# Hospital discharge and its impact on patient flow through hospitals

The Board of Community Health Councils (the Board) is pleased to submit this consultation response on behalf of Community Health Councils (CHCs) in Wales.

CHCs are independent bodies that reflect the views and represent the interests of people living in Wales in their National Health Service (NHS). CHCs encourage and support people to have a voice in the design, planning and delivery of NHS services.

There are 7 CHCs in Wales. Each one is made up of local volunteer members who live in the communities they serve, supported by a small team of paid staff. Each CHC:

- Carries out regular visits to health services to hear from people using the service (and the people providing care) to influence the changes that can make a big difference

- Reaches out more widely to people within local communities to provide information, and to gather views and experiences of NHS services.

- CHCs use what they hear to check how services are performing overall and to make sure the NHS takes action to make things better where this is needed

- Gets involved with health service managers when they are thinking about making changes to the way services are

delivered so that people and communities have their say from the start

- Provides a complaints advocacy service that is free, independent and confidential to help people to raise their concerns about NHS care and treatment.

The Board of CHCs (the Board) exists to support, assist, advise and manage the performance of CHCs. It represents the collective views of CHCs across Wales.

## The scale of the current situation

CHCs continually hear that there are large numbers of people still in hospital who do not need to be there.

In the Gwent area alone, it has been reported that there are currently 284 patients who are well enough to leave hospital but are unable to do so because arrangements are not in place to support them to return home.

CHCs in other areas report similar, ongoing concerns.

## The impact of delays in hospital discharge

CHCs have heard for a number of years about the impact on people stuck in hospital for longer than they need to be. Our earlier report 'Time to go home[1]' published in January 2020, shared people's experiences, in their own words, of the impact on them and their loved ones of being in hospital longer than they needed to be.

Since then, CHCs have seen the stark reality of how these existing, long standing challenges have been made even worse because of COVID-19.

[1] "Time to go home? The impact of delays when people are well enough to leave hospital" January 2020 is available at the following link https://boardchc.nhs.wales/files/what-weve-heard-from-you/time-to-go-home/

We have continued to hear how longer stays in hospital increases people's risk of contracting COVID-19 (or other hospital acquired infection) and/or suffering a fall and sustaining a new injury whilst in hospital.

The longer people stay in hospital the greater the impact on their overall physical health, strength and mental wellbeing. People in hospital when they are well enough to go home worry about losing their independence and not being able to do the things they used to do.

They worry about their homes and loved ones, and the impact on them. This is often the case when the person in hospital is themselves the main carer for a loved one still at home.

The longer they stay in hospital the more care they are likely to need when they can finally leave and return to their home and community.

For lots of people stuck in hospital during the pandemic, their loneliness and isolation has been made worse because visiting restrictions has meant they aren't able to see their families and friends in person like they would have been able to before.

Health boards are doing lots of things to help people stay in touch, eg., through video conferencing and telephone, but nothing can replace sitting down with and being close to people they care about.

Delays in people being able to leave hospital impacts on people needing care and treatment across the whole health and care system:

- People needing an ambulance in the community are waiting longer because ambulances are often waiting for a long time at the hospital door to transfer someone into the care of hospital staff

- People arriving at the hospital in an ambulance are often waiting in the ambulance in discomfort for a long time before being transferred to the care of hospital staff

- People waiting for urgent and emergency care are often in pain for longer as they cannot be seen quickly in very busy urgent care and emergency departments

- People needing to be transferred to a ward from the emergency department are often waiting may hours in unsuitable, uncomfortable places

- People waiting for planned care and treatment are having their procedures cancelled or delayed because there isn't a hospital bed available for them.

In Aneurin Bevan UHB for example, its Quality and Patient Safety Committee (QPSC) recently highlighted a risk of "Failure to meet the needs of the population who require high levels of emergency supportive care and an inability to release ambulances promptly to respond to unmanaged community demand."

## The main pressure points and barriers to discharging hospital patients with care and support needs, including social care services capacity

CHCs are consistently hearing about the following issues contributing to people's delays in going back into the community:

- A lack of social care or domiciliary care services to support people back to their own home. We have heard about delays in social worker assessments, assessments at a person's home and a lack of care staff to provide social/domiciliary care.

  We recognise that there is a national shortage of care workers especially for domiciliary care and social workers. The acute impact of COVID-19 self-isolation is putting additional pressure on the existing health and social care staffing structure and is impacting on the ability for people

to return home.

- Care home/nursing home closures to new admissions due to COVID outbreaks in the home.

- Care home/nursing homes not accepting a person back to their care or a new resident because a person has continued to test positive for COVID, even though an extended period has lapsed since the person was still ill with COVID. e.g., some people continue to test positive some 60+ days since first contracting the virus, even though no symptoms have continued.

Swansea Bay University Health Board for example has a database that captures the number of patients that are clinically fit but have not been disharged. The top 6 reasons routinely reported are:

1. Social services process not completed
2. Package of care not in place
3. A health related process not completed, albeit the person is clinically fit for discharge
4. Transfer to other site
5. Therapy process
6. Nursing homes.

Aneurin Bevan University Health board's Quality and Patient Safety Committee has identified a range of things that are impacting on demand and continued lengths of stay in hospital.

This includes "Increasingly aging population with complex healthcare needs and requirements and Health Board's inability to respond to the demands of this cohort of patient demographic."

## Involving families and carers

The scale of the challenges facing health and care services has meant that health boards have increasingly taken to social media to actively encourage families to assist in the hospital discharge process on a short term basis until a care package is made available.

For many families and unpaid carers, this is something they are able and happy to do, as long as they are properly involved in and part of the discharge planning process.

People regularly share with CHCs how much they value:

- Being told well in advance about the arrangements needed for their or their loved ones discharge from hospital, so they can properly plan

- Being reassured that the arrangements for care after leaving hospital are safe and will meet their or their loved ones clinical and care needs

- Being fully involved as family members and carers in discharge planning discussions and arrangements so people do not feel hastily discharged because beds need to be released

When this doesn't happen, things feel very different, as shown by the story shared with us by one family member, in their own words:

"…..My mother received a call that he was being discharged and to please collect him. With all of the above injuries, he was discharged. The male nurse….who communicated with my mother, said …. had been signed off by all his medical teams, she was strong armed into taking home as he confirmed they needed the bed. …..was given his medication, put in a wheel chair and left on the pavement for collection.

This raises the following serious concerns:

- How can medication be given to a patient in such poor health to administer himself, his extensive brain damage does not allow him to comprehend this.
- No care plan offered
- No psychiatric follow ups

How can a 71 year woman get him up and down the stairs and provide him the care he needs

In short, this was an unsafe discharge from …… when he should have been moved to the Neuro ward or a ward where his mental health and brain damage could be monitored and properly assessed."

For others, they may simply not be in a position themselves to provide the kind of care and support the person they care for and about needs after leaving hospital. It's important that people are themselves provided with the advice, information and support they need to help them to care for others.

It's also important that people do not feel pressured into taking on more than they can reasonably do.

## What health boards are doing to tackle the issues

CHCs are hearing across Wales about the things their local health boards are doing to tackle the issues so that people are not stuck in hospital longer than they need to be.  Here's some examples:

### **Aneurin Bevan University Health Board** is:

- trialling the use of a complex discharge team at the Grange University Hospital

- introducing a "Discharge Improvement Board" to focus on actions to improve discharge arrangements.

- responding to peoples worries about returning home when needing increased care in the community following their stays. This is because they don't know what any of their home adaptions look like and whether their needs will be met.

  An occupational therapy team recorded a video of a patients newly adapted support at home to virtually walk the person around their home showing them the adaptions.

  The CHC heard this really helped managed the person's anxiety and they felt more comfortable with the plan to return home.

### **Cwm Taf Morgannwg University Health Board** is:

- Meeting several times a week with social care colleagues to maintain an agreed understanding of the position, the causes of delays, and the constraints in community services

- Working with a shared commitment to resolve delays, icnluding shared data and agreed priorities

- Establishing new alternatives, eg., temporary care home stays for those awaiting a home care package

- Working on recruiting a combined health and social care team in Bridgend.

**Hywel Dda University Health Board** has introduced a new 'bridging' scheme. This involves employing health support workers to work in the community to assist people post-discharge.

Some new recruits started in December 2021.

It is hoped that recruiting NHS staff to work in the community might be an enticement for applicants as people may prefer to be NHS employees because of the potential career opportunities it might generate.

So far the level of interest has not been as high as hoped.

**Swansea Bay University Health Board** is taking a range of actions working with local authorities. These include:

- a working group made up of health and social care teams focused on clearing the backlog of people who are fit to leave hospital
- an "enhanced management of clinically optimised patients group" is monitoring the number of people waiting to leave hospital, identifying the challenges and the actions needed in response and the effectiveness of the actions and interventions taken
- capturing better data and agreeing common terminology between the health board and local authorities
- identifying alternative settings for people ready to leave hospital, including care homes and step down arrangements
- Re-aligning its regional 'Hospital to Home' model to include a

range of services to support hospital discharge.

- Patients are discharged home from hospital to recover then assess (with wraparound support if required). This is linked to a new reablement package of care to maximise independence (for up to 6 weeks) or an existing package of care where reablement potential has been reached.
- A Business Case to support the expansion of this pathway, with a clinical in reach function to support timely assessment and discharge has been agreed by the Health Board
- A pilot of the hospital to home: discharge to assess pathway was launched in October 2021. Funding is provided for assessment beds (out of hospital) to facilitate a timely discharge from hospital in a place of the individuals choosing (to avoid unnecessary moves).
- The pathway is intended to allow patients to recover then be reabled / assessed and supported as their needs dictate (with multidisciplinary in-reach as appropriate) before a long term decision for their care needs are made.

## What else is needed to enable people to return home at the right time, with the right care and support in place, including access to reablement services and the consideration of housing needs

As well as the things already identified in earlier sections, health and care bodies need to routinely review, evaluate and share with each other locally and more widely:

- What approaches are working well
- what hasn't worked well and why
- how things can be further developed and extended where needed.

This review and evaluation work needs to focus on what works and what doesn't from the viewpoint of patients, service users, families

and carers – and so should routinely include gathering feedback from patients, service users and their families and carers.
It's also important to reduce the delay in hospital discharge by making sure there is adequate stock of home care, aids and adaptations and timely installation.

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