Rhestr y Gymuned Iechyd Integredig / The Integrated Health Community List

Comisiwn Bevan Commission

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Project Background:

Good information sharing between the Health Board and Local Authorities is needed to support effective and efficient hospital discharge.

To help address the information gap and support the aim of improved discharge, Council and Health Board staff in Gwynedd and Môn now have access to a list that merges and presents patient data extracted from the respective systems.

The list contains core patient data, hospital setting, Community Resource Team area, social worker, home care provider, and ward/community contact details.

"The list is a great help. I check it daily to find out where an individual is, and whether they've been moved from Ysbyty Gwynedd to one of the peripheral hospitals." *RE – Social Work Team Leader, Gwynedd*

Project Aims/Objectives:

- Work with Social Services teams and Ysbyty Gwynedd to improve discharge procedures, using the list as a key tool.
- Have earlier conversations around discharge and the support needed.
- Identify over-prescription of statutory care and divert to 3rd sector support if needed.

Project Approach:

Project officer appointed to support use of list within SW teams and wards.

Project officer to challenge overprescription of statutory home care by wards and look at community/3rd sector input.

Start by focusing on two wards and one (adults) social work team, then expanding to all wards.

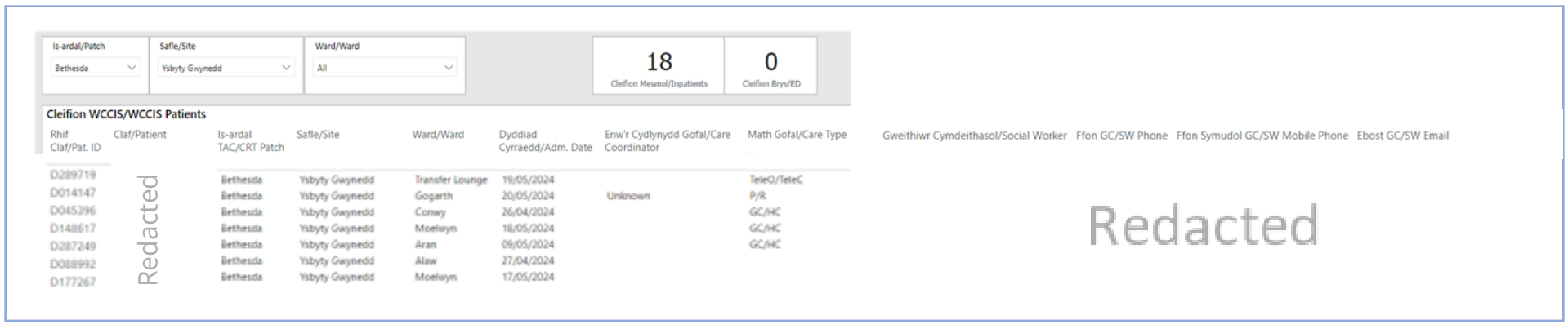
Project Outcomes:

Wales-wide interest in the list and its possible applications.

Support of senior leadership (HB & LA) to expand use of list.

Support of senior leadership (HB & LA) to continue exploring use of non-statutory support in discharge, using list as key tool.

"The list is like a direct hotline to every ward to see where people are and what their PDD (predicted discharge date) is. The team and I use it daily." *LLJ – Social Work Team Leader, Gwynedd*



Is-ardal/Patch: Bethesda | Safle/Site: Ysbyty Gwynedd | Ward/Ward: All

18 Cleifion Mewnol/Inpatients | 0 Cleifion Brys/ED

Cleifion WCCIS/WCCIS Patients

Rhif Claf/Pat. ID	Claf/Patient	Is-ardal TAC/CRT Patch	Safle/Site	Ward/Ward	Dyddiad Cyrraedd/Adm. Date	Enw'r Cydlynydd Gofal/Care Coordinator	Math Gofal/Care Type	Gweithiwr Cymdeithasol/Social Worker	Ffon GC/SW Phone	Ffon Symudol GC/SW Mobile Phone	Ebost GC/SW Email
D289719	Redacted	Bethesda	Ysbyty Gwynedd	Transfer Lounge	19/05/2024		TeleO/TeleC	Redacted			
D014147		Bethesda	Ysbyty Gwynedd	Gogarth	20/05/2024	Unknown	P/R				
D045396		Bethesda	Ysbyty Gwynedd	Conwy	26/04/2024		GC/HC				
D148617		Bethesda	Ysbyty Gwynedd	Moelwyn	18/05/2024		GC/HC				
D287249		Bethesda	Ysbyty Gwynedd	Aran	09/05/2024		GC/HC				
D088992		Bethesda	Ysbyty Gwynedd	Alaw	27/04/2024						
D177267		Bethesda	Ysbyty Gwynedd	Moelwyn	17/05/2024						

A snapshot of the list, filtered to show inpatients from the Bethesda CRT area in all wards in Ysbyty Gwynedd. A 'hover over' function provides further details e.g. ward phone number, NHS number, DOB, admission method and the Predicted Discharge Date.

Project Impact:

Social work teams are more proactive in their approach to hospital discharge.

Social work teams able to better plan discharge and coordinate with care providers.

Improved confidence within Social Work teams around discharge.

Easier for Social Work teams to contact wards to plan care and discharge.

Next Steps:

- Continued collaboration between LA and HB to develop end to end discharge process, with the list as a key tool
- Develop an approach to include non-statutory (3rd sector) support
- Expand to other counties
- Work on promoting the list within hospitals and among health board staff
- Discuss interest at national level
- Explore other potential applications of list and develop e.g. for CRTs
- Work with Social Work teams to analyse and compare with national data sets
- Improve data gathering and analysis within Social Work teams to make improvements

Key Conclusions:

- The list is useful, but much work is still needed around the hospital discharge system as a whole
- Inappropriate referrals for home care can be remedied by non-statutory support. Work is needed to develop this
- Progress is slow and not linear
- Issues around communication and information sharing persist – collaboration is not straightforward
- Change is hard
- Differing views around discharge are a barrier to change and improvement
- Jargon is a barrier – different interpretation by ward and community e.g. "baseline"
- Further development of the list would be beneficial, to include e.g. pharmacy and housing

"The list makes our work easier as we can check who is in hospital on a daily basis". *SEJ, Senior Manager, Adults Social Services, Gwynedd*