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ADULT CARE AND WELL BEING OVERVIEW AND SCRUTINY PANEL 20 MARCH 2024

UPDATE ON THE ROLE OF ADULT SOCIAL CARE IN COMPLEX HOSPITAL PATIENT DISCHARGES

Summary

1. The Panel has requested an update on the role of Adult Social Care in complex hospital patient discharges.

2. The Strategic Director for People and the Cabinet Member with Responsibility for Adult Social Care have been invited to the meeting to update the Panel and respond to any questions.

Background

3. Following the information shared with the Panel in July 2022, and a subsequent update in November 2022, the Panel have requested a further update relating to the role of Adult Social Cares within the wider urgent care system.

Types of Hospital Discharge

4. The Panel will be aware that there are two types of hospital discharge:
    - Simple discharge - where a patient is discharged to their own home and will need little or no additional care once they leave hospital, for example, a simple discharge is one that be carried out at ward level with the multidisciplinary team and this is often referred to as Pathway 0.
    - Complex Discharge – where a patient needs more complex care after discharge from hospital, for example, new or increased health and social care needs and or the potential for change of residence such as requiring a care home setting. Pathway 1 is used for people who can return home. 'Home First' is the principle followed, aiming to support as many people as possible to return to their own homes where it is believed they will recover best and regain independence. Pathway 2 has to be used for people who can't go home and need a rehabilitation bed, which is usually a community hospital setting, or Pathway 3 when there is limited rehabilitation potential and they will go to a care home bed for assessment, often referred to as a Discharge to Assess (DTA) bed.

5. For simple discharges (Pathway 0), Adult Social Care's role will be limited, but it will ensure there are universal and preventative services in place to support people/communities in order to facilitate simple discharges, such as Age UK, and

in supporting knowledge of these services across the health and social care system, such as by promoting the Community Services Directory.

6. For complex discharges, Adult Social Care has dedicated teams working with partners and operational updates about their work and progress is included below. The dedicated teams are the Reablement Service, which facilitate and support people who leave hospital to return home (Pathway 1), the Onward Care Team, which focus their work on the Acute Hospitals and plan for the correct discharge plan, and the Urgent Care Team which focus their work in the Community Hospitals (Pathway 2/3).

Operational Updates

Onward Care Team

7. The Onward Care Team has continued to operate as an integrated team within the County's two Acute Hospitals in Worcester and Redditch. This team includes Social Workers and Social Care Workers. The role of the Onward Care Team is to support discharge planning for patients. Together with the ward staff, they ensure that a patient's care and support needs are understood and determine the onward care pathway requirements. Through collaboration with teams across the health and social care provision, they ensure that person centred principles are applied and take into consideration the patient's personal circumstance. This includes undertaking activity such as completing Mental Capacity Assessments, liaising with family members and existing care providers and coordinating and communicating information between the hospital team and the eventual provider.

8. Since the previous report to the Scrutiny Panel there have been no significant changes to operational processes, although there have been several reviews undertaken of parts of the system in which they play an integral role. The biggest change for the team has been the implementation of the Care Navigation Hub (see paragraphs 14-16).

Urgent Care Team

9. The Urgent Care Team have continued to work in the Community Hospitals as part of multi-disciplinary teams working to discharge people to the right place when they need care and support. Similar to the Onward Care Team, the Urgent Care Team works collaboratively with Community Hospital Teams and providers to ensure that a person leaves hospital in a planned way to a provider, and an environment that is able to meet the person's care needs. The Urgent Care Team tend to focus on long term planning which includes some of the more 'typical' social work functions, including consideration of a person's care and support needs, funding requirements (including consideration of Continuing Health Care eligibility where appropriate) and sourcing a provider.

10. The Team, made up of Social Workers and Social Care Workers, have concluded a pilot called the Wrap Around service, which supports people to return home with 24-hour care for a short period of time. This pilot showed good outcomes for people and demonstrated that a service of this type can reduce and/or delay admissions to care homes by providing intensive support to people at home after a hospital stay. This service is now in the process of being commissioned on a two-

year contract and Adult Social Care will refine some of the referral and management processes to ensure the flow can be maximised.

Reablement Service

11. The Reablement Service has shown sustained improvement in performance over the last 12 months. The service is frequently held up as an exemplar of Pathway 1 and is frequently asked to showcase its model by other Local Authorities. In particular, the timeliness of response to referrals is celebrated (meaning less people waiting to leave hospital when they are ready to), and Worcestershire is seen as a trailblazer in terms of its integration with health partners in delivering therapeutic reablement (which results in positive outcomes for people's levels of independence). The Reablement Service also plays a significant role in the Care Navigation Hub (see paragraphs 14-16).

12. The Reablement Service reports activity and performance for Pathway 1 and a recent performance report is included as Appendix 1. A focus on recruitment over the last 12 months resulted in the creation of a Service Development Manager post. This role has been instrumental in addressing some of the challenges in recruitment and retention. A recent highlight report (included as Appendix 2) demonstrates the numbers of candidates worked with over the last 12 months and some of the activity that has led to this. The post holder is now in the process of refining service recruitment processes to direct this toward the activity that delivers the best results.

13. Appendix 1 includes details about Adult Social Care discharges for Pathway 1, including activity, performance, the source of the referral, and reasons for any failed discharges, for example equipment, family, patient not medically fit for discharge etc.

The Care Navigation Hub

14. In November 2023, the Care Navigation Hub was introduced. This is the name given to what is a 'team of teams' which are working together and are co-located, aiming to achieve the safe and timely coordination of care and support.

15. The Care Navigation Hub consists of teams (or representatives of teams) from across the Health and Social Care economy, including the Reablement Service, Capacity Management Team (who coordinate Community Hospital Beds), Age UK, Homelessness and Housing liaison, Continuing Health Care, Onward Care Team, and the Urgent Community Response Single Point of Access. A crucial element of this mix of teams is that there is now the ability to consider both hospital discharge and admission prevention within the entirety of resource.

16. Work is underway with the now-established Care Navigation Hub to further refine referral and triage processes, and this is being led by the Intermediate Care Leadership Team, which is an integrated leadership group from across Adult Social Care and the Herefordshire and Worcestershire Health and Care Trust.

Challenges

17. Whilst there is a significant amount of great work, and positive outcomes in this part of Adult Social Care, it is not without its challenges. Some of these challenges are borne out of the dynamics of partnership working, the volume of work and required timeliness of response, and an ever-present challenge around recruitment and retention.

18. Sustained high attendance at Worcestershire's Emergency Departments has meant that demand has continued unabated. The requirement to respond to this demand continuously means it can be challenging to implement change. However, various representatives from Adult Social Care play a part in a number of workstreams aimed at achieving sustainable improvements across the urgent and emergency care pathways. These include the Pre-Hospital Steering Group (which has a focus on activity which can avoid hospital admission), the Discharge Requirements Group (with a focus on activity which supports timely discharge from hospital) and other operational groups with a specific focus, such as Pathway 1 performance group and the Pathway 3 implementation group. These workstreams and groups all enable incremental changes to be made which all support improvement.

19. The Strategic Director, Assistant Directors and Head of Home First continue to represent Adult Social Care through system on call rotas at weekends, responding to Gold level pressure periods to support flow and share risk across the system.

20. Activity for the last 12 weeks is shown in Appendix 3. This data shows the numbers of discharges from Worcestershire Acute Hospitals Trust against the targets. Of particular note is the split between simple and complex discharge targets: 77.6% for simple and 22.4% for complex. The percentages of complex discharges for each pathway are based on the overall number of discharges. There is a total target of 165 weekly complex discharges, and the percentages of this figure by pathway is 61.2%, 32.7% and 6.1% for Pathways 1, 2 and 3 respectively.

21. The figures in Appendix 3 show that for complex hospital discharges the number of Pathway 1 discharges achieved is lower than the target by around 8 discharges per week. This is due, in part, to the number of referrals received being lower than the target, meaning there is no possibility of reaching this. In practice, there needs to be more referrals than the target to allow for any changes in need or failed discharges.

22. For Pathway 2 the performance appears to fall short by around 12 per week, despite receiving referrals that would allow the target to be met in most weeks. This suggests a flow problem in that pathway.

23. For Pathway 3 the target is exceeded quite significantly, and the driver for this may be the poor flow in Pathway 2, though further work is required to understand this.

Purpose of the Meeting

24. The Panel is asked to:
    - consider and comment on the information provided regarding the role of Adult Social Care in complex patient hospital discharges.

- Agree any comments to highlight to the Cabinet Member with Responsibility for Adult Social Care.
- Determine whether any further information or scrutiny on a particular topic is required.

Supporting Information

Appendix 1 – Pathway 1 performance data report
Appendix 2 – Recruitment Highlights 2023
Appendix 3 – Activity data versus targets

Contact Points

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Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance), the following are the background papers relating to the subject matter of this report:

- **Agenda and Minutes of the Adult Care and Wellbeing Overview and Scrutiny Panel on 18 July and 7 November 2022.**

All agendas and minutes are available on the Council's website here.