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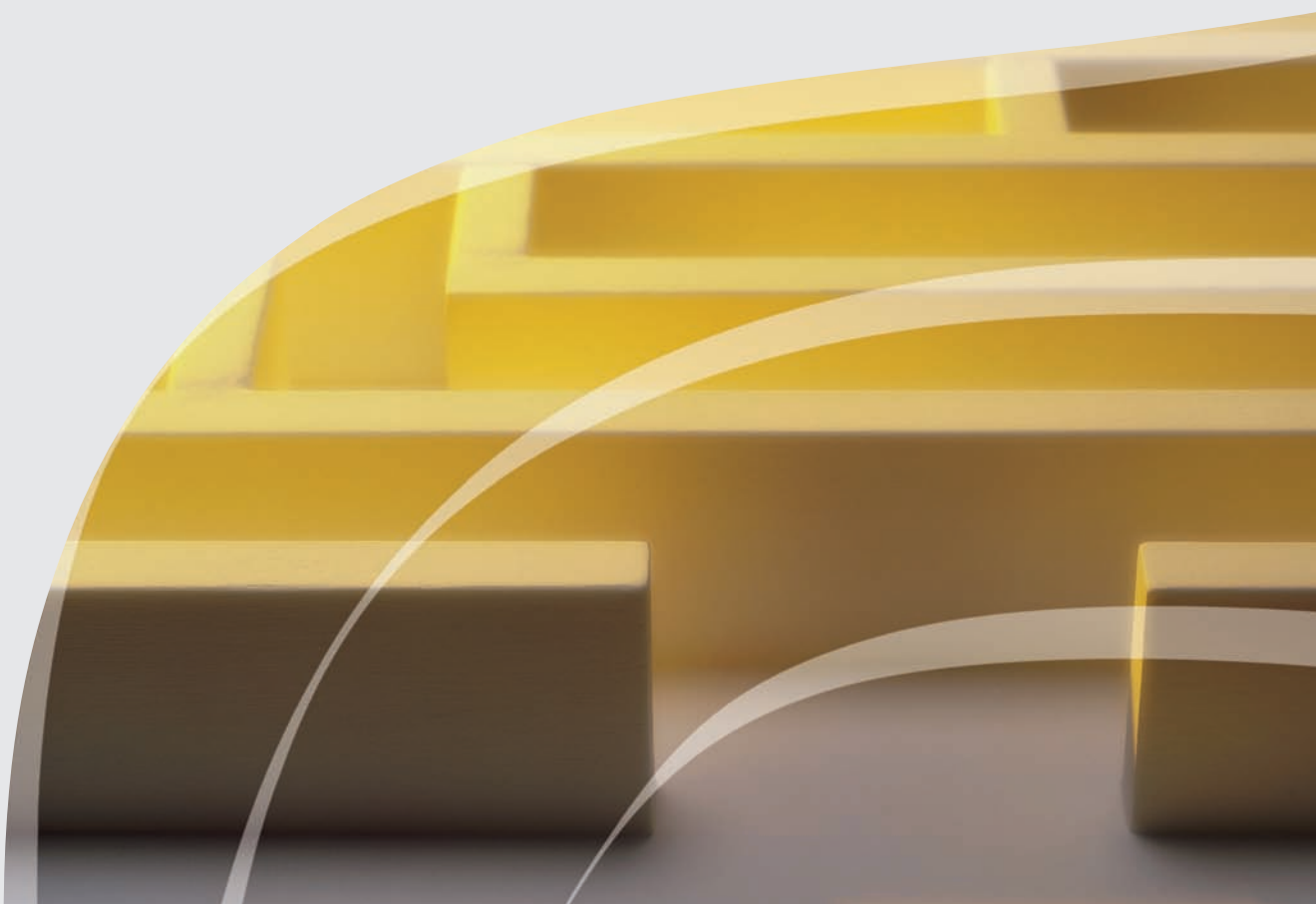
Follow up review of delayed transfers of care across the whole system - Carmarthenshire health and social care community



Tackling delayed transfers of care across the whole system - Carmarthenshire health and social care community

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

The Wales Audit Office study team that assisted me in preparing this report comprised Val Connors, Tracey Davies, Janet McNicholas, Geraint Morgan and Ceri Stradling.

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Carmarthenshire health and social care community has taken action to develop a whole system approach aimed at reducing the numbers of people affected by delayed transfers of care. However, there are still significant challenges to be addressed in order to bring about the lasting improvements required

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Summary

1 Patients experiencing delayed transfer of care has been a longstanding feature within the Carmarthenshire health and social care community, resulting in unacceptably high numbers over a sustained period.

2 The Wales Audit Office undertook a detailed review of delayed transfers of care within Carmarthenshire between 2004/2005 and 2005/2006. This was a cross sector review which identified that significant changes were required to develop a whole system approach across health and social care in order to support lasting reductions in delayed transfers of care.

3 The review found that if this was to be achieved all partner agencies would need to work together in a more effective way to address the issues collectively.

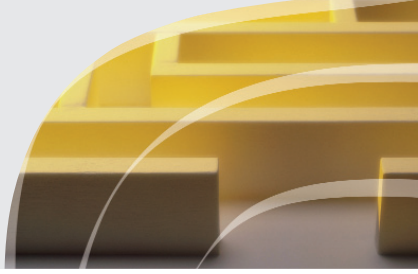
4 Shortly after the Wales Audit Office study, a Joint Review of Carmarthenshire County Council (the Council) was carried out by the Social Services Inspectorate Wales and the Wales Audit Office. This review also identified a range of key areas for action in relation to partnership working and the development of a whole systems approach. The specific recommendations within the Joint Review action will be followed up later in the year.

5 In response to these reviews and also the Community's Emergency Admissions Plan, Carmarthenshire Health and Social Care Community developed a multi-agency action plan. This sets out respective actions and responsibilities to address both the current levels of delayed transfers of care and to put in place sustainable solutions in order to reduce future delay levels. The plan has recently been updated to identify actions needed up to March 2008.

6 The Wales Audit Office has now completed a follow-up review to review the progress made in implementing the recommendations from our previous studies, as well as identifying good practice and barriers to progress.

7 We found that the Carmarthenshire Health and Social Care Community has taken action to develop a whole systems approach aimed at reducing the high numbers of delayed transfers of care in a sustainable way. This is reflected in the progress made in relation to the whole systems action plan and the promising signs that the partnership is becoming more successful in terms of developing and delivering service improvements.

8 There has been some improvement in the overall numbers of people affected by delayed transfers of care, but current figures are still too high and the number of bed days lost is increasing. Funding pressures and deficits across the NHS Trust, Local Health Board (LHB) and Local Authority (LA) Social Services remain a significant challenge. The numbers of people delayed in hospital because of social care reasons and issues in relation to continuing care funding, are examples of these pressures and remain a



significant barrier to achieving longer term reductions. Further progress is still needed to provide an adequate range of services within the resources available and addressing this through the joint commissioning strategy and new opportunities provided by the Local Service Board needs to be a key aim of the partnership working.

Recommendations

1 Carmarthenshire's joint commissioning strategy for health, social care and housing related services for the over 65s now needs to be fully implemented within the defined timescale. This should include:

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

2 Continue to progress and maintain the momentum of the delayed transfers of care whole system action plan. This could be further strengthened by the inclusion of anticipated outcomes against each action and by taking account of the appropriate recommendations within the delayed transfers of care overview report.

3 The LHB and Council should work in partnership with the Trust and other relevant parties to agree collective solutions to the management of continuing healthcare. Integral to this will be ensuring that core services are effectively commissioned in order to reduce the financial and personal impact of continuing healthcare processes and decisions.

Part 1 - Carmarthenshire health and social care community has taken action to develop a whole systems approach aimed at tackling the high numbers of delayed transfers of care

1.1 In 2003/2004, Carmarthenshire Health and Social Care Community was reporting unacceptably high numbers of people who were delayed in hospital. The figure peaked at 121 in February 2004 and an average of 107 patients were defined as a delayed transfer of care between January and May 2004. Despite improvements during the latter part of 2004, the situation deteriorated again in 2005 and the Wales Audit Office study at this time identified that significant changes were required. The report concluded that, in order to support lasting reductions in delayed transfers of care, a whole system approach across the health and social care system was needed to provide appropriate services in a timely manner. The review also identified that, if this was to be achieved, all partner agencies would need to work together in a more effective way to address the issues collectively.

1.2 Shortly after this study, a Joint Review of the Council's social services was carried out by Social Services Inspectorate Wales and the Wales Audit Office. This review also identified a range of key areas which required action in relation to partnership working, and the development of a whole systems approach to meeting the needs of vulnerable people who were at risk in the community and in hospital when delays occurred.

1.3 In response to these reviews and also the Community's Emergency Admissions Plan, Carmarthenshire a multi-agency action plan was developed which was led by the LHB following discussions with the Assembly Government's NHS Regional Office. This sets out respective actions and responsibilities to address both the current levels of delayed transfers of care and to put in place sustainable solutions in order to reduce future delay levels. The Plan has recently been updated to identify actions needed up to March 2008.

1.4 This follow-up work has identified that the Carmarthenshire Health and Social Care Community has taken action to develop a whole systems approach aimed at tackling the high numbers of delayed transfers of care in a sustainable way. Most of the recommendations identified within the Wales Audit Office's report on delayed transfers of care have been actioned (see Appendix 1 which summarises these key actions). Furthermore, substantial progress has been made in relation to the whole systems action plan which was developed in response to a number of critical reports, including the Wales Audit Office report, the Joint Review of the Council's Social Services carried out by the Wales Audit Office and Care and Social Services Inspectorate Wales, and the Emergency Admissions Plan which is led by Carmarthenshire LHB but with key responsibilities for all parties within the community, and with Pembrokeshire and Derwen NHS Trust for mental health patients.

There has been some improvement in the overall numbers of people affected by delayed transfers of care, but current figures are still too high and the number of bed days lost is increasing

1.5 The follow-up work identified that between 2005/2006 and 2006/2007 there has been an improvement in the number of people affected by delayed transfers of care in Carmarthenshire. The total number of people whose transfer of care was delayed in Carmarthenshire NHS Trust's beds fell by just over 6 per cent between April 2005 and March 2007, reflecting a longer-term fall in the number of people becoming a delayed transfer of care case since 2003.

1.6 The number of Carmarthenshire residents experiencing a delayed transfer of care (as measured by the monthly census) has been on average around 44 with a high of 50 in September 2006 and February 2007 and dropping as low as 28 in August 2006.

1.7 The main reasons for delays have remained unchanged over time, with delays for social care reasons consistently comprising the highest percentage of the total number. Carmarthenshire still remains in the bottom quartile for performance in this area (ranked 21 out of 22 local authorities in Wales).

1.8 Between June 2006 and June 2007, social care reasons accounted for around 63 per cent of all delays. This peaked at 77 per cent of all delays in December 2006 and went down to around 48 per cent in June 2006. Over the same period, the average numbers of delays for social care arrangements has been around 27, with a low of 20 in August 2006 and a high of 37 in January 2007.

1.9 Healthcare-related delays, both for assessment and provision of services assessed as necessary, remain consistently low. Since June 2006, healthcare assessment reasons have remained below two and for arrangements have ranged from nil to five.

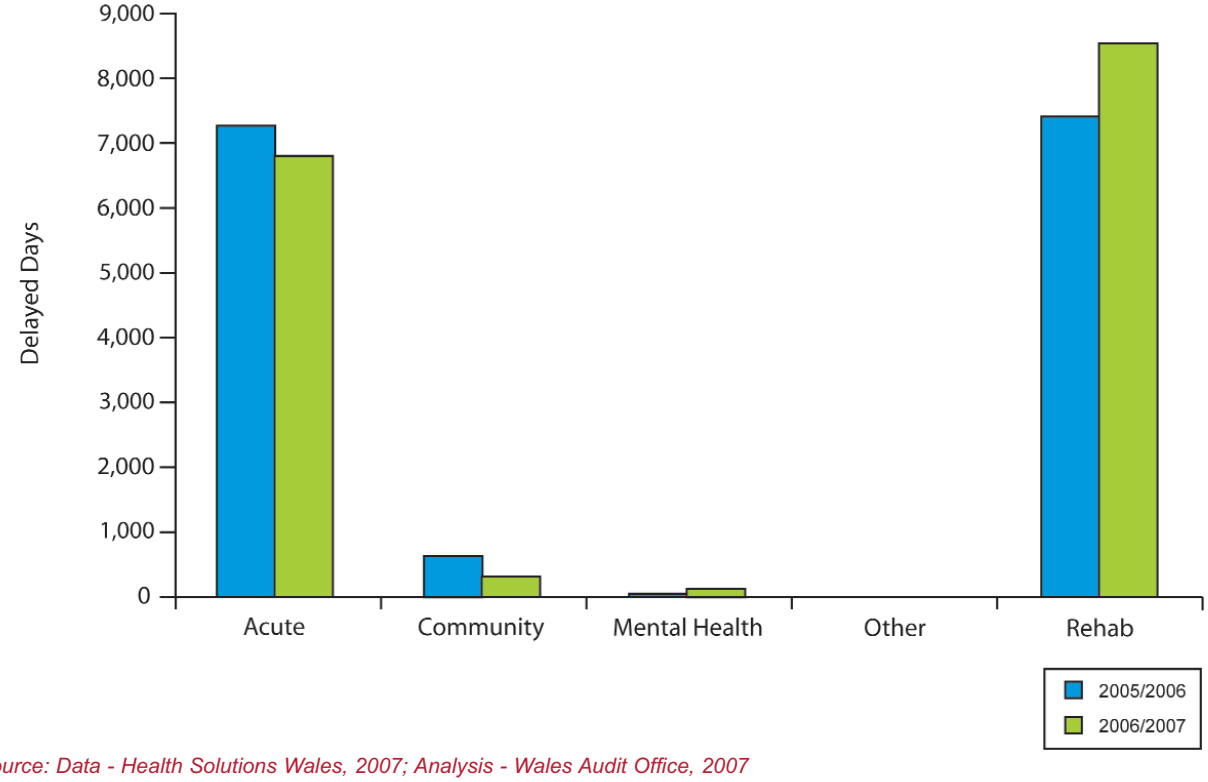
1.10 Choice-related delays have ranged from a high of 13 in October 2006 to a low three in December 2006. Over the past seven months, levels have generally been lower; this has been attributed to the jointly commissioned transition beds within Council residential homes.

The number of bed days lost through delayed transfers of care is increasing

1.11 Despite the overall reduction in the number of people who became a delayed transfer of care during this period, there was an increase in the number of bed days occupied by people whose transfer of care had been delayed.

1.12 In 2006/2007, 15,753 bed days were lost to delayed transfers of care in Carmarthenshire NHS Trust. This was an increase of 2.7 per cent compared to the previous year with 409 extra bed days lost. More specifically, the number of bed days lost in acute and community beds has reduced but there has been a 15 per cent increase within rehabilitation beds (Figure 1).

Figure 1: The number of bed days lost to delayed transfers of care in Carmarthenshire NHS Trust increased between 2005/2006 and 2006/2007



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

1.13 In 2006/2007, 56 per cent of bed days lost in the Carmarthenshire NHS Trust (or 8,853 bed days in total) were lost because of social care reasons. The average length of a delayed transfer of care in this category was just over 46 days which is above average. The delays were mainly due to funding. Conversely, delays whilst awaiting social care assessment are amongst the lowest, indicating the hospital based response to referrals for community care assessment is managed in a prompt and timely manner.

1.14 During the same period, the average duration of days for patients who are delayed has increased in all clinical areas with an overall average length of stay of just over 49 days. This has increased by just over four days on average since 2005/2006.

1.15 The Carmarthenshire community agrees that meeting the Service and Financial Framework (SaFF) target for bed days this year will be challenging. This is routinely monitored within the community and the actual performance for May 2007 is nearly double the SaFF target of 848 bed days.

1.16 Locally, action taken over the past year to try to reduce the impact of delays includes setting a more challenging target of 30 days, rather than the Assembly Government NHS Regional Office target of 60 days. This information is escalated to nominated senior officers and executives in an attempt to resolve the longer delays. Up until March 2007 there appeared to be little evidence of its success; however, the local authority has recently made a decision that no one will be

awaiting funding for social care beyond 60 days. This commitment was reported to be as a direct result of the escalation process.

1.17 The effective management of delayed transfers of care is complicated by the fact that, nationally, there are different targets for health and social services. The current SaFF includes two targets for health communities to reduce the rate of people experiencing a delayed transfer of care and number of bed days, in mental health facilities, and in non-mental health facilities, per 10,000 population over the age of 75. These targets are the joint responsibility of LHBs and trusts but are measured at the level of LHBs so that performance can be related to population size. The targets relate to localities achieving continuous improvements relative to the quartiles of performance in the previous year. However, this means that there is a focus at locality level rather than the whole system and there are consequently no overall targets to which all of the partners can work.

1.18 These targets do not apply to local government. Local authorities have a national strategic performance indicator which measures the rate of delayed transfers of care for social care reasons in residents aged 75 or over, but this is not aligned to any NHS targets. In addition, the indicator is calculated by adding up the number of people counted in each monthly census. This adds unnecessary confusion to the management of delayed transfers of care.

Delayed transfers of care continue to have negative consequences for the patients affected and on the whole system in Carmarthenshire

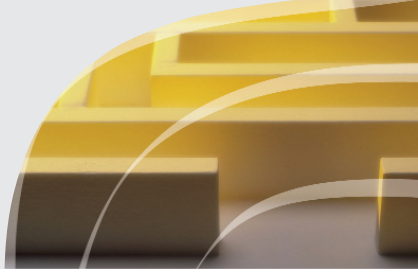
1.19 The main cost of being a delayed transfer of care falls on people who lose independence and function as a result of remaining in hospital. Vulnerable individuals can become locked into a vicious circle of dependence and reliance on acute hospital services.

1.20 In the Trust's rehabilitation beds during 2006/2007, the average duration of a delayed transfer was 51.6 days, this is in addition to the time spent rehabilitating. Whilst this potentially compromises the Trust's ability to rehabilitate patients effectively, it is notable that the Trust was largely able to meet its target rehabilitation length of stay of 28 days between April and July 2007. Despite this good performance, patients often have to wait on acute wards for a rehabilitation bed due mainly to the impact of delayed transfers and this has a negative impact on available overall trust capacity.

1.21 The average duration for patients on acute wards in 2006/2007 was just over 47 days and, as a proportion of the total delayed days, this was higher than any other Welsh Trust. This often results in elective procedures being cancelled due to a lack of a bed, and the Trust being unable to meet Accident and Emergency waiting time targets.

1.22 Currently, the Trust is unable to meet its Service Change and Efficiency Plan (SCEP) in this area due to delayed transfers of care running over and above the originally predicted levels. We estimate that the direct gross cost of the 'lost' bed days in Carmarthenshire NHS Trust in 2006/2007 to be £3.7 million which represents approximately three per cent of the Trust's income in that financial year.

1.23 The direct costs of bed days occupied by delayed transfer of care could not be released in full for reinvestment in other areas as, this is not fully realisable. However, using marginal bed costs of £110.00 per bed day, it has been estimated that £770,000 is currently tied up through the inappropriate utilisation of bed days. Therefore, working to SaFF target levels would support the Trust in delivering its SCEP and achieving financial balance.



Part 2 - There are some promising signs that the health and social care partnership is becoming more effective in terms of developing and delivering service improvements

2.1 A key feature in the development of the whole systems approach has been the improvement in partnership working at both a strategic and operational level across the health and social care community. The partnership difficulties present at the time of the Joint Review and to a lesser extent, at the time of the delayed transfers of care study, have been largely overcome through the development of more effective partnership arrangements. These have been designed to streamline the conduct of business, clarify the roles of constituent groups and strengthen commissioning and performance management.

2.2 A Partnership Forum and Modernisation Board with new chairs and terms of reference aim to secure, respectively, high level ownership of the modernisation of health and social care services and the commissioning and project management of the required improvements.

2.3 A development programme for members of the Partnership Forum and Modernisation Board has sought to recognise and strengthen the interdependence of stakeholders, identify priorities for action and draw up project plans to tackle the blockages to an effective health and social care system.

2.4 An advisory commission on the improvement of social care services for older people has also been established to ensure that:

- plans for modernisation are being developed;
- joint review action plan is robust and leading to better services;
- added value is being gained from partnerships;
- best practice is being identified; and
- social care and health plans complement each other.

2.5 Whilst there has been a joint commissioning team between the Council and the LHB since 2004, recent developments demonstrate more clearly the willingness to work in partnership and in more integrated ways. For example, from October 2007 there will be a single integrated commissioning team, encompassing all commissioning managers from the LHB and the Council, contracting and primary care commissioning. This team will be led by the Director of Planning and Primary Care, reporting directly to the LHB Chief Executive and the Director of Social Care, Health and Housing within the Council, governed by a formal partnership agreement.

2.6 The LHB will formally become lead commissioner for adult health and social care services. In addition, the Trust and the Council have agreed to the appointment of a strategic lead for health and social care provision. This post is currently at the recruitment stage. In addition to the joint commissioning strategy for older people, joint commissioning strategies have been developed, and are being implemented, for a range of other client groups/services including carers, learning disabilities and substance misuse.

2.7 As well as the above, key developments in the approach to managing delays include:

- a more effective management framework and operational systems and processes which are changing from reactive to proactive management of delayed transfers of care;
- a growing range of services in the community which provide additional options to prevent admission and expedite timely discharge;
- agreement between the Council and the LHB about a joint vision and service development principles for older people's services; and
- the development of a joint commissioning strategy which sets a much clearer direction for older people's services.

2.8 In addition, the acceptance by the Assembly Government for Carmarthenshire to be one of the pilot areas for a Local Service Board provides key opportunities to foster more effective, strategic partnerships between the organisations involved within the Carmarthenshire community.

The community's management framework and operational arrangements have been designed to support sustained reductions in delayed transfers of care. It is focused on action, with a consistent policy and clear accountability and processes are beginning to change from a reactive to proactive management of the problem.

2.9 Weekly multi-agency validation meetings have been established. These are held in different parts of the County and clinicians are encouraged to attend which helps to improve their understanding of the problem. The aim of these meetings is to agree what can be done collectively to facilitate discharge whether on a multi-agency basis or individually. A significant level of detail is available and the approach is also supported by an escalation process. Cases are escalated to nominated senior officers and executives once the delay has exceeded 30 days and targets are set for follow up and resolution on a case by case basis. Whilst this is closely monitored, the increase in the average duration of a delayed transfer since 2005/2006 suggests that there continue to be barriers to continued improvement and the inclusion of anticipated outcomes and a routine review of outcomes against each case may be required.

2.10 Detailed local information is available as part of the Trust information system. This is updated daily and printed off weekly to be used in the weekly meetings. The system has been adapted to accommodate delayed transfers of care performance management. The availability of this information allows for detailed and more frequent comparisons of trends than is available via the monthly census. The patterns and trends identified from the weekly monitoring process are likely to be of much more value to the local health and social care community in supporting the identification of and removal of variations in flow than a snapshot monthly profile. This is good practice and should therefore continue to be the key information source for local actions.

2.11 Operational and strategic arrangements have been strengthened through the senior officers' multi-agency delayed transfers of care group which meets monthly and focuses on delivery of the Wales Audit Office action plan and key operational issues.

Performance management has been significantly strengthened

2.12 Overall, project management arrangements have been strengthened by clearer accountability through partnership and statutory arrangements, improved availability and use of performance information, clearer terms of reference and objectives, along with improvements to evaluation. There is increasing evidence to show that the impact and outcomes from service developments and actions are being reported but more could be done to strengthen these further.

2.13 One very good example of development includes the agreement of key community performance indicators by the Modernisation Board. These are outside the usual target areas and cover a broad range of areas that all partners have agreed aimed at supporting and improving their delivery of health and social care. The information is used to inform real time capacity issues and decision making at both an operational and strategic level (Box 1). Whilst this system continues to evolve, a couple of key performance areas within the framework, such as admissions avoided by GPs and through working with care homes, are still not completed and this now needs to be resolved.

Box 1: Joint health and social care performance indicators

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

Source: Carmarthenshire health and social care organisations

2.14 However, it needs to be acknowledged that this has been developed partially in response to the absence of agreed joint health and social care performance indicators and targets for health and social care within Wales. This has been recognised and identified within the overview delayed transfers of care report.

Although the local measurement systems for delayed transfers provides a more accurate reflection of actual delays than in many other parts of Wales, it still tends to understate the full impact of delayed transfer of care

2.15 Like most other parts of Wales, the Council operates a 'local agreement' with the Trust around the measurement of delayed transfers of care. This is intended to reflect the actual time it takes to arrange social services assessments and arrangements in each area. The local agreement in Carmarthenshire includes:

- seven working days for completion of assessment and production of care plan;
- seven working days to facilitate admission to residential or nursing home;
- seven working days for a new package of care; and
- two working days for restart of home care package.

2.16 While these agreements reflect a shorter time period than many other parts of Wales, they do add a delay of between two and seven working days before a patient, deemed medically fit for discharge by their consultant, is counted as a delayed transfers of care and tend to understate the full impact of the problem in terms of bed days lost.

There is a growing range of services in the community to provide additional options to prevent admission and expedite timely discharge

2.17 The multi-agency action plan has resulted in a critical analysis of capacity and the models required to support sustainable improvements. Whilst there were a number of intermediate care schemes in place at the time of our original review, there appears to have been a shift of emphasis with the whole ethos now being about developing services at the front end of a person's need, with the aim of maintaining individuals within their own home.

2.18 As a result, a number of the previous intermediate care schemes, such as Canllaw, Acute Response Team (ART) and the Chronic Disease Team, have been mainstreamed and are now available across the whole county. There have also been other developments to support individuals to stay within their own home or to facilitate quicker discharge home. All the services demonstrate a focus on integrated working to prevent admissions of vulnerable people. Service developments within Carmarthenshire include:

- Canllaw, a reablement service which provides a range of support to address both admission avoidance and early discharge. The service is very flexible and can be provided in an individual's home, residential homes, sheltered accommodation and within extra care. Evaluation of the service demonstrates its effectiveness and potential to provide significant savings to social services by reducing care package requirements.

Case Study A: Acute Response Team

Mr L, 76 years old, has been under the care of the specialist respiratory team for the previous two years. Mr L lives with his wife, who herself has multiple medical conditions but is Mr L's main support. He has no other services visiting apart from the district nurses who visit twice a week for wound management of his ulcerated foot.

He has chronic obstructive pulmonary disease, as well as a tendency towards depression. During his last visit to the specialist respiratory team, it was noted that he had a chest infection. Following discussion, it was agreed that there were two possibilities for Mr. L – admission to receive intravenous antibiotics or alternatively to receive the treatment within his own home, avoiding disruption to his lifestyle and usual care arrangements.

The Consultant referred Mr L to the ART for home based twice daily intravenous antibiotic treatment. During the period of intervention, which lasted for 10 days, consultant access for advice was available, and the local GP kept informed of Mr L's condition and treatment regime. During the visits, the ART undertook the wound management regime, which the district nurses, had instigated, so as to avoid duplication of effort. Mr L was able to telephone the Team at any time should he need to. In the event of Mr L needing to be reviewed by the consultant, he would have attended as an outpatient, but this was not required during this period.

The treatment was completed over a 10 day period until the acute exacerbation of his chest condition had resolved. Both Mr and Mrs L were very impressed with the service they had received.

In the event of the ART not being in a position to administer this treatment regime within the community, Mr L's only option would have been to be admitted into hospital for treatment, which would have resulted in at least a 10 day admission, and significant disruption to his long standing care arrangements. During this time his wife would have not been able to visit on a daily basis due to transport difficulties and so Mr L could have become increasingly isolated from his only source of emotional and social support, his wife. If Mr L had been admitted he would have potentially been exposed to other risks as an inpatient and his health could have deteriorated further.

Source: Position Paper: Mid and West Wales region: Carmarthenshire delayed transfers of care

There is the potential for even greater savings but a key barrier has been the service not working to full capacity as it does not have the full complement of support workers. Recent joint commissioning decisions have secured four additional support workers for two areas which is a positive step forward.

- The ART, an extension of the District Nursing Service has continued to support both hospital discharge and avoid unnecessary admissions over a 24 hour period. This service demonstrates a good example of integrated working through the use of support workers in the Carmarthen town locality which are provided through the British Red Cross, commissioned through the LHB. Case Study A demonstrates the effectiveness of ART in preventing the admission of a patient with chronic obstructive pulmonary disease.

- A Chronic Disease Team that focuses on managing and maintaining individuals with chronic conditions within their own home and with patients increasingly encouraged to self-manage their condition. This will increase the management of chronic diseases in primary care and reduce the burden on the acute sector. The services which have now been in place for a year include coronary heart disease, chronic obstructive pulmonary disease and diabetes. Although there has been internal evaluation of performance, a formal evaluation has not yet been completed but this is reported to be due to commence.

- The development of intermediate and transitional care arrangements making better use of sheltered accommodation and residential care homes. For example, transition beds have been identified within Council residential homes to facilitate early

Box 2: Provision of 'Step Down' Service within Sheltered Accommodation Scheme

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

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

The rehabilitation period would be reviewed on a specific 'needs' basis.

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

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

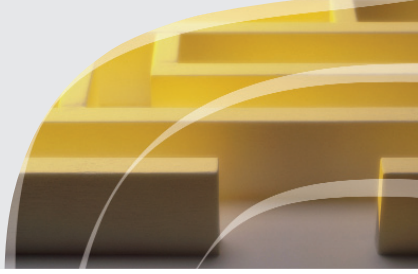
A multi-agency team will be set up to trawl the patient population in Llanelli to identify suitable users. The team will undertake an assessment prior to acceptance on to the scheme and will agree the expected outcomes for that person, the user and carer being part of the decision-making process. A written agreement will form part of the documented care plan for all parties involved. Staff at sheltered scheme will be given the care plan a minimum of three days prior to admission to the scheme. The operational team will meet weekly to identify, discuss and solve operational issues. In addition, there is a 'discharge planning' element to that group, linked to the individual user's care needs. In terms of evaluation, this service will be monitored against a number of set criteria.

Source: Carmarthenshire LA/LHB

discharge from hospital. The occupancy levels tended to be low initially but have now reached 70–80 per cent. Whilst the availability of these beds has impacted on a reduction in Residential Care choice, the anticipated reduction in social care funding delays has yet to be realised (Box 2).

2.19 The delivery of an effective district nursing service is a key factor in supporting individuals within their own home. The Carmarthenshire service has evolved over recent years and this continues with a resource mapping exercise of current primary and community nurses and proposals to integrate home care and the community nursing team. In addition, a task and finish group jointly led by the two nurse directors has been proposed to articulate a future vision for the community and primary nurse roles.

2.20 A key critical success factor in ensuring that services are effective has been the clear linkages and integration of services and the apparent seamless approach to working across the traditional sector boundaries. For example, the ability for these intermediate care schemes to support individuals in places outside of the traditional hospital setting as evidence in Box 2.



Better use is now being made of the voluntary sector to support low level needs

2.21 The use of the voluntary sector has been significantly strengthened within Carmarthenshire with examples of where they are already providing support, and a number of schemes that are being developed or recently commissioned. These include:

- The Carmarthenshire Twilight enterprise is aimed at promoting and developing support networks for older people in their own home to prevent admission, re-admission and functional decline. The Befriending Service (initially funded externally via the voluntary sector with match funding from the Council and LHB) is due to commence from 1 July 2007 and will be based in both of the Trust's A&E departments from 5pm – midnight. The service will initially be provided for five days a week within their homes to support people who present at A&E and provide transport to get home if required. A follow up visit will be undertaken on the following day from the British Red Cross Home from Hospital Team. While there are limitations to the scheme in as much as it will only cover one specific area within Carmarthenshire, it is assessed this service will potentially prevent two to three avoidable admissions per week. Projected savings from the scheme are estimated to be £43,000 (based on £300 per night for a hospital stay). The monitoring and evaluation of the scheme will be crucial in identifying the effectiveness of this type of preventative service in terms of saving money.
- The British Red Cross Home from Hospital scheme now includes the provision of personal care tasks as part of their remit. The extension of this service to West Wales General Hospital has only recently been available. However, support workers are now based within both main hospitals to facilitate access to this service.
- The LHB has funded additional home care capacity (76 hours per week) from Crossroads. This additional capacity is accessed via the Hospital Social Work Teams, and allocated where possible at the weekly multi-agency delayed transfers of care meetings to support hospital discharge and Continuing Healthcare.

Despite measures taken to reduce reliance on the acute sector, emergency demand continues to grow

2.22 Within Carmarthenshire there is recognition that the best way to tackle delayed transfers of care is to prevent admissions to hospital as far as possible and to ensure that patients pass through hospital 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.

2.23 The Emergency Medical Admissions Avoidance Plan (EMAAP) identifies a whole system approach to reducing admissions and this is an integral aspect of the multi-agency action plan. The plan identifies key actions, lead organisational responsibilities and targets for achievement.

2.24 However, despite this, a number of other initiatives and the growing development of community-based service provision to avoid admissions, emergency demand continues to rise. Within the Trust, overall admissions have increased between 2003/2004 and 2005/2006 with emergency admissions to medical specialties significantly higher. All emergency admissions, including surgical admissions, remained fairly stable as did emergency admissions of patients aged 65 and over (Figure 2).

2.25 In addition, Trust data shows that this trend has continued with the average monthly emergency medical admissions for 2006/2007 being nine per cent higher than 2005/2006.

2.26 Encouragingly, Trust data for the first quarter of this financial year shows a 10 per cent reduction in the rate of medical emergency admissions. Although, the reasons for this are not yet clear, this suggests that measures taken are now starting to have an impact on reducing demand, but this will need to be closely monitored.

Effective discharge planning is a high priority and the flow of patients through the system is being strengthened

2.27 Good progress has been made on improving patient flow and discharge processes overall. Measures taken include:

- daily patient flow meetings;
- weekly patient management group meetings;
- systems in place to inform processes, such as demand prediction, actual bed availability and profiling individuals likely to become delayed; and
- recording the estimated date of discharge (EDD) on admission which is recorded both manually and is a feature within the Trust's Myrddin Patient Administration System.

Figure 2: Admissions have been increasing, especially to medical specialities

	2003/2004	2004/2005	2005/2006	Change
Overall admission numbers	40,493	39,774	41,441	2.34%
Emergency admission numbers	19,046	19,242	19,223	0.9%
Emergency admissions in the 65+ age range	9,159	9,138	9,178	0.2%
Emergency admissions to medical specialties	10,902	11,796	12,696	16.45%

Source: Wales Audit Office analysis of PEDW data

Box 3: Profiling of individuals likely to become delayed if admitted

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

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

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

Based upon the profile developed on people likely to become delayed, further work has been progressed to examine why people receiving no services prior to admission are assessed as requiring a range of services following assessment during the inpatient stay. One theory is that community based assessment is not capturing those older people who are at the borderline between coping and failing to cope at home. These people are initially identified via a crisis admission to hospital linked to their inability to cope.

To further investigate this, a pilot study is underway within one GP practice (Nantgaredig) to target all age 75+ practice population for a proactive assessment, involving the local Canllaw (reablement) service and primary healthcare teams. The pilot is currently underway but, to date, 33 people have been identified as requiring multi-disciplinary assessment and support of which, nine were considered as high risk of emergency admission. This pilot was repeated in Llandeilo in June alongside similar pilots linked to LA Residential Homes in Carmarthen and Llandeilo.

Source: Trust interviews and regional review

2.28 The National Leadership and Innovation Agency for Healthcare (NLIAH) audit of discharge processes scored them around average, with good operational management identified, but more work required at policy and audit level and the Trust is working with its partners towards improvement in these areas.

2.29 An audit tool has been developed (based on an original tool utilised within a Wales Audit Office review) to ensure delays are captured and acted upon in a timely manner. This supports profiling of individuals who are likely to become delayed if admitted to hospital (Box 3).

2.30 Unified assessments can support effective assessment for discharge. The unified assessment process has many potential benefits but its implementation not only within Carmarthenshire but across Wales, has been problematic because of a lack of shared IT to support it and problems sharing information between agencies.

2.31 An additional block to the implementation of the unified assessment process is the lack of input from Primary Care due to non-participation from GP practices. Limited measures have been taken in Carmarthenshire to try to overcome this but our Overview Report stresses the need for Assembly Government action to ensure that the Informing Healthcare programme gives greater priority to the development of a shared ICT system for unified assessment and consideration of how this may link in with GP practices.

An agreed joint vision and joint commissioning strategy for older people's services now provides a clearer direction towards developing modern health, social care and housing services in Carmarthenshire

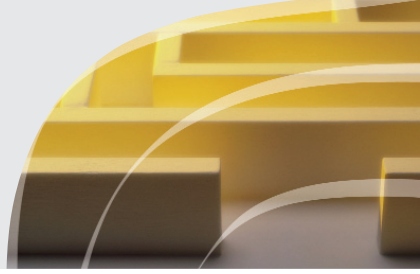
2.32 The significant shift towards integrated organisational arrangements and service delivery is underpinned by the development of a much clearer direction for older people's services within Carmarthenshire. The new ethos of multi-disciplinary working is reflected in the development of an agreed joint vision and joint commissioning strategy which sets out the types of services that the Health and Social Care Community in Carmarthenshire will commission to support older people. The joint commissioning strategy covers the period 2008–2011 and is intended to complement the Health Social Care and Wellbeing Strategy for the same years. The joint strategy was built on a number of key themes:

- the need for a greater focus on promoting reablement and independence – 'doing with rather than for';
- progressing the shift from healthcare acute services to primary and community care;
- supporting people at home, preventing unnecessary hospital admissions; and
- addressing the increasing demand for quality and dementia care.

2.33 In developing the strategy, good use has been made of a detailed population and needs analysis which includes likely demographic changes over the next 10 years and the impact these changes are likely to have on health, social care and housing. Work undertaken by the Institute of Public Finance provides a model to predict future dependency levels and also sets out the likely financial implications of a number of different scenarios. The strategy is structured around priorities which will be used as the basis for future purchasing and contracting activity. These include:

- ensuring access to, and choice between services;
- promoting independence through home based services;
- promoting independence through community based services;
- promoting independence through appropriate accommodation;
- ensuring a skilled and committed workforce across all sectors and providers; and
- making better use of resources.

2.34 The joint commissioning strategy is seen as a key driver in taking forward the service improvement programme for health and social care and for tackling the root causes of delayed transfers of care in the long term.



2.35 In addition, within Carmarthenshire a comprehensive multi-agency review of community services led by the LHB has been undertaken. Significant work programmes have been progressed as part of this review and there has been considerable public involvement in the process. The review includes a number of proposals and discussions including:

- primary care resource centres;
- different approaches to providing health and social care beds;
- locality developments; and
- associated financial, workforce and communication strategies.

2.36 The review is reported to be closely aligned to the joint commissioning strategy with senior representation from social services on relevant project groups. The resource centres are progressing well but the current status of other aspects of this review are unclear. Whilst funding is stated to be through more effective utilisation of current resources as part of modernising health and social care, we continue to have some concerns about the affordability of potential proposals given the community's financial position.

Part 3 - Despite the improvements in partnership and whole systems working, the health and social care community still face significant challenges and there are potential risks to further improvement

3.1 To its credit, the health and social care community in Carmarthenshire has recognised that the issue of delayed transfers of care can only be tackled through a robust multi-agency approach to whole systems working. Proposals set out in the expression of interest, development of the Local Service Boards, March 2007, aim to go beyond the joint commissioning of health and social care services and actually seek to integrate the operational delivery of services. Two key aspects include delayed transfers of care and Continuing Healthcare.

3.2 Nevertheless, the funding pressures and deficits across the NHS Trust, LHB and Council Social Services remain a significant challenge and a key risk to implementing the service improvement agenda set out in the joint commissioning strategy.

3.3 Whilst we are encouraged to note that negotiations between the three key partners are underway to agree how savings released through investments are shared amongst the partners, budgetary pressures continue to cause a vicious circle whereby financial pressures in one part of the public service cause costs to fall on another. The numbers of people in Carmarthenshire who continue to be delayed in hospital because of social care reasons is an example of this and remains a significant barrier to achieving longer term reductions.

3.4 The Joint Review of Social Services identified that the Council's expenditure on services for older people is above the Wales average. Since then, the Council has further increased investment and remains one of the highest spenders on older people's services in Wales (ranked four out of 22). One of the key recommendations of the review was the need to use funding more effectively by providing value for money, quality services through the promotion of a mixed economy of care and the development of costed commissioning strategies for core services.

3.5 There is evidence that the Council has begun to address these issues through major service reconfiguration in relation to day services, domiciliary dare and residential care services. For example, the approach to day services has seen a shift in focus from direct service provision to much more of a commissioning role with a greater investment in the voluntary and independent sector to address under capacity and achieve value for money.

3.6 Similarly, in domiciliary care, the Council has been developing block contracts with independent sector providers to improve cost effectiveness and has plans to introduce a brokerage system by April 2008. The longer term aim is to refocus the in-house service on community reablement to increase the independence of service users and reduce the level of care needed beyond six weeks.

Box 4: Extra Care Housing

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

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

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

All these developments form part of the county's Accommodation Strategy which will be formally launched in the second half of this year.

The redevelopment of the Llysybryn home in Llanelli has just been commissioned with specific provision for Integrated Beds in Rehabilitation, Respite and Convalescence.

All of the developments are and will be supported and enabled by intermediate care services such as Canllaw and the ART which further supports keeping people out of hospital.

Source: Joint Planning and Commissioning Manager Carmarthenshire LHB/LA

3.7 The modernisation programme for the Council's residential care homes is also aimed at providing further efficiencies in the system for reinvestment into an integrated range of services for older people which provide a greater diversity of accommodation. The development of extra care housing schemes is a good example of this approach (Box 4).

3.8 The Council has recognised that a contributory factor to poor performance is its historical under-investment in assessment and care management. Work is underway to restructure the Council's Older People's Division (assessment and care management as well as direct service provision) in order to provide more accountable, local management and to enable further integration with health services. Some good progress has already been made with the integration programme with health, for example, a joint equipment service is well advanced and the Occupational Therapists from the Council and the NHS Trust have been brought together to form a single team.

3.9 Despite these initiatives, Carmarthenshire County Council still remains in the bottom quartile for performance in relation to delayed transfers of care. In addition, waiting lists for social care services in the community remain a significant challenge and these factors, together with increased demand, means that the Council is reviewing its eligibility criteria thresholds for social care services. Consideration is currently being given to moving from meeting moderate, substantial and critical needs to substantial and critical needs only in terms of eligibility of access to service provision.

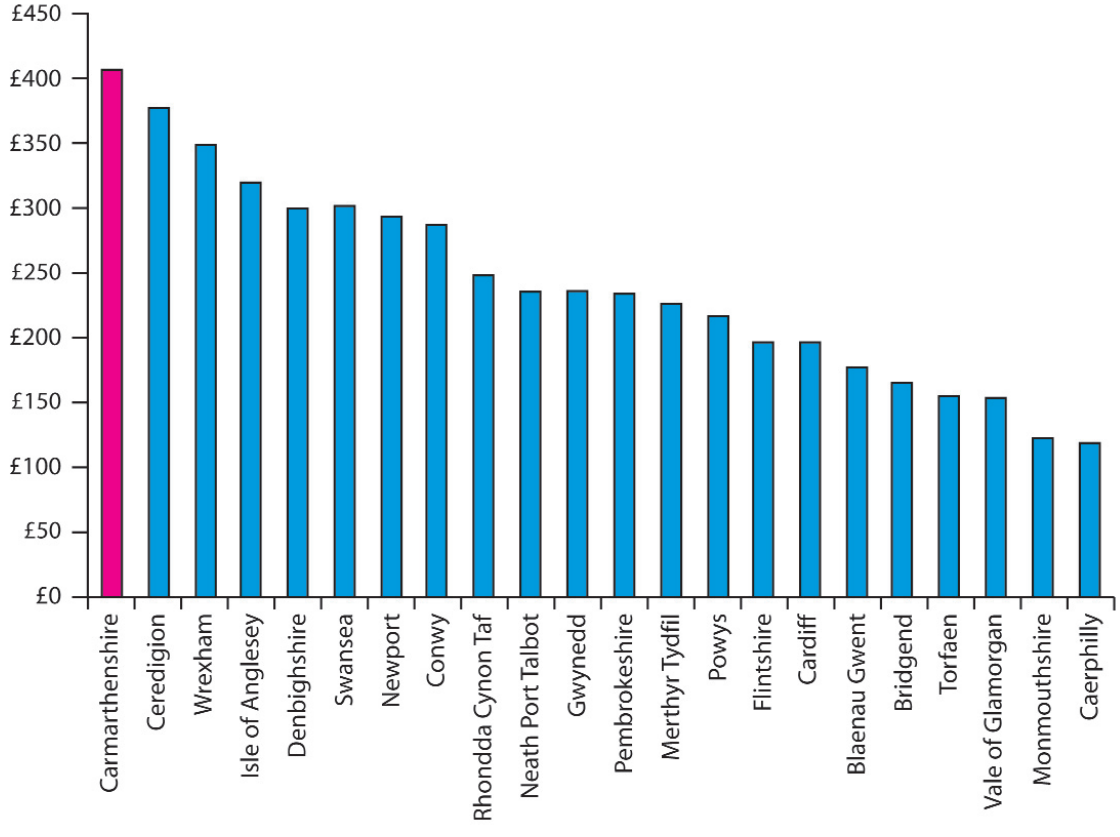
3.10 While the reconfiguration of services and the development of the joint commissioning strategy are vital to support and drive the changes needed in the long term, swifter progress is still required to change the pattern of current services to ensure that the needs of vulnerable people in Carmarthenshire can be met within the resources available.

Continuing Healthcare funding has the potential to undermine the partnership and threaten effective joint working

3.11 Continuing Healthcare is a significant risk to the effective operation of the whole system and can encourage silo working. Organisational barriers at the interface between health and social care can contribute to delayed transfers of care. In particular, decisions about whether a patient is eligible for full 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 which does not place the patient at the centre of care and encourages organisations to seek to protect their budgets and position.

3.12 The organisations within Carmarthenshire recognise that, increased demand for services funded through the continuing care route is one of the biggest challenges to health and social care commissioners and providers in Carmarthenshire. This has the potential 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 'overarching test' to determine whether the patient's primary need was for healthcare. This judgment, combined with

Figure 3: LHB expenditure on Continuing Healthcare per head of population 65 and over is the highest within Wales



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

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 service departments for long term care, and the removal of the financial cost from some people who had previously paid for their own care.

3.13 Currently within Carmarthenshire, there are significant financial pressures from continuing healthcare expenditure with the LHB spending more per 1,000 head of population on Continuing Healthcare on those aged 65 or over than any other area within Wales (Figure 3). During 2005/2006, LHB expenditure was £10.5 million; this grew to over £14.6 million in 2006/2007, an increase of just over £4 million.

3.14 There are a number of arrangements in place to ensure that the organisations have a partnership approach to managing continuing healthcare. However, the recent proposals by the LHB to move from weekly to monthly panels were not through a partnership approach and there had been no involvement of other organisations in the decision. Whilst this may have been seen as an operational decision by the LHB, the Trust has expressed concerns about the impact of this decision on patients who remain in either acute or rehabilitation beds causing delays in patient flow and undue anxiety to both patients and their families.

3.15 This decision has created significant tensions between partners particularly between the Trust and LHB which mirror the partnership problems and difficulties evident at the time of our previous review. Encouragingly, there has now been a multi-agency meeting to discuss continuing healthcare and there has recently been agreement for formal risk assessments to support the continuing healthcare process and to minimise any potential clinical risks. This should continue with an agreed focus of finding collective solutions to a very difficult issue.

3.16 It has been suggested that the key reason for higher expenditure is the difference in availability of services provided by NHS Trusts in some areas, compared to others, which are resulting in the demand for the continuing care funding route being used to meet needs which in other areas are being met as part of a core service. If that is the case, commissioners must ensure that core services are fully specified and funded to reduce the knock on impact of Continuing Healthcare funding.

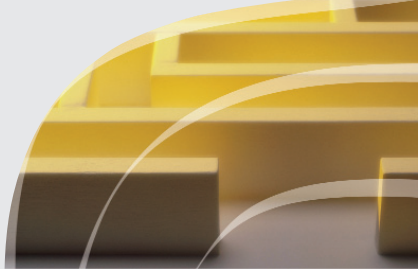
3.17 During this review we have generally been impressed with the success of partnership working through collective discussions, negotiations and joint solutions. The significant challenges presented in tackling the issue of Continuing Healthcare funding would also have benefited from this way of working. These recent events demonstrate that further progress is still needed to build on the successes to date such as the progress with the whole systems action plan and the development of the joint commissioning strategy.

3.18 Future success in terms of tackling the seemingly intractable issue of delayed transfers of care will depend on the willingness of partners to continue to engage with each other to resolve these difficult issues and to use the opportunities afforded by the establishment of the Local Service Board to drive the changes required to deliver the ambitious agenda proposed.

Appendix 1 - Delayed transfer in care in Carmarthenshire

Progress reported by Carmarthenshire against recommendations in the Wales Audit Office report 2003/2004.

Recommendations	Carmarthenshire actions
1. Rationalise Existing Project Groups and Boards to ensure work is linked and developed in a whole system way with clear: ■ lines of accountability; ■ agreed objectives; ■ communication and reporting lines; and ■ linkages of actions and outcomes.	■ strengthened multi-agency, operational linkages – validation group, social care allocation meetings, case management, communications; ■ clear escalation of processes of complex cases to executive; ■ strengthened tactical linkages through Senior Officers delayed transfers of care Group; ■ strengthened strategic direction through clear Partnership Priority Setting, Partnership Board, Partnership Executive Group and LSB; and ■ exec to Exec Groups includes all executive and Director of Social Services.
2. Prepare and implement strategies to support strengthened engagement and partnership working with: ■ GPs; ■ independent and voluntary sectors; and ■ public and patients.	■ regular GP/Consultant/Social Care Forum; ■ protected time for learning; ■ primary and Community Services Commissioning Group; ■ community Services Review; ■ independent and Voluntary Sector Liaison Forums; ■ joint contracting and commissioning; ■ strategic development of voluntary sector eg, Twilight Service, Hospital from Home; and ■ health panels.
3. Maintain and develop performance management frameworks to ensure: ■ clear lines of accountability and common agreed principles for service planning; ■ strengthened foundations on which to make commissioning decisions; ■ timely implementation of commissioned schemes; and ■ evaluation through the tracking and monitoring of agreed schemes.	■ key performance indicators agreed for Health and Social Care Community – real time capacity planning; ■ real time capacity planning eg, domiciliary and continuing care activity; ■ clear accountability through partnership and statutory structures; ■ joint planning, commissioning and delivery groups with clear Terms of Reference and objectives; ■ joint, needs based commissioning strategies; ■ project management to ensure scheme implementation; and ■ programme of service reviews and routine evaluation.



Recommendations	Carmarthenshire actions
4. Secure multi-agency agreement to an overall strategy to support: ■ fundamental changes to health & social care delivery; and ■ sustainable management of demand and reduction in delayed transfers of care. This will require: ■ working in different ways across organisational boundaries; ■ sharing risk and resources to secure alternative services; and ■ shared responsibility for service change and delivery.	■ Joint Commissioning Strategy for Older People; ■ linked community services review and social care modernisation programme; ■ integrating commissioning and delivery of adult health and social care; ■ integrated OT service; ■ creating capacity to meet demand in non acute settings eg, assistive technology; and ■ using existing resources/ capacity to better effect eg, sheltered housing units, residential homes.
5. The Partnership Board should ensure that all initiatives in the Wanless Local Action Plan are subject to: ■ clear objectives and accountability; ■ effective project management; and ■ evaluation for effectiveness and mainstreaming.	■ 'Wanless' schemes mainstreamed; ■ all services have clear objectives and performance management aligned to partnership priorities ie, admission avoidance & delayed transfers of care; ■ strong operational management including project management eg community operational groups; and ■ ongoing service reviews eg Canllaw as part of mainstreaming, continuous improvement.
6. Establish a range of services that support early intervention to minimise unnecessary admission.	■ Comprehensive Emergency Admission Avoidance Action Plan compliments delayed transfers of care plan; ■ CDM Team; ■ canllaw; ■ acute response Team; ■ GMS Enhanced Services; ■ plans for assistive technology – telecare, telehealth, reablement; and ■ step-up/step-down beds.
7. Agree a local model for securing effective and timely assessment of people's needs in the community that: ■ averts crisis management; ■ makes more sensitive use of resources; ■ provides a clinically robust assessment of need; and ■ supports effective management of demand.	■ assessment care management part of socialc are restructuring and joint commissioning strategy; ■ proactive assessment of vunerable groups through GMS enhanced services and intermediate care services; and ■ capacity developed to meet demand in non acute settings eg, step-down beds.
8. Through commissioning, partnership work and joint funding arrangements across health, social care and housing, maximise the impact of new technology in delivering independence.	■ assistive technology strategy is a key element of the Older People's Strategy; ■ integrated tele-care and tele-health plans developed; and ■ one of 3 pilot tele-health areas for Informing healthcare.

9. Investing and establishing intensive case management of older people in the community with the objective of reducing their dependency on acute services.	■ This is achieved through:
	  ■ core services;
	  ■ CDM, Canllaw, ART;
	  ■ proactive discharge planning; and
	  ■ robust operational multi-disciplinary working.
	■ Escalation processes and high level case management of complex cases.

Recommendations	Carmarthenshire actions
10. Ensure policies, procedures and guidance to support demand management processes and schemes: ■ provide clear linkages across each scheme; ■ are consistent across partner organisations; ■ are properly understood by operational managers; and ■ support routine evaluation.	■ joined up policies and procedures of community and intermediate care schemes co-ordinated through Community Operational Groups; ■ focused specifications and operational policies for all services; ■ regular programme of service reviews to ensure services eg, Canllaw, community nursing; and ■ ongoing evaluation of schemes and commitment to reuse resources if not having desire impact eg frail elderly LES.
11. As a matter of priority, improve understanding of all Wales continuing health care policy by partners to ensure the effective implementation at a local level.	■ agreed continuing care policy; ■ trust representation on continuing care panel; ■ joint education and training programme; ■ increasing demand for continuing care and Welsh Assembly Government policy continues to give cause for concern; and ■ continuing care recognised as a key partnership priority and top priority for the Local Service Board.