Is ‘DToC’ the wrong indicator?

- What is the ‘right’ number of people subject to a delayed transfer of care?
- Outcomes and options that support people in appropriately leaving hospital, at all stages, are key
- A simple number is mis-leading; features and factors of our population(s) need to be understood, as do all the elements that impact upon the support being offered, at all stages, and the systems understanding of challenges that impact upon ‘flow’

Onwards care: the IoW PA Hosp Discharge scheme

- We challenged ourselves about how to introduce more choice and control to people needing ongoing support when leaving hospital – our offer was “traditional”.

- Used winter pressures funds to introduce a pilot scheme using PAs for hospital discharge. Via our PA HUB, we asked for PAs interested in providing this service and brought 20 PAs together and provided them with training. The rate paid is £14 per hour (compared to £18.40 for hour of domiciliary care).

- DTA: for people needing onwards care (including self funders), the hosp SW now also asks if the person wants a PA to support their discharge from hospital. Our brokerage service then arranges for the PA(s) to visit the person whilst still in hospital we establish a temporary direct payment. The PA offer is for a two week recovery period post discharge, thereby allowing for longer term planning to take place.

- 30 individuals supported to return home from hospital in August via this pilot scheme – often those in the our most remote localities where domiciliary care agencies want a premium and sometimes for people needing very extensive support, meaning that some people have two+ PAs. As is the case for all PAs, the details of when, what and when of the support provided are controlled by the person in consultation with the PAs.

- The pilot scheme recruited 15 PA’s from our PA Hub – who have worked with us to develop and roll out this unique scheme. These PAs ONLY work on this scheme. That way, we have built in “flow”.

- Since it started, the scheme has delivered an additional 400 hours per week of care delivery for people on their discharge from hospital

- PA “I am proud to be part of this scheme…I have supported 4 different people to return home from hospital avoiding them from a potentially long stay in a hospital bed”

- Service User “I was in hospital following a fall at home, when I was ready to leave it was all very quick, I met my PA on the ward and we got along straight away, I returned home the following day with the PA.”

Supporting our futures for Reading
Adult Social Care
& Wellbeing

Busting the Myths and Legends of Delayed Discharges of Care

Myths and Legends

- Are system conference calls effective?
- Who is waiting to go home
- How will they get there and who is responsible?
- Does it matter whose delay it is?

Busting through

- System Meetings at DASS level weekly - focus on joint solutions
- Planning potential challenges for those in hospital
- Sharing resources where it makes sense
- Put on your walking shoes – walk the wards
- Everyone can make it happen