County Hall
Cardiff
CF10 4UW
Tel: (029) 2087 2000

Neuadd y Sir
Caerdydd
CF10 4UW
Ffôn: (029) 2087 2000

PAPURAU ATODOL

Pwyllgor	PWYLLGOR CRAFFU GWASANAETHAU OEDOLION A CHYMUNEDOL
Dyddiad ac amser y cyfarfod	DYDD MERCHER, 19 GORFFENNAF 2023, 4.30 PM
Lleoliad	YB 4, NEUADD Y SIR, CYFARFOD AML-LEOLIAD
Aelodaeth	Cynghorydd Taylor (Cadeirydd) YCynghorwyr Ahmed, Ahmed, Ash-Edwards, Boes, Lent, Lewis, Littlechild a/ac McGarry

Y papurau canlynol wedi'i farcio ' i ddilyn' ar yr agenda a ddosbarthwyd yn flaenorol

6 Rhyddhau Cleifion o'r Ysbyty yng Nghaerdydd ar gyfer y rhai sydd ag Anghenion Gofal*(Tudalennau 3 - 102)*
I ddod

Davina Fiore
Cyfarwyddwr Llywodraethu a Gwasanaethau Cyfreithiol
Dyddiadd: Dydd Iau, 13 Gorffennaf 2023
Cyswllt: Andrea Redmond, 02920 872434, a.redmond@caerdydd.gov.uk

Mae'r dudalen hon yn wag yn fwriadol

CYNGOR CAERDYDD
CARDIFF COUNCIL
COMMUNITY & ADULTS SERVICES SCRUTINY COMMITTEE

19 July 2023

HOSPITAL PATIENT DISCHARGE IN CARDIFF FOR THOSE WITH CARE NEEDS

Purpose of the Report

1. To provide background information to inform consideration of the hospital patient discharge process in Cardiff for those with care needs. Attendees are reminded, the examples and information provided in this Cover Report, is intended to provide an introductory based understanding on this topic.
   Due to the complexity and wide-ranging issues related to the topic, the information and examples provided in this Cover Report is not exhaustive.

2. Further, attendees are also advised to remain mindful that the information provided in this Cover Report relates to this issue on a Wales-wide basis. As such, information may not be applicable in the Cardiff context; a key purpose of the meeting will be for Members to explore the Cardiff context.

Structure of the Meeting

3. To inform the committee's considerations, the following individuals / organisations have been invited to attend the meeting to share their knowledge and perspectives of this issue in Cardiff:
   - Councillor Norma Mackie Cabinet Member, Adult Services
   - Jane Thomas, Director, Adults, Housing & Communities
   - Carolyne Palmer, Operational Manager, Independent Living Services
   - Lisa Wood, Operational Manager, Adult Community Services
   - Dawn Harries, Operational Manager, Local Community & Wellbeing

- Rebecca Knapp, Hospital Team Manager
- Diane Walker, Interim Head of Integrated Discharge Service
- Stephen Allen, Regional Director, Llais
- Demi Barnard, Cardiff IMHA Team, Advocacy Support Cymru

4. Due to the high number of individuals attending the meeting, the meeting will begin with each attendee introducing themselves. by providing their name and job title. Cllr Norma Mackie will then be offered the opportunity to make a brief opening statement (should they wish). After which, council officers will provide Members with the presentation, attached at **Appendix 1**. During the presentation there will be intermittent opportunities for group discussions.

5. All attendees are encouraged to participate and share their views and knowledge throughout the meeting's discussions. Attendees are encouraged to share examples and views of those they support, however are reminded, as the meeting is public, not to name any individuals' directly.

6. For the benefit of the meetings webcast, attendees are required to turn their microphone on before making a contribution and wait until their microphone shows a consistent red light prior to speaking.

Structure of the Papers

7. In addition to the background information set out in this Cover Report, attendees are also provided with the following appendices:

Appendix 1 – Presentation – providing an overview of this topic.
Attendees are advised the presentation will be delivered at the meeting and there will be sufficient breaks within the presentation for full group discussions.
Appendix 2 - Cardiff & Vale Discharge Policy Procedure
Appendix 3 – Anonymised survey undertaken by CRT workers in March 2023
Appendix 4 - Anonymised views of frontline care sector workers

Scope of Scrutiny

8. During the meeting, Committee Members will have the opportunity to explore:

- The hospital patient discharge process for those with care needs.
- Current context e.g., demand levels.
- The role of each stakeholder in the process toward facilitating safe, timely hospital discharge for those with care needs.
- The needs and views of those requiring support.
- What is working well.
- If there are any areas of improvement identified by the council, partners or individuals in receipt of support.
- The exact pressure points and how they are, or might be, best addressed.
- Partnership arrangements toward addressing this issue.
- The considerations for medium and long-term planning.

9. Attendees are reminded the purpose of this meeting is to explore and understand the hospital discharge process (for those with care needs). To identify what is working well, and any particular pressure points that may require development.

10. Following the meeting, Committee Members' will decide what comments, observations or recommendations they wish to pass on to the council's Cabinet Member to assist them in their work on facilitating safe and timely hospital patient discharge.

Strategic Background

11. The Welsh Government and NHS Wales have been developing ways to improve discharge planning since 'Passing the Baton' was first published in 2008**.**
The below bullet points provide attendees with a summary of recent Welsh Government, and the council's, strategic approach toward facilitating safe, effective hospital patient discharge.
As mentioned in point one of this Cover Report, the below information is not intended to be exhaustive.

- **The Social Services and Wellbeing (Wales) Act 2014**

  Fully implemented in April 2016, this is the main legislation covering the social care system in Wales, including:

  - The social care assessment process.
  - Related rules regarding arranging and paying for residential care homes or nursing care homes.
  - Related rules regarding arranging and paying for care at home and/or other non-residential services.
  - The guidance documents that local authorities must use when assessing needs; and
  - The guidance documents that local authorities must use when means testing people who may need to pay towards their services.

  In common with other legislation, there are Codes of Practice (CoP) which accompany the Social Services and Well-being (Wales) Act. The CoP guidance documents are backed by law, and aim to assist individuals, professionals, and organisations to work within and comply with the Act. The CoP in relation to this legislation are around:

  - General Functions
  - Assessing the needs of an individual
  - Meeting needs
  - Direct payments and choice of accommodation
  - Charging and financial assessment
  - Advocacy

- **Welsh Governments: 'A Healthier Wales: Our Plan for Health and Social Care' (AHW)**

  Published in June 2018, AHW sets out a long-term vision of a 'whole system approach to health and social care'. The vision outlines a shift from the reliance on traditional hospital services to a seamless approach of integrated care including health, local authority and third sector services.

To achieve the AHW actions, the Welsh Government offers funding streams, named, the Integrated Care Fund (ICF) and Transformation Fund (TF) to help explore new models of care[1].

As part of the AHW work, health, social care and third sector teams have been developing new partnerships and implementing new service models based on the principles of 'Home First' and 'Hospital to Home' (H2H). With the overall aim of reducing delays in transfers of care for people[2].

- **SAFER Patient Flow Guidance[3]**

  The Welsh Government issued this guidance in 2018. It is intended to provide an overarching good practice guide on improving patient flow. It is aimed at a range of agencies including health, social services, housing, wider statutory and third sector organisations.

  Some of the key principles included in this guidance are:

  - The focus should be on preventing the need for hospitalization.
  - Strong, effective partnership working is key.
  - Planning a prompt discharge should begin on admission, wherever possible, and involve everyone – the individual, their family (if requested/needed) and health and social care professionals.
  - The collective aim should be to optimise people's outcomes and enable as many people as possible to live their lives independently at home.

[1] These funds have recently been amalgamated – further information is provided in points 23-26 of this Cover Report.

[2] It is worth noting that service models in Wales have recovery and rehabilitation pathways that care for all types of patients, not just focusing on elderly patient care.

[3] 30263_SAFER_Patient_flow_Guidance_English_WEB.293426c11a0f200b3dd5881b2d8a7ca58150ddb774b766b860e7b84dfa5697ae (1).pdf Accessed, 4th July 2023

- **Discharge to Recover then Assess (D2RA) projects in Wales[4].**

  In 2018 the Health Inspectorate Wales found generally, Health Boards had the correct policies in place regarding discharge. However, there was a lack of awareness and understanding of the discharge processes amongst ward staff. This was corroborated by findings of the (then named) Wales Audit Office, who found that only a third of Welsh NHS bodies recorded the date a patient was declared medically fit for discharge.

  The findings of these reviews were then applied in the context of the Welsh Government's existing work on H2H and the in-place NHS England, 'Discharge to Assess' (D2A) model. As a result, in 2018, the Welsh 'Discharge to Recover then Assess' (D2RA) model was developed[5].

  The principles of D2RA are on achieving the best outcomes for people, whilst at the same time, making the most efficient and effective use of scarce resource.

  The overarching principles of D2RA are:

  - Think 'Home First' and keep the individual at the center of all discharge considerations.
  - Balance risk and agree co-produced, clearly documented plans.
  - Have the community services infrastructure in place.
  - Communicate

  Attendees are advised some organizations believe there is not enough knowledge known on the D2RA model within the sector and hold concerns this could impede its implementation and effectiveness[6].

  Further information on Cardiff's application of D2RA can be found in ***Appendix 1 & 4.***

[4] Delivering Home First (gov.wales) Accessed, 4th July 2023
[5] The roll out of the D2RA model was accelerated to address the challenges caused by COVID-19, with Welsh Government providing an additional £10m in funding in May 2020, to accelerate its roll out.
[6] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed 23 June, 2023

- **Cardiff & Vale Discharge Policy**

  All NHS Trusts in Wales have agreed discharge policies for the discharge of patients who are in need of long-term care. For attendees information, procedure for the Cardiff & Vale Discharge Policy can be found at **Appendix 2.** *Attendees are advised the procedure is due for review and possible update in September 2023.*

  The procedure sets out Cardiff and Vale UHB's approach to working with patients, their families and partner organisations to support a patient's safe and timely discharge from hospital. It sets out objectives, legal context and roles and responsibilities of relevant personnel and escalation procedures if required.

  It further advises that for individuals who, following hospital assessment, *require ongoing support in a care home*, the 'Choice of Accommodation' protocol is applied.

  In summary, the Choice of Accommodation protocol states, information must be provided at the earliest opportunity and the individual's choice should be central. However, when their chosen accommodation cannot be offered, interim accommodation is to be provided.
  Consideration of capacity and the principles and requirements of the Mental Capacity Act 2005, the Mental Health Measure 2010 and the Protection of Vulnerable Adult Procedures must also underpin the application of this protocol.

  Further, the protocol advises a patient's lack of cooperation with the discharge process and/or to make a choice of accommodation will not prevent the discharge process from proceeding. This may mean exploring alternative solutions.

  For attendees' information, the 'Choice of Accommodation' protocol can be found here.

- **Cardiff as an Age Friendly City**

  As detailed on the Welsh Government website, '*Wales is the only country in the world where every local authority is fully supported in one nationwide mission to become Age Friendly*[7].' In 2022, Cardiff became the first local authority in Wales to be accepted into the World Health Organisation's Global Network for Age Friendly Cities and Communities.
  To achieve this membership, an Action Plan, which set out how Cardiff will became an age friendly city was drawn, and is avilable here.

  In further work toward ensuring Cardiff is an Age Friendly City, the council produced the, Cardiff Ageing Well Strategy 2022-27 which sets out an overarching vision for services for older people in Cardiff. The strategy is underpinned with fundamental principles of empowering older people to live life as they choose, to be provided the right support, at the right time, and are helped to retain independence and achieve their chosen outcome.

  With specific regard to hospital discharge, the strategy sets out the following, 'we will' commitments:

  We will support timely and safe hospital discharge by:

  - Having a single point of contact in the hospital, which is fully aligned to our community, strengths-based model. To ensure safe & timely discharge, following Home First principles and empowering independence.
  - Incorporating the skills of our Community Occupational Therapists in the hospital, developing an enhanced triage process, to support independence.
  - Refining and simplify the Discharge to Recover and Assess model – assessing care needs in a person's home and not the hospital.

[7] Older People's Champions helping to create an Age Friendly Wales | GOV.WALES Accessed, 4 July 2023.

- **'Stronger, Fairer, Greener' and Corporate Plan 2023-26[8][9]**

  The above named polices, further embed the council's age friendly city commitments by pledging, in particular, to:

  - Tackle complex systems problems with partners to get people out of hospital as swiftly and safely as possible, whilst also working to keep them living independently at home for as long as possible.
  - Improve and strengthen management arrangements in the Integrated Discharge Hub.
  - Develop a suite of performance indicators by September 2023 to measure the success of pathways out of hospitals and to clearly demonstrate the impact of the council's activity.
  - Review the success of the hospital discharge pathways for Discharge to Assess (D2A) and Discharge to Recover and Assess (D2RA) and reporting on the findings.
  - Develop carers skills to support hospital discharge and reablement.
  - Contribute to a partnership approach to improve community-based services to prevent hospital admissions.
  - Continue to move towards locality working, bringing together multi-disciplinary services based in local communities to promote health and wellbeing, support independence and prevent unnecessary hospital admissions.

Context

12. The detrimental impact of hospital discharge delays is significant and wide reaching—both for the individual and services. Evidence[10] suggests, lengthy stays put patients at risk of hospital acquired infections and deconditioning leading to greater, ongoing care needs post-hospital discharge. A blockage in patient flow is generally deemed to affect individuals, inpatient care, emergency departments, ambulance services, primary care, planned admissions, carers, and staff wellbeing.

[8] Stronger Fairer Greener (cardiff.gov.uk)
[9] Corporate Plan 2023 to 2026 (cardiff.gov.uk)
[10] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed 21 June 2023

13. It is generally viewed that delayed transfers of care is an issue that disproportionately affects older people, who, conversely are at greater risk from hospital acquired infection and whose physical abilities deteriorate more rapidly.

14. The 'Get Up, Get Dressed, Get Moving'[11] campaign, acknowledged that patients aged over 80 who remain in bed lose up to 10% of their muscle mass in just 10 days. The campaign also noted that up to 50% of patients can become incontinent within 24 hours of admission and fewer than 50% of patients fully recover to preadmission levels within 1 year.

15. Similarly, written evidence from the Board of Community Health Councils ("CHCs") to the Senedd's Health & Social Care Committee states: "*The longer people stay in hospital the greater the impact on their overall physical health, strength and mental wellbeing*"[12]. In addition, research advises that the support an individual receives leading up to discharge and post-discharge, will impact the likelihood of them requiring care in the future[13].

16. The consequences of delayed discharges are well referenced, especially in respect of older people with frailty who are vulnerable to:
    - Loss of muscle strength
    - General decline
    - Loss of confidence and mobility
    - Delirium and deterioration of cognitive function
    - Increased risk of falls and hospital acquired infection[14]

17. The Senedd's Health & Social Care Committee's consideration on this matter in 2022, concluded it is essential, planning for discharge begins as early as possible, ideally on the patient's admission to hospital, and includes all relevant persons.

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[11] Get up, get dressed, get moving. - Cardiff and Vale University Health Board (nhs.wales) Accessed 21 June 2021
[12] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed 21 June 2023
[13] Delivering Home First (gov.wales) Accessed 22 June, 2023
[14] cavuhb.nhs.wales/files/policies-procedures-and-guidelines/corporate-policy/d-corporate-policy/discharge-from-hospital-procedure-pdf/ Accessed 22 June 2023

18. The Committee concluded this due to the evidence they received indicating that delays at the beginning of a hospital stay, can have a direct impact on an individual's length of stay in hospital. And, as already mentioned in this Cover Report, can also impact the level of care they require when they leave[15].

19. However, evidence from Age Cymru presented to the Senedd committee highlighted: "*Though Department of Health Guidance clearly demonstrates that the discharge process should begin at the point of entry, the cases that have come to us indicate a very rushed process that does not follow safe discharge practices*."[16]

Reasons for Delayed Transfers of Care[17][18]

20. Delayed transfers of care can occur for a range of reasons. Examples provided in Senedd publication include:
    - Waiting for health care or social care assessments.
    - Delay in the patients new, or continuing, medication being prepared and delivered by the hospital pharmacy.
    - Lack of transport avilable for patients to leave hospital.
    - Capacity issues in relation to service availability (including residential provision, new or a restart of domiciliary care packages).
    - Legal issues relating to discharge for example around the Human Rights Act, 1998, Mental Capacity Act, 2005 and NHS Continuing Health Care funding[19].
    - Disputes around funding of care packages (between individuals and/or local bodies).
    - Lack of consistent communication and joint working between health, social care and third sector bodies.

[15] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed 21 June 2023
[16] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed 21 June 2023
[17] Passing the Baton (NLIAH) (2008).2ebbf0ec0cdc4371619efbb02311869b3f9235406a94f616dd0e70a607e6b50d.pdf Accessed 5 July 2023
[18] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed 21 June 2023
[19] NHS Continuing Health Care Funding is where the NHS will manage and pay for an individual's care and support package. This is typically provided when the individual's primary need is judged to be a health need.

- Delays in ensuring home environment is safe.
- By the time a care package or a transitional phase is put in place, the person may have further deteriorated, or now have additional needs that then require a further assessment.

Issues

Workforce[20]

21. The Senedd's Health & Social Care Committee work, found the biggest contributor to delayed discharge was the lack of social care capacity. With staff shortages resulting in delays in assessment, and availability of care packages to allow discharge. The Welsh Government committee were of the view that '*until there is true parity in pay and terms and conditions for social care staff with their NHS counterparts; the sector will continue to struggle to recruit and retain staff*'[21].

22. National pressures in the social care and health sector workforce are well-documented, particularly in the wake of the pandemic. In 2023, the Welsh Government published its National Workforce Implementation Plan which included the following actions to address workforce pressures in the NHS:
    - ethically recruiting more nurses from overseas
    - to create an 'All-Wales Collaborative Bank' to enable the NHS to address short-term staffing issues and provide staff with choice and flexibility, while also encouraging a move away from agency working.

23. Attendees will be aware of the national shortage of qualified Social Workers and Occupational Therapists. Through the work of this committee, and in Full Council meetings[22], Committee Members have been informed work in Cardiff to address this includes:
    - Monitoring vacancies.

[20] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed 21 June 2023
[21] In response to this concern, the committee were informed Welsh Government continues to work with the Social Care Fair Work Forum, to address working conditions in the sector.
[22] Cardiff Council, Full Council Meetings: Nov 2022 & Jan 2023

- Attending open days and job fairs.
- Close working relationships with Cardiff Works
- Development of Cardiff Cares Academy.
- Reviewing processes for social workers to streamline work.
- Offering a range of initiatives such as higher education placements.
- Progressing locality working (to avoid carers spending more time travelling to calls).
- Cardiff Council's Cabinet Member for Adult Services writing to Welsh Government to make clear, the need for more funding to ensure more sustainable care provision, and the need to ensure equity in pay for social workers across local authorities.

24. Committee Members have further been advised, in Cardiff, care is avilable for those who need it. However, it can take time to assess an individual to ensure the right package of care is in place. Further Committee Members have previously been informed a key challenge facing Cardiff Council's Adult Services is around the complexity of need presenting[23].

Funding

25. As already mentioned in this Cover Report, the Welsh Government has funding streams to assist local bodies in their work on hospital discharge. Those funding streams include the Integrated Care Fund (ICF) and Transformation Fund (TF).

26. In 2022, an inquiry of the Senedd's, Health & Social Care Committee found there are different approaches to using ICF across Wales, with a lack of national consistency and mainstreaming of good practice. Further the inquiry also found reliance on short term funding when managing hospital discharge creates problems.[24]

[23] CASSC May meeting 2023 & Full Council Jan 2023 meeting.
[24] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed, 23 June 2023

27. 2022 saw the Welsh Government announcement of the 'Health & Social Care Regional Integration Fund'(RIF)[25]. The RIF brings together previous funding streams (including the ICF and TF) in a bid to provide greater alignment of resources, to maximize impact and reduce administrative burden.

28. The RIF will provide £144m (on a national basis) over 5 years, with a key focus on embedding integration between health and social care. In particular, it is planned the RIF will provide effective, seamless service in relation to:
    - Community based care – prevention and community coordination
    - Community based care – complex care closer to home.
    - Promoting good emotional health and well-being
    - Supporting families to stay together safely, and therapeutic support for care experienced children.
    - Home from hospital services
    - Accommodation based solutions.

Partnership Work[26]

29. It is widely viewed that strong practice and communication between all relevant professional bodies is vital. With Age Cymru calling for the "*long standing issue of health and social care case management systems not being joined up to be addressed*."

30. Further, GDPR has also been viewed as an obstacle for data sharing in this arena. However, it is viewed, through the use of Memorandums of Understanding and information governance protocols, it should be possible to have a truly shared electronic record.

[25] Health and Social Care Regional Integration Fund - Revenue Guidance 2022-27 (gov.wales) Accessed, 5 July 2023
[26] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed, 23 June 2023

Welsh Government – Delayed Transfer of Care Data Suspension[27]

31. Due to the covid-19 pandemic, and the unprecedented demands and challenges brought upon the health and social care sector, the Welsh Government suspended data collection of delayed transfers of care. Within the suspension, Welsh Government provided the view that this national measurement of delayed transfer of care was flawed, and required a review, to ensure data collection on this issue is both relevant and effective.

32. The national suspension of this data has been a key concern for the Community & Adult Services committee. When raising their concerns Committee Members have been informed work is ongoing on a national and local basis to reintroduce data measurement of this issue through new Key Performance Indicators (KPIs).

33. This same concern has been raised by Members of the Senedd, who have been informed by Welsh Government that, during this period of national data suspension, the Welsh Government has been working with the NHS Delivery Unit to collect weekly delayed discharge data as management information, which is then shared with partners to support effective planning of services.

34. Committee Members are advised the Council's Corporate Plan 2023/26[28] provides the following 'we will commitment':

    - Developing a suite of performance indicators by September 2023 to measure the success of pathways out of hospitals and to clearly demonstrate the impact of the Council's activity.

35. Committee Members attention is drawn to new KPI's proposed in the Adults, Housing & Communities 2023/24 Directorate Delivery Plan:

[27] Hospital discharge and its impact on patient flow through hospitals (senedd.wales) Accessed, 23 June 2023
[28] Corporate Plan 2023 to 2026 (cardiff.gov.uk)

Ref	Key Performance Indicators	2020/21 Result	2021/22 Result	2022/23 Result	2023/24 Target	Owner
CP K2.14	The percentage of permanent social worker vacancies in Adult Services	New Measure	New Measure	New Measure	12%	Angela Bourge
CP K2.15	The total number of domiciliary care workers in Cardiff registered with Social Care Wales	New Measure	New Measure	New Measure	2,600	Angela Bourge
CP K2.16	The number of domiciliary care workers registered with Social Care Wales in Cardiff as a percentage of the total number of domiciliary care workers registered in Wales	New Measure	New Measure	New Measure	7.5%	Angela Bourge
CP K2.17	The average time from referral to the Brokerage Team to the start of domiciliary care	New Measure	New Measure	New Measure	14 Days	Angela Bourge
CP K2.18	The average number of people waiting for domiciliary care at month end	New Measure	New Measure	New Measure	<30	Angela Bourge
DDP	Number of people aged 65 and over in residential care per 10,000 population.	76.6	63.0	67.6	No Target but year on year reduction	Lisa Wood
DDP	Number of placements in residential care prevented	New Measure	New Measure	New Measure	To be developed	Lisa Wood
DDP	Integrated Discharge Hub - Number of referrals triaged within 1 working day	New Measure	New Measure	New Measure	85%	Carolyne Palmer
DDP	Discharge medically fit people within 72 hours of triage	New Measure	New Measure	New Measure	To be developed	Carolyne Palmer
DDP	Review care package following discharge within 10 days at home	New Measure	New Measure	New Measure	To be developed	Carolyne Palmer

Community Resource Team – Key Performance Indicators (KPI)

36. The Community Resource Team (CRT), is a joint service provided by Cardiff and Vale University Health Board and Cardiff Council and play a key role in facilitating hospital discharge and work to prevent crisis in the community. The team provide domiciliary based support to individuals in their own home setting, with a focus on reablement and assisting people to retain or regain their independence *(further information on CRT can be found in Appendix 1).*

37. Through this committee's performance monitoring work, Committee Members raised concerns around the results of the KPI's related to the Community Resource Team. The recent performance reports presented to the committee confirmed that at year end (March 2023), 1,493 people had accessed CRT services (against a target of 2,000) and 37,801 hours of support had been provided (against a target of 50,000).[29]

38. When raising their concerns, Committee Members were advised work is ongoing

[29] Community & Adult Services Scrutiny Committee, May 2023 meeting.

to ensure the team returns to a focus of providing reablement care to individuals (as, due to the unprecedented challenges brought by the pandemic, the teams remit was widened). Further, an 'electronic call monitoring system' is being piloted in the team in a bid to reduce administrative requirements, and provide more effective rostering of care calls[30].

39. In June 2022, Care Inspectorate Wales (CIW) undertook an inspection of Cardiff Council's Domicillary Care Services (the Community Reablement Team, and Internal Supported Living). Overall, the inspection found People appear happy with the support they receive from both services. Their physical, mental, and social needs are recognised and supported, and the service is committed to achieve positive outcomes for them. Further, there is robust organisational and governance arrangements ensuring good quality of support.

40. The inspection found improvement is required in:
    - Pre -assessment, to ensure the suitability of the service for people being discharged from hospital. To elaborate, the inspection found on several instances in the CRT service; the information gathered via assessment in hospital was not reflective of the persons support needs – for example the individuals home environment was not adequate, or their needs could not be met by the CRT service. From the inspectorate's discussions, they were informed the team had already identified this as an issue and had plans in place to address this.
    - (Sometimes) delays in people accessing therapists like physiotherapists and Occupational Therapists to facilitate the transition from home to hospital.

      The CIW report can be found here. *Attendees are reminded that, in line with the focus of the meeting to review the findings in relation to the CRT team (all of which are summarised above).*

[30] Cardiff Council, Full Council Meeting, October 2022.

Cardiff Council

41. The service area, upon Committee Members request, have provided a briefing note, attached to this report at **Appendix 1** (in the format of a presentation). To assist Members in their consideration, council officers will briefly deliver the presentation at the meeting, with appropriate junctures during its delivery for group discussions.

    The presentation provides information on the following:

    - Scene setting information providing demand levels for services.
    - Insight into discharge pathways
    - Overview of council led services e.g., 'pink army' 'community resource team'.
    - Insight into the partnership working in Cardiff.

      Et.al.

42. In advance of the meeting, all attendees are encouraged to read all appendices attached to this report to inform their considerations and supplement the meeting's discussions.

Legal Implications

The Scrutiny Committee is empowered to enquire, consider, review and recommend but not to make policy decisions. As the recommendations in this report are to consider and review matters there are no direct legal implications. However, legal implications may arise if and when the matters under review are implemented with or without any modifications. Any report with recommendations for decision that goes to Cabinet/ Council will set out any legal implications arising from those recommendations. All decisions taken by or on behalf of the Council must (a) be within the legal powers of the Council; (b) comply with any procedural requirement imposed by law; (c) be within the powers of the body or person exercising powers on behalf of the Council; (d) be undertaken in accordance with the procedural requirements imposed by the Council e.g. Scrutiny Procedure Rules; € be fully and properly informed; (f) be properly motivated; (g) be taken having regard to the Council's fiduciary duty to its taxpayers; and (h) be reasonable and proper in all the circumstances.

Financial Implications

The Scrutiny Committee is empowered to enquire, consider, review and recommend but not to make policy decisions. As the recommendations in this report are to consider and review matters there are no direct financial implications at this stage in relation to any of the work programme. However, financial implications may arise if and when the matters under review are implemented with or without any modifications. Any report with recommendations for decision that goes to Cabinet/Council will set out any financial implications arising from those recommendations.

RECOMMENDATION

Committee Members are recommended to:

i) Consider the information in this report, its appendices and the information provided during the meeting and
ii) Determine whether they would like to make any comments, observations or recommendations to assist the Council with its role in facilitating safe and timely hospital patient discharge.

DAVINA FIORE

Director, Governance & Legal Services

14 July 2023

Mae'r dudalen hon yn wag yn fwriadol

Appendix 1

Hospital Patient Discharge for Adults Requiring Care Briefing

CASSC Wednesday 19 July

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

CARDIFF CAERDYDD

Final 14th July 2023

Setting the scene

Our services are directed to adults who need additional care and support to transition from hospital to their appropriate home, listening to the voice of the person and their support network to ensure they can live as independently for long as possible.

Our responsibilities as identified in Social Services and Wellbeing Act 2014 (Wales) are to:

Provide Information, advice, assistance and prevention activity.

Where appropriate to carry out an assessment of a persons need, proportionate to their circumstances and in line with what matters to the individual

Identify and meet any assessed care and support needs

Partner organisations are extensive some of these are:

Health board

Care services, public and private.

3rd sector

LA Colleagues

Legal (complex court of protection cases)

Advocates

And many more….

Our Hospital Team

Our Hospital Team

The multi-disciplinary team comprises colleagues from clinical, social care, preventative and holistic specialties:

Integrated Discharge Hub

- IDH Service Manager (Council managed integrated post)
- 2x Social worker/ Social work assistant
- 2x Community Resource Team therapist
- 1x Occupational therapist
- 14 Hospital Contact Officers (Pink Army)
- 1x Occupational Therapist assistant
- 2x Care Coordinators
- 2x IDH Nurses (in post now)
- 2x Admins

Hospital based Social Work team

- 1x Team Manger
- 6x Senior social workers
- 8x Social workers
- 8x Social work assistants

Integrated Discharge HUB

The Integrated discharge Hub is responsible for the triage of patients, to ensure a safe and timely, discharge to the correct pathway, working with the ward, the person, and/or their care network, to get the right support, at the right time, in the right place.

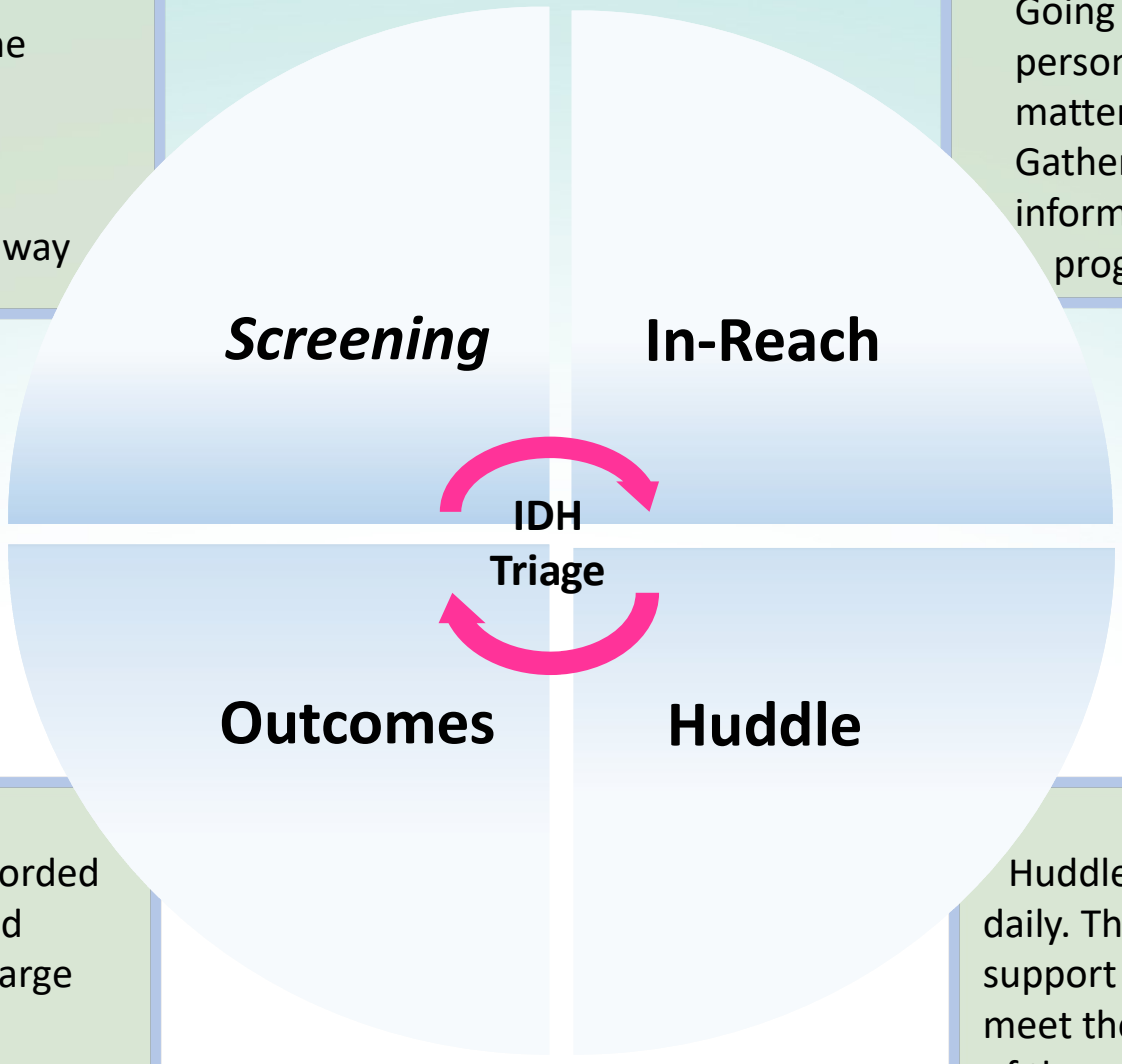
Following are our core values:

- The person is placed at the heart of the triage process to enable colleagues to determine the best outcome and pathway for the person in a collaborative way, also hearing and recording the person's voice
- To adopt “Home-first” principles
- Improve discharge flow
- Expand the Trusted Assessor role to support discharge flow

Integrated Discharge HUB

MDT is the first eyes on the referral
Check that the referral is appropriate
Determine predicted pathway

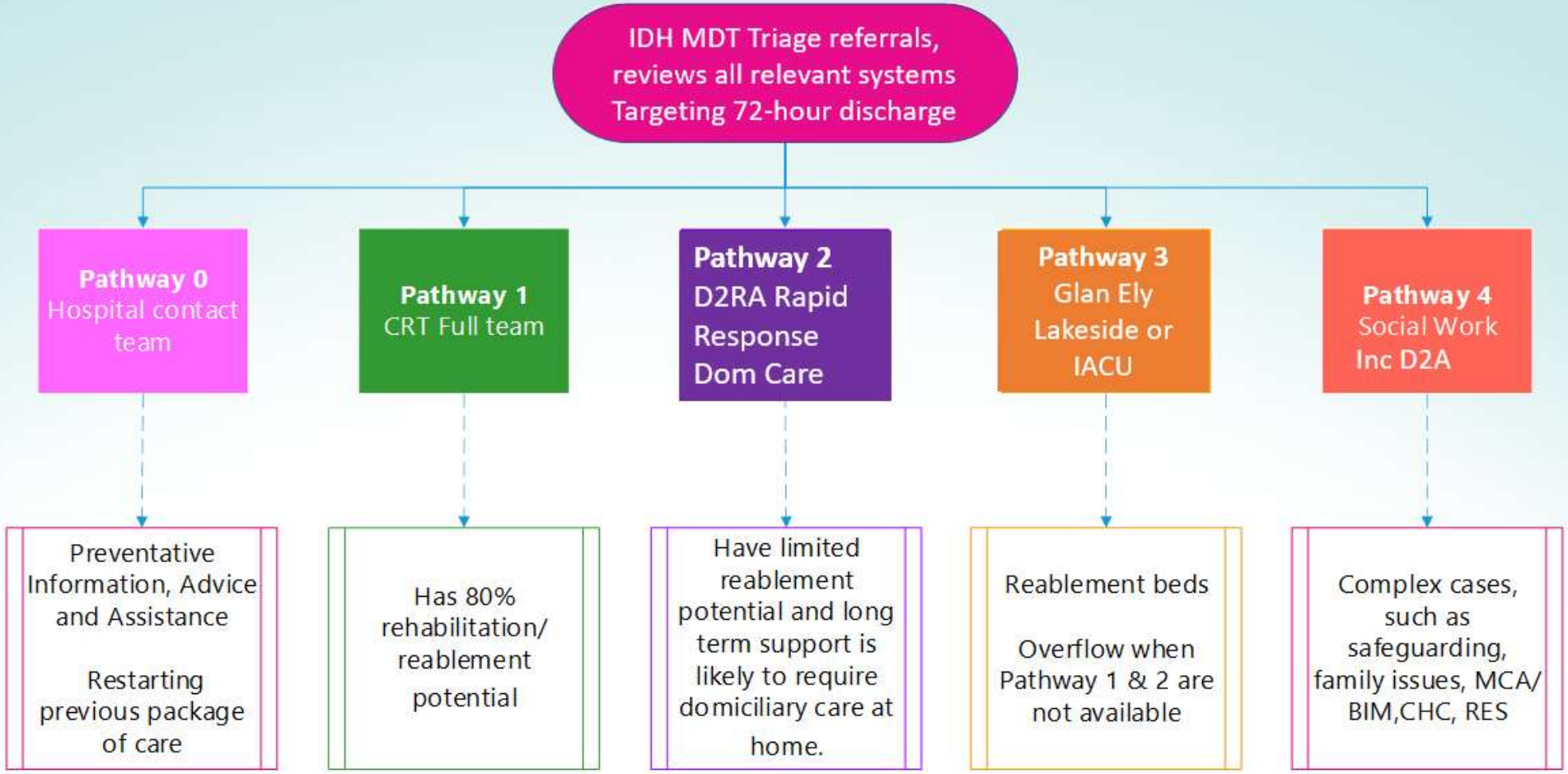
Going to the ward, meeting the person and hearing what matters to them
Gathering all relevant information and consent to progress the assessment



All outcomes must be recorded on appropriate system and referred to relevant discharge pathway

Huddle will take place twice daily. This is an MDT approach to support the best outcome to meet the needs and the wants of the person

Hospital Discharge Community Pathways (From Nov 2022)



IDH Performance Overview

Referrals into IDH

- An average of **86 referrals per week**, requesting community support to facilitate discharge (total number of referrals into IDH over past 6 months =**2,320**).

Triage

We are currently triaging live (as soon as referrals are received)

Triage Outcomes Last 6 months

- **8%** of referrals were resolved by **community solutions (195)**
- **32%** went to **CRT Full team for reablement support (752)**
- **8%** went for D2RA consideration**(190)**
- **2%** were identified for **reablement beds (54)**
- **25%** went to **social care (community and hospital) for complex discharge planning (577)**
- **24%** inappropriate referrals **(552)**

Any questions ?

The Pathways:

Pathway 0 – FPOC Hospital Contact Team (Pink Army)

- ✓ Attending board rounds on the wards
- ✓ Completion of 'what matters' conversations (WMC), empowering patients to have voice and control
- ✓ Live access to LA and health systems, enabling sharing of key information to inform MDT decision making and discharge planning
- ✓ Acting as a community connector, enabling quick responses from community teams/services, including direct links into CRT homecare, community SW teams , GP cluster MDT's and housing support
- ✓ The Pink Army are able to carry out Restart of Packages of Care and liaise with care providers directly
- ✓ EU - Collaborative working with frailty teams, supporting assessment to identify the right support, at the right time for the person ensuring their voice is champion. "Adopting home first principals".

Last 6 months activities -

WMC:	Restarts:	IDH support:	EU support:	Discharge Suport:	Other:
340	435	209	279	150	144

Pathway 1 – CRT Full teams (Home care)

CRT
Cardiff Community Resource Team

CRT is a joint service provided by Cardiff and Vale UHB and Cardiff Council which comprises of Home Care workers, Occupational Therapists, Physiotherapists, Dieticians, Nurses and Speech and Language Therapists.

The Community Reablement Team Home Care is hosted by Cardiff Council, who provide care and support for citizens in their home; with a focus on reablement, confidence and citizen empowerment, delivered through strength-based practice. The service supports hospital discharge, reducing the need for hospital admission and long-term Social Care services.

- ✓ Aim to support 28 discharges within a week
- ✓ Approximately up to 140 service users at any one time
- ✓ Up to 1200 care hour capacity at any one time
- ✓ Over 50% of service users are reabled through short term intervention, and therefore do not have an ongoing care need
- ✓ 1483 people were assessed for CRT Home Care support following a referral into the service 2022/23, of which over 75% were assessed as appropriate for CRT Home Care

Pathway 1 – CRT Home Care

Following a full post pandemic review of CRT Home Care, changes were needed.

Issues

- Several vacancies across the teams as a result of challenges with carer recruitment
- During covid, we had to repurpose our care to a more enhanced care, which required us to move away from the core values of reablement, we are now re-establishing our reablement ethos.
- Existing technology was not fit for purpose and planning care hours was a challenge.
- Existing cares rotas resulted in varying levels of care capacity on a daily basis, which in turn could create barriers in planning for care.

Benefits to Change

- October 2022 Carers posts were regraded; following job evaluation. As a result, the recruitment success rate has improved.
- The redefined discharge pathways supported us to go back to reablement care.
- In January 2023, the rollout of the new Electronic Call Monitoring system has improved our communication with carers, allowing them to plan their calls ahead
- In May 2023 new carer rotas were rolled out providing more continuity of care for service users and more effective planning to support discharge process

Pathway 2 - D2RA – rapid response care in person's own home

Aimed at people who are not appropriate for CRT, but would benefit from long term domiciliary care, and do not have multiple complex needs.

Benefits

- ✓ While there is currently no shortage of domiciliary care in Cardiff, setting up a permanent package of care through the brokerage system can take some time, this rapid response service avoids any delays
- ✓ Reduces the exposure to risks through prolonged admission, such as loss of physical and cognitive function, hospital-acquired, infections.
- ✓ Supports the person to achieve independence and for full assessment to take place in their own home.
- ✓ Working with 3 dedicated Care agencies.
- ✓ Care is reviewed and assessed within 10 day working days of returning home.
- ✓ If long term care is still required, it will be rightsized to meet the person's needs.
- ✓ We find once someone is settled at home, this often sees reduction in need as the person recovers and grows in confidence, which can often be the opposite if waiting in the hospital to be assessed.

Since end of Nov 2022 D2RA supported cases	Avg days taken for righsizing vist after discharge	D2RA end with long term POC
213	6	168

D2RA Framework working with our providers.

The Model is Delivered by 3 Framework Providers City wide

The Success of the Model is Predicated on:

- **Collaborative working** approach with Providers, Health & LA colleagues (coproduction)
- **Collaboration** between Framework providers
- **Reflective practice** – learning lessons from experience
- **Strong relationships** between providers and commissioners – enhanced monitoring
- Pathway is underpinned by **strength-based approach** with collaborative working between LA, Health, Care providers and person with their family/care network

Pathway 3 – Reablement beds

This is a health led pathway

Glan Ely in St Davids Hospital: Individuals who are medically optimised for discharge, no longer meet the criteria for an acute hospital bed, will benefit from short term rehabilitation to reduce care needs in the community and have rehabilitation potential.

Lakeside in UHW: Individuals who are ready for transfer of care to community services, do not require an acute or community hospital rehabilitation in-patient bed but may require complex discharge planning and support

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Pathway 4 – Hospital Social Work Team

- The aim of the IDH is to pass only the most complicated cases to the Hospital Social Work Team, all other cases will follow pathways 1 to 3.

- Social Workers support discharge planning and are experienced in undertaking Mental Capacity Assessments, Best Interest Decisions, Safeguarding, Identifying triggers for Continuing health care, Supporting cases via the Court of Protection, complex housing and social constraints which impact upon discharge planning.

- The Social Workers/Social Work Assistants and Council Occupational Therapist (trusted assessors) have a pivotal role in the assessment, care planning and discharge process.

- The social work role is essential in supporting the discharge of people whose social circumstances and or health needs are complex.

- The social work team are skilled and knowledgeable in supporting people to make informed choices, decisions and weighing up the risks and benefits of the available discharge options.

Pathway 4 – Hospital Social Work Team

Hospital social work team support people who are not appropriate for previous pathways

On Average there are **50** cases a month added to Hospital social work allocations

Average Time Taken to Allocate **Main Team** Work **= 24 working days**

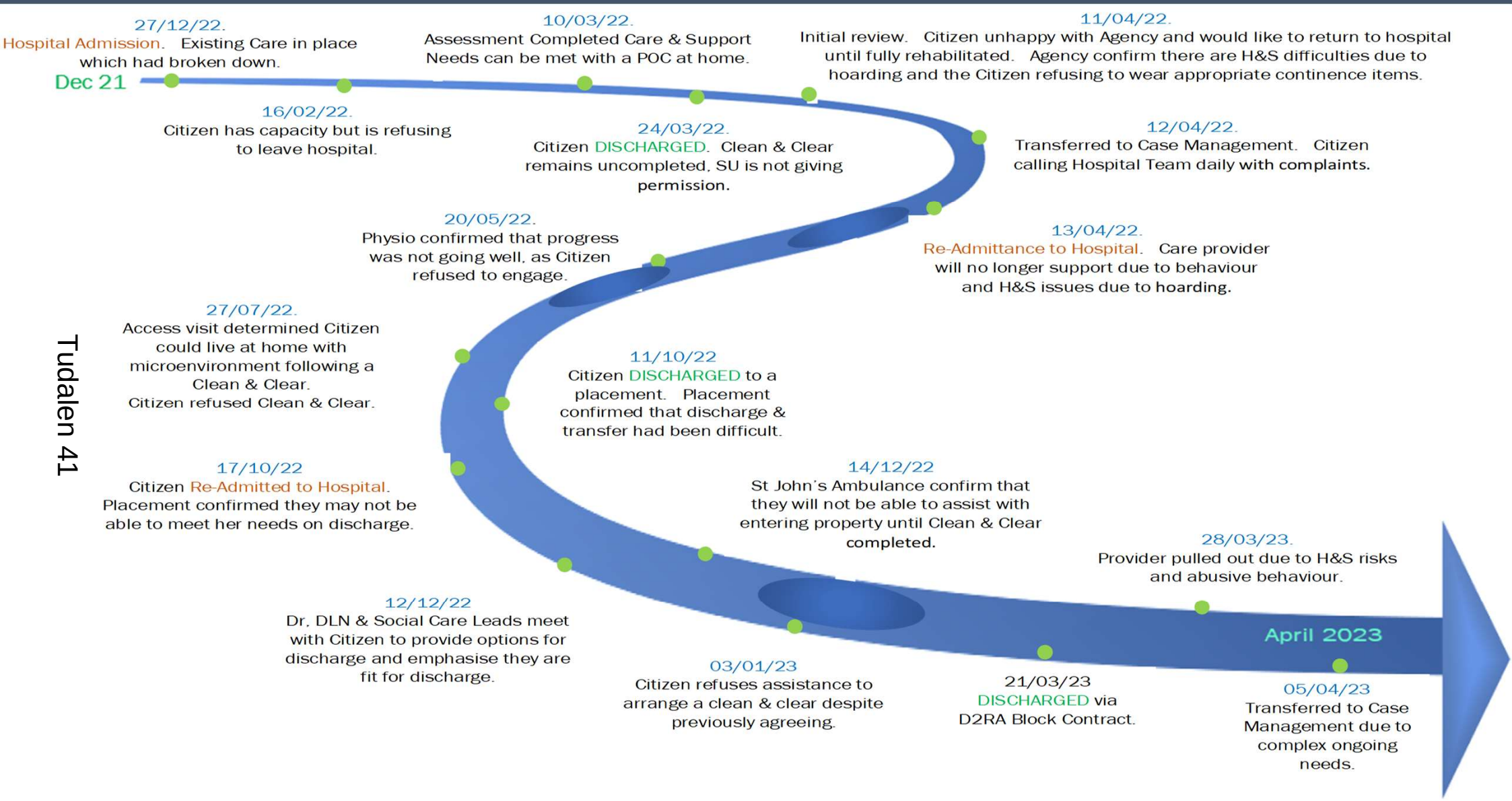
For Example:

- Cases with multiple complexities
- Court of Protection
- On-going safeguarding
- Persons who are objecting to next stage of discharge planning
- Family/support network constraints
- Ensuring a safe and supported discharge is achieved
- Persons requiring multiple capacity assessments as part of discharge planning eg, housing applications, finances, discharge destinations etc

- Cases require detailed work, can be very time consuming with lengthy processes, particularly if court action is required
- Allocating and responding to these cases in a timely manner remains a key issue

➢ Some Case examples…

Pathway 4 – Hospital Social Work Team example 1 timeline – complex case



Pathway 4 – Hospital Social Work Team example 2 – care home process

- Assessment identifies placement is appropriate setting in either residential or nursing care.
- Service user agrees to care home placement or the Best Interests decision is that a placement is in that persons best interests.
- Social Worker uses commissioning framework to identify potential homes that can meet the persons needs. Complex cases e.g. nursing/dementia, may take longer to secure.
- Service user/family /LPA has financial assessment and provided with CH options. This may mean a 3rd party payment. The Council has a charging policy and the cost of care fee level is the rate that we will fund.
- Family often chose to visit options and consider. The offer of the placement is limited to two days.
- Once home agreed, the provider has a duty under RISCA to assess and ensure that they can meet the need level. Provider may refuse at this point.
- If all agreed care plans are refined, clinical information provided where needed and ward arranges ambulance and medications.
- Person is discharged to care home and the person is then in the care of the community based social work teams.

❖ **This process can take up to 4-5 weeks and it is not appropriate to rush the decision making about a permanent care home placement**

Pathway 4 – D2A (Discharge to Assess) – intermediate step-down bed within a local care home for on-going assessment

The discharge to a care home is to assess the appropriate long-term arrangements, where they may not be safe between calls:

Benefits

- ✓ Ensures reduced length of stay in hospital and reduces the risk of deconditioning and risk of hospital infections
- ✓ Benefit from an assessment outside of an acute hospital setting to establish a more accurate account of the presenting care and support needs.
- ✓ Supports cases where Continuing Health Care requires joint assessment with health outside of an acute hospital setting.
- ✓ Supporting persons with eligible 24/7 needs to make an informed decision after being able to trial and experience a care home placement, prior to making a long-term decision for the future.

❖ **89 people discharged from hospital via this pathway since it was introduced in Jan 2023**

Pathway 4 – Hospital Social work Team - Staffing / workforce challenges

Currently the team has a reliance on Agency staff, this is reflective of the national position and is not unique to Cardiff. The driving need for agency staff and the risk this presents is:

- Short term funded posts: supporting Welsh Government Grant funded projects, such as D2RA and D2A
- Recruitment to permanent posts currently challenging, the market is competitive, with a limited resource pool
- Investment of training , and skills development is lost when staff move on from transient agency workforce

Pathway 4 – Hospital Social work Team - Staffing / workforce challenges

To Mitigate the work force challenges we have:

- Advertised permanent posts even where there is only short-term funding, taking a risk as the funding may not continue. Despite this we have been unable to attract non-agency staff.
- We have raised our market supplement to £3k
- We developed a clear Workforce Development Plan
- SWA – 2 staff currently seconded on the social work degree – long term positive for the development of the service - encouraging a "grow your own culture"
- Introduced trusted assessor arrangements – to increase the roles that can carry out assessment and care planning
- Piloting increased support for social workers though Social Work Resource Assistants – so social workers can focus on their key work

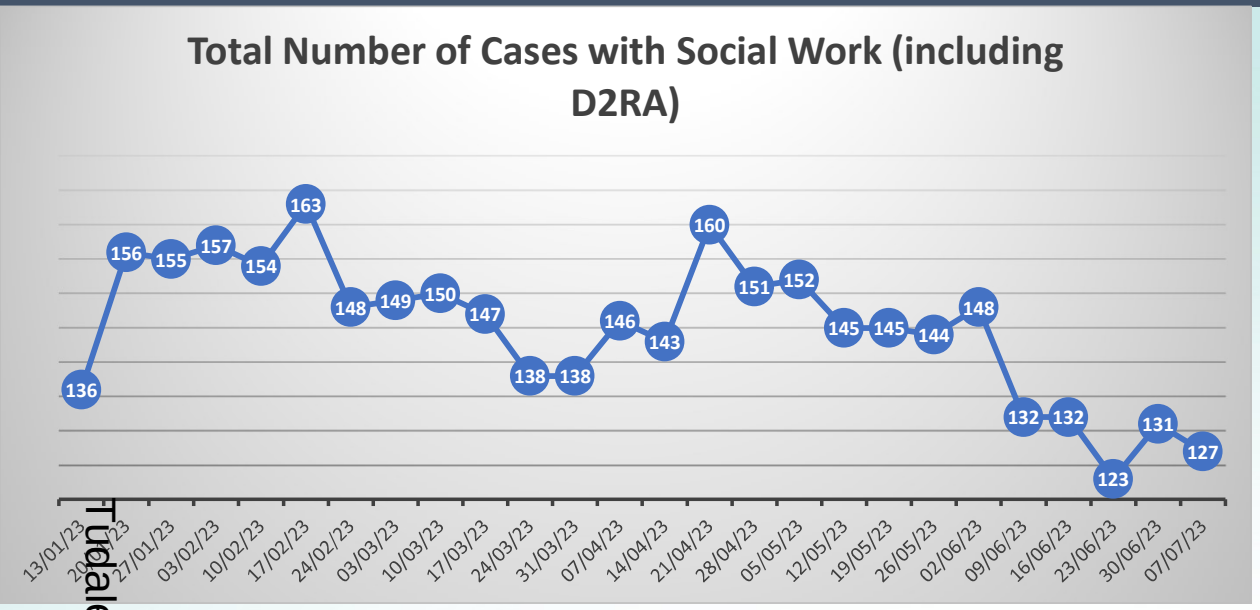
Embracing Trusted Assessor approach to support the pressure on SW and minimise delays

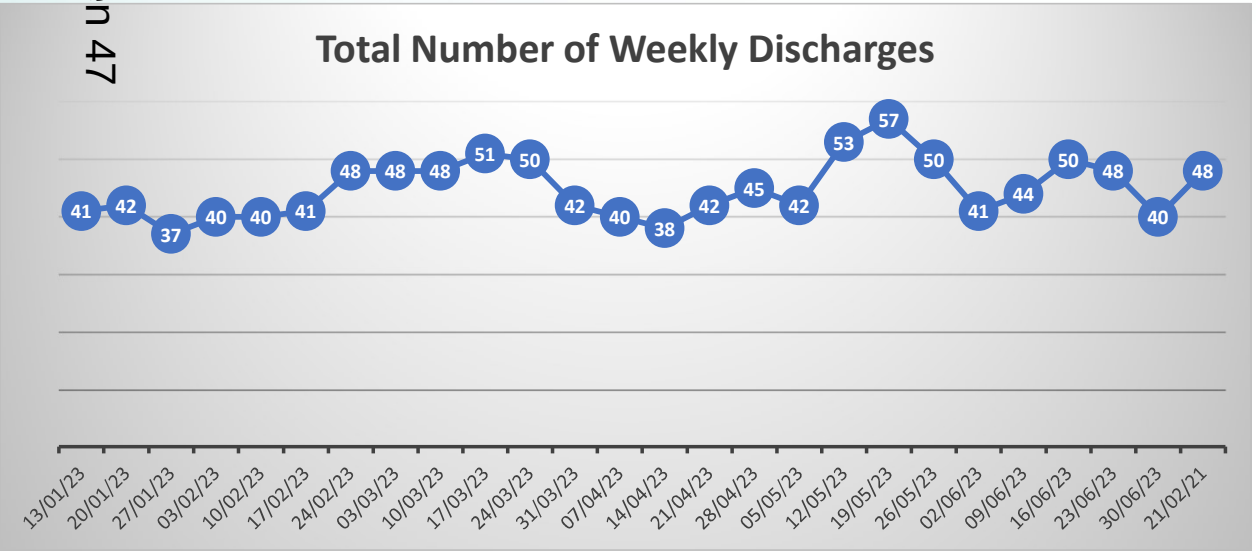
Using trusted assessors to carry out assessment of need avoids duplication and speeds up response times so that people can be supported and discharged in a safe and timely way. We have developed competency, training and skill matrixes to support and promote "Grow Your Own" ethos.

Current examples

- Community Occupational Therapist's (COTS) reviewing double handed packages of care in the community within 6 weeks of hospital discharge.
- The COT's are also supporting Discharge to Recover and Assess (D2RA) pathway.
- Wellbeing Visiting Officers are trained to Trusted Assessor level 3 and are empowered to prescribe aids and equipment.
- Empowering support staff to carry out more functions on completion of wellbeing assessment. freeing up staff from cumbersome administrative functions

Hospital Discharge weekly snapshot





Week ending 7th July 2023

Social Work Cases

127 cases are with the hospital discharge team
25 are unallocated
102 are allocated to a social worker – of these:

- 45 can be worked on with no constraints
- 3 discharges planned
- Constraint examples:

Not Medically fit **10**	District Liaison nurses **2**	Ward **7**	OT/Physio **6**	Equip **3**	Discharge Support Officers **3**
	Court Of Protection **3**	Housing **4**	Family **7**	Care Agency	Placement

Discharges

Of the 48 discharges with care:
24 were assisted by CRT
7 facilitated through normal social work process
17 were facilitated through the pathways:

- 4 - D2A (care home)
- 13 - D2RA (domiciliary care)

Hospital Discharge totals

Number of discharges from January to June:

Social Care complex needs (excluding D2RA /D2A)	189
Discharges to a D2A bed	89
Discharges to D2RA	192
Discharges to Reablement bed	43
Discharges to CRT	675
Total discharges from the hospital	1188

Any questions ?

DTOC, has been replaced with pathway of care delays (POCD)

Pathways of Care Delays definition:

A pathways of care delay is experienced by an inpatient occupying a bed in an NHS hospital, who is ready to move on to the next stage of care but is prevented from doing so by one or more reasons.

The revised definition for recording a delay is:

"any patient post 48 hours clinically optimised"

- The LA and UHB have agreed what constitutes clinically optimised and, will be applying the change from 3rd July

Clinically Optimised Meaning - A clinical decision has been made by the registered professional(s) that the patient is ready for transfer or discharge. This means that the patient no longer requires any treatment (medical nursing or therapy) in a hospital setting.

- Senior managers from LA and Health will validate the data with operational staff, for the first 6 months

Working with our Health colleagues - a flavour of our meetings

Formal meetings:

- ✓ Regional Partnership Board – quarterly
- ✓ Strategic Leadership Group in place - monthly
- ✓ @home board meetings – monthly

Operational meetings:

- ✓ Weekly strategic meeting LA Snr Management and Health
- ✓ Weekly POCD meetings for people deemed as delayed
- ✓ Weekly @home engine room - discuss joint partnership projects
- ✓ UHH operational monthly- joint meeting on flow , processes
- ✓ Validation process required following monthly census of POCD to ensure that Health and LA own, acknowledge and accept our POCD.
- ✓ Weekly review meetings for CRT reablement development planning

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Any questions ?

Next Steps

Better use of data

- ✓ Aligning our pathway recording so it is the same across LA and health
- ✓ Development and implementation of robust data sets including accessible live dashboards, to capture a consistent message of hospital discharge
- ✓ Working with Health colleagues, to develop pathways of care delays, data capture and review.

Simplifying our Processes and further developing Trusted Assessor Approach

- ✓ Expanding Trusted Assessor Approach, to reduce pressure on qualified staff
- ✓ Reviewing and simplifying documentation required for Package of Care to be put in place
- ✓ Deep dive into our Hospital Social Work end to end review – with the aim of simplifying our processes
- ✓ Development and implementation of new integrated Referral form for IDH and access to community support.

Improving Communication

- ✓ Development of a training and communications plan, to support learning for wider UHB staff on discharge processes.

Preventing admissions

- ✓ Early project work is under way to establish a joint working approach to avoid hospital admissions

Any questions ?

Appendix 2

Reference Number: UHB 372 **Version Number:** 2	**Date of Next Review: 03/09/2023** **Previous Trust/LHB Reference Number: UHB 372**

Discharge from Hospital Procedure

Introduction and Aim

The Hospital Discharge procedure is a document which is intended to support the Cardiff and the Vale UHB Discharge from Hospital Policy.
The aim of the Procedure is provide direction, support and guidance to the Policy and is to be utilised by ward based multidisciplinary teams when planning discharge.
The Procedure aims to ensure that each member of the Team has a clear understanding of their contribution to the effective, timely discharge and that staff recognise the importance of Patients and /or Carer engagement at the earliest possible opportunity.

Objectives

The objectives of the Discharge from Hospital Procedure are to :

- Identify the key principles of discharge and understand the links with other policies and how they impact upon the discharge process
- Clarify roles and responsibilities of key staff associated with the discharge process
- Promote a co-ordinated multidisciplinary team approach to discharge and care planning
- Promote a positive patient experience by ensuring that patients receive the right care at the right time in the right place
- Support good communication between clinical teams across the health community, patients and their families/carers
- Promote early engagement with the patient's GP; locality/neighbourhood team/case manager to ensure that the discharge plan is implemented in a safe and co-ordinated manner
- Promote IM&T communications i.e. e-discharge and e-bed management through the timely recording of inpatient admission and discharge record keeping on the clinical information systems
- Encourage a strengths based approach to the assessment of need ; and
- Provide key performance indicators

Scope

This procedure applies to all of our staff including those with honorary contracts involved in the discharge of patients from hospital sites of Cardiff and the Vale UHB. The procedure also provides advice on how other statutory organisations support the Discharge Policy.

Equality and Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has been completed and found there to be a positive impact
Documents to read alongside this Procedure	Discharge from Hospital Policy Choice of Accommodation Protocol for Inpatients
Approved by	Quality, Safety and Experience Committee
Accountable Executive or Clinical Board Director	Chief Operating Officer
Author(s)	Head of Integrated Care

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1			*new document*
2			Review of Document, update to include most recent legislation.

Index

1. Introduction

This Discharge from hospital Procedure reflects the principles identified in the Social Services and Well-being Act 2014 (the Act) which was implemented in April 2016. It will ensure that staff actively work towards a strengths based assessment of care needs recognising the importance of an integrated health and social care approach to discharge planning

Supporting the Act's principles is the local Strategy of the Cardiff and Vale University Health Board (UHB): 'Caring for People, Keeping People Well'. This procedure has been developed to provide the framework within which the UHB will support patients to be discharged from hospital at the earliest opportunity and in accordance with their individual ongoing needs as identified on the assessment document. It will include guidance to staff to provide a standardised approach to discharge planning.

The principle of making suitable information, assistance and advice available to patients, and their carers/families at the earliest opportunity is central to the discharge planning process. This should include information in relation to financial assessments and charging for social services and /or accommodation.

2. Statement

A safe discharge is one where the risks associated with the person's ongoing needs are identified and recorded. The UHB cannot prevent or reduce all risks but will work with patients and their families to make the discharge as safe as possible. All risks and discussions about risks should be recorded for those who may be involved in ongoing care.

Working in tandem with social care colleagues, Cardiff and Vale UHB will take all reasonable and practicable steps to provide a mutually agreed safe, effective and timely discharge service for people based on their assessed needs.

This procedure sets out Cardiff and Vale UHB's approach to working with patients, their families and partner organisations to support a patient's safe and timely discharge from hospital.

Central to the policy and procedure are these principles:

- Patients and/or their representative are involved
- Patients are informed
- Home First
- Using strengths based approach
- Discharges are safe
- Discharges are timely
- Discharges are co-ordinated

Consideration of capacity and the principles and requirements of the Mental Capacity Act 2005, the Mental Health Measure 2010 and the All Wales Safeguarding Procedures for Children and Adults at Risk of Abuse and Neglect (2020) must underpin the application of this policy which will include recognition of those who hold a Lasting Power of Attorney, a Court appointed Deputy and verification of an Advanced Decision to refuse treatment.

All patients should receive a leaflet with necessary information, detailing the discharge planning processes. This "Planning your Discharge" information leaflet can be found at

http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/PLANNING%20DISCHARGE%20BOOKLET%20-%20DEC%202012.PDF

3. Objectives

- To identify the key principles of discharge and understand the links with other policies and how they impact upon the discharge process.
- To clarify roles and responsibilities of key staff associated with discharge.
- Promote a co-ordinated multidisciplinary team approach to discharge and care planning.
- To promote a positive patient experience by ensuring that patients receive the right care at the right time in the right place.
- Support good communication between clinical teams across the health community, patients and their families/carers.
- Promote early engagement with the patient's GP; locality/neighbourhood team/case manager to ensure that the discharge plan is implemented in a safe and co-ordinated manner.
- To promote IM&T communications ie. e-discharge and e-bed management through the timely recording of inpatient admission and discharge record keeping on the clinical information systems.
- Strengths based approach and key performance indicators.

4. Responsibilities

The consequences of delayed discharges are well referenced, especially in respect of older people with frailty who are vulnerable to:

- Loss of muscle strength
- General decline
- Loss of confidence and mobility
- Delirium and deterioration of cognitive function
- Increased risk of falls and hospital acquired infections.

The Clinical Boards have operational responsibility to implement effective and efficient systems and processes to ensure that all patients receive evidence based person-centred care and treatment within the available resources. This will include ensuring that discharge planning is organised and managed so that patients get the right clinical care under the right clinical teams at the right time, and that they are supported to be discharged from hospital when they are fit for discharge.

5. Patient Experience

- The wishes of patients should inform the development of care plans and the discharge process.
- The patient and their family/representative (with the patient's consent) should be engaged at every stage of the discharge planning process and this should be recorded on the discharge plan.

- Every effort should be made to take into account cultural, religious, or language differences and sensory disabilities. All staff should be sensitive to special needs arising from these differences.

6. Legal context

- Where there is doubt about a patient's decision making abilities in relation to discharge destination, the Mental Capacity Act 2005 must be followed. https://www.gov.uk/government/statistics/mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england-2015-to-2016
- Patients who are subject to the Mental Health Act 1983, must have a robust management plan in place prior to discharge. http://www.legislation.gov.uk/ukpga/1983/20/contents
- If there are any concerns that the patient may be an 'Adult at Risk' as defined under the Social Services and Wellbeing (Wales) Act 2014, the assessing professional must follow local safeguarding procedures in line with the All Wales Safeguarding Procedures for Children and Adults at Risk of Abuse and Neglect (2020). If a patient requires care and support at home every effort will be made to carry out the assessment in the patient's own home.
- Must be compliant with Human Rights Act Articles 5 (Right to liberty) & 8 (Right to respect for private and family life).

7. Safety

- All staff should be aware of the increased risks to patients associated with an extended hospital stay.
- A Discharge Planning Checklist must be completed for every patient, with information provided, re: follow up appointments, on-going care of wounds, drains, vascular lines, catheter care, continence aids, gastrostomies and NG tubes.

8. Effectiveness

- Clinical Expected Length of Stay (CELOS) or Predicted Date of Discharge (PDD) should be set within 48 hours of admission, and discussed with the patient and their family.
- Decisions in relation to the discharge of patients should be made each day during Ward Board Rounds.
- Discharges should be planned to take place every day of the week.
- All staff in contact with patients should be clear to explain to patients and their families that once a patient is 'medically fit' i.e. no longer requires an acute hospital bed, they do not have the right to occupy that bed.

9. Timeliness

- Discharge planning should commence on admission in collaboration with the patient and their family with the patient's consent.
- Arrangements for discharge from hospital should ensure there is seamless care, so the person does not experience a gap in care due to hand over from hospital to home.
- Where arrangements for ongoing care are not in place and interim arrangements are made this should not disadvantage the person being discharged, such as where a

person agrees to move to temporary accommodation while awaiting grant work in their own property.

- Equipment required for discharge should be identified early in order to be in place when the person is discharged.
- An assessment of the person's needs should be carried out as early as possible and consideration of eligibility for Continuing NHS Health Care should be done by MDT as part of the discharge planning process.
- Patients identified as requiring a Fast Track Discharge, the ward MDT/Palliative Care Team must have early discussions with the patient and their families/carers and a referral to the Discharge Liaison Nurse to support the discharge plans.

10. Roles

Cardiff and Vale UHB through the Chief Executive as the 'Accountable Officer' **-** The Accountable Officer is responsible for setting the strategic direction and the policy framework. As part of the strategic direction and the policy framework, care will be provided using collaborative working arrangements across all the agencies responsible for the provision of health and social care for the population served, within Cardiff and Vale UHB.

A. Ward Nurses – Care Coordinator

- Act as care co-ordinator for own group of patients on each shift.
- Discharge plans (including Planned Date of Discharge) are discussed with patient and family/carer at intervals throughout their stay in ward area and written discharge information is provided.
- Coordinate proportionate, integrated and specialist assessments where appropriate.
- Discharge documentation (including Integrated Assessment/ Care Plans / Continued Health Care) is legible; outcomes and recommendations are documented and completed in a timely way as a part of the MDT assessment process.
- Ensure assessments and decision making documents provide evidence of needs and risks that inform discharge plan.
- Identify constraints in the patient's discharge plan and escalate as appropriate to Ward Sister / Charge Nurse or Deputy.
- Ensure reasons for delays or failure in meeting the Planned Date of Discharge are recorded on clinical information systems.
- Recording exact time of discharge on Clinical Information systems within 10 minutes of patient being discharged from the ward.
- Ensure all the relevant information is available at the Board Round.
- Early identification of equipment needs and discussion with appropriate therapist including alternatives for support on discharge e.g. Community Resource Team (CRT/VCRS) and anticipated delivery date of any equipment required.
- Ensure Discharge Planning Checklist is completed for **all** discharges.
- Ensure transport arrangements are discussed with family and where necessary book ambulance transport 24 – 48 hours prior to discharge. Transport arrangements must not delay discharge.
- Ensure take home medication is requested 24 – 48 hours prior to discharge.
- Effective use and early transfer to Discharge Lounge where appropriate.

B. Sisters/Charge Nurses

- Are responsible for the organisation and management of care provided to patients on their ward. This will include the co-ordination of care to ensure that all patients get the right care by the right professionals at the right time. In so doing they will ensure:
- That all patients have a CELOS/PDD set within 48 hours of admission and that this is recorded on the Clinical Work Station (CWS) and noted on the board round board.
- That all patients have a care, treatment and discharge plan that is reviewed daily so that patients and their families are kept fully up-to-date as equal partners on all aspects of their care.
- That efficient and effective multidisciplinary (MDT) board rounds are held every day, care plans for all patients are discussed and actions such as tests, treatments, assessments and referrals are carried out and all delays chased up.
- That every patient has a clear discharge plan that is reviewed daily and all delays escalated appropriately.
- That the **Choice of Accommodation Protocol** is properly implemented for **all** patients being discharged to a Care Home.
- That all formal MDT meetings are properly co-ordinated and managed so that all information to inform effective decision-making is presented and agreed actions documented and followed up.
- There is effective liaison between the ward and Integrated Discharge Service.
- That a 'live' bed state is maintained on the CWS at all times so that the Patient Access Team are able to co-ordinate the admission of new patients to the most appropriate ward.

C. Senior Nurses – in relation to discharge planning, senior nurses will ensure that this policy is implemented within their area of responsibility. This will include ensuring that:

- There is an effective board round regularly to assure that all patients are reviewed on a daily basis and meaningful decision are made and executed.
- Any discharge delays that cannot be resolved at ward level are escalated to Lead Nurse.
- They attend at multiagency weekly DTOC meetings to identify and escalate constraints.
- They act on escalated constraints to discharge.

D. Senior Medical Staff – are responsible for ensuring that there is a clear documented Clinical Plan that has been discussed with the patient, for all patients under their care. The Clinical Plan will include:

- Differential diagnosis.
- Investigations to confirm / rule out a diagnosis and how to act on results.
- Immediate treatment plans.
- Treatment to be started based on results.
- Any further functional assessment required.
- Anticipated need for therapies input.
- Anticipated need of social input.
- Clinical Expected Length of Stay (CELOS) / Predicted Date of Discharge (PDD).
- Post-hospital management plan.
- Relapse signatures and crisis management plan (for Mental Health).

E. The responsible Consultant (or their delegated deputy) will attend the daily board round to discuss all clinical plans with the MDT and ensure all decisions / changes to the plan are effectively communicated and acted upon and will also ensure that:

- All 'to take home' (TTH) medicines, etc, are completed in good time to enable early discharges - for example blister packs for medications are ordered a week prior to discharge.
- Discharge documentation (including Integrated Assessment / Continued Health Care) is legible; outcomes and recommendations are documented and completed in a timely way as a part of the MDT assessment process.
- Electronic discharge summaries are completed on day of discharge.
- A clear plan, including any follow-up care, is in place for patients who are likely to be discharged over the weekend.
- Where a person is not returning to the care of their previous GP the doctor has a responsibility to ensure the receiving GP is provided with appropriate information to provide ongoing care.

F. Allied Health Professionals, eg Occupational Therapists, Physiotherapists, Dieticians, Pharmacists will:

- Attend the daily board rounds to give professional input and participate in MDT discussion on individual Clinical Plans to ensure timely discharge.
- Provide advice, support and training to MDTs in planning safe and timely discharge of patients.
- Work with the CRTs to identify patients who can be 'discharged to assess'.
- Provide teaching, training and supervision to achieve best practice in discharge planning.
- Participate in CHC assessment processes and provide expert advice.
- Escalate any discharge delays to the appropriate level.
- Ensure that the ward clinical work station is maintained up-to-date so that the Integrated Discharge Service (IDS) and the CRTs are accurately informed about patient progress.

G. Directorate Managers /Lead Nurses – will ensure that the Policy and this Procedure are fully implemented within their area of responsibility.
This will include:

- Monitoring performance associated with discharge, freeing up bed capacity, reducing length of stay (LOS) and delayed transfers of care (DTOC).
- Ensuring that the ward clinical work stations are kept up-to-date at all times so that IDS and CRT are accurately informed about patient progress.
- Escalating any untoward patient delays that are likely to impact on patient flow issues to the appropriate level.

H. Clinical Board Management Teams - are responsible for ensuring that the Policy and Procedure are properly implemented within their Clinical Board. This includes ensuring that:

- All staff are made aware of their responsibilities within the Policy and Procedure.
- Adequate training and support is provided to facilitate adequate understanding and implementation of the Policy and Procedure.
- Effective systems are established to monitor the impact of the Policy and Procedure and the discharge planning processes.

11. Integrated Discharge Service IDS

The Integrated Discharge Service, supported by the Head of Integrated Care, will work with clinical teams to support discharge planning processes for people with complex ongoing health and social care needs.
The IDS Team will:

- Use a Standard Operating Procedure as a framework for a work plan
- Act as a resource to all members of the multi-disciplinary team, to provide expert discharge planning advice.
- Provide teaching and training, both formal and informal, at ward and departmental level to improve discharge planning.
- Support ward teams in the long-term placement assessment process.
- Act as a liaison point between ward teams and other agencies.
- Escalate any discharge delays appropriately.
- Ensure that the IDS activity on the ward clinical work station is maintained up-to-date so that the IDS and the CRTs are accurately informed about patient progress.

12. Discharge Documentation

All discharge arrangements should be recorded on the patient's own medical record **and** on the Health Board clinical information systems. If appropriate an accurate contemporaneous record will be available on Social Services client information systems.

13. Discharge Information for Patients and their Families

Patients and their families (where appropriate) will be engaged as equal partners in all aspects of care throughout the in-patient period. On discharge, individual members of the MDT will provide a written summary of the care and treatment while in hospital, including any changes to medication and any further tests, investigations and outpatient clinic appointments, which may be needed.

The patient and their family (where appropriate) will also be provided with any other appropriate information/ contact details relevant to their ongoing care and /or condition.

14. Discharge Summary / Communication with General Practitioners

The patient's Consultant will ensure that an electronic discharge summary is completed for all patients on their day of discharge and forwarded to the patient's GP. The discharge summary will include; the patient's diagnosis and treatment plan and any advice on on-going patient management and follow-up arrangements, details of medication particularly any changes in medication, and the date of discharge

Where there is a radical change in treatment or medication or where there are complex issues in relation to the ongoing medical care the patient's Consultant is responsible for ensuring the patient's GP is informed by telephone.

A comprehensive discharge summary will be sent to the General Practitioner within 14 working days of the patient's discharge by the patient's consultant.

15. Discharge against Clinical Advice

There are occasions when patients will want to discharge themselves against clinical advice. In these circumstances the ward staff must endeavour to establish the reason for the self-discharge. Where there is no reason to doubt a patient's capacity to make this decision, the ward team must respect the right of the individual to leave the hospital, ensuring that where possible they have been provided with sufficient information to make a fully informed decision. The 'Discharge Against Clinical Advice' procedure must be followed.
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/EMERGENCY_UNIT_CP/UHW%20EMEREGENCY%20UNIT%20DOCUMENTS/CLINICAL%20GUIDANCE/DACA%20PROCEDURE.PDF

16. Refusal to Leave Hospital/ Reluctant Discharges

If for any reason a patient refuses to leave hospital, every effort will be made to facilitate the discharge to the patient's place of choice. Where difficulties are experienced in transferring care of the patient to the care home of choice , the Multidisciplinary Team will work with the patient and their family/or representative to secure a suitable alternative. This will be done in accordance with the Choice of Accommodation Protocol alternatively the reluctant discharge protocol. Where there are unresolved issues the case should be escalated for consideration to the Clinical Board

17. Continuing NHS Healthcare (CHC)

For those patients with complex needs their on-going care will be determined following the completion of an 'Integrated Assessment' and, if necessary, the completion of the Decision Support Tool (DST), in accordance with the Continuing National Health Service Care guidance (2014).
http://nww.cardiffandvale.wales.nhs.uk/pls/portal/docs/PAGE/CARDIFF_AND_VALE_INTRANET/TRUST_SERVICES_INDEX/PRIMARY_COMMUNITY_AND_INTERMEDIATE_CARE/INTEGRATED_DISCHARGE_SERVICE/USEFUL%20DOCUMENTS%20/CHC%20-%20NATIONAL%20FRAMEWORK%20FOR%20IMPLEMENTATION%20IN%20WALES.PDF

If patients are deemed eligible for CHC or a joint package of care, the patient will be assessed by the MDT supported by the IDS Team and the package of care will be planned and implemented accordingly.

If a patient requires a bespoke/specialist piece of equipment there may be delays in the provision of this equipment so every effort must be made to order this as early as possible. While delays should always be minimised, they should however, be taken into account when planning the discharge and transitional placements used where appropriate.

18. Fast Track Continuing Health Care Discharge Integrated Discharge Service

The 2014 Continuing NHS Healthcare, National Framework for Implementation requires the UHB to have in place a fast track processes aimed at supporting individuals with a rapidly deteriorating condition who are entering a terminal phase of their disease and be in the last weeks or days of life. The fast track process enables them to be supported in their preferred place of care. All staff must ensure that this streamlined process provides enough

information to support the rapid approval and arrangement of an appropriate package of care.

All staff involved in the Fast Track process must read the guidance notes carefully and have a clear understanding of the requirements for this process including the need for the Fast Track Care Plan.

Patients and their recognised carers will have provided informed consent to share information about them with community staff who will be providing their care. Patients and their families will be provided with contact details of their Community Key Care Co-ordinator prior to discharge.

It is essential that a timely discussions and decisions are made by the Ward MDT and Palliative Care Teams in order that the patient receives their care in a setting which they and their families request as long as it can meet their identified needs. Early referrals to the Discharge Liaison Nurse to support the discharge plan is essential.

Where a person's home is a residential care home in usual circumstances they would not be able to return with nursing needs however if this is a placement they have been in for some time consideration will be given by the UHB for a return there for end of life care with support from primary care. It is essential that Primary Care services continue to oversee the clinical care and District Nurses are invited to participate in decision making to assure a safe discharge.

19. Choice of Accommodation Protocol

The Protocol sets out the process for the safe and permanent placement of patients in an appropriate care setting and in a manner which reflects their right to choose their accommodation. This is a significant decision and requires careful consideration by the patient (or their Lasting Power of Attorney, (if applicable), their advocate and their family and/or carers. Obtaining good advice from health care and social care professionals is essential, to ensure that the process is done effectively and efficiently.

Each stage of the discharge planning process should be approached in a supportive manner. The patient (or their LPA where applicable) and their family/carer/advocate should be offered explanations verbally and in writing, there should be counselling and further support throughout the process.

20. Vulnerable Groups

Some individuals may require additional support when planning their ongoing care arrangements and may include individuals with a learning disability; people who are homeless; those who have a physical or sensory disability; people who have a mental illness, including dementia; and those who are old with frailty. There should also be due consideration of those adults and children who have existing safeguarding plans in place. Any safeguarding concerns identified must be raised in line with the All Wales Safeguarding Procedures for Children and Adults at risk of Abuse and Neglect (2020).

21. Carers

The Social Services and Well-being (Wales) Act 2014 came into force on the 6th April 2016. The Act in Wales applies to people in need, of any age and introduces equivalent rights for

carers to those they care for. A carer's need assessment should be triggered if there appears that the carer needs support or if they are likely to need support in the future. Carers are legally entitled to a carer's need assessment regardless of the amount of care they provide or their financial means or the level of support they may need, this includes young carers. All carers are entitled to an assessment in their own right regardless of their age, care for someone who is disabled, ill or elderly. There must not be an assumption that carers are willing and able to meet the needs of the individual without having a conversation with the carer.

Young Carers

Young Carers are children under the age of 18 years old, with caring responsibilities. They will be assessed under the Social Services and Well-being Wales Act.

Assessment is the first stage in helping a child and their family. There must be particular considerations applied to the needs of the children.
Refusal of an assessment must be overridden, where there is a refusal this would be inconsistent with a child's well-being and referral to the local safeguarding team. Any safeguarding concerns identified must be raised in line with the All Wales Safeguarding Procedures for Children and Adults at risk of Abuse and Neglect (2020).

22. Performance Measures

Compliance with this Discharge Policy and Procedure will be monitored as part of Cardiff and Vale UHB's operational performance management process to include:

- Reduction in number of delayed transfers of care
- Reduction in number of bed days lost
- Reduction in number of complaints associated with the discharge process
- Achievement of expected Date of Discharge
- Increased number of discharges achieved before noon

The Clinical Boards are accountable for enforcing and supporting this Policy and Procedure and performance of Directorates will be reviewed at Operational Performance Group meetings

23. Review of Policy

The Policy will be reviewed every three years and will include:

- Regular audit of compliance
- Monitoring of complaints and reported incidents and areas of consistent difficulties
- Feedback from key stakeholders including patients/carers/advocates

24. References

This document needs to be read in conjunction with other resources/ polices. The appropriate links have been made on the electronic version but in the written document they are referred to in the index.

25. Glossary of Terms

Planned Date of Discharge (PDD)

- This is a date identified by the admitting ward team, based on information gained during admittance assessment, as to when the patient is likely to be discharged.

Ready for Transfer (RT)

- Ready for transfer of care date is the date on which a hospital inpatient is ready to move on to the next stage of care. This is determined by the clinician responsible for the inpatient care, in consultation with the multi-disciplinary team and all agencies involved in planning the patient's discharge or transfer to a more appropriate NHS care setting. A patient who continues to occupy a hospital bed after his/her ready for transfer of care date during the SAME inpatient episode experiences a delayed transfer of care

Discharge Fit (Fit for Discharge)

- Is when the patient no longer benefits from on-going hospital based inpatient services, within a tertiary / secondary care setting and where:
- on-going care and social needs have been agreed and can be met in another setting, home or through primary, community, intermediate care or social services.
- on-going care and social care needs can be met more appropriately in a secondary or community care setting closer to the patients' home.
- additional tests and interventions can be carried out in an outpatient or ambulatory setting.

Care Plan

- Where hospital staff provide a plan of care that documents the care a person requires how often and the risks to the person if care is not provided in order that all staff responsible for the patient's care are able to provide it consistently and identify any changes in needs.

Plan of Care and Support (POC)

- The documentation the local authority requires to be completed by the social care worker to ensure ongoing care. This is usually commissioned by a local authority.

26. Other sources of information can be found at IDS web site Integrated Discharge Service.

1. Standard operating procedure for Integrated Discharge Service
2. Choice Protocol
3. Simple/Supported/Complex Matrix
4. Clinical Workstation Operating Procedure
5. Ticket Home
6. Discharge Checklist (Draft)
7. Provision of Equipment
8. Procedure for requesting Non-Standard CHC Funded Equipment
9. Procedure for requesting CHC Equipment
10. The Discharge Pathway
11. Discharge Lounge Service
12. Pharmacy
13. CHC Fast Track Discharge
14. Hospital discharge for patients of no fixed abode

APPENDIX 3

CRT Staff Report

March 2023

Gweithio dros Gaerdydd, gweithio gyda'n gilydd
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Cardiff Research Centre delivers key research, information and multimedia services for Cardiff Council and other key organisations in Cardiff and Wales.

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Background

The Community Resource Team is a Reablement / Home Care Service that is registered by Cardiff Council with Care Inspectorate Wales. The staff who support the delivery of our Reablement/ Home Care Service are essential to the provision of quality care for some of Cardiff's most vulnerable adults.

This survey is a new part of staff engagement and feedback that will provide essential information that will assist the Responsible Individual to undertake the required Quality Assurance checks. This will ensure that Cardiff Community Care Services are not only compliant with regulatory requirements but provide high quality services underpinned by best practice.

Methodology

- The survey was developed in collaboration between the Community Resource Team and the Cardiff Research Centre, based on a similar staff survey used for staff in residential care homes in August 2020, September 2021, March 2022 and September 2022.
- The questionnaire was provided bilingually.
- Slight amendments were made to Questions 5 and 18 in September 2022 as such limited trend analysis was undertaken for these.

There were 48 valid responses received over the consultation period. Due to the small base size, figures shown in this report are actual numbers, rather than percentages.

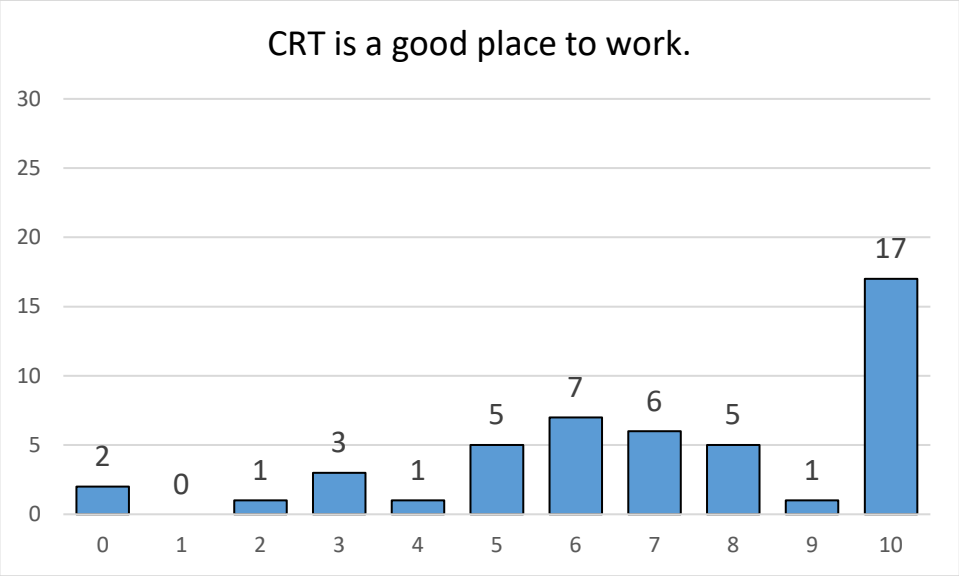
Research Findings

Summary of results

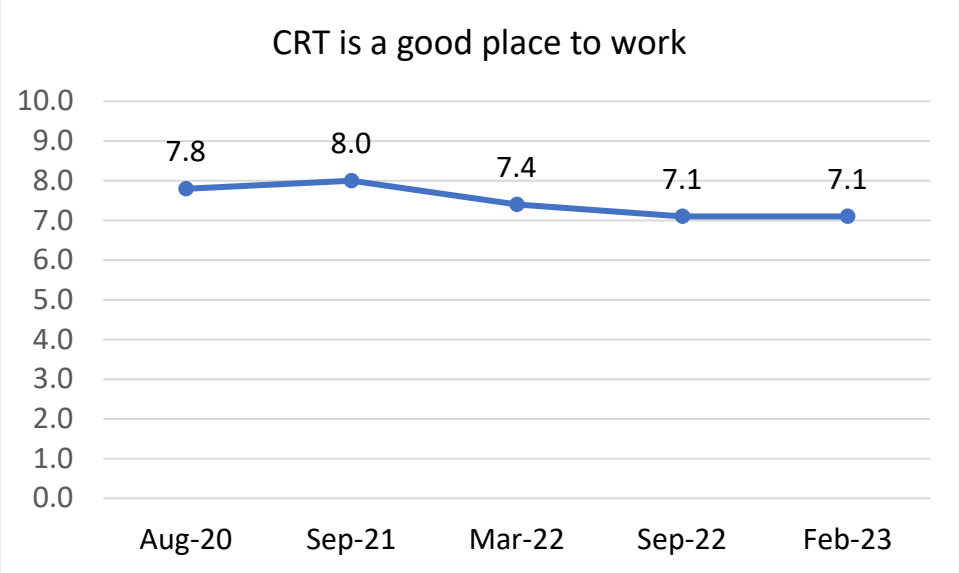
A summary of the scores given to the quantitative questions is listed below, in descending order. A full breakdown showing the range of responses to each question is examined in the main body of the report, where questions are shown in the order of the questionnaire.

	Question	Mean
Q14	I am supported to attend training that enhances my practice	9.1
Q11	I think that the needs of the Service Users in the service are respected/are at the centre of the work I do.	9.0
Q4	I am clear about the purpose of CRT	8.8
Q15	If I make a mistake I am supported to reflect on how things could be done differently	8.7
Q20	I receive regular communication from my line manager	8.5
Q12	I feel valued and respected by my colleagues	8.4
Q17	Relationships with colleagues and other agency partners are good	8.3
Q18	I know how to access support services through Employee Assistance" (Care First, counselling etc.)	8.3
Q19	I receive regular communication from Cardiff Social Services and Independent Living Services (Director, Comms, updates, staff information etc)	8.2
Q6	I receive regular contact providing support from my Managers.	8.1
Q13	I feel that I am listened to by my managers and colleagues	7.9
Q5	I have access to the correct equipment and information relating to all Service Users that I visit in order to provide their support appropriate	7.8
Q10	I feel supported if I need to raise a concern about a colleague or Service User	7.8
Q3	CRT has clear leadership	7.4
Q1	CRT is a good place to work	7.1
Q8	The amount of work expected of me is reasonable	6.7
Q2	I understand the vision for the future.	6.6
Q9	Team meetings are held regularly and staff are encouraged to contribute fully	6.0
Q16	I receive regular communication and updates from other partners (Health, Social Workers)	5.4
Q7	Morale within my service is high	5.2

CRT is a good place to work *(10 is 'agree completely' and 0 is 'disagree completely')*
Twenty-nine respondents provided this statement a rating of at least 7 out of 10, this included seventeen respondents that provided a maximum score of 10. There were seven respondents giving a score of under 5.



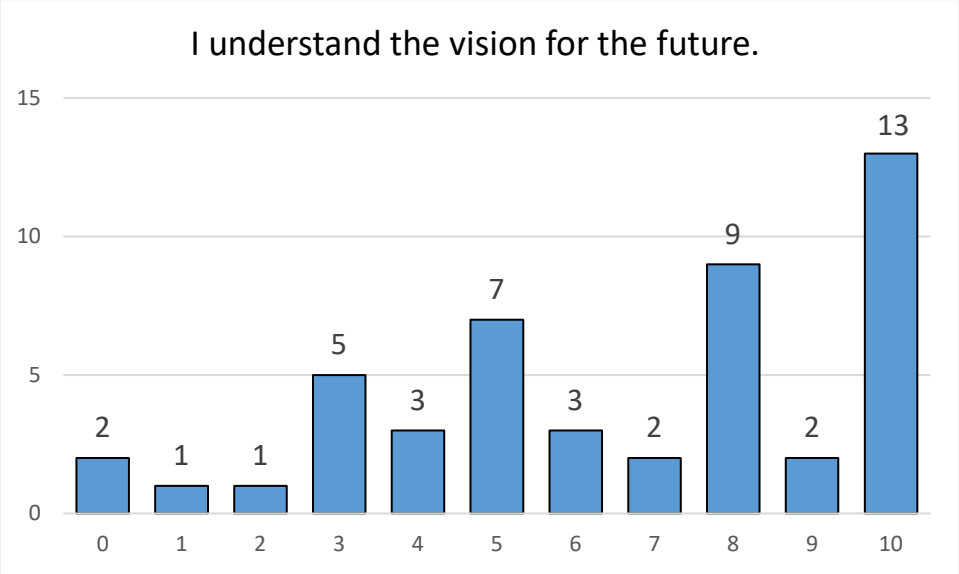
The average scoring for this statement was 7.1, in line with that recorded in Sept 2022.



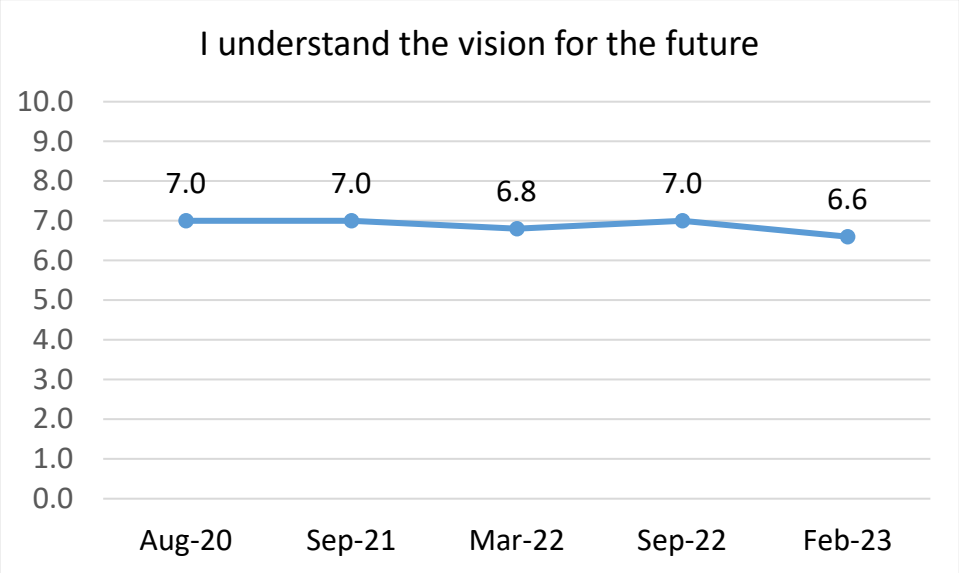
What needs to happen and what do you need to see to move you further up the scale?
Twenty-eight respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I understand the vision for the future. *(10 is 'agree completely' and 0 is 'disagree completely').*

Twenty-six respondents gave a rating of at least 7 out of 10; this included thirteen that provided a maximum score of 10. There were twelve respondents giving a score of under 5.



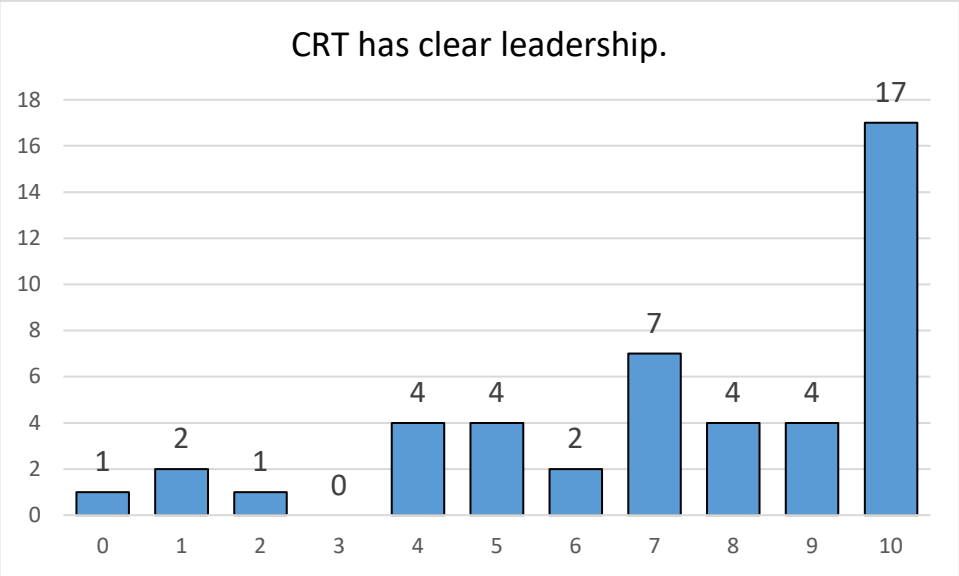
The average scoring for this statement was 6.6, the lowest score recorded for this statement across the surveys undertaken.



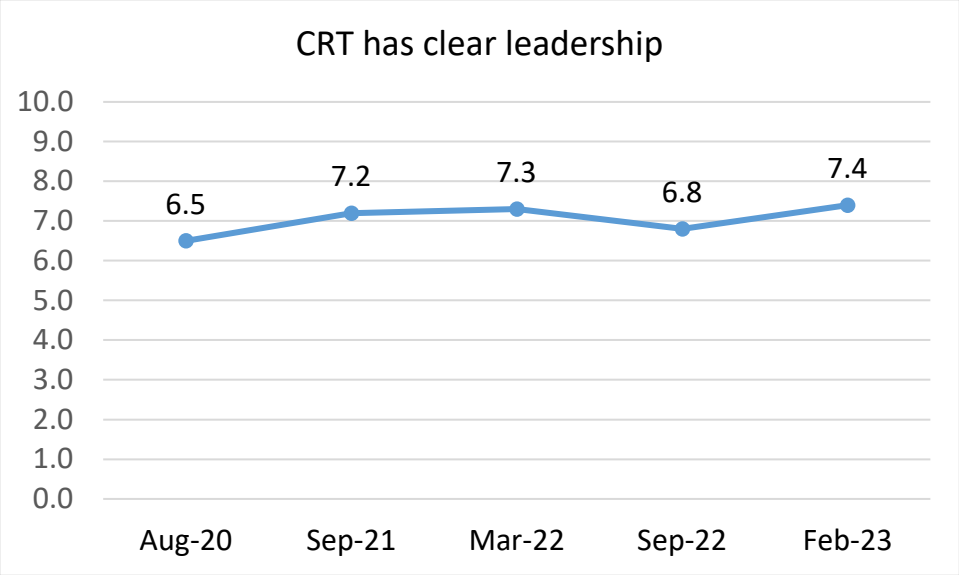
What needs to happen and what do you need to see to move you further up the scale?

Thirty-one respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

CRT has clear leadership *(10 is 'agree completely' and 0 is 'disagree completely').*
Thirty-two respondents gave a rating of at least 7 out of 10; this included seventeen who awarded a maximum score of 10. There were eight respondents giving a score of under 5.

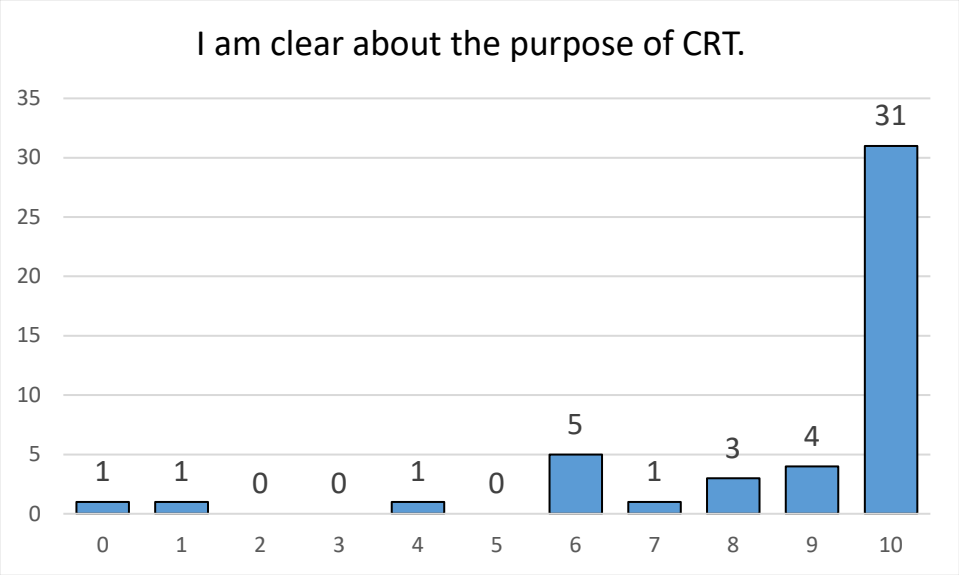


The average scoring for this statement was 7.4, the highest score recorded for this statement across the surveys undertaken.

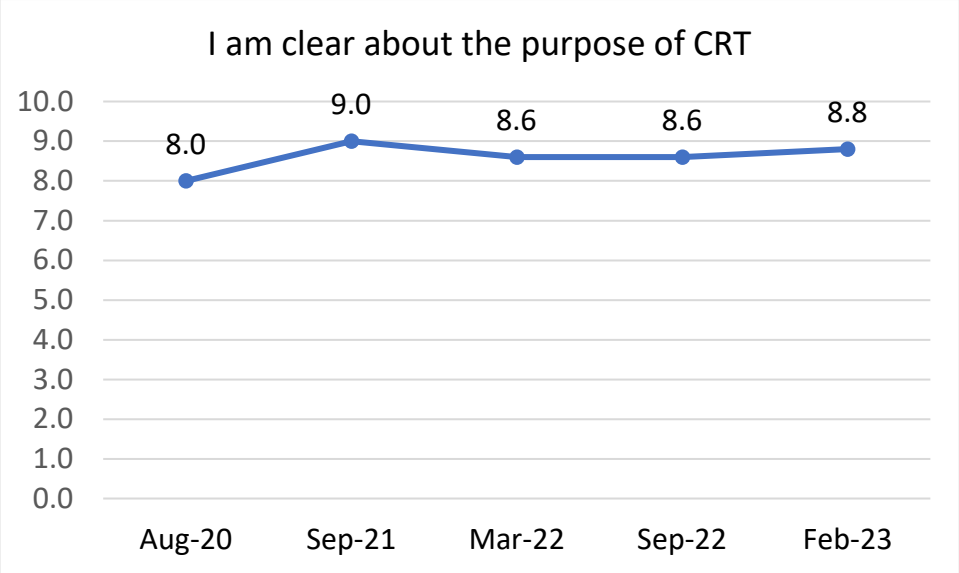


What needs to happen and what do you need to see to move you further up the scale?
Twenty respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I am clear about the purpose of CRT *(10 is 'agree completely' and 0 is 'disagree completely').*
Thirty-eight respondents gave a rating of at least 8 out of 10; this included thirty-one that awarded a maximum score of 10. There were three respondents giving a score of under 5.



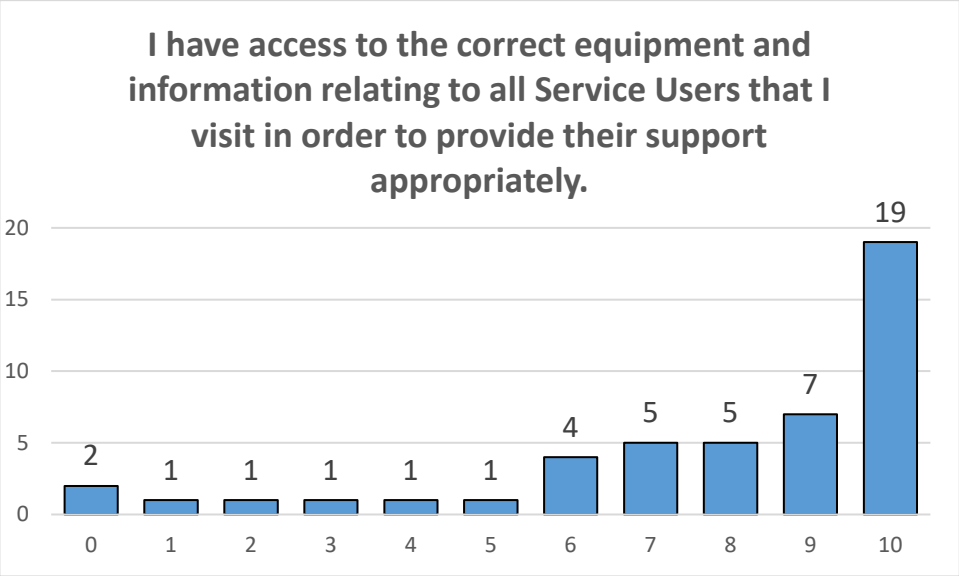
The average scoring for this statement was 8.6, a rise of 0.2 points recorded in September 2022.



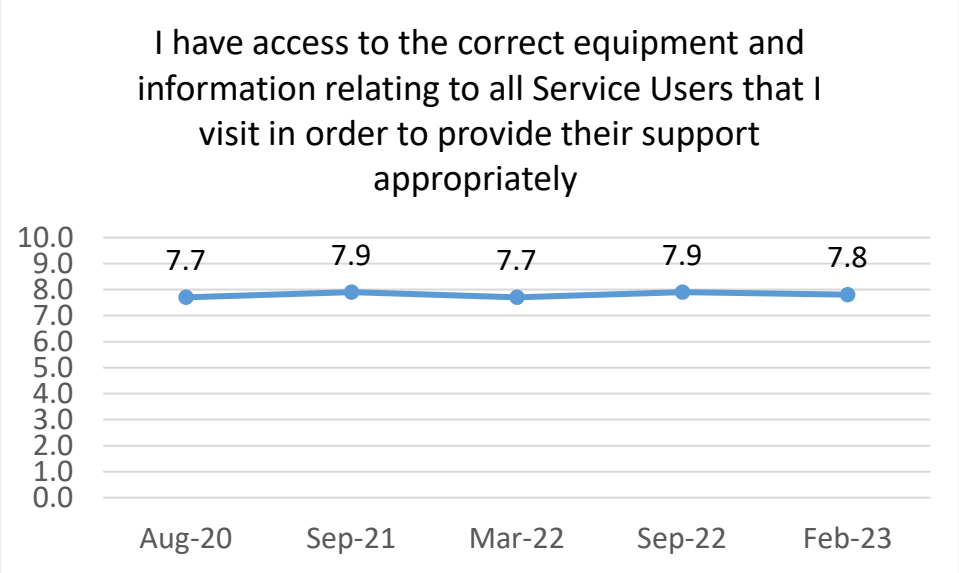
What needs to happen and what do you need to see to move you further up the scale?
Eight respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I have access to the correct equipment and information relating to all Service Users that I visit in order to provide their support appropriately. *(10 is 'agree completely' and 0 is 'disagree completely').*

Thirty-six respondents gave a rating of at least 7 out of 10. There were six respondents giving a score of under 5.



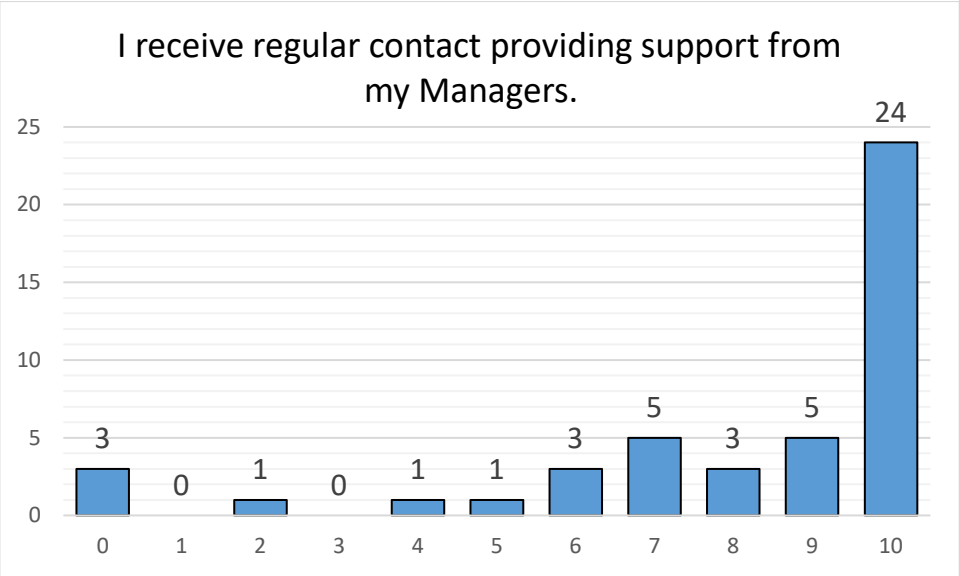
The average scoring for this statement was 7.8, broadly consistent with previous survey results.



What needs to happen and what do you need to see to move you further up the scale?
Twenty respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I receive regular contact providing support from my Managers *(10 is 'agree completely' and 0 is 'disagree completely').*

Thirty-seven respondents gave a rating of at least 7 out of 10; this included twenty-four that provided a maximum score of 10. There were five respondents giving a score of under 5.



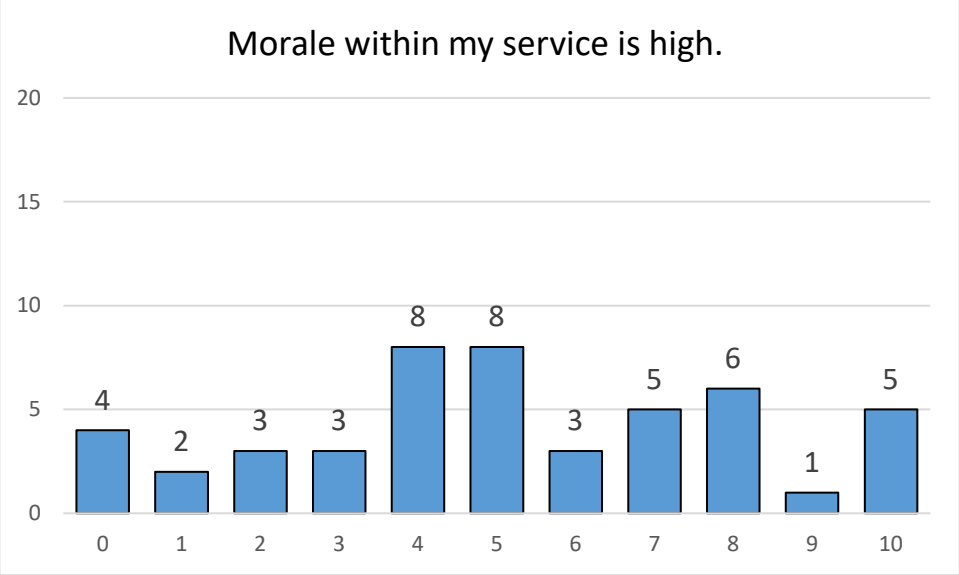
*This question was amended in Sep 22 from 'I receive regular supervisions from my Managers.'

The average scoring for this statement was 8.1, a rise of 0.5 points recorded in September 2022.

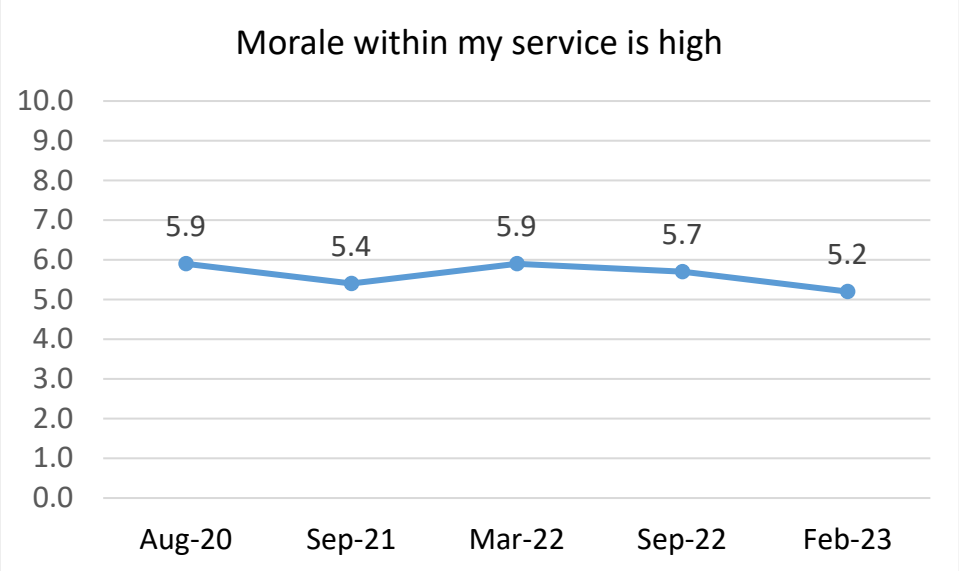
What needs to happen and what do you need to see to move you further up the scale?

Eleven respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

Morale within my service is high *(10 is 'agree completely' and 0 is 'disagree completely').*
Seventeen respondents gave a rating of at least 7 out of 10; this included five that provided a maximum score of 10. There were twenty respondents giving a score of under 5.



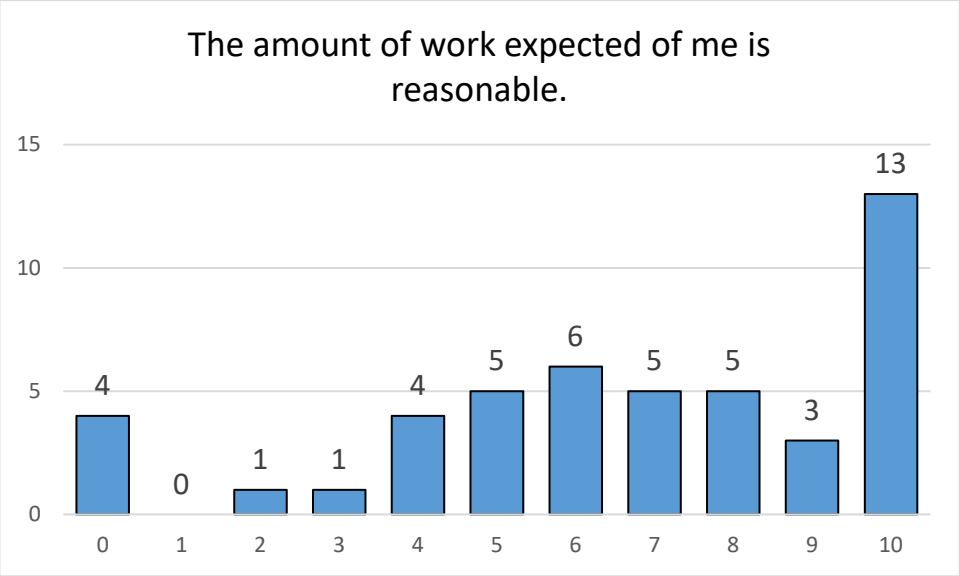
The average scoring for this statement was 5.2 the lowest score recorded for this statement across the surveys undertaken.



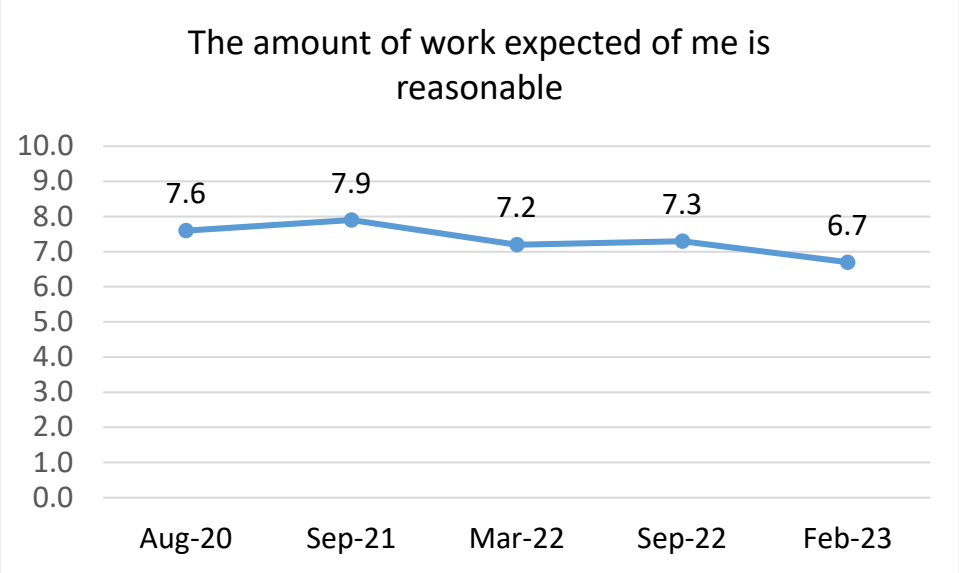
What needs to happen and what do you need to see to move you further up the scale?
Thirty-two respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

The amount of work expected of me is reasonable *(10 is 'agree completely' and 0 is 'disagree completely').*

Twenty-six respondents gave a rating of at least 7 out of 10; this included thirteen that provided a maximum score of 10. There were ten respondents giving a score of under 5.



The average scoring for this statement was 6.7 a fall of 0.6 points on the 7.3 recorded in September 2022.

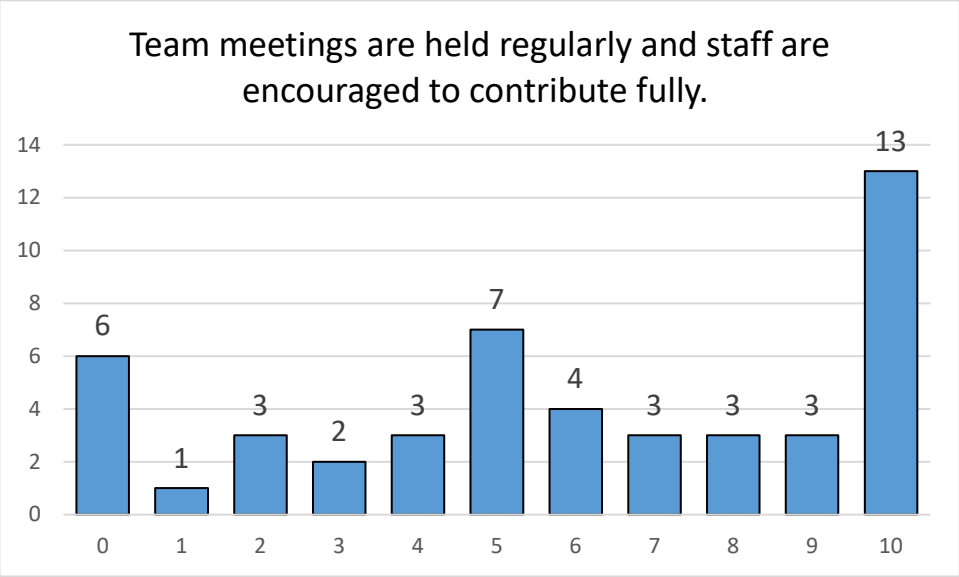


What needs to happen and what do you need to see to move you further up the scale?

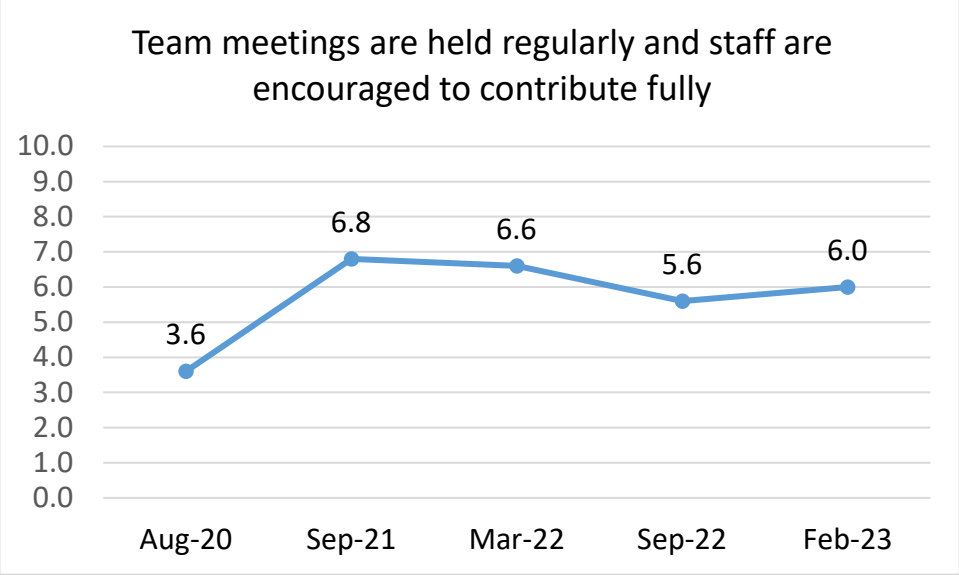
Twenty-six respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

Team meetings are held regularly, and staff are encouraged to contribute fully (*10 is 'agree completely' and 0 is 'disagree completely').*

Twenty-two respondents gave a rating of at least 7 out of 10; this included thirteen respondents that provided a maximum score of 10. There were Twenty-two respondents giving a score of five or less.



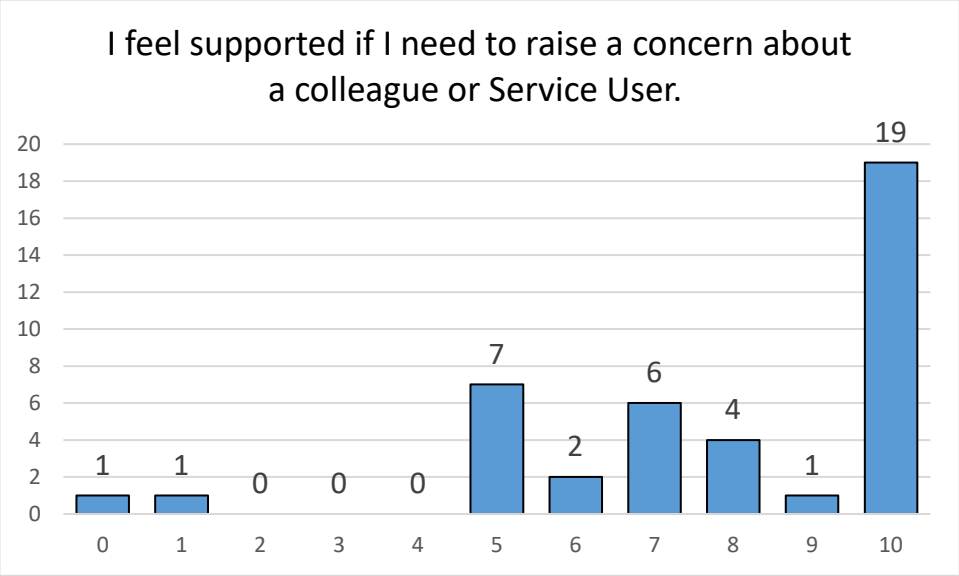
The average scoring for this statement was 6.0, a rise of 0.4 points compared to that recorded in September 2022.



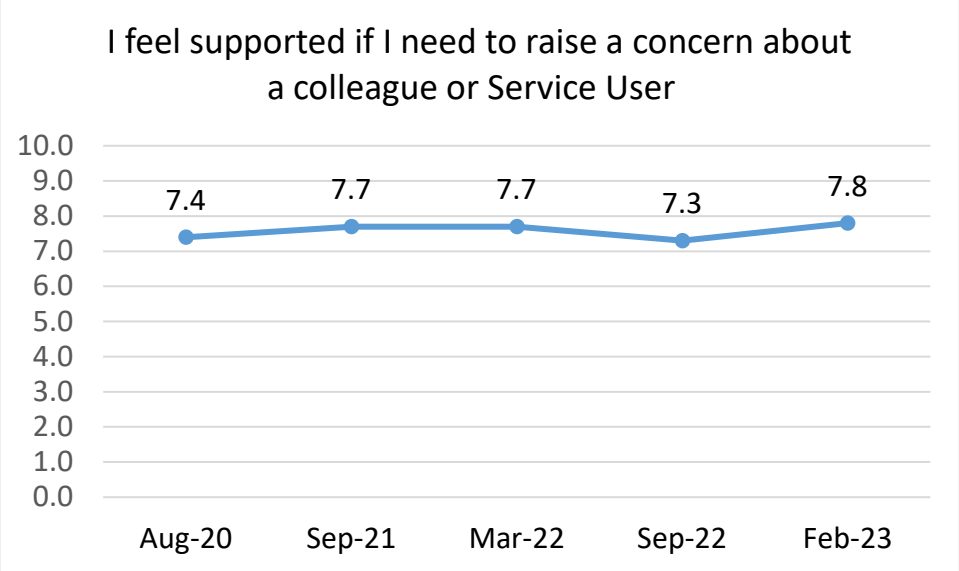
What needs to happen and what do you need to see to move you further up the scale?

Twenty-two respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I feel supported if I need to raise a concern about a colleague or Service User *(10 is 'agree completely' and 0 is 'disagree completely')*.
Thirty respondents gave a rating of at least 7 out of 10; this included nineteen that provided a maximum score of 10. There were two respondents that gave a score of under 5.



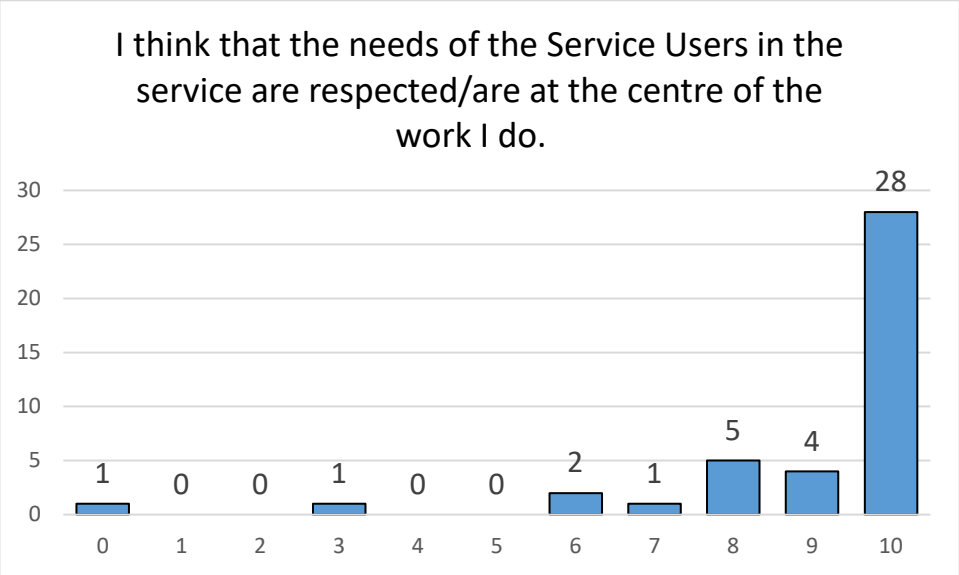
This gave an average score of 7.8, the highest score recorded for this statement across the surveys undertaken.



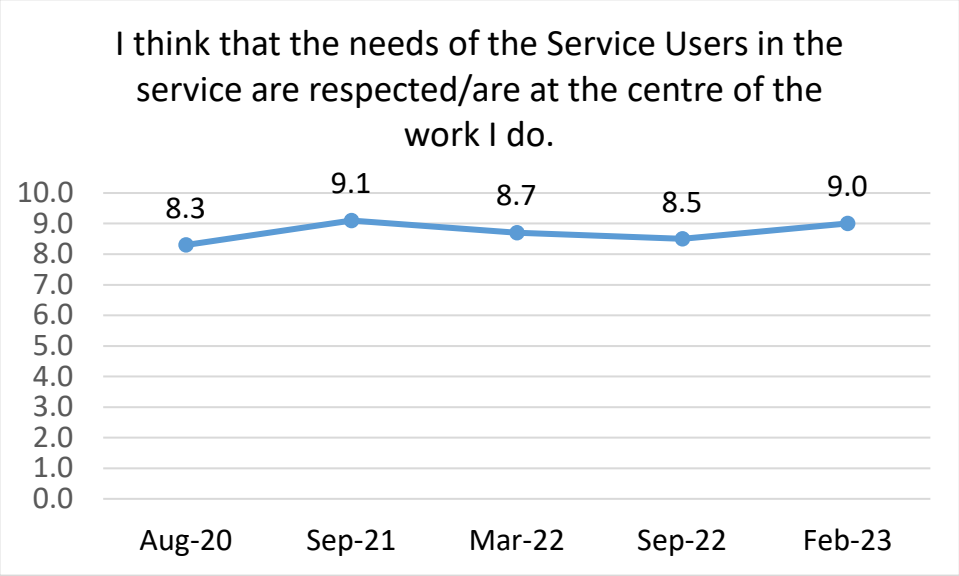
What needs to happen and what do you need to see to move you further up the scale?
Ten respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I think that the needs of the Service Users in the service are respected/are at the centre of the work I do. *(10 is 'agree completely' and 0 is 'disagree completely').*

Thirty-seven respondents gave a rating of at least 8 out of 10; this included twenty-eight respondents that provided a maximum score of 10. There were just two respondents giving a score of under 5.



The average scoring for this statement was 9.0, broadly returning to the results realised in September 2021.

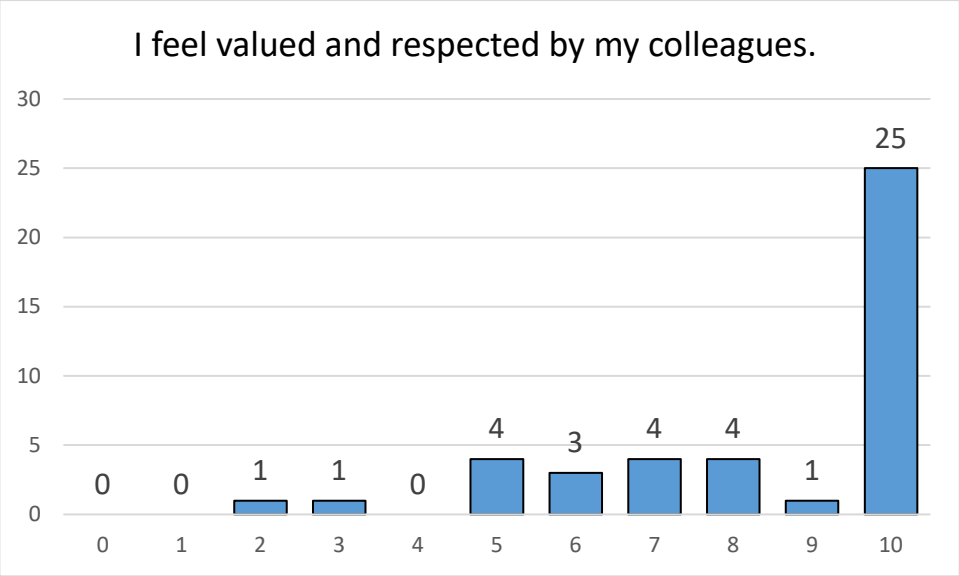


What needs to happen and what do you need to see to move you further up the scale?

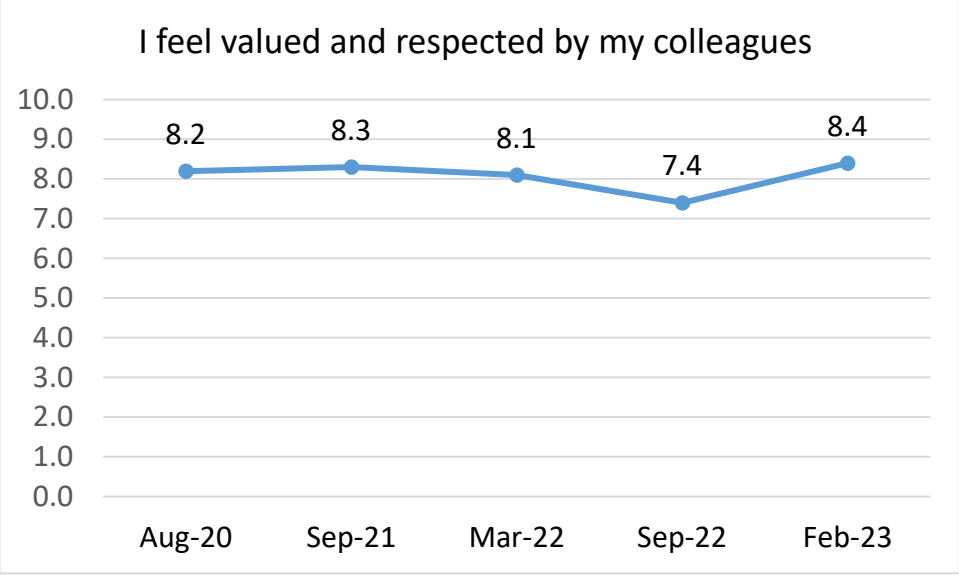
Seven respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I feel valued and respected by my colleagues *(10 is 'agree completely' and 0 is 'disagree completely').*

Thirty-four respondents gave a rating of at least 7 out of 10; this included twenty-five that provided a maximum score of 10. There were two respondents giving a score of under 5.



The average scoring for this statement was 8.4, the highest score recorded over the four years the survey has operated.

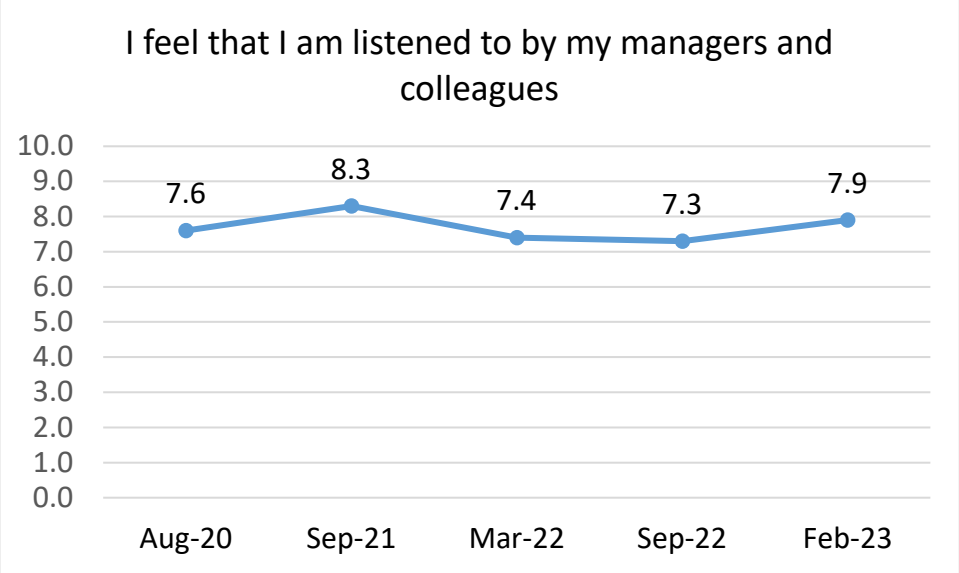


What needs to happen and what do you need to see to move you further up the scale?

Five respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

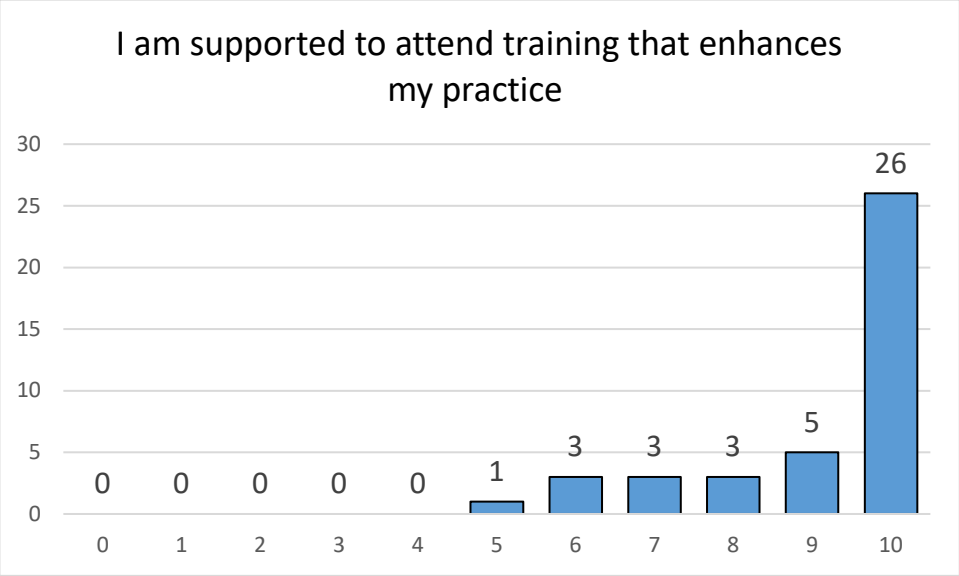
I feel that I am listened to by my managers and colleagues *(10 is 'agree completely' and 0 is 'disagree completely')*.
All respondents provided a score of at least 4 out of 10, this included seventeen that give the maximum score of 10 out of 10.

The average scoring for this statement was 7.9, a rise of 0.6 points from that realised in September 2022.

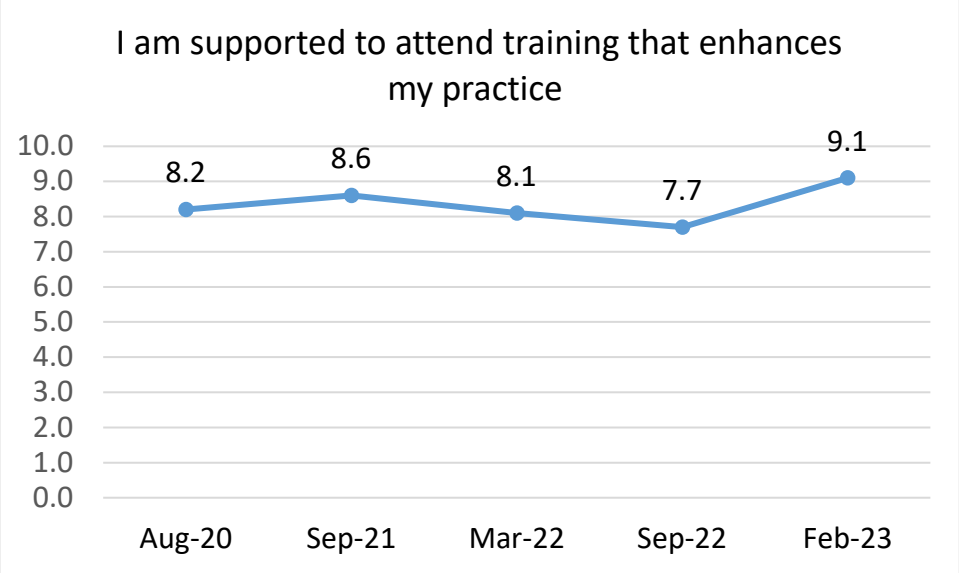


What needs to happen and what do you need to see to move you further up the scale?
Eight respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I am supported to attend training that enhances my practice *(10 is 'agree completely' and 0 is 'disagree completely')*.
Thirty-four respondents gave a rating of at least 8 out of 10; this included twenty-six that awarded a maximum score of 10. There were no respondents giving a score of under 5.



The average scoring for this statement was 9.1, the highest recorded since the survey's inception.

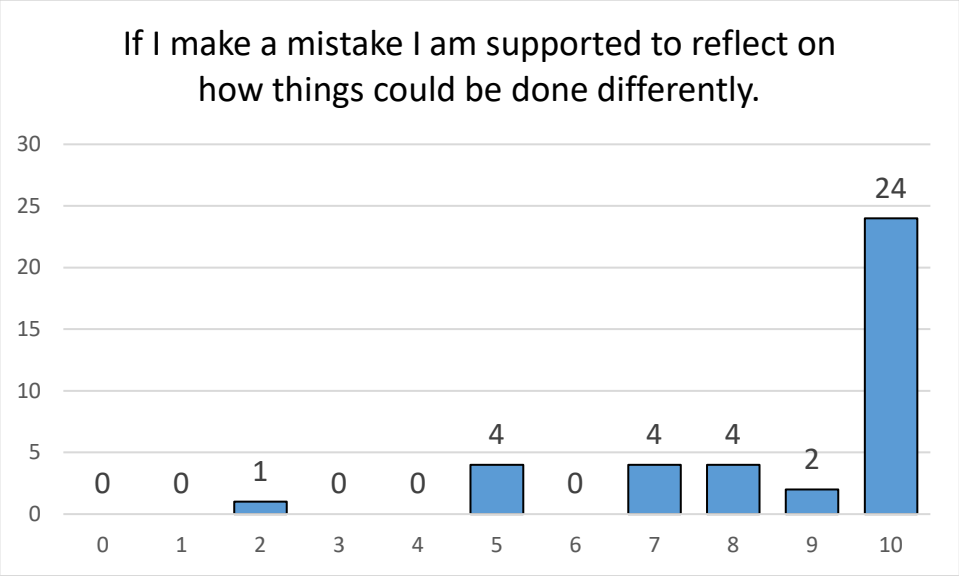


What needs to happen and what do you need to see to move you further up the scale?
Seven respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

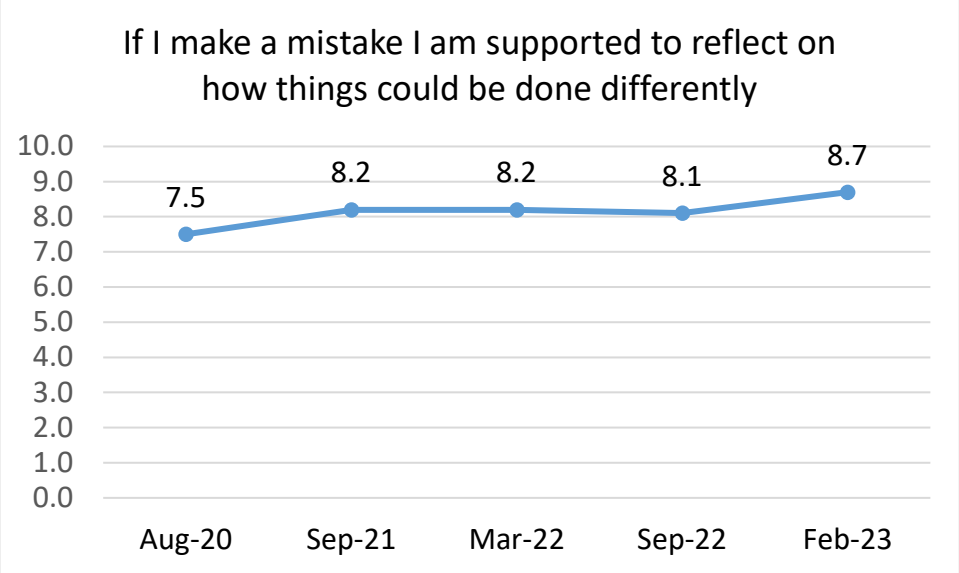
If I make a mistake, I am supported to reflect on how things could be done differently

(*10 is 'agree completely' and 0 is 'disagree completely'*).

Thirty-four respondents gave a rating of at least 7 out of 10; this included twenty-four respondents that provided a maximum score of 10. There was one respondent that gave a score of under 5.



The average scoring for this statement was 8.7, an increase of 0.6 points from the score realised in September 2022.



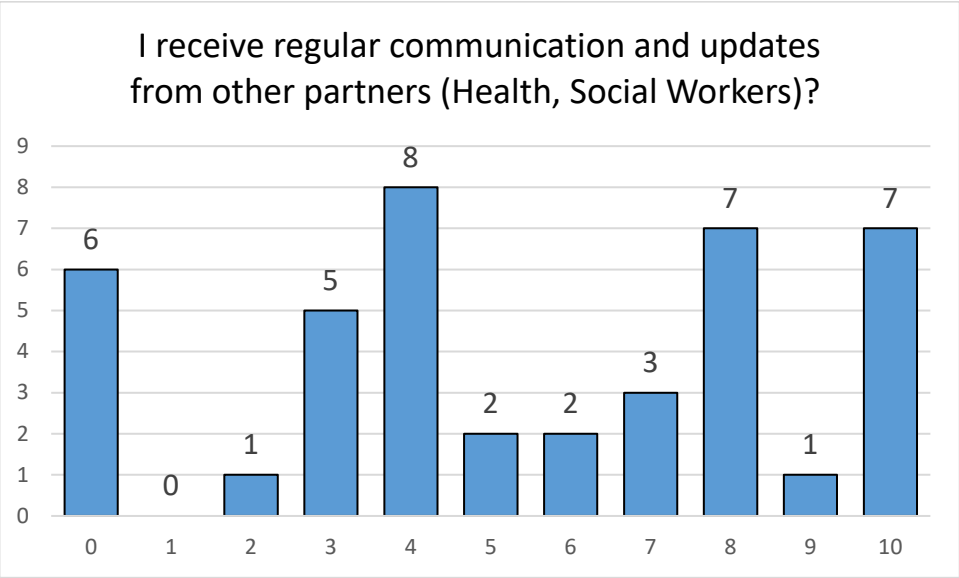
What needs to happen and what do you need to see to move you further up the scale?

Four respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

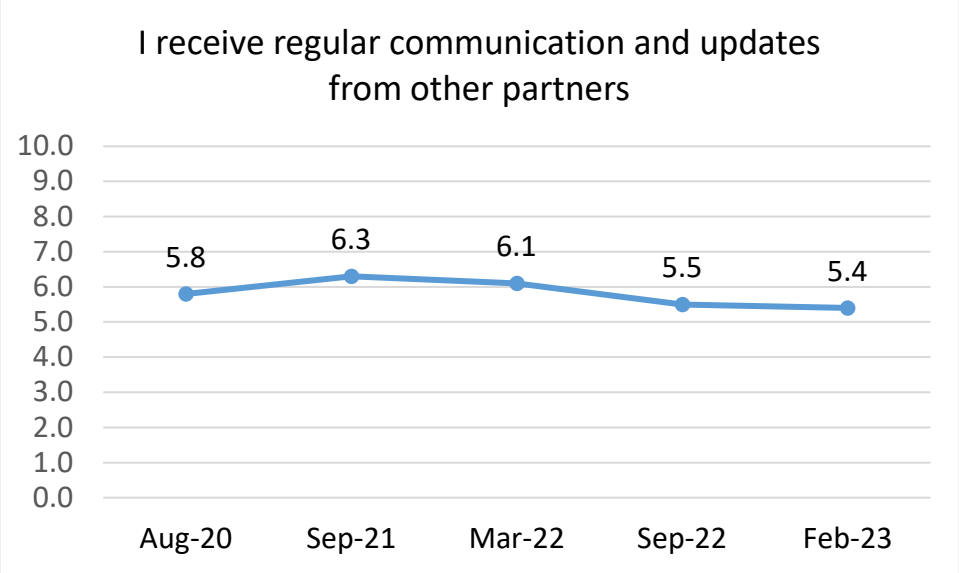
I receive regular communication and updates from other partners (Health, Social Workers)

(10 is 'agree completely' and 0 is 'disagree completely').

Eighteen respondents gave a rating of at least 7 out of 10, this included seven that provided a maximum score of 10. A further twenty-two respondents gave a score of 5 or less.



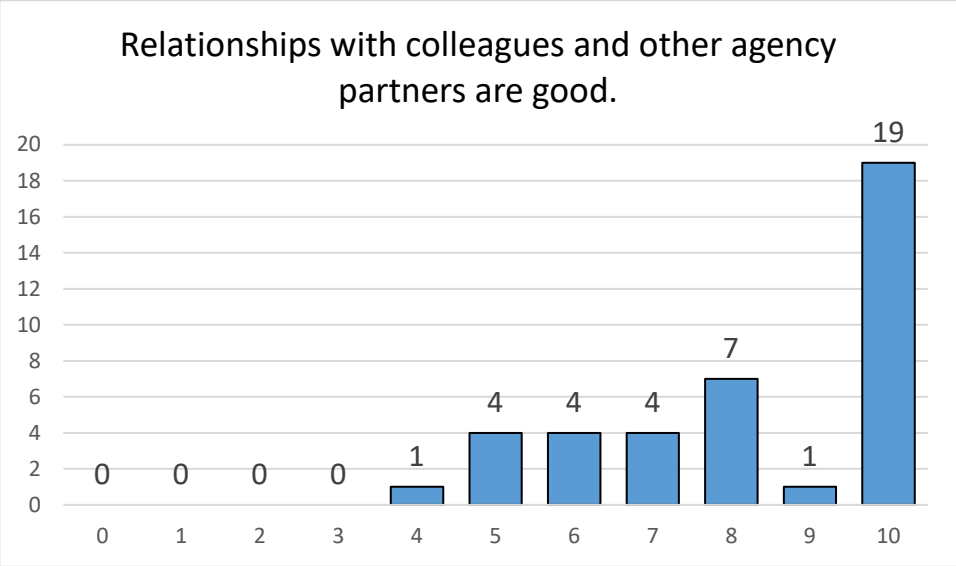
The average scoring for this statement was 5.4, the lowest seen in the five surveys undertaken.



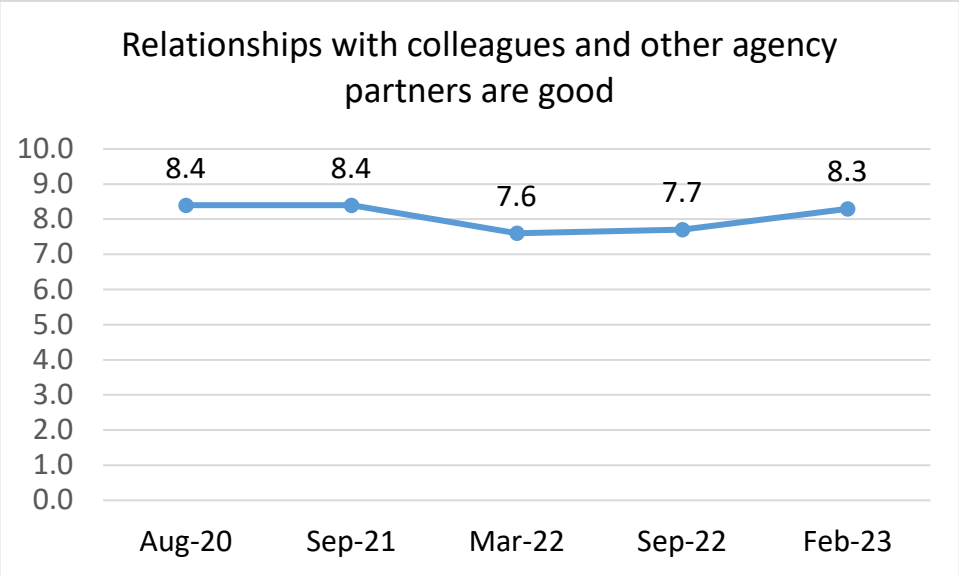
What needs to happen and what do you need to see to move you further up the scale?

Twenty-one respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

Relationships with colleagues and other agency partners are good (*10 is 'agree completely' and 0 is 'disagree completely')*.
Twenty-seven respondents gave a rating of at least 8 out of 10; this included nineteen that provided a maximum score of 10. There was one respondent that awarded a score of under 5.

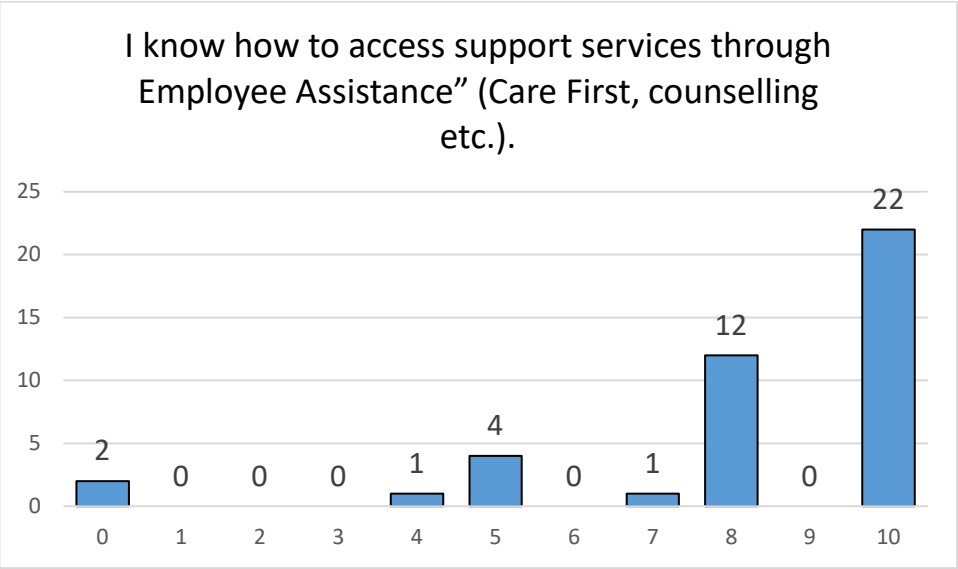


The average scoring for this statement was 8.3, returning to the levels recorded in 2020 and 2021.

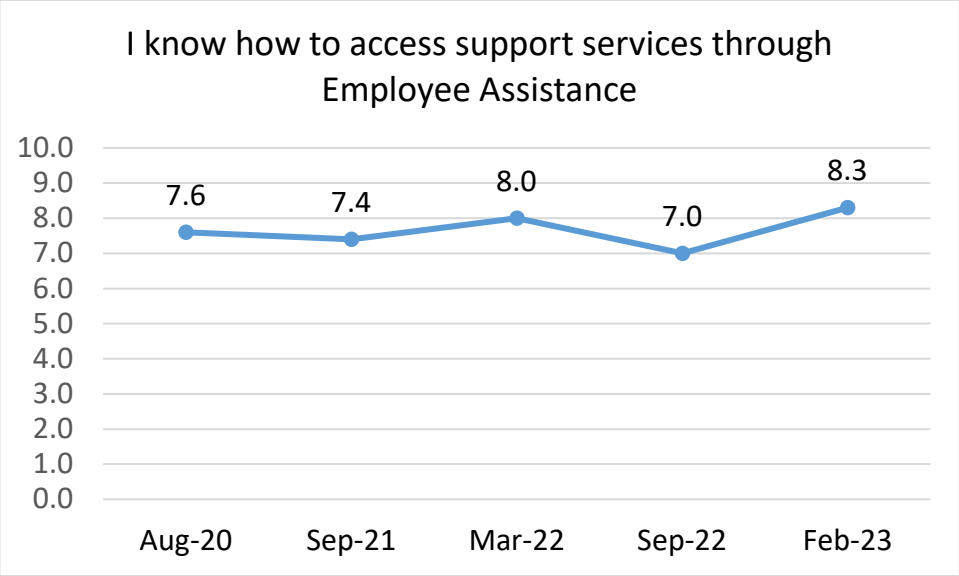


What needs to happen and what do you need to see to move you further up the scale?
Four respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I know how to access support services through Employee Assistance" (Care First, counselling etc.) *(10 is 'agree completely' and 0 is 'disagree completely')*.
Thirty-five respondents gave a rating of at least 7 out of 10; this included twenty-two that provided a maximum score of 10. There were three respondents giving a score of under 5.



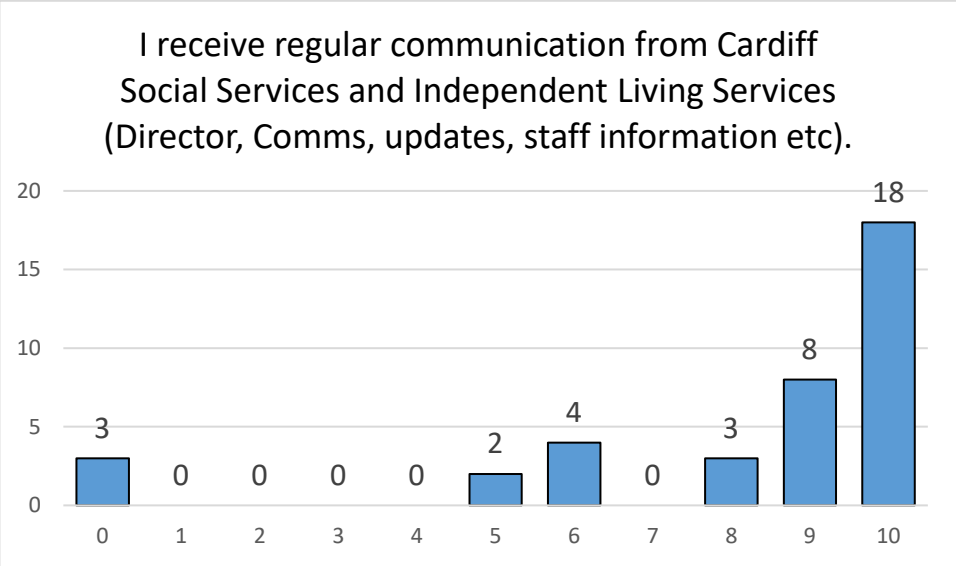
The average scoring for this statement was 8.3, the highest recorded over the last four years.



What needs to happen and what do you need to see to move you further up the scale?
Seven respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

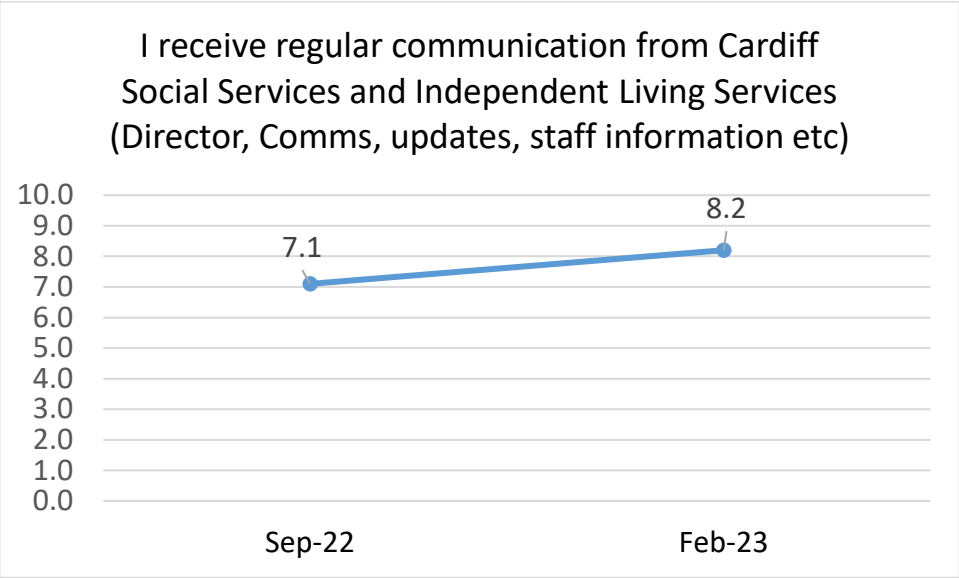
I receive regular communication from Cardiff Social Services and Independent Living Services (Director, Comms, updates, staff information etc). *(10 is 'agree completely' and 0 is 'disagree completely')*.

Twenty-nine respondents gave a rating of at least 8 out of 10; this included eighteen respondents that provided a maximum score of 10.



*This question was amended in Sep 22 from 'I receive regular communication from Cardiff Social Services (Director, Comms, updates, staff information etc)' as such limited trend analysis is available.

The average scoring for this statement was 8.2, an increase of 1.1 points to that recorded in September 2022.

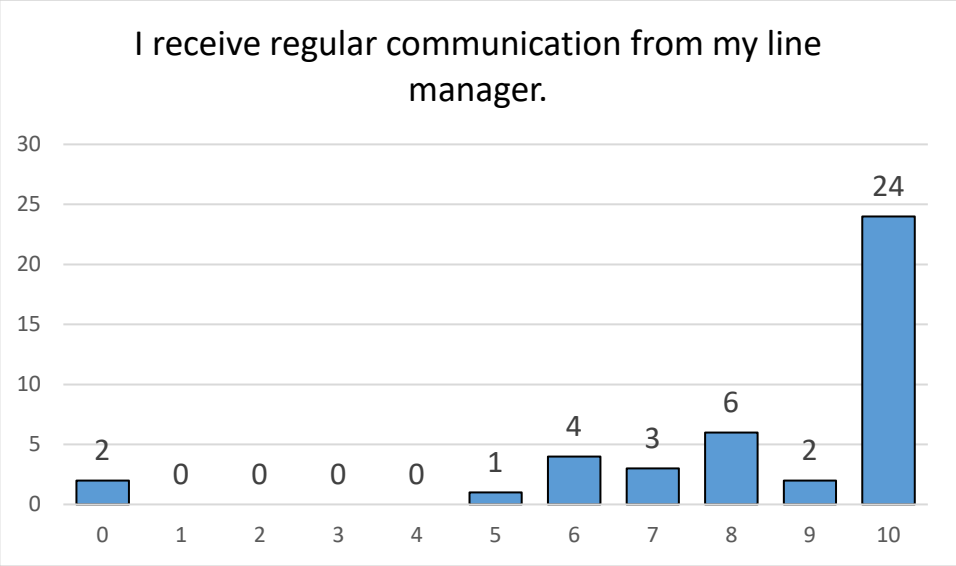


What needs to happen and what do you need to see to move you further up the scale?

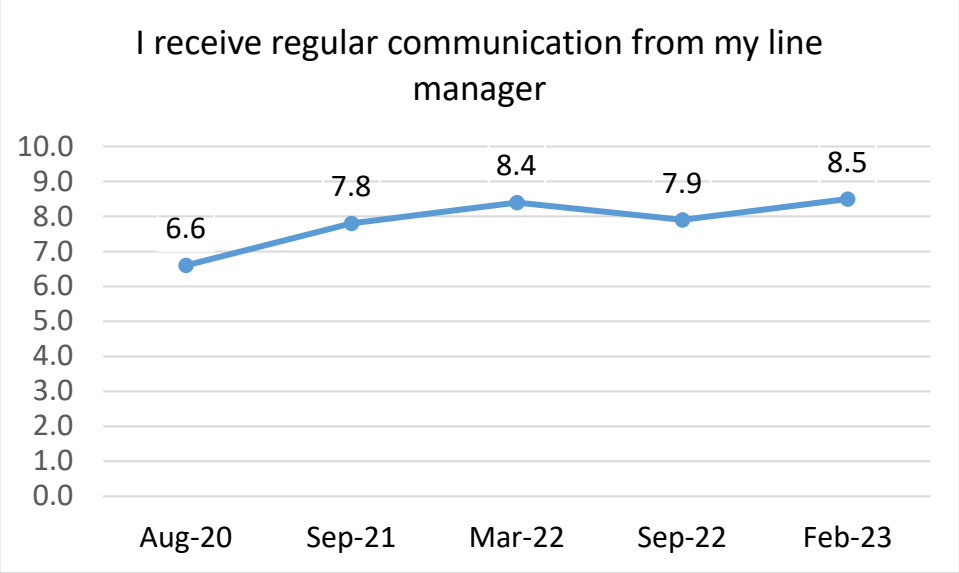
Six respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

I receive regular communication from my line manager *(10 is 'agree completely' and 0 is 'disagree completely').*

Thirty-five respondents gave a rating of at least 7 out of 10; this included twenty-four respondents that provided a maximum score of 10. There were two respondents giving a score of under 5.



The average scoring for this statement was 8.5, the highest score recorded for this statement across the surveys undertaken.



What needs to happen and what do you need to see to move you further up the scale?

Six respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

Is there anything else you'd like to tell us about working at CRT that you have not had an opportunity to cover in your previous responses?

Twenty-one respondents took the opportunity to leave feedback to this question, these comments have been passed to the Responsible Individual for consideration and any follow up action as appropriate.

Appendix A

	Question	Mar. 2023 Mean	Sept. 2022 Mean	Average Score Change
Q14	I am supported to attend training that enhances my practice	9.1	7.7	**1.4**
Q11	I think that the needs of the Service Users in the service are respected/are at the centre of the work I do.	9.0	8.5	**0.5**
Q4	I am clear about the purpose of CRT	8.8	8.6	**0.2**
Q15	If I make a mistake I am supported to reflect on how things could be done differently	8.7	8.1	**0.6**
Q20	I receive regular communication from my line manager	8.5	7.9	**0.6**
Q12	I feel valued and respected by my colleagues	8.4	7.4	**1.0**
Q17	Relationships with colleagues and other agency partners are good	8.3	7.7	**0.6**
Q18	I know how to access support services through Employee Assistance" (Care First, counselling etc.)	8.3	7.0	**1.3**
Q19	I receive regular communication from Cardiff Social Services and Independent Living Services (Director, Comms, updates, staff information etc)	8.2	7.1	**1.1**
Q6	I receive regular contact providing support from my Managers.	8.1	7.6	**0.5**
Q13	I feel that I am listened to by my managers and colleagues	7.9	7.3	**0.6**
Q5	I have access to the correct equipment and information relating to all Service Users that I visit in order to provide their support appropriately	7.8	7.9	**-0.1**
Q10	I feel supported if I need to raise a concern about a colleague or Service User	7.8	7.3	**0.5**
Q3	CRT has clear leadership	7.4	6.8	**0.6**
Q1	CRT is a good place to work	7.1	7.1	**0.0**
Q8	The amount of work expected of me is reasonable	6.7	7.3	**-0.6**
Q2	I understand the vision for the future.	6.6	7.0	**-0.4**
Q9	Team meetings are held regularly and staff are encouraged to contribute fully	6.0	5.6	**0.4**
Q16	I receive regular communication and updates from other partners (Health, Social Workers)	5.4	5.5	**-0.1**
Q7	Morale within my service is high	5.2	5.7	**-0.5**

Appendix 4 - Anonymised views of frontline care sector workers

On Committee's request, an email was sent to front line workers in Cardiff Council, inviting their anonymised views on the hospital discharge process for those with care needs.

The email sought the frontline workers specific views on what works well in the process, and areas for improvement.

The below provides the comments received:

Working Well:

"I have seen an improvement having one point of access to the Integrated Discharge Hub team, as this has given clear triage pathways and has enabled the right people to come through for a reablement service"

Areas for Improvement:

Better hospital transport:

Aiming for timely discharges as assessments can take some time to complete depending on the complexities.

Discussions with patients and Families or support networks on if able to support the individual overnight so assessment could be completed early the next morning – this will save on transport costs if family are able to collect from ward.

Home assessment visits by ward OT's:

When assessing a patient using equipment such as hoists or profiling beds, there used to be home assessments that took place with the patient in their own home. This identified the best equipment to prescribe based on the environment and took into consideration space and accessibility for carers providing care.

Appendix 4 - Anonymised views of frontline care sector workers

Alternatives to care:

Thinking outside the box, is there any technology, equipment or other services that could provide the support a carer could, i.e Meals on Wheels, Wiltshire Farm Foods, Telecare, Alexa etc. Trolley to transport food and drink from room to room, perch stool to enable a patient to sit at the kitchen counter and make their own drinks and snacks.

Medication:

It would assist if the ward staff were to think how medication was managed before admission, is it appropriate to change to alternative dispensing methods or better to stick to what they know and have managed. Can family or friends assist, were they assisting before admission, what has changed.

Ward Views:

Be less risk averse from a ward level, It may be that a patient requires 4 x daily assistance, but this does not mean that when home they would not have some reablement potential and the calls could be reduced from 4 to less or even none with a good reablement approach from Health and Social care and the right support networks around them. (I understand this will not be the case at all times)

Level of care required:

Currently there are no care constraints but when they do arise think about the level of care that is being requested, again looking at alternatives and ensuring that everything has been taken into consideration such as for an example if a request to support a patient with medication is required does the medicines regime fit with the care calls being requested if not rationalise the regime with the Ward Dr and Pharmacy.

Appendix 4 - Anonymised views of frontline care sector workers

Communication:

Open and honest communication, if someone has a prognosis of a terminal illness it is not always appropriate to send to a reablement team knowing that within maybe a couple of weeks they must move to another agency.

Take the patients word for it. If there is no doubt in relation to the capacity of a patient and they advise they don't want care when they go home, and you know this is an informed decision as they have been advised of all identified risks. Arrange the discharge, if anything then fails it would be picked up by either the GP or the First Point Of Contact Social work team in the community. (Give them the contact numbers for this service).

The below information was received in specific relation to the D2RA pathway:

The premise of D2RA is that the patient is assessed by either an Occupational Therapist (OT), Social Worker (SW) or Social Work Resource Assistant (SWRA) on the ward, with a view to providing a temporary care package, a review then conducted in their own home environment post-discharge with a view to providing a permanent care package.

The following comments for each process are below:

***Allocation**: each case is triaged at the Integrated Discharge Hub (IDH) at UHW – from an OT perspective we have an Occupational Therapy Assistant (OTA) working in the triage office – this has worked really well as the OTAs can in-reach onto the wards for further information. This may be further enhanced if an OT was in triage, to provide advice and support on manual handling/equipment/adaptations issues. Particularly from working in an NHS environment it is vital that Multi-Disciplinary Teams communicate and collaborate in this way. What is important is that all professions will view the patient from a different perspective, thus offering patient-centred care.*

Appendix 4 - Anonymised views of frontline care sector workers

Unfortunately, the triage team have recently been moved into the main First Point of Contact (FPOC) room, and they have to share one phone between four of them. Although this may appear minor, in their role it is vital that all equipment needs are in place as a matter of urgency. At present the current office environment at UHW is not conducive to allowing everyone to work to their full potential. The office is overcrowded, and can be noisy at times, particularly if a sensitive phone call for example would need to be conducted. FPOC/OT at County Hall work well, if this was replicated in a hospital environment, then this would only enhance working outcomes.

As the D2RA project is new, we appreciate that there are processes which are evolving and need to be resolved accordingly. For example, we are currently working with team managers to finely tune the allocation process, so after the triage stage to OT or SW – some patients require more manual needs over social issues and vice versa.

Assessment: *the allocated member of staff would receive the allocation via a joint Teams notification and within 24 hours they attend the ward (at present this could be UHW, UHL or St David's Hospital). The patient is spoken to, assessed, ward staff are consulted, ward notes perused and updated as necessary.*
This has worked well – Cardiff Council (CC) staff being able to in-reach onto the ward and again communicate and collaborate with NHS staff has been extremely successful.

There are several requirements needed to be made by NHS staff for the IDH team to commence D2RA pathway, it is felt these need to be listed below and comments made as some of these processes can delay a discharge:

Equipment*: all equipment needs to be in situ at the home environment – this is usually the responsibility of the ward OT/staff, prior to referral being made to IDH. However, there can be delays with this for various reasons. For example, a referral being received on a Monday, OT visits ward to assess patient on Tuesday, however only part-equipment delivered to home address. A decision needs to be made as to*

whether the patient needs to then be re-referred and go through the whole process again, or by Community Occupational Therapist (COT), OT and ward OT liaising with each other and D2RA co-ordinator, a temporary hold on the referral for one day, delivery of the final piece of equipment on Thursday means the patient can then be discharged Friday. This would not appear to be a smooth D2RA process 'on paper' however by collaborative working this has saved the patient being in hospital for another week and not having to be re-referred.

Medication: *a necessity for discharge via the D2RA pathway is that the patient can either self-medicate, family support is available to give medications or medications are in blister packs. Very often blister packs are difficult to get hold of in the community, which then causes a delay in discharge via this pathway. By resolving pharmacy supply of blister packs a huge amount of time and money could be saved.*

On numerous occasions CC staff have to reiterate to NHS staff that the above processes need to be in place in order for the patient to be D2RA suitable, this is not a complaint or a criticism as this could be resolved by presentations or information being made to NHS staff in order to clarify the pathway.

Interim care package: *the relevant process is followed on CareFirst, the D2RA care co-ordinator would commence their work and it is usually within 72 hours that the patient is discharged from hospital to their home environment, and a temporary care package is started for the patient. As the patient has been assessed on the ward and information gained to support the assessment the care package can be supported by this early intervention. For example, very often third sector support and CC referrals are made at this stage.*

Review visit: *the initial allocated worker (namely OT, SW or SWRA) would attend the patient's home to review the care package. This is the stage that differs according to profession for example, OT would usually visit 7-10 days post-discharge, SW 3 days post-discharge. The OTs arrange to meet the care agency at the property so they are able to observe the care provided. This allows for any amendments to be made, for example timing of calls or any equipment needs required.*

Appendix 4 - Anonymised views of frontline care sector workers

We feel strongly about the D2RA project and how this can aid a safe, timely and cost-effective discharge. It is appreciated that all professions will have a different perspective, however the end goal is the same, namely the patient/citizen. This is an excellent example of collaborative working.