AGENDA

SOCIAL CARE HEALTH AND WELLBEING SCRUTINY COMMITTEE

2.00 PM THURSDAY, 9 DECEMBER 2021

VIA MICROSOFT TEAMS

All mobile telephones to be switched to silent for the duration of the meeting

PART 1

1. Welcome and Roll Call

2. Chairs Announcements

3. Declarations of Interest

4. Minutes of Previous Meeting *(Pages 5 - 20)*

5. Delayed Transfers of Care and Community Pressures *(Pages 21 - 78)*

6. Pre-Decision Scrutiny
   To select appropriate items from the Cabinet Board agenda for Pre-Decision Scrutiny (Cabinet Board reports included for Scrutiny Members)

7. Forward Work Programme 2020/21 *(Pages 79 - 82)*

8. Urgent Items
   Any urgent items (whether public or exempt) at the discretion of the Chairperson pursuant to Section 100B (4) (b) of the Local

Government Act 1972.

9. Access to Meetings
Access to Meetings to resolve to exclude the public for the following item(s) pursuant to Section 100A(4) and (5) of the Local Government Act 1972 and the relevant exempt paragraphs of Part 4 of Schedule 12A to the above Act.

PART 2

10. The Regulated Service (Service Providers and Responsible Individuals) (Wales) Regulations 2017 and Hillside Secure Children's Home Update (Exempt under Paragraph 13)
(Pages 83 - 134)

11. Pre-Decision Scrutiny of Private Item/s
To select appropriate private items from the Cabinet Board agenda for Pre-Decision Scrutiny (Cabinet Board reports enclosed for Scrutiny Members)

K.Jones
Chief Executive

Civic Centre
Port Talbot **Thursday, 2 December 2021**

Committee Membership:

Chairperson: **Councillor L.M.Purcell**

Vice Chairperson: **Councillor C.Galsworthy**

Councillors: A.P.H.Davies, O.S.Davies, J.Miller, S.Paddison, S.H.Reynolds, D.Whitelock, A.N.Woolcock, C.Edwards, W.F.Griffiths, H.C.Clarke and N.J.E.Davies

Notes:

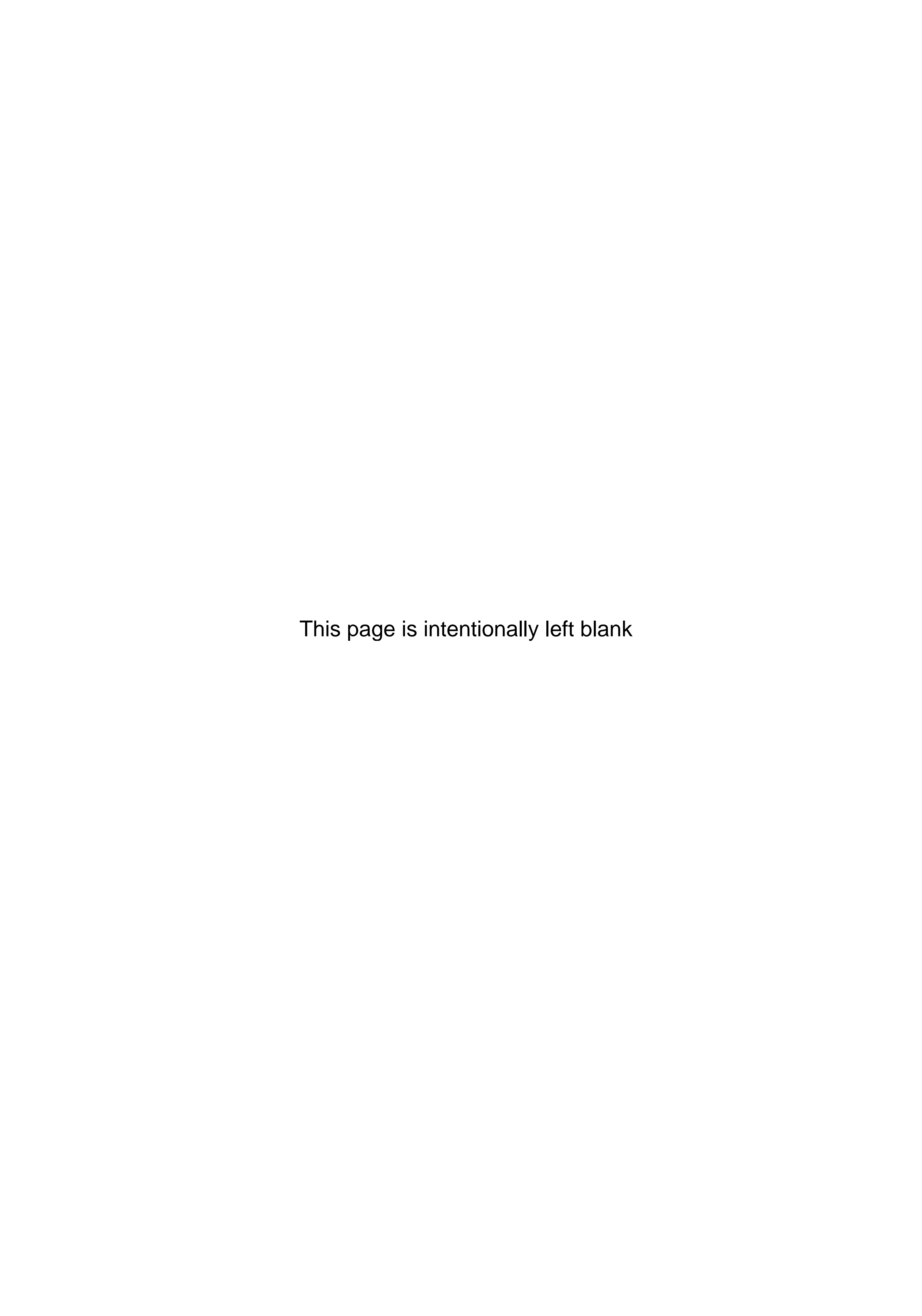
(1) If Committee Members or non-Committee Members wish to have relevant items put on the agenda for future meetings, then please notify the Chief Executive/Chair eight days before the meeting.

(2) If non-Committee Members wish to attend for an item of interest, then prior notification needs to be given (by 12.00 noon on the day before the meeting). Non-Committee Members may speak but not vote, or move or second any motion.

(3) For pre scrutiny arrangements, the Chair will normally recommend forthcoming executive items for discussion/challenge. It is also open to Committee Members to request items to be raised - though Members are asked to be selective here in regard to important issues.

(4) The relevant Cabinet Board Members will also be invited to be present at the meeting for Scrutiny/ Consultation purposes.

(5) Would the Scrutiny Committee Members please bring the Cabinet Board papers with them to the meeting.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Social Care Health and Wellbeing Scrutiny Committee

(Via Microsoft Teams)

Members Present: **16 September 2021**

Chairperson:	**Councillor L.M.Purcell**
Vice Chairperson:	**Councillor C.Galsworthy**
Councillors:	A.P.H.Davies, O.S.Davies, J.Miller, S.Paddison, S.H.Reynolds, A.N.Woolcock, C.Edwards, W.F.Griffiths, H.C.Clarke and N.J.E.Davies
Officers In Attendance	A.Jarrett, A.Thomas, K.Warren, J.Hodges, Chele.Howard, H.Short, N.Headon and C.Davies
Cabinet Invitees:	Councillors P.D.Richards and L.Jones

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1. **Minutes of Previous Meeting**

The minutes of the previous meeting held on 29th July 2021, were approved, Subject to the reference ‘Afan Valley’ within the minutes being amended to ‘Amman Valley’.

2. **Pre-Decision Scrutiny**

The committee chose to scrutinise the following cabinet board items:

West Glamorgan Safeguarding Annual Report 2020-21

Members were presented with the West Glamorgan Safeguarding Boards’ Annual Report 2020-2021, as detailed within the circulated report.

Members commended the enthusiasm that the young people had shown in shaping their plans and showing engagement across all areas.

Discussions took place around the statement detailed within the report around obtaining a clear picture of the spread of covid-19. Members asked when these priorities were set and what was done with the data once collected. Officers explained that following the pandemic the plan changed overnight to ensure that safeguarding was being adhered to. It was important to have an understanding on how the virus spread to see how we could try to reduce cases. It was noted that data was difficult to collate at the time due to workloads during the unprecedented time.

Following scrutiny, the report was noted.

West Glamorgan Safeguarding Boards Joint Annual Plan 2021/2022

To present the West Glamorgan Safeguarding Boards Joint Annual Plan 2021/22 for approval, as detailed in the circulated report.

It was noted that the previous ‘Education, leisure and Lifelong Learning Director - Aled Evans’ was detailed within the document. It was noted that this was written during Aled Evans being in post and the report was therefore correct.

Following scrutiny, the committee was supportive of the proposals to be considered by cabinet board.

Health Board Proposals to Change Older People Mental Health Services

Members were informed of the proposed changes that were being made by Swansea Bay University Health Board (UHB) to Older People Mental Health Services.

Members shared their concerns in relation to the timing of the conclusion of the Consultation on the proposals to change Older People Mental Health Services. Members felt that they should have been considered and invited to participate within the consultation and not been notified of the proposals following the conclusion of the consultation.

Members asked the following questions on the understanding that the relevant officers may not have a response and the questions would need to be put to the Health Board:

- It was discussed that within the report it mentions that there was a lack of confidence from Commission Colleagues in the Local Authority and that Care Homes could be a replacement for hospital care. It was noted that Officers had included this concern within their response to the Health Board and Members may wish to also raise this with the Health Board.
- Members asked that evidence be provided on the investment in to Community Services.
- Costings were discussed around the 24 hour care that would be required in care homes for those historically submitted as detailed within the report. It was noted that Officers had included this concern within their response and members may wish to also raise this with the Health Board.
- Discussions took place around the potential development of mental health concerns who is already a resident of a nursing home. What would be the result and replacement following the reduction of beds in Tonna?
- Members aired the concern around the centralisation of services in Swansea, creating further distance from the valleys.
- Members asked that Cross-boundary co-operation be considered.

Following the discussion Members proposed and agreed that the Chair write a letter to the Health Board on Behalf of the Committee, sharing their concerns around the proposals to change Older People Mental Health Services. Along with inviting the Health Board to a future meeting to discuss these proposals and give them an opportunity to respond to the questions that had been raised at today's meeting.

Following, scrutiny the Committee noted the report subject to the agreed proposal above.

3. **Forward Work Programme 2020/21**

The Forward Work Programme was noted.

4. **Access to Meetings**

RESOLVED: that pursuant to Section 100A(4) and (5) of the Local Government Act 1972, the public be excluded for the following items of business which involved the likely disclosure of exempt information as defined in Paragraph 14 of Part 4

of Schedule 12A to the above Act.

5. **Impact of Covid-19 on The Sustainability of Older People Care Homes In Neath Port Talbot (Exempt under Paragraph 14)**

Members were presented with the Impact of COVID-19 on the Sustainability of Older People Care Homes in Neath Port Talbot, as detailed within the private report.

Members commended the officers for their work and efforts during the pandemic.

Following scrutiny, the report was noted.

6. **Pre-Decision Scrutiny of Private Item/s**

The committee chose to scrutinise the following cabinet board items:

The Regulated Service (Service Providers and Responsible Individuals) (Wales) Regulations 2017

Due to the nature of the report members agreed that they would not scrutinise the report at today's meeting but instead include it on the Forward Work Programme to scrutinise the report in detail at a future meeting of the Social Care, Health and Wellbeing Scrutiny Committee.

CHAIRPERSON

Social Care Health and Wellbeing Scrutiny Committee

(Via Microsoft Teams)

Members Present: **21 October 2021**

Chairperson:	**Councillor L.M.Purcell**
Councillors:	A.P.H.Davies, O.S.Davies, J.Miller, S.Paddison, D.Whitelock, A.N.Woolcock, C.Edwards, W.F.Griffiths, H.C.Clarke and N.J.E.Davies
Officers In Attendance:	A.Jarrett, A.Thomas, K.Warren, J.Hodges, R Davies, T.Davies, C.Frey-Davies, Potts, D.Harding and C.Plowman
Invitees:	Councillors A.R.Lockyer, P.D.Richards, S.A.Knoyle and J.D.Morgan

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1. **Chairs Announcements**

It was announced that Agenda Item 7 on the Cabinet Board Agenda 'Carers Partnership Board Annual Report 2020/21' had been withdrawn from consideration at this meeting.

The Committee held a minute silence to mark the 55th Anniversary of the Aberfan Disaster.

(a) Update on the Impact of Covid-19 on Disabled Facility Grants

Officers provided an update report on the impact of the Covid 19 pandemic on the Disabled Facility Grant (DFG) service and recovery.

Members welcomed the significant increase in the number of jobs that had been completed from the end of May 2021 to September 2021 (raised from 19 to 73 during this period); and also welcomed the positive feedback received from clients who had a DFG carried out.

The circulated report detailed that demand for builders remained significantly higher than normal, with homeowners carrying out home improvements; and that some materials were still difficult to source. It

was queried how much of an impact this was having on the service, and if there was alternative ways of souring materials. Officers explained that this was a national problem, with the biggest issue being the shortage of contactors; the majority of contractors were still very busy carrying out the works that had been commissioned during the height of the pandemic. It was explained that the contractors were able to source materials, however there had been a significant rise in the cost of materials. Members were informed that the majority of the DFG works currently being carried out were tasks such as shower conversions; the materials for these types of jobs were easier to source, and there was less demand for plumbers as opposed to general builders. It was added that works relating to extensions had been most affected, however there were still jobs being completed, just at a slower pace than previous years; the Council had taken on additional builders to try and help progress the jobs, and were on a waiting list with contractors.

A discussion took place in regards to the Occupational Therapy (OT) Service and the capacity of the service. It was mentioned that the OT service was at full capacity for a short time, however there was currently a shortage due to staff leaving the service. Officers explained the reasons for the delays in service and the process behind the waiting list system; the report highlighted that there was currently a small waiting list of 15 awaiting release into the system. Despite this, it was confirmed that the flow through the service was working well.

Reference was made to the recent Welsh Government announcement regarding removing the means testing on small and medium sized adaptations. Members asked for information regarding Neath Port Talbot Councils position on this. Officers anticipated that the demand would increase massively if the means testing for small and medium DFGs were simply removed; if a decision was to be made to remove the means testing, it would be necessary to put conditions in place to try and control the demand. It was noted that there was various factors to take into account, particularly around the budget; however, it was important that this was controlled without discriminating against those who genuinely could not afford the works to be completed. Members were informed that discussions had started to take place with Welsh Government regarding the future process, and Officers had started to bring forward ideas; the Council was also working closely with Swansea and Bridgend Councils in order to obtain a regional approach to this. It was added that this was

a discretionary measure; therefore, the Council did not have to implement the change.

It was confirmed that a report on this matter will be presented to the Committee in due course, which will give Members the opportunity to share the views and to provide an input into the process, before any decisions were made or implemented.

Members complimented the Department and thanked Officers for their hard work in regards to DFGs.

Following scrutiny, the report was noted.

2. **Pre-Decision Scrutiny**

The Committee scrutinised the following Cabinet Board items:

Quarter 1 Performance Monitoring Report 2021

Members were provided with the Performance Information, and the Complaints and Compliments Data for Children and Young People Services, and Adult Services for the 1st Quarter Period (April 2021 – June 2021).

Members highlighted a number of the positive performance indicators, and congratulated Officers on their hard work in achieving targets; especially given the circumstances of the pandemic.

Reference was made to the graph contained within the circulated report which detailed the number of social worker vacancies, disciplinary investigations and grievances across Adult Services. It was asked why the social worker vacancies and the long term sickness levels were so high.

Officers explained that some elements of the report was misleading due to the way in which the data was presented; Members were assured that there were no current issues with vacancies or long term sickness levels within Adult Services. It was stated that the vacancies detailed in the graph related to vacancies across the whole of Adult Social Care, and were not specific to Social Workers. Officers confirmed that 20 of the vacancies were linked to the in-house domiciliary care service; these posts originally weren't filled as they were being retained to support the budget issue, however over the last two years there had been an external recruitment campaign for those posts. It was noted that the Council had unfortunately not been able to fill them; not being able to recruit people into domiciliary care

was a national issue. Members were informed that a further 20 of those posts were new posts which had been established on a temporary basis from different funding streams over the last two years; they were not vacancies within the Council, instead they were posts that had not been established permanently into the base budget. It was mentioned that the only vacancies within quarter 1 were 4.8 full time equivalent (FTE) posts.

Following this, Officers provided information on the sickness levels that were presenting high levels on the graph (39.5 FTE). It was noted that 21.5 FTE were staff from the in-house domiciliary care service; this was not unexpected due to the demand of this particular service throughout the pandemic. Members were informed that the Adult Service workforce was in the best position that it had been in for many years in terms of sickness levels; the sickness rates were currently in single figures.

It was stated that the Heads of Adult Services was working with Human Resources Officers to change how the data was presented; the data will be split into Principle Officer Remits to try and ensure that the figures were more meaningful and reflected a more accurate picture of Adult Services.

A discussion took place in regards to vacancies for Occupational Therapists. Officers confirmed that there were vacancies within this service, and that it was an ongoing, national problem with recruitment; there had been many occasions where individuals had opted to work for the National Health Service (NHS) instead of Local Authorities. However, it was mentioned that Officers had recently put out a joint advert on the NHS website in relation to vacancies, and following this had received 50 applicants across the region. It was highlighted that Officers were looking to provide Occupational Therapist Assistants employed by the Council, with a similar opportunity to the Social Worker degree funding; they would undertake a three year course at degree level, before they would be able to work in-house as a fully qualified Occupational Therapist.

Members queried who the Neath Port Talbot's Children and Adult's Quality Assurance and Learning Framework was issued to and used by. Officers confirmed that the document was designed for internal use. It was noted that the Customer Service Standards detailed in the framework was developed internally with Practitioners, Managers and Senior Mangers; however it was realised that it was also important to reach out to the wider community such as parents, children, carers,

care homes and other groups. Members were informed that Officers carried out this work to find out what was important to them; this helped set the outcome focused framework, to detail what the Council was seeking to achieve and identify what difference was being made. It was stated that the Customer Service Standards were essentially what the service users expects of the Council; when Officers carry out their quality assurance work, they use the questions/statements included in the standards to ensure that they achieve what was expected of them.

It was recognised that Neath Port Talbot's Children and Adult's Quality Assurance and Learning Framework included an element which stated that key decision-making meetings will be observed through a programme led by Senior Managers within the service; Members asked that with the significant amount of intense work that was currently being carried out, would Senior Managers be able to cope with observing the numerous meetings that take place. It was noted that the quality assurance group met on a fortnightly basis; representatives from both Children and Adult Services attended these meetings. Members were informed that the group had a forward work plan which listed various meetings that needed to be observed over time; the expectation was that Senior Managers would not observe all of the meetings at one point in time, and that it would be a phased approach. It was highlighted that the various pressures across the service were acknowledged.

Following scrutiny, the report was noted.

Fee Uplifts to Support the Sustainability of Domiciliary Care and Supported Living Services

The Committee received a report regarding a proposed implementation of a 10% uplift to the fees paid to providers contracted by Neath Port Talbot County Borough Council for the delivery of Domiciliary Care and Supported Living services.

Members welcomed the initiative and highlighted that the Members of the Valleys Wards were pleased to see the recognition that the Valley areas were disproportionately affected by this problem; however, the figures were extremely worrying.

It was asked if Officers could provide information regarding what the Council was currently doing to ensure that those who have had their care packages removed, were safe, well cared for and were managing to live independently. It was explained that in the past

week, the service had found itself in the most difficult position that it had ever been in; for the first time ever, staff found themselves having to offer individuals a place in a care home as opposed to staying in their own home with a package of care. It was noted that there were currently 41 people in the community, who had been assessed as requiring a package of care, being supported by family and friends; this was supported by a visit from the Social Worker every month, weekly telephone calls, welfare checks, and the use of the Local Area Coordinators to ensure that the families were coping. Since September, the service had received 50 handbacks from external providers, due to staff walking away from the job; there will be a further eight handbacks in the next two weeks. Officers assured Members that they were doing everything they possibly could, and offering someone a place in a care home, instead of providing them with their care package, was the last resort. It was mentioned that the recruitment process was active, and 10 people were being interviewed in the coming weeks.

Officers were asked if they were confident that the uplift was going to work in attracting staff, and if it would be enough. It was noted that the 10% uplift was a risk to take, and it was unknown if it would work in terms of attracting staff and/or keeping staff in the service. Officers had spoken to every provider and suggested a number of options to them; all of the providers stated that they wanted some form of continuity, and they were happy to accept 10% on the hourly rate. Members were informed that the contracted highlighted that the money will be passed onto the front line workers; Officers will be monitoring this via the Contracting Team.

The Director of Social Services, Health and Housing highlighted the various risks associated with the uplift. However, it was stated that the risk of not doing anything was much worse; currently a lot of staff in the external market were leaving in numbers that were affecting the ability to provide care, therefore it was essential to try and retain the current staff. Some of the risks mentioned included:

- The uplift was proposed for the external market, and not the internal market; it also did not cover residential care workers. These were risks as staff may choose to leave the service or migrate from one area to domiciliary care;
- The uplift was affordable for the rest of the civic year and the next civic year, however the ongoing funding for it was far from

clear; without additional monies from Welsh Government to support this, a pressure will be applied on the Councils budget.

Officers explained that they had been speaking to Welsh Government regarding sustainable funding; this would allow the Council to uplift the living wage for all of the care sector staff, and provide awareness and recognition of the huge benefits that caring staff make to those people who were most vulnerable.

It was queried whether the lack of European Union (EU) Nationals was a contributing factor to the issues with staffing. The Committee was informed that Officers had conducted research relating to this prior to leaving the European Union; this exercise was completed to gain an understanding of the impact that Brexit would have on the sector. It was confirmed that there were very low numbers of EU Nationals working in the care sector within Neath Port Talbot; and those that did, had applied for the EU Settlement Scheme. In regards to the staffing issues within the sector, it was highlighted that there were a number of factors contributing to this; including competition within the workforce, other companies/organisations offering very strong rates of pay and employment opportunities, and the impact that the pandemic has had on the care workforce which has resulted in individuals becoming exhausted.

Detailed in the circulated report it stated that there was a risk that not implementing the same level of uplift to the Older People Care Home sector could result in Care Home staff leaving their current employment to work in Domiciliary Care or Supported Living due to the higher rates of pay. Members asked what controls, if any, were in place to prevent this from happening. It was stated that at this stage, the Council was not in a position to replicate the uplift across the Residential Care Sector, however Officers had completed the necessary research and had taken a view that there was more of a need in the Domiciliary Care provision currently. The Director explained that there will be a re-distribution exercise in the near future that will occur across the residential care market, as the Welsh Government support funding comes to a conclusion; the 10% uplift was a calculated risk, however the Managers in the service were very knowledgeable for the market. Members were assured that despite what was trying to be achieved with the external market, the Council was taking a Council wide approach; and were utilising groups of Officers to look at targeting various groups and bodies, such as the universities and colleges.

Following scrutiny, the Committee was supportive of the proposal to be considered by the Cabinet Board.

Future of Trem Y Glyn Residential Care Home

Members were informed of the outcome from discussions with the Pobl Group, in relation to the continued operation of Trem Y Glyn Residential Care Home until 31 March 2025.

The circulated report detailed the two different funding arrangements for Members consideration, if they were minded to approve Option 2 or Option 3; funding arrangement A stated that Pobl would maintain repairs and maintenance liabilities. Members asked if Pobl would be in agreement with undertaking these arrangements. It was confirmed that Officers had been undertaking negotiations with Pobl for quite some time; they had been made aware of the report and were in agreement with it.

In the event of choosing to support Option 2 or Option 3, the circulated report highlighted that Pobl would require the Council to pay full cost recovery; Members requested further clarification on what this implies. Officers explained that this was the reason why the rates for contracting this service going forward were different to the previous rates that were paid; the detail behind this was included in the appendices of the circulated report. Members were informed that it was agreed that if an extension to the contract was going to be made, a separate contract would need to be developed which would take all of the costs of running Trem Y Glyn into consideration; this would be a standalone contract with Pobl in which they would charge the Council full rate of the 27 beds.

The Local Member for Blaengwrach and the two Local Members for Glynneath, who were in attendance at the meeting, shared their concerns in regards to the decision made in 2016 to close Trem Y Glyn, and the impacts the closure would have on the residents, staff and the wider community; highlighting in particular that there weren't any other community care homes in the Neath Valley or Dulais Valley. The Members shared their views on the various options contained within the circulated report and queried elements of the process leading up to the report being presented to Committee.

Members made queries relating to the exit strategy that Pobl were required to develop. Officers confirmed that Pobl were told to hold off on producing an exit strategy due to this report being brought for consideration on various options; if a decision was made to go with

Option 1, continue with the planned closure of Trem Y Glyn by 31st March 2022, then Pobl will need to create the exit strategy over the next few months.

The Committee raised their concerns regarding the transport issues associated with the closure of Trem Y Glyn. The circulated report stated that the Council would fund specific time-limited transport provision in proven cases of hardship; however, it was noted that the traffic survey that was intended to be carried out to identify potential traffic and transport issues, was not completed. Officers mentioned that the issue surrounding travel costs would be imbedded into an exit strategy; it was acknowledged that this will need to be looked into, however there currently wasn't a significant level of detail available.

A discussion took place regarding the current residents and staff working at Trem Y Glyn, and how this would impact on them. It was noted that the residents and staff were at the forefront of thinking, and Officers had been working to try and find ways of making sure they were supported when it closes.

Officers recommended that the Committee consider Option 3, which was a temporary situation in which the care home provision at Trem Y Glyn would be extended for a further year, with an option to continue to extend up to 2025. Members were informed that the residential market place was currently very different to when Officers last reported to Committee on Trem Y Glyn; the pandemic has had a marked impact on the uptake of residential care, on staffing and the ability to safely move residents from one home to another, and make assessments in a timely manner. It was noted that the market was currently very volatile, and Officers weren't able to judge what the market will look like in coming months; Option 3 provided an interim position in order for Officers to better understand the market next year, once the impacts from Welsh Government and their reduction of funding had been identified.

Members mentioned that they had previously asked Officers if a new build will be in place before Trem Y Gyn was closed; there had been no further report on this. The Director explained that when the decision was taken in 2016 to close the care home, it was also decided that a new care home would not be built in the Glynneath area; however, there was a proposal in place from Pobl to build some form of supported living. It was explained that although this proposal might provide for the needs of some residents, it could not be

described as a residential care home or a replacement for Trem Y Glyn. It was noted that Pobl had asked if the Council was interested in being involved in this development from a social care point of view for meeting the needs of older people; the Council had agreed to this, however Officers had yet to take part in detailed negotiations with Pobl in regards to what this arrangement will look like.

Following this, a discussion took place in regards to the future provision of care homes in the County Borough. It was noted that currently, there was over 150 empty residential care home beds across the County Borough; this was a significant number of beds. Officers added that some care homes in the area had occupancy levels of less than 70%; if this continued, these care homes would not be viable in the future.

The Committee highlighted that Trem Y Glyn still had a significant demand, compared to some other care homes across the County Borough which had a lower demand; and raised concerns with the volatility and uncertainly of care homes in the private sector. It was noted that Trem Y Glyn currently had around 3 or 4 bed vacancies; however, it was clarified that the number of vacancies will be affected across all care homes due to the upcoming dramatic changes in the market place over the next 6-8 months. Officers explained that there was a whole spectrum of care that people will need as they get older, and some of that need was with supported living; there were other options of care that needed to be explored and an overall strategy needed to be produced for the whole County Borough.

Discussions took place regarding the initial decision taken in 2016 to close Trem Y Glyn, and the decision taken after this to build two care homes instead of the original proposal of four; following legal advice, it was reiterated that the options for consideration in the meeting, were those contained with the circulated report. Members were informed that the Care Inspectorate Wales (CIW) would not allow Trem Y Glyn to be continued in the long term, in its current form, as it did not have the facilities expected in modern day care homes. It was noted that discussions regarding potential replacements would take place in the future. The Director highlighted that going forward with this matter, Members would need all of the relevant information regarding the strategy that was going to be taken into the future; this strategy would capture the needs of the County Borough, however this was not set to be developed just yet.

Following consideration of the various Options contained within the report, it was explained that Option 2 (enter into a new contract with Pobl to retain Trem Y Glyn for a period up to 31st March 2025) had significant costs associated with it.

The circulated report referenced the timely discharge of medically optimised patients, who will need care homes as a pathway; Members asked if discussions had taken place with the Health Board regarding their opinion on whether Trem Y Glyn would be required in the short or long term. Officers explained that specific discussions on the status of Trem Y Glyn had not taken place with the Health Board, however Officers were having weekly conversations with them in regards to the position of care homes across the County Borough; it was hoped that after the next 6-9 months, there would be more clarity around this.

The Chair summed up the discussions that had taken place; and a vote was undertaken to determine which of the three options, contained within the circulated report, Members were in favour of recommending to Cabinet Board. The results of the vote were as follows:

Option 1 – 0

Option 2 – 1

Option 3 – 10

Following the vote, Option 3 was proposed and seconded to be considered by Cabinet Board.

3. **Forward Work Programme 2020/21**

The following item was requested to be added to the Forward Work Programme:

- Disabled Facilities Grants (DFGs) and Waivers – a report which will provide Members with a better understanding of the processes.

Members noted the Social Care, Health and Wellbeing Scrutiny Forward Work Programme.

CHAIRPERSON

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Agenda Item 5

NEATH PORT TALBOT COUNTY BOROUGH COUNCIL

Social Care, Health and Wellbeing Scrutiny Committee

9th December 2021

Angela Thomas - Head of Adult Services

Matter for Information

Wards Affected: All Wards

Report Title: Delayed Transfers of Care and Community Pressures

Purpose of the Report:
This report is in response to the Committee's request for information in relation to Delayed Transfers of Care, for people being discharged from hospital.

Executive Summary:
This report provides an overview of the current challenges being experienced within Health and Social Care. Included in the report is information about people currently awaiting services.

Background:
Across the United Kingdom, Health and Social Care services are currently experiencing significant pressures, which has been well reported in the media. Locally, services are no different and currently Adult Services in Neath Port Talbot County Borough Council are experiencing challenges in the delivery of services. We have a number of people waiting for domiciliary care in the community. These people are currently reliant on support from family, friends and informal carers. In order to manage the risk to people waiting in the

community for domiciliary care, our social work teams are maintaining close contact with individuals who are waiting and their families. This is to assess the risk to the person and to put into action alternative arrangements, such as arranging for the commissioning of a placement in a care home on an interim basis, where risks are assessed as too high. The number of people waiting on brokerage has been increased further, due to the number of people whose domiciliary care provider has determined that they can no longer provide the person with a care package. Between 1st July 2021 and 30th November 2021, 96 domiciliary care packages have been handed back by providers. This is made up of full packages of care and packages where providers are unable to support an increase to calls. Some care package hand backs, have also been due to provider issues and staff have transferred to an alternative provider, who have agreed to take over the delivery of services.

One of the reasons given by providers, for handing back care packages, is care staff leaving and providers being unable to recruit sufficient care staff, to continue delivering the service. Alternative domiciliary care packages have been sourced for some people, but unfortunately not all and some people have needed to move into interim care homes placements or are being supported by families and informal carers.

Our commissioning team is continuing to work closely with domiciliary care providers and care home providers, to try and identify solutions to the current challenges being experienced by the care sector. In addition a taskforce, led by the Chief Executive, has been established to find solutions to social care recruitment.

Adult Services in partnership with the City and County of Swansea Council and Swansea Bay University Health Board, are operating a Discharge to Recover and Assess (D2RA) model, for people requiring support on discharge from hospital. This is a model promoted by the Welsh Government and involves individuals being discharged from hospital, to recover and be assessed in the community, rather than

being assessed in hospital. Further information on the Discharge to Recover and Assess model can be found in Appendix A.

At the start of the COVID pandemic, the Welsh Government stood down the requirement for Health Boards and Local Authorities to report on Delayed Transfers of Care. However operationally, managers from the Health Board and Local Authority have been continuing to meet, to try and overcome challenges to facilitating people's safe and timely transfers of care.

Due to delays in sourcing domiciliary care for some people who are in hospital, to return home, when a person has waited five days or more for a domiciliary care package, we are offering people the option of an interim placement in a care home. As of the 30th November 2021, 13 people have taken up this offer, with nine people still in an interim placement; the longest stay has been since the 18th August 2021. The Health Board have also commissioned beds in care homes in Swansea and Neath Port Talbot and from week beginning 15th November are also offering people, who have been assessed as ready to leave hospital, but are unable to safely return home, an interim placement in a care home.

At present Adult Services have been able to commission sufficient care home placements for those people who have been assessed as requiring this level of service. However there continues to be challenges in commissioning certain placements for older adults, in particular for people with dementia requiring nursing care.

Financial Impacts:
No implications

Integrated Impact Assessment:
There is no requirement to undertake an Integrated Impact Assessment as this report is for monitoring / information purposes

Valleys Communities Impacts:

No implications

Workforce Impacts:
No implications

Legal Impacts:
No implications

Risk Management Impacts:
No implications

Consultation:

There is no requirement for external consultation on this item

Recommendations:
This report is for information purposes

Appendices:
Appendix A – COVID-19 Hospital Discharge Service Requirements

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COVID-19 Hospital Discharge Service Requirements (Wales)

Published April 2020

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1. Executive Summary

1.1 This document sets out the Hospital Discharge Services Requirements for health, social care, third and independent sector partners in Wales, who must adhere to this guidance from 6th April 2020.

Much of the content will already be familiar as work has been ongoing to grow and embed the 'Every Day Counts; Home First' ethos and to implement the Discharge to Recover then Assess Pathways in Wales, illustrated as **Annexe A**.

The arrangements to manage discharge and hospital flow during the COVID-19 emergency period, require us to:

- expedite these service and practice developments at scale and pace; and
- pool the expertise and learning at local, regional and national levels.

1.2 For clarity, the discharge options and pathways referred to in this document are summarised below:

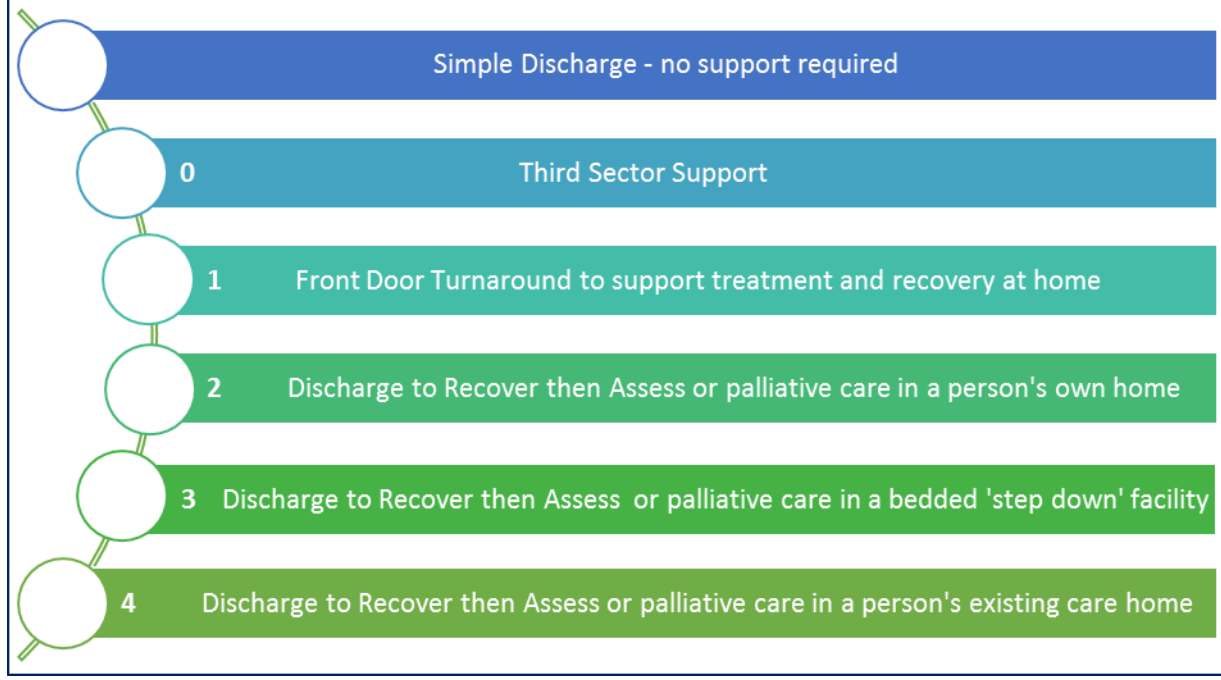


Figure 1: Discharge to Recover then Assess Model & options (Wales)

1.3 Unless required to be in hospital (see **Annex B**), patients must not remain in an NHS bed.

1.4 Based on these criteria, acute and community hospitals must discharge all patients as soon as they are clinically safe to do so. Transfer from the ward should happen within one hour of that decision being made to a designated discharge area. Discharge from hospital should happen as soon after that as possible, normally within 2 hours.

1.5 Acute and community hospitals must keep a list of all those suitable for discharge and report on the number of patients on the list who have left the hospital through the daily situation report.

1.6 Usual reporting procedures for Delayed Transfers of Care will be suspended during this period. Instead brief updates will be submitted to Welsh Government on a weekly basis, so that barriers to implementation can be understood and addressed. This data will not be used for performance management purposes.

1.7 Continuing NHS Health Care (CHC) assessments for individuals on the acute hospital discharge pathway and in community settings will not be required until the end of the COVID-19 emergency period.

1.8 The Welsh Government has commissioned a rapid analysis of the resources required to enable health and social care communities to fund the cost of new or extended out-of-hospital health and social care support packages referenced in this guidance. Further detail will be shared with Health Boards and Local Authorities imminently and this should not create a delay in implementing the guidance in the meantime.

1.9 The vast majority of patients will be able to be discharged without further support, other than that provided by their usual support mechanisms, such as family, friends and neighbours. Others will need some short-term practical help with tasks such as those provided by third sector discharge schemes (Option 0 in Figure 1). For those who will require ongoing support, the default will be <u>immediate</u> entry on to a Discharge to Recover then Assess Pathway (Options 1-4 in Figure 1).

1.10 The Discharge to Recover then Assess model can only be achieved through close partnership working. Local community co-ordination hubs will work together closely and on a daily basis:

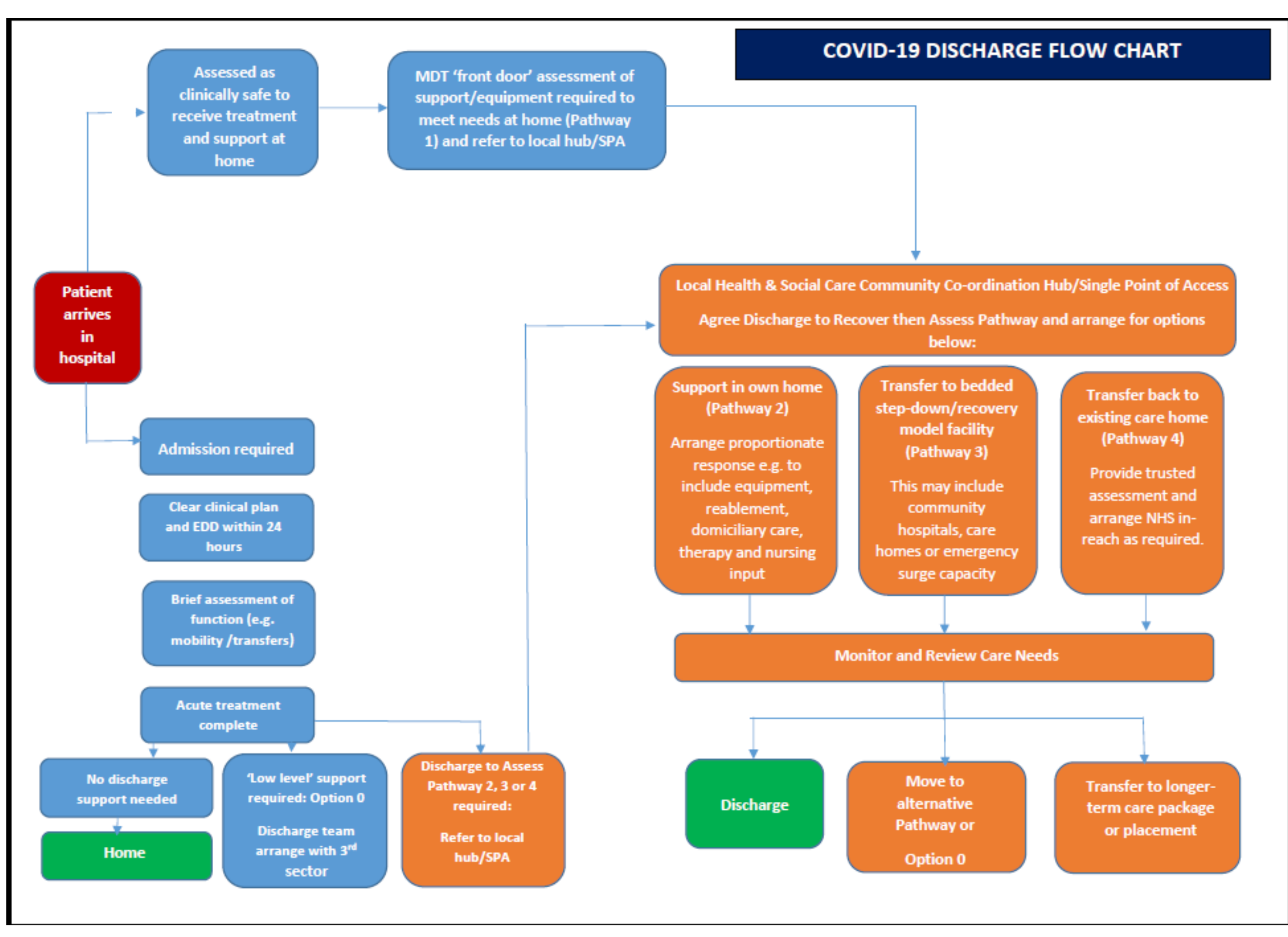
- Review available community capacity. To support this, key discharge leads will have access to the live Care & Support Capacity Tool from 6th April 2020;
- Minimise the risks associated with multiple contacts for patients, and actively seek to implement reciprocal arrangements for delegated tasks between health and social care staff. For example, subject to established guidelines and governance arrangements[1], simple nursing tasks that could be appropriately undertaken by domiciliary care staff and vice versa;
- Ensure there are robust tracking mechanisms so that care users do not get lost in the system at a time of very rapid response.

[1] https://heiw.nhs.wales/news/all-wales-delegation-guidelines/

1.11 The following sections detail what these changes mean for all health and care sectors with a role in hospital discharge and provide clarity on the actions organisations need to take straightaway. This information will be supplemented by specific action cards outlining how key roles should work differently during this period, which will be published separately and discussed as part of the national support for these changes (see Section 11).

1.12 There needs to be clear accountability and escalation mechanisms at each stage of the discharge to assess process in each locality (see **Annex G**).

Figure 2: Overview of COVID-19 Discharge Process



2. What do COVID-19 discharge arrangements mean for patients?

2.1 The Hospital Discharge Services Requirements set out in this document will already be familiar to health, social care, third and independent sector colleagues in Wales. Work has been ongoing to grow and embed the 'Every Day Counts; Home First' ethos and to implement the Discharge to Recover then Assess Pathways illustrated as **Annexe A**. 'What Good Looks Like' advisory papers have been developed in collaboration with the partner agencies and published[2].

2.2 The arrangements to manage discharge and hospital flow during the COVID-19 emergency period, require us to:

- expedite these service and practice developments at scale and pace; and
- pool the expertise and learning at local, regional and national levels.

Doing so will allow us to provide the best experience for those requiring urgent acute hospital care, whilst supporting recovery and minimising the risks for those who no longer need to be in an acute hospital bed.

2.3 The majority of patients will be able to be discharged without further support, other than that provided by their usual support mechanisms, such as family, friends and neighbours. Others will need some short-term practical help with tasks such as those provided by third sector discharge schemes. For those who will require ongoing support, the default will be immediate entry on to a Discharge to Recover then Assess Pathway. For clarity, the options referred to in this document are summarised in **Figure 1** below:

[2] http://howis.wales.nhs.uk/sitesplus/407/page/36206

http://extranet.wales.nhs.uk/howis/sitesplus/407/page/36206

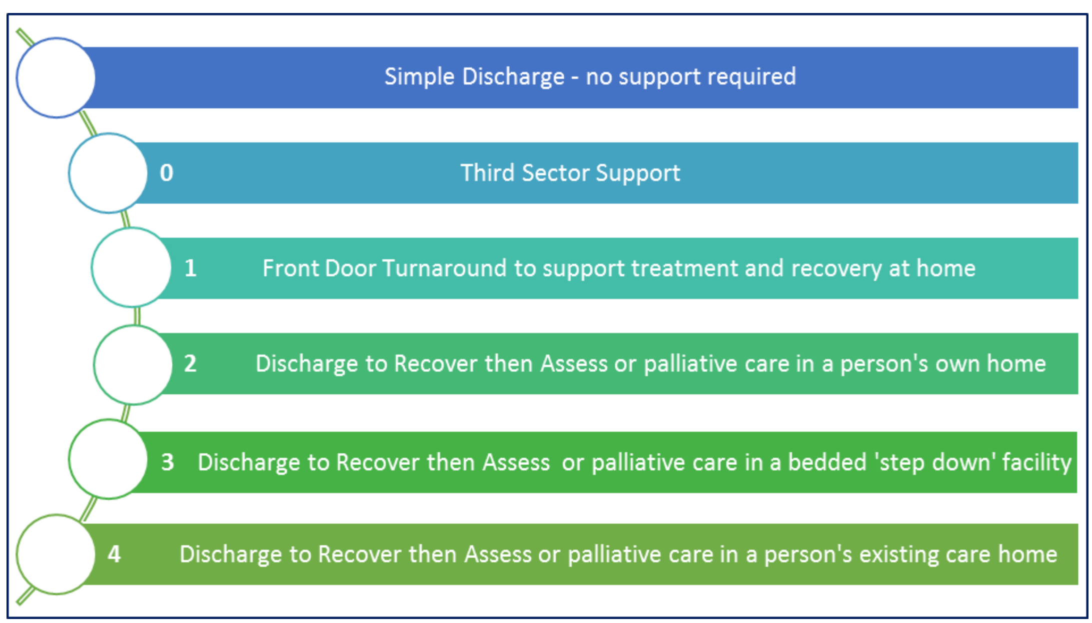


Figure 1: Discharge to Recover then Assess Model & options (Wales)

2.4 On the day a patient is to be discharged (following discussions with the patient, their family and any other professionals involved in their care, using leaflets B1/B2 in Annex C), within one hour the ward will arrange to escort the patient to the hospital discharge lounge, so their acute bed can be immediately used by someone being admitted who is acutely unwell.

2.5 Within two hours of arriving in the discharge lounge, transport home, any volunteer and voluntary sector support and immediate practical measures, such as shopping and the heating turning on, will be organised by the discharge co-ordinators for those who have no one else to do this.

2.6 Wherever possible, utilise trusted assessor protocols to ensure that arrangements are in place to meet the individual's immediate needs on discharge. Where trusted assessor protocols are not in place, a lead professional or multidisciplinary team, as is suitable for the level of care needs, will need to visit patients at home on the day of discharge or the day after to determine what support is needed in the home environment and rapidly arrange for that to be put in place. If care support is needed on the day of discharge from hospital, this will have been arranged prior to the patient leaving the hospital site, by a care coordinator.

2.7 For patients whose needs are too great to return to their own home, transfer will be arranged to a suitable ‘step-down’ bedded facility, which could be in a community hospital, care home or other emergency surge capacity.

2.8 During the COVID-19 pandemic, patients transferring to a new care home placement, will not be able to wait in hospital until their preferred choice of care home has a vacancy. This will mean a temporary stay in an alternative care home.

2.9 NHS and Local Authority partners will track and monitor all individuals in step-down bedded facilities and in care homes not of their first choice. The nominated care coordinators will follow up to ensure patients are able to transfer back to their own home, or move to their long-term care home, as soon as possible.

3. What are the actions for NHS Wales Health Boards?

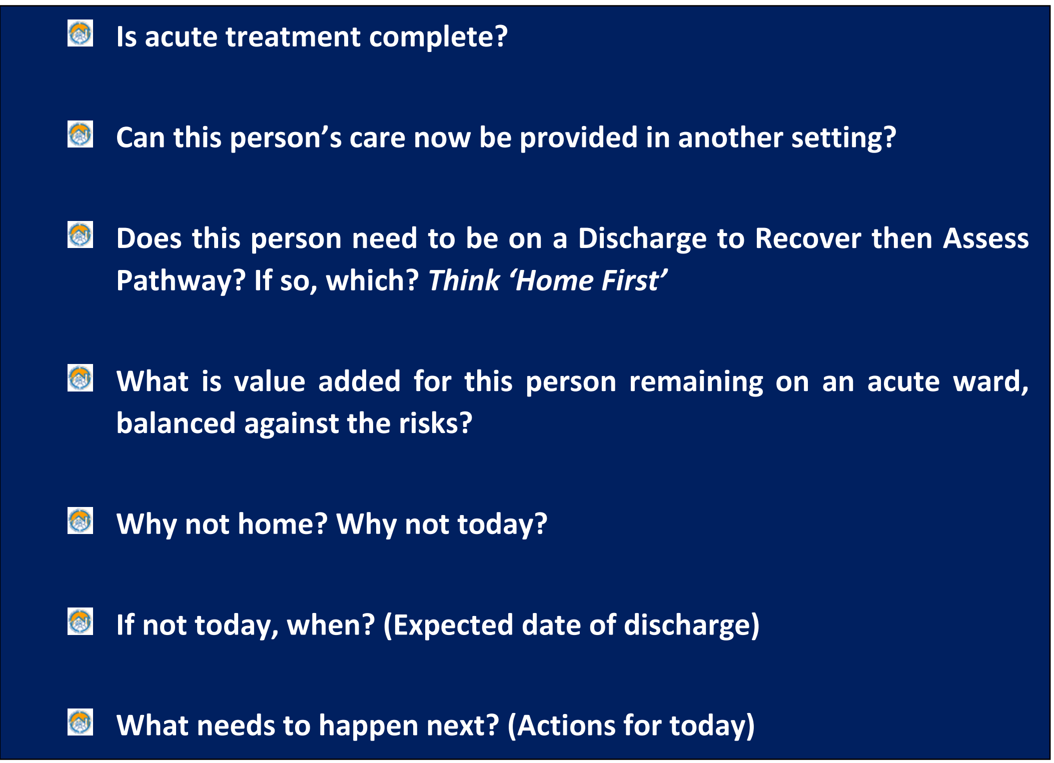
'Why not home? Every hour counts'

Health Boards need to rapidly review their processes and assure themselves that their practices are fit for purpose, to deliver the discharge to recover then assess model.

3.1 Ward level (acute and sub-acute hospitals):

- A clinically-led review of all patients will be undertaken at an early morning board round. Any patient meeting the revised clinical criteria, i.e. whose acute treatment is completed, will be deemed suitable for discharge.
- A second, afternoon board round will agree any further patients not required to be in hospital and therefore able to be discharged.
- Social care colleagues, or appropriate representatives from the integrated discharge team, should be involved in the twice daily ward reviews. This will help with the early identification of any possible care and support, placement or housing issues with discharge and allow the MDT to undertake arrangements in good time. Virtual options should be employed wherever practicable.
- Ensure professional and clinical leadership between nursing, medicine and allied health professions for managing decisions and use prompts in the box below:

Figure 3: Prompts for board rounds in acute hospital wards



- All patients who are not required to be in hospital and are therefore suitable for discharge will be added to the discharge list and allocated to a discharge pathway. Discharge home today should be the default pathway.

- On decision of discharge, the patient and their family or carer, existing care providers and any formal supported housing workers should be informed and receive the relevant leaflet (see Annex C).

- Individuals and their families must be fully informed of the next steps.

- The co-ordinator will ensure that all practicalities are addressed, including availability of existing care provider, transport arrangements, medication, discharge communication etc.

- Transfer off the ward into a discharge lounge within one hour of decision to discharge.

- During the COVID-19 period, patients should be discharged with up to 28 days' supply of medication, depending on their individual circumstances.

- In limited circumstances, depending on the individual's prognosis (e.g. 24 hours or less), it may be appropriate for hospitals to issue a small amount of palliative care medicines at the point of discharge, to support end of life care in their place of choice. However hospitals **must not** routinely do so. Any further supplies required after this timeframe can be accessed via the usual mechanisms.

3.2 **Hospital Discharge teams:**

- Provide expert advice and support to the ward teams on the appropriate Discharge to Recover then Assess Pathways. Act as a key problem-solving contact between hospital and community teams
- Arrange dedicated staff to support and manage all patients on Pathway 0. This will include:
    - co-ordinating with transport providers
    - local voluntary sector and volunteering groups helping to ensure patients are supported (where needed) actively for the first 48 hours after discharge
    - 'settle in' support is provided where needed
- Provide effective discharge planning for people with no home to go to and ensure that no-one is discharged to the street. See Annex D for further details on homelessness.
- Where not already in place, train discharge staff (potentially those who no longer have to undertake CHC assessments) to operate 'Trusted Assessments' for patients in hospital from care homes, so they can return to their care home promptly, and support all care homes with these new discharge arrangements.

Figure 4: Suggestions to increase confidence for discharging

To create a safety net and increase confidence in discharging, consider:

- **Patient initiated follow-up.** Give patients direct number for the ward they are discharged from, to call back for advice. (Do not suggest going back to their GP or coming to A&E)
- **Telephone the following day** after discharge to check and offer reassurance/advice
- **Call them back** with results of investigations and any changes or updates to a patient's management plan. Ensure this information is also conveyed to the Discharge to Recover then Assess team/care provider, and GP
- **If required, bring them back under the same team/speciality**
- **Request Community Nursing** follow up for a specific clinical need
- **Request GP follow up** in some selected cases

3.3 Hospital clinical and managerial leadership team:

- Create safe and comfortable discharge spaces for patients to be transferred to within one hour of decision to discharge, ensuring enough space for increased numbers of discharges.

- Maintain timely and high quality transfer of information to General Practice and other relevant health and care professional on all patients discharged.

- Senior clinical staff to be available to support ward and discharge staff with appropriate risk-taking and clinical advice arrangements.

- Where applicable to the patient, COVID-19 test results are included in documentation that accompanies the person on discharge. If results are not ready in time for discharge, ensure that they are forwarded in a timely manner to the patient, GP and any care or support Providers.

- Ensure all patients identified as being in the last days or weeks of their life are rapidly transferred to the care of community palliative care teams who will be responsible for co-ordinating and facilitating rapid discharge to home (which may be a care home) or a hospice. Community palliative care teams should have arrangements in place to provide advice, training and support to family / carers and care & support Providers.

- Follow the guidance on Continuing NHS Healthcare in line with the detail set out in Annex F.

- Free up staff resource from Continuing NHS Healthcare assessment processes to support the discharge to assess activities.

3.4 **Community Health Services**

Where not already in place, community healthcare teams are expected to update their processes and ways of working to deliver the discharge to assess model. Community health services will take overall responsibility for ensuring the effective delivery of the Discharge to Recover then Assess Pathways.

As part of this they should:

- Identify an Executive Lead to oversee the implementation and delivery of the discharge to assess model in the acute hospitals in their area. The model should operate at least 8am-8pm 7 days a week.

- Release staff from their current roles to co-ordinate and manage the discharge arrangements for all patients on Discharge to Recover then Assess Pathways. This will include patients being discharged from acute and community hospitals, and other bedded step-down facilities (in care homes or emergency surge capacity).

- Have an easily accessible single point of contact which will always accept assessments from staff in the hospital and source the care requested, in conjunction with local authorities.

- Provide a named point of contact to receive and respond to care provider queries.

- Deliver enhanced occupational therapy and physiotherapy 7 days a week to reduce the length of time a patient needs to remain in a step-down bed, subject to clinical prioritisation during the COVID-19 emergency period.

- Use multi-disciplinary teams on the day they are home from hospital, to assess and arrange packages of support for patients on Pathways 1 and 2.

- Ensure provision of equipment to support discharge.

- Ensure patients on Discharge to Recover then Assess Pathways 1 to 4 are tracked and followed up to assess for long term needs at the end of the period of recovery.

- Maintain the flow of patients from community beds including reablement and rehabilitation packages in home settings, to allow the next sets of patients to be discharged from acute care.

3.5 For patients identified as being in the last days or weeks of their life, community teams will work with specialist Palliative Care teams to co-ordinate and facilitate rapid discharge to home or hospice. This supersedes the current fast track end of life process.

4 What are the actions for Councils and Adult Social Care services?

As part of implementing the discharge to assess model, local authorities are expected to:

- Identify an Executive Lead for the leadership and delivery of the Discharge to Assess model.

- Agree a single point of contact arrangement for each health board, to approach when coordinating the discharge of all patients.

- Flexibly deploy social work, social care and occupational therapy staff across hospital and community settings to support patients on the Discharge to Recover then Assess pathways.

- Safeguarding investigations should continue to take place in a hospital setting, wherever necessary.

- Suspend the need for funding panels for hospital discharge during the COVID-19 incident, with additional funding available to local authorities to cover any increased costs during this period.

- Support real time communication between the hospital and the single point of contact, not just by email.

- Provide capacity to contribute to the review of care provision during the Discharge to Recover then Assess intervention.

- Ensure there is 7-day working for community health and social care teams.

5. What are the joint actions for Local Health & Social Care Partners?

5.1 **Close partnership working will be key to the delivery of these COVID-19 Hospital Discharge Requirements. Health and Social Care partners must:**

- Work together and pool staffing to ensure the best use of resources and prioritisation in relation to patients being discharged, respecting appropriate local commissioning routes.

- On a daily basis review capacity across the system, pooling information from hospital sites, community teams and the national Care and Support Capacity Tool, to which discharge teams will have access from April 2020.

- In order to minimise the risks associated with multiple contacts for patients, actively seek to implement reciprocal arrangements for delegated tasks between health and social care staff. For example simple nursing tasks that could be appropriately undertaken by domiciliary care staff and vice versa.

- Ensure there are robust tracking mechanisms so that care users do not get lost in the system at a time of very rapid response. Monitor all individuals in step-down bedded facilities and in care homes not of their first choice. The nominated care coordinators will follow up to ensure patients are able to transfer back to their own home, or move to their long-term care home, as soon as possible.

- Coordinate work with local and national voluntary sector organisations to provide services and support to people requiring support around discharge from hospital and subsequent recovery.

- Work together to expand the capacity in domiciliary care, care homes and reablement services in the local area.

5.2 **Equipment and assistive technology:**

Nominated lead co-ordinators for each local Joint Equipment Store will need to ensure that there is access to sufficient equipment to support discharge of people with reablement or rehabilitation needs at home:

- Local equipment services (across the NHS and local government) have a sufficiency of supply of the more common items of equipment used to support people with reablement or rehabilitation or longer-term care needs.

- Access to such equipment can be quickly (same day where needed) and easily facilitated seven days a week (utilising mutual aid with neighbouring areas or redeployment of community-based staff if required). This may include the purchase of additional equipment and the recycling, cleaning and reuse of equipment.

- Providers are prepared for rapid implication of increased volumes of rehabilitation equipment, including same day delivery requests.

- Use the cross border guidance to reduce unnecessary steps in provision routes and apply 'trusted assessor' status to partners (See Annex G)

- Ensure capacity to assess and make available equipment that can be used to reduce the need for two carers to provide care to individuals, or reduce call frequency releasing workforce capacity.

- A simple approval process should be initiated for more complex patients requiring hospital beds, pressure relieving equipment and hoists. This should be through discussion and verbal approval to order. Current senior clinician approval process and equipment prescription matrices will be stood down.

- Regular review and tracking of issued equipment to reduce over prescription of equipment. The responsibility for review of equipment once a patient is discharged will sit with the receiving care organisation.

- Where available, consider using photographs supplied by family/carers/community staff including District Nurses as an alternative to completing access and risk assessment visits for more complex patients. If a visit is required, this will need to be arranged within 4 hours of decision to discharge.

- Discharge tracking information is used to ensure regular restocking of buffer/satellite stores to maintain supply.

- There is a comprehensive range of assistive technology items that can support people to live safely and independently at home with next day access to support if required. This goes significantly beyond falls pendants.

- Stock includes gas, carbon monoxide, smoke alarms including devices that supports people who are blind and/or deaf, and temperature detectors. Movement detectors, bed/chair occupancy detectors and flood detectors. Work with other agencies, such as the fire service, wherever this is possible locally.

- There are enuresis sensors, epilepsy sensors and medication dispensers covering a 28-day period. Equipment can be made available at low-cost and can be simple to fit without hardwiring.

6. What are the actions for the Voluntary Sector?

Many systems already work with the voluntary sector to facilitate swift and safe discharges. Welsh Government will continue to fund the Emergency Department Wellbeing and Home Safe service delivered by British Red Cross, and the Hospital to Healthier Home service delivered by Care and Repair, to facilitate discharge from Welsh district general hospitals. These services remain available to Health Boards during the pandemic and throughout 2020/21, and both organisations have agreed to be flexible to the needs of Health Boards where appropriate, including through the enhancement of services if desirable/required.

6.1 **The sector should:**

- Mobilise quickly and focus on safety and positive experiences for patients on the discharge pathways, enabling patients to feel supported at home. They can also help reticent patients feel much more comfortable about being discharged.

- Provide a range of practical support to facilitate rapid discharge, including transport home and equipment such as key safes.

- Support discharged patients with home settling services to maintain wellbeing in the community (e.g. safety checks and essential food shopping).

- Provide ongoing community-based support to support emotional wellbeing, such as wellbeing daily phone calls and companionship.

- Engage with NHS providers (particularly discharge teams) to provide solutions to operational discharge challenges, freeing-up clinical staff for other activities – focusing on the patients on pathway 0.

- Utilise embedded local voluntary organisations in discharge pathways and enhance with input from large voluntary organisations.

- Coordinate support between voluntary organisations and existing volunteers within NHS providers.

- In advance of discharge be at the patient’s home to accept equipment.

6.2 NHS volunteers to support hospital discharge

In addition to the support being offered by the voluntary sector as part of the response to COVID-19, hospitals should consider how to deploy their NHS volunteers to volunteering roles that can most reduce pressure on services. Many hospitals utilise volunteers to assist people in getting ready to go home from hospital, ensuring they have everything they need and that everything is in place at their place of residence. They can greatly speed up the discharge process and also reduce the likelihood of readmission by ensuring that the person has the right support and resources in place at home. Volunteers can also provide advice and signposting to community support services and increase patients’ confidence about leaving hospital and going home.

The volunteering portal https://volunteering-wales.net/vk/volunteers/index.htm and County Voluntary Councils can also provide alternative opportunities to offer or search for volunteering support.

https://gov.wales/volunteering-during-coronavirus-pandemic

7. What are the actions for Care Providers?

Note: This chapter focuses on the discharge process.

Further advice on the care of patients being discharged to care homes or with domiciliary care support is being developed and will be published on the website detailed in Section 11.

7.1 **Care Home providers:**

- Maintain capacity and identify vacancies that can be used for hospital discharge purposes.
- Registered Managers are requested to use the Care & Support Capacity Tool App provided by DEWIS to make vacancy information available to NHS and social care colleagues in real time. (See Annex F)
- Providers of Care Homes, in partnership with their local Community Health teams, should consider how best to support residents' health needs, in their familiar environment, wherever possible.
- Where Trusted Assessor relationships and arrangements are not already in place, rapidly work with the discharge team to implement these rules and processes (See Section 11 for links to further information).

7.2 Domiciliary care providers:

- Work closely with health and adult social care contract leads to maximise existing capacity, and identify additional capacity if required, to support hospital discharge.

Patient Transport:

- Non-Emergency Patient Transport Services (NEPTS) are a critical resource in moving non-emergency patients from one care setting to a more appropriate setting on another site. Demand for NEPTS will increase through this period, and services will need to be more responsive. In Wales all non-emergency transport is co-ordinated through the Welsh Ambulance Service.

- Welsh Ambulance Services NHS Trust NEPTS, independent and voluntary sector providers, will be expected to provide support to enable the transfer of patients as part of the discharge process and to support transfers and discharge as a priority in order to maintain flow and maximise patient safety.

- Additional guidance on how NEPTS will be enabled to deliver through this incident.

- Organisations should consider mechanisms to inform WAST as escalation and additional capacity is utilised. This may involve alternative transport options and could include:
    - Local Authority owned or contracted vehicles
    - Volunteer cars
    - Voluntary sector resources
    - Taxi services

8. Monitoring and increasing rehabilitation capacity

8.1 After the first phase of discharging existing patients who do not meet the criteria for being in an acute hospital, it will be essential to maintain this approach in any rehabilitation and step down facilities and broader care-at-home services. This will avoid creating blockages in the community facilities/services and stop the next sets of patients being discharged from acute care.

8.2 **Pathways 1, 2 and 3: Step-down bedded facilities**

- All patients on these Pathways should have a clear recovery plan, with access to the therapeutic/reablement support required to deliver it.
- It is essential that they are tracked and assessed after this period of recovery. Longer-term care packages or placement must be made available at the right time to ensure that the pathways are not blocked for future patients needing discharge from hospital.

8.3 **Community Hospitals**

It is vital that discharges from community hospitals are increased and delays eradicated with the same approach and action taken in acute settings. This includes a daily review using similar prompts:

Figure 5: Prompts for board rounds in community hospital wards

- **Has this person recovered to the point that their care now be provided in another setting? *Think 'Home First'***
- **What is value added for this person remaining on a community hospital ward, balanced against the risks?**
- **Why not home? Why not today?**
- **If not today, when? (Expected date of discharge)**
- **What needs to happen next? (Actions for today)**

8.4 Short-term placement for people who require 24-hour supervision and care

- For people who need a 24-hour care setting, it is essential they are assigned a care co-ordinator (social worker, allied healthcare professional, discharge team nurse or CHC nurse) who will review their care and support needs regularly using the same questions as for community hospitals.

- Discharge should be arranged as soon as possible to their own home and packages of support made available.

8.5 Short term rehabilitation/reablement-at-home review

- Community Teams must review the needs of all people on their caseloads daily.

- The team will identify all people who have been on caseloads for an extended period and the reasons why.

- These cases are discussed using the following questions:
    - What is our current aim of support?
    - Have we met this? If not, what is going to change to enable us to meet this aim?
    - Are we best placed to support this need? Is there an alternative e.g. third sector support or remote self-managed rehabilitation programme?
    - Can we safely discharge this person?
    - Actions from the discussion are recorded and actions followed up daily.

9. Finance support

The Welsh Government has commissioned a rapid analysis of the resources required to enable health and social care communities to fund the cost of new or extended out-of-hospital health and social care support packages referenced in this guidance.

Further detail will be shared with Health Boards and Local Authorities imminently and this should not create a delay in implementing the guidance in the meantime.

10. Reporting

10.1 Current performance standards on DTOC monthly reported delays will be suspended from 1st April 2020.

10.2 Usual reporting procedures for Delayed Transfers of Care will be suspended during this period. Instead, in addition to the daily situation report outlined below, brief updates will be submitted to Welsh Government on a weekly basis, so that barriers to implementation can be understood and addressed. This data will not be used for performance management purposes.

The template and submission guidance will be circulated separately.

10.3 Health Boards will be required to report the following during the COVID-19 incident:

- Bed occupancy in hospitals
- Number of patients on daily discharge list
- Number and percentage of patients successfully discharged from discharge list
- Bed availability in community settings

11. Additional resources and support

11.1 It is acknowledged that practical implementation of this guidance will raise further questions and generate significant learning. In order to support implementation, Welsh Government and partner agencies will work together to provide regular updates and opportunity for dialogue, including Webinars, national calls and additional guidance where required.

Details will be circulated to the interested parties as the arrangements are made and in response to the issues arising.

11.2 The outputs from the calls will be widely disseminated and will include a Frequently Asked Questions repository.

Supporting guidance

All guidance issued on Covid-19 issued by Welsh Government to health and social care professionals is available at: https://gov.wales/health-professionals-coronavirus

https://www.adss.cymru/en/blog/post/covid19-commissioners

https://www.adss.cymru/en/category/coronavirus-covid-19

https://improvement.nhs.uk/documents/849/ECIP_RIG_Trusted_assessors_March2017.pdf
https://www.adass.org.uk/media/6030/developing-trusted-assessment-schemes_essential-elements-280717.pdf

Annex A:
The Discharge to Recover then Assess Model (Wales)

D2RA Pathway 1: Front Door Turnaround	D2RA Pathway 2: Home First!	D2RA Pathway 3: IC bed	D2RA Pathway 4: Existing Care Home
Is this person fit to admit?	Why not home? Why not today?	Are we providing the right conditions to maximise recovery & independence	Providing the least disruptive path & maximising recovery
Comprehensive assessment at the hospital front door	In-patient treatment is complete	Should only be considered if Pathways 1 & 2 are not appropriate for this individual i.e. they have high dependency and overnight needs that can't be met with short-term night sitting.	Same as Pathway 2 , with special considerations for delivering support within an individual's existing care home placement
Assess, treat and support at home	Default pathway for anyone who may need new or increased support at home, or a care home placement		Assessment for new placement must follow Pathway 2 or 3

Process for implementing the Discharge to Recover then Assess Model

<u>Stage 1: Decision to discharge</u>

- Clinically-led review of all patients at an early morning board round. Any patient meeting the revised clinical criteria will be deemed suitable for discharge.
- At least twice daily review of all patients in acute beds (daily in community hospital and other ‘step down’ beds) to agree who is not required to be in hospital, and will therefore be discharged
- Senior clinical staff should be available to support staff with positive risk taking and clinical advice.
- All patients who are not required to be in hospital and are therefore suitable for discharge will be added to the discharge list and allocated to a discharge pathway
- Discharge to the patient’s own home (Pathways 1, 2 and 4) should be the default
- The discharge list will be managed by the health board, in collaboration with social care partners.

Stage 2: Making the discharge arrangements

- On decision of discharge, the patient and their family or carer, and any formal supported housing workers, should be informed and receive the relevant leaflet (Annex C)

- Health, social care and housing staff need to work collaboratively to ensure that patients are discharged on time.

- Hospital discharge teams will lead on arranging discharges for those requiring support from third sector discharge schemes.

- The local community teams will lead on co-ordinating arrangements for patients discharged on any of the Discharge to Recover then Assess Pathways, including the allocation of the care co-ordinator as the key point of contact for patients and their families/carers.

- The care co-ordiantor will be responsible for:

    - Keeping individuals and their families fully informed of the next steps
    - Arranging patient transport home, where needed
    - Ensuring settling-in support is provided where needed.

- All patients must be transferred to an allocated discharge area/lounge within one hour of decision to discharge.

- Where applicable to the patient, COVID-19 test results are included in documentation that accompanies the person on discharge. Where results are not yet available a nominated professional e.g. discharge co-ordinator, must be clearly tasked with forwarding as soon as possible.

Stage 3: Post-hospital Recovery and Assessment

- Co-ordinated home assessments between health and social care, including equipment and reablement support, will take place ideally on the day of discharge, using a trusted assessor approach.

- The care co-ordinator will make the arrangements to ensure that the services and equipment are in place to meet the individual's immediate care needs and to review and assess for ongoing care if required.

- The local community service hub/single point of access will act as the point of interagency collaboration to ensure that the staff and infrastructure are in place to support such arrangements. To minimise the risks associated with multiple contacts for patients, this should include consideration reciprocal arrangements for delegated tasks between health and social care staff.

- The hub will draw on all available local resources, including voluntary, community and social care staff no longer undertaking assessment in acute hospitals.

Important considerations for all pathways:

- Duties under the Mental Capacity Act 2005 still apply during this period. If a person is suspected to lack the relevant mental capacity to make the decisions about their ongoing care and treatment, a capacity assessment should be carried out before decision about their discharge is made. Where the person is assessed to lack the relevant mental capacity and a decision needs to be made then there must be a best interest decision made for their ongoing care in line with the usual processes.

- If the proposed arrangements amount to a deprivation of liberty, Deprivation of Liberty Safeguards in care homes arrangements and orders from the Court of Protection for community arrangements still apply but should not delay discharge

Further guidance is currently under development and update information will be provided.

Key contacts for accessing support include:

- **The C.A.L.L. Helpline**
  A dedicated mental health helpline for Wales, it can provide you with confidential listening and emotional support, and help you contact support that may be available in your local area. Call 0800 132 737 or text 'help' to 81066.

- **Mind Cymru Infoline**
  For information on types of mental health problems, where to get help, medication, alternative treatments and advocacy. Call 0300 123 3393, email info@mind.org.uk or text 86463.

- **Samaritans Cymru**
  Offering a safe place for you to talk any time you like, in your own way – about whatever's getting to you. Call for free on 116 123 or email jo@samaritans.org

- **MEIC**
  Support for children and young people up to 25 years old open 8am to midnight, 7 days a week. You can contact them for free by phone 080880 23456, text and instant messaging on their website

- For patients identified as being in the last days or weeks of their life, community teams will work with specialist Palliative Care teams to co-ordinate and facilitate rapid discharge to home or hospice.

Annex B: Maintaining good decision making in acute settings

Every patient on every general ward should be reviewed on a twice daily board round to determine the following. If the answer to each question is 'no', active consideration for discharge to a less acute setting must be made.

- Requiring ITU or HDU care
- Requiring oxygen therapy/ NIV
- Requiring intravenous fluids
- NEWS2 > 3
  (clinical judgement required in patients with AF &/or chronic respiratory disease)
- Diminished level of consciousness where recovery realistic
- Acute functional impairment
  in excess of home/community care provision
- Last hours of life
- Requiring intravenous medication > b.d. (including analgesia)
- Undergone lower limb surgery within 48hrs
- Undergone thorax-abdominal/pelvic surgery with 72 hrs
- Within 24hrs of an invasive procedure
  (with attendant risk of acute life threatening deterioration)

Clinical exceptions will occur but must be warranted and justified. Recording the rationale will assist meaningful, time efficient review.

Review/challenge questions for the clinical team:

- Is the patient medically optimised? – (Don't use 'medically fit' or 'back to baseline').
- What management can be continued as ambulatory - e.g. heart failure treatment?
- What management can be continued outside the hospital with community / district nurses? E.g. IV antibiotics?
- Patients with low NEWS (0-4) scores – can they be discharged with suitable follow up?
    - If not scoring 3 on any one parameter e.g. – pulse rate greater than 130
    - If their oxygen needs can be met in a step-down facility
    - Stable and not needing frequent observations every 4 hours or less
    - Not needing any medical / nursing care after 8pm
        - Patients waiting for results – can they come back, or can they be phoned through?
        - Repeat bloods – can they done after discharge in an alternative setting?
        - Patients waiting for investigations – can they go home and come back as out patients with the same waiting as inpatients?

Criteria- led discharge:

- Can a nurse or allied health care professional discharge without a further review if criteria are well written out?
- Can a junior doctor discharge without a further review if criteria are clearly documented?
- How can we contact the consultant directly if criteria are only slightly out of range and require clarification?

Annex C: Patient discharge choice leaflets

It is recognised that issues of patient choice and engagement can often be significant barriers to hospital discharge where there are ongoing social care needs after discharge (particularly if moving to a residential or nursing home). During the COVID-19 response there will be suspension of choice protocols for this particular issue. The following leaflets have been produced to support the communication of this message.

- Leaflet A – to be shared and explained to all patients on admission to hospital
- Leaflet B – to be shared and explained to all patients prior to discharge, this is split into leaflets:
    - Leaflet B1 for patients who are being discharged to their usual place of residence
    - Leaflet B2 for patients moving on to further non-acute bedded care

Patient discharge choice Leaflet A – on admission to hospital

Hospital discharge information

It is important that our hospitals are ready to look after people who contract coronavirus (COVID-19) and need hospital care. Due to these pressures, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. You will not have a choice over your discharge, but it is always our priority to discharge people to a safe and appropriate place.

In most cases this will be to your home. You might need some extra support, for example with your care needs or shopping.

If you require more complex out of hospital care, this could be in another bed in the community, for example a residential nursing home.

Your needs and

discharge arrangements will be discussed with you.

What is Coronavirus?

COVID-19 is a new illness that can affect the lungs and airways. It is caused by a virus called coronavirus.

There is currently no specific treatment and some people who contract the illness will need to be admitted to hospital.

You can find out more about coronavirus and the best ways to stop it spreading by visiting www.nhs.co.uk/coronavirus

Patient discharge choice Leaflet B1 – for patients who are being discharged to their usual place of residence

Your hospital discharge: going home

This leaflet explains why you are being discharged from hospital an what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to return home.

Why can't I stay in hospital?

The health system is busy helping patients affected by coronavirus (COVID-19). This is a new illness that can affect the lungs and airways and some people who contract the illness will need to be admitted to hospital. It is important that our hospitals are ready to look after those people who need this hospital care.

Because of this, you will not have a choice over your discharge. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

It is our priority to ensure that you are discharged safely from hospital and to the most appropriate available place.

Your health team will discuss discharge and transport arrangements with you (and a family member, friend or carer if you wish). If you require care and support when you get home, this will be arranged.

Any care provided will be free of charge for a period of time to support your recovery. After this time you may be required to contribute to the cost of your care.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care you can contact <insert locally agreed details e.g. team name & contact number)

To find out more about coronavirus (COVID-19) and find out how to avoid catching or spreading it, visit www.nhs.uk/coronavirus

Patient discharge choice Leaflet B2 – for patients moving on to further non-acute bedded care

Your hospital discharge: another place of care

This leaflet explains why you are being discharged from hospital an what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to continue your recovery in another care setting.

Why can't I stay in hospital?

The health system is busy helping patients affected by coronavirus (COVID-19). This is a new illness that can affect the lungs and airways and some people who contract the illness will need to be admitted to hospital. It is important that our hospitals are ready to look after those people who need this hospital care.

Because of this, you will not have a choice over your discharge. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

It is our priority to ensure that you are discharged safely from hospital and to the most appropriate available place.

What can I expect?

Your discharge and transport arrangements will be discussed with you (and a family member, friend or carer if you wish) and you will be discharged with the care and support you need, to a bed in the community.

The care provided will be free of charge for a period of time to support your recovery. After this time you may be required to contribute to the cost of your care.

It is possible that you may be moved more than once after your discharge. This is because we will be trying to find the best place for your long-term care. Your health team are here to answer any questions you might have.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care you can contact (insert locally agreed details e.g. team name & contact number)

To find out more about coronavirus (COVID-19) and find out how to avoid catching or spreading it, visit www.nhs.uk/coronavirus

Annex D: Homelessness

- The requirements of the homeless and people living on the streets, also need to be reflected in any local framework to support the Government's COVID-19 emergency.
- Practices that have been developed in systems to support homeless persons need to be maintained and enhanced to reflect the need to support the needs of those who are without a home and living on the street. It is already known that this group has a high level of mortality, and support needs including mental ill-health and substance misuse which may present a barrier to self-isolation.
- Health Boards have a statutory duty to refer people who are homeless or at risk of homelessness to a local housing authority. This statutory duty remains.

Welsh Government has issued separate 'Guidance for local authorities: support rough sleepers – COVID-19 outbreak'. https://gov.wales/coronavirus-covid-19-local-authority-support-for-rough-sleepers

Annex E: Care & Support Capacity Tool

As part of current discharge planning there is an imperative to understand bed occupancy and vacancies in the community.

The Care and Support Capacity Tool has been developed by Data Cymru, in partnership with Welsh Government and Care Inspectorate Wales.

- This is web-based tool providing the opportunity to easily track bed capacity and vacancies to support system wide bed and discharge planning. The Tool will go live on 26th March 2020.

- The Tool covers all care homes for adults in Wales, including care homes for people with residential, nursing, mental health and learning disability needs. There is an intent to extend the Tool's function to include domiciliary care provision in future, but this is not currently available.

- This is not intended to replace current information systems already being used in some localities to track bed / room vacancies, but to run in parallel

- Providers are requested to use the Dewis website to provide updated information (in as close to real time as possible) on:

    - Number of bed vacancies
    - Current status i.e. Open / Closed to Admissions

- In the first instance, nominated discharge leads for each health board area will be given access to the Care and Support Capacity Tool Dashboard.

For further information about the Tool please email CareandSupportCapacityTool@gov.wales

Annex F: Continuing NHS Healthcare and COVID-19 Planning

Continuing NHS Healthcare (CHC) as referred to throughout this document relates to individuals aged 18 or over.

CHC assessments for individuals on the Discharge to Recover then Assess pathways and in community settings, will not be required until the end of the COVID-19 emergency period.

The Continuing NHS Healthcare, the National Framework for Implementation in Wales 2020 (Proposed) Framework was due to be published April 2020 but, in response to the current situation, the timetable for publication is being revised.

However, Section 4 of the proposed Framework, which sets out the assessments for eligibility for CHC during Pandemic and Other Emergency Situations will be implemented with immediate effect, as detailed below:

Pandemic and Other Emergency Situations

- There is an appreciation that completing a full CHC assessment in hospital during a declared emergency, such as pandemic influenza, would be problematic. As CHC is an assessment of long-term needs, decisions on CHC eligibility should not take priority in these situations. The priority instead should be the safety of the patient, and ensuring they receive the care they need.

- In these situations, Local Health Boards (LHBs) should be able to choose not to undertake a CHC assessment until after the emergency period. The intention of this is not to withdraw a duty of care over the patient. In most cases, the LHB will retain responsibility for organising, funding and providing care for them. This may happen in various ways and does not mean a continued presence in hospital; it may mean discharge to a care or nursing home with appropriate support or discharge to their own home with appropriate support. In some cases this will mean a situation not too dissimilar to finding someone eligible for CHC and arranging a care package for them.

- There is nothing which would prevent LA and NHS teams from working together to discharge to home, as necessary. During the pandemic response, or in guidance beforehand, local teams should be required to utilise their 'discharge to assess arrangements' to ease pressure on hospital beds if possible. This will be particularly relevant if a person does not wish to have their care provided by the NHS because they wish to retain direct payments. In such cases, the health board and local authority should work co-productively with the person to ensure they continue to have voice and control over their care. The health board and local authority should consider alternative arrangements such as joint packages of care or pooled funds to meet the person's needs in the most appropriate way. However, this should not delay discharge from hospital.
-
- Individuals can still make requests for a review of an eligibility decision (i.e. Local Resolution and Independent Review) however the time frame for a response will be relaxed.

- There is an expectation that LHBs will take a proportionate view to undertaking three- and twelve-month reviews to ensure that the individual's care package is meeting their needs and to ensure that any concerns raised are addressed as appropriate.

- During the COVID-19 emergency period, LHBs will not be held to account on the CHC Assurance Standards nor timeframes for dealing with CHC individual requests for reviews of eligibility decisions.

- These measures set out for NHS CHC are only in place for the duration of the COVID-19 emergency period.

- Local systems need to ensure that they have a method of monitoring actions taken during the COVID-19 emergency measures, for example using the NHS CHC Checklist, so that individuals are assessed correctly once business as usual resumes.

Implications for Adopting the COVID-19 Emergency Measures for Continuing NHS Healthcare

- If CHC full assessments of eligibility are deferred, a backlog will be created which will have future workload implications for NHS and Local Authority staff. The same will apply to individual requests for a review of an eligibility decisions (i.e. Local Resolution and Independent Review).

- A handling plan will need to be developed to enable the system to 'normalise' following the COVID-19 emergency period. For example, completing the CHC checklist prior to transfer, for patients who appear likely to need full assessment for eligibility.

- There may be a financial impact upon Health Boards funding under discharge to assess arrangements as part of the hospital discharge pathway for longer periods than usual. The rapid analysis referenced in Section 9 will include this consideration.

- Where social care has been provided free at the point of delivery for the emergency period, the expectations of individuals in receipt of funded care packages that may not continue to be funded after the COVID-19 emergency period, this will need to be managed, as some individuals will need to return to usual funding arrangements, which will mean they may have to contribute or fully fund their care.

- Although NHS CHC is effectively a 'funding stream', the clinicians involved in NHS CHC assessment and review are required to assess the specific needs of highly vulnerable individuals and to commission the relevant care. Therefore, it is still important to ensure that care packages are commissioned that meet the needs of these individuals.

Annex G: Community Equipment Cross Border Guidelines

Community Equipment Services:
Cross Border Guidelines (Wales)

This Guideline is owned and endorsed by the All Wales Occupational Therapy Advisory Forum (OTAF)

Guideline endorsed by OTAF: 15/11/18

Review date: 15/11/20

Introduction

The purpose of this guideline is to clarify and ensure transparent processes for the equity of access to community equipment for all citizens, those assessing needs and recommending equipment and the Community Equipment provider. It describes which community equipment partnership and service should provide and thereby fund equipment for individuals. The funding arrangements within the partnership are a matter for the partnership.

The guidance attempts to help all parties by avoiding time wasting trying to establish who should provide equipment.

The guidance should be used as the basis of negotiation with between individual Health Boards and those Local authorities outside of it's' borders that the health board identifies as frequently needing to repatriate patients to. Or in the case of looked after children or adults with additional learning needs reside outside of its borders or where there is joint residency across borders.

The guidance applies to equipment provided by the local community equipment service partnerships. Where they provide equipment for continuing care the protocol applies. N.B. Continuing care equipment may lie outside the pooled budget but funded by the Local health Board and managed by the community equipment service. It may be included within the pooled budget and managed by the community equipment service.

Where continuing care equipment and/or paediatric equipment lie outside the pooled budget and the community equipment service the LHB has to make its own arrangements for the supply and maintenance of community equipment. It is strongly recommended that continuing care equipment and paediatric equipment is brought within the remit of the community equipment service to ensure its professional management. Estimates can be used to include funding for this equipment within the pooled budget.

The guidance does not cover wheelchairs or any other equipment provided via WHSSC.

Key Principles

1. The safety and well-being of individuals is paramount.
2. Community equipment should promote the independence of the individual.
3. Community equipment services should be person centred in that they offer a flexible response to need, based on each local authorities priorities and performance targets.
4. Users have expertise about the challenges they face on a daily basis and must be involved in the assessment and choice of equipment.
5. Equipment provision is underpinned by timely and clear clinical decision making

Intended Outcomes

- To clarify an assessment process and responsibility for equipment provision
- To avoid delayed hospital discharges – and promote patient flow
- To prevent hospital admissions
- To enable staff to identify the correct equipment store to order equipment from.
- To avoid confusion to individuals and relatives
- To take into account of equipment costs on service provision

Operational arrangements to support principles.

1. Community Equipment Services will operate on Local Authority geographical boundaries and not registration of individuals with GPs. It should be relatively simple to establish the individual's county of residence and the county to whom he/she pays council tax. The community equipment partnership will fund equipment for residents living within the Local Authority or local authorities contained within the partnership.

2. Where the individual is being discharged to the home of a relative outside of his / her normal Local Authority of residence the local community service of the relatives' authority should provide the essential equipment required. This makes sense in the short term and if the arrangement turns out to be long term it becomes the user's ordinary residence. If the individual transfers to a different authority then the expectation is that the individual will contact the current and future Local Authority to ensure equipment suitability.

3. Ordering of equipment by a therapist who is not employed by the residing authority for adults or children will be undertaken by Trusted Prescribers who are staff employed by the discharging Health or Local Authority. It is the responsibility of each Health Board and Local Authority to nominate these posts and ensure they are updated as the post-holders change.

   What is a Trusted Prescriber?

   A Trusted Prescribers will be a registered member of staff employed by the discharging Health or Local Authority, who has the clinical knowledge and skills to undertake assessments and or sanction the equipment required. They will be fully aware of their accountability ensuring that equipment ordered is in accordance with the locality areas eligibility criteria for equipment – please refer to appendix 1 and 2 (to be completed locally). Therefore, trusted prescribers will be in situ where there is no joint equipment store agreement with the discharging organisation and receiving organisation/ locality.

   There is a requirement for the post holder to be updated by the equipment store they are a Trusted Prescriber for; to be updated of any changes in equipment or training needs (mechanisms to undertake this will need to be agreed locally when negotiating the agreement of a Trusted Prescriber).

4. For children and young people with special needs in special schools or children's homes or in foster care the funding of Community Equipment will be the responsibility of the local community equipment partnership encompassing the Local Authority funding the placement. This will avoid any authority being unfairly penalised due to the location of special facilities within its borders. The delivering authority will recharge the authority funding the placement.

5. Where equipment is required at two locations within the same Local Authority and community equipment partnership area for child with special needs; it is recommended that where a child is residing with both carers/parents equipment will be provide at both properties if the equipment is not transportable or transferable into different environments.

6. Where carers/parents have joint residency and share carer responsibility but where one of the carers has moved to a Local Authority outside the community equipment partnership area, the Local Authority of residence for this parent will be required to fund the equipment. It would be impractical for a Local Authority in South West Wales to assess, supply and maintain equipment in the home of the parent who has moved to North Wales. In these cases the carers

are both entitled to receive a service from their Local Authority and local health board. Please see appendix 3 for protocol on looked after children placed out of area.

7. For children and young people who are looked after, the authority who provide the looked after status is responsible to provide for all residences. The assessment for the equipment can be difficult where distances are involved, therefore the Trusted Prescribers for that area should assess and provide recommendations for the equipment required to the authority responsible for the looked after status. The ordering of the equipment should be made where the child is living for ease of delivery and cross charge and maintenance will need to be agreed and set up back to the looked after authority. It is essential that equipment needs are identified prior to the start of the placement to ensure smooth transitions. The Social Worker will be key in this liaison and collaboration. Repatriated equipment can either be purchased at reduced cost by the local equipment store or the originating authority can make individual local arrangements to have this transported to their own stores.

8. For children and young people from travelling families due to their limited time they can be in one area, assessment and delivery of equipment at each location takes too long. Therefore equipment should be provided from the authority they are residing to meet need and then this equipment should be provided to the family to take with them. The therapist in the area moved to should check the equipment for growth. When the child outgrows the equipment or needs change the authority they reside in at the time should re-assess and provide. Due to the mobile nature of this population, the duty of care and adequate information should be passed onto the parent/ carer regarding maintenance of equipment and contact numbers if required. It is not the intent of this guidance to identify how each authority will account for this "loss" on their stock.

9. Where the person moves from one Local Authority area to another every effort should be made to enable them to take any transferable equipment (i.e. not fixed) with them to avoid delays (this assumes the equipment is suitable for use in the new environment). The community equipment service in the new Local Authority should purchase the equipment at an appropriate rate of discount.

   It is not the intent of this guideline to address costs of equipment with regards to what discount should be applied to specific equipment; this should be negotiated locally via discussion between the store managers. The new Local Authority will assess the needs for any additional equipment or adaptations to support the individual in their new home.

   There is an expectation that individuals or their carers will inform the Local Authority of any relocation, contact details are to be provide on issuing of equipment.

10. Any individual within a given Local Authority in Wales will be eligible for equipment from the same Local Authority Community Equipment Service provider. For example any individual residing in Ceredigion and being discharged from a hospital in Carmarthen would have the equipment provided by the Ceredigion Community Equipment Service regardless if it is a social care or health care need. All deliveries will be in accordance with the local Authorities priorities and performance indicators.

11. Responsibility for the safe transfer of care from hospital remains with the NHS hospital. Hospital staff have the responsibility to communicate with primary and community NHS services and the local Social Services department with regard to the transfer of care of individual individuals. Hospital staff must do everything possible to engage the appropriate therapist or nurse in process of safe discharge at the earliest opportunity. This will help the local community equipment service to respond more quickly to facilitate discharge. The local community equipment service will ensure the safe fitting of equipment. In complex cases, for example, the hospital therapy staff and ward staff will be expected to liaise with the local receiving Occupational Therapist (OT). Complex cases may require a joint visit where possible to the home or hospital by both the discharging OT and local receiving OT. It is not the intent of this guidance to negotiate an all Wales key performance indicator for each authority and this remains a local target for each area.

12. Note any discharge protocols or new service developments must be discussed with the local Community Equipment Service provider in areas where the hospital regularly discharges individuals to. Any change in service delivery (e.g. the establishment of additional intermediate care services) must address the implications in terms of any changed demands on Community Equipment Services. This should ensure that service planning includes community equipment services in all service change, not simply when there may be additional demand, but recognises when there may be a reduced or very different demand.

13. Where the equipment provider has concerns about the appropriateness of the equipment (e.g. did not fit home environment) they will refer back to source of referral. The source of the referral should be provided with feedback if the equipment is not appropriate because may inform practice and raise training issues regarding prescription of equipment by different staff groupings.

14. For hospital discharge, where time scales allow the Trusted Prescriber will order the equipment via the protocol. However to support patient flow and where time scales are imminent, small pieces of equipment will be provided by the therapist from the satellite stores within the hospital. It is noted that at present there is no robust mechanism in place to recuperate the costs of using satellite stores equipment for out of area patients. It is not the intent of this guidance to address this issue, any associated costs and charging around this would this would need to be addressed local decisions by each equipment stores partnership board.

15. The local Community Equipment Service will monitor all referrals from Trusted Prescribers including individuals making referrals, equipment requested, and cost of equipment and date of delivery and/or installation. This will feature as part of a quarterly report to partnership board. Trusted Prescribers will need to be set up on the equipment stores IT system. The partnership board can then address any concerns with the hospital directly. This may include concerns about the referral, equipment prescribed or the eligibility criteria.

16. The Community Equipment Service will deliver and fit the equipment. The initial prescriber of the equipment should demonstrate the equipment where possible before hospital discharge. The initial prescriber should ensure that individuals know how to use equipment safely. Any concerns should be followed up with the appropriate local clinician. The local clinician or Trusted Prescriber may demonstrate the use of the equipment to the carer or other service providers when required. Service providers (e.g. Home Care Services, residential care services) including social services and the independent sector maintain responsibility to undertake their own risk assessment when using the equipment.

17. Trusted Prescribers will be Occupational Therapists at Band 7 or above (in exceptional circumstances e.g. Velindre this may need to be delegated to another registered but suitably skilled Occupational Therapist) or Local Authority nominated senior staff, working within identified teams who regularly need to request equipment for service user's resident outside of the Health Board or Local Authority area. They will be responsible for placing orders for colleagues within Health Board / Local Authority to ensure adherence to the agreed Trusted Prescriber and Community Equipment Services: Cross Border Protocol.

18. Responsibility for assessing and prescribing equipment lies with the discharging Health Board. It is the Occupational Therapist's responsibility within the discharging Health Board to ensure that the equipment requested from any local equipment service is equivalent to that identified on assessment and meets the individual's needs. (refer to appendix 2)

19. As equipment specification may vary across Joint Equipment Services Trusted Prescribers will need to specify equipment delivery details including height and location for equipment based on measurement not on equipment settings.

20. It is the responsibility of the Trusted Prescriber to ensure that the equipment is in situ prior to discharge using the established processes and delivery arrangements of each area.

21. Training will be provided for Trusted Prescribers by each partnership which reflects the training provided to local users.

22. Orders will be processed via the partnership's electronic ordering systems, e.g. CEquip however where this is not available or possible Trusted Prescribers will revert to using email on a standard request form sent to the Joint

Equipment Store. It is the responsibility of each health board and Local authority to check the security and GDPR guidance of its organisation (appendix 3 locally agreed forms).

23. Trusted Prescribers will be able to order equipment in line with locally agreed equipment for discharge lists and / or set budget limits. (See appendix 2).

24. Where equipment is identified as essential for discharge outside of this list Trusted Prescribers will be required to the seek authorisation from the relevant budget holder (See appendix 2).

25. Where it is applicable Trusted Prescribers will be required to order against criteria specifying long or short term loan.

26. Any concerns should be followed up with the appropriate Trusted Prescriber and / or prescribing clinician. Should the equipment be found to be unsuitable at the time of fitting the Joint Equipment Service will make contact with the Trusted Prescriber.

Governance

27. A record will be held of all those posts designated as Trusted Prescribers. This will be shared with each joint equipment service and budget holders. This list will be reviewed annually by all Occupational Therapy Leads to ensure that staff in these posts are updated on local processes and any equipment changes.

28. This protocol and the access to service user data will be agreed following the GDPR and information governance arrangements for each partnership.

29. All Trusted Prescribers will be expected to have completed mandatory training within their employing organisation in relation to information governance and IT security.

30. Equipment stores will inform Trusted Prescribers of any equipment changes and/or training requirements.

31. Trusted Prescribers will check that the OT has ensured patients and/ or carers are able to install and use the equipment correctly (e.g. raised toilet seat). The discharging OT will also ensure that any required follow up in the use of the equipment or installation of more specialist equipment e.g. hoist is in situ as part of robust discharge arrangements.

Monitoring Arrangements

32. Health Boards and Local Authorities are expected to provide quarterly reports on prescribing patterns of Trusted Prescribers through their established reporting mechanisms. Where patterns of prescribing are unexplained and diverge from local agreements this will be reviewed and discussed with Occupational Therapy Leads.

33. This guidance will be reviewed by Joint Equipment Service partnerships and the Occupational Therapy Leads should referral patterns change in line with major service developments or changes in patient flow.

Appendix 1 - Cross Border equipment essential for discharge from Local Authorities (required long term over 12 weeks) and Health Boards (for short term use under 12 weeks) in Wales

	Blaenau Gwent	Bridgend	Caerphilly	Cardiff	Carmarth-enshire	Caer-digion	Conwy	Denbigh-shire	Flint-shire	Gwynedd
Raised Toilet seat										
W.C. frame and seat.										
Toilet surrounds/frames –fixed / free standing										
Chemical W.C. (complete) and stand										
Commode - (static/mobile)										
Chair raisers										
Bed raising equipment.										
Bed stick										
Bed levers										
Turn discs										
Standing Turntables										
Handling belts										
Home patient helpers (over bed pull handles)										
Transfer board										
Portable ramps										
Glide Sheets										
Trolley										
Perching stool										
Walking frame Caddy										
Hoist										
Sling										
Polycarbonate Flooring										

Cross Border equipment essential for discharge from Local Authorities (required long term over 12 weeks) and Health Boards (for short term use under 12 weeks) in Wales

Raised Toilet seat	Vale of Glamorgan	Wrexham	Abertawe Bro Morganwg UHB	Aneurin Bevan LHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda LHB	Powys Teaching HB
Raised Toilet seat									
W.C. frame and seat.									
Toilet surrounds/frames –fixed or free standing									
Chemical W.C. (complete) and stand									
Commode - (static/mobile)									
Chair raisers									
Bed raising equipment.									
Bed stick									
Bed levers									
Turn discs									
Standing Turntables									
Handling belts									
Home patient helpers (over bed pull handles)									
Transfer board									
Portable ramps									
Glide Sheets									
Trolley									
Perching stool									
Walking frame Caddy									
Hoist									
Sling									
Polycarbonate Flooring									

Paediatric Equipment

	Blaenau Gwent	Bridgend	Caerphilly	Cardiff	Carmarth-enshire	Caer-digion	Conwy	Denbigh-shire	Flint-shire	Gwynedd
Specialist Seating										
Children’s Bathing										
Children’s toileting										
Children’s changing tables										
Children’s sleep systems										
Children’s beds										
Hoist										
Slings										
Glide Sheets										
Polycarbonate Flooring										

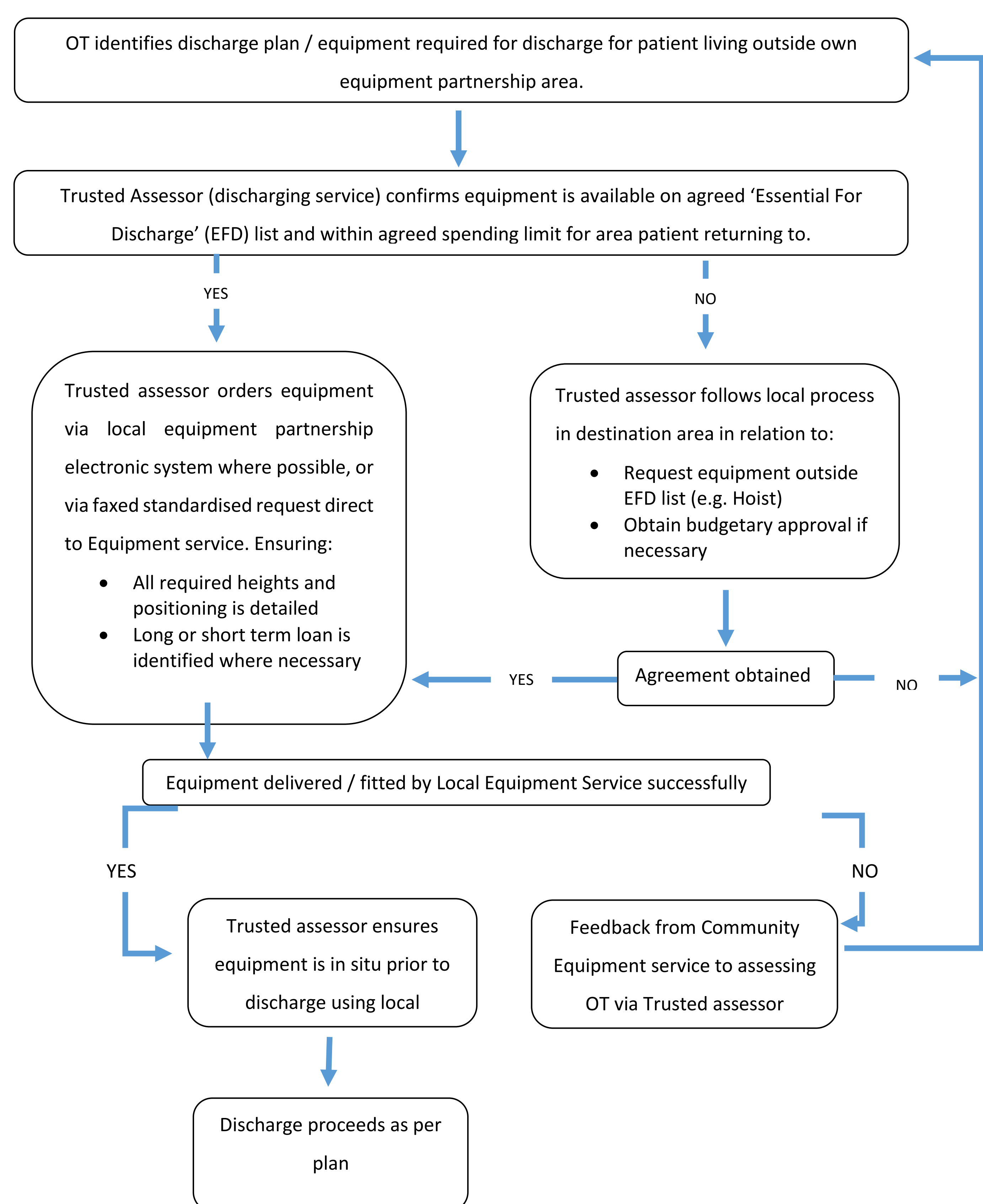
	Isle of Anglesey	Merthyr Tydfil	Monmouth shire	Neath Port Talbot	Newport	Pembrok eshire	Powys	Rhondda Cynon Taf	Swansea	Torfaen
Specialist Seating										
Children’s Bathing										
Children’s toileting										
Children’s changing tables										
Children’s sleep systems										
Children’s beds										
Hoist										
Slings										
Glide Sheets										
Polycarbonate Flooring										

Paediatric Equipment

	Vale of Glamorgan	Wrexham	Abertawe Bro Morganwg UHB	Aneurin Bevan LHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda LHB	Powys Teaching HB	
Specialist Seating										
Children's Bathing										
Children's toileting										
Children's changing tables										
Children's sleep systems										
Children's beds										
Hoist										
Slings										
Glide Sheets										
Polycarbonate Flooring										

Appendix 2

Flow chart of action for Trusted Prescriber for hospital discharge



Annex H: Overview of decision making and escalation

Overview of Discharge Decision Making & Escalation to ensure hospital and community beds are freed up

Key Steps	Decision Points & Responsibilities	Route of Escalation
Morning Ward Round	Medical decision to discharge discharge pathway confirmed (Lead: Senior Dr in ward)	Executive Director in Acute
Waiting in discharge area in hospital	Case manager agreed (Lead: Local coordinator in acute) Discharge activities agreed incl. transport and medication (Lead: Single coordinator in acute)	Executive Director in Acute
Patient leaves hospital or community bed	Transport to home / bedded setting (Lead: Single coordinator in acute)	Executive Director in Acute (for acute issues) and Director of Community Services (for community health issues)

Overview of Discharge Decision Making & Escalation to ensure assessment and support is provided

Key Steps	Decision Points & Responsibilities	Route of Escalation	
Assessment at home	Trusted assessor visit for those on pathway 1– acute or community health care professional (Lead: Single coordinator in acute)	Executive Director in Acute (for acute issues), Executive Director of Community Services (for community health issues) and Director of Adult Social Services (for social care issues)	Gold Command EPRR Team
Care provided as needed	At home support provided as needed by health and/or social care (Lead: Single coordinator in acute)	Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)	Gold Command EPRR Team
Review post short term support	Ongoing short term support as needed by health and/or social care or discharge from all support (Lead: Single coordinator in acute)	Executive Director of Community Services (for community health issues) and Executive Director of Adult Social Services (for social care issues)	Gold Command EPRR Team

Social Care, Health and Wellbeing Scrutiny Committee

Forward Work Programme 2021/22

Meeting Date	Agenda Item	Contact Officer
2021		
1st April	Update on Homelessness	Angela Thomas
13th May	Please see Cabinet FWP for items	
24th June (postponed to the 5th July)	Postponed	Postponed
5th July	Please see Cabinet Board FWP for items	
29th July	Please see Cabinet Board FWP for items	
13th September (Special)	Tai Tarian lettings policy consultation	Tai Tarian Officers/ Angela Thomas/ Robert Davies
16th September	Impact of COVID-19 on the Sustainability of Older People Care Homes in Neath Port Talbot	Chele Howard
21st October		
	Update Report on the impact of Covid-19 on Disabled Facilities Grants	Angela Thomas

Agenda Item 7

9th December	Impact of dischargers from hospitals on the availability of care packages. An update on Delayed Transfer of Care (DTOCS)	Angela Thomas
	The Regulated Service (Service Providers and responsible Individuals((Wales) Regulations 2017 (Hillside) Including - In the AUDIT section of agenda 9 there is a criticism of Hillside (pg93) which I feel we must investigate from cllr. purcell	Keri Warren
	JICPA report (included on Cabinet board FWP) will invite education	Andrew Thomas/ Andrew Jarrett
2022		
20th January	Older People’s Mental Health	Jo – Albott-Davies
	Draft Corporate Recovery Plan - Priorities	Caryn Furlow-Harris
3rd March	Recovery plan – specifically to do with social care, inclusion on care homes – is this going to change people decisions going forward. Welfare of staff to be included in this.	Angela Thomas
	The Neuro Diverse Plan– Post scrutiny	Keri Warren
7th April	Items to be confirmed	

To be confirmed:

- Invite Health Board – TBC

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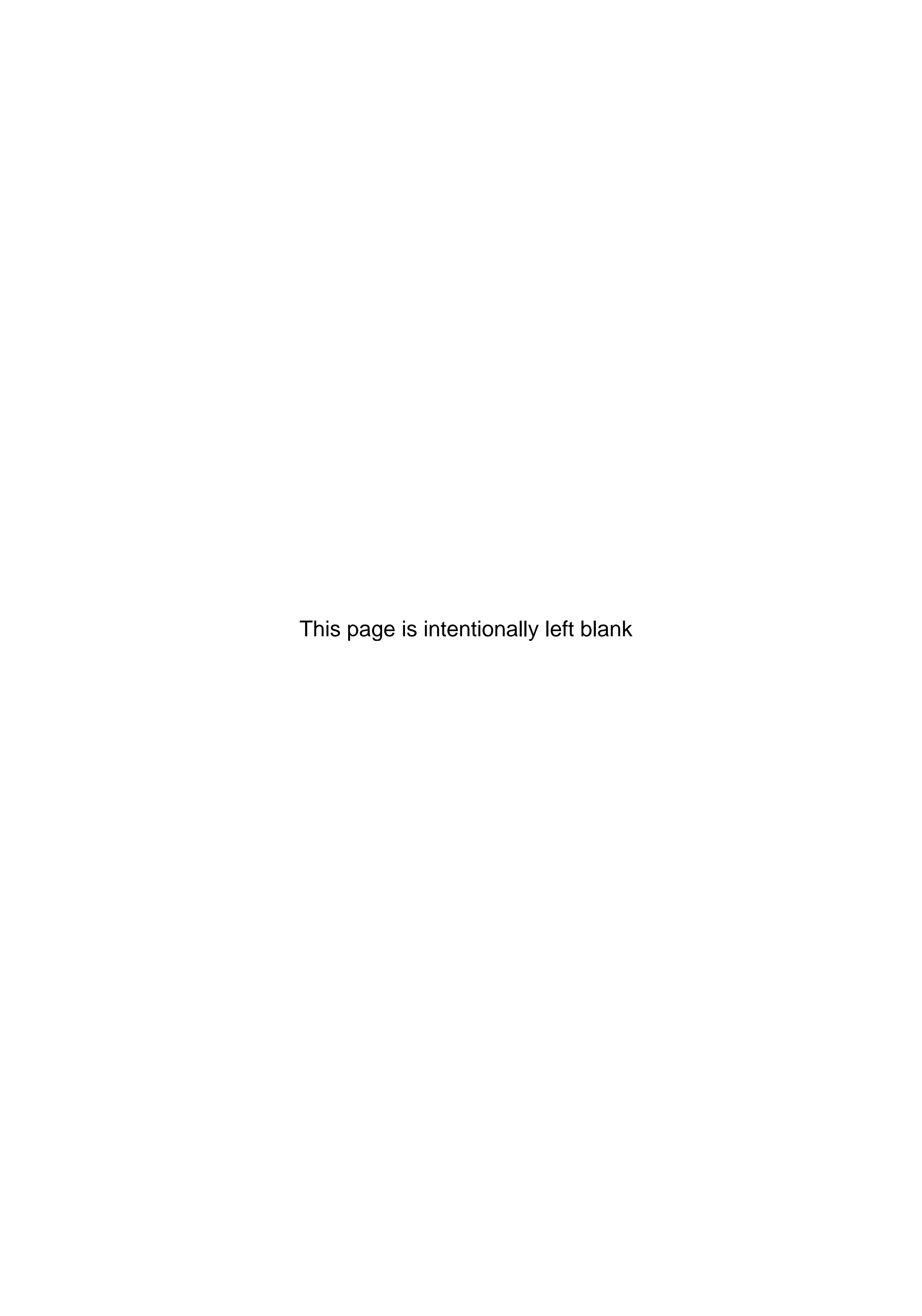

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