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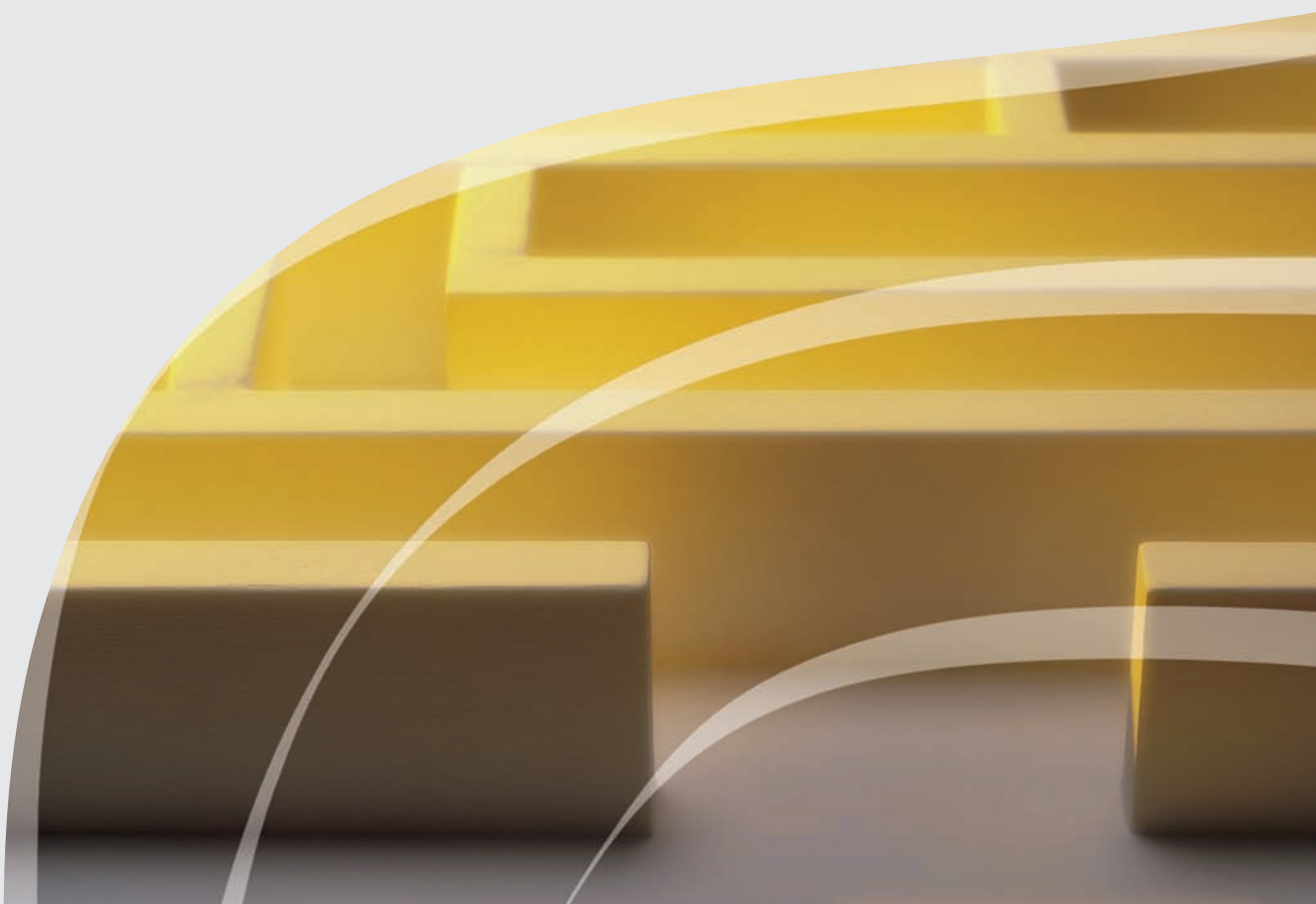
Tackling delayed transfers of care across the whole system - Gwent health and social care community



Tackling delayed transfers of care across the whole system - Gwent 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.

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

In the Gwent 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 whole system problem of delayed transfers of care has not been tackled in a whole systems way in the Gwent health and social care community

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Summary

1 A delayed transfer of care is experienced by a hospital inpatient when they are ready to transfer to the next stage of care and are deemed medically fit for discharge by their consultant, but this is prevented by one or more reasons and they remain in a hospital bed for longer than they need to. Delayed transfers of care generally arise from delays moving to healthcare provision outside the acute hospital, delays in assessments or arrangements for social care or for legal or choice issues relating to the patient, their family or carer. Delayed transfers of care have an immediate impact on the patients concerned but also affect wider service delivery and performance across the whole health and social care system.

2 Despite reductions in the number of people who became a delayed transfer of care in the beds of Gwent Healthcare NHS Trust (the 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 when measured by the number of bed days lost. Delayed transfers of care can be extremely damaging to patients who lose independence and function while in hospital, as well as to the whole system of health and social care, whose resources are tied up in the inappropriate use of hospital beds which could be used to treat patients who need the specialist services provided in those beds. Nevertheless, most patients who become delayed transfers of care generally have a complex range of needs although the fact that they are medically fit for discharge from hospital means that the care they require would be most appropriately provided in another setting.

3 People who experience a delayed transfer of care occupy the beds of the Trust 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 involves collaborative and co-ordinated approaches by numerous public bodies each with individual responsibilities, resources and constraints. The development of Local Service Boards (LSBs) is one potential mechanism to improve co-ordination and the focus on the citizen who needs care from the Welsh public service.

4 The Trust and the Local Health Boards (LHBs) and councils in the former Gwent County Council area (Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen) have ambitious plans, known as 'Clinical Futures', to remodel clinical services with an increased emphasis on out-of-hospital care. These will be phased in over the next five to ten years. We have used the phrase the 'Gwent health and social care community' to cover these bodies and others involved in health and social care services in the area. In the context of 'Clinical Futures', we examined whether the Trust, five LHBs and five unitary authorities were taking effective action across the whole system to tackle the extent and causes of delayed transfers of care in the Gwent health and social care community.

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

6 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 health and social care community. The appendices to this report summarise the position and recommendations for action in each of the individual organisations within the health and social care community.

7 While this report makes a number of recommendations that encourage joint working beyond borough boundaries, including some actions at a pan-Gwent level, other recommendations will require tailored approaches that address the specific circumstances of particular localities. It will be for the various bodies to decide when it is most appropriate to develop joint solutions, when to develop common approaches which can be varied to meet specific local circumstances and when they need to adopt specific local approaches to meet the needs of their resident populations.

8 We undertook similar work in the Cardiff and Vale 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 develop commissioning

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

2 In updating their needs assessments to inform reviews of their Health, Social Care and Wellbeing (HSCWB) strategies in 2008, local authorities and LHBs should:

- **a** using the findings of this review, a detailed analysis of why their residents experience delayed transfers of care and an analysis of intelligence from primary and social care practitioners, develop a robust assessment of the needs of the resident population for new models of service to promote the independence of vulnerable people in community and intermediate care settings;
- **b** identify clear and costed strategies to enable the transfer of resources from acute to community services to break the 'vicious circle' whereby vulnerable people are drawn towards inappropriate institutional care that can compromise their independence; this may require LHBs and councils to identify transitional funding to enable new services to be set up before existing models are decommissioned;

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

d discuss with the Trust opportunities to use the outcomes of the revised HSCWB strategies to inform the development of more robust plans to develop community-based and intermediate care services to support the delivery of the Clinical Futures vision.

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

4 Improving the operation of the whole system of health and social care, and the promotion of the independence of vulnerable people, depends fundamentally on the existence of a clear and shared vision of what services and care pathways should look like. Even where there is a clear vision of future service provision, the extent of local government engagement and involvement is variable.

Partners within the Gwent community should develop, as part of their HSCWB reviews, clear models of service provision and care pathways from which the configuration of future health and social care services can be developed, including consideration of:

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

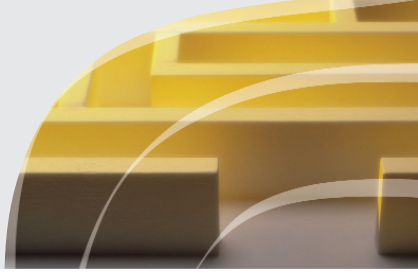
b the development of a 'virtual ward' approach to community provision, based on prediction of need, multi-disciplinary team work, a single point of contact and shared records and information;

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

To address problems arising from organisational and budgetary boundaries

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

- **a** using an LSB to explore how best to address delayed transfers of care;
- **b** if successful, how to make links between the five LSBs at a strategic, pan-Gwent level;
- **c** the use of a Public Service Trust covering all or some health and social care services;
- **d** the development of pooled budgets, adequacy of supporting information and governance arrangements for pooled budgets; and
- **e** depending on the effectiveness of the Section 33 agreements in Monmouthshire, consider the use of this mechanism to bring health and social care services together through a formal agreement.

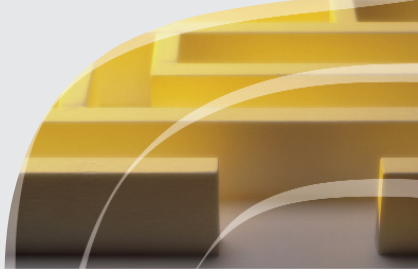
12 The Trust, LHBs and local authorities should set and monitor progress against common targets to reduce delayed transfers of care, but focus their performance management on addressing, in a sustainable way, the underlying causes of which delayed transfers of care are a symptom. Performance management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

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

To address issues of capacity

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

- **a** using the review of district nursing to clarify the role of district nurses in the patient pathway;
- **b** training nursing and medical staff to develop specialist skills in care of the elderly and those with dementia;
- **c** training nursing and medical staff about care pathways and intermediate care services available to elderly people at risk of becoming, or who have already become, a delayed transfer of care;



d using the recent restructuring of the Trust to question current practice and pathways to identify practical ways in which independence might be promoted more effectively; and

e addressing the inconsistency in practice between its main sites, perhaps by using clinical staff from Nevill Hall Hospital at the Royal Gwent Hospital to transfer some of the systems used in Nevill Hall Hospital.

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

To address risks associated with 'Clinical Futures' plans

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

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

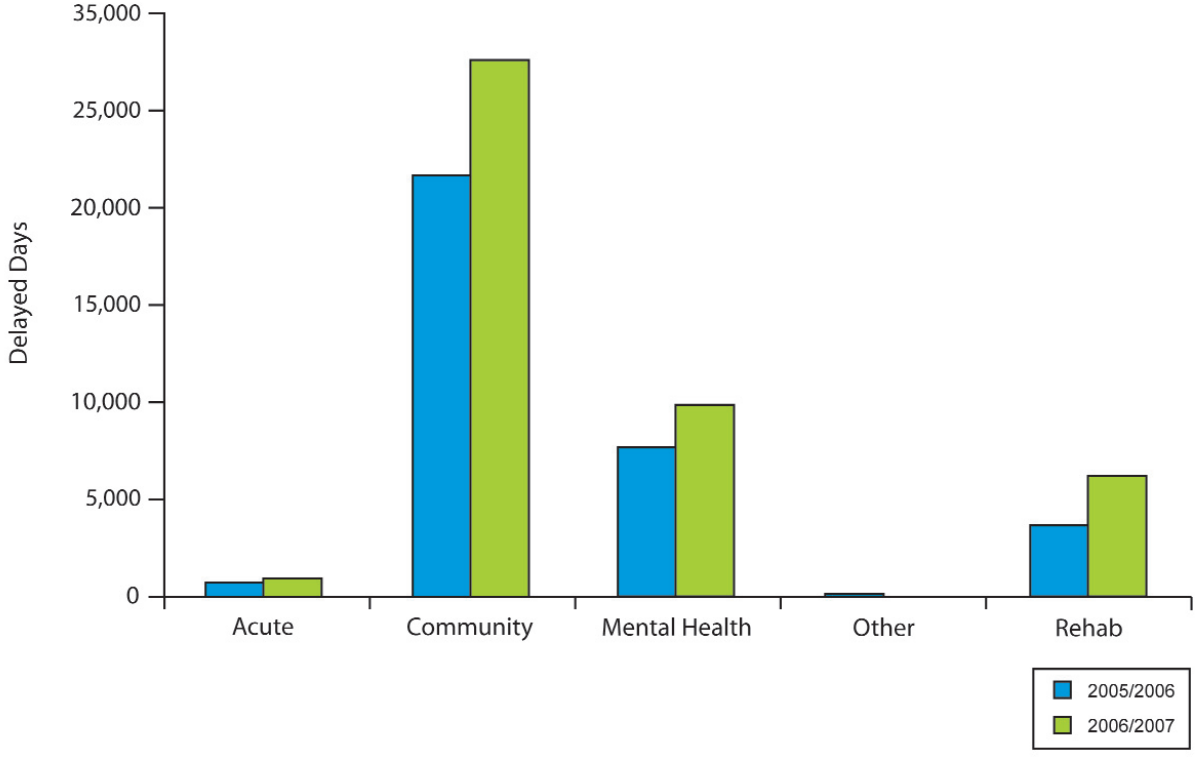
Part 1 - The data understates the duration of the delayed transfers of care which affect the independence of vulnerable older people

The incidence of delayed transfers of care is increasing, although understated by the statistics

1.1 There have been overall reductions in the extent of delayed transfers of care between September 2003 and March 2007, when the total number of people who became a delayed transfer of care in the Trust fell by 49 per cent. Some Gwent residents experience delayed transfers of care in trusts other than Gwent Healthcare.

1.2 However, there has been a pronounced increase towards the end of that period. In 2006/2007, delayed transfers of care occupied 44,456 bed days within the Trust, an increase of 31 per cent compared with 2005/2006 (Figure 1). Over half of these bed

Figure 1: The number of bed days occupied by delayed transfers of care increased by 31 per cent between the 2005/2006 and 2006/2007 financial years



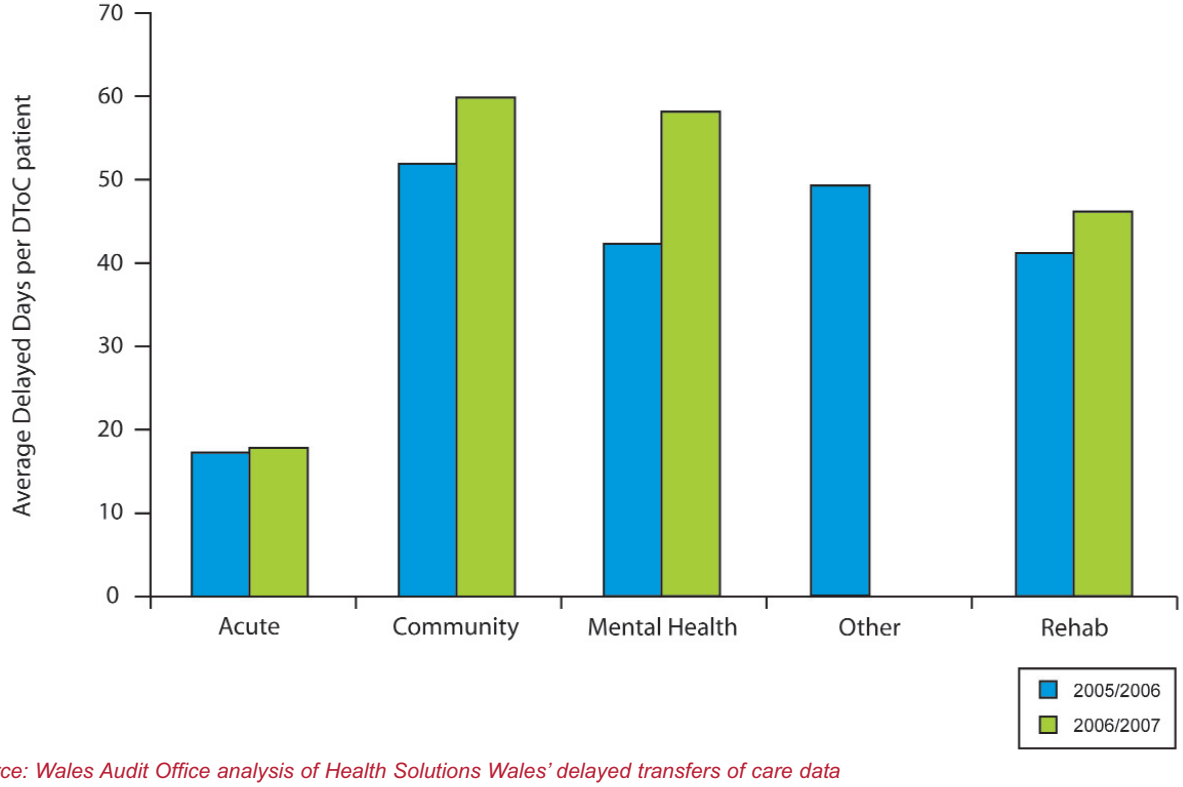
Source: Wales Audit Office analysis of Health Solutions Wales' delayed transfers of care data

days were in community beds: generally delayed transfers of care do not occupy acute beds within the Trust, although the 27,511 community bed days have consequences which compromise the optimal use of National Health Service (NHS) resources and the Trust's acute beds.

1.3 The average duration of each delayed transfer of care in Gwent was 55 days in 2006/2007. In rehabilitation beds, the average duration of a delayed transfer was 46 days, which is in addition to the time spent on rehabilitating the patient. This significantly compromises the Trust's capacity to rehabilitate other patients and potentially reduces the impact of rehabilitation services received by those who become a delayed transfer of care (Figure 2).

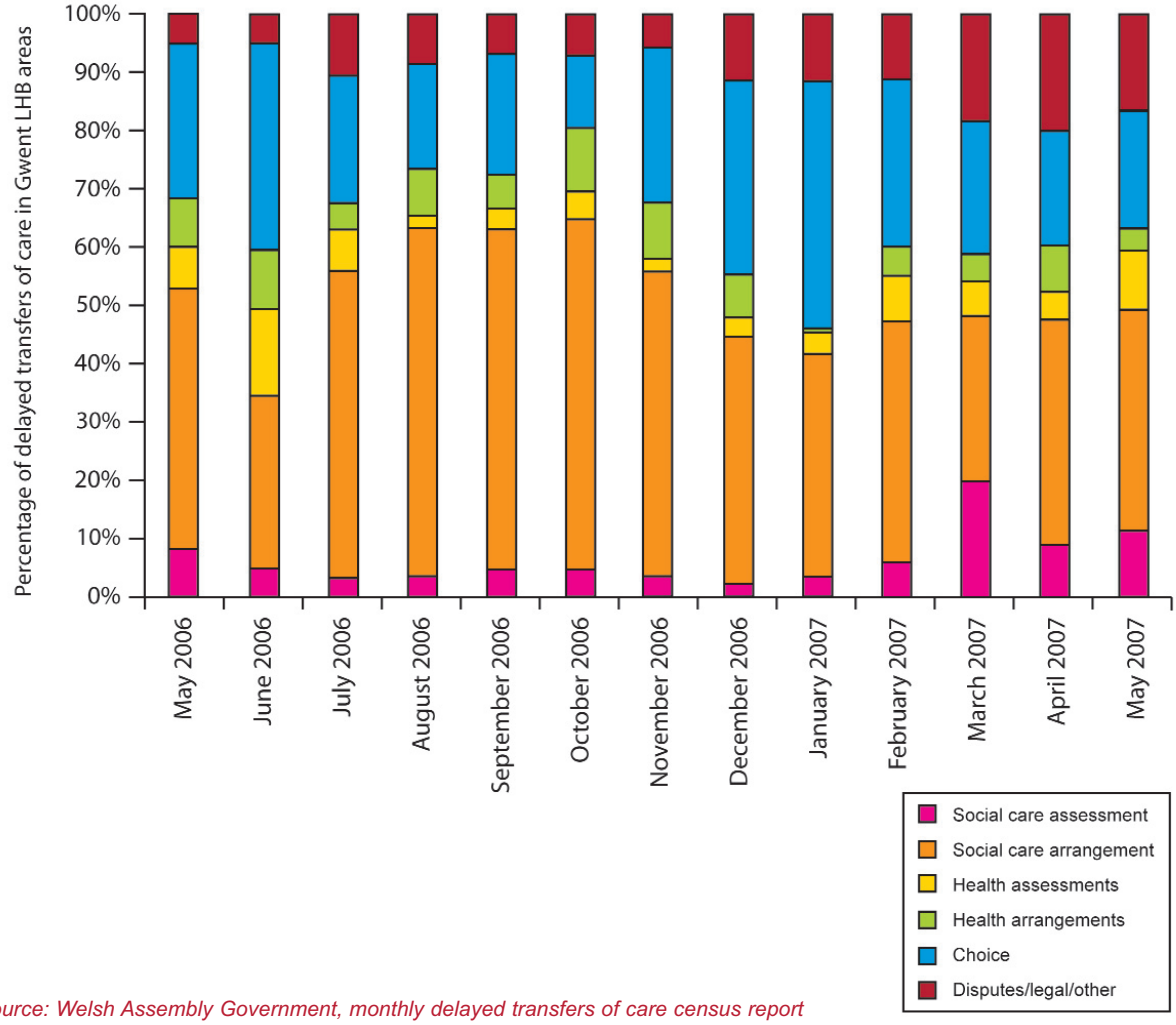
1.4 This impact of delayed transfers of care on the Trust's capacity increased between 2005/2006 and 2006/2007, driven primarily by a 64 per cent increase in bed days occupied by delayed transfers of care for social care reasons and a 14 per cent increase in bed days occupied by delayed transfers of care arising from patient, family or carer issues, often relating to choice of care home (Figure 3). The main cause of delayed transfers of care in Gwent between May 2006 and May 2007 was delays waiting for social care arrangements, which on average accounted for 46 per cent of delayed transfers of care and an average of 58 people each month in Gwent over that period (Figure 3).

Figure 2: The average duration of each delayed transfer of care increased significantly between 2005/2006 and 2006/2007



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

Figure 3: Percentage of delayed transfers of care by main reason in all Gwent LHBs, May 2006 to May 2007



Source: Welsh Assembly Government, monthly delayed transfers of care census report

1.5 There was an increase in the average duration of each social care delay of 26 per cent between 2005/2006 and 2006/2007, while the average duration of delays for patient/carer/family-related reasons increased by 15 per cent (Figure 4).

1.6 We estimate that the direct cost of the Trust providing the beds occupied by delayed transfers of care in 2006/2007 was £11 million (Appendix 3), which represents around two per cent of the Trust's income in that financial year. These costs represent an increase of about 36 per cent compared with 2005/2006 (Appendix 3). Social care delayed transfers of care accounted for around £5 million of direct bed costs, while patient/carer/family-related delayed transfers of care accounted for direct bed costs of some £4.6 million.

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

	Delayed days				Number of delayed patients				Average days delayed			
Reasons	2005/ 2006	2006/ 2007	Change	Percentage change	2005/ 2006	2006/ 2007	Change	Percentage change	2005/ 2006	2006/ 2007	Change	Percentage change
Healthcare reasons	4,542	4,561	+19	+0.4%	111	110	-1	-0.9%	40.9	41.5	+1	+1.5%
Patient/carer/ family-related reasons	16,293	18,600	+2,307	+14.2%	330	327	-3	-0.9%	49.4	56.9	+8	+15.2%
Principal reason not agreed	138	220	+82	+59.4%	2	3	+1	+50.0%	69.0	73.3	+4	+6.2%
Social Care reasons	12,856	21,075	+8,219	+63.9%	289	376	+87	+30.1%	44.5	56.1	+12	+26.1%
TRUST TOTAL	**33,829**	**44,456**	**+10,627**	**+31.4%**	**732**	**816**	**+84**	**+11.5%**	**46**	**54**	**+12**	**+26%**

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

1.7 Although delayed transfers of care manifest themselves within the Trust's beds, the costs are borne by the whole healthcare system, as the five LHBs in Gwent fund the capacity occupied by delayed transfers of care. The direct bed costs do not represent a sum of money which could be immediately redirected to other priorities as it includes overheads and other costs which are not realisable as direct savings. Based on an estimate of a marginal cost of a bed day of £100, we estimate that £4.4 million of realisable savings could be released by eradicating delayed transfers of care in the Trust, although there would still be costs of care associated with these patients elsewhere in the system. Delayed transfers of care impose costs on different parts of the system, for example problems with 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. There are also intangible system costs in terms of the time spent managing individual delayed transfers of care cases and poor use of capacity, resources and specialist staff skills. Some of the financial pressures on the system, to which delayed transfers of care contribute, include:

- avoiding the costs of paying for elective surgery to meet the Assembly Government's access targets through the Second Offer Scheme, which were £3.6 million among the Gwent LHBs in 2006/2007;
- addressing longstanding financial deficits, with a predicted financial shortfall of £7.1 million in Gwent for 2007/2008;
- investing more in intermediate care services;

- recognising the costs to the Trust of opening some wards which have not been formally commissioned to cope with the additional volume of patients arising from delayed transfers of care; and
- contributing to the projected additional costs of complying with the implications of the 'Grogan' judgement on Continuing Healthcare where the extent of the likely additional costs is still being assessed.

1.8 The extent of delayed transfers of care varies between the five LHB/unitary authority areas in Gwent, with particularly high levels in Newport, Torfaen and Caerphilly. In Blaenau Gwent there has been a significant reduction and there have been historically low levels of delayed transfers of care in Monmouthshire. Figure 5 shows the breakdown of bed days occupied by residents of each of the five unitary authority/LHB areas who have become delayed transfers of care. Figure 5 shows the following key issues:

- particular problems with social care delays in Caerphilly and Torfaen;
- issues relating to patient/family/care reasons, including choice, in Newport;
- the average duration of each delayed transfer of care in Torfaen in 2006/2007 was by far the highest in Gwent, standing at 81 days;
- bed days lost for social care reasons have increased in Blaenau Gwent; and
- even though the number of people whose transfer of care was delayed in Monmouthshire is relatively low, there was a significant increase in the number of bed days occupied by delayed transfers of care between 2005/2006 and 2006/2007.

Measurement systems for delayed transfers understate the extent of the problem

1.9 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.

1.10 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 of care had been delayed and the length of the delay. The figures are subject to the joint validation by the Trust and local authorities: although LHBs in Gwent are invited to these validation meetings, they rarely attend. The census approach, which has operated for some years, by focusing more on the number of patients delayed on a particular day each month than on how long each has been delayed, has tended to mask the bed days occupied by delayed transfers of care. Between 2005/2006 and 2006/2007 the number of bed days lost within the Trust rose by 31 per cent whereas the corresponding increase in the number of patients affected was 12 per cent. The census approach can also encourage organisations to focus management attention on clearing delayed transfers of care as census day approaches rather than dealing with the causes across the whole system. The census approach also fails to identify delayed transfers of care that commence after one census date but end before the next.

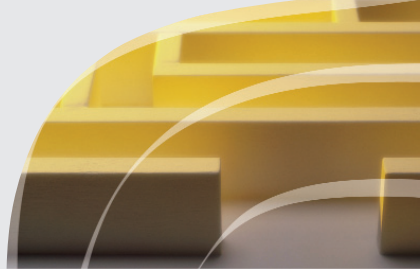


Figure 5: Days occupied by delayed transfers of care, number of patients affected and average duration of a delay by LHB and reason in 2005/2006 and 2006/2007

	Delayed days				Number of delayed patients				Average days delayed			
Reasons	2005/ 2006	2006/ 2007	Change	Percent change	2005/ 2006	2006/ 2007	Change	Percent change	2005/ 2006	2006/ 2007	Change	Percent Change
BLAENAU GWENT												
Healthcare reasons	277	236	-41	-14.8%	11	11	+0	+0.0%	25.2	21.5	-4	-14.7%
Patient/carer/family-related reasons	1,578	1,695	+117	+7.4%	40	39	-1	-2.5%	39.5	43.5	+4	+10.1%
Social Care reasons	472	641	+169	+35.8%	12	15	+3	+25.0%	39.3	42.7	+3	+8.7%
All reasons	**2,327**	**2,572**	**+245**	**+10.5%**	**63**	**65**	**+2**	**+3.2%**	**36.9**	**39.6**	**+3**	**+7.3%**
CAERPHILLY												
Healthcare reasons	1,821	742	-1,079	-59.3%	56	36	-20	-35.7%	32.5	20.6	-12	-36.6%
Patient/carer/family-related reasons	3,068	2,394	-674	-22.0%	67	49	-18	-26.9%	45.8	48.9	+3	+6.8%
Principal reason not agreed	62	0	-62	-100.0%	1	0	-1	-100.0%	62.0	0.0	-62	-100.0%
Social Care reasons	2,779	5,001	+2,222	+80.0%	76	141	+65	+85.5%	36.6	35.5	-1	-3.0%
All reasons	**7,730**	**8,137**	**+407**	**+5.3%**	**200**	**226**	**+26**	**+13.0%**	**38.7**	**36.0**	**-3**	**-7.0%**
MONMOUTHSHIRE												
Healthcare reasons	463	740	+277	+59.8%	16	24	+8	+50.0%	28.9	30.8	+2	+6.6%
Patient/carer/family-related reasons	1,196	2,509	+1,313	+109.8%	40	67	+27	+67.5%	29.9	37.4	+8	+25.1%
Principal reason not agreed	62	0	-62	-100.0%	1	0	-1	-100.0%	62.0	0.0	-62	-100.0%
Social Care reasons	894	1867	+973	+108.8%	27	39	+12	+44.4%	33.1	47.9	+15	+44.7%
All reasons	**2,615**	**5,116**	**+2,501**	**+95.6%**	**84**	**130**	**+46**	**+54.8%**	**31.1**	**39.4**	**+8**	**+26.7%**
NEWPORT												
Healthcare reasons	2,117	1,364	-753	-35.6%	43	30	-13	-30.2%	49.2	45.5	-4	-7.5%
Patient/carer/family-related reasons	7,467	9,352	+1,885	+25.2%	129	145	+16	+12.4%	57.9	64.5	+7	+11.4%
Social Care reasons	3,459	3,627	+168	+4.9%	88	69	-19	-21.6%	39.3	52.6	+13	+33.8%
All reasons	**13,043**	**14,343**	**+1,300**	**+10.0%**	**260**	**244**	**-16**	**-6.2%**	**50.2**	**58.8**	**+9**	**+17.1%**

	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
TORFAEN												
Healthcare reasons	982	2,021	+1,039	+105.8%	30	37	+7	+23.3%	32.7	54.6	+22	+67.0%
Patient/carer/family-related reasons	3,106	2,773	-333	-10.7%	59	30	-29	-49.2%	52.6	92.4	+40	+75.7%
Principal reason not agreed	138	220	+82	+59.4%	2	3	+1	+50.0%	69.0	73.3	+4	+6.2%
Social Care reasons	4,993	10,368	+5,375	+107.7%	81	120	+39	+48.1%	61.6	86.4	+25	+40.3%
All reasons	**9,219**	**15,382**	**+6,163**	**+66.9%**	**172**	**190**	**+18**	**+10.5%**	**53.6**	**81.0**	**+27**	**+51.1%**

Note
There were no delayed transfers of care where the principal reason was not agreed in Blaenau Gwent or Newport in 2005/2006 or 2006/2007.

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

Figure 6: Local agreements operate in Gwent which delay counting a patient as a delayed transfer of care after their consultant deems them fit for discharge

Unitary Authority	Codes	Local agreement before a patient is counted as a delayed transfers of care
Caerphilly	1.1, 2.3, 2.4, 2.5	If the assessment is commenced within seven days then the Council is given a further seven days to complete the assessment and make the necessary arrangements
Blaenau Gwent	1.1, 2.3, 2.4, 2.5	10 working days
Torfaen	1.1, 2.3, 2.4, 2.5, 3.9	15 working days
Newport	1.1, 2.2, 2.3, 2.4, 2.5, 2.6	seven working days
Monmouthshire	**No local agreement**	

Notes
Local agreements dated September 2004
Description of codes covered by local agreements
Code 1.1 Awaiting completion of community care assessment (beyond local agreement)
Code 2.2 Rehousing (local authority responsibility) sheltered or mainstream accommodation
Code 2.3 Awaiting start or re-start of home-based care package (beyond local agreement)
Code 2.4 Awaiting completion of residential care placement arrangements (beyond local agreement)
Code 2.5 Awaiting completion of nursing care placement arrangements (beyond local agreement)
Code 3.9 Awaiting completion of assessment for NHS-funded nursing care/continuing care

Source: Wales Audit Office

1.11 The Assembly Government has recognised the weaknesses of the census approach historically leading to a focus on the number of people delayed for the purposes of performance management and now sets additional targets covering the number of bed days occupied by delayed transfers of care for the Trust and LHBs.

1.12 The way the measurements are taken also understates the impact of delayed transfers of care. The four Gwent local authorities, other than Monmouthshire, operate 'local agreements' with the Trust which are intended to reflect the actual time it takes to arrange social services assessments and arrangements in each area. For certain types of delayed transfers of care, these local agreements add a delay of between seven and 15 working days before a patient, deemed medically fit for discharge by their consultant, is counted as a delayed transfer of care (Figure 6). Such vulnerable people lose further independence during this period of hospitalisation, which should be avoidable given the Trust's policy to set an estimated date of discharge for patients within 24 hours of admission (see Paragraph 2.40).

1.13 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 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 impacts on the patients affected

1.14 Notwithstanding the opportunity costs of delayed transfers of care to the health and social care system, the wider impacts are much greater. The primary impact falls on people who become delayed and can lose independence and function. They can be at far greater risk of readmission to hospital or no longer being able to live independently, which can lock vulnerable individuals into a vicious circle of dependence and reliance on acute hospital services. Of those that experienced a delayed transfer of care in the Trust at the time of our inpatient census, 88 per cent were over 65 years old.

1.15 The Trust, LHB and Council staff acknowledged the negative impact of becoming a delayed transfer of care, particularly:

- the loss of independence;
- reduced physical capabilities; and
- contribution to a loss of social and caring networks.

1.16 Patients who are delayed transfers of care within the Trust also tend to experience a number of movements from bed to bed within the Trust. Our survey of delayed transfers of care on 16 May showed that 46 per cent were admitted via accident and emergency, but only two per cent of bed days lost as a result of delayed transfers of care in 2006/2007

occupied acute beds. Patients who become delayed transfers of care tend to be moved from acute wards to a rehabilitation or community ward at least once and sometimes twice. Twenty-two of the 145 patients in our inpatient census arrived at the ward in which they were delayed on 16 May 2007 from another hospital within the Trust. Clinicians we spoke to considered that repeatedly moving vulnerable elderly patients was an unsettling experience for them. However, the Trust believed that such movements represented the most effective care pathway for those patients who may have been admitted to an acute bed but who no longer needed such a high level of care, and that this approach maintained acute capacity to admit other patients.

Part 2 - The impact of local examples of good practice has been compromised by the failure to tackle the whole systems problems of delayed transfers of care in a whole systems way across the Gwent health and social care community, resulting in a fragmented and confused pattern of services

Despite some examples of good practice, the current pattern of services does not promote as effectively as it should the independence of vulnerable people at each stage of the patient's care pathway

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

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 Trust staff acknowledged 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. A review of the management of chronic disease patients in Gwent reported in April 2007 that a significant proportion of patients are admitted for aspects of care that could be provided in the community[1]. Contributory factors to this over-reliance on the acute sector in managing chronic conditions and promoting people's independence 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 and fragmentation across Gwent; and
- the failure, as yet, to organise out-of-hospital services into an integrated network.

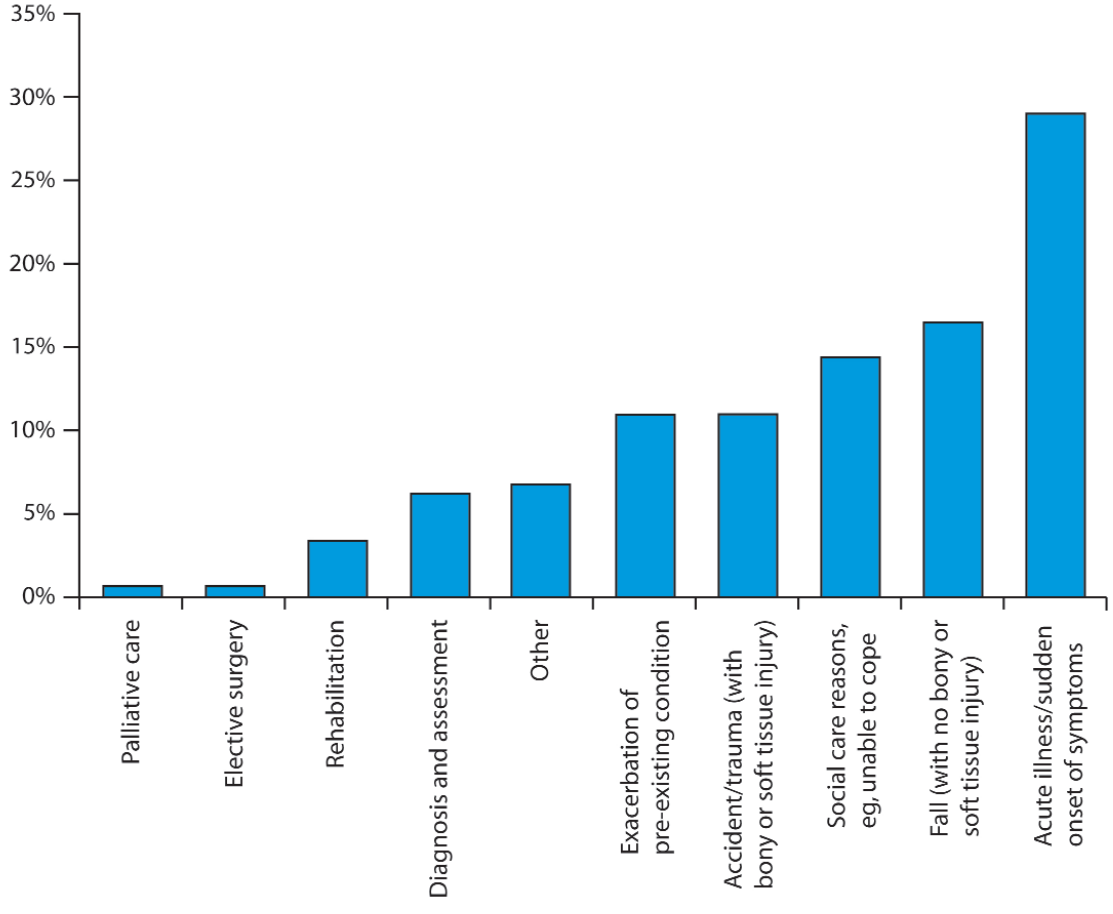
2.3 Our survey of inpatients who were delayed transfers of care in the Trust on 16 May 2007 suggested a culture where people who become a delayed transfer of care tend to lose independence. The Trust ward nursing staff and discharge liaison nurses completing our survey believed that 83 per cent of people who were a delayed transfer of care would be unable to return to their previous living arrangements, which in half of cases involved living alone. This may reflect a prevailing clinical culture which is predicated on

1 Wales Audit Office, 'Chronic Disease Management Review', Gwent Healthcare NHS Trust, April 2007.

institutional care for vulnerable elderly people, but may also reflect the likely care pathway for those who become a delayed transfer of care within the Trust. This clinical culture may also influence the care of other vulnerable older people who do not become delayed transfers of care.

2.4 Our inpatient census also asked nurses to state the primary cause of admission to hospital for patients who had become delayed transfers of care. Figure 7 provides a breakdown of the causes of admission and shows that 29 per cent of patients were admitted because of an acute illness or the sudden onset of symptoms. This is reflected by the fact that 48 per cent of delayed transfers of care were admitted via Accident and Emergency. In 17 per cent of cases, delayed transfers of care were admitted because of falls. Significantly, Figure 7 shows that nurses told us that in 14.5 per cent of cases delayed transfers of care were primarily admitted because of social care reasons, such as being unable to cope. There were 21 such cases, of which 17 were in Aberbargoed Hospital in Caerphilly. This once again suggests that some vulnerable people in need tend to go into hospital as a place of safety to meet social needs rather than for any specific

Figure 7: The main reasons for the admission of people who became delayed transfers of care in Trust beds



Source: Wales Audit Office inpatient census of delayed transfers of care in Gwent Healthcare NHS Trust, 16 May 2007

clinical interventions. With an average duration of a delayed transfer of care in 2006/2007 of 55 days, this can lead to a significant risk of loss of independence and function and, ultimately, heavier demand for care from the Welsh public service. It also reflects the long waits experienced by some people who need residential or nursing care.

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

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

2.6 For those people who face the prospect of not returning home after leaving hospital, the implications for them and their families are enormous. It is entirely reasonable for those people to make informed choices about their future. However, our analysis of social services case files showed that, in almost all cases of delayed transfers of care, the proposed service to which the patient would be transferred was some form of residential care. Although the case file analysis suggested that elements of good intermediate care existed across the community and that there are plans to develop further services, it was not clear from our analysis (which only covered those whose transfer of care was delayed) whether the intermediate care services that exist are part of the mainstream of options for vulnerable people.

Developing a more integrated range of services could reduce the fragmentation of the service model

2.7 There is an inconsistent approach to intermediate care services across the whole community which leads to a fragmented pattern of services and some evidence of duplication. The public, patients and staff within the Trust face a potentially confusing situation involving five different directories of intermediate care services, similar labels being attributed to different types of service (Appendix 4) and varied models and descriptions of services across the community. This problem is recognised within the community, and in Newport Council work has commenced to develop a common hierarchy of need and dependency in the community 'to maximise individual potential and minimise the progression to dependency'. If this emerging model proves effective, it may form the basis for developing a broader model across the whole Gwent community to provide a consistent framework for local service development.

2.8 Organisational boundaries have created variable service provision across the five Gwent localities in terms of intermediate care. This is driven by variations in commissioning structures, variation in funding and variation in local need. All five localities operate their own models of intermediate and community care services, and each has a number of schemes funded by so-called 'Wanless money', many of which are small scale and have not been evaluated, with staff involved in the schemes often providing anecdotal evidence of their concerns about value for money.

Case Study A: Intermediate care consultants

Wanless funds have been used to employ a Consultant Physician for Intermediate Care in Torfaen and a Consultant Geriatrician (Intermediate Care) in Newport.

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

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

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

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

Source: Wales Audit Office

The schemes are poorly linked with some duplication, for example similar services being provided in the same locality by both the Trust and LHB.

2.9 There are a number of intermediate care schemes which are being developed to support the strong focus on developing intermediate care services in some localities. For example, Torfaen has established an intermediate care consultant and jointly appointed intermediate care co-ordinator, while Newport LHB has also recruited an intermediate care consultant (see Case Study A) but these roles apply only to residents of the particular locality.

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

2.11 We also found that the failure to evaluate schemes and the nature of their initial funding (which often started out as short-term funding but was subsequently mainstreamed) means that many of the schemes are run in isolation and are poorly integrated. This problem is recognised in most parts of the community and steps are being taken to bring small-scale services together into a more integrated structure, for example:

- in Blaenau Gwent, the Rapid Response and Reablement teams have been co-located and jointly managed since 2005;
- in Newport, the Rapid Response, Reablement and Long Term Conditions teams are co-located with other services;
- in Torfaen, there are plans to co-locate the Advanced Clinical Assessment Team (Case Study E), Reablement and Long-Term Conditions teams;
- in Caerphilly, a community case management model is under consideration to help integrate a range of services by providing a single point of contact; and

Figure 8: Admissions have been reducing, especially in those aged 65 and over

	2003/2004	2004/2005	2005/2006	Change
Overall admission numbers	111,588	105,426	109,517	-1.86%
Emergency admission numbers	57,571	54,486	57,242	-0.57%
Emergency admissions in the 65+ age range	23,384	21,548	22,036	-5.76%

Source: Wales Audit Office, based on analysis of PEDW data

- in Monmouthshire there are two services provided through Section 33 agreements, where health and social care services are provided from a single location.

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

2.13 In common with other parts of Wales, we found little evaluation of the intermediate care schemes that exist in Gwent. The lack of evaluation has resulted in a situation where effective models or services have rarely extended beyond borough boundaries. Generally this means that the cost of services is higher, and learning has not been shared sufficiently at a pan-Gwent level to develop a common understanding of intermediate care services and to integrate the range of local schemes with community services provided by the Trust.

At each stage of the patient's pathway through the whole system, there is scope to promote more effectively the independence of vulnerable people

Local Health Boards can do more to commission alternatives to hospital admission and engage GPs more effectively in promoting the independence of vulnerable people

2.14 Focusing solely on resolving 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 and to ensure that patients 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.

2.15 Within the Trust, there has been an overall downward trend in the rates of emergency admissions for the over 65s between April 2003 and March 2006 although the trend was of a slight increase between 2004/2005 and 2005/2006 (Figure 8). Overall, emergency admissions have remained stable. This suggests that major changes in demand alone, measured through admissions of older

people, may not explain the incidence of delayed transfers of care. However, this analysis does not capture changes in the complexity of the case mix or the availability of alternative services to avoid admission.

2.16 Nevertheless, our survey of inpatients also suggested that the whole system of health and social care in Gwent was not effective in promoting independence – nurses told us that in 15 per cent of cases the main reason for admission was a social reason such as an inability to cope. We found that there were generally insufficient intermediate care services seeking to provide intensive and targeted care for people, to prevent the need for hospital admission, or to rehabilitate or reable them to support their discharge from hospital. In addition, there has been a long-term trend whereby increasing resources have been directed at a smaller number of people with the most complex needs, which in some areas may have squeezed out resources for more preventative services such as intermediate care.

2.17 We identified an ongoing need to provide more effective alternative services to prevent people from needing to be admitted to an acute hospital bed, primarily through the development of more effective care pathways that involve primary care, social care and community-based secondary care services. Preventing the admission of older people to hospital can significantly improve their independence. Case Study B provides an example of a voluntary sector scheme which has been able to prevent admissions to hospital for people in Newport for seven years, but which is available only to residents of Newport.

Case Study B: The Prevention of Admission to Hospital Scheme in Newport

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

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

Source: Maine Stream Report, PATH: a report on the service in Newport, October 2006, and the Wales Audit Office

2.18 The Trust and its commissioning partners have also sought to prevent admissions to hospital for patients with mental health needs. Case Study C explains a number of steps taken within the Trust's mental health services which aim to reduce unnecessary admissions to hospital. These services need to expand their out-of-hours coverage as between 40 and 50 per cent of mental health admissions take place out-of-hours.

Case Study C: Partners have sought to reduce unnecessary mental health admissions to the Trust

Schemes seeking to avoid unnecessary mental health admissions within the Trust include:

- First Access Service in Torfaen (FAST) – This service involves a dedicated team that sees all new mental health referrals to the Trust. The team has forged close links with primary care and is able to respond rapidly to carry out assessments and to intervene where necessary for patients who have mild to moderate health needs. The service aims to provide prompt and holistic assessments as well as providing options for treatment, improving communication between primary and secondary care, and the voluntary sector, signposting services and providing training to GP practices, the voluntary sector and other professionals on mental health issues. The team consists of a team manager, secretary, mental health nurses, clinical psychologist and social worker. The Trust claims the service is proving successful in preventing unnecessary admissions and also in reducing the length of stay for patients that have been admitted to hospital.
- Crisis Resolution Team – A crisis resolution team has been developed in the Trust initially commissioned by Newport LHB. The Trust's team is available out-of-hours and aims to provide rapid risk assessments in psychiatric emergencies for adults with mental health problems. The team offers community-based, rather than hospital-based interventions, to avoid unnecessary admissions. It also provides support and advice to carers, together with facilitating discharge from hospital by helping to prepare the patient. The team also helps to make arrangements in preparation for discharge. The team consists of psychiatric nurses, support assistant, social worker and psychologist. Provision of this service varies between Gwent's boroughs.
- Assertive Outreach Team – This service specifically targets 'revolving door' patients, patients who have severe and persistent mental illness, who have been difficult to engage with the traditional community services and who have had repeated periods of hospitalisation. The team's objective is to maintain the patient within the community through home-based assessment and treatment including symptom management, cognitive behaviour therapy and psychosocial interventions. The team consists of nurses, support workers, an occupational therapist, social worker and secretary. Staff have a small case load and are therefore able to spend significant periods of time with each patient. The Trust claims to be seeing early indications of success in the Assertive Outreach Team with a reduction in admissions from these patients, reduced length of stay for patients that require admission, a reduced number of formal detentions and improved quality of life indicators. This service is available in Torfaen, Newport and in Caerphilly, but not elsewhere in Gwent.

Source: Wales Audit Office fieldwork interviews

2.19 There is scope to improve the contribution of primary care practitioners in supporting patients in the community and making targeted interventions to prevent avoidable admissions to hospital. The importance of the role of GPs was a central finding of our focus group in Gwent, where participants identified it as the equal second most significant and difficult barrier to address to tackle the causes of delayed transfers of care. Among the suggestions made at the focus group to improve the position was the idea of including delayed transfers of care as part of GP training, and also to establish a GP with a special interest to champion issues relating to delayed transfers of care.

2.20 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. We found that the engagement of GPs has been inconsistent, with GPs often unaware that their patients have become delayed transfers of care and a perception that some GPs have a narrow view of the needs of their patients, and a consequent tendency to refer them to hospital-based services. Local Health Boards generally have not done enough to encourage GPs to make use of a wider range of services to support vulnerable people in the community, especially intermediate care services.

General Practitioner referral to intermediate care services appears mixed, as a result of poor awareness of services, insufficient marketing and feedback on services from LHBs, and the lack of a single point of contact for intermediate care services. Some GPs have very useful knowledge and ideas about how to improve the system and quality of care but are not engaged sufficiently in the processes that facilitate this.

2.21 General Practitioners are required by the new General Medical Services contract to maintain information about their patients, particularly disease registers. However, GPs generally do not know when one of their patients becomes a delayed transfer of care and have not routinely received information from LHBs or the Trust about patients who have been frequently admitted for the same condition. It is encouraging that the Trust has recently started to supply LHBs with information, which has been passed onto GPs, about those patients who had been frequently admitted to its acute sites. We met one GP in Gwent who had put this information onto his electronic notes in order to identify these patients and facilitate more proactive intervention to support their independence and avoid admission to hospital.

2.22 Some LHBs have done good work in tackling emergency admissions at GP practice level but our overall finding is that LHBs can do much more to integrate primary care services within the whole system, particularly by improving their knowledge of intermediate care services and awareness of the most appropriate care pathways for their patients. Case Study D describes the work of one LHB in tackling emergency admissions at practice level.

Case Study D: Tackling emergency admissions at practice level in Caerphilly

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

Source: Wales Audit Office fieldwork interviews

2.23 Torfaen LHB has also set up a team in which nurses target nursing homes to minimise admissions to hospital from nursing homes. Case Study E describes the work undertaken by the Advanced Clinical Assessment Team (ACAT).

Assessment processes need to improve significantly

2.24 We found that assessment processes need to improve significantly, particularly issues arising from the introduction of unified assessment, which was intended to deliver multi-disciplinary assessments of patients' needs. Our focus group identified 'unified assessment not being effective' as the most significant and difficult barrier to address.

Case Study E: Advanced Clinical Assessment Team

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

Contact telephone numbers have been rationalised within the Trust so all referrals to ACAT are to a single number.

Upon referral, a nurse will visit the patient to take a full history and carry out an extensive examination.

Diagnostic tests, including blood and oxygen tests and an electrocardiogram (ECG), are carried out immediately at the patient's home. The results take a number of hours to come through and this time is used by the nurse to make contact with social services or the reablement team if required. If an X-ray is required, the team has an arrangement with the Radiology Department at County Hospital where ACAT patients are given priority. The team also has close working relationships with the Welsh Ambulance Services NHS Trust so there is rapid access to transport when needed.

Clinical governance is provided through the Consultant Physician and a specialist Intermediate Care Registrar.

Advanced Clinical Assessment Team nurses are urged to ask their advice if they have any doubts about a patient and the clinicians are available to visit patients in the community or to see patients at regular hot clinics.

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

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

Source: Wales Audit Office fieldwork interviews

2.25 One reason for this, is the variations in the forms used for unified assessment in the five unitary authority areas in Gwent, with Caerphilly County Borough Council using a different form to other parts of Gwent. This has led to a lack of clarity within the Royal Gwent Hospital both about who should complete the form but also about which form should be used for which patient's assessment. Moreover, documentation started in one of the five boroughs may not be compatible with documentation in use in the area to which the patient is transferred. Throughout Gwent we heard that the unified assessment process had been intended to be supported by an electronic system but was still being run on paper, with very long forms (some 40 pages long) that had to be faxed to other members of the multi-disciplinary team.

2.26 Because the unified assessment process requires the involvement of a number of staff from various organisations, the duration of the assessments can be long and linear, and can take place after the patient is ready for discharge because of the time it takes to involve all members of the multi-disciplinary team. It can take up to two weeks for all assessments to be completed after the Multi-disciplinary Team has decided the patient is medically fit for discharge. Case Study F reflects the impact of delays in carrying out assessments.

2.27 The availability, knowledge and training of staff can also compromise the assessment process. Staff at operational level within the Trust are insufficiently trained to manage patients who become delayed transfers of care, especially bank and agency nurses who may not be familiar with the different care pathways and models of intermediate care services within the community. There is considerable scope to improve ward staff knowledge of intermediate care and community-based options available to patients. The problems for ward staff are exacerbated by the variability of social workers' presence on the ward, which impedes effective multi-disciplinary assessment and management of patient flow.

The process of determining eligibility for Continuing Healthcare is a serious barrier to developing patient pathways on a whole systems basis

2.28 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 which does not place the patient at the centre of care, and encourages organisations to seek to protect their budgets and position. Our case file review showed examples of assessments involving both health and social care with one partner effectively avoiding responsibility for progress until the case returned to them across the 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 role of the Practice Development Nurse system in Caerphilly in supporting nursing homes providing funded nursing care (Case Study P).

2.29 Determining eligibility for Continuing Healthcare in a consistent way is a significant challenge in all areas of Gwent, 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 working in health and social services assessments. There is an inconsistent approach within Gwent and significant variation in expenditure on Continuing Healthcare per 1,000 head of population aged 65 or over (Figure 9).

Case Study F: Delays in carrying out assessments

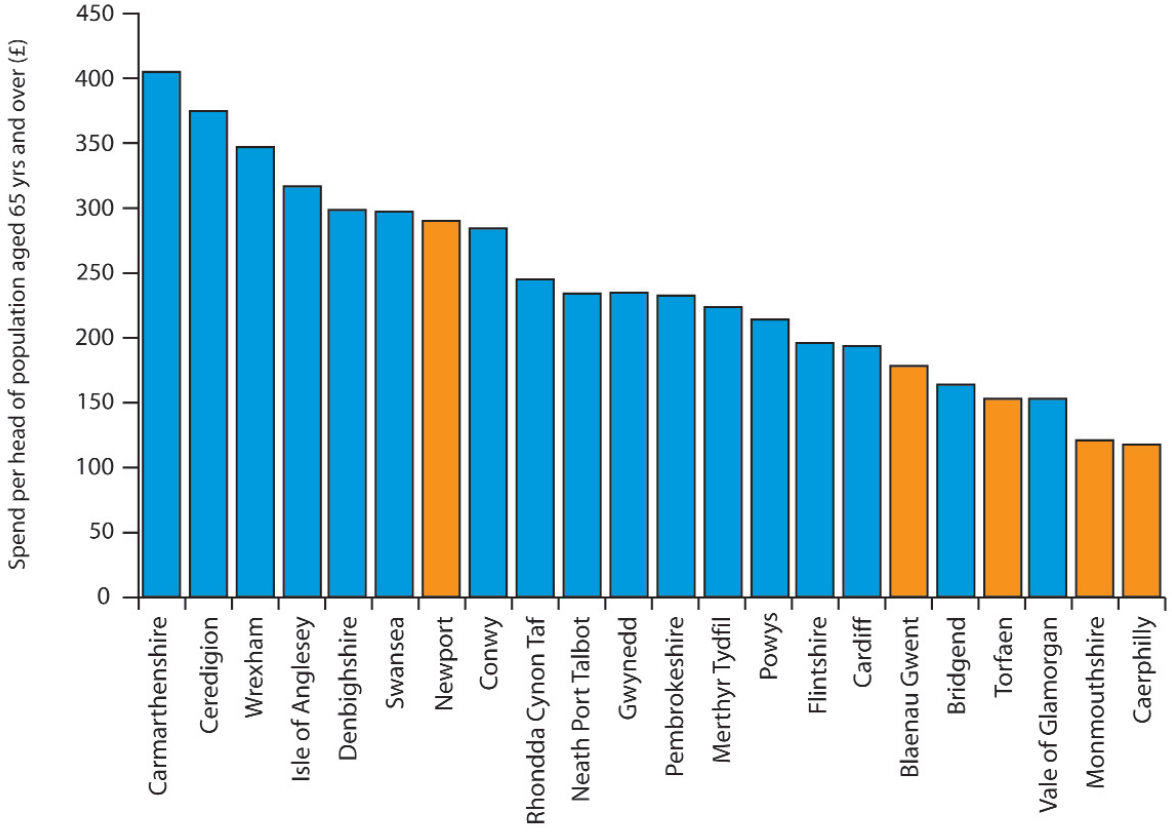
Mrs Z from the Gwent region was admitted to hospital with a urinary tract infection in January 2007. She had been diagnosed with dementia prior to admission and lived with her daughter who acted as her main carer. She was described as needing 24-hour supervision, being dependent on others to meet personal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

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

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

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

Figure 9: Gwent LHBs' accounts show variable expenditure on Continuing Healthcare per head of population over 65 although most have below average expenditure across Wales



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

The variation in expenditure may reflect variable provision of Continuing Healthcare beds within NHS trusts as part of their Long Term Agreement with commissioners. Recognising the inconsistent approach to Continuing Healthcare, the Trust has employed a continuing care co-ordinator to standardise processes on a pan-Gwent basis, for example by standardising forms. 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.

2.30 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 'overarching test' to determine whether the patient's primary need was for health care. 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. 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. In Gwent, the five LHBs initially estimated the financial cost associated with compliance with the 'Grogan' judgement as £31 million, which appear to have been based on a worst-case scenario and whose accuracy we have not assessed.

2.31 Disputes between LHBs and social services over assessing patients' eligibility for Continuing Healthcare are common. In one third of delayed transfers of care case files reviewed in social services, we found that delays associated with Continuing Healthcare were an issue in the case. The delayed transfers of care census figures suggest there has been a sharp increase in delayed transfers of care relating to Continuing Healthcare assessment, review and disputes between April and July 2007 in Gwent.

2.32 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. The case files suggested that their conditions deteriorated the longer they were 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 G provides an example of a case in Gwent where there was a delay arising from a dispute about Continuing Healthcare funding eligibility.

Case Study G: A delayed transfer arising from disputed eligibility for Continuing Healthcare

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

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

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

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

2.33 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, most of whom have contributed much to their communities, families and economy over many years. It is entirely reasonable for those people to expect to be helped to make informed choices about

the future. In some of the cases examined in the sample, the length of time taken to secure alternative arrangements for an individual is quite understandable, given the need to move at a pace that allows for the expression of choice and the appropriate involvement of relatives and carers. However, delayed transfers of care for choice reasons remain a significant problem in Gwent, with 42 per cent of bed days occupied by delayed transfers of care in 2006/2007 relating to codes covering a range of issues relating to financial and legal disputes and choice of home.
Often such delays relate to people who are moving from free healthcare to means tested social care services. There are disincentives to discharge both for users and councils who may have to pay for all or part of the services the person will receive if they are not eligible for Continuing Healthcare or funded nursing care.

2.34 In Gwent, there are inconsistent approaches to the management of patients' right of choice, particularly relating to transfers to residential care. Choice policies vary between the five authorities and are not consistently implemented. Families and carers also need support about what the right of choice really means, and to provide reassurance that moving out of the hospital environment is better for the patient's safety and wellbeing than remaining in the hospital bed. It is very difficult to operate an effective choice policy in the absence of spare capacity: for example in Newport homes often have no vacancies which can make it easy for patients and their carers to choose three homes without vacancies, or a need to move out of county which can be detrimental to the person and their carers.

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

2.36 The implications on delayed transfers of care of the implementation of the Mental Capacity Act in October 2007 are unknown. The Act regulates the management of decisions taken on behalf of people without the mental capacity to make their own decisions. It applies to patients with dementia, learning difficulties, brain injuries or disturbance (temporary or permanent) and severe mental illness and covers decisions, such as the choice of care home for patients who do not have capacity. The Act also provides the strongest guidance yet that carers should be included in decisions, although its emphasis on ensuring that wherever possible users and patients take their own decisions could increase delays or disputes about a person's capacity and the best option for their care.

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

2.37 We found that there were process weaknesses once patients are admitted to a hospital bed in Gwent, with the following symptoms of the system doing too little to 'pull' patients out of the hospital setting:

- care packages are sometimes temporarily stopped or frozen when patients are admitted to hospital, but delays can arise from the time it can take to restart or develop an entirely new Care Plan when the patient is discharged, with delays of this nature a significant cause of delayed transfers of care in Torfaen;
- elderly patients generally follow a pathway that moves them rapidly from acute to community beds with very long lengths of stay, with arrangements for rehabilitation only considered when the person arrives at a community bed rather than when they are admitted to hospital;
- complex delayed transfers of care may be placed in a 'holding' location such as Tredegar Ward at St Woolos Hospital, where there is little medical input; and
- utilisation of rehabilitation beds is poor, with the average duration of a delayed transfer of care in a rehabilitation bed some 46 days in 2006/2007. In addition to the length of stay the patient experiences before becoming a delayed transfer of care, this is well above any typical period of rehabilitation (usually up to six weeks) and affects the Trust's ability to rehabilitate other patients.

2.38 There are variable processes within the Trust itself. Particular wards, such as the stroke rehabilitation ward at Nevill Hall Hospital, have a strong culture where all staff work towards promoting independence while others, particularly at the Royal Gwent Hospital, have a culture that relies heavily on discharge liaison nurses to ensure arrangements are made for appropriate discharge. Case Study H provides an example of good practice in preparing patients for discharge on the stroke rehabilitation ward at Nevill Hall. However, this is an isolated example of the system effectively 'pulling' patients through to discharge.

Improving discharge planning and management could improve patient flow

2.39 There is a Trust-wide Discharge Policy and a Trust-wide policy for the management of delayed transfers of care. However, 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 a prevailing culture in some areas that being in hospital was good for the patient. There was a further perceived cultural barrier within the Trust whereby not all hospital staff were seen to 'trust' community schemes to meet the needs of patients.

2.40 While the Trust's policy is to estimate a patient's discharge date within 24 hours of admission (see Paragraph 1.12), there is evidence that there is inconsistency across the Trust in setting estimated dates of discharge, particularly in adding the information onto the Trust's Patient Administration System. There are also some problems with the quality of the data arising from the fact that the Patient Administration System will not allow staff to enter an actual discharge date which is later than the earlier entry for the estimated date of discharge. The Stroke Ward at Nevill Hall Hospital (Case Study H) plans discharge effectively and tracks patients through their stay setting measurable objectives. However, estimated dates of discharge are set less consistently where patients are moved from acute to community hospitals and rehabilitation wards. Patients are given a notional discharge date on admission to hospital but a new estimated date of discharge is given once they move to a community hospital/rehabilitation ward. At St Woolos Hospital the estimated date of discharge is usually set by the multi-disciplinary team between two and six weeks after admission depending on the patient's medical condition.

2.41 In addition, we found that the role of discharge specialists, such as discharge liaison nurses and nurse case managers, varied within the Trust (Case Study I). There was also variation in the reliance of ward staff on discharge specialists with insufficient accountability for discharge on the wards. The Trust is seeking to resolve this through an ongoing Lean Efficiencies Project, of which one aim is to improve accountability for discharge management.

2.42 Figure 3 showed that the proportion of delayed transfers of care while people waited for social care assessments increased between May 2006 and May 2007. There

Case Study H: Stroke rehabilitation ward, Nevill Hall Hospital

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

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

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

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

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

Source: Wales Audit Office fieldwork interviews

have been particular problems with increasing delays arising for social care assessments in Caerphilly where 25, 11 and 12 people experienced delayed transfers of care because they were waiting for social care assessments in March, April and May 2007 respectively. The Trust policy requires staff to set an estimated date of discharge for patients when they are admitted, which could be used to set an appropriate date for the assessment with social workers and other members of the Multi-disciplinary Team to avoid unnecessary delays waiting for an assessment whose timing should be predictable from the estimated date of discharge.

The existing system could be managed more effectively to promote the independence of vulnerable people

Despite joint working to resolve delayed transfers of care at locality level, there is scope to improve the operational management of delayed transfers of care particularly by working more effectively at a pan-Gwent level

2.43 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. In Gwent, we found some evidence of effective partnership working in all individual

Case Study I: The role of discharge specialists varies widely across Gwent

The remit and organisation of specialist discharge services varies widely between boroughs in Gwent:

- Monmouthshire – there are two teams of discharge liaison co-ordinators each having one nurse employed by the Trust and one social worker employed by the Council. Nurses can access social services funding and resources and are community-based. The aim is to get people out of hospital as effectively as possible, although the service has recently become more reactive rather than proactive.
- Caerphilly – Nurse case managers are employed by the Trust and the scheme is partly Wanless-funded. Current financial pressures within social services have prompted changes to the way in which case managers work, but until relatively recently, they have been given direct access to social services funding to commission packages of social care. With no hospital-based social workers in Caerphilly, the case managers carry out social care assessments.
- Blaenau Gwent – The Discharge Liaison Nurse Service has been discontinued due to the removal of LHB funding following an LHB review of the service. The nurses were moved into other roles such as district nursing and work within community hospitals which the Trust told us had proved effective in improving ward to ward pathways and liaison between senior nurses.
- Newport – Discharge liaison nurses are relied upon heavily by ward staff to deal with the vast majority of complex discharges. They also lead Continuing Healthcare assessments and applications but do not have access to social services funding to commission packages of care and cannot make decisions about social care. They contribute to multi-disciplinary team discussions and agreement about Continuing Healthcare eligibility.
- Torfaen – Discharge liaison nurses are currently based at County Hospital but there are plans to move them to the Royal Gwent Hospital. The aim will be for the discharge liaison nurses to see all Torfaen patients in Accident and Emergency and the Medical Admissions Unit. They will carry out assessments and intervene early to assist patients' swift return home. Operational managers at County Hospital will take over the liaison nurses' responsibilities for facilitating discharge.

Source: Wales Audit Office fieldwork interviews

Case Study J: The personal involvement of senior executives in resolving individual cases is an important factor in tackling the problem

Gwent Healthcare NHS Trust's Chief Executive held regular delayed transfers of care meetings until the Trust's reorganisation in 2007. At these meetings, he would hold ward managers to account for individual cases and challenge them about the actions they were taking to expedite the patient's transfer of care. The meetings were regarded as helpful in reinforcing the Trust's responsibilities in reducing health-related delayed transfers of care, as well as enabling the Chief Executive to contact LHB and Local Authority colleagues to address actions that fell to them.

Blaenau Gwent was experiencing significant delayed transfers of care in late 2002 when the LHB was in shadow form – at any one time there were 50-60 delayed transfers of care and two local hospitals provided slow-stream rehabilitation and were generally full of delayed transfers of care. Social Services saw it as a Trust problem of patient management whereas the Trust said that the local authority was not providing sufficient funding. Several delayed transfers of care had lasted for over two years, two of whom were amputees who needed rehousing to flats. Nobody owned the problem and there was no mechanism for discussion. The shadow LHB set up regular meetings with the Trust and local authority but the initial meetings were difficult with little dialogue.

In late 2003 the Assembly Government provided money to address delayed transfers of care but this was used to spot purchase additional places and so had little sustainable impact. The LHB then arranged training with the University of Glamorgan for 300 Health and Social Care staff on assessment. This did not include doctors and the staff did not like it because they were not used to working together. By the end of the training, health and social care staff were starting to work together which had not previously been the case, and this was the start of a two-year process of cultural change.

The LHB Director of Nursing found that the Trust was transferring patients from acute to community hospitals rather than discharging them home with support from community services which were available. This extended hospitalisation served simply to increase patients' dependency. Social Services said that they funded a large number of patients but the data suggested that Social Services had stopped funding places because of its cost pressures. Funding arrangements had not been maintained and there were problems in the independent sector where many of the beds in nursing homes were empty because patients were in community hospitals.

After a critical joint review of social services, a new interim director was appointed. There was a real cultural need for high level sign-up to addressing the delayed transfers of care problem, which was forthcoming from the LHB, local authority and Trust Chief Executives, all of whom met on several occasions. This group is still in place as part of the escalation procedure and it has great impact by addressing problems straight away. The overall approach was to get underneath the problem and manage individual patients while seeking to address the causes of delayed transfers of care.

The structure that helped to deliver the change was at three levels:

- regular high level Chief Executive meetings;
- a monthly Management Group, which no longer meets, involved the Head of Housing; and
- a weekly patient group which a housing officer attends.

Delayed transfers of care have generally remained much lower in Blaenau Gwent after this initial management effort to address the problem but there remain longer-term challenges, particularly the reliance on high cost packages in nursing and residential homes and a need to move the focus to promoting independence by providing alternatives to hospital admission and improving discharge options.

Source: Wales Audit Office

LHB/unitary authority areas but significant barriers to delivering effective partnership working across the whole Gwent health and social care community.

2.44 Within the Trust, patient flow meetings take place in all five localities, typically held weekly on a multi-agency basis at ward level. In some localities there have been reductions in delayed transfers of care through the resolution of individual cases by multi-agency groups of senior executives. Case Study J gives examples of effective personal involvement of senior executives in resolving individual cases of delayed transfers of care. Generally, such an approach has been effective not only because the senior executives are consistently able to progress individual cases, but also because the executives develop a better understanding of the constraints within the system which cause delayed transfers of care.

2.45 Despite the evidence of effective actions being taken to manage the problem at the level of the five localities, at a pan-Gwent level we identified the need for more effective strategic and operational partnership working.

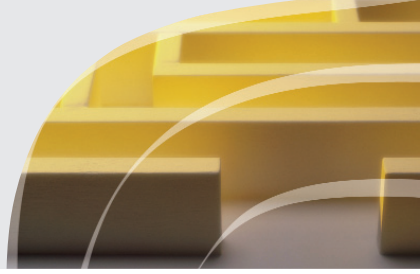
Commissioning could be improved to better promote the independence of vulnerable people by improving information and reducing commissioners' reliance on spot purchasing

2.46 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 five LHBs and five unitary authorities, remains under-developed and compromised by a lack of information and a reliance on spot purchasing. Delayed transfers of care are an indicator that commissioners have not secured the right services in the right place at the right time to meet the needs of their resident populations.

2.47 Assessing the needs of the resident population, to the level of individual GP practice population, is the foundation of effective commissioning. The whole system of health and social care is not working as effectively as it should be in Gwent, reflecting inadequacies in needs assessment and the development of commissioning strategies to meet those needs. Participants at our focus group highlighted problems in:

- identifying unmet needs to inform the development of commissioning approaches; and
- a failure to undertake effective capacity planning across the whole system.

2.48 Effective commissioning is further compromised by the lack of financial and service information about services, particularly intermediate care service. Many schemes in Gwent were set up by LHBs using additional money provided by the Assembly Government to meet the so-called 'Wanless' agenda, which led to disparate schemes which were set up quickly to address perceived problems with the operation of the whole system in accordance with local strategies. These tended to be localised solutions to address symptoms rather than integrated steps across the whole community to develop an effective whole system according to a clear and shared vision of what services should look like. We found that financial and service information about such services was weak, which meant that there had been little effective evaluation which included financial elements. Consequently effective schemes



had not been transferred beyond borough boundaries, while schemes that had not been cost-effective had often continued to operate. In Gwent, partners are working with NLIAH to pilot an evaluation tool to address weaknesses in evaluation.

2.49 There is little evidence that commissioning is related to outcomes and quality, with the current focus, especially for community services, on financial inputs. For example, Newport LHB told us that it wants to develop outcome-based commissioning based on quality of life indicators but felt that the available data did not permit this. For example, information about individual patients records a single cause of admission, when there may well be co-morbidities (other conditions) which contribute to considerable delays for inpatient assessment and which are directly relevant to needs assessment, commissioning and the development of service models.

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

2.51 The strategic direction in Gwent, encapsulated by 'Clinical Futures', is to shift resources from acute settings into the community. This should reduce demand on the acute sector, manifested in part by delayed transfers of care, and provide more appropriate preventative services to reduce admission to hospital. One reason why it is difficult to secure the community-based services LHBs want, is that the Long Term Agreements it has with the Trust for community services are not specific about the type and volume of services to be provided. This makes it difficult to monitor performance and also compromises LHBs' ability to demonstrate the potential impact of new models of service by moving resources from community hospitals into new community services.

2.52 Notwithstanding the absence of specific quantities within long-term agreements, even when hospital services have been decommissioned, LHBs have not always been able to transfer resources fully from hospital settings to new community-based services. There are some difficulties for commissioners in reinvesting funds currently invested in the acute sector. These arise partly from the fact that there is one Trust and five health commissioners, which makes it difficult in all cases to develop, where appropriate, a strategic pan-Gwent approach to service development to improve quality and deliver economies of scale, as well as developing services for specific localities where this is more appropriate. The number of commissioning bodies can also stretch the Trust's capacity to deal with individual commissioners. The LHBs are much smaller organisations than the Trust and so can experience problems in negotiation, while the Trust tends to regard the funding provided by

commissioners as its own. There are also problems in generating significant savings which tend to arise from the closure of an entire hospital rather than decommissioning some beds within a hospital. Therefore, when a service is decommissioned, the Trust generally believes it can reinvest the savings to address the opportunity costs of previously inefficient service provision. Case Study K shows how one LHB shared resource savings arising from the closure of a community hospital with the Trust.

Case Study K: Using savings arising from reductions in community hospital capacity in Blaenau Gwent

The significantly reduced level of delayed transfers of care in Blaenau Gwent enabled the LHB to de-commission community hospital beds at Ebbw Vale Hospital which closed two years ago in 2005, significantly earlier than the planned closure date of 2009/2010. The LHB closed a further 10 beds in Abertillery Hospital in March 2007 because of better patient management. The Abertillery bed closures released £106,000 in savings which have been shared equally between the LHB and the Trust, with £53,000 available to the LHB to manage cost pressures resulting from existing investment in community services, but only until the new local general hospital opens in Blaenau Gwent under the 'Clinical Futures' plans at which point the savings will transfer to revenue costs.

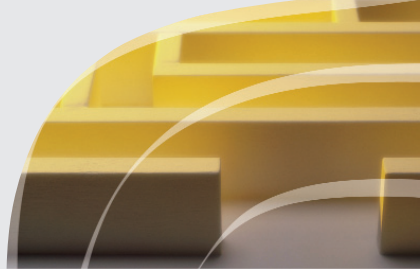
Source: Wales Audit Office

2.53 Local authority commissioners tend to rely on spot purchasing of care home capacity which increases costs and uncertainty of supply, partly because of a fear of paying for capacity which may not be utilised. Many home owners are reluctant to enter into block contracts as this reduces the chances of the local authority paying a rate above their standard fee, and because it enables them to protect placements for self-funders who pay higher fees. Variable fee levels between the local authorities in Gwent can lead to out-of-county placements when owners sell places to the local authority which will pay the highest rate.

2.54 Throughout Gwent, delayed transfers of care often arise as a result of care home places being unavailable, or through a lack of funding for them. In the last 12 months, a lack of funding for nursing or residential home placements has been a particular driver of the incidence of delayed transfers of care in Caerphilly and Torfaen. In Newport, the lack of availability of a suitable residential or nursing care placement has been the main cause of delayed transfers of care between May 2006 and May 2007.

2.55 Some areas in Gwent face potentially significant loss of independent sector capacity as some homes do not meet the required standards and this may result in possible closures as well as owners opting to leave the care home market.

2.56 Commissioning of care home capacity is not as well informed about quality as it should be – we found that those working within the whole system, whether in health, social care or the voluntary sector, had knowledge of concerns about the quality of care offered by particular homes. Where information was not passed on in respect of the Protection of Vulnerable Adults regulations, more general intelligence about perceived or actual shortfalls in the quality of care, which contributed to delayed transfers of care arising from choice, were not consistently fed back to local authority and LHB commissioning teams, nor to CSSIW, to inform future commissioning and inspection. Caerphilly LHB has appointed two nurses to



support care homes in improving quality in line with the Assembly Government's guidance, 'Fundamentals of Care', although it is too soon to assess their impact. And in Newport the LHB and Council have introduced a system of joint working to assess, monitor and report in a standardised way about quality issues in nursing homes. It has also established a matrons' forum to facilitate the sharing of best practice across homes and the development of a targeted training programme to address skills and knowledge gaps in a consistent fashion.

2.57 The Assembly Government's Clinical Governance Support and Development Unit undertook a survey in July 2006 about commissioning of care home services providing NHS-funded Continuing Healthcare or funded nursing care and the clinical governance implications of concerns about service quality[2]. This report identified inconsistent contracting relationships, style of contract documentation and level of joint working between local authorities and LHBs. It also highlighted the fact that many contracts and service specifications were not based on explicit standards. The review suggested the development of core standards-based service specifications for care homes covering both health and social care, better information sharing and clearer arrangements for contract monitoring and escalation procedures. The review also highlighted joint approaches being developed within Gwent, where Torfaen LHB operates as an agent for the other four Gwent LHBs in developing a single contract with each nursing home in the area whether the individual is self-funding or funded jointly with the local authority.

2.58 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.

2.59 Case Study B provided an example of a larger scheme commissioned from the voluntary sector in Newport. There are other examples of smaller schemes in Gwent that have contributed to the independence of vulnerable older people. For example, the Red Cross loans a wide range of non-electrical equipment to people in Gwent. The Red Cross estimates that the earlier discharge from hospital assisted by their equipment would have saved £94,000 in Gwent.

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

2.61 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, although commissioning has a significant lead time such that extra care schemes offer a medium-term solution.

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

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

Newport City Council has adopted a strategy of reducing residential homes and increasing extra care housing, of which it has four units of 40 beds and another due to open. It has offered 'extra care' at Aneurin Bevan Court since 1986, developed two further schemes managed with Housing Associations and a new scheme, Capel Court, is due to open in summer 2007 which will include provision for people with dementia. Our review has not established the impact these schemes are having on delayed transfers of care and maintaining independence and this may be a focus for further work.

Source: Wales Audit Office

In Newport, a form of extra care housing has been available for many years (Case Study L). The Assembly Government invited local authorities to bid for grants to develop extra care housing provision in 2006/2007 and a number of schemes are now progressing within Gwent, including a scheme in Torfaen which is due to open in late 2007.

Case Study M: Progress with joint commissioning in Gwent

Monmouthshire – The County Council and LHB have developed a joint commissioning structure with a jointly appointed individual acting as LHB Director of Commissioning and Head of Commissioning in the local authority's Social Services Department. There are joint reports on commissioning issues, and there has been an EMI demand review which led to the production of capacity and demand data for independent care home owners with a view to encouraging further investment in capacity. The joint commissioning structure involves the use of a care package broker who liaises with the hospital discharge social worker and care providers in the area to secure the most appropriate placement or service for people being discharged from hospital. The brokerage system has been operational for just under two years. Seventy per cent of domiciliary care placements are referred from hospital discharge. The scheme has been extremely successful making satisfactory placements in over 85 per cent of cases within the planned timescale (mostly same day).

Torfaen – There is a joint post of Head of Integrated Services (Torfaen County Borough Council) and Director of Planning and Commissioning (Torfaen LHB) and there is a planned appointment to a joint post of Intermediate Care Manager. The LHB and local authority are jointly developing an Intermediate Care Strategy and, through an Intermediate Care Co-ordinator employed by the LHB with 'Wanless' funding, and an Intermediate Care Steering Group and Operational Group.

Newport – Although there has not been a tradition of close partnership working between the local authority and LHB on commissioning or wider issues, officers told us that there was an increasing willingness to work together, particularly at a strategic level. For example, in the context of the Health, Social Care and Wellbeing Strategy the partners signed in May 2007 a memorandum of understanding to move the planning, commissioning and delivery of community-based health and social care services together. This improved strategic partnership will need to be translated to operational staff to lead to better commissioning and more effective whole systems working. We are aware that newly appointed senior managers are developing plans which aim to engage operational staff in delivering improved and better co-ordinated services to vulnerable elderly people. It is too early to assess the outcomes of these plans.

Blaenau Gwent – The LHB and local authority commissioners are co-located in the same office which facilitates communication about commissioning matters. The partners have developed joint commissioning posts for children, mental health, and older people are on joint commissioning strategies to support them. They are also working together on a review of intermediate care services which has arisen from concerns about duplication and value for money.

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

Source: Wales Audit Office

Case Study N: Seeking to address funding and capacity issues in Torfaen to reduce delayed transfers of care arising from shortage of social care capacity

In December 2006, Torfaen County Borough Council and Torfaen LHB calculated that the Council would need £550,000 to enable 40 people to be discharged (£13,875 per person) and noted that the cost of maintaining delayed patients in hospital incurred a significantly higher cost to health services (for residents of Torfaen the average duration of a delayed transfer of care for social care reasons in 2006/2007 was 86.4 days, which equates to an approximate cost of £21,500).

The Council had traditionally experienced problems of capacity as a result of paying fees well below the Gwent average. In December 2006, the Council agreed to a significant increase in fee levels paid to independent sector residential and nursing care providers to seek to increase capacity. It also agreed to identify opportunities to switch resources to prioritise action on delayed transfers during the last quarter of the year.

The number of delayed transfers of care coded as 'funding not available' reduced from 32 in November 2006 to 15 in March 2007 and to 10 by June 2007. In 2006/2007 the Council underspent against its social care budget by £982,000.

The expenditure by the LHB on Continuing Healthcare in Torfaen in 2006/2007 was low (the fourth lowest per head in Wales). The Gwent Health Community Annual Operating Framework 2007-2008 (second submission) indicates a provisional and unfunded estimate that the 'Grogan judgement' may lead to up to £5.7 million additional costs, some of which the Council currently funds.

Even if funding were available, there would be insufficient places for those leaving hospital and needing places. At the beginning of May 2007, there were a total of 13 vacancies across all types of residential and nursing homes in Torfaen whilst at the May census 50 people were delayed transfers of care, nearly all of whom were likely to need residential or nursing places.

Source: Wales Audit Office

2.62 The Assembly Government has recognised the need to develop a commissioning framework to deliver improvements in integrating primary, community, intermediate and social care. By the end of the 2007/2008 financial year LHBs need to have developed with their partners a Community Partnership Agreement, which represents a substantial opportunity to improve joint commissioning[3].

2.63 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. Although joint commissioning has been historically underdeveloped some promising models of joint commissioning are emerging in Gwent. Case Study M describes progress to date in all five localities. Effective joint commissioning is contingent on the development of a shared vision and model of services, not only within each locality but across the whole Gwent health and social care community so that individual and joint commissioning decisions fit within and support an agreed strategic framework.

3 Welsh Health Circular (2007) 023, NHS Commissioning Guidance

Case Study O: The impact of the lack of EMI capacity on a patient who is a delayed transfer of care

Mrs Y from the Gwent region was admitted to hospital, from a residential home, under Section 3 of the Mental Health Act in October 2006. She was declared fit for discharge on 14 December 2006, but was unable to return to her previous residential home due to the lack of qualified psychiatric staff in the home. Funding was agreed for an alternative placement but it took until 30 January 2007 for staff from two suitable homes to undertake specialist assessments. The lack of vacancies in either home meant that Mrs Y was still in hospital in June 2007.

Source: Care and Social Services Inspectorate for Wales review of social services case files following up the Wales Audit Office inpatient census

Addressing significant problems with the availability and use of capacity, particularly in relation to EMI care home capacity and the overall use of resources, could help address the problem of delayed transfers of care

2.64 Budgetary pressures appear to play a role in the delayed transfers of care position. Some of the Gwent authorities have experienced significant pressures on their social services budgets which appear to have contributed to increases in the level of delayed transfers of care at particular times. For example, when Caerphilly County Borough Council's adult social services budget forecast a significant overspend during 2006/2007, there was a significant rise in delayed transfers of care because of the availability of social services funding. However, levels of expenditure alone cannot fully explain the delayed transfers of care position in any given authority.

2.65 Such capacity pressures are exacerbated in some areas by a shortage of funds for placements. For example, there have been a high number of delays arising from a lack of council funding for residential and nursing places in Torfaen which the Local Authority has sought to address (Case Study N).

2.66 As well as resource pressures, there are some significant capacity shortfalls which contribute to delayed transfers of care. In particular, there is a significant capacity shortfall in capacity for EMI patients in all parts of Gwent (see Case Study O). During the week beginning 11 June 2007, there were only two nursing home vacancies for people with dementia in the whole of the Gwent health and social care community. One positive development has been the establishment of weekly capacity reporting on a pan-Gwent basis so that commissioners can identify available capacity and the overall supply of places across the Gwent health and social care community. Case Study O shows the impact of the lack of EMI capacity on an individual patient.

2.67 In some areas, there are care homes which face the threat of closure or owners are considering whether to remain in the care home market, which could further reduce capacity. Caerphilly County Borough Council faces problems of financial pressures in social services, with a projected £1.8 million overspend emerging at a time when delayed transfers of care have increased dramatically, a lack of EMI capacity and uncertainty about future capacity arising from care home quality issues being investigated by CSSIW.

2.68 Investigations of care homes arising from the Protection of Vulnerable Adults Scheme can also lead to capacity shortages, either through embargoes during an investigation or through the closure of a home. For example, Blaenau Gwent County Borough Council has five residential homes, with one home due to close and any vacancies in other council homes currently being used to transfer residents from the home that will close. There are embargoes on the use of two independent sector homes under the Protection of Vulnerable Adults arrangements. This raises concerns about the long-term viability of the homes at a time when in May 2007 there were no available EMI nursing or EMI residential places in Blaenau Gwent.

2.69 The perceived quality of care in homes is a driver of choice-related delayed transfers of care. We found some examples of LHBs and councils being proactive in using such feedback to inform commissioning and interventions to support the improvement of quality in care homes. Case Study P describes good practice examples in Caerphilly and Blaenau Gwent.

2.70 There also appears to be some evidence that there may be potential for some authorities to achieve better value for money by shifting from traditional models of service towards an approach more focused on earlier interventions to promote independence. For example, Caerphilly County Borough Council recognised that it had expensive and traditional service models and has recently agreed to implement plans to move from a reliance on traditional home care models, which are expensive, to an approach that focuses on reablement.

Case Study P: Nursing roles to support improved quality in care homes

Caerphilly LHB has commissioned two nursing roles to work in partnership with matrons/managers of independent sector care homes in order to facilitate improvements in the quality of services provided. The posts differ in scope and purpose: a specialist nurse was appointed from April 2006 to work specifically with residential and nursing homes whose residents are older people with a diagnosed mental illness or dementia. The post holder is a registered mental health nurse and provides advice and training on assessment and care planning, nursing management of challenging behaviours and related issues. A practice development nurse was appointed in January 2007 to work with nursing homes with which the LHB contracts for the provision of NHS-funded nursing care. The post holder is a registered general nurse and provides nursing advice and training to individual nursing homes based on the findings of an audit of compliance with the standards identified in the Assembly Government's 'Fundamentals of Care' guidance. Both post holders contribute to contract monitoring and Protection of Vulnerable Adults processes. Formal evaluation of outcomes has yet to be undertaken, however, anecdotal comments from the homes and other key stakeholders have been positive.

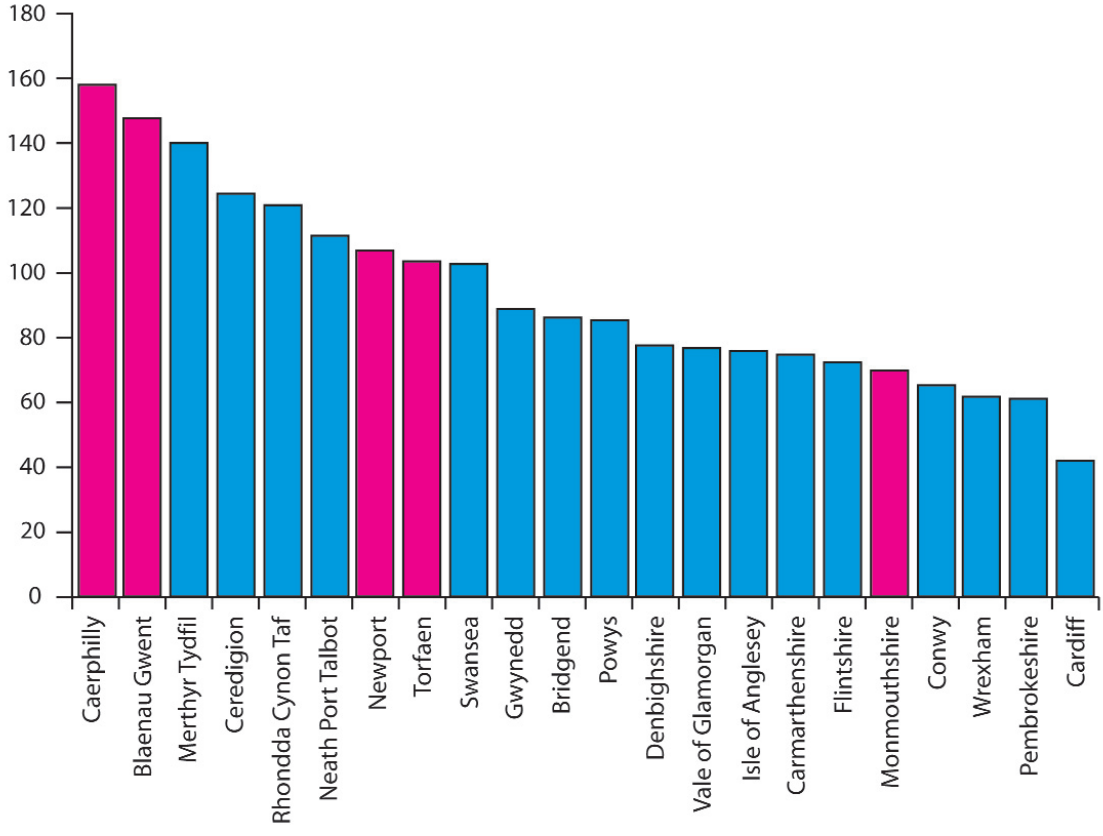
Newport LHB has a long term conditions nurse with specific responsibility for care homes, working with them to advise on care packages and facilitating links with intermediate care services. Blaenau Gwent LHB has commissioned a Psychiatric Liaison Service to support non-mental health trained staff, in all care settings, to care for people with mental health needs more effectively. It also employs a senior nurse who works closely with care homes to provide professional support to concerns raised through the Protection of Vulnerable Adults processes. This has led to the development of recovery plans for individual homes and more general support for home development. When a home closed through the Protection of Vulnerable Adults process in August 2007, all 19 residents were reassessed and transferred to alternative homes within 17 working days.

Source: Caerphilly and Blaenau Gwent LHBs

2.71 Spending on social services varies between Gwent local authorities, reflecting in part standard spending assessments and indicator-based assessments for individual service areas and political decisions about the use of resources. For example some councils spend less per head relative to others but may spend more than their indicator-based assessment. Our histograms, which are included in the appendices for each locality, show total expenditure and show that compared with other Welsh local authorities in 2005/2006:

- Blaenau Gwent had the fourth highest gross expenditure on social services per head of population and the fifth highest amount on older people's services per head of population over 65;
- Caerphilly had the sixth highest gross expenditure on social services per head of population and the fourth highest amount on older people's services per head of population over 65;

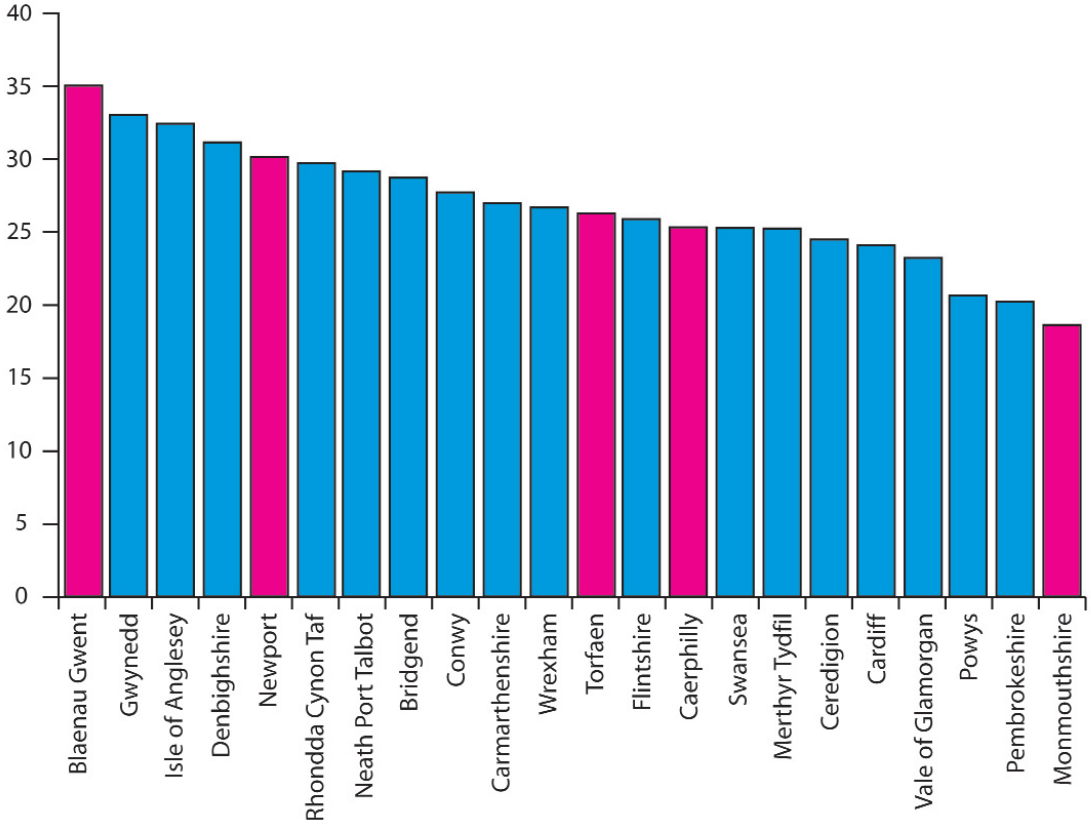
Figure 10: Rate of older people (65 or over) helped to live at home per 1,000 population over 65 in 2006/2007



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

Source: Local Government Data Unit, indicator SCA/002 a

Figure 11: The rate of older people (aged 65 or over) whom the authority supported in care homes per 1,000 population aged 65 or over in 2006/2007



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

Source: Local Government Data Unit, indicator SCA/002 b

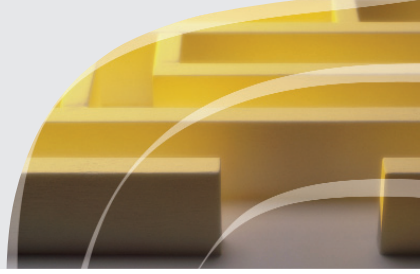
- Monmouthshire had the sixteenth highest gross expenditure on social services per head of population and the thirteenth highest amount on older people's services per head of population over 65;
- Newport had the second highest gross expenditure on social services per head of population and the eighth highest amount on older people's services per head of population over 65; and
- Torfaen had the ninth highest gross expenditure on social services per head of population and the ninth highest expenditure on older people's services per head of population over 65.

2.72 Figure 10 shows that four of the Gwent authorities help relatively high rates of older people to live at home, while Figure 11 shows a more even distribution of the Gwent authorities compared with those elsewhere in Wales in respect of the rate of older people they supported in care homes in 2006/2007.

2.73 We also identified capacity shortages in adult mental health services (18 to 64). Mental health staff within the Trust described how the shortage of mental health beds could result in patients spending long periods of time in non-specialist facilities which can increase clinical risks.

2.74 There are further capacity shortfalls in district nursing capacity which the Trust is seeking to address by implementing the recommendations of three reviews of the service which recommended that teams should be larger and geographically zoned with separate services for scheduled and unscheduled care. There are particular problems with occupational therapist capacity.

2.75 There are capacity issues relating to the opening hours of the various services. Social services cover outside of usual business hours is mixed, as are some clinical, diagnostic and therapy services in health. Delays, in particular over weekends, can be a significant factor in delayed transfers of care and reductions in independence.
For example, therapists do not work over the weekend, and patients are taken away from the ward for rehabilitation which can build in further delays meaning that rehabilitation is not continuous. The Trust has recognised the issue and is piloting new models of therapy which involve weekend working and the use of rehabilitation assistants to enable continuous rehabilitation on the wards.



Part 3 - Clear operational plans, based on whole systems thinking, should support the 'Clinical Futures' programme and address barriers between health and social care to promote the independence of vulnerable older people more effectively

While there is a generally shared vision for 'Clinical Futures', clear operational plans now need to be developed, particularly to develop intermediate care provision and manage the potential risk of increased delayed transfers of care arising from the planned reduction in community hospital beds

3.1 'Clinical Futures' sets out plans for remodelling and reconfiguring clinical services across the Gwent health community by providing more care directly to people in their own homes and in local communities. Routine hospital care will be delivered through a network of local general hospitals, with a single Specialist and Critical Care Centre providing care for people who are seriously ill or have complex problems that cannot be cared for in their local general hospital. The model is predicated on a transfer of resources from acute to non-acute services, although there is also a strong focus on reconfiguring secondary care services to ensure that they are sustainable. 'Clinical Futures' will be phased in over the next five to 10 years.

3.2 We found that there is significant support across the health and social care community for the vision and principles that underpin 'Clinical Futures'. This is a significant strength on which to build the delivery of the vision. At our focus group, 'Clinical Futures' was described as 'a once in a generation opportunity' to create a whole systems approach and person-focused services available in the right place at the right time, with perceived benefits in the following areas:

- developing care pathways that include social care;
- changing medical models and current practice;
- a more local service which could reduce transport problems;
- improved community services;
- improved community diagnostic services; and
- proof for GPs that community services, rather than hospital services, can be effective.

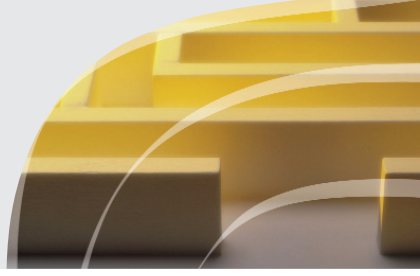
3.3 A planning group has been in existence for a year to take forward 'Clinical Futures' plans for out-of-hospital care (known as 'Level 1' care), chaired by the deputy Chief Executive of one of the LHBs. Nevertheless, we found some concerns about how the 'Clinical Futures' vision will be made operational, in particular a perception in local government

about their engagement in the process, which some see as health-driven and excessively focused on buildings rather than the development of integrated care pathways that include social care.

3.4 The programme now has a financial strategy that involves the transfer of resources to out-of-hospital care before beds are closed and assumptions about a reduced level of delayed transfers of care. Despite this, we identified concern with the resourcing of the 'Clinical Futures' programme. This related to concern surrounding a lack of clarity regarding the transfer of resources from acute community settings and a risk that there may not be sufficient resources, once new hospitals have been developed, to develop new community-based models of service. Social services departments also expressed concern about potential financial and service impacts of the plans on social services, particularly the risk that community services might prove more expensive for some people than care in hospital.

3.5 The 'Clinical Futures' plans include assumptions that are directly relevant to delayed transfers of care. The plans assume an underlying level of delayed transfers of care, once the 'Clinical Futures' model has reconfigured services in Gwent, of 50 across Gwent. This equates to 18,250 bed days each year, some 60 per cent lower than the 2006/2007 level of 44,456 bed days. Further, the plans assume that 500 community hospital beds will be transformed into 'virtual beds' in the community or people's homes, requiring the closure of many beds that currently accommodate delayed transfers of care. This equates to the loss of a further 182,500 bed days a year, which in total represents just over 200,000 community hospital bed days that will need to be replaced by different care pathways if 'Clinical Futures' is not to lead to an increased delayed transfers of care problem, focused on acute beds.

3.6 Part of the 'Clinical Futures' model assumes the avoidance of some of the bed days currently taken up because of inefficiencies in existing care pathways. The model anticipates a reduction in the overall use of bed days through improvements in assessment processes, more efficient delivery of inpatient care and improved integration of acute care, rehabilitation and mental health services. The need to develop new care pathways is supported by the findings of our previous work on chronic disease management in the Gwent community, which found that within the Trust, there was the potential to free resources associated with chronic disease-related admissions – up to 41,198 occupied bed days in 2005/2006 – to support alternative models of care for chronic disease management. Investments in intermediate care have to date had little impact on hospital admissions, which suggests a need for changes in clinical practice (admissions and referrals) and the development of more robust care pathways. One explanation is that intermediate care service may create new demand by tapping into latent needs for services for patients who were unlikely to need admission to hospital anyway. Although steps have been taken to engage GPs, there remains a significant need to engage all GPs in the process to ensure that their referral and patient management practice supports the realisation of a more community-based approach to care.



3.7 There are concerns about the maturity of plans to develop the new care pathways and associated community-based service models implied by the findings of this and previous Wales Audit Office work, their affordability and the potential for 'Clinical Futures' to exacerbate the impact and incidence of delayed transfers of care if these issues are not addressed. Given the reduction in traditional community hospital beds, unless the lower levels of delayed transfers of care under 'Clinical Futures' are achieved, such delayed transfers of care are likely to present more directly in acute beds as there will be fewer community beds to accommodate them.

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

3.8 Organisational and budgetary boundaries, opposing influences and general complications arising from the number of organisations within the Gwent health and social care community, reinforce the need for organisations to take decisions in the interests of the more effective operation of the whole system at the pan-Gwent level.
Earlier sections of this report identify the pattern of services, which remains fragmented across Gwent reflecting local priorities, inconsistent approaches to patient choice, differing approaches to unified assessment and Continuing Healthcare, and varying approaches to local agreements with the different localities. Unitary authorities set different starting fee rates for care homes which can lead to capacity problems arising from 'out of county' placements. We found examples of empty care home beds as a result of the requirement for top-up fees and patients awaiting placements.

3.9 The 11 organisations – one Trust, five local authorities and five LHBs – involved in operating the whole system of health and social care in Gwent have led to uncertain leadership of the health and social care system at a pan-Gwent level. The roll-out of Local Service Boards represents an opportunity to foster more effective strategic partnerships, although the risk remains that the existence of five localities could compromise the focus required across the whole Gwent community.

3.10 Several developments are in train within Gwent to develop more effective joint working. The Trust has recently undergone a major restructuring, of which one of the objectives is to improve joint working at locality level. There are now individual locality managers for the five unitary authority/LHB areas within the Community, Mental Health and Learning Disabilities Division. The restructuring has also swapped divisional managers with a view to sharing learning, knowledge and expertise across disciplines and to improve whole systems working. It is too soon to comment on the impact of this approach.

3.11 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, at the pan-Gwent level there is a need for greater co-ordination as the position in one local authority/LHB area directly affects other parts of the system.

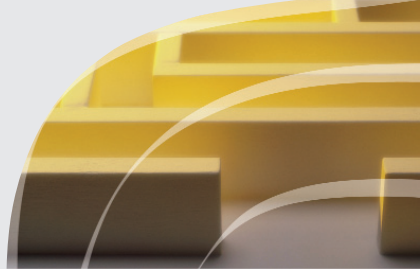
3.12 Performance management arrangements are particularly problematic, with the focus on delayed transfers of care by cause (health, social care and family/carer/other) and locality tending to lead to a focus on the numbers rather than the causes of delayed transfers of care. The absence of integrated targets for the whole community, where the target for the

Trust reflects targets for the LHBs and local authorities, dilutes ownership across organisations and the whole system and can lead to a failure to recognise vital inter-dependencies. For example, a delayed transfer of care for social reasons that affects a resident of Monmouthshire could lead to a resident of Newport 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.

3.13 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 Gwent appeared to be:

- leadership – while there was clear leadership within the five individual localities within the Gwent health and social care community, there was little effective strategic leadership at a pan-Gwent level;
- there has only recently been an acceptance and ownership of need to work together to address delayed transfers of care and their causes across the whole system;
- budgetary pressures, with Continuing Healthcare and the implications of the 'Grogan' judgement likely to increase budgetary pressures and conflict between health and social care;
- the number of localities with which the Trust must operate (five within Gwent plus Powys) creates problems of capacity and complexity in terms of joint working and developing whole systems solutions at the level of the community;
- the lack of a co-ordinated process and model for managing and developing the whole system of health and social care;
- a feeling that local authorities and the Trust do not engage as effectively as they should to address delayed transfers of care and their causes at a whole systems level; and
- the lack of joint performance targets for health and social services organisations, who work to different performance targets for delayed transfers of care, and measurement by reason for delay, leads to a culture of blame and defensive behaviours which attribute delayed transfers of care to external factors or the actions of other organisations rather than the failure to address the genuine whole systems causes of delayed transfers of care.

3.14 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. 'Clinical Futures' offers such a shared vision, but now needs to be supported by clearer operational plans to develop out of hospital services and intermediate care to ensure the engagement and commitment of local authority partners. 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.



3.15 One of the major challenges within a complex system is to address budgetary constraints, organisational boundaries, different accountabilities and leadership styles. 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.

3.16 Budgetary pressures have caused a vicious circle whereby financial pressures in one part of the public service cause costs to fall on another, for example immediate financial pressures in social services leading to short-term increases in delayed transfers of care. 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.

3.17 To address the problem of conflicting financial arrangements and pressures in different parts of the Welsh public service, the Assembly Government has emphasised pooled health and social care budgets as a solution to such problems. Pooled budgets should follow the development of a shared vision of service development and a clear view about the long-term nature of service provision. In this context, pooled budgets have significant potential to address some of the negative consequences of separate budgets and accountabilities. Some organisations within Gwent have already developed pooled budgets, using the flexibilities inherent in the Health Act (1999). Case Study Q describes the 'Section 33' agreements to pool budgets that exist in Monmouthshire, their impact and the lessons learned about developing pooled budgets. As well as formally pooling budgets, which can be a complex and time-consuming process, other localities have developed jointly funded services and posts.
For example, both Torfaen and Newport have developed intermediate care consultant posts (Case Study A).

3.18 As well as budgetary pressures, traditional leadership styles and skills are another barrier to effective whole systems working. Addressing the conflicting accountabilities and cultures of the organisations in Gwent requires new leadership skill sets where leaders are prepared to cede power and resources and to work in the interests of the whole system and the people it serves, rather than in the direct interest of their organisation.

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

Monmouthshire County Council and Monmouthshire LHB opened the Monnow Vale integrated care facility in May 2006. The facility has 19 inpatient beds where Monmouthshire GPs provide the medical care, a nurse led Minor Injuries Unit, a Community Care Team, Reablement Team, day hospital and day services, a mental health day hospital for older people, physiotherapy outpatients and occupational therapy sessions, an X-ray Department, community nursing teams and a range of outpatient and community health clinic services.

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

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

The project took nine years from vision to delivery although the development of the Section 33 agreement took only a matter of months. There have also been difficulties for the Integrated Services Manager to get clear financial reports back to enable greater flexibility in use of shared resources.

The LHB recognised the lessons of developing a Section 33 agreement and the need to ensure that:

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

Source: Wales Audit Office

3.19 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.

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

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

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

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

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

Source: Wales Audit Office

3.20 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.

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

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

Appendix 1 - Methodology

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

Document review

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

Focus group

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

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

Data analysis

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

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

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

Inpatient census and analysis of case files

7 We carried out a census of each delayed 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 councils in the Gwent area. This case file analysis produced a series of case examples which appear in this report.

Semi-structured interviews

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

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

Good practice

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

Public comments

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

Expert panel

12 As is customary for an examination of this type, we set up an expert panel to advise the study team at key stages of the project. The panel had no executive power over the project but provided advice and guidance to the project team. The panel met twice to discuss the approach to the project, emerging findings, key issues and potential recommendations. Some members of the panel provided comments on the draft national 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 report appendices 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, provide 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 on 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.

Description of histogram indicators

Indicator No:	1
Title	Number of delayed days for unitary authority/LHB residents in 2006/2007 for HEALTHCARE reasons per 1,000 population aged 65 years and over.
Source	Health Solutions Wales, 2007, Mid Year Estimates (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 were 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 delayed 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 Key Performance Indicators (KPI) 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 delayed 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 delayed 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 years 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 (>=65years) helped to live at home per 1,000 population (>=65years) in 2006/2007.
Source	Local Government Data Unit: SCA/002a.
Rank order	Highest rate = 1

9 This is a simple ranking of the national strategic performance indicator collected annually by every unitary authority of Wales and collated by the Local Government Data Unit. 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 of 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 1,000 population of residents in each unitary authority area (MYE 2005).

Number of spells with emergency admissions per UA area.	/	(MYE Population/1,000)

Indicator No:	8
Title	Local Health Board expenditure on CONTINUING HEALTHCARE 2006/2007 per 1,000 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.

Local Health Board spend 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 of Wales on Social Services in 2005/2006, divided by the resident population in the Mid Year Estimates 2005 to make the figures comparable between unitary authorities.

Unitary authority Revenue Outturn 2005/2006, 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 1,000 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 of Wales on Older People's Services in 2005/2006, divided by the resident population in the MYEs 2005 to make the figures comparable between unitary authorities.

Unitary authority Revenue Outturn 2005/2006, Form: RO3, Row: 37, Column: 5.	/	(MYE Population 2005/1,000)

Indicator No:	11
Title	Average duration of delayed transfers of care for each patient in 2006/2007.
Source	Wales Audit Office analysis of the Assembly Government's delayed transfers of care data.
Rank order	Lowest duration of a delayed 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	Care and Social Services Inspectorate for Wales, 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's 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 'local authority 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 authority 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)

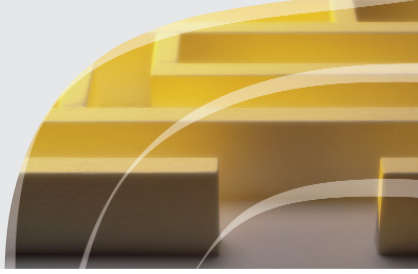
Appendix 3 - Breakdown on the costs of bed days occupied by delayed transfers of care in Gwent Healthcare NHS Trust

By bed type

	2005/2006			2006/2007		
	Delayed days	Cost per day £	Total cost £	Delayed days	Cost per day £	Total cost £
Acute	717	223	159,934	924	233	215,292
Community	21,665	242	5,238,164	27,511	252	6,932,772
Mental Health	7,651	239	1,825,529	9,803	249	2,440,947
Other	148	223	33,013	0	0	0
Rehabilitation	3,648	223	813,723	6,218	233	1,448,794
Totals	**33,829**	**239**	**8,070,363**	**44,456**	**249**	**11,037,805**

	Percentage change		
	Delayed days	Cost per day £	Total cost £
Acute	28.9%	4.5%	34.6%
Community	27.0%	4.2%	32.4%
Mental Health	28.1%	4.4%	33.7%
Other	-100.0%	-100.0%	-100.0%
Rehabilitation	70.4%	4.5%	78.0%
Totals	**31.4%**	**4.3%**	**36.8%**

Source: Wales Audit Office analysis of delayed transfers of care census data and Trust TFR returns



By reason

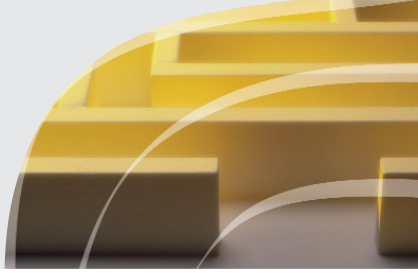
	2005/2006			2006/2007		
	Delayed days	Cost per day £	Total cost £	Delayed days	Cost per day £	Total cost £
Healthcare	4,542	238.00	1,080,996	4,561	248	1,131,128
Patient/carer/ family-related	16,293	238.00	3,877,734	18,600	248	4,612,800
Not agreed	138	238.00	32,844	220	248	54,560
Social	12,856	238.00	3,059,728	21,075	248	5,226,600
Totals	**33,829**	238.00	**8,051,302**	**44,456**	248	**11,025,088**

	Percentage change		
	Delayed days	Cost per day £	Total cost £
Healthcare	0.4%	4.2%	4.6%
Patient/carer/ family-related	14.2%	4.2%	19.0%
Not agreed	59.4%	4.2%	66.1%
Social	63.9%	4.2%	70.8%
Totals	**31.4%**	4.2%	**36.9%**

Appendix 4 - Rapid response and reablement services vary in their coverage, referrals and duration, between and even within Gwent boroughs

Rapid response services

Borough	Name of service	Provider	Accepted referrers	Opening hours	Other details
Blaenau Gwent	Rapid Response Team	Gwent Healthcare NHS Trust	Healthcare professionals or self referrers	8am to 8pm, seven days per week	Multi-disciplinary Team that responds within 90 minutes of referral. Primary aim to prevent admission. Patients must be 18+
Caerphilly	24/7 Nursing Response Team	Gwent Healthcare NHS Trust	Primary or secondary care health professionals	24 hours, seven days per week	Aims to facilitate early discharge and prevent admission.
Monmouthshire	No rapid response service	No rapid response service	No rapid response service	No rapid response service	No rapid response service.
Newport	Rapid Response Nurse Team	Newport LHB	Newport based GPs or hospitals	8am to 8pm, seven days per week	Treats patients with conditions that can be managed at home, including nursing and residential homes. Patients must be 16+
Torfaen	District Nurse Rapid Response Service (due to be integrated with Advanced Clinical Assessment Team)	Gwent Healthcare NHS Trust	Primary or secondary care health professionals, social services staff and community based therapists	9am to 10 pm, seven days per week	Treats patients who suffer sudden illness that would normally require admission to hospital. Patients must be 16+
Torfaen	Advanced Clinical Assessment Team (due to be integrated with rapid response team)	Gwent Healthcare NHS Trust	Healthcare professionals	8am to 8pm, Monday to Friday	Rapid assessment and diagnostic testing in patients' homes and care homes. To avoid admission. Patients must be over 75



Borough	Name of service	Provider	Accepted referrers	Opening hours	Other details
Torfaen	Emergency Care at Home	Torfaen County Borough Council and Torfaen LHB	GPs, district nurses, NHS Direct, Reablement Service, Social Services and hospital staff	24 hours, seven days per week	Supports patients with acute illness that can be managed at home. Patients must be 18+.

Reablement services

Borough	Name of service	Provider	Accepted referrers	Opening hours	Other details
Blaenau Gwent	Community Reablement Team	Gwent Healthcare NHS Trust	Health and social care agencies	8am to 8pm, seven days per week for existing clients 8.30am to 5pm, Monday to Friday, for new clients	Short term reablement programme to help maximise levels of independence. Patients must be 18+
Blaenau Gwent	Assist 2 Project	Gwerin Housing Association and Blaenau Gwent County Borough Council	Health and social care professionals	9am to 5pm, Monday to Thursday and 9am to 1pm on Fridays	Six-week reablement programme for people who would normally require hospital admission. Patients must be 55+ and registered with a local GP.
Caerphilly	Reablement Team	Gwent Healthcare NHS Trust and Caerphilly County Borough Council	Health and social care professionals	8.30am to 5pm Monday to Friday and 8am to 4pm Saturday and Sunday. Access to out of hours duty team	Multi-disciplinary, short term programme for intensive support and therapy in a patient's own home. Aims to prevent admission and facilitate early discharge. Patients must be 18+
Monmouthshire	Reablement Team – Staying Healthy at Home	Monmouthshire LHB	Health and Social Care professionals	9am to 4.30pm Monday to Friday	Available only to patients in Monmouth and Caldicott with significant changes in health or independence. Patients must be 60+

Borough	Name of service	Provider	Accepted referrers	Opening hours	Other details
Monmouthshire	Mardy Park Reablement Team	Monmouthshire County Borough Council and Monmouthshire LHB	Local GP, healthcare professionals, social services staff	24 hours, seven days per week	Service is available to patients who are registered with a local GP and require rehabilitation following a short illness or hospital stay. Patients must be over 65.
Newport	Reablement Team	Newport City Council	GPs, district nurses, hospital staff, voluntary agencies, physiotherapist, occupational therapists and social workers	8.30am to 5pm, Monday to Friday.	Provides intensive short term reablement to allow the user to return home or to allow the user to remain in their own home. Patients must be 18+
Torfaen	Reablement Service	Torfaen County Borough Council	GP, district nurses, social services staff, hospital staff and Emergency Care at Home	8.30am to 5pm Monday to Friday	Torfaen residents with significant changes to their health or independence. Patients must be 18+