Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Pwyllgor Archwilio

Mynd i'r afael ag achosion o oedi wrth drosglwyddo gofal yn y system gyfan

Adroddiad Pwyllgor AC(3) 02-08
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PWYLLGOR ARCHWILIO CYNULLIAD CENEDLAETHOL CYMRU

Adroddiad a gyflwynwyd i Gynulliad Cenedlaethol Cymru ar 20 Chwefror 2008 yn unol ag adran 143(1) o Ddeddf Llywodraeth Cymru 2006

Mynd i'r afael ag achosion o oedi wrth drosglwyddo gofal yn y system gyfan

ATODIADAU

Atodiad A	Trafodion perthnasol y pwyllgor – Cofnodion y dystiolaeth (dydd Iau 22 Tachwedd 2007)
Atodiad B	Papur briffio: *Unified Assessment Progress – pan Gwent*, a anfonwyd at Glerc y Pwyllgor Archwilio gan Ann Lloyd, 20 Rhagfyr 2007.

Crynodeb

1. Ceir oedi wrth drosglwyddo gofal pan fydd claf mewnol yn barod i symud i'r cam gofal nesaf, ond caiff y broses drosglwyddo ei rhwystro am reswm neu resymau penodol. Mae oedi wrth drosglwyddo gofal yn niweidiol i'r bobl sy'n dioddef yn sgil yr oedi, a hefyd i'r system iechyd a gofal cymdeithasol yn ehangach. Gall y canlyniadau fod yn ddifrifol iawn, gan fygwth annibyniaeth pobl hŷn sy'n agored i niwed, sef y mwyafrif o'r bobl sy'n wynebu oedi.

2. Nid yw nifer y bobl sy'n wynebu oedi wrth drosglwyddo gofal – nifer sydd wedi gostwng – yn dangos gwir ddifrifoldeb y sefyllfa gan nad yw'n adlewyrchiad o hyd yr oedi sy'n rhaid i gleifion ei wynebu. Ffordd well o fesur hyn yw nifer y gwelyau ysbyty a roddir i bobl sy'n wynebu oedi, ac yng Nghymru cododd y nifer hwnnw 2 y cant rhwng 2005-06 a 2006-07, o 262,595 i 268,491. Mae'r ffaith y bu gostyngiad yn nifer y bobl a wynebodd oedi, ar yr un pryd â chynnydd yn nifer y gwelyau a ddefnyddiwyd, yn arwydd o gynnydd yn hyd cyfartalog yr oedi. Mae'r rhesymau dros yr oedi wrth drosglwyddo gofal yn amrywio'n fawr, ac nid problemau mewn rhannau penodol o'r system iechyd a gofal cymdeithasol yn unig sy'n gyfrifol.

3. Ar sail adroddiad diweddar gan yr Archwilydd Cyffredinol yn crynhoi gwaith y system gyfan yng nghymunedau iechyd a gofal cymdeithasol Caerdydd a Bro Morgannwg, Gwent a Sir Gaerfyrddin,[1] cyflwynwyd tystiolaeth i ni am y camau y mae Llywodraeth Cynulliad Cymru a sefydliadau iechyd a gofal cymdeithasol lleol yn eu cymryd i gyfyngu ar effeithiau oedi wrth drosglwyddo gofal. Mae Llywodraeth y Cynulliad wedi comisiynu adolygiad annibynnol ar achosion o oedi wrth drosglwyddo gofal, a bydd yr adolygiad hwn yn canolbwyntio ar yr ardaloedd hynny yng Nghymru na chafodd sylw yn adroddiad yr Archwilydd Cyffredinol. Y tystion a gyflwynodd dystiolaeth i'r Cyngor oedd Mrs Ann Lloyd, Cyfarwyddwr Adran Iechyd a Gofal Cymdeithasol Llywodraeth Cynulliad Cymru, a Jonathan Isaac, Pennaeth y

[1] Adroddiad Archwilydd Cyffredinol Cymru, *Mynd i'r afael ag achosion o oedi wrth drosglwyddo gofal yn y system gyfan,* 1 Tachwedd 2007

Gangen Polisi Pobl Hŷn a Gofal Hirdymor. Cyflwynwyd tystiolaeth hefyd gan Mrs Abigail Harris, Prif Weithredwr Bwrdd Iechyd Lleol Bro Morgannwg, Mr Hugh Ross, Prif Weithredwr Ymddiriedolaeth GIG Caerdydd a'r Fro a Ms Alison Ward, Prif Weithredwr Cyngor Bwrdeistref Sirol Tor-faen.

4. Ein gwaith oedd penderfynu a yw sefydliadau iechyd a gofal cymdeithasol, ar y cyd â Llywodraeth Cynulliad Cymru (Llywodraeth y Cynulliad), wedi gwneud digon o gynnydd wrth fynd i'r afael ag oedi wrth drosglwyddo gofal yn y system gyfan.

5. Daethom i'r casgliad bod angen cydweithredu'n well er mwyn i'r system gyfan weithio'n fwy effeithiol a lleihau effaith gynyddol achosion o oedi wrth drosglwyddo gofal.

Mae angen gweledigaeth leol a chlir o'r modelau gwasanaeth a fydd yn hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed, gyda fframwaith addas i reoli o'r canol

Dylai cymunedau iechyd a gofal cymdeithasol ddod ynghyd i ddatblygu gweledigaeth glir o batrwm y gwasanaethau sy'n angenrheidiol i weithio'n llwyddiannus drwy'r system gyfan

6. Mae achosion o oedi wrth drosglwyddo gofal yn arwydd o broblemau yn y system iechyd a gofal cymdeithasol drwyddi draw. Mae gwir angen i sefydliadau partner lleol ddod ynghyd i ddatblygu gweledigaeth ar gyfer gwasanaethau a fydd yn hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed, ac yn rhoi diwedd ar yr oedi sy'n arwydd o ddiffyg cydbwysedd ar hyn o bryd. Mae'r gweledigaethau presennol ar gyfer y gwasanaethau'n dueddol o ganolbwyntio'n ormodol ar iechyd, heb roi digon o sylw i rannau allweddol eraill o'r system gyfan – yn enwedig gofal cymdeithasol a'r gwasanaethau a allai gadw pobl allan o'r ysbyty. Nid yw meddygon teulu ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru yn cyfrannu'n ddigonol ar hyn o bryd, a gallant gyfrannu'n llawnach i system gyfan sy'n canolbwyntio fwy ar anghenion pobl hŷn sy'n agored i niwed. Mae gan awdurdodau lleol gyfraniad

mwy i'w wneud wrth ddarparu dewisiadau tai eraill fel tai gofal ychwanegol. Mae cynlluniau gofal canolraddol, sy'n darparu ymyriadau tymor byr rhwng gwasanaethau iechyd a gwasanaethau gofal cymdeithasol, yn dameidiog ar hyn o bryd, pan ddylent greu rhwydwaith o wasanaethau cydlynol sy'n rhwystro cleifion rhag cael eu derbyn yn ddiangen i'r ysbyty a'u galluogi i adael yr ysbyty'n fuan ar ôl cyrraedd.

7. Ceir tystiolaeth bod sefydliadau lleol mewn rhai ardaloedd wedi cydnabod effaith gynyddol oedi wrth drosglwyddo gofal, ac wedi cydweithredu i fynd i'r afael â phroblem sy'n bodoli drwy'r system gyfan. Ceir enghreifftiau o arferion da mewn mannau allweddol drwy'r system gyfan. Gwelliant amlwg yw bod partneriaid lleol, ac yn arbennig awdurdodau lleol, wedi cydnabod bod angen i oedi wrth drosglwyddo gofal fod yn uwch ar eu hagenda, a sicrhau gwell cydweithredu ar yr un pryd. Serch hynny, mae cyfle amlwg i sefydliadau partner wneud defnydd llawnach o'r arferion da sy'n bodoli.

Dylai Llywodraeth y Cynulliad drefnu ei harweiniad, ei chyllidebau, ei blaenoriaethau, ei mesurau perfformiad a'i chymhellion mewn ffordd sy'n cyd-fynd yn well â'i gweledigaeth ar gyfer y system gyfan. Yn benodol, dylai wella'r systemau mesur presennol gan nad ydynt yn gywir nac yn rhoi digon o bwyslais ar effeithiau oedi wrth drosglwyddo gofal

8. Nid yw fframwaith arweiniad, cyllidebau, blaenoriaethau, mesurau perfformiad a chymhellion Llywodraeth y Cynulliad yn ddigon cydlynol, a gallai'r fframwaith hwnnw fod yn fwy effeithiol wrth ddatblygu gwasanaethau ar y cyd sy'n hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed. Dylai Llywodraeth y Cynulliad annog cydweithredu cadarnach drwy'r system gyfan, a sicrhau cydbwysedd rhwng arwain o'r canol a hyblygrwydd lleol. Ar hyn o bryd, nid oes dim cymhellion ffurfiol i annog cydweithio ac nid yw'r mesurau perfformiad presennol yn rhoi syniad cywir o effeithiolrwydd y system gyfan, tra rhoddir y bai ar sefydliadau unigol. Er mwyn cael gweledigaeth sy'n llai dibynnol ar wasanaethau ysbyty, mae angen symud adnoddau o leoliadau

acíwt i leoliadau cymunedol. Ar hyn o bryd, nid yw fframwaith Llywodraeth y Cynulliad yn rhoi cyllid i bontio yn y fath fodd, a dylai sefydliadau lleol edrych ymhellach ar y cyfleoedd i gyfuno'u hadnoddau.

9. Rhwng 2005-06 a 2006-07, bu cynnydd o ddau y cant yng Nghymru yn effeithiau oedi wrth drosglwyddo gofal, yn ôl cyfanswm y gwelyau ysbyty a roddwyd i gleifion a oedd yn wynebu oedi. Amrywiai difrifoldeb yr oedi wrth drosglwyddo gofal drwy Gymru, ac roedd y cynnydd rhwng 2005-06 a 2006-07 wedi'i seilio'n bennaf ar gynnydd sylweddol yng Nghaerdydd, Bro Morgannwg, a pum ardal yr awdurdodau unedol/byrddau iechyd lleol yng Ngwent.

10. Fodd bynnag, mae cyfyngiadau'r systemau mesur presennol wedi arwain at ddata nad yw'n adlewyrchu gwir effaith oedi wrth drosglwyddo gofal. Mae'r dull presennol o fesur wedi'i gyfyngu gan ddull monitro perfformiad sydd wedi canolbwyntio'n hanesyddol ar nifer y bobl sy'n wynebu oedi, yn hytrach na'r amser a dreuliwyd ganddynt mewn gwely ysbyty. Nid yw'r data'n dangos gwir ddifrifoldeb yr oedi gan fod cytundebau lleol yn caniatáu i sefydliadau gytuno ar amserlen ar ôl i glinigwr benderfynu symud claf i gam nesaf eu gofal, a chyn yr ystyrir bod oedi wedi bod wrth drosglwyddo gofal. Yn ystod y cyfnod hwn, gall awdurdodau lleol a byrddau iechyd lleol gynnal asesiadau neu wneud trefniadau ar gyfer cam nesaf gofal y claf.

Mae angen arweinyddiaeth drwy'r systemau cyfan er mwyn gwireddu'r weledigaeth

11. Er mwyn gwireddu'r weledigaeth ar gyfer y gwasanaethau, mae angen arweinyddiaeth drwy'r systemau cyfan ar lefel y gymuned, a hynny wedi'i ganoli ym mhob ymddiriedolaeth GIG. Er mai megis dechrau yw hyn i ddatblygu'r meysydd sy'n cael sylw yn adroddiad yr Archwilydd Cyffredinol, ceir tystiolaeth nad yw rhai sefydliadau lleol yn ddigon ymrwymedig i weithio er budd yr holl gymuned, yn hytrach nag er budd eu sefydliad hwy'n unig. Dylai Llywodraeth y Cynulliad roi arweinyddiaeth gref ar draws y system gyfan

ar lefel genedlaethol, yn arbennig o ran cysylltu iechyd a gofal cymdeithasol yn fwy effeithiol.

Nid yw'r prosesau comisiynu wedi'u datblygu'n ddigonol a rhaid sicrhau bod gan gymunedau iechyd a gofal cymdeithasol gapasiti priodol mewn amrywiaeth eang o wasanaethau sy'n hyrwyddo annibyniaeth

12. Ar hyn o bryd, nid yw ffurf y gwasanaethau iechyd a gofal cymdeithasol - o ran eu hamrywiaeth a'u natur - yn rhoi gwir ddewis i bobl dros eu gofal yn y dyfodol. Ceir diffygion o ran capasiti mewn rhai meysydd a gorddibyniaeth ar leoliadau sefydliadol yn hytrach na gwasanaethau cymunedol neu yn y cartref. Mae pobl hŷn sy'n agored i niwed yn dueddol o gael eu rhoi'n syth mewn gwely ysbyty pan fydd argyfwng, ac felly maent yn dod yn rhan o'r system sefydliadol pan allai ymyriad cynharach fod wedi bod yn ffordd fwy effeithiol o gynnal eu hannibyniaeth.

13. Yn benodol, nid yw'r gwaith o gomisiynu gwasanaethau gofal canolraddol wedi'i ddatblygu'n ddigonol. Nid yw'r ddarpariaeth yn gyson, a cheir dryswch ynghylch pwy sy'n gymwys i gael y gwahanol wasanaethau sy'n bodoli ar draws ffiniau bwrdeistrefol a sefydliadol. Nid yw'r byrddau iechyd lleol na'r awdurdodau lleol yn comisiynu'n ddigon effeithiol, ac mae'n ymddangos nad yw'r ymdrechion i weithio drwy'r systemau cyfan yn rhoi sylw cyson i gomisiynu ar y cyd, gan ganolbwyntio'n ormodol ar gomisiynu gwasanaethau iechyd yn hytrach na gofal cymdeithasol. Mae prinder gwybodaeth reoli a dibyniaeth ar brynu yn ôl y galw hefyd yn cael effaith niweidiol ar gomisiynu.

Rhaid cryfhau'r prosesau ar hyd y llwybr cyfan fel bod y ddarpariaeth yn canolbwyntio ar anghenion gofal y claf

14. Ceir cyfleoedd i wella'r prosesau ar hyd y llwybr cyfan er mwyn sicrhau bod y ddarpariaeth wedi'i seilio ar anghenion gofal y claf. Nid yw prosesau'r ysbytai'n ddigon effeithlon a cheir oedi diangen wrth gynllunio ar gyfer rhyddhau cleifion a chynnwys aelodau'r teulu a gofalwyr wrth wneud penderfyniadau allweddol. Mae'r polisïau dewis yn amrywio mewn gwahanol

ardaloedd, ac yn aml nid yw'r broses o roi'r polisïau hyn ar waith yn ddigon effeithiol. Mae'r broses Asesu Unedig yn rhwystr amlwg ar hyn o bryd wrth geisio sicrhau bod y system gyfan yn gweithio'n effeithiol. Mae'r broses yn amrywio'n fawr rhwng sefydliadau. Fe'i gwelir yn broses fiwrocrataidd a chaiff asesiadau ar gyfer Gofal Iechyd Parhaus eu gweld fel asesiadau ychwanegol yn hytrach na rhan o un broses asesu gyfan. Mae angen gwell prosesau hefyd ar gyfer rhannu gwybodaeth rhwng sefydliadau iechyd a gofal cymdeithasol.

Mae angen i sefydliadau gwasanaethau iechyd a gofal cymdeithasol ddatblygu eu gweithlu i greu diwylliant llai gwrth-risg

15. I hyrwyddo cydweithio mwy effeithiol, mae cyfle i sefydliadau iechyd a gofal cymdeithasol ddatblygu eu gweithlu er mwyn creu diwylliant llai gwrth-risg. Caiff pobl yn aml eu rhoi yn y lleoliadau gofal sydd â'r risg isaf, pan fyddai'n fwy addas datblygu pecyn gofal a fyddai'n hyrwyddo'u hannibyniaeth yn well, cyn eu rhoi mewn lleoliad gofal sefydliadol.

Argymhellion

Mae angen gweledigaeth leol a chlir o'r modelau gwasanaeth a fydd yn hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed, gyda fframwaith addas i reoli o'r canol

Dylai cymunedau iechyd a gofal cymdeithasol ddod ynghyd i ddatblygu gweledigaeth glir o batrwm y gwasanaethau sy'n angenrheidiol i weithio'n llwyddiannus drwy'r system gyfan

(i) Mae Strategaethau Iechyd, Gofal Cymdeithasol a Lles yn rhoi gweledigaethau ar y cyd ar gyfer y blaenoriaethau mewn cymuned iechyd a gofal cymdeithasol, a hynny'n seiliedig ar asesu'r anghenion. Bydd adolygu'r strategaethau hyn yn 2008 yn gyfle da i wella'r ddealltwriaeth o anghenion lleol ac i ganfod anghenion sy'n gyffredin rhwng cymunedau cyfagos. **Rydym yn argymell bod adolygiad arfaethedig Llywodraeth y Cynulliad o'r**

strategaethau hyn yn canolbwyntio ar sicrhau bod y cynigion yn ddigonol ac yn ddigon uchelgeisiol i fynd i'r afael â gwendidau yn y system a hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed. Dylai ymddiriedolaethau, y byrddau iechyd lleol a'r Cynghorau perthnasol ganfod yr anghenion cyffredin rhwng bwrdeistrefi a cheisio datblygu modelau gwasanaeth cyffredin pan fydd hynny'n addas, gyda nod penodol o ddatblygu gwasanaethau gofal canolraddol sy'n fwy rhesymol a chynaliadwy.

(ii) Mae system bresennol y gwasanaethau gofal canolraddol yn dameidiog. Gall hyn beri dryswch i'r rheini sy'n cyfrannu ar adegau allweddol at lwybrau gofal cleifion, fel meddygon teulu ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru. Hefyd, mae gan y gweithwyr hyn wybodaeth reoli bwysig iawn am bobl hŷn a allai fod yn agored i niwed, a gallai'r wybodaeth hon fod yn sail i ddull mwy rhagweithiol o weithio drwy'r system gyfan. Fodd bynnag, nid yw'r wybodaeth hon yn cael ei rhannu'n systematig ar hyn o bryd.

Argymhellwn y canlynol:

a) **dylai byrddau iechyd lleol gydweithio'n fwy effeithiol â meddygon teulu drwy'r system gyfan, a hynny i symleiddio llwybrau cleifion a sicrhau bod yr amrywiaeth o wasanaethau sydd ar gael i gynnal annibyniaeth pobl hŷn sy'n agored i niwed yn fwy eglur;**

b) **pan na fydd meddygon teulu yn cyfeirio pobl at ofal canolraddol neu at wasanaethau eraill yn lle ysbytai, dylai'r byrddau iechyd lleol greu systemau i gydweithio â hwy er mwyn hyrwyddo gwell dealltwriaeth o'r dewisiadau eraill sydd ar gael;**

c) **dylai'r byrddau iechyd lleol hefyd geisio datblygu systemau newydd er mwyn rhannu gwybodaeth allweddol gyda phartneriaid ynghylch pobl hŷn sy'n agored i niwed; er enghraifft, gallai'r byrddau iechyd lleol ac Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru rannu gwybodaeth am bobl sydd wedi disgyn a'u cyfeirio at glinig .**

Dylai Llywodraeth y Cynulliad drefnu ei harweiniad, ei chyllidebau, ei blaenoriaethau, ei mesurau perfformiad a'i chymhellion mewn ffordd sy'n cyd-fynd yn well â'i gweledigaeth ar gyfer y system gyfan. Yn

benodol, dylai wella'r systemau mesur presennol gan nad ydynt yn gywir nac yn rhoi digon o bwyslais ar effeithiau oedi wrth drosglwyddo gofal

(iii) Mae'r system genedlaethol bresennol o fesurau perfformio yn golygu bod tuedd i ganolbwyntio ar achos yr oedi yn hytrach na'r achos drwy'r system gyfan. Gall hyn amharu ar gydweithio effeithiol i fynd i'r afael ag oedi wrth drosglwyddo gofal. O fis Ebrill 2008, ni cheir cytundebau perfformio sy'n ymwneud yn benodol ag oedi wrth drosglwyddo gofal.

Ynghyd â'r adroddiad hwn ac adroddiad yr Archwilydd Cyffredinol, dylai Llywodraeth y Cynulliad ystyried casgliadau ei adolygiad annibynnol ar oedi wrth drosglwyddo gofal. Dylai ddatblygu fframwaith rheoli perfformiad newydd sy'n sicrhau bod y cymunedau iechyd a gofal cymdeithasol drwyddynt draw yn atebol am berfformiad y system gyfan, ond bod y fframwaith hefyd yn rhoi digon o hyblygrwydd i bartneriaid ddatblygu targedau ar y cyd. Dylai'r fframwaith olygu bod partneriaid iechyd a gofal cymdeithasol yn dod ynghyd i gytuno ar dargedau sengl ar gyfer trosglwyddo gofal, wedi'u mesur yn ôl diwrnodau gwelyau. Dylai Llywodraeth y Cynulliad gytuno i bob targed lleol o'r fath.

(iv) Nid yw trefniadau canolog presennol Llywodraeth y Cynulliad yn rhoi fframwaith cydlynol ar gyfer canllawiau, cyllidebau, blaenoriaethau, mesurau perfformiad a chymhellion sy'n galluogi partneriaid lleol i sicrhau cymaint o annibyniaeth â phosibl i bobl hŷn sy'n agored i niwed. **Argymhellwn fod Llywodraeth y Cynulliad yn datblygu fframwaith sy'n fwy cydlynol, a fydd yn galluogi partneriaid lleol i ddod ynghyd i ddatblygu targedau er mwyn hyrwyddo annibyniaeth a lleihau effaith negyddol oedi wrth drosglwyddo gofal. Dylai'r fframwaith hwn ddarparu'r mesurau ariannol sy'n hwyluso ac yn mesur effaith newid yn y gwasanaeth, a chymhellion clir i sefydliadau allu cydweithio o ddifrif.**

(v) Yn briodol, mae Llywodraeth y Cynulliad wedi hyrwyddo'r hyblygrwydd sydd ar gael yn y Ddeddf Iechyd. Mae'r hyblygrwydd hwn yn galluogi sefydliadau iechyd a llywodraeth leol i rannu adnoddau drwy gyllidebau cyfun. Fodd bynnag, nid yw cyllidebau cyfun yn atebion ynddynt eu hunain, ac mae'n annhebygol iawn y byddant yn effeithiol wrth ddarparu gweledigaeth glir ar y cyd ar gyfer gwasanaethau yn y dyfodol. **Argymhellwn, tra dylai**

sefydliadau iechyd a gofal cymdeithasol edrych yn llawn ar bosibilrwydd cyfuno cyllidebau er mwyn datblygu gwasanaethau y tu allan i'r ysbyty, dylai hyn gefnogi'r gwaith o ddatblygu gwasanaethau yn y dyfodol ynghyd â chydweithio'n well ym maes iechyd a gofal cymdeithasol.

(vi) Mae cyfle i Lywodraeth y Cynulliad sicrhau bod iechyd a gofal cymdeithasol yn cael eu cyfuno'n fwy effeithiol. Mae cyfrifoldebau iechyd a gwasanaethau cymdeithasol Mrs Lloyd yn wahanol iawn, ac ychydig o gyfle sydd ganddi i ddylanwadu ar y gwasanaethau gofal cymdeithasol a ddarperir gan awdurdodau lleol, a chyfle yr un mor brin i ddylanwadu ar gyrff y GIG. Efallai fod hyn yn awgrymu bod rhwystrau mewnol rhwng maes iechyd a llywodraeth leol sy'n atal dull digon cydlynol o weithio o'r canol. **Argymhellwn y dylai Llywodraeth y Cynulliad ystyried a yw ei strwythur presennol yn galluogi dull digon cydlynol o ddatblygu'r system gyfan ym maes iechyd a gofal cymdeithasol.**

(vii) Nod y cytundebau lleol oedd creu disgwyliadau rhesymol ar gyfer yr amser y byddai'n ei gymryd i gynnal asesiadau neu i wneud trefniadau. Fodd bynnag, mae'r cytundebau'n gohirio'r broses ddechrau mesur hyd yr oedi wrth drosglwyddo gofal. Maent hefyd yn cuddio gwir ddifrifoldeb y sefyllfa ac yn achosi rhagor o oedi yn y system. **Argymhellwn y canlynol:**

a) **dylai Llywodraeth y Cynulliad orfodi sefydliadau partner lleol i roi'r gorau i ddefnyddio cytundebau lleol sy'n gohirio'r broses o ddechrau mesur hyd yr oedi wrth drosglwyddo gofal;**

b) **dylai ymddiriedolaethau, byrddau iechyd lleol a Chynghorau ddechrau mesur hyd yr oedi wrth drosglwyddo gofal o'r dyddiad yr ystyrir bod claf yn barod i gael ei ryddhau o'r ysbyty, a dylent ganolbwyntio ar y dyddiad rhyddhau disgwyliedig er mwyn sicrhau bod gwasanaethau addas ar gael er mwyn trosglwyddo'r gofal ar y dyddiad hwnnw neu'n agos ato;**

c) **dylai Llywodraeth y Cynulliad roi arweiniad ar yr amseroedd ymateb derbyniol er mwyn cynnal asesiadau a gwneud trefniadau.**

(viii) Mae oedi wrth drosglwyddo gofal yn arwydd o'r problemau sy'n bodoli yn y ffordd mae'r system iechyd a gofal cymdeithasol yn gweithio. Nid yw'r ystadegau'n rhoi sylw i'r canlyniadau i gleifion, fel cadw annibyniaeth. **Dylai**

partneriaid ddatblygu dulliau ar y cyd o fesur y canlyniadau i bobl hŷn sy'n agored i niwed. Dylai hynny fesur pa mor effeithiol yw modelau gwasanaeth newydd a gynlluniwyd i hyrwyddo annibyniaeth a mynd i'r afael ag oedi wrth drosglwyddo gofal a'i effeithiau.

Mae angen arweiniad drwy'r system gyfan i wireddu'r weledigaeth

(ix) Gall arweiniad strategol effeithiol ar lefel gymunedol, a hwnnw wedi'i ganoli yn Ymddiriedolaeth y GIG, gyfrannu'u sylweddol at fynd i'r afael â'r rhesymau drwy'r system gyfan dros oedi wrth drosglwyddo gofal. Mae hyn yn cynnwys cyfraniad sylweddol ar lefel weithredol a chydnabyddiaeth gref bod sefydliadau partner yn ddibynnol ar ei gilydd er mwyn i'r system gyfan weithio'n effeithiol. **Argymhellwn fod Prif Weithredwyr Ymddiriedolaethau'r GIG, y byrddau iechyd lleol a'r Cynghorau perthnasol mewn cymuned iechyd a gofal cymdeithasol yn cyfarfod i gytuno ar gyfeiriad strategol clir, er mwyn mynd i'r afael ag oedi wrth drosglwyddo gofal a'r rhesymau sylfaenol drosto.**

Nid yw'r prosesau comisiynu wedi'u datblygu'n ddigonol a rhaid sicrhau bod gan gymunedau iechyd a gofal cymdeithasol gapasiti priodol mewn amrywiaeth eang o wasanaethau sy'n hyrwyddo annibyniaeth

(x) Nid yw'r prosesau comisiynu wedi'u datblygu'n ddigonol a cheir diffygion yn y capasiti i wneud hynny mewn rhai ardaloedd, sy'n amharu ar ddewis y cleifion ac yn arwain at brinder dewis penodol o ran gofal y tu allan i'r ysbyty. Dylai'r prosesau comisiynu ganolbwyntio fwy ar ganlyniadau y gellir eu mesur drwy'r system gyfan. Dylid canolbwyntio fwy ar gomisiynu gofal cymdeithasol a chomisiynu ar y cyd rhwng iechyd a gofal cymdeithasol. **Er mwyn mynd i'r afael â'r gwendidau presennol o ran comisiynu, argymhellwn y canlynol:**

a) **dylai byrddau iechyd lleol a Chynghorau ddefnyddio canlyniadau gwaith diweddar ar gydgomisiynu lleoliadau i blant er mwyn gwneud gwaith yn y dyfodol ar gydgomisiynu gwasanaethau i bobl hŷn sy'n agored i niwed;**

b) **dylai byrddau iechyd lleol a Chynghorau ddatblygu dulliau comisiynu sy'n canolbwyntio ar ganlyniadau i bobl hŷn sy'n agored i niwed, a hynny'n cynnwys cymhellion i ddarparwyr**

sicrhau bod pobl hŷn sy'n agored i niwed mor annibynnol â phosibl;

c) **dylai byrddau iechyd lleol a Chynghorau wneud llawer mwy i geisio rheoli'r farchnad gofal cartref, fel cynyddu eu pŵer prynu drwy gydweithredu wrth gomisiynu a gwella diogelwch refeniw cyflenwyr drwy ddatblygu statws darparwyr a ffafrir;**

d) **dylai Llywodraeth y Cynulliad gael dull cyffredin o dalu am wasanaethau y tu allan i'r ysbyty. Dylai hyn alluogi comisiynwyr i ddatblygu trefniadau cadarnach hirdymor gyda darparwyr, hwyluso'r gwaith o gymharu a gwerthuso costau ac ansawdd gwasanaeth, a'i gwneud yn haws i gomisiynwyr lleol nodi a defnyddio arferion da;**

e) **dylai Llywodraeth y Cynulliad nodi cyfleoedd i rannu arferion da wrth gomisiynu a datblygu capasiti comisiynwyr lleol.**

(xi) Er mwyn canolbwyntio ar ddarparu gwasanaethau yn y gymuned yn hytrach na gwasanaethau mewn lleoliadau gofal sefydliadol a thraddodiadol, bydd angen newid y ffordd y defnyddir adnoddau yn yr un modd. Mae patrwm anodd yn bodoli sy'n clymu adnoddau ynghlwm wrth wasanaethau ysbyty, gan annog gofal sefydliadol anaddas a chyfyngu ar gyfleoedd pobl i gadw'u hannibyniaeth. **Dylai byrddau iechyd lleol ac awdurdodau lleol lunio strategaethau clir ar gyfer trosglwyddo gwasanaethau o leoliadau sefydliadol acíwt i wasanaethau cymunedol a chartref. Dylai Llywodraeth y Cynulliad ystyried rhoi arian sefydlu ar gyfer camau o'r fath, gydag arian wedi'i neilltuo ar gyfer y gwaith o ailfodelu darpariaeth gwasanaeth heb beryglu diogelwch pobl hŷn sy'n agored i niwed.**

Rhaid cryfhau'r prosesau ar hyd y llwybr cyfan fel bod y ddarpariaeth yn canolbwyntio ar anghenion gofal y claf

(xii) Ar hyn o bryd, mae'r broses Asesu Unedig yn rhwystr sylweddol rhag cynnal asesiad llwyddiannus o anghenion gofal cymhleth pobl hŷn sy'n agored i niwed. Defnyddir gwahanol brosesau a dogfennaeth mewn gwahanol ardaloedd drwy Gymru, ac mae cysylltiadau gwybodaeth gwael rhwng

sefydliadau partner sy'n gofalu am yr un person yn amharu ymhellach ar y broses fiwrocrataidd. Os bydd person yn cael asesiad ar gyfer Gofal Iechyd Parhaus, gwelir hynny fel asesiad ychwanegol yn hytrach nag yn rhan ganolog o un broses asesu gynhwysfawr. **Argymhellwn fod Llywodraeth y Cynulliad yn adolygu ei ganllawiau ar Asesu Unedig ac yn llunio dogfennaeth safonol newydd y gellir ei defnyddio drwy Gymru. Dylid cwtogi'r ddogfennaeth y mae'n rhaid i weithwyr gofal iechyd proffesiynol ei llenwi, a dylai Gofal Iechyd Parhaus fod yn rhan ganolog o'r broses asesu sengl. Dylai Llywodraeth y Cynulliad wella capasiti sefydliadau sy'n gofalu am bobl hŷn sy'n agored i niwed i rannu gwybodaeth am y bobl sy'n eu gofal.**

(xiii) Mae oedi sy'n gysylltiedig â dewis yn un o brif achosion oedi wrth drosglwyddo gofal. Mae'r polisïau dewis yn amrywio drwy Gymru. Ceir diffygion sylweddol o ran capasiti mewn rhai ardaloedd, yn enwedig o ran darpariaeth i henoed eiddil eu meddwl, ac mae hynny'n golygu nad oes gan bobl mewn rhai ardaloedd wir ddewis ynghylch gofal cartref. **Argymhellwn fod Llywodraeth y Cynulliad yn llunio polisi dewis pendant, a hwnnw wedi'i ddatblygu drwy ymgynghori gyda chynrychiolwyr pobl hŷn a'r sector gofal cartref. Dylid defnyddio'r polisi hwn wedyn drwy Gymru. Dylai fynnu'n benodol bod staff iechyd a gofal cymdeithasol yn cynnwys teuluoedd a gofalwyr cyn gynted â phosibl wrth roi gofal i unigolyn, er mwyn cynllunio cam nesaf eu gofal a rhoi digon o amser i deuluoedd wneud dewis mor bwysig.**

Mae angen i sefydliadau gwasanaethau iechyd a gofal cymdeithasol ddatblygu eu gweithlu i greu diwylliant llai gwrth-risg

(xiv) Ceir diwylliant gwrth-risg mewn rhai rhannau o'r system iechyd a gofal cymdeithasol, o ran rheoli pobl hŷn sy'n agored i niwed. Gall hyn olygu derbyn pobl yn syth i leoliadau acíwt neu leoliadau sefydliadol, a bydd hynny'n amharu'n sylweddol ar eu hannibyniaeth yn y dyfodol. **Dylai'r ymddiriedolaethau a'r cynghorau roi addysg i'w staff ynghylch risgiau gofal sefydliadol diangen. Dylid adolygu llwybrau a pholisïau asesu a rhyddhau, er mwyn i staff deimlo'n ddigon hyderus i ystyried**

dewisiadau diogel sy'n osgoi derbyn pobl hŷn sy'n agored i niwed i leoliadau gofal acíwt neu ofal preswyl heb fod angen hynny.

Mynd i'r afael ag achosion o oedi wrth drosglwyddo gofal yn y system gyfan

Mae angen gweledigaeth leol a chlir o'r modelau gwasanaeth a fydd yn hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed, gyda fframwaith addas i reoli o'r canol

Dylai cymunedau iechyd a gofal cymdeithasol ddod ynghyd i ddatblygu gweledigaeth glir o batrwm y gwasanaethau sy'n angenrheidiol i weithio'n llwyddiannus drwy'r system gyfan

16. Mae oedi wrth drosglwyddo gofal yn digwydd oherwydd y diffyg cydbwysedd yn y system iechyd a gofal cymdeithasol drwyddi draw. Yn y cyd-destun hwn, dylid eu gweld fel arwydd o broblemau ehangach yn y systemau cyfan yn hytrach nag fel un broblem benodol. Ar hyn o bryd, achosir y diffyg cydbwysedd gan batrwm gwasanaethau sy'n arwain at roi gofal i gleifion pan fydd argyfwng, yn hytrach na thrwy ymyriadau cynharach fel gwasanaethau gofal canolraddol. Mae'r gwasanaethau hynny'n gallu golygu nad oes yn rhaid derbyn cleifion i'r ysbyty ac maent yn fodd o'u helpu i fyw bywyd annibynnol eto mewn byr o dro.[2] Ceir problemau hefyd oherwydd bod gwasanaethau gofal canolraddol o'r fath yn dueddol o fod yn dameidiog.[3] Yn gyffredinol, mae gwasanaethau iechyd a gofal cymdeithasol yn dal i fod wedi'u cynllunio o amgylch darparwyr, a cheir gorddibyniaeth ar wasanaethau ysbyty yn hytrach na rhai mewn lleoliadau eraill neu yn nes at gartrefi cleifion. Gall gwasanaethau gwahanol o'r fath roi cymorth sylweddol i bobl hŷn sy'n agored i niwed gadw'u hannibyniaeth. Mae'r holl wendidau hyn yn arwain at ddefnydd gwael o adnoddau drwy roi gofal acíwt drud i bobl, ac erbyn hynny bydd yn aml yn rhy hwyr i gynnal eu hannibyniaeth.

17. Er mwyn cymryd y cam cyntaf tuag at wella'r system gyfan, dylai pob sefydliad partner lleol ddod ynghyd i gytuno ar weledigaeth ynghylch natur eu

[2] Adroddiad Archwilydd Cyffredinol Cymru, paragraffau 2.51-2.57 ac Atodiad A, paragraffau 182-187
[3] Adroddiad Archwilydd Cyffredinol Cymru, 2.58-2.66

gwasanaethau, a hynny er mwyn rhoi sylw i anghenion y boblogaeth leol. Mae Strategaethau Iechyd, Gofal Cymdeithasol a Lles yn rhoi gweledigaethau ar y cyd ar gyfer y blaenoriaethau ar gyfer gweithredu mewn cymuned iechyd a gofal cymdeithasol, a hynny wedi'i seilio ar asesu anghenion lleol. Caiff y strategaethau gwreiddiol eu hadolygu yn 2008, sy'n rhoi cyfle da i gasglu rhagor o wybodaeth am anghenion lleol a nodi'r anghenion cyffredin rhwng cymunedau cyfagos. Roeddem yn falch o glywed Mrs Lloyd yn dweud y bydd Llywodraeth y Cynulliad yn profi'r strategaethau hyn yn y misoedd nesaf, er mwyn asesu a ydynt wedi bod yn ddigon uchelgeisiol ac a ydynt yn rhoi sylw i ddewisiadau ehangach eraill.[4]

18. Yng nghymunedau Gwent a Chaerdydd a Bro Morgannwg, canfu'r Archwilydd Cyffredinol bod y gweledigaethau presennol ar gyfer y system gyfan wedi'u seilio ar iechyd ac yn canolbwyntio ar yr ystadau yn hytrach na'r system gyfan.[5] Yn ôl y dystiolaeth a gyflwynwyd i ni gan sefydliadau lleol, os yw'r holl sefydliadau partner yn y gymuned o ddifrif ynghylch dilyn y weledigaeth ar y cyd, rhaid cydnabod bod pob sefydliad partner yn ddibynnol ar ei gilydd wrth sicrhau system gyfan effeithiol.[6]

19. Er mwyn i'r gwasanaethau ar y cyd lwyddo i hyrwyddo annibyniaeth, rhaid cynnwys meddygon teulu'n effeithiol. Mae ganddynt gyfraniad arwyddocaol i'w wneud wrth benderfynu a ddylid anfon cleifion i'r ysbyty neu beidio, ac os na ddylid, at ba wasanaeth y dylid eu cyfeirio er mwyn rhoi sylw i'w hanghenion gofal. Dywedodd Ms Ward ei bod yn ystyried ysbytai'n llefydd peryglus oherwydd y risg gorfforol sydd i gleifion o ddal heintiau sy'n gysylltiedig â gofal iechyd, ac oherwydd y risg emosiynol y bydd cleifion yn dod yn rhan o'r system sefydliadol po hwyaf y byddant yn aros yn yr ysbyty.[7] Mae manteision amlwg i gynnwys meddygon teulu yn y system gyfan fel rheolwyr risg rhagweithiol, sy'n gofalu nad yw cleifion yn wynebu'r peryglon hyn cyn belled ag y bo modd.[8] Mae angen i feddygon teulu deimlo bod y gallu

[4] Atodiad A, paragraff 68
[5] Crynodeb o adroddiad Archwilydd Cyffredinol Cymru, paragraff 27
[6] Atodiad A, paragraff 116
[7] Atodiad A, paragraff 185
[8] Atodiad A, paragraff 194

ganddynt i wneud hynny a dylent fod yn bartneriaid llawn wrth ofalu nad yw cleifion yn cael eu derbyn i'r ysbyty os nad oes rhaid, ond dywedodd Mr Ross bod hyn ymhell o gael ei gyflawni.[9] Dywedodd Ms Ward bod contract newydd y Gwasanaethau Meddygol Cyffredinol yn bwysig wrth hyrwyddo cyfraniad meddygon teulu, ac efallai fod angen cymell meddygon teulu i gynorthwyo i gadw pobl yn eu cartrefi eu hunain.[10] Da o beth oedd clywed am y trafodaethau â meddygon teulu fel rhan o ddatblygu'r *Rhaglen ar gyfer Gwella Gwasanaeth Iechyd* Caerdydd a'r Fro.[11] Dywedodd Mrs Harris fod hyn yn dangos bod meddygon teulu yn gweithio yn y maes ond fod y system bresennol yn ei gwneud yn anodd iddynt gyfeirio cleifion at wasanaethau eraill ac eithrio'r rheini a ddarperir yn yr ysbyty.[12] Dyma fater system gyfan y mae angen i'r byrddau iechyd lleol, gyda chymorth eu partneriaid lleol a Llywodraeth y Cynulliad, roi sylw iddo ar frys.

20. Yn yr un modd, gall Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru gyfrannu'n allweddol i'r weledigaeth o ddod â gwasanaethau ynghyd, a hynny drwy gynorthwyo â'r gwaith rhagweithiol o reoli'r risg o dderbyn cleifion i'r ysbyty heb fod angen hynny. Gan ddefnyddio'r enghraifft o bobl sy'n disgyn yn eu cartrefi, bydd parafeddygon Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru yn gwybod pan fyddant wedi ymweld â chartrefi fwy nag unwaith ar ôl digwyddiadau o'r fath, a gallant roi gwybod i gomisiynwyr er mwyn sicrhau bod y cleifion yn cael cymorth addas. Er enghraifft, mae Bwrdd Iechyd Lleol Bro Morgannwg yn ystyried llwybr cyfeirio gwahanol fel y gallai parafeddygon gyfeirio'r cleifion hyn at eu meddygon teulu neu at glinig a ddarperir gan yr ymddiriedolaeth leol, yn hytrach na chludo'r claf i'r ysbyty acíwt.[13]

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[9] Atodiad A, paragraff 198
[10] Atodiad A, paragraff 233
[11] Y Rhaglen ar gyfer Gwella Gwasanaeth Iechyd yw model y dyfodol ar gyfer gwasanaethau clinigol yng Nghaerdydd a Bro Morgannwg, ac mae'n nodi'r newidiadau sy'n angenrheidiol er mwyn ateb heriau'r *Cynllun Oes*, sef strategaeth ddeng mlynedd Llywodraeth y Cynulliad i ddatblygu gwasanaethau iechyd a gofal cymdeithasol o'r radd flaenaf.
[12] Atodiad A, paragraffau 193 a 194
[13] Atodiad A, paragraff 195

21. Dylid cynnwys dewisiadau tai arloesol yn y weledigaeth ar y cyd. Dywedodd Mr Ross fod ei sefydliad yn gweithio gydag adrannau tai awdurdodau lleol i edrych ar ffyrdd gwahanol o ddarparu gwasanaethau drwy ofal ychwanegol a thai gwrachod.[14] Mae angen gwneud rhagor o waith i ddatblygu enghreifftiau o arferion da tebyg mewn meysydd eraill.

22. Rhan allweddol o weithredu'r system gyfan yn effeithiol yw datblygu gwasanaethau gofal canolraddol sydd ar y naill law'n osgoi derbyn cleifion yn ddiangen i'r ysbyty ac ar yr un pryd yn helpu cleifion ysbyty i ddychwelyd i'w cartrefi cyn gynted â phosibl. Dywedodd Mrs Harris fod gormod o bobl ar hyn o bryd yn y man anghywir yn y system ac yn cael eu derbyn i'r ysbyty. Byddai newid y model gofal yn gofyn am lai o welyau ysbyty ac ail-fuddsoddi mewn modelau gofal eraill sy'n osgoi derbyn cleifion i'r ysbyty.[15]

23. Pan fydd cymunedau'n llunio ac yn addasu eu gwasanaethau ar y cyd, dylent fod yn arloesol ond dylent hefyd geisio datblygu ymhellach ar yr arferion da sy'n bodoli. Un enghraifft o hyn yw'r model o ward rithiol a ddatblygwyd gan Ymddiriedolaeth Gofal Sylfaenol Croydon. Ffordd yw hyn o edrych ar ddarpariaeth gwasanaethau cymunedol yn seiliedig ar ragfynegiadau o angen, gwaith tîm amlddisgyblaethol, un pwynt cyswllt a rhannu cofnodion a gwybodaeth.[16] Cydnabu Ms Ward y gwaith pwysig sy'n cael ei wneud i fabwysiadu'r model hwn yn Nhor-faen gan yr ymgynghorydd ar ofal canolraddol, yr Athro Bim Bhowmick. Cyfeiriodd at y manteision sy'n dod yn sgil darparu gwasanaethau yng nghartref person yn hytrach nag yn yr ysbyty. Roedd gennym ddiddordeb yn y model hwn ac roedd yn galonogol clywed bod Ymddiriedolaeth GIG Gofal Iechyd Gwent yn edrych ar hyn fel rhan o'i rhaglen *Clinical Futures*.[17]

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[14] Atodiad A, paragraff 163
[15] Atodiad A, paragraff 126
[16] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.140 ac Astudiaeth Achos R ac Atodiad A, paragraff 205
[17] Atodiad A, paragraff 205; Clinical Futures yw model y dyfodol ar gyfer gwasanaethau clinigol yng Ngwent, ac mae'n nodi'r newidiadau sy'n angenrheidiol er mwyn ateb heriau'r *Cynllun Oes*

24. Rhoddodd y tystion dystiolaeth helaeth bod sefydliadau lleol mewn rhai ardaloedd wedi cydnabod difrifoldeb ac effaith oedi wrth drosglwyddo gofal, ac wedi cymryd camau gweithredu ar y cyd i roi sylw i natur systemau cyfan y broblem. Er enghraifft, cryfhawyd y trefniadau cydweithio rhwng y pum sefydliad sy'n ymwneud ag iechyd a gofal cymdeithasol yng Nghaerdydd a Bro Morgannwg wrth i'r holl Brif Weithredwyr gyfarfod i drafod sut i roi sylw i argymhellion adroddiad yr Archwilydd Cyffredinol. Dywedodd Ms Ward wrthym hefyd am y cyfarfodydd strategol sydd wedi dechrau cael eu cynnal yn Nhor-faen.[18] Roedd yn galonogol clywed am yr enghreifftiau o arferion da a nodwyd yn adroddiad yr Archwilydd Cyffredinol ac am y cynnydd a ddisgrifiodd y tystion. Mae'n ymddangos bod mynd i'r afael ag oedi wrth drosglwyddo gofal yn uwch ar restr blaenoriaethau awdurdodau lleol nag ydoedd rai blynyddoedd yn ôl, a rhoddodd Mr Ross deyrnged i'r awdurdodau lleol am roi sylw i'r mater ar lefel uwch.[19]

Dylai Llywodraeth y Cynulliad drefnu ei harweiniad, ei chyllidebau, ei blaenoriaethau, ei mesurau perfformiad a'i chymhellion mewn ffordd sy'n cyd-fynd yn well â'i gweledigaeth ar gyfer y system gyfan. Yn benodol, dylai wella'r systemau mesur presennol gan nad ydynt yn gywir nac yn rhoi digon o bwyslais ar effeithiau oedi wrth drosglwyddo gofal

25. Mae angen i Lywodraeth y Cynulliad ddarparu fframwaith systemau cyfan a fydd yn galluogi cymunedau iechyd a gofal cymdeithasol lleol i ddatblygu eu gweledigaethau eu hunain o fodelau gwasanaeth, gan droi'r rheini yn ffyrdd ystyrlon o hyrwyddo annibyniaeth. Drwy ddatblygu a darparu gweledigaeth gydlynol yn fwy effeithiol er mwyn hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed, dylai Llywodraeth y Cynulliad a phartneriaid lleol leihau difrifoldeb ac effaith oedi wrth drosglwyddo gofal. Mae angen i'r fframwaith canolog gynnwys canllawiau, cyllidebau, blaenoriaethau, mesurau perfformiad a chymhellion cydlynol, ac ar yr un pryd dylai sicrhau bod gan bartneriaid lleol

[18] Atodiad A, paragraffau 116 a 120
[19] Atodiad A, paragraff 122

ddigon o hyblygrwydd i ddatblygu atebion ac arferion da sy'n addas i'w hamgylchiadau penodol hwy.

26. Pan nad yw sefydliadau lleol yn cydweithio'n effeithiol, rhaid i Lywodraeth y Cynulliad gynnig y cydbwysedd priodol o arweinyddiaeth a hyblygrwydd i hyrwyddo cyd-weithredu ar draws y system gyfan. Dywedodd Mr Isaac wrthym fod y Fframwaith Gwasanaeth a Chyllid (SaFF) ar gyfer y flwyddyn nesaf yn debygol o gynnwys gofyniad bod sefydliadau yn cydweithio.[20] Yn ychwanegol, pwysleisiodd Mrs Lloyd pa mor bwysig yw cymell cymunedau cyfan i gydweithio'n fwy effeithiol. Dywedodd mai'r unig ffordd o gael sefydliadau i gydweithio yn ystod cyfnodau o bwysau cynyddol, diffyg adnoddau a chraffu trwm yw drwy ddefnyddio cymhellion a all fod yn effeithiol iawn wrth glymu pobl at ei gilydd ar adegau o'r fath.[21]

27. Mae system o 'draws dalu' wedi cael ei chyflwyno yn Lloegr, lle mae awdurdodau lleol yn wynebu cosb ariannol am bob diwrnod gwely a gaiff ei golli oherwydd oedi wrth drosglwyddo gofal am resymau gofal cymdeithasol.[22] Rhoddodd y tystion sylwadau anghyson i ni ar effeithiolrwydd mesurau o'r fath. Dywedodd Mr Ross wrthym am ei brofiad fel Prif Weithredwr ymddiriedolaeth yn Lloegr pan gyflwynwyd y dirwyon. Dywedodd fod cyflwyno'r dirwyon wedi arwain at godi'r mater o oedi wrth drosglwyddo gofal i frig yr agenda, ac mai anaml iawn yr oedd angen gweithredu unrhyw ddirwyon am fod pob sefydliad yn sicrhau ei fod yn faes blaenoriaeth ar gyfer gweithredu.[23] Roedd Mrs Harris o'r farn bod effaith y system hon yn Lloegr wedi bod yn gymysg, gyda thystiolaeth bod dirwyon wedi niweidio'r berthynas rhwng rhai sefydliadau.[24] Mae hyn yn amlwg yn groes i'r effaith a fwriadwyd a chredwn fod angen system amgen o gymhellion yng Nghymru, o gofio bod

[20] Mae'r Fframwaith Gwasanaeth a Chyllid yn cysylltu'r adnoddau sydd ar gael i gymuned iechyd dros gyfnod o flwyddyn gyda'r gweithgarwch a'r datblygiad sydd i'w gyflawni yn y cyfnod hwnnw. Nod y broses yw rhoi eglurder, cynorthwyo i gynllunio ar y cyd a rhoi sail i reoli perfformiad dros y flwyddyn. Mae cyfres o flaenoriaethau cenedlaethol, a nodwyd gan Lywodraeth y Cynulliad, yn sail i'r broses. Atodiad A, paragraff 34
[21] Atodiad A, paragraff 81
[22] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.132
[23] Atodiad A, paragraff 268
[24] Atodiad A, paragraff 266

awdurdodau lleol bellach yn ymgysylltu fwy â'r angen i wneud gwelliannau ar draws y system gyfan.

28. Rhaid cael cydbwysedd rhwng y defnydd o weithgareddau a gaiff eu hybu'n ganolog i hwyluso cydweithio, a'r angen i ganiatáu hyblygrwydd lleol. Dywedodd Mr Ross y gallai targedau a osodir yn lleol fod yn fwy effeithiol na'r rhai a osodir yn ganolog am fod pobl yn dueddol o fod yn fwy uchelgeisiol wrth osod eu targedau eu hunain ac ymgyrraedd tuag atynt.[25] Mae angen hyblygrwydd i gydnabod y cymhlethdod a'r amrywiaeth a geir yn lleol. Siaradodd Mr Ross am y gwahanol bolisïau, agweddau, galluoedd ariannu ac anghyfartaledd y ddarpariaeth gwasanaeth a geir yng Nghymru a dywedodd y byddai unrhyw beth y gellir ei wneud i ddileu'r amrywiaeth hon a gwella'r cydgysylltiad y tu hwnt i ffiniau bwrdeistrefi o fudd i'r claf.[26]

29. Dywedodd Ms Ward nad yw defnyddio oedi wrth drosglwyddo gofal fel dangosydd perfformiad yn ddefnyddiol gan nad yw'n gysylltiedig â chanlyniadau cleifion a'i fod yn rhoi'r bai ar sefydliadau unigol yn hytrach nag ystyried materion ehangach y system gyfan.[27] Er hynny, mae'n bwysig bod rhai dulliau o fesur pa mor effeithiol y mae'r system gyfan yn gweithredu o ran hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed a thrwy hynny leihau effaith negyddol oedi wrth drosglwyddo gofal. Heb fodolaeth cytundeb perfformiad penodol o ran oedi wrth drosglwyddo gofal o 1 Ebrill 2008,[28] mae angen i Lywodraeth y Cynulliad ddatblygu fframwaith rheoli perfformiad sy'n galluogi sefydliadau iechyd a gofal cymdeithasol i osod targedau system gyfan. Roedd Mr Isaac yn gywir pan ddywedodd bod angen targedau sy'n canolbwyntio ar ganlyniad sy'n llwyddo i roi cyfrifoldeb ar gymunedau a hefyd yn llwyddo i ddwyn sefydliadau at ei gilydd yn hytrach na'u gwahanu.[29] Dywedodd Mrs Harris y dylai'r targedau gael eu plethu rhwng sefydliadau a

[25] Atodiad A, paragraff 243
[26] Atodiad A, paragraff 122
[27] Atodiad A, paragraff 246
[28] Atodiad A, paragraff 34
[29] Atodiad A, paragraff 99

hefyd gael eu plethu â thargedau eraill fel nad ydynt yn gwrthdaro yn erbyn mesurau perfformiad eraill ar hyd llwybr y claf.[30]

30. Gallai'r cyfeiriad strategol olygu y bydd angen cydbwyso gwasanaethau eto rhwng lleoliadau acíwt sy'n ymdrin ag argyfyngau a gwasanaethau y tu allan i'r ysbyty a all rwystro argyfyngau o'r fath rhag digwydd. I gynorthwyo hyn, mae angen fframwaith ariannol priodol sy'n hwyluso'r defnydd mwyaf effeithiol o arian cyhoeddus ar draws y system gyfan yn hytrach na chyfeirio adnoddau tuag at leoliadau acíwt drud sy'n ymdrin â phroblemau a allai fod wedi eu hosgoi yn aml drwy ymyriadau cynharach. Gall triniaeth pobl eraill gael ei oedi wrth i welyau gael eu defnyddio mewn achosion o oedi wrth drosglwyddo gofal gan achosi anawsterau o ran cyrraedd targedau mynediad cynyddol Llywodraeth y Cynulliad am driniaethau dewisol.[31] Dywedodd Mr Ross y gallai costau darparu gofal y tu allan i'r ysbyty fod llawer iawn uwch na'r costau ar gyfer y cleifion hynny sy'n aros yn yr ysbyty, sy'n fater polisi ar raddfa fwy.[32] Mae hyn yn gysylltiedig â chostau, amseru ac effeithiolrwydd gwahanol fathau o ymyriadau. Bydd angen cymorth Llywodraeth y Cynulliad ar y Comisiynwyr wrth symud adnoddau ariannol o ysbytai ac i'r cymunedau.

31. Bydd angen buddsoddi mewn gwasanaethau yn y gymuned wrth newid y ffocws hwn yn y ddarpariaeth gwasanaeth a dywedodd Ms Ward y dylai Llywodraeth y Cynulliad ystyried arian trosiannol i dorri'r cylch dieflig sy'n clymu adnoddau yn y rhannau acíwt o faes iechyd a gofal cymdeithasol.[33] Efallai y bydd angen rhoi arian sefydlu er mwyn torri'r hyn a ddisgrifir gan yr Archwilydd Cyffredinol fel y methiant presennol.[34] Dywedodd Mrs Lloyd y bydd yn aros am ganlyniadau'r prosiectau peilot presennol ar reoli afiechydon cronig cyn rhoi cyngor pellach i'r Gweinidog ar y mater hwn.[35] Dywedodd Mr Ross y byddai darparu adnodd penodol a glustnodwyd yn gweithio i hwyluso cydweithredu.[36] Ond, credwn mai dim ond pe bai'n cynorthwyo i ddarparu

[30] Atodiad A, paragraff 244
[31] Atodiad A, paragraff 124
[32] Atodiad A, paragraff 128
[33] Atodiad A, paragraff 232
[34] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.131
[35] Atodiad A, paragraff 83
[36] Atodiad A, paragraff 134

gweledigaeth glir, gytûn lle y gallai'r adnoddau hynny gael eu targedu orau i wneud i'r system gyfan weithredu'n fwy effeithiol y byddai arian penodol o'r fath yn gweithio orau.

32. Gallai cydnabyddiaeth ehangach o gyd-ddibyniaeth sefydliadau partner wrth fynd i'r afael â materion system gyfan arwain at fwy o barodrwydd i rannu adnoddau drwy gyllidebau ar y cyd. Dywedodd Mrs Lloyd fod Gweinidogion yn awyddus i ganiatáu i gyllidebau ar y cyd gael eu defnyddio ymhellach er mwyn sicrhau bod gan sefydliadau partner weledigaeth fwy cynhwysfawr a chyfannol o'r dewisiadau amgen i ofal mewn ysbyty.[37] Dywedodd fod hyblygrwydd o dan y Ddeddf lechyd sy'n caniatáu ar gyfer mesurau o'r fath ond bod gwaith yn mynd rhagddo i archwilio a yw'n bosibl ymestyn yr hyblygrwydd hwn i annog cyllidebau cyfun.[38] Rhoddodd yr Archwilydd Cyffredinol enghreifftiau o gyllidebau ar y cyd yng Nghymru ond mae'r rhain yn dueddol o fod yn rhai diweddar iawn ac yn anodd eu gwerthuso, er bod tystiolaeth newydd yn dangos bod comisiynu ar y cyd yn arwain at lwybr esmwythach.[39] Dywedodd adroddiad yr Archwilydd Cyffredinol hefyd y dylai cyllidebau cyfun ddilyn gweledigaeth ar y cyd o natur hirdymor darpariaeth gwasanaethau.[40] Gan gydnabod y pwynt hwn, croesawyd barn Mr Ross fod lle i symud oddi wrth y ddarpariaeth bresennol – lle mae cydlyniad gwasanaethau a chyllidebau yn awgrymu cronni diffygion – tuag at gronni gweddillion rhwng y maes iechyd a chyrff llywodraeth leol i ddatblygu gwasanaethau newydd yn y gymuned.[41]

33. Gwelwyd bod lle i Lywodraeth y Cynulliad ei hun blethu iechyd a gofal cymdeithasol yn fwy effeithiol er mwyn cefnogi ffordd o gydweithio i wella systemau cyfan. Dywedodd Mrs Lloyd wrthym fod ei chyfrifoldebau hi yn hollol wahanol rhwng iechyd a gwasanaethau cymdeithasol ond gwadodd bod ei swydd fel pennaeth yr Adran Iechyd a Gwasanaethau Cymdeithasol yn cyfrannu at

[37] Atodiad A, paragraff 68
[38] Atodiad A, paragraff 22
[39] Adroddiad Archwilydd Cyffredinol Cymru, paragraff crynodeb 30
[40] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.133
[41] Atodiad A, paragraff 131

wendid mewn rheolaeth strategol gan Lywodraeth y Cynulliad.[42] Credwn fod lle i gael cydlynu mwy effeithiol rhwng y meysydd iechyd a gofal cymdeithasol, ac arweinyddiaeth strategol drwy hynny, o fewn Llywodraeth y Cynulliad ei hun.

34. Mae angen hefyd i Lywodraeth y Cynulliad wella'r system o fesur oedi wrth drosglwyddo gofal. Dywedodd Mrs Lloyd wrthym ei bod yn derbyn bod cyfyngiadau yn y dull presennol o fesur oedi wrth drosglwyddo gofal.[43] Mae effeithiolrwydd system fesur fisol sy'n canoli rheoli perfformiad ar un diwrnod bob mis yn peri pryder i ni.[44] Er bod y mesuriad yn briodol yn cyfrif nifer y dyddiau gwely a gollir, mae ffocws yr adrodd yn ôl yn parhau i ganolbwyntio ar nifer y bobl sy'n wynebu oedi. Mae hyn yn cynnig cymhellion croes i glirio achosion o oedi wrth drosglwyddo cyn dyddiad y cyfrifiad heb fynd i'r afael â'r achosion o yn y system gyfan. Roeddem yn falch bod Mrs Lloyd yn cydnabod y gwendidau yn y systemau mesur presennol a'i sicrwydd y byddai'r adolygiad annibynnol o oedi wrth drosglwyddo gofal, a gomisiynwyd gan Lywodraeth y Cynulliad, yn edrych yn feirniadol ar y mesurau a ddefnyddir yng Nghymru.[45]

35. Cyfyngir yn sylweddol ar y mesurau perfformiad presennol gan gytundebau lleol rhwng sefydliadau iechyd a gofal cymdeithasol sydd â'r nod o adlewyrchu'r amser gwirioneddol a gymerir i gynnal asesiadau gofal cymdeithasol a rhoi trefniadau gofal cymdeithasol ar waith. Roedd y trefniadau lleol hyn ar waith ym mhob ardal a gwmpaswyd gan adolygiad yr Archwilydd Cyffredinol ac eithrio Sir Fynwy.[46] Mae'n hollol annerbyniol bod cytundebau o'r fath ar waith. Nid yw'r cytundebau hyn yn gwneud dim ond cuddio'r gwir broblem, ac mae'r anghysondeb rhwng y cytundebau lleol mewn gwahanol ardaloedd yn gostwng hygrededd y data a gynhyrchir ymhellach.[47] Rydym yn croesawu'r ffaith bod Llywodraeth y Cynulliad yn bwriadu dileu'r cytundebau hyn.[48] Er hynny, cawsom ein synnu fod Mrs Lloyd yn teimlo bod

[42] Atodiad A, paragraff 90
[43] Atodiad A, paragraff 24
[44] Atodiad A, paragraff 23
[45] Atodiad A, paragraff 24
[46] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 1.22 a Ffigwr 9
[47] Atodiad A, paragraff 40
[48] Atodiad A, paragraff 38

angen cael cyngor cyfreithiol ynglŷn â dileu'r cytundebau hyn pan ymddengys ei bod, fel Cyfarwyddwr yr Adran Iechyd a Gwasanaethau Cymdeithasol, yn rhydd i fanteisio ar y pwerau angenrheidiol i weithredu hyn drwy orchymyn cyrff y GIG nad ydynt i gymryd rhan bellach mewn cytundebau o'r fath.[49]

36. Dangosodd adroddiad yr Archwilydd Cyffredinol ei bod yn bwysig mesur effaith gynyddol oedi wrth drosglwyddo gofal yn gywir. Er bod yr achosion o oedi wrth drosglwyddo gofal wedi gostwng yn sylweddol ers mis Medi 2003, bu cynnydd yn y cyfanswm o ddyddiau gwely ysbyty a ddefnyddiwyd gan y bobl hyn rhwng 2005-06 a 2006-07. Yn 2006-07, nifer y dyddiau gwely a ddefnyddiwyd oherwydd oedi wrth drosglwyddo gofal oedd 268,491, a oedd ddau y cant yn uwch nag yn 2005-06 ac a ysgogwyd gan gynnydd yn hyd cyfartalog yr oedi wrth drosglwyddo gofal.[50]

37. Nododd adroddiad yr Archwilydd Cyffredinol bod graddau oedi wrth drosglwyddo gofal yn amrywio mewn gwahanol rannau o Gymru.[51] Yn achos saith o'r wyth awdurdod unedol/bwrdd iechyd lleol a gwmpaswyd gan yr adroddiad, roedd cynnydd yn y nifer o ddyddiau gwely a ddefnyddiwyd o ganlyniad i oedi wrth drosglwyddo gofal rhwng 2005-06 a 2006-07.[52] Dengys dadansoddiad o'r wybodaeth hon yn ôl ardal breswyl y claf bod y cynnydd yn y nifer o ddyddiau gwely a gollwyd o ganlyniad i oedi wrth drosglwyddo gofal yn cael ei lywio'n bennaf gan gynnydd yng Nghaerdydd, Bro Morgannwg a Gwent. Gostyngodd nifer y dyddiau gwely a gollwyd yn achos 10 o'r 22 bwrdd iechyd lleol dros yr un cyfnod.[53]

Mae angen arweinyddiaeth drwy'r systemau cyfan er mwyn gwireddu'r weledigaeth

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[49] Atodiad A, paragraff 36
[50] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 1.6, 1.7 a Ffigwr 4
[51] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 1.7
[52] Bu cynnydd yn nifer y gwelyau a ddefnyddiwyd o ganlyniad i oedi wrth drosglwyddo gofal yng Nghaerdydd, Bro Morgannwg, Blaenau Gwent, Caerffili, Sir Fynwy, Casnewydd a Thorfaen, tra bu gostyngiad yn Sir Gaerfyrddin
[53] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 1.7

38. Yn ogystal ag arweinyddiaeth effeithiol mewn sefydliadau unigol, ni all y system gyfan weithredu'n briodol heb arweinyddiaeth strategol yn y gymuned iechyd a gofal cymdeithasol sydd wedi ei ganoli'n aml ar y brif Ymddiriedolaeth, ond nid bob amser. Rhaid i arweinwyr ar y lefel ehangach hon fod yn fodlon rhannu pŵer ac adnoddau, a gweithio er budd y gymuned gyfan yn hytrach na buddiannau cul eu sefydliadau eu hunain. Gwelir y materion hyn mewn anghydfodau rhwng sefydliadau o ran pwy ddylai ariannu gofal parhaus unigolyn sydd ag anghenion gofal cymhleth. Mae anghydfodau am gymhwysedd Gofal Iechyd Parhaus yn rhwystrau mawr i alluogi'r system gyfan i weithredu mewn ffordd sy'n canolbwyntio ar anghenion unigolion a cheir enghreifftiau o ffiniau sefydliadol nad ydynt yn llwyddo i roi'r person yn ganolog.[54] Gall goresgyn rhwystrau sefydliadol o'r fath alw am sgiliau arweinyddiaeth clir i edrych y tu hwnt i gyllidebau unigol, rheolaeth sefydliadol a'r cyfuniad presennol o wasanaethau, ac edrych yn fanylach ar anghenion dinasyddion a'r ffordd orau o gyfuno gwasanaethau, defnyddio adnoddau cyhoeddus prin a sicrhau gwell canlyniadau.

39. Clywsom fod arweinyddiaeth systemau cyfan yn dechrau datblygu yn y cymunedau a gaiff eu cwmpasu gan adroddiad yr Archwilydd Cyffredinol. Mae ymgysylltiad ar lefel weithredol wedi cynyddu yng nghymunedau iechyd a gofal cymdeithasol Caerdydd a Bro Morgannwg, ble roedd y berthynas rhwng iechyd a gofal cymdeithasol a sefydliadau unigol o fewn y gymuned yn drafferthus yn draddodiadol.[55] Er i'r berthynas rhwng sefydliadau partner ddirywio'n gyhoeddus yn ddiweddar, mae'r sefydliadau lleol hyn bellach wedi cymryd y camau cyntaf tuag at ffordd wirioneddol o gydweithio a chydweithredu, gan ddatblygu tuag at strategaeth gomisiynu ar y cyd ym maes gofal hirdymor. Rydym yn falch iawn o glywed fod disgwyl i'r pum Prif Weithredwr yn y gymuned gwrdd i drafod sut i fynd i'r afael â'r argymhellion yn adroddiad yr Archwilydd Cyffredinol, fel y dywedir ym mharagraff 23.[56] Dywedodd Ms Ward y bu enghraifft debyg o arweinyddiaeth strategol yn Nhor-faen, ble daeth Prif Weithredwyr yr awdurdod lleol, Ymddiriedolaeth y

[54] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.13-2.26
[55] Atodiad A, paragraff 241
[56] Atodiad A, paragraff 120

GIG a'r Bwrdd Iechyd Lleol at ei gilydd i benderfynu ar y cyfeiriad strategol mewn cysylltiad ag oedi wrth drosglwyddo gofal a hefyd o ran yr holl ffordd o osgoi gadael i bobl ddod yn rhan o'r system sefydliadol.[57] Awgrymodd adroddiad yr Archwilydd Cyffredinol ar Sir Gaerfyrddin bod gwelliannau wedi digwydd yn y Sir hefyd o ran gweithio mewn partneriaeth.[58]

40. Er bod y byrddau gwasanaethau lleol yn parhau i fod yn sefydliadau ifanc, mae'r potensial ganddynt i wella partneriaethau ac arweinyddiaeth strategol ar draws ffiniau ac ar draws y system gyfan. Yn ganolog i'r amcanion a nodir gan y chwe bwrdd cyntaf a sefydlwyd, rhaid gwella'r ffordd y mae'r system iechyd a gofal cymdeithasol yn gweithio o ran darparu gwasanaeth da i gleifion.[59] Nodwn farn Mrs Lloyd fod y sefydliadau newydd hyn eisoes yn hybu gweithredu. Fodd bynnag, mae'n amlwg bod risg y gallai byrddau gwasanaethau lleol geisio mynd i'r afael â rhai o'r cymhlethdodau ac amrywiadau strwythurol y cyfeiria Mr Ross atynt, sy'n deillio o'r nifer o sefydliadau sy'n gysylltiedig â'r system gyfan, yn hytrach na sicrhau gwelliannau cadarn a gwell canlyniadau.[60] O ganlyniad, dylai byrddau gwasanaethau lleol, fel y disgrifiodd Mrs Lloyd, annog sefydliadau i gydweithio'n well i ddatrys rhai o'r problemau anhydrin sy'n eu hwynebu.[61] Bydd hyn yn golygu sicrhau gwelliannau cadarn mewn canlyniadau yn ogystal â gwell trafodaethau rhwng partneriaid.

41. Mae'n hanfodol bod Llywodraeth y Cynulliad yn rhoi arweinyddiaeth ar lefel genedlaethol a fydd yn hwyluso'r system gyfan i wella. Roedd yn galonnog clywed Mrs Lloyd yn dweud bod mynd i'r afael ag oedi wrth drosglwyddo gofal yn un o brif flaenoriaethau ei hadran.[62] Er hynny, credwn y gallai Llywodraeth y Cynulliad fod wedi gwneud mwy i arwain y blaen wrth ddatrys rhai o'r materion yn y system gyfan rhwng iechyd a gwasanaethau

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[57] Atodiad A, paragraff 116
[58] Adroddiad Archwilydd Cyffredinol Cymru, *Mynd i'r afael ag achosion o oedi wrth drosglwyddo gofal yn y system gyfan – Cymuned Iechyd a Gofal Cymdeithasol Sir Gaerfyrddin,* paragraffau 2.1-2.8
[59] Atodiad A, paragraff 101
[60] Atodiad A, paragraff 122
[61] Atodiad A, paragraff 101
[62] Atodiad A, paragraff 17

cymdeithasol. Er enghraifft, er ein bod yn cydnabod nad yw'n hawdd datrys y problemau sy'n ymwneud â'r broses Asesu Unedig, teimlwn y dylai Llywodraeth y Cynulliad fod wedi chwarae rhan fwy gweithredol wrth ddatblygu atebion mewn ardaloedd sydd â phroblemau penodol megis Gwent.[63]

Nid yw'r prosesau comisiynu wedi'u datblygu'n ddigonol a rhaid sicrhau bod gan gymunedau iechyd a gofal cymdeithasol gapasiti priodol mewn amrywiaeth eang o wasanaethau sy'n hyrwyddo annibyniaeth.

42. Dylai system gyfan effeithiol ym maes iechyd a gofal cymdeithasol roi dewis gwirioneddol i bobl o ran y lleoliad a'r math o ofal a gânt, yn arbennig er mwyn diwallu anghenion gofal hirdymor megis cartrefi preswyl neu gartrefi nyrsio. Mae'r dewis o gartref gofal yn benderfyniad allweddol ac yn un o'r penderfyniadau mawr olaf y bydd unrhyw un yn ei wneud gyda'i deulu am ei fywyd. Fodd bynnag, golyga'r sefyllfa bresennol yng Nghymru bod diffyg capasiti mewn rhai ardaloedd yn cyfyngu ar ddewis y claf i'r graddau mai ychydig iawn o ddewis sydd ar gael neu nad oes unrhyw ddewis o gwbl. Soniodd Mr Ross am y gostyngiad serth mewn capasiti cartrefi nyrsio yng Nghaerdydd a Bro Morgannwg yn ystod y blynyddoedd diweddar ac er bod peth o'r capasiti hwn bellach yn cael ei adfer, mae llawer o'r ddarpariaeth newydd o ansawdd uchel iawn, felly mae'n rhy ddrud i awdurdodau lleol a llawer o deuluoedd.[64] Dywedodd hefyd ei fod yn credu mai dim ond dau gartref nyrsio yng Nghaerdydd fydd yn derbyn cyfraddau'r awdurdod lleol, sy'n golygu nad oes gan lawer o gleifion ddewis realistig dros eu gofal.[65] Gwnaeth adroddiad yr Archwilydd Cyffredinol hefyd sylwadau am y capasiti cyfyngedig ar gyfer gofal mewn lleoliadau sefydliadau allanol, megis gwasanaethau gofal canolraddol, adsefydlu, nyrsio ardal a gwasanaethau therapi.[66] Dywedodd Mr Ross y byddai mabwysiadu ffordd wirioneddol gytûn, sy'n canolbwyntio ar gomisiynu gwasanaethau i hyrwyddo annibyniaeth yn hytrach na dibynnu ar

[63] Atodiad A, paragraff 53
[64] Atodiad A, paragraff 112
[65] Atodiad A, paragraff 162
[66] Adroddiad Archwilydd Cyffredinol Cymru, paragraffau 2.51-2.66 a 2.94-2.96

ofal sefydliadol, yn cael effaith sylweddol ar gleifion a'r system gyfan.[67] Nod hyn fyddai peidio â derbyn pobl i'r ysbyty pan fyddai gofal mewn lleoliad arall yn fwy priodol iddynt ac yn eu galluogi i ddychwelyd adref yn gynharach.

43. Cawsom ein calonogi gan barodrwydd y tystion i ystyried defnyddio mwy o'u hadnoddau y tu allan i'r lleoliadau sefydliadol traddodiadol o ran y meysydd iechyd a gofal cymdeithasol.[68] Dywedodd Mrs Harris y dylai hyn gynnwys tynnu rhai o'r gwasanaethau traddodiadol o'r ysbytai a'u rhoi mewn cymunedau drwy ddefnyddio canolfannau adnoddau sylfaenol a gofal cymdeithasol.[69] Dywedodd Ms Ward fod angen arian pontio i gynorthwyo sefydliadau iechyd a gofal cymdeithasol i fuddsoddi mewn gofal canolraddol.[70] Fodd bynnag, roedd Mrs Harris a Ms Ward yn cydnabod nad yw comisiynwyr yn gwneud digon ar hyn o bryd i gomisiynu'r gwasanaethau y tu allan i'r ysbytai hyn.[71] Mae hyn yn adlewyrchu canfyddiad yr Archwilydd Cyffredinol am ddatblygiad gwael y Cytundebau Hirdymor am wasanaethau cymunedol rhwng darparwyr a chomisiynwyr.[72]

44. Nid yw'r gwaith o gomisiynu gofal canolraddol wedi ei ddatblygu'n llawn a gwael iawn yw'r integreiddio rhwng y gwasanaethau sy'n bodoli. Dywedodd adroddiad yr Archwilydd Cyffredinol fod gwasanaethau gofal canolraddol yn dameidiog a dywedodd Mrs Harris fod hyn yn rhannol oherwydd y patrwm hanesyddol o ariannu'r gwasanaethau hyn.[73] Roedd arian yn aml yn cael ei ddarparu drwy arian grant arbennig a ddyrannwyd i faes penodol, a thrwy hynny'n creu anghyfartaledd mewn darpariaeth gwasanaeth ar draws ffiniau bwrdeistrefi. Gall hyn fod yn ddryslyd i weithwyr proffesiynol iechyd a gofal cymdeithasol sy'n ei chael yn anodd gwybod weithiau pa wasanaethau sydd ar gael i gleifion o wahanol ardaloedd, gyda rhai cleifion mewn ysbytai yn gymwys i gael gwasanaeth arbennig lle nad yw eraill yn gymwys am eu bod

[67] Atodiad A, paragraff 134
[68] Atodiad A, paragraff 132
[69] Atodiad A, paragraff 132
[70] Atodiad A, paragraff 232
[71] Atodiad A, paragraffau 204 a 205
[72] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.78
[73] Adroddiad Archwilydd Cyffredinol Cymru, paragraffau 2.78-2.66, ac Atodiad A, paragraff 189

yn byw mewn ardal Bwrdd Iechyd Lleol/awdurdod unedol gwahanol. Rhaid i sefydliadau lleol gydweithio i integreiddio gwasanaethau gofal canolraddol yn well fel bod gwell eglurder, darpariaeth fwy cyfartal a gwell mannau mynediad. Dywedodd Mrs Harris bod ei sefydliad hi wedi ymrwymo i symleiddio rhai o'r gwasanaethau hyn er mwyn sicrhau eu bod yn defnyddio'u capasiti yn fwy effeithiol.[74]

45. Mae gan awdurdodau lleol ran hanfodol i'w chwarae wrth adeiladu'r gwasanaethau gofal canolraddol sy'n cynnig dewisiadau amgen i ofal mewn sefydliadau, ond nododd y Pwyllgor fod diffyg tystiolaeth yn gyffredinol gan y tystion am gomisiynu gofal cymdeithasol mewn cysylltiad â'u pwyslais ar gomisiynu gwasanaethau iechyd. Awgryma hyn mai'r maes iechyd yw'r gwasanaeth pennaf o hyd a rhaid i hyn newid er mwyn cynnig amrywiaeth o wasanaethau system gyfan fwy cydlynol.

46. Dywedodd Ms Ward fod gan ei sefydliad ddiddordeb mawr mewn darparu gwasanaethau gofal canolraddol amgen megis trawsnewid rhai unedau tai lloches yn welyau gofal canolraddol, er ei bod yn cyfaddef nad yw ei sefydliad yn comisiynu mor effeithiol ag y gallai yn y maes hwn.[75]

47. Mae sefydliadau'r sector gwirfoddol hefyd yn bartneriaid allweddol wrth ddarparu gwasanaethau amgen sy'n hyrwyddo annibyniaeth pobl hŷn sy'n agored i niwed. Mae gweithgor cenedlaethol a gaiff ei gadeirio gan Mrs Lloyd yn ystyried y ffyrdd gorau o gyflwyno arferion da wrth gomisiynu, ac mae asiantaethau gwirfoddol wedi cael eu cynnwys er mwyn gweld pa wasanaethau y gellir eu comisiynu ganddynt hwy.[76] Dywedodd Mr Ross fod Ymddiriedolaeth GIG Caerdydd a'r Fro yn gweithio gyda sefydliadau gwirfoddol megis Gofal a Thrwsio Cymru a Gweithredu Gwirfoddol Caerdydd i ystyried pa wasanaethau y mae'n bosibl y gallent hwy eu darparu yng nghartrefi pobl.[77] Roeddem yn falch o weld yr astudiaethau achos yn adroddiad yr Archwilydd Cyffredinol a oedd yn dangos yr ymyriadau lefel isel

[74] Atodiad A, paragraffau 188-191
[75] Atodiad A, paragraff 205
[76] Atodiad A, paragraff 77
[77] Atodiad A, paragraff 163

a gaiff eu darparu gan y sector gwirfoddol i sicrhau bod gan bobl hŷn sy'n agored i newid fwy o annibyniaeth. Mae'r enghreifftiau hyn yn cynnwys darparu sliperi newydd i'w rhwystro rhag disgyn, benthyca offer gofal a chymorth rhagweithiol i ofalwyr.[78]

48. Caiff gwaith comisiynu effeithiol a'r gwaith cloriannu o'r newydd o ganlyniad i hynny oddi wrth y lleoliadau acíwt eu rhwystro ar hyn o bryd gan ddiffyg gwybodaeth ddigonol am gostau. Soniodd adroddiad yr Archwilydd Cyffredinol am y diffyg gwybodaeth am wasanaethau y tu allan i ysbytai sydd wedi arwain at ddiffyg gwerthusiad digonol a'r defnydd anghyson o arferion da.[79] Cyfeiriodd Mrs Lloyd at yr anawsterau sy'n wynebu sefydliadau wrth fod yn bendant am gostau cymharol cadw claf yn y lle anghywir mewn ysbyty o'u cymharu â chostau'r pecynnau sylweddol o ofal sy'n debygol o fod eu hangen i ddarparu gwasanaethau i gleifion y tu allan i'r ysbyty.[80] O'r £69 miliwn o gostau cyfle uniongyrchol o ddyddiau gwely a ddefnyddir oherwydd oedi wrth drosglwyddo gofal, mae'r Archwilydd Cyffredinol yn amcangyfrif y gallai £26.8 miliwn o gostau ymylol gwelyau gael eu rhyddhau'n uniongyrchol i gael eu hail-fuddsoddi mewn maes arall yn y system iechyd a gofal cymdeithasol.[81] Dywedodd Mrs Lloyd fod angen tystiolaeth bendant o ran costau gwasanaethau er mwyn dileu'r ansicrwydd presennol ynghylch y ffordd fwyaf effeithiol o ail-fuddsoddi'r arian hwn.[82]

49. Un o'r ffactorau eraill sy'n cyfyngu ar effeithiolrwydd comisiynu gan y byrddau iechyd lleol ac awdurdodau yw dibyniaeth ar brynu capasiti yn ôl y galw. Mae adroddiad yr Archwilydd Cyffredinol yn tynnu sylw at brynu capasiti cartrefi gofal yn ôl y galw gan awdurdodau lleol gan arwain at gostau uwch ac ansicrwydd o ran cyflenwi.[83]

50. Mae prynu yn ôl y galw yn peri ansicrwydd hefyd o ran y galw am ddarparwyr sector annibynnol sy'n amlinellu'r angen ehangach i gomisiynwyr

[78] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.82
[79] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.77
[80] Atodiad A, paragraff 18
[81] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 1.16
[82] Atodiad A, paragraff 18
[83] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.79

weithio'n fwy effeithiol i reoli'r sector annibynnol. Mae angen i lywodraeth leol a sefydliadau iechyd gynorthwyo'r sector annibynnol i ddatblygu ystod ehangach o ddarpariaeth. Dywedodd Ms Ward fod y sector annibynnol yn dioddef: er bod ei sefydliad wedi cynyddu'r ffioedd a delir ganddo i'r darparwyr hyn, dywedodd na fydd hyn, ynddo'i hun, yn datrys y broblem o leoliadau da, safonol a fforddiadwy.[84] Gall comisiynwyr wneud mwy drwy ddefnyddio statws darparwr dewisol a thrwy gomisiynu ar y cyd lle mae awdurdodau comisiynu'n cydweithio i drafod contractau llawer rhatach gyda darparwyr preifat a fydd yn cael sicrwydd refeniw yn gyfnewid am hyn drwy warantu'r galw.[85] Potensial hyn yw y bydd yn gwella ansawdd, yn gwella sicrwydd cyflogaeth i'r rhai sy'n gweithio mewn cartrefi gofal ac yn rhoi mwy o sicrwydd gofal i breswylwyr y cartrefi. Roeddem yn falch o nodi gwaith parhaol Rhaglen Welliant Gydweithredol De-Ddwyrain Cymru[86] a'r berthynas gadarnhaol mae Llywodraeth y Cynulliad wedi ei meithrin gyda Fforwm Gofal Cymru, er ei bod yn amlwg bod angen rhoi gwell cefnogaeth i'r farchnad drwy fwy o gydberthnasau aeddfed i roi mwy o safon, dewis a gwerth am arian.[87]

Rhaid cryfhau'r prosesau ar hyd y llwybr cyfan fel bod y ddarpariaeth yn canolbwyntio ar anghenion gofal y claf

51. Rhaid i brosesau ysbytai fod yn fwy effeithiol er mwyn galluogi cleifion i ddychwelyd i'w cartrefi a'u bywydau arferol cyn gynted ag y mae hynny'n briodol ar gyfer eu cyflwr. Cyfaddefodd Mr Ross bod elfennau o aneffeithiolrwydd i'w cael yn y prosesau a gaiff eu gweithredu gan ei ysbytai, a chanfu'r Archwilydd Cyffredinol:

a) bod oedi sylweddol o ran ailddechrau pecynnau gofal unwaith y byddant wedi eu rhewi dros dro pan fydd claf yn cael ei dderbyn i'r ysbyty;[88]

[84] Atodiad A, paragraff 178
[85] Atodiad A, paragraffau 117 a 210
[86] Mae Rhaglen Welliant Gydweithredol De-Ddwyrain Cymru (SEWIC) yn cynnwys naw awdurdod lleol yn yr ardal sy'n gweithio gyda'i gilydd i arwain amrywiaeth o raglenni cydweithredol ym maes gwasanaethau cymdeithasol.
[87] Atodiad A, paragraffau 211 a 65
[88] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.37

b) bod y gwaith o reoli'r broses o ryddhau claf o'r ysbyty yn amrywio o ran ansawdd;[89]

c) bod y prosesau ar gyfer cyfathrebu â theuluoedd a gofalwyr yn amrywio.[90]

52. Rhaid cryfhau'r prosesau o ymdrin â materion cleifion a theuluoedd. Roedd Mr Isaac yn gywir i gydnabod pwysigrwydd rhoi'r holl gymorth ac amser sydd ei angen ar bobl i wneud y dewis cywir am eu dyfodol hirdymor.[91] Cytunwn na ddylai unrhyw beth amharu ar hyn, hyd yn oed os nad oes gwely yn wag. Er hynny, dylai sefydliadau iechyd a gofal cymdeithasol geisio cadw unrhyw oedi hir diangen mor fyr â phosibl yn y broses hon gan y gall y rhain effeithio ar ofal yr unigolyn dan sylw a gofal cleifion eraill sydd â mwy o angen gwely'r ysbyty. Dylai gweithredu polisi dewis effeithiol gynorthwyo teuluoedd i wneud y penderfyniad gorau heb oedi gormod.

53. Amlinellodd Mr Ross y problemau sy'n bodoli pan fydd cymunedau gwahanol yn gweithredu polisïau gwahanol o ran dewisiadau. Dywedodd wrthym fod y ddwy ran o'r gymuned iechyd a gofal cymdeithasol a wasanaethir gan ei Ymddiriedolaeth bellach wedi cytuno ar bolisi cyffredin ond dywedodd bod gan gymunedau eraill bolisïau gwahanol. Dywedodd y byddai'n croesawu arweiniad penodol gan Lywodraeth y Cynulliad o ran dewis.[92] Ond er i Ms Ward fynegi y byddai hithau hefyd yn croesawu arweiniad o'r fath, dywedodd mai dim ond cuddio'r problemau y byddai hyn oni bai y caiff y farchnad ei rheoli'n fwy effeithiol ac y rhoddir mwy o fuddsoddiad mewn gofal canolraddol, gan mai ychydig iawn o effaith y caiff polisi dewis da yn y sefyllfa bresennol lle nad oes dewis gwirioneddol i bobl.[93]

54. Gall polisi effeithiol o ran dewis helpu hefyd i leihau'r achosion o drafferthion gyda rhai teuluoedd. Dywedodd Mr Ross y gall gymryd tri neu bedwar mis i gwrdd â rhai teuluoedd i benderfynu ar y camau gorau i ofalu am

[89] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.41
[90] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.35
[91] Atodiad A, paragraff 66
[92] Atodiad A, paragraff 162
[93] Atodiad A, paragraff 174

eu perthynas.[94] Yn ystod y cyfnod hwn, efallai y bydd cyflwr y claf wedi dirywio'n sylweddol. Dywedodd Mrs Harris y dylai'r broses o gynllunio i ryddhau claf o'r ysbyty gynnwys teuluoedd cleifion cyn gynted â phosibl er mwyn gwybod am yr angen i chwilio am gartref gofal a rhoi pob cyfle i deuluoedd gynllunio ymlaen.[95] Soniodd Mrs Harris hefyd am y llwyddiannau a gyflawnwyd drwy ddefnyddio aelod o staff yr awdurdod lleol i weithredu fel swyddog cyswllt y teuluoedd pan fydd angen gwneud penderfyniadau fel hyn am gartrefi gofal.[96]

55. Gofynnodd Ms Ward a oes digon yn cael ei wneud i alluogi teuluoedd i ofalu am bobl yn eu cartrefi eu hunain. Dywedodd bod angen i'r system fuddsoddi mewn teuluoedd er mwyn rhoi pob cyfle iddynt gynorthwyo eu perthynas, os ydynt yn dewis, gan fod y sefyllfa bresennol yn aml iawn yn eu gorfodi i ddewis yr unig opsiwn o benderfynu pa gartref gofal sydd fwyaf addas.[97]

56. Mae'n anodd goresgyn y problemau sy'n ymwneud â gweithredu'r prosesau Asesu Unedig, ond mae'n hanfodol cael trefn ar hyn er mwyn sicrhau y caiff anghenion gofal pobl eu nodi'n gywir ac yn effeithiol.[98] Cytunwn â Mrs Lloyd bod angen i hyn fod yn un o brif flaenoriaethau ei hadran. Awgryma'r dystiolaeth fod gweithredu'r prosesau Asesu Unedig yn parhau i fod yn fiwrocrataidd a llafurus, ac nad oes gan sefydliadau lleol yr atebion electronig angenrheidiol i rannu gwybodaeth yn effeithiol rhwng partneriaid.[99] Mae amrywiaethau yn y ffordd y caiff dogfennau asesu eu cwblhau felly mae angen dogfen graidd sy'n gyffredin i bob sefydliad yng Nghymru.[100] Wrth ymateb i gwestiwn yn ystod sesiwn y Pwyllgor Archwilio, ymrwymodd Mrs Lloyd ei hadran i ddadansoddi'r problemau penodol sydd wedi rhwystro'r broses o Asesu Unedig rhag cael ei gweithredu yng Ngwent.[101] Mewn llythyr

[94] Atodiad A, paragraff 215
[95] Atodiad A, paragraff 220
[96] Atodiad A, paragraff 221
[97] Atodiad A, paragraff 223
[98] Atodiad A, paragraff 42
[99] Atodiad A, paragraff 167
[100] Atodiad A, paragraff 42
[101] Atodiad A, paragraff 54

i'r Pwyllgor, mae Mrs Lloyd yn nodi bod Asesu Unedig yn cael eu cymryd o ddifrif yng Ngwent, a bod llawer o gydweithredu wedi digwydd, gan gynnwys rhoi trefniadau cydgysylltu strategol ar waith, datblygu dogfennaeth, hyfforddi staff, prosesau cyfathrebu, prosesau rhannu gwybodaeth, atebion technoleg gwybodaeth a lledaenu arfer da.[102] Ond, cawsom ein siomi nad oedd dadansoddiad Mrs Lloyd yn ystyried yn gliriach y rhwystrau sydd wedi atal yr Asesiad Unedig yng Ngwent rhag datblygu.

57. Mae hefyd yn hanfodol bod Asesiad Unedig, lle mae'n briodol, yn cynnwys asesiad o gymhwysedd rhywun am arian Gofal Iechyd Parhaus. Mae hyn yn penderfynu a yw anghenion iechyd y claf mor uchel bod angen i'r GIG dalu costau ei gofal yn llawn. Caiff y penderfyniad hwn o gymhwysedd ei gymhlethu'n fawr gan oblygiadau dau achos diweddar na chododd o'r blaen – sef achosion 'Grogan' a 'Coughlan'.[103] Dywedodd Mrs Harris nad yw prosesau asesu a Gofal Iechyd Parhaus yn canolbwyntio ddigon ar y claf ar hyn o bryd a bod enghreifftiau lle caiff asesiadau ar gyfer Gofal Iechyd Parhaus eu hystyried yn ychwanegiad sydd ar wahân i'r Asesiad Unedig. Ceir anghydfod yn aml rhwng y meysydd iechyd a gofal cymdeithasol am gymhwysedd i gael Gofal Iechyd Parhaus, sy'n gwneud ychydig iawn o synnwyr i'r rhai yr effeithir arnynt. Yn fwy difrifol, cytunwn yn llwyr â Ms Ward bod siawns rhywun yn lleihau fesul eiliad y mae cyrff cyhoeddus yn ei dreulio yn cweryla am gyfrifoldeb ariannu'r gofal, am eu bod yn dirywio tra maent yn y system.[104] Mae angen gweithredu ar y cyd i fabwysiadu dulliau system gyfan cryfach sy'n rhoi'r person hŷn sy'n agored i niwed yn ganolbwynt cadarn i benderfyniadau: mae'n hollol annerbyniol bod lles a dyfodol pobl fel hyn yn gostwng o ganlyniad i gyrff cyhoeddus yn dadlau dros gyfrifoldeb ariannu'r gofal.

58. Dylid meithrin prosesau gwell i rannu gwybodaeth a gwella gweithredu system gyfan ym maes iechyd yn ogystal â rhwng y meysydd iechyd a gofal cymdeithasol. Dywedodd Mr Ross fod y mater o rannu gwybodaeth wedi

[102] Atodiad B
[103] Adroddiad Archwilydd Cyffredinol Cymru, paragraff 2.19
[104] Atodiad A, paragraffau 153 a 154

drysu'r sefydliadau iechyd a gofal cymdeithasol am flynyddoedd ac er iddo roi enghraifft o lwyddiant yn y maes hwn drwy roi contractau anrhydeddus i weithwyr cymdeithasol a thrwy hynny ganiatáu iddynt allu defnyddio cyfrifiaduron yr Ymddiriedolaeth, dywedodd mai dyma'r unig enghraifft ac ni wyddai sut y gellid ystyried y mater hwn yn well yn y dyfodol.[105] Dywedodd fod mentrau ar y cyd yn aml yn fwy anodd eu cynnal gan fod gan wahanol sefydliadau wybodaeth anghyson sy'n golygu bod gan y cyrff hyn ddealltwriaeth wahanol o'r broblem y maent yn ceisio'i datrys.[106]

59. Pan fo gan sefydliadau partner systemau gwybodaeth gwahanol, mae angen iddynt geisio sicrhau bod y systemau electronig hynny'n siarad â'i gilydd. Mae hyn yn amlwg yn fater y dylai'r gwahanol raglenni Hysbysu Gofal Iechyd a Hysbysu Gofal Cymdeithasol[107] fynd i'r afael â hwy. Dywedodd Mrs Harris bod llawer o gynlluniau peilot sy'n ceisio cyflawni hyn a dywedodd fod ei sefydliad wedi ymweld ag Ymddiriedolaeth Gofal Sylfaenol Swindon i archwilio sut mae wedi datblygu cofnod cleient claf unigol yn llwyddiannus a gaiff ei ddefnyddio ar draws y meysydd iechyd a gofal cymdeithasol.[108] Dywedodd Ms Ward nad yw datblygu technoleg i gynorthwyo i rannu gwybodaeth yn broblem na ellir ei goresgyn a siaradodd am y gwaith a gaiff ei wneud fel rhan o fwrdd rhanbarthol awdurdodau lleol de-ddwyrain Cymru i archwilio'r potensial i rannu gwasanaethau. Dywedodd fod technoleg ar gael i alluogi systemau gwybodaeth gwahanol i siarad â'i gilydd; fodd bynnag, nid technoleg yw'r broblem wirioneddol ond amharodrwydd sefydliadau partner i rannu gwybodaeth sensitif am gleifion.[109] Cytunwn â Ms Ward y dylai Llywodraeth y Cynulliad ystyried darparu arweiniad canolog i hwyluso'r gwaith o rannu gwybodaeth sy'n debyg i'r protocolau rhannu gwybodaeth sy'n bodoli rhwng awdurdodau lleol a'r heddlu, gan fod canlyniadau negyddol methu â rhannu gwybodaeth yn effeithiol yn annerbyniol.[110]

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[105] Atodiad A, paragraff 248
[106] Atodiad A, paragraff 248
[107] Mae Hysbysu Gofal Iechyd yn un o raglenni Llywodraeth y Cynulliad a luniwyd i wella gwasanaethau iechyd yng Nghymru drwy gyflwyno ffyrdd newydd o gael gafael ar wybodaeth, ei defnyddio a'i storio. Mae Hysbysu Gofal Cymdeithasol yn rhaglen ar wahân sy'n ceisio hyrwyddo dull strategol o roi'r agenda e-lywodraeth ar waith ym maes gofal cymdeithasol.
[108] Atodiad A, paragraff 252
[109] Atodiad A, paragraff 255
[110] Atodiad A, paragraff 255

60. Nid oes angen i'r broses o rannu gwybodaeth yn effeithiol rhwng partneriaid ddibynnu'n llwyr ar atebion technolegol, fel y dangoswyd gan y prosiect llyfr melyn a ddisgrifiodd Mrs Lloyd. Defnyddir y llyfrau hyn ar gyfer cleifion sydd angen pecynnau gofal cymhleth ac maent yn aros gyda'r claf lle bynnag mae'n defnyddio gwasanaethau. Cânt eu defnyddio fel ffynhonnell wybodaeth gyffredin i bob sefydliad sy'n rhan o ddarpariaeth gofal y claf.[111]

61. Rhaid i'r broses o rannu gwybodaeth wella ar draws y system gyfan, er mwyn i'r holl sefydliadau a'r holl staff sy'n rhan o ddarpariaeth gofal y claf gael gwybodaeth gywir am ei amgylchiadau unigol. Mae lle yn arbennig i wella'r broses o rannu gwybodaeth o ran gofal sylfaenol, a chyfeiriodd Ms Ward at hyn wrth sôn am y wybodaeth reoli sylweddol sydd gan feddygon teulu, ond nad yw'r wybodaeth honno'n cael ei defnyddio ar hyn o bryd i wella effeithiolrwydd gwaith comisiynu.[112] Argymhellodd adroddiad yr Archwilydd Cyffredinol y dylai byrddau iechyd lleol roi gwybodaeth glir i feddygon teulu am y gwasanaethau gofal canolraddol sydd ar gael ac y dylai'r ymddiriedolaethau roi gwybodaeth reolaidd i feddygon teulu am gleifion hŷn sydd wedi cael eu derbyn i'r ysbyty, a'r cleifion hynny sydd wedi wynebu oedi wrth drosglwyddo gofal.[113]

Mae angen i sefydliadau gwasanaethau iechyd a gofal cymdeithasol ddatblygu eu gweithlu i greu diwylliant llai gwrth-risg

62. Rhaid i staff iechyd a gwasanaethau cymdeithasol gael eu haddysgu'n briodol a chwarae rhan fwy canolog os oes disgwyl iddynt ddefnyddio'r prosesau priodol o fewn y system gyfan. Cawsom ein hysbysu o'r diwylliant o fewn gofal sylfaenol, gofal eilaidd a gofal cymdeithasol, lle gall rhai staff fod yn wrth-risg wrth reoli pobl hŷn sy'n agored i niwed. Dywedodd Mrs Harris nad oes rhesymau dilys yn aml dros gadw claf mewn gwely ysbyty ac y caiff claf ei symud i gartref nyrsio preswyl yn rhy aml pan ddylai gofal cartref fod wedi'i

[111] Atodiad A, paragraff 36
[112] Atodiad A, paragraff 117
[113] Adroddiad Archwilydd Cyffredinol Cymru, argymhelliad 16

dreialu yn gyntaf.[114] Caiff gofal mewn sefydliad ei ystyried fel y dewis isaf ei risg yn aml, ond mae gan feddygon teulu ran fawr i'w chwarae wrth benderfynu ar ddyfodol darpariaeth gofal eu cleifion a dywedodd Ms Ward bod angen iddynt gydnabod efallai mai ysbytai a chartrefi gofal yw'r dewis gwaethaf ar gyfer siawns bywyd y claf hwnnw.[115] Dywedodd Mr Ross fod ei ymddiriedolaeth bellach yn ailysgrifennu ac yn ail-lansio eu polisïau a'u trefniadau rhyddhau o'r ysbyty mewn ymgais i droi'r diwylliant gwrth-risg presennol ar ei ben.[116]

[114] Atodiad A, paragraff 184-187
[115] Atodiad A, paragraff 185
[116] Atodiad A, paragraff 184

Atodiad A

Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Archwilio
The Audit Committee

Dydd Iau, 22 Tachwedd 2007
Thursday, 22 November 2007

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau Cynulliad yn bresennol
Assembly Members in attendance

Lorraine Barrett	Llafur Labour
Eleanor Burnham	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Chris Franks	Plaid Cymru The Party of Wales
Janice Gregory	Llafur Labour
Lesley Griffiths	Llafur Labour
Irene James	Llafur Labour
Huw Lewis	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Melding	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Darren Millar	Ceidwadwyr Cymreig Welsh Conservatives

Eraill yn bresennol
Others in attendance

John Baker	Swyddfa Archwilio Cymru Wales Audit Office
Jeremy Colman	Archwilydd Cyffredinol Cymru, Swyddfa Archwilio Cymru Auditor General for Wales, Wales Audit Office
Abigail Harris	Chief Executive, Vale of Glamorgan Local Health Board Prif Weithredwr, Bwrdd Iechyd Lleol Bro Morgannwg
Jonathan Isaac	Pennaeth y Gangen, Polisi Pobl Hyn a Gofal Hirdymor Head of Branch, Older People and Long Term Care Policy
Gill Lewis	Swyddfa Archwilio Cymru Wales Audit Office
Ann Lloyd	Pennaeth, Adran Iechyd a Gofal Cymdeithasol Head, Department for Health and Social Services
Hugh Ross	Chief Executive, Cardiff and Vale NHS Trust Prif Weithredwr, Ymddiriedolaeth GIG Caerdydd a'r Fro
Alison Ward	Chief Executive, Torfaen County Borough Council Prif Weithredwr, Cyngor Bwrdeistref Sirol Tor-faen

Swyddogion Gwasanaeth Seneddol y Cynulliad yn bresennol
Assembly Parliamentary Service officials in attendance

Dan Collier	Dirprwy Glerc Deputy Clerk
Dr Kathryn Jenkins	Clerc Clerk

Dechreuodd y cyfarfod am 1.31 p.m.
The meeting began at 1.31 p.m.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introduction, Apologies, Substitutions and Declarations of Interest

[1] **David Melding:** Good afternoon, everyone. I welcome you all to this meeting of the Audit Committee. These proceedings will be conducted in English and Welsh. When Welsh is spoken, a translation will be available on channel 1 of your headsets, and channel 0 will amplify our proceedings. Please turn off all electronic equipment completely, as it interferes with our recording equipment; do not just put them on the 'silent' setting.

[2] No fire drill has been planned for today, so, if the fire alarm sounds, please follow the instructions of the ushers, who will help us to leave the building safely.

[3] I invite any Member who wishes to make a declaration of interest to do so now.

[4] **Chris Franks:** I declare that I was a member of the Vale of Glamorgan Local Health Board—an excellent organisation, according to the chief executive. On my election to the Assembly, I ceased to be a member. I have taken advice and understand that I should not ask a particular question to the Vale of Glamorgan LHB, but I may participate in the proceedings.

[5] **David Melding:** Thank you, Chris. Are there any other declarations of interest? I see that there are not.

1.33 p.m.

Mynd i'r Afael ag Oedi wrth Drosglwyddo Gofal: Adroddiad Gorolwg yn Seiliedig ar Waith yng Nghymunedau Iechyd a Gofal Cymdeithasol Caerdydd a Bro Morgannwg, Gwent a Sir Gaerfyrddin
Tackling Delayed Transfers of Care: Overview Report Based on Work in the Cardiff and Vale of Glamorgan, Gwent and Carmarthenshire Health and Social Care Communities

[6] **David Melding:** We will now discuss the findings of the report of the Auditor General for Wales, 'Tackling delayed transfers of care across the whole system'. Reducing delayed transfers of care would clearly have wide-ranging benefits for patients and for the NHS as a whole. In this session, we will examine the current extent of delayed transfers of care in the areas covered by the report, and will look in more detail at whether the appropriate actions are in train to minimise this problem. We will split the session into two parts: we will first take evidence from a central perspective from the Welsh Assembly Government, and we will then take the local perspective from a trust, council and LHB chief executive.

[7] I welcome to the meeting Mrs Ann Lloyd, director of the Department for Health and Social Services and Jonathan Isaac, head of the older people and long term care policy branch, both of whom are from the Welsh Assembly Government. I know that Ann is very familiar with our proceedings. I also extend a particular welcome to Jonathan Isaac. We have a range of questions to put to you, and these will be asked by Members in turn. However, I will start by asking how effective the Assembly Government and local health and social care organisations have been in tackling delayed transfers of care over the past few years.

[8] **Ms Lloyd:** There is ample evidence in the auditor general's report to show that there has been a joint approach to trying to solve the issues that arise from delayed transfers of care. It is a difficult problem to solve, and it has been a difficult problem throughout the United

Kingdom, despite everyone's best efforts to try to ensure that people get the appropriate care that they need. As the auditor general has pointed out, it is a whole-systems approach that is needed. So, having seen his case studies and our case histories of good practice assembled by the Social Services Improvement Agency and by the health service, you will know of the good attempts made by individual organisations and organisations working together to try to solve the problem.

[9] Where issues of definition and of money have arisen, and where it has been believed that a little more flexibility or some pump-priming money would change how care is provided across the whole system, I think that the Assembly Government has done its best to appreciate the problem and then to try to facilitate an improvement. The statistics, certainly since 2003, have shown a significant reduction in the number of days delayed and individuals delayed. However, we are dealing with a vulnerable group of clients and patients, who have many complex needs. Every day's delay is a risk to that patient. So, I do not think that anyone in the whole system takes this lightly; it is a serious issue. The view of the services, and our view, is that we must tackle this together, not from the point of view of just getting rid of this top end, which is a symptom, but by trying to provide a much more effective range of care for individuals.

[10] **David Melding:** You say that it has been a problem for quite some time, and it was one of the issues highlighted when the Assembly first met in 1999. Targets were set in 2002 and you are right to say that there have been improvements since then, but those targets have not been met. Why do you think that the current situation is significantly better, and is not such an acute problem?

[11] **Ms Lloyd:** I hate to disagree with you, Chair, but the targets set have been met. However, we are still not satisfied. You will see from the targets that have been set by the Minister this year and those that she is considering for next year that we aim to improve performance in the upper quartile, so that everyone moves up. In the targets that were set, we had a baseline in September of over 100,000 days delayed, and the service has managed to meet the targets for April 2005, April 2006 and March 2007. It has not been easy for it to do so. However, on days delayed, which is an issue highlighted by the auditor general, those targets have been met according to the official statistics. I can provide you with a copy of the official statistics.

[12] **David Melding:** Just to clarify, the report that I was referring to, on page 52 of the auditor general's report, was 'A Question of Balance', which set targets in 2002 to reduce delayed transfers of care to 200 across Wales. Obviously, we are nowhere near meeting that.

[13] **Ms Lloyd:** No, not yet.

[14] **David Melding:** So, it depends on the measure of it, does it not, when it comes to seeing whether there has been significant progress?

[15] **Ms Lloyd:** Yes, but although that was the target suggested in 'A Question of Balance' was an independently commissioned report—I commissioned it from Paul Williams—and it was based on some of the targets suggested at the time. However, the targets that the Minister set were different. Nevertheless, we cannot be complacent; we have got to try to sort out this problem.

[16] **Lorraine Barrett:** I am looking at paragraphs 1.14 to 1.17, showing that the direct cost of bed days lost across Wales as a result of delayed transfers of care was estimated to be around £69 million in 2006-07. Could you tell us what you are doing to reduce the direct and indirect costs associated with delayed transfers of care, and how much of a priority this issue is for your department?

1.40 p.m.

[17] **Ms Lloyd:** It is a major priority for the department, because I am held to account for how effectively the resource is used. We have to come at this by looking at the type of individual that is now put into the category of delays. They are now very many people who have very complex care packages.

[18] One of the issues that we are trying to cost at the moment is how we can better manage the chronic diseases that we find in our communities, in association with this whole system of care that we are trying to change. As you know, Carmarthenshire and one of the organisations in north Wales will be used in the demonstrator schemes for a different way of managing people with chronic diseases, because that is a major issue for us in Wales, to see how those resources can be utilised more effectively, whether or not there is pump-priming that the Minister needs to consider putting in from her budget, but I fully understand the direct costs that have been enunciated here. However, we have to remember that, although patients might be absorbing costs in hospital and where they are at the moment, many of these patients will have significant care packages and will require ongoing care, and it is quite difficult to be absolutely definitive about how much it costs to keep a patient in the wrong place—apart from personal costs. That is the sort of care package that they want and that is why the pilot scheme in chronic disease management is so important, because those real costs can be flushed out for the first time. At present, what we might regard as indirect costs are a good guess, but we need definitive evidence so that we can rebalance the system.

[19] **Lorraine Barrett:** When you say that we do not know what the real cost might be, do you mean that it could cost more?

[20] **Ms Lloyd:** For some patients it could cost more. When the community care Acts came into effect many years ago, one of the arguments was that community care was not cheap. It might not be cheap but it might be more effective, and it is the cost-effectiveness that we have to evaluate.

[21] **Lorraine Barrett:** If the £27 million marginal bed day costs could be more effectively used in social care services, does the mechanism exist to allow the money to be transferred?

[22] **Ms Lloyd:** We have flexibilities under the 2006 Act that can be used and they are not just about pooled budgets. Mike Chown is doing a report for Ministers at the moment on a greater use of pooled budgets to be rolled out within the local service boards, but you can also use the flexibilities for one individual organisation to commission on behalf of several others or to have much more joined-up provision of care than has been possible in the past. So, the flexibilities are there, but Ministers are exploring whether or not those flexibilities can be enhanced.

[23] **Janice Gregory:** Paragraphs 1.19 to 1.20 explain how the Assembly Government monitors delayed transfers of care through a monthly census approach. Historically, the focus of performance management was on the number of people delayed, but the Assembly Government moved to a focus on the number of days lost, as mentioned in its performance management arrangements from 2006-07. I was surprised when I read in the report that, apparently the measurement was taken on one particular day a month, which seemed a bit strange to me, but there we are. Given that we tend to hear about a number of people's experience in a delayed transfer of care, do you plan to move the focus of your public reporting further towards the number of bed days lost as result of delayed transfers of care?

[24] **Ms Lloyd:** As you will be aware, the Assembly has asked for an independent review into delayed transfers of care. We have always accepted that the method of measurement used

to date has limitations but it is similar to the measurement used throughout the UK, although I think that ours is possibly a little more transparent. We have asked the independent review team to look critically at a better way of capturing the number of people delayed and the days that they are delayed for, and it will report—when is it now?

[25] **Mr Isaac:** It will be in February.

[26] **Ms Lloyd:** It will report back to the Minister and then the Assembly in February.

[27] **Janice Gregory:** I also have a follow-up question. I was fortunate in that my particular trust and local health board area, prior to 2004, had a very good record. It is not so good now, unfortunately. We all know that delayed transfers of care can result from the failure of a wider system if everyone is not working together—that is quite evident from the report; if that is so, then things can fall down. Are there better measures that should be used as indicators of the whole-systems performance?

[28] **Ms Lloyd:** Yes, I think that there probably are. I have just commissioned some work, as it happens, on how best to hold whole health communities to account and on what joint targets and performance measures might be available, so that we can test whatever comes out of an independent review much more widely. Also, as you know, the Minister for Finance and Public Service Delivery is doing work on holding local service boards to account in a much wider way than individual services have.

[29] We have tried to focus some of the targets in the health service to represent more of a community approach, particularly with delayed transfers of care, and I would hope to be in a position in the next four to five months to give Ministers advice, arising from the independent review and from the work that I have commissioned, to allow them to consider how best we can hold people to account.

[30] **Mr Isaac:** 'Fulfilled Lives, Supportive Communities: Plan for Social Services in Wales for the next 10 years' includes an objective to really develop objectives that will tie in the whole system so that they do not end up playing off one service or sector against another. The independent review of delayed transfers of care that is taking place will look at how the performance monitoring system, the information system, will actually set up the right sort of levers and incentives to work towards partnership. Our current system does that to some extent, but we are always learning, of course.

[31] **Helen Mary Jones:** At present, how consistent are the indicators and measures for local authorities and health bodies? Is there any tension between them? Will the work that you mentioned, Mrs Lloyd, on reviewing what is measured, address that? It seems to me that, if two organisations are involved, and we ask one to measure in one way and the other to measure in another way, the Government will have created a built-in disincentive for them to co-operate.

[32] **Ms Lloyd:** Yes, there are inconsistencies—or there were, because the performance indicators for local government stopped on 1 April 2007. Dr Gibbons is taking a view on whether or not they should be reinstated and, if they are reinstated, what they should look like. He is well aware, as you would guess, of the whole issue of what the health service is trying to measure. The potential for partners to draw away from each other can be intensified by slightly different targets and a slightly different emphasis in targets, and that is one thing that we absolutely must avoid. Hopefully, the work being done on how to hold a total community to account for a whole system is really where we are trying to get to in looking at health and local authority targets for the future.

[33] **Helen Mary Jones:** Do I understand from what you say that it is possible that we

might reach a situation, after April, in which there is no local government performance indicator for this?

1.50 p.m.

[34] **Mr Isaac:** The performance indicators are actually continuing; they are the information system, as it were, for local government. The performance agreements are the element that is being reconsidered at this stage, so from 1 April 2008 there will not be a specific performance agreement relating to delayed transfers of care. However, we have the service and financial framework system in the NHS, and the way in which the target for the next year is likely to be set up is to require the organisations to work together. So, from the NHS and SaFF point of view, there is definitely a requirement for that collaboration, but we need to look carefully at the way in which performance agreements develop, and we are feeding into that discussion at the moment.

[35] **Darren Millar:** One of the problems that the auditor general highlighted in his report was the issue of local agreements before assessments take place, and therefore before a delayed discharge was counted. Do you agree that this does nothing more than mask the reality of the problem and distort the figures?

[36] **Ms Lloyd:** We are taking legal advice on trying to eradicate local agreements, and we believe that we will be able to do this. When you look at the difference between organisations, it is unacceptable that there is such a difference in local agreements. One can imagine that, when they were first initiated, there was practical common sense behind them, but they have developed as an unhelpful block in the system, and, as you said, it masks the whole problem. We do not want organisations to be encouraged to leave discharge planning until they reach the limit; discharge planning must start straight away. Given the systems that are out there, where many patients likely to require complex packages of need already have their yellow books, so everybody knows what care they are receiving and what the complications are, there should be no delay built into any system. We have taken legal advice and we are waiting for the definitive guidance to come through.

[37] **Darren Millar:** So, is it your intention to remove local agreements from the picture altogether?

[38] **Ms Lloyd:** Yes.

[39] **Mr Isaac:** I think that local agreements were there originally for the right reasons, because there is always tension between centralist target-setting and local variation according to circumstances, and those local agreements rightly give local organisations the right to work in partnership to agree the types of arrangements that they will have in place. However, the time has definitely come for that to be reviewed and the independent review will specifically and thoroughly look at that issue. To keep it in some proportion, the local agreements only apply to a small proportion of the overall delays, so it is by no means the case that, when we look at the delay figures, they are all affected by local agreements; less than a quarter of the delays are affected by local agreements.

[40] **Darren Millar:** What I found remarkable was the inconsistency even just within Gwent, for example, from no local agreement with certain local authorities and up to 15 days being allowed in other authorities. It is quite astonishing, really, but thank you for that clarification.

[41] **Chris Franks:** What needs to be done to make unified assessment work more effectively?

[42] **Ms Lloyd:** A number of things can be done with unified assessments. We have just had a major seminar, involving health and social services and the voluntary sector, to look at the problems of unified assessment. Much of it is put down to the fact that no computer system will allow both types of organisation to input into it. I have asked Informing Healthcare and the social services information lead to get together quickly to see how the problem of confidentiality, which is what tends to block that, can be overcome to get a sensible IT system. However, because there is such huge variation in the way in which people will fill in a unified assessment, much more training and the quality assurance of the process itself must go on in Wales, and we all agreed that at the seminar. It must be improved because it is the core document into which the patient has their own input, and it should almost act as the bible for the care that people require and should be able to be picked up by any professional to see what the needs of that individual are and how they are being met at the moment and whether they are changing. It has to be regarded as not just a form that you fill in, but as the record of the care needs of an individual, what they themselves believe that they want and how they are going to be provided with that. So, it is essential that this is improved. There are very good examples of unified assessment and consequent care planning and there are some dire examples, too. One of our key priorities for this year and next is to improve it.

[43] **Chris Franks:** We have heard how important this document is—I think that you used the words ‘key’ and ‘bible’—so why on earth has the department not already insisted that this be done? It is a bureaucratic thing that should have been tackled ages ago, if it is so important. You have no doubt had a very important seminar, with hundreds of people there, at vast expense—

[44] **Ms Lloyd:** No, not hundreds.

[45] **Chris Franks:** No? Why has this work not been done? Why are there all sorts of forms? I have read the examples and I think that one involves a Mr C. If I have read this right, he was ready for discharge—

[46] **David Melding:** Which page are you on?

[47] **Chris Franks:** Sorry, I am on page 40. Mr C was available to be discharged on 22 February, but he was still there in June. Was that all for the sake of a lack of a form?

[48] **Mr Isaac:** I think that unified assessment is a major challenge. It is a highly ambitious project and its equivalents in other UK countries have been equally challenging. We are by no means in a unique position on that front. There are some very real constraints in terms of the technology and major IT systems talking together. That is being looked at, but it is not something that is easily overcome. We have commissioned independent research. Again, ‘Fulfilled Lives, Supportive Communities’ identifies UAP as something for real development. The National Leadership and Innovation Agency for Healthcare has done a huge amount of really constructive work on this and progress is taking place, but it is an enormous challenge.

[49] **Chris Franks:** Well—

[50] **David Melding:** Before you go on, Chris, I think that the witnesses have accepted that unified assessment is an important element of responding to delayed transfers of care—

[51] **Chris Franks:** I am trying to work out why we are still in this position.

[52] **David Melding:** I will let you back in, but it will have to be an additional point to the importance of unified assessments, because the witnesses have already acknowledged that.

[53] **Chris Franks:** Okay. I take your hint, but all I will say is that I do not really think that Gwent is such a vast area that these problems cannot be overcome. They should have been overcome by now. All I am asking is: why has the department not shown more leadership in resolving these problems?

[54] **Ms Lloyd:** We have shown leadership. It was at our insistence that unified assessment started, because it was not done at all in Wales previously and it was being undertaken in other parts of the United Kingdom. It is complicated and a lot of training and joining up of systems are required. I will take up the issues with Gwent and do an analysis for the committee of what the handicaps have been in that area, because, in some places, it has been done extremely successfully.

[55] **Chris Franks:** Thank you.

[56] **Irene James:** Mrs Lloyd, if we look at paragraphs 2.13 to 2.26, on pages 41 to 45, we can see that they give details of problems associated with determining patients' eligibility for continuing healthcare. Disputes are becoming more and more frequent between health-service and social-care organisations about who is going to pay. How do we assess the current position on continuing healthcare and how will the Assembly Government try to reduce the variability in expenditure, process and outcome?

[57] **Ms Lloyd:** We have a test case on continuing care going through the courts in September 2008—we had hoped that it would be before that, so that there would be absolute clarity. The issue of continuing healthcare, as you know, has been complicated by the two major judgments that were slightly different. The Grogan judgment was slightly difficult in terms of its interpretation. It is all about whether the individual has such serious health needs that he or she actually requires a complete package of healthcare, which would mean that instead of just receiving NHS-funded care, all of their care is funded by the NHS.

2.00 p.m.

[58] Calculations have been done on how much this would cost the health service, if everyone receiving an NHS package of care was suddenly eligible for continuing health care. The cost is high, I must say, and is one of the major risks, as the Minister is aware. We are issuing guidance in April 2008, which will involve three months of prior consultation, to try to clarify, at this point in time—and we will have to do this now, because the test case has been delayed—how we can better assess people with continuing healthcare needs, and determine which category they fall under. However, at the moment, one thing that we simply must eradicate from the system is the situation where people have a unified assessment and then, somehow or other, have a continuing care assessment. It should be a single assessment, and people should get the care that they need without a further assessment or having to go through any more hoops. However, it is difficult.

[59] We are assessing the risk from a major switch of patients to continuing healthcare through our financial flows exercise, which is currently being undertaken by the health service to look at the movement of resources. However, it is a serious problem. The social services directors produced some additional guidance for their staff—I know that they were trying to help—but we have to consolidate that guidance within a decision tool that will be available in April 2008 as part of the extra guidance that we will be putting out. It is extremely complicated, and we must remember that there are individuals stuck in the middle of this dispute.

[60] **Irene James:** Are you satisfied that LHBs are providing an equity of service across Wales in the way that they are assessing, managing and funding continuing healthcare?

[61] **Ms Lloyd:** There are differences in the ways the LHBs apply this, which is why, in discussing it with the LHB chief executives and their teams, we considered that it was essential that the Government put out the guidance and the decision tool to ensure that there can be some consistency.

[62] **Eleanor Burnham:** Looking at recommendation 15,

[63] 'the Audit Committee suggests that the Assembly Government develop a clear national policy on patient choice',

[64] and then paragraph 2.27 on page 46, and the next few pages, what will the Assembly Government do to address the causes of delayed transfers of care that arise from patient choice, which we all know has a major impact on health and social care systems?

[65] **Ms Lloyd:** We revised the guidance in 2002 but, to introduce choice, there must be choices available. Much of the choice seems to have been about which nursing home people wanted to go to. Both local government and the health service have been putting a huge amount of effort into real alternative forms of care, and that is where we must place our effort. We have had a constructive relationship with the care forum, which looks after the care forum for independent nursing home providers, and they have been helpful in trying to ensure that a range of alternative care is available across Wales. However, we know from the examples of good practice in this paper, and many more, that there are alternatives that can be developed for individuals, so that the choice is not just between going into a community hospital or a nursing home and having individual intervention in your own home. Listening to clients and patients, most of them want to be at home, and our aim, and the aim of local government and the health service is that, wherever possible, the maximum effort should be made to retain people in their homes and to provide packages of care there, and that, when that is not possible, there should be a real alternative. Therefore, it is a matter of whether there is a choice.

[66] **Mr Isaac:** There is a balance to be struck here, because we are talking about a time in people's lives when they are vulnerable and long-term decisions have to be made. We are rightly analytical when we look at the number of delays due to choice reasons. However, it is so important to remember that the people in the hot seat at the time, who have to make the decision, must be afforded all the support and time necessary to make the right decision for the long-term future. Nothing should compromise that, even if a bed is occupied. That is such a critical decision. We have issued choice guidance, and we have visited every local authority in Wales to engage people on the issue of choice and to see what more can be done to take policy and practice forward. You will get sick of me saying this, but this is another issue that will be looked at carefully in the independent review, because it is such a significant issue.

[67] **Eleanor Burnham:** In my earlier career, I was a home care manager, and I know exactly what you are talking about. My mother was lucky in Denbighshire to have the most fantastic support in her own home. I thoroughly agree with you. An enormous number of elderly people wish to retain their dignity in their own homes. I am concerned because point 2.31 of the Audit Commission paper notes that local authorities may not have sufficient resources to fund placements for all people currently delayed as a result of exercising the right of choice and that there is huge pressure on capacity in some areas. Therefore, how realistic is it, Mrs Lloyd, that local authorities will be able to work more in tandem with healthcare providers to ensure that the choices that you have discussed and I have just mentioned will be real options?

[68] **Ms Lloyd:** There is evidence from throughout Wales that that is starting to happen more and more. People are looking at the resources that are absorbed by the frail and elderly in our communities and at how best those resources might be targeted together. That is why

Ministers are so keen to enable pooled budgets to be taken a stage further, so that there is a more holistic and comprehensive view of the alternatives to traditional care, how much those actually cost and how they will vary over time. That is the whole focus of what Government is trying to do at the moment. We have also been looking at the evidence that is coming through on how individual organisations commission care, what range of care they plan to provide, how well they meet the needs of patients, and whether they comply with best practice and on some of the innovation going on. As the commissioning and the health and wellbeing strategies come through in the next three to four months, we will be testing whether they have been ambitious enough and whether they are giving weight to a wider range of alternatives.

[69] **Helen Mary Jones:** You mentioned the role of the independent review, which will obviously be important. Will the review be able to look at the impact on cost of choice to the service user? I am aware of anecdotal evidence that, rather than people allegedly blocking hospital beds because they are waiting for the nursing homes of their choice, the reality is that people are waiting for local authority nursing home places that they can actually afford. I am concerned that the issue of choice is sometimes used by healthcare and care providers as an excuse for not dealing with some of the issues. Some of the things that you have said, Mrs Lloyd, about a range of provision are certainly true in that it is what we should be aspiring to, but the reality is that many patients have no choice at all, because of the lack of provision and the cost to them if they then go from a health setting into a social care setting. Will the review be able to look at how real this choice is, or is it a question of having to stay where you are until a place that you can afford comes up, because that is not choice?

2.10 p.m.

[70] **David Melding:** Before you respond, there have been several references to the independent review that is going on. That is a separate piece of work. I know that the review body and the Audit Commission have been in touch, and, of course, we encourage that sort of joint working where appropriate. Our work here stands discretely on its own, although we hope that it will influence the Government's future response when it carries out its own independent review. I ask you to turn that into a question rather than it being a plea for the independent review body to consider things.

[71] **Helen Mary Jones:** Well, I did ask whether the review will able to look at this. My point is that it is a level of detail that a national review might find difficult to address, whereas the targeted work that we have commissioned might be able to do so.

[72] **Ms Lloyd:** Yes.

[73] **Irene James:** There always seems to be a problem when a patient is admitted to hospital and he or she has a social care package as everything seems to stop. Is that a uniform response, and how can we support trusts to improve their internal processes to ensure that these things do not happen? That delays the process yet again. If everything stops, when someone is due to be discharged everything has to be reassessed.

[74] **Ms Lloyd:** If someone is not using it, the package of care will cease. However, we must place the emphasis on the fact that it then does not take forever to restart it. As you know, many patients who have multiple problems now have their yellow books, so, if they are admitted as an emergency or for any sort of reason, the individuals in the health system will know exactly what the package was and be much more enabled to reassess with their social services colleagues whether the patient's former package is still adequate or whether they will need a top-up in terms of care. I think that the intermediate care schemes that have been developed in Wales are serving a really good purpose in that you have more consistency of care. We are evaluating at the moment whether they enable reassessment to take place much

more quickly and therefore enable people to get out of their care context more easily. That is part of some work that we have commissioned separately.

[75] **Lesley Griffiths:** I am looking at paragraphs 2.68 to 2.75, which deal with the commissioning of services. Any delayed transfer of care indicates a weakness or difficulty in commissioning, because if anyone has to stay in hospital for longer than necessary, the specific services that they require were probably not available at that time. Are commissioners sufficiently effective in commissioning services that act as the front door to the system to prevent unnecessary admissions and promote independence? How can you ensure that social care support is in place to ensure that the right services are available when people need them and that they are in the right place?

[76] **Ms Lloyd:** Commissioning is very underdeveloped, and health and social services in Wales and the UK will agree with that. We published NHS commissioning guidance in March, and we are publishing collaborative commissioning guidance in the spring of 2008. The work that health and social services organisations have been doing together in all the communities is looking to ensuring that commissioning is done more effectively, given the health needs of the population, and the way in which they are described as getting better, and is more matched with the whole issue of whether we can retain people's independence and the range of services that we will need to deliver for them. As you know, in the health service, the secondary care services are now starting to be commissioned almost en masse within communities, so that a number of communities will band together to commission secondary care, while still retaining their individual responsibilities for meeting the health and social care needs of their populations.

[77] Work is being done by the WLGA and the Social Services Improvement Agency, again, to train and develop individuals in local government to commission more effectively. A big training programme is going on in the health service too, to ensure that commissioning skills are improved. We also have a major piece of work being undertaken, which includes the voluntary sector and a range of partners, by a national working group that I chair. That is looking at the best ways of rolling out good practice in commissioning, to ensure that there is a synergy between the agencies. That includes the voluntary agencies and what services can be commissioned from them, and how appropriately that might be done, to ensure that people do not get stuck in the wrong places. It is being taken very seriously.

[78] **Lesley Griffiths:** Talking about other sectors, the report states that there is a need to reduce the spot purchasing of care home capacity, and to better engage the independent sector. Looking at case study J, on page 63, how do you believe the independent sector could be more effectively engaged to address the points outlined in this case study?

[79] **Ms Lloyd:** We have been working well with Care Forum Wales, and it is part of this national group too. Therefore, it will also have been engaged in the preparation of the guidance that will come out on collaborative commissioning, to ensure that we are clear about the sorts of outcomes of commissioning that Care Forum Wales representatives can provide to the whole system, and to ensure that we start to commission against outcomes more than we have ever done before. Therefore, it is part of that solution.

[80] **Helen Mary Jones:** Are there sufficient incentives for health and social care bodies to work effectively together, and to make the best use of public money?

[81] **Ms Lloyd:** That is a serious question. In times when pressures increase, resources get tighter, and scrutiny gets heavier, the one way in which you can get organisations to more effectively work together is to use incentives. As you know, the Minister has just signed off an incentives programme within the health service. However, we have to take that one step forward, to look at, in line with the collaborative commissioning guidance, what incentives

can then be placed in the system that will allow the whole community to work more effectively together. It is serious, because incentives help enormously to gear people together.

[82] **Helen Mary Jones:** Three of the auditor general's recommendations—8, 11 and 19—refer to the need for transitional funding to break the current vicious circle that draws resources into the acute parts of health and social care. Does the Government plan any such financial pump-priming to help local partners to break the stalemate in the use of resources that the auditor general has identified?

[83] **Ms Lloyd:** The Minister is currently looking at her budgets. At present, there is a pump-priming resource in those budgets, and it will be for her to decide what she wants to do with that in the future, and how she wants to direct it. We are waiting to give her further advice from the pilot projects on chronic disease management, to see where, within that change from where we are now to where we might collectively want to get to in five years' time, pump-priming moneys would be most effective. That will be part of the evidence that we will give her to allow her to consider what she then wishes to do with the pump-priming money that she already has in her budget, and whether she wishes to retain that.

[84] **Helen Mary Jones:** Would you advise the Minister that that pump-priming funding should be ring-fenced for that specific purpose within the system?

[85] **Ms Lloyd:** The resources that we have in Minister's budgets are so precious that we would want to see them directed very much at solving some of the problems of changing the system.

[86] **Helen Mary Jones:** I understand that, but that was not quite what I asked. There are different ways of attempting to ensure this, and, in some cases, ring-fencing is the only one that ultimately works.

[87] **Ms Lloyd:** It is ring-fenced at present. However, I cannot speak for the Minister on the budget.

2.20 p.m.

[88] **Helen Mary Jones:** I was asking about your advice to her, not what she will do.

[89] **Huw Lewis:** The question that I was going to ask concerned locality level targets, which has largely been explored by Helen Mary's earlier question. So, with your permission, I will roam a little wider. We keep coming back to an inherent weakness in our system, which is a weakness in strategic control, and the ability of the Welsh Assembly Government—through you and the Minister—to set targets and minimum levels, ensure that they are complied with, and to ensure a minimum standard of care across the country. Would you not say, Mrs Lloyd, that part of the problem is your role as the head of the Department of Health and Social Services, and the relationship between the part of your job as head of the NHS and the part involving your headship of social care as it happens out there on the ground in Wales? Both roles are very different in terms of influence, particularly given the role of local government social services departments? When we get down to it, is that not part of the problem that we are trying to wrestle with?

[90] **Ms Lloyd:** I do not know that it is part of the problem, but my responsibilities are certainly completely different, between health and social services. However, I have not seen evidence of local government not taking this problem as seriously as the health service. That is why you find so much activity going on throughout Wales, with health authorities and local authorities coming together in a far more proactive way than ever before, to try to solve this jointly. Their desire to do it has been shown tangibly by their asking us to provide resources

for them to set up their Social Services Improvement Agency. Under the leadership of Meryl Gravell, who chairs that part of the WLGA, huge efforts are being made to ensure that there is greater transparency about what each local authority can achieve with its partners or on its own, and assistance and support has been given to those who are having difficulties trying to solve these problems on their own, in isolation. So, yes, it is true that my responsibilities are completely different, but there is a movement within local government now to come together to solve the problem and to learn from each other.

[91] **Huw Lewis:** Thank you, Mrs Lloyd, for your generous and diplomatic answer. I do not doubt that there are good people with goodwill working very hard to deal with a great octopus of a problem. However, you have said yourself—and it comes across in almost every answer—that we attempt to encourage, incentivise, and to bring people together. When it comes to something that is self-evidently a block in the system, like the local agreements, we cannot just get rid of them; we have to take legal advice on whether we can do so. This is a small country. Could a number of these problems not be solved simply by asking those people who work hard with goodwill in the system to work in a seamless service, and to run social care in Wales as we do the NHS: through the Assembly?

[92] **Ms Lloyd:** That is interesting. Many different models have been used to try to bring health and social services together, and to work far more effectively, where there was perceived to be a problem. One of my former colleagues is running one of the five care trusts in England. His experience is quite interesting. However, that was a reorganisation generated by the staff who were working together in the system. It may or may not work depending on different circumstances. Structural reform might seem to be an answer, but a huge amount has been done by the organisations, separate though they might be, to recognise that there is a major problem and it will not be solved until they work together seamlessly.

[93] In many instances, you will find individuals within communities looked after by intervention teams or rapid-response teams whose staff are employed by completely different people, but that makes no difference to the individual. The different people involved will not recognise that one of them is employed by social services and another by the health service, because they work as a seamless team and that is what we are aiming for.

[94] **Huw Lewis:** So, we are aiming for a seamless service.

[95] **Ms Lloyd:** A virtual seamless service.

[96] **Huw Lewis:** A virtual seamless service. Okay. I often wonder, Chair, why we pussyfoot around this—not that I am accusing Ann of pussyfooting around this, and I did not mean for that to sound the way it did. However, if we are truly aiming for a seamless service, as far as the consumer of the service is concerned, it does not make a difference as long as the service is of a very high quality. All that we have is an historic inheritance of large bureaucratic organisations that try their very best but come from two traditions, and they keep tripping over one another because of those two traditions. It almost seems as though we are asking to be made virtuous, but not quite yet.

[97] **David Melding:** I think that we are now very much in the realms of policy. I could quote a section of the Welsh Conservative Party's manifesto to endorse what you just said, but I do not think that that would help your political position. [*Laughter.*] For our purposes, we have to concentrate on the evidence before us and not wander too much into policy.

[98] I am not sure whether we did exhaust the point that, if we want to encourage seamless or joint working—call it what you will—we need targets that are the same, and not in how they are calculated statistically, but in that they are shared by both organisations, or more than two, in some cases. That has been lacking from performance data in the past.

[99] **Mr Isaac:** That is a very real issue: we need targets that pull people together rather than push them apart. Over time, our targets on the performance agreements and the service and financial framework have become more coherent, but there is some way for that to go yet. 'Fulfilled Lives, Supportive Communities' sets this out as a particular objective, in that we need a series of outcome-focused targets that will bind social services and the health service together.

[100] **David Melding:** Thank you. That is clear. The final question comes to me. How can the Assembly Government best support the delivery of the shared vision of services? We have talked a little about flexible working and pooled budgets, and Mr Isaac then mentioned outcomes. In a sense, that is an outcome of organisations sharing a vision for health and social care in a particular region. If we are encouraging people to do a bit of joint working, in a project-based way, with ring-fenced funding, that will have a very different outcome from a shared vision leading to a culture of deep co-operation.

[101] **Ms Lloyd:** Yes, I would agree with that. There are several ways in which we can do this and, of course, local service boards are now being set up as development areas. All the first six have, at the core of their stated aims, the improvement of the working of health and social services and the voluntary organisations in achieving a seamless service for patients. They are very young organisations, but it is interesting to see the exposition of the work being done within those local service boards at the moment. They are all different and are all going about it in a different way. However, it is interesting to see how it has already galvanised people to take a more proactive approach to working between local government, trusts and local health boards to start to solve some of the intractable problems in communities and in the provision of their health and wellbeing services. That is one way in which we can encourage these organisations to work together better.

[102] I am a member of the Carmarthenshire Local Service Board, and it is one of its top priorities. Very good practices have already started to develop over the last year in between the local authority trust and the local health board.

2.30 p.m.

[103] They do not have a tremendous track record on having a united vision for health and social services. However, there has been a huge and encouraging change. We need to continue to evaluate the effectiveness of these very young constructs to see whether they really can add value and provide solutions to those problems of co-operation.

[104] **David Melding:** Do you believe that we should focus on local government, because there is now a cultural shift, and it sees the importance of the joint approach in health and social care terms? Therefore, a system of fining, as they have done in some places in England, would be off the agenda completely in your view, would it?

[105] **Ms Lloyd:** We have looked at fining. There has been a recent report on the consequences of this, which was not as positive as it might have been.

[106] **Mr Isaac:** The Commission for Social Care Inspection in England looked at the reimbursement provisions and released a report in October 2004. The findings were mixed. In some cases, there had been an impact on delayed transfers of care, but, in general, this system worked where mature and effective partnership approaches were already in place. It seemed to lead to poor outcomes in those places where partnership was not working very well. A system of fining was brought into operation, and some of the outcomes were really quite worrying: patients were discharged before they were ready to be. So, the results of that intervention were mixed.

[107] **Ms Lloyd:** It would affect only a third of our delays.

[108] **David Melding:** Thank you very much. We have completed our questions. Thank you for your attendance this afternoon and for giving such candid answers. We are very grateful.

[109] We will now break for 15 minutes. We will return just after 2.45 p.m..

Gohiriwyd y cyfarfod rhwng 2.32 p.m. a 2.48 p.m.
The meeting adjourned between 2.32 p.m. and 2.48 p.m.

[110] **David Melding:** I welcome everyone to the second half of our evidence session on delayed transfers of care. We will now take evidence from the chief executives of bodies in the Gwent, Cardiff and Vale of Glamorgan localities. The purpose of this part of the session is to probe the issues raised by the Assembly Government and to improve our understanding of the opportunities, constraints and challenges that face those running local organisations, who must tackle the very complex issue of delayed transfers of care. In this way, we will be better able to make recommendations to improve the situation.

[111] I welcome Mrs Abigail Harris, chief executive of the Vale of Glamorgan Local Health Board, Mr Hugh Ross, chief executive of the Cardiff and Vale NHS Trust and Alison Ward, chief executive of Torfaen County Borough Council. I know that you were kind enough to be here earlier and that you listened to the earlier evidence, so you will know how the committee will run this session. I am particularly pleased to see Alison Ward here as chief executive of a local authority, but I remind Members that, as such, she is responsible to her local authority and in no way owes any allegiance to us, other than in having a deep interest in these issues and how they relate to policy priorities. I will ask the first question to Hugh. Why does your trust currently have by far the longest average duration of a delayed transfer of care in Wales?

2.50 p.m.

[112] **Mr Ross:** I think that the answer to that, Chair, is that we face the most complex series of issues of any of the trusts in dealing with delayed transfers of care. There are a number of generic issues across Wales that I think cause the problems, but there are some that are specific to the Cardiff area. The generic issues are very well laid out in the report and I do not think that I should be repeating those. However, in Cardiff, we have had some additional difficult factors, some of which also apply to the Vale. One has been the quite steep reduction in nursing-home capacity in recent years—there has been a loss of around 150 residential and nursing care bed places over three years. Those are now starting to be replaced but, unfortunately, perhaps from the perspective of patients and their families, although much of the new provision is of a very high quality, it is extremely expensive, and therefore is outwith the means of the local council and many families.

[113] Another issue that we face is the intense pressure on services in the Cardiff area, which leads to higher levels of demand than are faced elsewhere in Wales, particularly in terms of unscheduled access. The combination of the two issues, which leads to very high occupancy rates in the hospitals, makes internal processes pressurised and difficult. So, there are a number of reasons why we have those long delays, although, I have to say, it has been a interesting feature in recent years that, as we have succeeded in reducing the overall number of delayed transfers of care—I suspect that in some ways we have dealt with some of the most simple-to-deal-with problems—as the Wales Audit Office has observed, the average length of stay for those remaining has risen. The delayed transfer of care position is just part of it, and the continuing healthcare issue is also very important. We have as many beds occupied by

continuing healthcare patients or patients who are awaiting a continuing healthcare assessment as we have by formerly designated delayed transfers of care patients, which is also a very serious issue for us.

[114] **David Melding:** I now turn to the other two witnesses. There has been an increase in bed-days lost in your localities for social care reasons over the last two years. Are there any particular reasons for that that you wish to bring to our attention?

[115] **Ms Harris:** Committee members might be aware that we had some issues in our patch in terms of the local authority that are being worked through on the budget position and what is being commissioned by the local authority. Since last year, we have seen real improvements in joint-working arrangements. We are making progress in getting a better joint-commissioning strategy around long-term care, which I think will lead to a greater improvement. Some of the other issues, which have been identified in the report, are about ensuring that we have the processes working effectively across health and social care, and some of the issues discussed with Ann around getting assessments done at the right time will make a real impact in terms of this.

[116] **Ms Ward:** I am happy to look at Torfaen, if that is what you want to do, but I think that it is more helpful to look at the general issues, because they are relevant to everyone. Our issues are no different from everyone else's. In Torfaen, delays for social care reasons are declining, because of continuing healthcare and the Grogan case, which means that delays because of health reasons are going up. The issue is that, certainly in my area, we have said that we cannot be in a silo in this regard; we have to work together and see this as a whole-systems problem. If we do not do that, what will happen is that we will shift cost and blame between each other. We have been looking at a whole-systems approach. I have had some very useful strategic planning meetings with the chief executive of the trust, the local health board and the management teams. We have taken three days out of our schedules at a management level to look at where we are going strategically. That is one of the most useful things that I have done in a very long time. It is not just around delayed transfers of care; it is around our whole approach to this issue of what happens to someone when they become a medical case as opposed to a social care case and how we stop that person becoming institutionalised. So, that has been tremendously helpful and if it has taught me one lesson, it is that joined-up leadership is important. Going back to the point that was made earlier, and I do not necessarily think that it is about structures, but I do believe that it is about people at the top of organisations saying, 'This is a whole-systems issue, and we will work together to address it, in a different way than we have been'. Therefore, there is no point in the chief executive of the trust picking up the phone to me and saying, 'What are you going to do about your delayed transfers of care, Alison?', because I cannot solve it without his assistance, and without the assistance of the chief executive of the local health board. Therefore, that leadership issue is the key.

[117] Commissioning must get better. We have a lot of management information, much of it held by GPs, who are paid to hold it but not to use it effectively. Therefore, commissioning must get much stronger. An important part of commissioning is how we then manage the markets. One of the key issues is that we can be as good as we like as three agencies at trying to deliver reduced delayed transfers of care, but if the independent sector is falling apart, and we are not supporting it, and we are not using preferred-provider status to support certain good-quality independent providers, then we are setting ourselves up to fail.

[118] Ann made the point earlier, and I totally agree with it, that there is no choice if the choice is, 'Which of these homes do you want to go to?'—when you do not want to go to any of them. That is not choice. Choice is where you can be supported in your own home, with a high-level of care, or you can go to such and such a home, which we have invested in as health Wales, and therefore we know that it is a supported provider, with good levels of care,

which we endorse. Therefore, real choice is about looking at things in a very different way.

[119] **David Melding:** We will examine some of these issues, as we develop these points. However, could Hugh and Abigail reflect on Alison's point on leadership in terms of, in this instance, looking at delayed transfers of care, although it is about the health and social care community as a whole?

[120] **Ms Harris:** It is; it is a whole-system problem, as we have all identified. Tomorrow there is a meeting across the five organisations in Cardiff and the Vale of Glamorgan to look at how we will tackle the recommendations together. That is at leader and chief executive level in the local authority, and chair and chief executive level in the NHS organisations. We recognise that we need to have our own local plans across health and social care, but, if they are not joined up across the whole health and social care community, there will be difficulties in dealing with the really wicked issues across the patch.

[121] Locally, one thing that I have found useful over the last year is that I have been chairing a meeting of the chief executives of the local authority and the two trusts. That has been about getting the dialogue going, and understanding each other's issues, because we understand the difficulty of financial pressures across the system—we have all worked in that kind of environment—and it has been about sharing the problems and building up trust between organisations. Therefore, it is about creating a culture where we recognise that it is not just my problem, and not just the local authority's problem—we can only solve this by working effectively together.

[122] **Mr Ross:** I would only add that one of the most difficult tasks is reducing the complexity and variation. There are many players on the pitch, which leads to a lot of variation, different policies, different approaches, different funding abilities and inequity of service provision in different areas. From the trust point of view, looking outwards, anything that we can do to try to remove variation and make things smoother and simpler can only benefit the patient flows. Therefore, through the sorts of meetings that Abi is talking about, that is one thing that we are starting to do. Our relevant local authorities are much better apprised of the issue, and have it much higher on their own priority list than perhaps was the case a few years ago. I would like to pay them credit, because they have seized it at their senior levels and have engaged with the problem with us, which is great.

[123] **Lorraine Barrett:** My questions are to Hugh and Abi. Looking at some of the figures in the auditor general's report, paragraph 1.16 suggests that £26.8 million could be directly released to be spent elsewhere in the health and social care system. Assuming that a reduction in delayed transfers of care can be secured in Cardiff and the Vale of Glamorgan, how would or could the resultant savings be spent more effectively? Would they all be your savings, from Cardiff and Vale NHS Trust?

3.00 p.m.

[124] **Mr Ross:** If we managed to reduce delayed transfers of care substantially, and thereby free up capacity, we would have several choices with regard to how we could use the resources that were freed up. One immediate call would be the need to do more and more scheduled work in order to meet the Welsh Assembly Government's targets for elective access. The amount of work required to meet those targets is ramping up significantly from April as we get closer to Access 2009 and the targets therein. Another possible call on the money would be to reduce the overcrowding in my hospitals and reduce the occupancy levels to ones that I know are more consistent with efficient working, better cleanliness and better control of infection, because the hospitals are currently running at occupancy rates in the mid 90 per cents, and all the evidence suggests that that is inefficient and potentially detrimental to better patient care.

[125] If we solved those two problems I have no doubt that my LHB colleagues would want to try to shift resources into admission avoidance and prevention, because there is so much more that we could be doing with health and social care collectively to try to stop people coming into hospital in the first place, and so many older people find their way unnecessarily into our hospitals and stay there for much longer than they should. That is probably a good point at which to hand things over to you, Abi.

[126] **Ms Harris:** We know that there are too many people who end up in the wrong part of the system who end up in hospital. There are a number of schemes in intermediate care that provide an opportunity to prevent admission, but there are not enough of those in the system. The question is how to break the vicious cycle, because the funding is tied up in staff and beds in the hospital, and we need to find a way of disinvesting in that part of the system and investing in out-of-hospital care. That is very difficult when you are working in a health and social care community where there is no slippage at all in funding positions. Therefore, it must be done within the existing budget, and one of the important components of the programme for health service improvement, on which we are working with the trust, is about remodelling care and realising that, if we model the care all the way through, we will need fewer hospital beds and we will need to reinvest the money in alternative models of care that prevent hospital admissions.

[127] That is really exciting work. For example, our ambition for Barry Hospital is that it will become a much more integrated health and social care facility. The point has been raised before with regard to getting the teams to work together; whether they are in single teams or single management, it is about staff on the ground working together. We have set out such things in both the programme for health service improvement and in our local health, social care and wellbeing strategy, on which we are consulting at the moment. It is about how we can use the money more effectively through the system. Ann mentioned the financial flows work that is being done at an all-Wales level and some of the commissioning work, which will be crucial to this, because the least developed bit of the commissioning system is that for out-of-hospital care. We need to ensure that the framework enables us to move money through the system effectively and invest in those services.

[128] **Mr Ross:** I wish to reiterate Mrs Lloyd's point about packages of care not necessarily being cheaper outside. It is a fact that several of the continuing healthcare patients in my hospitals are not there because the local authority and the LHB have failed to reach agreement about the funding; they are there because, frankly, it is cheaper to keep them there than to find the money for the packages of care that would be necessary outside, some of which would be many many times the cost of those patients remaining in hospital. That is a much bigger policy issue, and it was important that Mrs Lloyd referred to it.

[129] **Ms Ward:** I know that you did not address your question to me, but I wished to comment because Hugh's answer was so interesting. It highlights a point that I was hoping to be able to make today. You asked Hugh what he would spend the money on, and he said that he would first deal with elective surgery and then with cleaning up the hospital. Of course that is what Hugh would deal with because those are his targets; that is where he is held to account. Thirdly, some money would go into intermediate care. However, the trust and the LHB are not actually incentivised to prioritise intermediate care above other things, and that is one of the issues that we face. I totally understand why colleagues are in that position, but the system causes that to happen.

[130] **Lorraine Barrett:** I will expand a little on the potential £27 million that could be saved. I said two trusts when I obviously meant two local health boards—we have one trust covering the two local health boards. Does the mechanism exist to allow money to be transferred? Abi said what she would like to use the money for, but is there agreement across

the trust and the two local health boards on how those savings could be used? That is what I meant when I asked whether it was your money.

[131] **Mr Ross:** I think that there is a whole raft of things that we would like to spend money on, developing all sorts of service in the community. If we had the resources, we would, hopefully, even be able to get to the point where we could pool them successfully. Rather than pooling deficits or potential deficits, which is what we are talking about at the moment, we could actually pool surpluses, in effect, in order to create a different scenario with local government altogether. I do not think that we would be short of things, but let us not forget that Abi has responsibilities to ensure that the trust hits its elective access targets as well. So, she is in the same dilemma as I am in, in terms of what the use might be of any resources that could be freed up. We always have to weigh—

[132] **Ms Harris:** Sometimes, it is just about changing the focus of where the services look. We know, around some of the chronic-conditions-management work that we have been doing, that it is actually about taking out some of our services that sit in hospital; it might be around taking out out-patients, so that the consultants work alongside primary care in a different way. Perhaps some of the diagnostic services that are provided in hospitals could also come out. I guess that the concept of primary and social-care resource centres is the model that we are working up, through the programme for health service improvement. Our complication is that we are doing it with Bro Morgannwg, at the western end of the patch, and with Cardiff and Vale, so there is duplicate work. However, I am quite confident that although they might be articulated slightly differently, the models remain the same in terms of what it means for patients. At the end of the day, what patients need is a straightforward service that is not complicated by whether it is health or social care. So, the model of where we can have a much closer reliance between health and social care is where we have a common ambition.

[133] **Darren Millar:** I can understand the comments that you made, Mr Ross, regarding sharing deficits, but are you seriously suggesting that, if there was extra cash in the system as a result of tackling the delayed discharges of care from within the NHS, you would be prepared, and quite happy, to pass some of that on to local government to deliver better social services to prevent admissions into hospitals?

[134] **Mr Ross:** Absolutely. I think that we could make a very clear case that if we could adopt a genuinely joint approach, using health and social care resources out in the community, in people's homes and neighbourhoods, in clinics and primary care settings, we could have a significant impact, first, on our ability to stop people coming to hospital when they should not, which in itself is a huge part of the problem, and when they need to come to hospital we could get them enabled and back in their own homes and, more appropriately, more quickly. So, yes, I think that I would very much welcome some targeted, ring-fenced resource going in to those areas. The Minister's recent statements lead me to believe that there may be some hope in that direction. Of course, as Mrs Lloyd said, we do not yet know what will be forthcoming, but that would be great. It would also be a huge sort of lubricant to joint working, to have something to really get our teeth into, rather than scratching around, as we are at the moment, on the margins of pressurised budgets to try to put little bits of resource together.

[135] **Chris Franks:** I am looking at page 33 and paragraph 1.25. There is a very stark sentence here that says, 'We can see no justification for local agreements'. Is it reasonable for me to say that the purpose of local agreements is to delay the start of counting? Is it not just simply a method of masking the true scale of delayed transfers of care?

[136] **Mr Ross:** Are you asking me?

[137] **David Melding:** I think that all of you could give us a view on that. You have clearly heard that the Welsh Assembly Government is looking at the issue of local agreements before the clock starts, as it were, and its thinking is that it is now difficult to justify those agreements. Do you agree with that, even though you may currently be embroiled in them and would have to get out of them?

[138] **Mr Ross:** I am guilty of introducing one of them. When I came to Cardiff, I found that there were no agreements between the trust and Cardiff County Council as to how long it should take to get the process started, so we agreed some maximum times, which are reflected in the report, which we agreed that we would negotiate down over time. That was the first time that there had been any kind of performance measurement of what Cardiff local authority was doing in terms of starting assessments. I will not deny for a moment that some of the more historic, long-term agreements may have been put in place as a way of protecting resources and slowing up the process—defensive measures, if you like—but I do not know of any specific measures of that kind, although I have experienced it elsewhere. A local authority in England put such measures in place as a way of restraining the use and commitment of resources. Certainly, with regard to the first one, the Cardiff and the Vale report was at my instigation to try to put some grip in the system.

3.10 p.m.

[139] **David Melding:** We will bring the auditor general in on this point.

[140] **Mr Colman:** If I may clarify, Chair, what we intended by the sentence that Mr Franks quite rightly described as ‘stark’, it is precisely the part of the local agreement that says that the clock does not start until so many days have elapsed. The concept of setting a minimum standard described by Mr Ross is unexceptionable—we would not criticise that at all. The aspect of the local agreement that we found unjustifiable was the one leading to the figures being understated, and not even systematically so, but understated variably because of the existence of local agreements.

[141] **Ms Ward:** I can answer your question. I have looked at our position and I do not really see why we have them, to be honest. I was surprised to hear Ann say that she had taken legal advice about whether we could dispense with them, because I am sure that, from a local government point of view, the Welsh Local Government Association would be quite happy to enter discussions on a negotiated release of local agreements. That is from our point of view—obviously, I cannot speak for health colleagues. The important thing is the estimated date of discharge being fixed as soon as the person is admitted. That is what we all want to focus on. So, from the local government perspective, I really cannot see doing away with them as being an issue.

[142] **David Melding:** I think that that deals very succinctly with that question.

[143] **Eleanor Burnham:** May I have an additional question before I carry on to my own?

[144] **David Melding:** Do you want to ask the indicated question first?

[145] **Eleanor Burnham:** No. Before I ask the question indicated, I am intrigued by Mr Ross’s earlier statement. I am a north Wales person, so I do not know your ins and outs, but were you suggesting that Cardiff and the Vale trust is in such a happy financial situation that you would have some spare money to share with your community colleagues, or were you alluding to your aspiration for having sufficient cash?

[146] **David Melding:** I think that the witness was acknowledging the data presented.

[147] **Eleanor Burnham:** That is okay.

[148] **David Melding:** It is possible that that sort of saving could be generated, and there may then be agreements on how it is used, and that is not solely our focus, but a health and social care focus.

[149] **Eleanor Burnham:** Fine. Referring in particular to figure 12 on page 44 of the report, the Grogan judgment must fill people like you with some horror, given the expected estimated costs of compliance. This question could be to Abigail Harris, Alison Ward or to Hugh Ross. Given the level of delayed transfers of care resulting from this Grogan dispute over continuing healthcare, eligibility is increasing. What should be done to reduce such disputes between LHBs and local authorities? I am heartened by what I have heard, because some situations in north Wales are not as rosy as your wonderful relationship—I will leave it at that. I am sure that you will be able to enlighten us on your views on the implications and on how to reduce the disputes.

[150] **David Melding:** I think that that is principally for the health board and the local authority. In this case, happily, they are not—

[151] **Eleanor Burnham:** Mr Ross as well—

[152] **David Melding:** No; I think that it is principally the funding bodies in this case. I do not know—

[153] **Ms Harris:** I am happy to kick off. Locally, we are aligning our processes so that we do not sit in one office looking at continuing healthcare from our point of view while the local authority looks at it from its own office. There are grey areas that need to be discussed to understand the individual's care needs, so we are now aligning our processes so that there is open discussion about what the genuine need is and, if it does fall in the grey area, how we, together, can provide the effective package of care and to ensure that it does not cause delay in the system. One of the key issues is ensuring that the continuing healthcare assessment is done as part of the unified assessment process and that it is not seen as a bolt-on further down the line. One of the things that I have observed in chairing the monthly meeting to look at the individual cases is that it is depressing seeing someone start off with an assessment where they are placed in a residential home, but because they have been delayed they are then sent to a nursing home, where a full-blown continuing healthcare assessment is required. That is not generally about people just delaying the system to get a continuing healthcare assessment—it reflects the fact that people deteriorate in the system. So, we must get the system working from day one, which goes back to the comment about the fact that the process needs to start at admissions so that we can understand and predict what kind of package of care people are likely to need, so that they get out of hospital quickly.

[154] **Ms Ward:** Continuing healthcare and the figures in the table only become frightening if you do not regard it as a whole-systems approach. If you say that it is now health's problem and it was social care's problem, I could rub my hands and say 'Great, that will solve some of my budget problems', but that does not solve the problems for the people that I serve in any way. As Abigail says, for every moment we spend wrangling, someone's chances go down. To give you an example, our local health board, my colleagues and I took a report to our cabinet recently to try to get our politicians on board with the idea that this a whole-systems issue. With the numbers of delayed transfers of care at which we were looking at the time, we said that the social care budget probably needs about another £0.5 million if we were to just clear those delayed transfers of care. One has to put the caveat that that is not necessarily the best outcome for the people concerned, but it clears the performance indicator. In fact, the cost to the healthcare service in terms of what it could give to its patients is seven times that amount. So, it would cost me £0.5 million to put it right from a social care angle,

but the opportunity cost to my health colleagues is seven times that amount, so it is £3.5 million. If we start to think of it in that way, in terms of 'Here is some money with which we can meet people's social care and health needs across the piece without silos', this becomes an irrelevant issue.

[155] **David Melding:** That is very heartening, I think.

[156] **Eleanor Burnham:** So, Mr Ross, what impact do you think that the continuing healthcare issues have on your organisation, and, from a trust perspective, how do you think the systems can be improved or do you think that you are working so holistically that you are quite positive about it?

[157] **Mr Ross:** Other than doing our bit in the process, we are not able to have a great deal of influence on the continuing healthcare discussions. Paragraphs 2.24 and 2.25 are an accurate representation of the position. The personal implications for patients and families that Abigail described are very real, and my perspective is that a continuing healthcare assessment patient who is delayed is, in turn, delaying a patient in an acute bed, who is delaying a patient in an assessment bed, who is delaying a patient in the emergency unit. So, it ripples right back through the hospital system, therefore every patient that is delayed is effectively delaying three or four other patients. That gives an illustration of what an enormous problem it is. The level of maturity about the debate is improving all the time, because these are very real problems for financially challenged organisations, and I do not think that I am speaking out of turn when I say that Cardiff City Council and Cardiff Local Health Board, for example, are finding it very difficult to get to grips with this issue with the two organisations being under immense pressure, and the potential bill and resource commitment for the organisations being so big.

[158] **Ms Harris:** May I just add another issue, which it is important to reflect? Some of these cases are incredibly complex; one of the cases that I have been dealing with for a long time relates to a young man with a mental health problem, and it is incredibly difficult to find the right package of care for him. This case involves the mental health tribunal, and it involves dealing with someone who is very vulnerable. It is true to say that the patient is not in the right bed, but along with the clinicians and the full multidisciplinary team, we are working through what is the best package of care, and we had the experience of trying some things out that did not work, so we must be very careful. So, the clock still ticks in terms of the bed days lost. You sometimes see quite sharp rises, and you will see drops if you solve a case by finding the right package of care and moving the individual through the care plan. This means that the numbers can drop off overnight. So, some of them are very complex cases that take a lot of work from clinicians and managers across the health and social care system.

[159] **Eleanor Burnham:** Moving on to discuss the percentage of bed day loss across Wales and the reasons accounted for half of the total number of bed days occupied by delayed transfers of care, you are obviously aware of these things. How are your organisations, Hugh and Abigail, working to minimise the extent of delays? You have explained about the complexity, and I am sure that it is not an easy process, but I am also sure that you can help.

3.20 p.m.

[160] **Lorraine Barrett:** It is 'due to choice'.

[161] **Eleanor Burnham:** Sorry, yes. How are your organisations working to minimise the extent of delays due to choice, whatever that might be?

[162] **Mr Ross:** That is a very tough issue. We had different choice policies between the

two parts of our community. We have now agreed a common one, which is in the process of being signed off by all the partners, which is important. However, I am very conscious that, up the road, in another local authority and local health board area, there will be another choice policy, and one of the things that we would very much welcome—and I gather from what Ann Lloyd said that this is on its way—is definitive guidance that applies right across Wales that is carefully tested and thought through, because, as you might imagine, we come up against difficult challenges all the time. Ann's point about 'what choice?' is extremely relevant in this part of the world. I think that only two nursing homes in Cardiff will accept the local authority rate. So, in reality, for many patients, there is no choice at all. As the rules stand, patients and their families can put their name down for one of those nursing homes with there being no realistic possibility of a place being available for many months and, frankly, they are then stuck because of the lack of alternatives.

[163] So, we have to do a number of things. First—and I am sure that Abi will want to talk about commissioning strategies, so I will leave that—we have to do whatever we can to increase capacity in the system in different ways, and we are doing some quite imaginative work with housing departments in the councils to see what sheltered housing, extra-care-type housing, might be available as alternatives. We are talking with the voluntary sector, with Care and Repair Cymru and Voluntary Action Cardiff, for example, to see what the voluntary organisations can do to help support in the home. That is often in very simple, practical ways, but it can make all the difference. So, we are exploring what we can do on that too—anything, really, to avoid patients going to this narrower and narrower funnel that, at the moment, is choice. So, there is a lot that we can do but it probably needs some all-Wales decisions as soon as reasonably possible to try to nail the issue.

[164] **David Melding:** [*Inaudible.*] proceedings. Do the other two witnesses agree that Welsh Assembly Government guidance on the issue of patient choice would be welcome? If you have a contrary view, please express it now, but otherwise—

[165] **Eleanor Burnham:** I was going to ask that question about what the Assembly Government should do to address—

[166] **David Melding:** I think that it is redundant now as Hugh has addressed it, but if the other witnesses have a view that that should not be the direction of travel, I would like to hear it.

[167] **Mr Ross:** There is one other bit that I should add, if I may, particularly from the trust perspective, which is that we need to keep improving our processes. They are a lot better than they were but there is still plenty of room for improvement in how quick, slick and organised we are in doing all the things that we need to do. Unified assessment is a pain: it is desperately bureaucratic and very lengthy. We lack an electronic solution and we would all like to see a much simpler, quicker and more effective UA system to be put in place, again, on an all-Wales basis. So, I would not want the committee to think—not that it would for a moment, I am sure—that the trust does not have room for improvement in this area. We have lots to do too.

[168] **Eleanor Burnham:** In case anybody does not know, could you remind us what UA is?

[169] **Mr Ross:** Sorry, that is unified assessment.

[170] **David Melding:** Eleanor, do you want to ask—

[171] **Ms Ward:** May I—

[172] **Eleanor Burnham:** I have a question for you—

[173] **David Melding:** Hang on, I think that one of the witnesses has a slightly different view.

[174] **Ms Ward:** I would welcome the guidance but I think that it is merely a sticking plaster unless we address managing the market and investing in intermediate care, because there is no real choice.

[175] **Eleanor Burnham:** Appendix 2 shows an 11 per cent decrease in bed days occupied by choice related to delays in your situation. How did you achieve that?

[176] **Ms Ward:** Well—

[177] **Eleanor Burnham:** I thought that you would be rushing to tell me.

[178] **Ms Ward:** There are lots of things that one can do around choice. One of the things that we have done in Torfaen is to increase the fees that we pay to independent sector providers. We were a low payer and one of things that were happening was that we were losing placements within our area to other authorities that paid more. So, we had to put right a problem there. We have all of the issues that everyone else has around the independent sector and the need to bring quality up while investing in those who deliver good quality and ensuring that their businesses are viable. So, we may have made some increase and, obviously, one is pleased about that, but it is not, by any means, going to solve the issue.

[179] **Eleanor Burnham:** Did you mean to say ‘viable’ rather than ‘vulnerable’?

[180] **Ms Ward:** I said ‘viable’.

[181] **Eleanor Burnham:** Forgive me.

[182] **Huw Lewis:** A little snippet of the auditor general’s report says that nursing staff believe that 80 per cent of patients experiencing a delayed transfer of care would not be able to return to their previous living arrangements. Do you think that there is a mindset here—something in the culture of nursing, as nurses have inherited it—that has a default setting towards an institutional care setting, rather than thinking about the independence of vulnerable people? Are we on tramlines here in terms of the profession’s way of thinking?

[183] **Ms Harris:** My experience, looking at individual cases every month, is that this does not necessarily apply only to nurses, as it sometimes applies to social care staff as well. I think that it is true that we have a risk-averse culture. In some cases, when I question why a person cannot go home, some of the reasons do not seem to be genuine; it is about risk, and whether it is safe to let them go home. We need to shift the culture so that we try packages of care. If they do not work, then we need to think again, but a lot of people want to go home, and too often we end up moving people into residential nursing homes when we should have tried sending them home first, with a package of care and perhaps more intensive support. The evidence shows that people reach a higher level of independence than predicted, and I think that we have to shift the culture a bit.

[184] **Mr Ross:** It is an interesting point, and I had some correspondence with the Welsh Audit Office about this. I do not disagree at all with Abigail’s comments. To some extent, this problem reflects the level of frustration and helplessness felt by the clinical staff. They perceive that there are so many obstacles in the way of returning patients from whence they came that it is almost as if that default option kicks in. I am afraid that older people, in particular, can deteriorate rapidly in hospital, for all the reasons that we have talked about. So,

I think that that is a real issue. One of the things that we are doing in the trust, in rewriting and relaunching our discharge policies and arrangements, is to try to turn that on its head, and make a presumption that the patient will go home as quickly as possible as opposed to being kept in until we can sort something out. We must try to turn that round, with the help of all concerned, including relatives. In many cases, relatives themselves can be a major obstacle, because they feel that mum or dad will no longer be safe at home, and they put pressure on us to keep their elderly relative in the system. That is another perception that we need to turn around sometimes as well.

[185] **Ms Ward:** I may be presumptuous in answering this question, as it is not my area, but I did have a chat with Martin Turner, the chief executive of our trust, before I came here, just to check out my thinking on the matter. We both think that hospitals are quite dangerous places; there is physical risk around the infections that older people can pick up, and there is also a huge emotional risk—the longer you are in there, the more institutionalised you become. So, there is quite a lot of risk, and people working in the hospital do not necessarily perceive that staying in hospital is a risky business. The other thing is that GPs have a big role to play in choosing whether to admit a person to hospital or not. For them, as I perceive it, the low-risk option is to admit the person to hospital, but that might be the worst option for that person's life chances. However, it makes GPs feel that they have taken the best option and done their duty. So, I think that there is an issue around GPs as well.

[186] **Huw Lewis:** There is a 'safety first' attitude.

[187] **Ms Ward:** Yes.

[188] **David Melding:** The auditor general says that the intermediate care sector is quite fragmented as there are different schemes operating. I just wonder what experience you have had in that respect. Is it becoming more integrated across the health and social care community? What progress is being made?

[189] **Ms Harris:** Some of that relates to history, in terms of how those services were funded. Quite often, they were funded with special grant money for new services, which meant that it was a bidding process or an allocation process, so it related to a specific geographical area. One example is that the elderly care assessment service works in Cardiff, but it does not work in the Vale of Glamorgan, and one of the things that we want to do as part of the broader programme for health service improvement is to align some of those services.

3.30 p.m.

[190] For a GP out in their patch, knowing exactly which is the right service when there may be eight, nine or 10 different alternatives is quite a difficult thing to work through. So, we have committed to streamlining some of those services, looking at how we can use their capacity more effectively. If some of them are more effective than others, we need to tweak them to look the same. We need to address the issue, but it is challenging in the financial climate. Where we have had investment in one patch, but not in the other, how do we find the funding to roll that good practice out? We have identified the elderly care assessment service for the Vale of Glamorgan as an area that we would like to develop, but the question is how to find the funding for that. It has had a real impact in Cardiff.

[191] **Mr Ross:** That is a very good summary, certainly from our local perspective.

[192] **David Melding:** I was going to ask how we could engage GPs more effectively, and part of it is to have a more integrated system available to them.

[193] **Ms Harris:** In the Cardiff and Vale, we are very fortunate in that, as one of the work streams under the overarching programme of health service improvement, we have an unschedule care board, and we have very good GP engagement in that. They tell us that it is difficult to know exactly which service to refer to when they are out doing house calls. We have talked about making it much simpler for them to provide alternatives, so that when they talk about admission to hospital, that may be an admission for assessment. Hugh may want to talk about his experiences of acute physicians who discharge people much earlier because they are confident that they have done the assessment, and they can then get them back out again. It may be an urgent district nurse visit that is required, or access to social care support through short-term intervention service. We need to ensure that the GP provides them with those alternatives at the point of access.

[194] **Ms Ward:** There is something around GPs being proactive in managing risk, on the prevention end. Certainly in Torfaen, we are looking at a falls strategy at the moment with GPs being the key managers of that, so that they know who is at risk of having a fall. We know that falls are a major cause of people being admitted to hospital and resulting in delayed transfers of care. So, it is more than just what GPs do when they have a crisis; it is about how we can involve them as proactive risk managers. That may mean looking at how the contracts are structured and rewarded.

[195] **Ms Harris:** May I just follow on from that? That also involves the role of the ambulance trust in transporting people to hospital. We are doing some work on the same issue of falls with the ambulance trust, because it is our paramedics that transport people to hospital, and they often have to go to the same house three of four times to pick up someone who has fallen. So, we are looking at how staff of the ambulance trust can make a referral, either to the GP to say that they have been to that house twice and are worried about the risk of fall, or to the falls clinic provided by the trust, working through the GP. So, this is about making an alternative pathway available when the ambulance trust picks up on a risk area that we need to reflect on.

[196] **Eleanor Burnham:** What you say about GPs is interesting, but they work only from 9 a.m. until 5 p.m. on a Monday to Friday. It is a huge discomfort to some of us in some areas, and GP contracts have obviously been well researched by the audit office. We have previously discussed it, and I have a bit of a bee in my bonnet about it. I am absolutely thrilled to hear what you say, but, given that I come from north Wales, I want to know whether this best practice is being disseminated throughout the whole of Wales.

[197] **David Melding:** That is not solely your responsibility, of course. [*Laughter*.]

[198] **Mr Ross:** There are pockets of good practice. I think that some of the issues that the auditor general identified on the clarity of GPs' roles, incentives and how they are aligned remain unanswered. I am trying to use my words carefully, but I hope that we can move towards a situation in which GPs feel empowered to be full partners in preventing admissions to hospital wherever possible, and where every unplanned admission is seen as a failure. We are a long way from that at the moment. That is a systemic issue that we need to grapple with somehow. If we can do that, together with the other things that we have been talking about, we would make a difference.

[199] **David Melding:** Thank you. I am sure that that point is well understood.

[200] **Helen Mary Jones:** Paragraph 2.69 in the report tells us that,

[201] 'By their nature, delayed transfers of care indicate weaknesses in commissioning because the delayed transfers signify that the services people need are not available at the appropriate time'.

[202] I would like to ask Abigail Harris and Alison Ward whether their organisations are commissioning effectively to ensure the availability of a sufficiently wide range of alternative services in the community to avoid hospital admission and to promote independence. I think that you said a bit about that in some of your previous answers, but could you expand on that? I am not sure who would like to go first.

[203] **Ms Harris:** As you are looking at me, I will go first.

[204] This is not entirely the case, if I am honest about it. The challenges lie in one of the things that I said before around out-of-hospital care. That is the area in which commissioning is least developed. We are making progress on the currencies for hospital care, but the currencies in the approaches that we use for out-of-hospital care need to be developed. In the joint approach with the local authority, that was one target set out in the older people's strategy. Given some of the changes that we have had locally, we have not made as much progress around that as we would like to have made. So, we have further progress to make, but we have good foundations to build upon.

[205] **Ms Ward:** From the local authority perspective, we are both commissioner and provider, so we have a dual role in that respect. An important part of our role is to build up those options that one can commission against. We are very interested in looking at intermediate care solutions. We are looking at some solutions around sheltered housing, and about turning some sheltered housing units into intermediate care beds. We have an intermediate care group with a wonderful consultant called Bim Bhowmick, whom we commissioned using Wanless money. He is looking at a virtual-ward model, which means that you substitute a hospital bed for the person's bed, and you deliver the services at that person's home rather than in hospital, but at the same level. For people with co-morbidity, instead of having lots of consultants dealing with separate issues—for example, one dealing with their diabetes, another with their chest infection—one intermediate care consultant manages that virtual ward. That is an exciting model, and it is also the one that the Gwent Healthcare NHS Trust is looking at in its Clinical Futures programme. So, that is where we are going. However, to answer your question about whether we are commissioning as well as we could be, the answer is 'No, not at the moment'.

[206] **Ms Harris:** I would like to come back to some of the complex cases. It does not just sit within the work of the local health board. I have talked about the example of the mental health case, and we recognise that we are working with nine LHBs in the south-east Wales region to look at the low secure mental health commissioning. In effect, we do not have the capacity or the expertise to commission those services, and we know that it is a critical point. Quite often, it is market driven and new providers are popping up all over the place for some of these more specialist mental health services. We have collaborated and put money into a pot, along with some Assembly Government money, to develop a commissioning strategy for mental health services across the nine LHBs. So, we have a critical mass of patients and clients, and we can ensure a more effective care outcome for them through a better commissioning arrangement.

[207] **Helen Mary Jones:** On a similar theme about systems, Mr Ross, does the extent of delayed transfers of care in your trust show that the system is, effectively, a vicious circle that locks resources into acute health and social care settings and prevents spending on the alternatives to hospital admission, including some of the innovative work that the three of you have already talked about?

[208] **Mr Ross:** The short answer is that that ties up resources and, even more importantly, individual people in circumstances and situations that are not in their or the taxpayer's best interests. As we discussed in response to Lorraine Barrett's question earlier, if the money

were freed up, there are some dilemmas about the choices that face us as health and social care providers about where we invest whatever resources we can free up. However, I would like nothing more than to have no patients in the hospital beyond the moment that it was imperative for them to be there.

[209] **Darren Millar:** Alison, earlier on, Hugh referred to the problem with delayed discharges in his area being partly due to the lack of capacity—or beds—in the independent sector to discharge people when they no longer need hospital care. You referred earlier to the work that your authority has done on raising the fee levels to ensure that there was capacity and there were places for people within Torfaen. There is a problem here, is there not? If one local authority is paying more for beds, owners of local care homes may take individuals from that authority's area over those from yours. I know that that was happening. What else do you think you could do to secure the supply of beds in Torfaen? Are you, for example, looking at the block purchasing of beds, given that the auditor general indicates in his report that spot purchasing is not necessarily the best tool for ensuring capacity?

3.40 p.m.

[210] **Ms Ward:** The raising of fees sorted out a problem in the immediate sense, but it was not going to resolve the issue. It was just a survival tactic, if you like, because Newport and other authorities were taking beds in Torfaen. We must have a much more mature relationship with the independent sector, and say that we are going to have some preferred providers, and that we will guarantee them a certain amount of business but that the quid pro quo of that is that they make a certain number of beds available to us at a price that we negotiate with them.

[211] Some very interesting work is being done by the South East Wales Improvement Collaboration, through the regional board of south-east Wales, around commissioning placements for children. It has found that it can negotiate hugely cheaper contracts at a level of quality that is acceptable to everybody, just by being much more organised as a group of authorities in commissioning placements. We certainly need to be working together on this. The situation of having one local authority fighting against the other to see who can pay the most to get the beds is in nobody's interest, and certainly not that of the council tax payer. Neither is that in the independent sector's interest, because it has no security in its businesses, so why invest in them?

[212] **Darren Millar:** To what extent is social work time spent on negotiating contracts rather than delivering the assessments that people need? How is that impacting on delayed discharges? I notice that your local agreement is 15 working days, which is the longest of all of those cited in the report. Could you deliver quicker assessments were there more of these block contracts rather than individuals having to do the spot contracts and negotiate the fees with providers?

[213] **Ms Ward:** I would imagine so. I could not say, hand on heart, that there would be evidence of that at present. One interesting piece of anecdotal evidence that I can tell you is that the chief executive of the trust, the local health board and I have now started to meet regularly to discuss delayed transfers of care, and one of the comments that we had from the trust and LHB staff was, 'Gosh, it takes a long time to negotiate these placements now that we have more continuing healthcare responsibilities; we never realised how much of your time it took up'. So, you can see that the experience is unhelpful to everybody concerned and is dead time, really.

[214] **Darren Millar:** This next question is for all of you. One big reason for delayed discharges is the patient's choice, or other patient matters. There seems to be some indication in the report that the system does not really help patients, their carers, or their families to make a choice, because the financial arrangements would have an impact on the families if

their relative went into care. To what extent are there families—and perhaps local authorities—who play the system in trying to keep people in hospital to avoid the cost implication that might be incurred afterwards?

[215] **Mr Ross:** I am afraid that that does happen. I regularly see reports and discuss with my senior staff the longer delayed transfers of care, and I ask regularly for anonymised individual patients' stories about what is going on, so that I can share them with the trust board, for example. I am afraid that some families prove to be very difficult. They will agree to meet and not turn up, or they will say that they are away for a couple of months and, sometimes, it takes three to four months to pin the relatives down to a meeting, to decide the best way forward for their loved one, by which time, as Abigail was saying, the elderly relative's condition may have deteriorated seriously. I do not want it to appear in any way as though I am blaming anybody, as it is a dreadful situation for any family to find themselves in. However, in many cases, providing care means selling the family home, and the family assets disappearing at a potentially rapid rate. The cut-off point at which you have to contribute to the cost of care is when you have assets worth something like £20,000, so that must capture virtually every homeowner. That is a really difficult dilemma for relatives. A care relationship has been built up between the care team and the patient, and it cuts right across that. One of the most uncomfortable and difficult things that my staff have to do—and my managers and I support them in this as best we can—is to face relatives with this dilemma and to try to get them to address it. It is a difficult human situation all round.

[216] **David Millar:** How do you see that being addressed in the longer term? You mentioned the level of assets. Do you think that has to be addressed?

[217] **David Melding:** That is quite political.

[218] **David Miller:** It is just a question. How do you solve the problem?

[219] **Mr Ross:** While families remain responsible for a substantial proportion of the cost of residential nursing home care for their relatives, it will remain a problem.

[220] **Ms Harris:** I think that there are areas in which we can make the process a bit easier. One of the questions that we put early on to Paul Williams in our chief executive group was, 'Why is there a differential in terms of the position in Bro Morgannwg?'. One of the issues that they picked up in terms of some of their processes was that they need to have the discussion very early on in the pathway so that, as soon as someone is admitted to hospital, knowing that there is quite a good indicator of predicting where someone might need to go on to, you start the discussion. That means that it does not come as a shock to families that they may need to find a nursing home and they can start planning for that and look at homes during the period that their relative is in hospital. We need to build that into the discharge process.

[221] Another thing that we did, which we need to re-establish, is that we had an individual in our local authority who acted as a liaison between families, provided information about homes and took families to visit them, in some cases, so that they had support. It is not an easy decision to make, particularly for lone carers who have to trudge around nursing homes on their own and make decisions about their relatives. The post-holder left and went to another job and, because of changes in the council, the post was not continued. However, I am discussing the issue with the newly appointed social services director in the Vale of Glamorgan—he has not started yet, but I already have my list of things to discuss with him—because that seemed to have an impact and it was regarded as very helpful for people who are trying to work through what is quite a difficult decision. There are people in the category that Hugh described, but there are also some people who find it very difficult to do.

[222] **Mr Ross:** That is absolutely fair, and I would not underestimate the point that I made earlier about the sheer relief felt in many cases by families in knowing that their older relatives are in a place of safety when they have been extremely concerned about them for many months as they have been living in what they perceive to be a vulnerable situation on their own. All of that is in the mix as well.

[223] **Ms Ward:** I wish to come in from a slightly different angle. The question triggered off in my mind a thought about whether we invest enough in families to enable them to care for people in their own homes. If you look at the hierarchy of what people would want for their parents, or what we would all want for ourselves, first, we would like to be independent in our homes and, if that is not possible, we would like to be living independently in extra care housing, for example. I suspect that the third choice would be for us to be supported within our families, and yet the system does not really invest in families and give them the opportunity to have some sort of support and financial backing perhaps to enable them to care for people at home. So, people get into that trap of trying to decide which nursing home they want for their mum or dad, which is going to cost a certain amount, instead of us asking, 'How can we support you in caring for mum or dad at home?'.

[224] **Mr Ross:** I think that I am right in saying that entitlement to the carers' allowance is lost once you reach pensionable age, which is perhaps the very time when your carer responsibilities are becoming very significant. I know that Age Concern consistently lobbies about that, quite rightly.

[225] **Helen Mary Jones:** I have a very big question to ask all three of you. To reduce significantly delayed transfers of care and promote independence for vulnerable people, what would you prioritise in developing the Welsh health and social care system in the longer term? This is an opportunity, perhaps, for you, not to give us a wish list exactly, but to think a little bit further ahead than the immediate problem.

[226] **Ms Harris:** I think that it goes back to the issue of making sure that those reformed community services include the alternatives, which include the example that Alison gave about supporting people in their families, because we do not have that full range. Also, the equation does not stack up at the moment; certainly, in some localities, our population projections are very steep in terms of the numbers of those aged over 65, 75 and 85, and yet we know that the budget allocations are not necessarily going to keep up with that level of growth. So, we are going to have to take some difficult decisions about how we provide that care jointly with the local authority in the future. Therefore, it is about having an appropriate framework and making those commissioning decisions, and ensuring that we have the full range of options in place to commission from.

3.50 p.m.

[227] **Ms Ward:** I did bring a wish list—I was hoping that you might ask me. [*Laughter*.]

[228] **Eleanor Burnham:** Oh dear.

[229] **Ms Ward:** It is not very long.

[230] **Eleanor Burnham:** Christmas is coming.

[231] **Ms Ward:** It is not very expensive either. [*Laughter*.]

[232] First, we need a combination of national guidance and flexibility for local leadership. It must be something that requires us to work together, whether through local service boards, or some other way, so that we are required to do that. The second point is the incentives issue

that I raised. As long as people in the health system are incentivised to do certain things, such as reduce waiting lists in priority to intermediate care, then I believe that we will always have that problem, which is understandable. Thirdly, we need some transitional funding to enable us to shift from this delayed transfers of care problem in which we are stuck to investing in intermediate care—I am talking about transitional funding, and not about funding for forever. I would ask the Assembly to think more widely about the sort of investment that would reduce admissions in terms of outside of social care and health, around some of the things that we could do on housing. Extra social housing grant would enable us to have more extra care housing; more disabled facilities grants would enable us to make people's houses safer so that they would not fall.

[233] Therefore, those sorts of things are outside the bracket that we may initially think about, but they are important. GP contracts are important, for the reasons that I mentioned, to look at whether GPs are incentivised to reduce risk and help people to stay at home. Therefore, those are the issues. You would not expect me to come here without saying that the budget settlement has not done local government any favours in terms of trying to deliver this.

[234] **Mr Ross:** I would just add a couple of things. The committee talked with Ann Lloyd earlier about seamless services. The number of hand-offs that are illustrated in the report between different bodies is frightening. I believe that we have 58 bodies, either delivering or commissioning health and social care in Wales. I fail to see how that can be in the public interest in terms of seamless integrated services. That is possibly the single biggest problem facing the health and social care system. In addition to that, I agree with what my colleagues have said.

[235] **Helen Mary Jones:** Thank you. That is helpful. I have a question for Hugh Ross and Abigail Harris. Have working relationships between health and social care organisations improved in your health and care community, and how are you working towards a whole-system approach that proactively involves social care as well as health? You have said something about this already, but I do not know whether you would both like to expand a little on that.

[236] **Mr Ross:** I believe that relationships have improved. The personal relationships between senior officers are good. I believe that it is fair to say that, after some difficult times a year or two ago, we now have senior level commitment all the way round to the problems that we are facing. As Abi mentioned earlier, all five chief executives and chairs, or leaders, are meeting tomorrow to discuss how to take the messages in these reports forward. Cardiff County Council has been particularly imaginative in how it has engaged with us in the last few months about doing some of the sorts of things that Alison was talking about in terms of being proactive with the nursing home care sector, saying, 'If we were able to offer you a long-term security of contract, would you be able to reconfigure your facilities?', and so on. Therefore, that is encouraging. With the new director of social services appointed in the Vale of Glamorgan, I am sure that we will see a similar positive movement there. Therefore, we are in a much better place than we were a few years ago—that would be my take on it. We are already well under way in trying to tackle many of the problems that are outlined in the report.

[237] **Ms Harris:** That is very fair; I agree with everything that Hugh said. In the Vale of Glamorgan, we have chief executive level engagement, which we did not have a few years ago, in terms of recognising this as a big issue; the council is a partner in resolving the issue.

[238] **Helen Mary Jones:** What factors do you believe have led to that improvement in relationship? You have mentioned the importance of senior level engagement. Are there other particular things that have changed that have made things better?

[239] **Ms Harris:** There are some specific issues. You could say that things have to get to a very bad point, before they improve. The changes in the council regarding social services staff, and the change in leadership in the Government, came about because of the issues around social services budgets and, linked to that, delayed transfers of care. That provided a catalyst for a different working relationship. Some of the working relationships on the ground have always been excellent. Sometimes, just joining up together in terms of our vision for services and ensuring that we have aligned the vision for services, the budgets for commissioning those, and some of the issues around priorities that we have discussed is what is required. It does not help when we are operating to different priorities because we work against each other and not even on parallel tracks.

[240] **Helen Mary Jones:** Would you agree with that, Mr Ross?

[241] **Mr Ross:** I would. There was a similar catalyst in Cardiff about a year or a year and a half ago now when my chairman made some quite public statements about what he felt to be the lack of priority that the council was giving to the issue. That led to some strong words in private, but, as is often the case, it cleared the air and a joint determination came out of it to do better. We have moved on steadily from there.

[242] **Helen Mary Jones:** That is helpful, thank you. I would like comments from all of you on this question. By having locality level targets that are the joint responsibility of the trusts and the LHBs, there are no overall targets to which partners can work. What whole-system measure would you use to monitor success in promoting the independence of vulnerable people and minimising the negative impacts of delayed transfers of care, and do you believe that such targets are best set locally or centrally?

[243] **Mr Ross:** My experience is that targets that people set and own themselves are usually tougher than those that are set by the centre, because people are genuinely ambitious to do better. Therefore, I would like to see more locality in target setting if possible. The difficulty with target setting, particularly when you are working across sectors, is that it can sometimes be very hard to know where you start from to make a sensible target that you can measure. For example, if we wanted to measure any increase in the number of admissions of elderly patients that were avoided over a certain time by a series of actions, isolating that from all the other variables in the system in a way that could be measured meaningfully would be difficult. Therefore, we tend to fall back on process measures, which are not completely inadequate. If you can show evidence of all sorts of new processes that of themselves should lead to improvements, that is a good start. Setting targets that really drive things successfully is very difficult, which is no doubt why the Assembly Government is thinking carefully about what the better joined-up targets might be. It is certainly not easy.

[244] **Ms Harris:** Targets need to be joined in two ways—joined up between organisations, but also so that they make sense across the pathways. Therefore, if we are looking at stopping people going into hospital, we need to ensure that there are appropriate targets that reflect the age and sex of the communities, because that differs between different health communities. Once someone is in hospital, it is a case of looking at how that pathway can progress rapidly so that people get to the right next phase of care quickly. There are targets at the other end of the system, because we need to have the front door and the back door covered. Sometimes those things do not join up and the targets do not link effectively together.

[245] Hugh's point about local targets is really important. Mention was made in the paper of variations in admission rates by GP practice, and we have started to get underneath some of that. Sometimes there is a story to tell beneath the figures, which will not reflect the fact that some practices might have three or four nursing homes in their catchment areas and that the workloads associated with their practice populations have a bias in terms of their admission

rates. It does not always explain the variation, but there are issues underneath this. Therefore, sometimes very local variation in targets is required to reflect local circumstances.

[246] **Ms Ward:** I am not sure what they are off the top of my head, but I would like to see targets being much more patient-focused than they are at present. Delayed transfers of care is a very bad performance indicator, because it does not relate to patient outcomes. If I had a wodge of money I could buy placements anywhere that I could get them and get people out of hospital, but those would not necessarily be the placements that would suit them and they might not provide the sort of thing that I should be providing for them, but that is what delayed transfers of care is; it is a very crude measure. Therefore, I would like to see some targets on things that actually improve people's quality of life. I would also like to see some targets on the health and wellbeing agenda, looking at how we can stop people becoming so ill that they enter this vicious cycle. At the moment, there is a great deal of incentive for local authorities to do that work, but that is not really the case for health colleagues. It is hard for someone to say that they want to prioritise health and wellbeing when they have to meet targets on elective surgery. That is quite understandable, but that is the system that we are in at the moment.

[247] **Lorraine Barrett:** On information sharing within health and between health and social care organisations, the auditor general identified some problems in that area as there are no single records for patients, even within the NHS. Do you have any thoughts on that, with regard to us achieving best value for the public purse?

4.00 p.m.

[248] **Mr Ross:** That issue has dogged us for years. We have found a way around it in one service in the trust, in the mental health service. Through the device of issuing social workers with honorary contracts for trust employment, they have been able to access our information services—our patient records on mental health—so that they can work as effectively as possible, as a team, with health staff. However, I am afraid that that is the only large-scale example where we have successfully been able to access joint information systems. It is something that always dogs healthcare and local authorities. On what ideas there are for better joint information systems in the future, I am afraid that I am not aware of any. It may be something that Informing Healthcare has been asked to look at, but I am not sure that it is. However, we have to find better ways of sharing information, because, so often, when we try to work out a joint initiative, we find that we are starting with a different understanding of the problem, which is clearly not helpful.

[249] **Lorraine Barrett:** Information sharing would also involve council staff at various levels, such as social workers and housing staff. Should it be done on a pan-Wales basis? Should some system be set up to help you across Wales or is it for you, on a local level, to sort it out among yourselves?

[250] **Mr Ross:** Different trusts in Wales use different information systems and different local authorities have developed different information systems. I think that I am right in saying, Alison, that those systems do not necessarily talk to other local authorities' information systems and the same is true in health. So, we are not starting from a very good place, really. It may be that an all-Wales approach, which is what Informing Healthcare is gradually trying to do for health, is the way forward. I do not know.

[251] **Lorraine Barrett:** The Cardiff and Vale NHS Trust, of course, has two local authorities to work with and to share information with.

[252] **Ms Harris:** As technology improves, one issue that Informing Healthcare is looking at is how you can make existing systems talk to each other. I think that much more progress is

being made on that. Some of the issues are around security and the sharing of data. There are some very good pilot schemes in Informing Healthcare that have been tested as a result of patients' willingness to share data across systems. We just need to build on those areas and things like the unified assessment process.

[253] Also, I am all for nicking other people's good ideas. Where something is working in other places, where they have health and social care working very closely together and they are using the same patient database, they have obviously cracked that problem about sharing information and the level at which you might need to access someone's medical history, which may not be relevant. We have been down to look at Swindon Primary Care Trust where the chief executive of the primary care trust is also the director of social services. They have put the teams together and they use one patient client record. In a sense, that is the way that we need to be going, but we just need to find the right pathway to get there.

[254] There are some practical issues that do not require very snazzy IT solutions. Ann talked about yellow folders. The chief executive from the care trust in Torbay came to talk to the NHS confederation a few weeks ago and it is very simple idea. The yellow folder is in someone's home and it just records all the different components of the care package and who has been in. However, it is connected through to things like the ambulance system, so that ambulances know which house to go to and which person has a yellow folder; if they go to pick somebody up who requires an emergency admission, the yellow folder goes too. The hospital will then know what has been happening for that individual and what their care package has been.

[255] **Ms Ward:** I do not think that technology is an insurmountable problem. I am coming at this from a different angle. I am the lead chief executive of the south-east Wales regional board of 10 local authorities and we have been looking at a shared-services project. We have been looking at something called Tools on Top; you can all have different systems for payroll and human resources and so on, but it does not really matter, because you can have a technology system that sits on top, allowing everybody to talk to each other. I do not think that technology is the issue; the issue, as Hugh says, is around the kind of culture that says, 'We cannot share our records; we are not allowed to do so'. Is there not something about being given permission to do that? We have done it with the police and things like protecting communities from paedophiles; we have an information-sharing protocol that works. It could not be more sensitive than that, yet we manage to share the information in that situation. So, there must be ways around it. It does need some guidance from above—I think that that would be very helpful.

[256] **Eleanor Burnham:** Briefly—

[257] **David Melding:** We are out of time, Eleanor, unless it is hugely material and I will rule it out of order if it is not.

[258] **Eleanor Burnham:** I was very interested in Alison Ward's mention of positive targets. Do you feel that, in your particular mode of working, with a holistic approach and perhaps sharing budgets, a greater emphasis should be put on education in preventative measures to enhance wellbeing and to keep people better, instead of the current position of looking at a sickness service, which we are all part of?

[259] **David Melding:** Happily, it is relevant.

[260] **Eleanor Burnham:** Thank you, Chair. [*Laughter*.]

[261] **Mr Ross:** May I give you a very simple example, Chair? We run something called the Sloppy Slipper campaign in our trust. Our community staff are alert to any elderly people

whom they visit whose standard domestic footwear is likely to cause them to fall or trip, because it has holes in it or it is shabby or whatever. We issue people with new pairs of slippers. We can demonstrate that that has made people who are susceptible to falls and so on less susceptible to them. You cannot get much of a simpler or cheaper idea, which is why it won a quality award under the chairman's scheme. So, you can do some simple, practical things.

[262] **David Melding:** I am sure that no-one disagrees that, if we are trying to prevent admissions, we want training and targets that concentrate on that part of the patient pathway.

[263] I would encourage a brief response to the final question, which you will have heard me put to Ann Lloyd. It is really about pooled budgets, flexible working and all the rest of it. There is a sense that, if you do not have the shared vision to start with, it does not really matter what wheezes we come up with; it will not be embedded in our culture. I would like your views on that. Also, is there any profit in going down some sort of route of fining, in essence, organisations that are seen not to be moving quickly enough? Shall we start with Alison on this one?

[264] **Ms Ward:** I think that you are absolutely right that shared vision is key. If you do not have that shared vision at the top, and there is not leadership at the top, then people will pay lip service to whatever you put in place. As I said, the three days that I spent with the other chief executives was incredibly useful to me in terms of setting the vision and in saying, 'We will all sign up to this; we will all go back to our boards or cabinets and we will table a report saying that we will deliver on what we have promised each other'. That is really important.

[265] In terms of fines, I just think that that money could be better spent on patient care.

[266] **Ms Harris:** Yesterday, I attended a day involving English colleagues, and I asked whether it really had an impact. The sense that I got was that, although it might have been a bit of a shock to the system, the number of instances involving fines was very small, and it was negative in terms of the damage that it did to some of the relationships. There is a sense here that we know that it is a common problem; it probably would not add much. We need to find the right kind of incentives to ensure that everyone is playing his or her part in this and that we are not allowed to walk away from the table when the going gets tough in terms of getting through the really difficult issues of culture and financial pressures. This goes back to the point about strategic leadership—we have to do this together as leaders of our health and social care community.

[267] **David Melding:** Hugh, do you want to play hard cop?

[268] **Mr Ross:** I can talk about my personal experience, Chair, in a large English city. I was chief executive of a trust with a significant delayed transfer of care problem when the fine system was introduced, and it immediately rocketed to the top of the joint agenda. It was not necessary to levy any fines thereafter, because people made sure that it was a joint priority. As a last resort, in some cases, it may be necessary to pull that lever, but I would like to think that it would not be necessary.

[269] **David Melding:** Thank you. That concludes our evidence gathering session. I am grateful to you all for taking time to come here and for speaking so candidly and openly about these difficult issues. I hope that you found it to be a rigorous but not intimidating process. We are grateful—thank you.

4.09 p.m.

Cofnodion y Cyfarfod Blaenorol
Minutes of the Previous Meeting

[270] **David Melding:** Do Members agree the minutes of the previous meeting? I see that you do.

Cadarnhawyd cofnodion y cyfarfod blaenorol.
The minutes of the previous meeting were ratified.

Cynnig Trefniadol
Procedural Motion

[271] **David Melding:** I propose that

the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order No. 10.37(vi).

Derbyniwyd y cynnig.
Motion carried.

Daeth rhan gyhoeddus y cyfarfod i ben am 4.09 p.m.
The public part of the meeting ended at 4.09 p.m.

Atodiad B

Llywodraeth Cynulliad Cymru
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Eich cyf / Your ref:
Ein cyf / Our ref: AJL/ CO

20th December 2007

Dear Kathryn

FURTHER INFORMATION RESULTING FROM ASSEMBLY AUDIT COMMITTEE EVIDENCE SESSION, 22nd November 2007 – WAO Review of Delayed Transfers of Care in Cardiff and the Vale, Gwent and Carmarthenshire.

Further to the Committee's session on 22nd November, I undertook to write to you with further information on a number of aspects/issues.

I undertook to look into issues around the implementation of the Unified Assessment Process (UAP) in Gwent in response to questions from Chris Franks AM.

The detail of the situation is described in the annex. This includes an analysis of progress to date and future plans for the further implementation of UAP.

It is clear that much concerted action has already taken place across the various agencies including putting in place strategic co-ordination arrangements; the development of documentation; training of staff; communication processes; information sharing processes, information technology solutions; and the spreading of good practice.

However, the agencies involved are determinedly pressing on with progress and future actions will continue to progress the issues identified above. In addition to these, work will take place to ensure that UAP is integrated with other care planning processes. Action will also take place to produce information explaining UAP to the general public.

Therefore it is apparent that UAP is being taken seriously in Gwent with significant evident commitment to taking it forward. However, there is still much further to go and as mentioned during the Audit Committee session, the Welsh Assembly

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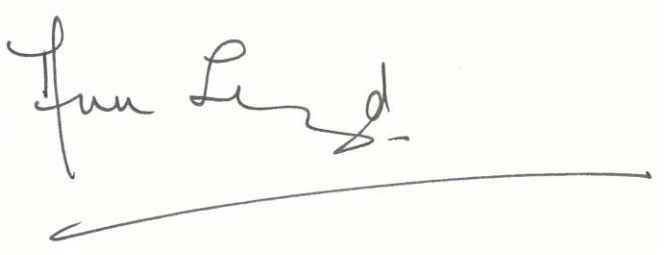
Government will be further supporting progress through the implementation of Fulfilled Lives, Supportive Communities and the work of the National Leadership and Innovation Agency for Health and Informing Healthcare."

I am copying this letter to the Auditor General for Wales and the Corporate Governance Unit.

Yours sincerely



Mrs ANN LLOYD
Head, Department for Health & Social Services
Chief Executive, NHS Wales
Pennaeth, Adran Iechyd a Gwasanaethau Cymdeithasol
Prif Weithredwraig, GIG Cymru

Briefing Paper : Unified Assessment Progress – pan Gwent

The introduction of Unified Assessment (UACM) across the pan Gwent area commenced in 2003, with the establishment of 5 local implementation groups across each of the Unitary Authority areas, with multi agency representation, including some voluntary bodies. To promote partnership working and offer a standardised approach across the area, the pan Gwent Co-ordinating Group was set up. It took a strategic lead to implementation, introducing a framework of documentation and training that the local groups then implemented.

Progress to date:

- Adoption of UACM as the standard method of assessment across all agencies. Some of the teams within the agencies are at different stages of implementation and integration. Continued support is given by the pan Gwent Co-ordinator to ensure ongoing implementation.
- Development of a pan Gwent framework document, that replaces previously used assessment documentation in all partner agencies, incorporating the requirements for Mental Capacity, IMCA, Advance Directives, Patient Equality Monitoring, Nursing Needs Decision Record and Continuing Health Care.
- Integration of the UACM process into the admission / treatment record of the Trust.
- Integration of UACM domain based approach into the nursing assessment.
- Multi agency training planned centrally, but delivered locally. Sessions are ongoing to ensure continuity and continued implementation.
- Development of:
    - UACM newsletter
    - Practitioner UACM handbook
    - UACM handbook for paid direct care staff.
- Pan Gwent UACM template for WASPI, for Tiers 2 and 3 of the guidance, to produce an overall pan Gwent arrangement on the sharing of personal information.
- Development of web based systems within the Local Authority Consortia: SWIFT in Caerphilly, Monmouth and Newport, DRAIG in Blaenau Gwent and Torfaen.
- Presentation and paper to an All Wales Stakeholder meeting, highlighting partnership working within Gwent.
- Presentation at a workshop for NLIAH, highlighting the collaborative work in Gwent.
- Poster presentation for NLIAH conference on partnership working.

Future Plans:

- Integrating UACM with all developing care pathways and Long Term Conditions Work.
- To further improve how and when we share assessment information between agencies.
- To work with provider organisations on the sharing of information within the WASPI framework.
- Local projects on: care co-ordination, access to partners IT system, outcome based multi disciplinary care plans.
- Development of UACM pages on all partner agencies Intranet and Internet sites.
- Completion of a UACM handbook for the general public.
- To work with IHC within the Trust to ensure UACM functionality.
- To develop Telecare projects, integrated with UACM.
- To integrate UACM into the Map of Medicine process where appropriate.
- To integrate the UACM concept and process within the Clinical Futures Programme.
- To ensure UACM is recognised in all the organisations activities.