Cordis Bright

Delayed transfer of care – part 3

May 2017

Anecdotally, we've noticed that integrated hospital discharge teams can find it hard to recruit and retain social workers. It seems critical, but somewhat overlooked, in the research we have seen about how best to tackle DToC. Here we share our understanding of why this problem occurs and the tactics which can improve things. We also explore options for diverting existing expenditure to try to improve retention.

Why is it hard to recruit and retain in DToC teams?

It's not clear why this might be, although our conversations with social workers and their managers suggest the following:

- It can be frustrating to work in a hospital discharge team if the system and process is either not clear, or not properly followed. It can be dispiriting to track down cases which need social work support if paperwork is misaligned, communication is poor or the value of social work input is not understood. All too often, we hear that hospital / health staff don't understand social work, and vice versa.

- Social workers are the link between the hospital and the social care market, and (as we have discussed in previous updates) lack of suitable social care provision is a very significant barrier to effective hospital discharge. Repeatedly searching for solutions in a care market which is unable to cope is a frustrating experience.

- Social workers in a hospital discharge team are often required to work with a high volume of clients whose cases are particularly time-sensitive and require quick funding decisions and placement outcomes. When coupled with the challenges of the hospital environment and under-supply in the social care market, this fast pace can lead social workers to become de-motivated.

What steps can we take to improve things?

Some of these issues are hard to fix. But for those struggling to manage rising DToC rates, this is an issue which should not be overlooked. Here are some solutions which we have seen. At first glance, they don't all seem like tactics for improving staff retention. But all of them have the effect of removing frustration from the job, making it easier for social workers to stay motivated and engaged in the work.

- Review the process or patient journey, to ensure that it is as effective as possible.

- Ensure that decisions are made swiftly: this could mean reviewing multi-disciplinary team meetings to ensure they are effective, and/or reviewing levels of authority for

signing off care packages. Anything which helps the case to progress without unnecessary hurdles will benefit the patient and reduce frustrations for all staff involved in hospital discharge.

- Devote time to building understanding between different teams and stakeholders. We have found that bringing together all involved in hospital discharge for a frank discussion about roles, timings, decision making and overall process improvements can improve working relationships quite significantly.

- Work hard to ensure the local social care market is viable and responsive – encourage innovative approaches, fund providers to extend their remits and ensure that CCGs and local authorities are working together to improve the availability of local provision.

Are there solutions related to pay?

Of course one solution is simply to tempt good people to the role by paying an attractive pay rate, perhaps including a "golden handshake" or bonuses based on effective reduction of DToC.

This is a slightly uncomfortable "commercial" approach. It also risks de-stabilising the local market for recruiting social workers for other roles. But we wondered if it could be justified, especially given the costs which poor rates of DToC brings to the health and social care economy as a whole.

We decided to crunch some numbers to put this all into context.

Re-directing unnecessary expenditure

The Skills for Care National Minimum Dataset shows that social workers supporting older people in community support and outreach settings are being paid an average of £22,434 per annum. In the table below, we apply these figures to a fictional hospital discharge team which has 5 social workers and is currently spending 35% of its staff costs on agency and sickness[1].

No of social workers	Total salary budget including on-costs at 10%	Amount spent on agency / sickness (assumes 35%)
5	£123,378	£43,185

In this fictional example then, a total of **£43,185** is being spent, perhaps unnecessarily, by a hospital discharge team on social work agency / sickness fees.

[1] We know of one hospital discharge team which formerly spent 45% of staff costs on agency and sickness, so we believe this to be a conservative figure for the purposes of modelling.

Fines are another simple example of expenditure being unnecessarily accrued as a result of DToC[2]. On average (according to NHS England statistics published for January 2017) there are 69,624 days of delayed transfer due to social care. If this figure is divided evenly between the 152 local authorities in England, it amounts to 458 days per local authority. If this is expressed in terms of financial fines (at £100 per day) it amounts to **£45,800** per local authority.

Taking these figures together, you could argue that local authorities are "spending" an average of £88,000 on DToC which may secure better results if channelled elsewhere. For example, if just 25% of this expenditure could be used as a wage increase for the 5 members of staff in our fictional example above, their salaries would each increase by an average of £4,400 (a 20% increase on the average salary of £22,434). Set in this context, it's possible that a fairly significant pay rise could be offered without extending beyond existing budgets

Of course this is an untested approach which assumes that sickness, agency, and DToC rates fall as a direct result of this pay increase. And ultimately, we just don't know what impact such a pay increase might have. We also don't know what affect it might have on the wider market for recruiting and retaining social workers.

But given the criticality of tackling DToC, we suggest this might be one of those occasions where a modest risk could be taken, on a small scale, to see what difference it makes.

[2] We appreciate that in reality these fines are rarely charged, however they remain a very real liability for the health and social care economy.