PARTNERIAETH IECHYD & GOFAL CYMDEITHASOL INTEGREDIG
Caerdydd & Bro Morgannwg

Cardiff and Vale of Glamorgan
INTEGRATED HEALTH & SOCIAL CARE PARTNERSHIP

Briefing on Delayed Transfers of Care (DToC)
Strategic Leadership Group, 26th January 2017

Current Performance Status: December 2016

1. Situation

Indicator	December 2016 Position	Comparison to previous month (RAG)	Comment
Total number of delays	61	Green	➢ Decrease of 17 patients as the total is 78 for November 2016. ➢ This is a 13% decrease on the same period last year when DToCs were 70
Number of delays over the age of 75	41	Green	➢ Decrease of 8 patients from the total of 49 in November 2016. ➢ This is a c.0% improvement against the Dec 2015 position of 41.
Number of bed days lost as result of delay.	1960	Green	➢ Decrease of 103 days from November 2016 ➢ Increase of 246 days from the Dec 2015 position of 1714.

2. Background

- **22** of these patients are within **mental health services**, a decrease of **5** patients since the previous month. These delays are in the main attributable to capacity issues within the Move On Team which impacts upon the QA process, placement sourcing and the appeals process.
- The remaining patients rest within acute, **non mental health** services, **30** of whom are within Medicine.
- **38** of the delayed patients live in Cardiff, whilst **21** reside within the Vale of Glamorgan. **2** of the delayed patients are from Out of Area.
- The three main reasons for delay are **choice (24 patients)**, **health (23 patients)** and **social (10 patients)**. Whilst the choice of care home accounts for a significant number of DToCs , the lack of available and suitable care home beds restricts the choice for families .

The following graph details the DToC position since April 2015 and although the number has decreased over the past month focussed work needs to continue, particularly over the coming winter months; however, of note there does remain a significant reduction in the position as compared to this time last year

- Along with many regions across Wales, the Partnership continues to face significant emergency pressures across our services:

  - The UHB continues to experience significant pressures across all hospitals. Domiciliary care capacity is improving although the capacity to meet increased demand still remains a concern.
  - The average number of service users supported by home care within the CRT at any given time is approximately 230; at present they are supporting almost 280, placing significant pressure and risk upon the service as a whole.

- **Target:** the Partnership has identified a target of DTOCs in 2016/17, aiming to achieve a 25% reduction on the February 2016 position (**79 delays**), which has once again been achieved this month.

Appendix 1 provides an overview of the latest performance figures submitted to Welsh Government for activity during October 2016.

2. Assessment and Action

2.1 Health Related Issues and Actions

Weekly Review of DToCs
The weekly DToC review meeting chaired by Head of Integrated Care continues as a mechanism to review cases and offers challenge to process, problem solve and escalate constraints both occurring in non mental health and mental health directorates.

Patient Choice /Disputes
In order to support the ward based teams in the management of the very difficult and complex disputed cases the internal escalation process continues within Medicine Clinical Board to ensure senior overview of the cases. Case conference type meetings have been held with agreed actions to expedite discharge where possible in Medicine, Surgical and Specialist Clinical Boards. A series of case reviews is planned Chaired by Head of Integrated Care, to discuss with MDT s every case which has been included in two or more DToC audit cycles.

Mental Health Assessment Issues
Recruitment processes continue to ensure full establishment within the Move On team, and the weekly review meeting chaired by Head of Integrated Care , continues to review cases and offer challenge to process, problem solve and escalate constraints and develop contingency plans to address capacity issues.

Delivery Unit Report
Delivery and Support Unit audit recommendations continue to be reviewed and work is now planned to consider the outcomes of the National Care Home placement audit .The Head of Integrated Care continues to have responsibility for the overview of both aspects of this work, working in close conjunction with Clinical Boards and senior Health Board colleagues. Further development and training is planned to reinforce the messages of effective discharge planning.

2.2 Social Care Issues and Actions

Domiciliary Care Capacity
Domiciliary Care capacity remains a concern both in Cardiff and Vale, both organisations are currently experiencing high demand for complex packages of care which also continue to be more difficult to source.

Nursing Home Capacity
EMI Nursing Home capacity continues to be of concern within **Cardiff and the Vale.** Within **Cardiff** a number of care providers are currently being managed via the Escalating Concerns procedure which has affected capacity across the area. The Escalating Concerns procedure is being following as quickly as possible in order to increase capacity whilst ensuring safe and effective services for citizens.

3. Partnership Response

ICF Funded Projects
Projects funded via the ICF continue to be on track. The Integrated Discharge Team (IDT) is now working across the organisation and the Discharge Support Officers are all in post along with the Nurse to support education and development. These posts work in conjunction with the additional Social Workers. However recruitment continues to secure the appointment of further Assistant Social Worker roles. The ICF supported Discharge to Assess residential model has commenced and has been successful in a supporting a small number of patients within the community.

Home First Plan
The Partnership continues to implement a Home First agenda to improve both the number of delayed transfers of care and the flow of citizens across our services the agreed Home First plan is provided for information as ***Appendix 2.***

This regional plan is the latest version of the Delayed Transfers of Care Action Plan which has been updated to provide an overview of arrangements to:

- focus the development of services to expedite the progress of citizens using our acute and / or long term care services and;
- where possible, to reduce the number of people who require those services.

The elements within the plan were identified by the Whole Systems Partnership to identify areas where further integration of services would be of mutual benefit to partners and citizens.

- **First contact (FC) i.e. when people present with a potential need**
- **Ongoing support (OS) i.e. when people have an ongoing, though relatively stable, set of needs**
- **Crisis response (CR) i.e. when people have a crisis or short lived exacerbation of need**
-

Intermediate Care Fund
The ICF (ICF) projects are all now at varying stages of implementation with anticipated state of readiness in time to support the additional demand of winter pressures.

The SLG has previously been made aware of the agreed projects which include:

- Preventative services aligned across the region to maximise opportunities to prevent escalation of need to hospital admission;
- Alignment of a single point of access service across both Local Authorities;
- Expansion of existing integrated Community Resource Teams
- Expansion of Community Resource Team to support a residential discharge to assess model
- Expansion of a multi-disciplinary Integrated Discharge Team;
- Continued accommodation solutions model;
- Various services for the care of patient's dementia.

Both the Head of Integrated Care (Operations) and the Assistant Director for Integrating Health and Social Care, continue to work across Cardiff & Vale UHB, Cardiff Council and Vale of Glamorgan Council, driving forward the discharge agenda and integration agenda in order to reduce the number of delayed transfers of care and facilitate the prompt discharge of Patients working with Partners to secure effective out of hospital services.

Collaborative work continues to support work associated with reducing admissions and assisting in improving the discharge process.

Examples include:

- **Preventative Interventions -** First point of contact to provide information, advice and signposting to local events and team of Independent Living Officers to help people remain in their own homes:

  - **Over 2909 calls have been made to the service since April 2016 of these an average of 25% were referrals from Health partners**

  - **94%** felt able to remain living in their own home
  - **92%** felt the services provided had improved their quality of life
  - **£3.079m** additional unclaimed welfare benefits released to Cardiff citizens though income assessment during this financial year

- **Single Point of Access –** provision of integrated locality social care and community health services. Services include Adult social services, Locality Community Health Services, District Nursing, GP Out of Hours, Dental Helpline, Podiatry, Nurse Assessor Team, Elderly Care Assessment Service, Generic Continence Services, equipment requests etc

- **Housing Solutions Team**

- **401 referrals** have been made to the Housing Solutions Team since April 2016 from a variety of ward and hospitals across the UHB region.

  - **177** patient discharges have been assisted directly by the team.
  - Provision of **8 Step Down Flats** have been used by patients as interim accommodation following a hospital stay - **32** of these people had been listed as Delayed Transfers of Care. It is estimated that in total **1258 bed days** have been avoided through the use of Step Down Accommodation.

The **Primary Care Fund** is also being utilised to good effect with 7 day working for Community Resource Teams implemented from January 2016

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Appendix 1

Delayed Transfers of Care - Latest Month's Census -21 Dec 2016

Introduction

A delayed transfer of care (DTOC) is experienced by an inpatient occupying a bed in an NHS hospital who is ready to progress to the next stage of care but is prevented from doing so for one or more reasons. The arrangements for transfer to the next stage of care can either be within or outside of the NHS. Timely transfer and discharge arrangements are important as delays lead to poor patient experience and increased operational pressures on the whole unscheduled care system. The two Current Internal Targets for the number of DTOCS agreed by the Partnership are a 25% reduction on June 2015 position of 82 Patients and a 25% reduction on February 2015 position of 117 Patients. The Target for the number of bed days Lost is a 25% reduction on June 2015 position 2305.

Key Messages for December 2016

- The total number of DTOCS for December 2016 is 61 compared to 78 for November 2016, a decrease in month of 22%

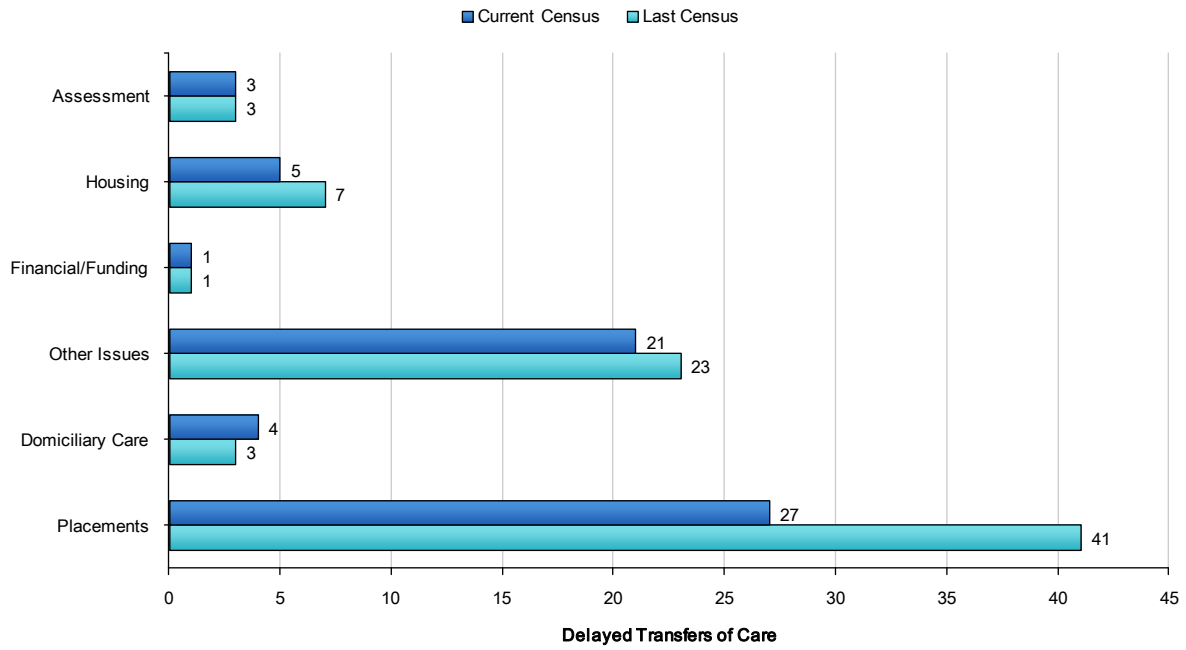
- The number is 13% lower than the same period last year (70)

- The total number of DTOCS Aged 75+ for December 2016 is 41 compared to 49 for November 2016 a decrease in month of 16%

- The Number of Bed Days Lost for December 2016 is 1,960 compared to 2,063 for November 2016 a decrease in month of 5%

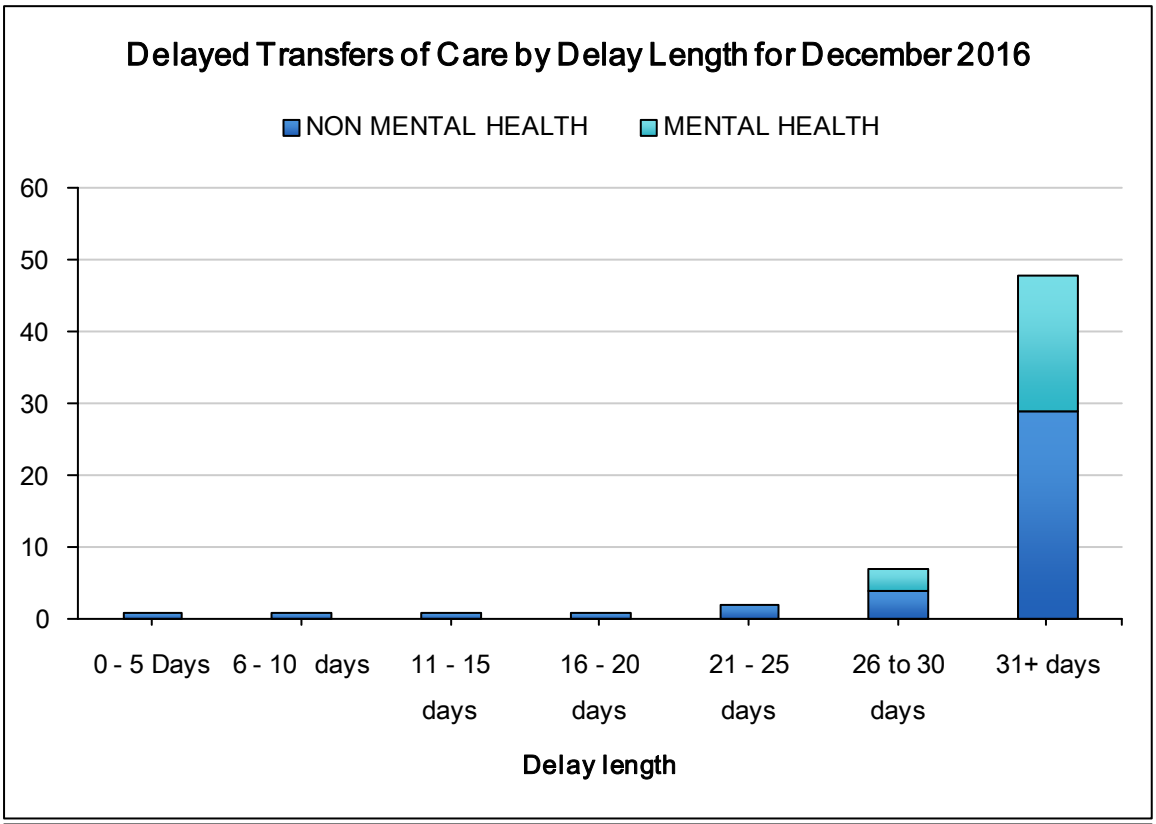
- Change from last Month, Mental Health (Decrease of 5), Specialist (Decrease of 1), Surgery (Increase of 1) and Medicine (Decrease of 12)

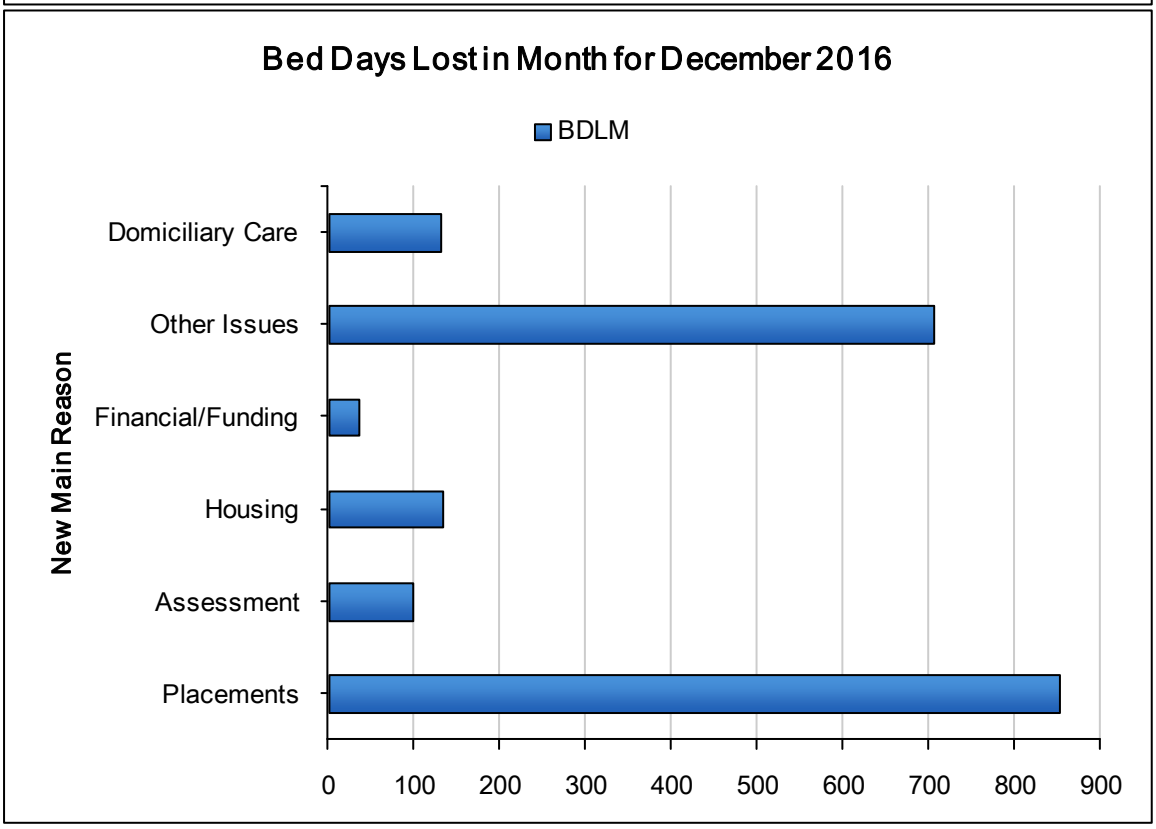
Section 1: Delayed Transfers of Care – Current position as of December 2016 Compared to Previous Month



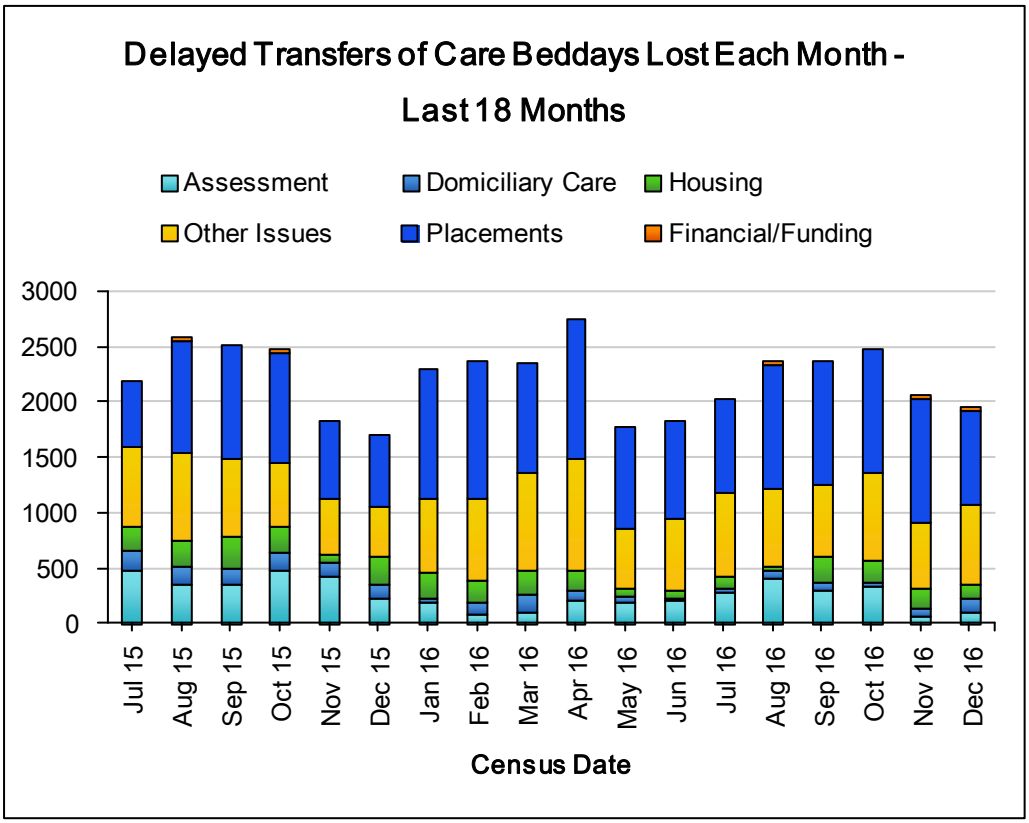
Breakdown of Overall DTOC reasons for Current Month against Previous Month	Cardiff Residents		Vale Residents		Out of Area Residents		Not Known		CurrTotal	Last Total
	Current Census	Last Census	Current Census	Last Census	Current Census	Last Census	Current Census	Last Census		
Assessment	2	3	1	0					3	3
Housing	3	5	1	1	1	0	0	1	5	7
Financial/Funding			1	1					1	1
Domiciliary Care	3	2	1	1					4	3
Other Issues	13	17	7	5	1	1			21	23
Placements	17	17	10	24					27	41
Placements EMI	6	8	2	12					8	20
Placements Nursing Home	3	1	4	7					7	8
Placement Arrangements	1	3	0	1					1	4
No Placement Identified	2	0	4	3					6	3
Placement Other	5	5	0	1					5	6
Total	38	44	21	32	2	1	0	1	61	78

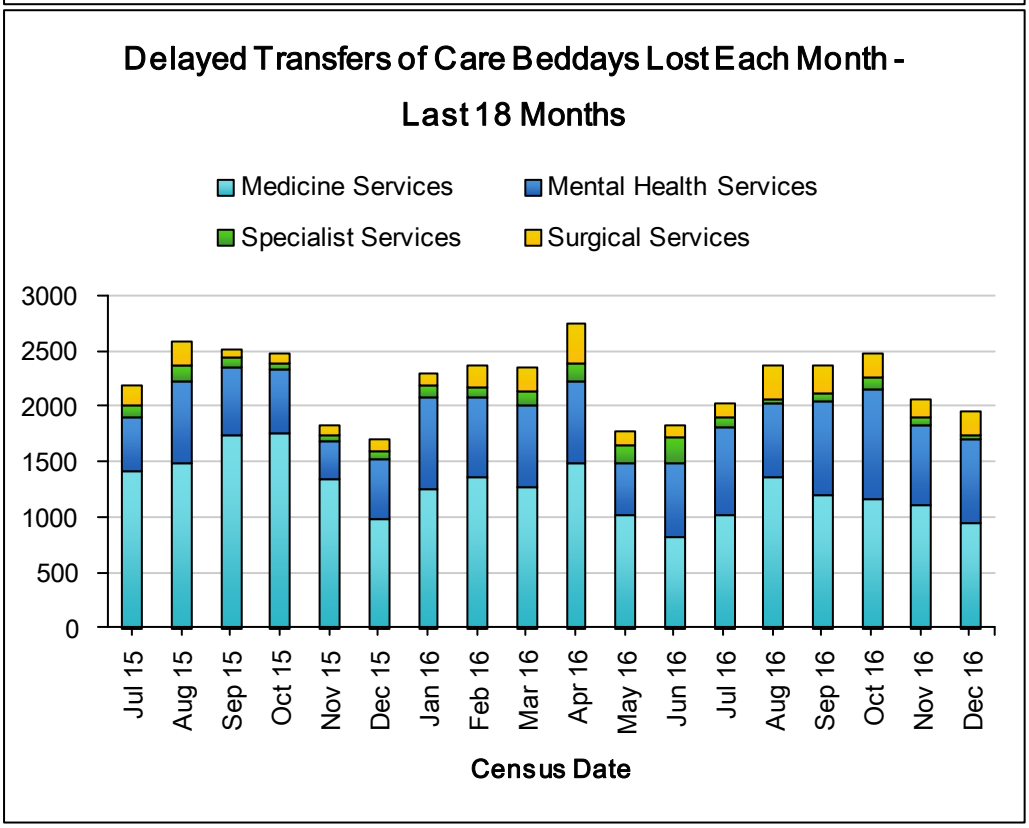
Section 2: Breakdown of Delay Reasons and Bed Days Lost – December2016

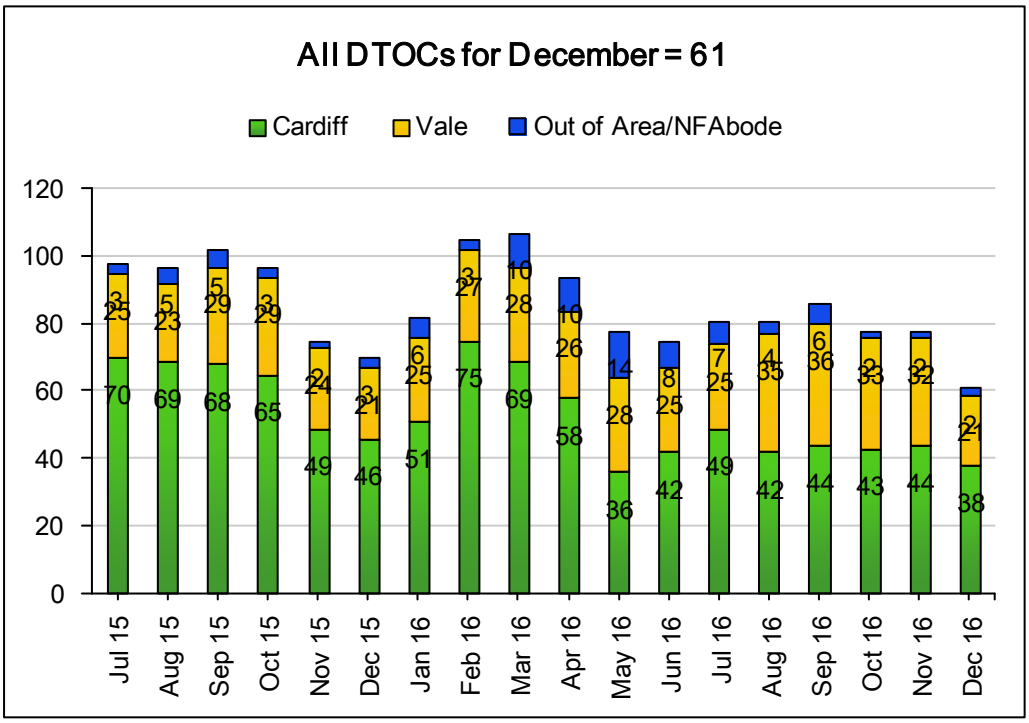


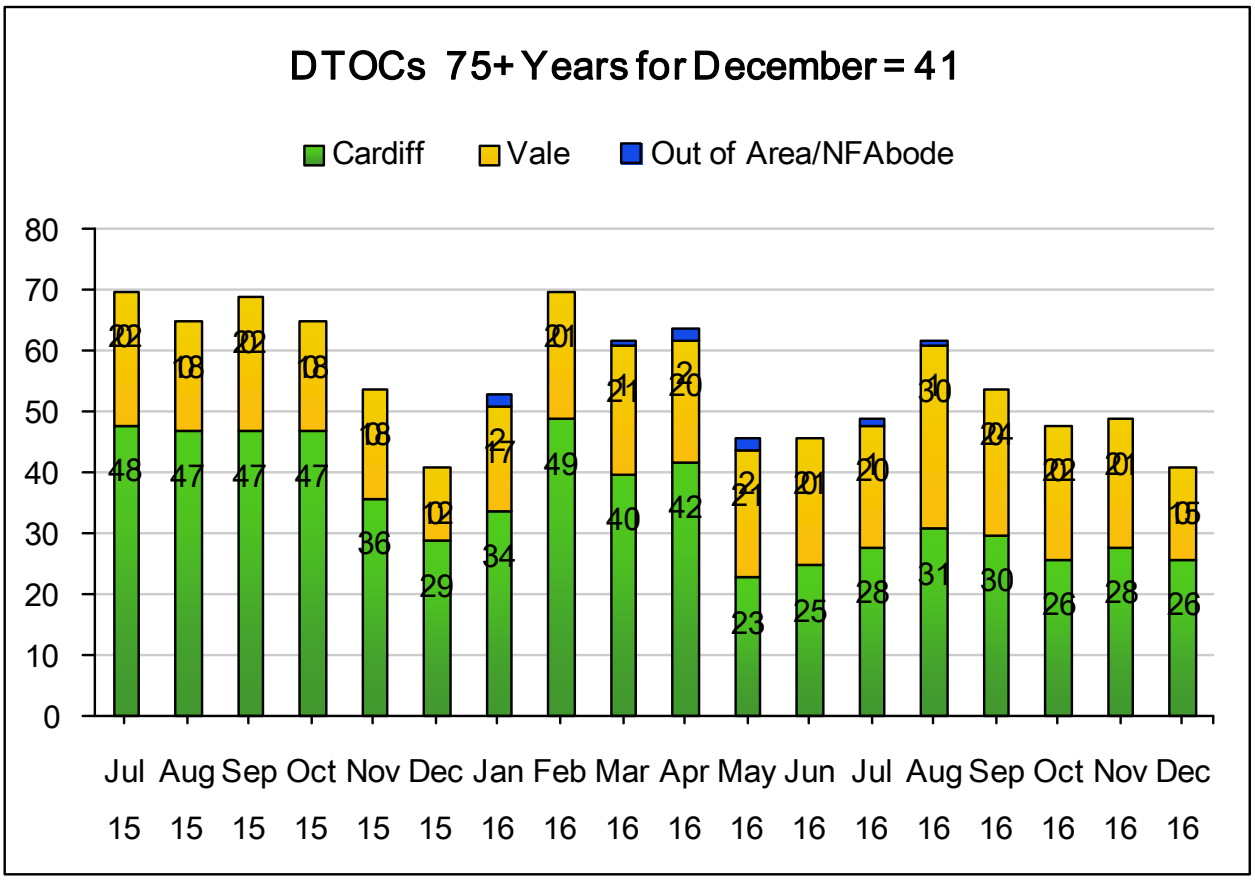


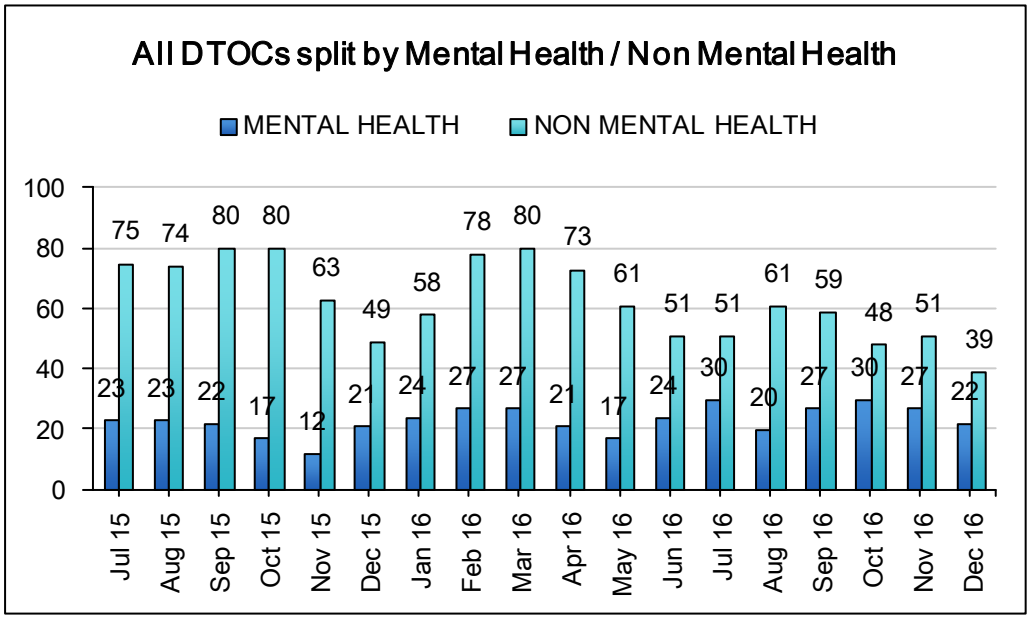
Section 3: 18 Month Trend Analysis of Number and Reasons for Delay

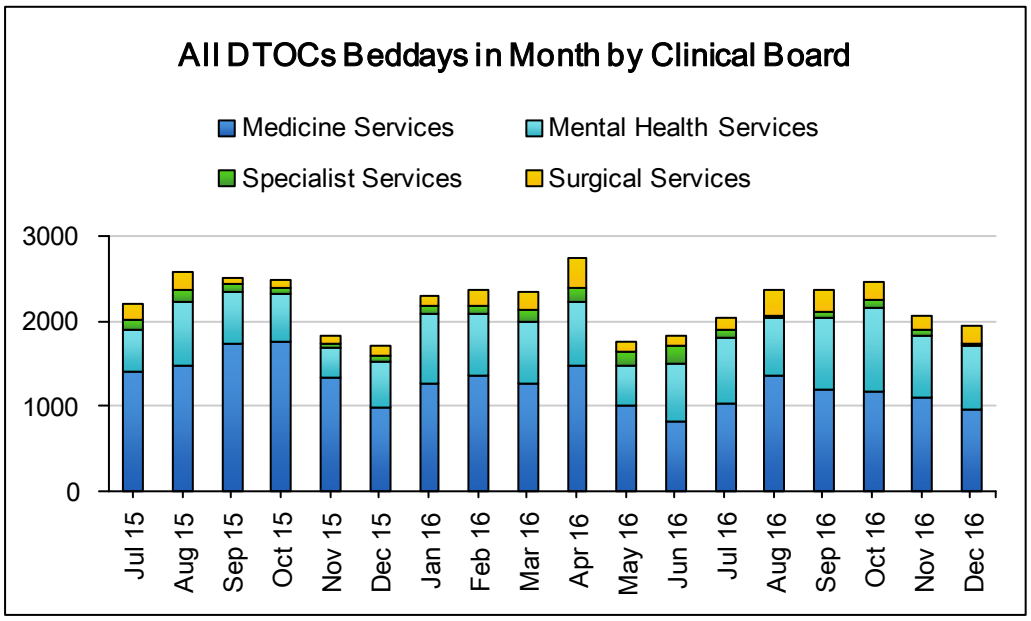


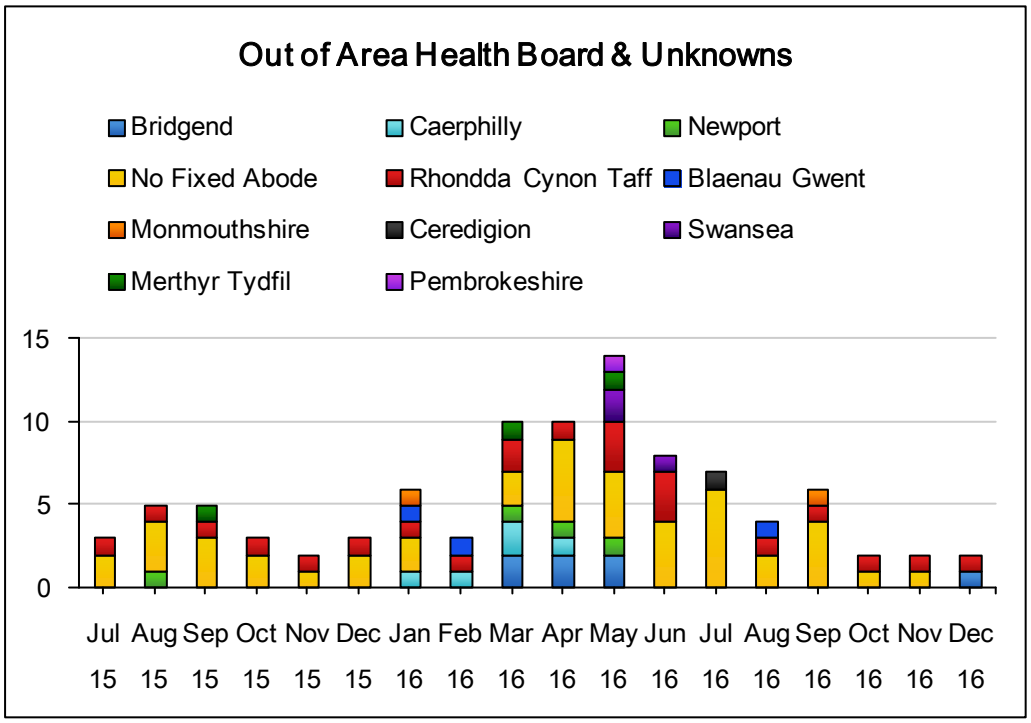


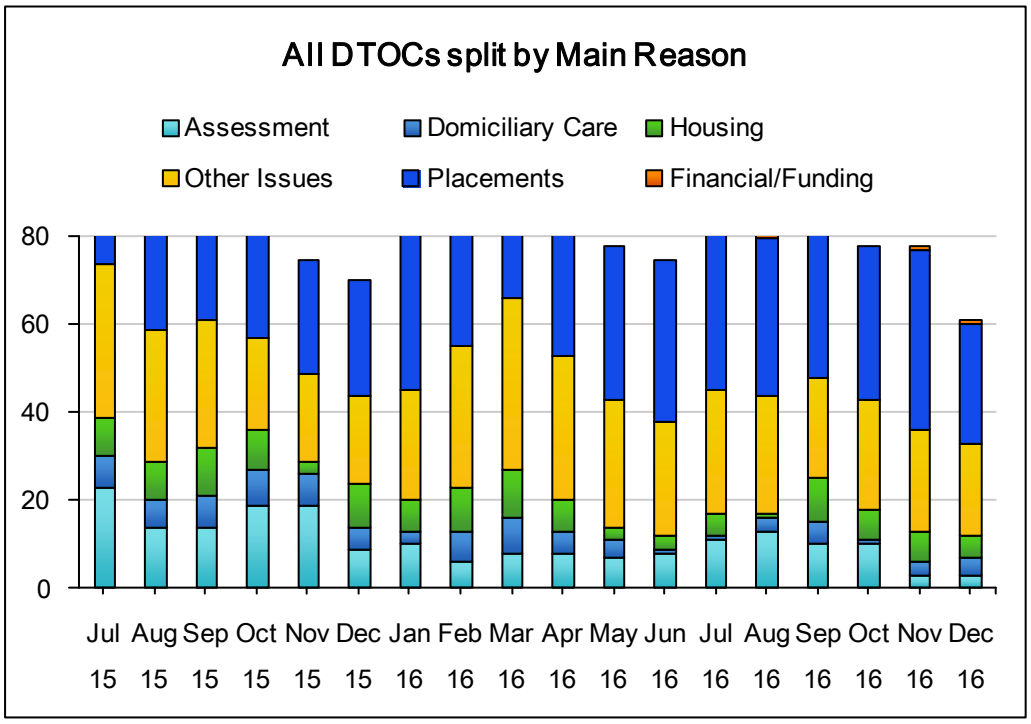

All DTOCs for December = 61
Cardiff
Vale
Out of Area/NFAbode
120
100
80
60
40
20
0
Jul 15
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16

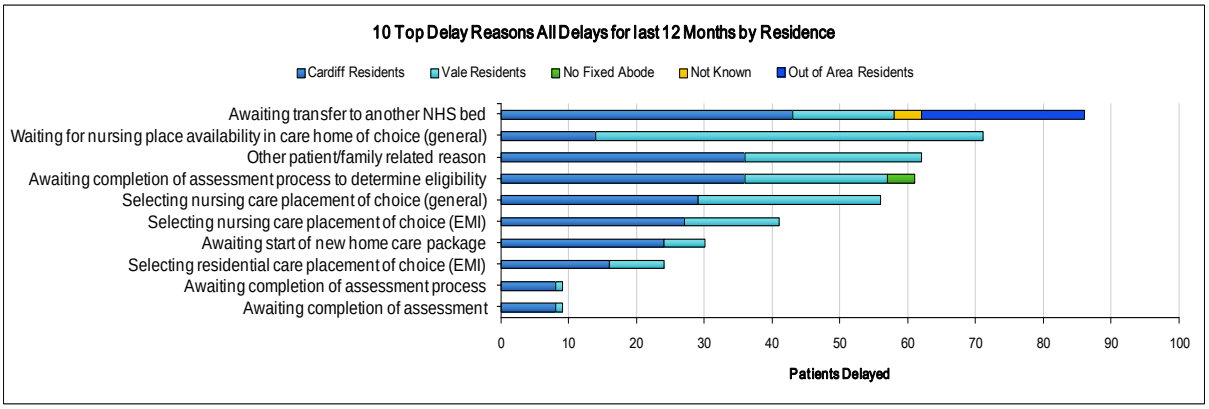

DTOCs 75+ Years for December = 41
Cardiff
Vale
Out of Area/NFAbode
80
70
60
50
40
30
20
10
0
Jul 15
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16

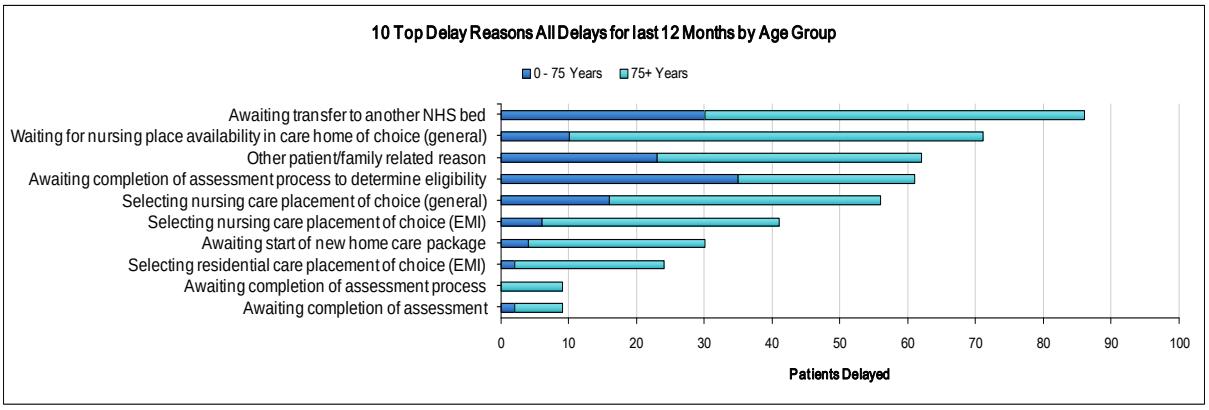

All DTOCs split by Mental Health / Non Mental Health
MENTAL HEALTH
NON MENTAL HEALTH
100
80
60
40
20
0
75 74 80 80 63 49 58 78 80 73 61 51 51 61 59 48 51 39
23 23 22 17 12 21 24 27 27 21 17 24 30 20 27 30 27 22
Jul 15
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16

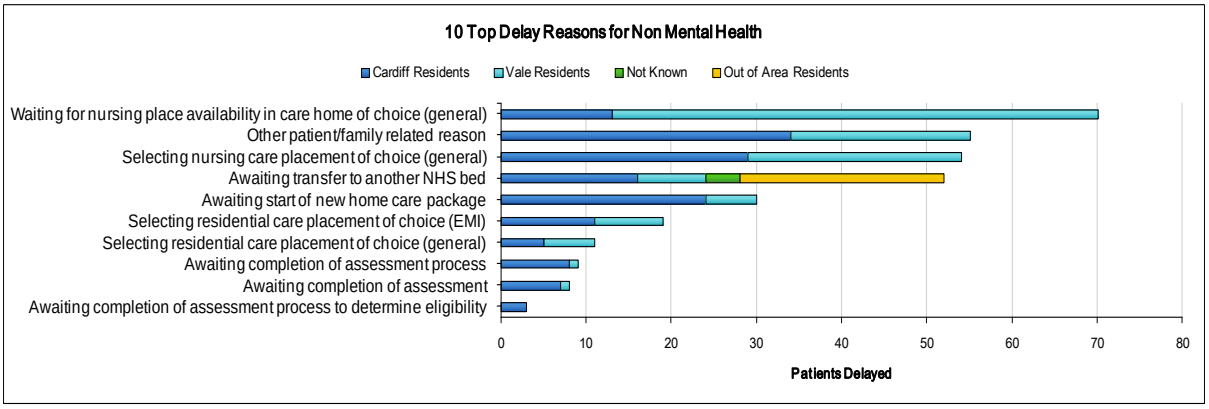

All DTOCs Beddays in Month by Clinical Board
Medicine Services
Mental Health Services
Specialist Services
Surgical Services
3000
2000
1000
0
Jul 15
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16

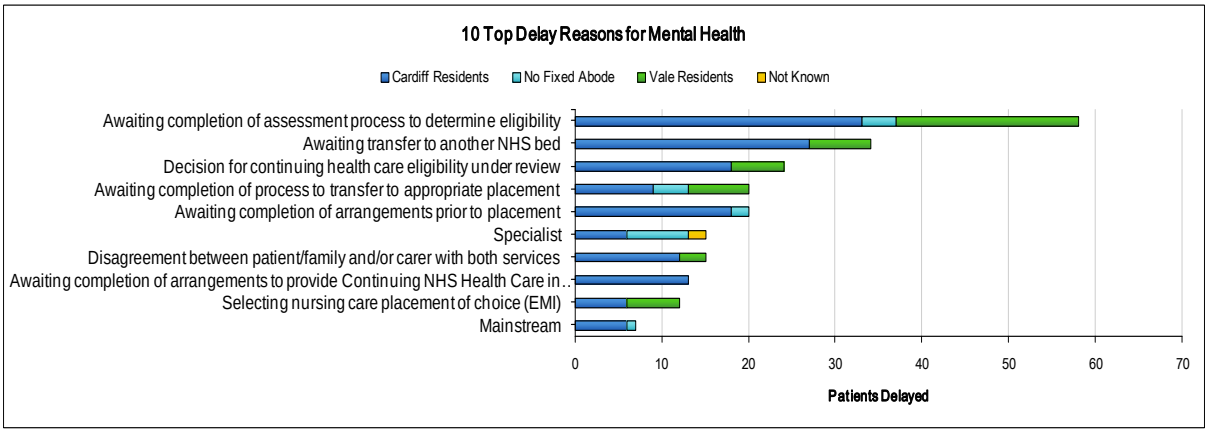

Out of Area Health Board & Unknowns
Bridgend
Caerphilly
Newport
No Fixed Abode
Rhondda Cynon Taff
Blaenau Gwent
Monmouthshire
Ceredigion
Swansea
Merthyr Tydfil
Pembrokeshire
15
10
5
0
Jul 15
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16

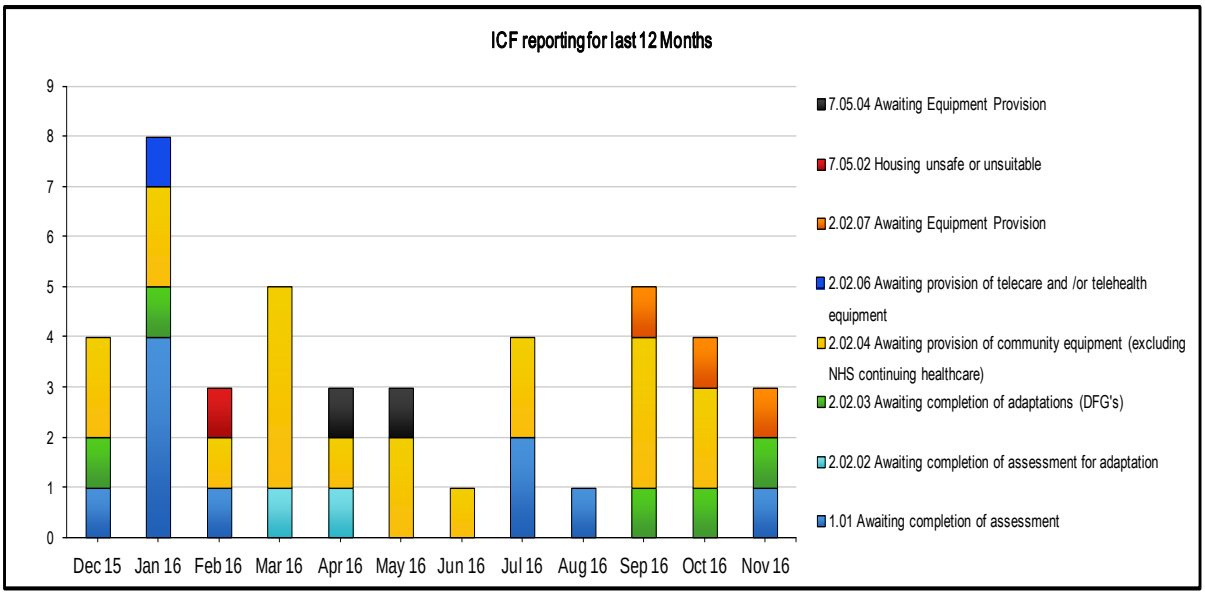

All DTOCs split by Main Reason
Assessment
Domiciliary Care
Housing
Other Issues
Placements
Financial/Funding
80
60
40
20
0
Jul 15
Aug 15
Sep 15
Oct 15
Nov 15
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
Dec 16


10 Top Delay Reasons All Delays for last 12 Months by Residence
Cardiff Residents
Vale Residents
No Fixed Abode
Not Known
Out of Area Residents
Awaiting transfer to another NHS bed
Waiting for nursing place availability in care home of choice (general)
Other patient/family related reason
Awaiting completion of assessment process to determine eligibility
Selecting nursing care placement of choice (general)
Selecting nursing care placement of choice (EMI)
Awaiting start of new home care package
Selecting residential care placement of choice (EMI)
Awaiting completion of assessment process
Awaiting completion of assessment
0 10 20 30 40 50 60 70 80 90 100
Patients Delayed


10 Top Delay Reasons All Delays for last 12 Months by Age Group
0 - 75 Years
75+ Years
Awaiting transfer to another NHS bed
Waiting for nursing place availability in care home of choice (general)
Other patient/family related reason
Awaiting completion of assessment process to determine eligibility
Selecting nursing care placement of choice (general)
Selecting nursing care placement of choice (EMI)
Awaiting start of new home care package
Selecting residential care placement of choice (EMI)
Awaiting completion of assessment process
Awaiting completion of assessment
0 10 20 30 40 50 60 70 80 90 100
Patients Delayed


10 Top Delay Reasons for Non Mental Health
Cardiff Residents
Vale Residents
Not Known
Out of Area Residents
Waiting for nursing place availability in care home of choice (general)
Other patient/family related reason
Selecting nursing care placement of choice (general)
Awaiting transfer to another NHS bed
Awaiting start of new home care package
Selecting residential care placement of choice (EMI)
Selecting residential care placement of choice (general)
Awaiting completion of assessment process
Awaiting completion of assessment
Awaiting completion of assessment process to determine eligibility
0 10 20 30 40 50 60 70 80
Patients Delayed


10 Top Delay Reasons for Mental Health
Cardiff Residents
No Fixed Abode
Vale Residents
Not Known
Awaiting completion of assessment process to determine eligibility
Awaiting transfer to another NHS bed
Decision for continuing health care eligibility under review
Awaiting completion of process to transfer to appropriate placement
Awaiting completion of arrangements prior to placement
Specialist
Disagreement between patient/family and/or carer with both services
Awaiting completion of arrangements to provide Continuing NHS Health Care in...
Selecting nursing care placement of choice (EMI)
Mainstream
0 10 20 30 40 50 60 70
Patients Delayed


ICF reporting for last 12 Months
9
8
7
6
5
4
3
2
1
0
Dec 15
Jan 16
Feb 16
Mar 16
Apr 16
May 16
Jun 16
Jul 16
Aug 16
Sep 16
Oct 16
Nov 16
7.05.04 Awaiting Equipment Provision
7.05.02 Housing unsafe or unsuitable
2.02.07 Awaiting Equipment Provision
2.02.06 Awaiting provision of telecare and /or telehealth equipment
2.02.04 Awaiting provision of community equipment (excluding NHS continuing healthcare)
2.02.03 Awaiting completion of adaptations (DFG's)
2.02.02 Awaiting completion of assessment for adaptation
1.01 Awaiting completion of assessment

Appendix 2: Home First Plan – December 2016 Update Home First Plan – December 2016 Update

1. INTRODUCTION

This regional plan is the latest version of the Delayed Transfers of Care Action Plan which has been updated to provide an overview of arrangements to:

- focus the development of services to expedite the progress of citizens using our acute and / or long term care services and;
- where possible, to reduce the number of people who require those services.

To achieve these aims, the plan outlines a variety of focused pieces of work to address key stages in the citizen journey when the need for additional support and care is required. The stages were identified in work by the Whole Systems Partnership to identify areas where further integration of services would be of mutual benefit to partners and citizens. These are:

First contact (FC) i.e. when people present with a potential need	*Users first contact with services may arise at different levels of need, which means this part of the system requires a high level of connectivity with statutory and third sector services. Increased connectivity will facilitate getting the individual to the right professional first time and assist in demand management through the provision of advice and sign posting to third sector and community resources. First contact may also result directly in the need for a Comprehensive Assessment (CA).*
Ongoing support (OS) i.e. when people have an ongoing, though relatively stable, set of needs	*These needs are not necessarily low, just stable. This service function should have a significant preventative or enabling element and should be provided in partnership with both the patient/client and, where appropriate, their carer.*
Crisis response (CR) i.e. when people have a crisis or short lived exacerbation of need	*Responding to crisis or exacerbation to ensure optimum recovery or rehabilitation of either a single condition or the cumulative effect of multiple needs. This service function requires timely, co-ordinated and personalised responses that are able to minimise the extent to which the outcome from such events is either an inappropriate admission to hospital or an admission to long-term care when alternative support at home could have been provided.*
Comprehensive Assessment (CA) i.e. when people experience a significant and permanent stepped change	*Assessment, care planning and prescription is undertaken for people entering the care system or at points of recognisable transition as their needs change. Such services ensure that people with complex needs receive the right support on an ongoing basis as well as at times of significant change or crisis. This function often needs a degree of specialisation and therefore coordination is very important. It requires high levels of connectivity in order to avoid duplication or missed opportunities for appropriate care and support.*

At each point, our aim is to return the citizen to, or as close to their own home, as possible. The Home First Plan is intended to provide a strategic overview of the work that is underway to reduce delayed Transfers of care and improve the overall care of citizens who require care and support. It forms a fundamental component of the Patient Flow workstream within the Integrated Health and Social Care (IHSC) Partnership for Cardiff and the Vale of Glamorgan.

2. GOVERNANCE FRAMEWORK

The Governance structure to deliver implementation of this plan is overseen by the Regional Partnership Board and comprises key partners across Cardiff and Vale UHB, Cardiff Council, Vale of Glamorgan Council, the Third Sector and independent service providers.
A Scrutiny Task Group consisting of the UHB Chair, and both Council Cabinet Leads for Adult Services oversee progress on a quarterly basis.
The Chief Operating Officer holds responsibility for Patient Flow on behalf of the Partnership with delegated responsibility to the Head of Integrated Care. An outline of the Governance arrangements is provided as **Appendix 1**.

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	November 2016 Update
Assurance of partnership-wide governance arrangements for patient flow.	Instigate Scrutiny Task Group	March 2015	IHSC Partnership	**Complete**
	Initiate Regional Partnership Board to include responsibility for Patient Flow.	April 2016	IHSC Partnership	**Complete**
	Appoint Head of Integrated Care as delegated lead for Home First Plan.	June 2016	IHSC Partnership	**Complete:** post commenced October 2016.
Assurance of partnership-wide policies for Patient Flow and Choice	Approve Discharge (Patient Flow) Policy for 2016-17	June 2016	Head of Integrated Care	**Delayed:** Policy is now in draft from and will be sent for formal consolation over the next few weeks.
	Implement Choice Protocol as part of Discharge Policy (to include public facing communications campaign).	May 2016	Chief Operating Officer, UHB	**In progress:** Protocol re-drafted and legal advice received. Further development underway to ensure compliance with Social Services and Wellbeing (Wales) Act 2014 before being launched formally as part of Discharge Policy.

3. OPERATIONAL ARRANGEMENTS

The IHSC Strategic Leadership Group maintains oversight of progress via this Home First Plan to ensure a strategic fit with other integration objectives. An Operational Group, chaired by the Head of Integrated Care meets on a monthly basis to progress operational issues in relation to the management of Delayed Transfers of Care. This work is supported by weekly meetings with operational-level, multi-disciplinary staff to review all Non Mental Health and Mental Health patients with a length of stay of 100 days and over.

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	November 2016 Update
Assurance of partnership-wide operational arrangements for patient flow.	Delegation to Strategic Leadership Group for onward monitoring of Home First Plan	April 2016	IHSC Partnership	Complete
	Appoint Head of Integrated Care as delegated lead for Home First Plan.	June 2016	IHSC Partnership	**Complete:** post commenced October 2016.
Assurance of performance monitoring to support Home First Plan	Revise local monthly performance monitoring proforma to include trend analysis in addition to in-month performance.	October 2016	DTOC Operational Group	**Complete:** Final version now in circulation
	Appointment of Data Analyst to support development of Home First Data as part of wider Partnership Dashboard.	September 2016	IHSC Partnership	**Complete:** post commenced end October 2016.
	Implement full use of clinical workstation as a tool to monitor discharge across a multi-agency environment.	Ongoing roll out.	Deputy Director of Nursing, UHB	**In progress.** Training undertaken and compliance protocol implemented to ensure thrice daily updates with positive feedback.

DELIVERY PLAN

4.1 First contact (FC) i.e. when people present with a potential need AND Ongoing support i.e. when people have an ongoing, though relatively stable, set of needs

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	December **2016 Update**
There is a need to ensure a structured approach to maintaining the health and wellbeing of people in the community to prevent, wherever possible, their escalation of need.	Evaluate current initiatives funded through the ICF and PCF in 2015-16 to guauge effectiveness.	10.03.16	Programme Manager, Health Social Care and Wellbeing, UHB	**Complete.** Ongoing review of outcomes for 2016/17 schemes are being monitored to inform investment in 2017/18
	Establish ICF funded region-wide preventative intervention priorities for 2016-17 to include day opportunities, assistive technology, rapid response adaptations, locality working, be-friending and establishing a Dementia Friendly Region.	Sep 2016	Assistant Director, Housing and Communities, Cardiff Council	**In progress.** Work programme initiated, supported by capital investment to provide new assistive technology and enhanced community centre accommodation. A range of initiatives to further support preventative interventions have also been approved in principle over the winter period. This includes the development of Good Gym across Cardiff and the Vale, support for Dementia Friendly Llanishen and signposting support for CaVAMH and the British Red Cross.
Increased connectivity will facilitate getting the individual to the right professional first time and assist in demand management through the provision of advice and sign posting to third sector and community resources. Assurance of comprehensive	Evaluate the Vale of Glamorgan Single Point of Access and Cardiff First point of Contact, both funded through the ICF in 2015-16 to gauge effectiveness.	10.03.16	Programme Manager, Health Social Care and Wellbeing, UHB	**Complete.** Ongoing review of outcomes for 2016/17 are being undertaken to inform investment in 2017/18.
	Develop First Point of Contact / Single Point of Access arrangements across Cardiff and Vale.	March 2017.	Head of Adult Services/Vale Locality Manager, UHB; Operational Manager for	**In progress.** Work programme initiated. The Partnership is working to identify an admission avoidance pilot with WAST colleagues over the winter

assessment in promoting wellbeing is required.			Preventative Services, Cardiff Council	period.

3.2 Crisis response (CR) i.e. when people have a crisis or short lived exacerbation of need

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	August 2016 Update
Need to ensure timely, co-ordinated and personalised responses that are able to minimise the extent to which the outcome from such events is either an inappropriate admission to hospital or an admission to long-term care when alternative support at home could have been provided.	Implement 7/7 FOPAL in EU to interface with 7/7 CRT service as part of ICF investment priorities in 2016-17.	Sep 2016	Head of Operations and Delivery, Medicine Clinical Board, UHB	**Delayed.** Proposal to implement 7/7 day FOPAL service prepared but on hold as anticipated Older People / Mental Health Fund was unforthcoming. 1wte FOPAL nurse has been approved as part of ICF slippage for 2016-17. Further plans are also underway to extend the FOPAL team to provide additional immediate support to enable patients to return to their own home during out-of-hour periods. This will provide additional occupational therapy and care support to carry out visits to provide equipment, ensure safe environment re-establish at home for patients who may not require the care element of CRT over the winter period.
	Undertake needs analysis of 7/7 FOPAL requirement in MEAU as part of ICF investment priorities in 2016-17.	Sep 2016	Head of Operations and Delivery, Medicine Clinical Board, UHB	**Delayed.** Proposed to implement 7/7 day FOPAL service prepared but on hold as anticipated Older People / Mental Health Fund was unforthcoming.
	Inpatient Integrated Assessment processes to be reviewed and performance indicators established for ongoing monitoring.	June 2016.	Head of Integrated Care, UHB / Deputy Director of Nursing.	**In progress.** Assessment Documentation in final consultation stage when complete will inform completion of agreed Discharge Policy.
	Implement full use of clinical workstation as a tool to monitor	Ongoing roll out.	Deputy Director of Nursing, UHB	**In progress. C**ompliance protocol implemented to ensure thrice daily updates with positive feedback.

	discharge across a multi-agency environment.			Work ongoing to support the introduction of Simple/Supported/Complex discharge notification
Need to ensure timely, co-ordinated and personalised responses that are able to minimise the extent to which the outcome from such events is either an inappropriate admission to hospital or an admission to long-term care when alternative support at home could have been provided.	Establish partner-wide training programme for discharge planning across the organisations.	March 2017	Head of Integrated Care, UHB/ Locality Manager North/West Cardiff, UHB	**In progress:** Nurse now appointed to support Education and Training programme .Education programme now under development .Advice and information session currently being held weekly on both UHW and UHL sites.

4.3 Comprehensive Assessment (CA) i.e. when people experience a significant and permanent stepped change

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	Update
Assessment, care planning and prescription is undertaken for people entering the care system or at points of recognisable transition as their needs change. Such services ensure that people with complex needs receive the right support on an ongoing basis as well as at times of significant change or crisis. This function often needs a degree of specialisation and therefore coordination is very important. It requires high levels of connectivity in order to avoid duplication or missed opportunities for appropriate care and support.	Establish the Discharge to Assess model of care (Domiciliary, residential).	Sep 2016	Clinical Board Director of Operations / Deputy Director of Primary, Community and Mental Health, PCIC, UHB	**Suspended:** Discharge to Assess model of care in both a domiciliary setting using ICF monies has been suspended. **Complete:** Residential Discharge to assess models are now in operation both in the Vale and Cardiff .
	Establish enhanced Accommodation Solutions team and additional step down housing.	Oct 2016	Director of Environment & Housing Services, Vale of Glamorgan Council	**In progress:** Recruitment to embed Accommodation Solutions teams across the Region is underway. Additional step down accommodation in place by end March 2017.
	Domiciliary Care: stabilise market (financial and quality issues) and inform new longer term care model across the region.	Current implem entation	Assistant Director (Adult Services) Cardiff Council. Head of Adult Services/Vale Locality Manager, UHB Interim Head of Service, Vale of Glamorgan Council.	• Actions being taken forward to include establishment of a bridging team; ongoing engagement with providers and review of brokerage systems • Locality focussed pilot being undertaken in supported accommodation in a ward of Cardiff to trial new approach • Outcomes based commissioning exercise to commence in the Vale of Glamorgan with providers – now initiated. • Introduction of minimum hourly rate introduced to try to stabilise the market in the Vale of Glamorgan to commence from 1st October, 2016.
	Care Homes – Older People – deliver	Current Implem	Assistant Director – Integrating Health and	• Following a Partnership workshop in May on joint commissioning, a new Joint Commissioning Project

	requirements of Social Services and Well-Being Act - Part 9.	entation .	Social Care.	Board has been established to meet the SSWB Act requirement of developing pooled budgets for care accommodation by 2018. • Data collation across the region has commenced to inform the baseline and this will also include the WG Care home census on 1st August • The region has participated in the WG workshop on developing pooled budgets for care accommodation by March 2018 • Working group reconvened to discuss fee setting for 2017-18 for Care Home Placements.
	Care Homes – Younger Adults	Current implem entation	Interim Head of Service, Vale of Glamorgan Council. Assistant Director (Adult Services) Cardiff Council. Head of Outcomes Based Commissioning, Cardiff & Vale UHB Integrated Operational Change Manager, Cardiff and Vale of Glamorgan Children's Services	The 2 Cardiff and Vale of Glamorgan LAs and HB are signed up to the OJEU Notice for the IHSCCP Framework contract for care homes for younger adults with LD / MH needs and independent hospitals. Following the IHSCCP Programme Board on 5th September, Partners will be considering the implications of utilising the framework before any formal decision is made. As part of the Regional Programme established for Integrated Services for People with Learning Disabilities and Children with Complex needs (with support from ICF Funding) services are being developed for:- - **Supported accommodation for young adults with complex needs –**providing local and specialised accommodation for young adults with learning disabilities working towards lower cost delivery models of care and support at the earliest opportunity. - **Bespoke flexible respite provisions –** To support

				and maintain carers to be able to continue in their role. Adult Placement Schemes delivered regionally would provide more adults with the opportunity to receive their respite locally in a home based community environment. Existing provision will be enhanced in order to deliver this. For individuals who require more specialised respite, a remodelling of provision on a regional basis is required which this model would support.
	Intermediate Care – establish evidence based intermediate care services across Cardiff and Vale of Glamorgan.	Current implementation	Assistant Director – Integrating Health and Social Care.	The Intermediate Care Fund for 2016-17 is being utilised as a pooled budget across the Cardiff and Vale region to further support key areas of work in relation to the priority areas, including an improved whole system approach supporting early intervention and prevention; accommodation solutions; first point of contact and single point of access; integrated discharge teams; discharge to assess models; integrated autism service and a joint service for learning disabilities and complex needs. An ICF Programme Board has been established to review progress and identify opportunities for maximising collaboration across the whole system and prioritising any slippage within the Programme. Each project is reporting outcomes using Results Based Accountability. Provision of capital funding has now been confirmed for the next 4 years. However, concerns remain regarding the uncertainty / prioritisation of revenue funding going forward and the impact this has on recruitment and establishment of new services.
	Ensure delivery of WCCIS across region.	Autumn 2017	Deputy Clinical Board Director, PCIC,	**In progress:** Programme team now in place to undertake preparatory work for WCISS with regular updates to Implementation Group.

			UHB	Further investment has now been allocated via the ICF for 2016-17 and future years to support ongoing development.
	Establish shared accommodation for Mental Health Move-on team	December 2017	Mental Health HOD.	**In progress:** capital development using ICF monies underway.

4.3 Comprehensive Assessment (CA) i.e. when people experience a significant and permanent stepped change

Issue	Strategic Intention / Key action	Time-scale	Suggested Lead / Decision body.	Update
Assessment, care planning and prescription is undertaken for people entering the care system or at points of recognisable transition as their needs change. Such services ensure that people with complex needs receive the right support on an ongoing basis as well as at times of significant change or crisis. This function often needs a degree of specialisation and therefore coordination is very important. It requires high levels of connectivity in order to avoid duplication or missed opportunities for appropriate care and support.	Establish the Discharge to Assess model of care (Domiciliary, residential).	Sep 2016	Clinical Board Director of Operations / Deputy Director of Primary, Community and Mental Health, PCIC, UHB	**Suspended:** Discharge to Assess model of care in both a domiciliary setting using ICF monies has been suspended. **Complete:** Residential Discharge to assess models are now in operation both in the Vale and Cardiff .
	Establish enhanced Accommodation Solutions team and additional step down housing.	Oct 2016	Director of Environment & Housing Services, Vale of Glamorgan Council	**In progress:** Recruitment to embed Accommodation Solutions teams across the Region is underway. Additional step down accommodation in place by end March 2017.
	Domiciliary Care: stabilise market (financial and quality issues) and inform new longer term care model across the region.	Current implementation	Assistant Director (Adult Services) Cardiff Council. Head of Adult Services/Vale Locality Manager, UHB Interim Head of Service, Vale of Glamorgan Council.	• Bridging team will be established fully by end January 2017 with ongoing engagement with providers and review of brokerage systems • Locality focussed pilot being undertaken in supported accommodation in a ward of Cardiff to trial new approach • Outcomes based commissioning exercise commenced in the Vale of Glamorgan with providers. • Introduction of minimum hourly rate introduced to try to stabilise the market in the Vale of Glamorgan commenced from 1st October, 2016.
	Care Homes – Older People – deliver requirements of Social Services and Well-Being Act - Part 9.	Current Implementation.	Assistant Director – Integrating Health and Social Care.	• Following a Partnership workshop in May on joint commissioning, a new Joint Commissioning Project Board has been established to meet the SSWB Act requirement of developing pooled budgets for care accommodation by 2018. • Data collation across the region has commenced to

				inform the baseline and this will also include the 'Day of Care Home' Audit which took place on 1st August. • Participation in WG Care home census on 1st August • Working group reconvened to discuss fee setting for 2017-18 for Care Home Placements; • Draft Population Needs Assessment presented to Regional Partnership Board in January 2017.
	Care Homes – Younger Adults	Current implementation	Interim Head of Service, Vale of Glamorgan Council. Assistant Director (Adult Services) Cardiff Council. Head of Outcomes Based Commissioning, Cardiff & Vale UHB Integrated Operational Change Manager, Cardiff and Vale of Glamorgan Children's Services	The 2 Cardiff and Vale of Glamorgan LAs and HB are signed up to the OJEU Notice for the IHSCCP Framework contract for care homes for younger adults with LD / MH needs and independent hospitals. Following the IHSCCP Programme Board on 5th September, Partners will be considering the implications of utilising the framework before any formal decision is made. As part of the Regional Programme established for Integrated Services for People with Learning Disabilities and Children with Complex needs (with support from ICF Funding) services are being developed for:- - **Supported accommodation for young adults with complex needs –**providing local and specialised accommodation for young adults with learning disabilities working towards lower cost delivery models of care and support at the earliest opportunity. - **Bespoke flexible respite provisions –** To support and maintain carers to be able to continue in their role. Adult Placement Schemes delivered regionally would provide more adults with the opportunity to

				receive their respite locally in a home based community environment. Existing provision will be enhanced in order to deliver this. For individuals who require more specialised respite, a remodelling of provision on a regional basis is required which this model would support.
	Intermediate Care – establish evidence based intermediate care services across Cardiff and Vale of Glamorgan.	Current implementation	Assistant Director – Integrating Health and Social Care.	• The Intermediate Care Fund for 2016-17 is being utilised as a pooled budget across the Cardiff and Vale region to further support key areas of work in relation to the priority areas, including an improved whole system approach supporting early intervention and prevention; accommodation solutions; first point of contact and single point of access; integrated discharge teams; discharge to assess models; integrated autism service and a joint service for learning disabilities and complex needs. • An ICF Programme Board has been established to review progress and identify opportunities for maximising collaboration across the whole system and prioritising any slippage within the Programme. Each project is reporting outcomes using Results Based Accountability. • Draft Population Needs Assessment presented to Regional Partnership Board in January 2017. • Concerns remain regarding the uncertainty/prioritisation of the funding going forward and the impact this has on recruitment and establishment of new services.
	Ensure delivery of WCCIS across region.	Autumn 2017	Deputy Clinical Board Director, PCIC, UHB	**In progress:** Programme team now in place to undertake preparatory work for WCISS with regular updates to Implementation Group.

	Establish shared accommodation for Mental Health Move-on team	December 2017	Mental Health HOD.	**In progress:** capital development using ICF monies underway.