Meeting of:	**SUBJECT OVERVIEW AND SCRUTINY COMMITTEE 2**
Date of Meeting:	**23 SEPTEMBER 2024**
Report Title:	**COMMUNITY RESOURCE TEAM AND PACKAGE OF CARE DELAYS (PoCD)**
Report Owner / Corporate Director:	**CORPORATE DIRECTOR SOCIAL SERVICES AND WELLBEING**
Responsible Officer:	**JACQUELINE DAVIES HEAD OF ADULT SOCIAL CARE**
Policy Framework and Procedure Rules:	**There is no effect upon the policy framework or procedure rules.**
Executive Summary:	**The purpose of the report is to provide details of the current Community Resource Team pressures being experienced in Adult Social Care, describe the mitigating actions that the service is undertaking and how we are working within the integrated services to support individuals who require care when discharged from hospital. The report also provides details of the work relating to the national requirement to report on Pathways of Care Delays (PoCD) in hospital and how we are working across the region and locally on a whole system approach to improve performance in this area.**

1. Purpose of Report

1.1 The purpose of the report is to provide details of the current Community Resource Team pressures being experienced in Adult Social Care, describe the mitigating actions that the service is undertaking and how we are working within the integrated services to support individuals who require care when discharged from hospital. The report will also provide details of the work relating to the national requirement to report on Pathways of Care Delays (PoCD) in hospital and how we are working across the region and locally on a whole system approach to improve performance in this area.

2. Background

2.1 In Bridgend we have been developing our integrated service since 2010 and the services and structures that we currently have in place are managed jointly with the Local Authority and the Health Board and overseen by a joint partnership board. Previously we benefitted from a clear vision for the service and structures that are based on a 'team around a person' approach with the 'Jones' central to our everyday practice. The Cwm Taf Morgannwg (CTM) region are currently reviewing the integrated service model.

2.2 The Community Resource Team is a community based, integrated, health and social care service. It works with adults living within the boundaries of Bridgend County Borough. It works within a person centred, proactive, case management model, with an emphasis on improving independence and outcomes for an individual from multi-disciplinary team input. The Community Resource Team aims to maximise independence at home through input from the community team or the team based in the Reablement Unit at Bryn y Cae.

2.3 The Community Resource Team (CRT) is the amalgamation of Intermediate Care Services in Bridgend into a single service. To date, these include:

- Acute Clinical Team.
- BridgeLink Telecare.
- Community Reablement Team – Therapies.
- BridgeStart enabling home care - Therapies.
- Bryn y Cae Reablement Unit - Therapies.
- Specialist Assessment Team that includes the Sensory and Community Occupational Therapists Teams.
- Integrated Community Equipment Service.
- Early Intervention & Prevention Hub including the Hospital Social Work Team.
- Mental Health Link worker & Dementia Support Worker.

2.4 Individuals can step up and step down between these intermediate care elements within the framework that makes up the team. The different elements are as follows:

2.4.1 **Acute Clinical Team**

The Acute Clinical model is led by a highly experienced clinical practitioner workforce and overseen by a Consultant Geriatrician. The team aims to provide rapid (within 4 hours) assessment, diagnostics, and treatment in the community, thus avoiding a hospital admission.

2.4.2 **Bridgelink Telecare**

Bridgelink Telecare is an assistive technology service that helps people stay independent in their own homes. It offers the security of knowing someone can help 24 hours a day, 365 days a year.

Telecare uses:

- a lifeline unit
- a pendant
- and sometimes other complex sensors

All the equipment can raise an alarm to the Alarm Monitoring centre, or if preferred, via a telephone call to a chosen family member, carer, or friend. The Alarm Monitoring centre can arrange for help from the in-house 24-hour Mobile Response Team or the emergency services, as well as anyone listed as emergency contacts.

As long as someone does not need medical assistance, the Mobile Response Team can help someone up from the floor. The team also provides personal care, and ensures people are left as comfortable and secure as possible.

2.4.3 **Community Reablement**

Community Reablement offers a brief period of therapeutic assessment and intervention in a person's own home. People accessing this service are assessed as requiring a multi-disciplinary approach. Members of the service may visit up to 4 times a day to provide the person with support to help them to regain the skills they need for maximum independence.

2.4.4 **Bridgestart**

BridgeStart is a short-term enabling domiciliary care service providing Occupational Therapy with enabling care support for all people who are assessed as potentially needing long term home care. Members of the service may visit up to 4 times a day to provide the person with support to help them to regain the skills they need to maximise their independence at home.

2.4.5 **Reablement Unit**

The Bryn y Cae Reablement Unit is suitable for individuals who, for short periods of time, are likely to need more intensive support with activities of daily living than it would be possible to provide at home. The Reablement Unit of 6 units is situated in a dedicated wing of the Bryn y Cae Residential Care Home, Brackla, Bridgend.

2.4.6 **Specialist Assessment Team**

This includes the Sensory Team which is a short-term assessment service delivering assessment and care coordination for people living with sensory loss. The team works with children and adults. The Team also includes the Community Occupational Therapists who also work with people of all ages who are living with a disability. They conduct practical assessments of people's ability to carry out normal activities of daily living: this could include personal care, household tasks, ability to care and be cared for, and to live safely in their own home. Following the assessment, the Occupational Therapy staff may give advice, arrange equipment, or recommend alterations to the home.

2.4.7 **Early Intervention & Prevention Hub (EIPH)**

The EIPH is the front door to Adult Social Care for individuals who have not previously been known to the services but have presenting care and support needs. Referrals to the EIPH can come via individuals themselves, family members/carers, GPs or other professionals. Individuals contacting the EIPH will have their request for help listened and responded to by a suitable qualified social care practitioner, ensuring that the individual's voice and choice regarding their desired outcomes are considered along with their current strengths. At the point of first contact, depending on the presenting needs, individuals can be provided information and advice, signposted to community assets, referred to the relevant enabling service or referred to the appropriate specialist team within Social Care if the needs are evident.

Where the needs are not evident for onward referral, the individual will have a proportionate assessment carried out and will remain under the care of the EIPH Social Worker for a period of up to 12 weeks where evidence informed decision making, focusing on the individual's strengths and outcomes will take place. Where social care needs are identified, the EIPH Team will make the necessary arrangements for the individual's agreed package of care and support to be implemented and transferred to the appropriate social care team, whether this be our

Integrated Community Network Team or one of the specialist Social Care Teams (e.g. Older People Mental Health Team).

Part of the Team are based within the Princess of Wales Hospital, and they focus on people presenting in the main that have been admitted to wards. They also respond to referrals from other hospitals in the Health Board or wider. The Team can provide information or advice, support discharge planning or provide more complex social intervention that will include assessment.

3. Current situation / proposal

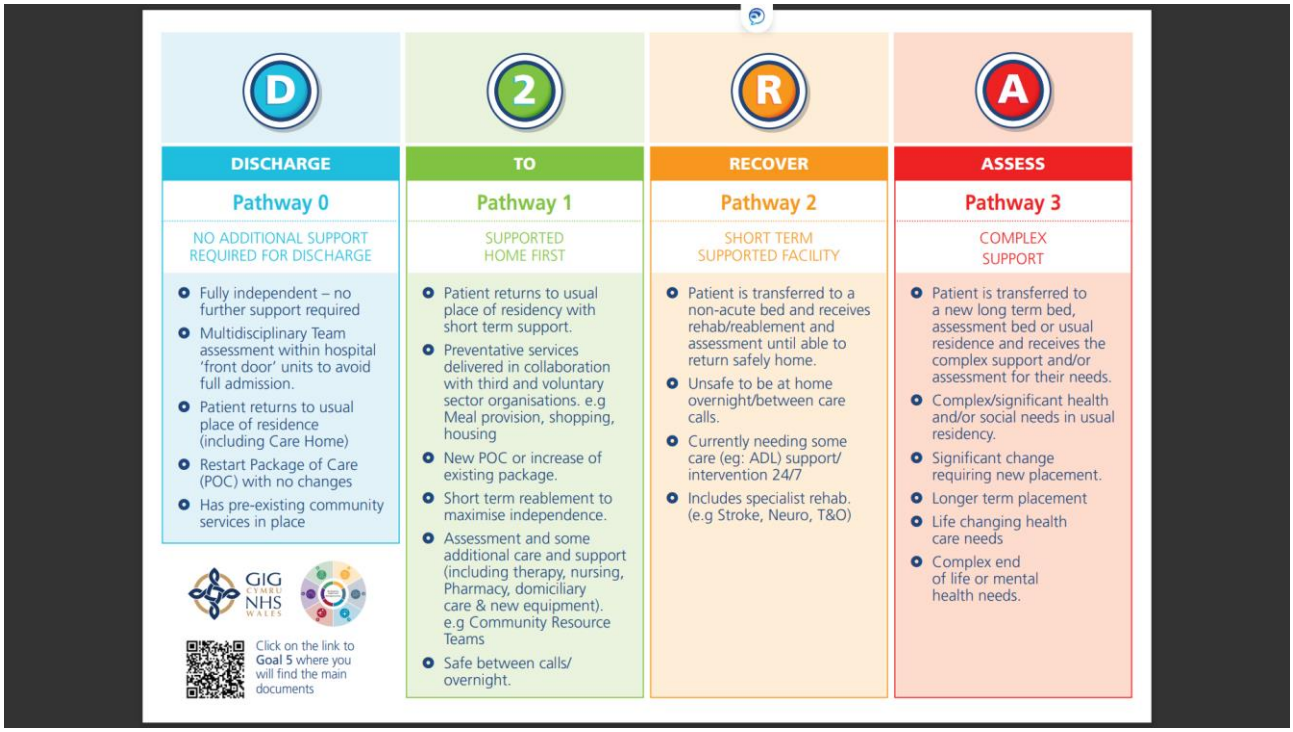
3.1 A report in February 2023 for Subject Overview Scrutiny Committee 2 (SOSC2) was presented on the services pressures being experienced in Adult Social Care. There have been significant improvements since that report and a number of a number of key developments have been implemented across the region and locally in Bridgend Integrated services. The key ones are:

3.2 Discharge to Recover and Assess (D2RA)

The regional introduction of the Discharge to Recover and Assess process known as D2RA has been driven by the national agenda. The aim of D2RA is to support people to leave hospital at the right time, continuing their care, recovery, and assessment for any long-term needs in the right place, which is usually at home.

In the CTM region to aid the implementation there has been the introduction of an electronic transfer of care proportionate assessment (EToC) and the use of an Electronic White Board (EWB) to record if the patient meets '*criteria to reside'* in a hospital bed and any delay to discharge. The EToC assessment completed at ward level informs the transfer of care into community services. EWB has been implemented in all general adult in-patient wards in CTM where live information is pulled at ward level situational reporting and Pathway of Care Delay (PoCD) reporting which is detailed later in this report.

The D2RA pathways are:



3.3 The Community Resource Team has been working with colleagues in the Health Board to implement the D2RA process; this has meant significant changes within its internal process and there have been a number of issues that continue to be worked through collectively.

3.4 **The Integrated Discharge Hub**

3.4.1 An Integrated Discharge Hub in Princess of Wales hospital was created in the Summer of 2022 and is responsible for the triage of EToC's. The aim is 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. The team consists of Care Coordinators, who aim to meet the national standard which states that a patient should be discharged within 48 hours of being clinically optimised for discharge.

3.4.2 **Integrated Discharge Delivery Board**

The region has also seen the development of the Integrated Discharge Board; its purpose is to be accountable for the design and delivery of Discharge to Recover then Assess (D2RA) in region, aligning to national best practice and guidance, and ultimately ensuring that patients get the right care at the right time in the right place, irrespective of hospital and system pressures. Also to be accountable for discharge performance identifying areas for improvement and making appropriate challenge where performance is stalled and to ensure effective accountability of D2RA, Unscheduled Care, Community Care and Social Care. The Objectives of the Board are to:

- Ensure effective contribution to the Healthy Days at Home Measure – which will see a reduction in Length of Stay and Pathway of Care Delays.

- Be responsible for the oversight of Discharge Operational Groups.
- Act as point of escalation for any unresolved issues/risks and provide recommendations regarding additional mitigating actions as necessary.
- Ensure that 'home first: discharge to assess' ways of working are embedded, including D2RA at the front door.
- Review nationally reported pathway of care delay data, with the aim of reducing the overall number of delays and associated days lost.
- Through analysis of the data, be responsible to authorise recommended changes to discharge arrangements and operating model in CTM.
- Oversee implementation of the CTM Discharge Policy, which will include reluctant and adverse discharge monitoring.

The Board have agreed a work plan and achieved the following: -

- Developed and received approval through governance a CTM Discharge Policy in line with national protocol.
- Developed an integrated escalation framework.
- Developing an Integrated Flow and Discharge App which can be used in daily patient flow meetings, site meetings and Integrated Discharge Delivery Board.
- Operational embedding of discharge hub and central coordination of flow and discharge via a Service Operational Policy.
- Recruited regional trusted assessor roles.
- Quarterly report on PoCD action plan with the aim of a reduction in PoCD and Assessment Delays.
- Proportionate Assessment form completed at ward level to inform the transfer of care (EToC) into community services.
- One central record the Electronic White Board (EWB) implementation across the CTM region and compliance is improving.
- Significant change to the interface between acute sites, community hospitals, primary and community and local authorities.
- Culture change to operational practice is being embedded across sites.
- Understood and acknowledged that when we started this system that our numbers of delays in the system would increase across CTM.

3.5 **Pathways of Care Delays (PoCD)**

3.5.1 There is a requirement for each Health Board to measure delayed transfer of care on a monthly basis and to take necessary actions to alleviate those numbers of people who are delayed. This return is known as the pathways of care delay (PoCD) return.

3.5.2 A PoCD 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 'next stage of care' covers all appropriate destinations out of NHS hospitals. This information is captured on a census day, which is a snapshot of those people delayed on the 3rd Wednesday of each month. Below are the criteria that is used nationally: -

- This definition covers all adults.

- Implicit within the definition is the existence of harmonious working arrangements between all agencies involved in the patient's discharge

planning, including efficient, effective, and timely communication, which expedite the patient's transfer of care to the optimum destination.

- Multi-agency transfer of care processes are complex; many agencies can be involved in the care and discharge planning for a patient and account must be taken of the patient's own wishes and family/carer issues.

- The purposes of the census. All patients who continue to occupy an NHS inpatient bed after their clinically optimised date, post 48 hours must be reported, i.e. locally agreed timescales must not be applied prior to reporting a delay as part of the census process.

- The definition covers adults - Clinically Optimised: "A clinical decision has been made by the registered professional(s) that the patient is ready for discharge."

- The registered professional will be part of the multi-disciplinary team and have discharge/transfer rights through the governance processes, policy and pathways of individual Health Boards and partnership agreements.

- Discharge does not require an MDT collective decision; it is the lead registered professional who will determine the patient is optimised for discharge.

- The agencies involved in hospital discharge planning will vary from patient to patient.

- The "next stage of care" covers all discharge destinations out of NHS hospitals.

- Patients will be excluded from the census who are subject to infection protection and control processes within the hospital and have been previously deemed clinically optimised.

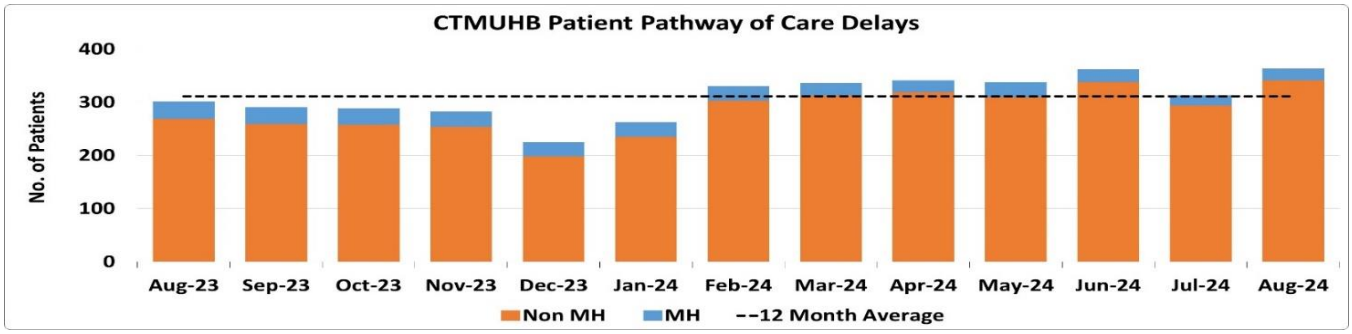
- When presenting the results in a graph format, a decision may be made to only include decision codes above a certain number of patients within that decision code, for example, codes with ten or more patients may be shown.

- During the first year of collecting the data following the revision in guidance (2023/24), it is recognised that flaws are likely to have occurred in the first few months of data collection whilst the new process was being embedded.

3.5.3 The Trend Data

CTM PoCD

The following tables show the key data from the reporting of PoCDs across the region and specifically for Bridgend residents. MH refers to Mental health patients and Non-MH refers to those people not on a specific mental health ward.



The graph shows that since February 2024 there has been a rise in the regional PoCD numbers with only a slight dip in July. There was a recognition that since the D2RA launch and the central electronic recording CTMs PoCD numbers have increased due in part to a revised reporting process i.e. previously a manual trawl by nurses but now they are electronic reporting at ward level.

There has also been a revised definition of 'criteria to reside' where a patient has to meet specific criteria to remain in a hospital bed, which does not include assessment or therapy intervention that should be competed in a community setting, including bed based.

National benchmarking of PoCD is a subjective process as there is significant variation in application of criteria to reside as well as recording, reporting of patients delayed, with CTM having one of the only bespoke recording systems at ward level in the country.

Bridgend PoCD

NB: The data below shows all patients who reside in the Local Authority (LA) area and not those delayed and attributed to a LA delay code for the month of August.

Delays by Local Authority - August 2024											
Healthcare Facility	Blaenau Gwent	Bridgend	Caerphilly	Cardiff	Merthyr Tydfil	Neath Port Talbot	Powys	Rhondda Cynon Taff	Swansea	Vale of Glamorgan	Total
PCH	3		2		11		1	12			29
POW		80				4		3		4	91
RGH		1	1					97			99
YCC			1		19			50	1		71
YCR											0
Glanrhyd		8		1				64			73
Grand Total	3	89	4	1	30	4	1	226		4	363

PCH – Prince Charles Hospital
POW – Princess of Wales Hospital
RGH – Royal Glamorgan Hospital
YCC – Ysbyty Cwm Cynon
YCR – Ysbyty Cwm Rhondda

BCBC PoCD

The table below shows the trend data since November 2023 for social care reasons that in the main are the responsibility of the LA. Bridgend has seen a decrease in delays in two of the top six social care delay reasons between the census dates in November 2023 and August 2024. Overall delays have reduced by one between these dates for the top six social care delay reasons within this period but noting that May and June saw the highest overall numbers.

	Nov-23		Mar-24		Apr-24		May-24		Jun-24		Jul-24		Aug-24		
Social Care Delay Reason (Top six)	Bridgend No. of Delays	Bridgend Ranking	Bridgend No. of Delays	Bridgend Ranking	Bridgend No. of Delays	Bridgend Ranking	Bridgend No. of Delays	Bridgend Ranking	Bridgend No. of Delays	Bridgend Ranking	Bridgend No. of Delays	Bridgend Ranking	Bridgend No. of Delays	Bridgend Ranking	Increase/Decrease in Delays Between Nov 23 & Aug 24
Awaiting completion of assessment by social care	18	3	28	2	27	1	23	3	19	3	12	5	12	6	Decrease
Awaiting start of new home care package	14	2	21	2	18	1	27	1	29	1	18	1	19	2	Increase
Awaiting Social worker allocation	2	13	1	17	8	8	6	6	16	1	2	11	2	13	Same
Awaiting NH availability	11	2	3	4	3	5	2	12	4	4	5	2	3	6	Decrease
Awaiting reablement care package	1	12	2	10	1	15	4	7	3	9	8	2	4	6	Increase
Awaiting RH availability	2	10	9	2	6	4	9	1	2	11	3	10	7	3	Increase
Total	48	-	64	-	63	-	71	-	73	-	48	-	47	-	

3.5.4 The table below provides an analysis of the top six social care delay reasons, where Bridgend has been ranked against all other Local Authorities in Wales based on the rate of delays per 1,000 of the population as at the census date in August 2024.

August 2024

Social Care Delay Reason	Bridgend No. of Delays	Bridgend Rate per 1,000 of population	Bridgend Ranking	All Wales Rate per 1,000 of population	Above/Below All Wales Rate
Awaiting completion of assessment by social care	12	0.38	6	0.37	Above
Awaiting start of new home care package	19	0.61	2	0.24	Above
Awaiting Social worker allocation	2	0.06	13	0.14	Below
Awaiting NH availability	3	0.10	6	0.07	Above
Awaiting reablement care package	4	0.13	6	0.10	Above
Awaiting RH availability	7	0.22	3	0.11	Above

3.5.5 This shows that Bridgend has ranked higher than the All-Wales rate for 5 of the 6 top reasons for social care delay, with awaiting start of new homecare package and awaiting residential home availability being the highest followed by awaiting completion of assessment by social care, awaiting nursing home availability, and awaiting reablement care package being only slightly above the All Wales rate. All the actions contained in this report are to support the service to improve performance in these areas. Bridgend ranked below the All-Wales rate for August 2024 for awaiting social worker allocation.

3.5.6 Monitoring of the data is nationally via NHS Executive, regionally via the Integrated Discharge Board and locally within adult social care.

There are monthly national monitoring meetings where the regional action plans and performance are discussed. The details from these meetings are then reported to the Care Action Committee overseen by the Cabinet Secretary for Health and Social Care and the Minister for Social care. A letter attached as **Appendix 1** details the recent targets that have been set in Wales which will be monitored via the nation and region process's already in place.

Work continues across the CTM region on an action plan known as the Six to Fix plan, details of which are shown in **Appendix 2**.

Within Adult social care there is senior management oversight via fortnightly meetings known as Silver - Adults Social Care pressures where focussed action plans are detailed. Key actions to date include:

- Biweekly triage meetings of all people awaiting in the system both in the community and the hospital.
- Weekly reporting to senior management.
- Remodelling in house support at home service delivery model to maximise reablement and short-term capacity to support hospital discharge and avoiding hospital admission. The service has been working towards increasing those individuals who go through the short-term services to ensure we maximise independence before we commission long term care packages our current performance is that 53.98% of individuals who completed a package of reablement during Qtr1 2024/25 had no ongoing service need. In 2023/2024 38.6% of people had a short term service prior to have a long term package, the service has been working towards increasing this number to 80% of people, in July the figure had increased to 60% of people who had a short term service prior to have a long term package people.
- Workflow processes being redesigned including how we ensure a timely discharge from that service to next point of care if assessed as requiring once a person's short-term service has concluded.
- Strong links with our independent support at home providers.
- Working with colleagues in Princess of Wales hospital on timely discharges via D2RA and setting up routine meetings to support communication and discharge planning.
- Use of agency social work staff in the hospital social work team at times of reduced capacity.

3.5.7 In addition, the team are in the process of developing a more focused local Six to Fix action plan which will align to the regional one and includes:

- A review of the process and seek to increase the licences and training for the e-whiteboards for social workers in the hospital team and Team Leaders in Support at Home. This will enable us to update the system in live time.
- Training and awareness of effective implementation of the Integrated Discharge Policy and Procedure.
- Ensure that the Standard Operating Procedure would support use of the e-whiteboards across the teams.
- Seek to establish how the regional Trusted Assessors could support with PoCD and the connections with the hospital social work team.
- Ensure staff have regular training such as Continuing Health care.
- Review compliance with the D2RA within the team.
- Work with colleagues on the need for proportionate assessments and how risk is managed in the community.
- Ensure that the right referral goes to the right place for it be actioned and processed in a timely way.

3.6 **Enhanced Community Care (Level 4) – National Model in Wales**

3.6.1 Services to support effective hospital discharge were developed at pace in the early 2000's and are known as Intermediate Care. Delivery has evolved over the past two decades, resulting in NICE guidelines and development of an Enhanced Community Care (ECC) model for Wales.

3.6.2 The Health Board are currently progressing with ECC level 4 which will provide a rapid multi-disciplinary response to patients in a crisis, with a time standard of a 2hr response time. This service would rapidly progress patients who are delayed to discharge as well as support avoiding hospital admission.

There are currently no services across CTM that meet criteria and standards for Crisis Response/ECC level 4. So, whilst the Acute Clinical Team (ACT) described in paragraph 2.4.1 was initially set up to perform a similar role, the current national benchmarking shows that there are gaps in the skill mix and the level of resources in the team, which compromises its ability to perform the full function as outlined in the national model.

3.6.3 A proposal has been made to create ECC level 4 services across the CTM footprint with the ACT action as the core team for delivery. The proposal involves additional therapy and Health Care Support Worker resource. Pump priming funding has been secured through the national 6 goals of Urgent and Emergency Care Programme and a delivery model is rapidly being developed in conjunction with CTMUHB.

3.6.4 The EIPH has seen significant absences through sickness. It has also experienced difficulties recruiting appropriately skilled and experienced staff. This has created service capacity issues that has impacted its ability to maintain case flow through the short-term assessment services. To address this situation, the service has prioritised the release of capacity within the short-term assessment services that will in turn facilitate hospital discharges for those people awaiting D2RA Pathway 1 (return home with short term support).

In addition, resources have been deployed from other social work tiers in adult social care, reviews of the systems and processes are ongoing, the use of agency staff and senior management focus via daily meeting, weekly sitrep reports and overseen by a fortnightly Silver group chaired by the Corporate Director – Social Services and Wellbeing.

4. Well-being of Future Generations implications and connection to Corporate Well-being Objectives

4.1 The delivery of domiciliary care / care at home services supports the five ways of working under the Well-being of Future Generations (Wales) Act 2015, as follows:

Long Term – our service models will be a more person-centred and outcome-focused way of working, more in keeping with the requirements of the Social Services and Well-being (Wales) Act 2014, and more appropriate for the longer-term.

Prevention – domiciliary care / care at home services are essential preventative services to mitigate the need for more costly residential care placement, where

individuals are supported to maintain independence and live in their own homes for as long as is possible and appropriate to do so.

Integration – the service providers will need to work with a wide range of stakeholder groups and organisations (such as Health) to ensure the best possible outcomes for individuals in receipt of these services.

Collaboration – the service model is predicated on close collaboration between the service provider, social work teams, wider stakeholders and communities, and the individuals themselves.

Involvement – Key stakeholders and providers have been involved to help shape and inform our domiciliary care / care at home services.

5. Climate Change Implications

5.1 There is no impact or link to Bridgend County Borough Council's climate change aspirations as a result of this report.

6. Safeguarding and Corporate Parent Implications

6.1 This report outlines the PoCD performance, and the actions taken to support timely discharges which will ensure effective safeguarding arrangements and support the wellbeing of adults for whom the Council has a statutory responsibility.

7. Financial Implications

7.1 There are no direct financial implications arising from this report however, at times of pressures within the Health and Social Care system or as government set targets that the local authority is expected to meet, additional resources maybe required, either through specific grants or as potential future budget pressures to be considered as part of the Medium-Term Financial Strategy.

8. Recommendation

8.1 It is recommended that the Committee note and consider the contents of this report; and provide feedback on the actions being undertaken by the Council.

Background documents

None