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Review of delayed transfers of care – **Cardiff and Vale Health and Social Care Community**

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Contents

Partners are working well together to manage delayed transfers of care, whilst realising their plans for a whole systems model.

Summary report

Background

1 A delayed transfer of care (DToC) is when a hospital inpatient is ready to move to the next stage of care, but for one or more reasons is unable to do so. DToC can harm the wellbeing of those who suffer them and can have a negative impact on their independence. It also has an adverse effect on the wider health and social care system as delays can potentially deprive others from receiving timely care.

2 After a stay in hospital, most patients need little or no onward care. DToCs are associated with complex cases where patients need a care package or move to a different care setting such as a care home. These patients are more likely to be older, vulnerable people. A national audit of intermediate care in England showed that for older patients, 'a wait of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10 per cent decline in muscle strength'. This highlights the urgent need to ensure older patients do not stay in hospital for longer than needed. A prolonged stay may mean a patient admitted to hospital with simple discharge needs, which means not needing any or little onward care, may leave a hospital needing a more complex care package.

3 As with the rest of the UK, Cardiff and the Vale of Glamorgan has an aging population. Over the next 10 years, the number of over 65s in the region will grow by 22 per cent, from approximately 74,000 in 2014 to just over 91,000[1]. Whilst many older people will have little or no need for health and social care services, for others, old age is associated with a number of complex medical conditions that may have an impact on their quality of life and independence. The focus of current policy is to shift demand from expensive services such as acute hospitals and nursing homes to managing conditions in a community setting.

4 DToCs are a complex problem and require effective partnership working by health and social care organisations. Transferring patients from one care setting to the next relies on appropriate joint processes and a patient centred approach. Therefore, DToC can be an indication of ineffective partnership working and issues along the patient journey. In effect, a DToC is a symptom of a broken patient journey.

[1] Fast Tracking Integration of Health and Social Care Services: a review of community health and social care services and options for integration. Report by Whole Systems Partnership.

5 In 2007, we carried out a review of DToC in Cardiff and the Vale of Glamorgan, and in 2009, we followed-up progress on our recommendations. Around the same time, the Welsh Assembly Government commissioned an independent review of DToC in Wales. Collectively, the findings from these reviews highlighted challenges across the whole system and recommended a more integrated approach to promoting older people's independence, and ensuring optimal use of capacity across the whole system. This work recognised that long-term improvement would need a considerable amount of prolonged and focussed attention from all partner organisations.

6 A whole systems approach means putting the patient at the centre, by looking at what care a person needs instead of which organisation will deliver or pay for it. This way of working reduces duplication, can deliver cost savings, and ultimately ensures patients receive the right care, at the right time and by the right person. The best way of achieving a whole systems approach is by integrating services. Over the years, the Welsh Government has released funding streams that aim to foster greater collaboration between services[2].

7 In April 2016, the Social Services and Well-being (Wales) Act 2014 (the Act) came into force. The Act aims to improve the wellbeing of people who need care and support, as well as carers who need support. It changes the way people's needs are assessed and services are delivered, giving people more of a say in what they receive. The expectation is for organisations delivering health and social care services to take a more integrated approach to develop early intervention and preventative services to help people live independently and reduce the need for planned, formal support. It also ensures that people have access to clear information and guidance.

8 Cardiff and Vale has one of the highest numbers of DToCs in Wales. Unlike other health board regions, Cardiff and Vale has no community hospitals to provide step-down intermediate care. In addition, University Hospital Wales is a tertiary, specialist hospital, so demand from outside the region is greater. These two complications mean there is added pressure on acute hospital beds and extra demand on community services.

9 This review sought to answer the following question: **Are partners making a sustainable improvement in delayed transfers of care?** We undertook the review between March and June 2016 and the approach taken to deliver this audit is set out in Appendix 1.

[2] Regional Collaboration Fund and Intermediate Care Fund

Main findings

10 We concluded that partners are working well together to manage DToC, whilst realising their plans for a whole systems model.

11 In reaching this conclusion we found that:

- Independence of older people is being prioritised through joint working and the implementation of an integrated service model, however, continuity of joint funding is a risk:
  - strategies are in place that guide short-term improvements and wider long-term transformation, and plans to integrate health and social care services are well underway;
  - addressing limitations to effective joint working has been prioritised, although, it is recognised that some areas of improvements will take longer to realise;
  - new service models and hospital prevention activities demonstrate a commitment to promoting the independence of older people, and
  - there is intelligent use of the intermediate care fund, but there are no plans in place if the fund was to stop.
- There is a maturing, dynamic partnership in place with strong governance, performance monitoring and evaluation arrangements:
  - there is a consensus that relationships between partners have improved over the past year and there is a strong and well integrated governance structure in place;
  - partners jointly own delayed transfers of care and collective action is being taken to tackle the issue;
  - the Partnership has a learning culture and a lot of energy has gone into identifying barriers to progress;
  - performance is widely and regularly reported across the Partnership ensuring a sustained focus, but there are concerns about how it is measured; and
  - findings from a recent audit on discharge planning supports plans to introduce a patient flow performance dashboard.
- Performance is steadily improving though delayed transfers of care remain the second highest in Wales.

Recommendations

Exhibit 1: Recommendations

We made two recommendations and these are set out in the table below.

Recommendations	
Discharge planning audit	
R1	Address the findings from the Delivery Units discharge planning audit either by: • developing a separate action plan; or • incorporating actions into existing service improvement action plans.
Intermediate Care Fund (ICF)	
R2	Explore ways of mainstreaming services funded through the ICF to ensure services remain resilient.

Detailed report

Independence of older people is being prioritised through joint working and the implementation of an integrated service model, however, continuity of joint funding is a risk

Strategies are in place that guide short-term improvements and wider long-term transformation, and plans to integrate health and social care services are well underway

12 Better integration of health and community care services is key to reducing delayed transfers of care (DToC). Cardiff and Vale Integrated Health and Social Care (IHSC) partnership (the Partnership) has ambitious plans to integrate health and social care services. The Partnership has clear plans in place to govern operational improvements in the short term and long-term transformation. The strategies and action plans have a clear link from the strategic vision down to operational delivery plans.

13 Health Enterprise Alliance for Regional Transformation is the overarching blueprint for regional change over the next 10 years. This is a new strategy (March 2016) which includes plans for supporting an aging population in Cardiff and the Vale of Glamorgan, including dementia friendly initiatives and localities based service models.

14 In June 2015, the Whole Systems Partnership[3] delivered a report that the Cardiff and Vale Councils and Cardiff and Vale University Health Board (the Health Board) jointly commissioned. The aim of the study was to establish a commonly agreed baseline, and opportunities and options for integrating regional health and social care services. The study analysed population health needs, mapped community services including associated spend and activity levels, and analysed the workforce. The recommendations from this review form the basis of the Partnership's fast track integration implementation plan. It is a three year plan that runs until 2016-17 with a virtual team at assistant director level managing its implementation.

[3] Fast Tracking Integration of Health and Social Care Services: a review of community health and social care services and options for integration.

15 Short-term plans to manage DToC are outlined in the Home First Plan. The plan is the latest version of the DToC action plan, which partners developed following a peak in DToCs in February 2015. It is clear that the focus has shifted from organisational and service based actions to implementing a regional whole systems model. The plan aims to speed up the progress of those needing acute or long-term care services and, where possible, to reduce the number of people needing these services in the first place. The Partnership's home first ethos means that whatever care a person needs, the aim will be to return them home or as close to home as possible. The actions within the plan reflect the different stages of the patient journey as identified in the report delivered by the Whole Systems Partnership, these being:

- First contact – when people present with a potential need;
- Ongoing support – when people have an ongoing, though relatively stable set of needs;
- Crisis response – when people have a crisis or short lived exacerbation of need; and
- Comprehensive assessment – when people experience a significant and permanent stepped change.

16 The Home First plan details evaluations of existing schemes, development of new initiatives, and opportunities for regionally integrated services. It also identifies which initiatives will be funded through the intermediate care fund (ICF)[4].

17 Although the plans for integration are ambitious, the Partnership is not starting from scratch. There are already examples of co-located health and social care teams, joint posts and pooled budgets. However, the strategies detailed above show a coordinated, phased and regional approach to service transformation.

Addressing limitations to effective joint working has been prioritised, although, it is recognised that some areas of improvements will take longer to realise

18 Our initial review in 2007 highlighted a number of organisational barriers that were preventing effective partnership working. Our follow-up review in 2009 found that partners had not taken sufficient action to address some of these barriers such as shared ICT systems, pooled funds and sharing human resources. Positively, our recent review found that partners are taking actions to address these barriers, and improvements are at various stages of development.

[4] Welsh Governments intermediate care fund aims to facilitate integrated working between social services, health and housing and the third and independent sectors.

19 Currently different ICT systems are used for managing patient cases. The Health Board uses the Mental Health and Community Information System (PARIS), and the two councils use Care First and Swift. Staff have developed working practices to overcome this difficulty, but as more services become integrated, separate ICT systems will become increasingly impractical. This is a Wales wide issue, and as such, Welsh Government is investing £6.7 million in developing the Welsh Community Care Information System (WCCIS). The WCCIS will allow information to be easily shared between health and social care service providers. The Partnership is aiming to implement the WCCIS by 2017-18. Whilst those interviewed felt that the implementation timescales were ambitious, there was agreement that this was a clear indication of the Partnership's commitment to integrating services. In the meantime, we were told that a number of methods are used to share information. For example, where health and social care staff are co-located, they have login details for both health and local authority ICT systems, printouts from PARIS are taken to the weekly DToC review meetings and colleagues share verbal updates.

20 Creating posts that work across organisational barriers is an important step in breaking down silo working and promoting integration. In 2010, the Vale of Glamorgan Council and the Health Board jointly appointed the Head of Adult Services/Locality Manager. This was the first joint appointment in the region. Those interviewed consider the appointment to have been instrumental in facilitating closer working relationships between the two organisations. For example, Vale's Community Resource Team (CRT) has co-located staff and joint management of health and social care budgets. The team provides a single point of access for intermediate home-based rehabilitation (health) and reablement (social care) service referrals. There have been other joint appointments made since, however, recently, the Partnership has taken joint appointments a step further. In 2016 Cardiff and Vale Councils and the Health Board jointly appointed two posts at assistant director level, these being Assistant Director, Integrating Health and Social Care (February 2016), and a Head of Integrated Care (starting in October 2016). Both posts report to the three responsible directors, which allows strategic oversight across the region. Collectively, the posts are responsible for driving integration, improving patient flow and reducing levels of DToC.

21 The Partnership is in the early stages of exploring formally pooled budgets and joint commissioning arrangements. Currently, the ICF provides a pooled resource for the region that does not adversely impact local budgets. The fund is for initiatives that prevent admission to hospital, reduce DToC, and is important for innovation. Outside of this fund, there are some examples of centrally managed budgets. For example, Vale's CRT manager centrally manages both health and local authority budgets. But for a more sustainable solution, the Partnership is exploring further options for pooling and aligning budgets, this was one of the recommendations made by the Whole Systems Partnership. Another recommendation was around joint commissioning. At the time of this review, partners had held their first workshop to start exploring options for joint commissioning of older people services. The workshop had a particular emphasis on home care and care home services, where there are significant capacity issues.

New service models and hospital prevention activities demonstrate a commitment to promoting the independence of older people

22 In 2015, we undertook a national review looking at whether councils in Wales were doing enough to support the independence of older people. The review found that whilst the challenges of an aging population were recognised, there were some key barriers stopping the focus shifting to reduce demand for health and social care services and support older people to live independently. The barriers included underestimating the value of other services such as those provided by partner organisations, and public services such as libraries and public toilets.

23 The Partnership has a strong focus on prevention, which is reflected in their joint initiatives and strategies. Since 2013's Wyn Campaign[5], a number of projects and teams have been set up with the intended purpose of preventing older and vulnerable people losing independence. For example by:

- Strengthening access to information – Vale of Glamorgan's integrated contact centre provides signposting for community health services. The service aims to direct callers to the right service first time, and includes a representative from Age Connects to advise callers about older people's services. In 2016-17, Cardiff's First Point of contact is due to merge with Vale's contact centre to create a regional single point of access for community health services.

[5] The Wyn Campaign was a workstream of the IHSC Programme, and was a milestone in the journey towards integrating community health and social services in Cardiff and the Vale of Glamorgan.
The Campaign involved health, social care and third sector partners working together to improve the experience of older people in the region.

- Increasing access to information – one of the requirements of the Social Services and Wellbeing (Wales) Act 2014 is to ensure people have access to clear information. Dewis Cymru is an online directory of wellbeing services in Wales. Cardiff and Vale was one of the first regions to include information on the directory.
- Helping to maintain wellbeing – Cardiff's Independent Living Officers visit older people in their own home to help maintain their health, wellbeing and safety. This includes helping them with financial management.
- Preventing unnecessary hospital admissions – the Frail Older Person's Advice and Liaison (FOPAL) service is based in the emergency unit. The service is responsible for preventing unnecessary admission of older people brought to hospital, by assessing and diverting them to a more appropriate service. The FOPAL service has recently become a seven-day service.

24 For some older people hospital admission is unavoidable. But once the patient is deemed medically fit, it is imperative they are discharged quickly to avoid harm. Cardiff and Vale has a number of integrated teams and practices aimed at co-ordinating discharge and preventing readmission, such as:

- Daily Board rounds – each day, a multi-disciplinary team at each ward meets in front of the patient information white board. The meeting is to review each patient's status to see what actions can be taken to help their discharge.
- Accommodation solutions team – include housing resettlement officers and occupational therapists who work with hospital staff to assess and plan for a person's housing needs on discharge. This can range from adaptations to arranging a deep clean to make homes safer on a patients return.
- Integrated discharge service (IDS) – is made up of discharge liaison nurses, social workers, contact officers and Age Concern advisors. The service aims to provide a more cohesive discharge service to patients with complex needs.
- Community Resource Teams – play a role in preventing hospital admission (when referred by a GP) and facilitating early discharge by providing a reablement and rehabilitation service in people's homes.

25 A prolonged stay in hospital for an older person can result in deteriorated health, loss of confidence and independence. Increasingly, a discharge to assess model is seen as best practice for patients that need onward care. In practice, this means assessing patients long term care needs in the comfort of their own home instead of at hospital. This type of model allows a person's level of independence and care needs to be assessed in a familiar environment, which may remove the need for a care home placement or long term care.

26 Cardiff and Vale has adopted a home first ethos, which includes implementing a discharge to assess model from 2016-17. In preparation, last year the Partnership reviewed all patients waiting for care home placements with a view to helping them return home. A home care fund of £100,000 (ICF funding) was set aside for any help that a patient needed to be discharged home, in total the pilot helped 39 patients home who were waiting in hospital for a care home place.

27 A further extension of the home first model is piloting a locality model for older people's services. The aim of the pilot is to provide more integrated and effective local services for older people. The first pilot will be run in Llanishen in Cardiff. The project was developed following a mapping exercise that found a number of home care providers serving a small area. For example, one sheltered housing block had five different home care providers visiting residents, meaning five different commissioning arrangements and the care workers having to travel. The pilot will see a locally based home care team established providing a more efficient and cost effective service. In addition, the pilot project will look to map and co-ordinate day care opportunities for older people. This would involve the third sector providing some services and looking to use older peoples housing complexes as a community hub for older people in the wider community.

28 It is too soon to comment on the success of the home first ethos, but the Partnership is developing innovative solutions to address the challenge of maintaining older people's independence. Embedding a home first culture will require all partner organisations to change their behaviour and way of thinking. Encouragingly, the Home First Plan includes details to promote a home first culture across the Partnership. Appendix 2 sets out example case studies of service models that other health and social care services in England and Wales are using to reduce DToC.

There is intelligent use of the intermediate care fund, but there are no plans in place if the fund was to stop

29 The Welsh Government introduced the ICF in 2013-14. The aim of the fund is to support older people to live independently by encouraging social services, health, housing, and third and independent sectors to work together. Initially the ICF was a one off fund, but in 2015-16, the fund became recurrent to support successful initiatives developed in its first year. In late 2015-16, an extra sum was released to specifically tackle delayed transfers of care.

30 There is no doubt that the Partnership use the fund intelligently. For example, the majority of the preventative initiatives and services detailed in the previous section are funded, fully or partially, through ICF monies, as well as preparations for service transformation such as WCCIS and the fast track integration review.

31 The Partnership has an ICF Programme Board which has overall responsibility for ensuring the programme of work funded through ICF is delivered. For 2016-17, all partners signed a memorandum of understanding that sets out their intention to work together to make effective use of the ICF and the document details the schemes agreed for 2016-17 by the Regional Partnership Board[6]. ICF projects are evaluated annually and a report submitted to Welsh Government, lessons learned are used to develop and improve projects the following year. To enhance performance management we were told that Results Based Accountability[7] has recently been introduced for all ICF funded services. All projects have set targets with performance information already being collected for projects that were initiated in previous years. New projects are scheduled to start from quarter 3 onwards and arrangements are in place for data capture.

32 Those interviewed agreed that the fund has been invaluable in facilitating partnership working and encouraging innovation. However, there are risks, although the ICF is now recurrent, there is no guarantee that it will continue indefinitely. The fund is released on an annual basis, which does not allow for long term planning. And some salaries are reliant on the fund which jeopardises continuity of service, for example the Accommodation Solutions Officers and where services like IDS, CRT and FOPAL have been expanded. The Partnership needs to explore ways of mainstreaming services funded by the ICF to ensure services remain resilient.

[6] Regional Partnership Boards are a requirement of the Social Services and Wellbeing (Wales) Act 2014

[7] Results Based Accountability is an outcomes based model that starts with the end point, what we want to achieve, and then works backwards to identify the steps needed to achieve the outcomes. Performance indicators are then developed to measure progress against each outcome.

There is a maturing, dynamic partnership in place with strong governance, performance monitoring and evaluation arrangements

There is a consensus that relationships between partners have improved over the past year and there is a strong and well integrated governance structure in place

33 Integrating health and social care services has been a priority in the region for some time and was initially driven by the Integrated Health, Social Care and Wellbeing Board. In 2013, the Integrated Health and Social Care Partnership superseded the Board and its initial focus was on improving services for older people. The Partnership includes; the Vale of Glamorgan Council, Cardiff Council, the Health Board, the third sector[8] and, more recently, the independent sector[9].

34 There is a clear intention by all partners to work together; partners demonstrated this by signing and submitting a statement of intent to the Welsh Government in 2014.
The document sets out their commitment to increase the scale and pace of partnership working so that older and disabled people receive high quality, integrated services that respond to their needs. Appended to the document is the Partnership's vision and a wider collaborative agreement.

35 Amongst those interviewed, the feeling was that in the past, partners have not always worked well together. However, over the last 12-18 months, partnership working has greatly improved and interviewees attributed this to the recognition that within the current financial climate they need to work together to improve services and maximise resources. Partners reported open and honest dialogue at leadership and strategic level so that all parties were clear about the pressures and challenges each organisation faced. There is, however, a healthy level of challenge and there can still be disagreements, but this was seen as part of a maturing working relationship.

[8] Third sector is represented by Glamorgan Voluntary Services and Cardiff Third Sector Council.

[9] Care Forum Wales represents the independent sector.

36 It is good practice for local authorities to share their savings plan with their partner health board, this is because it allows them to have a say in decisions that may affect their services. Each year we review the governance and financial arrangements at all health boards in Wales[10] and our findings show that sharing saving plans is not common. Both Cardiff and Vale Councils share their savings plans with the Health Board. This means that the Partnership is maturing and there are transparent working practices in place.

37 At an operational level, a number of interviewees praised the way Cardiff Council and partners worked together to manage a recent issue with a lack of available domiciliary care capacity. Both councils outsource the majority of home care services to local home care providers. Due to significant capacity issues and care packages not being able to be delivered during a particular period, the Council worked with Cardiff's Community Resource Team and other care providers to find home carers at short notice to cover all of the care packages in place. The Care and Social Services Inspectorate Wales (CSSIW) told us that they received no complaints from service users during this period.

38 The Partnership is starting to benefit from having a stable, consistent management tier in place. This has not always been the case, especially with regard to the Director of Social Services at Cardiff, where there has been significant turnover. The current director has been in post for two years.

39 As well as good strategic leadership, the Partnership has a strong governance structure in place. The governance arrangements support the region's vision for whole systems working. Exhibit 2 shows that the governance structure is well integrated across the region. At its highest level, Cabinet, scrutiny committees, the Health Board, and the two Public Service Boards[11] link with the Regional Partnership Board. It also incorporates the various working groups set up to meet the requirements of the Social Services and Wellbeing Act and regional integration plans. The working groups report up to the IHSC Strategic Leadership Group.

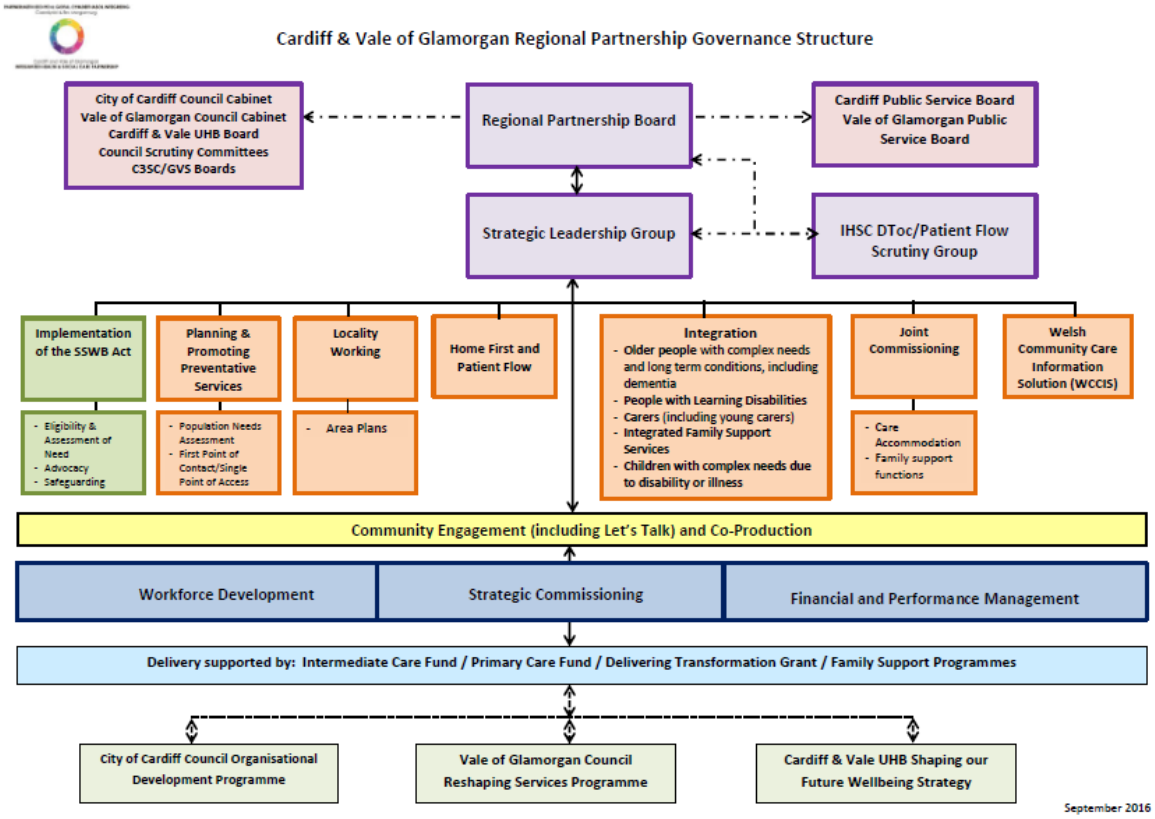
40 To establish a greater focus on tackling DToC, partners recently created a separate governance structure, but to ensure a strategic link, the top of this structure is also the Regional Partnership Board.

[10] Wales Audit Office Structured Assessment

[11] Public Service Boards are a requirement of the Wellbeing of Future Generation Act, 2015.

Exhibit 2: Cardiff and Vale of Glamorgan, Regional Partnership Governance Structure

Chart showing Cardiff and Vale of Glamorgan's Regional Partnership governance structure as at September 2016.



Data source: Provided by the Partnership

Partners jointly own delayed transfers of care and collective action is being taken to tackle the issue

41 In February 2015, the number of DToCs in the region peaked at 155. In response, the Partnership developed a DToC action plan and set themselves the target of reducing the numbers of DToCs by 25 per cent within six months, which they achieved. The action plan clearly identifies issues causing DToCs, actions to address the issues, the lead organisation, timeframes and progress updates. The IHSC Governance Board[12] monitored the action plan at a strategic level. Membership of the Board included leaders of Cardiff and Vale Councils, and the Chair of the University Health Board.

42 The Home First Plan is the latest version of the DToC action plan and the recently developed DToC governance structure provides its monitoring framework. A number of these groups existed before the governance structure was developed. However, the formality clarifies the membership, roles, and responsibilities of the various groups, which strengthens accountability and creates a greater sense of ownership of the issue. The operational level of the structure outlines weekly meetings to review the progress of delayed patients. Monthly, the DToC improvement group agree data for the DToC census. This group is also responsible for practical delivery of the Home First Plan. The strategic level of the structure includes a two monthly meeting, which oversees the plan and considers strategic developments such as regional commissioning. The quarterly leadership group is the scrutiny function, the Cabinet Members responsible for health, the chair of the Health Board, and the strategic directors for each organisation attend. The Regional Partnership Board has overall oversight.

43 Partners take DToC seriously, but realised that for greater impact, a more co-ordinated approach was needed. As already mentioned, at the time of this review, partners had recently recruited a Head of Integrated Care. The purpose of the joint post is to improve patient flow and reduce levels of DToC across the region. The post reports to the three strategic directors, Cardiff and Vale Councils and the University Health Board.

[12] The IHSC Governance Board has been superseded by the Regional Partnership Board.

The Partnership has a learning culture and a lot of energy has gone into identifying barriers to progress

44 Over the past 18 months, the Partnership has undertaken a number of reviews and evaluations. Together, the reviews have helped to identify barriers to reducing DToC, and establish a baseline from which to improve current services and plan future service models. Those interviewed agreed there was a learning culture in place and gave examples of reviews that involved both strategic and operational staff, and internal and externally commissioned work.

45 The reviews and evaluations cited include:

- Whole Systems Partnership review which led to options for fast track integration and the associated implementation plan.
- Operational level DToC workshop, facilitated by GE healthcare consultants. The issues identified through this workshop form the basis of an operational level DToC action plan.
- ICF initiatives are evaluated each year and lessons learned used to improve and develop projects.
- GE healthcare consultants 'day of care audit' revealed that approximately a quarter of patients in acute wards at University Hospital Wales did not need to be there. The same audit is planned for University Hospital Llandough.
- Commissioning older peoples services workshop, facilitated by IPC (part of Oxford Brookes University), saw partners explore options for joint commissioning.
- The Home First Plan and original DToC action plan were based on needs and issues analysis.

46 Interviewees highlighted a number of barriers to managing DToC. However, they were also clear about how the issues were being addressed. Both issues and solutions are outlined in the Home First Plan and/or the operational DToC action plan. Some of the frequently raised issues included, implementing the choice policy[13], capacity and referrals to the IDS and care home and domiciliary care home capacity.

47 For example, interviewees said that some ward staff lacked the confidence to implement the choice policy. This involves staff having difficult conversations with patients and their families about care home choices, which sometimes resulted in families bringing their solicitors to meetings. To address this issue we were told about plans to train staff on the choice policy and introduce performance indicators. The policy was being reviewed at the time of this audit.

[13] When a patient needs to be discharged to a care home, the Choice Policy sets out the process and procedures.

48 Some interviewees felt the Integrated Discharge Service (IDS) was too complicated, there was confusion about when to refer patients to the service and there are capacity issues. On reviewing the operational level DToC action plan, there are a number of actions which will help to improve communication between wards and the integrated teams such as IDS and CRTs. For example, representation at multi-disciplinary team meetings, early referral and for IDS and CRT to attend monthly DToC data validation meetings. In addition, part of the 2016-17 ICF allocation is being used to increase IDS capacity.

49 Domiciliary care and care home capacity is a national issue for which a more sustainable solution has to be sought. As mentioned above, partners are exploring joint commissioning and locality model options for older people's services, which is part of their fast track integration plans.

Performance is widely and regularly reported across the Partnership ensuring a sustained focus, but there are concerns about how it is measured

50 Regular and wide reporting ensures there is a sustained focus on tackling DToC. Performance is reported at strategic partnership boards as well as through local authority and health board governance structures. At a partnership level, DToC performance is reported to the Regional Partnership Board and to the IHSC Strategic Leadership Group. At both Cardiff and Vale Councils, Cabinet receives a quarterly update through regular performance reporting and DToC performance is scrutinised at the relevant scrutiny committees. At the Health Board, the Board meets every two months and receives a performance report that includes DToC. As part of this review, we interviewed key stakeholders from each partner organisation. Positively the interviews showed that all parties had a collective understanding of regional performance, issues and actions being taken to improve performance.

51 Interviewees had mixed feelings about the usefulness of DToC as a measure. Those whose role involved overseeing and scrutinising performance, such as cabinet and scrutiny committee members, thought the measure was useful in providing a snapshot of performance from which to explore issues further. However, stakeholders involved in operational and strategic planning highlighted a number of issues with the measure.

52 On the third Wednesday of each month all health board regions take a census of DToC. Health boards upload their DToC numbers to the NHS DToC database and the data is made available on Welsh Government's StatsWales website. Before DToC data is uploaded on the database, health and social care partners at Cardiff and Vale meet to agree the figures. At these meetings, partners assign and agree a reason for each delayed patient, the reason codes generally fall into either social care (local authority) or health reasons. Some of those interviewed felt the categories reinforced a blame culture, which at times caused disagreements. There were also issues raised about the short amount of time allowed to agree data. Local authorities do not have access to the NHS DToC database, which some reported felt like health controlled DToC data. Another issue raised was that the figures underestimate the complexity of some of the cases, for example sourcing a care home with bariatric equipment and suitably qualified staff.

53 DToC is the only national performance measure shared by health boards and local authorities. However, at a time when health boards and local authorities are being encouraged to integrate services it is unclear how DToC as a measure supports this vision.

54 Currently, one of the national strategic performance indicators is 'rate of delayed transfers of care for social care reasons per 1,000 population for those aged 75 and over'. Moving forward, this measure is part of a suite of Social Services and Wellbeing Act performance indicators. Whilst the Partnership has little control over reporting against national performance measures, there are plans in place to develop a 'patient journey dashboard'. The dashboard will allow partners to see performance at various stages of a patients care journey, this means from when a person first needs help to when they go home or to another care setting. Seeing the whole process will allow partners to tackle issues before the patient becomes a DToC. At the time of this review, the dashboard was in development and the intention is to report performance to the IHSC Strategic Leadership Group each quarter.

Findings from a recent audit on discharge planning support plans to introduce a patient flow performance dashboard

55 Planning for discharge from hospital is fundamental to a patient's safety. Ultimately, poor discharge planning leads to DToC, which in turn can have a negative effect on a person's health. In January 2016, the Delivery Unit[14] carried out a review of discharge planning at all acute hospitals in Wales. For Cardiff and Vale, this meant a review of all case notes for patients discharged from University Hospital Wales and University Hospital Llandough during the second week of January 2016. The Delivery Unit reviewed patient case notes against the Welsh Government's Discharge Process Map, which is seen as best practice.

56 Findings from the hospital audits were less than positive and collectively concluded that extended lengths of stay and less than optimal discharge planning had led to poor patient experience, increased risk of harm, and readmission in some cases. Issues highlighted by the Delivery Unit could have been avoided by ensuring discharge planning processes were followed. For example, by identifying whether a patient has simple or complex discharge needs and for complex cases assigning a care co-ordinator to avoid delays in onward care. The audit found that acute hospitals were reasonable at considering alternative community pathways, for example home care package and rehabilitation/reablement, but waits to access those services extended patients length of stay. In general, managing complex cases was found to be ineffective. For example, patient notes showed few multi-disciplinary team (MDT) case conferences. At MDT meetings discharge plans and/or assessments are agreed. There was also no evidence of assigning a care co-ordinator; for complex cases a care co-ordinator acts as the liaison person between the patient/family and the care services the patient needs.

57 The findings from the Delivery Unit's discharge audit adds weight to the Partnership's plans to introduce a patient flow performance dashboard. Moving forward, the Partnership needs to develop an action plan outlining how they will tackle the findings from the discharge planning audit.

[14] The First Ministers Delivery Unit evaluates and reports on progress against Welsh Government priorities. The Delivery Unit was created in 2011.

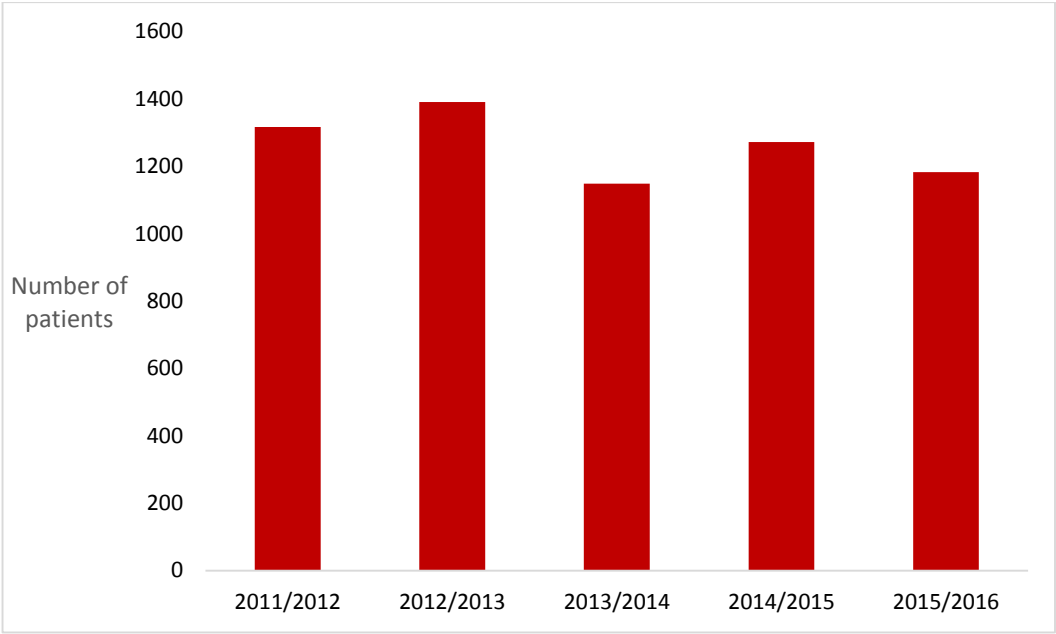
Performance is steadily improving though delayed transfers of care remain the second highest in Wales

58 Over the past five years, the region has seen a steady decline in the number of people experiencing DToC. In 2011 and 2012, Cardiff and Vale had the highest average number of DToCs reported each month in Wales, since then, the region has maintained second place. The improvement extends to the number of bed days lost and average length of stay, which have both seen a steady decline. These figures show that onward care for delayed patients is resolved more quickly than in the past, which in turn points to better co-ordination between partner organisations.

59 Exhibit 3 shows the total number of patients delayed between 2011-12 and 2015-16. The number of patients experiencing a delay has fluctuated, but overall there has been a 10 per cent reduction. In particular, there was a dramatic drop between 2012-13 and 2013-14. Numbers increased again the following year, but last year (2015-16), the region saw a seven per cent reduction in overall numbers. Exhibit 4 shows that the reduction was across all delay categories except for those waiting for a care home place. In addition, the region saw a nine per cent reduction in the total number of bed days lost (between 2014-15 and 2015-16).

Exhibit 3: Total number of patients delayed between 2011/12 and 2015/16

Graph showing the total numbers of patients experiencing a delay over the past five years (2011-12 and 2015-16). Numbers have fluctuated but there has been an overall reduction.



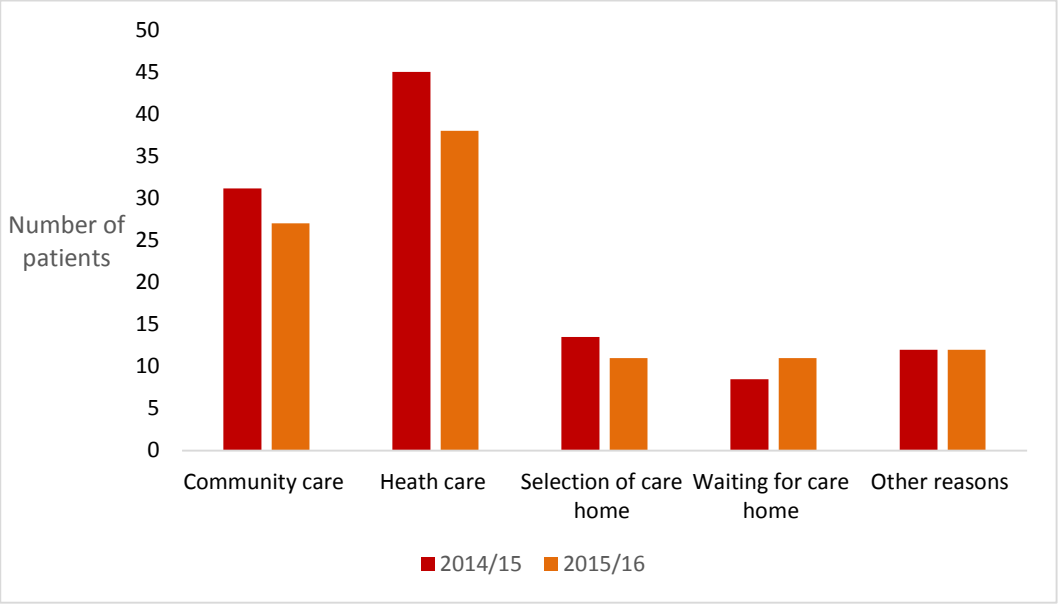
Data source: The Health Board's DToC report, March 2016

60 Delays for health care and community care reasons account for the majority of DToCs, in 2015-16 this was 65 per cent. The largest number of delays are because of health care reasons, such as waiting for equipment, assessment/arrangements by physiotherapists, occupational therapists, and palliative care team. Last year, approximately 40 per cent of delays were because of health care reasons and 63 per cent of these were because of delays in health care assessments. However, between 2014-15 and 2015-16 there was a drop in the average number of DToCs reported each month for health care reasons (from 45 to 38).

61 The second largest number of delays are for community care reasons, which could mean waiting for suitable housing such as sheltered accommodation, home adaptations and for a home care package. Last year approximately 30 per cent of delays were because of community care reasons and 90 per cent of these were because of delays in community care arrangements. Mirroring the overall trend, between 2014-15 and 2015-16 there was a drop in the average numbers reported each month for community care reasons (from 31 to 27).

Exhibit 4: Average number of delayed patients per month, by reason, in 2014/15 and 2015/16

Graph showing the average number of patients delayed per month, split by reason, in 2014-15 and 2015-16. Delays for health care and community care reasons are the highest for both years but there has been a reduction.

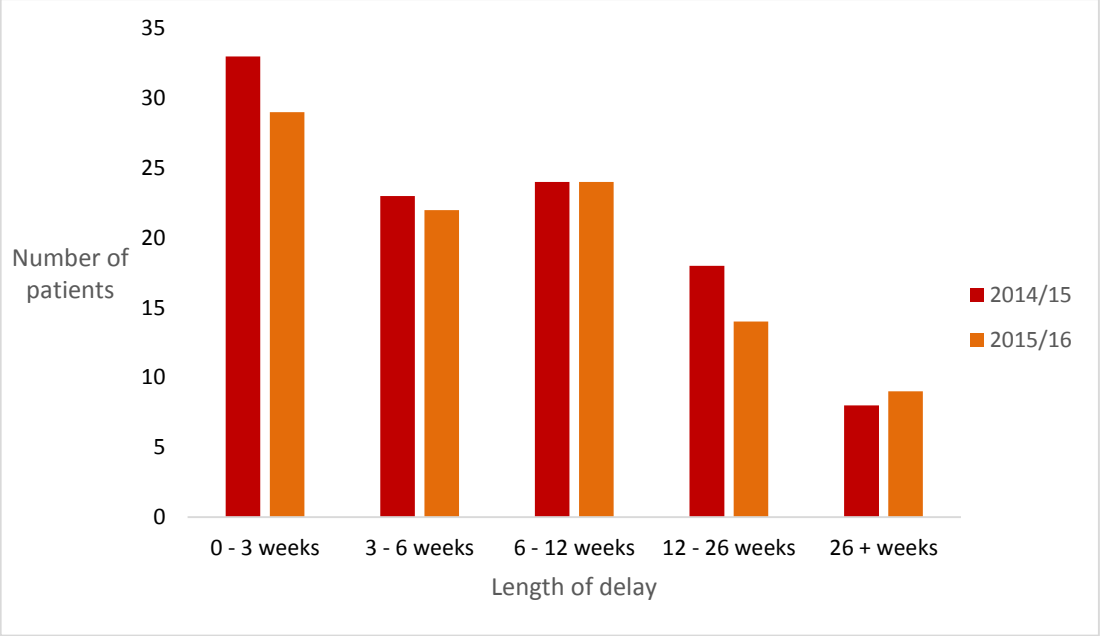


Data source: NHS Wales delayed transfers of care database and Wales Audit Office analysis.
Note: 'Other reasons' include legal, financial, disagreements etc.

62 As well as a fall in the actual numbers of patients delayed, patients are also delayed for a shorter length of time. Between 2014-15 and 2015-16 the average length of delays fell across most time categories (Exhibit 5). There was little change in the number of patients delayed for 6-12 weeks and there was a slight increase in those delayed for 26 weeks and over (from an average of 8 to 9).

Exhibit 5: Average number of patients delayed per month, by length of delay, in 2014/15 and 2015/16

Graph showing the average number of patients delayed per month, split by length of delay, in 2014-15 and 2015-16. Graph shows the average length of delay fell across most time categories.



Data source: NHS Wales delayed transfers of care database and Wales Audit Office analysis

63 For local authorities, a key performance indicator is the rate of delays per 10,000 of the population aged 75 and over. At 28 (Cardiff) and 27 (Vale) the average rate for both local authority areas is similar. The same is true for mental health delays, with six (Cardiff) and five (Vale) in every 10,000 residents aged 75 and over delayed (averages based on 2015-16 performance data).

Appendix 1

Audit approach

Audit approach

We carried out this review through semi-structured interviews with key stakeholders, reviewing documents, and analysing performance data with further detail provided in the table below.

Method	Detail
Stakeholder interviews	We conducted semi-structured interviews with a range of key stakeholders, these included: **Cardiff and Vale University Health Board** Chief Operating Officer Director of Planning Head of Operations and Delivery, PCIC Cardiff Locality Manager Clinical Board Lead Nurse, PCIC Assistant Director of Nursing **Cardiff Council** Cabinet Member for Health, Housing and Wellbeing Chair of Community and Adult Services Scrutiny Committee Director of Social Services Assistant Director of Social Services Head of Housing Integrated Discharge Service Team Manager Adult Social Services Operational Manager **Vale of Glamorgan Council** Chair of Social Care and Health Scrutiny Committee Cabinet Member for Adult Services Director of Social Services Head of Housing Head of Adult Services/Locality Manager **Third sector** CEO Glamorgan Voluntary Services CEO Cardiff Third Sector Council **Partnership posts** Assistant Director, Integrating Health and Social Care Programme Manager for Health, Social Care and Well-Being Implementation Lead for Social Services and Wellbeing Act

Method	Detail
Document review	We requested and reviewed documents, these included: • DToC and integration strategies and action plans • Minutes of relevant meetings where DToC issues and performance are discussed • Partnership governance structures • Evaluation reports from internal and external reviews
Data analysis	We analysed performance data from the NHS Wales delayed transfers of care database, which is available on the Welsh Government's StatsWales website, and data provided by the Health Board.

Appendix 2

Good practice case studies

Good practice case studies

Example case studies of service models and initiatives that other health and social care services in England and Wales are using to reduce DToC.

Good practice case studies
Croydon Health Services Trust: Enhanced front door model, Edgecombe Unit As part of a radical plan to enhance the patient journey and redesign the front-end (emergency unit) model of care, the trust decided to co-locate acute assessment, ambulatory and comprehensive geriatric care services under one umbrella and in one single environment. These services now work collaboratively with the support of community and mental health services, creating a first-of-its-kind unit with one-stop consultant high quality care.
Powys Teaching Health Board: Virtual Ward The Virtual Ward operates in the same way as a normal hospital ward, the difference is the patient stays comfortably and safely in their own home. The service is for patients who are at risk of emergency hospitalisation that can be avoided by a more coordinated and collaborative case management approach by their GP, District Nurse, Social Services, the third sector and specialist nurses. People are admitted and discharged from the Virtual Ward whilst they are at home. This is a number of named patients who are being proactively case managed or targeted to prevent deterioration in condition or home circumstances to prevent a hospital admission. The GP, District Nurse and Social Worker have a daily ‘ward round’ where they discuss and assess the patients on the virtual ward. In line with the principles of prudent healthcare, the most appropriate professional will attend the specific needs of the patient, and co-ordinate with the wider multi-disciplinary teams. This greatly improves the quality of care and patient outcomes and eliminates any duplication. There is a weekly multi-disciplinary team meeting where patients on the frailty register are discussed, and team working evaluated. The wider multi-disciplinary team meetings reach out to specialist services and the third sector.
Northern Devon Healthcare Trust: Enters the home care market The trust has won a bid to be prime contractor for domiciliary care services in Northern and Mid Devon, in a contract let by Northern, Eastern and Western Devon Clinical Commissioning Group (CCG), South Devon and Torbay CCG, and Devon County Council Northern Devon Healthcare Trust picked up three of the eight contract lots available. As prime contractor for Devon Cares, Northern Devon will not directly deliver the services, but will manage providers who will. If the trust has oversight of the local domiciliary care market, it can hopefully manage the services to prevent avoidable hospital admissions.

Good practice case studies
Aneurin Bevan Health Board: Trip Advisor style review site for Care Homes[15] Aneurin Bevan Health Board is using a Trip Advisor style website to help people select care homes. The 'Think About Me: Good Care Guide' allows people to leave reviews about care homes to help families make informed decisions. So far, 80 out of the 96 homes across Gwent have joined this pilot project.

[15] Trip Advisor style review site for Care Homes. Aneurin Bevan University Health Board website

Appendix 3

Management response

Management response

The table below shows the Partnership's response to our recommendations.

Ref	Recommendation	Intended outcome/ benefit	High priority (✓)	Accepted	Management response	Completion date	Responsible officer
R1	Address the findings from the Delivery Units discharge planning audit either by: • developing a separate action plan; or • incorporating actions into existing service improvement action plans.	**Improved discharge planning to prevent delays in discharging patients**	High	Accepted	A well-developed Discharge/Transfer plan is already in existence which includes many of the recommendations made as a result of the Delivery Unit audit. The plan will be reviewed and any omissions will be added. The Integrated Health and Social Care Partnership's Home First Plan also includes aspects of the DU audit recommendations. Progress against this plan is regularly reported within the partnership governance arrangements.	End October 2016 Ongoing	Head of Integrated Care in collaboration with relevant Clinical Boards. Integrated Health and Social Care Partnership

Ref	Recommendation	Intended outcome/ benefit	High priority (✓)	Accepted	Management response	Completion date	Responsible officer
R2	Explore ways of mainstreaming services funded through the ICF to ensure services remain resilient.	**Strengthened service resilience and continuity**	Medium	Accepted	The ICF Programme Board is reviewing progress of all ICF projects and makes recommendations in relation to priorities and investment to the Strategic Leadership Group. All projects/services are using RBA to demonstrate outcomes, impact and value for money. A review of existing ICF projects will be undertaken by the SLG in November 2016 to inform prioritisation of investment in 2017/18 following WG's recent notification of recurrent ICF funding. Through the existing Partnership arrangements and reporting mechanisms projects will be subject to ongoing scrutiny and decisions made to secure funding streams which may include diversion of funding from existing mainstream services and informing new commissioning approaches based on services which have been piloted through ICF funding.	31 March 2017	Strategic Leadership Group/ Regional Partnership Board

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