



Cyngor Castell-nedd Port Talbot  
Neath Port Talbot Council

## **NEATH PORT TALBOT COUNTY BOROUGH COUNCIL**

### **SOCIAL SERVICES, HOUSING AND COMMUNITY SAFETY CABINET BOARD**

**25<sup>th</sup> January 2024**

**Report of the Head of Adult Services – Ms A. Thomas**

#### **Matter for Information**

**Wards Affected:**

All Wards

**Report Title:**

Hospital admission and discharge processes.

**Purpose of the Report:**

To provide Members with information on hospital admission and discharge processes.

## **Executive Summary**

This report sets out the staff teams and processes in place to support hospital admission and safe discharge, highlighting the challenges faced by Adult Social Care services.

## **Background**

Hospital admission and discharge processes have remained challenged since the COVID pandemic. This has been attributed to issues with recruitment and retention of care and support staff, increased pressure on hospitals and a fragile Provider market.

In response to COVID, a hospital social work team was established to work alongside health professionals to facilitate timely assessments and discharges from hospital.

In recent months, this team has expanded to include a Team Manager, a Deputy Team Manager, three Social Workers, a Community Wellbeing Officer and a Contact Officer to support the increasing demand.

The team are based in Neath Port Talbot hospital and have recently established a temporary base in Morriston hospital.

## **Hospital Admission Process**

Individuals of Neath Port Talbot are admitted to one of three hospitals, which includes Morriston, Singleton and Neath Port Talbot. Due to the different expertise of each hospital, individuals may be transferred between hospital sites depending on the medical support they require.

Individuals can be admitted into hospital via a number of ways:

- Ambulance service

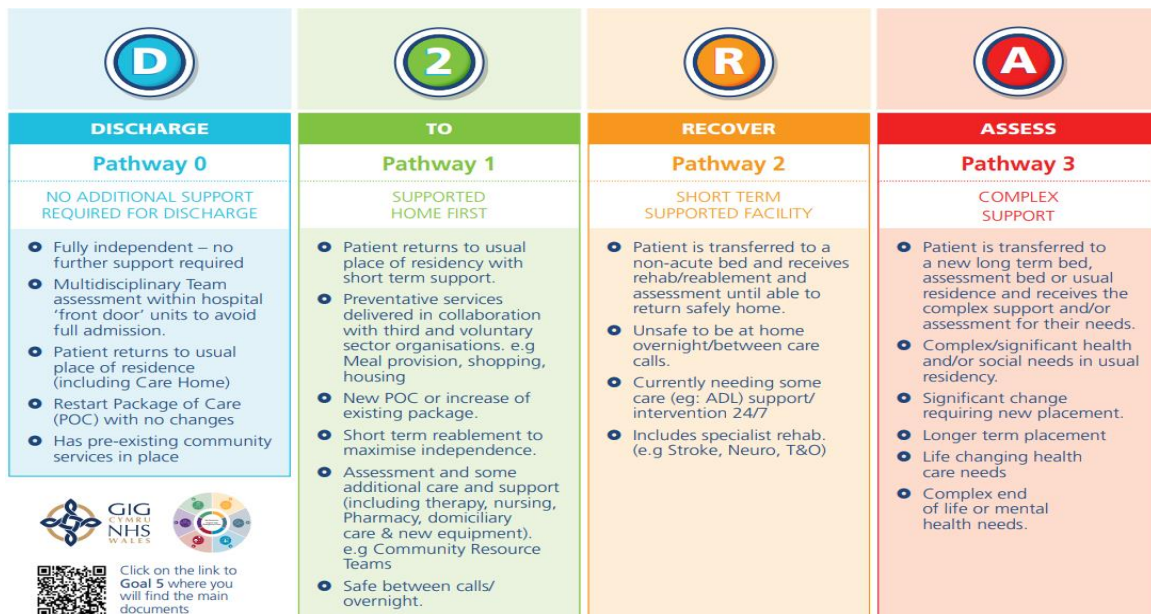
- GP referral
- Out of hours service
- A&E walk in
- Referral from another hospital

As soon as an individual is admitted into hospital, there are a number of processes in place to review an individual’s needs and to ensure the correct steps are in place to expedite timely discharge.

## Hospital Discharges

Once an individual’s health needs have been met, i.e. Medically Fit for Discharge (MFFD), each individual should be assigned to a “Pathway” in accordance with Welsh Government guidance named Discharge to Recover then Assess (D2RA).

This process supports individuals to be discharged from hospital at the earliest opportunity. The diagram below illustrates the different pathways a person can be discharged.



Further information around this model can be found at Appendix A.

### Pathway 0

If an individual is being discharged within 7 days and has no change in care and support need, the social work team will support discharge arrangements by liaising directly with Providers.

### Pathway 1

The social work team will undertake assessments proportionate to the needs of the individual in relation to POC requests as well as re-directing individuals for preventative services.

Individuals requiring reablement in the community are supported by the Community Recourse Team (CRT).

### Pathway 2

There is currently no residential reablement provision within Neath Port Talbot and as a result, there are a disproportionate number of people entering residential or nursing care too soon.

The Adult Services Strategic Plan has identified this gap in provision and plans are in place to deliver residential reablement within Trem Y Glyn.

### Pathway 3

Complex individuals who can require a multi-agency response are included within this pathway. A joint assessment takes place between the social work team and discharge liaison nurse (DLN) teams for individuals requiring long term residential or nursing care.

## **Brokerage Team**

In addition to the social work teams, there is a Brokerage Team in place to support hospital discharge.

The Brokerage Team sits within the Common Commissioning Unit (CCU).

When an individual is assessed as requiring a package of care or a care home placement, a referral is made to the Brokerage Team to support.

If an individual requires a package of care the Brokerage Team will liaise with the in house and external domiciliary care Providers to arrange a POC at the earliest convenience.

Individuals requiring a care home placement will be supported by the Brokerage team to locate a care home on an urgent basis to support timely discharge.

Brokerage Officers will work to support hospital discharge urgently, however there are a number of factors that can delay this process, including; shortage of care and support workers, limited capacity with Providers and lack of appropriate care home placements.

As of 16<sup>th</sup> January 2023, external Domiciliary Care Providers were delivering 9090 of hours of care per week and the internal team were delivering 1459 hours of care per week.

This is made up of a combined total of 787 Individuals in receipt of a package of care, which is supported by approximately 597 staff.

NPT care home market had been impacted by a recent home closure, which resulted in the relocation of 68 residents across the region and

out of county, however the market position is showing signs of improvement.

As of 16<sup>th</sup> January 2023, we have 15 nursing home vacancies and 15 general residential vacancies.

Officers are also working with a Provider to reopen a unit of 10 beds.

### **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.

### **Consultation**

There is no requirement for external consultation on this item.

## **Appendices**

Appendix A - The discharge to recover and assess model guidance.

### **List of Background Papers**

N/A

#### **Officer Contact:**

For further information on this report item, please contact:

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