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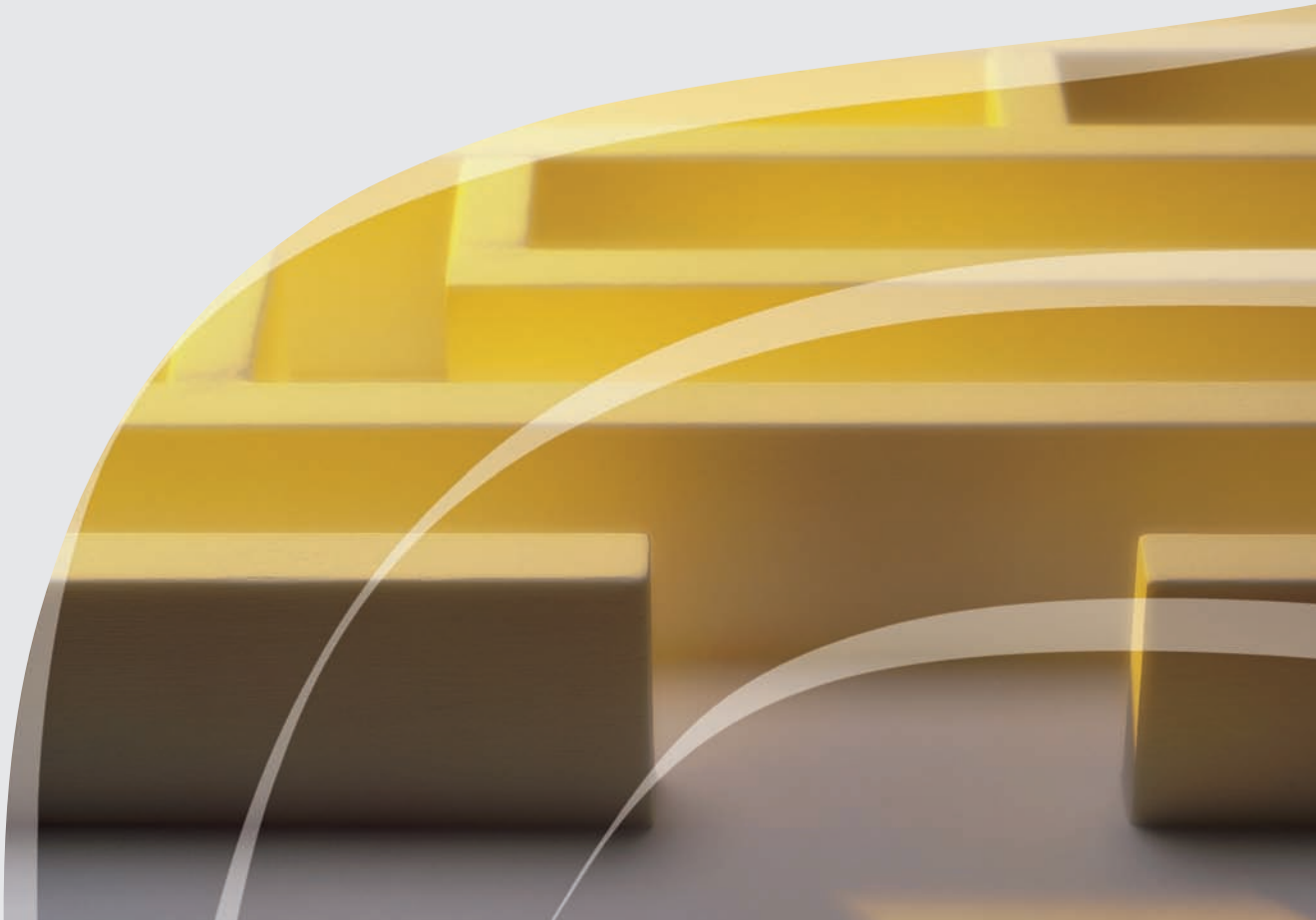
Tackling delayed transfers of care across the whole system - Overview report based on work in the Cardiff and Vale of Glamorgan, Gwent and Carmarthenshire health and social care communities



Tackling delayed transfers of care across the whole system - Overview report

In relation to the Welsh Assembly Government and NHS bodies, I have prepared this report for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006. In relation to local government bodies, I have prepared and published it in accordance with the Public Audit (Wales) Act 2004.

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Report presented by the Auditor General for Wales to the National Assembly on 1 November 2007

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Summary

1 A delayed transfer of care is experienced by a hospital inpatient, when they are ready to transfer to the next stage of care, but this is prevented by one or more reasons. Delayed transfers of care have negative impacts on the people who become delayed, with significant implications for their independence. Delayed transfers of care also have an impact on wider service delivery and performance across the whole health and social care system but the immediate effects manifest themselves within hospitals.

2 Through its Older People's Strategy and the National Service Framework for Older People, launched in March 2006, 'Designed for Life' (its 10 year strategy to develop world-class health and social care services) and 'Fulfilled Lives, Supportive Communities', its 10 year strategy for social services, the Welsh Assembly Government (Assembly Government) has made clear its intention to promote the independence of vulnerable people and to reduce their reliance on the acute hospital sector. These documents reflect the findings of previous external reviews[1] which identified the imbalance within the health and social care system and the need to reduce reliance on the acute sector. However, performance against Assembly Government targets to reduce the number of delayed transfers of care has been variable – although there have been reductions in the numbers of delayed transfers of care since 2003, there have been recent increases particularly in the Cardiff and Vale and Gwent health and social care communities.

3 Tackling the problem requires effective and mature systems thinking across health services, social services and the independent sector, each with individual responsibilities, resources and constraints. It has long been recognised that there is a system problem in the way that the health and social care sectors interact, with concerns about potentially conflicting agendas and complexities arising from different performance management frameworks. While there are some examples of effective interactions between health and social care in the communities covered by this review, the development of Local Service Boards is one potential mechanism to improve co-ordination and the focus on the citizen who needs care from the Welsh public service.

4 Delayed transfers of care emerged as a risk from our risk assessments in local government and NHS bodies in Cardiff and the Vale of Glamorgan and Gwent. This, coupled with the need to follow-up an earlier project in Carmarthenshire, led us to decide to undertake cross-cutting work on delayed transfers of care in these three health and social care communities. The Care and Social Services Inspectorate for Wales (CSSIW) worked alongside us and made a valuable contribution to the project. This report summarises the key themes and issues emerging from this local work. The National Leadership and Innovation Agency for Healthcare's Change Agent Team carried out detailed work on delayed transfers of care in the Cardiff and Vale community which

1 A Question of Balance, a review of capacity in the health service in Wales, 2002, and Review of Health and Social Care in Wales, 2003.

reported in March 2006 and led to the production of a detailed report and action plan. This formed part of the backdrop to this project and the National Leadership and Innovation Agency for Healthcare's ongoing 'Six Steps from Delayed Transfers of Care to Effective Transfer of Care' project.

5 We examined whether trusts, Local Health Boards (LHBs) and local authorities were taking effective action across the whole system of health and social care to tackle the extent and causes of delayed transfers of care in the Cardiff and the Vale of Glamorgan, Gwent and Carmarthenshire health and social care communities.

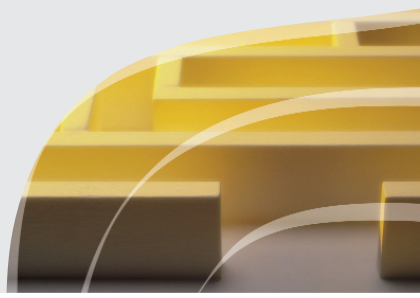
6 We found that the independence of vulnerable people and treatment of others continues to be compromised by unnecessary delays in hospital because the whole system problem of delayed transfers of care has not been tackled effectively in a whole systems way.

7 We have worked closely with the contractor undertaking an independent review of delayed transfers of care across Wales on behalf of the Assembly Government. Our findings are based on detailed work in three of the largest health and social care communities in Wales: Cardiff and the Vale of Glamorgan, Gwent and Carmarthenshire. This report sets out our findings from these localities which will inform the independent review as it considers the position throughout Wales. We have shared our extensive analysis of national data with the contractor to inform the independent review they are undertaking on behalf of the Assembly Government. Consequently, we elected not to publish all of our national analysis in this report. Unless otherwise stated, our references to trusts, LHBs and councils relate to those in the areas covered by this review. The independent review will test the relevance of recommendations in this report for other health and social care communities in Wales. The recommendations in this report relate naturally to the findings from the communities we have examined and we strongly believe that these need to be implemented in the three communities even if they are not ratified nationally.

The data understates the duration of the delayed transfers of care which affect the independence of vulnerable older people

8 While there are always likely to be some delayed transfers of care in any system, the current scale of the problem suggests that the whole system of health and social care is not meeting the needs of many vulnerable people because they are being cared for in a setting from which they have been declared fit to leave. Those who are delayed transfers of care often have a complex range of needs for care and may be adversely affected if they are discharged rapidly into an inappropriate setting. However, being unduly delayed in hospital is bad for those concerned because they can lose mobility, mental function and physical abilities and therefore reduce their independence. Our survey of delayed transfers of care and previous research[2] suggest that being delayed in hospital can affect people's chances of living independently after their discharge and can lead to a significant loss of independence. An extended hospital stay also increases

2 Audit Commission, The Way to Go Home, (2000), Audit Commission in Wales, Transforming Health and Social Care (2004) and Losing Time (2002)



infection risks and the risk of falls for vulnerable older people. As a consequence of these problems, delayed transfers of care represent a clinical governance risk but do not sufficiently feature within trust and LHB clinical governance considerations.

9 Half of the days occupied by delayed transfers of care in Wales in 2006/2007 related to patient reasons, such as choice of care home, disputes and legal and financial issues. Over one quarter related to social care delays – either delays in conducting assessments or in making arrangements to meet assessed needs. Twenty-one per cent of days occupied by delayed transfers of care in 2006/2007 related to healthcare reasons – either delays in carrying out assessments or making arrangements. In some areas, delays arising from the need to assess eligibility for Continuing Healthcare have risen significantly in recent months with 57 delayed transfers of care across Wales awaiting a Continuing Healthcare assessment in May 2007.

10 Between 2005/2006 and 2006/2007 there has been an overall downward trend in the number of people whose transfer of care was delayed in Wales but the number of hospital bed days occupied increased. In 2006/2007 a total of 268,491 bed days were occupied by delayed transfers of care in Welsh hospitals, an increase of two per cent compared with 2005/2006. This increase was largely driven by increases in the bed days occupied by delayed transfers of care in Cardiff, the Vale of Glamorgan and Gwent: the number of days lost decreased in 10 out of 22 LHBs between 2005/2006 and 2006/2007.

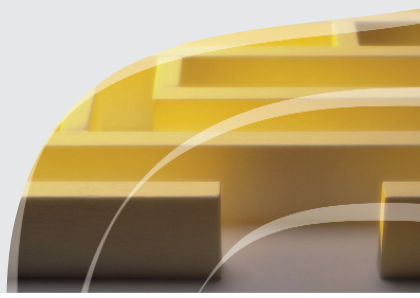
11 Delayed transfers of care also have a negative impact on the operation of the health and social care system. The direct cost of the bed days occupied by delayed transfers of care across Wales was £69 million in 2006/2007, although these costs could not be released in full for reinvestment. We estimate that the marginal cost of these bed days, which could be more easily released for reinvestment elsewhere, would be around £27 million across Wales. If these resources were moved to support in a non-hospital setting patients whose transfer of care was delayed, there would still be costs associated with their care. The use of hospital bed days for patients who no longer need treatment in that sort of hospital facility has direct and indirect consequences for other people needing care. In some Trusts, such as Cardiff and Vale, many acute beds are occupied by delayed transfers of care which is one of a number of factors that directly affects the trust's ability to admit other medical patients, to provide elective treatment or to meet Assembly Government access targets in its accident and emergency department. In Gwent Healthcare NHS Trust, most delayed transfers of care occupy community beds with very few in acute beds but even this has a knock-on effect on the Trust's ability to manage patient flow efficiently and to provide elective treatment to those requiring it. And poorly managed inpatient episodes leading to longer than necessary stays in hospital can increase the longer-term costs of care to the Welsh public service.

12 The reasons for delayed transfers of care vary significantly between localities. In Cardiff and the Vale of Glamorgan, for example, patient reasons are the major category of delayed transfers of care: increases in patient related delays mask a five per cent fall in the number of days occupied for social care reasons. In Gwent, however, there was a 64 per cent increase between 2005/2006 and 2006/2007 in the number of bed days occupied by delayed transfers of care for social care reasons.

13 While there are limitations with all performance measures, the measurement systems for delayed transfers of care understate the extent of the problem. The performance management framework has in the past tended to focus on the number of cases without giving appropriate priority to available data on the impact in bed days lost. Since 2006/2007 days lost have been appropriately included in the Assembly Government's performance management framework for local health bodies. It also appears until recently to have missed some patients in specialist learning disability facilities in Bro Morgannwg NHS Trust although this issue of interpretation has now been resolved. The Assembly Government acknowledges the weaknesses of the census snapshot and has included measurement systems within the terms of reference of the independent review of delayed transfers of care it has commissioned.

14 The existence of 'local agreements' in all but one of the localities we looked at means that there is an agreed period, after a patient is declared fit for discharge and before they are counted as a delayed transfer of care, during which local authorities can arrange certain types of assessment or arrangements for care. Such local agreements have two negative consequences: they lead directly to an understatement of the delayed transfers of care statistics; and potentially they create a perverse incentive to delay conducting an assessment until the time allowed by local agreement has elapsed and the patient is about to be counted as a delayed transfer of care. This might increase the lengths of the delays experienced by patients who are clinically ready to move on. The local agreements cover a range of types of delayed transfer that goes beyond that allowed by Assembly Government guidance and varies between local authority areas. In Gwent they ranged from 7 to 15 working days. As most patients whose transfer of care is delayed face an average delay of 55 or 82 days in Gwent and Cardiff and Vale NHS Trusts respectively and face a significant loss of independence as a result, building in further delays not only understates the extent of the problem but also impacts on the quality of patient care. The National Leadership and Innovation Agency for Healthcare (NLIAH) has recommended, within broader guidance and self-assessment tools on effective discharge, that trusts should follow good practice by operating a system of setting an estimated date of discharge when they admit a patient and the Assembly Government made this a requirement of trusts through a Welsh Health Circular in 2005[3]. Consequently, there is no obvious reason why multi-disciplinary assessments cannot be set up at an appropriate time in advance of this date.

3 Welsh Health Circular (2005) 035



Local improvements are feasible in the short-term, pending longer-term action across the whole care system

15 Despite examples of local good practice, there is a need to provide more effective alternative services to prevent avoidable admissions to hospital – in our survey of delayed transfers of care on 16 May, Discharge Liaison Nurses and ward nursing staff told us that almost one in six delayed transfers of care in Gwent Healthcare NHS Trust had been admitted for social reasons such as an inability to cope. There is scope to use the new General Medical Services Contract more effectively to encourage GPs to help avoid unnecessary admissions to hospital for their patients. And, consistent with the Assembly Government's 'Delivering Emergency Care Services' strategy, there is considerable scope for the Welsh Ambulance Services NHS Trust to provide interventions in the community to avoid having to take patients to Welsh hospitals.

16 Once patients are admitted to hospital there are process weaknesses which compromise the efficient flow of patients through the system. Once care packages have been temporarily frozen as a consequence of a person's admission to hospital there can be considerable delays in restarting this package or putting in place alternative arrangements. While some wards operate efficient processes, others could apply their good practice. There is some evidence of a culture where some patients, staff and relatives see institutional care as the best option for patients and which is not as well informed about other options, such as intermediate care, as it should be. Nurses responding to our survey told us that around 80 per cent of people who were delayed transfers of care would not be able to return to their previous living arrangements when they left hospital. Such perceptions, and the prevailing culture they suggest, may also influence the way care is managed for vulnerable older people who do not actually become a delayed transfer of care.

17 There is scope to improve discharge planning and management where good practice needs to be mainstreamed within each Trust, particularly using the estimated date of discharge to pull patients through the system to care provided in the most appropriate setting, as well as a need to address cultural barriers through education, training and clarity about roles and responsibilities.

18 There are particular problems with the assessment of patients' needs while they are in hospital. The Assembly Government has recently introduced a new unified assessment system[4] which has many potential benefits but is causing significant problems because of a lack of shared ICT systems to support it.

19 Determining eligibility for NHS-funded Continuing Healthcare is a particularly difficult area, exacerbated by the emerging implications of recent case law. There is evidence of tensions between health service and social care staff, and with patients and their carers, in determining whether and when people transfer from free NHS care to means-tested social and personal care. The problems surrounding Continuing Healthcare cannot be completely resolved without central action but there is scope for improved coordination of processes at a local level. LHBs' accounts show that expenditure

4 The Assembly Government Introduced unified assessment in April 2005. This process involves a multi-disciplinary team of health and social care staff assessing an older person's care needs.

on Continuing Healthcare varies significantly by LHB, beyond what might be expected because of differential demand, reflecting possible inconsistencies in assessment and the variable extent to which Continuing Healthcare is provided within existing trust services.

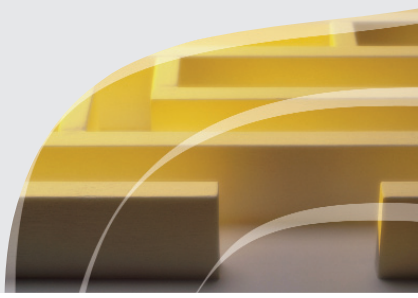
20 Patient choice of a residential or nursing home remains a major cause of delayed transfers of care – while it is entirely reasonable for people to exercise choice at an extremely difficult and vulnerable time in their lives, choice issues have a significant impact across the whole system. The inconsistent management of patient choice in individual localities and across Trust areas, and confusion about how best to handle delays arising from choice, exacerbates its impact. Very high care home occupancy levels make it difficult to operate a realistic choice policy for those people for whom a care home placement is the most appropriate option.

21 We also found examples of effective intermediate care schemes – intensive, time-limited interventions to prevent admission to hospital or to support patients on their discharge. However, these were often established using additional funds provided by the Assembly Government, in isolation from developments in neighbouring boroughs and without a common understanding of levels of care. Such variation and fragmentation can be confusing for Trust staff and patients and is exacerbated by the failure to evaluate many of the schemes effectively, including a robust financial analysis. In Gwent, partners are working with NLIAH to pilot an evaluation tool to address weaknesses in evaluation.

Even within the constraints of the existing system, organisations can work more effectively

22 In general, organisations within specific localities – local authority and LHB areas – had sought to work together operationally to tackle delayed transfers of care. Our work identified a large number of good practice examples which are set out in case studies within the report and on the Wales Audit Office Good Practice Exchange website (www.wao.gov.uk). There were several examples of strong leadership and the personal involvement of senior executives in resolving individual cases. The Good Practice case studies were often recent and so suggest scope to deliver quantifiable improvements as they bed in.

23 Notwithstanding the good local practice, there was much weaker evidence of effective joint working across the whole health and social care system, particularly at the level of communities centred on a particular Trust, where this was appropriate. A community-wide strategic focus is one important tool in tackling delayed transfers of care on a genuinely whole systems basis. There is a need to recognise that a delayed transfer of care involving a patient from one borough might affect the care of a resident from a neighbouring borough. Ambitious plans to reconfigure services in Gwent (the 'Clinical Futures' programme) and Cardiff and the Vale of Glamorgan (the 'Programme for Health Service Improvement') provide an opportunity to develop a clearer vision and approach across the whole system.



24 The effectiveness of commissioning, both by LHBs and local authorities, was compromised by a lack of information and a reliance on spot-purchasing of capacity. The assessment of unmet need is not well informed and is compromised by the poor quality of contracts for community health and social services, which are insufficiently specific about what trusts should provide. There are also serious problems with information – services provided, costs and outcomes – about intermediate care services. These make it difficult to develop a shared service model and to pool budgets. There is scope for commissioners to take a more strategic approach to engaging the voluntary sector to provide a range of services that can promote independence. Councils and LHBs should also exploit the potential to use the services provided by housing departments, such as extra care housing schemes to link housing, health and social care services. The ongoing reviews of Health, Social Care and Wellbeing Strategies, and the Assembly Government's requirement for LHBs to develop by the end of the 2007/2008 financial year a Community Partnership Agreement to better integrate primary, community, intermediate and social care, represent substantial opportunities to improve joint commissioning.

25 We found that there were problems with the availability and use of capacity in some areas. There are some significant capacity problems within the system, particularly care home capacity for the Elderly Mentally Infirm (EMI), which affects issues of patient choice and is further compounded by threats to the future supply of independent sector capacity. There is also scope to make better use of existing health and social care resources, as well as addressing cultural and workforce issues. In particular, despite some positive examples we found a significant need to engage GPs and primary care more effectively in the whole system of care for their patients. There is also scope to improve the availability and use of social workers on hospital wards, the roles of community and district nurses and therapists.

Longer-term whole systems solutions should follow from the development of shared service models and existing good practice

26 The problem of delayed transfers of care often arises at the interface between health and social care services, where different budgetary and organisational accountabilities and systems can act as a barrier to whole systems working focused on the needs of the citizen. Issues such as disputes between health and social care organisations over Continuing Healthcare eligibility, delayed transfers of care arising from local authorities' inability to fund placements and delays in carrying out health or social care assessments all reflect these problems.

27 The first step towards more effective joint working is to develop a genuinely shared vision of what services, both health and social care, should look like in a particular area ('shared service model'). Although there has been engagement with local government, views were expressed that plans to reconfigure services in Gwent and Cardiff and the Vale had been health-led and driven by estates issues rather than genuinely whole systems and reflective of intermediate care services. In both cases we were told that local authorities were becoming increasingly involved.

28 Once there is a vision of this type, organisations need to align the constraints and incentives at the interface between organisations and with the shared model of service delivery. In particular, organisations including the Assembly Government need to find solutions to budgetary barriers, traditional leadership styles and diverse accountabilities.

29 Budgetary pressures have caused a vicious circle whereby financial pressures in one part of the public service lead to costs falling on another, for example the practice of some local authorities effectively operating a 'one in, one out' policy for care home beds at the expense of trusts and LHBs who bear the cost of people delayed remaining in a hospital bed. Similarly, health bodies may have avoided the costs of some Continuing Healthcare cases that may now fall on them as a result of a recent judgement. Both health and social care organisations may not be able to invest in solutions to whole systems problems as a result of the cost pressures they face as individual organisations. Until this vicious circle is broken, funding is likely to remain locked in acute care, with an effective 'stalemate' arising from the combination of budgetary pressures in individual organisations leading to a failure to invest in solutions to whole system problems which would deliver much more effective use of the total resources available to the Welsh public service.

30 Some organisations have started to develop joint approaches to such issues, including using Health Act (1999) flexibilities to develop a formal 'Section 33' agreement between health and social care services to provide integrated services and using a pooled budget to run a service if it cuts across health and social care. Some areas have developed, in accordance with the National Service Framework for Older People, joint commissioning arrangements between health and social care. These examples are often very recent and so are difficult to evaluate although the emerging evidence suggests that a joint commissioning approach can help to develop a more seamless approach to meeting people's needs. A recent Welsh Health Circular[5] has strongly emphasised the importance of developing joint commissioning arrangements and Health Act flexibilities.

31 In England, some authorities are starting to develop public service trusts providing both health and social care services, and are developing pooled budgets and multi-disciplinary teams to meet the needs of older people. Such developments require different leadership skills to those traditionally required to run an effective public sector organisation. In Wales, the development of Local Service Boards represents an opportunity to develop more effective strategic working. On the other hand the existence of multiple Local Service Boards for each trust area could perpetuate the current duplication without effective joint working at the whole health and social care community level.

32 The performance management system for delayed transfers of care is also confused in that separate frameworks exist for the NHS and for local government. Across health and social care communities the targets do not fully align and the existence of organisational targets can dilute shared ownership and commitment to resolving a problem where inter-dependencies and the impacts of delayed transfers of care should be a problem to all organisations within a given community. The measurement of reasons for delayed transfers of care, while not inappropriate,

5 WHC (2007) 023, NHS Commissioning Guidance

can lead to a perception that delays in another sector are the fault of those working in that sector rather than a whole systems problem that all partners need to tackle together.

33 Another opportunity to address barriers to whole systems working is to share staff or facilitate the rotation of staff between health and social care bodies. This can help to raise awareness of the issues facing partners within the system and improve knowledge of care pathways. For example, both health and social services employ occupational therapists, which presents opportunities to share staff, operate secondments or develop a joint multi-disciplinary team. We identified some recent examples of joint appointments made by the LHB and local authority on intermediate care. However, the different terms and conditions of service for staff employed in local government and health bodies can present a barrier to developing such joint approaches to workforce issues.

Recommendations

1 These recommendations relate to the implications of our work in Gwent, Cardiff and the Vale of Glamorgan and Carmarthenshire, which together accounted for 51 per cent of bed days occupied by delayed transfers of care in Wales in 2006/2007. They generally relate to issues which either need action from the Welsh Assembly Government or to common issues from our local work.

2 Alongside this overview report, we have published and laid before the National Assembly three reports on each of the three health and social care communities covered by this project – Cardiff and the Vale of Glamorgan, Gwent and Carmarthenshire. The Carmarthenshire report is a short report following up an earlier detailed review by the Wales Audit Office. The Cardiff and Vale and Gwent community reports are more detailed and are supported by individual appendices for each organisation in Cardiff and the Vale of Glamorgan, and for the Trust and each locality (LHB and Council) in Gwent. We have not laid these appendices before the National Assembly as they are intended to guide specific local actions which do not require joint action at the community level. Figure 1 shows how this report aligns with the other outputs of this project.

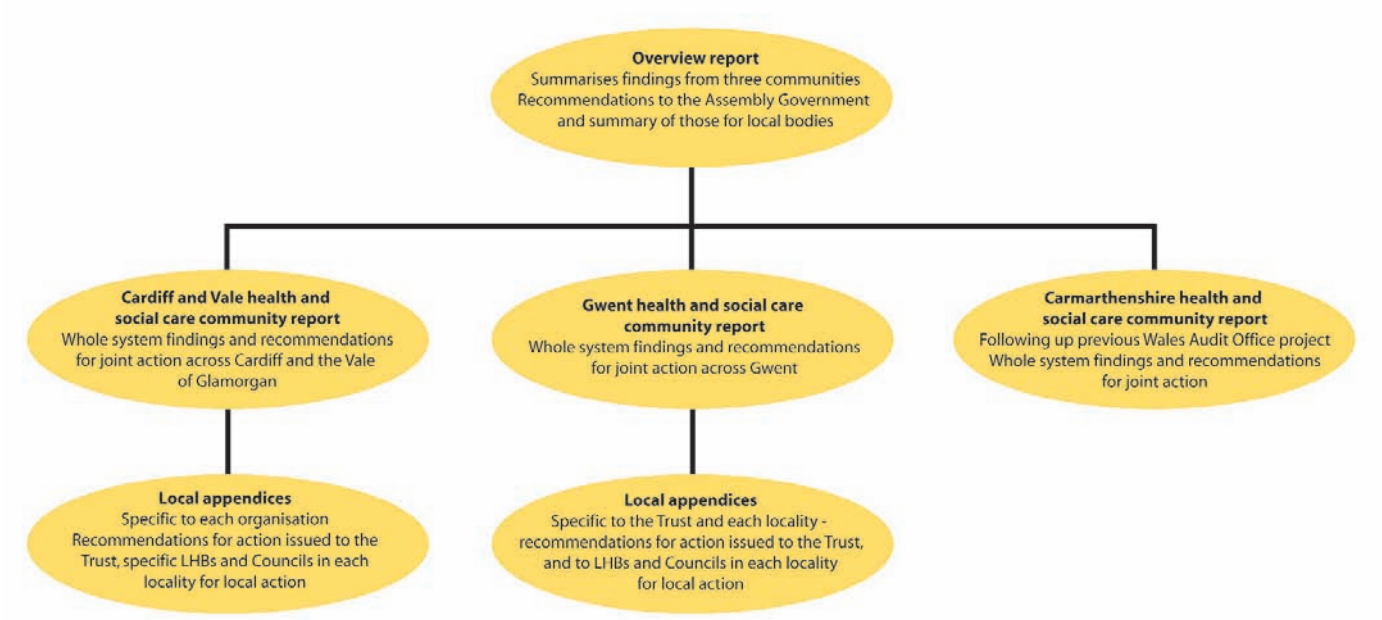
3 The specific recommendations in this report have equal status with, and should be read alongside, the recommendations made in each health and social care community report, which are set out in Appendix 4. The independent review of delayed transfers of care, commissioned by the Assembly Government, will examine whether these recommendations are applicable in the parts of Wales not covered by this review, as well as the wider policy implications of delayed transfers of care.

4 The recommendations in our community reports focused on the following broad areas to be taken forward together by the relevant Trusts, Local Health Boards and Councils:

a further developing and delivering a shared vision for services that promote the independence of vulnerable older people;

b using the ongoing reviews of Health, Social Care and Wellbeing strategies to identify clear and costed strategies to break the 'vicious circle' that draws vulnerable older people towards inappropriate institutional care and improve commissioning;

Figure 1: Wales Audit Office reports on delayed transfers of care



Source: Wales Audit Office

c addressing problems at each stage of the patient pathway, including the proactive identification of those at risk of frequent admission to provide more proactive care in community settings;

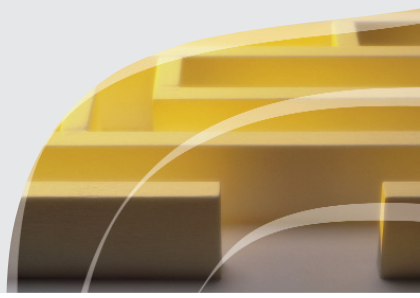
d addressing issues of capacity, especially care home capacity for the elderly mentally infirm;

e improving process weaknesses; and

f improving partnership working to address issues arising from organisational and budgetary boundaries, for example through pooled budgets and the development of Local Service Boards.

To improve the measurement of delayed transfers of care and their whole system causes

5 Local agreements build in additional delays and lead to the official delayed transfers of care statistics under-stating the true extent and impact of delayed transfers of care. In our community reports, we recommend that Trusts and Councils should end local agreements. **The Assembly Government should make clear its expectation that local authorities and trusts cease using local agreements to delay the start of counting a delayed transfer of care. It should monitor trusts' compliance with NLIAH guidance to set an estimated date of discharge which can then be used to arrange timely assessment of need and build into processes the time required to make arrangements in the light of assessed needs. To support this process, the Assembly Government should consider issuing national guidance on expected national response times.**



6 Patients with learning disabilities whose transfer of care is delayed in assessment and treatment units have not been consistently counted in the census figures. **The Assembly Government should reaffirm the current arrangements on counting delayed transfers of care for patients in learning disability units to ensure their consistent recording.**

7 In managing delayed transfers of care, there need to be clear accountabilities (as well as responsibilities) at every level. There needs to be robust performance management, supported by systematic and proactive processes. **To achieve improvements in performance management and processes, trusts, Councils and LHBs should:**

- a **standardise where appropriate the operational management of delayed transfers of care across trusts and with partners. In order to reduce systematically delayed transfers of care each case must be routinely and regularly reviewed and action challenged, with personal responsibility allocated for action and reported back through multi-agency meetings;**
- b **set trigger points throughout the care pathway with responsible managers accounting for the reasons for any delay for particular patients; and**
- c **develop a clear and robust escalation policy that has triggers for starting the process, which involves decision making senior managers across each organisation.**

To improve commissioning

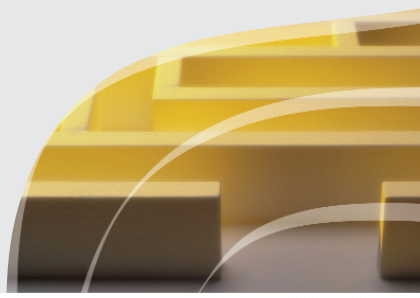
8 In updating their needs assessments to inform reviews of their Health, Social Care and Wellbeing Strategies in 2008, **local authorities and LHBs should:**

- a **using the findings of this review, a detailed analysis of why residents experience delayed transfers of care and an analysis of intelligence from primary and social care practitioners, develop a robust assessment of the needs of the resident population for new models of service to promote the independence of vulnerable people;**
- b **identify clear and costed strategies to enable the transfer of resources from acute to community services to break the 'vicious circle' whereby vulnerable people are drawn towards inappropriate institutional care that can compromise their independence; this may require LHBs and councils to identify transitional funding to enable new services to be set up before existing models are decommissioned;**
- c **share the content of their draft strategies through workshops involving the relevant Trust/s, to identify opportunities to develop joint services to meet similar needs and transfer good practice across borough boundaries; and**
- d **discuss with the relevant Trust/s opportunities to use the outcomes of the revised Health, Social Care and Wellbeing strategies to inform the development of more robust plans to develop community-based and intermediate care services to support the delivery of their 'Designed to Deliver' visions.**

9 Improving the operation of the whole system of health and social care, and the promotion of the independence of vulnerable people, depends fundamentally on the existence of a clear and shared vision of what services and care pathways should look like. Even where there is a clear vision of future service provision, the extent of local government engagement and involvement is variable. **Partners within health and social care communities should develop as part of their Health, Social Care and Wellbeing Strategy reviews clear models of service provision and care pathways from which the configuration of future health and social care services can be developed, including consideration of:**

- **a the development of primary care resource centres that co-locate key parties from the multi-disciplinary teams that can promote the independence of vulnerable people, reduce hospital admissions and therefore minimise delayed transfers of care;**
- **b the development of a 'virtual ward' approach to community provision, based on prediction of need, multi-disciplinary team work, a single point of contact and shared records and information;**
- **c the creation of community-based specialist teams, headed by an appropriate clinician and including specialist nursing and therapies staff, to provide access to expert care for older people without requiring hospital admission;**
- **d as part of the virtual ward approach, preparing a predictive assessment of people at risk of hospital admission, using long-term condition, age and information about social circumstances, which should be reviewed quarterly;**
- **e the development of extra care and other forms of sheltered housing schemes, supported by multi-disciplinary teams targeting early interventions to avoid hospital admission;**
- **f proposals to make effective use of hospital rehabilitation beds so that they make a more consistent contribution to the rehabilitation of patients that need them, including monitoring lengths of stay;**
- **g the relationship between rapid response, reablement, district nursing and social care teams, including the desirability of co-location and single points of contact; and**
- **h developing services to ensure that patients' physical abilities do not deteriorate while on a medical ward.**

10 There was a lack of robust service and cost information both for social care services and intermediate care and chronic disease management schemes. There had been only patchy evaluation of schemes and fragmented service models with some duplication between neighbouring localities. This can cause confusion at the level of the provider Trust in a health and social care community. **The Assembly Government should produce a model describing common levels of intermediate care services and dependence so that locally developed**



schemes are easily understood within the whole system. This model should provide a common currency that facilitates the robust costing and evaluation of schemes. It should also help the communities identify, evaluate and disseminate good practice based on a clear assessment of the cost-effectiveness of service models in promoting the independence of vulnerable people and making the whole system work more effectively. The Assembly Government should also encourage local partners to join up chronic disease management and intermediate care services beyond borough boundaries wherever appropriate.

11 The Assembly Government's strategies for health stress the importance of transferring resources from the acute sector to community based services to prevent admission and re-able vulnerable people but LHBs have found it difficult to transfer resources because of financial pressures within the system and workload pressures within trusts. This is compounded by Long Term Agreements for community services being insufficiently specific about outcomes and volumes of service. **The Assembly Government should develop improved model Long Term Agreements for community services, with a clear focus on measuring outcomes. It should also establish a system to measure the transfer of services from acute to community settings, supported by a system of transitional funding to enable local partners to set up new services before existing models are decommissioned.**

12 Supply of care home capacity, especially for EMI patients, is a significant problem, partly as a result of the current culture which tends to emphasise a reliance on care in institutional settings but also as a result of shortages of registered mental health nurses, market forces, property prices and quality requirements. Commissioning of care home capacity is compromised by a reliance on spot purchasing. In the relevant community reports, we recommended that partners in the Cardiff and Vale and Gwent health and social care communities develop commissioning strategies to address the current shortages of care home capacity, particularly EMI capacity. **Using local information about capacity, the Assembly Government should review capacity across Wales to identify the overall scale of the capacity shortfall and to develop a national strategy to improve the supply of places and registered mental nurses, with a particular focus on the key barriers to the development of capacity. Such strategies should seek to encourage health and social care commissioners to place much greater reliance on block purchasing of capacity and improve engagement with the independent and voluntary sectors.**

13 Issues relating to patient choice of care home account for half of bed days occupied by patients deemed to be delayed transfers of care. Often these delays relate to concern about the quality of particular care homes. There is inconsistent feedback to commissioners when such concerns are raised, nor effective systems to help support the owners of homes at risk of failing to deliver improved quality of care. **The Assembly Government should develop systems to support earlier intervention to address concerns about quality, in**

consultation with CSSIW and Care Forum Wales, including peer support schemes for owners of homes where there are concerns about quality.

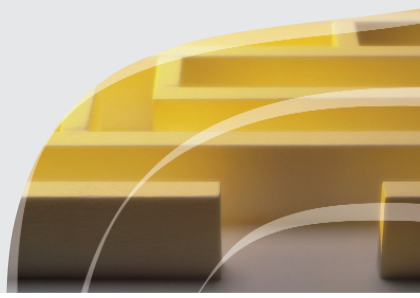
To improve the operation of the whole system to promote the independence of vulnerable people

14 Improving the operation of the whole system of health and social care, and the promotion of the independence of vulnerable people, depends fundamentally on the existence of a clear and shared vision of what services and care pathways should look like. Even where there are clear visions about future service provision, the extent of local government engagement and involvement is variable. **Local partners should develop clear visions of future service provision that support the independence of vulnerable people, drawing on existing good practice such as the 'virtual ward' model from Croydon. As new models of service emerge from the reviews of Health, Social Care and Wellbeing Strategies and implementation of Designed to Deliver, the Assembly Government should provide a mechanism to help local bodies to share the results of and lessons learned from developing new models of service provision and care pathways.**

15 It is entirely reasonable that vulnerable people facing a transfer of care should be able to exercise choice of care home but around half of bed days occupied by people whose transfer of care is delayed arise from patient/carer/family-related reasons, often because there is insufficient capacity to offer a realistic choice to those for whom a care home is the most appropriate option. Assembly Government guidance on managing patient choice has not been consistently applied in local communities. **The Assembly Government should develop a clear national policy on patient choice which is more specific about the nature of a choice and how long it is reasonable for a vulnerable elderly person to remain in a hospital bed awaiting the placement of their choice. This should include specific timescales and time limits within which decisions should be made, as well as clear guidance about how local bodies should handle situations where patients and their families do not comply with the guidance.**

16 Primary care practitioners have a critical role in making the whole system work effectively in the interests of vulnerable older people but are inconsistently engaged in the care pathway. The implementation of the Assembly Government's Delivering Emergency Care Services strategy should lead to the development of new care pathways for unscheduled care services. In this context, **the Assembly Government should explore opportunities through the new General Medical Services contract and Delivering Emergency Care Services strategy to help local organisations to develop stronger care pathways that reduce admissions to hospital and improve wellbeing. To improve the engagement of primary care practitioners in the care pathway:**

a **LHBs should work with their GPs to develop a proactive case management approach to identify those patients who have been frequently admitted to hospital or to predict those who have multiple chronic conditions and are at risk of admission or frequent readmission;**



b **LHBs should provide clear information to their GPs about the range of intermediate care services available and how they should be accessed and should monitor the referral rates to hospitals and to intermediate care services, seeking to work with GPs who have low referral rates;**

c **Trusts should provide GPs and social services departments with regular information about elderly patients who have been admitted to hospital, especially those whose primary reason for admission was a social reason to enable them to develop more proactive approaches to their management in the community; and**

d **Trusts should inform GP practices if one of their patients experiences a delayed transfer of care.**

17 Unified Assessment has many potential benefits but is currently proving difficult to implement effectively because the Informing Healthcare programme has not yet produced a shared ICT system to support it, meaning that long paper based documents have to be faxed between the members of the multi-disciplinary team. There are variations in approaches to unified assessment which can make it difficult for trusts working with several LHB/council areas. **The Assembly Government should ensure that the Informing Healthcare programme gives greater priority to the development of a shared ICT system for unified assessment, considering how this might link in with GP practices. It should also issue revised guidance setting out a standard, shorter form and process for unified assessment to make the process simpler for trusts working across different areas.**

18 The expertise required to support elderly people, including those whose transfer of care has been delayed, and to expedite their transfer to a more appropriate setting is often in short supply or is dispersed around trusts' sites which can complicate timely discharge. **The Assembly Government should develop a long-term plan to develop clinical capacity and career paths in care of the elderly to ensure sufficient skills to meet projected future demographic demand and to help trusts to develop more specialist teams to care for the elderly, enable targeted interventions from specialists and members of the multi-disciplinary team to ensure the smooth transfer of their care to the most appropriate setting.**

To address problems arising from organisational and budgetary boundaries

19 The current financial management regime makes sense at the level of individual organisations but at the expense of individual organisations taking steps that push costs onto other parts of the Welsh public service. Different financial regimes within the Welsh public service can create a vicious circle where resources are locked into the acute health sector and high cost social care packages, with short-term financial pressures on individual organisations squeezing the ability to invest in the long-term solutions across the whole system. **The Assembly Government should develop systems to encourage a stronger whole systems approach to budgeting, which should include:**

a **establishing a financial regime that better supports joint working, in particular a community-level shared responsibility for costs so that one organisation does not stand to gain financially through a delayed transfer of care that affects another;**

b **partners setting joint efficiency targets, for example for older people's services, that provide a clear incentive to deliver whole systems efficiencies at community level, rather than potentially conflicting targets for individual organisations;**

c **'invest to save' grants to provide the transitional funding to move services from acute to community settings; and**

d **reinforcing to local authorities that operating an effective 'one in, one out' approach to using care home beds is unlawful and effectively imposes costs on the NHS while denying citizens access to the services they require.**

20 Continuing Healthcare is a significant risk to the effective operation of the whole system because of inconsistent approaches to the management of Continuing Healthcare and significant budgetary tensions between different organisations and sectors. **The Assembly Government should produce clear guidance to support the consistent assessment of eligibility for Continuing Healthcare and conduct a review of Continuing Healthcare funding covering its equity, the nature and appropriateness of the boundary between nursing care and personal care, and the timeliness of decision making and initiation of payments.**

21 The whole system does not work as effectively as it should in promoting the independence of vulnerable older people, partly because of the impact of boundaries between health and social care organisations. **The Assembly Government should provide good practice guidance on opportunities to bring health and social care commissioners and providers together in a more formal way to reduce the negative impact on citizens caused by barriers between organisations and budgets. As local partners apply such models, the Assembly Government should disseminate lessons learned to support local action. Options to consider include:**

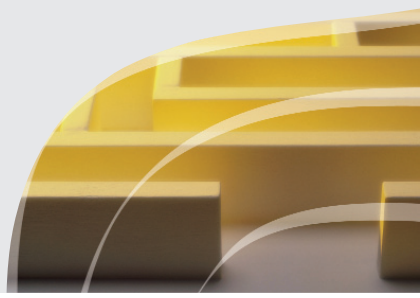
a **using a Local Service Board to explore how best to address delayed transfers of care and to develop a clear and shared vision of future services;**

b **if successful, how to make links between the various Local Service Boards at the strategic level centred on the providing trust;**

c **establishing robust information to support a shared vision of service provision, and shared performance management arrangements;**

d **joining up all or some health and social care service functions, which could start with the commissioning of long-term care for older people; and**

e **drawing on guidance being prepared by the Assembly Government, the use of formal 'Section 33' agreements to bring health and social care services together, supported by pooled budgets or shared funding.**



22 The development of shared cultures and a shared understanding of service models and care pathways appears as, if not more important than formal, structural changes such as pooled budgets and 'Section 33' agreements, which are effective when they support a clear vision. Workforce issues also arise from different terms and conditions in the NHS and local government. **To make it easier for local bodies to develop joint cultures, for example through secondments, joint posts and joint teams, the Assembly Government should identify potential solutions to the problem of different terms and conditions in the NHS and local government.**

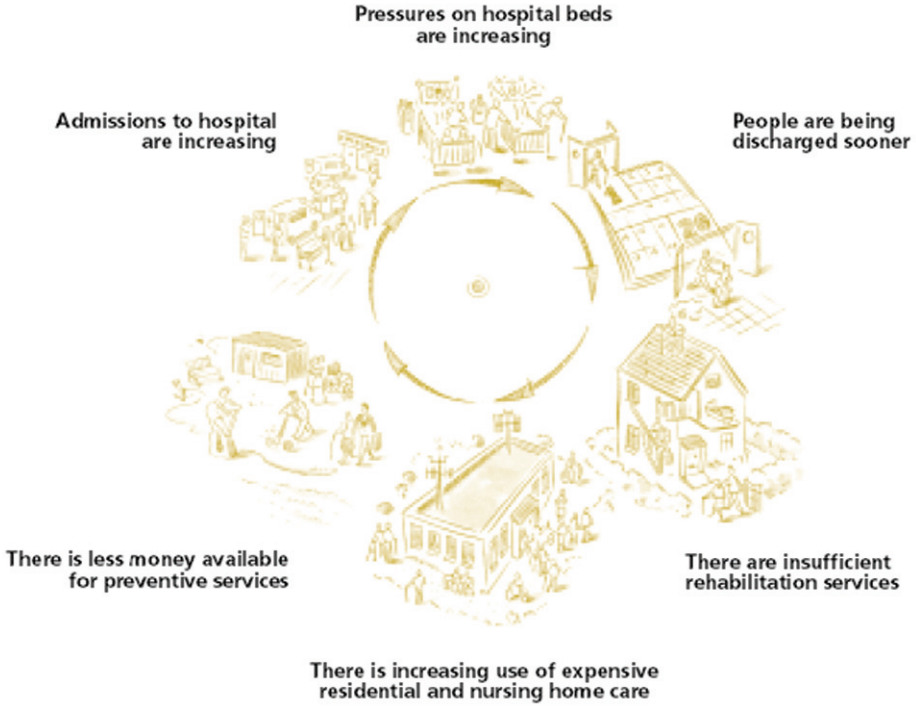
23 Different performance targets exist for health service and social care organisations. The Assembly Government sets LHBs targets to reduce the number of bed days occupied by delayed transfers of care but these are set across Wales rather than being tailored to address local circumstances. The existence of a different performance indicator for local government, relating only to delayed transfers of care for social care reasons, can reduce ownership for tackling delayed transfers of care and is a barrier to a genuinely whole system approach which would recognise that delayed transfers of care affect all organisations within a community. **Locally, LHBs, trusts and councils should set joint targets to reduce delayed transfers of care and their causes. The Assembly Government should no longer manage performance through specific delayed transfers of care targets for local NHS organisations. Instead it should require LHB and Council partners to set single joint targets, that are consistent with trust targets, to reduce the number of bed days lost across the health and social care community, which would be subject to scrutiny and acceptance by the Assembly Government. These targets should be a key element of discussion and monitoring by the emerging Local Service Boards.**

Part 1 - The data understates the duration of the delayed transfers of care which affect the independence of vulnerable older people

Delayed transfers of care compromise the needs of vulnerable people

1.1 In Gwent Healthcare and Cardiff and Vale NHS Trusts, 82.5 per cent of delayed transfers of care were over 65 years old on the date of our inpatient census. People whose transfer of care is delayed have significant requirements for ongoing care. They can lose independence and function while in hospital, and thus be at far greater risk of re-admission to hospital or no longer being able to live independently. The net effect of a delayed transfer of care can be to lock vulnerable individuals into a vicious circle of dependence and reliance on acute hospital and social care services (Figure 2). Effectively, a delayed transfer of care can have a significant impact on the independence of those predominantly elderly people who are affected.

Figure 2: The vicious circle of healthcare and social services



Source: Audit Commission, The Way to Go Home, (2000)

1.2 Trusts, LHBs and local authority staff in the communities we examined acknowledged the negative impact of a delayed transfer of care on those affected, particularly the loss of independence, reduced physical capabilities and contribution to a loss of social and caring networks (Box 1).

Box 1: losing mobility while a transfer of care is delayed

This review gathered information from a wide range of people in the communities it covered, including carers, Older People's Fora, voluntary organisations and private service providers. There was a recurring message from these groups about the loss of mobility experienced by some older people when they were admitted to hospital. We were told that older people start to lose their mobility after a short time in an acute hospital bed and that the longer vulnerable people are kept on acute wards, the greater is the risk of them losing their physical abilities. We were told of people who were able to walk into hospital but who lost that level of mobility as a result of prolonged time in an acute bed. Sometimes there may be a loss of mobility as a result of a medical condition, but at other times such a loss of mobility can occur as a result of limited physiotherapy resources to assist people in acute wards. We also heard of good results when intensive therapy services are provided to people in rehabilitation wards.

Source: Wales Audit Office

1.3 There are also increased risks of falls while in hospital as well as the risk of vulnerable older people being more susceptible to picking up a Healthcare Associated Infection while in hospital. These issues represent clear clinical governance risks, but trust and LHB clinical governance arrangements took little account of delayed transfers of care.

The problem of delayed transfers of care is increasing although under-stated by the statistics

1.4 Delayed transfers of care are a complex problem with a wide range of causes and impacts. This can make measurement difficult. We have examined the number of people experiencing a delayed transfer of care, the number of bed days they occupy and compared the position across Wales. We also analysed the direct and indirect costs that are a consequence of delayed transfers of care. The following sections set out our findings and also provide commentary on the adequacy of the way delayed transfers of care are measured.

The true incidence and impact of delayed transfers of care is increasing in the communities covered by our review

There has been an increasing number of bed days lost as a result of delayed transfers of care

1.5 The Assembly Government has been operating a census approach to measuring the incidence of delayed transfers of care since September 2003. It measures the number of people who are delayed transfers of care in Welsh hospital beds on the third Wednesday of each month. In September 2003, there were 1,116 delayed transfers of care in Welsh hospital beds, of which 310 were in Mental Health beds. Thirty-three per cent of non-Mental Health delays related to social care reasons, 32 per cent to healthcare reasons and 36 per cent to patient/carer /family reasons.

1.6 Figure 3 shows the substantial overall reduction in the number of people who experienced a delayed transfer of care between September 2003 and May 2007. The overall number of delayed transfers of care in non-Mental Health beds has reduced by 41 per cent between September 2003 and May 2007, while delayed transfers of care in mental health beds fell by 47 per cent.

1.7 However, our analysis of recent trends in bed days lost as a result of delayed transfers of care suggested that the trend is increasing, particularly in some Trusts. Between 2005/2006 and 2006/2007, the total number of bed days occupied by delayed transfers of care increased by 2 per cent across Wales to 268,491 (Figure 4). In all of the Trusts covered as part of this project there were increases in the number of bed days occupied by delayed transfers of care between 2005/2006 and 2006/2007 - Cardiff and Vale (6 per cent), Bro Morgannwg (16 per cent), Gwent Healthcare (31 per cent) and Carmarthenshire (3 per cent). We also considered the area of residence of patients who experienced delayed transfers of care. Our analysis showed that the increase in bed days lost as a result of delayed transfers of care between 2005/2006 and 2006/2007 was largely driven by increases in Cardiff, the Vale of Glamorgan and Gwent: the number of days lost decreased in 10 out of 22 LHBs over the same period.

1.8 In the health and social care communities on which we focused, our analysis shows that while the number of patients who became a delayed transfer of care did not increase, the number of days occupied by delayed transfers of care did. We found that between 2005/2006 and 2006/2007:

- in Cardiff and Vale NHS Trust, the number of days increased by six per cent but the number of patients delayed reduced by eight per cent;
- in Gwent Healthcare NHS Trust, the number of days increased by 31 per cent whereas the number of patients increased by 11 per cent; and

Figure 3: Across Wales there has been a significant reduction in the overall number of delayed transfers of care between September 2003 and May 2007

	September 2003	May 2007	% change
Non-mental health, of which:	806	478	-41 per cent
■ Social care	■ 262 (33 per cent)	■ 134 (28 per cent)	-49 per cent
■ Healthcare	■ 255 (32 per cent)	■ 115 (24 per cent)	-55 per cent
■ Other	■ 289 (36 per cent)	■ 229 (48 per cent)	-21 per cent
Mental health	310	164	-47 per cent
Total	1,116	642	-42 per cent

Source: Wales Audit Office analysis of Welsh Assembly Government delayed transfers of care data

Figure 4: Bed days occupied by delayed transfers of care, and the number of patients affected by Trust in 2005/2006 and 2006/2007

	Bed days			Patients		
Trust	2005/2006	2006/2007	Change	2005/2006	2006/2007	Change
Carmarthenshire	15,344	15,753	3%	338	317	-6%
Bro Morgannwg	13,948	16,194	16%	278	318	14%
Gwent Healthcare	33,829	44,456	31%	732	816	11%
Cardiff & Vale	72,787	77,513	6%	1,034	949	-8%
All Wales total	262,595	268,491	2%	5,454	5,182	-5%

Note
The figures for the number of patients are slightly different to those for the census because the census counts all people whose transfer of care was delayed on a particular day each month, which means that many individuals are counted in more than one monthly census. On the other hand, this figure counts the total number of individuals whose transfer of care had been delayed, counting each case only once.

Source: Wales Audit Office analysis of Health Solutions Wales delayed transfers of care data

- in Carmarthenshire NHS Trust, the number of days increased by three per cent whereas the number of patients fell by six per cent.

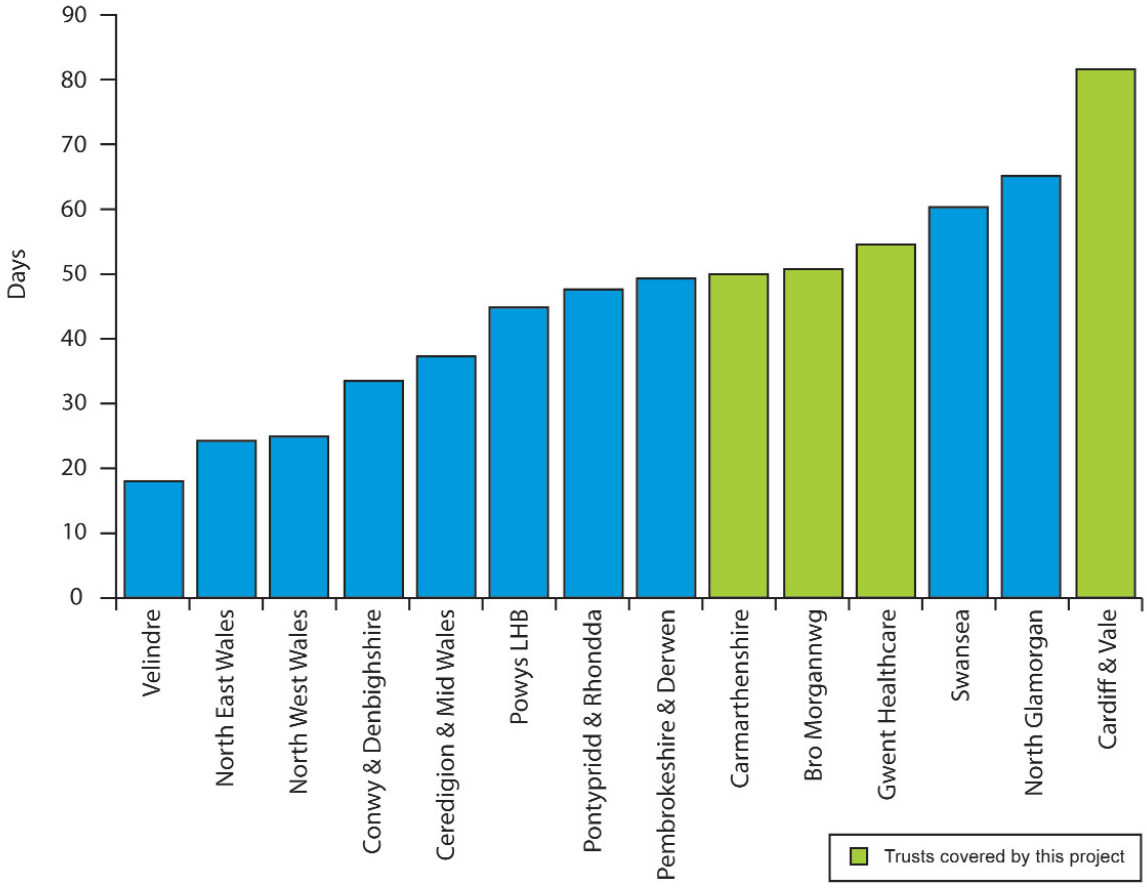
1.9 This pattern was driven by increases in the average duration of a delayed transfer of care. This increase in the length of an unnecessary stay in hospital is bad for the patient but also significantly increases the impact on the health and social care community, particularly the opportunity costs of being unable to offer appropriate care to other people. Figure 5 shows the average duration of a delayed transfer of care in Welsh Trusts. In 2006/2007, both Cardiff and Vale (82 days) and Gwent Healthcare (55 days) had a very significant average duration of each delayed transfer of care. These average durations were also significantly higher – 18 per cent higher in Gwent and 16 per cent higher in Cardiff and Vale - than the equivalent figure for 2005/2006.

The impact, extent and causes of delayed transfers of care vary significantly between local authority and LHB areas

1.10 Across Wales, half of bed days occupied by patients whose transfer of care had been delayed in 2006/07 related to patient/family/carer reasons, while 27 per cent related to social care reasons and 21 per cent healthcare reasons (Appendix 3).

1.11 Delayed transfers of care also take place in different parts of the hospital system. In Cardiff and Vale NHS Trust, 24 per cent of bed days occupied by delayed transfers of care were in acute beds and three per cent in community beds, whereas in Gwent Healthcare NHS Trust 62 per cent of bed days occupied by delayed transfers of care were in community beds and two per cent in acute beds.

Figure 5: The average duration of a delayed transfer of care in a Welsh Trust in 2006/2007



Source: Wales Audit Office analysis of Health Solutions Wales delayed transfers of care data

1.12 The reasons for increases in the number of bed days occupied by delayed transfers of care also varied between the health and social care communities we examined (Appendix 3). For example between 2005/2006 and 2006/2007:

- in Cardiff and Vale NHS Trust the number of bed days occupied by delayed transfers of care for social care reasons fell by 11 per cent but bed days occupied by delayed transfers of care for other reasons (patient, family, carer) increased by 18 per cent with the average duration of a delayed transfer of care for other reasons (patient, family, carer) increasing to 91 days, the highest in Wales;
- in Gwent Healthcare NHS Trust, there was a 64 per cent increase in the number of bed days occupied by delayed transfers of care for social care reasons, and a 14 per cent increase in bed days for other (patient, family, carer) reasons; and
- in Carmarthenshire NHS Trust, there were six and three per cent increases respectively in the number of bed days occupied by delayed transfers of care for social care and patient/family/carer reasons, while the number of bed days occupied by healthcare-related delays fell by 24 per cent.

Figure 6: Primary causes of delayed transfers of care in each of the LHB/local authority areas covered by this examination

LHB/local authority area	Two most common codes for delayed transfers of care between June 2006 and June 2007
Cardiff and Vale	
Cardiff	Patient waiting for residential care place availability in care home of choice (code 7.04a) Patient waiting for nursing care place availability in care home of choice (code 7.04b)
Vale of Glamorgan	Patient waiting for residential care place availability in care home of choice (code 7.04a) Patient waiting for nursing care place availability in care home of choice (code 7.04b)
Gwent	
Blaenau Gwent	Patient waiting for residential care place availability in care home of choice (code 7.04a) Patient waiting for nursing care place availability in care home of choice (code 7.04b)
Caerphilly	Awaiting completion of assessment (beyond local agreement) (code 1.01) Funding not available for nursing or residential placement (code 2.09)
Monmouthshire	Patient waiting for residential care place availability in care home of choice (code 7.04a) No appropriate placement available (code 2.07)
Newport	Patient waiting for residential care place availability in care home of choice (code 7.04a) No appropriate placement available (code 2.07)
Torfaen	No appropriate placement available (code 2.07) Funding not available for nursing or residential placement (code 2.09)
Carmarthenshire	
Carmarthenshire	Funding not available for nursing or residential placement (code 2.09) Funding not available for home care package (code 2.10)

Source: Wales Audit Office analysis of Welsh Assembly Government data from delayed transfers of care census, June 2006-June 2007

1.13 There are further significant variations between localities in the impact, extent and causes of delayed transfers of care. Figure 6 outlines the primary causes of delayed transfers of care in each local authority/LHB area in Wales, while Appendix 2 sets out an analysis of the extent and impact (in terms of bed days) of delayed transfers of care in each LHB/local authority area in Wales covered by this review.

There are indirect costs associated with delayed transfers of care, both to the whole system and to other people who cannot receive the care they need

1.14 Using our analysis of the number of bed days occupied by delayed transfers of care in 2005/2006 and 2006/2007, we calculated the direct costs of those bed days. Although the costs currently sit within NHS Trusts with indirect funding from LHBs, our calculations provide an indicator of the value to the whole

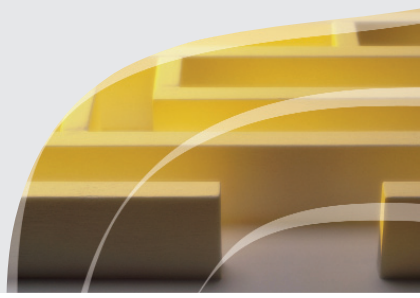
system of the resource used in the direct provision of bed days to accommodate delayed transfers of care. The overall cost of bed days occupied by delayed transfers of care in Welsh Trusts was £69 million in 2006/2007, a six per cent increase on the equivalent figure in 2005/2006. The direct cost of bed days in Cardiff and Vale NHS Trust was £18.6 million in 2006/2007, while the equivalent costs were £11 million in Gwent Healthcare NHS Trust and £3.8 million in Carmarthenshire NHS Trust (Appendix 3). We also analysed the cost of bed days by bed type and reason for the delayed transfer of care. Figure 7 shows that there has been a 10 per cent increase in the cost of social care delays across Wales between 2005/2006 and 2006/2007, while delayed transfers of care in mental health beds produce the highest cost in terms of the type of bed in which the delay takes place.

Figure 7: Direct bed costs associated with delayed transfers of care by bed type and reason across Wales, 2005/2006 to 2006/2007

	2005/2006		2006/2007		Change			
Bed type	Delayed Days	Total cost £million	Delayed Days	Total cost £million	Delayed Days	Total cost £million	Delayed Days	Percentage Change
Acute	58,816	15.5	60,413	16.3	1,597	0.82	2.7%	5.3%
Community	63,539	14.7	68,945	17.2	5,406	2.5	8.5%	17.1%
Mental Health	84,222	23.6	73,682	21.4	-10,540	-2.2	-12.5%	-9.4%
Other	11,734	2.9	11,983	3.1	249	0.21	2.1%	7.3%
Rehabilitation	44,284	8.9	53,468	11.1	9,184	2.3	20.7%	25.6%
Totals	**262,595**	**65.6**	**268,491**	**69.1**	**5,896**	**3.6**	**2.2%**	**5.5%**

	2005/2006		2006/2007		Change			
Reason for delay	Delayed Days	Total cost £million	Delayed Days	Total cost £million	Delayed Days	Total cost £million	Delayed Days	Total cost
Healthcare reasons	56,992	14.1	57,018	14.7	26	0.59	0.0%	4.2%
Patient reasons	133,222	33.2	135,128	34.6	1,906	1.4	1.4%	4.2%
Not agreed	3,868	1.0	3,085	0.85	-783	-0.1	-20.2%	11.1%
Social reasons	68,513	17.2	73,260	19.0	4,747	1.8	6.9%	10.2%
Totals	**262,595**	**65.5**	**268,491**	**69.0**	**5,896**	**3.6**	**2.2%**	**5.6%**

Source: Wales Audit Office analysis of Health Solutions Wales delayed transfers of care data and Trust Financial Return (TFR) returns



1.15 These costs are only the direct costs of the bed days – there are indirect costs in respect of:

- managing the problem of delayed transfers of care;
- poor utilisation of capacity;
- inability to make the best use of specialist staff resources;
- consequences for the management of beds and patient flow within the hospital, for example in meeting Assembly Government access targets in accident and emergency and for elective patients; and
- inability to provide the most appropriate treatment for other people needing both scheduled and unscheduled care.

1.16 The direct costs of bed days occupied by delayed transfers of care could not be released in full for reinvestment in other areas, not least because of the impact of delayed transfers of care on trusts' financial positions and ability to meet Assembly Government access targets both for scheduled and unscheduled care. If these resources were moved to support patients whose transfer of care was delayed, there would still be costs associated with their care. Across Wales, using marginal bed costs used in Cardiff and Vale and Carmarthenshire NHS Trusts, we estimate that £26.8 million could be directly released for reinvestment elsewhere in the system of health and social care. Of this:

- £7.8 million relates to Cardiff and Vale NHS Trust;
- £1.6 million relates to Carmarthenshire NHS Trust; and
- £4.4 million relates to Gwent Healthcare NHS Trust.

1.17 We were unable to quantify directly how the resources tied up providing beds to accommodate people who no longer had a clinical need for them might better be deployed across the whole system. This was primarily because of inadequate information about the costs and outcomes of intermediate care services. Nevertheless, we developed a suite of indicators in Cardiff and Vale NHS and Gwent Healthcare NHS Trusts which enabled us to demonstrate the relationship between delayed transfers of care and some of the consequences of how poorly the system uses its resources. If delayed transfers of care were eradicated or reduced, there would be a number of areas in which commissioners might wish to invest to improve the operation of the whole system, in particular to:

- avoid the costs of paying for elective surgery to meet Assembly Government access targets through the Second Offer Scheme, which were £5.4 million in Cardiff and the Vale of Glamorgan and £3.6 million among the Gwent LHBs in 2006/2007;
- address longstanding financial pressures, which include a predicted financial shortfall of £7.1m in Gwent Healthcare NHS Trust for 2007/2008 and an £18m savings target for Cardiff and Vale NHS Trust in 2007/2008;
- invest more in intermediate care services;
- recognising the costs to the Trust of opening some wards which have not been formally commissioned to cope with the additional volume of patients arising from delayed transfers of care (Cardiff and Vale

NHS Trust estimates that it provides £2 million of 'uncommissioned' beds to accommodate delayed transfers of care each year); and

- contributing to the projected additional costs to LHBs of complying with the implications of the 'Grogan' judgement on Continuing Healthcare, where the extent of the likely additional costs are still being assessed.

Measurement systems for delayed transfers of care understate the extent of the problem

1.18 The true incidence of delayed transfers of care is masked by weaknesses in their measurement. There have been historical problems with the emphasis of what is reported and systematic deficiencies in the way measurements are taken.

1.19 As to what is measured, the Welsh Assembly Government operates a census system which captures a snapshot once a month of the number of patients within Trust beds on that day whose transfer of care had been delayed and the length of their delay. The figures are subject to the joint validation by the Trust, LHBs and local authorities. The approach to performance management historically focused on the number of delayed patients on one day each month, without giving equal priority to available data on the impact in bed days lost until 2006/2007 when bed days lost was appropriately included in the Assembly Government's performance management framework for local health bodies. Figure 3 showed that between 2005/2006 and 2006/2007 Trusts which experienced increases in delayed transfers of care tended to see a higher number of bed days lost compared with the corresponding increase in the number of patients affected.

1.20 The Assembly Government has recognised the weaknesses of a census approach and has included measurement systems within the terms of reference of the independent review of delayed transfers of care it has commissioned. The Assembly Government now sets additional targets covering the number of bed days occupied by delayed

Figure 8: Councils and NHS bodies have different indicators for delayed transfers of care

Agency	
Councils SCA/001	The rate of delayed transfers of care for social care reasons per 1,000 population aged 75 or over.
NHS Bodies SaFF 16 (2006/2007)	To reduce the number of delayed transfers of care in mental health facilities per 10,000 population aged 75 or over.
NHS Bodies SaFF 17 (2006/2007)	To reduce the number of days delayed for delayed transfers of care in mental health facilities per 10,000 population aged 75 or over.
NHS Bodies SaFF 19 (2006/2007)	To reduce the number of delayed transfers of care (excluding mental health) per 10,000 population aged 75 or over.
NHS Bodies SaFF 20 (2006/2007)	To reduce the number of days delayed for delayed transfers of care (excluding mental health) per 10,000 population aged 75 or over.

Source: Wales Audit Office

transfers of care for the Trust and LHBs. The current Service and Financial Framework includes two targets for health communities to reduce the rate of people experiencing a delayed transfer of care and number of bed days, in mental health facilities and in non-mental health facilities per 10,000 population over 75 (Figure 8). These targets are the joint responsibility of LHBs and trusts but are measured at the level of LHBs so that performance can be related to population size. The targets relate to localities achieving continuous improvements relative to the level of performance in the previous year. However, this means that there is a focus at locality level rather than the whole system in which the Trust operates, and there are consequently no overall targets to which all of the partners can work.

1.21 This is exacerbated by the fact that the targets do not apply to local government. Local authorities have a national strategic performance indicator which measures the rate of delayed transfers of care for social care reasons in residents of 75 or over, but this is not aligned to any NHS targets (Figure 8). In addition, the indicator is calculated by adding up the number of people counted in each monthly census. If a patient's hospital stay spans two or more census days the performance indicator for local authorities will count the same person more than once. This is clearly an issue considering the average duration of a social care delay during 2006/2007 ranged from 36 to 86 days in the seven local authority areas in Cardiff and Vale and Gwent. Although the indicator provides an overall rate based on the number of people remaining delayed on each census date, it is a less meaningful measure than one based on bed days occupied by delayed transfers of care.

1.22 The way the measurements are taken also understates the impact of delayed transfers of care. Most local authorities operate 'local agreements' with the Trust which are intended to reflect the actual time it takes to arrange social services assessments and arrangements in each area. The four local authorities in Gwent other than Monmouthshire operate local agreements, which for certain types of delayed transfers of care add a delay of between 7 and 15 working days before a patient, deemed medically fit for discharge by their consultant, is counted as a delayed transfer of care (Figure 9). Some of these local agreements have been applied to codes for which Assembly Government guidance does not provide for local agreements. Such vulnerable people lose further independence during this period of hospitalisation, which should be avoidable given systems within most trusts to estimate a patient's discharge date as soon as they are admitted to a bed.

1.23 Within its 'Six Steps to Effective Discharge' report and 'Effective Discharge Planning Self-Assessment Tool', the National Leadership and Innovation Agency for Healthcare (NLIAH) has pointed out to trusts that good practice is to set an estimated date of discharge when they admit a patient. This was made a requirement for trusts through a Welsh Health Circular in 2005[6]. Bro Morgannwg NHS Trust already operates such a process (Case Study F), which enables it to set an estimated date of discharge within 24 hours of admission. It then operates a colour coding system: for example black means has 'exceeded estimated date of discharge', red 'leaving today', amber 'leaving tomorrow', green 'leaving in two days', blue 'leaving in more than two days'. It is easier in this system to see:

6 Welsh Health Circular (2005) 035

Figure 9: Local agreements operate in Gwent which delay counting a patient as a delayed transfer of care after their consultant deems them fit for discharge

Local Authority	Codes	Local agreement before a patient is counted as a delayed transfer of care
Caerphilly	1.1, 2.3, 2.4, 2.5	If the assessment is commenced within seven days then the Council is given a further seven days to complete the assessment and make the necessary arrangements.
Blaenau Gwent	1.1, 2.3, 2.4, 2.5	10 working days
Torfaen	1.1, 2.3, 2.4, 2.5, 3.9	15 working days
Newport	1.1, 2.2, 2.3, 2.4, 2.5, 2.6	Seven working days
Monmouthshire	No local agreement	
Cardiff/Vale of Glamorgan	1.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 3.2, 3.3, 3.4, 3.5, 4.3, 7.3 a,b, 7.4 a,b	Various – see Cardiff and Vale of Glamorgan report
Carmarthenshire	1.1 2.4, 2.5, 2.9 2.10 2.3	Seven working days for completion of assessment and production of care plan Seven working days to facilitate admission to residential or nursing home Seven working days for a new package of care Two working days for restart of home care package

Notes
Local agreements dated September 2004
Description of codes covered by local agreements
Code 1.1 Awaiting completion of community care assessment (beyond local agreement)
Code 2.2 Re-housing (Local Authority responsibility) sheltered or mainstream accommodation
Code 2.3 Awaiting start or re-start of home based care package (beyond local agreement)
Code 2.4 Awaiting completion of residential care placement arrangements (beyond local agreement)
Code 2.5 Awaiting completion of nursing care placement arrangements (beyond local agreement)
Code 2.6 Awaiting home adaptation/equipment
Code 2.7 No appropriate placement available
Code 2.9 Funding not available for nursing or residential care package
Code 2.10 Funding not available for home care package
Code 3.2 Awaiting opinion of another consultant
Code 3.3 Awaiting assessment by discharge nurse
Code 3.4 Awaiting completion of Occupational Therapist assessment (including manual handling assessment)
Code 3.5 Awaiting assessment/completion of healthcare arrangements by community health services
Code 3.9 Awaiting completion of assessment for NHS funded nursing care/continuing care.
Code 4.3 Awaiting Occupational Therapy home visit
Code 7.3a/b Patient/family/carer selecting residential/nursing care placement of choice
Code 7.4a/a Patient waiting for residential/nursing care place availability in care home of choice

The Assembly Government's census guidance provides for local agreements to apply to codes 1.1, 2.3, 2.4 and 2.5

Source: Wales Audit Office

- what was originally expected to happen with the patient;
- what has since happened, for example when the patient was actually declared fit to move on; and
- who is and who is not in the delayed transfer category.

1.24 Cardiff and Vale NHS Trust's current system is manual with no function within its Patient Management System either to record when a patient is expected to leave or when a patient is considered 'fit for discharge'. The Trust's processes for collecting and recording this information differ between general and mental health areas. Discharge Liaison Nurses rely on ward staff to tell them about any delays but sometimes patients slip through. The Trust plans to address this through the Clinical Workstation project. Gwent Healthcare NHS Trust's policy is to estimate a patient's discharge date within 24 hours of admission but there is evidence that there is inconsistency across the Trust in setting estimated dates of discharge. And in Carmarthenshire NHS Trust, the Patient Administration System records the estimated date of discharge.

1.25 We can see no justification for local agreements. If, in accordance with good practice, partners know the likely date of discharge shortly after admission, it should be possible to make arrangements for a timely assessment of need and then to make arrangements for the transfer of care. And even if good practice in this respect is not being followed, and such arrangements can only be made after the decision that a patient is clinically fit to transfer, it makes no sense to exclude the resultant delay from the statistics.

1.26 It is important to note that the extent of delayed transfers of care shown by the current measurement systems is not necessarily an indicator of good practice across the whole system. Low levels of delayed transfers of care do not necessarily reflect an effective focus on the whole system or effective promotion of the independence of vulnerable people. Some areas with low levels of delayed transfers of care also support very high rates of people in residential homes, which may perpetuate a culture of dependence. In other areas, there are examples of good practice in seeking to address the whole system causes of delayed transfers of care and promoting the independence of vulnerable people but this has not yet been translated into significant or consistent reductions in the extent of delayed transfers of care.

1.27 We also found that until very recently, some delayed transfers of care which occur in Assessment and Treatment Units for people with a learning disability have not been included in the national census arrangements for delayed transfers of care (Box 2). Bro Morgannwg NHS Trust provides three such units to serve people from seven local authority areas in South Wales. They offer specialist services for people who have been living in the community and who need a specialised assessment and a change to their treatment. The service is designed to offer a maximum stay of six months. Some people have not been able to return to the community after they are medically fit to do so. At the time of this review, there are four people who are still in the units whose transfer of care has been delayed for between 11 and 22 months. However, due to some confusion about the interpretation of the Assembly Government's census guidance as

Box 2: Delayed transfers of care in learning disabilities units covered by this review have not been consistently counted in the census figures

Following the closure of long stay hospitals, residential services for people with a learning disability provided by the National Health Service are now of a highly specialist nature. The services fall into two categories Assessment and Treatment Units and Medium to Long Stay Continuing Healthcare. Bro Morgannwg NHS Trust provides three Acute Admission and Treatment Units each containing eight beds. These are located in Swansea, Cardiff and Llantrisant. These units provide for people normally resident in social care community services but who have a specific mental health or behavioural need that requires in-patient assessment and treatment. Such admissions can involve stays of up to six months but some people can remain within the units for significantly longer times, even years, after the treatment period has been concluded. During their stay they may be made homeless by their social care provider service. Such delays have until recently, not been reported with all other delayed transfers of care in secondary care even though they affect the capacity of such specialist units to care for other vulnerable people. Such significant delays tend to occur as a result of disputes over funding (between local authorities and local health boards) or termination of tenancies, with vulnerable individuals caught in the middle of such disputes and withdrawal of services.

Source: Wales Audit Office

service models have changed, such patients were historically not counted as a delayed transfer of care. Since June 2007, Bro Morgannwg NHS Trust has been recording these patients as delayed transfers of care. The guidance on the census arrangements still includes an exclusion that means patients with learning disabilities who are awaiting resettlement are not counted as delayed transfers of care, but this is no longer an issue in the Bro Morgannwg area as all resettlement is complete.

Part 2 - Local improvements are feasible in the short-term, pending longer-term action across the whole care system

2.1 The impact of the local examples of good practice has been compromised by the failure to tackle the problem of delayed transfers of care in a whole systems way. Despite the need for longer-term changes in approaches to joint working, organisations are still not managing as effectively as they could within the existing system because:

- the strategy to promote the independence of vulnerable people and reduce the reliance on the acute hospital sector has not yet been translated into effective action at each stage of the patient pathway through the whole system;
- even within the constraints of the existing system, organisations can work more effectively; and
- longer-term whole systems solutions should follow from the development of shared service models and existing good practice.

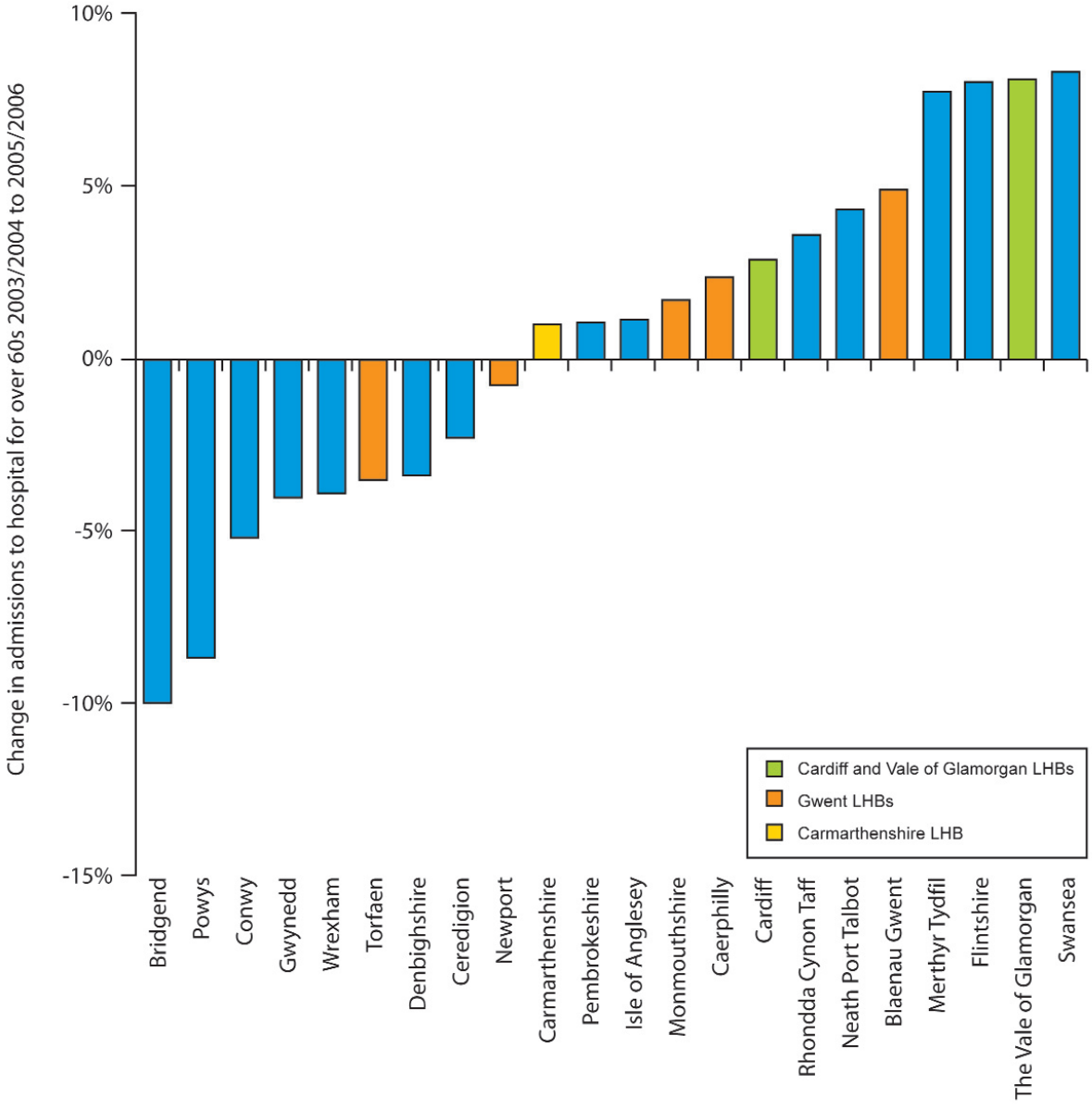
Action is needed throughout the patient pathway to promote the independence of vulnerable people

2.2 In March 2006, the Assembly Government launched its National Service Framework for Older People, which contained 10 standards that included intermediate care services, the provision of hospital care, challenging dependency and promoting health and wellbeing. Building on the principles of the Assembly Government's Strategy for Older People in Wales of 2003, the National Service Framework repeatedly emphasises the need to minimise delayed transfers of care and unnecessary admissions or stays in hospital.

2.3 The Assembly Government and its local delivery partners are currently working through the implementation of the standards. We found that some progress was being made but that there remains significant scope to promote more effectively the independence of vulnerable people at all stages of the patient's pathway through the whole system.

2.4 The Assembly Government's 10 year strategies for health and social care, 'Designed for Life' and 'Fulfilled Lives, Supportive Communities' also emphasise the importance of rebalancing the whole system to provide care closer to people's homes and to develop intermediate care and preventative services to reduce dependency.

Figure 10: Change in admissions to Welsh hospitals for the over 60s between 2003/2004 and 2005/2006 by LHB area



Note
This data relates to residents of Welsh LHBs admitted to Welsh hospitals. For some LHBs with significant cross-border patient flows, such as Powys and Flintshire, this skews the figures.

Source: Wales Audit Office analysis of Patient Episode Database Wales (PEDW) admissions data

By addressing problems at all stages of the patient's pathway through the system, there can be more effective promotion of the independence of vulnerable people consistent with the principles of the National Service Framework for Older People

Alternatives to hospital admission are still needed

2.5 Although there has been an overall downward trend in emergency admissions for those over 65 in both Trusts between 2003 and 2006, the level of overall (scheduled and unscheduled) admissions to Welsh hospitals for LHB residents aged 60 years and above is increasing for all but two of the LHBs covered by this project (Figure 10). This suggests an ongoing need for LHBs to commission alternatives to hospital admission. Moreover, in all of the LHB areas in Cardiff and the Vale of Glamorgan and Gwent, our work on chronic disease management showed that hospital admission rates vary considerably between GP practices for both localities, which need to be examined and, if necessary, addressed by the LHBs. The new General Medical Services Contract allows LHBs to use powers to incentivise GPs to provide enhanced services to support their patients in the community rather than admitting them to hospital although these have not developed quickly, partly as a result of the time it takes to shift resources from existing secondary care services to new primary care services[7].

2.6 Local Health Boards have a vital role to play in establishing schemes that prevent unnecessary admissions to hospital and promote the independence of vulnerable people. Although we found that LHBs generally need to do more to target proactively people at risk of becoming delayed transfers of care to reduce admissions to hospital and maintain people's independence (managing the 'front door' as well as the 'back door'), we identified some good examples of effective schemes that have prevented the admission of vulnerable elderly people at risk of experiencing a delayed transfer of care if admitted to hospital (Case Study A).

2.7 Another opportunity to provide alternatives to hospital admission is to utilise the Welsh Ambulance Services NHS Trust to provide a wider range of community-based services, consistent with the Assembly Government's 'Delivering Emergency Care Services' strategy. Our recent report on ambulance services in Wales highlighted the scope to develop a wider range of ambulance services that focus as much on treating people in the community as transporting them to hospital. Essentially this would lead to ambulance services becoming clinically-driven mobile providers of healthcare services, rather than solely a patient transport or emergency service[8]. There is also scope for the Welsh Ambulance Services NHS Trust's Patient Care Service to play an important role in expediting patients' timely discharge from hospital.

7 Auditor General for Wales, 'Review of the new General Medical Services Contract in Wales', August 2007, paragraph 1.51.

8 Auditor General for Wales, 'Ambulance Services in Wales', December 2006, paragraphs 2.3-2.8.

Case Study A: Providing alternatives to hospital admission

The Prevention of Admission to Hospital Scheme in Newport
Newport LHB commissions Age Concern Gwent to provide a scheme to prevent admission to hospital. The scheme was set up in 1999 and enables any health professional with admitting rights to hospital (GPs and Trust staff working in accident and emergency or the Medical Assessment Unit but not social workers) to make referrals for intensive short-term (up to a maximum of 10 days) social care in the homes of people aged 50 or over. The service provides care seven days a week and provides a response within two hours of referral with a view to preventing an emergency medical admission. The scheme assists over 200 people a year at an annual cost of £180,000, which broadly means that each admission it avoids costs around £880. Based on an average cost of a hospital bed day of £300 and an average length of stay of seven days, a recent independent review of the scheme estimated that it saved £420,000 bed costs each year, a net saving of £240,000.

There are some areas in which the scheme could operate more effectively including:

- three LHBs have patients in the Royal Gwent hospital but they have different care pathways and different ways of accessing them which is potentially confusing for staff in wards such as Accident and Emergency and the Medical Assessment Unit; and
- there are highly variable referral rates to the scheme from Newport GPs and Trust staff.

Source: Prevention of Admission to Hospital, 'PATH', a report on the service in Newport, Maine Stream, 2006

The Short Term Intervention Service in the Vale of Glamorgan
The Vale of Glamorgan Council runs an effective Short Term Intervention Service (the STIS homecare team). The STIS team was set up to reduce the need for admissions and to assist discharges from hospital. There is an Occupational Therapist as a member of the team and the team is involved for a fixed time - usually six weeks. The team is in demand, is carefully monitored and appears to be working well.

Source: Wales Audit Office

The Intermediate Care Service provided by the Red Cross in Torfaen
This team was established in April 2006 and aims to reduce admissions and facilitate discharges by providing six week tailored packages of care to support people who are living alone and vulnerable. Over the last year, to April 2007, 236 people have been helped by the scheme: 126 prevented admissions and 110 facilitated discharges. This represents a saving compared to the costs of hospital care, and the service aims to promote people's ability to remain safely in the community. This service includes the involvement of the LHB Pharmacist who provides advice and training for staff so that they can administer medication, if needed.

Source: Wales Audit Office

Acute Response Team in Carmarthenshire

Mr. L, 76 years old, has been under the care of the specialist respiratory team for the previous two years. Mr. L lives with his wife, who herself has multiple medical conditions but is Mr. L's main support. He has no other services visiting apart from the district nurses who visit twice a week for wound management of his ulcerated foot. He has chronic obstructive pulmonary disease, as well as a tendency towards depression. During his last visit to the specialist respiratory team, it was noted that he had a chest infection. Following discussion, it was agreed that there were two possibilities for Mr. L – admission to hospital to receive intravenous antibiotics or alternatively to receive the treatment within his own home, avoiding disruption to his lifestyle and usual care arrangements.

The Consultant referred Mr L to the Acute Response Team (ART) for home based twice daily intravenous antibiotic treatment. During the period of intervention, which lasted for ten days, consultant access for advice was available, and the local GP was informed of Mr. L's condition and treatment regime. During the visits, the ART undertook the wound management regime, which the district nurses had instigated to avoid duplication of effort. Mr. L was able to telephone the ART at any time should he need to. In the event of Mr. L needing to be reviewed by the consultant, he would have attended as an outpatient, but this was not required during this period.

The treatment was completed over a ten day period until the acute exacerbation of his chest condition had resolved. Both Mr. and Mrs. L were very impressed with the service they had received.

In the event of the ART not being in a position to administer this treatment regime within the community, Mr. Ls' only option would have been to be admitted into hospital for treatment, which would have resulted in at least a ten-day admission, and significant disruption to his long standing care arrangements. During this time his wife would have not been able to visit on a daily basis due to transport difficulties and so Mr. L could have become increasingly isolated from his only source of emotional and social support, his wife. If Mr L had been admitted he would have potentially been exposed to other risks as an inpatient and his health could have deteriorated further.

Source: Position Paper: Mid and West Wales region: Carmarthenshire Delayed Transfers of Care

Patient flow can be improved by addressing assessment, Continuing Healthcare and patient choice

Unified assessment has potential benefits but its implementation has been problematic because of a lack of IT and problems sharing information between agencies

2.8 Finding the most appropriate way to care for vulnerable older people requires a robust assessment of their needs by relevant health service and social care staff. Unified Assessment is the process of assessment, by a multi-disciplinary team of health and social care staff, of an older person's care needs. Unified Assessment was introduced in April 2005[9] and was intended to deliver multi-disciplinary assessments of patients' needs. Throughout our work we heard that the unified assessment process had been intended to be supported by an electronic system but was still being run on paper, with very long forms (some 40 pages long) that had to be faxed to other members of the multi-disciplinary team. The Informing Healthcare programme intends to develop an electronic system to support unified assessment. In Gwent, our focus group identified 'unified assessment not being effective' as the most significant and difficult barrier to address although it was seen as a less significant barrier in Cardiff and the Vale.

2.9 One possible reason for the higher significance of unified assessment as barrier in Gwent is the variation in the forms used for unified assessment in the five local authority areas, with Caerphilly County Borough Council using a different form to other parts of Gwent. This has led to a lack of clarity within the Royal Gwent Hospital both about who

9 'Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care'. Issued by the Social Services Inspectorate of the Welsh Assembly Government 1 April 2002.

Case Study B: Delays in carrying out assessments

Mrs Z from the Gwent region was admitted to hospital with a urinary tract infection in January 2007. She had been diagnosed with dementia prior to admission and lived with her daughter who acted as her main carer. She was described as needing 24 hour supervision, being dependent on others to meet her personal care needs. She was declared fit for discharge in late March, but the assessment was not completed until 9 May.

Mrs A from the Gwent region has dementia, insulin dependent diabetes and is also unable to mobilise without support. Following the admission of her husband (main carer) to hospital, she was admitted to respite care and then to hospital in early January 2007. On 17 January the case file noted a doctor saying that she was fit for discharge but the actual fit for discharge date on the computer systems was noted as 4 May. At a case conference on 4 April a nursing assessment was requested, there was then a debate about who was able to advise on the category of care with the ward staff concerned that they were being asked to make this recommendation. The assessment was completed on 18 May – six weeks later, but there was then another four-week delay for completion of a Continuing Healthcare assessment.

Mrs B from Gwent is 92 and has dementia. She was admitted to hospital in March 2007 and towards the end of March a nursing assessment was requested from the social services occupational therapist. Mrs B was declared fit for discharge in mid-April, but the nursing assessment was not completed until 1 May. There was no recording on the social services file between 10 April, when social services' occupational therapist closed the case, and 6 June when funding was agreed and contracts were sent to the nursing home. Social services' decision to close the case, while understandable from their perspective, does not support the effective performance management of timely discharge. Even if discharge arrangements were being expedited by health organisations, the closure of the social services case file suggests that they were not chasing, monitoring and taking an active interest in the progress of Mrs B. Mrs B was due to be admitted to the home in late June.

Mr C was admitted to University Hospital of Wales (UHW) in November 2006 with prostrate problems. He had short term memory loss but was declared fit for discharge on 22 February 2007. The unified assessment form was completed by ward staff, but not to the social worker's satisfaction because it was 'incomplete and not signed'. A new social worker was still trying to sort this out during the first week of June. A nursing home placement was required but the home of choice required a top up payment, which had not yet been agreed at the time of our case file analysis. In addition, the LHB had not agreed the placement.

Key issues:

- after earlier hospital admissions, Mr C had successfully received help from the 'intensive support team' on his return home;
- there were evident tensions between hospital social worker and ward staff over completion of the unified assessment; and
- a large number of people needed to have an input in this case – ward staff to complete unified assessment, LHB assessors (once they get the unified assessment), contracts officer in the local authority (to negotiate the price, given the need for a top up payment), family/carers over both funding/finances and the choice of home.

Source: Care and Social Services Inspectorate for Wales analysis of social services case files, following up the Wales Audit Office inpatient census of delayed transfers of care on 16 May 2007

should complete the form but also about which form should be used for which patient's assessment. Moreover, documentation started in one of the five boroughs may not be compatible with documentation in use in the area to which the patient is transferred.

2.10 Because the unified assessment process requires the involvement of a number of staff from different organisations, the duration of the assessments can be long and linear, and can take place after the patient is ready for discharge because of the time it takes to involve all members of the multi-disciplinary team. Case Study B reflects the impact of delays in carrying out assessments.

2.11 The availability, knowledge and training of staff can also compromise the assessment process. In general, staff at operational level within the trusts were insufficiently trained to manage patients whose transfers of care was

delayed, especially bank and agency nurses who may not be familiar with the different care pathways and models of intermediate care services within the community. There is considerable scope to improve ward staff knowledge of intermediate care and community-based options available to patients, exacerbated by the variability of social workers' presence on the ward, which impedes effective multi-disciplinary assessment and management of patient flow.

2.12 We also found some examples of good practice in assessment. Case Study C shows the benefits of the Elderly Care Assessment Service (ECAS) available in Cardiff and the Advanced Clinical Assessment Team (ACAT) in Torfaen.

The process of determining patients' eligibility for Continuing Healthcare does not place the patient at the centre and encourages silo working

2.13 Organisational barriers at the interface between the NHS and social care contribute to delayed transfers of care. In particular it is proving increasingly difficult for multi-disciplinary teams to agree on whether a patient:

- is eligible for fully NHS-funded Continuing Healthcare;
- is eligible to receive an NHS contribution to nursing care; and/or
- requires a means-tested service involving personal, residential or nursing care commissioned through social services.

Case Study C: Good Practice in assessment

Emergency Care Assessment Service in Cardiff
The ECAS which provides rapid access to multi-disciplinary team assessment for patients who are failing in the community. This scheme is well-established and has been evaluated and has achieved some notable results although there have been some problems with accommodation and flexibility in the use of staff such as therapists.

Advanced Clinical Assessment Team in Torfaen
The ACAT consists of three Clinical Nurse Assessors who respond rapidly to referrals in order to prevent admission from patients in the community and care homes. It was started in November 2006 and was developed by Torfaen's Consultant Physician for Intermediate Care who also leads the team.

Contact telephone numbers have been rationalised within the Trust so all referrals to ACAT are to one number. Upon referral, a nurse will visit the patient to take a full history and carry out an extensive examination. Diagnostic tests, including blood and oxygen tests and an electrocardiogram (ECG), are carried out immediately at the patient's home. The results take a number of hours to come through and this time is used by the nurse to make contact with social services or the reablement team if required. If an X-ray is required, the team has an arrangement with the radiology department at County Hospital where ACAT patients are given priority. The team also has close working relationships with the Welsh Ambulance Services NHS Trust so there is rapid access to transport when needed.

Clinical governance is provided through the Consultant Physician and a specialist Intermediate Care Registrar. ACAT nurses are urged to ask their advice if they have any doubts about a patient and the clinicians are available to visit patients in the community or to see patients at regular hot clinics.

Referrals are now being received from all GP practices in Torfaen and close working with the borough's care homes has virtually eliminated unnecessary admissions from this source.

The scheme is currently available to people aged over 75, between 8am and 8pm, Monday to Friday.

Source: Wales Audit Office

2.14 A person is eligible for NHS Continuing Healthcare if their overall healthcare needs are judged so significant that the NHS has to take responsibility for managing and paying for all the care they need. A person is eligible for Continuing Healthcare if one or more of four criteria are met.

- the nature, complexity, intensity or unpredictability of the individual's healthcare needs means that regular input is required by one or more members of the multi-disciplinary team, such as a doctor, nurse or therapist;
- the individual requires routine use of specialist healthcare equipment involving supervision by NHS staff;
- the individual has a rapidly deteriorating or unstable condition requiring regular intervention; and/or
- the individual is in the final stages of a terminal illness.

2.15 If eligibility is confirmed, an NHS clinical professional is designated as the individual's care co-ordinator, and this clinician supervises the agreed care plan. The care co-ordinator (in collaboration with any specialist clinicians needed for advice) is responsible for reassessing needs on a regular basis. Someone may move in and out of eligibility for Continuing Healthcare.

2.16 Many patients deemed eligible for Continuing Healthcare will be, and will remain, in hospital. Care may also be provided in other settings including a person's own home, a hospice, or a care home. Care may include primary care, rehabilitation, specialist medical, nursing, respite, provision of equipment and transport.

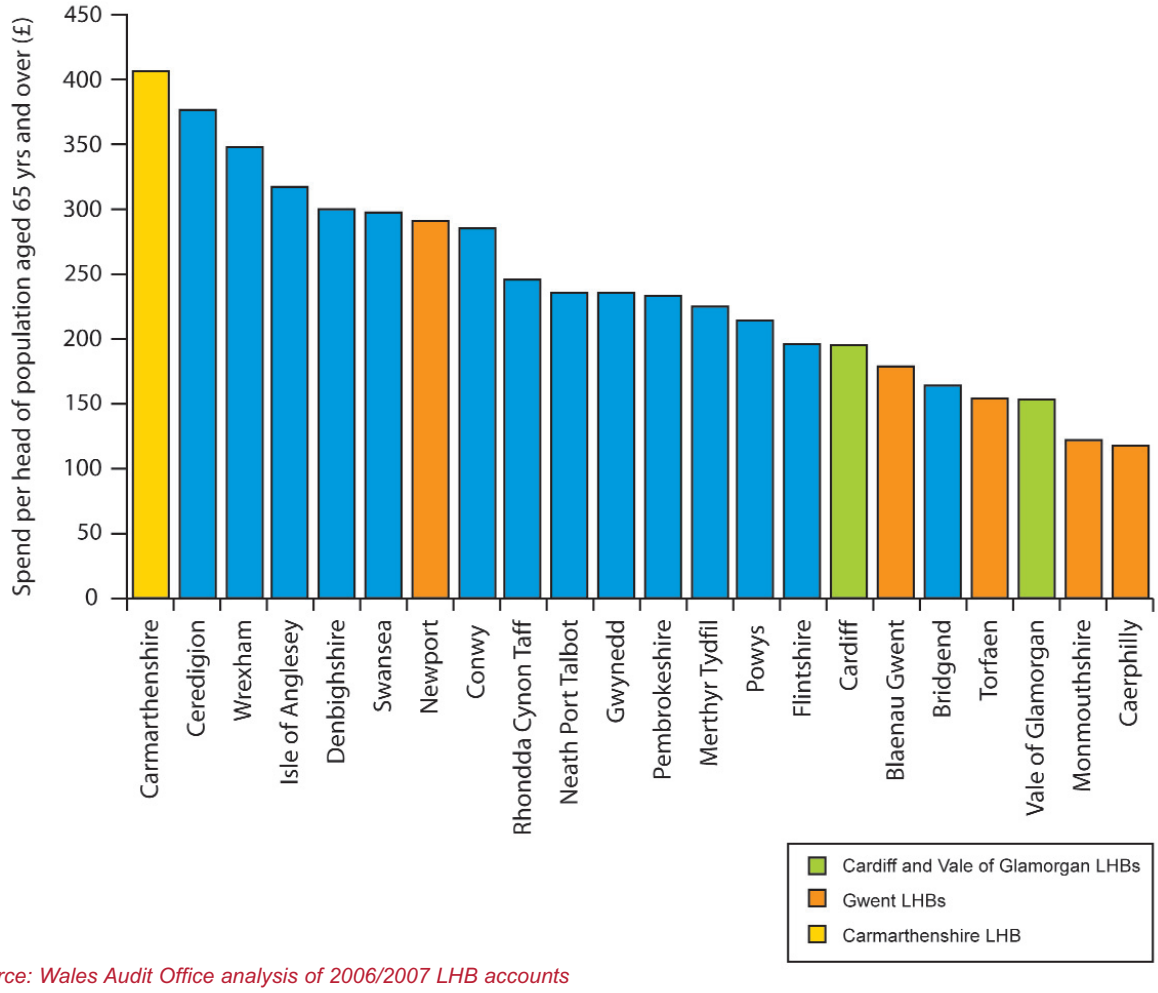
2.17 When eligibility for Continuing Healthcare is confirmed, the NHS becomes responsible for funding the full package to meet the user's health and personal care needs. Formal funding decisions are made by LHB panels often sitting monthly which can lead to additional delay and uncertainty for patients. It is not the job of the panel to challenge the decision of the multi-disciplinary team, but panel members can ask for additional evidence to support the case and can request that all options for the provision of Continuing Healthcare have been considered. They can, for example, suggest that Continuing Healthcare is provided in a cheaper care home.

2.18 If the judgement is that the person is not eligible for Continuing Healthcare, there may still be provision for NHS funded nursing care. This is a flat rate allowance (around £115 per week) paid by the LHB for any person in a care home in a designated nursing bed as a contribution to the cost of their nursing care. The remainder of the costs are met by the local authority and/or the person and their family. As with Continuing Healthcare someone may move in and out of eligibility for funded nursing care.

2.19 The 'Grogan judgement' in January 2006 established that a Primary Care Trust in England had failed to apply an 'over arching test' to determine whether the patient's primary need was for healthcare.
This judgment, combined with earlier cases involving the Ombudsman and Coughlan, all point in the same general direction: an expectation that the NHS will assume a greater responsibility for funding care.
The direct consequences are a reduction of the financial burden on social service departments for long term care, and the removal of the financial cost from some people who had previously paid for their own care.

2.20 Local Health Boards' expenditure on Continuing Healthcare, as recorded in their annual accounts, varies significantly per head of population aged over 65 (Figure 11). The extent of the variation – the LHB with the highest expenditure per head of population over 65 is more than three times that of the LHB with the lowest expenditure. This may reflect so-called 'cost shunting' between the NHS and local government where LHBs and local authorities may be inappropriately assessing people's needs and eligibility for funded nursing care and Continuing Healthcare, with consequences for expenditure. The variation in expenditure may also reflect variable provision of Continuing Healthcare beds within NHS Trusts as part of their Long Term Agreements with commissioners. The data is also complicated by the fact that LHBs have Continuing Healthcare expenditure for people aged under 65, for example those with Learning Disabilities or Mental Health needs. To understand fully Continuing Healthcare funding would require significant additional work which was beyond the scope of this

Figure 11: LHBs' accounts show variable expenditure on Continuing Healthcare per head of population over the age of 65 in 2006/2007



Source: Wales Audit Office analysis of 2006/2007 LHB accounts

Figure 12: Local Health Board estimates of the additional costs of Continuing Healthcare arising from the 'Grogan' judgement

LHB	Estimated cost of compliance with Grogan judgement (£ million)
Cardiff	20.7
Vale of Glamorgan	10.3
Cardiff and Vale total	**31**
Newport	8.1
Torfaen	5.7
Caerphilly	5.3
Monmouthshire	5.5
Blaenau Gwent	6.1
Gwent total	**30.7**
Carmarthenshire	12.5

Source: Wales Audit Office analysis of Service and Financial Frameworks 2007/2008

project. The Wales Audit Office's recent consultation on a programme of studies in health and social care included Continuing Healthcare as a possible future study.

2.21 LHB Directors of Finance have estimated the additional costs of NHS Continuing Healthcare in preparing the 2007/08 Service and Financial Framework. Within Gwent, the total estimate of the additional annual cost is £30.7 million, in Cardiff and the Vale of Glamorgan £31 million and £12.5 million in Carmarthenshire (Figure 12). We understand that this figure has been calculated on the basis of a worst case scenario of full cost conversions in each nursing home bed from funded nursing care funding to Continuing Healthcare funding, and have not examined its accuracy.

2.22 Whatever the true figure, some of this cost will be offset by savings from social services and would in effect be a recycling of public funds. However, a substantial and unknown proportion would be absorbed by the NHS paying for the care of people who had previously met their bills in full themselves.

2.23 The practical, financial and political implications of Continuing Healthcare are significant. The likelihood is of more Continuing Healthcare assessments being requested and undertaken, and the probability of more appeals. Increasing assessments for those being discharged from hospitals are likely to lead to increases in the numbers of delayed transfers of care.

Case Study D: A delayed transfer arising from disputed eligibility for continuing healthcare

Mrs X had a mental health condition and became very distressed and agitated if any aspect of her routine was changed. Her hospitilisation was a consequence of attempted self-harm. There had been social work involvement with Mrs X since September 2004. She has been in receipt of home care and respite care and moved to a residential home in 2006. She was admitted to hospital from the residential home in October 2006. She was declared medically fit for discharge in December 2006, but her old placement was no longer seen as appropriate for her. An alternative placement in a nursing home was found by March 2007, but there was a funding shortfall of about £40 per week once social services and the LHB had made their respective contributions. The social worker wrote to the senior nurse in early March, asking for this to be taken to the 'panel' for consideration for Continuing Healthcare funding. The panel met and decided that Mrs X did not meet the criteria. The social worker asked for a review of this decision, but as at the end of June 2007 this remained unresolved.

Mrs X remained in hospital 6 months after being fit for discharge and three months after a suitable placement was identified.

Source: Review of case files for live delayed transfers of care in June 2007, undertaken by CSSIW as a follow up to the Wales Audit Office inpatient census

2.24 Disputes between LHBs and social services have become common in respect of eligibility for Continuing Healthcare funding. For example six of the 34 Vale of Glamorgan delayed transfers of care in June 2007 were waiting for their Continuing Healthcare assessment to be completed, and a further three waiting for their original Continuing Healthcare decision to be reviewed. This means that Continuing Healthcare considerations were involved in at least a quarter of all delayed transfers of care in the Vale of Glamorgan. In one third of delayed transfers of care case files reviewed in social services, we found that delays associated with Continuing Healthcare were an issue in the case. The delayed transfers of care census figures suggest there may have been a recent increase in delayed transfers of care relating to continuing healthcare, particularly in Torfaen where the June 2007 census included 10 delays arising from a review of eligibility for Continuing Healthcare.

2.25 Continuing Healthcare decisions are a vivid manifestation of the problems that can arise at the interface between health and social care. Decisions about whether a patient is eligible for Continuing Healthcare, an LHB contribution to nursing care or requires means-tested personal care is a time consuming and difficult process which does not place the patient at the centre of care and can provide an incentive for organisations to seek to protect their budgets and positions. We found evidence from our case file review of assessments involving both health and social care services with one partner effectively avoiding responsibility for progress until the case returned to them across an organisational boundary. There may be scope to develop jointly funded health and social care posts to help co-ordinate older people's pathway through the system, building on some of the principles of existing good practice, for example the nurse case manager system in Caerphilly (Case Study Q) and the 'virtual ward' model in Croydon (Case Study R). Case Study D provides an example of a delay arising from an assessment of eligibility for Continuing Healthcare.

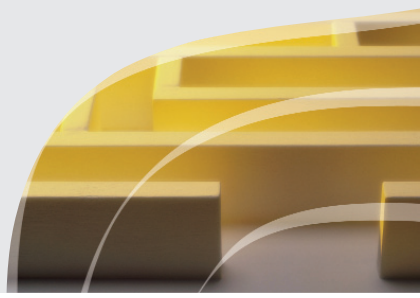
2.26 Assessing eligibility for Continuing Healthcare funding may raise questions about equity. At the root of this is the fact that NHS Continuing Healthcare funding is likely to be more advantageous to the better off. For example if full costs are to be met by the NHS, the costs are likely to be higher in connection with a relatively wealthy individual who may well have chosen to live in a higher-priced home when self-funding, than for a relatively poor person who had been placed in a lower cost home by their local authority when they first needed residential care because of the Council's payment cap. Under current guidance, Continuing Healthcare funds could, in effect, end up being used in two separate streams – one high cost the other low cost.

Patient choice needs to be managed more consistently to overcome ethical and financial problems as people move from 'free' care to means-tested services

2.27 Admission to hospital is a dramatic and potentially life changing event. For those who face the prospect of not returning home after leaving hospital, the implications for them and their families and carers are enormous. Behind the statistics about delayed transfers of care are people facing very significant choices about their future independence and lifestyles. It is entirely reasonable for people to expect to be helped to make informed choices about the future. The situation is further complicated by the fact that many people whose transfers of care are delayed are not capable of making an informed choice and so rely on their carers.

2.28 In some of the cases examined in our sample of social services case files, the length of time taken to secure alternative arrangements for an individual is quite understandable, given the need to move at a pace that allows for the expression of choice and the appropriate involvement of relatives and carers. However, choice remains a very significant cause of delayed transfers of care in Wales.

2.29 In 2004, the Assembly Government issued WHC (2004) 066 providing revised guidance on choice of accommodation. The guidance stressed the importance of trusts and local authorities developing local protocols for the management of choice. It also identified the need for local authorities to ask patients in hospital who had been assessed as needing residential or nursing care to identify at least three suitable care homes so that the local authority, which has the statutory duty to make arrangements for placements, could pursue all three simultaneously. Interim placements could be used if the preferred accommodation was not available although movements between care settings should be kept to a minimum because of the unsettling effect on the person concerned. Care Forum Wales told us that one practical problem with interim placements is the fact that there is often a four week notice period before the patient can move from an interim placement to their home of choice. They said that this means that if the home of choice has a waiting list the vacancy is unlikely to remain open for the four week notice period during which time the Council will not wish to pay for two places for the same person.



2.30 Across Wales, delayed transfers of care for patient/carer/choice reasons accounted for 135,128 lost bed days in 2006/2007 (Figure 7), half of the total number of days occupied by delayed transfers of care. Sixty-two per cent of bed days lost in Cardiff and Vale NHS Trust arose because of patient/carer/choice issues, accounting for over 48,000 bed days, an 18 per cent increase compared with 2005/2006. The average duration of a delayed transfer of care for patient/carer/choice reasons in Cardiff and Vale NHS Trust was the highest in Wales, 91 days. In Gwent Healthcare NHS Trust, 18,600 bed days were occupied in 2006/2007 by delayed transfers of care that arose because of patient choice issues, a 14 per cent increase compared with 2005/2006.

2.31 The significance and increasing impact of patient choice on the extent of delayed transfers of care is mainly due to a shortage of realistic and acceptable residential and nursing home options for those medically fit to leave hospital and who are unable to fund their own placements. In some areas, such as Cardiff, occupancy levels in homes are so high that there is insufficient spare capacity to operate an effective choice policy. It is also important to note that local authorities may not have sufficient resources to fund placements for all of the people currently delayed as a result of exercising their right of choice.

2.32 Often such delays relate to people who are moving from free healthcare to means-tested social care services. There are disincentives to discharge both for users and councils who may have to pay for all or part of the services the person will receive if they are not eligible for Continuing Healthcare or funded nursing care.

2.33 In both Gwent and Cardiff and the Vale, we found inconsistent approaches to the management of patients' right of choice, particularly relating to transfers to residential care. Choice policies vary between local authorities and not consistently implemented. For example, while Assembly Government guidance talked about identifying three care homes, in the Vale of Glamorgan the choice policy has operated on the basis of first choice only. Some believe that there is a need to support and educate families and carers about what the right of choice means and to provide reassurance that moving out of the hospital environment is better for the patient's safety and wellbeing than remaining in the hospital bed.

2.34 In many areas covered by this review, there was a view that there needs to be more robust implementation of choice protocols, particularly in setting and operating time limits for patients and their carers to make decisions. Clinicians we spoke to indicated that they often experience problems with relatives who do not want to sell the home and their view that there needs to be greater managerial support and intervention to enable clinicians to step back because of the ongoing need to manage a clinical relationship with the client and their carers. In areas with very high occupancy rates in care homes, there are questions about the reasonableness of delayed transfers of care when people are waiting for a placement in their preferred accommodation, but the lack of vacancy means that the particular home is not a viable choice at that time.

2.35 To avoid confrontation, the expectations of patients and their carers about their discharge need to be managed at a very early stage. During fieldwork we were told by some health service and social care staff that families are becoming more aware of the issues and implications of moving from free healthcare to means-tested personal care and are seeking to delay their relatives' transfers of care, causing inappropriate delays. It is almost impossible to discharge a patient against their will. Ward managers find that it compromises their position as a provider of care if they have to suggest 'evicting' a patient from hospital rather than following an agreed discharge. Communication is vital in situations where someone is going to move from a hospital bed into residential care – an important measure in these situations is to inform the family as soon as possible if long-term care is going to be required.

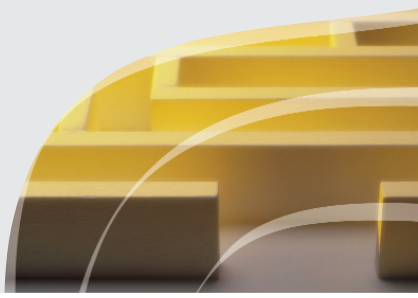
2.36 The implications on delayed transfers of care of the implementation of the Mental Capacity Act remain unknown. The Act provides a clear legal framework for people without the mental capacity to make their own decisions. It targets patients with dementia, learning difficulties, brain injuries or disturbance (temporary or permanent) and severe mental illness and covers decisions such as the choice of care home for patients who do not have capacity. The Act also provides the strongest guidance yet that carers should be included in decisions although its emphasis on ensuring that wherever possible users and patients take their own decisions could increase delays or disputes about a person's capacity and the best option for their care. The Act could make the process of placing people without mental capacity more resource intensive, although it also has the potential to help make better and more timely decisions about the care of vulnerable older people who lack mental capacity. It is likely that case law will arise soon after the full implementation of the Act in October 2007.

By addressing process weaknesses once patients are admitted, partners could improve patient flow and reduce the incidence of delayed transfers of care

2.37 We found that there were process weaknesses once patients were admitted to a hospital bed in both trusts although work is ongoing to improve patient flows. One weakness in the operation of the system is that social services care packages tend to be frozen or stop altogether when an older person is admitted to hospital. This can lead to breaks in the care pathway and a need to reassess needs and set up new care packages, all of which can be time consuming and duplicate previous work.

2.38 Pathways for patients whose transfers of care are delayed vary between and within the two trusts. Gwent Healthcare NHS Trust operates a pattern where elderly patients move from acute beds to community beds with very long lengths of stay once their transfer of care has been delayed.

2.39 In Cardiff and Vale NHS Trust, rehabilitation beds are not used effectively to rehabilitate patients within the Trust as the rehabilitation capacity is compromised by either delayed transfers of care, many of whom have Mental Health needs, or Continuing Healthcare patients. Around 40-50 Continuing Healthcare patients per month continue to be cared for within an inpatient setting, of whom the Trust told us 50 per cent could be managed in a care home setting. We found that between 17 and 25 per cent of the Trust's rehabilitation beds are occupied by delayed transfers of



care. This rises to 42 per cent when Continuing Healthcare patients are included who are no longer a delayed transfer of care but who, arguably, should not be in these beds and could be cared for within a care home setting. The Trust has very limited community hospital provision and many of the beds that are available are occupied by delayed transfers of care or Continuing Healthcare patients who have become long stay patients.

2.40 However, both Trusts are taking steps to address these problems with the patient pathway. Specifically they are seeking to move towards a hospital system which much more effectively 'pulls' the patient through it, rather than the current system which 'locks' patients into hospital settings, leading to people becoming delayed transfers of care. Case Study E shows how a new approach to rehabilitation for medical elderly patients in Cardiff and Vale, and the stroke rehabilitation ward in Nevill Hall Hospital in Gwent seek to pull patients through the system more effectively.

Better discharge planning and management would improve patient flow

2.41 Active discharge management processes once a patient is in hospital are a critical part of the effective management of patient flow and contribute directly to promoting the independence of vulnerable people by ensuring that transfers of care take place at the most appropriate time. Discharge management for patients who become, or are at risk of becoming, a delayed transfer of care is often complex with many agencies involved. In both trusts we found that discharge planning and management was of variable quality.

2.42 Cardiff and Vale NHS Trust has undertaken considerable work to improve all aspects of the patient pathway, including improved bed management, unscheduled care pathways and discharge management. But there is recognition within the Trust that the key requirement for delivering the necessary improvement centres on changing clinical behaviour and strengthening multidisciplinary team working which requires further development. The key actions that are in train within the Trust are:

- implementation across a small number of wards of a computerised system, Clinical Workstation, which is a tool to support clinical practice offering a number of functions including discharge planning and other functions to support the progressive movement of patients through wards, including the ability to identify predicted date for discharge; and
- the development of a new discharge policy framework which has been developed across all partners which the Trust now needs to translate into action.

2.43 In Gwent Healthcare NHS Trust, we found that discharge planning and management varied because of different ward arrangements in terms of access to therapists, social workers and differences in the roles and caseloads of key hospital staff. Our focus group identified concerns that patients and their carers were not sufficiently engaged in discharge planning, and a prevailing culture that being in hospital was good for the patient.

Case Study E: 'Pulling' patients through the hospital system

Focused Rehabilitation for Medical Elderly (FRAME) in Cardiff and the Vale NHS Trust
This model set up by the Trust includes early rehabilitation and maintenance of basic functional and physical health during initial stages of medical treatment and stabilisation. This model operates a 'pull' system whereby the rehabilitation consultant visits the Emergency Unit, Medical Admissions ward and other relevant areas and identifies suitable patients for transfer into this service. Multi-disciplinary working is a key aspect of this service and it includes seven days per week physiotherapy and occupational therapy and a dedicated social worker. The social worker is funded by the Trust through a Service Level Agreement (SLA) with the Local Authority.

Initial results have been promising with increased throughput and a high proportion of patients being discharged back to their own home (83 per cent).

Stroke rehabilitation unit, Nevill Hall Hospital
The stroke rehabilitation ward at Nevill Hall Hospital is held in high regard within the Trust for its culture of promoting independence and ensuring patients are given every chance of transferring to the next stage of their care in a timely and appropriate manner.

Communication within the ward's multi-disciplinary team and between staff and patients/family/carers is seen as critical to the patient's progress through the system. Staff start communicating with relevant parties as soon as a patient arrives on the ward. All the necessary referrals are made swiftly and staff realise the need to talk to family members and carers to quickly pick up any issues that might act as a barrier to discharge. Carers and family members are also surveyed every month about various aspects of care but including questions about personal circumstances that could delay discharge.

Multi-disciplinary team meetings are held weekly where discussions involve the patient's remaining care needs, medication needs, need for further investigations and discharge arrangements. Staff told us this forum is particularly effective because all disciplines are present and problems are solved quickly. Having all disciplines present also means the meeting can receive all relevant information about the patient and that the collective knowledge about intermediate care services is broad.

The ward also uses multi-disciplinary note writing. All disciplines write in the patient's notes to detail exactly what actions they have taken. This is seen as effective in improving communication between disciplines and ensuring all actions are being progressed.

Further documentation used on the ward includes a multi-disciplinary discharge plan which details all arrangements that must be made before a patient can be safely discharged. Copies of this form are retained by the patient and the ward and a copy is placed in the patient's notes. A separate discharge planning document is used that contains a discharge/transfer checklist that nurses must sign when certain actions have been completed. Actions include informing the patient of discharge, arranging transportation and having a care plan in place.

Western Vale rehabilitation team
There is a multi-disciplinary team serving the Western Vale of Glamorgan, provided through Bro Morgannwg NHS Trust. This team includes a Physiotherapist, an Occupational Therapist and Social Care workers. The team's aim is to provide short-term intensive services to assist people in their reablement. Visits are made by the team to people's homes, so they do not need to travel to outpatient clinics. Staff make as many visits as needed, so can visit a number of times during the week. The scheme has reported that over 80 per cent of service users have succeeded in their reablement. This service is funded through fixed-term flexibilities funding.

Consolidating cases at the Princess of Wales Hospital, Bridgend – Bro Morgannwg Trust
Managers and clinicians at the Princess of Wales hospital decided in April 2007 to designate the hospital's Ward 19 as the multi-disciplinary assessment ward. The ward has 12 beds – all of which are occupied by patients who are already delayed in hospital or at risk of being delayed. The new system has not yet been formally evaluated, but the early signs are said to be encouraging. The concentration of the individuals in one part of the hospital is said to be making effective use of the clinical and social services assessment skills available in the Trust.

Source: Wales Audit Office

Case Study F: Good practice in discharge planning and management at Bro Morgannwg NHS Trust

The Trust has a real time computer system which it uses to track patients. In April 2005 the system was expanded to include monitoring of expected dates of discharge (EDD). All admissions expected to have an EDD within 24 hours, and nurses are responsible for inputting this. Every patient in the trust is then colour-coded:

Black = exceeded EDD;

Red = leaving to day;

Amber = leaving tomorrow;

Green = leaving in two days; or

Blue = leaving in more than two days.

The Trust holds separate weekly meetings in its two main district general hospital sites in Neath Port Talbot and Bridgend to go through lists of potential and actual delayed transfers of care with cases colour coded according to three priority levels. Discharge Liaison Nurses play a key role in providing information and driving the meetings. There are more problems at present in Neath Port Talbot than in Bridgend (which cares for some patients resident in the Vale of Glamorgan). There is practically no spare nursing home capacity in Neath Port Talbot.

The Trust recently decided to set up a specific ward as the multi-disciplinary team assessment ward with 12 beds. This has enabled multi-disciplinary team expertise to be concentrated. Although this is a recent departure, Trust staff told us that the early signs are good.

Source: Wales Audit Office

2.44 Across all of the local authority areas we found variability in the presence of hospital-based social workers on the ward. Among hospital staff, there was a clear view that the consistent presence of a named social worker within the hospital environment was an enabler of more effective discharge planning and management.

2.45 The National Leadership and Innovation Agency for Healthcare has recommended as good practice the establishment on admission of an estimated date of discharge for patients. In our view, this good practice should negate the need for local agreements by enabling the partners to arrange timely assessments that relate to the estimate date of discharge. This should help resolve the current extent of delayed transfers of care because patients are awaiting assessments, with seven people waiting for social care assessments and 65 waiting for health assessments in June 2007, of whom 47 were waiting for a Continuing Healthcare assessment.

2.46 Bro Morgannwg NHS Trust demonstrated good practice in discharge planning and management (Case Study F).

Previous reviews have identified that delayed transfers of care are a symptom of a lack of a systems approach across the NHS and social care

2.47 Previous reviews of health and social care have identified the significance of problems with delayed transfers of care in Wales and the need to address their whole system causes. Both 'A Question of Balance' (2002) and the 'Review of Health and Social Care in Wales' (2003) highlighted the need for immediate action to reduce the level of delayed transfers of care, which they attributed to imbalances in the whole system of health and social care (Box 3). The Assembly Government reflected these points in its 10-year strategies for health and social care, 'Designed for Life' and 'Fulfilled Lives, Supportive Communities'.

Box 3: 'A Question of Balance' highlighted the need for more effective whole systems working across health and social care

'This report has demonstrated that hospital capacity is affected by capacity in all other key sectors. Capacity issues can only be understood, capacity fully utilised and adequately planned through a whole systems approach.'

Source: 'A Question of Balance', a review of capacity in the health service in Wales, 2002, page 133

2.48 'A Question of Balance' highlighted the impact on acute sector demand and capacity arising from capacity and resources within the social care and independent sectors, and recommended the establishment of a longer-term target to reduce delayed transfers of care to 200 across Wales (a 75 per cent reduction compared with the 2001/2002 average of 806 delayed transfers of care). Between June 2006 and June 2007, the average number of delayed transfers of care was 662, an 18 per cent reduction compared with the figures cited in 'A Question of Balance'.

2.49 The 'Review of Health and Social Care in Wales' highlighted the need to adjust services to focus them on prevention and early intervention, to deliver long-term cost and quality of life gains. The report highlighted that this necessitated service reconfiguration and adjusted roles for social, primary and secondary care. The report stated that there were short-term imperatives to provide services outside hospital by making 'bed equivalents' available and addressing as a priority delayed transfers of care.

2.50 Responding to the 'Review of Health and Social Care in Wales', the Assembly Government's ten year strategy to deliver world class health and social care services, Designed for Life, identified targets and milestones to reduce delayed transfers of care.

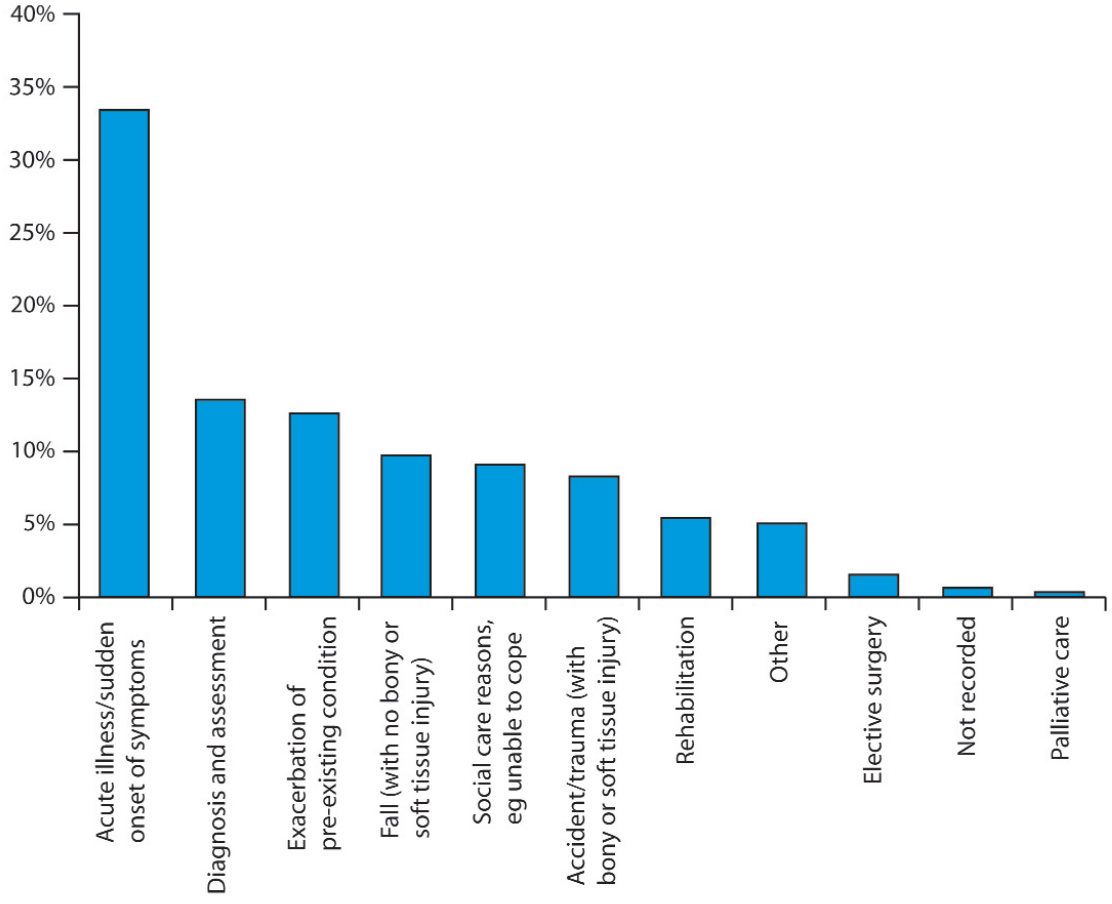
There is evidence of a culture that promotes institutional care rather than people's independence

2.51 Trust staff told us during interviews that they acknowledge that unnecessary hospital admission and prolonged lengths of stay are detrimental to patients. They recognised that unnecessary periods of institutional care directly cause a loss of independence, reduced physical capabilities and can contribute to a loss of social/caring networks. Reviews of the management of chronic disease patients in both Trusts found that a significant proportion of patients are admitted for aspects of care that could be provided in the community[10]. Our work on chronic disease management identified the scope to release over 40,000 bed days a year in each of Cardiff and Vale and Gwent Healthcare NHS Trusts through the more effective management of chronic conditions in the community.

2.52 Our survey of inpatients who were delayed transfers of care in the Trust on 16 May 2007 also suggested a culture where people default to institutional settings where they face a significant risk of becoming a delayed transfer of care. In both Cardiff and Vale and Gwent Healthcare NHS Trusts, Discharge Liaison Nurses and ward nursing staff completing our survey told us that around 80 per cent of people who were a delayed transfer of care would be unable to return to their previous

10 Wales Audit Office, 'Chronic Disease Management Review', Gwent Healthcare NHS Trust, April 2007 and 'Chronic Disease Management Review', Cardiff and Vale NHS Trust, July 2007.

Figure 13: The main reasons for the admission of people who became delayed transfers of care



Source: Wales Audit Office inpatient census of delayed transfers of care, 16 May 2007

living arrangements, which in half of Gwent cases, and one third of Cardiff and Vale cases, involved living alone. This may reflect a prevailing clinical culture which is predicated on institutional care for vulnerable elderly people, but may also reflect the likely care pathway for those who become a delayed transfer of care within the Trusts. Such perceptions, and the prevailing culture they suggest, may also influence the way care is managed for vulnerable older people who do not actually become a delayed transfer of care. We did not ask nurses to speculate on whether patients would have been able to return to their previous living arrangements had they not experienced a delayed transfer of care.

2.53 Our inpatient census also asked the nurses to state the primary cause of admission to hospital for patients who had become delayed transfers of care (Figure 13). Our breakdown of the information on admissions from the inpatient census shows that:

- 33 per cent of patients were admitted because of an acute illness or the sudden onset of symptoms;

- 31 per cent of delayed transfers of care were admitted via accident and emergency, which rose to 48 per cent in Gwent Healthcare NHS Trust;
- in 10 per cent of cases, delayed transfers of care were admitted because of falls; and
- significantly, nurses told us that in Gwent, 14.5 per cent of people whose transfer of care had been delayed were admitted primarily because of social reasons, such as being unable to cope, compared with 5 per cent in Cardiff and Vale.

2.54 This once again suggests that some vulnerable people in need can go into hospital as a place of safety to meet social needs rather than for any specific clinical interventions. With an average duration of a delayed transfer of care in 2006/2007 of 55 days in Gwent and 82 days in Cardiff and Vale, this can lead to a significant risk of loss of independence and function and, ultimately, heavier demand for care from the Welsh public service.

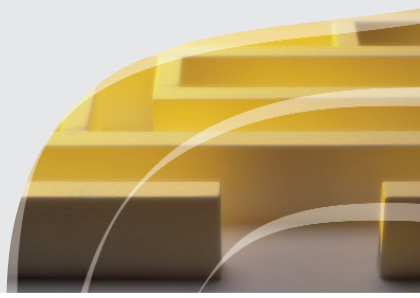
2.55 Our inpatient census also suggested that nursing staff did not have sufficient information available to them about the social circumstances of delayed transfers of care prior to their admission to hospital. Our census survey asked for a range of information about patients' social circumstances. For example in Gwent:

- in 25 per cent of cases, nurses completing our survey did not know or did not respond to a question asking whether patients had a social worker prior to their admission; and
- we asked a series of questions about support and services accessed by patients prior to their admission – for the majority of these cases, more nurses did not know whether such support had been in place prior to admission than those who did.

2.56 In Cardiff and Vale NHS Trust our survey showed that:

- for 66 per cent of the mental health delayed transfers of care, the nurses did not know whether a Community Psychiatric Nurse had previously been involved;
- for 44 per cent of general patients the nurses did not know whether they had previously received home care support, and;
- for 37 per cent of rehabilitation patients the nurses did not know whether they were being supported by family, carers or neighbours before their admission.

2.57 Our analysis of social services case files showed that, in almost all cases of delayed transfers of care, the proposed service to which the patient would be transferred was to some form of residential care. Although the case file analysis suggested that elements of good intermediate care existed, services that exist were generally not yet part of the mainstream of options for vulnerable people.



There is a fragmented approach to meeting local needs through intermediate care services which could be more effective if rationalised appropriately across health and social care communities

2.58 One of the key components of an effective whole systems approach to promoting the independence of vulnerable people is to establish intermediate care services, both to prevent admission to hospital and support people before their symptoms become so acute as to require a hospital admission, and to help rehabilitate or reable patients once they have left hospital. Such intermediate care services are typically jointly provided, involving the NHS, social care services and sometimes the voluntary sector. They usually last for up to six weeks.

2.59 Welsh health and social care communities have set up intermediate care schemes, initially using so-called 'Wanless money' made available by the Assembly Government to support the development of schemes consistent with the 'Review of Health and Social Care in Wales' led by Sir Derek Wanless. For example, individual localities within Gwent and Cardiff and the Vale had their own Rapid Response Teams and Reablement Services. Although these services were designed to meet local needs, we identified clear scope to join them up to provide a more seamless service. The amount of 'Wanless money' made available to each LHB varied and is reflected in the extent of services available within each locality.

2.60 One consequence of this pattern of services is that the availability and nature of services which can promote the independence of vulnerable people is not well known within the whole system. For example, we found evidence that GPs were not aware of all of the schemes that were available to prevent admission or to provide intensive interventions to support patients in regaining their independence after discharge. The variable GP referral rates to the Prevention of Admission to Hospital Scheme (PATH) scheme in Newport (Case Study M) reflect the scope for better GP engagement in the system.

2.61 We also found that many of the intermediate care schemes are run in isolation within particular localities and are poorly integrated across the whole health and social care community. This problem is particularly acute in Gwent where the Trust deals with the five constituent localities and Powys LHB. Within each locality, steps are being taken to bring small-scale services together into a more integrated structure, for example:

- in Blaenau Gwent the Rapid Response and Reablement teams are being co-located, although still separately managed;
- in Newport, the Rapid Response, Reablement and Long-Term Conditions teams are co-located; the LHB has also run a case management pilot within its Long Term Conditions Team whose first six months suggest a significant reduction in admissions to hospital and lengths of stay within target patient groups;
- in Torfaen there are plans to co-locate the Advanced Clinical Assessment Team (Case Study G), Reablement and Long-Term Conditions teams;

Case Study G: Intermediate care schemes

Canllaw in Carmarthenshire
Carmarthenshire County Council, the Trust and Carmarthenshire LHB have set up a partnership to provide an intermediate care service across the county, which is called 'Canllaw' – Community Intermediate Care Service. Set up in 2002 using 'Wanless' funding, the service provides an intensive rehabilitation service for up to six weeks through multi-disciplinary teams set up in six locations across the county.

At the end of the six week period the team either discharges the service user if there are no further care needs or hands their care over to existing services, such as domiciliary care. Three months following the rehabilitation period, the team reviews the person's progress and then carries out a final review before final discharge six months after rehabilitation.

The scheme had a budget of £1.5 million in 2005/2006 and helped 134 people avoid admission to hospital. The scheme had wider impacts, supporting the earlier discharge of 104 people from hospital, and reducing demand for domiciliary care services which yielded an estimated saving to the council of £1.4 million in 2005/2006.

Source: Cannlaw: Progress and Evaluation Report 2006, Huw Dylan Owen

Provision of 'Step Down' Service within Sheltered Accommodation Scheme in Carmarthenshire

Utilising Council sheltered housing voids, 10 ground floor placements have been approved by the Local Authority to support delayed transfers of care, with the initial unit being commissioned in May 2007 supported by the Carmarthenshire Community Reablement Intermediate Care Team (Canllaw). These Units will be used for "step up and step down" placements for up to 12 weeks' duration whilst intermediate care services are provided.

The Scheme would provide enabling care and support for an assessed user on transfer from hospital for a period of up to three months. The initiative is intended to assist the person to establish or re-establish a level of confidence and independence prior to returning to their permanent home. Social Services and the Trust would work jointly to achieve this objective.
The rehabilitation period would be reviewed on a specific "needs" basis.

The Primary Care Team based within the area will also provide support, while Canllaw and/or Social Services Home Care Service will provide the therapy-backed rehabilitation care and support to enable the users of the facility to be transferred from hospital. The teams will work with the person using the scheme, over the three month period before they return home. Carers will be offered the opportunity to be involved in the rehabilitation programme. There will also be support from the British Red Cross in the initial stages as part of their Hospital Homecoming Scheme.

Carmarthenshire County Council will provide a Telecare monitoring service for this project. This will include access via a 24 hour response service accessed through the Careline system. This response, using agreed protocols, will provide reassurance and support and act as the communication link between all agencies. New technology will allow the scheme participants to have 24 hour cover without having to call on the services of the sheltered accommodation staff in emergencies.

A multi-agency team will be set up to trawl the patient population in Llanelli to identify suitable users. The team will undertake an assessment prior to acceptance on to the scheme and will agree the expected outcomes for that person, the user and carer being part of the decision-making process. A written agreement will form part of the documented care plan for all parties involved. Staff at the sheltered scheme will be given the care plan a minimum of three days prior to admission to the scheme.

The operational team will meet weekly to identify, discuss and solve operational issues. In addition, there is a "discharge planning" element to that group, linked to the individual user's care needs.

In terms of evaluation, this service will be monitored against a number of set criteria.

Source: Carmarthenshire Council/LHB

Intermediate care consultants in Gwent

Gwent Healthcare NHS Trust has employed a Consultant Physician for Intermediate Care in Torfaen and is has recently appointed a Consultant Geriatrician (Intermediate Care) in Newport. In addition there is a jointly appointed intermediate care co-ordinator in Torfaen

The Consultant Physician for Intermediate Care in Torfaen is leading the locality's Advanced Clinical Assessment Team (ACAT) which consists of three specialist nurses who rapidly respond to GP and nursing home referrals with the aim of avoiding hospital admission. The consultant has also been involved in engaging Torfaen GPs with the alternatives to hospital admission and another role has been in the involvement with the locality's Intermediate Care Steering Group.

Newport LHB has funded a post for an intermediate care consultant whose role focuses on admission avoidance by providing hot clinics, supporting members of the intermediate care team and undertaking patient reviews in the community.

Torfaen's Intermediate Care Co-ordinator was jointly appointed with the aim of ensuring a consistent approach to developing, monitoring and benchmarking intermediate care services. The co-ordinator was also recruited to work closely with front line health and social care managers to promote the intermediate care philosophy.

Other LHBs in Gwent have sought to recruit intermediate care consultants but have been unable to do so because they are in such short supply.

Source: Wales Audit Office

- in Caerphilly, a community case management model is under consideration to help to integrate a range of services by providing a single point of contact; and
- in Monmouthshire there are two services provided through 'Section 33' agreements, where health and social care services are provided from a single location.

2.62 We found that there was insufficient capacity or poor utilisation of some intermediate care options that were available in Gwent. For example, Blaenau Gwent had three intermediate care beds in an independent home to which GPs had access but between April 2006 and March 2007 there were only 26 admissions. There were no referrals from the Rapid Response Team, even though these people could not have been supported at the home, leading to emergency admissions to hospital beds. The LHB is likely to withdraw the beds because they are not cost effective at this level of utilisation.

2.63 We found little effective evaluation, including robust financial assessment of services, of the intermediate care schemes that have been set up in Cardiff and Vale and Gwent. Officials also told us of concerns they had about the value for money of some intermediate care services. The lack of evaluation has resulted in a situation where effective models or services have rarely extended beyond borough boundaries. The schemes are poorly linked with some duplication, for example similar services being provided in the same locality both by the Trust and LHB and with scope for greater joint working to reduce running costs and increase the impact of effective schemes. Generally this situation means that the cost of services is higher, and learning has not been shared sufficiently at the level of the whole health and social care community to develop a common understanding of intermediate care services and to integrate the range of local schemes with community services provided by the respective Trusts. In Gwent, partners are working with NLIAH to pilot an evaluation tool to address weaknesses in evaluation.

2.64 Some of the intermediate care schemes have achieved positive impacts locally: a key challenge for the Assembly Government and local partners will be to ensure that the learning and good practice is disseminated to develop intermediate care services further. There are a number of intermediate care schemes which have been successful and in a number of localities there is a strong focus on the development of intermediate care services. Both Newport and Torfaen LHBs have established intermediate care consultants and Torfaen has a jointly appointed intermediate care co-ordinator but these roles apply only to residents of the particular locality. Case Study G provides details of some of the intermediate care schemes.

2.65 There is an inconsistent approach to intermediate care services across whole health and social care communities which can lead to some fragmentation in the pattern of services and some evidence of duplication. The public, patients and staff within trusts face a potentially confusing situation because of the local variations in service provision.

2.66 For example in Gwent the five LHBs have individual directories of intermediate care services, and sometimes attach similar labels to different types of service with varied models and descriptions of services across the community. This problem is recognised within the community, and in Newport City Council work has commenced to develop a common hierarchy of need and dependency in the community 'to maximise individual potential and minimise the progression to dependency'. If this emerging model proves effective, it could form the basis for developing a broader model across the whole Gwent community to provide a consistent framework within which local service development could take place.

Even within the constraints of the existing system, organisations can work more effectively to promote the independence of vulnerable people

Co-ordinating action beyond borough boundaries can deliver more effective improvement

2.67 One of the main findings of our local work in specific health and social care communities reflected the need where appropriate for more effective co-ordination of action at a whole community level – centred on the main NHS Trust – as well as at locality (LHB and local authority) level. This was a particular issue in Gwent where good practice at locality level had not been effectively joined up across the whole community which led to some duplication and fragmentation. In Cardiff and Vale there was also some evidence that more co-ordination of action across locality boundaries could make the existing system function more effectively and reduce the reliance on single-organisation or locality solutions to what are common problems across the areas served by the Trust. Local Service Boards and forums to deliver regional reconfiguration plans arising from 'Designed for Life' – 'Clinical Futures' and the 'Programme for Health Service Improvement' - provide opportunities to provide a clear lead to develop common solutions.

Commissioning could better promote the independence of vulnerable people

By commissioning more effective preventative services to reduce demand on the acute sector

2.68 Commissioning of health, social care and intermediate care services is a key driver of the whole system. The Assembly Government included integrated joint commissioning of services for older people, by local authorities and LHBs, as a central component of its National Service Framework for Older People. The National Service Framework includes targets for health and social care communities to:

- develop by the end of March 2007 local commissioning strategies that include a joint strategic plan for the delivery and evaluation of intermediate care services, based on a whole systems analysis of local need; and
- develop by March 2007 joint service and commissioning plans for the integrated care of older people which would inform the local Health, Social Care and Wellbeing Strategies.

2.69 While communities are developing strategies to undertake more effective joint commissioning of services to meet the needs of vulnerable older people, we found that commissioning generally remained under-developed and that it was compromised by the poor quality of management information and a reliance on spot purchasing. By their nature, delayed transfers of care indicate weaknesses in commissioning because the delayed transfers signify that the services people need are not available at the appropriate time.

2.70 Our focus groups identified weaknesses in terms of the assessment of need to inform commissioning. This identified weaknesses in collecting information to predict need and identify unmet needs to inform the commissioning agenda. Needs assessment should be the foundation on which services are commissioned and developed. The needs assessment process should build on detailed knowledge of the needs of resident populations at the level of individual GP practices both to facilitate screening of vulnerable older people at risk of hospital admission but also to predict needs and develop services accordingly.

2.71 Rebalancing the health and social care system, consistent with the findings of 'A Question of Balance' and the 'Review of Health and Social Care in Wales', relies on effective commissioning of services to meet identified needs. This will often require local authority and LHB commissioners to work together to secure services that provide community-based alternatives to hospital admission and which are effective in promoting people's independence in order to avoid admission to hospital.

2.72 Our recent work on chronic disease management supported the findings of this project that there were insufficient preventative services to avoid admission to hospital. While there are examples of good practice in both of the communities involved in this project, there remains considerable scope to develop a wider range of alternative services in the community to avoid admission to hospital.

Box 4: Defining extra care housing

Extra care housing, very sheltered housing and a range of other terms are often used interchangeably to describe a type of housing, care and support that falls somewhere between traditional sheltered housing and residential care.

Extra care housing offers an environment in which care and support is close at hand, but where an independent lifestyle can be retained as far as possible. It includes housing that offers self-contained accommodation for rent, equity share or outright sale, together with communal facilities, and where care, as well as support services, is available from a team based on site.

While the primary purpose of residential care is to provide care and support within safe and secure accommodation the primary purpose of extra care housing is to provide easy to manage accommodation that supports residents' independence. Care and support are available on site but residents have the option of purchasing services either directly from the extra care provider or from elsewhere should they wish.

Extra care housing can be seen to offer an alternative to residential care and play a useful role providing respite care, together with a base for good intermediate and rehabilitative care. Most importantly it has the flexibility to provide added health gains and reduce pressures on acute services, such as tackling delayed transfers of care from hospital.

Extra care can be a major contributor to local authorities' 'preventative strategy', enabling residents to sustain high levels of independence. Most extra care housing schemes include residents with a range of dependencies.

In the UK in the early 1990s extra care housing began to attract attention as the public agenda began to recognise and plan for the needs of an increasing older population. Whilst extra care housing can vary in design and service delivery, it is now generally agreed that good extra care housing is as much to do with its philosophy as to do with bricks and mortar. The philosophy is one of independence, enablement and choice. Residents are encouraged to do things for themselves and other residents and staff are trained to assist rather than 'do for'.

Source: Welsh Assembly Government, Guidelines for developing extra care housing in Wales, April 2006

2.73 Housing is an important element of the more effective promotion of the independence of vulnerable older people. The Welsh Local Government Association (WLGA) has stressed the need for more joined up policy, provision and resources for health, social services and housing at local, regional and national level[11]. One mechanism is extra care housing (Box 4), which is commissioned by local authorities and provides housing services, usually with mixed tenure, for older people so that the domiciliary care they need can be provided at the same site, in accordance with an agreed care plan. There is 24/7 cover as back-up along with the scope to use assistive technology to monitor and support people and Telecare at the site to support vulnerable older people more effectively. The Assembly Government invited local authorities to bid for grants to develop extra care housing provision in 2006/2007 and a number of schemes are now progressing. Commissioning extra care schemes involves a long lead time such that schemes offer a medium term solution.

2.74 Schemes that take account of people's need for housing alongside the provision of health and social care services can be very effective as a strategic alternative to residential home provision (Case Study H).

2.75 The benefits of commissioning services to provide alternatives to hospital admission are obvious in terms of patient care but there are also potentially significant financial benefits for the system. For example, one scheme in Newport that provides early intervention and intensive support to maintain people at home to avoid admission to hospital cost £886 for each admission it prevented (Case Study A), which compares with an indicative cost of

11 WLGA Housing Policy Statement, May 2007, page 13

Case Study H: Housing is an important factor in taking a whole systems approach

Newport City Council has adopted a strategy of reducing residential homes and increasing extra care housing, of which it has four units of forty beds and another due to open. It has offered 'extra care' at Aneurin Bevan Court since 1986, developed two further schemes managed with Housing Associations and a new scheme, Capel Court, is due to open in Summer 2007 which will include provision for people with dementia. Our review has not established the impact these schemes are having on delayed transfers of care and maintaining independence and this may be a focus for further work.

Source: Wales Audit Office fieldwork

Extra care housing in Carmarthenshire

Plasymor unit in Burry Port opened in July 2004 as an Extra Care facility which replaced a Local Authority Residential Home. There is also a 15-place day centre attached to the unit (utilisation within the day centre is not as good as would be expected and it is being evaluated). The whole unit is jointly supported through housing and the Supporting People Grant – with the original capital funding for the unit being awarded through the Social Housing Grant from the Assembly Government.

The facility has 38 units in total with 20 Extra Care flats and 18 sheltered housing flats. Individuals access these flats through the normal housing allocation procedure.

A similar unit is being built in the North West of the county, to ultimately replace a local authority Residential Home, with 14 of the 40 planned units intended for patients with dementia. There are also plans for Extra Care Units in Ammanford and Carmarthen which will see the planned closure of four more Local Authority Residential Homes, while the development of a further Extra Care unit in Llanelli is also a consideration.

All these developments form part of the county's Accommodation Strategy.

The redevelopment of a home in Llanelli is about to be commissioned with specific provision for Integrated Beds in Rehabilitation, Respite and Convalescence.

Source: Wales Audit Office

£248 per day in a Gwent Healthcare NHS Trust bed. The average duration of a delayed transfer of care in Gwent was 55 days in 2006/2007, over and above the average length of stay prior to becoming a delayed transfer of care, which would cost £13,640 per delayed transfer of care.

By collecting the service and financial information needed to support joint commissioning

2.76 Effective commissioning is further compromised by the lack of good quality service and financial information, particularly in relation to intermediate care services. There is not a common model of intermediate care services, with the same name describing very different type of service in the various localities, and no common currency within which to commission and monitor service provision and outcomes.

2.77 Intermediate care schemes were often set up using additional funds provided by the Assembly Government to meet the 'Wanless' agenda, which has led to disparate schemes that were set up quickly to address perceived problems with the operation of the whole system in accordance with local strategies. These tended to be localised solutions to address symptoms rather than integrated steps across a whole community to develop an effective whole system according to a clear and shared vision of what services should look like. We found that financial and service information about such services was

Case Study I: Taking a strategic approach to the development of capacity in Cardiff and Monmouthshire

Cardiff County Council has drafted a comprehensive accommodation strategy which includes an analysis of the needs and preferences of Cardiff residents. The Council recognises the need to become better aware of the market and to understand the position of providers.

Monmouthshire County Council has completed a review of EMI capacity over the next 10 years in an attempt to understand the scale and nature of the current situation where there is generally no EMI capacity available within the county. Further planned developments within Monmouthshire should ensure that the medium-term capacity challenge is met.

Source: Wales Audit Office and PricewaterhouseCoopers fieldwork

weak, which meant that there had been little effective evaluation, including a robust financial analysis. Consequently, effective schemes had not been transferred beyond borough boundaries, while schemes that had not been cost-effective had sometimes continued to operate.

2.78 Another key barrier to more effective commissioning was the poor quality of information about community-based services and intermediate care. Long-Term Agreements between LHBs and Trusts did not specify clearly the type and volume of community services to be provided or their intended outcomes. This makes it difficult to monitor services but also compromises the ability of LHBs to demonstrate the potential impact of new models of services by moving resources to community-based services. There is little evidence that commissioning is currently focused on outcomes which is another barrier to more effective whole systems working. The focus is on inputs, which encourages provider Trusts to regard the Long-Term Agreement as 'their' funding rather than an input provided to deliver specific outcomes for patients. The lack of good quality information about financial flows makes it difficult for commissioners to develop robust business cases for new services and also to make decisions about the future configuration of services to promote the independence of vulnerable older people. In the absence of transitional or pump-prime funding, and in the context of significant financial pressures on some organisations, it can be very difficult to develop alternative models of service and release efficiency gains as it is impractical to move immediately from one service model to another without a period of transition.

By minimising the use of spot purchasing of care home capacity and engaging with the independent and voluntary sectors

2.79 In the areas covered by our review we found that local authority commissioners tend to rely on spot purchasing of care home capacity which increases costs and uncertainty of supply. The extent of delayed transfers of care arising from patient choice suggests that block purchasing capacity would not lead to places remaining empty. There is also a perception that some owners are reluctant to enter into block contracts as this reduces the chances of the local authority paying a rate above their standard fee, and because it enables them to protect placements for self-funders who pay higher fees. Variable fee levels between local authorities can lead to out-of-county placements when owners sell places to the local authority which will pay the highest rate. Some authorities have produced detailed strategies for independent sector capacity development (Case Study I).

Case Study J: Suggestions made by Care Forum Wales to improve their engagement in the commissioning process

- unified contracts between councils and LHBs, with a review of contractual arrangements;
- reduce volatility in demand, for example reductions in demand at the end of the financial year;
- remove the need for owners to charge top-up fees from families and councils, using the Laing and Buisson toolkit, commissioned by the WLGA using an Assembly Government grant, to identify what providers consider a fair fee level;
- involve homes in unified assessments and share the results with owners;
- make it easier for home owners to bring in physiotherapy services after someone has been discharged from hospital to assist reablement;
- involve homes more in the workforce development strategy and training by building on the good practice that exists in some areas;
- it should be faster and easier for home owners to change registration categories;
- commissioners should share best practice more effectively and develop strategies to support homes experiencing difficulties;
- statutory bodies should improve communication and strategic planning with the independent sector, through the establishment of local Independent Sector Providers' Forums, which forms part of the Assembly Government's strategy, 'Fulfilled Lives, Supportive Communities'; and
- Councils, LHBs and CSSIW should be more consistent in dealing with the independent sector.

Source: Wales Audit Office fieldwork

2.80 For example in Gwent, we found that delayed transfers of care often arose as a result of care home places being unavailable, or through a lack of funding for them. In the last 12 months a lack of funding for nursing or residential home placements has been a particular driver of the incidence of delayed transfers of care in Caerphilly and Torfaen. In Newport, the lack of availability of a suitable social care placement has been the main cause of delayed transfers of care between May 2006 and May 2007. The extent of delayed transfers of care for reasons of choice may mask shortfalls in available funding – local authorities may not be able to fund the placements that would be required if there were no delayed transfers of care arising from choice of home.

2.81 Exacerbating the current position, a number of areas face potentially significant loss of independent sector capacity as a result of inspections and possible closures as well as owners opting to leave the care home market. Commissioners face a challenging agenda to manage the independent sector market, through block contracts as well as spot purchasing, to ensure adequacy and security of supply. Independent sector providers told us that they wanted to be more effectively engaged in the commissioning process so that their knowledge and the potential to develop the services they provided was an integral part of the commissioning process (Case Study J sets out the suggestions for improved engagement with the independent sector made by Care Forum Wales).

Case Study K: The voluntary sector can provide low level interventions which promote independence effectively

Staff in the voluntary sector and the Community Health Councils told us that many older people are vulnerable to hospital admission both as a result of physical risks; 'slips, trips and falls', and through social isolation. We were also told of the benefits in supporting carers.

Voluntary agencies are working to reduce these risks and to promote independence when these services are commissioned.

Some examples of these services we heard about were:

1. Reducing physical risks

- the Safe Slippers campaign. The Safe Slippers service is provided by the Red Cross in parts of West Wales but is not available in Cardiff and the Vale of Glamorgan or Gwent where our inpatient census showed that 10 per cent of patients who became a delayed transfer of care had been admitted primarily as a result of a fall. Safe slippers campaigns visit older people who have been admitted to hospital after a fall and are offered a safe pair of slippers which are secured with a Velcro fastening and have a non-slip sole. An assessment is made of any other household risks, such as rugs and other community equipment needs.
- Manual handling training. Newport City Borough Council is providing manual handling training for carers which has helped reduce the number of falls and in maintaining the health of carers.
- Community equipment. The Red Cross loans a wide range of non-electrical equipment to people in the Gwent and Cardiff and Vale of Glamorgan areas. After a telephone assessment, the equipment is delivered to the person's home in a few days, subject to availability. There have been over 1,000 requests for equipment in the six months before this review. 831 of these requests were health-related with 219 requests for people in hospital. The Red Cross has evidence of assisting with 79 discharges from hospital during this time. If the cost-saving of three days of hospital care is used, the Red Cross estimates that the earlier discharge from hospital assisted by their equipment would have saved £94,000 in Gwent. There are statements from people who have used this service on the importance of community equipment in helping them return home.

2. Reducing Social Isolation

Gwent Association of Voluntary Organisations is involved in supporting a range of community-based activities which help people to be socially involved and to reduce the need for hospital admissions by promoting healthy lifestyles. For example, Mr W is aged 55 and broken his leg in three places. He was provided with a wheelchair and a leg extension which enabled him to move safely around the house and to go out.

3. Proactive support for carers

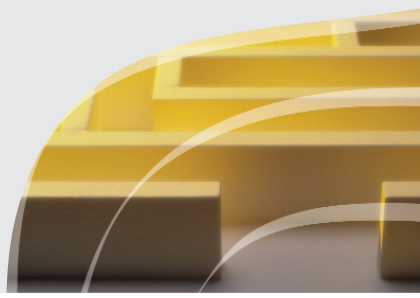
Effective support for carers can help them to continue coping. This can be through a variety of ways, such as a carers' centre and self-help group, provision of advice on available services and respite care.

4. Night time support services

If a night-time support service is available at a time of crisis, it can reduce the need for hospital admission, for example night-time service/night sitter. The voluntary sector often provides such services.

Source: Wales Audit Office

2.82 There is a similar need to engage more effectively with voluntary sector providers, many of whom can provide low-level services and interventions which can have a significant impact in promoting the independence of vulnerable people (Case Study K). The voluntary sector is often able to provide useful intelligence about the needs of older people and gaps in services which could be used to inform the needs assessment and commissioning processes.



2.83 Commissioning of care home capacity is not as well informed about quality as it could be. Care home quality is a very difficult issue – although a home may meet all of the statutory requirements of inspectors, there may be other qualities that affect care and people's choices about where they wish to be placed, such as the location of a home, attitude of its staff and availability of therapy and other services. We found evidence that those working within the whole system, whether in health, social care or the voluntary sector, had knowledge of the views of patients and carers about the quality of care offered by particular homes. This intelligence about perceived or actual shortfalls in the quality of care, which contributed to delayed transfers of care arising from choice, was not consistently fed back to local authority and LHB commissioning teams, nor to the Care and Social Services Inspectorate for Wales, to inform future commissioning and inspection. Caerphilly LHB has appointed two nurses to support care homes in improving quality in line with the Assembly Government guidance, Fundamentals of Care, although it is too soon to assess their impact. Cardiff LHB and Vale of Glamorgan LHB both employ a team of nurse assessors who review patient placements and provide input into the LHBs' commissioning of long-term healthcare. And in Newport the LHB and Council have introduced a system of joint working to assess, monitor and report in a standardised way about quality issues in nursing homes. It has also established a matrons' forum to facilitate the sharing of best practice across homes and the development of a targeted training programme to address skills and knowledge gaps in a consistent fashion.

2.84 Similarly, we found little evidence that the inspection regime, which registers homes, provides targeted interventions to support homes at risk of closure because of problems with quality. For example, systems of peer support for home owners could be established, co-ordinated by CSSIW or the Care Forum Wales, to link knowledge, experience and systems with a view to improving the quality of care and home management to reduce the risk of any further loss of capacity within the overall system. The inspection regime in Wales also operates more stringent requirements about the need for separate EMI and general provision than exists in England, which may act as a barrier to enabling sufficient supply to meet demand.

2.85 The Assembly Government's Clinical Governance Support and Development Unit undertook a survey in July 2006 about commissioning of care home services providing NHS-funded Continuing Healthcare or funded nursing care and the clinical governance implications of concerns about service quality[12]. This report identified inconsistent contracting relationships, style of contract documentation and level of joint working between local authorities and LHBs. It also highlighted the fact that many contracts and service specifications were not based on explicit standards. The review suggested the development of core standards-based service specifications for care homes covering both health and social care, better information sharing and clearer arrangements for contract monitoring and escalation procedures. The review also highlighted joint approaches being developed within Cardiff and Vale and Gwent, with Torfaen LHB operating as an agent for the other four Gwent LHBs in developing a single contract with each nursing home in the area whether the individual is self-funding or funded jointly with the local authority.

12 Clinical Governance Support and Development Unit, Improving quality assurance and clinical governance in care homes

By developing joint commissioning arrangements and linking the needs identified in updated Health, Social Care and Wellbeing Strategies

2.86 Even when acute services have been decommissioned, we found little evidence that LHBs have easily been able to transfer resources from acute settings into new community-based services in line with 'Designed for Life'. LHBs clearly experience difficulties in reinvesting funds currently funding hospital-based services. The LHBs are much smaller organisations than the Trusts and the commissioning relationship between them is insufficiently mature to enable resources easily to be switched. These health and social care communities have a significant opportunity to improve their whole systems approach to commissioning services to promote the needs of vulnerable people and therefore to reduce delayed transfers of care through the review of Health, Social Care and Wellbeing Strategies by 2008.

2.87 The weaknesses in current commissioning are complicated by the existence of multiple LHBs for each Trust, which the Assembly Government is seeking to address by establishing three Regional Commissioning Units to commission secondary care services on behalf of regional groups of LHBs. These Regional Commissioning Units will work at a regional level and the Assembly Government has set cancer services as an immediate priority but the Regional Commissioning Units can set other local priorities and also have the flexibility to undertake commissioning at sub-regional levels, which could enable them to focus commissioning around a Trust and its constituent LHBs.

2.88 Health and social care partners are reviewing their Health, Social Care and Wellbeing Strategies for 2008. This provides a major opportunity to assess local needs more robustly but also to draw out common needs between the Health, Social Care and Wellbeing strategies in each community and, where appropriate, to develop joint approaches between localities or across a whole community. The review of the strategies, allied to good practice beyond identified within this project, provides a further opportunity for the Health, Social Care and Wellbeing strategy review to embed good practice and develop common solutions to meet common needs.

2.89 The Assembly Government has recognised the need to develop a commissioning framework to deliver improvements in integrating primary, community, intermediate and social care. By the end of the 2007/2008 financial year LHBs need to have developed with their partners a Community Partnership Agreement, which represents a substantial opportunity to improve joint commissioning[13].

2.90 Most localities have begun to develop joint commissioning approaches which vary in their extent and depth, and whose recent establishment makes evaluation difficult. Joint commissioning of services has the potential to develop integrated care pathways and shape a more seamless experience for the citizen where the boundaries between organisations providing or commissioning services do not affect their experience. For example, in Gwent and Carmarthenshire there are a range of approaches which include the LHBs and local authorities operating joint commissioning posts and approaches between the LHB and local authority (Case Study L). Some of these examples are very recent developments and

13 WHC (2007) 023, NHS Commissioning Guidance

Case Study L: Joint commissioning approaches are emerging

Caerphilly – working relationships between the LHB and local authority are close. This is demonstrated by frequent high level meetings and by the Director of Social Services sitting on the LHB board and management team. An example of formal joint commissioning in Caerphilly is the planned development of the North Resource Centre. This joint health and social care centre will house intermediate care beds, integrated health and social care staff, a mental health team, district nursing and a social work team. It is due to be operational by 2010. The project is currently experiencing difficulties securing funding because of complications with funding streams for jointly commissioned services.

Monmouthshire – the County Council and LHB have developed a joint commissioning structure with a jointly appointed individual acting as LHB Director of Commissioning and Head of Commissioning in the local authority's social services department. There are joint reports on commissioning issues, and there has been an EMI demand review which led to the production of capacity and demand data for independent care home owners with a view to encouraging further investment in capacity. The joint commissioning structure involves the use of a care package broker who liaises with the hospital discharge social worker and care providers in the area to secure the most appropriate placement or service for people being discharged from hospital. The brokerage system has been operational for just under two years. 70 per cent of domiciliary care placements are referred from hospital discharge. The scheme has been extremely successful, making satisfactory placements in over 85 per cent of cases within the planned timescale (mostly on the same day). The broker uses delayed transfers of care as one of her major drivers and on the occasions when she cannot prevent a delayed transfer of care will circulate all interested parties in an attempt to find a solution. The Council believes this has had an impact on delayed transfers of care, but has been unable to quantify it in terms of a specific reduction in delayed transfers of care.

Torfaen – the Council and LHB partners are moving to a joint strategy that is focused on prevention and independence, and has laid some of the foundations to improve the operation of the whole system. To date, they have established a joint post of Head of Integrated Services (Torfaen County Borough Council) and Director of Planning and Commissioning (Torfaen LHB) and there is planned appointment to a joint post of Intermediate Care Manager. The LHB and local authority are jointly developing an Intermediate Care Strategy and, through an Intermediate Care Co-ordinator employed by the LHB with 'Wanless' funding, and an Intermediate Care Steering Group and Operational Group.

Joint Commissioning Strategy for Older People's Services in Carmarthenshire

Carmarthenshire County Council and Carmarthenshire LHB have had a joint commissioning team since 2004 and will have an integrated commissioning team from October 2007, working under a formal partnership agreement and incorporating all Council, LHB, primary care and contracting commissioning managers. The partners have also agreed a joint commissioning strategy for older people's health, housing and social services. This provides a clearer idea of what type of services are needed to keep pace with the projected increase in the number of older people in Carmarthenshire in the future. This joint commissioning strategy is a three year strategy (2008-2011) which focuses on demand, pressures and services. The joint commissioning director will take the lead on the joint commissioning arrangements.

Source: Wales Audit Office fieldwork

so are difficult to evaluate but the emerging evidence suggests that a joint commissioning approach, supported by sound processes such as the use of brokers or nurse case managers, can help to develop a more strategic and seamless approach to meeting people's needs. Collaboration in commissioning is much less developed in the Cardiff and Vale health and social care community, although plans are in train in both localities to develop stronger joint commissioning. In Carmarthenshire the LHB and local authority have advertised for a joint strategic post but have not yet appointed.

Addressing cultural and workforce issues

2.91 An effective whole systems approach to promoting the independence of vulnerable people and reducing delayed transfers of care needs the people within that system to work effectively together across organisational and

Case study M: Engaging primary care practitioners in patient pathways that promote the independence of vulnerable people

In 2007, Gwent Healthcare NHS Trust started to send LHBs information about patients who have been frequently re-admitted to its hospitals. LHBs have sent this on to GPs - we met one GP who had used this to flag the issue on electronic patient notes to help inform a more proactive approach to their management in primary care.

In Newport GPs are able to refer vulnerable older people to the PATH which is run by Age Concern, rather than referring them to the Trust. There are significant variations in referral rates among GPs in Newport.

Caerphilly LHB introduced its Provider Team in October 2005 intending to work with general practices to set up robust systems for chronic disease management. The Wanless-funded team used information on list sizes, referral rates, Quality and Outcome Framework achievement and other indicators to draw up a list of practices that were most in need of support. The team of GPs, pharmacists, practice nurses, healthcare assistants and administrators works with the practices on the list to ensure they have appropriate processes for managing patients with certain conditions, such as respiratory problems and coronary heart disease. Reviews are carried out of the practice's register of patients with these conditions to ensure it contains all appropriate individuals. The team ensures these patients have been appropriately diagnosed before making sure adequate clinics are developed for the regular monitoring of these patients. The team involves the practice in its work with the intention of the practice carrying on the work once the Provider Team's support has ended. Eight practices have been supported so far and the LHB reports improvements have been secured in terms of quality indicators.

Profiling individuals likely to become delayed if admitted to hospital in Carmarthenshire

An audit tool has been developed (based on an original tool utilised within a Wales Audit Office review) to ensure delays are captured and acted upon in a timely manner and has been used to date within Prince Phillip Hospital and one of the community hospitals. There is a commitment to roll out across all areas.

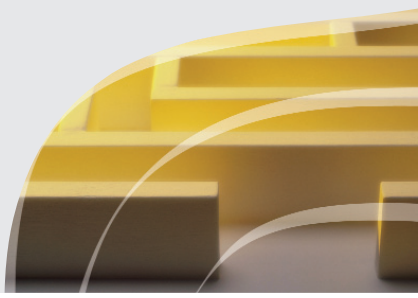
An audit of delays was conducted in 2005/2006 and recently repeated. Analysis of this data has shown it is possible to develop a profile of people likely to become delayed if admitted to hospital. Features include:

- age 75+;
- living alone or with elderly partner;
- admitted with non-specific diagnosis;
- recent history of not coping at home but not receiving care services;
- history of falls, or admission as a result of falling; and
- significant proportion with early dementia.

Based upon the profile developed on people likely to become delayed, further work has been progressed to examine why people received no services prior to admission. One theory is that community based assessment is not capturing those older people who are at the borderline between coping and failing to cope at home. These people are initially identified via an emergency admission to hospital linked to their inability to cope.

A pilot study is now underway within one GP practice to target all practice population for a proactive assessment, involving the local reablement service and primary health care teams. To date the ongoing pilot has identified 33 people who require multi-disciplinary assessment and support of whom nine were considered a high risk of an emergency admission. This pilot will be repeated in Llandeilo in June alongside similar pilots linked to Local Authority Residential Homes in Carmarthen and Llandeilo.

Source: Wales Audit Office fieldwork



sector boundaries. This style of working requires particular skills. We found some very good examples of effective working across boundaries, often driven by individuals' attitude and personal approach, but also identified particular parts of the system where workforce and cultural issues needed to be addressed to improve its effectiveness.

2.92 In particular, we found a significant need to engage GPs and primary care more effectively in the whole system of care for their patients, since primary care practitioners should be the 'glue' that links the different parts of the system together to provide a person-centred approach to promoting the independence of vulnerable people. Despite examples of the effective engagement of primary care practitioners in the system (Case Study M), we found a number of common barriers in the context of delayed transfers of care:

- GPs are not routinely informed that one of their patients have experienced a delayed transfer of care;
- there are opportunities to provide better GP-led services in the community that would serve to avoid the unnecessary admission of vulnerable older patients to hospital, although the new General Medical Services Contract gives LHBs powers to commission local enhanced services which could include those aimed at avoiding unnecessary hospital admissions;
- the inability to share information between primary and secondary care, and between health and social services reduces the scope for GPs to take a holistic approach to the management of their patients in the community;
- GPs often lacked a full awareness of the range and benefits of intermediate care services in their area, which was reflected in significant variations in referral rates to such services;
- LHBs did not routinely monitor rates of referrals to intermediate care services so that they could provide feedback to GPs and seek to market such services more effectively;
- GPs did not generally use their disease registers and information systems to identify vulnerable older people at risk of becoming a delayed transfer of care (using factors such as age, medication, number of conditions and admissions to hospital) with a view to more proactive intervention within primary care and the community to reduce the risk of admission to hospital and becoming a delayed transfer of care; and
- issues about the lack of specialist clinical capacity close to the community and an absence of medically defined care pathways to assist GPs in supporting care pathways that are not based on hospital or residential care settings.

2.93 The local authorities covered by this review have variable approaches to social worker presence on hospital wards. Trust nursing staff generally believed that the consistent presence of a ward-based social worker was very helpful in improving communication and joint working to facilitate vulnerable older people's transfer of care.

2.94 We also identified variable roles for community and district nurses. The NHS Confederation Wales told us that they believed that there are over thirty types of community nurse job descriptions within Wales. We identified 35 district nurse teams within Cardiff and Vale NHS Trust's district nurse service, which the Trust is now changing to create a locality model with a new service specification to support new ways of working. The existing plethora of teams leads to a fragmented approach to care pathways and makes it more difficult to develop a consistent approach to the whole system.

2.95 In both Cardiff and Vale and Gwent Healthcare NHS Trusts, Discharge Liaison Nurses have variable roles which have variable impact, with particular confusion between the Discharge Liaison Nurse role and that of ward managers, who sometimes neglected the basic discharge management function on the ward as they expected the Discharge Liaison Nurses to manage complex cases such as delayed transfers of care. In contrast, the role of the Discharge Liaison Nurses in Bro Morgannwg NHS Trust is regarded as having been pivotal to the effective management of patient flow (Case Study F).

2.96 Within the hospital there is also scope to prioritise the maintenance of mobility and function. From our user focus groups we heard of cases where mobility became impaired due to delays in securing a bed on rehabilitation wards. This was often due to rehabilitation capacity being compromised by patients who were delayed. Both communities have problems with therapist capacity, both employed by trusts and local authorities. One potential solution to problems of therapist capacity is to seek to develop joint health and social care teams so that the patient pathway is smoother and all therapists, for example occupational therapists and physiotherapists, have a better awareness of the whole patient pathway.

2.97 There is also scope to develop the role of community pharmacists in assisting with medication management in the community to reduce the impact of life limiting illnesses with a view to minimising the risk of medication issues causing avoidable admission to hospital. For example, community pharmacy can play a significant role in supporting people in the community with wet eye macular degeneration (blindness) and early-stage dementia. For example, the Monnow Vale facility in Monmouthshire (see Case Study P) which operates under a Section 33 agreement, includes an enhanced role for community pharmacist who undertakes a medicine review with people who attend Monnow Vale, whom they would not normally see in their high street pharmacy.

2.98 Cardiff LHB runs a scheme through which pharmacies prepare medical dispenser packs for vulnerable people and the administration of the medication can be assisted by homecare staff working for or on behalf of social services. Medication is stored safely in the person's home. Community pharmacists can review medication to ensure that only current medication is provided. Although the scheme is relatively new and has not been evaluated, the LHB is confident that it is improving the safe administration of medication.

Improving the availability and use of capacity in some areas

There is a need to address problems of capacity, particularly EMI care homes

2.99 The number of care homes in Wales has fallen in recent years, with a reduction of 34 per cent in the number of residential homes and 17 per cent in nursing homes, a 30 per cent reduction overall. However, the number of places available has reduced by a smaller amount – eight per cent - as a result of a trend whereby homes are becoming larger. This may affect the ability of Councils and LHBs to place people in homes that are close to family and friends.

2.100 We identified some significant capacity problems within the system, particularly care home capacity for the EMI. Many residents of care homes have dementia, and the WLGA estimated in a recent paper that 25 per cent of those over 85 will have dementia[14]. Our focus groups in Cardiff and Vale and Gwent both highlighted the general lack of sufficient capacity for EMI beds, which was reinforced by our fieldwork in the localities. CSSIW's analysis of social services case files identified as one of the key factors in delayed transfers of care the lack of specialist care home placements for those with complex additional needs, including nursing home options for those with dementia.

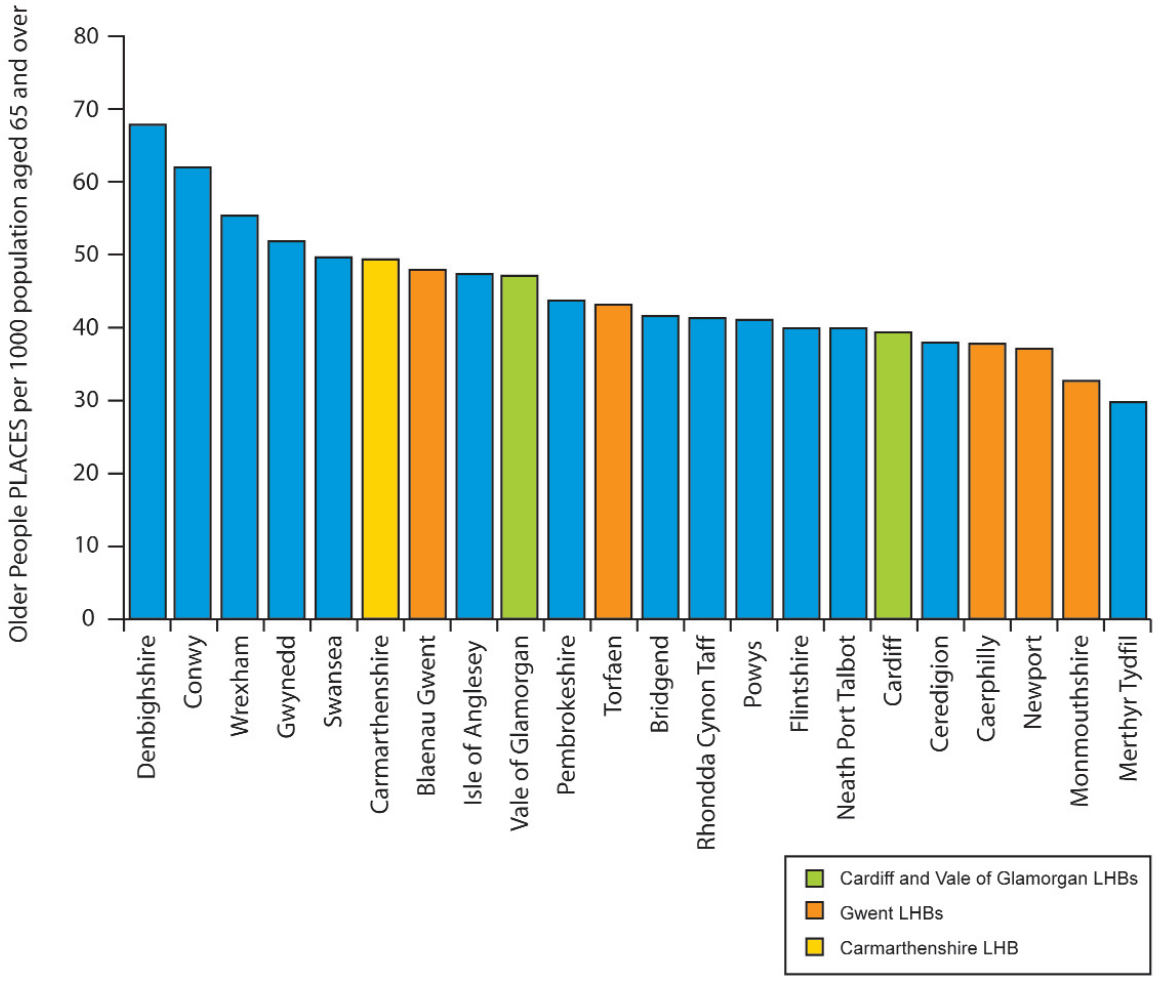
2.101 In Cardiff and the Vale of Glamorgan the significant lack of affordable EMI home capacity served to limit choice and led to patients remaining inappropriately within Trust inpatient settings. We understand that the Vale of Glamorgan Council pays the second lowest standard weekly rates of any local authority in Wales. In addition to the low fee rates, the perceived poor quality of EMI accommodation is resulting in too many people with EMI needs being placed in local authority residential accommodation which is not intended to cater for the elderly mentally infirm.

2.102 In some parts of Gwent, there are similar capacity problems. For example, in the week commencing 11 June 2007, there were only two nursing home vacancies for people with dementia in the whole of Gwent. A positive development in Gwent has been the development of a system of weekly capacity reporting on a pan-Gwent basis so that commissioners can identify available capacity and the overall supply of places across the Gwent health and social care community. This is in contrast to Cardiff and the Vale of Glamorgan, where our focus group and subsequent fieldwork identified significant shortfalls in the information available on capacity for beds and services.

2.103 Care home capacity within each borough is only an indicator of potential available capacity. Because the different local authorities pay different basic rates for placements, which either they or the elderly person sometimes 'top up', which leads to capacity being filled from 'out of county' or by self-funders, it is difficult to compare available capacity. Using data supplied by CSSIW we compared the number of registered places available in residential and nursing homes for older people by local authority population aged over 65. While this tells us nothing about the utilisation of capacity by individual authorities, it shows that on 31 March 2007 there was a twofold difference in the potential supply of older people's places within each local authority area (Figure 14).

14 'Gearing up to respond to Fulfilled Lives, Supportive Communities', a WLGA paper on Social Services, March 2005, page 7.

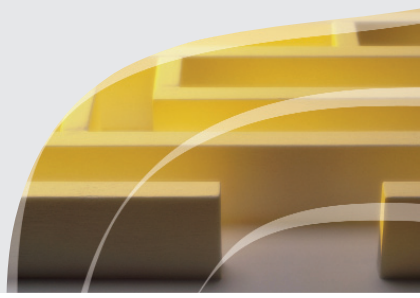
Figure 14: The availability of care home places per head of population over 65 varied between the local authorities in Wales on 31 March 2007



Source: Data supplied by CSSIW on the number of places available by local authority area at the end of March 2007

2.104 In some areas there appears to be a relationship between the number of places available per 1,000 head of population aged over 65 and the incidence of delayed transfers of care for social care reasons. For example, Conwy and Denbighshire had a significantly higher – nearly 50 per cent – number of places potentially available per 1,000 population over 65 than any other authority and had the lowest rates of social care delayed transfers of care in Wales. However, across Wales the potential supply of care home places alone does not explain the rate of delayed transfers of care for social care reasons.

2.105 Differential starting fee rates between local authorities reflect different economic circumstances and cost bases. However, we heard that care home owners often seek to provide care to authorities with the highest rates or which are prepared to pay a larger 'top up' to their basic fee. In certain localities, such as Cardiff, very few home owners



accept the local authority fee which means that individual negotiation has to take place in each case which exacerbates the uncertainty of supply. This could be compounded by planned private sector developments which aim to care for self-funding people.

2.106 In many areas, there is further pressure on capacity because care homes face the threat of closure or where owners are considering whether to remain in the care home market. For example:

- Caerphilly County Borough Council faces the problems of significant financial pressures in social services, large increases in delayed transfers of care, a lack of EMI capacity and uncertainty about future capacity arising from care home quality issues being investigated by CSSIW.
- Blaenau Gwent Council has five residential homes with 164 places, with one home due to close and any vacancies in other Council homes currently being used to transfer residents from the home that will close. There are embargoes on the use of two independent sector homes under the Protection of Vulnerable Adults scheme. This raises concerns about the long-term viability of the homes at a time when in May 2007 there were no available EMI nursing or EMI residential places in Blaenau Gwent.
- A popular care home in Cardiff is due for closure which will exacerbate the current shortage of affordable home capacity, especially for patients with EMI or dementia which directly limits choice. The weekly rates paid by the local authority are below the average in Wales although the costs of providers in the capital city are likely to be higher than average.

2.107 There are likely to be further pressures on available care home capacity arising from increasing referrals under the Protection of Vulnerable Adults (POVA) scheme. The potential impact of POVA referrals is that they may lead to embargoes on placements in particular homes which can compromise capacity (paragraph 2.106). The Welsh Local Government Association has highlighted an increasing rate of POVA referrals which could mean that many homes are under embargo during the investigations.

2.108 We identified other capacity problems within the system:

- shortages in the availability of mental health services for adults aged between 18 and 64 was an issue in the communities covered by our review which contributed to delayed transfers of care in mental health settings; this reflected the findings of our previous baseline review of implementation of the Assembly Government's National Service Framework for Mental Health[15] which found that there are key gaps in community based services across Wales that act as an alternative to hospital admission, that support safer and more prompt hospital discharge and that support wellbeing and recovery; the Assembly Government is progressing the implementation of the recommendations of our report and those of the National Assembly's Audit Committee report[16].

15 Wales Audit Office, Adult Mental Health Services in Wales: a baseline review of service provision, October 2005. http://www.wao.gov.uk/assets/englishdocuments/Adult_Mental_Health_Services_Baseline_Review.pdf

16 National Assembly Audit Committee, Adult Mental Health Services in Wales: a baseline review of service provision, Committee Report (2) 05-06, July 2006 http://www.assemblywales.org/N0000000000000000000000000046595.pdf

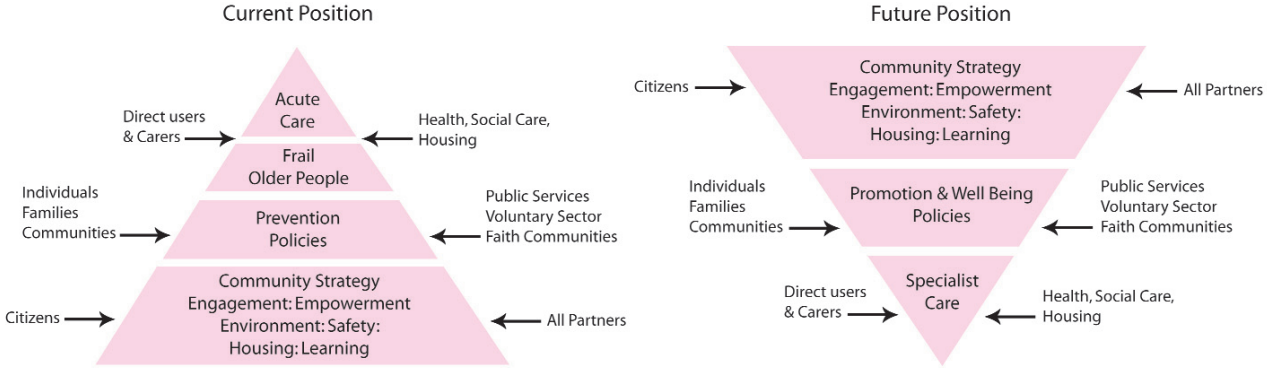
- District Nursing capacity is an issue in Gwent Healthcare NHS Trust which the Trust is seeking to address by implementing the recommendations of three reviews of the service.
- Occupational Therapy capacity is a problem in Gwent, and more broadly because social services and Trusts operate separate services; staff in Cardiff and the Vale told us about shortfalls in therapist capacity.
- the operating hours of services can contribute to the duration of delayed transfers of care – social services cover outside usual business hours is mixed. There is also mixed cover outside usual business hours in some clinical, diagnostic and therapy services in health. Delays over the weekend can be a significant factor in delayed transfers of care and can contribute to patients losing independence, for example because therapists are not available over the weekend.

There is a need to make better use of social services resources

2.109 There has been a long-term trend whereby eligibility criteria for social services support have been tightened and resources are being used to care for a smaller number of people with more complex and expensive needs. National data on social services provision show that despite overall increases in social services expenditure, the number of people receiving homecare provided or commissioned by social services reduced from nearly 60,000 households in 1992/1993 to 20,200 people over the age of 65 in a sample week in 2005/2006. Between 2001/2002 and 2005/06 the average home care hours per client rose by 31 per cent, from 6.18 to 8.08, while the number of people funded by local authorities to receive homecare reduced by 1.2 per cent. Some councils and LHBs have increased their commissioning of services from the voluntary sector to support people with lower levels of need but the tightening of eligibility criteria for home care services, and their provision to a smaller number of people with higher needs, may not be in keeping with the Assembly Government's new emphasis on early intervention and may result in missed opportunities to prevent or reduce the usage of more expensive social care and health services. The Assembly Government will need to consider how councils can deliver its strategy of earlier intervention and prevention given the financial pressures they face, particularly the financial headroom that may be required in some areas to reconfigure service provision.

2.110 In England, the Local Government Association and Association of Directors of Social Services have referred to the need to 'invert the triangle' so that there is more low level intervention to prevent needs from growing and to reduce the current burden of complex, high-level needs for social care (Figure 15). The Assembly Government strategy for social services, 'A Strategy for Social Services in Wales over the Next Decade - Fulfilled Lives, Supportive Communities', also sets out a vision for services that are rebalanced towards earlier, low level intervention in order to grasp opportunities for prevention, to support people at home and reduce admission to hospital. The 'Review of Health and Social Care in Wales' pointed out that the people were drawn into acute settings when services could be provided earlier and closer to their homes to free the acute sector to deal with more complex cases.

Figure 15: Inverting the triangle in social care



Source: All our tomorrows, inverting the triangle of care, Local Government Association and Association of Directors of Social Services, October 2003, page 9

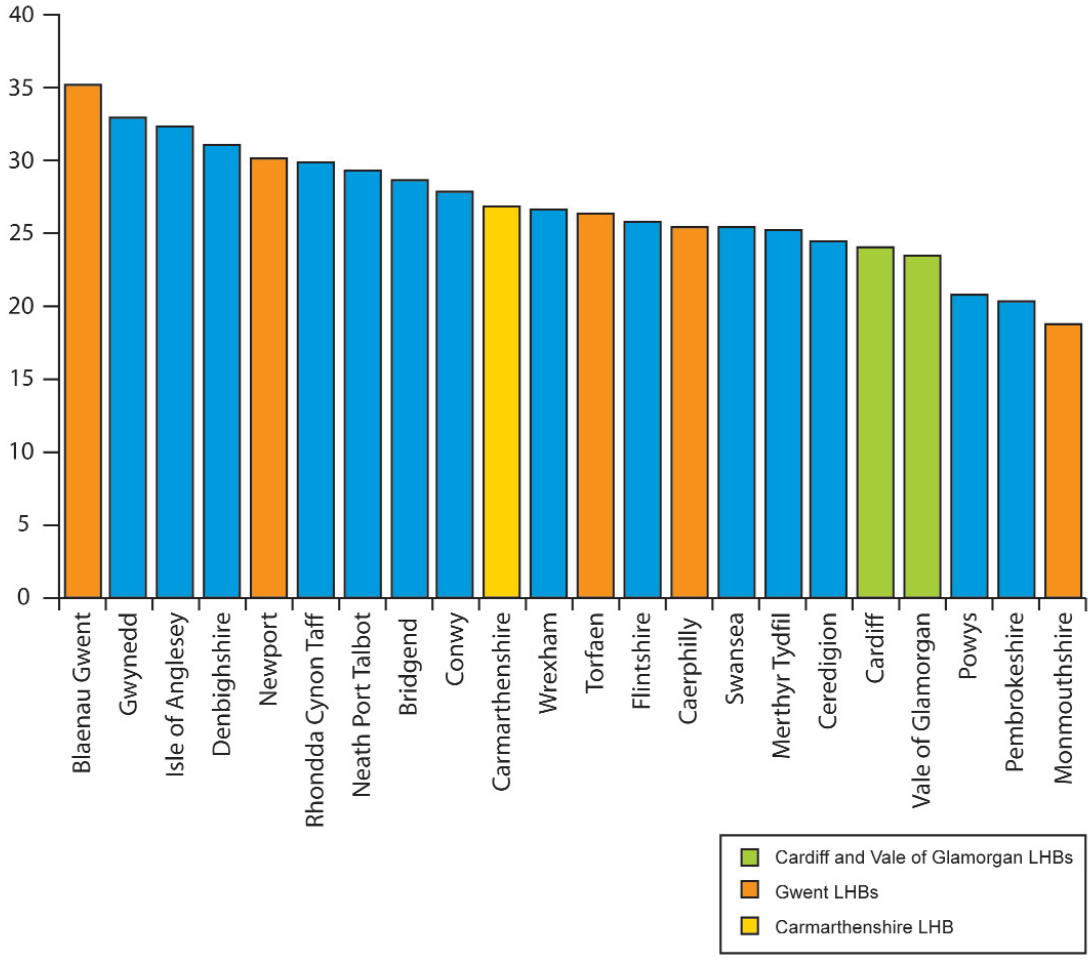
2.111 There are also significant and unexplained variations between councils in the number of people they support through the provision of home care and residential/nursing home care. Figure 16 shows that there was nearly a two-fold variation between the lowest and highest rates of people supported by local authorities in care homes in 2006/2007. This reflects in part the relative affluence in certain parts of Wales where a higher proportion of self-funding people is likely to reduce the number supported by the local authority. The majority of local authorities examined as part of this project had rates below the median.

2.112 Although across Wales it is difficult to prove a direct correlation between financial resources available to social services departments and delayed transfers of care for social care reasons, we found local examples where immediate financial pressures within social services clearly led to short-term increases in delayed transfers of care. This could lead to costs effectively being borne by the NHS Trusts and its commissioners as a result of financial pressures in local government. For example:

- when Caerphilly County Borough Council's adult social services budget forecast a significant overspend during 2006/2007, there was a significant rise in delayed transfers of care because of the availability of social services funding; and
- in late 2006, Vale of Glamorgan Council had significant financial pressures in social services and was operating a 'one in, one out' policy in placing people in care homes, which led to a high level of social care delayed transfers at that time.

2.113 We also examined the outcomes in terms of the rate of people local authorities supported at home. Figure 17 shows significant variation in the rate between Welsh local authorities, including between the communities we examined. Across Wales, there was just under a fourfold difference between the rate supported at home in Cardiff (the lowest in Wales at 42.10) and in Caerphilly (the highest in Wales at 157.71). We also analysed the relationship between this indicator and the incidence of delayed transfers of care in 2006/2007 and found that there was not a correlation between high rates of people

Figure 16: Rate of people over 65 supported by local authorities in care homes in per 1,000 of population over 65 in 2006/2007



Note
The NSI data has been audited by the Wales Audit Office and signed off by the authorities prior to sharing. Doubt has been expressed about the reliability of authorities' arrangements for producing the information in Gwynedd Council.

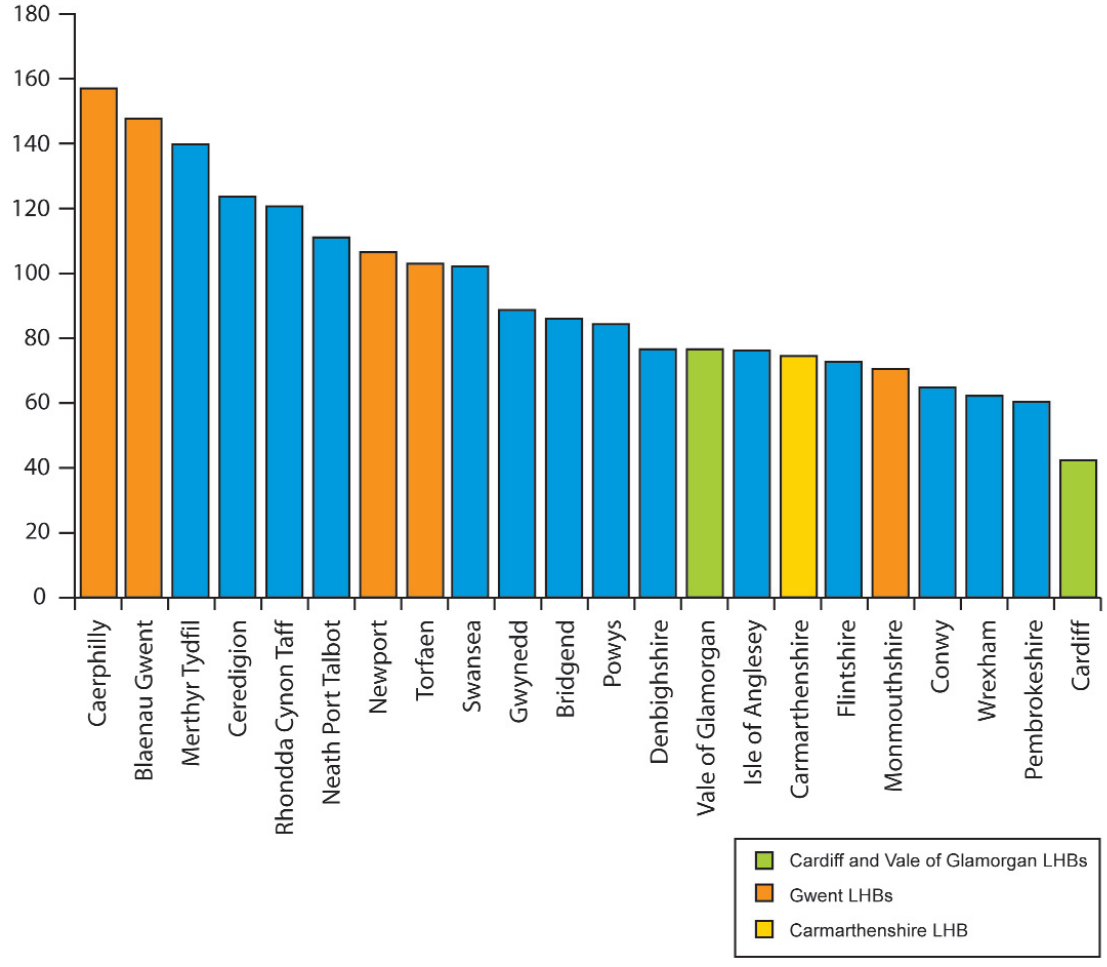
Source: Local Government Data Unit, SCA/002b

supported at home and low rates of delayed transfers of care for social care reasons. This may reflect the fact that the statistics on the rate of people supported at home do not tell us the extent to which this support promotes independence.

There is a need to make better use of health service resources, particularly rehabilitation capacity

2.114 By their nature, delayed transfers of care indicate that NHS resources are not being used optimally. In Cardiff and Vale NHS Trust, which runs one of Europe's largest teaching hospitals, 18,631 acute bed days are occupied by delayed transfers of care. In Gwent Healthcare NHS Trust, delayed

Figure 17: In 2006/2007 there was almost a fourfold variation between local authorities in the rate of people (over the age of 65) supported at home per 1,000 population over 65



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Source: Local Government Data Unit, SCA/002a

transfers of care tend to occupy community hospital beds, with 27,511 bed days occupied in this way during 2006/2007. The delayed transfers of care in acute beds prevent Cardiff and Vale NHS Trust from using its resources to treat other patients – either for scheduled or unscheduled care – in their specialist acute beds. The extent of bed days occupied by delayed transfers of care in Gwent have consequences for the use of acute beds but also act as a barrier to moving provision from community hospital beds towards 'virtual beds' by developing new service models in community settings, consistent with the Clinical Futures vision.

Figure 18: Impact of delayed transfers of care in rehabilitation beds

NHS Trust	Number of rehabilitation bed days occupied by delayed transfers of care in 2006/2007	Average duration of a delayed transfer of care in a rehabilitation bed in 2006/2007
Cardiff and Vale	19,760	73.5 days
Carmarthenshire	8,513	51.6 days
Gwent Healthcare	6,218	46.1 days

Source: Wales Audit Office analysis of Health Solutions Wales delayed transfers of care data

2.115 In both Trusts, the extent of delayed transfers of care increases the number of patients outlying (occupying a bed in an inappropriate ward for the type of care they require), which means that the Trusts are not able to accommodate them on the most appropriate ward. This increases the complexity of medical ward rounds for physicians and may contribute to extended delays for patients who are a delayed transfer of care. There may be merit in accommodating all of the delayed transfers of care on particular wards in both Trusts to enable a more targeted and consistent multi-disciplinary approach to managing the cases.

2.116 However, our work highlighted some other indicators that NHS bodies could make better use of their resources, in particular, the use of rehabilitation beds. The average length of stay in Cardiff and Vale NHS Trust was well above the Welsh average and appeared longer than would be expected for rehabilitation at 48.2 days in 2005/2006. In 2005/2006 the average length of stay in rehabilitation bed in Gwent Healthcare NHS Trust was 34.4 days. Data was not available on the average length of stay in rehabilitation beds in Carmarthenshire NHS Trust.

2.117 In addition, rehabilitation beds in all three Trusts were occupied by significant numbers of delayed transfers of care, with a long average duration of a delayed transfer of care (Figure 18) in 2006/2007. The impact of the delayed transfers of care is significant in that it compromises available capacity for the Trusts to rehabilitate other patients.

Enacting robust operational management of delayed transfers of care

2.118 All organisations involved in this project were taking action to try to improve the delayed transfers of care position within their locality. Organisations often invested significant time resource into systems for the operational management of delayed transfers of care. Whilst we found evidence of effective joint operational working at local authority/LHB level, there was less evidence of effective operational management of the problem across the whole health and social care community.

2.119 Some general lessons emerged from our work which suggested that the critical success factors in the effective operational management of the problem of delayed transfers of care were:

- the consistent and direct involvement of senior managers from partner organisations in the resolution of individual cases not only helped to remove barriers to specific patients' transfers of care but also served to improve senior managers' understanding of the constraints they needed to address to develop whole systems solutions;
- the development of a shared information set and understanding of the extent and causes of delayed transfers of care;
- a recognition and acceptance of the whole systems causes of delayed transfers of care and the ability to take both a short-term approach to the resolution of specific cases and also a longer-term approach to addressing the underlying causes of delayed transfers of care, which went beyond the monthly statistics and recognised that low levels of delayed transfers of care do not necessarily guarantee the existence of good practice;
- involving the full range of interests in solving the problem, for example including housing and the voluntary sector in finding solutions; and
- where the level of delayed transfers of care reduced as a result of a reliance on high cost packages in care homes, focusing on better use of resources in promoting independence through an improved range of alternatives to hospital admission and discharge options.

Longer-term whole systems solutions should follow from the development of shared service models and existing good practice

Emerging models of future services need to be agreed with all partners and supported by robust operational plans

2.120 To address delayed transfers of care and to promote the independence of vulnerable people more effectively, the partners within each health and social care community need to develop a clear and shared model of the services they wish to provide to meet the need of their resident populations and to do so in a way in which localities develop their local plans within the context of an overall strategy for the whole community. This needs to include a recognition that all organisations within a community are interdependent in securing a balanced range of services to support individuals in the right place, at the right time and cared for by the right person. Critically, this then needs to translate into action and a commissioning strategy to address current gaps, particularly in intermediate care and EMI services.

2.121 Both Cardiff and the Vale and Gwent health and social care communities are in the process of developing models for the future provision of healthcare services. Cardiff and Vale is developing the 'Programme for Health Service Improvement', while in Gwent the 'Clinical Futures' programme is further advanced and will be phased in over the next five to 10 years (Box 5).

Box 5: Both Cardiff and Vale and Gwent are developing future models of clinical services

In Gwent, 'Clinical Futures' sets out plans to remodel and reconfigure clinical services in the Gwent health community by developing a network of Local General Hospitals working closely with primary and community out of hospital services, supported by a single Specialist and Critical Care Centre. The model is predicated on a transfer of resources from acute to non-acute services although there is also a strong focus on reconfiguring secondary care services.

In Cardiff and the Vale of Glamorgan, the 'Programme for Health Service Improvement' sets out the areas of need set out in 'Designed for Life' and sets out a series of necessary local changes including:

- development of primary and community based services, in particular to support the needs of people with long term conditions;
- greater provision of rehabilitation and intermediate care services to help people maintain their independence;
- transformation of local mental health services;
- better access to hospital based services; and
- planning for the development of specialised and tertiary services.

There is now recognition that this requires a whole system approach and the timeframe for the 'Programme for Health Service Improvement' has slipped to respond to the Health, Social Care and Wellbeing Strategies and work on modelling and options is ongoing. Formal public consultation will now be in 2008.

There has been some progress in terms of thinking about the way services should be provided, such as early proposals for priority areas to meet the needs of the frail elderly, rehabilitation and long term care provision but to date this has been NHS driven.

The 'Delivering Integrated Services' project, which covers health, social care and voluntary services in the Bro Morgannwg area is relevant to the residents of the western Vale of Glamorgan. This has drawn upon the 'virtual ward' concept used developed by Croydon Primary Care Trust (Case Study R) in developing its community care models.

Source: Wales Audit Office

2.122 We found that there is significant support in Gwent for the vision and principles that support 'Clinical Futures', both from health and social care partners. However, consistent with the programme's current stage of development, there remain concerns about how that vision will be made operational, in particular a perception within local government about their engagement in the process, which some see as NHS-driven and excessively focused on buildings with insufficient social care input into the development of integrated care pathways. We also identified concerns about the resourcing of the 'Clinical Futures' programme, in particular concerns about:

- the availability of resources, once new hospitals have been developed, to enable new out-of-hospital services to be developed;
- the financial and service impact of the plans on social services, particularly the risk that community services will prove more expensive to the system than treatment in hospital;
- the risk that developing intermediate care service models might create new demand by tapping into latent needs that had not previously been identified and for people not likely to have needed a hospital admission; and

- potential increases in delayed transfers of care arising from the need to transform 500 community hospital beds into 'virtual beds' in the community, over and above the 121 beds occupied on average each day in 2006/2007 by a delayed transfer of care.

2.123 In Cardiff and the Vale, although partnership working has improved there are significant cultural barriers that are evident at the following levels:

- at a strategic level there has only recently been a joint acceptance that service and financial issues in relation to delayed transfers of care are inter-linked and can only be successfully managed in partnership;
- services are not yet designed around the needs of the individual rather than the needs of the different organisations;
- there is a culture of dependency on institutional care; and
- a lack of ownership of the problem amongst some operational staff, including clinicians and nursing staff, which will need to be addressed by changes to ways of working and roles.

2.124 Although early signs are promising, there remain significant barriers to the resolution of the current position across Cardiff and the Vale of Glamorgan primarily the lack of a shared health and social care strategy. Whilst the establishment of the 'Programme for Health Service Improvement' is a welcome step towards stronger partnership working and service change to date it has been very health service orientated and has not yet developed a whole system approach that includes social care. The timeframe for 'Programme for Health Service Improvement' implementation was extended in response to clarification of the Assembly Government's timetable for the updates of the Health, Social Care and Wellbeing strategy update by 2008, and to allow more robust public consultation. The 'Programme for Health Service Improvement' provides a significant opportunity to develop a stronger whole systems approach to promoting the independence of vulnerable older people.

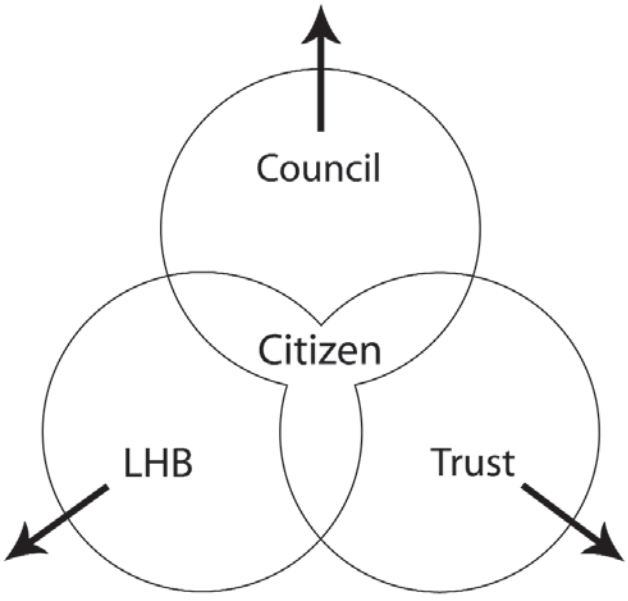
By addressing organisational barriers at the interface between health and social care services

2.125 We found that organisational and budgetary boundaries, naturally opposing influences and general complications arising from the number of organisations within health and social care communities could serve to reinforce the need for more effective partnership working at a community level. The patient needs to be at the centre of care rather than caught between the responsibilities, budgets and accountabilities of different parts of the Welsh public service (Figure 19).

2.126 This report highlights several examples where the actions of one organisation, though rational within their own circumstances, cause negative consequences elsewhere in the system. The impact of tensions at the interface between individual organisations and between health and social care manifest themselves particularly in:

- inconsistent approaches to patient choice;
- differing approaches to unified assessment;
- variable approaches to Continuing Healthcare;

Figure 19: Competing organisational pressures lead to a focus that is sometimes not on the citizen



Source: Wales Audit Office

- the existence of local agreements in different localities which lead to inconsistent measurement of the duration of a delayed transfer of care; and
- local authorities setting different starting fee rates for care homes which can lead to capacity problems arising from 'out of county' placements.

2.127 Our focus groups asked a number of questions about partnership working. Along with our fieldwork at individual bodies, this showed that while most participants thought that there was a willingness to work together, joint working had so far only led to limited outcomes and progress. The main barriers to effective partnership working across both the Cardiff and Vale and Gwent communities were:

- leadership – while there was clear leadership within the individual localities, it was more difficult to generate effective strategic leadership at the level of the wider community centred on the Trusts;
- in both communities, there has only recently been full acceptance and ownership of need to work together to address delayed transfers of care and their causes across the whole system;
- budgetary pressures, with Continuing Healthcare and the implications of the 'Grogan' judgement likely to increase budgetary pressures and conflict between health and social care;
- the number of localities with which the Trusts operate creates problems of capacity and complexity in terms of joint working and developing whole systems solutions at the level of the community-wide whole system;

Case Study O: Joint health and social care performance indicators in Carmarthenshire

Key community performance indicators have been agreed by the Modernisation Board for the health and social care partners within Carmarthenshire. These are outside the usual target areas and cover a broad range of areas that all partners have agreed will help improve their delivery of health and social care. They have recently included capacity indicators covering not only health but social care and also the independent sector. Although further work is required to secure consistent information from the independent sector, good progress is being made. The information is routinely used to inform operational and strategic decision making. There is currently consideration of creating a centralised bed bureau covering health, social care and the independent sector which will be informed by the capacity information.

The Carmarthenshire community also captures and monitors delayed transfers of care information on a regular weekly basis as part of an expanded multi-agency dataset in addition to that required for the monthly census. The availability of this information allows for detailed and more frequent comparisons of trends than is available via the monthly census.

The patterns and trends identified from the weekly monitoring process help the local health and social care community identify and address variations in patient flow and are a key information source for local actions.

Source: Wales Audit Office

- the lack of a co-ordinated process and model for managing and developing the whole system of health and social care;
- a feeling that local authorities and the relevant trusts do not engage as effectively as they should to address delayed transfers of care and their causes at a whole systems level; and
- the lack of joint performance targets for health and social services organisations, which work to different performance targets for delayed transfers of care, and measurement by reason for delay, leads to a culture of blame and defensive behaviours which attribute delayed transfers of care to external factors or the actions of other organisations rather than the failure to address the genuine whole systems causes of delayed transfers of care.

2.128 Performance management arrangements are particularly problematic, with the focus on delayed transfers of care by cause (healthcare, social care and family/carer/other) and locality tending to lead to a focus on the numbers rather than the causes of delayed transfers of care. The absence of integrated targets for a whole community, where the target for the Trust reflects targets for the LHBs and local authorities, dilutes ownership across organisations and the whole system and can lead to a failure to recognise vital inter-dependencies. For example, a delayed transfer of care for social reasons that affects a resident of one local authority area could lead to a resident of another locality being unable to receive elective surgery. All delayed transfers of care, regardless of cause or where the patient comes from, are a problem for the Trust in which the delay is taking place and should be regarded as a common systems problem for all of the partners within the wider community. One community has started to develop joint health and social care performance measures (Case Study O).

2.129 The census approach can also encourage organisations to focus management attention on clearing delayed transfers of care as census day approaches rather than dealing with the causes across the whole system. The census approach also fails to identify delayed transfers of care that commence after one census date but end before the next census date.

2.130 The key challenge is to develop a genuinely shared vision of how the whole system will work and then to ensure that all of the individual organisations take actions and develop services that are consistent with and support that vision. Once there is a genuinely shared vision of how the whole system is to operate, organisations need to align the constraints and incentives at the interface between organisations with the shared model of service delivery.

2.131 Budgetary pressures have caused a vicious circle whereby financial pressures in one part of the public service cause costs to fall on another, for example the practice of some local authorities operating a 'one in, one out' policy for care home beds at the expense of trusts and LHBs who bear the cost of people so delayed remaining in a hospital bed. Similarly, NHS bodies may have avoided the costs of some Continuing Healthcare cases that will now fall on them as a result of the recent 'Grogan' judgement. Both NHS and social care organisations may not be able to invest in solutions to whole systems problems as a result of the cost pressures they face as individual organisations but which make no sense at the level of the Welsh public service and making the best use of 'the public pound'. Until this vicious circle is broken, funding is likely to remain locked in acute care, with an effective 'stalemate' arising from the combination of budgetary pressures in individual organisations leading to a failure to invest in solutions to whole system problems which would deliver much more effective use of the total resources available to the Welsh public service.

2.132 In England, the Government has introduced a system of 'cross charging' whereby local authorities pay on a daily basis for delayed transfers of care for social care reasons. One of the main reasons for introducing this approach was to provide local authorities with a clear incentive to minimise delayed transfers of care for social care reasons. The Assembly Government has not adopted such a 'fining' approach, reflecting risks associated with perverse incentives, short-term gaming rather than adopting a genuinely whole system approach, and the risk of adversely affecting joint working between health and local government bodies.

2.133 To address the problem of conflicting financial arrangements and pressures in different parts of the Welsh public service, the Assembly Government has emphasised pooled health and social care budgets as a solution to problems of budgetary tensions at the interface between organisations. Pooled budgets should follow the development of a shared vision of service development and a clear view about the long-term nature of service provision. In this context, pooled budgets have significant potential to address some of the negative consequences of separate budgets and accountabilities, particularly in identifying or protecting a whole system or health and social care economy fund which may avoid the temptation for organisations to seek to shift costs when they are under financial pressure. Some organisations within Gwent have already developed pooled budgets, using the flexibilities inherent in the Health Act (1999). Case Study P describes the larger of the two 'Section 33' agreements to pool budgets that exist in Monmouthshire, its impact and the lessons learned about developing pooled

Case Study P: Developing a Section 33 agreement and pooled budget for the Monnow Vale facility in Monmouthshire

Monmouthshire County Council and Monmouthshire LHB opened the Monnow Vale integrated care facility in May 2006. The facility has 19 inpatient beds where Monmouthshire GP's provide the medical care, a nurse led Minor Injuries Unit, a Community Care team, Reablement team, day hospital and day services, a Mental Health day hospital for older people, Physiotherapy outpatients and Occupational Therapy sessions, an X-ray department, Community Nursing Teams and a range of outpatient and community health clinic services.

This scheme has a pooled budget and a service manager who manages Trust, LHB and council staff. As part of this scheme, Discharge Liaison Nurses have access to social services budgets. Even though the facility is in an early stage of development, which means that it is not yet possible to evaluate its impact, there have been process improvements in respect of Reablement services. The facility is already operating at full capacity. However there are empty beds within the facility because of the strict eligibility criteria used for patients which may compromise capacity for rehabilitation. The joint Monnow Vale team has reviewed the operation and drafted a business plan to go to the Local Health Board in the second half of 2007 to help the facility improve its operation.

The main perceived benefits of the Monnow Vale arrangements are the development of robust multi-disciplinary team working under a common management structure within a single facility. There is a weekly multi-disciplinary team meeting on the ward and a single unified management arrangement gives the manager the ability to effect changes in practice to ensure things are patient-centred, rather than passed between departments. Also, the common leadership is extremely helpful around developing the concept of single pathway and encouraging staff to work outside rigid boundaries.

The development of the 'Section 33' agreement was a lengthy process that took some time. The LHB told us that the lessons of developing a 'Section 33' agreement are then need to ensure that:

- robust Partnership Board arrangements are in place such as the establishment of the multi-agency Partnership Board for Monnow Vale, which we were told has operated very openly and has been crucial in maintaining the credibility of the arrangement across the individual organisations within the partnership;
- there is a recognition that formal 'Section 33' agreements do not in themselves change practice without a clear, shared vision and common leadership; the formal agreement can provide an important baseline for integration but it takes time for the benefits to be demonstrated and there is a need to look closely at practices, including relationships and the care pathway;
- robust financial management systems are in place to support the management of integrated services to enable greater flexibility in the use of shared resources; and
- implementation of unified assessment is key to delivering the long-term benefits of the 'Section 33' agreement.

Source: Wales Audit Office

budgets. As well as formally pooling budgets, which can be a complex and time-consuming process, other localities have developed jointly funded services and posts. For example, both Torfaen and Newport have developed intermediate care consultant posts (Case Study G).

2.134 As well as budgetary pressures, traditional leadership styles and skills are another barrier to effective whole systems working. Addressing the conflicting accountabilities and cultures of organisations requires a different leadership skill set where leaders are prepared to share power, resources and to work in the interests of the whole system in the wider interest of their organisation and the people it serves, rather than in the direct interest of that organisation.

Case Study Q: Nurse case managers in Caerphilly attempt to provide a more seamless service to the user

In the absence of hospital-based social workers, a model has been developed in Caerphilly where nurse case managers work across both health and social care. The scheme is partly Wanless-funded and involves Trust-employed managers carrying out both discharge liaison and social care assessment.

The four nurse case managers work in specific regions of Caerphilly with the project lead providing cover for leave and absence.

The scheme is credited with contributing to a sustained period of lower delayed transfers of care numbers with the average monthly number being 24.9 in 2005 and 18.6 in 2006. Their work in facilitating discharge and their direct access to social services funding to commission social care packages appears to have worked well in providing a more streamlined service.

However, enforced changes to the way in which nurse case managers work has recently contributed to a rise in delayed transfers of care numbers in Caerphilly. Financial pressures within the local authority's adult services budget resulted in the case managers being prevented from commissioning care packages. New guidance on continuing care also resulted in the decision that nurse case managers' uni-agency assessments are no longer adequate. Health and social care partners are currently developing plans to streamline assessment in Caerphilly whilst adhering to Continuing Healthcare guidance.

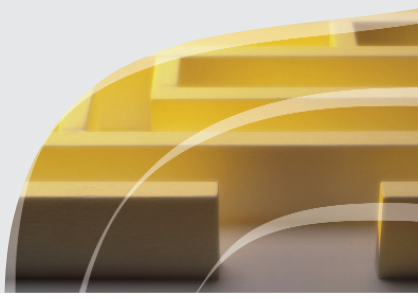
Source: Wales Audit Office fieldwork interviews

2.135 Rotating staff between health and social care services is a potentially powerful way to improve understanding of the whole system and pathways through it. However, the different terms and conditions between health and social care are a potential barrier to such rotation. There is particular scope to align health and social services occupational therapy teams, to second directors of finance between organisations, and to develop new roles that cut across organisational boundaries, such as case managers and care brokers. Monmouthshire has developed a brokerage system.

2.136 The organisational boundaries can make the system very confusing for the citizen and their families and carers. Care and Social Services Inspectorate for Wales' analysis of social services case files identified the impact of diverse accountabilities and responsibilities leading to services appearing not to centre on the citizen. The case file sample produced several examples where a piece of work - for example, an assessment, traversed the boundary between health and social care and led to one partner effectively 'washing their hands' of accountability for progress until another had dealt with an aspect of the case and passed it back to them for action.

2.137 In some areas, models are emerging where one member of the Welsh public service takes responsibility for co-ordinating a larger part of the older person's journey through the whole system of health and social care. For example, in Caerphilly, a system of nurse case managers has been established to work across health and social care boundaries (Case Study Q).

2.138 There are also barriers to joint working arising from the lack of shared information between health and social care organisations. This compromises the ability to work jointly across the Welsh public service. For example, there is no single record for patients even within the NHS – although developments are in train through 'Informing Healthcare', GPs and the Trust do not yet work within a single shared patient record. And social services do not have access to the records of patients within health services.



2.139 The roll-out of Local Service Boards represents an opportunity to foster more effective strategic partnerships between the organisations involved in the whole system, of health and social care, although the risk remains that the existence of different localities could compromise the focus required across the whole community. The Cardiff Local Service Board pilot includes as one of its four workstreams work on the commissioning of long-term care for the elderly which is intended to lead to the development of pooled budgets. The lessons from this 12 month pilot in a locality with one of Wales' highest rates of with delayed transfers of care is likely to generate significant lessons which can be applied across Wales. And there is a Local Service Board pilot in Carmarthenshire which will focus on the integration of health and social care, and will prioritise in particular delayed transfers of care and Continuing Healthcare.

There are some examples of potential good practice relating to joint working which could have a wider application

2.140 In addressing the issues arising from organisational barriers at the interface between health and social care, organisations in Wales can learn general lessons from examples of approaches adopted elsewhere. Indeed, some of the models have been examined by Welsh public sector organisations with a view to their application in the Welsh context. The case studies are:

- Case Study R - a model of providing health services through the development of 'virtual wards' in the community in Croydon, which has been influential so far in development of Clinical Services in Gwent;
- Case Study S - long-term structural integration of health and social care commissioning and provision in Northern Ireland;
- Case Study T - a proposal to create a public service trust to commission health and social services for the people of Herefordshire; and
- Case Study U - the development of a new model of community health care in Dudley.

2.141 The case studies which we set out below expose some key lessons which can be applied to addressing delayed transfers of care in Wales. This report has not undertaken detailed evaluation, nor can we comment on the merits of policy, which means that the Assembly Government needs to undertake or commission some more work to evaluate which lessons should be drawn out from these examples. However, the following general lessons are clear from the examples and the independent review commissioned by the Assembly Government might examine the policy implications of these case studies:

- structural change without changes in culture and approach to service provision will not deliver genuinely joined up services on its own (Northern Ireland/ Herefordshire);
- creating new structures that integrate health and social care has the potential to reduce the negative impact of budgetary boundaries (Herefordshire/Northern Ireland);
- developing a clear and shared service model – between health and social care services or between the parts of the healthcare system - to which NHS and

Case study R: The Croydon virtual ward model of patient care in the community has been used to inform the development of 'Clinical Futures' in Gwent and is relevant to promoting independence and reducing delayed transfers of care

Croydon Primary Care Trust has redesigned the health services it provides in the community using a model of service called 'virtual wards'. The project was piloted in May 2006 and involves community-based health services that are organised using the systems, staffing and daily routine of a hospital ward but without the physical structure of a hospital building: patients are cared for in their own homes.

Two virtual wards are now in operation in Croydon and the Primary Care Trust plans to put in place a further eight. Each ward covers a specific geographical region of Croydon and is closely linked with the GP practices in that catchment area. A computer model is used to decide which of the catchment area's patients would most benefit from 'admission' to the ward. The 100 individuals that are judged to be at highest risk of unplanned hospital admission are included within the virtual ward.

Services within the ward are multi-disciplinary and are provided by nurses, a Health Visitor, Pharmacist, Social Worker, Physiotherapist, Occupational Therapist, Mental Health worker and Voluntary Sector helper. These services are led by a Community Matron and an administrator called the Ward Clerk acts as a central contact point.

Medical input to the ward is provided by a duty doctor at each GP surgery. The Community Matron has a bypass telephone number to be able to contact the duty doctor and can also directly book appointments with GPs.

Before a patient is 'admitted' the Community Matron visits the patient at home to carry out an initial assessment. The resulting documentation, and any further information provided by ward staff, is entered into a shared set of electronic notes. Prior to the initial assessment, a summary from the patient's GP practice is entered onto the electronic system thereby providing the Community Matron with background information.

Communication between all health services in the catchment area is critical. GP practices are informed of any significant changes to the patient's management and a nightly email is automatically sent to local hospitals, NHS Direct and GP out-of-hours cooperatives, giving a list of the ward's current patients. Should a virtual ward patient present to any of these other services, staff working there are automatically alerted to their status on the virtual ward. Staff can contact the ward clerk for further details about the patient and can also arrange discharge of the patient back to the virtual ward.

Virtual ward staff hold an office-based ward round every day. Patients are discussed at different frequencies depending on their circumstances. Patients in the highest intensity 'beds' are discussed every day and the most stable patients are discussed every month.

Once a patient has been in the lowest intensity bed for an extended period of time, ward staff may take the decision to discharge the patient back to the care of their GP. A discharge summary is sent to the practice and a discharge letter is sent to the individual. For the first two years following discharge, the GP carries out quarterly reviews of the patient. Information from these reviews is fed back to inform the predictive risk computer model.

The virtual ward project aims to reduce the overall use of emergency beds in Croydon by five per cent. The scheme is yet to be formally evaluated but inpatient spells were reduced by 1,488 during 2006/2007. The Croydon model has influenced the development of 'Clinical Futures' in Gwent.

Source: Wales Audit Office

Case study S: Northern Ireland's system of integrated health and social care

The integration of health and social services began in Northern Ireland in the early 1970s with the creation of four health and social services boards. These took over the welfare functions of the county and county borough councils and the health functions of the Northern Ireland Hospitals Authority.

In 1991, the Health and Personal Social Services (Northern Ireland) Order created new health and social services trusts with responsibility for providing health and social services. The health and social services boards adopted a purchasing and commissioning function while the trusts delivered services and managed their own budgets. In addition to these structures, four health and social services councils monitored services in the four board areas.

On 1 April 2007, health services and social services in Northern Ireland were reorganised again with the creation of five 'super' health and social services trusts, replacing the 18 existing acute and community trusts. From April 2008, their services will be commissioned by a single new health and social services authority for Northern Ireland which will take over from the boards and will commission services through seven local commissioning groups.

Research at the University of Ulster in 2003 suggested the advantages to the integrated system include the facilitation of discharge from hospital, enhanced understanding between health professionals and social care teams, improved level of community care, more efficient use of resources than in Great Britain and improved focus on the needs of the client[17].

However, reviews of the system have also highlighted some major limitations of the integrated system. The same research at the University of Ulster described an undercurrent of tension between medical and social services professionals and it found that while the structures were in place for integration, a culture of integration was not always in place. Structural integration had not necessarily led to integrated practices.

A report in 2005 revealed concerns that integration had led to the diversion of social services funding to acute health services, causing a vicious circle of delayed discharge from hospitals which put long term pressure on acute services. The report recommended that the first stage of re-examining the health and social care system in Northern Ireland should involve the ring-fencing of social services funding.

A separate review carried out in 2002[18] said the integrated system had produced many examples of new and innovative practices in community care. However it concluded that these examples had often developed in isolation with non-recurrent funding and that staff were frustrated at the lack of collaborative working between trusts. It also highlighted views that patient flow between hospitals and care homes was not as seamless as would be expected from a genuinely integrated health and social care system.

It is hoped that the five new super trusts will help promote stronger links between the hospitals and community based services as well as further develop integration across boundaries and professional groupings.

Source: Wales Audit Office

social care partners have signed up is an absolute pre-requisite to a more effective whole systems approach (Croydon/Dudley);

- good communication between partners is vital to effective whole systems working, through single contact points and shared information systems and records (Croydon/Dudley);
- the central role of primary care practitioners and engaging them with other members of a multi-disciplinary health and social care team in the community (Croydon/Dudley); and
- needs assessment and the development of good predictive information on which to commission services and target their provision on people with the most need or highest risk in the community (Croydon/Dudley).

17 The Integration of Health and Social Care: The Lessons from Northern Ireland. Social Policy and Administration, Vol 40, Number 1, February 2006, pp47-66(20).

18 DHSSPS, First Report of the Review of Community Care, 2002

Case study T: Herefordshire consultation on the proposed creation of a public service trust

Herefordshire Primary Care Trust and Herefordshire Council are proposing to create an ambitious new partnership that they are calling a Public Service Trust from 1 April 2008. The new arrangements would mean that the two organisations would jointly plan, purchase, design and integrate all local public services around the needs of individual citizens and patients in order to improve those services, provide better value for money and safeguard local services. Whilst there would be a single Chief Executive and senior team, the Primary Care Trust and Council would individually remain as the statutory responsible bodies but intend to delegate their commissioning responsibilities to the joint body so that they could work in an integrated and co-ordinated way to plan and commission a wide variety of public services.

The objectives of setting up the Public Service Trust are:

- plan and commission a range of excellent and integrated public services, which would be designed around the needs and expectations of individual people;
- require providers of services to deliver improved customer and patient care, to reduce inequalities, promote healthier lifestyles, support older people and vulnerable adults in achieving greater independence and increase choice for children and young people to improve their life opportunities;
- provide better value for money by achieving savings on management and other costs, via a single management structure, and by removing duplication so that efficiencies can be reinvested in local services; and
- safeguard local services (both the Council and Primary Care Trust are relatively small and cover one of the largest geographical areas in England but with one of the smallest populations).

The critical success factors in securing agreement to the proposed Public Service Trust have been to:

- achieve sign up by all partners at an early stage, including all-party support at a Council level and the buy-in of key stakeholders such as clinical practitioners, patient and customer groups, the voluntary sector, providers and employees of the Primary Care Trust and the Council and regional and national government departments;
- agree corporate governance arrangements, to operate in the best interests of the local community, and clinical governance, to ensure services are safe and using up to date information, techniques and facilities;
- ensure the necessary focus on the achievement of requirements for the Children's Trust arrangements and adult care services;
- commit to principle of the genuine pooling of resources and maturity in 'sharing funds' to ensure that the best use is made of money, assets and other resources available by optimising the benefits gained from the use of Section 75 (the equivalent of Section 33 in Wales) of the NHS Act; and
- agree a shared risk register for the Primary Care Trust and Council, with identified joint risks and action plans.

Nevertheless, the project has ongoing risks that require active management:

- implementing a shared strategy for accommodation, to bring key employees together to work in teams in one building;
- bringing information protocols and systems together;
- putting aside cultural and organisational boundaries to support and improve the health wellbeing and prosperity of people in Herefordshire and make public services more responsive and accountable with better outcomes;
- clarity of the governance arrangements and lines of accountability to be founded on the principles of unified appointments, collocation and single vision and set of values, aims and priorities; and
- agreement with all regulatory/inspection bodies about roles and responsibilities.

Source: Wales Audit Office visit to Herefordshire

Case study U: Dudley Primary Care Trust has improved many aspects of patient care through changing its model of care

Dudley Primary Care Trust has developed a new model of care that aims to improve patient care through case management, patient involvement and self care.

A range of community teams have been developed that have all adopted a case management approach to assessment and management of care. In order to create seamless flow through the patient pathway and to prevent avoidable hospital admissions, a single assessment process has been developed along with new clinical care pathways. All changes have been underpinned by training plans and workforce development plans

A primary care nurse consultant post has been introduced to manage patients in the community who have complex health and social care needs. The nurse consultant targets the 100 patients in the Primary Care Trust's catchment area that are most frequently readmitted to hospital. She works to empower the patient to self manage their condition and aims to intervene early to prevent readmission.

Community Discharge Co-ordinators based within Dudley Social Services take referrals to see patients in their own home and to look holistically at their needs. The team take new referrals from healthcare professionals as well as seeing patients who have been discharged from hospital.

The Primary Care Trust has also taken the step of mainstreaming rapid response resulting in all district nurse teams becoming rapid response teams. Empowerment of the rapid response teams has led to tangible improvements to patient care including the removal of catheters in patients' homes. This procedure used to require hospital admission but the new care protocol has saved 312 bed days per year, reduced infection rates and improved patient satisfaction.

A GP consultant hotline has been developed where GPs and consultants set aside time to talk on the telephone. This aims to reduce referrals to Accident and Emergency and to the Medical Admissions Unit.

Mental health link workers have been allocated to GP surgeries to be a practice-based resource to carry out rapid assessments, free up GP time and signpost to mental health services. This has reduced referrals to secondary care and is liked by patients who would rather be seen at the practice than at a local mental health unit.

Finally, the Pathways Team has been introduced in the north of the borough to improve the patient journey for those having hip and knee replacements. The team support the patient through the preoperative process, operation and recovery and work closely with social services.

Overall outcomes from the new model of care have included a demonstrable improvement in the level of unplanned admissions to the acute hospital, an increase in the scope and range of services provided at home and a robust clinical governance framework which supports development and change. The average length of stay in General Medicine at hospitals in Dudley has also reduced.

Source: Wales Audit Office based on the Dudley Primary Care Trust website

Appendix 1 - Methodology

1 We used a broad methodology for this cross-cutting review which is set out below.

Document review

2 We carried out a document review looking at key documents relating to delayed transfers of care within each community and at national level.

Focus group

3 At the outset of the project we conducted a one day focus group in each of the Cardiff and Vale and Gwent communities attended by representatives of each organisation covered by this project. The focus groups used software that enables participants to submit anonymous views electronically, to see the views of other participants, assign priority to them, and to propose solutions to those problems. The focus groups built on an initial survey questionnaire on partnership working, based on the Nuffield Partnership Model. We supplied the Chief Executives of the organisations concerned with our analysis of the results of the focus groups, which covered:

- barriers to addressing the delayed transfers of care problem;
- what was working well;
- capacity issues;
- potential solutions to delayed transfers of care; and
- the effectiveness of joint working and ideas about improving it.

Data analysis

4 We carried out a detailed analysis of the Assembly Government's delayed transfers of care census data and also relevant performance indicators from the Local Government Data Unit. We also used data on the number of care home beds available on 31 March 2007 provided by CSSIW. Using data supplied by Health Solutions Wales we developed measures of the numbers of bed days lost, as well as patients affected, in the 2005/2006 and 2006/2007 financial years. This enabled us to analyse the impact of delayed transfers of care by Trust and also for the resident populations of the 22 LHBs in Wales.

5 We carried out a financial analysis of the position in each organisation covered by the review both in respect of the costs of bed days occupied by delayed transfers of care but also in terms of expenditure on key areas such as social services, social services for older people and Continuing Healthcare per head of population aged 65 or over.

6 We brought all of this data together in histogram format for each Council/LHB area in Wales using a system of ranking. We shared these histograms in the individual appendices produced for each organisation in Cardiff and Vale, and for the Trust and each locality in Gwent. The purpose of the histograms is to identify key questions and possible relationships and factors affecting the delayed transfers of care position, rather than answering questions directly.

Inpatient census and analysis of case files

7 We carried out a census of each delayed transfers of care in Cardiff and Vale and Gwent Healthcare NHS Trusts on 16 May 2007. We are extremely grateful to both Trusts, and to nursing staff on relevant wards, for their prompt and efficient completion of the census forms.

8 Our analysis of these patients was followed up by colleagues from CSSIW who undertook an analysis of social services case files for a sample of people in Cardiff, the Vale of Glamorgan and the five Councils in the Gwent area. This case file analysis produced a series of case examples which appear in this report.

Semi-structured interviews

9 We conducted detailed interviews with key stakeholders in each organisation covered by the review and among wider stakeholders in the health and social care communities, including:

- the Assembly Government and its Department of Health and Social Services South East Wales Regional Office;
- Care Forum Wales;
- care home owners;
- GPs in Cardiff and the Vale and Gwent;
- patients and carers;
- social workers; and
- voluntary sector organisations in each community.

Good practice

10 We focused on good practice both within the communities covered by the review and from elsewhere. This resulted in the inclusion of 21 case studies in the report.

Public comments

11 We set up a page on the Wales Audit Office website (http://www.wao.gov.uk/whatwedo/1612.asp) inviting the public to tell us about their experiences of delayed transfers of care.

Expert panel

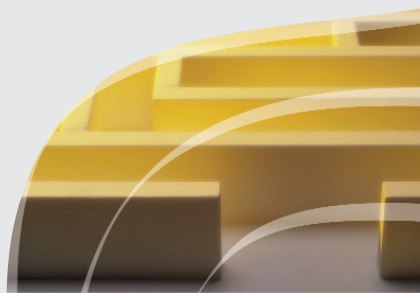
12 As is customary for an examination of this type, we set up an expert panel to advise the study team at key stages of the project. The panel had no executive power over the project but provided advice and guidance to the project team. The panel met twice to discuss the approach to the project, emerging findings, key issues and potential recommendations. Some members of the panel provided comments on the draft overview report. We are extremely grateful to the following individuals for their help and support during the course of the project.

Lynda Chandler	Change Agent, National Leadership and Innovation Agency for Healthcare
Paul Williams OBE	Chief Executive, Bro Morgannwg NHS Trust
Hilary Dover	Director of Community and Therapy Services, Bro Morgannwg NHS Trust
Dr Joe Grey	Care of the elderly physician, Cardiff and Vale NHS Trust
Beverlea Frowen	Director of Social Services and Health Improvement, Welsh Local Government Association
Gaynor Williams	Waiting Times and Emergency Care Branch, Welsh Assembly Government
Richard Tebboth	Care and Social Services Inspectorate for Wales
Kevin Barker	Care and Social Services Inspectorate for Wales
Mel Evans	Chief Executive, Rhondda Cynon Taff LHB
Mike Ponton	Director, NHS Confederation Wales
Michael Kemp	Care Forum Wales
David Murray	Director, Age Concern Gwent
Mike Shanahan	Director of Older People and Long Term Care Policy, Welsh Assembly Government
Dr Pradeep B Khanna	Chief of Staff, Gwent Healthcare NHS Trust

Appendix 2 - Delayed transfers of care affecting residents of each LHB/Council area covered by this review in 2005/2006 and 2006/2007

Patient area of residence		Delayed Days				Number of delayed patients				Average days delayed			
	Reasons	2005/2006	2006/2007	Change	Percent Change	2005/2006	2006/2007	Change	Percent Change	2005/2006	2006/2007	Change	Percent Change
Blaenau Gwent	Healthcare reasons	277	236	-41	-14.8%	11	11	+0	+0.0%	25.2	21.5	-4	-14.7%
Blaenau Gwent	Patient/ carer/ family-related reasons	1578	1695	+117	+7.4%	40	39	-1	-2.5%	39.5	43.5	+4	+10.1%
Blaenau Gwent	Social Care reasons	472	641	+169	+35.8%	12	15	+3	+25.0%	39.3	42.7	+3	+8.7%
Blaenau Gwent	**All reasons**	**2327**	**2572**	**+245**	**+10.5%**	**63**	**65**	**+2**	**+3.2%**	**36.9**	**39.6**	**+3**	**+7.3%**
Caerphilly	Healthcare reasons	1821	742	-1,079	-59.3%	56	36	-20	-35.7%	32.5	20.6	-12	-36.6%
Caerphilly	Patient/ carer/ family-related reasons	3068	2394	-674	-22.0%	67	49	-18	-26.9%	45.8	48.9	+3	+6.8%
Caerphilly	Principal reason not agreed	62	0	-62	-100.0%	1	0	-1	-100.0%	62.0	0.0	-62	-100.0%
Caerphilly	Social Care reasons	2779	5001	+2,222	+80.0%	76	141	+65	+85.5%	36.6	35.5	-1	-3.0%
Caerphilly	**All reasons**	**7730**	**8137**	**+407**	**+5.3%**	**200**	**226**	**+26**	**+13.0%**	**38.7**	**36.0**	**-3**	**-7.0%**
Monmouthshire	Healthcare reasons	463	740	+277	+59.8%	16	24	+8	+50.0%	28.9	30.8	+2	+6.6%
Monmouthshire	Patient/ carer/ family-related reasons	1196	2509	+1,313	+109.8%	40	67	+27	+67.5%	29.9	37.4	+8	+25.1%

Patient area of residence		Delayed Days				Number of delayed patients				Average days delayed			
	Reasons	2005/2006	2006/2007	Change	Percent Change	2005/2006	2006/2007	Change	Percent Change	2005/2006	2006/2007	Change	Percent Change
Monmouthshire	Principal reason not agreed	62	0	-62	-100.0%	1	0	-1	-100.0%	62.0	0.0	-62	-100.0%
Monmouthshire	Social Care reasons	894	1867	+973	+108.8%	27	39	+12	+44.4%	33.1	47.9	+15	+44.7%
Monmouthshire	**All reasons**	**2615**	**5116**	**+2,501**	**+95.6%**	**84**	**130**	**+46**	**+54.8%**	**31.1**	**39.4**	**+8**	**+26.7%**
Newport	Healthcare reasons	2117	1364	-753	-35.6%	43	30	-13	-30.2%	49.2	45.5	-4	-7.5
Newport	Patient/ carer/ family-related reasons	7467	9352	+1,885	+25.2%	129	145	+16	+12.4%	57.9	64.5	+7	+11.4%
Newport	Social Care reasons	3459	3627	+168	+4.9%	88	69	-19	-21.6%	39.3	52.6	+13	+33.8%
Newport	**All reasons**	**13043**	**14343**	**+1,300**	**+10.0%**	**260**	**244**	**-16**	**-6.2%**	**50.2**	**58.8**	**+9**	**+17.1%**
Torfaen	Healthcare reasons	982	2021	+1,039	+105.8%	30	37	+7	+23.3%	32.7	54.6	+22	+67.0%
Torfaen	Patient/ carer/ family-related reasons	3106	2773	-333	-10.7%	59	30	-29	-49.2%	52.6	92.4	+40	+75.7%
Torfaen	Principal reason not agreed	138	220	+82	+59.4%	2	3	+1	+50.0%	69.0	73.3	+4	+6.2%
Torfaen	Social Care reasons	4993	10368	+5,375	+107.7%	81	120	+39	+48.1%	61.6	86.4	+25	+40.3%
Torfaen	**All reasons**	**9219**	**15382**	**+6,163**	**+66.9%**	**172**	**190**	**+18**	**+10.5%**	**53.6**	**81.0**	**+27**	**+51.1%**
Cardiff	Healthcare reasons	10445	12749	+2,304	+22.1%	151	143	-8	-5.3%	69.2	89.2	+20	+28.9%
Cardiff	Patient/ carer/ family-related reasons	31273	34742	+3,469	+11.1%	447	391	-56	-12.5%	70.0	88.9	+19	+27.0%



Patient area of residence		Delayed Days				Number of delayed patients				Average days delayed			
	Reasons	2005/2006	2006/2007	Change	Percent Change	2005/2006	2006/2007	Change	Percent Change	2005/2006	2006/2007	Change	Percent Change
Cardiff	Principal reason not agreed	741	190	-551	-74.4%	5	3	-2	-40.0%	148.2	63.3	-85	-57.3%
Cardiff	Social Care reasons	11998	9341	-2,657	-22.1%	159	167	+8	+5.0%	75.5	55.9	-20	-26.0%
Cardiff	**All reasons**	**54457**	**57022**	**+2,565**	**+4.7%**	**762**	**704**	**-58**	**-7.6%**	**71.5**	**81.0**	**+10**	**+13.3%**
Vale of Glamorgan	Healthcare reasons	4308	2737	-1,571	-36.5%	74	42	-32	-43.2%	58.2	65.2	+7	+12.0%
Vale of Glamorgan	Patient/ carer/ family-related reasons	10641	14328	+3,687	+34.6%	172	155	-17	-9.9%	61.9	92.4	+31	+49.3%
Vale of Glamorgan	Principal reason not agreed	135	31	-104	-77.0%	3	1	-2	-66.7%	45.0	31.0	-14	-31.1%
Vale of Glamorgan	Social Care reasons	2428	4439	+2,011	+82.8%	48	66	+18	+37.5%	50.6	67.3	+17	+33.0%
Vale of Glamorgan	**All reasons**	**17512**	**21535**	**+4,023**	**+23.0%**	**297**	**264**	**-33**	**-11.1%**	**59.0**	**81.6**	**+23**	**+38.3%**
Carmarthenshire	Healthcare reasons	3009	1593	-1,416	-47.1%	57	37	-20	-35.1%	52.8	43.1	-10	-18.4%
Carmarthenshire	Patient/ carer/ family-related reasons	6751	7312	+561	+8.3%	132	127	-5	-3.8%	51.1	57.6	+7	+12.7%
Carmarthenshire	Principal reason not agreed	50	0	-50	-100.0%	1	0	-1	-100.0%	50.0	0.0	-50	-100.0%
Carmarthenshire	Social Care reasons	12261	10603	-1,658	-13.5%	209	220	+11	+5.3%	58.7	48.2	-11	-17.9%
Carmarthenshire	**All reasons**	**22071**	**19508**	**-2,563**	**-11.6%**	**399**	**384**	**-15**	**-3.8%**	**55.3**	**50.8**	**-5**	**-8.1%**

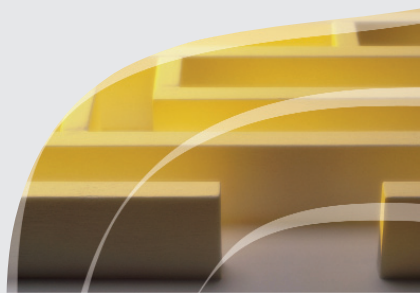
Appendix 3 - The direct cost of bed days occupied by delayed transfers of care in 2005/2006 and 2006/2007 by reason and bed type

Wales

	2005/2006			2006/2007			Change			Percentage change		
Bed type	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Acute	58,816		15,528,720	60,413		16,348,713	1,597		819,993	2.7%		5.3%
Community	63,539		14,721,006	68,945		17,233,431	5,406		2,512,425	8.5%		17.1%
Mental Health	84,222		23,643,889	73,682		21,422,294	-10,540		-2,221,595	-12.5%		-9.4%
Other	11,734		2,856,050	11,983		3,065,719	249		209,669	2.1%		7.3%
Rehabilitation	44,284		8,856,571	53,468		11,125,102	9,184		2,268,531	20.7%		25.6%
Totals	**262,595**	**250**	**65,606,236**	**268,491**	**258**	**69,195,259**	**5,896**		**3,589,023**	**2.2%**		**5.5%**

Wales

	2005/2006			2006/2007			Change			Percentage change		
Reason for delay	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Healthcare reasons	56,992		14,102,079	57,018		14,690,237	26		588,158	0.0%		4.2%
Patient reasons	133,222		33,195,322	135,128		34,604,901	1,906		1,409,579	1.4%		4.2%
Not agreed	3,868		955,989	3,085		849,895	-783		-106,094	-20.2%		-11.1%
Social reasons	68,513		17,243,362	73,260		18,997,903	4,747		1,754,541	6.9%		10.2%
Totals	**262,595**	**250**	**65,496,752**	**268,491**	**258**	**69,142,936**	**5,896**		**3,646,184**	**2.2%**		**5.6%**



Cardiff and Vale NHS Trust

	2005/2006			2006/2007			Change			Percentage change		
Bed type	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Acute	15,827	244	3,864,162	18,631	254	4,732,274	2,804	10	868,112	17.7%	4.0%	22.5%
Community	1,219	295	359,239	2,691	308	828,828	1,472	13	469,589	120.8%	4.5%	130.7%
Mental Health	32,126	237	7,599,084	27,203	247	6,719,141	-4,923	10	-879,943	-15.3%	4.4%	-11.6%
Other	6,914	244	1,688,053	9,228	254	2,343,912	2,314	10	655,859	33.5%	4.0%	38.9%
Rehabilitation	16,701	191	3,184,046	19,760	199	3,932,240	3,059	8	748,194	18.3%	4.4%	23.5%
Totals	**72,787**	**229**	**16,694,584**	**77,513**	**240**	**18,556,395**	**4,726**	**11**	**1,861,811**	**6.5%**	**4.6%**	**11.2%**

Cardiff and Vale NHS Trust

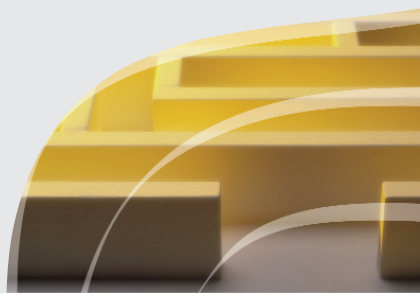
	2005/2006			2006/2007			Change			Percentage change		
Reason for delay	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Healthcare	15,489	229	3,546,981	15,362	240	3,686,880	-127	11	139,899	-0.8%	4.8%	3.9%
Patient	41,046	229	9,399,534	48,403	240	11,616,720	7,357	11	2,217,186	17.9%	4.8%	23.6%
Not agreed	1,050	229	240,450	190	240	45,600	-860	11	-194,850	-81.9%	4.8%	-81.0%
Social	15,202	229	3,481,258	13,558	240	3,253,920	-1,644	11	-227,338	-10.8%	4.8%	-6.5%
Totals	**72,787**	**229**	**16,668,223**	**77,513**	**240**	**18,603,120**	**4,726**	**11**	**1,934,897**	**6.5%**	**4.7%**	**11.6%**

Carmarthenshire NHS Trust

	2005/2006			2006/2007			Change			Percentage change		
Bed type	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Acute	7,263	305	2,215,215	6,785	318	2,157,630	-478	13	-57,585	-6.6%	4.3%	-2.6%
Community	668	139	92,852	334	145	48,430	-334	6	-44,422	-50.0%	4.3%	-47.8%
Mental Health	37	139	5,143	121	145	17,545	84	6	12,402	227.00%	4.3%	241.1%
Rehabilitation	7,376	175	1,290,800	8,513	182	1,549,366	1,137	7	258,566	15.4%	4.0%	20.0%
Totals	**15,344**	**234**	**3,604,010**	**15,753**	**239**	**3,772,971**	**409**	**5**	**168,961**	**2.7%**	**2.0%**	**4.7%**

Carmarthenshire NHS Trust

	2005/2006			2006/2007			Change			Percentage change		
Reason for delay	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Healthcare	1,206	234	282,204	914	239	218,446	-292	5	-63,758	-24.2%	2.1%	-22.6%
Patient	5,804	234	1,358,136	5,986	239	1,430,654	182	5	72.518	3.1%	2.1%	5.3%
Not agreed	0	234	0	0	239	0	0	5	0	0.0%	2.1%	0.0%
Social	8,334	234	1,950,156	8,853	239	2,115,867	519	5	165,711	6.2%	2.1%	8.5%
Totals	**15,344**	**234**	**3,590,496**	**15,753**	**239**	**3,764,967**	**409**	**5**	**174,471**	**2.7%**	**2.1%**	**4.9%**



Gwent Healthcare NHS Trust

	2005/2006			2006/2007			Change			Percentage change		
Bed type	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Acute	717	223	159,934	924	233	215,292	207	10	55,358	28.9%	4.5%	34.6%
Community	21,665	242	5,238,164	27,511	252	6,932,772	5,846	10	1,694,608	27.0%	4.2%	32.4%
Mental Health	7,651	239	1,825,529	9,803	249	2,440,947	2,152	10	615,418	28.1%	4.4%	33.7%
Other	148	223	33,013	0	0	0	-148	-233	-33,013	-100%	-100%	-100%
Rehabilitation	3,648	223	813,723	6,218	233	1,448,794	2,570	10	635,071	70.4%	4.5%	78.0%
Totals	**33,829**	**239**	**8,070,363**	**44,456**	**249**	**11,037,805**	**10,627**	**10**	**2,967,442**	**31.4%**	**4.3%**	**36.8%**

Gwent Healthcare NHS Trust

	2005/2006			2006/2007			Change			Percentage change		
Reason for delay	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £	Delayed Days	Cost per day £	Total cost £
Healthcare	4,542	238	1,080,996	4,561	248	1,131,128	19	10	50,132	0.4%	4.2%	4.6%
Patient	16,293	238	3,877,734	18,600	248	4,612,800	2,307	10	735,066	14.2%	4.2%	19.0%
Not agreed	138	238	32,844	220	248	54,560	82	10	21,716	59.4%	4.2%	66.1%
Social	12,856	238	3,059,728	21,075	248	5,226,600	8,219	10	2,166,872	63.9%	4.2%	70.8%
Totals	**33,829**	**238**	**8,051,302**	**44,456**	**248**	**11,025,088**	**10,627**	**10**	**2,973,786**	**31.4%**	**4.2%**	**36.9%**

Appendix 4 - Recommendations from the Cardiff and Vale and Gwent health and social care community reports

Gwent health and social care community

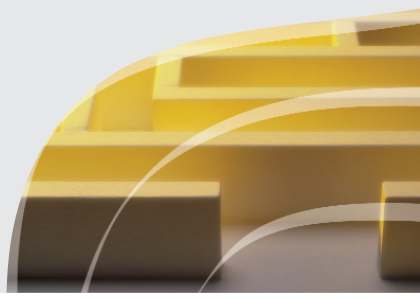
To develop commissioning

1 The health and social care community should develop common descriptions of services across Gwent, for example rehabilitation and reablement, so that there is greater clarity about the nature of available services, linked to models of dependence. This should also be supported by the commissioning and development, as appropriate, of common services at operational level.

2 In updating their needs assessments to inform reviews of their Health, Social Care and Wellbeing Strategies in 2008, local authorities and Local Health Boards should:

- **a** using the findings of this review and a detailed analysis of why their resident populations become delayed transfers of care alongside analysis of intelligence from primary and social care practitioners, develop a robust assessment of the needs of the resident population for new models of service to promote the independence of vulnerable people in community and intermediate care settings;
- **b** identify clear and costed strategies to enable the transfer of resources from acute to community services to break the 'vicious circle' whereby vulnerable people are drawn towards inappropriate institutional care that can compromise their independence; this may require LHBs and councils to identify transitional funding to enable new services to be set up before existing models are decommissioned;
- **c** share the content of their draft strategies through a pan-Gwent workshop, involving the Trust's locality managers and a senior executive lead from the Trust, to identify opportunities to develop joint services to meet similar needs, and transfer good practice, across borough boundaries; and
- **d** discuss with the Trust opportunities to use the outcomes of the revised Health, Social Care and Wellbeing strategies to inform the development of more robust plans to develop community-based and intermediate care services to support the delivery of the Clinical Futures vision.

3 Our overview report recommended that the Assembly Government develop a model for costing, monitoring and evaluating intermediate care schemes. LHB and local authority commissioners should compare the costs and outcomes of schemes and identify, evaluate and disseminate good practice based on a clear assessment of the cost-effectiveness of service models in promoting the independence of vulnerable people and making the whole system work more effectively. This should enable effective schemes to be rolled out beyond borough boundaries, which could reduce costs through greater economies of scale and broaden the beneficial impact of effective schemes.



4 Improving the operation of the whole system of health and social care, and the promotion of the independence of vulnerable people, depends fundamentally on the existence of a clear and shared vision of what services and care pathways should look like. Even where there is a clear vision of future service provision, the extent of local government engagement and involvement is variable. Partners within the Gwent community should develop as part of their Health, Social Care and Wellbeing Strategy reviews clear models of service provision and care pathways from which the configuration of future health and social care services can be developed, including consideration of:

- **a** the development of primary care resource centres that co-locate key parties from the multi-disciplinary teams that can promote the independence of vulnerable people, reduce hospital admissions and therefore minimise delayed transfers of care;
- **b** the development of a 'virtual ward' approach to community provision, based on prediction of need, multi-disciplinary team work, a single point of contact and shared records and information;
- **c** the creation of community-based specialist teams, headed by an appropriate clinician and including specialist nursing and therapies staff, to provide access to expert care for older people without requiring hospital admission;
- **d** as part of the virtual ward approach, preparing a predictive assessment of people at risk of hospital admission, using long-term condition, age and information about social circumstances, which should be reviewed quarterly;
- **e** the development of extra care and other forms of sheltered housing schemes, supported by multi-disciplinary teams targeting early interventions to avoid hospital admission;
- **f** proposals to make effective use of hospital rehabilitation beds so that they make a more consistent contribution to the rehabilitation of patients that need them, including monitoring lengths of stay;
- **g** the relationship between rapid response, reablement, district nursing and social care teams, including the desirability of co-location and single points of contact; and
- **h** developing services to ensure that patients' physical abilities do not deteriorate while on a medical ward.

5 Although some spot purchasing may be appropriate, local authorities and LHBs should increasingly use block commissioning across the whole range of care options, including care home placements and homecare. This should improve the quality of care, provide greater certainty of supply and improve value for money. This block commissioning could also be extended to cover new service models including intermediate care services such as rehabilitation and reablement.

6 In managing delayed transfers of care, there need to be clear accountabilities (as well as responsibilities) at every level. There needs to be robust performance management, supported by systematic and proactive processes. To achieve improvements in performance management and processes, the Trust, Councils and LHBs should:

a standardise where appropriate the operational management of delayed transfers of care across the Trust and with partners. In order to reduce systematically delayed transfers of care each case must be routinely and regularly reviewed and action challenged, with personal responsibility allocated for action and reported back through multi-agency meetings;

b set trigger points throughout the care pathway with responsible managers accounting for the reasons for any delay for particular patients; and

c develop a clear and robust escalation policy that has triggers for starting the process, which involves decision making senior managers across each organisation.

To address problems at the different stages of the patient pathway through the whole system

7 LHBs should provide clear information to their GPs about the range of intermediate care services available and how they should be accessed and should monitor the referral rates to hospitals and to intermediate care services, seeking to work with GPs who have low referral rates.

8 LHBs should work with their GPs to develop a proactive case management approach to identify those patients who have been frequently admitted to hospital or to predict those who have multiple chronic conditions and are at risk of admission or frequent readmission. To support such an approach, the Trust should provide GPs and social services departments with regular information about elderly patients who have been admitted to hospital, especially those whose primary reason for admission was a social reason.

9 The Trust should inform GP practices if one of their patients experiences a delayed transfer of care.

10 The Trust should work with LHBs and social services departments to develop more robust pathways for patients using its rehabilitation beds to ensure that those beds are appropriately used to rehabilitate patients and to avoid their occupation by delayed transfers of care which compromises the potential rehabilitation of others.

To address problems arising from organisational and budgetary boundaries

11 Health and social care partners should explore, at a pan-Gwent level, the opportunities to bring health and social care commissioners and providers together in a more formal way to reduce the negative impact on citizens of the barriers between organisations and budgets. Options to consider include:

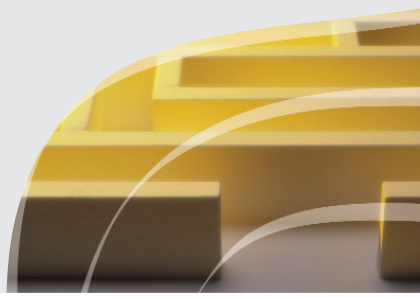
a using a Local Service Board to explore how best to address delayed transfers of care;

b if successful, how to make links between the five Local Service Boards at a strategic, pan-Gwent level;

c the use of a public service trust covering all or some health and social care services;

d the development of pooled budgets, adequacy of supporting information and governance arrangements for pooled budgets; and

e depending on the effectiveness of the Section 33 agreements in Monmouthshire, consider the use of this mechanism to bring health and social care services together through a formal agreement.



12 The Trust, LHBs and local authorities should set and monitor progress against common targets to reduce delayed transfers of care, but focus their performance management on addressing in a sustainable way the underlying causes of which delayed transfers of care are a symptom. Performance management should be used to inform needs assessment, commissioning, service monitoring and evaluation and the development of new service models.

13 The Trust, LHBs and local authorities should end the local agreements which lead to the extent and impact of delayed transfers of care being understated in the official statistics. Instead, local authorities and the Trust should use the estimated date of discharge to schedule assessments of need in good time to facilitate the patient's transfer of care.

To address issues of capacity

14 The Trust should develop plans to change its culture and clinical approach to promote more effectively the independence of vulnerable people, for example by:

- **a** using the review of district nursing to clarify the role of district nurses in the patient pathway;
- **b** training nursing and medical staff to develop specialist skills in care of the elderly and those with dementia;
- **c** training nursing and medical staff about care pathways and intermediate care services available to elderly people at risk of becoming, or who already have become, a delayed transfer of care;
- **d** using the recent restructuring of the Trust to question current practice and pathways to identify practical ways in which independence might be promoted more effectively; and
- **e** addressing the inconsistency in practice between its main sites, perhaps by using clinical staff from Nevill Hall Hospital at the Royal Gwent Hospital to transfer some of the systems used in Nevill Hall Hospital.

15 The LHBs and Councils should develop a commissioning strategy to address the current shortages of care home capacity, particularly EMI capacity. These strategies should address threats to the stability of the local market and actions to engage with providers. While initial strategies will be developed within each locality, the results should be shared to identify scope for joint commissioning and economies of scale across Gwent, as well as seeking to minimise the negative consequences of competition for placements between the five localities.

To address risks associated with Clinical Futures plans

16 The Trust and LHBs should lead the development of robust plans to develop the 'virtual bed' capacity required by Clinical Futures plans and the current level of delayed transfers of care, including more effective engagement of local authorities and GPs in Clinical Futures.

17 The Trust and LHBs should review carefully the financial models within the Clinical Futures plans.

Cardiff and the Vale of Glamorgan health and social care community

To improve partnership working to support a shared vision and strategy for health and social care within Cardiff and the Vale

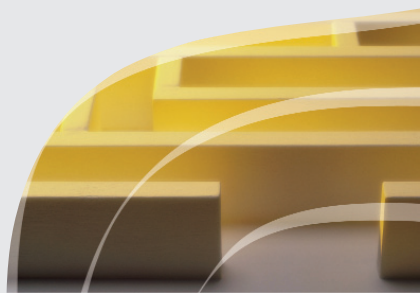
1 The Trusts, LHBs and Councils need to develop, building on progress to date on the Programme for Health Service Improvement, an over-arching vision and service model covering health and social care services for older people that crosses organisational and service boundaries and addresses the causes and impacts of delayed transfers of care. Critical to its future implementation and delivery will be:

- **a** continued momentum and pace;
- **b** clear objectives and accountability;
- **c** a framework to hold officers and organisations to account;
- **d** clear and challenging targets and milestones for actions;
- **e** expected outcomes; and
- **f** monitoring and evaluation mechanisms.

2 In developing this vision, partners need to recognise that service and financial issues in relation to delayed transfers of care are interlinked and can only be successfully managed in partnership. There needs to be recognition of inter-dependence in securing a balanced range of services to support individuals being cared for in the right place, at the right time and by the right person.

3 The review of the Health, Social Care and Wellbeing Strategies for 2008 provides a major opportunity to assess the local needs more robustly and to also draw out common needs across the two Health, Social Care and Wellbeing strategies and where appropriate develop joint approaches. In conducting new needs assessments to inform reviews of their Health, Social Care and Wellbeing strategies in 2008, Councils and LHBs should:

- **a** use the findings of this review and a detailed analysis of why their resident populations become delayed transfers of care alongside analysis of intelligence from primary and social care practitioners, develop a robust assessment of the needs of the resident population for new models of service to promote the independence of vulnerable people in community and intermediate care settings;
- **b** consider the future needs of its population (including increased demand for EMI and for care home places for younger people with disabilities);
- **c** identify clear and costed strategies to enable the transfer of resources from acute to community services to break the 'vicious circle' whereby vulnerable people are drawn towards inappropriate institutional care that can compromise their independence; this may require LHBs and Councils to identify transitional funding to enable new services to be set up before existing models are decommissioned;
- **d** share the content of their draft strategies through a pan-Cardiff and Vale workshop, involving the Trust's locality managers and a senior executive lead from the Trust, to identify opportunities to develop joint services to meet similar needs, and transfer good practice, across boundaries; and



e discuss with Cardiff and Vale and Bro Morgannwg NHS Trusts opportunities to use the outcomes of the revised Health, Social Care and Wellbeing strategies to inform the development of more robust plans to develop community-based and intermediate care services to support the delivery of the Programme for Health Service Improvement and Delivering Integrated Services.

4 Improving the operation of the whole system of health and social care, and the promotion of the independence of vulnerable people, depends fundamentally on the existence of a clear and shared vision of what services and care pathways should look like. Even where there is a clear vision of future service provision, the extent of local government engagement and involvement is variable. Partners within the Cardiff and Vale of Glamorgan community should develop as part of their Health, Social Care and Wellbeing Strategy reviews clear models of service provision and care pathways from which the configuration of future health and social care services can be developed, including consideration of:

a the development of primary care resource centres that co-locate key parties from the multi-disciplinary teams that can promote the independence of vulnerable people, reduce hospital admissions and therefore minimise delayed transfers of care;

b the development of a 'virtual ward' approach to community provision, based on prediction of need, multi-disciplinary team work, a single point of contact and shared records and information;

c the creation of community-based specialist teams, headed by an appropriate clinician and including specialist nursing and therapies staff, to provide access to expert care for older people without requiring hospital admission;

d as part of the virtual ward approach, preparing a predictive assessment of people at risk of hospital admission, using long-term condition, age and information about social circumstances, which should be reviewed quarterly;

e the development of extra care and other forms of sheltered housing schemes, supported by multi-disciplinary teams targeting early interventions to avoid hospital admission;

f proposals to make effective use of hospital rehabilitation beds so that they make a more consistent contribution to the rehabilitation of patients who need them, including monitoring lengths of stay;

g the relationship between rapid response, reablement, district nursing and social care teams, including the desirability of co-location and single points of contact; and

h developing services to ensure that patients' physical abilities do not deteriorate while on a medical ward.

5 Our overview report recommended that the Assembly Government develop a model for costing, monitoring and evaluating intermediate care schemes. LHB and local authority commissioners should compare the costs and outcomes of schemes and identify, evaluate and disseminate good practice based on a clear assessment of the cost-effectiveness of service models in promoting

the independence of vulnerable people and making the whole system work more effectively. This should enable effective schemes to be rolled out beyond borough boundaries, which could reduce costs through greater economies of scale and broaden the beneficial impact of effective schemes.

6 Although some spot purchasing may be appropriate, local authorities and LHBs should increasingly use block commissioning across the whole range of care options, including care home placements and homecare. This should improve the quality of care, provide greater certainty of supply and improve value for money. This block commissioning could also be extended to cover new service models including intermediate care services such as rehabilitation and reablement.

7 In developing commissioning strategies to deliver the shared vision, where they have not already done so, LHBs and local authorities should explore the merits of 'virtual ward management' developed by Croydon Primary Care Trust to establish community-based alternative services and to assess and prioritise people receiving out of hospital services.

To address problems at the various stages of the patient pathway

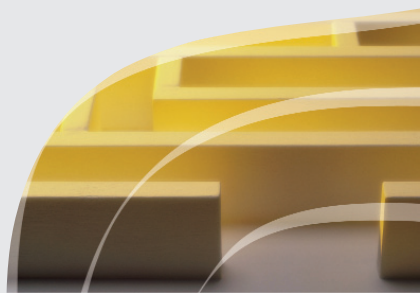
8 LHBs should monitor unscheduled admissions to help focus their admission prevention efforts and GP referral rates not only to hospital sites but also to intermediate care schemes. Where a GP or practice does not refer to intermediate care schemes, the LHB should seek to provide information to the GP but also ask a GP who makes good use of such schemes to speak to their colleague about the potential benefits for patients with a view to providing some clinical assurance about the services provided.

9 LHBs should develop a proactive case management approach to identify those patients who have been frequently admitted to hospital or to predict those who have multiple chronic conditions and are at risk of admission or frequent readmission. The Trusts should provide GPs and social services departments with regular information about elderly patients who have been admitted to hospital, especially those whose primary reason for admission was a social reason to enable them to develop more proactive approaches to their management in the community.

10 The Trusts should inform GP practices if one of their patients experiences a delayed transfer of care.

11 Local Health Boards and Councils need to develop robust and costed plans to strengthen community based services and change the clinical culture from one based on the medical model of care to a model where admission to hospital is no longer considered the norm for vulnerable elderly people and that wherever possible individuals are supported at home or in the community through earlier intervention to maintain their independence. This needs to be supported by:

- **a** a focus on prevention and maintenance and reduced dependency;
- **b** a shift away from making permanent decisions about an individual's future in an acute setting, supported by a comprehensive care of the elderly assessment before decisions are made; and



c provision of alternatives to care home settings such as sheltered housing or extra care homes.

12 In reviewing existing therapy services as part of the Programme for Health Service Improvement, the Trust, Councils and LHBs should identify ways to develop further multi-disciplinary team working. The review should assess critically whether the current level of therapy capacity is sufficient to support reductions in patient dependency. The results of this assessment should be used to inform commissioning decisions.

To address problems arising from organisational and budgetary boundaries

13 All partners should set and monitor progress against common targets to reduce delayed transfers of care, but focus their performance management on addressing in a sustainable way the underlying causes of which delayed transfers of care are a symptom. Performance management should be used to inform needs assessment, commissioning, service monitoring and evaluation and the development of new service models.

14 The Trust, LHBs and local authorities should end the local agreements which lead to the extent and impact of delayed transfers of care being under-stated in the official statistics. Instead, local authorities and the Trusts should use the estimated date of discharge to schedule assessments of need in good time to facilitate the patient's transfer of care.

To address process issues

15 In managing delayed transfers of care, there need to be clear accountabilities (as well as responsibilities) at every level. There needs to be robust performance management, supported by systematic and proactive processes. To achieve improvements in performance management and processes, the Trusts, Councils and LHBs should:

a Standardise where appropriate the operational management of delayed transfers of care across the Trusts and with partners. In order to systematically reduce delayed transfers of care each case must be routinely and regularly reviewed and action challenged, with personal responsibility allocated for action and reported back through multi-agency meetings.

b Set trigger points throughout the care pathway with responsible managers accounting for the reasons for any delay for particular patients.

c Develop a clear and robust escalation policy that has triggers for starting the process, which involves decision making senior managers across each organisation.

16 Health and social care providers need to improve their own processes. Individual appendices contain specific recommendations to improve processes, focusing on the following broad areas:

a changing their working cultures to focus more effectively on promoting the independence of vulnerable people;

b reviewing the availability, use and skills of staff providing care to vulnerable older people; and

c improving operational processes to ensure that key decisions are made in a timely fashion.

To address issues of capacity

17 Each organisation should take all opportunities to make more effective use of its own resources but should also recognise that they each have an impact on how other agencies utilise their available resources. Along with changes to service delivery, the Trust, Councils and LHBs should work together to:

a reduce duplication;

b ensure clarity of roles;

c engage clear lines of communication; and

d streamline pathways of care that embraces whole system working.

18 The LHBs and Councils should develop a commissioning strategy to address the current shortages of care home capacity, particularly EMI capacity, and also to make better use of the overall resources available across the whole system of health and social care. These strategies should address threats to the stability of the local market and actions to engage with providers. Partners should develop costed plans to improve capacity, recognising a shared responsibility for the costs of delayed transfers of care, both to individual residents and also to the whole system of health and social care. Individual organisations should:

a review the adequacy of their information on costs, particularly intermediate care, and develop more robust systems;

b assess their investment in services for the elderly and identify potential efficiencies in current service provision;

c taking into account potential efficiency gains, consider whether there is scope to make additional investments in services for the elderly with a particular focus on EMI; and

d consider the benefits of pooled budgets to recognise that better overall use of public money across the whole system is likely to deliver better care and also better value for money.