SOCIAL AND HEALTH CARE OVERVIEW AND SCRUTINY COMMITTEE

Date of Meeting	28th March 2019
Report Subject	The function and process of Delayed Transfer of Care from a hospital setting
Cabinet Member	Cabinet Member Social Services.
Report Author	Chief Officer Social Services
Type of Report	**Operational**

EXECUTIVE SUMMARY

This report explains the role and function of the Delayed Transfer of Care process, the structure of hospital based social work and its collaboration with health colleagues. The report will focus on the patient flow through the discharge process and explain why delays occur, and how we minimise such delays for social care reasons.

RECOMMENDATIONS	
1	Members are informed and are aware of the process of Delayed Transfers of Care and how it is monitored and managed each month.

REPORT DETAILS

1.00	Explaining what Delayed Transfer of Care means
1.01	The delayed transfer of care statistical release shows data on the number of people experiencing a delay in being discharged from hospital. This information is released on the same day each month. The day is known as census day. The data collected is a snapshot of the number of people who are medically fit for discharge but are delayed in hospital.

1.02	The definition of a delay is a patient who continues to occupy a hospital bed after his or her "ready to transfer of care date". This date is determined by the clinician responsible for inpatient care, in consultation with colleagues in the hospital multi-disciplinary discharge team. This team covers both NHS and Social Services staff.
1.03	A monthly census covers acute and community hospitals which occurs on the 3rd Wednesday of every month.
1.04	The reason for the delays are coded. The statistics are classified by the principle reasons for delay, type of ward and next stage of care. Codes range from Categories 1–8 within each category there are 8 separate sub codes. An example of which would be 2.3 for Home Care related issues sub codes being 2.3.1 awaiting start of new home care package, and 2.3.2 awaiting restart of previous home care package. **See Appendix 1**
1.05	The aim of the Census data collection is to provide a summary of the numbers of people delayed in NHS hospitals in Wales. Patients from Flintshire who are admitted to the Countess of Chester are not included in the numbers for the census. The Countess of Chester has a separate system whereby people who are delayed transfers of care are highlighted to senior manager on a weekly basis. Considerable resources are dedicated to managing the flow of discharges from the Countess. Weekly meeting are attended by Senior staff and Team Managers.
1.06	From April 2019 we will collect local data regarding Delayed Transfers of Care from the Countess of Chester.
1.07	**RESOURCE IMPLICATIONS (Service Structure)**
1.08	Flintshire residents have access to three acute hospitals. Wrexham Maelor Hospital, Ysbyty Glan Clwyd Hospital and Countess of Chester Hospital. The team also provide support to three community hospitals in Deeside, Holywell and Mold.
1.09	Flintshire have the equivalent of two fulltime social workers based at each of the Acute sites and providing support to the community hospitals via a peripatetic Hospital Social Worker. Health provide admin support at the 3 acute settings, Glan Clwyd, Countess and the Maelor Hospitals. Hospital Social Worker's do not hold a long term case load. Their remit is purely to facilitate a safe discharge from hospital. If ongoing social work is required the case is transferred to the Locality Teams for allocation. This enables us to concentrate on discharge, quality and throughput.
1.10	In 2018 the total number of referrals to the hospital social work teams across the three acute and community sites totalled 1251. The breakdown being for the acute hospitals: Countess of Chester: 381 Wrexham Maelor: 545 Glan Clwyd: 325

	These figures represent cases from January to December 2018. This figure has steadily increased over the last two years with an additional 50 individuals seen by hospital social worker between April and December 2018. There is considerable work going on in the community to avoid hospital admission and the relatively low increase in figures appear to demonstrate this.
1.11	The national performance measure counts Delayed Transfers of Care for people over the age of 75 only. Figures for Flintshire under this new measure are as follows: 2017/2018 — 25 2018 to date — 29 Welsh Government do not publish data for the over 75 delayed population, however this report confirms Flintshire is in the top quartile on performance across Wales. Since April 2018, Flintshire, with the highest population in Wales, has reported a total of 44 Delayed Transfers of Care for people aged 18 and over. This compares to: Anglesey — 59 Gwynedd — 76 Conwy — 13 Denbighshire — 24 Wrexham — 102
1.12	**DISCHARGE PROCESS**
1.13	When a person has been admitted to hospital and the acute episode has been dealt with a referral may be required for Social Work assessment. The named nurse on the ward in consultation with the patient will complete a "What Matters" conversation which will form the basis of the initial referral to our Social Work Team. The referral is then passed to Hospital Social Workers who screen and monitor process and have daily conversations with the named nurse on the ward. The assessment starts when the person is stable enough to respond to the process and is able to contribute to planning the discharge. We have moved away from the label of being medically fit as this may contribute to a delay in the assessment starting.
1.14	Hospital social workers will only deal with patients who are new to the service and who don't have an existing social worker. Cases that are open to locality social workers remain with that worker. These cases are often complex and will need ongoing support post discharge. Maintaining continuity of locality worker is good practice and beneficial for service users. Significant life changing decisions are difficult to make in a hospital environment. All efforts are made to ensure that the person is at their optimum and stable before long term plans are made. Decisions involving significant life changing decisions are rarely made in a hospital environment as this is not considered good practice.

1.15	Hospital Social Workers liaise closely with Discharge Liaison teams based within the acute hospital settings and aim to provide an assessment of need in a timely manner.
1.17	Once a fit for discharge date has been agreed, the social worker will continue with the “What Matters” assessment in order to establish discharge needs and identified outcomes. There are many reasons a person may be delayed in hospital. The majority of referrals to the hospital social workers are for very elderly frail people with multiple health complications.
1.18	Close liaison with therapy (physical and occupational) staff in the hospital and community is often required with most complex discharges requiring a multidisciplinary approach.
1.19	Many people have benefitted from an initiative to be discharged from hospital to have further assessment in a care home. This discharge arrangement is funded via the Intermediate Care Fund, and is called discharge to assess or step down. This approach provides a more relaxed realistic and homely care environment, where more time can be taken to assess and all care needs and frees a hospital bed. The assessment is completed in line with Social Services and Well Being Act.
1.20	The aim of our teams is to support people to go home first. However, the domiciliary care market is fragile and there are some difficulties recruiting care staff to the sector. We continually strive to be creative in our efforts to recruit and retain staff, but this issue remains a challenge, particularly in rural areas.
1.21	Our aim each month to have no delayed transfers of care. In managing this, weekly reviews are undertaken and each person who may be ready for discharge is carefully tracked through the process. Priority is always given to hospital discharges.
1.22	There can sometimes be difficulties in relation to the complexity of a person care and support needs, in all cases the social work and health team consider the need for Continuing Health Care. It would be fair to say the Continuing Health care agreements can often be complex but the hospital social work team staff are very experienced and are all level three social workers who understand and manage the process very well.
1.23	**BROKERAGE PROCESS CARE**
1.24	Flintshire has a well-developed Brokerage process and once domiciliary care needs have been identified the broker will liaise with care agencies in the community to find available care. They also produce a weekly directory of available care home placements. Social workers will support family members in locating a care home as required. Brokerage will assist with specialist high cost placements and liaise as appropriate with social workers.

1.26	Managers and all staff are very aware of the need to minimise hospital delays. People who are delayed are at risk of infections, loss of independence, increased reliance on carers and loss of confidence. Hence we have hospital based social work teams who focus only on hospital discharge, and support people to return home.
1.27	The Reablement team assists with hospital discharges and enable people to reach their potential in the community. Flintshire local authority home care team are able to provide short term support in the form of reablement care package to support the hospital discharge. This support is tailored following review on a weekly basis to ensure that the service user is reaching potential and remaining as independent as possible, which helps to manage demand on the service.
1.29	Significant joint working takes places with our colleagues in the health service and this takes the form of very regular ward meetings, video conference meetings and email correspondence, in order to appropriately track each person's hospital discharge.

2.00	**RESOURCE IMPLICATIONS**
2.01	None

3.00	**CONSULTATIONS REQUIRED / CARRIED OUT**
3.01	N/A

4.00	**RISK MANAGEMENT**
4.01	N/A

5.00	**APPENDICES**
5.01	Delayed Transfer of Care codes
5.02	Delayed Transfer of Care codes 2

6.00	**LIST OF ACCESSIBLE BACKGROUND DOCUMENTS**
6.01	**Contact Officer:** Janet Bellis – Service Manager - First Contact & Locality Services **Telephone:** 01352-702540 **E-mail:** janet.bellis@flintshire.gov.uk

7.00	GLOSSARY OF TERMS
7.01	(1) Delayed Transfer of Care Codes – these refer to the codes used between health and social services to identify the reasons for the delay. (2) Discharge Protocol – joint arrangement between both health and social services around the process for discharges from hospital. (3) Hospital Social Work referral numbers – these refer to the numbers of referrals received between January – December 2018. (4) Discharge Liaison Team – this is the named nurse with responsibility of coordinating and liaising with all the relevant agencies in order to facilitate a safe and timely discharge.