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.

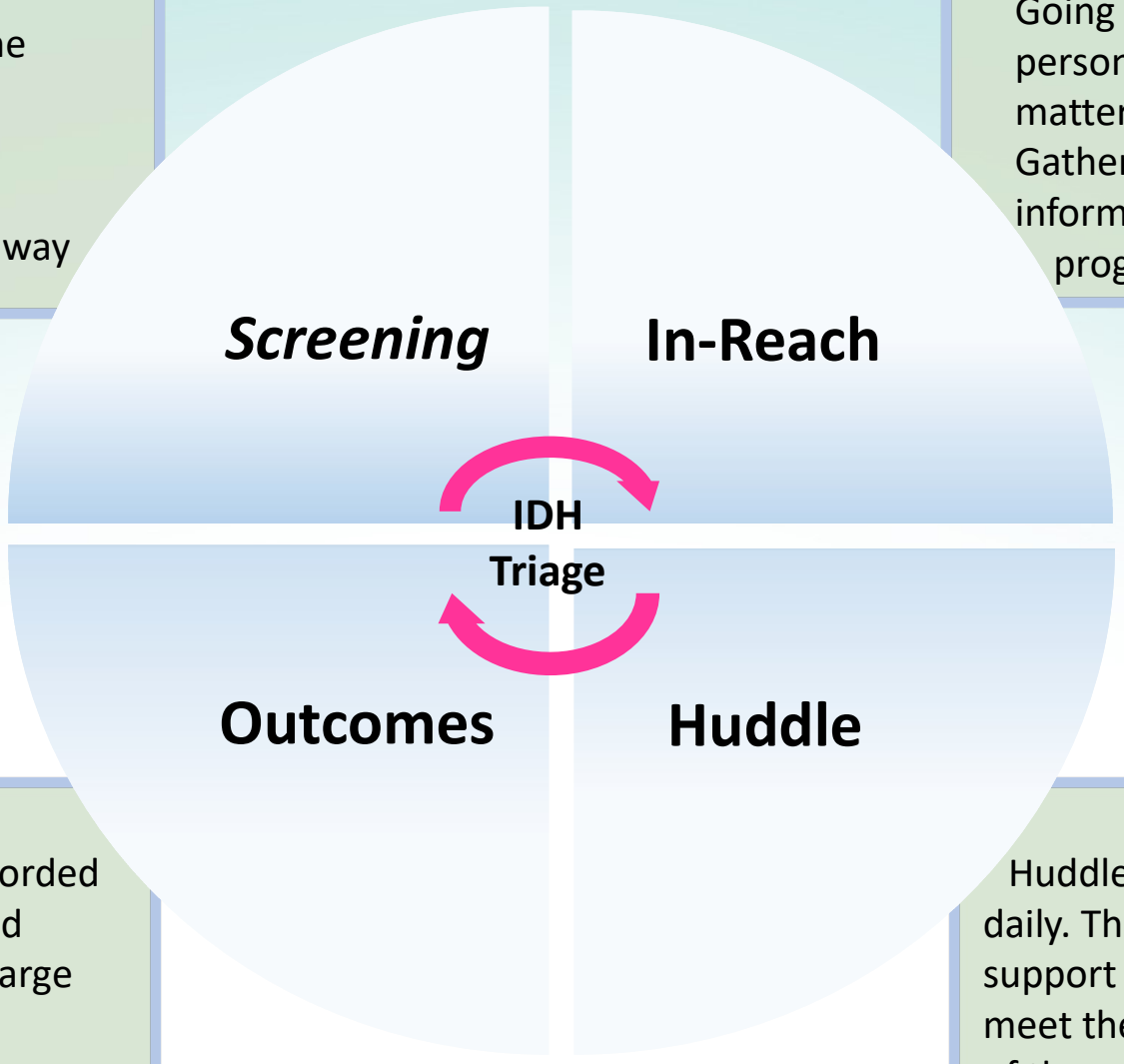
Following are our core values:

- 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

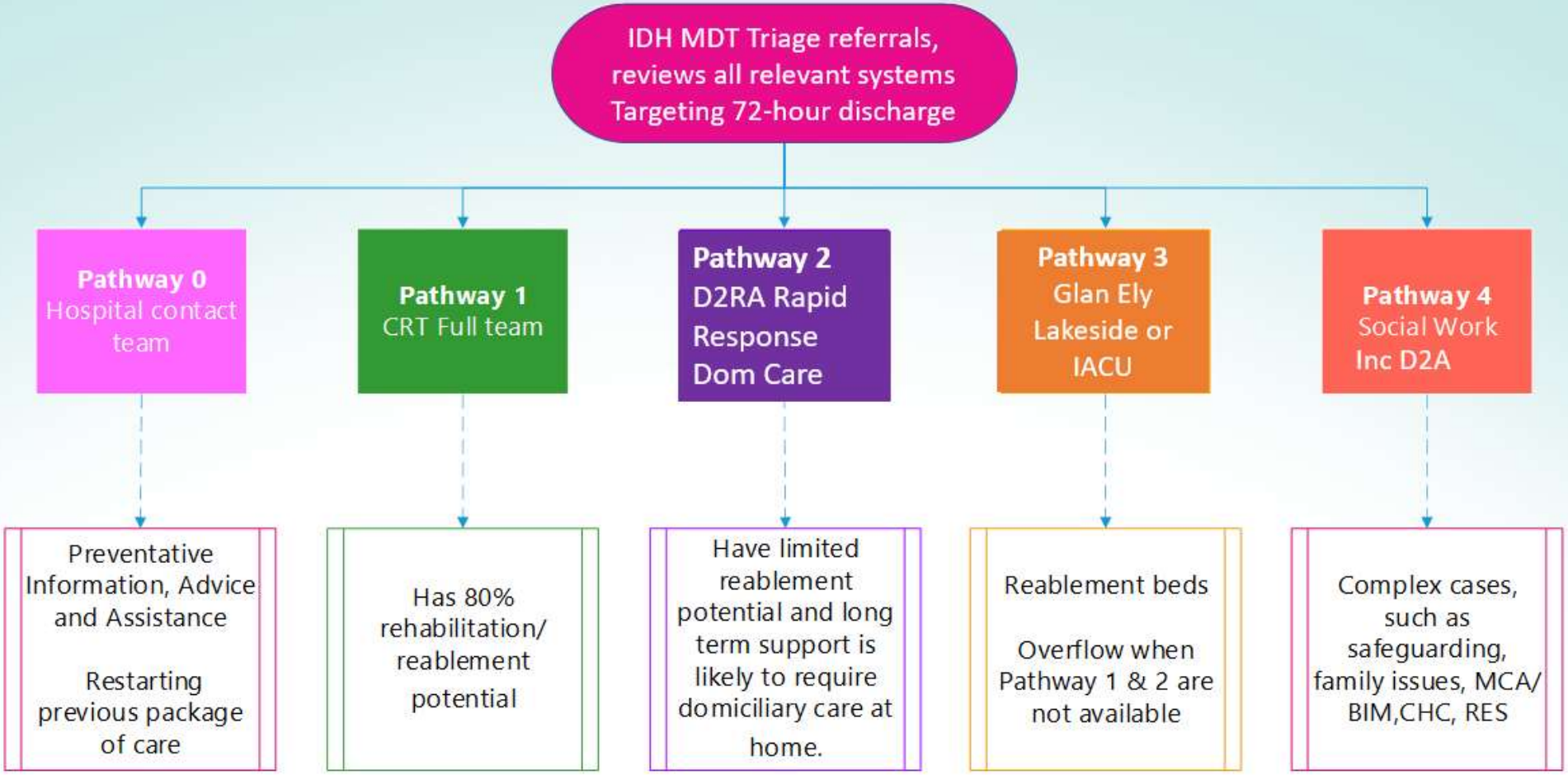
Going to the ward, meeting the person and hearing what matters to them
Gathering all relevant information and consent to progress the assessment



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**

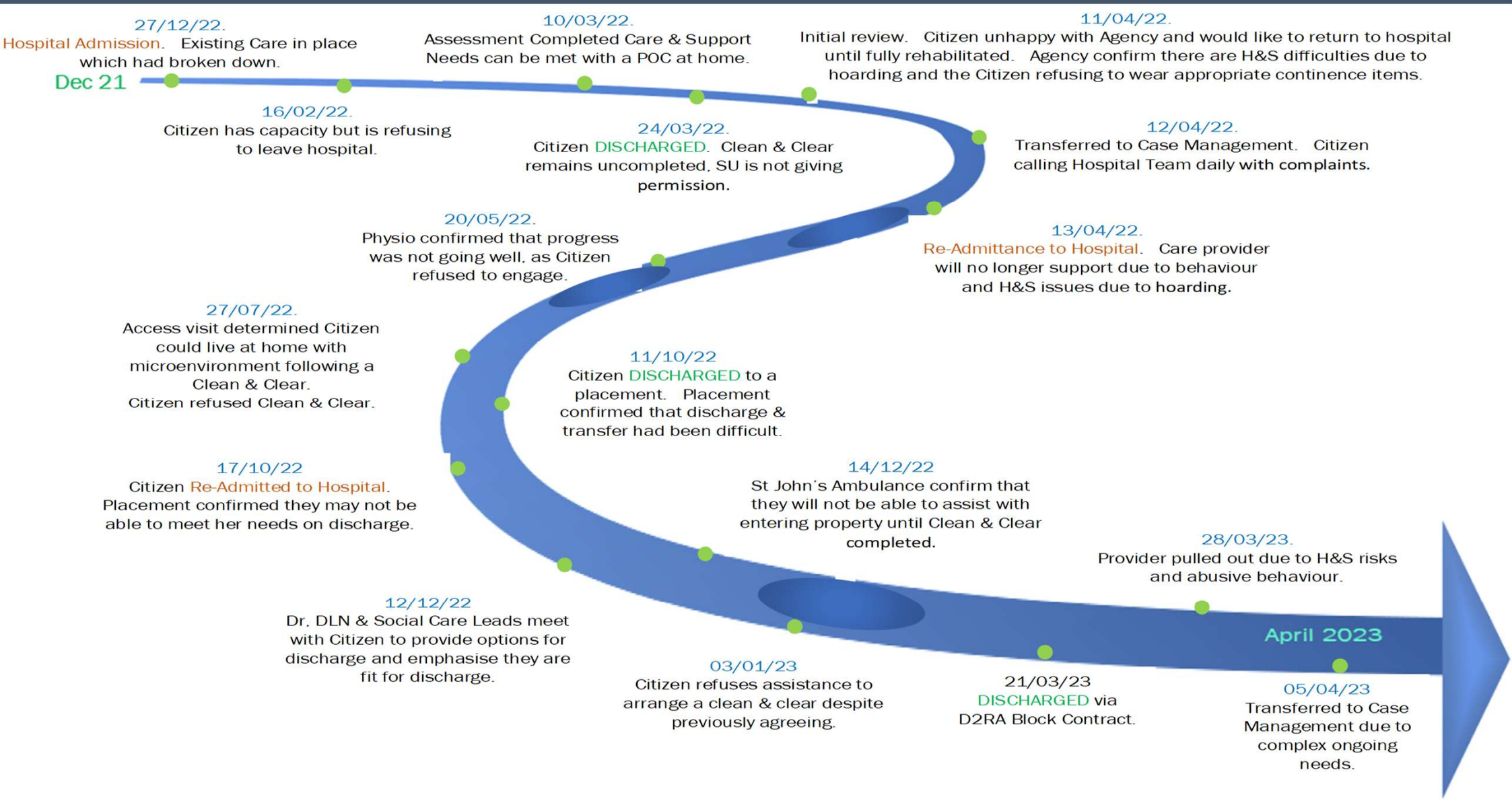
For Example:

- 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

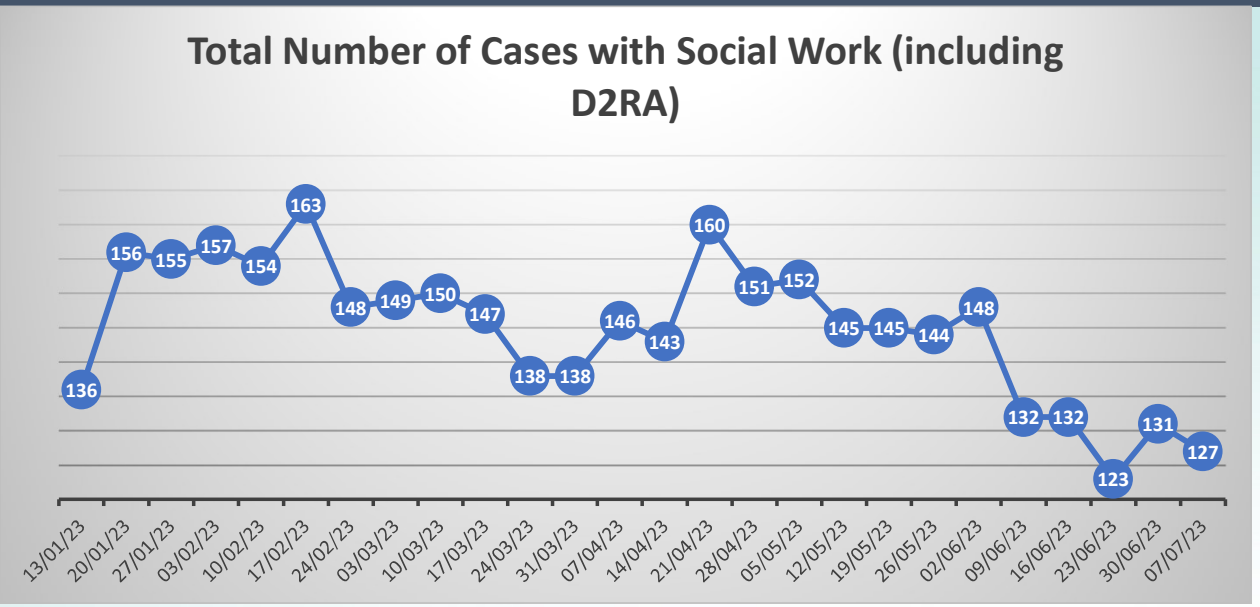
Embracing Trusted Assessor approach to support the pressure on SW and minimise delays

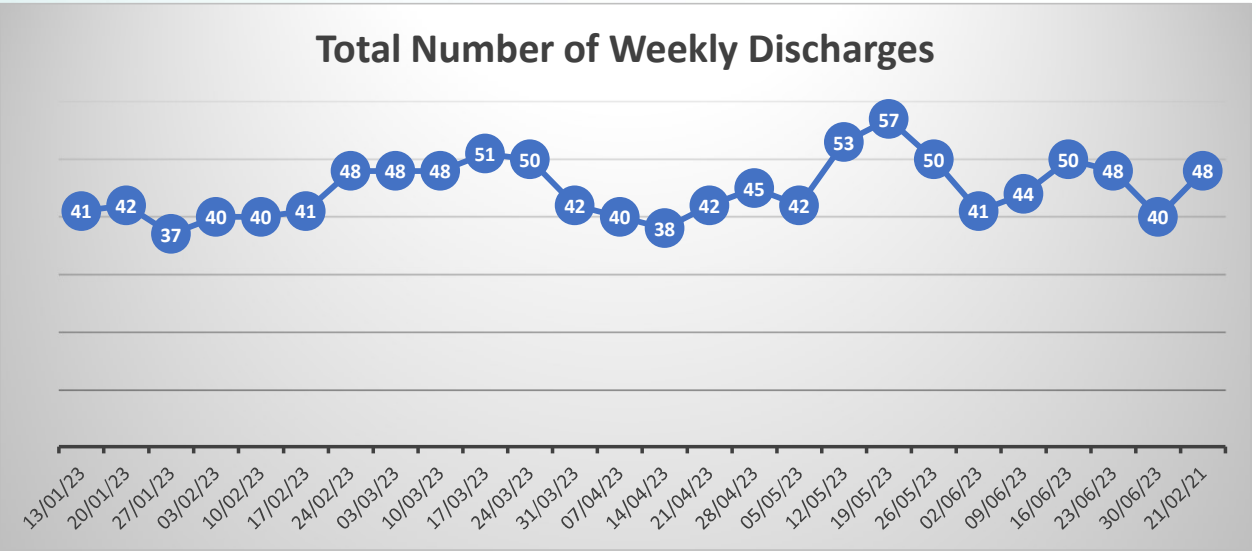
Using trusted assessors to carry out assessment of need avoids duplication and speeds up response times so that people can be supported and discharged in a safe and timely way. We have developed competency, training and skill matrixes to support and promote "Grow Your Own" ethos.

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)

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
- ✓ IDH 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 ?