RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL
MUNICIPAL YEAR 2019/20

HEALTH & WELLBEING SCRUTINY COMMITTEE **7TH JANUARY 2020** **REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES**	**Agenda Item No: 4** **DELAYED TRANSFERS OF CARE**

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1. PURPOSE OF THE REPORT

1.1. This report has been prepared to update the Health and Wellbeing Scrutiny Committee on the performance of Delayed Transfers of Care (DTOC) in Rhondda Cynon Taf. This report also draws Scrutiny Committee's attention to the plans in place across health and social care for the winter pressures period to ensure continued focus on managing DTOC.

2. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Scrutiny Committee:

2.1. scrutinise and comment on the information provided

2.2. consider whether there is any further information or matters contained in the report that the it wishes to receive and scrutinise in greater depth

3. REASONS FOR RECOMMENDATIONS

3.1. To provide the Health and Wellbeing Scrutiny Committee with an opportunity to examine the performance of DTOC and the plans in place to support the increased pressures placed on health and social care during the winter period.

4. BACKGROUND

4.1. As part of the Health and Wellbeing Scrutiny Committee work programme it is agreed that Committee receive regular updates on DTOC performance in Rhondda Cynon Taf.

4.2. A DTOC is defined as being experienced by an inpatient occupying a bed in an NHS hospital, who is ready to move on to their next stage of care usually in their own home or in a residential or nursing care in the community, but cannot be discharged from the hospital environment for one or more reasons. This can also be called bed blocking.

4.3. No-one wants to remain in hospital for any longer than they need to and after a stay in hospital, most patients need little or no onward care and are discharged timely. However, discharge planning for people often older people with complex support needs will, quite rightly, take longer and involves a multi-disciplinary response from both health and social care working alongside the person to achieve the ultimate goal for that person - going home. Therefore, tackling DTOC is an important task.

5. DTOC PERFORMANCE

5.1. The Social Services and Wellbeing (Wales) Act 2014 introduced a new performance measurement framework for local authorities in relation to their social services functions. As a result, new performance information requirements were introduced from 2016/17 and local authorities are required to collect a number of performance measures detailed in the Code of Practice in relation to social services performance issued under the Act, which includes "the rate of delayed transfers of care for social care reasons per 1,000 population aged 75 or over".

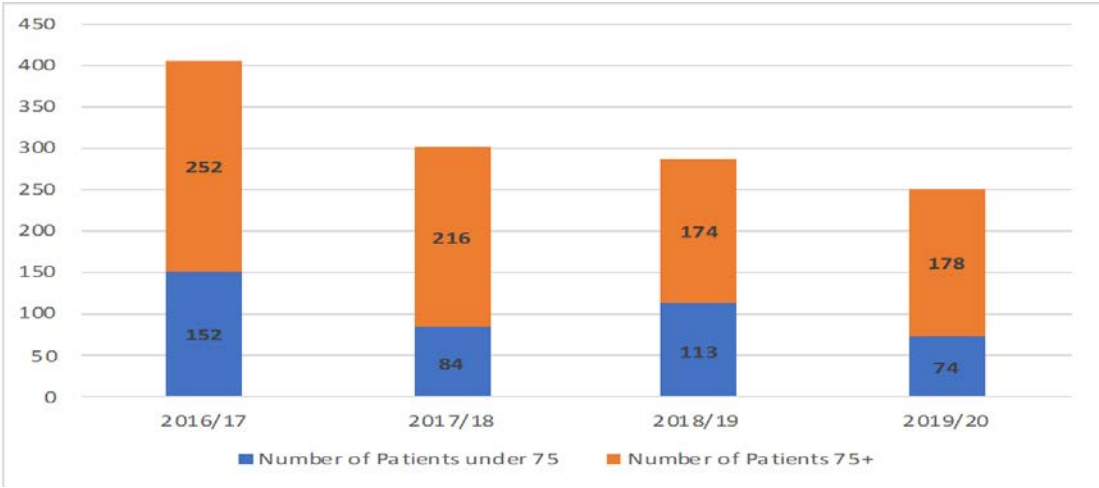
5.2. The table below shows Rhondda Cynon Taf and Wales average data for the national performance measure compared annually back to 2016/17.

	2016/17		2017/18		2018/19		2019/20 (Qtr 2)	
Performance Measure	**Wales**	**RCT**	**Wales**	**RCT**	**Wales**	**RCT**	**Wales**	**RCT**
The rate of delayed transfers of care for social care reasons per 1,000 population aged 75+	2.8	4.95	3.48	1.88	4.9	3.43	TBD	3.48

5.3. Whilst the rate of delayed transfers of care for social care reasons (per 1,000 population aged 75 or over) is increasing and mirroring the overall trend across Wales there has been an overall reduction in the number of delays since 2016/17 in Rhondda Cynon Taf.

5.4. Over the 3 years, from 2016/17 to 2018/19, Rhondda Cynon Taf has seen a steady decline in the number of people experiencing DTOC. The number of patients experiencing a delay has fluctuated, but overall there has been a 29% reduction. However, based on current performance, we are experiencing an increase in the number of delays in 2019/20, in line with the national trend, and in particular patients aged 75 and over.

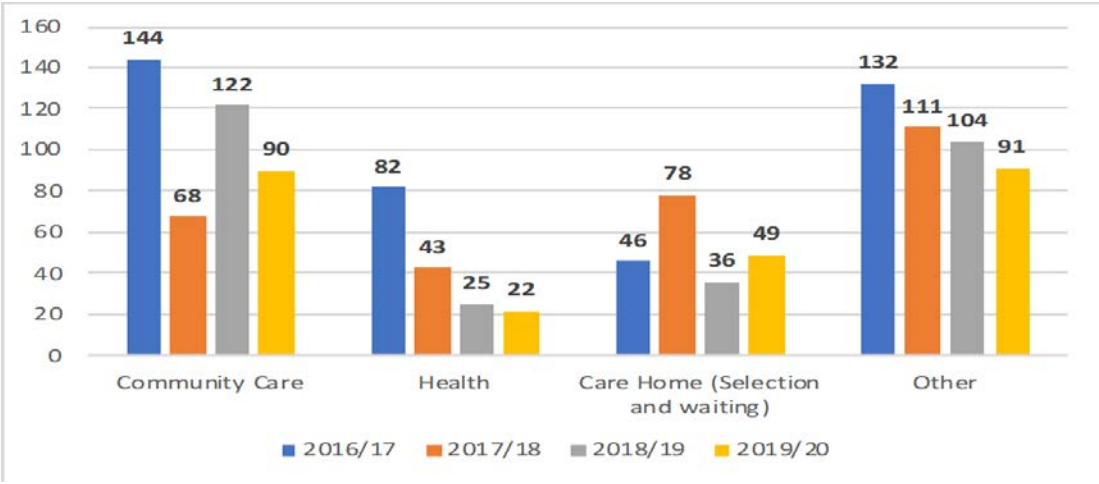
5.5. The graph below shows the total number of patients delayed between 2016/17 and 2019/20 (up to November 2019).



5.6. The reasons for a patient being a DTOC are varied and complex with over 120 different codes to classify them, although they can be summarised under the following broad headings:

- Community Care - which relates to social care assessment and care arrangements including housing, adaptations and equipment, and domiciliary care
- Health - like community care these would include reasons relating to assessment and care arrangements, including mental health
- Care Home - which includes care home placement choice and selection availability
- Other - which includes for example adult protection, mental capacity, disagreements, legal and financial related issues.

5.7. The graph below shows that the reduction over the 3 years from 2016/17 to 2018/19 was across all delay categories. However, as previously mentioned we are experiencing an increase in the number of delays in 2019/20 for health reasons and in relation to the selection of and waiting for a care home.



5.8. The causes of a DTOC are complex and many. However, we know from our analysis that patients have become more frail and require greater support on

discharge. The main reasons for the delays, in particular those being experienced in 2019/20, are summarised below:

- There continues to be high demand for home care as we successfully support people with more complex care packages to live at home rather than in a care home. This continues to put pressure on supply and capacity in some areas of the County Borough at “peak call” times. Providers continue to recruit staff in these areas, although this is being managed across care providers, through the Brokerage Team, to minimise impact on delays awaiting commencement of care packages. We continue to actively support and work with care providers to build capacity and resilience of the domiciliary care market. Support is provided by the local authority in-house Support @Home Service as a short term measure where there is a lack of capacity in the independent sector.

- There is reducing capacity across dementia care homes, in particular nursing care capacity i.e. those people with the most complex needs, which is adding pressure onto residential placements which require transfer to nursing. To reduce this risk, we have developed in partnership with Health the Specialist Dementia Team to support people with dementia and behaviours that challenge, and it provides training and support plans for staff. Capacity of the Team has been increased to meet an increase in demand for the services provided.

- Demand for assessment remains high. We continue to prioritise hospital discharges and we have used additional funding to increase social work support to both reduce the number of admissions to hospital and create some additional capacity to respond to hospital patients and reduce length of stay in hospitals and minimise delays in a person’s discharge from hospital.

- There is a growing number of cases that require referral to the Court of Protection (COP) to confirm ongoing care arrangements, in particular placement into a care home when the person is firmly stating they want to return home. Legal advice regarding our practice for referrals to the COP, confirms our actions are according to the Law; although this is causing delays for some patients.

- There is also an increase in demand for housing and housing related support, with a particular increase in demand for specialist and adapted housing. Work is being done to improve the supply of adapted housing with Housing Strategy and Housing Providers and ensure early identification of complex needs to ensure bespoke adaptations can be prioritised as early as possible to prevent delayed discharge. In addition, some people who are admitted to hospital when of no fixed abode are appropriately prioritised in the highest band but encountering delays when bidding via the choice based letting system as they wish to live in very high demand areas. We are working with Housing Strategy to review the process for these people to improve timely access to housing via the general needs register.

6. WINTER PRESSURES

Annual Winter Pressures and Preparedness Plan

6.1. Cwm Taf Morgannwg University Health Board (CTMUHB) is required to prepare and publish an annual Winter Pressures and Preparedness Plan in partnership with its local authority partners and the Welsh Ambulance Service Trust.

6.2. The plan predominantly focuses on the contingency plans that CTMUHB have in place to deal with periods of increased demand and inclement weather to ensure that they continue to deliver services during these periods. Locally the winter plan will be monitored via monthly planned joint Winter Pressures Meetings. However, during periods of increased demand the frequency of these meetings will increase.

6.3. Rhondda Cynon Taf's contribution to the plan focuses on the existing arrangements that support the hospital discharge process; primarily Stay Well @Home (SW@H).

6.4. As the Scrutiny Committee will be aware, Rhondda Cynon Taf, in partnership with Merthyr Tydfil and CTMUHB, have developed a multi-disciplinary team, SW@H based on the two acute hospital sites of Royal Glamorgan and Prince Charles. SW@H are primarily based at A&E but also support discharges from the Acute Medical Unit and Clinical Decision Unit, additionally supporting all wards as capacity dictates.

6.5. SW@H complements the existing discharge services already in place (e.g. the Health and Social Care Discharge Coordinators, the Psychiatric Liaison Service and Discharge Liaison Service and services provided by the Third Sector including Age Connects Morgannwg and Cwm Taf Care and Repair).

6.6. SW@H undertake a proportionate assessment and commission appropriate community services to support discharge home with the aim of supporting the individual at A&E to safely return home and avoid any unnecessary hospital admissions. They can commission a range of community responses such as Nursing @Home including the IV service and social care community package of support within 4 hours, 7 days a week. To support these arrangements the capacity of community services have been enhanced and access arrangements and eligibility criteria have been revised.

6.7. Rhondda Cynon Taf's domiciliary care Support @Home Service also supports discharge and hospital avoidance through:

- Providing a 4 hour response to referrals from the SW@H hospital based team and community professionals 7 days a week
- Providing Intermediate Care and Reablement Services including a duty Occupational Therapist response
- Community equipment out of hours
- Additional community based social workers

6.8. Health and Social Care Discharge Coordinators based at both the acute and community hospital sites support more complex discharges - supported by additional social worker capacity at the two community hospitals. The social workers attend multidisciplinary meetings, patient flow meetings and support timely discharges home.

6.9. SW@H continues to demonstrate measurable improvement on individual outcomes through enhanced communication and integration of health and social care services at the critical interface that occurs during presentation at A&E and hospital admission through to discharge. A copy of the SW@H evaluation highlight report for 2018/19 is attached as Appendix 1 for members perusal.

6.10. Further development of SW@H is planned for later in 2019/20 with the planned role out of phase 2 from January 2020, as part of the Welsh Government's Transformation Fund announced in the Summer.

6.11. SW@H phase 2 aims to further support hospital avoidance - Rhondda Cynon Taf (and Merthyr Tydfil) will extend the Single Point of Access opening hours from 8.30am to 5.00pm (5 days a week) to 8.30am to 8.00pm (7days per week), including bank holidays.

6.12. Access to services such as CTMUHB @home nursing, local authority commissioned enabling services and community equipment, will be provided to community professionals such as GP, GP out of hours, Welsh Ambulance Service Trust, District Nurses and Social Care Emergency Duty Teams to provide services as an alternative to avoid conveyance to hospital.

6.13. The Transformation Fund is also supporting Rhondda Cynon Taf to develop a new model for Assistive Technology to be implemented from January 2020, which will include:

- a 24 hour mobile response service to support people in their own homes by responding to non-medical emergencies such as falls, supporting hospital avoidance and reducing conveyances to hospital

- as proof of concept a proactive outbound calling system to support those at risk in the community and to prevent crisis response.

Additional Winter Pressures Funding

6.14. In September 2019, in recognition of the ongoing challenges across the health and social care system, the Minister for Health and Social Services agreed a package of £30 million to support delivery of health and social care services over the remainder of 2019/20, with a particular focus on winter. Of which,

- £17 million has been allocated to Regional Partnership Boards (RPB) to administer and should promote integrated, regional planning across health and social care services, through joint decision making and formal agreement via RPBs.

For Cwm Taf Morgannwg RPB, the allocation amounts to £2.7 millon, allocated per organisation to focus on community based solutions as follows:

Bridgend	£850,000
Merthyr Tydfil	£330,500
Rhondda Cynon Taf	£1,300,000
CTMUHB (community wide)	£270,000

- £10 million has been made directly available to local health boards to support immediate action and support delivery of integrated winter delivery plans, alongside the ambulance service, local authority and third sector partners.

  For CTMUMB, the allocation amounts to £1.6 million.

- £3 million has been retained centrally by Welsh Government to target funding for nationally agreed priorities.

6.15. This funding is being made available earlier than ever before and reflects the unrelenting pressure being experienced by services across the whole system. Welsh Government have been clear that this funding must be used to target action against the following key themes identified for winter, or related action to support improved flow through the health and social care system that will optimise patient experience and outcomes:

- Optimising cross organisational and sector working
- Urgent primary care out of hours resilience
- Preventing unnecessary conveyance and admission to hospital
- Discharge to assess/ recover (D2AR)
- Community step down capacity
- An enhanced focus on the respiratory pathway
- An enhanced focus on frailty pathway

6.16. These themes are focused on enabling at-risk and vulnerable populations to remain at home or in their community through integrated action and promoting flow through the system to enable people to leave hospital when they are ready to do so, with any ongoing care or support they require in place. Delivery of these actions should strengthen resilience for the winter period.

6.17. In terms of Rhondda Cynon Taf, it has been agreed that the additional £1,300,000 funding allocated through the RPB be used to facilitate hospital discharge and prevent admission and provide additional:

- interim placements
- intermediate care and reablement capacity
- domiciliary care capacity

- social work assessment capacity at the hospital interface
- community occupational therapist capacity

6.18. The CTMUHB will also provide additional district nurse, GP out of hours and mental health practitioner capacity from its RPB allocation.

7. EQUALITY AND DIVERSITY IMPLICATIONS

7.1. This is an information report - there are no equality and diversity implications associated with this report.

8. CONSULTATION

8.1. This is an information report - there is no consultation required for this report.

9. FINANCIAL IMPLICATION(S)

9.1. This is an information report - there are no financial implications aligned to this report.

10. LEGAL IMPLICATIONS OR LEGISLATION CONSIDERED

10.1. This is an information report – none at present

11. LINKS TO THE CORPORATE AND NATIONAL PRIORITIES AND THE WELLBEING OF FUTURE GENERATIONS ACT

11.1. This report supports two of the Council's corporate priorities, namely:

- People - promoting independence and positive lives for everyone
- Living within our means - where services are delivered efficiently to achieve value for money for the taxpayer

12. CONCLUSION

12.1. This report aims to update Scrutiny Committee on DTOC performance and the plans in place to support the increased pressures placed on health and social care during the winter period.

Stay Well @ Home Team - Highlight RBA report: 2018/2019

	2018/2019	Compared to 2017/2018
Total Number of referrals	3005	13%
Total number of assessments completed	1870 (62%)	8%
Number of referrals responded to in less than 1 hour	1532 (82%)	3%
Number of those discharged home	1435 (77%)	6%
Number of those discharged home in less than 24 hours following assessment by SW@HT	1212 84%	5%
Number of social care packages of support	738 (51%)	8%
Support@ Home	664 (46%)	7% ↑
Initial Response	74 (5%)	1% ↑
Number of referrals to Nursing @ Home (4Hr response)	12 (1%)	
Number of @Home referrals	132 (9%)	119
Number of referrals to YMS@H	51 (4%)	No comparable 12 month data
Total Number of community based services commissioned to support discharge	2610	2501
Number of unmet needs captured	311	352
Service User experience - (Voting Button & Survey comments)	98% ☺	No comparable 12 month data