action and learning, implementing small changes and reflecting on whether the changes have achieved the intended improvements;
  - adopting secondary objectives around empowering these nurses to effect change in their clinical setting.

A Medical Fastrack Assessment Unit at the Princess of Wales Hospital, Bridgend, was opened in September 2001. Its main aim is to avoid unnecessary admissions. After six months, indications show the success of this pilot with only 13% of patients seen in the Unit over a 19-week period being admitted. The remaining 87% were either discharged or followed up in an outpatient setting.
### Introduction

- The capacity of a hospital to admit emergency patients and still deliver on waiting list targets depends crucially on how well it plans for, and utilises, its staffed bed stock. Failing in this area increases the number of cancelled operations, the placement of patients in inappropriate care environments and the imposition of additional pressures on staff. Bed management is rarely considered as a strategic function and this suggests that its potential to ensure effective use of resources may be under-utilised.

- Robust bed management requires a centralised, 24-hour dedicated bed management team that must manage beds in all acute hospitals within the trust and may also take responsibility for bed use in its community hospitals. This team should have clear lines of accountability to, and the active involvement of, senior managers. The importance of their ability to react swiftly and effectively during times of peak demand should not be underestimated or dismissed as simple fire fighting. An effective bed management system depends on staff with a highly developed ability to negotiate with, and influence, staff at all levels of the organisation, as well as good analytical skills. They are key players in providing information for the trust’s daily and weekly SITREPS returns.

- Managing the “whole system” requires the bed management team to maintain overall awareness of all admissions to both elective and emergency beds if the objective of any bed management policy is not to be frustrated. The best bed management systems have clearly articulated escalation strategies, agreed by senior clinicians and managers and other key stakeholders, including local ambulance services and referring GPs.

- Robust bed management provision is fundamental to providing high standard patient care and to the prevention of long trolley waits in A&E. The control of all admissions, proper discharge planning and the use of predictive analysis to ensure that enough beds are available for the next 24 hours, should all be linked.

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To understand and predict the bed need, and ensure that capacity exists to meet this need, trusts need:

- written policies and protocols to underpin all trust bed management functions. These need to be agreed by all clinicians and managers;

- to maximise the use of beds across all their hospitals during times of peak pressure.

### Trust management arrangements:

- The executive director or general manager responsible for the bed management function puts key performance indicators in place for regular review and action, for example operations cancelled and numbers of outliers.

- Routine feedback is provided to the bed management team and the responsible executive director or general manager on performance against both new and existing indicator sets and Patient's Charter measures.

- Trusts should co-operate with neighbouring trusts and make the development of a coherent strategic response to a signalled bed crisis a priority.

- Information must be provided for the Trust's SITREPS return.

- All existing bed bureau and other bed finding functions should be placed within the remit of the bed management team.
Bed Management forward planning:

- Evidence from the Modernisation Agency in England has proved the benefits of using prediction toolkits to optimise all bed usage.
- Links with the Capacity mapping exercise will determine how local services need to plan their bed management function.

Evidence of work undertaken in the Greater Manchester area:

- **Organisational Context:** South Manchester University Hospitals NHS Trust (SMUHT) has one acute hospital with approximately 700 beds under control of the bed management function. The bed management function covers 8am to 8pm. Complications at the trust include the consolidation of all acute services on one site (over 2001) and the introduction of a new PAS (Easter 2002). The senior bed manager at SMUHT, Kim Gordon, was inspired by the system developed by Aintree to attempt to develop a simpler system tailored to the situation at her trust. Dr Nathan Proudlove, a lecturer in Operational Research at the University of Manchester Institute of Science and Technology (UMIST), has been working with NW Region and the Greater Manchester trusts’ bed managers for many years on a variety of process and capacity issues. The Department of Health WEST team has provided some funding for Dr Proudlove and Mrs Gordon to further develop this, with the intention of producing a ‘toolkit’ of ideas supported by Excel workbooks to help trusts currently doing little or no analysis of bed supply and demand, and support moves towards anticipatory bed management.

- The Toolkit aims to help bed managers a) anticipate the daily pressure on beds by predicting and monitoring bed supply (discharges) and demand (elective and emergency admissions) in order to reduce backlogs in A&E, and b) illustrate the patterns of pressure on beds over the course of the week to support initiatives to change working practices.

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**Links to other areas:** Sponsored by Dr Matthew Cooke, A&E Adviser to WEST.
Background

- Timely transfer and effective discharge may be viewed as the most critical contribution to a hospital’s continuing ability to deal with increased emergency pressures. The ability to effect a timely discharge requires the efficient use of resources across general hospitals, community hospitals, social services and the independent and private sectors. The patient who no longer needs services only provided in a district general hospital should be transferred elsewhere.

- Options at discharge depend upon the needs of the individual patient and will reflect any requirements for further care. These may include:
  
  - the need for rehabilitation or recuperation, either within community hospitals, care home settings, or in the person’s own home;
  
  - the need for minimal follow-up by a primary care team or for limited home-based support; and
  
  - those patients who continue to have complex care requirements or chronic medical problems which may be met within the community or care home setting.

This guide is arranged around two main themes:

- Requirements to speed up uncomplicated discharges/transfers, once a decision has been made that a patient may be discharged or transferred.

- Planned discharge arrangements for patients requiring complex after-care in the short, medium or long-term, following their discharge or transfer from acute care.

- Prediction and pre-planning will be beneficial for any discharge or transfer but in the situation of high pressure on beds, a key measure must be the time taken between a decision to discharge or transfer and the patient leaving hospital. The ability to respond rapidly to the decision to discharge requires a great degree of co-ordination and co-operation between a variety of staff groups and organisations.

- It is particularly important to identify as early as possible the need for a complex package of care to support discharge or transfer and make early arrangements for this. The most effective systems for transferring patients to community hospitals, independent or private care environments or discharging patients to their homes, are those where clearly agreed protocols are signed up to by clinicians, GPs, social services and voluntary agencies.

**Bronglais General Hospital, Discharge Liaison Nurse**

The appointment of a Discharge Liaison Nurse and the introduction of 7-day working in pharmacy, radiology and pathology have assisted in appropriate and timely discharge arrangements. Provision has also been made for ‘out of hours’ transport to allow for patients to be discharged.
Lead: Gaynor Williams

**Trust-wide management arrangements** to be put in place to ensure uniformity across all discharge processes are essential.

- A multi-disciplinary group should comprise senior staff involved in the discharge and transfer of patients, to review existing arrangements and ensure maximum effectiveness. This should include the timing of ward rounds, the availability of transport, the priority given in pharmacy to discharge medication rather than ward stocks, and the availability of sufficient supplies of pre-packaged medicines out of hours. The group should review the efficiency of these processes against the delayed transfer of care census returns to ensure delays in the discharge of non-complex discharges are avoided.

- Planning for patient transfer or discharge must begin at or even before admission and should be managed or overseen by a discharge co-ordinator/team, working closely with the ward team. The involvement of staff from other disciplines, community hospitals and organisations should be arranged at as early a stage as possible, rather than waiting until discharge/transfer becomes a probability or, worse still, when the decision has been made that the patient no longer needs acute hospital care.

- In some circumstances, it will be appropriate to initiate the discharge assessment prior to admission, either within pre-admission clinics or by close liaison and communication with primary care teams. Trusts are to ensure that pre-admission clinics meet this need.

- Links should be established between discharge processes and the bed management function to provide the team with sufficient understanding and information to predict future bed availability.

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**Swansea NHS Trust – Morriston Hospital Arthroplasty Services**

Morriston hospital has developed multidisciplinary pre-admission assessment services for all patients requiring joint replacement surgery. This enables problems to be identified and resolved, reducing cancellations and delays, while maximising resources. Pre-admission is the ideal time to start discharge planning by matching the patient’s plans to their actual needs. The occupational therapist undertakes a detailed assessment of the patient and advises the patient on how to prepare their home and themselves for discharge. If furniture adaptations are required they are put in place usually before admission. The physiotherapist will demonstrate the exercises that are required and how to use the walking aids so that the patient has time to practice before surgery. The arthroplasty liaison nurse (ALN) will refer the patient if appropriate to the orthopaedic multidisciplinary bridging team, which allows the patient to continue with their rehabilitation in their home environment and so reduce the patient’s length of stay in hospital. If the patient requires extra rehabilitation the ALN will pre-book a bed in the local community hospital. Referrals are made to the social worker for further support and advice if required.

Linda Ryan – Arthroplasty Liaison Nurse
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Simple, non-complex discharge planning still needs robust arrangements in place.

**Not requiring complex care following discharge:**

- During times of peak demand, investigations, tests and the production of results for patients whose discharge is dependent on them should be expedited. This will require the active co-operation of all departments.

- A stock level of aids to assist with daily living should be built up and maintained for the periods of peak demand. It cannot be acceptable for a patient’s discharge/transfer to be delayed for want of an essential but common item such as a commode. Links need to be created between the management of the home loans service and the discharge/transfer planning team, with analysis of previous demand used to assist in predicting equipment requirements.

- Negotiations should take place with the providers of ambulance services to the trust to increase the availability of staff and vehicles for transfers and discharge at weekends and evenings following late ward rounds.

- Protocols for post-discharge/transfer care should be agreed and established with primary care teams that identify an appropriate point on a patient’s care pathway when further care may be provided by the primary and community care teams rather than by the acute hospital.

**Targeted Improvements in Discharge in Pembrokeshire**

Pembrokeshire Local Health Group has invested in community care and agreed new packages on funding with the Trust and Social Services to ensure that additional nurses, consultant physician cover, home care and community services are available. Additional resources have provided an out-of-hours nurse triage service at Pembroke Dock to provide advice on the availability of local services and the self-administration of medication.

The LHG has also established a joint policy between Primary Care Providers and Pembs & Derwen NHS Trust on admissions to the emergency admission unit resulting in the majority of patients receiving a treatment plan within 24 hours. An agreed hospital discharge policy between the LHG, social services & the Trust facilitates timely discharge and ensures that vulnerable patients have appropriate support in the community.
Complex cases

The following should be applied to complex cases:

- Formal discharge planning should commence on, or where possible prior to, the patient's admission to the district general hospital;
- Delayed transfer of care data from the Welsh Assembly Government census database should be utilised and regular feedback provided to multi-agency teams involved in the care of individual patients for validation and analysis. Local action plans should be developed to address the issues identified by the census;
- Trusts should provide support for the establishment of intermediate or step-down care facilities to provide care at a level between acute and primary care and between NHS and social services to facilitate early discharge;
- An intensive rehabilitation service should be developed to maximise the independence of patients and broaden the range of options available to them in terms of accommodation and care after discharge. Active rehabilitation may enable people to return to their homes and communities rather than a residential or nursing home placement;
- Work should be undertaken with social services to identify and fund accelerated placement in nursing or residential homes where this is the only alternative for patients.

Use of Private Sector Intermediate Beds – North East Wales NHS Trust.

The Trust has a contract with a Nursing Home to place patients who were medically fit for discharge but awaiting other Social Services inputs, such as home alterations and assessments. A multidisciplinary group of Trust, Social Services, Local Health Groups and Private Health Care Sector representatives quickly agreed criteria arrangements and cover for the transferred patients. An agreed discharge date was also agreed on admission to the care home. Potential patients were assessed by the Trust's Discharge Coordinator and, once transferred, were monitored by the Rapid Response Team.

Patient satisfaction surveys were extremely positive. Only one patient missed the planned discharge date, due to deterioration in physical condition.
Service development

In future:

- Trusts are to work with community and social services to develop “hospital at home” services that will allow patients to be discharged home whilst continuing to receive interventions that are normally seen as more appropriate to a district general hospital environment.

- Hospital-based social workers are to be introduced to improve links between wards and social services, to assist collaborative discharge planning and decrease delays in discharge attributed to slow or late social services assessment.

- A discharge/transfer lounge facility is to be introduced. This is to concentrate on discharge and transfer functions and to provide a comfortable and suitable environment for patients who are medically fit for discharge/transfer but who may still feel unwell.

- The ambulance service is to be involved in any plans to change ward rounds and patterns of discharges or transfers. It may even be possible to concentrate routine patient discharge/transfer journeys as far as possible at times when the ambulance services are less stretched.
EMERGENCY PRESSURES
3.4 PREFERRED/PATIENT CHOICE

Lead: Claire Rowlands

Background

Hospital patients selecting and/or waiting for an unavailable care home place is increasingly cited as a reason for a delayed transfer of care, or in this case discharge. The following aims to clarify the present situation in this area, giving some of the legal background and providing suggested good practice, together with an example of how choice is currently being handled in Wales.

If we are to deal with the issue of delayed discharge while at the same time offering the patient an appropriate choice it is essential that the patient, their relatives or carers are involved at the earliest possible opportunity and provided with relevant information.

DIRECTIONS ON PREFERRED CHOICE


Social Services are required to make arrangements for suitably assessed users to be admitted to a care home of their choice. These Directions and accompanying guidance place Local Authorities under an obligation to make arrangements for placing a person assessed as in need under section 47, in accommodation of their preferred choice under section 21, subject to certain specified conditions.

Conditions for the Provision of Preferred Accommodation

“If the individual concerned expresses a preference for particular accommodation ("preferred accommodation") within the UK, the authority must arrange for care in that accommodation, provided:

- The accommodation is suitable in relation to individual’s assessed needs.
- To do so would not cost the authority more than it would usually expect pay for accommodation for someone with the individual’s assessed needs.
- The accommodation is available.
- The person in charge of the accommodation is willing to provide accommodation subject to the authority’s usual terms and conditions for such accommodation.”

There is a “a general presumption in favour of people being able to exercise choice over the service they receive”. Where, for any reason, a Local Authority decides not to place a person in their preferred accommodation it must have a clear and reasonable justification for that decision which relates to the criteria of this direction.

SUGGESTED GOOD PRACTICE

A number of issues tend to be brought together and classified as the patient exercising preferred choice. The term is often applied to patients who are, in fact, refusing discharge for a variety of reasons. There are patients who are in the process of selecting or waiting for the home of their choice – exercising preferred choiece and those refusing to be transferred and the following deals with the former:
Preferred Choice - Selecting and Waiting for a Care Home Place

The above directions protect peoples’ right to choose preferred accommodation and local authorities recognise that people need time and help to make this choice. However, where the care home of choice is not available and the choice process is not managed effectively, people can remain in hospital longer than is necessary, or good for them. There are examples around Wales and in England of approaches to avoid this happening.

A Welsh Example

This Welsh approach to managing preferred choice has successfully reduced the numbers of delays experienced in the area due to choice. Nevertheless, it emphasises that the general presumption in favour of people exercising choice remains paramount and that service users must be treated with dignity and respect.

The Process:
- Patients who are identified as requiring placement in a care home setting have the choice process explained to them fully before being asked to make their choices;
- Service Users are asked to nominate up to three care homes. Service Users are reassured that once their first choice is available they have the option to transfer;
- When funding is available they will be moved into one of these homes provided there are vacancies;
- If there are no vacancies in any of the nominated homes, the client is asked to make a further choice. If a suitable placement cannot be found/made, the funding is reallocated.

Main Features of the Policy:
- meets the legal requirements;
- encourages people to engage in discussion on their choices of home early in the process;
- Service Users benefit from multi-disciplinary team working (Whole Systems Approach);
- sets out clear expectations and responsibilities;
- establishes clear practice and processes within agreed time-scales;
- funding fully utilised.

Outcomes:
- Dramatic decrease in length of wait time for choice of home;
- positive feedback from service users;
- lost bed days have reduced from 1,238 in first 6 month period to 502 in the second half of the year;
- partnership working has improved with all agencies taking responsibility and action;
- there have been no legal challenges or complaints and no Service Users have requested a transfer to their first choice home once settled in an alternative.
Protocols

Advice provided by Social Services Inspectorate Wales (SSIW) issued to Delayed Transfers of Care contacts in December 2000 suggested there should be local protocols for hospital discharge in place, which reflect these issues. This acknowledged that, although it is not appropriate to delay discharge while choice is exercised, it is unlikely that it will be possible to eliminate all delays that occur due to “client choice”.

Local health and social care communities are encouraged to agree a set of operating protocols that deal with choice. The protocols would cover clarity around who does what and when, and address ways of avoiding conflict over choice, including managing patient expectations.

Information and Managing Patient Expectation.

Local partners should review the quality and timing of the information given to patients and their carers/relatives. They should consider how to manage patient expectation by, for example using leaflets or standard letters signed by the Trust and Social Services Department setting out discharge options where appropriate before or on admission.

Clarify Roles and Responsibilities.

Making sure that there is clarity around roles and responsibilities, for example:

- Clarifying the precise role and responsibility of the discharge co-ordinator as opposed to the Care Manager;
- Ensuring that consultants and ward staff understand the discharge process; and
- Trying to prevent unilateral declarations of outcome, i.e. the patient being referred to the social care system because the consultant or other has decided that they should be in a home rather than allowing an inclusive multi-disciplinary assessment work with the patient and their carers/relatives to determine the most appropriate outcome.

In addition, health and social care communities are advised to use their local delayed transfers of care data to look at when and how agencies should be involved, for example:

- If some of the delays arise from elective admissions what pre-assessment work was undertaken and was the social care teams involved;
- How clear are the pathways for both elective and emergency admissions;
- If protocols appear to be in place does everyone know about them and does every one share the same interpretation;
- Ensuring A&E staff are aware of and able to access relevant services and at differing times of the day.
Introduction

- This guidance sets out new unified year-round arrangements for capacity planning for health and social care in 2002-03. This recognises that within the challenging wider innovation and modernisation agenda, capacity to meet seasonal peaks in demand can only be delivered as part of year-round planning of capacity across the whole system.
- Capacity mapping will highlight universal capacity problems, enable identification of good practice that can be shared with other organisations and draw attention to inherent structural problems and the options to tackle these.
- In line with this, multidisciplinary local emergency pressures groups should operate year round transcending trust borders.
- It is essential that the actions detailed in this section are read in conjunction with the rest of the ‘Emergency Pressures Planning Guidance 2002-03’.
- It should be noted that a number of the elements to be used within the Capacity Maps are collected by the SITREPS system and other existing data sources. The Welsh Assembly Government will be monitoring the Capacity Maps against the SITREPS returns and other existing data sources. This will assist in highlighting ‘Good Practice’, supporting the identification of universal capacity problems, and will draw attention to inherent structural problems. This will include emergency, elective and social care services.

Action needed

Health Authorities should as appropriate join together to:

- extend the role of the Local Emergency Pressures Groups to also act as Local Capacity Mapping Groups (LCMGs) with a remit to plan capacity for the whole system year round for 2002-03;
- ensure that the Group includes as a minimum representatives of all NHS organisations including ambulance services, NHS Trusts, Local Health Groups, representatives from primary care and ‘out-of-hours’ primary care providers, NHS Direct Wales, Local Authorities, the whole range of local independent sector providers, the voluntary sector, and other relevant local partners;
- ensure that within this year-round approach organisations retain a clear focus to plan and deliver sufficient capacity for emergencies and electives.

Health and Social Care communities should:

- Ensure that full use is made of the local independent health care sector where this is required to match capacity with demand.

Emergency Care Intervention and Support Facility

A multidisciplinary team of NHS and Social Care staff will be available during 2002-03 to support local planning and service delivery. This year the team will operate year round and focus on capacity planning and service modernisation.
EMERGENCY PRESSURES
4.1 CAPACITY MAPPING

Lead: Rob Hemmings

Health Authorities and Social Services should:

- each nominate a senior officer to lead on capacity planning for 2002-03;
- plan capacity for the health and social care community for 2002-03 covering all the areas named in the ‘Emergency Pressures Planning Guidance 2002-03’;
- produce for the whole health and social care community a capacity map on the basis of provider trusts. This will show predicted available capacity on a week by week basis as at the following dates: 30 September 2002, 2 December 2002, and 3 February 2003. This is to be agreed with all community partners;
- submit this capacity map by 27 September 2002 to the NHS Performance Management Division at the Welsh Assembly Government offices on a standard pro-forma that will be available from 31 July 2002 from the NHS Performance Management Division;
- submit updated capacity information to the offices above on 9 December 2002 and 10 February 2003 using the standard pro-forma.

Chief Executives of all NHS Organisations and Directors of Social Services should:

- plan, and when required, map their organisation's available capacity, throughout the year;
- ensure that their planning covers all the issues detailed in ‘Emergency Pressures Planning Guidance 2002-03’;
- during periods of increased pressure, when escalation plans are being implemented, ensure that available capacity is considered on a regional basis, in line with an agreed policy for managing pressures across the region.

Documentation relating to Capacity Mapping has been circulated to Chief Executives of NHS Health Authorities and Trusts and to Directors of Social Services.
4.2 Escalation Procedures

Lead: Roger Perks

Escalation Procedures

NHS Organisations

In the past, health communities within Wales have experienced significant pressures on the acute bed base which result in disruption to services leading to delays in admitting emergency patients to hospital beds, diversion of patients and high levels of cancelled elective surgery.

Mechanisms for collaboration and escalation exist but are considered in some cases to be reactive, rather than proactive, and, so, inadequate for the task. The purpose of an escalation policy is not simply to help manage pressures in one organisation but should be developed with partners as part of a whole system approach to effectively managing increased workload. The policy should list a staged approach to escalation.

NHSWD therefore requires each organisation to review its escalation policy to ensure that:

- the objectives are understood;
- the policy is agreed by the appropriate staff;
- staff are clear with regard to expectations;
- trigger points are identified and timely;
- the response is appropriate;
- where required the ‘whole system’ is involved.

Each organisation should have a nominated point of contact through which decision making can flow and actions must derive from the Escalation Policy during times of pressure. The nominated contact must be identified to partners in the local community and to the NHSWD.

A clear and comprehensive escalation policy is an essential part of a trust’s response to increasing pressures. It is therefore essential that:

- the policy is written, specific, unambiguous and available, and agreed by the Trust Board following consultation with partner organisations) and signed-off by the Chief Executive;
- relevant sections of the policy are shared with neighbouring trusts and other local partners and this is evidenced by a signature within the policy document. Partners include:
  - Primary Care (LHGs)
  - Social Care (SSDs)
  - The Ambulance Service
- the policy is developed by appropriate staff and is clear about staff’s:
  - delegation and authority;
  - responsibilities;
  - involvement;
  - training.
- information requirements are built in and the policy is clear about:
  - what is the minimum dataset to allow for appropriate decision making;
  - how timely information is obtained;
  - how the information is to be used.
4.2 ESCALATION PROCEDURES

Lead: Roger Perks

- patient flows and trends within the trust and adjacent trusts/organisations are understood and that the patient is at the centre of the policy;

- there are internal trigger points within each stage of the policy that determine action, including at least reference to A&E SAPhTE score, SITREPS status and the bed position regarding emergencies and electives;

- there are external trigger points in the policy that lead to specific action – primary care information, ambulance information, requests for assistance or notice of closures from other trusts;

- the policy contains a graduated response to the build up of pressures and reaching trigger points - the policy should not be initiated only when the trust is in crisis and stepped down when this point has past;

- the policy includes clear instructions regarding the notification of pressures to the:
  - Welsh Assembly Government;
  - Primary Care;
  - Social Services;
  - Neighbouring trusts.

The policy should be clear about who makes the contact, who (names, designation, telephone numbers, etc.) is to be contacted and what is expected of them. The list of contacts should be circulated to all parties.

- there is clear and defined links between the escalation plan and the bed management policy;

- a clear set of actions are defined on the basis of requests from neighbouring trusts or the ambulance service;

- the plan must allow for high level executive collaboration between trusts and other organisations given severe pressure in one or more locations. At its simplest this may be a conference call between Chief Executives;

- provision exists for updating the policy and that:
  - the policy is continually reviewed and developed;
  - innovation is not stifled;
  - the plan can be amended if it is not working, e.g. if there is a continual high level of escalation.

Welsh Assembly Government

The need for accurate reporting via the SITREPS system to the Welsh Assembly Government cannot be overstated. It is imperative that the Assembly is kept informed of increases in emergency pressures that are likely to compromise patient care. Misreporting may lead to further action.

The emergency pressures team of the Assembly must be informed by exception of any closures of A&E departments and/or diversions of emergency admissions before or as they occur.

Immediately a site reaches status 4 (during office hours) or status 5/6 (in or out-of office hours), the chief executive or designated deputy (in line with local arrangements) must contact the Assembly.
4.2 ESCALATION PROCEDURES

Lead: Roger Perks

The appropriate contact numbers are shown below:

Office hours escalation telephone numbers (weekdays 8.30am – 5.30pm):

<table>
<thead>
<tr>
<th>Name</th>
<th>GTN</th>
<th>STD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roger Perks</td>
<td>1208 6736</td>
<td>029 20826736</td>
</tr>
<tr>
<td>Dan Isaac</td>
<td>1208 1417</td>
<td>029 20801417</td>
</tr>
<tr>
<td>Adam Thomas</td>
<td>1208 3715</td>
<td>029 20823715</td>
</tr>
</tbody>
</table>

Out-of-hours escalation pager number (weekdays 5.30pm – 8.30am & all weekends/bank holidays):

07669 129039

When using the pager number, wait for the automated message to finish and then hold for the “live” operator, who will request your message. Leave your name, contact number and the name of the trust (no more than 15 words). The message will take approximately 1 minute to reach the pager and the “on-call” Assembly Official will return your call within 15 minutes.

When the NHSWD Official returns the call, a series of questions will need to be answered. The NHSWD will need to know:

- name of trust/site;
- name of contact;
- reasons for escalation;
- extent of problem;
- effect on neighbouring trusts;
- cancellation of elective work;
- likely timescales;
- what action is being taken;
- whether the HA/LHG/Social Services have been informed.

NHSWD should be kept informed of any developments until the trust returns to status 3, 2 or 1. If the situation deteriorates, the trust must immediately inform the appropriate member of the Emergency Pressures Team, who will be responsible for briefing the Minister and NHS Director. It is NOT the responsibility of the official to inform the Health Authority or take any direct action on behalf of the trust.

Assembly Escalation

At all status levels, currently 1 – 6, the Emergency Pressures Team will advise the Minister and senior management of the ‘all Wales’ position using the daily emergency pressures map.

At status level 4 and 5, the Emergency Pressures Team will provide more detailed information to the Minister and senior management using details taken from the escalation call (see above) and, information and comments from daily and weekly SITREPS. In addition, Patch Managers may contact the trust.

At status level 6, the Emergency Pressures Team will require the Trust to provide a written report to the Director of Performance, Regulation and Quality in the Assembly within 5 working days, to include:

- the circumstances, including contributory factors;
- steps taken to manage pressures - in line with the escalation policy?;
- actions taken to avoid recurrence.

At all levels, the Emergency Pressures Team will be reviewing data from SITREPS and information available from other sources and assessing it against the declared status (1-6). False reporting misleads partners at all levels and is unacceptable. Where it is felt that the declared status may not reflect the true underlying
Lead: Roger Perks

position, then the Director of NHS Wales may ask for a formal review of the position in the relevant hospital/trust and to report back.

If a hospital reaches status 4 during the day, or status 5/6 out of hours, and does not notify the Assembly, then the emergency pressures lead will be expected to provide the Director of Performance, Quality and Regulation with a written explanation of the circumstances within 24 hours.
EMERGENCY PRESSURES
4.3 DELAYED TRANSFERS OF CARE

Lead: Gaynor Williams

Background

Delayed transfers of care, including discharges, can significantly affect the ability of the healthcare system to effectively manage emergency pressures. A sub-group of the Emergency Pressures Task Force considered the impact of this and related issues in Wales and concluded that:

- inter-disciplinary care pathways should explicitly recognise that discharge planning is a process that begins on admission. Local inter-disciplinary protocols must emphasise communication and agree arrangements to facilitate this process;
- whilst a patient’s consultant is responsible for identification of readiness for transfer/discharge, decisions should only be made in consultation with all the agencies involved, both NHS and non-NHS and include the patient, family and carers;
- local multi-agency agreements should be in place to support this. However, this consultation process cannot delay the identification of a patient ready for transfer/discharge;
- hospital discharge is a process and not an event that becomes more complex for patients requiring support and ongoing care;
- the ability to identify and monitor delays in transfer of care must be an integral part of the discharge process.

Delayed Transfers of Care Census – amended process following the introduction of the new database

Health Solutions Wales has developed a web-based database to replace the Access database in use throughout the pilot. The web-based system is accessed via HOWIS and allows for password protected data to be transferred electronically, thus removing the need to submit data to health authorities for data extraction purposes.

The reporting capabilities of the new database are greatly enhanced and will allow local agencies to generate detailed reports based on the data entry fields. Local health groups, health authorities and the Welsh Assembly Government will also be able to generate reports on validated census data.

The development of this amended database has been overseen by an all-Wales Working Group consisting of NHS and local government representation. It will continue to oversee the implementation of the new system. The new database:

- was introduced in April 2002 for the monthly census required by the Welsh Assembly Government;
- has the ability to operate as a real-time system and to generate comprehensive local reports;
- should be used as a local information tool in addition to census requirements;
- will ensure comprehensive data recording and analysis at local level;
- has not changed the requirements of the census – each trust is required to identify all patients in all NHS hospitals experiencing a delay in transfer of care and the reasons for this. As previously, validation of census data is a key requirement prior to submission but the database now provides 15 working days to validate data.

Whilst the definitions to be adopted will remain unchanged, some amendments and additions to the reasons for delay codes have been introduced to take account of comments and suggestions from service users. The definition and reasons for delay codes are accessible via the HOWIS Emergency Pressures website.
EMERGENCY PRESSURES
4.3 DELAYED TRANSFERS OF CARE

Lead: Gaynor Williams

To ensure that an effective monitoring process is in place to report delayed transfers of care and that appropriate actions are directed at the main issues identified:

- each trust should use the data collated via the database to review issues directly within its influence;
- each trust should develop and agree protocols with local authority partners to share access to the database in order to generate reports additional to the local authority download file;
- similarly, local health groups are required to agree protocols for local authority access to HOWIS and delayed transfers of care report generation;
- trusts and their partner local authorities should consider collecting delayed transfers of care information more frequently than, and in addition to, the mandatory monthly census. The database has been developed specifically to support this and can be used between census dates to monitor and analyse delayed transfers of care data. The benefits of using the database as a real-time system should be considered and issues relating to amended processes and validation requirements explored;
- the database should be utilised to provide detailed local information to support local multi-agency teams in addressing a reduction in delayed transfers of care;
- local systems should be developed to ensure multi-agency discussion and actions to address issues identified that relate to multi-agency assessments or provision. Trusts, local health groups, local authorities and independent sector representatives will be key participants in this process;
- discharge planning policies and processes should be jointly audited by trusts and social services departments (or external bodies, where appropriate) on a regular basis to ensure that policies reflect the most effective and efficient discharge planning process and that these are being effectively implemented.

Facilities and services available to support people following discharge are of particular importance and may affect discharge timing. Ensuring effective transfer arrangements, particularly for patients requiring ongoing care, relies upon both accurate, timely assessments and availability of services.

Services may be required on a multi-agency basis in a community or residential setting to effect a transfer of care, such as for rehabilitation, or for discharge. Delays may occur through problems of process (where assessments may not have been conducted promptly or resultant actions taken in a timely manner) or through difficulties in providing care (where required services are unavailable). Delays in ensuring appropriate care can therefore be viewed as:

- internal issues within NHS trusts that may cause difficulties in the transfer of patients to the most appropriate care setting; and
- issues at the interface between health and social care, where a discharge may be impeded due to difficulties in providing appropriate services which have been identified as necessary to support patients on leaving hospital.

The Task Force concluded that more could be done to understand the causes of delays in transfers of care (including, but not confined to, discharge) and to identify ways to quantify the extent of the problem, through the development of nationally agreed processes. The ongoing development of all-Wales monitoring systems to identify both the numbers of patients affected and the reasons for delay in transfer continues to be a key
In 2000, a pilot all-Wales monitoring and reporting mechanism was developed based on systems in use in both Wales and Scotland. Each trust in Wales undertook the first monthly census of numbers of delayed transfers of care (including discharge) in December 2000. The census was based on a standardised all-Wales definition and data collection process, enabling the monitoring of the number of delays, plus reasons for delays across Wales.

At no stage will local health groups, health authorities or the Welsh Assembly Government be able to access data that has not been validated by the appropriate local authority. The inability of local authorities to access HOWIS at present is recognised – this guidance includes requirements for trusts and local health groups to agree access procedures with their local authority partners.

To ensure that an effective monitoring process is in place it is essential that:

- a consistent approach be maintained, especially in the fields of definition and reasons for delay;
- there is firm managerial control at all stages of the process;
- a monthly census is conducted using the database provided for this purpose, and that the definition and reasons for delay are included within the database and supporting guidance;
- the census take place on the third Wednesday of each month. The internal processes adopted to ensure that information on all appropriate patients is captured are for individual trusts – in collaboration with their local authority partners – to develop. This ensures the method applied is best suited to local circumstances;
- agreements as to the reasons for delay are reached between trusts and local authorities within 15 working days from the date of the census. At the end of this period, validated census returns must be available and certified for electronic submission to the Welsh Assembly Government;
- each organisation identifies a named individual to co-ordinate this work across the trust and that either the chief executive, executive director or nominated deputy confirms that validation has taken place prior to electronic submission of census data;
- local protocols for reaching agreement with local authority representatives are developed, agreed and reviewed on a regular basis. Reasons for individual delayed transfers of care must be agreed with local authority representatives. The database includes a field to confirm that validation has taken place, and will not allow trusts to submit data that has not been validated, except in circumstances where local authorities are not involved in arranging or providing ongoing care.
Background

In recent years, it has become increasingly evident that emergency pressures have become a year-round phenomenon, with a range of pressures causing problems for the NHS and social services at different periods throughout the year. These pressures can result in long-lasting difficulties in trying to treat elective patients and deliver improved waiting lists and times.

Furthermore, tackling emergency pressures accounts for a considerable amount of NHS and local authority resources across the entire spectrum of care. In recent years, the winter peak in demand for NHS services has caused immense strain on the system.

One of the recommendations of the Emergency Pressures Task Force was to introduce a robust monitoring system, collecting timely management information and indicators of pressure.

This saw the introduction of SITREPS in December 2000, a data collection and reporting system developed by the Department of Health (though refined to be more applicable to Wales), which involves the collection of key indicators to help determine the extent of emergency pressures on NHS organisations. Since its introduction, the system has been modified (based on the views of NHS Wales colleagues) though one of its strengths is the ability to make comparisons over time, which is why changes to the system and definitions are limited. SITREPS information is available via HOWIS/Cymruweb (the NHS Intranet in Wales).

SITREPS in Wales has three significant uses:

- To assist local management by producing timely emergency pressures indicators and enabling comparative analysis:
- To share key data with the NHS and partners in Wales:
- To inform the Welsh Assembly Government of the levels of pressure on the NHS.

Weekly SITREPS are collected by each acute hospital and inputted onto a web-based system, enabling information to be accessible straight away. All indicators are mandatory.

Daily indicators were collected each working day between December 2000 and June 2001. In September 2001, daily reporting was re-launched with slight amendments and indicators have been collected on a daily basis (including weekends and holidays) ever since. The indicators are provided on an acute site basis and supplied to the Assembly by 3.00pm. These report the level of pressure and include:

- An emergency pressures status (on a scale of 1 to 6 depending on pressure on the acute site):
- 6 key indicators (including bed availability at midday) to report the level of pressure on a timely basis. Data submitted is based on the midday situation.

Daily briefing to the Minister and Director of NHS Wales

On completion of the analysis of the daily reports, an end of day briefing is provided to the Minister, the Director of NHS Wales and other Welsh Assembly Government colleagues. This summarises the current pressure within the acute sector of NHS Wales.

Feedback from NHSWD

Analysis is presented on the NHSWD emergency pressures web site on a daily basis. This ensures that timely, relevant data is accessible at all times to NHS colleagues with access to HOWIS/Cymruweb and provides a valuable source of information. There are also plans to develop a site on the Internet, which will be accessible to the public and will contain summary SITREPS details. A separate mechanism also gives local authority colleagues access to some SITREPS data.
EMERGENCY PRESSURES

4.4 SITREPS

Lead: Dan Isaac

Changes to SITREPS

Once again, colleagues have been consulted on what changes could be made to situation reporting coming into winter 2002-03 and the consensus view was to minimise revisions. This has two benefits – allowing comparisons to be made with historical data and limiting the additional burden of collecting a different data set.

However, a detailed breakdown of cancelled operations data has been collected through a separate system since June 2002 and this is on-going. This data set supplements cancelled operations data provided for weekly SITREPS. Many hospitals have already adopted the A&E SAPhTE scoring system, which indicates levels of pressure in A&E. NHSWD will be promoting the rollout of this system to all A&E departments on a pilot basis and will incorporate this as part of daily reporting.

Reporting pressures on a daily basis, using the scale of 6 status levels has continued to cause some problems, due to different interpretations of the definitions. With this in mind, alternatives will be considered over the coming months but it should be emphasised that status reporting remains a key indicator and should provide an accurate reflection of pressures on the system. Status levels are provided at midday but pressures can fluctuate greatly throughout the day. Therefore, it is essential that daily reporting includes narrative to explain the extent to which emergency pressures have affected the hospital in the previous 24 hours and how these may be felt in the next 24-hour period.

Future Developments

One of the messages that has been relayed by service colleagues is the need to extend SITREPS to include primary care (including NHS Direct), community, mental health, social care and ambulance indicators. When SITREPS was introduced, it was always intended to extend coverage to include these other areas, though processes may not currently exist to collect indicators or it may not be obvious what indicators could be collected. Any suggestions about how this could be taken forward should be discussed with officials in NHSWD.

Cancelled operations (by the hospital) are distressing and inconvenient for patients. Patient cancellations and ‘Did Not Attends’ waste valuable operating theatre resources. Tackling Cancelled Operations interim guidance produced by the Modernisation Agency Theatre Project Group in England provides NHS trusts with practical actions they can take to reduce cancellations and optimise theatre utilisation.

It draws on the initial findings of the Theatre Project pilot sites; good practice identified within NHS hospital trusts; and existing guidance available from organisations such as the Audit Commission, the Royal Colleges and the National Confidential Enquiry into Perioperative Deaths (NCEPOD).

A survey of cancelled operations carried out in the Theatre Project pilot sites recorded the reasons for cancellations. Tackling Cancelled Operations focuses on the reasons for cancellations that can be influenced by the planning and management of operating theatres – operating list overruns; consultant and theatre staff availability; emergencies and trauma; and equipment failure and availability. These reasons together accounted for half of all hospital-initiated cancellations reported in the Theatre Project cancelled operations survey.

The cancelled operations survey showed that the main reason for hospital-initiated cancellations was unavailability of ward beds. Bed unavailability is not necessarily due to bed shortages, but may be caused by other factors such as delayed discharges, or by patients who should be seen as daycases occupying inpatient beds.
SITREPS is the primary method of transferring timely emergency pressure information within the NHS, between the NHS and the Assembly and with partners. It is therefore important that:

- reports are always submitted in a timely manner to enable sufficient time for analysis to be undertaken and briefings produced: daily reports using the midday position by 3.00pm; and weekly trust reports using the week to midnight Monday position should be completed by close of business two working days after the end of the reporting period (Wednesday);

- trusts/acute sites use the most appropriate systems to collect the indicators required to undertake validation. Accountability for the data lies with the trust Chief Executive;

- daily reports, including the daily status, are authorised by the Chief Executive or their designated deputy and that this person is available to authorise the daily report in a timely manner (i.e. by 3.00pm each day);

- NHS colleagues familiarise themselves with all SITREPS definitions and abide by them;

- daily reporting data is submitted retrospectively for weekends and bank holidays (i.e. on the next working day);

- the status level reported is an accurate reflection of the pressures faced by the acute site at midday;

- explanatory comments are included on both reporting systems at all times with extra detail at times of increased pressure;

- each Trust (or acute site) has a written escalation policy for dealing with the build up of pressure. This must include responsibilities for notifying the Assembly, Health Authority, other local hospitals, GPs (LHGs), local authorities and other partners. NHS colleagues should also familiarise themselves with the Assembly escalation procedure set out in section 4.2;

- information is shared with local GP’s, Social Services and any other appropriate NHS/Social Services departments.

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**Met Office Forecasting**

The Met Office currently produces a workload report and forecast for the regions of England. During winter 2001/2002, web site access to the information was granted on a pilot basis to Welsh Assembly Government officials.

- Only about 20% of the forecast is based on weather information; the other 80% of the workload forecast comes from other sources, including NHS Direct, GP Co-ops and hospital trusts.
- The existing input from Wales is from the NE Wales GP co-operative.
- It is proposed to liaise with the Met Office on a research project, providing forecasts based on historical trends of weather and the consequent respiratory illness patterns.
Background

- The NHS is a large and complex organisation, providing a range of services for the public. It also has responsibility for protecting public health and working in partnership to promote health and wellbeing. Daily, thousands of people in Wales come into contact with the NHS, either in hospital premises, by visiting community facilities or in their own homes.

- The modern NHS puts people first. It is committed to working in partnership with people, enabling them to make informed decisions and become partners in their own healthcare. Good communication must be at the very core of all that the NHS does.

- The NHS often finds it difficult to get its message across to both opinion leaders and the public. This is partly because much of the work is still driven by the need to react to short-term needs as opposed to a planned approach based on long-term communication objectives.

- The NHS is increasingly recognising the importance of planned communications work. Good communication work is essentially about knowing what your organisation stands for, shaping its image and reputation and being proactive in positioning the organisation.

- NHS organisations must take the initiative and proactively manage this process, because if they do not, others will create the organisations image and reputation.

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**Principles of good communication**

- Be planned, co-ordinated, evaluated and proactive;
- Be strategic and not follow a series of piecemeal operational activities;
- Be factual and present information in plain language;
- Involve dialogue - it is not a one-way system;
- Have the skills and the right tools for the job within the organisation.

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**Developing a communication strategy**

The Welsh Assembly Government, the NHS and partner organisations need to ensure that they have a communication strategy that addresses the following:

- Internal communications to ensure a well-informed workforce;
- Communication between health professionals, patients and their families;
- Communication between the NHS and partner organisations, e.g. social services and the voluntary sector;
- Communication with the public;
- A constructive working relationship with the media.
Implementing a Communication Strategy

- Implement the agreed Emergency Pressures Communications Protocol. This covers developing a communications strategy across all organisations, a proactive approach to news and the handling of negative news.

- Appoint a senior manager to be responsible for developing and implementing the protocol.

- Develop a constructive working relationship with the media.

- Develop a media relations policy, which outlines how the organisation is going to work with the media, identifies authorised spokespersons, outlines formal clearance procedures and how the work will be monitored and evaluated.

- Ensure that there are robust out-of-hours arrangements for media relations work.

- Train spokespersons to work with the media.

- Ensure that patients and their families have access to accurate, timely and relevant health information as part of their healthcare.

- Take action to ensure that all information presented to the media and to the public is jargon-free and in plain language.

- Ensure that formal communication systems are in place between organisations that work together. Ensure that there is a record of these and a regular review process.

- Collect and publish information about services in local areas over holiday periods.

- Ensure that managers and professionals working in the service agree key messages, so that the occasions when the service sends out mixed messages are reduced. This is important because mixed messages cause confusion and undermine public confidence in the service.

Take the information outside - Ideas for Communicating Information to the Public

- Set up a stand in your local town centre with information on healthcare over the winter and particularly the holiday period. Provide first aid demonstrations or health checks to gain extra interest.

- Offer to hold workshops in local schools on how to get the best out of the NHS. This could include take-home information about local arrangements for healthcare over the winter period.

- Link up with pharmacies and supermarkets as places to distribute information about opening hours and out-of-hours arrangements.

- If producing a newsletter, remember that costs can be reduced by allowing appropriate advertising.

- Link up with your local council and see if you can include a leaflet with any free newspapers that they may be delivering in the area.

Cardiff and the Vale NHS Trust

Working with the local evening newspaper, the Trust ran a number of features on people who work in the organisation during the winter period.

One example was the three-quarter page feature article in the Health Focus section of the South Wales Echo on Nurse Sally Davies, who heads the team responsible for the safe transfer of patients out of hospital into the community.

The article outlines the team’s role, puts their work in the context of increased pressures faced by the service, highlights their role in building the bridge between hospital and home, and in supporting families during this process. Above all the article reflects the human face of the NHS and the unstinting care and commitment of those who work in the service.
Communication Strategy

Internal communications

NHS organisations employ large numbers of staff who, as part of their day to day work, are ambassadors for the service. It is therefore essential that:

- Good internal communication systems are in place, both to keep staff informed and involved, and to ensure that they are able to inform patients and their families;

- Front line staff in particular, are well informed so that they understand what is going on, can make informed decisions and deal with patients and their families sensitively.

Communication between NHS organisations

The NHS in Wales comprises a large number of organisations that work together regularly, on a range of issues. In the context of emergency pressures it is important that:

- Communication protocols are in place to deal with service issues.

- Staff are well briefed about these service issues.

- When communicating with the public, messages are agreed beforehand, so that all involved “sing from the same hymn sheet”.

Communicating with the public

The NHS has a responsibility to inform local people about their health service, to understand their health needs and to form their views on the service.

- There is a need to communicate information about changing service provision and to respond to public concerns.

- Senior management input is needed for effective systems to be in place to deal with the fluid situation that the service has to manage during peak periods.

- In most organisations, jargon has its place as a means of shorthand between those who understand it. **When communicating with the public, do not use jargon.** Use more widely understood language and be sensitive to the signals that vocabulary sends to people outside the service.

Communication with partner organisations

The NHS works with a large number of partners in both the statutory and voluntary sector on both policy development and service delivery. It is important that:

- Partners are involved and informed of key developments so that they are able to plan services accordingly.

- The links with social services are strengthened to enable partners to ensure a seamless service to the patient.

- When communicating with the public, partners agree key messages so that the message gets across most effectively.

Developing a constructive working relationship with the media

The public gains much of their information about the NHS from the media. Very often the media sets the public agenda and shapes public opinion on health issues. It is therefore important that NHS organisations develop a constructive and proactive approach to media relations work.
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