| SOCIAL & HEALTH CARE OVERVIEW & SCRUTINY COMMITTEE |
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| **Date of Meeting** | Thursday 26th January, 2017 |
| **Report Subject** | The function and process of Delayed Transfer of Care from a hospital setting |
| **Cabinet Member** | Cabinet Member for Social Services. |
| **Report Author** | Chief Officer – Social Services |
| **Type of Report** | Operational |

## EXECUTIVE SUMMARY

This report will explain the role and function of the Delayed Transfer of Care process. The structure of hospital based social work and its collaboration with health colleagues, is also outlined. The report will focus on the patient flow through the discharge process and will look to explain why delays occur.

| RECOMMENDATIONS | |
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| 1 | The committee 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 |
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| 1.01 | The delayed transfer of care statistical release shows data on the number of people experiencing a delay in being discharge from hospital. This information is released on the same day each month. The day is known as census day. The date 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. The team covers both NHS and Local Authority 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 delay are coded. The statistics are classified by the principle reasons for delay, type of ward and next stage of care. [Appendix1] 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. |
| 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. |
| 1.06 | To provide trend data for total numbers, reasons for delay and the stage at which people are delayed in Wales. |

| 2.00 | RESOURCE IMPLICATIONS |
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| 2.01 | Flintshire residents have access to three acute hospitals. Wrexham Maelor Hospital, Ysbyty Glan Clwyd and Countess of Chester Hospital. The social work teams also provide support to three community hospitals in Deeside, Holywell and Mold. |
| 2.02 | Flintshire have the equivalent of two fulltime social workers based at each of the Acute sites and provide support to the community hospitals via a peripatetic Hospital Social Worker. Health provide admin support at the 3 acute settings ie Glan Clwyd, Countess and the Maelor Hospitals. Hospital Social Workers do not hold a long term case load. Their remit is purely to facilitate a safe discharge from hospital, and provide support during this process. If ongoing social work is required the case is transferred to the Locality Teams for allocation of long term social worker. This enable us to concentrate on discharge and through put. |
| 2.03 | In 2016 the total number of referrals across the three acute and community sites totalled 1205. This figure represents cases from January to December 2016. This figure has remained fairly static for the past 2 years. There is |

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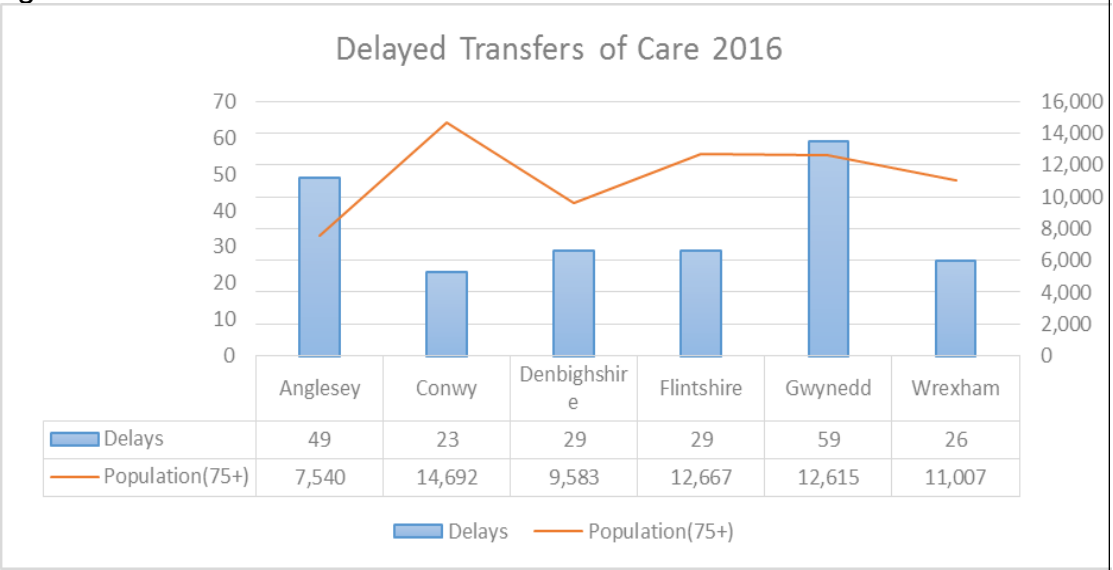
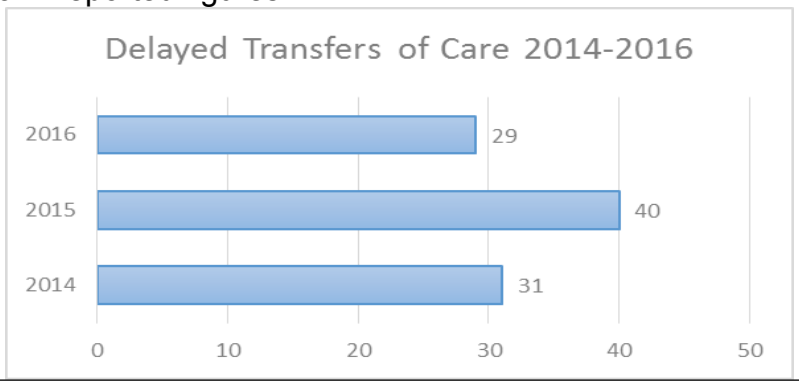
| | considerable work going on in the community to avoid hospital admission and the static figures appear to demonstrate this. |
| 2.04 | Over the past twelve months Flintshire has reported a total of 29 Delayed Transfer of Care.<br><br>The chart below shows the number of Delayed Transfers of Care during 2016 across North Wales local authorities compared with the population aged 75 and over. |




The management of Delayed Transfers of Care in Flintshire has improved in the last year. Reported figures in:




| 3.00 | **DISCHARGE PROCESS** |
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| 3.01 | 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 Social Work Team. The referral is then passed to Hospital Social Workers who screen and monitor process and have daily conversations with name nurse on the ward. When the patient is deemed medically fit for discharge the social worker will visit them on the ward. |
| 3.02 | 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 |

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| | will need ongoing support post discharge. Maintaining continuity of locality worker is good practice and is beneficial in the long term for the person. 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.<br><br>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.<br><br>Each hospital has a Discharge liaison nurse whose role it is to monitor the progress of each patient through the admission and discharge process. They liaise with social work team on a daily basis in order to facilitate a timely safe discharge.<br><br>Once the medically fit for discharge date has been agreed, the social worker will continue with the "What Matters" assessment in order to establish discharge needs. 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.<br><br>Providing appropriate care requires specialist skills, training and experienced carers to maintain health and wellbeing. Organising and co-ordinating care in the community can take time. If a care / nursing home placement is required this can also take a considerable amount of time to organise and agree.<br><br>Close liaison with therapy staff in the hospital and community is often required with most complex discharges requiring a multidisciplinary approach<br><br>Many patients have benefitted from an initiative to be discharged from hospital to have further assessment in a care home. This assess to discharge arrangement is funded under Intermediate Care .This provides a more homely and relaxed realistic care environment and frees a hospital bed. This process is known as "step down" The assessment is completed in line with Social Services and Well Being Act. The emphasis being placed on "What Matters" to the patient.<br><br>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. |

| **4.00** | **BROKERAGE PROCESS** |
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| 4.01 | 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. Brokerage produces a weekly directory of available care home placements that have approved provider status. 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.<br><br>Brokerage staff meet with managers weekly to discuss and monitor |

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| | availability of domically care. |
| 4.02 | 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.<br><br>Weekly often daily contact is made with ward staff and discharge liaison nurses in order to maximise efforts to facilitate a safe discharge.<br><br>In Flintshire we aim to use our Community Reablement team to assist with hospital discharges and enable people to reach their potential in the community.<br><br>We also aim to avoid hospital admissions where possible in order to assist with patient flow through the hospital.<br><br>Delayed Transfers of Care is high on Team Managers agenda and great efforts are made to minimise them.<br><br>There is significant joint working 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. |
| 4.03 | Discharge pressures – A report from Welsh Government in 2015 titled "Informal review to identify good practice" highlighted four areas in creating good patient flow across the system is key to creating and maintaining hospital capacity<br>Recommendations of the Report<br>**Capacity** – Maintain close working relationships between key parties in primary and community.<br>**Consistency** – Health & Local Authority partners working together on their regional collaborative to develop consistent approaches.<br>**Communication** – Open and clear lines of communication patient, family, NHS, Social Services and wider community.<br>**Culture** – Respecting different perspectives and drivers whilst working together for the benefit of patients.<br><br>Its Flintshire view that these are the things we do as our everyday practice. |

| **5.00** | **APPENDICES** |
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| 5.01 | Appendix 1 - Numbers of Hospital Social Work referrals Jan – Dec 2015<br><br>Appendix 2 - Delayed Transfer of Care codes<br><br>Appendix 3 – Delayed Transfer of Care Population stats |

| 6.00 | LIST OF ACCESSIBLE BACKGROUND DOCUMENTS |
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| 6.01 | (1) Betsi Cadwaladr University Health Board Discharge Policy and Protocol for Adults<br><br>**Contact Officer:** Janet Bellis<br>Service Manager - First Contact & Locality Services<br>**Telephone:** 01352-702540<br>**E-mail:** janet.bellis@flintshire.gov.uk |

| 7.00 | GLOSSARY OF TERMS |
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| 7.01 | Examples:<br>(1) Delayed Transfer of Care Codes – these refer to the codes used between health and social services to identify the reasons for the delay.<br><br>(2) Discharge Protocol – joint arrangement between both health and social services around the process for discharges from hospital<br><br>(3) Hospital Social Work referral numbers – these refer to the numbers of referrals received between January – December 2016<br><br>(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.<br><br>(5) What Matters - “What matters” is term used to describe the conversation that takes place when completing the Specialist Social work assessment document |