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Tackling delayed transfers of care across the whole system - Cardiff and Vale of Glamorgan health and social care community

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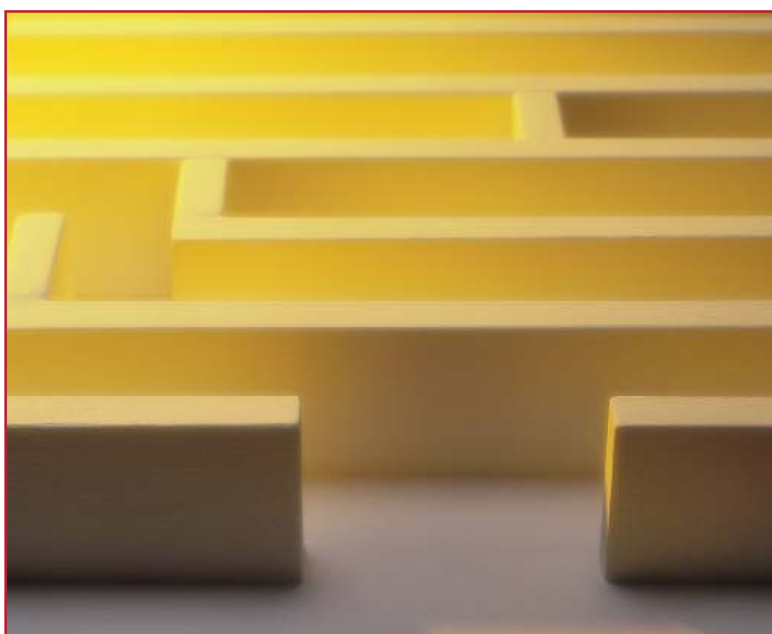
Report presented by the Auditor General for Wales to the National Assembly on 1 November 2007

In the Cardiff and Vale of Glamorgan health and social care community, the independence of vulnerable people and treatment of others continues to be compromised by unnecessary delays in hospital because the problem of delayed transfers of care has not been tackled in a whole systems way



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Summary

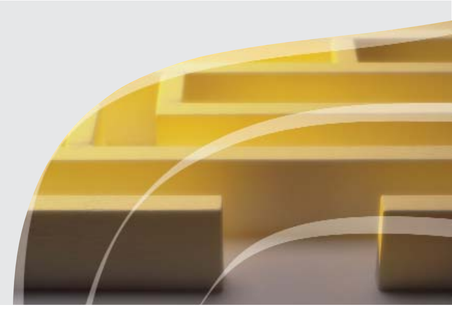
1 A delayed transfer of care happens when a hospital inpatient is ready to move to the next stage of care, but the transfer is prevented by one or more reasons and they remain in a hospital bed for longer than they need to. Delayed transfers arise from delays in moving a patient to a healthcare setting outside the acute hospital, from delays in assessments or making arrangements for social care, or for legal or choice issues relating to the patient, their family or carer.

2 Delayed transfers of care impact on wider service delivery/performance across the whole health and social care system but the immediate effects are on patients. Being delayed in hospital can be extremely damaging to patients if they lose their independence and their ability to function as they had functioned before entering hospital. Delays also mean that resources tend to be tied up in the inappropriate use of hospital beds, which could be better used for the treatment of other patients who need the specialist services that can best be provided in these settings.

3 Despite an overall reduction in the number of people who became a delayed transfer of care in the beds of Cardiff and Vale NHS Trust between 2003 and 2007, the scale and impact of delayed transfers of care have increased significantly between the 2005/2006 and 2006/2007 financial years. The delayed transfers of care problem, in terms of the numbers of people affected, remains bigger in this health community than in any other part of Wales. The country's biggest hospital, the University Hospital of Wales (UHW), also loses a higher proportion of its available bed days through delayed transfers of care than any other hospital in Wales. For the Trust, there is an impact both on patients, who are local residents, as well as on those who travel to Cardiff to use its services from other parts of Wales.
The National Leadership and Innovation Agency for Healthcare's Change Agent Team carried out detailed work on delayed transfers of care in the Cardiff and Vale community, which reported in March 2006 and led to the production of a detailed report and action plan.

4 Delayed transfers of care manifest themselves in the Trust's beds but are a symptom of a complex overall system of health and social care which is not working effectively. Tackling the problem requires effective and mature systems thinking across health, social services and the independent sector. This in turn requires collaborative and co-ordinated approaches by several public bodies each with individual responsibilities, resources and constraints.

5 In this context, we examined whether the Cardiff and Vale NHS Trust, the Cardiff and Vale of Glamorgan local authorities and two Local Health Boards (LHBs), along with Bro Morgannwg NHS Trust (which cares for residents of the western part of the Vale of Glamorgan), were taking effective action to tackle the extent and causes of delayed transfers of care in the Cardiff and Vale of Glamorgan health and social care community.



6 We found that the independence of vulnerable people and treatment of others who need the beds occupied by delayed transfers of care continue to be compromised by unnecessary delays in hospital, because the whole system problem of delayed transfers of care has not been tackled in a whole systems way in the Cardiff and Vale of Glamorgan health and social care community.

7 This was a cross-cutting review which considered delayed transfers of care and their causes at the level of the health and social care community - this report is aimed at the level of the whole community. The appendices to this report summarise the position and recommendations for action in each of the individual organisations covered by the project.

8 We undertook similar work in the Gwent health and social care community, and followed up previous work in Carmarthenshire. The results of our work on delayed transfers of care across all three communities are summarised in an overview report on delayed transfers of care.

Recommendations

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

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

   a continued momentum and pace;

   b clear objectives and accountability;

   c a framework to hold officers and organisations to account;

   d clear and challenging targets and milestones for actions;

   e expected outcomes; and

   f monitoring and evaluation mechanisms.

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

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

   a use the findings of this review, and a detailed analysis of why their resident populations become delayed transfers of care alongside analysis of intelligence from primary and social care practitioners, develop a robust assessment of the needs of the resident population for new models of service to promote the independence of vulnerable people in community and intermediate care settings;

b consider the future needs of its population (including increased demand for Elderly Mentally Infirm and for care home places for younger people with disabilities);

c identify clear and costed strategies to enable the transfer of resources from acute to community services to break the 'vicious circle' whereby vulnerable people are drawn towards inappropriate institutional care that can compromise their independence – this may require LHBs and local authorities to identify transitional funding to enable new services to be set up before existing models are decommissioned;

d share the content of their draft strategies through a pan-Cardiff and Vale workshop, involving the Trust's managers and a senior executive lead from the Trust, to identify opportunities to develop joint services to meet similar needs, and transfer good practice, across boundaries; and

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

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

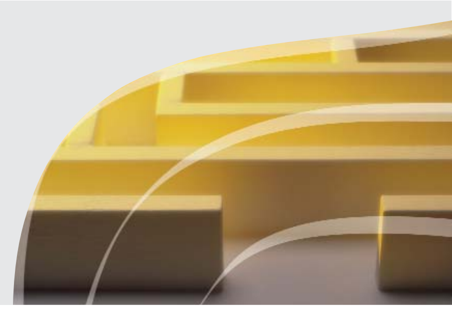
a the development of primary care resource centres that co-locate key parties from the multi-disciplinary teams that can promote the independence of vulnerable people, reduce hospital admissions and therefore minimise delayed transfers of care;

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

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

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

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



- **f** proposals to make effective use of hospital rehabilitation beds so that they make a more consistent contribution to the rehabilitation of patients who need them, including monitoring lengths of stay;
- **g** the relationship between rapid response, reablement, district nursing and social care teams, including the desirability of co-location and single points of contact; and
- **h** developing services to ensure that patients' physical abilities do not deteriorate while on a medical ward.

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

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

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

To address problems at the various stages of the patient pathway

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

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

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

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

a a focus on prevention and maintenance, and reduced dependency;

b a shift away from making permanent decisions about an individual's future in an acute setting, supported by a comprehensive care of the elderly assessment before decisions are made; and

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

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

To address problems arising from organisational and budgetary boundaries

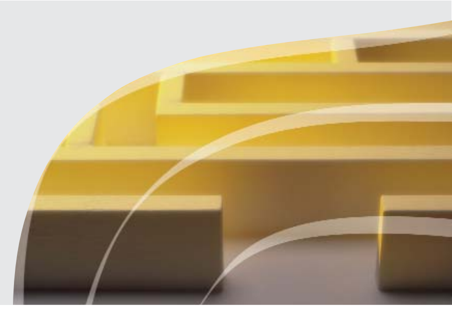
13 All partners should set and monitor progress against common targets to reduce delayed transfers of care, but focus their performance management on addressing, in a sustainable way, the underlying causes of which delayed transfers of care are a symptom. Performance management should be used to inform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

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

To address process issues

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

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



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

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

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

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

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

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

To address issues of capacity

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

a reduce duplication;

b ensure clarity of roles;

c engage clear lines of communication; and

d streamline pathways of care that embrace whole system working.

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

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

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

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

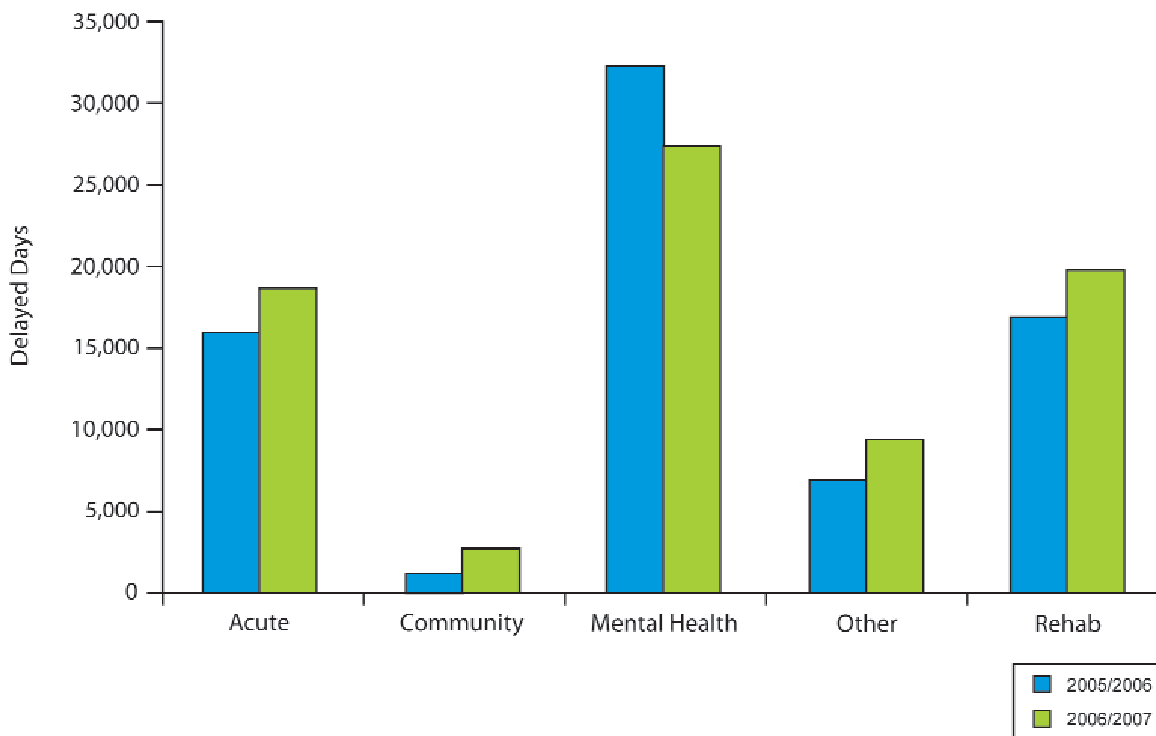
d consider the benefits of pooled budgets to recognise that better overall use of public money across the whole system is likely to deliver better care and also better value for money.

Part 1 - The data understates the impact of delayed transfers of care

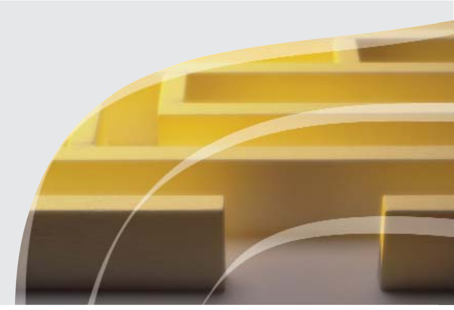
The impact of bed days lost through delayed transfers of care is increasing although the number of people affected has reduced

1.1 The total number of people who became a delayed transfer of care in Cardiff and Vale NHS Trust's beds fell by 15 per cent between April 2005 and March 2007, reflecting a longer-term fall in the number of people becoming a delayed transfer of care since 2003. Despite falling numbers, the impact upon patients and health and social care services has increased. This is because patients who have become delayed transfers of care have remained in hospital for a longer time, and so the total number of bed days lost due to delayed transfers of care has increased over this period.

Figure 1: The number of bed days occupied by delayed transfers of care in Cardiff and Vale NHS Trust increased between 2005/2006 and 2006/2007



Source: Data - Health Solutions Wales, 2007; Analysis – Wales Audit Office, 2007



1.2 In 2006/2007, 77,513 bed days were occupied by delayed transfers of care in Cardiff and Vale NHS Trust; this was an increase of 6.5 per cent compared with the previous year with over 4,700 extra beds days lost. Over 18,000 of the days were in acute beds, nearly 20,000 were in rehabilitation beds and just over 27,000 in mental health beds. Although there was a 15 per cent reduction in the occupied days within mental health, all other parts of the Trust experienced an increase in bed days lost (Figure 1).

1.3 Around 15 per cent of the Vale residents use the services provided by the Princess of Wales Hospital in Bridgend which is part of the Bro Morgannwg NHS Trust. While for Bro Morgannwg NHS Trust, there had been an overall increase of 14 per cent in the numbers of delayed transfers of care and a 16 per cent increase in the number of bed days lost to delayed transfers of care between 2005/2006 and 2006/2007, the increases were primarily for the residents of Neath Port Talbot rather than the Vale of Glamorgan. Vale residents are primarily admitted to the Princess of Wales Hospital where there has been a 16 per cent reduction in numbers of patients delayed, a 31 per cent reduction in the bed days lost and nearly a 19 per cent reduction in the average duration of delay between 2005/2006 and 2006/2007.

1.4 In April 2007, the percentage of available beds lost in Cardiff and Vale NHS Trust was 8.1 per cent – the third highest in Wales. The only Trusts with higher rates were Velindre and Powys LHB, which are not useful comparisons because of the unique structure of the services they provide.

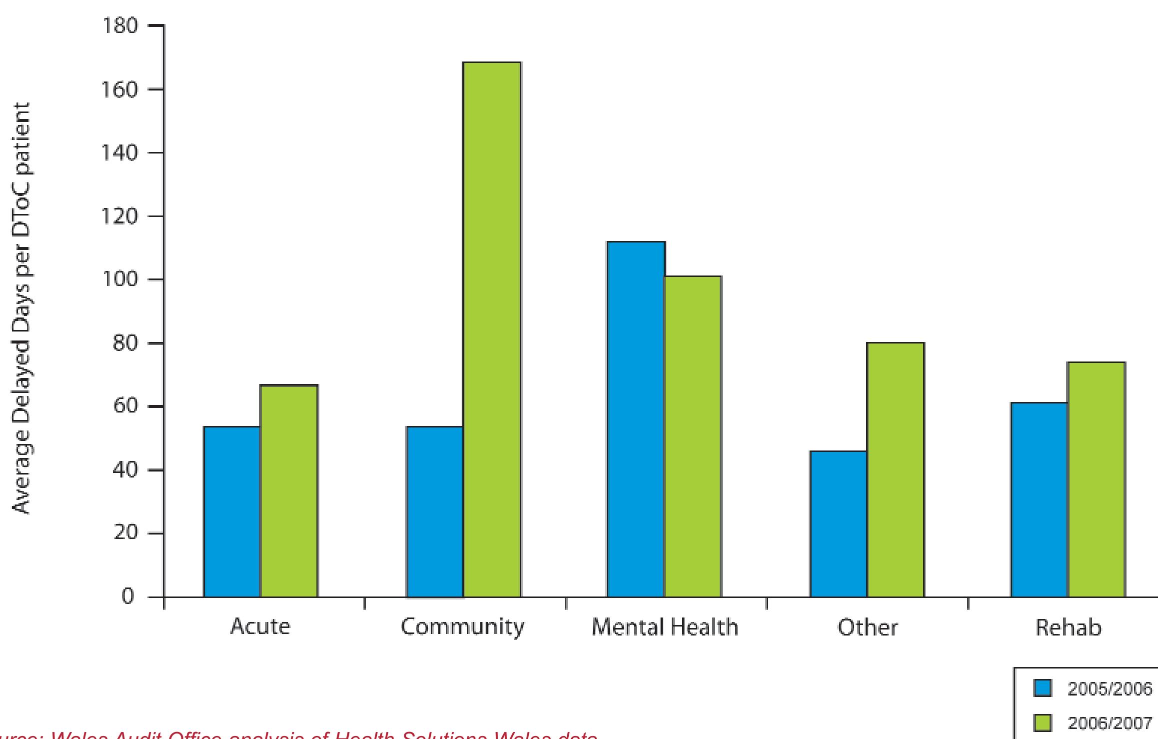
1.5 In 2006/2007, 62 per cent of the bed days occupied in the Cardiff and Vale NHS Trust (over 48,000 bed days in total) were lost because of patient/carer/choice issues. The average length of a delayed transfer of care in this category was 91 days, the longest of any trust in Wales. The delays were mainly due to a shortage of realistic and acceptable residential and nursing home options for those medically fit to leave hospital. Bed days lost for social care reasons reduced by 11 per cent, but the average delay for these at 58 days was the second highest in Wales.

1.6 Each of the two local authorities and LHB areas share broadly similar delayed transfers of care patterns. Cardiff is the larger of the two authorities and around three-quarters of people whose transfer of care is delayed within Cardiff and Vale NHS Trust are Cardiff residents. The breakdown of delayed transfers of care between the two localities is as follows:

- In Cardiff, the number of people experiencing a delayed transfer of care (as measured by the monthly census) rose from 113 in July 2006 to a high of 161 in November 2006. There has been a relatively steady decrease since to 131 in June 2007 with an average of 140 Cardiff residents delayed in Cardiff and Vale NHS Trust each month between June 2006 and June 2007.

- In the Vale of Glamorgan, there has been less fluctuation in the incidence of delayed transfers of care, which peaked at 58 in November 2006. They have reduced in 2007 with June 2007 seeing the lowest level for some time at 34 recorded cases. The average number of Vale of Glamorgan residents delayed in each month between June 2006 and June 2007 was 47 –

Figure 2: The average delay increased significantly in all types of bed other than mental health between 2005/2006 and 2006/2007



Source: Wales Audit Office analysis of Health Solutions Wales data

a handful of which were typically delayed within Bro Morgannwg NHS Trust. For example, in April 2007, five of the LHB's 46 delayed transfers of cares were in the care of Bro Morgannwg NHS Trust.

1.7 Although the number of patients, living in the Vale of Glamorgan, who experienced delays actually fell between 2005/2006 and 2006/2007, and fell further to 34 in June 2007, over 4,000 extra bed days (a 23 per cent increase) were lost between 2005/2006 and 2006/2007. The average length of delay rose from around 60 days to more than 80 days.

1.8 When bed days occupied by delayed transfers of care are measured by resident population, Cardiff had the highest rate of any local authority in Wales in 2006/2007. And, like the Vale of Glamorgan, the average duration of delays has increased. The total number of days spent in hospital by Cardiff residents after they had been declared fit for discharge increased by almost five per cent from 54,500 to 57,000 between 2005/2006 and 2006/2007, and the average length of delay rose by 10 days from 71 to 81 days (Figure 2).

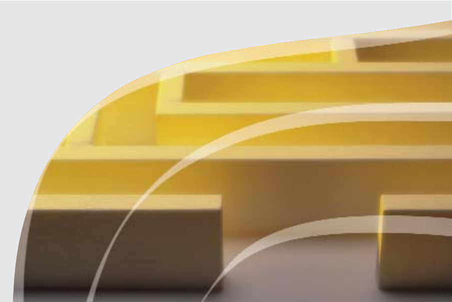
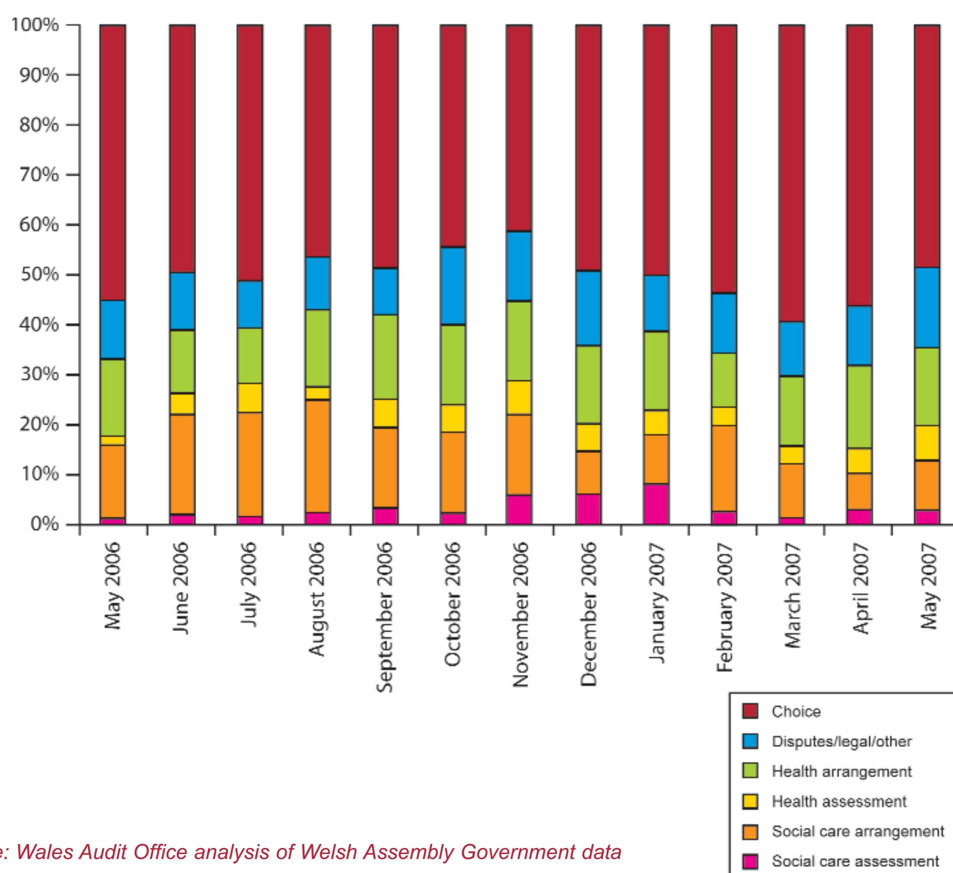


Figure 3: Percentage of delayed transfers of care by main reason in Cardiff and Vale NHS Trust, May 2006 to May 2007



Source: Wales Audit Office analysis of Welsh Assembly Government data

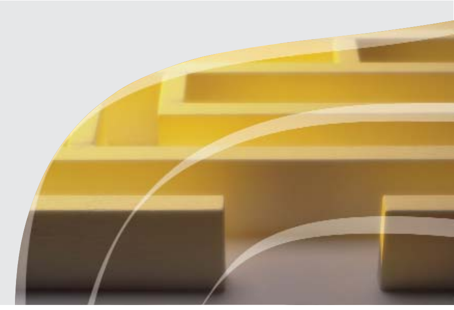
1.9 The main reason for delayed transfers of care in the Cardiff and Vale community was patient choice. In most months between May 2006 and May 2007, delayed transfers of care arising from patient choice accounted for around half of all cases (Figure 3). Health and social care arrangements were the next two most common reasons for delay.

1.10 The impact of patient/carer/family-related reasons for delayed transfers of care is significant, with over 49,000 bed days occupied in 2006/2007. It is also noteworthy that the average delay for patient/family/carer related reasons increased significantly between 2005/2006 and 2006/2007, by 19 days (27 per cent) in Cardiff and 31 days (49 per cent) in the Vale of Glamorgan. While the overall picture is of an increasing number of bed days being occupied by delayed transfers of care in Cardiff and the Vale of Glamorgan, it is encouraging that the average duration of a social care delay in Cardiff fell by 20 days (26 per cent) between 2005/2006 and 2006/2007 (Figure 4). However, over the same period it rose by 17 days (33 per cent) in the Vale of Glamorgan (Figure 4).

Figure 4: Delayed transfers of care in 2005/2006 and 2006/2007 by LHB and main reason

Patient area of residence		Delayed days				Number of delayed patients				Average days delayed			
	Reasons	2005/ 2006	2006/ 2007	Change	Percent Change	2005/ 2006	2006/ 2007	Change	Percent Change	2005/ 2006	2006/ 2007	Change	Percent Change
Cardiff	Healthcare reasons	10,445	12,749	+2,304	+22.1%	151	143	-8	-5.3%	69.2	89.2	+20	+28.9%
Cardiff	Patient/ carer/ family-related reasons	31,273	34,742	+3,469	+11.1%	447	391	-56	-12.5%	70.0	88.9	+19	+27.0%
Cardiff	Principal reason not agreed	741	190	-551	-74.4%	5	3	-2	-40.0%	148.2	63.3	-85	-57.3%
Cardiff	Social care reasons	11,998	9,341	-2,657	-22.1%	159	167	+8	+5.0%	75.5	55.9	-20	-26.0%
Cardiff	**All reasons**	**54,457**	**57,022**	**+2,565**	**+4.7%**	**762**	**704**	**-58**	**-7.6%**	**71.5**	**81.0**	**+10**	**+13.3%**
Vale of Glamorgan	Healthcare reasons	4,308	2,737	-1,571	-36.5%	74	42	-32	-43.2%	58.2	65.2	+7	+12.0%
Vale of Glamorgan	Patient/ carer/ family-related reasons	10,641	14,328	+3,687	+34.6%	172	155	-17	-9.9%	61.9	92.4	+31	+49.3%
Vale of Glamorgan	Principal reason not agreed	135	31	-104	-77.0%	3	1	-2	-66.7%	45.0	31.0	-14	-31.1%
Vale of Glamorgan	Social care reasons	2,428	4,439	+2,011	+82.8%	48	66	+18	+37.5%	50.6	67.3	+17	+33.0%
Vale of Glamorgan	**All reasons**	**17,512**	**21,535**	**+4,023**	**+23.0%**	**297**	**264**	**-33**	**-11.1%**	**59.0**	**81.6**	**+23**	**+38.3%**
Cardiff & Vale	Healthcare reasons	14,753	15,486	733	5.0%	225	185	-40	-17.8%	65.6	83.7	27	41.2%
Cardiff & Vale	Patient/ carer/ family-related reasons	41,914	49,070	7,156	17.1%	619	546	-73	-11.8%	67.7	89.9	49.4	73.0%
Cardiff & Vale	Principal reason not agreed	876	221	-655	-74.8%	8	4	-4	-50.0%	109.5	55.3	-98.9	-90.3%
Cardiff & Vale	Social care reasons	14,426	13,780	-646	-4.5%	207	233	26	12.6%	69.7	59.1	-2.9	-4.2%
Cardiff & Vale	**All reasons**	**71,969**	**78,557**	**6,588**	**9.2%**	**10,59**	**968**	**-91**	**-8.6%**	**68.0**	**81.2**	**32.1**	**47.2%**

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



Measurement systems for delayed transfers understate the extent of the problem

1.11 The true incidence of delayed transfers of care is masked by weaknesses in their measurement. There are problems with what is measured and systematic deficiencies in the way measurements are taken.

1.12 As to what is measured, the Assembly Government operates a census system which captures a snapshot once a month of the number of patients within Trust beds on that day whose transfer has been delayed and how long they have been delayed. The figures are subject to joint validation by trusts, local authorities and LHBs.

1.13 Across Wales, we consider that the census may be encouraging organisations to focus their attention on clearing patients as census day approaches, rather than dealing with the causes of delayed transfer. The census also fails to identify delayed transfers of care that commence after one census date but end before the next.

1.14 There are two different patient information systems within the Trust. There is the Patient Management System (PMS) in all general areas and the PARIS system within mental health. The intention is to interface these systems with the roll out of the Clinical Workstation within the Trust (the functionality of the Clinical Workstation is outlined in Paragraph 2.56).

1.15 However, the key issue is that whilst PMS and the Clinical Workstation have patient discharge date functionality, the measurement of delayed transfers remains manual. Potentially, this further masks the actual rate of delayed transfers. Processes for collection differ between general and mental health areas. Discharge Liaison Nurses rely on ward staff to tell them about any delays, so if the discharge liaison nurses are not told the delays would not be picked up. They prompt the ward staff but sometimes patients are not included in the figures.

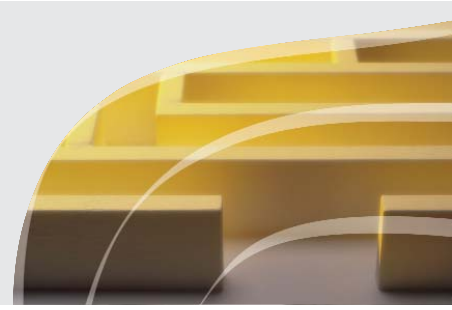
1.16 The PMS is not seen to be user friendly, partly because it is difficult to measure delays more frequently than monthly. Some trusts have overcome this by using their own IT systems to act as a live system to support weekly measurement and validation. This more proactive approach can help tackle delayed transfers of care. A weekly monitoring process is likely to provide more timely data to support the identification of and removal of delayed transfers of care than a snapshot monthly profile, and is a key information source for local actions.

1.17 The Assembly Government has recognised the weaknesses of its performance management system historically relying on a census, and now sets additional targets which track the number of bed days occupied by delayed transfers of care for the Trust and LHBs. The current Service and Financial Framework includes two targets for health communities to reduce the number of patients delayed, as well as the number of bed days, separately in both mental health facilities and in non-mental health facilities. These targets are the joint responsibility of LHBs and trusts but are measured at the level of LHBs so that performance can be related to population size.

Figure 5: Local agreements operate in Cardiff and the Vale of Glamorgan which delay counting a patient as a delayed transfer of care after their consultant deems them fit for discharge

Codes	Definition	Local agreement before patients are counted as delayed transfers of care
1.1	Awaiting completion of assessment (beyond local agreement)	Initial contact – five working days Completion – 10 working days Total – 15 working days
2.2	Rehousing (council responsibility) sheltered or mainstream accommodation	From date of referral Total – 15 working days
2.3	Awaiting start or restart of home-based package of care packages (beyond local agreement)	Seven days after being identified
2.4 2.5	Awaiting completion of residential/nursing care placement arrangements	Four weeks for patient and family to select Two weeks to wait for a vacancy
2.6	Awaiting home adaptation/equipment	Five working days for equipment 10 working days for adaptations
2.7	No appropriate placement	Six weeks
3.2	Awaiting opinion of another consultant	10 working days
3.3	Awaiting assessment by Discharge Liaison Nurse	Two working days
3.4	Awaiting completion of occupational therapy assessment	Initial assessment – two working days Kitchen assessment – five working days
3.5	Awaiting healthcare assessment/completion of healthcare arrangements by community health service	Five working days
4.3	Awaiting occupational therapist home visit	Seven working days
7.3 a,b	Patient/family/carer selecting residential/nursing placement of choice	Six weeks to identify home
7.4 a,b	Patient waiting for residential/nursing care place availability	Six weeks for care plans, finance and acceptance and placement of individual

Source: Trust documented code definitions



1.18 The way the measurements are taken also understates the impact of delayed transfers of care. Local agreements operate across the Cardiff and Vale communities and are intended to reflect the actual time it takes to plan for assessments and set up arrangements for care beyond hospital. For certain types of delayed transfers of care, these local agreements can add a further delay before a patient, already deemed medically fit for discharge by their consultant, is counted as a delayed transfer of care (Figure 5).

1.19 Code definitions have been documented by the Trust and were tabled at the Timely Discharge Programme Board, which the Trust hosts monthly and involves the LHBs in supporting timely patient discharge, including delayed transfers of care. Nevertheless, there is confusion between partners about when an individual actually becomes a delayed transfer of care and definitions were due to be reviewed in June 2007.

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

Delayed transfers of care have negative consequences for the patients affected and for the whole system

1.21 The main cost of being a delayed transfer of care falls on people who lose independence and function as a result of being stuck in hospital. Vulnerable individuals can become locked into a vicious circle of dependence and reliance on acute hospital services. Effectively, becoming a delayed transfer of care can mark the end of an independent life.

1.22 There are numerous examples of delay directly impacting on patient welfare – one recent example within Cardiff and Vale NHS Trust is summarised in Case Study A.

1.23 Patients who became delayed transfers of care in Cardiff and Vale NHS Trust in 2006/2007 suffered a longer average delay (82 days) than in any other Welsh trust. Such long delayed transfers of care are one of several factors that have a significant impact on the workload and treatment times in the Trust's emergency unit. For example, during July 2007 the Trust was unable to meet its four-hour and eight-hour target within Accident and Emergency (A&E) with performance being the lowest within Wales. Over 2,300 patients waited more than four hours within A&E, with 79 per cent compliance with the target, and nearly 700 patients had to wait longer than eight hours for a bed with 93.6 per cent compliance. This was mainly due to a lack of available bed capacity from patients still inappropriately occupying a bed. This often results in the A&E department being full and patients being cared for in corridors or having to stay within ambulances outside the department, which is unacceptable. In response, the Trust has

opened additional beds which the LHBs have not commissioned with significant financial impacts but this has still not improved A&E performance. It is important to note the other factors that impact upon the workload and treatment times in the Trust's emergency unit. These include a shortage of middle grade doctors and nurse sickness levels and, as reported in the recent Delivery and Support Unit (DSU) review, a number of internal operational arrangements that compromise the Trust's bed availability.

1.24 In rehabilitation beds, the average duration of a delayed transfer was 73.5 days, which is in addition to the time spent rehabilitating. This significantly compromises the Trust's capacity to rehabilitate other patients and potentially reduces the impact of rehabilitation services received by those that become a delayed transfer of care.

1.25 Some of the Trust's rehabilitation capacity is being taken up by delayed transfers of care, often with mental health needs, or those delayed waiting for NHS Continuing Healthcare (Continuing Healthcare). At any one time up to 40 patients are typically in an acute ward waiting for a rehabilitation bed to become available. This compromises capacity to rehabilitate patients effectively.

1.26 Indirectly, delayed transfers of care adversely affect other patients via constraints on available Trust capacity. During March 2007, for example, 55 elective procedures were cancelled due to a lack of a bed, and the Trust was unable to meet certain waiting time targets.

1.27 Additionally, the bed constraints result in the Trust caring for large numbers of patients on wards that are not appropriate for their care needs, with some patients experiencing a number of movements from bed to bed. The Trust's policy is not to move delayed transfers of care patients, but this often results in other patients having to be moved to unsuitable outlier wards.

1.28 In the short term, until the delayed transfer of care situation is improved, bed constraints may require changes to the current ward configuration with those whose transfer of care has been delayed, and possibly Continuing Healthcare patients, receiving care within a limited number of areas. These areas would have dedicated multi-disciplinary teams whose ethos is one of pulling the patient through the system towards a more suitable environment. Such a system has recently

Case study A: Negative impact of a delayed transfer of care on an individual patient

Mrs H was previously living in sheltered accommodation and was receiving support from a reablement team, but frequent falls and weight loss led to an admission to Cardiff and Vale Trust in April 2007. She was declared medically fit for discharge on 19 April and expressed a desire to a particular residential care home. Staff from this home said she was not suitable, not sufficiently mobile and too 'confused', and the family looked for another home. After a month the family become concerned about Mrs H becoming 'institutionalised' in hospital. In early June, the family moved Mrs H to a home, in effect bypassing the system.

Key issues identified:

- hospital social worker allocated and work deemed as good;
- pressure on ward staff to be aware of protocols about communication and contact with social services;
- six to seven week delay before placement, but the patient may have been able to return home while waiting or at least moved to a transitional bed; and
- extra care may have been a good option if in place.

Source: Care and Social Services Inspectorate for Wales (CSSIW) review of social services case files following up Wales Audit Office inpatient census on 16 May 2007

been introduced in Bro Morgannwg NHS Trust (Case Study B). In the longer term it will be important to identify more cost-effective alternatives to hospital-based Continuing Healthcare.

1.29 Early discussions within Cardiff and Vale NHS Trust indicate that it is considering focusing its care for delayed EMI patients, who are currently located across several general wards, on one dedicated ward. These patients can be challenging to care for and these proposals would focus skills and multi-disciplinary management in one area which should help improve care and reduce further delays. The plan could also lead to closer working between mental health and older people's services.

1.30 Ignoring the potential under-recording of delayed transfers of care which results from the operation of local agreements, we estimate that the direct cost of the 'lost' bed days in Cardiff and Vale NHS Trust in 2006/2007 was £18.6 million (Appendix 3) which represents three per cent of the Trust's income in that financial year. This was an increase of nearly £2 million or 11 per cent on 2005/2006. Patient/carer/family-related delayed transfers of care accounted for direct bed costs of some £11.6 million, while social care delayed transfers of care accounted for around £3.2 million of direct bed costs.

1.31 Although delayed transfers of care manifest themselves within the Trust's beds, the costs are to the overall whole system as the Trust and Cardiff and the Vale of Glamorgan LHBs fund the capacity occupied by delayed transfers of care. Partly as a conseuence of delayed transfers of care, the Trust decided to open a number of additional 'uncommissioned' beds.

Case study B: Consolidating cases at the Princess of Wales Hospital, Bro Morgannwg NHS Trust

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

Source: Wales Audit Office

1.32 Delayed transfers of care impose indirect costs on other parts of the health and social care system, for example problems delivering elective surgery in accordance with the Assembly Government's access targets, in providing responsive unscheduled care, and in seeking to develop new models of services in the community and closer to patients' homes. In particular, the Trust has experienced problems meeting Assembly Government access targets for elective surgery and in A&E (Paragraph 1.23). There are also intangible system costs in terms of time spent managing delayed transfers of care cases and poor use of capacity, resources and specialist staff skills.

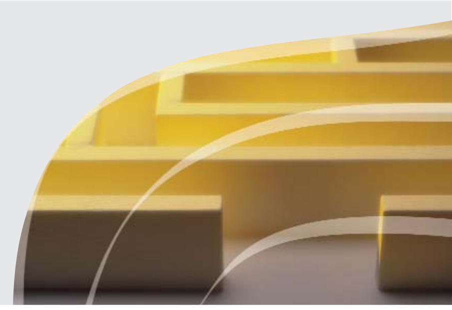
1.33 The direct costs of bed days occupied by delayed transfers of care could not be released in full for reinvestment in other areas, not least because of the impact of delayed transfers of care on the Trusts' financial positions and ability to meet Assembly Government access targets both for scheduled and unscheduled care. Using marginal bed costs, we estimate that £7.8 million could be directly released in Cardiff and Vale NHS Trust for reinvestment

elsewhere in the system of health and social care if delayed transfers of care were totally eradicated although the costs of care for those currently delayed would fall elsewhere in the system.

1.34 It has proved impossible to quantify accurately how the resources currently tied up providing beds to accommodate delayed transfers of care might be better deployed across the whole system, because we have inadequate information about the costs and outcomes of intermediate and social care services.

1.35 However, if delayed transfers of care were eradicated or reduced, there would be a number of areas in which commissioners might wish to invest to improve the operation of the whole system, in particular to:

- avoid the costs of paying for elective surgery to meet Assembly Government access targets through the Second Offer Scheme, which in 2006/2007 were £5.4 million, in Cardiff and the Vale of Glamorgan LHBs;
- address some of the long-standing financial pressures, which include an £18 million savings target for Cardiff and Vale NHS Trust in 2007/2008;
- invest more in intermediate care services;
- recognise the costs to the Trust of opening some wards which have not been formally commissioned to cope with the additional patients who are delayed transfers of care (Cardiff and Vale NHS Trust estimates that it provides £2 million of 'uncommissioned' beds to accommodate delayed transfers of care each year); and
- contribute to the projected additional costs to LHBs of complying with the implications of the 'Grogan' judgement on Continuing Healthcare where the extent of the likely additional costs is still being assessed.



Part 2 - More effective joint action is vital to ensure that individuals are managed and cared for in the most appropriate way

Despite examples of good practice, the current pattern of services needs to promote more effectively the independence of vulnerable people at each stage in their pathway

The culture needs to promote people's independence rather than institutional care

2.1 Through its National Service Framework for Older People, launched in March 2006, 'Designed for Life', its 10-year strategy to develop world-class health and social care services, and 'Fulfilled Lives, Supportive Communities', its 10-year strategy for social services, the Assembly Government has made clear its intention to promote the independence of vulnerable people and to reduce their reliance on the acute hospital sector.

2.2 During our fieldwork, Trust staff acknowledged that unnecessary hospital admission and prolonged lengths of stay are detrimental to vulnerable older people. They recognised that unnecessary periods of institutional care contribute to a loss of independence, reduced physical capabilities and can contribute to a diminution of social/caring networks.

2.3 A review of the management of chronic disease patients in Cardiff and Vale NHS Trust reported in April 2007 that a significant proportion of patients are admitted to hospital for aspects of care that could be provided in the community[1]. Contributory factors to this default to institutional care may include:

- a lack of awareness in primary care and ward-based staff about the alternatives to hospital admission;
- confusion about the services that are available due to duplication;
- fragmentation across Cardiff and the Vale of Glamorgan; and
- the lack of sufficient and appropriate out-of-hospital services.

2.4 Further, our survey of inpatients who were delayed transfers of care in the Trust on 16 May 2007, suggested a culture where people default to institutional settings where they face a significant risk of becoming a delayed transfer of care. Trust nursing staff told us that 78 per cent of people would be unable to return to their previous living arrangements. In one third of cases these people had lived alone prior to admission, while another third had lived with their family or carer. This may reflect a prevailing clinical culture which is predicated on institutional care for vulnerable elderly people, and may also reflect the likely care pathway for those who become a delayed transfer of care within the Trust and those who do not.

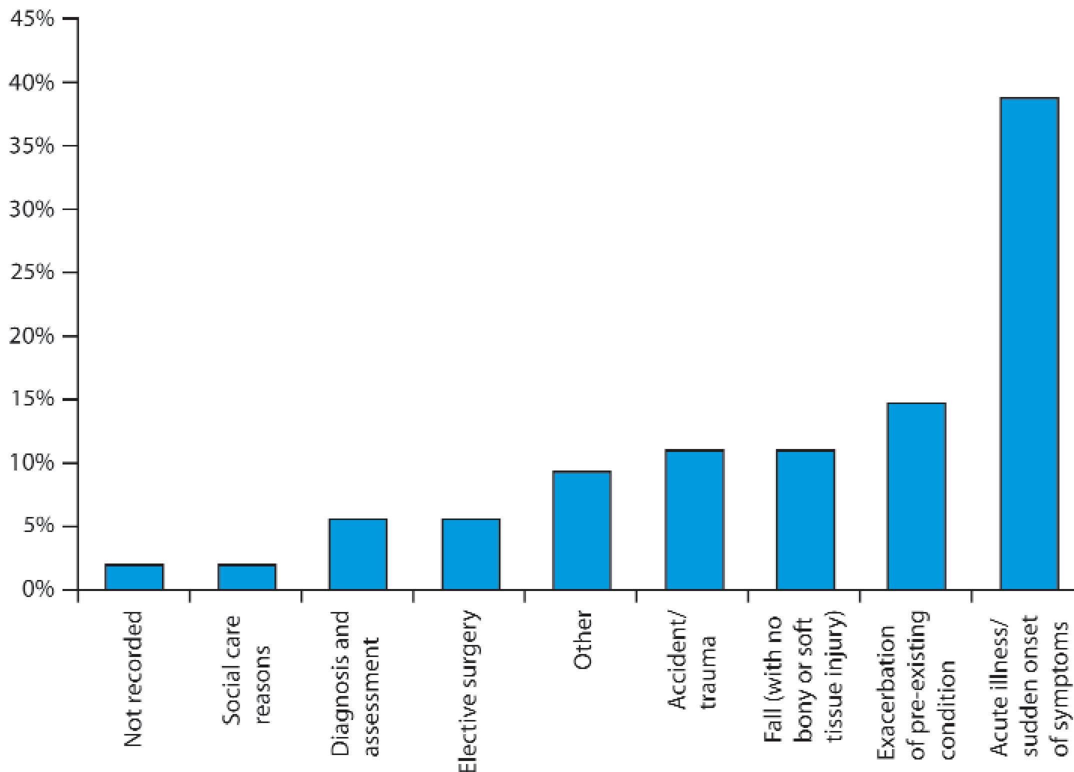
1 Wales Audit Office, Chronic Disease Management Review, Cardiff and Vale NHS Trust, July 2007.

2.5 The results of our inpatient census and interviews suggest that cultural attitudes to the care of the elderly may sometimes be focused on institutional care, with a lack of ownership of the problem amongst many acute clinicians. Consequently, there needs to be a shift away from making permanent decisions about an individual's future in an acute setting, and that there should be a comprehensive care of the elderly assessment before decisions are made.

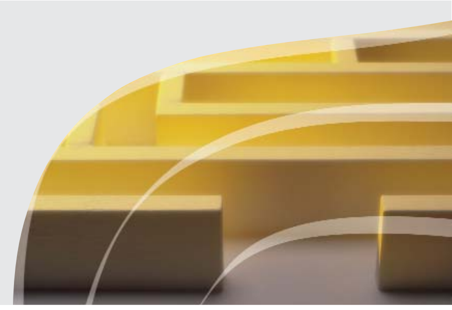
2.6 Our inpatient census also asked nurses to state the primary cause of admission to hospital for patients who had become delayed transfers of care. At the time of the survey 30 per cent of patients whose transfer of care had been delayed were in the Trust's general beds, 33 per cent were within rehabilitation beds, while 38 per cent were within mental health beds.

2.7 Of the patients experiencing a delayed transfer of care in acute beds in Cardiff and Vale NHS Trust, Figure 6 shows that 39 per cent were admitted because of an acute illness or the sudden onset of symptoms and 15 per cent with an exacerbation of a pre-existing condition. Two per cent of patients whose transfer of care was delayed were identified as being admitted for social care reasons; the data shows that 11 per cent of patients were admitted following a fall with no bony or soft tissue injury and who may not therefore have required admission to an acute bed. This suggests that 13 per cent of

Figure 6: Main reasons for admission of delayed transfers of care to acute beds in Cardiff and Vale NHS Trust



Source: Wales Audit Office inpatient census



patients may have been in an acute hospital bed not as a result of a clinical condition, but as a result of being unable to cope. This suggests that some vulnerable people tend to go into hospital as a place of safety to meet social needs rather than for any specific clinical interventions and that many continue to rely on institutional care following an admission.

2.8 Case Study C identifies that some patients' needs for care are neither identified prior to nor during admission and a different approach may have enabled this lady to continue living within her own home.

Case Study C: Gaps in assessment of need and support

An elderly lady who lived alone with no support from family, carers or any other support was admitted following a fall. She had experienced multiple falls, had dementia and a respiratory problem. She had been in hospital for four months and was awaiting a home of choice but there was no evidence of a multi-disciplinary assessment of need to assess whether this lady could have managed within her own home with support.

Source: Wales Audit Office inpatient census

2.9 Notably, few delayed transfers of care patients at the time of the inpatient census had a single clinical condition: most had multiple medical problems, with eight patients having four or more medical problems. This highlights the inherent challenges and complexities of managing these patients.

There is a need to develop more community-based provision to support independence, avoid admissions and enable earlier discharge

2.10 Although there are some 15 intermediate care schemes (intensive, time-limited interventions to prevent admission to hospital or support patients on their discharge) in existence in both the Vale of Glamorgan and Cardiff, many are small scale and are not available across both localities. There is not a common model of intermediate care services within which to develop a Cardiff and Vale wide approach that can be tailored to reflect local needs. An analysis of these intermediate care schemes, undertaken as part of the 'Programme for Health Service Improvement', also identified problems with the multiplicity of schemes, the lack of a common point of referral, areas of duplication and gaps, and poor levels of awareness of the role of intermediate care within the Trust and primary care. The 'Programme for Health Service Improvement' is proposing to develop a single gateway for referrals to intermediate care and also the reconfiguration of existing services to produce integrated intermediate care teams.

2.11 Our chronic disease review identified scope to reduce significantly (the equivalent of six per cent of the Trust's bed days) the number of occupied bed days through the more effective management of chronic conditions and the development of community-focused services. Cardiff LHB told us that it has started a process of implementing clinical case management of services for patients with chronic conditions to improve the current co-ordination of services for such patients within the Trust.

2.12 Cardiff and Vale NHS Trust operates a range of community services. For example, the Trust provides the following services to support elderly patients and patients with specific health conditions:

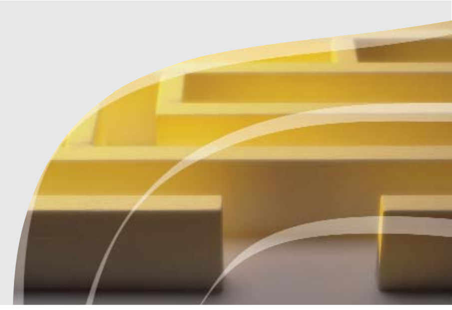
- Elderly Care Assessment Service;
- Community Rehabilitation Team;
- Acute Response and Reablement teams;
- Stroke Outreach Service;
- Diabetes Care;
- Community Respiratory Resource Unit; and
- Day Hospital Services.

2.13 Not all services commissioned from the Trust are provided uniformly across the two LHB areas as a result of local commissioning decisions; the range of services available is more limited within the Vale of Glamorgan. Typically, the Trust's community services are focused more on facilitating early discharge and rehabilitation than preventing unnecessary admissions. Their potential success in relation to admission avoidance is limited by the hours the services operate and by protocols which define the circumstances in which referrals should be made.

2.14 Additionally, there is very limited community hospital provision and there is no GP access to community hospital beds. Many of the beds are being blocked by delayed or Continuing Healthcare patients with some of these becoming long stay patients.

2.15 However, there are a number of examples of good practice both in Cardiff and in the Vale of Glamorgan which are working to limit admissions and to reduce the length of stay once individuals are admitted. For example:

- in Cardiff the Elderly Care Assessment Service/Reablement Team based at Rookwood Hospital prevents hospital admissions through the provision of a multi-disciplinary assessment and rapid response Home Care. It claims that it prevented 96 hospital admissions in 2006/2007. The team also facilitates hospital discharge with a therapy-led reablement package of care;
- also in Cardiff, the Care and Repair agency helps support older and/or disabled people to repair and improve their homes, enabling them to retain their independence with increased safety and comfort. The agency provides a variety of Caseworker and Handyperson services and undertakes the Rapid Response Adaptation Programme to prepare homes for discharged patients; and
- the Vale of Glamorgan Council runs an effective Short Term Intervention Service (the STIS Homecare Team). The STIS Team was set up to reduce the need for admissions and to assist discharges from hospital. There is an occupational therapist as a member of the team and the team is involved for a fixed time – usually six weeks. Bro Morgannwg NHS Trust also operates a similar reablement service for residents in the Western Vale who fall within the Bro Morgannwg catchment area, including those discharged from Cardiff and Vale NHS Trust.



2.16 There are some ongoing challenges within some of these services which may be compromising their full effectiveness. For example, within the Elderly Care Assessment Service there have been some problems with accommodation and flexibility in the use of staff such as therapists, with risks arising from the fact that a number of therapists are on short-term contracts. There are also concerns that the effectiveness of the so far successful stroke outreach service in Cardiff may be hampered by the team's capacity.

2.17 While some of the services appear to have been well evaluated, including their cost effectiveness, this was not always the case. The initial funding mechanisms for these schemes mean that many are run in isolation and are not integrated. This has been recognised within the Trust and there are moves to develop a single point of contact for the Elderly Care Assessment Service, the Acute Response Team, day hospitals and district nurses.

2.18 The Trust's Community Nursing Service has been the subject of a recent external baseline assessment. Initial results showed that the role of community nursing services needs to be re-focused, particularly in supporting primary and intermediate care as well as hospital-based secondary care services, and the report recommended changes to process and practice for the Trust to resolve the identified problems.

2.19 The Trust is seeking to redefine the Community Nursing Service as there are competing pressures to support more patients with long-term conditions and to support primary/secondary care and palliative care patient needs. There has been some tension with GPs about changes to the district nursing service and Trust management is meeting the Local Management Committee representing GPs to discuss the future for the Community Nursing Service.

2.20 In the Cardiff and Vale community, the voluntary sector could play a far greater role in providing services within the community for individuals with relatively low-level needs. There are examples in other communities where this has been successful, for example, services aimed at promoting and developing support networks for older people in their own home to prevent admission, re-admission and functional decline. Integrated commissioning between health and social care for voluntary services is one way to support this.

At each stage of the patient's pathway through the whole system, there is a need to promote more effectively the independence of vulnerable people to reduce delayed transfers of care

Local Health Boards can do more to engage GPs more effectively in promoting the independence of vulnerable people

2.21 Focusing solely on reducing the number of delayed transfers of care fails to recognise the whole systems nature of the problem. The best way to tackle delayed transfers of care is to prevent admissions to hospital as far as possible. If patients are admitted, it is important to ensure that they pass through hospitals as quickly and safely as possible in order to promote the maintenance of their independence. Consequently focusing on

minimising admissions to hospital – managing the 'front door' as well as the 'back door' of the hospital – is a crucial part of any whole systems approach to tackling delayed transfers of care.

2.22 The need to develop more community-based provision was identified within the previous section and it is encouraging to note that the Programme for Health Service Improvement includes an unscheduled care workstream which will put a mechanism in place to direct patients to the most appropriate service to meet their needs, with a view to avoiding unnecessary admissions. However, this will only be fully effective if appropriate services are available.

2.23 Within the Trust, there has been an overall downward trend in rates of emergency admissions for those aged over 65 years between April 2003 and March 2006, although overall emergency admissions have increased over the same period (Figure 7). This suggests that major changes in demand, measured through emergency admissions of older people, may not have driven the increasing rate of delayed transfers of care. However, older people tend to have longer lengths of stay, which means that the impact of admission trends can lead to difficulties of interpretation.

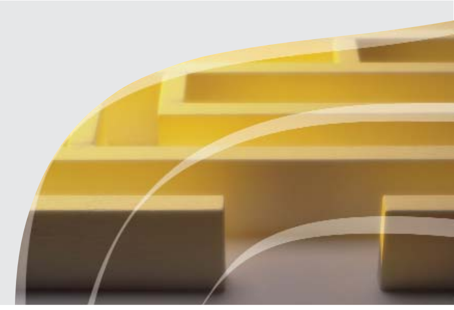
2.24 We know from our chronic disease review that hospital admission rates for patients with chronic conditions vary considerably between different GP practices in both LHBs, but particularly so for Cardiff LHB. This variation persists even when taking into account demographic and age characteristics, which suggests that these factors do not explain admission patterns by practice.

2.25 The Vale of Glamorgan LHB has introduced a system to receive and monitor GP elective referrals which it provides directly for its own residents and on behalf of Cardiff LHB which funds the service for Cardiff residents. Both LHBs should start to collect details of unscheduled admissions to help focus their admission prevention efforts. The 'Programme for Health Service Improvement' includes an unscheduled care workstream which plans to develop a single point of contact for unscheduled care services to direct people to the most appropriate service and avoid unnecessary admissions. This should help GPs to access a single point of contact to get the most appropriate unscheduled care response to meet their patients' needs.

Figure 7: Admissions have been reducing, especially in the over 65 age range

	2003/2004	2004/2005	2005/2006	Change
Overall admission numbers	104,973	105,787	109,111	3.9%
Emergency admission numbers	41,976	40,598	42,701	1.7%
Emergency admissions in the 65+ age range	15,365	14,607	14,454	-6.0%

Source: Wales Audit Office analysis of PEDW data



2.26 Primary care practitioners have a key role to play in the care of vulnerable people and in making the system function more effectively to meet the needs of their practice populations. Although there are exceptions, we found that the engagement of GPs in relation to delayed transfers was inconsistent. General Practitioners are frequently unaware that their patients are staying in hospital for longer then they need to, and there is a general perception amongst Trust staff that some GPs take the narrow view that their patients are safer in hospital than using other services or in their own home. Cardiff LHB has attempted to address this by using the Cardiff Practice Education Programme with GPs, to inform them of the alternatives to admission and to encourage utilisation of intermediate care schemes.

2.27 The involvement and engagement of GPs were not identified as a key barrier to tackling delayed transfers of care within our Cardiff and Vale community focus group. This could be interpreted in one of two ways; either that there are no barriers involving GPs, or that they are considered less influential in managing the delayed transfers of care problem than others in the system, for example, trusts and social services. Our fieldwork suggested that GPs could have a significant potential impact on the delayed transfers of care problem through finding safe alternatives to acute hospital admissions, and should be seen as part of the solution. A key challenge will be for LHBs to use the new General Medical Services contract to create incentives for GPs to avoid admissions to hospital, where appropriate alternatives exist.

2.28 We consider that the Cardiff and Vale NHS Trust (and other trusts including Bro Morgannwg) should formally notify GPs that a patient's transfer of care has been delayed. The Trusts and the LHBs could also circulate information amongst GPs on which GPs are most frequently referring to services outside hospital. There is scope for both LHBs to use the new primary care contract to involve GPs more effectively in preventing the admission of their vulnerable elderly practice population. Better information about the local use of other options would be a good first step.

2.29 There are opportunities to provide better GP-led services in the community that would serve to avoid the unnecessary admission of vulnerable elderly people to hospital. The new General Medical Services Contract contains provisions which enable LHBs to commission local enhanced services which could include more proactive intervention to support vulnerable older people in the community and in supporting patients upon their discharge from hospital. However, in the absence of new funding, the speed with which these new opportunities can be used is compromised by the time is takes to shift resources from existing secondary care services to new primary care services. There has been some progress: for example, Cardiff LHB is developing a service specification for a local enhanced service within nursing homes whose purpose will be to intervene to avoid hospital admission wherever possible for nursing home residents.

2.30 Consistent with the Assembly Government's 'Delivering Emergency Care Services' strategy, there is scope for commissioners to use the Welsh Ambulance Services NHS Trust increasingly to provide community-based services as a mobile provider of unscheduled healthcare services and also to expedite discharge through its Patient Care Service.

2.31 The strategic direction within the Trust's Mental Health Service is increasingly focused on care in the community. The LHBs have invested in a crisis team and a community rehabilitation team within the Trust's mental health services which has reduced admissions and enabled closure of beds within Whitchurch Hospital. An evaluation of the first Crisis Team's impact has recently been completed by Imperial College London. While the study demonstrated a reduction in adult acute admissions of approximately 25 per cent over the two-year period, it is not possible to state that this was solely due to the work of the Crisis Team as there were also improved emergency assessment arrangements in that part of the service which the Crisis Team did not then cover.

Assessment processes need to improve

2.32 Our census asked for a range of information about delayed transfers of care patients prior to their admission. In response, many nursing staff were unable to provide information about the social circumstances of delayed transfer of care patients prior to their admission which suggests that many nursing staff do not holistically assess their patients even though these patients have been in hospital for an extended period. We found, for example, that nurses did not know whether:

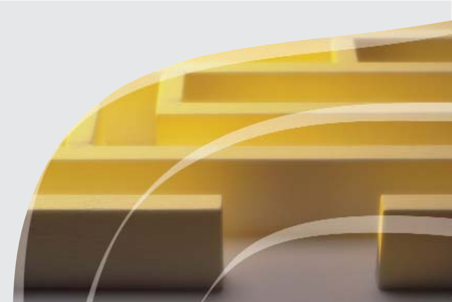
- a Community Psychiatric Nurse (CPN) had been involved in 66 per cent of mental health patients who experienced a delayed transfer of care;
- 44 per cent of general patients classed as delayed transfers of care had been receiving home care support prior to coming into hospital; and
- 37 per cent of rehabilitation patients listed as delayed transfers of care had been supported by their family, carer or neighbours before their admission.

2.33 The unified assessment process, which was intended to deliver a more multi-disciplinary approach to assessing patients' needs, has potentially significant benefits but its implementation has been problematic because of a lack of a shared IT system and problems with information sharing between agencies.

2.34 Staff find the unified assessment process confusing and time-consuming and it can be difficult for managers to make sure the job is properly completed. Social workers in the Vale of Glamorgan perceive that too much of the form-filling burden is falling on them. There is also some duplication of effort.

2.35 The Trust's intention is to provide the unified assessment forms electronically through the Clinical Workstation. However, this system is not compatible with either of the systems used by the two local authorities. Cardiff Council and the Trust have been trying to find local solutions to this problem but the IT incompatibility is very difficult to resolve. An interim short-term solution has been found by providing social workers with temporary contracts to enable social workers to access the Trust's system.

2.36 As well as sorting out how best to complete the paperwork, there needs to be a greater emphasis on educating those filling in the forms to explain to them the benefits arising from properly completed documentation.



Case Study D: Assessment processes

Mr C was admitted to the UHW in November 2006 with prostrate problems and short-term memory loss. Mr C was declared fit for discharge on 22 February 2007. Ward staff completed the unified assessment, but not to the social worker's satisfaction – 'incomplete and not signed'. New social worker still trying to sort this out during the first week in June. A nursing home placement was required but the home of choice required a top-up payment which had not yet been agreed. The LHB also needs to agree the placement.
Key issues:

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

Source: CSSIW review of social services case files following up Wales Audit Office inpatient census on 16 May 2007

2.37 The current 'linear model' approach is causing delays and contributing to lengths of stay and delayed transfers of care. Improved co-ordination is required so that all professional groups start at the same point and end at the same point. Case Study D reflects some of the issues with assessment processes.

2.38 We have found some good examples of effective assessment supporting good discharge planning and timely discharge from within the hospital. In the better examples, social workers and other care managers worked effectively with their partners and took the initiative to chase and monitor progress.

Case Study E: Effective joint working and assessment

Mrs B was admitted to hospital in January 2007. She felt that she needed 24-hour support and asked to move to a care home. She was declared fit for discharge in April 2007. A practising Catholic she already had strong links with a particular home to which she moved in June 2007.
The delay in this case was as a consequence of a debate about the nature of Mrs B's needs; staff at the home suggested she needed one of their 'nursing care' beds.
The family agreed to pay the £100 a week top-up.
The unified assessment completed by the social worker was strong, and the liaison with family and health staff positive and purposeful.

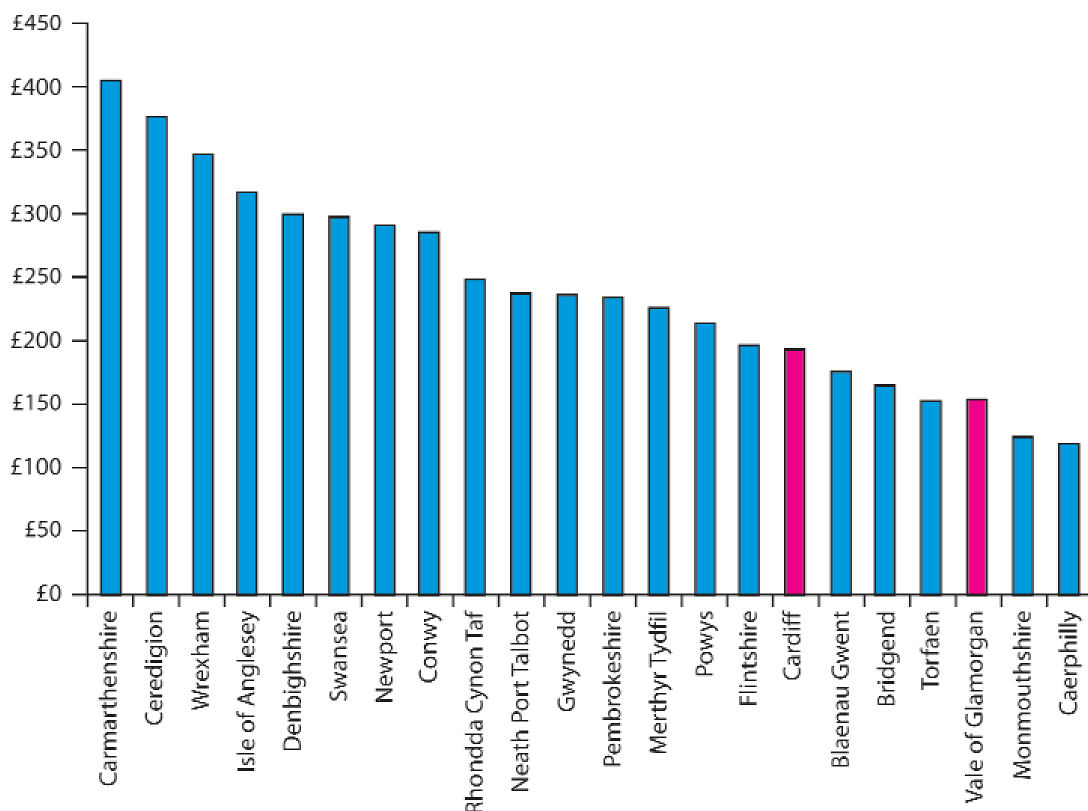
Source: CSSIW review of social services case files following up Wales Audit Office inpatient census on 16 May 2007

Case Study E is an example where joint working and assessment appear to have been effective.

The process of determining eligibility for Continuing Healthcare funding remains a serious barrier and has the potential to deteriorate further

2.39 Organisational barriers at the interface between health and social care contribute to delayed transfers of care. In particular, decisions about whether a patient is eligible for fully NHS-funded Continuing Healthcare, whether they receive an NHS contribution to nursing care and/or require means-tested social services personal, residential or nursing care, can be a time-consuming and difficult process. This does not place the patient at the centre of care and encourages organisations to seek to protect their budgets and position. We found evidence from our case file review of assessments involving both health and social care, with one partner effectively avoiding responsibility for progress until the case returned to them across the

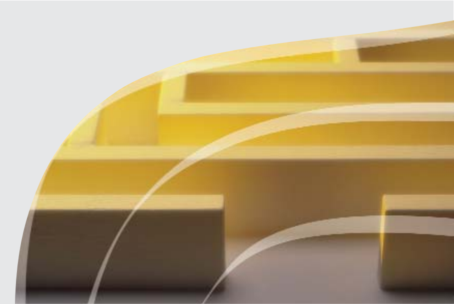
Figure 8: LHBs' accounts show variation in expenditure on Continuing Healthcare per 1,000 head of population 65 and over



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

organisational boundary. There may be scope to develop jointly funded health and social care posts to help co-ordinate older people's pathway through the system, building on some of the principles of existing good practice, for example, the nurse care manager system in Caerphilly and the development of 'virtual wards' in Croydon.

2.40 Consistently determining eligibility for Continuing Healthcare is a significant challenge across Cardiff and the Vale, which can lead to disputes between health and social care that can significantly increase the extent of delayed transfers of care. Assessing the eligibility of patients for Continuing Healthcare is time-consuming and difficult both for patients and those carrying out health and social services assessments. Both LHBs' expenditure on Continuing Healthcare per 1,000 head of population aged 65 or over is low compared with other LHBs (Figure 8). The variation in expenditure across Wales may reflect variable provision of Continuing Healthcare beds within NHS Trusts as part of their Long Term Agreement with commissioners. Continuing Healthcare is an area where further work is underway to develop a better understanding of the current position which, along with any additional future work, might address in more detail the issues identified in this report.



2.41 The cost of Continuing Healthcare to LHBs is likely to increase as a result of the 'Grogan' judgement of January 2006, which established that some primary care trusts in England had failed to apply an 'over arching test' to determine whether the patient's primary need was for healthcare. This judgement, combined with earlier cases involving the Ombudsman and Coughlan, all point in the same general direction: an expectation that the NHS will assume a greater responsibility for funding care than previously. The direct consequences are a reduction of the financial burden on social services authorities for long-term care, and the removal of the financial cost from some people who had previously paid for their own care. In Cardiff and the Vale of Glamorgan, the two LHBs produced initial estimates of the financial cost associated with compliance with the 'Grogan judgement', which appear to have been based on a worst-case scenario and whose accuracy we have not assessed, as £31 million.

2.42 Disputes between LHBs and social services are increasingly common in respect of eligibility for Continuing Healthcare funding. For example, in the Vale of Glamorgan six of the 34 delayed transfers of care cases in June 2007 were waiting for their Continuing Healthcare assessment to be completed, a further three were waiting for their original Continuing Healthcare decision to be reviewed, and one was awaiting a Continuing Healthcare bed. The local authority is likely to be arguing in some of these cases that funding responsibility belongs to the NHS rather than the Council. In Cardiff, in June 2007, eight of the 131 delayed transfers of care related to a review of a decision on eligibility for Continuing Healthcare, five were waiting for their Continuing Healthcare assessment to be completed, two were waiting for a Continuing Healthcare bed and one was waiting because of a dispute between the Trust and the LHB over eligibility for Continuing Healthcare funding.

2.43 The dynamic around Continuing Healthcare assessments and decisions is complicated by the fact that an individual patient's needs can change significantly during their stay in hospital, which can lead to a need to reassess eligibility for Continuing Healthcare. Such multiple assessments do not contribute to a genuinely person-centred response to their identified needs. Case Study F provides an example of a case where issues arose as a result of Continuing Healthcare processes.

A more consistent approach to managing patient choice could reduce its serious impact as a cause of delayed transfers

2.44 Admission to hospital is a dramatic and potentially life-changing event. For those who face the prospect of not returning home after leaving hospital, the implications for them and their families and carers are enormous. Behind the statistics about delayed transfers of care are people who quite reasonably expect to be helped to make informed choices about the future.

2.45 Delayed transfers of care for choice reasons are a significant problem in the health community, as they are elsewhere in Wales. In November 2006, when the numbers of delayed transfers of care had peaked at 219, 84 of the community's cases (or 38 per cent) were categorised as delayed because of a choice reason. Although the actual number of recorded delayed transfers of care has since dropped, figures for June 2007 suggest that 37 per cent of delayed transfers of care cases are delayed either because the patient and family are still in the process of choosing a home or because the placement of choice is not available.

Case Study F: Examples of the impact of processes to assess eligibility for Continuing Healthcare funding
Mr A was admitted to hospital with advanced dementia. On 2 August 2006, he was declared medically fit for discharge. At this point the opinion in the hospital was that he needed nursing home care. A social worker was not allocated until early September and a long debate followed about eligibility for Continuing Healthcare funding – the social worker arguing that it applied but 'the rest of the team' saying it did not. Mr A is now (June 2007) in an EMI nursing home and it seems from the file that Continuing Healthcare funding is not being paid. There was a delay in allocating a social worker, plus evident difficulty in communicating with the team manager for Older People's Mental Health Team. The psychiatric assessment (part of the Continuing Healthcare assessment) also took several weeks to deliver. It took two weeks to set up the appeals or dispute panel.
Mr S was admitted to the University Hospital of Wales in October 2005 with complex medical problems and was transferred to Rockwood Hospital in December 2006. There was a multi-disciplinary meeting held in April 2007 and Continuing Healthcare criteria were agreed. In May 2007 the paperwork for Continuing Healthcare was submitted to the LHB meeting panel. This was not decided at the June LHB panel meeting and the request has been referred to the September panel meeting. During this time, the planned placement in a nursing home has been lost and an alternative placement is being sought.

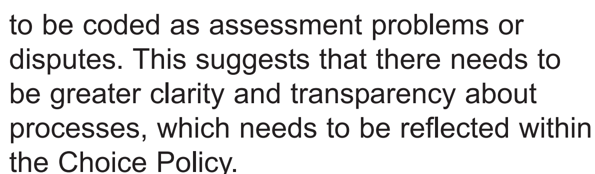
Source: Wales Audit Office fieldwork

2.46 Most officers we have spoken to within the Cardiff and Vale health and social care community have cited the shortage of care home places as the biggest barrier to reducing the levels of delayed transfers of care. In our survey, Cardiff and Vale NHS Trust nursing staff told us that only one in five delayed transfers of care patients would be able to return to their previous living arrangements (paragraph 2.4). This may reflect a prevailing clinical culture in which the medical model of care is dominant and therefore most of those fit for discharge are seen to need either a care home place or a long-stay bed within the Trust. The Programme for Health Service Improvement has recently agreed new models of rehabilitation and intermediate care services for Cardiff and the Vale of Glamorgan.

2.47 We found that there is a need for the health and social care community to take a more radical approach to managing the flow of people through the system, particularly to encourage patients to return to their own home, or to sheltered housing, or to a carer's home – supported as necessary – and to regard a care home placement as a last resort. There is currently an over-reliance on the care home sector which could be reduced if there were a greater range of community services available and an increased focus on returning individuals to their optimum functional levels.

2.48. Often there are better options for many of the individuals who are discharged from hospital into a care home place. The health and social care community has a chronic shortage of care home places which is made worse by local funding pressures (in both LHBs and both local authorities) and by disagreements over funding responsibility (whether responsibility sits with the Council or the NHS).

2.49 The current system allows patients and their carers to choose a home, even though they know there is no vacancy and/or that this choice cannot be fully publicly funded. There is no control in the system at present to make sure that choices are affordable or available, meaning that various problems of choice are more likely, in the current system,



to be coded as assessment problems or disputes. This suggests that there needs to be greater clarity and transparency about processes, which needs to be reflected within the Choice Policy.

2.50 While there is an agreement across the community on how to handle choice, there needs to be more consistent implementation of choice policies and protocols supported by time limits for decisions. Clinicians we spoke to indicated that they often experienced problems with relatives concerned about having to sell a home to raise funding for care. In these circumstances clinicians told us that there should be managerial support to establish all of the practical options and to enable the clinicians to step back.

2.51 In trying to overcome some of the capacity issues, transitional beds are being used within a care home in the Cardiff area. To date, this has provided an additional eight beds. Until recently the utilisation of these beds was not good as the cases being considered were too complex. This has now been addressed through changes to the case mix and a determination by the LHB commissioner to utilise fully these beds. This is only a short-term solution as the care home is due to close in March 2008.

2.52 We also heard the perception among public service bodies in Cardiff and Vale that families are becoming more aware of the issues and implications of moving from free healthcare to means-tested personal care, and sometimes seek to delay their relative's transfer of care, causing inappropriate delays. It is extremely difficult to discharge someone forcibly from hospital. Trust staff told us that the legal advice available to them was limited and difficult for them to access. Ward managers find that if they have to suggest evicting a patient from hospital, it would compromise their position as a provider of care. Communication is vital in situations where someone is going to move from a hospital bed into residential care. In such circumstances an important measure is to inform the family as soon as possible if long-term care is going to be required.

2.53 The implications on delayed transfers of care of the implementation of the Mental Capacity Act remain unknown. The Act regulates the management of decisions taken on behalf of people without the mental capacity to make their own decisions. It targets patients with dementia, learning difficulties, brain injuries or disturbance (temporary or permanent) and severe mental illness, and covers decisions such as the choice of care home for patients who do not have capacity. The Act also provides the strongest guidance yet that carers should be included in such decisions.

Partners need to improve throughput and discharge in hospital by tackling remaining barriers

2.54 The Trust's Modernisation Framework – Improvement by Design to Deliver Safe, Effective, Efficient and Compassionate Care – identifies the key areas of work that need to be progressed to modernise the service and improve patient flows. This works on the principles of right care, right place, right time, and right person/team.

2.55 The aim is to improve all aspects of the pathway from improving bed management, the emergency streams and discharge management. There is recognition within the Trust that the key requirement for delivering the necessary improvement centres on changing clinical behaviour and strengthening

multi-disciplinary team working and it acknowledges that there is still some way to go. The NLIAH will be supporting the Trust in providing relevant examples of good practice elsewhere and developing leadership skills to translate plans into action.

2.56 There are some good examples of where the modernisation process is showing early success. This includes the implementation across a number of wards of the Clinical Workstation. This system will be a key tool to support clinical practice in improving patient flow, including discharge planning and reporting on results, with early indications suggesting reduced lengths of stay in some areas. The Clinical Workstation also includes the ability to identify the predicted date for discharge which is good practice. The system is being rolled out gradually across each of the directorates but there is an acknowledgement that this needs to be supported by clarification of roles and responsibilities, the use of clinical champions and education.

2.57 In addition there are also a number of proposals for streamlining patient flow which include:

- A new bed management model; promoting a more proactive approach to the management of the complete patient flow, which moves away from finding and allocating beds to improving patient flow through a 'pull' system whereby patients are drawn through the system. The Clinical Workstation will be a key component of this model which has been piloted in a number of areas.

- There is an emerging medical emergency stream model aimed at a single medical model across both sites, with all patients seen by consultant physicians and senior decision makers within 24 hours, with an ethos of assessing to admit rather than the other way around.

2.58 Our interviews with Trust staff suggested that there is a developing recognition of the positive impact of multi-disciplinary working on patient flow and outcomes. A new model of working on Ward C6 at the University Hospital of Wales, is Focused Rehabilitation for Medical Elderly (FRAME) which is showing promising outcomes. Case Study G demonstrates some of the positive attributes of this model.

2.59 The Trust believes that the FRAME model is the required future direction to support improved patient flow and reduce the level of patients being cared for on inappropriate wards. Therefore they have decided to invest in the FRAME model on the understanding that this may result in an overall reduction in beds elsewhere as a result of improved efficiencies. It will be formally evaluated and presented to the Management Board for consideration for expansion.

2.60 Working with a multi-disciplinary model and an increased focus on rehabilitation demonstrates where working differently can improve flow and patient outcomes and make more effective use of staff resources.

2.61 A key factor in successful multi-disciplinary working is a sufficient and effective therapy service. While there has been recent significant investment within therapy services this has mainly been targeted at delivery of 'Access 2009' waiting time targets, modernisation and streaming of patients to support reduced lengths of stay. Some believe that there remains significant unmet need in a number of areas, such as rehabilitation and surgery.

Case Study G: Focused Rehabilitation for Medical Elderly

FRAME includes early rehabilitation and maintenance of basic functional and physical health during the initial stages of medical treatment and stabilisation. This model operates a 'pull' system where the rehabilitation consultant visits the Emergency Unit, Medical Admissions ward and other relevant areas and identifies suitable patients for transfer into the service. Multi-disciplinary working is a key feature and physiotherapy, occupational therapy and a dedicated social worker are available seven days a week.
Initial results have been promising with so far five out of every six patients using FRAME being safely discharged back to their own home.

Source: Trust evaluation of C6 model

2.62 Throughout the review we found consistent messages that there were insufficient therapists within the Trust's acute and community service, and changing the way they work or indeed increasing their capacity could prevent admission, reduce dependency and support improved management of individuals who are delayed at the earlier stage of their pathway.

2.63 Within general wards rehabilitation tends to be a lower priority and for therapists the acute care needs are the main focus. There are no direct referrals to therapies within the community and therapy services can only be accessed if patients are referred to the Elderly Care Assessment Service or the Acute Response Team. The Elderly Care Assessment Team is only available within the Cardiff area.

2.64 Some therapy capacity, particularly within the community, has been secured through short term, non-recurrent funding which has resulted in a limited therapy resource for some services and year-to-year contracts which can make recruitment and retention difficult. This limits the ability to focus on maintenance and prevention within the community and presents a risk for the continuation of these services when funding ceases.

2.65 Poor access to local authority occupational therapists reduces the chances of successful rehabilitation happening at home.
For example, the Vale of Glamorgan Council's occupational therapy team is under pressure as the demand for its services outweighs the resources in the team. There has been a history of long waiting lists for occupational therapy assessments, which has been exacerbated by having posts frozen since September 2006. There has been recent recruitment to the team, but the waiting list for non-urgent cases is still long. The work of the team is dominated by high priority cases, including people waiting for discharge from hospital. This reduces the chances of meeting low-level needs of people in the community which may contribute to more serious problems occurring. Carers, home care staff and social workers told us of the valuable contribution made by occupational therapists in assisting people to remain safely in the community. The current arrangements mean that many people have to wait to access this expertise.

2.66 It is important to note that there are many positive experiences of effective rehabilitation and hospital discharge. Case Study H demonstrates the impact of effective rehabilitation on discharge from hospital.

2.67 Enhanced therapy services play a key role in reducing dependency and reliance on institutional care which include hospitals and care homes. With a growing elderly population this may be a key area for development. An integrated occupational therapy service, which is in place in some other areas, may be one solution.

Case Study H: Effective rehabilitation on discharge from hospital

Mrs D was admitted to the West Wing Reablement ward in Cardiff, after treatment on an acute medical ward. She received intensive physiotherapy and occupational therapy. There was a planned discharge which put all the necessary services in place. Mrs D regained her mobility and confidence and was safely discharged and is still coping well in the community.

Source: Wales Audit Office

2.68 The Trust and partners have agreed a joint discharge policy framework which has been agreed with the Clinical Governance Group. Cardiff Council is awaiting legal advice before final agreement. The Trust has completed the NLIAH self-assessment tool and has identified a number of areas for improvement which are already being processed through the Timely Discharge Programme Board (TDPB).

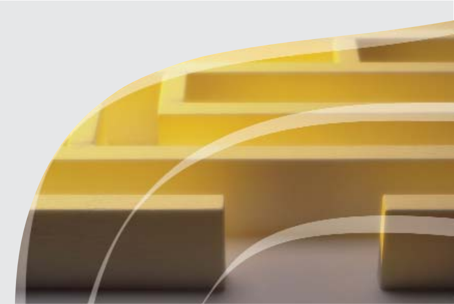
2.69 We found that discharge planning and management varied because of different ward arrangements in terms of access to therapists, social workers and differences in the roles and caseloads of key hospital staff. Our focus group highlighted concerns about the effectiveness of discharge management, with patients and carers not engaged sufficiently early in discharge planning, and we found a lack of clarity about roles and responsibilities, and duplication of effort.

2.70 We found that ward staff relied heavily on discharge liaison nurses to support discharge planning. Often ward staff do not see discharge planning as their role and sometimes neglected the basic discharge management function on the ward. The discharge liaison nurse role is intended to support and facilitate mainly complex discharges but they increasingly take on the discharge planning for ward staff. We found that discharge liaison nurses have variable roles which have variable impact, with particular confusion between the discharge liaison nurse role and that of ward managers. In contrast, the role of the discharge liaison nurses in Bro Morgannwg NHS Trust is regarded as having been pivotal to the effective management of patient flow.

2.71 The management arrangements for discharge liaison nurses are fragmented, with some having a corporate function and others aligned to directorates, for example, neurology. Many operate in different ways with some more effective than others. Within mental health the role is very different and the posts are funded through flexibilities funding which was due to cease earlier this year.

2.72 Our interviews suggested that there is acknowledgment within the health and social care community that in general the district liaison nurse roles are not effective and there are proposals for changes to the mental health team. Recently the social workers and district liaison nurses at Llandough Hospital have been integrated to create a discharge planning team. This model will be evaluated before further changes are made to the remaining district liaison nurses.

2.73 The Trust works with the ‘Theory of Constraints’ model which aims to improve the operation of a system by identifying the key constraint and developing appropriate steps to manage its impact. In the case of discharge management in the Trust, Theory of Constraints work has identified the need to focus on improving discharge planning by ward staff. This focus on discharge planning includes relevant areas using weekly ‘buffer’ meetings and initially there was a drive to utilise this system for improving discharge management, particularly of delayed transfers of care patients. Some acute areas appear to be disengaged from the ‘buffer’ meetings and do not see the proactive management of delayed transfers of care as a priority.



2.74 However, in mental health, most areas still have ‘buffer’ meetings and the discharge liaison nurse attends. The discharge liaison nurse is acutely aware of patient issues and has an in-depth knowledge. Every delay is discussed and actions are assigned with meetings minuted. Some multi-disciplinary members attend but not social workers. There is clear accountability, roles and responsibilities and a clear expectation for resolving problems. The meetings are not optional and they are part of a routine way of working. The general manager is heavily involved and is personally responsible in supporting this process with weekly meetings. He reinforces responsibilities and whilst line managers have responsibilities, they often defer to discharge liaison nurses as they tend to have more knowledge and skills in this area.

2.75 There is no function within Cardiff and Vale NHS Trust’s Patient Management System to record when a patient is expected to leave or when a patient is considered ‘fit for discharge’. The Trust’s processes for collecting and recording the information about when a patient is expected to leave or is fit for discharge differ between general and mental health areas with mental health ward staff closely involved in documenting delays, but in general areas there is total reliance on the discharge liaison nurses. Discharge liaison nurses rely on ward staff to tell them about any delays but sometimes patients slip through.

2.76 Arrangements for managing the discharge process from a patient’s admission are different in Bro Morgannwg NHS Trust from those in Cardiff and Vale NHS Trust. In April 2005, Bro Morgannwg NHS Trust introduced a system known as PIMS+ which uses Expected Dates of Discharge (EDDs). All admissions are expected to have an EDD within 24 hours, and nurses are responsible for inputting these. Every patient in the Trust is then colour coded: for example black means has ‘exceeded EDD’, red ‘leaving today’, amber ‘leaving tomorrow’, green ‘leaving in two days’, blue ‘leaving in more than two days’. It is easier in this system to see:

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

2.77 The Clinical Workstation has these functions and provides an opportunity for electronic identification of all patients who are ‘fit for discharge’. This system, like the Bro Morgannwg NHS Trust system, allows an estimate of a patient’s discharge date as soon as they are admitted to a bed and should support more effective multi-agency patient management. The Clinical Workstation should provide a powerful tool if implemented across the Trust.

There is a need to address varied social worker presence, approaches and procedures within hospitals

2.78 Cardiff Council’s social work teams are based either in UHW or in the south west hospitals, including Llandough. The teams operate on a different basis; due to the volume of referrals, the UHW team uses unqualified contact officers to assist a Senior Social Worker in the processing of assessments, while the south west team uses only qualified social workers. Both systems experience difficulties. The role

of the contact officers at UHW is limited in that they do not undertake a full assessment and direct contact with patients is not generally encouraged as it can be difficult to explain their differing role to the patient. With the social worker system, pre-assessments are made on admission, which can relieve the pressure on the remainder of the team, who will focus their work on patients becoming ready for discharge. However, situations do occur where an assessment is undertaken again should the patient's situation or condition change. Both hospital teams operate a duty social worker system to ensure the absence of a named case manager does not unnecessarily delay assessment; however, there are instances where some delays occur during holiday/sickness periods. At present, both systems are experiencing difficulties in coping with the volume of referrals and the challenge of communicating with the wards.

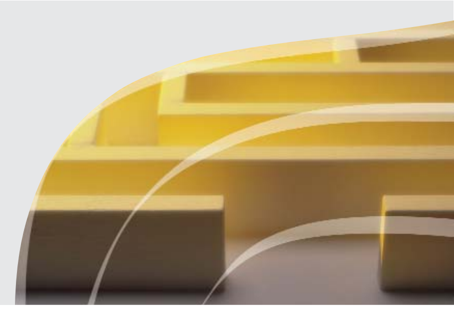
2.79 The social work team at UHW meets three times a week to allocate referrals of patients needing assessment to prepare for discharge. The contact team at UHW meets with the occupational therapists on a daily basis and the Llandough Contact Officer meets with the discharge liaison nurses also on a daily basis; however, social workers report difficulties in procuring bed places and appropriate home care services.

2.80 With regards to problems procuring bed places, although receiving daily vacancy information, Cardiff Council's social workers commented that the vacancy numbers fluctuate hourly, let alone daily and the most popular places were oversubscribed leading to difficulties in locating suitable accommodation. This situation has been exacerbated by the lack of 'step down' intermediate care beds.

2.81 Cardiff Council's social workers reported that the Council's directly provided home care services are being used to capacity and it was difficult to obtain whole area coverage due to lack of resources. Therefore, independent services were used and social workers were often urged to go for the cheapest options. In the current financial climate within adult services, social workers consider the associated costs of commissioning a care package, in relation to the varying costs of different agencies, although we heard concerns that other criteria should be given equal significance.

2.82 In response Cardiff Council is currently reviewing the possibility of introducing a specialist Brokerage Service which should cover both domiciliary and residential care services; however, as resources are limited, it would need to be introduced on a cost-neutral basis. The resources to initiate a pilot scheme have now been identified and joint meetings have been set up with the Vale of Glamorgan Council to learn from their good practice, and so a sharing of knowledge and experience should help progress its development.

2.83 The major examples of communication difficulties between Cardiff social care staff and health workers include inappropriate referrals and their timing. Despite the existence of clear referral criteria, there are instances where verbal referrals are given to discharge liaison nurses and so bypass social workers. Furthermore, occupational therapy staff are called in when patients are not yet ready for intervention. Carers report that there do not appear to be clearly defined areas of responsibility, which leads to confusion as to who is taking charge of the patient's case. All staff therefore need to be kept fully aware of, and understand, the processes in place.



2.84 There are also issues between Cardiff community and hospital-based social workers. When a client, whose case is being overseen by a community social worker, is admitted as a patient, the hospital-based social worker takes over and 'caretakes' the case; as a result of this lack of continuity, information on case files is frequently found to be inaccurate or has become out of date. There is also no standardised IT system for easy exchange of information. Although the current system encourages a more timely response from hospital based social workers, in practice both sets of social workers experience duplication or lack of information. The Council has acknowledged the difficulties being experienced and is planning further training in the use of the IT System (CareFirst) and are considering the use of the PARIS IT System for mental health social work services.

2.85 There are a small number of specially allocated social workers to specific wards in Cardiff but in general they currently operate on a generic basis. Also, only a small number of wards operate a multi-disciplinary team. The various teams – social workers, physiotherapists, occupational therapists, and nursing staff – currently work to a 'linear model' where these various professional groups will wait for the other to finish their part of the assessment before beginning their assessment. This style of working is causing delays and duplication of efforts and contributes to the length of stay. Although it may be more difficult to achieve in an acute setting, both health and social care workers need to consider how to improve co-ordination so that all professional groups start and end at the same point.

2.86 With regard to working practices between Cardiff health and social care staff, there does not appear to be a standardised approach to effective communications or linkages between the two groups. This has led to confusion and lack of knowledge of processes on each side. For example, there was confusion over the procedures for existing care packages when patients were admitted (whether or not they were temporarily suspended) and tensions over the completion of unified assessment forms which social workers felt were overly bureaucratic. Although there is work in progress to overcome these organisational boundary issues, for example the discharge liaison nurse attending social work team meetings, there are examples of poor information exchange and joint working which had led to uncertainty on how to improve current practices. However, social workers were optimistic about the current FRAME scheme in Ward C6 and considered that a multi-disciplinary approach would help improve working relations as well as clarify roles and responsibilities. The Timely Discharge Board has also identified the improvement of communication as a priority action.

2.87 There are also communication problems in the Vale of Glamorgan. For example, we heard that the Vale of Glamorgan Council operates an 'answer phone' Contact Centre system which takes calls from hospital nurses about individual patients, but does not reliably result in calls back confirming that the message has been received or that the patient has been allocated a social worker. This can lead to misunderstandings and potential conflict on both sides.

2.88 Furthermore, there is variation in the allocation of responsibilities; for example, hospital-based social workers from the Vale of Glamorgan Council deal only with hospitalised patients who have not received Social Services within the last three months, and so do not have any case records. Conversely, the Vale of Glamorgan Council's older people's social workers have to deal with the remaining patients and thus have to visit their allocated cases within hospital, and subsequently experience difficulties contacting and working with doctors. At a focus group, social workers suggested that the Vale of Glamorgan's hospital-based social workers should respond to all hospital referrals.

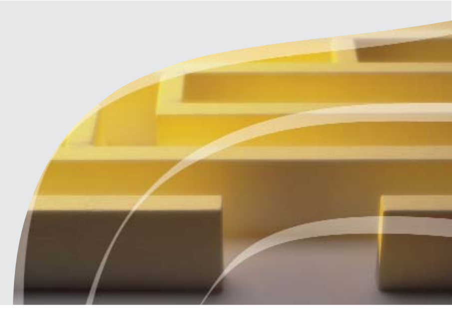
2.89 The general problems have already been recognised, resulting in the launch of some improvement initiatives, for example, the integrated team in Llandough (paragraph 2.72) and the use of a dedicated social worker from Cardiff Council on Ward C6 of UHW, which have strengthened multi-disciplinary working. There was optimism about these models and those we spoke to felt that a multi-disciplinary approach would improve patient flow, help improve working relations as well as clarify roles and responsibilities. Such collaborative working is starting to improve between Trust staff and social care teams but more needs to be done. For example, there may be benefits in the two local authorities developing standard processes where appropriate. They should also consider re-introducing dedicated hospital social workers with specific ward responsibilities.

The current operational processes need to support more effectively sustainable reductions in delayed transfers of care

2.90 In many cases, we found that processes are often reactive and respond to crisis and in many instances were not sufficiently focused on identifying solutions to problems. The management of delayed transfers of care is often reliant on an individual's enthusiasm and judgement rather than on robust and consistent policies. The approach differs across and between the different organisations with some more successful than others. Evidence shows that routine personal involvement by a senior officer with clear accountability and responsibility is effective in reducing delays (as referred to above within mental health) but this is not happening in a consistent manner within the Cardiff and Vale community.

2.91 More generally, the focus on resolving delayed transfers of care issues in meetings appears to be aimed at the longest-stay patients. While it is necessary to consider such cases, it is also important to make earlier intervention at the 'front end' of the system by using triggers at various points along the pathway, to reduce the numbers who will eventually become a delayed transfer of care and to reduce the impact once they become a delayed transfer of care.

2.92 Although there is an escalation policy for delayed transfers of care, its implementation is currently ad hoc and variable with poor awareness of its existence amongst some staff. Again, there need to be inbuilt triggers throughout that result in action being initiated. The Trust needs to raise awareness of the escalation process and ensure that the policy is implemented in a face-to-face and multi-disciplinary manner, supported by empowerment of individual officers to make decisions to resolve individual cases.



2.93 The Timely Discharge Programme Board, which is held monthly and hosted by the Trust, is attended by key members of the LHB to support timely patient discharge including delayed transfers of care. NLIAH's Change Agent Team's Action Plan is a key part of the agenda. Although the Timely Discharge Programme Board has enabled good engagement with partners, has supported improved partnership working and has taken forward some of the actions within the Change Agent Team's Action Plan, the current format of this forum is unlikely to secure sustainable reductions in delayed transfers of care. The Timely Discharge Programme Board's aims and objectives need to be reviewed and refocused.

Addressing problems in the availability and use of capacity, particularly a shortage of affordable care home capacity and insufficient links with housing services could help address the problem of delayed transfers of care

There is a need to address significant capacity pressures, especially EMI care home capacity

2.94 Throughout the health and social care community, a large number of delayed transfers of care have arisen because of a simple shortage of care home places. There remains a pressing shortage of affordable care home capacity. This shortage is particularly critical for patients with EMI or dementia – at least four popular nursing homes in Cardiff never have vacancies and are always able to fill spaces from their waiting lists. Very few homes accept the standard local authority funding rates with almost all relying on third party top-ups either by the Council, LHB or the patient and their carers.

2.95 In its report of March 2006, the Change Agent Team said that 'demand for general residential care is decreasing, demand for general nursing care remains stable and demand for 'EMI' residential and 'Enhanced Social Care' for individuals with mental health needs is increasing. The perceived poor quality of independent care home provision in the area leads to long waiting lists in those with a reputation for being of a higher standard. Effective joint working will be required to support struggling facilities and raise both public and professional confidence in the sector'.

2.96 The situation remains the same or worse as it was when the Change Agent Team reported to the partners in Cardiff and Vale on delayed transfers of care in March 2006. Cardiff Council is facing a loss of residential/nursing beds that is expected to total 143 by March 2008 although it is progressing plans that will see an additional 422 residential, nursing and extra care beds generated in the independent sector over the same time period. While this would produce a net gain of 279 places, it is still unclear as the extent to which the Council will be able to purchase these beds. There is also potential for current residential facilities to upgrade to accommodate nursing/EMI, but this is a short term solution and is yet to be achieved; furthermore, the number of places to be created is relatively few.

2.97 The current position with patient choice is compounded by some concerns about perceived quality of homes in the area, particularly those catering for EMI and commissioning of care home capacity is not as focussed on quality as it might be.

We have been told that those who work in the system, whether in health or social care, know about the quality of care offered by particular homes, and the perception of people and their carers about which homes to avoid. This intelligence about perceived or actual shortfalls in the quality of care, which contributes to delayed transfers of care arising from choice, is not being consistently passed on to local authority or LHB commissioning teams, nor to the Care and Social Services Inspectorate for Wales, to inform future commissioning and inspection. There are some systems in existence, for example Cardiff LHB and the Vale of Glamorgan LHB each employ a team of nurse assessors who review patient placements and inform the LHB's commissioning of long-term healthcare.

2.98 Local authority commissioners tend to rely on spot purchasing of care home capacity which increases costs and uncertainty of supply. Home owners may be reluctant to enter into block contracts as this reduces the chances of the local authority paying a rate above their standard fee, and makes it more difficult for them to protect placements for self-funders who normally pay higher fees. On the other hand, accepting block contracts provides a guaranteed income.

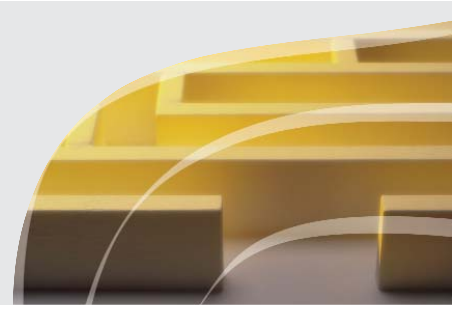
Housing should be an important factor in developing a whole system approach to capacity problems

2.99 A whole systems approach to commissioning needs to include consideration of potential links between housing, health and social care services. Extra care housing can be a positive alternative to residential home provision and has the potential to join up public services and to support the independence of vulnerable people more effectively than residential homes. However, commissioning extra care schemes can involve a significant lead time which means that new developments offer medium-term solutions.

2.100 Both Councils need to consider how best to involve their housing services within their strategic plans designed to minimise delayed transfers of care. There is a clear potential strategic housing role to limit the numbers of delayed transfers of care including Disabled Living Grants, provision of minor adaptations and telecare. As well as the shortage of residential homes, we have also been told by the Vale of Glamorgan Council that there is a shortage of appropriate emergency housing. The Council's Housing Service gets involved in individual cases but not strategically as it is no longer part of a combined Housing and Social Services Directorate.

2.101 Cardiff Council has already begun to recognise the linkages between social care and housing, but needs to support these with robust joint working. For example, the Council has recognised the need that a partnership approach, including its Housing Service, is the only way to progress its Accommodation Strategy which prioritises the need to enhance community care so that the elderly can remain in their homes for the longest possible period.

2.102 Furthermore, the Housing Service is also currently developing ideas for intermediate care provision, but they need to be jointly explored and progressed with social services. There are also joint discussions taking place between housing and the health bodies with regard to the use of flexibilities funding and support grants to enable people to move into appropriate housing.



2.103 There is also awareness by Cardiff Council of the possible funding of extra care housing schemes, resulting from the closure of residential care homes. They have suggested that the Council's Planning Department could help provide more information on care home developments and closures, to improve social services' level of knowledge and understanding of market fluctuations.

2.104 Within the Vale of Glamorgan, the Council's Housing Service is involved in individual cases but not strategically – it is no longer part of a combined Housing and Social Services Directorate – and the post of Housing Director is currently being advertised. There is a need to address the lack of appropriate emergency housing stock, and the 'Homes 4U' process is said to be long and drawn out.

2.105 There is clear potential for housing to play a greater strategic role in limiting the numbers of delayed transfers of care. This can include Disabled Living Grants, provision of minor adaptations, Extra Care schemes and telecare:

- Working on behalf of Cardiff Council, via a Service Level Agreement, the Care and Repair Agency helps support the elderly and/or disabled to repair and improve their homes, enabling them to retain their independence with increased safety and comfort. The agency provides a variety of Caseworker and Handyperson services for clients and undertakes the Rapid Response Adaptation Programme to prepare homes for discharged patients.

- The Vale of Glamorgan Council had established an Extra Care Housing Scheme located in Penarth three years ago but this did not work as planned. Most of the people placed there were from the Barry area and their own GPs were not able to provide healthcare services to them as they were living outside of the catchment area. The Council submitted a bid for an Assembly Government grant for extra care which is now proceeding.

- There is a Care and Repair Service in the Vale of Glamorgan which provides a prompt and valuable service for home owners in installing minor adaptations such as handrails. However, this service is not available to tenants. If people are tenants of the Council, they need to go through an assessment process before any work can be done and this has a waiting list.

- In Cardiff, the Telecare Service is seen as a viable option to provide care in the home for the vulnerable and elderly. It has been operational since March 2007 and is currently providing a service for approximately 40 clients but has the potential to assist 880.

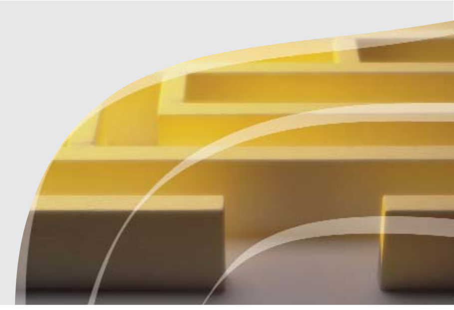
There is a need to make better use of resources across the whole system

2.106 Delayed transfers have often arisen because the authorities have not been able to afford placements. At one point, for example, the Vale of Glamorgan Council was applying a 'one in, one out' policy to stay within budget. Although this rule no longer applies, we have been advised that the Vale of Glamorgan Council currently pays the second lowest rates of any council in Wales. Cardiff Council is also facing financial pressures following a £7.6 million overspend. Relative expenditure is difficult to assess because it reflects in part standard spending assessments and indicator-based assessments for individual service areas, and political decisions about the use of resources. For example, some local authorities spend less per head relative

to others but may spend more than their indicator-based assessment. Compared with other local authorities in Wales, both had relatively low levels of expenditure on social services for people aged 65 or over in 2005/2006:

- Cardiff Council's social care spending per head of population was the fifth highest in Wales but for residents aged 65 and over expenditure is the ninth lowest in Wales; and
- while the Vale of Glamorgan Council's overall expenditure on social services per head of population was the Welsh median, it had the second lowest expenditure on services for older people per head of population aged 65 or over.

2.107 In 2006/2007, Cardiff Council helped the lowest rate of people to live at home of any Welsh local authority, while the Vale of Glamorgan Council had the fourteenth highest rate, having had the eighth highest rate in 2005/2006. Both councils supported relatively low rates of people in care homes per 1,000 population in 2006/2007.



Part 3 - Partners need to develop and implement a long-term strategy that promotes the independence of vulnerable older people and tackles the barriers to more effective joint working

Partners need to develop a joint acceptance that service and financial issues are interlinked and can only be successfully managed and delivered in partnership

3.1 Within health, the Assembly Government's South East Wales Regional Office plans to deliver the Assembly Government's 'Designed for Life' strategy and makes clear that there is a need in the Cardiff and Vale of Glamorgan health community to reduce demand on the two main acute hospitals (UHW and Llandough Hospital). The plan envisages the development of new services in primary and community based settings that support people in maintaining their health and independence.

3.2 In addition, social and health care organisations across Cardiff and the Vale are reviewing their Health, Social Care and Wellbeing strategies for 2008. This provides a major opportunity to undertake a robust update of the needs assessment and also to draw out common needs across the two Health, Social Care and Wellbeing strategies and, where appropriate, develop joint approaches. The review of these strategies provides a good opportunity to develop common solutions to meet common needs.

3.3 There needs to be further development and broadening of this community vision with full involvement of the Trust, LHBs and local authorities beyond organisational boundaries. Partners need to recognise that all organisations are inter-dependent in securing a balanced range of services to support individuals in the right place, at the right time and cared for by the right person. Critically, this vision then needs to translate into commissioning activity to fill the current capacity gaps including intermediate care and EMI services.

3.4 Critically, within Cardiff and the Vale there needs to be a clear, shared strategy, supported by a meaningful strategic forum, which is beginning to emerge through the Programme for Health Services Improvement.

3.5 In April 2006, the Cardiff and the Vale of Glamorgan LHBs published a project initiation document, 'A Programme for Health Service Improvement – The Case for Change' (PHSI), which responded to the Assembly Government's 'Designed for Life' Strategy and sets out the reasons and nature of change to local health services across Cardiff and the Vale of Glamorgan. 'Delivering Integrated Services' is the parallel document covering health, social care and voluntary services in the Bro Morgannwg area which is relevant to residents of the Western Vale of Glamorgan.

3.6 PHSI is regarded as the centrepiece of health partnership working to effect change. The consultation paper points to the areas of need set out in 'Designed for Life' and sets out a series of necessary local changes including:

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

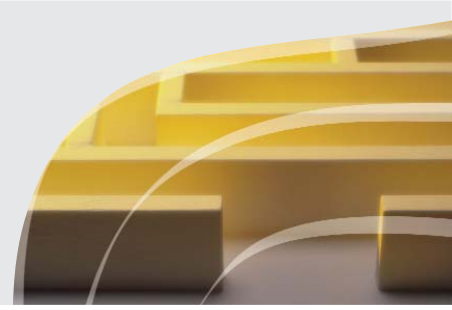
3.7 The project initiation document included a number of issues which relate to the agenda underpinning the Health, Social Care and Wellbeing Strategy. However, there has been very little inclusion of the local authorities to date. There is now recognition that this requires a whole system approach and senior local authority representatives now sit on the PHSI Project Board. The timeframe for PHSI has been extended in response to clarification of the Assembly Government's timetable and to allow time for public consultation on the Health, Social Care and Wellbeing strategies and work on modelling and options is ongoing.

3.8 There has been some progress in terms of thinking about the way services should be, such as early proposals for priority areas to meet the needs of the frail elderly, rehabilitation and long-term care provision. However, to date this has been health driven and focused and is not based on a whole system approach. The development of joint commissioning of long-term care will need to progress in tandem with improvements in the management of patient choice both locally and at a national level.

3.9 We found concerns about how any future vision would be operationalised. Successful implementation of PHSI will be reliant on clear leadership to secure agreement across all partners and a robust commissioning strategy to timely support delivery.

3.10 Improving the operation of the whole system, and tackling delayed transfers of care is one of the most challenging aspects of partnership working across the Welsh Public Service. We can see that each of the partners in the Cardiff and Vale health and social care community recognises the need to improve partnership working. We can also see that while improved relationships between partners have solved some problems, and helped reduce the numbers of cases becoming delayed transfers of care, various barriers remain.

3.11 Although we consider there is a sound understanding of the current and potential future issues, this has not always been successfully translated into service improvements. For instance, there remains an urgent need to develop specific commissioning proposals to re-balance the system from mainly acute settings towards more community and preventative services out of hospital. So far, there has been little transfer of resources from acute settings to new community-based services, reflecting the difficulty commissioners experience in reinvesting funds currently in the acute sector in alternative models of care. Short-term funding for schemes and staff has plugged some gaps but this does not support sustainable service delivery.



3.12 Encouragingly, delayed transfers of care are now seen as a priority at executive level, and Chief Executives of all partner agencies have met on a number of occasions to discuss what can be done. However, examples of effective joint working tend to take place in isolation or at operational level with insufficient strategic partnership working.

3.13 In the main, although there is evidence of collaboration, proper trust has not yet been established between the organisations in the community and relationships are not as open as they could be. This has also been demonstrated at an operational level and our case file analysis frequently found explicit and implicit tensions between health and social services about respective responsibilities. This is not just our view and has been a recurring theme throughout this review. For example, social workers in the Vale of Glamorgan told us that they do not think that partnership working is effective at either operational or strategic levels. The overriding message from these social workers was that there were not enough resources, either in social work time or in available funding, to enable effective working through partnership.

3.14 Delivery of health and social care, particularly for older people is complex and requires a whole systems approach, often fundamentally rethinking the way services are delivered. Failure to achieve this, particularly given the current and predicted level of older people in the community is likely to result in the current demand on acute health and complex social care services becoming unsustainable.

Commissioners need to base their commissioning decisions on better information about the needs of service users

3.15 Commissioners have a key role to play in shaping the overall system of health and social care and should lead the development of an effective whole system so that the right capacity is available in the right place to meet people's needs. Commissioning by the LHBs and the local authorities remains underdeveloped and compromised by a lack of information and a reliance on spot purchasing. Delayed transfers of care are one indication that commissioners have not secured the right services in the right place at the right time to meet the needs of their resident populations.

3.16 Recognising commissioning weaknesses, Cardiff LHB and Cardiff Council procured an external review of their report to the LHB and Council about their commissioning performance and potential solutions, including jointly commissioning long-term care.

3.17 Assessing the needs of the resident population, to the level of individual GP practice population, is the foundation of effective commissioning. Needs-based commissioning is currently potentially stronger in Cardiff than in the Vale of Glamorgan. Cardiff Council has drafted a comprehensive Accommodation Strategy which includes an analysis of the needs and preferences of Cardiff residents. The Council recognises that it needs to become better aware of the market and to understand the position of providers within it.

3.18 We have seen no evidence of an equivalent approach in the Vale of Glamorgan Council. There is some information available from the 2004 Health, Social Care and Wellbeing Strategy but this needs to be updated. Without a clear and robust picture of the whole system it is not straightforward to design or construct an effective Commissioning Strategy or Plan.

3.19 Within Cardiff and the Vale, effective commissioning is further compromised by the lack of financial and service information, particularly intermediate care services. More generally, there is little evidence that commissioning is related to outcomes. The current focus, especially for community services, is on financial inputs and cost savings.

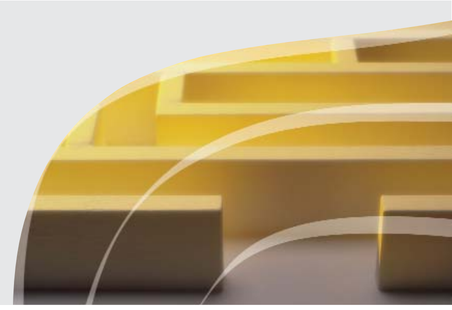
3.20 Joint commissioning between local authorities and LHBs can be an effective way to take a stronger whole systems approach to promoting the independence of vulnerable people, and is a requirement of the Assembly Government's National Service Framework. Joint commissioning is under-developed within Cardiff and the Vale of Glamorgan and we found no established joint commissioning arrangements in Cardiff or the Vale of Glamorgan and often commissioning decisions tend to be made unilaterally. However, the Vale of Glamorgan Council and LHB are developing plans to develop a joint Commissioning Strategy for older people, while the Local Service Board (LSB) Project in Cardiff should lead to integrated commissioning of independent sector capacity for the long-term care of older people. In Cardiff, the LSB Project should lead to integrated commissioning of independent sector capacity for the long-term care of older people, and the partners have recently accepted the recommendations of a consultant's report to move towards a pooled budget for long-term care.

3.21 Effective joint commissioning will be contingent on the ongoing development of a shared vision and model of services, not only within each locality but across the whole Cardiff and Vale of Glamorgan health and social care community so that individual and joint commissioning decisions fit within and support an agreed strategic framework. PHSI should provide the basis for this vision.

3.22 A more intractable commissioning problem relates to the services which have to be commissioned from Cardiff and Vale NHS Trust. If the LHBs are to gain greater influence over what Cardiff and Vale NHS Trust (and Bro Morgannwg NHS Trust) provides, they will need to do so through the Long Term Agreement (LTA) process. The current LTA between the Trust and the two LHBs is not specific about the community services that LHBs expect the Trust to provide within the available funding envelope, which can make it more difficult to plan transfers of resources from hospital to non-hospital services.

3.23 The LHBs are much smaller organisations than the Trust and face significant problems negotiating finance and service changes. At present some reconfiguration ideas are being developed, but Cardiff and Vale Trust is taking the lead. The LHBs will need to take more control in helping to move the Trust from the current emphasis on illness to one based on wellness or well-being.

3.24 Additionally, there is scope to engage more effectively with the independent and voluntary sectors in commissioning. As service providers and advocates for the elderly, such organisations have expertise and ideas about how to improve the operation of the whole system as well as older people's service needs.



Organisational barriers at the interface between health and social care prevent effective joint working

3.25 Organisational and budgetary boundaries, naturally opposing influences and general complications arising from working with a number of different organisations reinforce the need for organisations to take decisions in the interests of the more effective operation of the whole system across Cardiff and the Vale of Glamorgan. Earlier sections of this report identify different patterns of services and ways of working.

3.26 While we found strong leadership in some specific localities, including the personal involvement of senior executives in resolving individual cases and effective action to reduce delayed transfers of care, there is a need for greater co-ordination as the position in one local authority/LHB area directly affects other parts of the system.

3.27 Performance management arrangements are particularly problematic, with the focus on delayed transfers of care by reason (health, social care and family/carer/other) and locality tending to lead to a focus on the numbers rather than the causes of delayed transfers of care. The absence of integrated targets for the whole community, where the target for the Trust reflects targets for the LHBs and unitary authorities, dilutes ownership across organisations and the whole system and can lead to a failure to recognise vital interdependencies. For example, a delayed transfer of care for social care reasons that affects a resident of Cardiff could lead to a resident of the Vale of Glamorgan being unable to receive elective surgery. All delayed transfers of care, regardless of cause or where the patient comes from, are a problem for the Trust and should be regarded as a common systems problem for all of the partners within the wider community.

3.28 Our focus group asked a number of questions about partnership working. This showed that while most participants thought that there was a willingness to work together, joint working had so far only led to limited outcomes and progress. The main barriers to effective partnership working in Cardiff and the Vale of Glamorgan appeared to be:

- leadership – while there was clear leadership within the two individual Unitary Authority/LHB areas aimed at improving the extent of delayed transfers of care there was little effective strategic leadership across health and social care which would provide long-term solutions to this problem;
- budgetary pressures and the absence of one budget to support sustainable improvement with Continuing Healthcare and the implications of the 'Grogan' judgement are likely to increase budgetary pressures and conflict between health and social care;
- there has only recently been an acceptance and ownership of the need to work together to address delayed transfers of care and their causes across the whole system;
- concerns about effectiveness of communication between and within organisations;
- the lack of a co-ordinated process and model for managing and developing the whole system of health and social care;

- a belief that the different priorities for health and social care results in a lack of accountability and engagement for improving delayed transfers of care within local authorities to address delayed transfers of care and their causes at a whole systems level; and

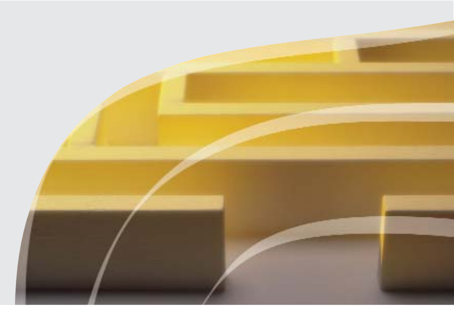
- the lack of joint performance targets for health and social services organisations, which work to different performance targets for delayed transfers of care, and measurement by reason for delay, lead to a culture of blame and defensive behaviour which attribute delayed transfers of care to external factors or the actions of other organisations rather than the failure to address the genuine whole systems causes of delayed transfers of care.

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

3.30 One of the major challenges within a complex system is to address budgetary constraints, organisational boundaries, different accountabilities and leadership styles. In the last few years each of the health and social care agencies in Cardiff and the Vale of Glamorgan have managed a challenging range of financial and service delivery issues, along with the delivery of national imperatives and policies. This report highlights several examples where the actions of one organisation, though rational within their own circumstances, cause negative consequences elsewhere in the system. Often such actions relate to budgetary pressures, with Continuing Healthcare and the implications of the 'Grogan judgement' likely to increase budgetary pressures and conflict between health and social care.

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

3.32 Addressing the conflicting accountabilities and cultures of the organisations will require new skills where leaders are prepared to share power and resources and to work in the wider interests of the whole system and the people it serves, rather than in the direct interest of their own individual organisation.



3.33 The Assembly Government has emphasised pooled health and social care budgets as a solution to such problems. Responding to this agenda, the Local Service Board pilot in Cardiff has set an objective to develop a pooled budget for commissioning long-term care for the elderly. Although there is potential to share responsibilities and pool budgets, disputes and poor financial information will need to be addressed to enable pooling to work properly. The simple shortage of cost information relating to delayed transfers presents a major hurdle in setting up any pooled fund that partners will agree to support. Pooled budgets should support a shared vision of service development across the community, a clearer view about the long-term nature of service provision and significant improvements in cost information on which to make decisions.

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

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

3.36 In some areas, models are emerging where one member of the Welsh public service takes responsibility for co-ordinating a larger part of the older person's journey through the whole system of health and social care. While this is not in place within Cardiff and the Vale of Glamorgan, within Caerphilly for example, a system of nurse case managers has been established to work across health and social care boundaries.

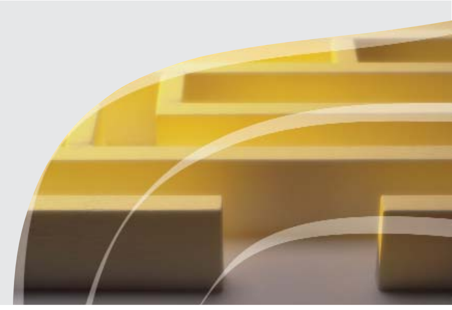
3.37 At present there are barriers to joint working arising from the lack of shared information between health and social care organisations. For example, there is no single record for patients even within health. Although developments are in train through Informing Healthcare, GPs and the trusts do not yet work within a single shared patient record. And social services do not have access to the records of patients within health.

3.38 The Cardiff Local Service Board pilot represents an opportunity to foster more effective, strategic partnerships between the organisations involved within the Cardiff community. The Local Service Board is considering community priorities, learning the lessons of partnership working, tackling barriers where they exist and providing a strategic direction to inform other partnership working. It is reported to have brought a renewed sense of purpose and urgency to progressing more effective joint working.

3.39 The intended key outcomes include:

- more integrated health and social care services;
- more efficient use of resources through synergy and alignment;
- improved performance in terms of delayed transfer of care and NHS continuing care; and
- better structured working arrangements between health and social care.

3.40 While we recognise that this has the potential to transform the approach to partnership working and commissioning, the existence of different localities could compromise the focus required across the Cardiff and Vale of Glamorgan communities and there are concerns that there is a risk that the Local Service Board will not deliver concrete improvements.



Appendix 1 - Methodology

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

Document review

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

Focus group

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

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

Data analysis

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

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

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

Inpatient census and analysis of case files

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

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

Semi-structured interviews

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

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

Good practice

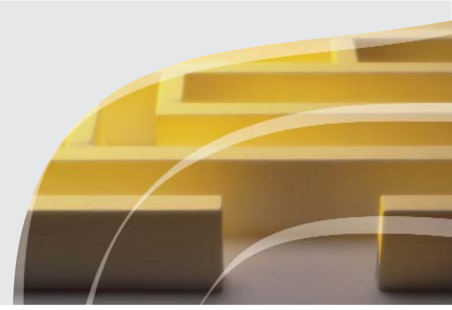
10 We focused on good practice both within the communities covered by the review and from elsewhere. This resulted in the inclusion of numerous case studies in the report.

Public comments

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

Expert panel

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



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

Appendix 2 - Note about histograms included in appendices for each organisation

1. Our community reports include charts that rank each council/LHB area on key indicators of delayed transfers of care. For each indicator, each area is ranked from 1-22. The following description of each indicator explains how we have ranked each indicator. For all indicators, shorter bars reflect comparatively higher expenditure, the provision of more services or that delayed transfers of care have a smaller impact on residents of that area. Longer bars denote comparatively lower expenditure, a larger problem with delayed transfers of care or lower service provision.

2. The purpose of the histrograms is not to answer questions but to help identify the right questions to ask about a particular area. They are exploratory and support our other work rather than being the primary evidence from which our conclusions have been drawn. Most importantly, they are intended to help local communities identify and set priorities for action.

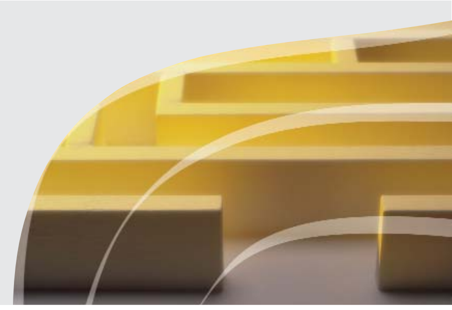
3. Most of the indicators relate to 2006/2007, but for a small number, 2006/2007 data was not available to us. We have considered this issue carefully and believe that in terms of ranking areas from 1-22, the use of 2005/2006 data remains valid in helping to identify the right questions to ask, although we will re-issue the histograms to bodies in Cardiff, the Vale of Glamorgan, Carmarthenshire and Gwent as soon as 2006/2007 data is available for all indicators.

Indicator No:	1
Title	Number of delayed days for Unitary Authority/LHB residents in 2006/2007 for HEALTHCARE reasons per 1,000 pop aged 65 yrs and over
Source	Health Solutions Wales, 2007, Mid Year Estimate (MYE) 2005 and Wales Audit Office analysis
Rank order	Lowest number of delayed days = 1

4. Using the delayed transfers of care database specified in Appendix 1 to quantify the number of delayed days in 2006/2007. The delayed transfers of care database also recorded the Unitary Authority in which the patient resides and the reason for their delay. The sum of delayed days was cross-tabulated by Unitary Authority in which the patient resides and the reason for the delayed transfer of care. This figure was then divided by the population for each Unitary Authority aged 65 years and over, taken from the MYE 2005, ie,

Number of delayed days per Unitary Authority area and reason for dealyed transfers of care being healthcare	/	(MYE population 65 years and over/1,000)

5. The ranking of the resulting data placed the numeric values in descending order and illustrated in the Kep Performance Indicator Histogram for each Unitary Authority/LHB area.



Indicator No:	2
Title	Number of delayed days for Unitary Authority/LHB residents in 2006/2007 for PATIENT/CARER/FAMILY-RELATED reasons per 1,000 population aged 65 years and over
Source	Health Solutions Wales, 2007, MYE 2005 and Wales Audit Office analysis
Rank order	Lowest number of delayed days = 1

6 As Indicator 1, but the reason for the delayed transfer of care being recorded as being patient/carer/family-related.

Number of delayed days per Unitary Authority area and reason for dealyed transfers of care being patient/carer/ family-related	/	(MYE population 65 years and over/1,000)

Indicator No:	3
Title	Number of delayed days for Unitary Authority/LHB residents in 2006/2007 for SOCIAL CARE reasons per 1,000 population aged 65 years and over
Source	Health Solutions Wales, 2007, MYE 2005 and Wales Audit Office analysis
Rank order	Lowest number of delayed days = 1

7 As Indicator 1, but the reason for the delayed transfer of care being recorded as being social care.

Number of delayed days per Unitary Authority area and reason for dealyed transfers of care being social care	/	(MYE population 65 years and over/1,000)

Indicator No:	4
Title	Number of delayed days for Unitary Authority/LHB residents in 2006/2007 for ALL REASONS per 1,000 population aged 65 yrs and over
Source	Health Solutions Wales, 2007, MYE 2005 and Wales Audit Office analysis
Rank order	Lowest number of delayed days = 1

8 As Indicator 1, but including all reasons for the delayed transfer of care.

Number of delayed days per Unitary Authority area	/	(MYE population 65 years and over/1,000)

Indicator No:	5
Title	The rate of older people (>=65 years) helped to live at home per 1,000 population (>=65 years) in 2006/2007
Source	Local Government Data Unit (LGDU): SCA/002a
Rank order	Highest rate = 1

9 This is a simple ranking of the national strategic performance indicator collected annually by every UA of Wales and collated by the LGDU. In 2004/2005, this indicator was known as NAWPI 3.7.

Indicator No:	6
Title	Rate of people aged 65 or over whom the Unitary Authority supports in care homes per 1,000 population aged 65 or over in 2006/2007
Source	LGDU: SCA/002b
Rank order	Highest rate = 1

10. As Indicator 5, this is a simple ranking of the national strategic performance indicator collected annually by every Unitary Authority in Wales and collated by the Local Government Data Unit. In 2004/2005, this indicator was known as NAWPI 3.13.

Indicator No:	7
Title	Emergency Admissions spells of Unitary Authority residents in 2005/2006 to Welsh and English NHS hospitals
Source	Health Solutions Wales, 2007, MYE 2005 and Wales Audit Office analysis
Rank order	Lowest Emergency Admissions spells = 1

11 Using data previously sourced from Health Solutions Wales e-PEDW and used in our national study into chronic conditions management, we have counted the total number of spells of Welsh residents with an emergency admission into a Welsh or English NHS Trust in 2005/2006. The number of spells was divided by 1000 population of residents in each Unitary Authority area (MYE 2005).

Number of spells with emergency admissions per Unitary Authority area	/	(MYE population/ 1,000)

Indicator No:	8
Title	LHB expenditure on CONTINUING HEALTHCARE 2006/2007 per 1000 population
Source	Wales Audit Office extraction from 2006/2007 LHB accounts
Rank order	Highest expenditure = 1

12 Local Health Board expenditure on Continuing Healthcare was a direct extract from their 2006/2007 accounts.

LHB spending on Continuing Healthcare in 2006/2007	/	(MYE population 65 years and over/1,000)

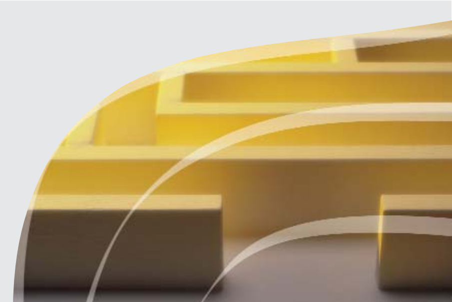
Indicator No:	9
Title	Unitary Authority gross expenditure on SOCIAL SERVICES 2005/2006 per 1,000 population
Source	Wales Audit Office extraction from 2005/2006 Unitary Authority accounts
Rank order	Highest expenditure = 1

13 Extract from the Revenue Outturn forms that the Assembly Government requires all local government bodies to complete. The accounts figures have been divided by 1,000 resident population (MYE 2005).

14 The gross expenditure recorded by each Unitary Authority in Wales on Social Services in 2005/2006, divided by the resident population in the MYE 2005 to make the figures comparable between unitary authorities.

Unitary Authority Revenue Outturn 2005-06, Form: RO3, Row: 84, Column: 5	/	(MYE population 2005/1,000)

Indicator No:	10
Title	Unitary Authority gross expenditure on OLDER PEOPLE 2005/2006 per 1000 population
Source	Wales Audit Office extraction from 2005/2006 Unitary Authority accounts
Rank order	Highest expenditure = 1



15 Extract from the Revenue Outturn forms that the Assembly Government requires all local authorities to complete. The accounts figures have been divided by 1,000 resident population (MYE 2005) to make the figures comparable between unitary authorities.

16 The gross expenditure recorded by each Unitary Authority in Wales on Older People's Services in 2005/2006, divided by the resident population in the MYE 2005 to make the figures comparable between unitary authorities.

Unitary Authority Revenue Outturn 2005-06, Form: RO3, Row: 37, Column: 5	/	(MYE population 2005/1,000)

Indicator No:	11
Title	Average duration of Dealyed Transfers of Care for each patient in 2006/2007
Source	Wales Audit Office's analysis of Assembly Government's dealyed transfers of care data
Rank order	Lowest duration of a dealyed transfers of care patient = 1

17 Using the data source as described for Indicator 1, of those patients experiencing a delay in the transfer of care in 2006/2007, the delayed days were totalled before being divided by the number of patients.

Indicator No:	12
Title	Total of OLDER PEOPLE'S PLACES per 1,000 population aged 65 and over
Source	CSSIW, March 2007
Rank order	Highest number of places = 1

18 The data supplied by CSSIW on the total number of places for older people was divided by the MYE 2005 resident population aged 65 years or more.

Total of older people places	/	(MYE population 65 years and over/1,000)

Indicator No:	13
Title	Older people receiving LOCAL AUTHORITY RESIDENTIAL care per 1,000 population aged 65 and over in 2005/2006
Source	Social Services Statistics Wales 2005/2006
Rank order	Highest number of people = 1

19 Using the Social Services Statistics Wales for 2005/2006, PM2 Table L column 2 as a source, ie, the number of older people receiving 'LA residential care'. This figure was divided by the MYE 2005 population figure for the number of residents aged 65 years or more.

Older people receiving local authoirty residential care, year ending 31 March 2006	/	(MYE population 65 years and over/1,000)

Indicator No:	14
Title	Older people receiving INDEPENDENT SECTOR residential care per 1,000 population aged 65 and over in 2005/2006
Source	Social Services Statistics Wales 2005/2006
Rank order	Highest number of people = 1

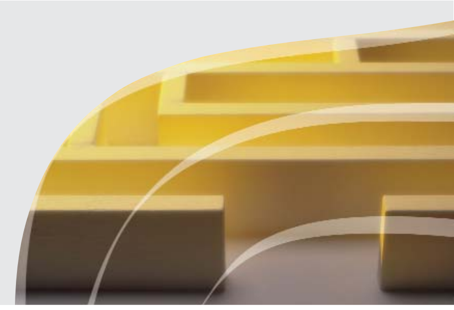
20 Using the Social Services Statistics Wales for 2005/2006, PM2 Table L column 2 as a source, ie, the number of older people receiving 'independent sector residential care'. This figure was divided by the MYE 2005 population figure for the number of residents aged 65 years or more.

Older people receiving independent sector residential care, year ending 31 March 2006	/	(MYE population 65 years and over/1,000)

Indicator No:	15
Title	Older people receiving NURSING HOME care per 1,000 population aged 65 and over in 2005/2006
Source	Social Services Statistics Wales 2005/2006
Rank order	Highest number of people = 1

21 Using the Social Services Statistics Wales for 2005/2006, PM2 Table L column 2 as a source, ie the number of older people receiving 'nursing home care'. This figure was divided by the MYE 2005 population figure for the number of residents aged 65 years or more.

Older people receiving nursing home care, year ending 31 March 2006	/	(MYE population 65 years and over/1,000)



Appendix 3 - Breakdown of the costs of bed days occupied by delayed transfers of care in Cardiff and Vale NHS Trust

By bed type

	2005/2006			2006/2007		
	Delayed days	Cost per day £	Total cost £	Delayed days	Cost per day £	Total cost £
Acute	15,827	244.15	3,864,162	18,631	254.00	4,732,274
Community	1,219	294.70	359,239	2,691	308.00	828,828
Mental Health	32,126	236.54	7,599,084	27,203	247.00	6,719,141
Other	6,914	244.15	1,688,053	9,228	254.00	2,343,912
Rehabilitation	16,701	190.65	3,184,046	19,760	199.00	3,932,240
Totals	**72,787**	**229.36**	**16,694,584**	**77,513**	**239.87**	**18,556,395**

	Change			Percentage Change		
	Delayed days	Cost per day £	Total cost £	Delayed days	Cost per day £	Total cost £
Acute	2,804	9.85	868,112	17.7%	4.0%	22.5%
Community	1,472	13.30	469,589	120.8%	4.5%	130.7%
Mental Health	-4,923	10.46	-879,943	-15.3%	4.4%	-11.6%
Other	2,314	9.85	655,859	33.5%	4.0%	38.9%
Rehabilitation	3,059	8.35	748,194	18.3%	4.4%	23.5%
Totals	**4,726**	**10.51**	**1,861,811**	**6.5%**	**4.6%**	**11.2%**

Source: Wales Audit Office analysis of delayed transfers of care data and Trust's Financial Returns

By reason

	2005/2006			2006/2007		
	Delayed days	Cost per day £	Total cost £	Delayed days	Cost per day £	Total cost £
Healthcare	15,489	229.00	3,546,981	15,362	240.00	3,686,880
Patient	41,046	229.00	9,399,534	48,403	240.00	11,616,720
Not agreed	1,050	229.00	240,450	190	240.00	45,600
Social Care	15,202	229.00	3,481,258	13,558	240.00	3,253,920
Totals	**72,787**	229.00	**16,668,223**	**77,513**	240.00	**18,603,120**

	Change			Percentage Change		
	Delayed days	Cost per day £	Total cost £	Delayed days	Cost per day £	Total cost £
Healthcare	-127	11.00	139,899	-0.8%	4.8%	3.9%
Patient	7,357	11.00	2,217,186	17.9%	4.8%	23.6%
Not agreed	-860	11.00	-194,850	-81.9%	4.8%	-81.0%
Social Care	-1,644	11.00	-227,338	-10.8%	4.8%	-6.5%
Totals	**4,726**	10.87	**1,934,897**	**6.5%**	**4.7%**	**11.6%**

Source: Wales Audit Office analysis of delayed transfers of care data and Trust's Financial Returns