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SWYDDFA ARCHWILIO CYMRU

13 May 2009
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Delayed transfers of care follow-through

I have prepared this report for presentation to the National Assembly under the Government of Wales Acts 1998 and 2006.

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Report presented by the Auditor General to the National Assembly on 13 May 2009

Contents

Summary 6

Recommendations 11

1 There is evidence of improvement in the extent and impact of delayed transfers of care and some positive local developments in Cardiff, the Vale of Glamorgan and Gwent 13

The problem of delayed transfers of care has been generally taken seriously 13

The extent and impact of delayed transfers of care is reducing despite some periodic challenges to the sustainability of the improvement 19

2 Partners have not yet delivered consistently effective action to address the longer-term barriers to independence across the whole system 25

There are strategic visions for promoting independence but at a local and national level, there is little evidence of robust long to medium-term planning to turn these visions into reality 25

Partners have not yet, in general, developed effective approaches to sharing financial and human resources 32

Clinical, executive and political leaders will need to plan for the longer-term to deliver a more integrated approach to promoting the independence of vulnerable older people 37

Partners have still not developed an effective way of measuring the performance of the whole system in promoting the independence of vulnerable people 38

Problems with processes remain a barrier to a more citizen-focused approach 40

To deliver better outcomes for vulnerable older people, partners will need to address new challenges and seize new opportunities that will emerge from the restructuring of the Welsh NHS 43

Appendices 44

Appendix 1 - Methodology 44

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. These delays have negative impacts on the people who suffer them and can have 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. The Auditor General produced a series of reports on tackling delayed transfers of care in November 2007, covering the health and social care communities of Cardiff, the Vale of Glamorgan, Gwent and Carmarthenshire[1]. The Auditor General also produced an overview report which the National Assembly's Audit Committee considered in November, producing its own report whose 14 recommendations the Assembly Government accepted[2]. The Assembly Government also commissioned an *Independent Review of Delayed Transfers of Care* which reported in April 2008[3].

2 We concluded that delayed transfers of care are a whole systems problem which had not been tackled in a sufficiently whole systems way. The Auditor General's and Audit Committee's reports contained a series of recommendations. Early signs suggested that partner organisations had generated momentum in implementing the recommendations. Between April and November 2008 the Wales Audit Office carried out follow-through work on delayed transfers of care in Cardiff, the Vale of Glamorgan and Gwent. We decided to carry out this follow-through so soon after our initial work because we wanted to ensure that partner organisations[4] remained focused on solving the whole system problems of which delayed transfers of care are a symptom.

3 We also believed that our work would help partner organisations share learning about the actions they had taken since our initial study, as well as drawing upon more detailed consideration of good practice from outside Wales. Consequently, a major focus of this project was a seminar in November 2008 which was attended by around 70 delegates from across Cardiff, the Vale of Glamorgan and Gwent as well as a number of external speakers from Wales, England and Scotland.

4 Our follow-through work considered whether early momentum in tackling the causes of delayed transfers of care was likely to be sustained. We concluded that there has been positive progress which will only lead to sustainable improvement if partners seize longer-term opportunities to design the whole system in a way that more effectively promotes independence.

1 The three community reports can be found at the following links: http://www.wao.gov.uk/assets/englishdocuments/DToC_Cardiff_Eng.pdf
http://www.wao.gov.uk/assets/englishdocuments/DToC_Gwent_eng.pdf
http://www.wao.gov.uk/assets/englishdocuments/DToC_Carmarthenshire_eng.pdf

2 The Auditor General's overview report of November 2007 can be found at http://www.wao.gov.uk/assets/englishdocuments/DToC_Overview_eng.pdf

3 Welsh Institute for Health and Social Care, *Independent Review of Delayed Transfers of Care*, March 2008 http://www.wihsc.co.uk/content/public/publications/resource/?id=603

4 By 'partner organisations' we mean all health, social care and voluntary sector organisations involved in planning and delivering services for vulnerable people.

There is evidence of improvement in the extent and impact of delayed transfers of care and some positive local developments in Cardiff, the Vale of Glamorgan and Gwent

The problem of delayed transfers of care has been generally taken seriously

5 We found clear evidence that partner organisations are taking the issue of delayed transfers of care more seriously. Some areas have begun to think more holistically about the solutions. Instead of solely focusing on improvements to individual services, some areas have begun to make visible changes to the service models they operate by looking at all of the services available and how these services interact.

6 As well as collaboration at a strategic level, many partner organisations have improved the way they work together at an operational level to ensure individual cases of delayed transfers of care are resolved as quickly as possible. In many areas there is now a greater sense of urgency and joint ownership of these operational problems, supported by more robust management of individual cases of delayed transfers of care.

7 Many of the recommendations of the Auditor General and Audit Committee required action by the Assembly Government. The Assembly Government has clearly stated its commitment to more effectively promote the independence of vulnerable older people, in part by resolving the problem of delayed transfers of care and has taken a number of actions in support of this commitment. However, building on the progress made, there remains scope for the Assembly Government to provide a more robust national framework to deliver a more integrated approach across health and social care.

There have been welcome reductions in the extent and impact of delayed transfers of care

8 Across Wales, the extent and impact of delayed transfers of care continues to reduce. Census data suggests that across Wales there has been a significant reduction in bed days lost since our original reports of November 2007. Our own analysis of the actual bed days lost, rather than the snapshot census data, also showed an encouraging downward trend. The extent of delayed transfers of care in Cardiff and Vale NHS Trust decreased between 2006-07 and 2007-08, mainly due to significant reductions in bed days lost in mental health settings rather than in general beds. The number of lost bed days fell 24 per cent with particular reductions in the bed days lost because of social care and patient/family/carer reasons. The number of people who experienced a delayed transfer also decreased 20 per cent over this period. The long-term trend in the number of patients experiencing a delayed transfer also appears to have fallen, particularly for residents of Cardiff. In addition, the average duration of each delay remains high relative to other trusts at 78.5 days in 2007-08. The Trust reported 42 per cent of the total bed days lost because of delayed transfers of care at the December 2008 census.

9 However, during this time there appears to have been an emergence of problems relating to hospital beds in Cardiff and Vale NHS Trust occupied by patients at various stages of the NHS Continuing Healthcare (CHC) process who were not captured by the definitions of the delayed transfers of care census[5]. If hospital beds are occupied unnecessarily because of an absence of alternative and often more appropriate services, this has a direct impact on the trust's ability to deliver services for people who genuinely require hospital care. Delayed transfers of care and bed pressures arising from Continuing Healthcare have been a significant factor in exacerbating severe winter bed pressures within Cardiff and Vale NHS Trust in December 2008 and January 2009.

10 In Gwent, there was a slight increase in the impact of delayed transfers of care in terms of bed days between 2006-07 and 2007-08, but more recently there has been a considerable reduction in the number of people experiencing delays. Between 2006-07 and 2007-08 the number of lost bed days increased by seven per cent, mainly due to a rise in delays for healthcare-related and patient/family/choice-related reasons. In June 2008 the Assembly Government's census data showed that 148 people in Gwent Healthcare NHS Trust experienced a delayed transfer of care but in December 2008 this had decreased to 56.

Partners have not yet delivered consistently effective action to address the longer-term barriers to independence across the whole system

There are strategic visions for promoting independence but at a local and national level, there is little evidence of robust long to medium-term planning to turn these visions into reality

11 Despite the attempts made by health and social care organisations, the problems that remain today are the most difficult to solve across the whole system. There are clear plans to reconfigure health services but, at a national and a local level, there is a need for partners to more consistently translate their objectives into more direct action across the system. Partner organisations also need to increase the momentum behind the implementation of their reconfiguration plans, which include the *Programme for Health Service Improvement* (PHSI) in Cardiff and the Vale of Glamorgan as well as Clinical Futures in Gwent.

12 At a national level, despite its clear commitment to preventing the delays that affect vulnerable older people, the Assembly Government has not yet provided a clear overall direction to tackle the whole systems problems that can be manifested by delayed transfers of care. And at a local level we have identified some encouraging examples of strategic thinking although there are examples of innovative approaches from outside Wales from which Welsh organisations could learn.

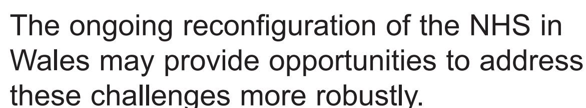
5 A person is eligible for Continuing Healthcare if their overall healthcare needs are judged so significant that the NHS has to take responsibility for managing and paying for all the care they need. A person is eligible for Continuing Healthcare if one or more of four criteria are met:

a. 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;

b. the individual requires routine use of specialist healthcare equipment involving supervision by NHS staff;

c. the individual has a rapidly deteriorating or unstable condition requiring regular intervention; and/or

d. the individual is in the final stages of a terminal illness.



The ongoing reconfiguration of the NHS in Wales may provide opportunities to address these challenges more robustly.

13 Medium to long-term planning is inhibited by poor information about the existing and forecast needs of the population. A fundamental problem with planning processes at a local level is that partners are not consistently moving resources around the system to reduce pressure on the acute sector. This results in resources being locked into certain parts of the system when they might be better invested elsewhere to promote independence rather than institutional care.

14 The imbalance of services adversely affects the independence of vulnerable older people but it also results in ineffective use of the totality of resources available to the local partners. In particular, the continued absence of a clear framework through which to reconfigure services, for example through the more holistic development of intermediate care services, is a barrier to breaking the 'vicious circle' which draws citizens towards more expensive, institutional forms of care without doing enough to prevent an admission or to expedite their return to independent living. And where people need residential or nursing home care but are stuck in a hospital bed, there are significant ongoing problems with care home capacity, quality and fee levels, particularly in relation to care for the Elderly Mentally Infirm (EMI). The Assembly Government is undertaking extensive policy work on chronic condition management which emphasises preventative activity.

Partners have not yet, in general, developed effective approaches to sharing financial and human resources

15 Due to the human and financial costs associated with a system that is working sub-optimally, the partners in each locality need to consider how they might use their collective resources more effectively to deliver a more integrated approach to promoting independence. Whilst the pooling of budgets is not a panacea – good practice examples often align rather than pool budgets – some health and social care communities in Wales have benefitted from pooling parts of their budgets. Despite these examples and guidance from the Assembly Government, sharing of financial resources between health and social care is still not highly developed. A significant barrier to the sharing of financial resources is that partner organisations are operating within considerable financial constraints which make some organisations reluctant to relinquish any control over current resources despite potential longer-term efficiencies and service improvements.

16 In setting out its budget for 2008-09 the Assembly Government announced that it would make an additional £100 million available for CHC services. Of this sum, £50 million has been made available through Local Health Board (LHB) discretionary budgets to meet increasing demands and a further £50 million was held centrally. Of the £50 million held centrally, the Assembly Government has made £37.5 million available through a bidding process to support local partners in addressing the complex problems surrounding CHC. The majority of bids have now been determined after a lengthy process.

17 There has also been mixed progress in sharing human resources. While there are numerous examples of small-scale local initiatives to share staff, there has been little progress in developing a framework that would allow a flexible workforce to function across health and social care, for example, through standardised terms and conditions in health and social care.

Clinical, executive and political leaders will need to plan for the longer term to deliver a more integrated approach to promoting the independence of vulnerable older people

18 To address the systemic causes of delayed transfers of care, political, non-executive and executive leaders must not only be committed to tackling performance within their own organisations but they must also be committed to a collaborative approach to meeting the needs of whole populations. To meet these higher-level objectives, organisational leaders will often need to give up some power to gain a greater influence. Competing priorities for different organisations, together with ongoing financial tensions, remain a barrier to further collaboration.

19 One example of a more proactive and strategic approach, is the encouraging work that is underway in Gwent to develop a collaborative approach to improving results for the frail elderly population. In West Lothian, positive impacts on the independence of vulnerable people followed the formation of a formalised Community Health and Care Partnership (CHCP).

Partners have still not developed an effective way of measuring the performance of the whole system in promoting the independence of vulnerable people

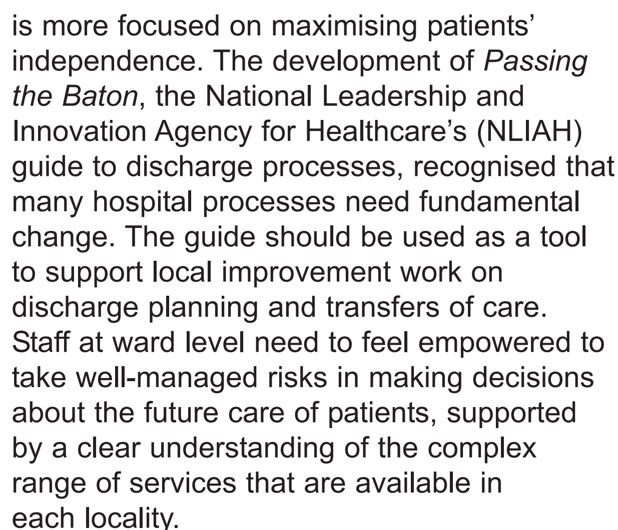
20 Different performance indicators for delayed transfers of care still exist for health and social care organisations. These measures focus on limited aspects of the whole system rather than measuring whether vulnerable people are getting the help and support they require. These problems are typified by the continued existence of local agreements[6]. Although these local agreements apply to a minority of codes for types of delays, they mask the true extent of delayed transfers of care. As well as accepting that the local agreements should be excluded from the census process, the Assembly Government has indicated that it has work underway to look at shared approaches to performance management including how to measure improvements across organisations.

Problems with the assessment of citizens' needs and discharge processes remain a barrier to a more citizen-focused approach

21 Problems remain with the assessment of citizens' needs with little progress in improving the Unified Assessment Process, which remains overly bureaucratic and inadequately supported by electronic solutions. There is also evidence of long delays in people receiving assessments for their eligibility for CHC and we found that these assessments can sometimes lack flexibility.

22 Whilst we found improvements in some of the processes that govern hospital discharge, some of these processes remain risk averse and often result in decisions to provide institutional-based care rather than care that

6 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 put in place arrangements for care. The local agreements currently apply to four of the 47 reasons for delay codes.



is more focused on maximising patients' independence. The development of *Passing the Baton*, the National Leadership and Innovation Agency for Healthcare's (NLIAH) guide to discharge processes, recognised that many hospital processes need fundamental change. The guide should be used as a tool to support local improvement work on discharge planning and transfers of care. Staff at ward level need to feel empowered to take well-managed risks in making decisions about the future care of patients, supported by a clear understanding of the complex range of services that are available in each locality.

To deliver better outcomes for vulnerable older people, partners will need to address new challenges and seize new opportunities that will emerge from the restructuring of the Welsh NHS

23 The reorganisation of the NHS in Wales will combine LHBs and NHS trusts into single boards responsible for the planning and delivery of services. As well as the opportunity to put in place planning arrangements that deliver more timely, cost effective and sustainable service models, the creation of the new organisations potentially risks short-term discontinuity within the existing partnerships based on LHB and unitary authority boundaries. The new bodies will need to ensure they achieve the benefits of scale while preserving effective local engagement and collaboration. It may become more difficult, at least in the short-term, to align resources as organisational structures, budgets and financial processes change.

24 The ongoing internal reorganisation of the Assembly Government, which will involve a new structure of directors-general, with remits covering cross-cutting issues rather than isolated service areas, provides an opportunity for the Assembly Government to deliver a more coherent approach to policy across the whole system of health and social care.

Recommendations

This is a follow-through report which means that the various organisations are still in the process of implementing our previous recommendations, alongside those of the National Assembly's Audit Committee. While our previous recommendations stand, we have made a small number of additional recommendations to address circumstances that have changed since our original report.

1 The Assembly Government has set new delayed transfers of care targets for health bodies but this does not align with the performance management framework for local authorities. **The Assembly Government should ensure that there are single targets for health and social care bodies, and that the wider performance management framework encourages the assessment of the extent to which partners promote independence for their populations as well as minimising the negative consequences of delayed transfers of care which are a performance indicator of a symptomatic problem. The Assembly Government should use any broader measures to support longer-term system improvements, recognising that delayed transfers of care figures may get worse initially as the system changes.**

2 The Wales Audit Office's website http://www.wao.gov.uk/whatwedo/delayedtransfersofcare.asp contains a range of resources relating to delayed transfers of care. **Local bodies should use these resources to help inform and shape the next stages of their responses to the Auditor General's and National Assembly**

Audit Committee's recommendations on delayed transfers of care.

3 There remains significant scope to deliver a more integrated approach to strategy, delivery, resourcing and performance management across health and social care services to provide a more seamless service that promotes the independence of vulnerable older people. **Councils and the new health boards should seek to:**

- a **develop clear, shared service visions to promote independence;**
- b **provide clear joint leadership and firm plans to support the delivery of these visions;**
- c **identify mechanisms through which to share human and financial resources more effectively to support their visions and service models, by pooling or aligning budgets, and using human resources more flexibly across the system;**
- d **establish arrangements to profile discharges and proactively manage complex cases, with a view to solving problems for individual patients as rapidly as possible; and**
- e **develop clear, shared performance indicators that focus on the results health and social care partners wish to deliver for vulnerable older people.**

4 Continuing Healthcare remains a significant barrier in terms of promoting independence and making effective use of resources within the health and social care system. **To improve the management of CHC cases, the Assembly Government should expedite the production of central guidance which includes:**

- a **greater flexibility, in particular the need for shorter-term interim CHC to support reablement and to allow people to move more easily into and out of eligibility for CHC;**
- b **arrangements to share information within the multidisciplinary team using ICT; and**
- c **stronger guidance on the time the assessment process should take, supported by systems to measure any delays which may not be picked up within the delayed transfers of care census data.**

5 The reorganisation of the NHS in Wales provides a number of opportunities to improve the management of the whole system to promote independence more effectively and to make better use of resources. Nevertheless, the reorganisation needs to manage carefully a number of potential risks in the context of delayed transfers of care. **In particular, the Assembly Government should:**

- a **exercise caution in designing the new structures and associated funding mechanisms to ensure that resources can be more easily shared between health and social care;**
- b **ensure that local partnerships can be maintained, strengthened and developed within the new structures; and**
- c **ensure that its internal reorganisation includes a stocktake about how the internal operations of the Assembly Government will address issues at the interface between health and social care.**

Part 1 - There is evidence of improvement in the extent and impact of delayed transfers of care and some positive local developments in Cardiff, the Vale of Glamorgan and Gwent

The problem of delayed transfers of care has been generally taken seriously

Partners have developed and attempted to implement action plans to address our recommendations

1.1 The extended period of time that patients spend in hospital during a delayed transfer of care can have negative consequences for their independence. These people, who are often vulnerable older people, can become institutionalised during their stay in hospital, meaning they become more dependent on others to care for them. This loss of independence can directly lead to them needing some form of care for the rest of their lives. Delayed transfers of care are therefore in direct conflict with the United Nations Principles for the Older Persons[7] which include the following statements:

- **a** older persons should be able to reside at home for as long as possible;
- **b** older persons should have access to healthcare to help them to maintain or regain the optimum level of physical, mental and emotional well-being and to prevent or delay the onset of illness; and
- **c** older persons should be able to utilise appropriate levels of institutional care providing protection, rehabilitation and social and mental stimulation in a humane and secure environment.

1.2 Delayed transfers of care do not solely impact on the person suffering the delay. If a bed is occupied unnecessarily because a patient is experiencing a delayed transfer of care, then that bed is unavailable to others. The direct costs of these lost bed days sit with NHS trusts but there are also indirect costs such as staff working to resolve the problems surrounding these delays. We estimate that the direct cost of lost bed days across Wales due to delayed transfers of care in 2007-08 was just under £66.5 million; this is less than our estimate of just over £69 million in 2006-07.

1.3 We were encouraged to find evidence that partner organisations are now acknowledging the impacts of delayed transfers of care and are taking the issue more seriously. One of the most striking developments within the Cardiff and Vale health and social care community has been the improved executive leadership and focus to address the problems of delayed transfers of care.

1.4 There is a greater awareness that the status quo is unsustainable and there is a stronger sense of corporate responsibility. An indication of this growing engagement was in the significant attendance at our Shared Learning Seminar in November 2008. This was attended by around 70 delegates from across Cardiff, the Vale of Glamorgan and Gwent, the Assembly Government and a number of external speakers from Wales, England and Scotland. The outcomes of the seminar are available on our website (http://www.wao.gov.uk/2305.asp) and reflect

7 The United Nations Principles for Older Persons aim to ensure that priority attention will be given to the situation of older persons. The principles address the independence, participation, care, self-fulfilment and dignity of older persons. General Assembly resolution A/RES/46/91 of 16 December 1991.

recognition during the seminar that things now need to change.

1.5 In our interviews with key managerial and operational staff across the localities, we found a general acceptance that despite some of the improvements in the statistics, the system is not currently working in favour of the individual and that services are not sufficiently focusing on returning the person to the way of life they had before they came into hospital.

1.6 Most of the localities included in our initial work have responded to the Auditor General's recommendations by developing multi-agency action plans. In many localities, senior executives were involved in agreeing these action plans which is an indication that resolving delayed transfers of care is now a high priority.

1.7 We found that partner organisations have begun to implement their action plans. Progress has generally resulted in some 'quick wins' but for genuinely sustainable improvements in independence and reductions in the remaining delayed transfers of care, partner organisations must now begin to address the more challenging, long-term problems.

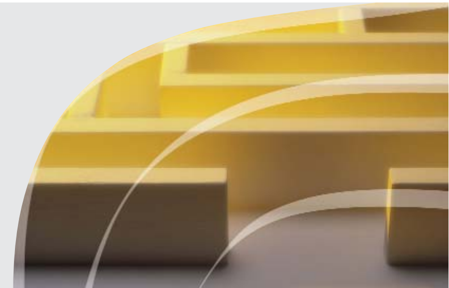
In some localities, partners have begun to develop service models and shared resources to address the needs of vulnerable people in a more holistic way

1.8 Some areas have begun to think more holistically about the ways in which they can resolve the issues that manifest themselves in people suffering delayed transfers of care. Rather than focusing on improving individual services, some areas have started to make changes to the service models they operate by looking at the entirety of services available and how these services interact. A number of localities in Gwent have begun to rethink their service models and at a pan-Gwent level there are the beginnings of an important collaborative approach to focus on improving the quality of life for frail older people. The Pan-Gwent Frail Older Person's Project involves 11 partner organisations signing an agreement to work together to resolve the whole systems issues that currently impinge on quality of life outcomes for frail older people (Case Study A). This is a potentially significant break-through in multi-agency engagement and commitment and the project has already found that if there is a strong enough moral imperative to improve the situation for individuals, organisations can rise above the territorialism that might have prevented earlier progress.

1.9 We identified several other examples of partner organisations working together at a strategic level to improve the model of services within their health and social care community. Full details of these examples can be found at our website (http://www.wao.gov.uk/2302.asp) but some of the case studies are summarised in Box 1.

1.10 Whilst the emergence of pooled budgets in a small number of localities suggests a more co-ordinated approach to funding cross-organisational solutions, these measures should follow and not lead the development of strategic models. The case studies given in Box 2 represent encouraging developments but it is important to recognise that pooled budgets are not the panacea for solving all of the whole systems problems, especially if they are put in place in the absence of an overarching strategic framework.

1.11 As well as the examples we found of partner organisations pooling financial resources, we have also found positive developments involving organisations sharing their human



Case Study A - The Pan-Gwent Frail Older Person's Project is an encouraging example of service models beginning to change and stronger multi-agency commitment

In October 2007, chief executives from across the local health and social care community in Gwent established a joint working group to focus on what they could do to improve the outcomes for frail older people on a pan-Gwent basis. A task group of senior managers decided that the best approach to take would be to develop an improved and standardised care pathway for frail older people, ranging from GPs managing fall prevention through avoidance of emergency admissions to alternatives to institutional forms of care. The next stage was to hold a series of workshops of front line practitioners, managers and clinicians from organisations across Gwent.

A pan-Gwent programme board was formed made up of representatives from each of the five LHBs and local authorities, Gwent Healthcare NHS Trust, Gwent Age Concern and the Welsh Ambulance Service NHS Trust. This board is chaired by a local authority chief executive and aims to achieve transformational change by moving the focus for frail older people from acute and institutional care to independent living.

A further meeting was held of the 11 chief executives who agreed that the project should aim for a common service model across Gwent with shared outcomes and standards but with the flexibility for local variations. At the same meeting the chief executives signed off a pan-Gwent continuing care bid that included funds for the appointment of a programme manager seconded to the Chair of the programme board.

The model that is currently developing covers the provision of care for all frail patients in Gwent regardless of whether they are in hospital, at home or in the community. It focuses on providing a single point of referral for all services targeting prevention of admission, early supported discharge, management of long term conditions and independent living within the community.

There are four work streams and each is led by a task group reporting to the programme board:

a Shared Outcomes - The overarching shared outcome is that frail older people should be happily independent. All other outcomes cascade down from this, with the proviso that they must all be focused on the benefit for the individual older person not on organisational convenience. A range of consultation meetings are being held to test public opinion on these outcomes.

b Crisis Prevention and Clinical Governance – This aims to create a range of services with common standards and outcomes for older people across Gwent. This would include a pan-Gwent patient pathway with a single point of referral. It focused on a much wider range of services, including clinical testing, to be provided on a 'virtual ward' model without the older person needing to leave their own home.

c Independent Living and Reablement – This is looking at the range of services that need to be in place to support people to live independently, and includes a common approach to reablement looking at current best practice within Gwent.

d Financial Modelling – If the programme board is to be successful in achieving its goals there has to be a movement of investment into prevention from acute and institutional care. This group is looking at how financial planning can be constructed to support the changes that will need to take place and how this will be managed through a period of transition.

While the pathway is still in the early stages of development, support for the model appears to be strong and growing in Gwent. Bringing in front line managers to develop the model has fostered empowerment and ownership of the work streams. One of the most important lessons learned from the work so far has been that by focusing the work so clearly on improving the lives of older people, this has helped win over hearts and minds, secure political support and prevent technical objections that might otherwise have stalled the project. It is this strong moral imperative that has dissolved some of the previous cross-organisational barriers to improvement.

Source: Wales Audit Office fieldwork

Box 1 - Other case studies from across Gwent, Cardiff and the Vale of Glamorgan demonstrate that partner organisations in some areas are beginning to work together to rethink their service models

Advanced Clinical Assessment Team
http://connections.wao.gov.uk/gpx/search_case_studies_library_detail.aspx?Snippet_ID=573
This award-winning team was established in Torfaen to prevent hospital admissions from patients in the community or in care homes. The team consists of clinical nurse assessors who respond rapidly to referrals as part of what is, in effect, a virtual medical assessment unit model. The locality's Intermediate Care Steering Board has played a key role in ensuring there is a multi-organisational framework to commitment and a shared framework of services to ensure that the Advanced Clinical Assessment Team (ACAT) can function within a supportive and effective service model. An internal evaluation[8] of the service in June 2008 reported that between January 2007 and April 2008, 1208 patients were referred to ACAT. The number of hospital admissions avoided during this period was 975 (81 per cent). Based on an estimate cost of £226 per day in a district general hospital and an average length of stay of between 10 and 12 days, the evaluation concluded that the team's admission avoidance has resulted in savings of more than £2,000,000 between January 2007 and April 2008.

Cardiff East Locality Team
http://connections.wao.gov.uk/gpx/search_case_studies_library_detail.aspx?Snippet_ID=594
Cardiff and Vale NHS Trust has developed a geriatrician-led multidisciplinary team as part of a new service model in the east of Cardiff. The Cardiff East Locality Team (CELT) aims to reduce avoidable emergency hospital admissions from the community and care homes as well as facilitating earlier discharge. The team works alongside GPs to manage patients whose needs are not currently being fully met in the community.

Continuing Healthcare in-reach Team
http://connections.wao.gov.uk/gpx/search_case_studies_library_detail.aspx?Snippet_ID=595
The service model in Cardiff has been revised further by the implementation of another team developed by Cardiff and Vale NHS Trust. The Continuing Healthcare in-reach Team that became operational in November 2008 will use its expert knowledge of CHC processes to support the timely completion of CHC assessments at ward level. The overall aim will be to reduce timeframes for assessment and submission of CHC applications to the LHBs and improve discharge rates to normal places of residence.

Collaborative work to alter the service model in Caerphilly
Partners in Caerphilly have worked jointly to move away from a dependence model to focus more on promoting reablement and enablement of vulnerable people. The service model in Caerphilly has been amended in three important ways. Firstly, patients who upon admission to hospital are identified as being at risk of experiencing a delayed transfer of care are admitted to the new Frail Elderly Ward at Caerphilly Miners' Hospital. The consultant geriatrician-led ward has processes that are geared towards efficient hospital discharge and the staff have access to rapid diagnostics. Secondly, the locality has developed a Joint Hospital Discharge Team (JHDT); this consists of health and social care staff working jointly to facilitate discharges. Thirdly, the council's overhaul of its homecare services has resulted in a 40 per cent expansion of its reablement service and the development of an intake model that can respond quickly and equitably across the borough.

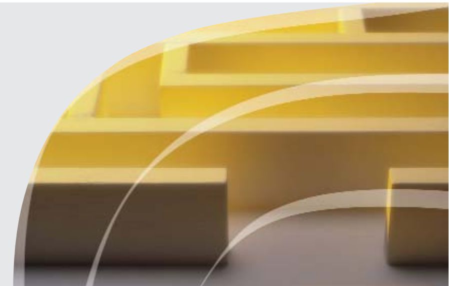
Collaborative work to develop falls services across Gwent
Research within Gwent has suggested that up to half of the delayed transfers of care in hospital are experienced by people who have fallen. This has been a key driver for a project to develop a falls service in Torfaen. The project is being led by Torfaen LHB's Intermediate Care Coordinator and is currently planning to develop a falls service covering Torfaen. There is a longer term aim of rolling the service out to all localities in Gwent and incorporating the service in the new pan-Gwent patient pathway which is being developed through the Pan-Gwent Frail Elderly Person's Project (Case Study A).
The falls service will comprise a team of people providing a rapid response to the needs of those who have fallen. The falls project has secured a grant worth £330,000 over three years to appoint three occupational therapists. The occupational therapists will work alongside the ACAT in Torfaen. The service will work by:

a GPs identifying patients at high risk of falls and referring them into the falls service; and

b the Welsh Ambulance Services NHS Trust taking action to stop the person who has fallen going into hospital by passing the patients directly on to the occupational therapists.

Source: Wales Audit Office fieldwork

8 Torfaen ACAT, Promoting patient choice and preventing unnecessary hospital admissions, A Bupa foundation award submission June 2008.



Box 2 - Partner organisations in some areas have begun to work towards whole systems solutions through pooling parts of their budgets

Monmouthshire has taken a positive approach to sharing financial resources
Partners in Monmouthshire have used the Health Act (1999) flexibilities to develop two formal 'Section 33' agreements between health and social care services to provide integrated services using a pooled budget. These are at Monnow Vale and Maerdy Park.

Monmouthshire County Council, Monmouthshire LHB and Gwent Healthcare NHS Trust opened the Monnow Vale integrated care facility in 2006. The facility has a pooled budget and offers inpatient beds where GPs provide medical care, a nurse-led Minor Injuries Unit, a community care team and a reablement team as well as a wide range of other services. One service manager manages staff from all three partner organisations and as part of a Monmouthshire-wide scheme, discharge liaison nurses have access to social services budgets.

The main benefits from the scheme include robust multidisciplinary and multi-organisational working, under a common management structure within a single facility. Weekly multidisciplinary meetings and the use of a single unified management arrangement mean that patients are at the centre of the unit's processes and they are not passed between organisations or departments. Also, the common leadership has helped to develop a concept of a single patient pathway and has encouraged staff to work outside their rigid organisational boundaries.

Further lessons learned from the development of a Section 33 agreement are included in the more detailed information on our website (http://www.wao.gov.uk/assets/englishdocuments/DTOC_workshop_3_outputs.doc).

Partners in Cardiff are pooling parts of their budgets to provide CHC and long-term bed capacity
Cardiff Council and Cardiff LHB have agreed in principle to establish a pooled budget of the provision of CHC and long-term beds. The aim of these beds would be to provide care for patients who are awaiting an assessment of their eligibility for CHC funding, rather than keeping these patients in hospital beds until the end of the assessment process. This arrangement is likely to start with a shadow budget rather than a formal, pooled budget.

Source: Wales Audit Office fieldwork

resources. These examples have resulted from partners recognising that to put the citizen's needs at the centre of their service model, using staff in a more integrated way, has the potential to result in people receiving more seamless, co-ordinated and efficient care. Box 3 gives some of the positive examples we identified.

Senior engagement in tackling the problem has led to improvements in operational collaboration across the whole system

1.12 As well as collaboration at a strategic level, partner organisations need to work together at an operational level to ensure individual cases of delayed transfers of care are resolved as quickly as possible. In many areas there is now a greater sense of joint ownership of these operational problems. In general, organisations are working together more effectively to the benefit of the person experiencing the delayed transfer. Examples of progress are included in Box 4.

The Assembly Government has taken a number of positive steps to tackle delayed transfers of care

1.13 Many of our previous recommendations, as well as those made by the National Assembly's Audit Committee required action by the Assembly Government. We found that the Assembly Government has now taken a number of positive steps towards tackling the problems that result in delayed transfers of care. These steps include the Assembly Government's decision to accept all 14 recommendations made by the Audit Committee's report, alongside its consideration of the findings of the *Independent Review of Delayed Transfers of Care* commissioned by the Minister for Health and Social Services (the Minister).

Box 3 - Human resource sharing

Integrated management of intermediate care services in Torfaen

Partner organisations in Torfaen have developed a model of intermediate services that is managed in an integrated way. This approach was implemented because intermediate care services in the county had developed in a piecemeal fashion and were not working together effectively to address the needs of vulnerable people.

A single manager was appointed in March 2008 to manage Torfaen's main intermediate care teams. Some of these teams consist of health service staff while other teams are made up of social care staff.

The partner organisations introduced the integrated management approach as part of a move towards integrated commissioning of intermediate care. By integrating the commissioning process, the partner organisations hoped to achieve more joined up planning of intermediate care and services that are more efficient and effective with less duplication of effort and greater pooling of resources, ideas, knowledge, manpower and purchasing power.

Integrated occupational therapy in Monmouthshire

Monmouthshire has restructured its occupational therapy services so that therapists from Monmouthshire County Council and those from Gwent Healthcare NHS Trust can work in a more integrated fashion to promote independence and build confidence of individual service users. A trust therapist is now managing the therapists from the trust as well as those from the council. This is enabling therapists to work more flexibly between the community and the hospitals. The approach has been rolled out across Gwent but the most significant progress appears to have been made in Monmouthshire and Torfaen.

Joint Hospital Discharge Team in Caerphilly

The JHDT in Caerphilly (Box 2) involves a single team comprising nurse case managers employed by Gwent Healthcare NHS Trust and social workers employed by Caerphilly County Borough Council operating flexibly across health and social care. Full details of this case study can be found on our website.

Joint Head of Adult Services and Director of Commissioning in the Vale of Glamorgan

Vale of Glamorgan Council and Vale of Glamorgan LHB have recently made a joint appointment of a Head of Adult Services/Director of Commissioning to strengthen partnership working in the commissioning and delivery of services.

Source: Wales Audit Office fieldwork

Box 4 - Partner organisations in many areas have improved the way they work together to resolve operational problems

Weekly locality meetings across Gwent have increased tactical awareness of the operational problems

In Caerphilly, where there have been significant problems with delayed transfers of care in 2008-09, senior managers of the LHB, local authority and Gwent Healthcare NHS Trust attend weekly meetings to discuss the locality's progress against the Auditor General's recommendations but also to deal with cross-organisational problems that are contributing to individual people experiencing delayed transfers of care. This senior manager involvement ensures that delayed transfers of care remain high on the agenda of the partner organisations and that the senior executives remain sighted of the problems facing operational staff and patients.

Weekly meetings of senior managers are also held in Torfaen and Blaenau Gwent. These have been effective in the early identification of operational problems. Partners in the Newport locality have agreed new escalation procedures where matters are referred to progressively more senior officials if problems relating to delayed transfers of care cannot be resolved. Previous escalation processes remain in place in Blaenau Gwent.

Monmouthshire report positive impact from discharge liaison nurses pulling patients through the system. There is senior involvement at discharge meetings and escalation mechanisms are in place.

The Community Timely Discharge Board in Cardiff and the Vale of Glamorgan

In Cardiff and the Vale of Glamorgan the multi-organisational Community Timely Discharge Board has been used as a forum for addressing the operational problems that contribute to delayed transfers of care.

The remit of this forum has recently been refocused and its work re-energised under the leadership of the trust's Chief Executive.

Source: Wales Audit Office fieldwork

1.14 The Minister indicated the commitment of the Assembly Government to tackling delayed transfers of care in a statement she made on 1 November 2007[9]. She acknowledged that delayed transfers of care mean that patients are receiving an inappropriate service and scarce resources are not being used effectively. She said that work was already underway to tackle delays but the change needed to go further and faster. The Minister has also set new targets for NHS bodies.

1.15 The Minister also wrote to NHS organisations and councils in October 2008 setting out her concerns about the risks to independence identified by our original reports and reaffirming her expectation that each community take the issue of delayed transfers of care as a key priority. She also set out her expectation that there should be profiling and early identification of likely delays and a more proactive approach to the management of complex discharges. A review of the current Choice guidance is underway and is expected to conclude during the summer of 2009.

1.16 Another significant action taken by the Assembly Government in addressing the problems contributing to delayed transfers of care, was in supporting NLIAH to develop the Passing the Baton programme. This programme was launched in June 2008 to promote effective discharges of care by providing organisations with numerous simple tools to apply to their services. During our fieldwork we found that Passing the Baton has been well received within the health and social care arena and if implemented properly the programme is expected to support improved management of patient flow through Welsh hospitals.

1.17 Work is also underway to remove local agreements from the census process, revise the delayed transfers of care database and review the central choice guidance. Local organisations have provided feedback to the Assembly Government, which is now considering its response. The Assembly Government has also commissioned NLIAH's Change Agent Team to repeat its discharge self-assessement tool work during the 2009-10 financial year to focus on improving discharge and transfer practice. Discussions are at an early stage within the Assembly Government about how the health and local government performance management frameworks might be aligned.

The extent and impact of delayed transfers of care is reducing despite some periodic challenges to the sustainability of the improvement

There have been welcome reductions in the number of bed days lost in Cardiff and Vale NHS Trust, but progress may be difficult to sustain

1.18 Measuring the true extent and impact of delayed transfers of care is difficult to achieve. By definition, delayed transfers of care are a symptom of wider, whole systems problems and are therefore a surrogate measure of these whole systems problems. But the value of measuring the extent of delayed transfers of care is that it gives an indication of the problems inherent in the system and the specific problems for individual citizens and their families.

9 Minister for Health and Social Services,1 November 2007 http://wales.gov.uk/news/topic/health/2007/1776169/?lang=en.

1.19 Census data suggests that across Wales there has been a significant reduction in bed days lost since our original reports of November 2007. Our own analysis of the actual bed days lost, rather than the snapshot census data, also showed an encouraging downward trend.

1.20 Within the Cardiff and Vale and Gwent communities, our analysis in Figure 1 shows that the total extent of delayed transfers of care across Wales reduced slightly between 2006-07 and 2007-08. The census data suggests more rapid progress during 2008-09. Figure 1 also shows that the number of bed days lost in Cardiff and Vale NHS Trust reduced by 24 per cent between 2006-07 and 2007-08, driven by reductions in mental health delays rather than delays in non-mental health settings. This number has reduced 20 per cent for Cardiff residents and 28 per cent for residents of the Vale of Glamorgan.

1.21 Figure 2 shows that in Cardiff and Vale NHS Trust there have been particular improvements in the number of bed days lost due to delayed transfers of care for social care reasons and patient/family/carer reasons. The number of bed days lost because of social care reasons has fallen by 36 per cent between 2006-07 and 2007-08 and the bed days lost for patient/family/carer reasons has reduced by 26 per cent.

Figure 1 - The total extent of delayed transfers of care across Wales reduced slightly between 2006-07 and 2007-08

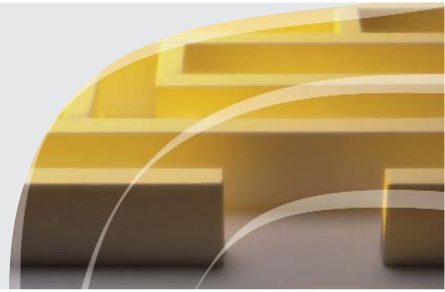
	Bed days			Patients		
Trust	**2006-07**	**2007-08**	**Change**	**2006-07**	**2007-08**	**Change**
Cardiff and Vale	77,513	59,257	-24%	949	755	-20%
Gwent Healthcare	44,456	47,350	+7%	816	815	-0.1%
All Wales total	268,491	257,507	-4%	5,182	5,079	-2%

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

Figure 2 - There have been large reductions in the number of bed days lost due to social care reasons and patient/family/carer reasons in Cardiff and Vale NHS Trust

	Bed days		
Reason	**2006-07**	**2007-08**	**Change**
Healthcare reasons	15,362	14,645	-5%
Not recorded	0	0	0%
Patient/carer/family	48,403	35,718	-26%
Principal reason not agreed	190	237	25%
Social care	13,558	8,657	-36%

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

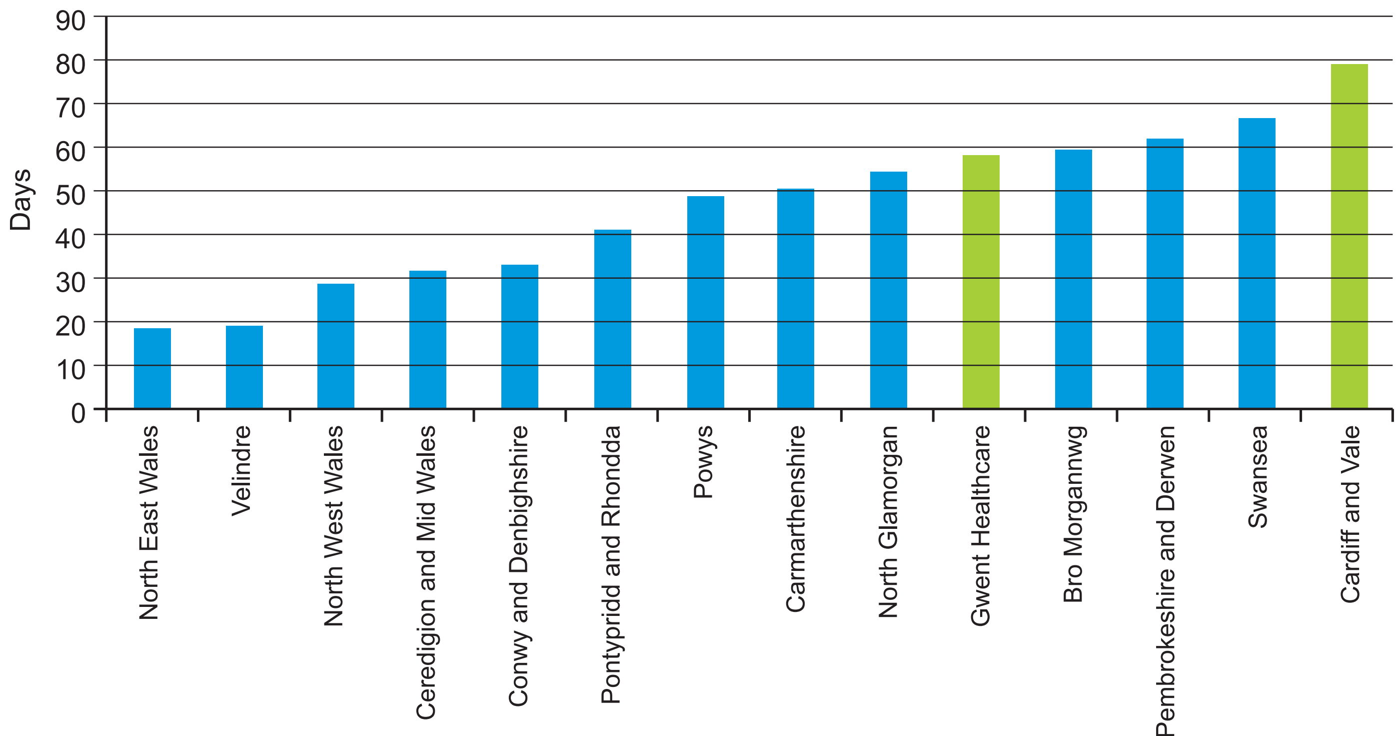


1.22 Figure 3 shows that the average duration of a delayed transfer of care in Cardiff and Vale NHS Trust is the highest of all trusts in Wales. However, the average duration of a delayed transfer of care has reduced slightly in Cardiff and Vale NHS Trust from 82 days in 2006-07 to 79 days in 2007-08.

1.23 Although the actual bed days lost in the 2008-09 financial year are not yet available, the monthly census shows that the number of patients experiencing a delayed transfer of care in Cardiff and Vale NHS Trust had experienced an increasing trend between April and December 2008. While the census figures represent a notable improvement relative to April 2007 when there were 181 people experiencing a delayed transfer of care, the 119 people in December 2008, which reduced to 101 in February 2009, still represents a significant drain on the trust's capacity. There has been a particularly dramatic reduction in delayed transfers of care among residents of Cardiff, with a fall of 44 per cent in the numbers counted by the census between April 2007 and December 2008. Figure 4 shows the trend in the census data for residents of Cardiff and the Vale during the first nine months of the 2008-09 financial year.

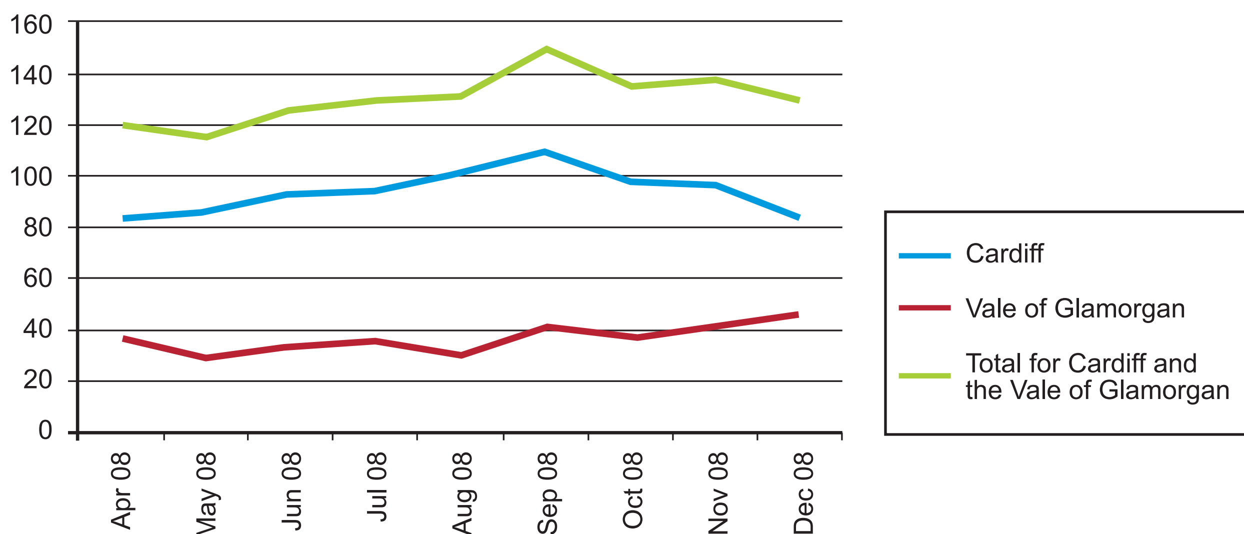
1.24 In Cardiff and Vale NHS Trust beds, the problems sustaining the initial progress have been accompanied by an apparent emergence of delays due to patients at various stages of the NHS CHC process (assessing eligibility or those remaining in trust beds as the most appropriate place for them to receive their CHC) which are not consistently captured within the definitions

Figure 3 - Cardiff and Vale NHS Trust had the longest average duration of a delayed transfer of care in Wales during 2007-08



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

Figure 4 - Number of patients in Cardiff and the Vale experiencing a delayed transfer of care between April 2008 and December 2008



Source: Wales Audit Office analysis of delayed transfers of care census data.

that govern the delayed transfers of care census. It is to the Trust's credit that it has introduced an additional census in an attempt to quantify the extent of this pressure on its beds. In October 2008 this census showed that there were 27 CHC patients who were counted as delayed transfers of care and a further 111 CHC patients who were occupying trust beds but for various reasons were not being counted as a delayed transfer of care. Of this 111 people, 27 were in the process of being assessed for CHC eligibility, 49 were considered to be eligible for CHC and 35 were not eligible for Continuing Healthcare.

1.25 When hospital beds are occupied unnecessarily, either through delayed transfers of care or because of some aspect of the CHC process, this has a direct impact on a trust's ability to deliver services for people who genuinely require hospital care. Delayed transfers of care have been a significant factor in exacerbating severe winter bed pressures within Cardiff and Vale NHS Trust in December 2008 and January 2009. The trust's Management Board says these pressures are the worst ever seen within the trust and in December 2008, the minutes of the Community Timely Discharge Board described these winter pressures as representing 'the highest risks ever seen by the trust'. The trust's Management Board is now planning urgent action to free up the significant minority of the trust's beds that are occupied by delayed transfers of care or those awaiting CHC assessments or arrangements.

Between 2006-07 and 2007-08, there was a slight increase in the impact of delayed transfers of care through bed days lost in Gwent, but more recently there has been a considerable reduction in the number of people experiencing delays

1.26 Figure 1 shows that in Gwent, the number of lost bed days increased seven per cent between 2006-07 and 2007-08. This increase was primarily driven by a 97 per cent increase in lost bed days resulting from healthcare reasons and a 37 per cent increase in the bed days lost because of patient/family/choice

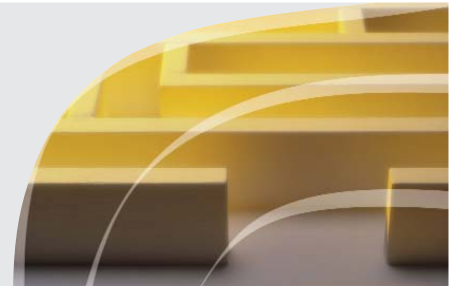


Figure 5 - There has been variable progress in the Gwent localities

	Lost bed days			Census data
	2006-07	**2007-08**	**% change**	**% change in the number of patients April 2007 to December 2008**
Blaenau Gwent	2,572	3,142	+22	Single patient – numbers very low
Caerphilly	8,137	12,799	+57	-79%
Monmouthshire	5,116	4,378	-14	Single patient – numbers very low
Newport	14,343	9,842	-31	-33%
Torfaen	15,382	20,100	+31	-52%

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

reasons. The average duration of a delayed transfer of care increased from 55 days in 2006-07 to 58 days in 2007-08 suggesting that those patients that become a delayed transfer of care are staying in hospital even longer. Figure 2 shows that the average duration of a delayed transfer of care in Gwent Healthcare NHS Trust is the fifth highest of the trusts in Wales.

1.27 Figure 5 shows that within the five localities in Gwent there has been variable progress between 2006-07 and 2007-08. Whilst the number of lost bed days has decreased by 14 per cent in Monmouthshire and 31 per cent in Newport, this figure increased by 57 per cent in Caerphilly, 31 per cent in Torfaen and 22 per cent in Blaenau Gwent.

1.28 Between 2006-07 and 2007-08 in Gwent Healthcare NHS Trust there was a large increase in the number of bed days lost through healthcare-related delayed transfers of care. Figure 6 shows that this figure increased 97 per cent while the number of bed days lost for patient/family/carer reasons increased 37 per cent. The number of bed days lost for social care reasons has fallen by 40 per cent over the same period.

1.29 There are suggestions that the extent of delayed transfers of care in Gwent has begun to decrease but there is not enough evidence about the number of bed days lost to quantify this.

1.30 However, we can draw from the census, which counts the number of patients experiencing a delayed transfer of care once a month. This is a snapshot and is therefore by its nature limited in the sense that it provides an indication of the number of delays and the number of patients delayed during a given period each month. Nevertheless, it provides some evidence about trends and indicates the extent of bed days lost to the NHS due to delays. For the 2008-09 financial year, the number of patients experiencing a delayed transfer of care in Gwent has decreased considerably. The number of patients who experienced a delayed transfer of care remained stable in most localities, with significant reductions between April 2007 and December 2008 in the Caerphilly and Torfaen localities which experienced the most significant problems with delayed transfers of care. The census also suggests an encouraging long-term trend across the five Gwent localities, with a reduction from

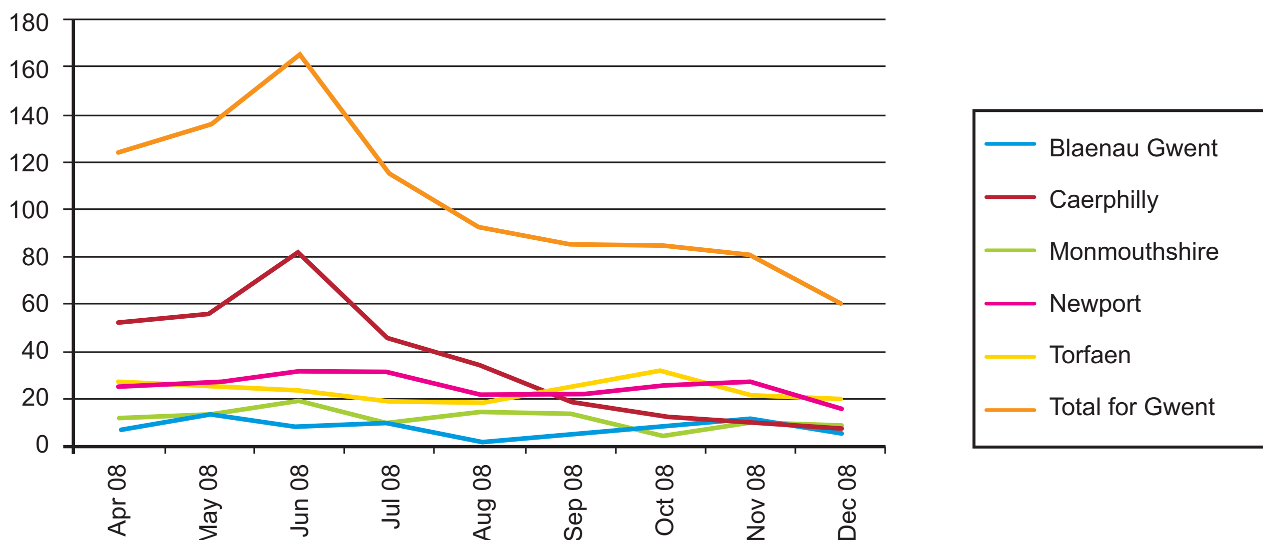
124 people in April 2007 to 60 in December 2008 (Figure 7). This reduced further to 40 in February 2009.

Figure 6 - There has been a large increase in the number of bed days lost due to healthcare reasons in Gwent Healthcare NHS Trust

	Bed days		
Reason	**2006-07**	**2007-08**	**Change**
Healthcare reasons	4,561	8,974	97%
Not recorded	0	0	0%
Patient/carer/family	18,600	25,418	37%
Principal reason not agreed	220	290	32%
Social care	21,075	12,668	-40%

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

Figure 7 - Changes in the number of people experiencing a delayed transfer of care in the Gwent localities between April and December 2008



Source: Wales Audit Office analysis of delayed transfers of care census data

Part 2 - Partners have not yet delivered consistently effective action to address the longer-term barriers to independence across the whole system

There are strategic visions for promoting independence but at a local and national level, there is little evidence of robust long to medium-term planning to turn these visions into reality

There is not a coherent national vision of how health and social care communities should tackle the whole systems problems that cause delayed transfers of care

2.1 Part 1 of this report shows that there has been some good progress in addressing the barriers that contribute to delayed transfers of care. Part 2 of this report shows that while this progress is very welcome, the problems that remain today are the most difficult to solve.

2.2 One of the most fundamental remaining problems is that there is still not a clear strategic framework, at either a national or local level, for rebalancing the system of health and social care. Such a strategic framework is vital because the remaining problems that contribute to delayed transfers of care are intractable and manifest themselves throughout the whole system. The need to establish a coherent strategic vision to improve the function of the whole system emerged as a key theme from our Shared Learning Seminar where delegates felt that local action was taking place in the absence of an overall national vision.

2.3 Despite the positive steps taken by the Assembly Government (paragraphs 1.13-1.17) there is not yet a clear overall direction to tackling the whole systems problems of delayed transfers of care. The strategic context is set by the various documents listed in Figure 8 but the high level objectives from these national strategies have not been consistently linked to local business and financial planning and there is no Wales-wide vision of how the whole system should function.

2.4 The Assembly Government's response to our previous work has correctly recognised that the multi-factorial nature of the problems of delayed transfers of care and the Assembly Government has concluded that there is no 'one-size-fits-all' solution. This is a perfectly reasonable position to take because our work has highlighted the differences in the problems being faced between Gwent and Cardiff and the Vale of Glamorgan, as well as in Carmarthenshire as part of the original report of 2007. Nevertheless, there are important common factors in the challenges being faced by health and social care communities across Wales and partner organisations may benefit from a firmer central steer on how they should approach these whole systems problems.

There are some examples of innovative strategic thinking at a local level but most areas still need to develop clearer plans to deliver services that effectively promote independence across the whole system

2.5 Delayed transfers of care are a symptom of problems at various points along the patient's pathway through the health and social care system. Therefore local partner organisations need to develop local strategic visions that plan improvements across the whole system to promote independence more effectively. We found that there has been little progress in this area. A key finding of our follow-through work has been that many of the actions that partner organisations have taken so far have been implemented in the absence of any overarching vision of how the whole system should function which may compromise the sustainability of any incremental improvements.

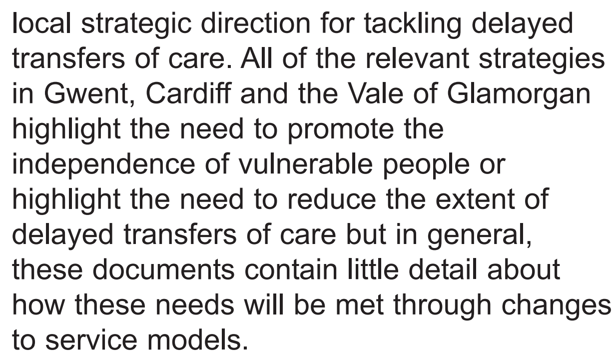
2.6 In respect of developing a clear and shared vision of services, the Assembly Government is relying heavily on Local Service Boards (LSBs) and Health, Social Care and Well-Being (HSCWB) strategies. This is potentially problematic because LSBs are not statutory decision-making bodies and do not control resources.

2.7 Local partner organisations are statutorily bound to collaborate in the production of HSCWB strategies. This process provides an opportunity for these organisations to map out their strategy for improving the function of the whole system to remove problems such as delayed transfers of care. These strategies were revised in 2008 and this was a major opportunity to improve the whole systems approach to commissioning services so that they work more in favour of vulnerable people. However, HSCWB strategies are, in their current form, insufficient for setting the

Figure 8 - There are several documents that set out the strategic context for addressing delayed transfers of care

Document	Relevance to delayed transfers of care
Making the Connections	Sets out the Assembly Government's overall agenda for Welsh public services, which is based around a focus on the citizen, value for money, collaboration in service delivery and public engagement.
Designed for Life, 2005	The Assembly Government's 10-year plan to create world-class health and social care in Wales, covering the period 2005-2015, which indicates a number of targets that communities will have to set and achieve.
Fulfilled Lives Supportive Communities, February 2007	Ten-year strategy for social services in Wales, which sets out a general direction to improve the effectiveness with which social services promote independence. Work to implement Fulfilled Lives, Supportive Communities is ongoing.
National Service Framework for Older People, 2006	National standards for health and social care services and equity of access for older people in Wales.
Strategy for Older People, 2003	The Assembly Government's 10-year strategy for older people in Wales.
Annual Operating Framework 2008-09	Sets new targets for delayed transfers of care for each health community.

Source: Wales Audit Office



local strategic direction for tackling delayed transfers of care. All of the relevant strategies in Gwent, Cardiff and the Vale of Glamorgan highlight the need to promote the independence of vulnerable people or highlight the need to reduce the extent of delayed transfers of care but in general, these documents contain little detail about how these needs will be met through changes to service models.

2.8 Within the Cardiff and Vale and Gwent health and social care communities there are other key strategic documents that set out high-level visions for the future of local health services, responding to the Assembly Government's Designed for Life strategy. In both communities, there are key risks that may affect the delivery of the strategic plans.

2.9 In Gwent, this vision is provided by Clinical Futures, which was developed in 2006 to address the health service modernisation agenda across the Gwent health and social care community. A separate piece of Wales Audit Office assurance work in Gwent found that while considerable progress has been made in developing arrangements to support the implementation of Clinical Futures, there remain a number of high level risks which need to be addressed to ensure the programme is implemented comprehensively and within required timescales. The Assembly Government's Minister for Health and Social Services recently called for a further review of the £292 million business case for the Specialist Critical Care Centre, asking the partners to undertake further work assessing the service model changes and demonstrating that proposals are 'ambitious, right and deliverable'.

2.10 In Cardiff and the Vale of Glamorgan, the equivalent programme is the PHSI. Our fieldwork identified that while there is widespread commitment to the principles of PHSI, there needs to be rapid progress in translating PHSI into tangible service change at a level that will promote the independence of vulnerable people.

2.11 Torfaen is one health and social care community that has begun to think comprehensively about how to develop a strategy which involves each partner organisation contributing to a better-functioning whole system. The council and LHB in Torfaen have been developing joint approaches to commissioning and intermediate care with a view to improving results and the patient journey. And the LSB is encouraging all partner organisations to use an approach to systems planning and performance management which focuses more clearly on results for older people.

2.12 Another example of a health and social care community taking an innovative and holistic approach to tackling delayed transfers of care is in West Lothian, Scotland. Partner organisations in this locality have developed a long-term strategic vision of how the whole system should function and this has helped to deliver sustainable change, improve outcomes for patients and find new ways of working across health and social care to deliver the shared vision (Case Study B). The improvements in West Lothian highlight the importance of taking a holistic view of the issues to produce sustainable changes.

Case Study B - A whole systems approach resulting in sustainable improvement – West Lothian

http://www.wao.gov.uk/assets/englishdocuments/West_Lothian_case_study_full_eng.pdf
Health and social care partners in West Lothian took their close collaborative working to the next level when in 2005 NHS Lothian and West Lothian Council entered into a formal partnership agreement. This was the beginning of a vision of health and social care services that has developed into cost benefits and positive impacts on service users.

Scottish health boards and councils were required to establish Community Health Partnerships, but building on a tradition of strong collaboration, the partners in West Lothian saw an opportunity to also include the 'care' element within the West Lothian CHCP.

The CHCP board became responsible for planning a substantial range of services including all primary care services and social services.

An immediate priority for the partnership was to develop a clear vision of how services should be delivered through innovative joint working and by focusing on the things that really make a difference to people. Partner organisations carried out a joint assessment of the current and projected needs of the population and used this information to set out the outcomes that the partnership should deliver for service users. These outcomes, which included improving health and wellbeing, reducing health inequalities and giving children the best start in life, were the focus of the partnership's vision document entitled Better Health Better Care.

A major finding from the needs assessment was that demand was predicted to rise among people who have fallen or who were at risk of falling. The vision therefore set out the potential to use smart technology and different telecare initiatives were trialled. The partnership has now developed a proactive and preventative approach by creating an integrated home safety service.

Staff have been brought into joint teams and budgets have been aligned rather than pooled. An integrated team of health and social care professionals runs the 24 hour Home Safety Service . Every user of the Home Safety Service has a lifeline machine that acts as the hub for two-way communications between the person's home and the service's call centre.

The lifeline machine uses various technologies to monitor factors such as the person's movements and blood pressure as well as technology to raise an alarm if the house becomes flooded or if it has high carbon monoxide levels.

The partnership is now the biggest user of telecare services in Europe and there is evidence that the Home Safety Service is making a real difference. There has been very positive feedback from service users, there has been a considerable reduction in the number of people experiencing delayed discharges and there has been a reduction in the average length of stay in care homes. There are also cost benefits of the Home Safety Service because the annual cost of supporting a person within the service is £8,681 compared to the £21,122 annual cost of a care home placement and the £46,696 annual cost of a long term hospital bed place.

Key success factors in West Lothian have been the emphasis placed on empowering staff and strong financial management with knowledge of unit costs allowing for convincing business cases. Change has been driven by a high level of senior executive commitment at all stages and by investing time in raising the awareness of staff, users and carers so that there is shared understanding.

Telecare is now firmly embedded as a key service in the community but there is scope for further development. The partners now aim to formalise their governance arrangements, develop pooled budgets, implement joint performance management and expand the use of the technology to manage long-term conditions.

Source: Wales Audit Office visit to West Lothian and Shared Learning Seminar

Problems with medium to long-term planning are resulting in models of care that do not consistently promote the independence of vulnerable people

Medium to long-term planning is poorly informed because of weak forecasting of need and the need for more effective transfer of innovative practice

2.13 In the general absence of coherent, shared visions of how the whole system should function, it is difficult for medium to long-term planning within the local communities to decide on the most appropriate range and balance of services that should be provided.

2.14 Effective planning is inhibited by insufficient and inadequate forecasting of demand and costs. The limited forecasting work that has been carried out relies on insufficiently detailed information, leading to predictions about the demand for services and the costs of service models that are not as robust as they should be. An example of success in this area is shown in Case Study C where partner organisations in Poole collaborated in carrying out a holistic assessment of need before planning the community's revised model for intermediate care services.

2.15 Planning is further inhibited by the generally poor evaluation that takes place once a health and social care community implements an innovative approach to promoting the independence of vulnerable older people. This lack of robust evaluation has contributed to difficulties mainstreaming successful approaches because many communities are reticent about adopting innovative approaches unless there is robust evidence that the approaches work and are scalable to their own circumstances.

Medium to long-term planning does not consider effectively how resources might be moved around the system to break the vicious circle that draws people towards institutional care

2.16 A fundamental problem with local level planning is that partners are not considering effectively how resources might be moved from one part of the system to another. In our 2007 report, we said that the remodelling of services was being hindered because of the cost pressures facing individual organisations that restrict their ability to invest in whole systems solutions; this continues to be a problem today. Financial resources are being locked into certain services, such as the acute health sector and high-cost social care packages, thereby drawing people towards institutional care and propagating a circle of dependency where individual vulnerable people are not given a sufficient chance of maintaining and regaining their independence. This expenditure, which represents 'failure demand' where the system is paying an increased cost because it is not able to provide the most appropriate services, effectively crowds out investment in earlier, lower-level interventions that might prevent admission in the first place or significantly reduce the risk of readmission. Perversely, financial pressures and the costs of the current service configuration can act as a rational driver for local authorities to consider more restrictive eligibility criteria for social services.

2.17 In 2007, we recommended that local authorities and LHBs should identify clear and costed strategies to enable the transfer of resources from acute to community services, which may require LHBs and councils to identify transitional funding to enable new services to be set up before existing models are decommissioned. We have found little evidence of any progress in this area within Cardiff and the Vale of Glamorgan and Gwent. However, the success of a pilot scheme to integrate intermediate care between health and social care in Poole has resulted in a shift in NHS funding from secondary care to primary care (Case Study C).

By failing to commission the right balance of services, partner organisations are now suffering problems with the cost and capacity of their services

2.18 The failings of medium to long-term planning are having a direct impact on patients because most areas continue to have an inadequate range of services and there are cost and capacity problems in the services that they do provide.

2.19 Not every patient experiencing a delayed transfer of care requires a care home placement - many patients with mental health needs or learning disabilities require a move

Case Study C - Partner organisations in Poole have successfully moved financial resources around the system of health and social care to fund a new model of services

Partner organisations in Poole recognised that their model of services was not optimally addressing the needs of vulnerable people. They collaborated in preparing a holistic assessment of needs to inform their redesign of services. This assessment drew on information held by NHS Bournemouth, the Borough of Poole Council and it used other national data sources.

The analysis identified pressure points in services and found that three ward areas were suffering higher than average admissions to hospitals and high levels of delayed discharges from hospital.

Bournemouth and Poole Primary Care Trust (PCT) and Poole Borough Council then agreed to develop a pilot integrated health and social care service for these wards. The scheme successfully bid for a grant from the Department of Health's Partnerships for Older People Project and the £400,000 was used to establish integrated teams in each ward. The grant funding was essential in developing the pilot approach.

The Poole Integrated Care (PIC) Service was designed to prevent unnecessary admissions to hospital and residential care, facilitate rapid hospital discharge and support carers at times of need. To achieve these aims the service included:

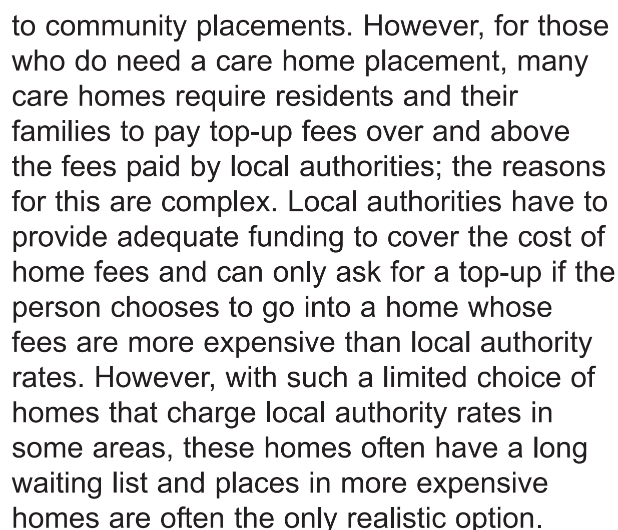
- **a** close collaboration with GPs in the ward areas with a single phone number for GPs to use as a gateway to intermediate care services;
- **b** a single locality manager to work closely with GPs; and
- **c** providing a range of services to prevent unnecessary admissions such as rapid access to diagnostic tests, prompt assessments from therapists and intensive home care support.

The PIC pilot proved to be very effective and resulted in a reduction in the number of hospital bed days lost through delayed transfers of care and a reduction in hospital admissions.

This clear evidence of success persuaded the trust to adjust its allocation of resources from secondary care to integrate primary care services. The PIC received £920,000 in NHS funding plus £535,000 from the council.

From February 2008, the integrated approach adopted in the pilot scheme was rolled out across the borough.
http://www.wao.gov.uk/assets/englishdocuments/Poole_partnerships_case_study_full_eng.pdf

Source: Wales Audit Office fieldwork



to community placements. However, for those who do need a care home placement, many care homes require residents and their families to pay top-up fees over and above the fees paid by local authorities; the reasons for this are complex. Local authorities have to provide adequate funding to cover the cost of home fees and can only ask for a top-up if the person chooses to go into a home whose fees are more expensive than local authority rates. However, with such a limited choice of homes that charge local authority rates in some areas, these homes often have a long waiting list and places in more expensive homes are often the only realistic option.

2.20 An indication of localities having an imbalance in the range and capacity of services they provide, is the existence of vacancies in care homes. We found that vacancies are widespread despite a high incidence of delayed transfers of care. For example, analysis by one of the LHBs suggested that across Gwent on 15 January 2009 there was a total of 112 residential placement vacancies, 120 nursing home placement vacancies, 21 EMI residential placement vacancies and 20 EMI nursing placement vacancies. These vacancies can occur for a wide range of reasons including placements being unaffordable due to the need for top-ups, concerns about the quality of care leading to people avoiding such homes and because the type of beds available in homes might not match demand in the locality, for example, homes may be registered to offer places for frail elderly patients when the major demand is for EMI places.

2.21 Many of the health and social care staff that we interviewed during our fieldwork told us that there is insufficient affordable EMI capacity in their community. As a result, patients with EMI needs often face long delays in hospital beds before an EMI nursing or residential bed can be found. However, with most communities uncertain about the ideal range and extent of services that their local population needs, it is difficult to say whether these patients could be appropriately provided for in other ways. It is true to say that many care homes are reluctant to offer EMI placements because the regulatory requirements for organisations inspected by the Care and Social Services Inspectorate Wales (CSSIW) are much more stringent, as well as shortages of registered mental health nurses. These requirements drive up the cost of these beds and local authorities and LHBs can be reluctant to pay such fees.

2.22 Some areas have begun to develop innovative approaches to providing services for people with EMI needs. These include:

- **a** In an effort to ensure the right types of capacity are developed in Caerphilly, the LHB and council have advertised for expressions of interest to develop EMI facilities. The council is also considering redeveloping some of its existing homes so that services for people with dementia can be developed.
- **b** Partners in Newport are considering developing a reablement service that focuses specifically on people with dementia.

2.23 Commissioners are also struggling to ensure there is an appropriate range of local services for delivering CHC services in Gwent and in Cardiff and the Vale of Glamorgan. This is resulting in significant numbers of NHS trust beds being occupied by patients receiving CHC when their care might be better delivered in an alternative setting. The marginal cost of these placements is potentially significant particularly given the long-term nature of patients' stays in such beds. Large numbers of Cardiff and Vale NHS Trust's beds are occupied by patients

receiving CHC but the LHBs have only recently set out clearly how many of the trust's beds they wish to commission for CHC patients. A separate problem for Gwent Healthcare NHS Trust is that it continues to provide long-term care for most of its delayed transfers of care in community hospital beds which will significantly reduce in number under the plans set out in Clinical Futures.

The planning of intermediate care has not yet succeeded in removing the fragmentation, overlap and poor linkages that exist between services but there are early indications of progress in many areas

2.24 Our 2007 work highlighted problems with intermediate care. There was scope to better integrate these services to remove duplication of effort and ensure services are appropriately resourced to meet demand. Health and social care staff were often confused about the availability of intermediate care services because the range and extent of services varied widely between different locations and because similar services were called different things in different areas.

2.25 We recommended that the Assembly Government should produce a model describing common levels of intermediate care services to improve understanding and encourage more appropriate use of these services. There appears to have been no progress in the development of the model. However, in 2008 the Change Agent Team in NLIAH launched a Community of Practice for Intermediate Care to support practitioners in raising the profile of these services and also to bring practitioners together to explore solutions to common issues. In addition, the Social Services Improvement Agency is working with a group of authorities looking at reablement.

2.26 Whilst our follow-through work found that, in general, the provision of intermediate care services remains fragmented with duplication of some services, we have also found several examples that suggest some of these issues are beginning to be addressed, in accordance with the broader aims of the National Service Framework for Older People. These examples are highlighted in Box 5.

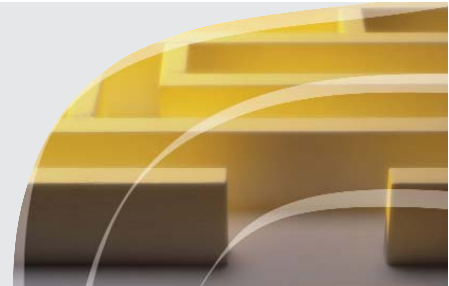
Partners have not yet, in general, developed effective approaches to sharing financial and human resources

Financial resources have not been consistently shared across the whole system

There are examples of effective sharing of financial resources outside Wales but there has been little progress within Wales

2.27 Our original report described the 'vicious circle', whereby resources are locked into the acute health sector and high cost social care packages, with short-term financial pressures on individual organisations squeezing longer-term investments across the whole system. It also highlighted the fact that partner organisations were not consistently sharing financial resources.This is still the case.

2.28 The Assembly Government is actively encouraging the use of pooled budgets in Wales and has issued central guidance on how to develop such approaches (http://wales.gov.uk/topics/improvingservices/poolbudgets/?lang=en). Although there is now clearly raised awareness and some services are developing, including the Community Equipment Services capital grant which has required the use of pooled budgets, these efforts have not yet delivered new examples



Box 5 - We identified several examples of partner organisations beginning to address the problems of poorly integrated intermediate care services

Torfaen – Partner organisations in Torfaen have agreed a shared model for integrated Intermediate Care Services. The joint intermediate care strategy was agreed in December 2007 and the strategy includes plans for a single contact point for all intermediate care services. A manager was appointed to run the integrated service in March 2008.

Pan-Gwent – Since we last reported, two multi-agency events have been held in Gwent to discuss intermediate care provision. The Clinical Futures level 1 sub group is the community's main forum for discussing intermediate care and community services and included within the Pan-Gwent Frail Older People's Project (Case Study A) is the intention of implementing a single access point for intermediate care services across Gwent.

Newport – Partner organisations in Newport have developed a joint Intermediate Care Strategy through the multi-agency Intermediate Care Policy Group. Since March 2005, the main intermediate care services in Newport have been co-located at St Woolos Hospital. This facility provides multi-professional support from organisations including the council, LHB, NHS trust and Age Concern. Whilst the services are not entirely integrated, they do have overarching aims and integrated working practices to ensure care is provided by the right person at the right time. Partner organisations are now considering further expanding the integrated facility to include a rapid response social care function.

Caerphilly – Wanless funding has been used to provide numerous intermediate care services in Caerphilly but our initial work highlighted that there was a lack of robust evaluation of the effectiveness of these services. The LHB's Service Evaluation Group has now implemented a formalised annual programme of evaluation of such schemes. This has already resulted in the disinvestment in certain ineffective schemes to redirect funding towards successful schemes that required additional resources to meet demand.

Cardiff and the Vale of Glamorgan – CELT is a recent development which has the potential to be a positive example of admission avoidance and discharge facilitation (Box 1).

Recognising that the time patients remained in beds designated for CHC while they awaited assessment was unacceptably long, the LHBs and trust in Cardiff and the Vale of Glamorgan have recently commissioned 70 transitional care beds in non-hospital settings to allow the assessment of CHC eligibility to be managed in a more appropriate setting.

Source: Wales Audit Office

of financial resources being shared to support service delivery across health and social care. Options available to the Assembly Government include compelling the use of Health Act flexibilities, setting up care trusts or aligning the budgets of partner organisations. Our Shared Learning Seminar included a workshop on sharing resources, which identified the range of available options, and the fact that there is no one-size-fits-all answer. Box 6 sets out the main conclusions from the workshop.

2.29 Some health and social care communities in Wales have derived benefits from pooling parts of their budget. One example is the Gwent Wide Integrated Community Equipment Service. This project was awarded a grant by the Assembly Government in 2007 to work towards an integrated equipment store with a common IT system, common policies and procedures, shared good practice and joint training. The partner organisations all contribute funds to the service that provides equipment such as bath seats, grab rails and stair lifts for vulnerable people across Gwent and partners are currently developing a formal Section 33 agreement. Another example of Welsh organisations pooling parts of their budget is in Cardiff where partner organisations have agreed in principle to pool funding for CHC services. Our previous report highlighted the two Section 33 agreements in place between

Box 6 - Main conclusions from our Shared Learning Seminar workshop regarding shared resources

The workshop concluded that sharing resources can have wide-ranging benefits for service users and for the various organisations providing services. However, the act of sharing resources is not enough on its own to improve the system. Delegates at the workshop felt that there are various factors that should be in place before sharing resources can be truly successful:

a partner organisations need to have agreed a common aim of partnership working that is specifically targeted at improving outcomes for individual people;

b regardless of the formal arrangements for partnership working and sharing resources, these arrangements will only lead to improvements in the system if there is good will and positive working relationships between operational staff from different agencies;

c communication between partners is essential to keepin initiatives on track and continually focused on the ultimate aim of improving services for people;

d the complications and difficulties in developing formal Section 33 agreements can derail efforts to share resources but delegates felt that where consultants, lawyers and finance experts were slowing down the process, there was scope to remind them of their role to move things forward rather than hold things up; and

e there may be objections to developing formal Section 33 agreements because partners might feel they are not worth the effort: delegates suggested carrying out a cost benefit analysis to decide these matters.

Source: Wales Audit Office Shared Learning Seminar http://www.wao.gov.uk/assets/englishdocuments/DTOC_workshop_3_outputs.doc

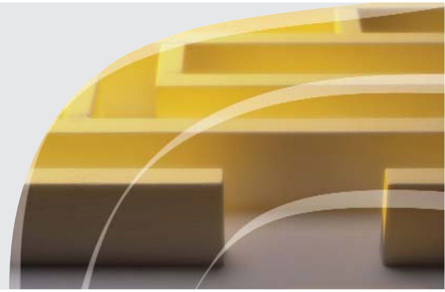
Monmouthshire County Council, Gwent Healthcare NHS Trust and Monmouthshire LHB.

2.30 There has been more progress in sharing financial resources in England and Scotland (Box 7), although not all of the examples involve formal pooling of budgets. The formal pooling of budgets is just one of a wide range of options available. Welsh organisations now need to learn from these examples.

Financial constraints, such as through the requirement to fund NHS Continuing Healthcare, are a major barrier to organisations sharing their financial resources

2.31 A significant barrier to the sharing of financial resources is that partner organisations are operating within considerable financial constraints. These constraints make some organisations reluctant to relinquish any control over their current resources despite the possible longer-term efficiencies and service improvements that might result from sharing resources. Constraints are placed on NHS bodies through the efficiency savings they are required to make through strategic change and efficiency plans; and the financial constraints in local government are such that some local authorities are considering further tightening eligibility criteria for their services so that they are obliged to provide services to fewer people.

2.32 An additional major cause of financial pressure for LHBs is through the requirement to fund NHS CHC. The 'Grogan judgement' of January 2006, together with other case law, has resulted in the NHS assuming greater responsibilities for funding long-term care. The direct consequences of the interpretation of policy after the 'Grogan judgement' are a reduction of the financial burden of long-term care on social services departments, and the



Box 7 - Organisations in England and Scotland have succeeded in addressing some of the whole systems problems by sharing financial resources

Care trusts have been developed in a number of communities in England.

In 2002 the Department of Health introduced a new type of NHS body responsible for providing integrated health and social care services. These care trusts are organisations that combine NHS responsibilities and the health responsibilities of local authorities under a single management structure. The aim is to provide more seamless care for individuals with simplified administration and management. Demonstrator sites include Bexley Care Trust, Bradford District Care Trust, and Camden and Islington Mental Health and Social Care Trust. Further details are available at the Department of Health's website at the following link: www.dh.gov.uk/en/Healthcare/IntegratedCare/Caretrusts/index.htm

Oxfordshire can demonstrate effectiveness of pooling budgets in minimising the impacts of delayed transfers of care.

During the late 1990's, Oxfordshire County Council and the then five Oxfordshire PCTs were faced with considerable budgetary pressure in respect of care for older people. Increased demand for services led the parties to conclude that it was only through partnership working, sharing resources to achieve common goals and smarter working that effective service provision could be sustained in the medium to long term.

Over a period of time the parties, started to collaborate more closely in respect of older people's services. Initially partnership arrangements did not include pooling of budgets. The arrangements developed incrementally and involved a joint service strategy and joint commissioning. The next stage was the development of a pooled budget arrangement covering care homes, intermediate care, equipment and continuing care. This arrangement has been successful in reducing financial and service pressures.

West Lothian CHCP has delivered tangible improvements through shared resources.
Details of this scheme can be found in Case Study B and on our website
http://www.wao.gov.uk/assets/englishdocuments/West_Lothian_case_study_full_eng.pdf.

Poole has had success in sharing resources across health and social care.
Details of this scheme can be found in Case Study C and on our website
http://www.wao.gov.uk/assets/englishdocuments/Poole_partnerships_case_study_full_eng.pdf.

Source: Wales Audit Office

removal of the financial cost from some people who had previously paid for their own care. This has resulted in significant increases in the CHC costs for LHBs and certain boards are now suffering severe challenges in meeting these costs. In Newport for example, the LHB's CHC costs have risen from around £7 million in 2005-06 to around £15 million in 2008-09.

2.33 When considering cases of individual patients who require long-term care, it is not always clear who should fund this care because of the difficulties determining eligibility for CHC; this can cause tensions between LHBs and local authorities. We understand that the relationships between these bodies have been tested further by local authorities choosing to dedicate staff to the sole purpose of reassessing cases where the local authority is funding continuing care to see whether these costs should now be met by the NHS because the patient's needs would be most appropriately met by health staff.

2.34 The Assembly Government has implemented changes that aim to ease the funding problems surrounding CHC. In setting out its budget for 2008-09, the Assembly Government announced that it would make

an additional £100 million available for CHC services. Of this sum, £50 million has been made available through LHB discretionary budgets to meet increasing demands, and a further £50 million was held centrally.

2.35 Of the £50 million held centrally, the Assembly Government has made £37.5 million available through a bidding process. There are risks about how effective the bidding process will be as bids were invited at the end of July with a deadline of the end of September. As of December 2008, decisions had not been made on all of the bids, although we understand that the majority were resolved by the end of January 2009. There will be a need to ensure that the delay in deciding the bids and allocating the funding does not affect the value for money it might achieve or lead to slow progress in improving processes that support CHC.

2.36 The Cardiff and Vale of Glamorgan community was recently successful in a joint bid for Assembly Government funding to support reductions in the impact of delays arising from the complex assessment processes for CHC funding, as well as to commission some new models of long-term community care. The community received the full amount of funding requested in its joint bid and sees the developments as a major opportunity to address the considerable and complex problems surrounding CHC.

Despite some positive examples of partner organisations using their staff in a more integrated way, there is not yet an effective framework for sharing human resources between health and social care

2.37 For the whole system to function smoothly and provide seamless care for citizens, people working within the system need to be able to work together effectively across organisational and sector boundaries.

2.38 In 2007, we identified scope to share staff or facilitate the rotation of staff between health and social care bodies. This, we said, would help to raise awareness of the issues facing individual bodies and increase understanding between these partner organisations. We recommended that the Assembly Government should look into potential solutions to the problem of health and social care staff being employed under different terms and conditions which was acting as a barrier to developing joint cultures; there appears to have been little progress in this area. At a local level, there has been little progress in developing a framework to support the use of generic health and social care workers or aligning terms and conditions between health and social care for those working in community settings.

2.39 Nevertheless, Box 3 gives examples of organisations sharing human resources to provide more seamless and efficient care despite the absence of an overarching framework. We found another positive example in Gwent where occupational therapists who are employed by Health and Social Services work together more effectively. Further details of this case study can be found on our website (http://www.wao.gov.uk/2302.asp). A positive example from outside Wales is in Poole (Case Study C) where NHS and local government organisations now provide the Poole Integrated Care (PIC) Service. This service involves integrated health and social care teams, with a single management structure.

2.40 A key message from our Shared Learning Seminar workshop regarding the sharing of resources was that staff often fear that the integration of health and social care workers will lead to a loss of professional identity. Delegates who have been through the integration process said that these fears are

unfounded and morale often improves if there is clarity about roles and responsibilities and about the value of each person's contribution to the overall results the partners wish to achieve for the population of vulnerable older people.

2.41 There is scope to develop a specialist career path in care of the elderly to avoid some of the problems experienced by localities wishing to recruit consultant geriatricians able to work in the community or a 'virtual ward'.

Clinical, executive and political leaders will need to plan for the longer-term to deliver a more integrated approach to promoting the independence of vulnerable older people

Political and executive leadership is needed to enable effective joint working as it requires organisations to give up some control to gain greater influence over the whole system

2.42 Solving the problems that cause delayed transfers of care requires co-ordinated change across the boundaries of all partner organisations. This kind of multi-organisational change needs to be driven by senior executives who are able to generate genuinely shared commitment to developing and implementing the change programmes. To meet these difficult challenges, organisational leaders, particularly at a political level, will often need to give up some power to gain a greater influence over results for their communities.

2.43 In general, we found evidence of greater awareness of the problems that cause delayed transfers of care and a greater sense of shared responsibility to address these problems; but we also found that partner organisations in many communities continue to face competing priorities, often created by their financial constraints, which act as a barrier to collaborating effectively to focus on the independence of vulnerable people.

2.44 Executive leadership is a key driver of successful collaboration and we have found evidence of greater executive awareness and engagement in issues related to delayed transfers of care. However, we have found that this senior engagement often focused on dealing with operational problems rather than changing the system.

2.45 An example of significant success in leaders committing to improving services for vulnerable older people is the Pan-Gwent Frail Older Person's Project (Case Study A) where 11 chief executives from Gwent signed a declaration to work together. The lessons learned from this example are that collaboration is difficult to achieve and it requires patience, the building of trust, the letting go of power and a constant focus on what is important for individual citizens. If partner organisations are to work together formally then there must be strong governance arrangements between these bodies.

2.46 The Assembly Government has emphasised the importance of LSBs in the future development of joint health and social care performance targets and performance management. Local service boards undoubtedly have a key role to play in providing strategic leadership for a more integrated approach to provision for vulnerable older people and, in recognition, some LSBs have focused their work on improving integration between health and social care. However, LSBs do not have formal decision-making powers or control of resources of their constituent members which could be a barrier to driving change if there is not strong collaborative leadership at political level.

Stronger clinical engagement is needed to deliver a model of care that focuses more strongly on promoting the independence of vulnerable older people

2.47 Health and social care communities might have robust and coherent plans for changing the function of the whole system but if they have done so without the support of the people who work within the system then these plans will fail.

2.48 Changes in the model of care will inevitably mean clinicians are required to change the way they work and therefore senior, influential clinicians must be engaged in the development of service models from the earliest opportunity. And even once the service model is implemented, partner organisations must succeed in persuading clinicians throughout the system to use services in the most appropriate way.

2.49 Emergency medical admissions in Blaenau Gwent have reduced considerably because of successful collaborative working between Blaenau Gwent LHB and GP practices in the community. The LHB has led changes that have resulted in fewer single handed practices and the use of more practice nurses. This has resulted in improved medicines management and more proactive, preventative work through initiatives such as disease registers and annual reviews.

2.50 A key success factor in the PIC Service (Case Study C) has been the close collaboration of the integrated teams with GPs. Each team has a locality manager who is specifically tasked with linking in with primary care to ensure GPs use the PIC Service whenever appropriate.

Partners have still not developed an effective way of measuring the performance of the whole system in promoting the independence of vulnerable people

There continues to be different performance indicators for delayed transfers of care in health and social care

2.51 One of our recommendations in 2007 said that local organisations should set joint targets to reduce delayed transfers of care and their causes. The setting of joint targets would ensure that partners have the same priorities and by making the partner organisations jointly accountable this would reinforce the message that partners need to find genuinely shared solutions to solve the problems across the whole system.

2.52 In October 2008, the Assembly Government altered its delayed transfers of care targets for health bodies, developing a three-year family of targets based on all LHB areas achieving, by March 2011, top ten percentile performance based on a 2007-08 baseline. The targets relate to the number of people and bed days per 10,000 population aged 75 or over. There are different targets for non Mental Health and Mental Health delays but the targets apply to all categories of delays to encourage partnership working and joint ownership by health and social care organisations.

2.53 Although the new targets clearly recognise the importance of partnership working, there remain different performance indicators for delayed transfers of care in health and social care organisations. This absence of genuinely shared joint targets for a whole community risks diluting the sense of joint ownership across organisations in health and social care.

Work is starting to address the failure to develop a whole systems performance measurement framework that focuses on outcomes

2.54 Unless a health and social care community's performance measurement framework monitors the outcomes of the system for citizens then there can be no effective evaluation of whether services are succeeding in providing the appropriate care for people. The CSSIW is currently commissioning a pilot of outcome based planning for this purpose.

2.55 The Welsh Local Government Association's Social Service Improvement Agency is also looking at outcomes and has commissioned four pilots across Wales aimed at developing an outcome-based approach.

Long-term agreements for community services are not as clear about the costs and outcomes they should provide as the equivalent agreements for acute services

2.56 There has been little progress to share information more effectively between health and social care and to develop a more robust long-term agreement for community services, where the data supporting the long-term agreement are not as robust as those supporting the long-term agreement for acute services. This needs to be supported by clearer financial arrangements to support the long-term agreements for community services, particularly to detail service volumes, standards, costs and outcomes.

Work is in progress to abolish local agreements

2.57 In all but one of the localities we examined during 2007 we found the existence of local agreements that distort the measurement of the extent of delayed transfers of care. Under such agreements, which apply to a limited number of codes for delayed transfers of care, 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.

2.58 We said at that time that there was no justification for these local agreements because they served merely to understate the extent of delayed transfers of care and potentially create perverse incentives for local authorities to wait until the time allowed by the agreement has nearly elapsed before making arrangements for the individual's care.

2.59 The Auditor General recommended that 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. Disappointingly, all of the local agreements remain in place today. The Assembly Government has accepted the Audit Committee's recommendation to abolish local agreements from the census process and has decided to progress this as part of wider work on the delayed transfers of care census and database development currently underway.

Problems with processes remain a barrier to a more citizen-focused approach

Unified Assessment remains a problem because its weaknesses have not yet been addressed

2.60 Unified Assessment is the process of assessment, by a multi-disciplinary team of health and social care staff, of an adult's care needs. Unified Assessment was introduced in April 2005 and was intended to deliver multi-disciplinary assessments of patients' needs.

2.61 In our 2007 work we found that the Unified Assessment had many potential benefits but was proving difficult to implement because of ICT issues and because of variations, by area, in the approach to Unified Assessment. There is also a view that Unified Assessment is a social care, rather than joint, assessment process. These problems remain today although the Assembly Government, in partnership with the NLIAH, is currently reviewing specific aspects of the Unified Assessment Process. Once it has issued the final CHC framework, the Assembly Government will then consider the feasibility of issuing all-Wales documentation for Unified Assessment.

A more flexible approach to the assessments for Continuing Healthcare could deliver a more citizen-focused approach

2.62 We found evidence that processes surrounding the CHC framework do not always provide people with appropriate opportunities to maximise their independence, for example, assessments for CHC eligibility do not tend to consider the possibility of the individual undergoing a programme of reablement. And once a package of CHC has been agreed there is a need for greater flexibility so that people who are found to be eligible for such care do not necessarily go into a nursing home for the rest of their lives.

2.63 To ensure that people who qualify for CHC are given every opportunity to regain and maximise some degree of independence, the Assembly Government should consider models that allow individuals to receive CHC as an interim solution followed by a programme of re-assessment to ensure their package of care remains the most appropriate. In 2008, the Assembly Government consulted on a revised Continuing NHS Healthcare framework, which included a tool to support decision making, but has not yet issued the final document pending the resolution of legal advice. We held a workshop on CHC as part of our Shared Learning Seminar, which identified the following key points in respect of improving the position on CHC (http://www.wao.gov.uk/assets/englishdocuments/DTOC_workshop_2_outputs.doc):

- **a** Those taking part expressed frustration about the time the consultation had taken and felt that the Assembly Government needed to issue the revised framework as a matter of urgency as they felt that they were 'in limbo' in the meantime.
- **b** It would be worthwhile exploring the feasibility of more effective ICT support in order for the management of CHC to be achieved and sustained.
- **c** An agreement to provide pooled funding for placements and services during the time needed for a CHC assessment. The person can then be placed appropriately with decisions about funding resolved after the assessment.
- **d** Financial issues are a major issue for patients, their carers and families because the NHS pays for CHC while the patients,

families or carers pay are subject to means testing for social and personal care.

e Shortage of suitable placements for people who are EMI.

f Enhance end-of-life support for terminally ill CHC patients who often wish to be at home at the end of their lives.

2.64 Monmouthshire LHB has employed a CHC Manager who assists when a patient is deemed eligible for CHC to avoid unnecessary delays in discharge, and also provides training for staff in Monmouthshire to ensure the process is facilitated in a timely manner and that individual patient applications reflect the needs of the patient and the collection of appropriate documentary evidence to support the application.

Although there have been some significant improvements, hospital discharge processes remain inadequate in some areas

Many hospital discharge processes are risk averse and result in patients being discharged to institutional facilities when there may be more innovative packages of care available

2.65 In 2007 we said that there was scope to improve discharge planning and whilst we found examples of good practice, these needed to be mainstreamed across communities.

2.66 Although we have found significant improvements in some hospital processes in Cardiff and the Vale and Gwent Healthcare NHS Trusts, other processes remain unfit for purpose and fail to adequately consider what the citizen wants or needs.

2.67 Examples of progress in Gwent Healthcare NHS Trust include:

a internal reviews of the hospital discharge processes;

b a review of the criteria for patient transfer between occupational health and physiotherapy; and

c implementation of the visual hospital board in the Royal Gwent Hospital which is a whiteboard containing the status of each patient in the hospital and is used as a visual cue to ensure everything possible is being done to make discharge efficient and effective.

2.68 Progress in Cardiff and Vale NHS Trust includes:

a a specific focus on improving and implementing discharge protocols; and

b the intended implementation of early day discharge with a target of achieving 50 per cent of discharges before midday.

2.69 Despite these actions Cardiff and Vale is not meeting its 50 per cent target of discharges happening before midday and despite the intention of sending people home on Fridays, this is still not happening. There is also slow take-up on using intended date of discharge and the Clinical Workstation is not being used consistently. The Focused Rehabilitation for Medical Elderly (FRAME) model at the University Hospital of Wales was a case study in our original report[10] . We highlighted the pull system within the model whereby the rehabilitation consultant visits the Emergency Unit, Medical Admissions Ward and other areas of the hospital to identify patients suitable for treatment within the FRAME Ward. Only elements of this model have been rolled out to a limited number of other wards,

10 *Tackling delayed transfers of care across the whole system – Overview Report*, Auditor General for Wales, November 2007, Case Study E

and the consultant who led the development of FRAME has not been fully involved in developments elsewhere within the trust.

2.70 In Gwent, we found large variations in discharge processes and practices between clinicians. This was resulting in large variation in the lengths of stay for patients being cared for by different doctors. Estimated date of discharge was still not being consistently used and uncertainty about the support available from community services was one factor in preventing facilitated discharge.

2.71 Our Shared Learning Seminar workshop regarding discharge processes concluded that the current ways of working are ineffective in helping people receive timely and appropriate discharge from hospital. Delegates felt that strong leadership was required to break the risk-averse culture that is currently preventing proactive and pragmatic approaches to patient discharge. Staff at ward level need to feel empowered to take well-managed risks in making decisions about the future care of patients and this needs to be supported by a better understanding of the complex range of services that are available in the various localities covered by each major hospital.

2.72 In 2008, NLIAH established a Community of Practice for discharge liaison practitioners which sought to build on Passing the Baton which has proved a valuable forum through which to capture information and learning from handling complex discharges.

Some areas continue to suffer problems with ineffective implementation of choice processes

2.73 The issue of patient choice continues to be a major factor in delayed transfers of care. It can be extremely difficult for vulnerable people and their families or carers to make choices about their future care. However, partner organisations should be doing all they can to simplify and inform this decision process so that the most appropriate decisions can be made without causing unnecessary delays.

2.74 While there has been some work to standardise choice policies and to shorten the timescales for escalation, we heard views across Gwent, Cardiff and the Vale of Glamorgan that these policies are not being implemented consistently and that they lack the teeth necessary to speed up the decision-making process. The lack of availability of care home placements in some localities further complicates the decision making process and fails to offer people genuine choice. The Assembly Government has sought views from stakeholders to inform its plans to update its guidance on the issue of choice.

2.75 These problems are shown in the data relating to delayed transfers of care. Patient/family/carer-related census codes, which include choice, remain the most commonly recorded reason for delayed transfers of care in Wales, as opposed to social care or healthcare reasons. In both Cardiff and the Vale and Gwent Healthcare NHS Trusts, bed days occupied for patient/family/carer-related issues, which include choice, accounted for 60 and 54 per cent of bed days lost in 2007-08.

2.76 In line with the Minister's response to the National Assembly's Audit Committee, the Assembly Government has recently completed a consultation to capture views on how revised guidance on choice might better support effective practice. The next stage of this work is to convene a reference group to oversee the review. Part of the consultation process has been to canvass views on the potential to develop all-Wales policies and processes to support more effective and equitable practice across Wales.

To deliver better outcomes for vulnerable older people, partners will need to address new challenges and seize new opportunities that will emerge from the restructuring of the Welsh NHS

Commissioning will need to be replaced by planning arrangements that are more effective across the whole system in delivering more timely, cost-effective and sustainable service models that make the best use of resources

2.77 In July 2008, the Minister announced plans to reorganise the NHS in Wales. Local health boards and NHS trusts will be combined to produce single organisations responsible for both planning and delivering services.

2.78 The creation of these organisations presents an opportunity to remove some of the current problems in the commissioning process and put in place planning arrangements that deliver more timely, cost-effective and sustainable service models. The reorganisation may offer opportunities to pilot improved models through which health and social care partners might develop stronger joint approaches to promoting the independence of vulnerable older people.

There is a need to maintain and improve partnerships between health and social care at a time when existing structures are changing

2.79 In addition to the opportunities presented by the reorganisation, there are also risks of a loss of focus on local issues and the loss of existing partnerships. The new bodies will need to ensure they achieve the benefits of scale while remaining sufficiently engaged and committed to community-level issues.

2.80 In the midst of such wholesale change, it will be difficult to maintain existing relationships between health and social care organisations. Nevertheless it is vital that the progress that has begun to emerge continues to develop and that new, stronger relationships are forged.

Aligning resources could become more difficult as organisational structures and funding mechanisms change

2.81 Organisational change may be a barrier to aligning and pooling resources. The process of the new health boards combining the budgets of their legacy bodies, with particular complications around how to align budgets for primary and secondary care, may act as a short-term barrier to pooling resources. There is also the possibility that the creation of the new health boards could change the allocation of funding between those boards, which could also act as a barrier to the sharing of resources.

The Assembly Government's internal reorganisation will need to deliver a more coherent approach to policy development and service models across the whole system

2.82 On top of the reorganisation of the NHS in Wales, there is an ongoing internal reorganisation of the Assembly Government. The new structure will involve a new managerial tier of directors-general, with remits covering cross-cutting issues rather than isolated service areas. This provides an opportunity for the Assembly Government to deliver a more coherent approach to policy across the whole system of health and social care.

Appendix 1 – Methodology

1 For this follow-through review we used a range of methods which are 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 a national level.

Survey

3 All NHS trusts, LHBs and local authorities in Gwent, Cardiff and the Vale of Glamorgan completed a very brief survey setting out the main areas of progress and remaining barriers in their health and social care communities.

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. Using data supplied by Health Solutions Wales we developed measures of the numbers of bed days lost, as well as patients affected, in 2005-06, 2006-07 and 2007-08. 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.

Semi-structured interviews

5 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.

6 We began our fieldwork by meeting the chief executives of each organisation covered by our work. Our fieldwork focused on interviews with key operational and managerial staff.

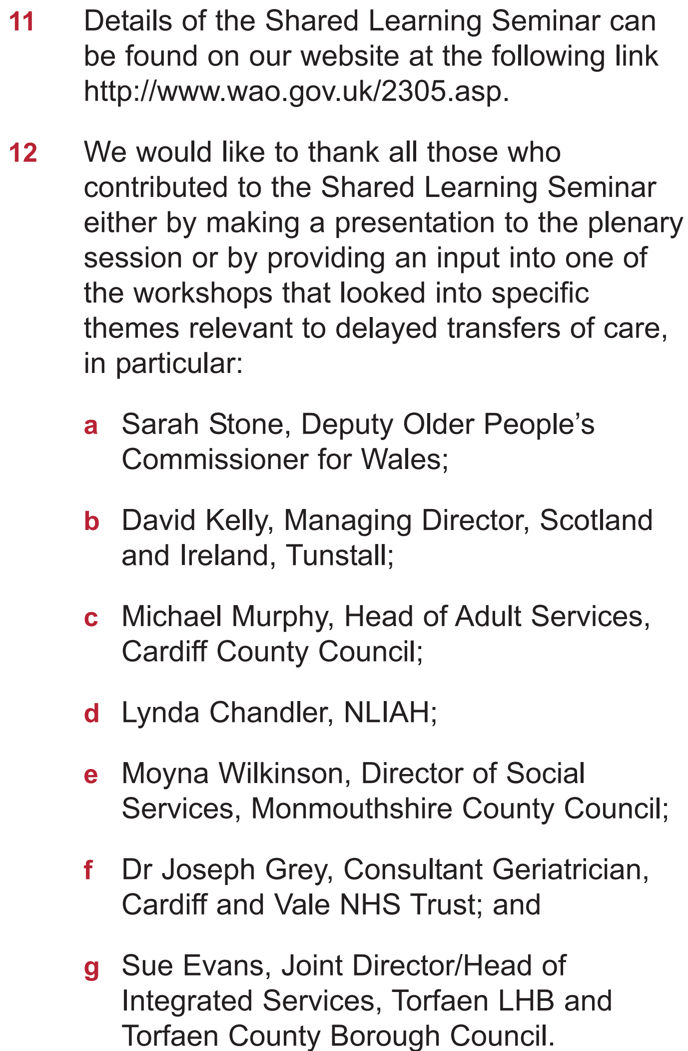
7 Specific fieldwork was carried out within the Assembly Government to identify the main ways in which the Assembly Government has responded to our initial work.

Shared learning and good practice

8 To learn from successful examples of innovative practice related to the promotion of independence in vulnerable people we carried out three good practice visits to Poole in Dorset, West Lothian and Oxford. These led to the production of case studies and material to inform our Shared Learning Seminar on 19 November 2008.

9 Throughout our work we sought to identify examples of innovative practice. Case studies giving details of our findings are included on our website (http://www.wao.gov.uk/whatwedo/delayedtransfersofcare.asp).

10 We held a Shared Learning Seminar on 19 November 2008 where we presented our emerging findings and facilitated discussions about how to progress the issues identified by our work. Over 70 people attended from Cardiff and the Vale of Glamorgan health and social care communities, the Assembly Government, NLIAH and CSSIW. We are extremely grateful to all those who attended this event.



11 Details of the Shared Learning Seminar can be found on our website at the following link http://www.wao.gov.uk/2305.asp.

12 We would like to thank all those who contributed to the Shared Learning Seminar either by making a presentation to the plenary session or by providing an input into one of the workshops that looked into specific themes relevant to delayed transfers of care, in particular:

- **a** Sarah Stone, Deputy Older People's Commissioner for Wales;
- **b** David Kelly, Managing Director, Scotland and Ireland, Tunstall;
- **c** Michael Murphy, Head of Adult Services, Cardiff County Council;
- **d** Lynda Chandler, NLIAH;
- **e** Moyna Wilkinson, Director of Social Services, Monmouthshire County Council;
- **f** Dr Joseph Grey, Consultant Geriatrician, Cardiff and Vale NHS Trust; and
- **g** Sue Evans, Joint Director/Head of Integrated Services, Torfaen LHB and Torfaen County Borough Council.