RHONDDA CYNON TAF COUNTY BOROUGH COUNCIL
MUNICIPAL YEAR 2022/23

COMMUNITY SERVICES SCRUTINY COMMITTEE **28TH NOVEMBER 2022** **REPORT OF THE GROUP DIRECTOR, COMMUNITY & CHILDREN'S SERVICES**	**Agenda Item No. 6** **HOSPITAL DISCHARGE PRESSURES**

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1. PURPOSE OF THE REPORT

1.1 This report has been prepared to provide the Community Services Scrutiny Committee with an update on the pressures across the Health and Social Care system and the impact on hospital discharges and the actions that are being taken.

2. RECOMMENDATIONS

It is recommended that the Community Services Scrutiny Committee:

2.1 Note the content of this report.

2.2 Consider whether they wish to scrutinise in greater depth any matters contained in the report.

3. REASONS FOR RECOMMENDATIONS

3.1 To provide the Community Services Scrutiny Committee with an opportunity to examine Adult Social Care's response to the hospital discharges pressures across Health and Social Care system in Rhondda Cynon Taf.

4. BACKGROUND

4.1 There is a clear interdependency between Adult Social Care in Rhondda Cynon Taf and Cwm Taf Morgannwg University Health Board in supporting people who have been in hospital to return safely to their usual place of residence or to the next stage of their care. In addition, in Adult Social

Care, we support people to remain at home rather than be admitted to hospital as a result of changes to the support people require.

4.2 Capacity within the hospital system in Health is dependent on the ability to continuously move people through the various stages of care and back to the community in order to maintain capacity for new admissions. This process is referred to as patient flow.

4.3 Prior to the pandemic, Adult Social Care's ability to place people in care homes was generally good, except for previously reported limited availability of nursing dementia placements in Rhondda Cynon Taf. In addition, whilst we experienced some periods of reduced capacity in some areas in Rhondda Cynon Taf, we were able to support people to return home on a timely basis through the provision of domiciliary care packages, where needed.

4.4 The pandemic initially resulted in high numbers of people requiring admission to hospital because they were experiencing significant symptoms associated with Covid. Over time the numbers of people requiring hospitalisation because of symptoms of Covid have decreased due to the success of the vaccination program. Whilst admissions of people with symptoms of Covid have lessened, the pressure on the hospital system has not eased.

4.5 Each year, we see increased pressures across the Health and Social Care system through the winter months and whilst we have established processes in place to manage these, we are now experiencing these pressures throughout the year.

4.6 Since the pandemic, there has been a reduction in capacity in both the care home and domiciliary care sector, primarily due to increased demand and workforce issues, which has affected our ability to support people who require care and support as part of their discharge plans, as quickly as we would like. This ultimately affects hospitals to maintain flow as people cannot be discharged and remain in hospital.

4.7 The pressures in the domiciliary care sector are significant and, at the time of writing this report, the numbers of people waiting for a package of care is 48, (as of 18th November 2022). During the year, we have worked proactively with our providers to reduce the waiting list and it is now significantly less than the 82 people waiting for a package of care on 1st April 2022.

4.8 Information currently collected by Adult Social Care shows that there are 23 people in hospital allocated for a social care assessment of their care and support needs on discharge and 69 people ready to leave awaiting a package of care or care home placement.

4.9 The ability to discharge people directly affects the hospital's ability to admit new patients and Members will have seen media reports of ambulances not being able to respond as they are outside hospitals waiting for beds to become available for them to be admitted.

4.10 The pressures that are being experienced are not wholly due to capacity within Social Care, there has also been an increase in the number of people presenting at hospital. This current challenging position across the Health and Social Care system is being experienced across Wales and is not unique to Cwm Taf Morgannwg University Health Board and the local authorities in this region.

5. DELAYED TRANSFERS OF CARE

5.1 Delayed transfers of care (DToC) have been a high profile priority for Health and Social Services for some time.

5.2 A patient becomes a DToC when they are ready to move on to the next stage of care but is prevented from doing so for one or more reasons. After a stay in hospital, most patients need little or no onward care. Delayed transfers are usually associated with complex cases where patients need a care package or move to a different care setting such as a care home. These patients are more likely to be older, vulnerable people.

5.3 DToC monthly data reporting was suspended by Welsh Government at the start of the pandemic to help ease pressures on Health resources. The previously reported monthly DToC data, verified by Health and Social Care, provided a helpful insight over time into the way the Health and Social Care system was functioning in this area. As a result of this decision, no verified reporting system has been in place since the start of pandemic in the Cwm Taf Morgannwg region.

5.4 Recognising the importance of this data collection in helping to ensure efficient patient flow, Welsh Government has recently requested to reinstate this reporting. As a result, work has been undertaken by Heath and Social Care, in collaboration with Welsh Government, to develop a new reporting system, called “Pathways of Care Delays”.

5.5 The new framework is not intended to reinstate the former DToC reporting but instead implement a refreshed system that incorporates a range of improvements and new measures that form a standardised system that provides comparable data. This in turn will provide reliable consistent information aligned with the Six Goals for Urgent and Emergency Care Programme in order to address delays.

5.6 The new framework is being implemented in a three phase approach. The first phase, which was completed in September 2022, was piloted in three Health Boards – Cardiff and Vale, Hywel Dda and Betsi Cadwaladr. The feedback and testing of the new system has informed changes ready for the introduction of the second phase.

5.7 The second phase of implementation involves extension of the pilot on an all Wales basis from 1st November 2022 to 31st January 2023. This phase will provide a full data set and overview across Wales, to allow for any final

adjustments before formal implementation for public reporting, post January 2023.

5.8 A copy of attached "Pathways of Care Delays" reporting system is attached as Appendix 1.

6. SUMMARY OF REGIONAL ACTIONS

Six Goals for Urgent and Emergency Care Programme

6.1 In July 2021, Welsh Government launched its Six Goals for Urgent and Emergency Care Programme, which sets out its expectations for health, social care, independent and third sector partners for the delivery of the right care, in the right place, first time. A copy of the Six Goals Policy handbook is attached at Appendix 2 of this report, for Members perusal.

6.2 The Six Goals for Urgent and Emergency Care Programme are:

1. Coordination, planning and support for people at greater risk of needing urgent or emergency care
2. Signposting to the right place, first time
3. Access to clinically safe alternatives to hospital admission
4. Rapid response in a physical or mental health crisis
5. Optimal hospital care following admission
6. Home-first approach and reduce risk of readmission

6.3 The following four work streams in the Cwm Taf Morgannwg region have been set up to implement the Six Goals Programme with varied implementation timescales, though not all will be implemented in time to achieve significant reduction in demand in time for the anticipated winter pressures:

- Avoiding admission
- Integrated front door
- Effective hospital care
- Discharge to Recover then Assess

6.4 Further reports will be presented to Scrutiny to report and monitor the implementation progress of the Six Goals Programme of work.

Discharge to Recover then Assess

6.5 Discharge to Recover then Assess (D2RA) supports people to leave hospital at the right time, continuing their care, recovery, and assessment for any long term needs in the right place.

6.6 There are four pathways of support through D2RA as follows:

- **Pathway 0 – Simple Discharge**

The patients' needs have not changed, and they can return home with the support they had previously, which will include a package of care, community nursing or care home.

- **Pathway 1 – Supported Home**

  The patient returns home with new or additional support from Health and/or Social Care to be assessed in their own environment to inform any long term needs.

- **Pathway 2 – 24/7 Short term recovery**

  The patient is not safe to return home overnight or in between care calls, so transfers to a short term facility (community hospital or care home) for rehabilitation and recovery before they go home on Pathway 1.

- **Pathway 3 – Complex Assessment**

  The patient has complex health and care needs and is transferred to a bedded facility (community hospital or care home) to conduct an in-depth integrated assessment and inform the on-going plan.

6.7 Under D2RA assessments for longer term care and support needs should take place after patients have had a period of recovery (not in hospital). These assessments should be based around the patient's level of function, environment and care needs to ensure they remain as independent as possible for as long as possible.

6.8 Most of our current hospital discharge arrangements for long term care work on an assess to discharge model and flipping this around does require some significant changes across the Health and Social Care system. Research shows that for D2RA to effectively work, Health and Social Care need to provide a combined set of services (known as intermediate care) in the community (including bedded facilities) into which people can be placed to support their recovery. The use of community beds should be interim rather than permanent admission and is intended to support a return to independence and discharge home.

6.9 Implementation of D2RA across the Cwm Taf Morgannwg region is planned for 5th December 2022, and whilst we are working at pace, with the Health Board and the other local authorities in the region, to introduce the necessary infrastructure for the D2RA to be successfully implemented, there is still considerable work that needs to be completed before the planned go live date on 5th December 2022. This includes:

- all wards in acute hospital settings will operate an electronic white board that will support a focus on hospital discharge and assist ward staff, using technology, to prepare more effectively to support people home or to a more appropriate environment for convalescence. The Health Board are working to install the whiteboards and finalise the software to manage this process

- creation of a discharge hub for Cwm Taf Morgannwg region that will act as the triage centre for all hospital discharge referrals from hospital wards across the region. Health Board Business Support staff will primarily triage the information from the ward, but social workers and discharge liaison nurses will be assigned to the hub to provide support until the process has settled

- a joint operational process for the Health and Social Care hospital discharge team across the region is under development to manage the support required for people needing Pathway 2 and 3 to continue to facilitate an effective flow of people through the hospital system, in particular the acute hospitals

- re-organising the work of our Adult Social Care hospital discharge team to ensure they respond flexibly to assess people in the hospitals, step down facilities and at home depending on the pattern of demand

- managing capacity in Council's in-house home care to ensure people discharged from hospital on Pathway 2 can access good quality home care pending assessment

- working with WCCIS to ensure the monitoring of a person's journey after discharge and along the Pathways is captured to continually improve the process.

6.10 Given the fluidity of the current situation, a further update will be provided to the Community Services Committee at its meeting on 28th November 2022.

Welsh Government Initiative: 1000 beds / additional community capacity

6.11 Traditionally the demand for Health and Social Care Services increases during the winter period. In response to this concern a Ministerial Group has been established to review what actions can be taken to relieve some of the pressures during the winter months. This Group is being supported by the NHS Delivery Unit who are working with the regions to identify local plans.

6.12 One of the key actions to mitigate against the increase in pressures is to increase the equivalent of a 1,000 beds or additional community capacity across Wales. This number is based on the number of patients reported by Health Boards, as discharge delays. This has been aggregated to each region and the anticipated extra capacity required for the Cwm Taf Morgannwg region is 188.

6.13 Our regional proposals to achieve the additional community capacity is summarised below:

- development of step-down "bridging" beds from hospital for those who require additional support to enable them to return home. This includes

the temporarily development of up to 10 step down beds at the Council's Parc Newydd Care Home in Talbot Green, as agreed by Cabinet in July 2022

- provision of additional "bridging" beds on the Health Board hospital sites and additional capacity for early stroke rehabilitation beds

- block purchase of "bridging" beds by Health in independent care homes

- provision of additional reablement hours

6.14 It was anticipated that additional revenue funding would be available to support these developments however we have now been advised that no funding will be available, and any plans will need to be resourced from existing core funding.

7. EQUALITY AND DIVERSITY IMPLICATIONS / SOCIO-ECONOMIC DUTY

7.1 There are no equality and diversity or socio-economic implications arising directly from report.

8. WELSH LANGUAGE IMPLICATIONS

8.1 There are no Welsh Language implications arising directly from this report.

9. CONSULTATION / INVOLVEMENT

9.1 There are no consultation requirements arising directly from this report.

10. FINANCIAL IMPLICATION(S)

10.1 There are no financial implications arising directly from this report.

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11. LEGAL IMPLICATIONS OR LEGISLATION CONSIDERED

11.1 There are no legal implications arising directly from this report.

11.2 The Social Services and Wellbeing (Wales) Act 2014 and accompanying Part 4 Code of Practice sets out that where a local authority has carried out an assessment which has revealed that the person has needs for care and support then the local authority must decide if those needs meet the eligibility criteria, and if they do, it must meet those needs.

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

12.1 Supporting the discharge of someone from hospital links with the Council's priority: "Ensuring People are independent, healthy, and successful". It also allows the Council to meet the requirements of the Social Services and Wellbeing (Wales) Act 2014 and the Wellbeing of Future Generations (Wales) Act 2015, in that they meet the needs of the Council's residents, including an ageing population and those with more complex needs, are more sustainable and increase focus on wellbeing and independence, resulting in the wellbeing goals of a Wales of cohesive communities, and a healthier Wales being supported

13. CONCLUSION

13.1 Rhondda Cynon Taf, along with all other local authorities continues to face significant pressures across the Health and Social Care system. As we move into the busy winter months, Adult Social Care will be working together with Health and our commissioner providers to prevent people remaining in hospital longer than is necessary.